



CASEBOOK

This issue...

FROM THE CASE FILES

Our latest collection of case reports

RISK ALERT – ANTICOAGULANT MONITORING AND DOSING

Advice on how to lower the risks associated with prescribing anticoagulants

CHALLENGING INTERACTIONS WITH COLLEAGUES

How to maintain relationships and communicate effectively with colleagues

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WELCOME

Dr Marika Davies
EDITOR-IN-CHIEF



In this edition of *Casebook* we have a particular focus on communication, whether that is with a patient or with a colleague. In our experience, poor communication between doctor and patient, or doctor and colleague, is the root cause of many of the complaints, claims and disciplinary actions we see.

On page 6, we look at communicating with patients around the issue of consent. Many complaints and claims against our members stem from poor communication or poor documentation when seeking consent from a patient. This article explores the legislation governing consent and what it means for doctors.

On page 8, our director of education, Dr Mark Dinwoodie, takes a look at challenging interactions with colleagues. He provides practical tips, based on those in our Mastering Professional Interactions workshop, to help you through these difficult situations.

The case reports in this issue demonstrate yet again the importance of good history taking, performing appropriate examinations, communicating well with colleagues, and keeping full and complete clinical records. These themes are almost a permanent feature of our case reports, but this is because every day we see cases where a failure to do one or all of these has caused members difficulty.

I hope you enjoy this edition. We welcome all feedback, so please do contact us with your comments or if you have any ideas for topics you'd like us to cover.

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PROVIDING INFORMATION TO THE POLICE

Jennifer Pritchard offers advice on what to do if you are asked to provide records or information to the police

It is likely that, at some point in your career, you will be in a position where you are approached by the police and asked to give information. When the law is involved, the stakes are high, so it's advised that you contact one of our expert medical advisers before disclosing information about a patient. You should seek advice from us at the first available opportunity should allegations be made against you as a doctor. That being said, there are some important pieces of guidance to bear in mind when dealing with the police which can help ensure fairness and compliance for all parties.

The Medical Council of New Zealand (MCNZ) outlines your responsibilities as a doctor when it comes to investigations and legal processes. The MCNZ states that “you must cooperate fully with any formal inquiry or inquest”. However, it also makes it clear that “you have the right not to give evidence that may lead to criminal proceedings being taken against you”. When you do provide information, “you must be honest, accurate, objective and the information provided must be based on clear and relevant clinical evidence”¹.

There are two distinct circumstances in which you would have to provide information to the police. The more common scenario is that you, the doctor, are not the subject of the inquiry, and you are being asked to provide health information or records about a patient. Alternatively, and less frequently, doctors find themselves being investigated by the police, usually as a result of a complaint from a patient.

For most people, the gut reaction to being asked to help is to engage in discussion, provide a statement and answer questions. However, when it comes to police investigations, there are a number of legal dilemmas to be aware of. When asked to provide information by the police, you must ascertain why. Are they investigating a complaint? If so, are you implicated in the complaint? Are you the most appropriate

source from whom to get this information?

WHEN THE POLICE INQUIRY IS ABOUT THE PATIENT

It is likely that when the police are investigating a patient, they will ask you to disclose confidential information. This can be a legal obstacle course for doctors. In complying with a request for information, you may come under fire for violating the Privacy Act. If you are at all uncertain about whether or not to provide the information, contact Medical Protection at the earliest opportunity.

You do not have to release health information unless a court order, search warrant or production order has been obtained by the police. Otherwise, it is within your discretion whether or not to provide the health information, and you must take into consideration a number of factors such as:

- the seriousness of the alleged offence
- the extent to which the safety of a patient, or others, is threatened
- the potential for a serious breach of the law
- the sensitivity of the information requested
- the importance of protecting the therapeutic relationship.

Although it is not always appropriate or possible, you should try to discuss with the patient the police's request for information. Disclosing information without the patient's consent is provided for in the Health Information Privacy Code² but we advise that you contact one of our medical advisers in this situation.

WHEN YOU ARE THE SUBJECT OF THE POLICE INQUIRY

Being the subject of a police inquiry can happen to the best of us, and just because a doctor is accused, it does not mean they are guilty. Allegations can often arise from misunderstandings, and can be made against anyone. You should seek advice from a medical adviser at Medical Protection immediately. Each situation is very different, but in nearly every circumstance you should exercise your right to remain silent. There will be every opportunity to give a thorough statement once you've sought advice and been able to see the information held by the police.

Being asked to provide information to the police can be a daunting prospect, regardless of the situation, but we are on-hand to guide you through what can be a medicolegal minefield. Whatever the circumstance, keep calm, remember your rights, and always seek advice.

MORE ADVICE

If you find yourself facing any of the dilemmas outlined in this article, our medical advisers are on hand to provide advice and support.

To contact them call **0800 225 5677** (0800 CALL MPS) or email advice@mps.org.nz



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A PRACTICAL APPROACH TO CONSENT

Sam McCaffrey explains why the process of taking consent should be regarded as an opportunity to build trust in the doctor-patient relationship

As a doctor, you know that you need to obtain a patient's consent before beginning clinical treatment. But our experience of helping members – whether through a medical council investigation, or simply by offering professional advice – shows that taking valid consent, with a discussion and documentation of relevant risks, is not always as simple as it might seem.

THE IMPACT OF RECENT CASE LAW

One of the most challenging aspects of taking valid consent is judging how much information to give about the risks associated with a particular clinical treatment. Doctors have always relied on the principle that as long as they have acted reasonably, which is having given advice in accordance with a responsible body of medical opinion (the Bolam test), they will be protected. However, many countries have increasingly adopted the principle that doctors must take patients' needs into consideration when deciding how much to warn or inform them of risks and options. Cases such as *Rogers v Whitaker* in Australia and more recently *Montgomery* in the UK have reinforced this trend.

Cole's Medical Practice in New Zealand also acknowledges this change. It states: "Informed consent is more than getting a patient to sign a consent form. The consent form is merely the written acknowledgment of a process that provides the patient with sufficient information in order to make an informed decision about their treatment. It is a two-way communication process between a doctor and patient which results in the patient feeling confident that they have enough information to agree to undergo a specific medical intervention. It is also more than a one-off action. It is a process throughout all stages of treatment or procedure."

It also makes reference to the case of *B v Medical Council of New Zealand* (2005) in which "the high court stressed the importance of assessing the adequacy of information conveyed by a doctor to a patient from the viewpoint of the patient and warns that inadequate information will almost always be professional misconduct".¹

WHAT IS VALID CONSENT?

Valid consent requires the patient to be competent, to have given consent freely, and to have received and understood sufficient information to make an informed choice.

When taking consent, doctors have a duty to advise the patient on:

1. Treatment options including, where appropriate, the option of non-treatment, with a broad description of the processes and consequences of non-treatment
2. Benefits of the relevant treatment options available
3. Significant risks, such as common complications and rare, but catastrophic, complications
4. Material risks that are relevant to the particular (individual) patient, requiring consideration of the patient's particular circumstances, resulting in the doctor having to explain or emphasise some risks more than others, taking into account such things as the patient's job, pre-existing medical conditions or particular anxieties or concerns (*Rogers v Whitaker 1992*).

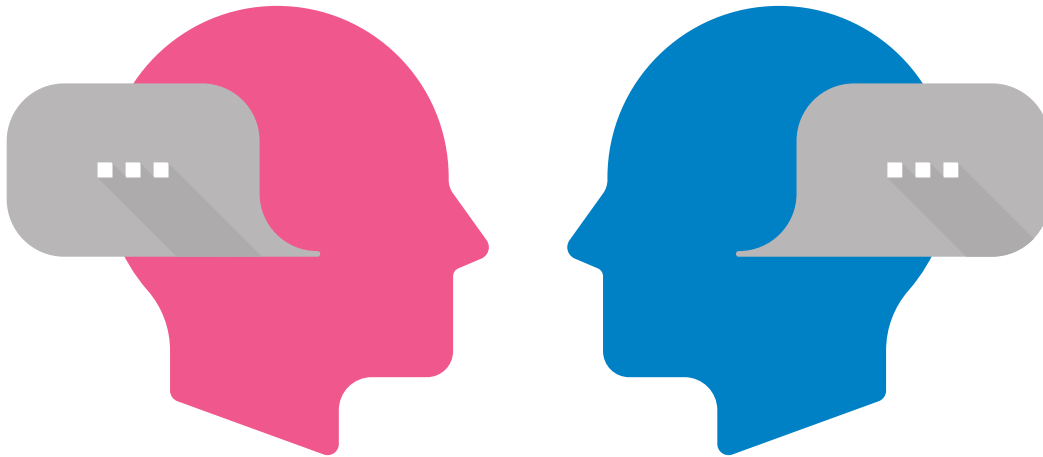
Giving advice on risks and complications is not merely providing a list; it must be explained clearly in a caring, non-adversarial and sympathetic manner, so that the patient can understand and weigh up the pros and cons. It is helpful to provide the information and advice in a balanced way, so that it is easier for patients to digest the information. Consider providing leaflets explaining the procedure or treatment.

You must also document clearly what was discussed and the relevant advice given. Good clinical record keeping is part of good medical practice.





Consent is a dialogue, where you have a responsibility to provide patients with an adequate explanation of their medical condition and options for treatment



CONSENT IS A DIALOGUE

Taking valid consent is not about quickly running through a consent checklist just before a clinical procedure takes place, nor is it just a patient's signature on a consent form or a tick box exercise.

Consent is a dialogue, where you have a responsibility to provide patients with an adequate explanation of their medical condition and options for treatment, so that they can participate in the decision-making process. If a clinical procedure needs to be performed, you should want to make the patient aware of the benefits, risks and possible complications of the procedure, and any alternatives.

For minor invasive procedures, verbal consent is acceptable and can be documented in the patient's notes. Written consent is required for major treatments, invasive procedures, and any treatment which carries significant risks.

If you are providing the treatment or performing the procedure, you are responsible for obtaining valid consent. At times when it is impractical or impossible for you to personally take consent, you must ensure that there is an appropriately qualified colleague or team member who can do this.

THE HEALTH AND DISABILITY COMMISSIONER

The majority of consent issues fall under right 6 of the Code of Health and Disability Services Consumers' Rights. Right 6 is the "Right to be Fully Informed", which states that providers have a duty to give "sufficient" information to the patient.

Complaints relating to the Code are considered by the Health and Disability Commissioner (HDC). A breach of right 6 may be found by the HDC regardless of whether the consumer would have chosen to proceed with the health services had the information been provided, and harm does not need to have been incurred.

If the HDC finds that a doctor has failed to comply with any right in the Code, they have a number of options available to them. These include referral to the MCNZ, or to the Director of Proceedings to consider laying charges in the Health Practitioners Disciplinary Tribunal or the Human Rights Review Tribunal; the latter has the power to award damages of up to \$200,000.

CONSENT PROTECTS YOU AND THE PATIENT

Valid consent protects the patient; they are part of the discussion about what will happen during their clinical treatment, and why. It also presents an opportunity to build trust in the doctor-patient relationship, which can help to lessen the likelihood of a complaint should something go wrong. Ensuring you have obtained valid consent protects you, the doctor, too.

For more help with consent and involving patients in the decision making process why not try our FREE workshops on *Mastering Shared Decision Making?*

To find out more and book a place, go to:

[medicalprotection.org/newzealand/events-e-learning](https://www.medicalprotection.org/newzealand/events-e-learning)



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CHALLENGING INTERACTIONS WITH COLLEAGUES

Poor communication between doctors lies at the heart of many complaints, claims, and disciplinary actions. Dr Mark Dinwoodie, Director of Education, explains the importance of maintaining good relationships with colleagues and communicating effectively with other health professionals

Interactions with colleagues can be one of the most challenging aspects of medicine. The people you work with have a profound effect on how you practise – colleague interactions can lighten the burden, or make it infinitely heavier.

Our experience is that poor communication between two or more doctors providing care to patients lies at the heart of many complaints, claims and disciplinary actions.

It is inevitable at some point throughout your career as a doctor that you will come across at least one colleague with whom you have issues working. It is therefore important to be aware of different strategies and techniques you can use to deal with this situation.

IDENTIFYING RISKS

There are many reasons why doctors may not communicate sufficient clinical information to their colleagues about patients under their care. These can include pressures of time, difficulty in accessing colleagues, and difficult relationships with them.

Changes in working patterns and the resultant increase in shift work and cross cover mean that more doctors may be involved in a patient's care. This has increased the risk of failures in communication because passing care between doctors (in a referral or a handover) increases the possibility that patient information will not be shared optimally. As a result, abnormal investigation results may be missed, treatments may be monitored inadequately, or important

comorbidities may not be taken into account, which all put the patient at risk of harm.

So what can you do to reduce the risk around interactions with difficult colleagues?

PICK YOUR BATTLES

Use your energy wisely – you might have several issues with colleagues but some will generate more risk to patients and yourself than others. It is wise to concentrate your efforts and energy on high risk areas with the best interests of the patient at the centre of discussions.

CATCH AND STOP RISKY ASSUMPTIONS

Assumptions are a common human error that we all make. They are especially prevalent when dealing with colleagues we dislike or find challenging. We can be more likely to make an assumption relating to clinical communication rather than check with that colleague. This generates a variety of risks that can lead to catastrophic outcomes.

Checklists can reduce this type of risk. They are a useful method of ensuring completeness of communication when referring a patient, and they can be used as memory aids or integrated into the records or correspondence. They also enable doctors to focus on more complex tasks by reducing the amount of information they need to remember and process at one time.

HANDOVER

Where all responsibility for patient care is being handed over – for example, to the hospital night team or to a GP colleague when going on leave – a handover model such as SBAR (situation, background, assessment, recommendation) or the MPS SHIFT[®] model (status of patient, history, investigations pending, fears of what may unfold, treatment planned) can be used to ensure all relevant information is passed on and recorded.

It can be useful to ask the recipient to repeat back a summary of what they have understood to confirm the accuracy of information transfer.

Other ways to reduce risk when passing care to a colleague include the use of information, technology systems to automate information transfer, as well as tracking systems for referrals, investigations and follow-up to ensure safe completion of processes. Patients may also be recruited to “check” the communication between colleagues – for example, a referral letter can be dictated in their presence or they can be given a copy of their discharge summary or clinic letter. Doctors should take action if the communication they receive about a patient is inadequate.

ACTIVELY MANAGE DISAGREEMENTS

Differences of opinion between doctors also pose a risk. Disagreements may arise over diagnosis, treatment or management, as well as interpretation of investigations, resource allocation, and end of life issues. The breakdown of a working relationship between doctors can have a detrimental effect on colleagues and patient care. When raising concerns with colleagues over disagreement about patient care you should emphasise the importance of achieving the best outcome for the patient, while maintaining dignity and respect for your colleague, and attempt to negotiate a mutually agreeable resolution.

If you think that a colleague is routinely putting you or your patient at risk through inadequate communication and your attempts to give subtle feedback have not been effective, you should raise your concerns with the colleague directly, making suggestions for improvements to enhance clinical communication and framing the conversation in terms of the risk to everyone concerned. You should emphasise that you are committed to taking action, document your concerns, and explain what you have done to tackle them. If that does not work you should discuss the matter with your clinical lead or defence organisation for support and advice on what to do next.

CASE STUDY

WE DON'T TALK ANYMORE

Mr Y, a 35-year-old marine engineer, was undergoing surgery to treat a congenital vascular lesion in the posterior compartment of the thigh. Mr O, consultant vascular surgeon, was carrying out the procedure. The lesion was closely related to the sciatic nerve and some of its branches, and Mr O was aware of the risk of damaging the sciatic bundle.

The anaesthetic was given by Dr A, consultant anaesthetist. During the induction phase Mr Y had suffered repeated generalised muscular spasms, so Dr A had given a muscle relaxant to prevent intraoperative movement of the surgical field.

Intraoperatively, Mr O used tactile stimulation to ascertain if a nerve that was likely to be compromised by his surgical approach was the sciatic nerve, or a branch of the peroneal nerve. Reassured by a lack of contraction of relevant muscle groups, he continued to operate under the impression that the structure about which he was concerned was not the sciatic nerve.

Unfortunately, in the context of neuromuscular blockade, there was no rationale for this approach. It transpired that Mr Y suffered severe foot drop as a result of extensive damage to the sciatic nerve. Mr Y made a complaint about Mr O as a result of his injuries.

The case hinged on whether Mr O had taken sufficient care in establishing the relevant anatomy during surgery. Dr A had documented in the anaesthetic record that he had given the muscle relaxant, and was adamant that he had told Mr O this fact. Mr O was insistent that Dr A had not informed him about the administration of the drug and so had left him open to the error that he made.

During an investigation of events surrounding the case it emerged there were unresolved investigations into allegations of bullying and harassment between Mr O and Dr A and they were barely on speaking terms.

The case went to the Health and Disability Commissioner (HDC) who opined that concerns specific to the case and patient must be raised by any member of the theatre team who is aware of them. All team members have a responsibility to raise issues and ask questions, and they must promote an organisational culture that encourages this. The HDC found Mr O and Dr A to be in breach of the Code of Rights for failing to co-operate to ensure quality and continuity of services.

The HDC recommended Mr O and Dr A apologise to the patient, and referred the matter to the MCNZ to investigate the doctors' conduct.

LEARNING POINTS

- Effective clinical communication between healthcare professionals is essential for safe patient care. In the context of an operating theatre, where there are anaesthetic factors that may have an impact on the surgical outcome (and vice versa), it is vital that this information is shared.
- Unresolved personal or professional disagreements between healthcare professionals who share responsibility for patients are potentially prejudicial to patient care. It is the responsibility of all who work in the clinical team, and those who manage them, to make sure that patients are protected from any adverse outcome that results from doctors not working together properly. The wellbeing of patients must always significantly outweigh the personal disagreements of doctors.
- The rights and wrongs of any argument come second to their conduct. Both individuals could find themselves the subject of investigation by the regulatory authorities.
- Independent, external professional assistance with conflict resolution may sometimes be necessary and can be extremely effective.

The case mentioned in this article is fictional and is used purely for educational purposes.

For more help in dealing with clinical communication between colleagues why not try our FREE workshops on *Mastering Professional Interactions*? To find out more and book a place, go to: [medicalprotection.org/newzealand/events-e-learning](https://www.medicalprotection.org/newzealand/events-e-learning)

RISK ALERT

ANTICOAGULANT MONITORING AND DOSING

Julie Price, Head of Risk Management and Education Consultancy, provides advice on how to lower the risks associated with prescribing anticoagulants

Around 43.1 million prescription items were issued in primary care in New Zealand in 2015, costing around \$795 million.¹ According to the PRACTiCe study (2012),² one in 20 prescription items was associated with a clinically important error, and one in 550 was associated with a serious error. Prescribing errors in primary care can cause considerable harm, with adverse drug events accounting for around 7% of hospital admissions in the UK, and half of these are judged to be preventable.³

Evidence from a systematic literature review⁴ revealed that 47% of all serious medication errors were caused by seven drugs or drug classes:

- methotrexate
- warfarin
- nonsteroidal anti-inflammatory drugs (NSAIDs)
- digoxin
- opioids
- aspirin
- beta-blockers.

Warfarin is the medicine most frequently associated with adverse drug reactions in New Zealand.⁵

There are common themes where safety incidents relating to anticoagulants occur, and we have compiled risk management advice for each:

FAILURE TO MONITOR

- It is essential that a practice has a robust monitoring system in place. Always check INR results before generating repeat prescriptions for warfarin.
- The practice should also implement appropriate strategies to ensure non-attendees are identified and monitored. If a patient fails to attend for a blood test, the practice should schedule a new appointment within one week.
- If no result is available, for example if the patient has undergone the test in a community laboratory, the GP should telephone the laboratory to request the result. Discuss with the community medical laboratory how INR results could be delivered to the practice prior to issuing a prescription or advising the patient of a dose change.
- The National Patient Safety Agency (NPSA) in the UK states: “Ensure that before issuing a repeat prescription for anticoagulant medication, the GP checks that the patient’s INR is being monitored regularly and that it is at a safe level for the repeat prescription to be issued. The easiest way to do this is to ask to see the patient-held INR record, which may be in the form of a single printed sheet, a small booklet or another format used locally.”⁶ In New Zealand, many practices use screening templates that are available in the Practice Management Software (PMS) system, which allow easy tracking of INR results, dosage and when the next test is due.
- The patient’s red warfarin booklet should be updated at every INR test. If this booklet is not available, a temporary record booklet must be completed and given to the patient. The patient should be encouraged to take the booklet to every appointment.
- If, as is common, patients are having their warfarin levels monitored in a pharmacy, it is important that the pharmacist notify the GP of this and provide the GP with a copy of the patient’s INR on each occasion it is measured.

WRONG DOSE/STRENGTH

- The NPSA also states: “It is essential for the safe use of anticoagulants that patients and carers receive adequate verbal and written information about their treatment. This information should be provided before the first dose of anticoagulant is administered, and reinforced at hospital discharge, at the first anticoagulant clinic appointment, and when necessary throughout the course of their treatment. It is important that the healthcare practitioner who first provides this information records in the patient’s healthcare records that this information has been supplied.”⁷
- In New Zealand, there are two brands of warfarin available. Coumadin is available in 1mg, 2mg and 5mg strengths. Marevan is available in 1mg, 3mg and 5mg strengths. It is important to remember that the two brands are NOT interchangeable, and the patient should be stabilised on one brand and then stay on that.

CONTRAINDICATIONS AND INTERACTIONS

- Before starting warfarin, it is important to consider possible contraindications, and where warfarin is being used to reduce stroke risk in atrial fibrillation the HAS-BLED score should be calculated, discussed with the patient, and this discussion should be documented in the notes. The HAS-BLED score helps to estimate the risk of a major bleed for a patient with atrial fibrillation who is taking warfarin.⁸
- It is important that prescribers consider interactions between warfarin and commonly prescribed medicines or complementary medicines. Do not overlook over-the-counter and herbal products; certain food substances can also interact with prescribed medication. Prescribers should refer to New Zealand Formulary online⁹ for a list of drugs known to interact with warfarin.
- Advise the patient to inform a healthcare professional (including anticoagulant clinic staff, GP, dentist, pharmacist, or nursing staff) of changes to their lifestyle, for instance, if he/she starts, stops or changes



the dose of other medications. Other medicines include not only prescribed drugs, but also products that may be bought without a prescription, such as aspirin and medicines containing aspirin, vitamins, food supplements, and herbal or homeopathic remedies.¹⁰

- If an antibiotic or other medication which may cause an interaction is being started on a patient with warfarin, the prescribing clinician must ensure that an INR test will be taken three days after starting the new medication and the warfarin level adjusted as necessary.¹¹

COMMUNICATION ISSUES ACROSS CARE SETTINGS

Discharge arrangements for warfarin monitoring should be clearly established and documented. Responsibility for the discharge arrangements lies with the clinician referring the patient. Patients should remain the responsibility of the hospital team until arrangements and agreement have been made with the GP to take over.

The front of the patient's red warfarin booklet should be completed to include the indication of treatment, INR target range, duration of treatment, person with clinical responsibility and emergency contact number. The patient's GP should contact the initiating hospital if any of these details are omitted.

DELEGATION OF ANTICOAGULANT MONITORING TO OTHER HEALTHCARE PROFESSIONALS

In our experience, GPs frequently delegate the role of anticoagulant monitoring (and sometimes dosing) to other healthcare professionals such as practice nurses, practice pharmacists or healthcare assistants. Many practices use *The Best Practice Advocacy Centre New Zealand (BPACNZ)* guidelines for making decisions on dosage.¹²

In *Good Medical Practice*,¹³ the MCNZ makes clear that if a GP delegates this task to another healthcare professional, the GP must ensure that the healthcare professional is trained and competent to undertake the tasks delegated to him/her, and that accountability is clear. He/she should be supervised and work to practice protocols.

It is important to have a robust protocol in place for monitoring those patients who are taking warfarin. This should be reviewed regularly, and issues raised about the system in place addressed. The protocol should ensure all of the following:

- all INR test results are received and appropriate action taken
- patients are aware of how they will be informed of their INR result, dosing instructions and recall date
- patients with specific needs are identified and appropriately managed (for example, where there are communication problems and patients in social care settings).

The protocol should be available to all staff, including locums, be signed and dated by staff and reviewed on a regular basis. Warfarin clinic practitioners should also follow other relevant protocols, including infection control, needlestick injuries, venous sampling, disposal of clinical waste and spillages.



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BEING PROACTIVE ABOUT PRIVACY



Charles Mabbett, Senior Communications Adviser in the Office of the Privacy Commissioner, discusses a recent complaint that demonstrates the importance of taking a proactive approach to information security

One of the foundations of New Zealand's privacy law is the obligation for organisations to keep personal information safe. Every year, the Office of the Privacy Commissioner receives more than 800 complaints from people who say that their privacy has been interfered with in some way. About 13% of those relate to patients and their experiences in the health system.

When we resolve a complaint, we usually make a judgment about whether the case has lessons for other organisations. The following case study is a real example and we think it may be of interest to Casebook readers.

CASE STUDY

We received a complaint from an employee of a large health agency. The complainant, Miss X, had been notified by the agency that a former colleague of hers, Miss Y, had been dismissed for accessing her health records without proper reason. Miss X and Miss Y had worked in administrative roles but had access to health and medical information.

The records "browsed" by Miss Y included extremely sensitive emergency department and mental health information about Miss X. Miss X's records were accessed on numerous occasions over two years. This showed a pattern of behaviour and gave meaning and context to some comments her former colleagues had made about her health while they worked together.

After finding out about this, the complainant asked for an audit of access to her records so she could be sure none of her other colleagues had inappropriately accessed her information.

The access audit revealed a further instance of browsing of Miss X's health information by another former colleague. This was especially distressing for Miss X because it renewed her concerns that her colleagues had treated her unfairly and had been sharing sensitive

information about her with each other.

Both Miss X and the health agency agreed to participate in a mediation arranged by our office. The mediation was successful and the health agency, following on from earlier apologies, provided a formal apology and agreed to provide financial compensation for the harm caused to Miss X. The health agency also undertook an independent review of its information audit process to reduce the risk of this happening again and went on to carry out the recommended changes.

LEARNING POINTS

It is important that agencies take a proactive approach to information security and make continuing efforts to put in place and improve their security processes. Inappropriate access to personal information by employees, called 'employee browsing', is a problem for many large agencies.

The Health Information Privacy Code requires an agency to ensure that reasonable security safeguards exist to prevent loss, unauthorised access or disclosure of the health information it holds. This is specified in rule 5 of the Code.

Assessing what is reasonable depends on the sensitivity or confidentiality of the information involved. Reasonable also depends on the ease with which safeguards can be put in place to protect the information. An agency's policies and practices are relevant factors.

Some of the tools an agency can employ to help maintain a good culture of privacy include system audits, staff training, policies and technology upgrades.

Although the health agency in this case took a proactive, sympathetic and responsible approach to the interference with Miss X's privacy, it had limited measures in place to catch inappropriate access to its files.

The extent of the browsing and length of time before detection also indicate that

its safeguards were not good enough. The browsing took place over many months and was not an isolated incident. The fact that people Miss X worked with were responsible heightened her feelings of violation and humiliation.

The harm suffered by Miss X was ongoing and substantial. She experienced high levels of anxiety, nightmares, and was fearful of further browsing of her health information. She also felt any future employment at the agency was impossible because not only did she feel her reputation had been damaged, she no longer trusted the organisation.

This is one example of how our office works to settle privacy complaints and disputes. If you, your practice or health agency encounters a privacy issue, we encourage you to contact our office for advice. We also have a range of resources and tools to help health professionals. Visit [privacy.org.nz](https://www.privacy.org.nz) to find out more.

WHAT DO YOU THINK?

We want to hear from you. Send your comments to: casebook@medicalprotection.org



FROM THE CASE FILES

Dr Janet Page, Medical Claims Adviser, introduces this edition's case reports



Join the discussion about this edition's case reports. Visit [medicalprotection.org](https://www.medicalprotection.org) and click on the 'Casebook and Resources' tab.

In a world in which technological advances and medical innovation abound, it is very easy to overlook the importance of the fundamental clinical skills of history taking and clinical examination. Yet, as some of the cases you will be reading about in this edition illustrate, a few extra minutes taken to ask pertinent questions and perform relevant examinations pays dividends. Not only may it result in an earlier diagnosis and improved outcome for the patient, but it could also reduce the risk of a complaint or a clinical negligence claim.

In 'Tunnel vision', having failed to take a proper history at the first consultation, Mrs O's doctors fell into the trap of going along with the earlier presumptive diagnosis. Despite repeated attendances by the patient with worsening symptoms, no further history was elicited and no examination undertaken. The correct diagnosis was ultimately made when Mrs O collapsed, resulting in an emergency admission to the local hospital.

In 'Tripped up', Master Y was reviewed twice by his GPs, Dr E and Dr B, three and seven weeks after his fall when he was still complaining of unremitting pain, but despite this there was no attempt to revisit the history and review the original diagnosis. It was only by chance that an unrelated abnormality on a knee x-ray prompted orthopaedic referral which led to the correct diagnosis being made.

Making a diagnosis is particularly challenging for patients with more than one co-existing condition, as illustrated in 'Back to front'. In this case, a careful review of the character of Mr W's pain after he failed to respond to treatment may have prompted consideration of alternative diagnoses.

Communication and process errors are other themes emerging from this edition's case reports. In Mr T's case, an abnormal MSU result was marked as normal and filed in the records without action. Notwithstanding that Dr W had no record of having received the health screener's letter, the practice's failure to communicate the abnormal result to the patient or to flag it up in the records led to further

actions, which compounded the problem and was indefensible. 'Turning a blind eye' is another example of how a failure to communicate an abnormal result to a patient can have devastating consequences. In this case Dr L, in his desire not to alarm the patient or to disclose sensitive information in a letter, failed to convey to Mrs R the urgency of his request such that she chose to ignore it. In such circumstances it is imperative that the request is followed up if the patient fails to attend within the anticipated timeframe.

Poor communication between healthcare providers can also lead to problems, as illustrated by 'A risk of harm' and 'Paediatric brain injury'. In both cases the failure to give clear, explicit and documented instructions to nursing staff led to a misunderstanding as to the level of observation required, which contributed to a delay in treatment of a post-operative complication in BC's case and to Miss A suffering serious harm.

Finally, time and time again, we see the impact of poor record keeping on our ability to defend our members' actions, particularly when it comes to issues of consent and providing evidence of discussions of risks and complications. The case of Mrs W and Mr D is no exception. Master Y's doctors, Dr E and Dr B, are also criticised for their poor record keeping, and our GP expert in that case remarks on the discrepancy between their described usual practice and the paucity of the records. Today's doctors are practising in an increasingly pressured and challenging environment in which the temptation to take shortcuts is a strong one. By continuing to practise those core skills of history taking, clinical examination and communication, doctors can reduce substantially the risk of an adverse outcome and provide safer and more reliable care to their patients.

Case outcomes

These cases are selected from Medical Protection's international case load and are offered as examples for members to learn from. In New Zealand cases are handled differently due to the ACC and are rarely settled or litigated. Possible outcomes for doctors involved in similar cases could include being found in breach of the HDC Code of Rights, referral to the MCNZ for a review of competency, or even charges in the Health Practitioners Disciplinary Tribunal.

A HIDDEN PROBLEM

A failure to act on an abnormal test result means a serious diagnosis is missed

Mr T, a 40-year-old accountant, attended a private health check under his employer's healthcare scheme. Blood and protein were noted on urinalysis and his eGFR was found to be 45 ml/min/1.73 m². He was asked to make an appointment with his GP and was given a letter highlighting the abnormal results to take with him.

Mr T saw his GP, Dr W, shortly after and told her that blood had been found in his urine on dip testing during a health check. Dr W arranged for an MSU to be sent to the laboratory. The MSU showed no infection or raised white cells but did confirm the presence of red blood cells. Unfortunately the result was marked as "normal" and filed in the notes without any action.

A year later Mr T saw Dr W again with a painful neck following a road traffic accident. Dr W prescribed diclofenac tablets to help with the discomfort. A week later he booked an urgent appointment because he had developed a severe headache and felt very lethargic and breathless. He was seen by Dr A, who diagnosed a chest infection and prescribed a course of amoxicillin.

Mr T went home but was taken to hospital later the same day following a fit. He was subsequently diagnosed with malignant hypertension and severe renal failure with pulmonary oedema. Again, blood and protein were found in his urine but this time his eGFR was 12 ml/min/1.73 m². Mr T stabilised but needed assessment for possible kidney transplantation.

Mr T was angry and upset about the care he had received from his GP. He alleged that he had given Dr W a letter from the healthcare assessment when he consulted with her and that she had failed to act on it. He also alleged that Dr W had failed to diagnose his renal disease or refer him to the renal team. He claimed that this delay had resulted in progression of his condition to end stage renal failure.



EXPERT OPINION

Medical Protection sought the advice of a consultant nephrologist, Dr B. Dr B was of the opinion that Mr T's renal impairment was probably due to glomerulosclerotic disease rather than hypertension, at the time of the health check. He felt that the diclofenac prescribed caused the clinical situation to deteriorate, leading to the acute presentation of severe hypertension and renal failure. He advised that if Mr T's condition had been diagnosed earlier, this would have allowed monitoring and control of his blood pressure. It would also have been unlikely that NSAIDs would have been prescribed, thus avoiding the acute presentation. It was Dr B's opinion that earlier diagnosis and treatment would have delayed the need for renal transplant by a period of between two to four years.

Dr W specifically denied that she had been given the letter from the private health check and indeed there was no evidence of it within the GP records. She did however accept that she had erroneously marked the MSU result as normal and had thus not taken any action. In view of this, it was agreed that Dr W was in breach of duty in this matter and the case was settled for a high sum.

Learning points

- This case raises issues about communication between healthcare providers. Doctors should seek the patient's permission for, and explain the benefits of, sharing relevant information with other health practitioners and agencies involved in their care, including their GP. Once you have the patient's permission to share information, you must provide your colleagues with the information they need to ensure that the patient receives appropriate care without delay.¹ Doctors need to consider whether their systems for receiving and recording information, written or verbal, from other healthcare providers are sufficiently robust.
- Mistakes can be easily made when working under stress with high workloads. It is important, however, to be thorough and to ensure that all elements of a test result are reviewed before marking the result as normal.
- The assessment and management of non-visible haematuria in primary care is discussed in a useful clinical review published by *The BMJ* in 2009.²

AF

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1. MCNZ, *Good Medical Practice* (2016) mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf
2. Kelly JD, Fawcett DP and Goldberg LC, Assessment and Management of Non-visible Haematuria in Primary Care, *BMJ* 338: a3021(2009)

DIATHERMY DRAMA

Minor surgery to remove a skin tag is complicated by an unexpected event



Mr P was a 32-year-old runner. He had a skin tag on his back that kept catching on his clothes when he ran. It had become quite sore on a few occasions and he was keen to have it removed. He saw his GP, Dr N, who offered to remove the skin tag in one of his minor surgery sessions.

The following week, Mr P attended the minor surgery clinic at his GP practice. Dr N explained that he was going to use diathermy to remove the skin tag and Mr P signed a consent form.

Mr P lay on the couch and a sterile paper sheet was tucked under him. The assisting nurse sprayed his skin with a topical cryo-analgesic. The spray pooled on his back and soaked into the paper sheet. No time was left for the alcohol-based spray to evaporate. Mr P's back was still wet when Dr N began the diathermy to remove the skin tag. Unfortunately, the paper sheet caught fire along with the pooled spray on his back. Mr P suffered a superficial burn. Dr N and the nurse apologised immediately and applied wet towels and an ice pack. The burn area was treated with Flamazine cream and dressings. Mr P was left with a burn the size of a palm on his back which took two months to heal fully.

Mr P made a claim against Dr N, alleging that his painful burn had been the result of medical negligence. It is well known that alcohol-based solutions pose a risk of fire when diathermy is used, and in failing to ensure the area was dry before applying the diathermy Dr N was clearly in breach of his duty of care. Medical Protection was able to settle the claim quickly, thus avoiding unnecessary escalation of legal costs.

Learning points

- Flammable fluids employed for skin preparation must be used with caution. GP practices should refer to safety data sheets before using these products.
- The UK Medicines and Healthcare products Regulatory Agency (MHRA) warns that "spirit-based skin preparation fluid should not be allowed to pool and should be dry or dried before electro-surgery commences".¹
- The fire triangle is a simple model illustrating the three necessary ingredients for most fires to ignite: heat, fuel, and oxygen. In clinical situations such as the one described above, diathermy provides the heat and skin preparation fluids provide the fuel.²
- When a medical error occurs it is important to document the incident as soon as possible after it has happened. This should include the date, time, and location of events. It is best practice to apologise as openness and honesty can help to prevent formal complaints.³ Where appropriate, you should also complete an ACC treatment injury claim form for the patient.

REFERENCES

1. Medicines and Healthcare Products Regulatory Agency, *Use of Spirit-based Solutions During Surgical Procedures Requiring the use of Electrosurgical Equipment*, London: MHRA (2000)
2. Rocos B, Donaldson L, Alcohol Skin Preparation Causes Surgical Fires, *Annals of the Royal College of Surgeons of England*. 94(2):87-89 (2012)
3. MCNZ, *Disclosure of Harm Following an Adverse Event*, mcnz.org.nz/assets/News-and-Publications/Statements/Disclosure-of-harm.pdf

TURNING A BLIND EYE

A delay in sharing an urgent result with a patient results in a loss of vision

Mrs R, a 56-year-old freelance journalist, became aware she had reduced vision in her right eye. She saw her optician who noted that her visual acuity was 6/18 in the right eye and 6/6 in the left eye. Examination confirmed a nasal visual field defect in the right eye with a normal visual field in the left eye. The right optic disc was atrophic but the left appeared normal. Mrs R's optician referred her to the local ophthalmology emergency unit, where Dr S confirmed his findings and also detected a right afferent pupillary defect and reduced colour vision in the right eye. He made a diagnosis of right optic atrophy and arranged blood tests to investigate this further.

Two weeks later Dr S received a telephone call from the virology department informing him that Mrs R had tested positive for syphilis. Dr S immediately contacted Mrs R's GP, Dr L, informing him of the result and the need for urgent treatment.

On the same day, Dr L wrote a letter to Mrs R asking her to book an appointment. His letter said: "Please be advised that this is a routine appointment, and there is no need for you to be alarmed."

Mrs R did not take this letter seriously and no appointment was made. Dr L did not pursue the matter.

Seven months later, Mrs R was referred to Dr D in the neuro-ophthalmology clinic for deteriorating vision affecting both eyes. Dr D diagnosed bilateral optic atrophy and repeated the blood tests for syphilis. He arranged for Mrs R to be admitted to hospital, where lumbar puncture and examination of the cerebrospinal fluid confirmed the diagnosis of neuro-syphilis.

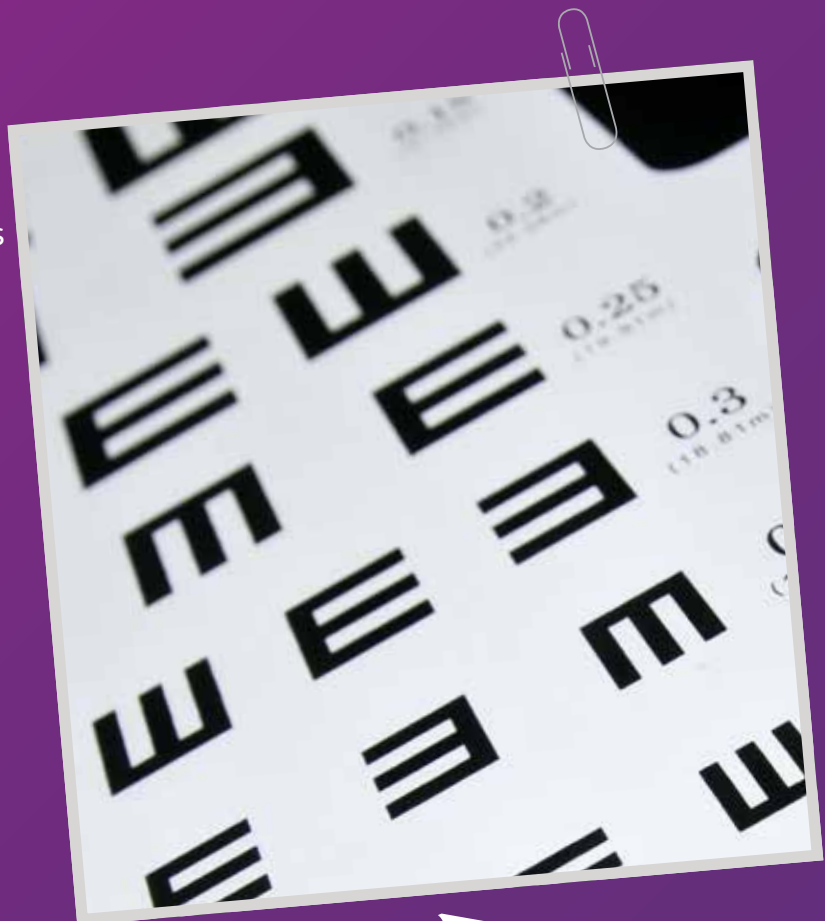
Mrs R was treated with penicillin and corticosteroids, which cleared the infection. Post-treatment visual acuity in the left eye was 6/5 but she had a severely reduced field of vision. In the right eye her visual acuity was light perception only. Although these changes had stabilised, Mrs R was assessed as legally blind.

Mrs R brought a case against her GP alleging that the delay in treatment led to her losing her sight. Due to this she had lost her driving licence which substantially reduced her earning capacity.

EXPERT OPINION

A GP expert considered that in failing to follow up on an important laboratory result, Dr L was in breach of his duty of care. Ophthalmology expert opinion concluded that the delay in treatment resulted in loss of the remaining 50% of vision in the right eye and 80% of vision in the left eye. The loss of sight impacted substantially on Mrs R's lifestyle and earning capacity. Both the virology department and the ophthalmologist were deemed to have acted appropriately and promptly.

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



Learning points

- When faced with a serious condition requiring urgent treatment you should be diligent in your attempts to communicate this to the patient promptly and sensitively.
- When communicating urgent information to colleagues, direct conversations are the most effective. It may be useful to follow a conversation with a letter as this may reinforce a point and prompt further action. A letter on its own may be insufficient in that it may be mislaid, misfiled or the importance not understood.
- When communicating sensitive information to patients, a face-to-face consultation is most appropriate. Communicating such information in writing could lead to misunderstanding, a breach of confidentiality, or may downplay the urgency of the matter.
- Be aware of local practice: the management of neuro-syphilis is often initiated through neurology or medical teams and the ophthalmologist should consider direct referral when the condition is sight threatening. Ophthalmologists should also be prepared to discuss laboratory results with patients and, where appropriate, emphasise the need for prompt treatment.
- In New Zealand, it would be unusual clinical practice for a GP to be requested to take responsibility for treatment in this situation. However, if the handover of care had been clear and accepted by the GP, then the GP would bear primary responsibility for not taking action.

AK

TRIPPED UP

A child is unable to weight bear after a fall



Master Y, aged nine, was walking home from school when he tripped over and fell. He was usually very stoical but after the fall he cried with pain when he tried to stand on his right leg. His mother took him into the local Emergency Department (ED) where, after a brief examination, he was discharged home with a diagnosis of a torn quadriceps muscle. No x-rays were taken. He was advised to avoid weight bearing for two weeks.

Master Y was no better three weeks later. His mother rang their GP, Dr E, who saw him the same day. Dr E noted the history of a fall and recorded only “tenderness” and “advised NSAID gel and paracetamol”.

Master Y continued to complain of pain in his thigh and also his knee. A month later, he saw another GP, Dr B, who assessed him and diagnosed “musculoskeletal pain”. There was no record of any examination. Master Y’s knee pain continued over the next month. Dr B reviewed him and arranged an x-ray of his knee. The only entry on the records was “pain and swelling right knee”.

The x-ray showed signs of osteoporosis and features consistent with possible traumatic injury to the right proximal tibial growth plate. The report advised an urgent orthopaedic opinion, which Dr B arranged.

The orthopaedic surgeon noted an externally rotated and shortened right leg. An urgent MRI revealed a right-sided slipped upper femoral epiphysis and Master Y underwent surgery to stabilise it. The displacement was such that an osteotomy was required later to address residual deformity.

Despite extensive surgery Master Y was left with a short-legged gait and by the age of 16 he was increasingly incapacitated by pain in his right hip. Surgeons considered that he would need a total hip replacement within 10 years, and that a revision procedure would almost certainly be required approximately 20 years after that.

his slipped upper femoral epiphysis. It was alleged that they failed to conduct sufficiently thorough examinations, arrange imaging and refer for timely orthopaedic assessment.

EXPERT OPINION

Medical Protection instructed a GP expert who was critical of both GPs’ unacceptably brief documentation. He noted the discrepancy between what was actually written down by the GPs in the contemporaneous records and their subsequent recollection of their normal practice. The expert felt that their care fell below a reasonable standard.

Medical Protection also obtained an opinion from a consultant orthopaedic surgeon. The expert was critical of the assessment

undertaken in the ED and advised that knee pain can be a feature of slipped upper femoral epiphysis. The expert considered that the fall caused a minor slippage of the right upper femoral epiphysis which was a surgical emergency and the appropriate management would have been admission for pinning of the epiphysis in situ. In the presence of a slight slip and subsequent fusion of the epiphysis, recovery without functional disability would have been expected. As a consequence of failure to diagnose an early slip, Master Y lost the chance of early correction. Instead, he developed a chronic slippage with associated disability necessitating osteotomy.

The case was settled for a high sum, with a contribution from the hospital.

Learning points

- Slipped upper femoral epiphysis is a rare condition in general practice. It usually occurs between the ages of eight and 15 and is more common in obese children. It should be considered in the differential diagnosis of hip and knee pain in this age group.
- Because patients often present with poorly localised pain in the hip, groin, thigh or knee, it is one of the most commonly missed diagnoses in children.¹ In 15% of cases, knee or distal thigh pain is the presenting feature. Referred pain can cause diagnostic error and orthopaedic examination should include examination of the joints above and below the symptomatic joint.
- The medical records were inconsistent with the GPs’ accounts. When records are poor it is very difficult to successfully defend a doctor’s care. The MCNZ² requires that “you must keep clear and accurate patient records that report all of the following:
 - relevant clinical information
 - options discussed
 - decisions made and the reasons for them
 - information given to patients
 - the proposed management plan
 - any medication or other treatment prescribed.”
- Safety-netting is important and follow-up should be arranged if patients are not improving or responding to treatment. This should prompt a thorough review and reconsideration of the original diagnosis.

AF

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1. Peck D, Slipped Capital Upper Femoral Epiphysis: Diagnosis and Management, *Am Fam Physician* 82(3):258–62 (2010)
2. MCNZ, *Good Medical Practice* (2016)

A claim was brought against GPs Dr E and Dr B, and the hospital for failing to diagnose

TUNNEL VISION

A patient presents several times with a worrying vaginal discharge

Mrs O, a 34-year-old mother of three, visited her GP with a two-month history of worsening vaginal discharge which had recently become malodorous. Her husband had urged her to see the doctor as he was particularly concerned when she had admitted to the discharge being blood-stained.

The first GP she saw, Dr A, took a cursory history and simply suggested she should make an appointment with the local sexual health clinic. Of note, Dr A didn't enquire about the nature of the discharge, associated symptoms or note that she had not attended for a smear for over five years, despite invitations to do so. Dr A did not examine Mrs O, nor did he arrange investigations or appropriate follow-up. Mrs L was deeply offended that Dr A had implied the discharge was likely to be secondary to a sexually transmitted infection and did not feel the need to attend a sexual health clinic.

She re-presented to another GP, Dr B, several months later complaining that her discharge had worsened. Dr B reviewed the previous notes and encouraged her to make an appointment with the sexual health clinic as previously recommended by Dr A. There was no evidence from the notes that a fresh review of the history had been undertaken. No examination was performed and Dr B did not arrange vaginal swabs or scans despite Mrs O's continued discharge.

A week later, Mrs O re-attended the surgery where Dr B agreed to try empirical clotrimazole on the premise she may be suffering from thrush. Again, no examination or investigations were discussed, and there was no evidence of safety-netting advice documented in the records.

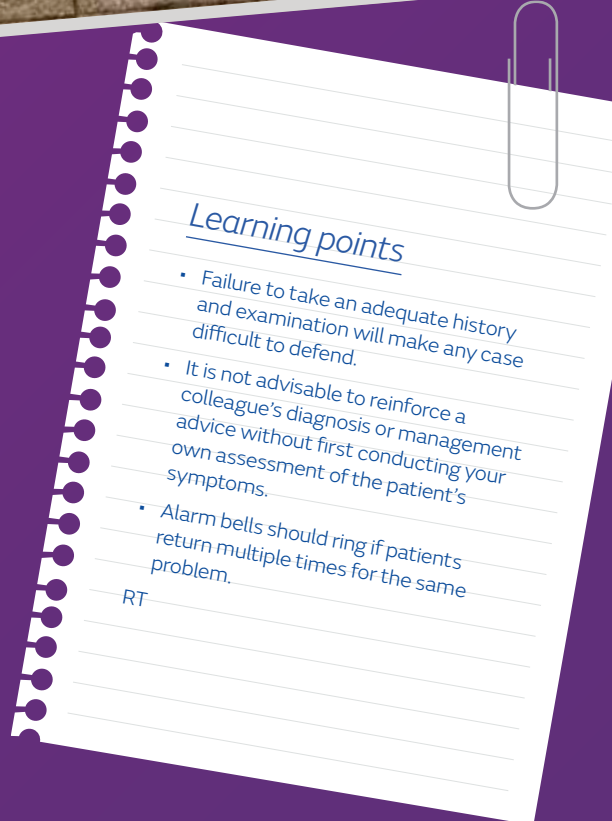
Two months later, Mrs O saw a third GP, Dr C, as the clotrimazole had failed to resolve her worsening symptoms. By now she had started to lose weight, had developed urinary symptoms, and her bloody vaginal discharge had worsened. Despite her malaise and pallor, Dr C again failed to take an adequate history or examine Mrs O and further reinforced the original advice that Mrs O attend the sexual health clinic.



Mrs O collapsed later that week and was taken by ambulance to the Emergency Department (ED) of her local hospital. She was found to have urosepsis and was profoundly anaemic with a haemoglobin of 60 g/l. Examination by the ED team revealed a hard, irregular malignant-looking cervix and a large pelvic mass. She was admitted under the gynaecology team, who arranged an urgent scan. The scan revealed an advanced cervical cancer with significant pelvic spread and bulky lymphadenopathy.

After an MDT meeting and a long discussion with her oncologist, Mrs O and her husband elected to try a course of neoadjuvant chemotherapy and debulking surgery. Unfortunately, prior to surgery, she experienced severe pleuritic chest pain and a working diagnosis of pulmonary embolism was made. Further investigations excluded embolic disease but confirmed tumour deposits in the lung and liver.

It was agreed she would forego chemotherapy and Mrs O was referred to the palliative care team. Her symptoms were managed in the community until her death at home two months later.



EXPERT OPINION

A claim was brought against all three GPs for failure to take adequate histories, failure to examine, failure to accurately diagnose and failure to safety net. An expert witness was highly critical of the care Mrs O received by all the GPs involved and advised that her death was potentially avoidable with better care and a more robust smear-recall system. Breach of duty and causation were admitted and the family's claim was settled for a high amount.

AN UNLUCKY TUMMY TUCK

A patient is unhappy with the outcome of cosmetic surgery



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A 34-year-old lady, Mrs C, consulted a private plastic surgeon, Mr Q, about her lax abdominal skin. Nine days later, she was admitted under his care for an abdominoplasty procedure (tummy tuck). The procedure was uneventful and the patient was discharged after 24-hours.

A fortnight later, at a post-operative nurse-led clinic, Mrs C complained of lower abdominal swelling. This was identified as a seroma and she was briefly admitted for aspiration by Mr Q.

Three months later she was seen again at a nurse-led clinic, on this occasion complaining of peri-umbilical pain. She was reviewed two days later by Mr Q himself, whose examination noted nothing amiss. Her symptoms continued and four months later her GP referred her to the local general hospital, raising the possibility of an incisional hernia. Mr Q was contacted by the hospital and reviewed Mrs C again. He offered to perform a scar revision and to waive his fee.

Three months after this revision surgery was performed, Mrs C had further problems around the scar site, this time manifesting itself as an abscess, which developed into an abscess. Initially her GP treated this with antibiotics and dressings. However, despite this intervention, she was seen again by Mr Q, who re-admitted Mrs C for drainage of the abscess and revision surgery to the scarring around the umbilicus.

Mrs C was unhappy with the cosmetic result, and after her discharge from hospital, Mr Q referred her to a colleague, Mr H, for a further opinion. Mr H reviewed Mrs C and replied that in his view the umbilicus and the horizontal scar were placed too high, and he recommended a further revision. Subsequently, Mr Q received a letter of claim from Mrs C's solicitors alleging that the surgery had been carried out negligently and she had been left with an unsatisfactory cosmetic outcome requiring further surgery.

EXPERT OPINION

An expert opinion obtained by Medical Protection was critical of a number of aspects of Mr Q's management, including the positioning of the incision line, consent issues around scarring, and some technical aspects of Mr Q's wound-closure methods.

In the light of the expert's comments the case was settled for a moderate amount.

Learning points

A patient's decision to make a claim against his or her clinician often reflects more than one point of dissatisfaction or poor performance. Some of the important points in this case include:

- The interval between Mrs C having her first consultation with her surgeon and the subsequent operation was just nine days. When cosmetic surgery is being considered it is good practice to allow a cooling off period of at least two weeks before the surgery. The patient should be provided with, or directed to, sources of information about the proposed procedure. It is also best practice to offer patients a second consultation, which allows the patient to discuss any doubts or questions which may have arisen. Patients should be under no pressure to proceed with aesthetic surgery.
- Complications can occur after any surgery. In abdominoplasty, issues of scarring and the formation of seromas can occur. It is vital that these possibilities are discussed during the pre-procedure consultations. It is insufficient to simply list them on a consent form, signed in a rush on the morning of operation by a nervous patient.
- It is vital to ensure careful documentation of the pre-procedure consultations. This should outline what has been discussed, including the alternatives, potential outcomes and possible risks associated with any procedure. You should also document any literature that has been supplied to the patient or sources of information that were signposted.
- Aesthetic surgery requires a strong element of psychological understanding of the patient, and patients need to feel supported by their surgeon. Good communication and timely reviews are essential in maintaining a good relationship.
- Being asked to provide a second opinion can be an extremely challenging task, particularly where you may disagree with the original doctor. In this case, Mr H was critical of the repeat surgery carried out by Mr Q. Doctors should always convey their honest opinion to patients. However you should consider the effect that the manner you express an opinion can have. Excessive or derogatory comments to a patient about a colleague are unlikely to be helpful and may encourage a patient to complain.

PM

A RISK OF HARM

A psychiatric patient is placed under close observation



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Miss A, a 30-year-old teacher, saw Dr W, a consultant psychiatrist, in the outpatient clinic. Dr W noted Miss A's diagnosis of bipolar affective disorder, her previous hospital admission for depression and her history of a significant overdose of antidepressant medication. Dr W found Miss A to be severely depressed with psychotic symptoms. Miss A reported thoughts of taking a further overdose and Dr W arranged her admission informally to hospital.

During Miss A's admission Dr W stopped her antidepressant medication, allowing a wash-out period before commencing a new antidepressant and titrating up the dose. He increased Miss A's antipsychotic medication and recommended she be placed on close observations due to continued expression of suicidal ideation. He documented that Miss A appeared guarded and perplexed, did not interact with staff or other patients on the ward, and spent long periods in her nightwear, lying on her bed. He did not document the content of her suicidal thoughts. Dr W reiterated to nursing staff that close observations should continue.

During the third week of her admission, Miss A asked to go home. Miss A's named nurse left Miss A alone to contact the team doctor to ask whether Miss A required assessment. While alone in her room, Miss A set fire to her night clothes with a cigarette lighter and sustained burns to her neck, chest and abdomen. She was transferred to the Emergency Department and then to the plastic surgical team and remained an inpatient on the burns unit for three months, requiring skin grafts to 20% of her body.

Miss A made a good recovery from this incident and subsequently brought a claim against Dr W and the hospital. She alleged Dr W had failed to prescribe adequate doses of medication to ensure the optimal level of improvement in her mental health symptoms, failed to adequately assess the level of risk she posed, and failed to ensure constant specialist nursing care was provided to supervise her adequately during her hospital stay. She also alleged the hospital had failed to ensure she did not have access

to a cigarette lighter. Miss A claimed that she would not have suffered the severe burns and subsequent post-traumatic stress disorder if not for these failings.

EXPERT OPINION

An expert opinion was sought from a psychiatrist. The expert made no criticism of the medication regimen or changes to it, but was critical of the communication between Dr W and nursing staff over the meaning of the words "close observation", and the lack of a policy setting this out. She was also of the view that additional nursing staff should have been requested to ensure one-to-one nursing of the patient during her admission. She was critical of the hospital for allowing the patient access to a lighter on the ward, and concluded that the incident could have been avoided if these failures had not occurred.

Dr W acknowledged Miss A had been the most unwell patient on the ward at the time and in hindsight agreed that additional nursing staff should have been requested. Dr W highlighted that there was pressure on consultants not to request additional nursing staff due to cost implications. He also acknowledged that by close observations he had expected the patient to be within sight of a member of nursing staff at all times but had not ever communicated this specifically to the ward staff.

The claim was settled for a substantial sum, with the hospital contributing to the settlement.

REFERENCES

1. MCNZ, *Statement on Safe Practice in an Environment of Resource Limitation*, mcnz.org.nz/assets/News-and-Publications/Statements/Safe-practice-in-an-environment-of-resource-limitation.pdf

Learning points

- Mental health units should have clear policies regarding observation levels and all staff should be aware of these. The observation level deemed appropriate for each patient should be clearly discussed with ward staff and documented within the notes, both on admission and whenever changes are made. The justification for any changes in the level of observation should be clearly documented.
- Robust risk assessment is always important. Risk assessment tools are available, and you should be familiar with any relevant local policies regarding these. Decisions made about the risk posed by a patient to themselves or others should be clearly documented and communicated.

- Mental health units should also have policies surrounding the requirement to check patient's belongings when they are admitted and for removing any items that may pose a risk, including lighters and any sharp implements.
- If a lack of resources results in patient safety concerns, these should be raised by the clinician involved, following guidance set out by the MCNZ.¹

CNR

Further Reading

Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of deliberate self-harm:

ranzcp.org/Files/Resources/Submissions/Deliberate-self-harm-CPG.aspx

The Assessment and Management of People at Risk of Suicide:

health.govt.nz/system/files/documents/publications/suicide_guideline.pdf

PAEDIATRIC BRAIN INJURY

Surgery for an arachnoid cyst is complicated by an intra-cranial bleed



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A three-year-old child, BC, was admitted to hospital for investigation following an epileptic fit. A CT scan demonstrated a left-sided Sylvian fissure arachnoid cyst with bulging of the overlying temporal bone (but no midline shift).

BC underwent cyst drainage with insertion of a shunt under the care of Mr S, a consultant paediatric neurosurgeon, but it was complicated by an intra cranial bleed. Intraoperative exploration revealed that there had been an injury to the temporal lobe that was likely to have been associated with the insertion of the ventricular catheter (which was not inserted entirely under direct vision). The haemorrhage was under control when the operation was concluded.

Following the surgery, BC was transferred to the paediatric ward as a high-care patient. Mr S left the hospital having handed over care to Dr K, a consultant paediatrician, and Mr P, a consultant neurosurgeon. Mr S explained that BC had had an intra-operative bleed, that a clotting screen should be checked (to exclude an underlying bleeding disorder) and that regular neurological observations should be undertaken. Unfortunately the handover discussions were not documented in the records.

BC remained stable until early evening when Dr K was asked by the nursing staff to review her because she had started to vomit and had developed a dilated left pupil. A repeat scan demonstrated a haematoma in the Sylvian fissure with consequent displacement of the shunt, impingement of both the temporal and parietal lobes, together with a midline shift. Mr P was called and immediately returned BC to theatre in order to evacuate the haematoma.

Unfortunately BC sustained a neurological injury, which left her with a right-sided hemiparesis, cognitive difficulties and ongoing epilepsy.

The parents pursued a claim alleging:

- the original procedure was not indicated (and that non-surgical approaches were not considered)
- the shunt was negligently inserted, which led to the bleeding and associated brain injury
- the bleeding was not adequately controlled in the context of the first procedure
- BC should have been transferred to a paediatric intensive care facility in order that her neurological condition could have been intensively monitored.

EXPERT OPINION

Medical Protection sought an expert opinion from a consultant paediatric neurosurgeon, who was not critical of Mr S' decision to drain the cyst and insert a shunt. However concerns were raised in relation to the operative technique which, the expert said, was not according to standard practice. The expert indicated that the preferred approach would be to insert the ventricular catheter under direct vision and postulated that there may have been damage to one of the branches of the middle cerebral artery.

The expert was not critical of the decision to transfer BC to a paediatric ward (on the basis that she did not require ventilation and that the monitoring facilities on the ward were appropriate) but was concerned about the lack of written and verbal instructions (particularly directed towards the nursing staff) relating to the post-operative care

and neurological observations. In addition, the expert was of the opinion Mr S should have reviewed BC on the ward given that he had performed a surgical procedure on her that had been complicated by bleeding.

In light of the vulnerabilities highlighted by the expert, the claim was resolved by way of a negotiated settlement.

Learning points

- The allegations were wide-ranging and although the expert was supportive of some aspects of Mr S' involvement in BC's care, the concerns in relation to the operative technique and handover meant that there was no realistic prospect of successfully defending the case.
- The case emphasises the importance of communication and record keeping, particularly with reference to providing clear verbal and written handover to all relevant staff.
- It may be entirely appropriate to leave the care of a patient in the hands of colleagues at the end of a shift but it would have assisted Mr S' defence if he had reviewed BC on the ward post-operatively in light of the fact that the neurosurgical procedure had been complicated by bleeding.

Further reading

MCNZ, *Good Medical Practice*, pages 23 to 25, 'Continuity of Care'.

RS

BACK TO FRONT

An unusual presentation masks a significant underlying diagnosis

Mr W was a 55-year-old diabetic who worked in a warehouse. He began to get pain across his shoulders when he was lifting boxes and walking home. He saw his GP, Dr I, who noted a nine-month history of pain in his upper back and around his chest on certain movements. She documented that the pain came on after walking and was relieved by rest. Her examination found tenderness in the mid-thoracic spine area. Dr I considered that the pain was musculoskeletal in nature and advised anti-inflammatory medication and a week off work.

Two weeks later Mr W returned to his GP because the pain had not improved. This time Dr I referred him to physiotherapy. Mr W did not find the physiotherapy helpful and four months later saw another GP, Dr J, who diagnosed thoracic root pain and prescribed dothiepin. He also requested an x-ray of Mr W's spine, which was normal, and referred him to the pain clinic. The referral letter described pain worse on the left side that was brought on by physical activity and stress.

At the pain clinic, a consultant documented a two-year history of pain between the shoulder blades. The examination notes stated that direct pressure to a point lateral to the thoracic spine at T6 could produce most of the pain. Myofascial pain was diagnosed and trigger point injections were carried out.

Three months later Mr W was still struggling with intermittent pain in his upper back. He went back to see Dr J, who referred him to orthopaedics. His referral letter described pain in the upper thoracic region with radiation to the left side, aggravated by strenuous activity and stress. Again, it was recorded that the pain was reproduced by pressure to the left thoracic soft tissues.



Two months later Mr W was assessed by an orthopaedic surgeon who diagnosed ligamentous laxity and offered him sclerosant injections.

Mr W took on a less physically demanding role and the pain came on less often. After a year, however, his discomfort increased and his GP referred him back to the orthopaedic team.

A consultant orthopaedic surgeon found nothing of concern in his musculoskeletal or neurological examination. X-rays were repeated and reported as normal. It was thought that his symptoms were psychosomatic and he was discharged.

Six months later, Mr W was struggling to work at all. He rang his GP surgery and was given an appointment with a locum GP, Dr R. Her notes detailed a several year history of chest

and back pain on lifting and exercise that had worsened recently. Pain was recorded as occurring every day and being "tight" in character. It was also noted that he was diabetic, smoked heavily and that his mother had died of a myocardial infarction at the age of 58. Dr R referred him to the rapid access chest pain clinic.

Angina pectoris was diagnosed and an ECG indicated a previous inferior myocardial infarction. Mr W was found to have severe three-vessel disease and underwent coronary artery bypass grafting, from which he made an uncomplicated recovery. He was followed up in the cardiology clinic and continued to be troubled by some back pain.

Mr W brought a claim against GPs Dr I and Dr J for the delay in diagnosis of his angina.



EXPERT OPINION

Medical Protection sought the advice of an expert GP, Dr U. Dr U pointed out that Mr W appeared to have two chest pain syndromes: coronary artery disease causing angina, and chronic musculoskeletal pain causing back and chest pain, as evidenced by some continuing musculoskeletal pain even after his coronary surgery. She thought that his angina had presented in a very atypical manner with features that had reasonably dissuaded the GPs and specialists from making the diagnosis. She supported the GPs' early management but believed that angina should have been considered when Mr W failed to respond to treatment. Dr U commented that pain brought on by stress and exertion should have raised suspicions of angina. She also felt that the GPs should have assessed cardiovascular risk factors sooner.

An opinion from a consultant cardiologist, Dr M, was also sought. Dr M explained that diabetic patients are more likely to have atypical presentations of angina and that, depending on which part of the heart is deprived of blood supply, the pain can sometimes be more posteriorly situated. He commented that if Mr W had been diagnosed earlier he would have commenced aspirin, statin, and beta-blocker therapy and been advised to stop smoking. This would have reduced his risk of myocardial infarction. Dr M believed that if this had been prevented Mr W's life expectancy could have been improved.

Based on the expert opinion the case was deemed indefensible and was settled for a high amount.

Learning points

- Pain that is precipitated by exertion should always raise suspicion of angina. The National Institute for Health and Care Excellence (NICE)¹ in the UK defines stable angina symptoms as being:
 - constricting discomfort in the front of the chest, in the neck, shoulders, jaw, or arms
 - precipitated by physical exertion
 - relieved by rest or glyceryl trinitrate (GTN) within about five minutes.
- People with typical angina have all three of the above features. People with atypical angina have two of the above features.
- Angina can present in uncharacteristic ways. There can be vague chest discomfort or pain not located in the chest (including the neck, back, arms, epigastrium or shoulder); shortness of breath, fatigue, nausea or indigestion-like symptoms. Atypical presentations are more frequently seen in women, older patients and diabetics.²
- Multiple conditions can run alongside each other and we must try to untangle them by careful questioning and listening. Stepping back and looking at the bigger picture can help if a patients' symptoms are persistent.
- Confirmation bias can lead to medical error. The interpretation of information acquired later in a medical work-up might be biased by earlier judgments. When we take medical histories it can be tempting to ask questions that seek information confirming earlier judgments, thus failing to discover key facts. We also can stop asking questions because we have reached an early conclusion. *The BMJ* published an article about the cognitive processes involved in decision making and the pitfalls that can lead to medical error.³

AF

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3. Klein JG, Five Pitfalls in Decisions about Diagnosis and Prescribing, *BMJ* 330(7494): 781–3 (2005)

A MISSED OPPORTUNITY?

A patient suffers complications following spinal surgery



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Mrs W, a 58-year-old business manager, consulted Mr D, an orthopaedic surgeon, with exacerbation of her chronic back pain. She had a history of abnormal clotting and had declined surgery three years earlier because of the attendant risks. An MRI scan confirmed degenerative spinal stenosis for which Mr D recommended an undercutting facetectomy to decompress the spinal canal while preserving stability. On this occasion, Mrs W agreed to the proposed procedure. Surgery was uneventful, and she was discharged home on the fourth post-operative day.

At her outpatient review 11 days later, Mrs W complained that she had been unable to open her bowels and that she had also developed a swelling at the wound site, from which Mr D aspirated “turbid reddish fluid”. Suspecting a dural leak, Mr D undertook a wound exploration, which confirmed that the dura was intact. At the same time, a sacral haematoma was evacuated. In the two years following surgery, Mrs W was seen by Mr D and a number of other specialists complaining of ongoing constipation, urinary incontinence and reduced mobility, which, although atypical, was thought to be due to cauda equina syndrome.

Mrs W brought a claim against Mr D, alleging that she had not been advised of the risks of the surgery and that no alternative options were offered to her. Furthermore, she claimed that had she been properly advised, she would have declined surgery, as indeed she had done in the past. She also alleged that Mr D failed to arrange appropriate post-operative monitoring such that her developing neurological symptoms were not acted on, and that she should have undergone an urgent MRI, which would have revealed a sacral haematoma requiring immediate evacuation.

EXPERT OPINION

An orthopaedic expert instructed by Medical Protection made no criticism of the conduct of the surgery, but was very critical of the poor quality of Mr D’s clinical records. Although Mr D was adamant that the risks of surgery and alternative treatment options

were discussed with Mrs W, he made no note of this in the patient’s records nor did he make reference to any such discussions in his letter to the GP. Furthermore, despite Mr D’s assertions that he reviewed Mrs W every day post-operatively prior to her discharge, he made no entries in the records to this effect, stating that he had relied on the nurses to do so. The nursing records did not corroborate this.

The claim was predicated on the basis that Mrs W suffered from cauda equina syndrome and that earlier intervention to evacuate the haematoma would have improved the outcome. In the expert’s opinion, there was insufficient evidence to support a diagnosis of cauda equina syndrome, hence it was unlikely that earlier decompression would have made a difference. However, the absence of documentary evidence of her post-operative condition made it very difficult, if not impossible, to rebut this claim.

In any event, Mrs W would have been successful in her claim if she could establish that she was not properly advised of the risks and alternative options, and that if she had been she would have not proceeded with the surgery. This is because, on the balance of probabilities, the complications she suffered would not have occurred had she been properly counselled. The absence of any record of the advice given, coupled with the documented reasons for her earlier refusal of surgery lent significant weight to Mrs W’s claim.

On the basis of the critical expert report the claim was settled for a substantial sum.

Learning points

- Good clinical records are essential to the ability to defend a doctor’s actions in the event of a claim.
- An appropriate clinical note should be made by the attending doctor or explicitly delegated to another appropriately skilled healthcare professional.
- Patients are entitled to expect they will be advised of all relevant and material risks of a proposed treatment and of any alternative treatment options (including no treatment). Any advice given should be clearly documented.

JP

DIAGNOSING PNEUMONIA OUT OF HOURS – CORRECTION

Thank you for the latest edition of *Casebook* which I found informative. However I would like to draw your attention to what I believe are a couple of mistakes in the learning points to your article 'Diagnosing pneumonia out of hours'.

The second paragraph of the advice given states: "According to NICE guidance...GPs should use the CURB65 score to determine the level of risk...One point is given for confusion (MMSE 8 or less ...)".

I believe that NICE's guidance for GPs is to use the CRB65 algorithm, and this appears to be the algorithm referred to in the rest of the article. The CURB is slightly different, includes a blood test for urea and is intended mainly for hospital use.

More importantly, NICE advises doctors to assess confusion using the Abbreviated Mental Test Score (AMTS),¹ not the Mini Mental State Examination (MMSE)² as stated in the article. The AMTS is scored out of 10, the MMSE out of 30; so whilst a score of 8/10 on the AMTS is consistent with mild confusion (allowing for the crudity of the AMTS), a score of 8/30 on the MMSE would be indicative of very severe confusion. Use of the MMSE in an acute respiratory infection would be time-consuming and could give false assurance.

Dr Brian Murray

Response



Thank you for pointing out the two errors in the case report from the last edition. You are correct that it should have been the CRB65 algorithm and the Abbreviated Mental Test Score that were referred to. We regret that these were not picked up on clinical review and we apologise for any confusion caused.

FAILURE TO DIAGNOSE PRE-ECLAMPSIA

The learning points arising from this case missed arguably the most important learning point - that both patients and doctors are more likely to experience adverse outcomes if patients are seen at home rather than in surgery.

The GP involved was criticised for failing to keep adequate records, an outcome far more likely after a home visit than after an attendance at the surgery, where the computer records system is accessible immediately.

The GP was also criticised for failing to test urine; obtaining a urine sample from patients is far easier to manage in surgery, where the delays involved can be mitigated by seeing other patients whilst the specimen is produced, and where specimen pots and urine test sticks are immediately to hand. A busy GP will simply not have the time for a prolonged wait in a patient's home until the specimen is eventually produced.

Finally, the decision-making capacity of the doctor will be impaired if in an unfamiliar location and stressed by congestion and route finding whilst travelling to a patient's home, as well as consulting without immediate access to the full medical record.

Dr Douglas Salmon

A FAMILY MATTER

I read the case study regarding the doctor prescribing an antibiotic for her daughter. Having retired recently after 25 years as a GP partner it surprises me that common sense is not applied by the GMC in such circumstances.

How this can ever be considered a serious complaint baffles me. Being a GP is stressful enough, and cases like these make me angry that as a profession we have to suffer such indignity when we can't be trusted to treat our families for minor illnesses.

Dr M Shah

PROBLEMATIC ANAESTHETIC

I read with interest the unfortunate case of neurological injury following attempted paravertebral blockade.

What the learning points do not mention is the expert opinion that this procedure should have been performed awake or under light sedation. Many anaesthetists perform this procedure under anaesthesia with exemplary results, but I have to agree with the expert opinion. When struggling with a procedure we can sometimes get too preoccupied with succeeding. Awake patients do not like needles in places where they should not be and this helps prevent multiple attempts by the operator. In this case it may have led to the doctor abandoning this unnecessary procedure.

Dr Mohammed Akuji

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REVIEWS

From books to apps, podcasts to training courses, we invite doctors to review what has helped them improve their practice



OMNIFOCUS (IOS, MAC) OMNI GROUP

omnigroup.com/omnifocus

Review by: *Dr Jennifer Munroe-Birt*

The Omnifocus app can't technically grant you the extra ten hours a day that everyone wishes they had, but what it can do is focus you, organise you, and maximise your productivity so you do in fact seem to end up with more time. At first glance it doesn't seem much of an upgrade on a to-do list – albeit a rather expensive one – but further inspection reveals an intuitive, multi-level application that will afford you levels of organisation you always assumed were beyond you.

For doctors, the app is useful to arrange and categorise the abundance of tasks at hand (projects, meetings, CV, CPD). You can easily categorise individual tasks into bigger projects (holiday, that audit you've been meaning to finish

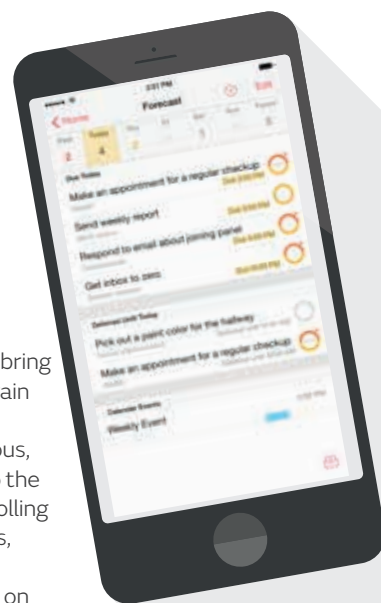
all year) and assign deadlines to each task. Being able to break each 'project' into smaller, more manageable chunks will appeal to anyone who has sat down to start a big piece of work and found themselves still on Facebook half an hour later because they are too daunted to take the first step.

Each project can be contextualised to various aspects of your life, and each 'context' can be location-based using GPS. This way Omnifocus knows when you're at home ('paint shelves'), when you're at work ('arrange educational supervisor meeting'), or even when you're walking past the supermarket ('buy mustard').

One of my favourite features is the ability to defer certain tasks once they are out of your control

(for example, if you've sent an email and are waiting for a reply) and bring them back into view again once you're required to respond. It seems obvious, but this minor tweak to the interface saves you scrolling through irrelevant tasks, making you feel more motivated and focused on the things that you are able to control.

Currently the app is limited in a clinical setting primarily due to confidentiality issues. Perhaps one day our archaic bleeps will be replaced with hospital-issue encrypted smartphones with apps such as Omnifocus to help co-ordinate tasks...but I won't hold my breath.



RISE

By *Sian Williams*

Review by: *Rosie Wilson*

Rise describes itself as a "psychological first aid kit" and it's easy to see how – to a certain reader – it could serve as just that. The autobiographical book follows BBC newsreader Sian Williams' journey through the treatment of, and recovery from, breast cancer.

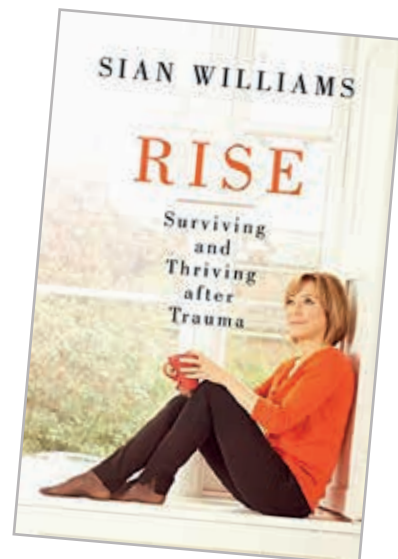
From a doctor's perspective, it is interesting to see the patient's perception of her medical journey. The book includes a lot of medical jargon, records of what was told to Williams, followed immediately by her confessions of feeling confused and overwhelmed. It can be easy to forget how alien all the information about a disease or condition is to a patient when you've been immersed in it for years.

Treat Rise almost as a manual, then; Williams talks in detail about the doctors she liked – and the ones she didn't – and the differences in their treatment of her. Compassionate, matter-of-fact and not at all pandering, Williams' accolades for her favourite doctors reflect the sort of praise we might want to hear about ourselves professionally.

From a general human perspective though, the reader is struck by the emotion and candour of the book. Williams focuses not just on herself but on those around her: her mother, who died of cancer just a few years before she was diagnosed herself; her brother-in-law, who she perceives to have "worse cancer" than she does; and the

interactions she has with her young children as they struggle to understand the situation. After all, medical professional or not, all of us have experienced – or will experience – cancer on a personal level at some point in our lifetimes, and it's the relatability that makes the book so hard to put down.

Thanks to her background as a journalist, Williams understands the balance between facts and feeling. The book is an insight into the typical everyday thoughts of a patient going through long-term treatment – not just for cancer, but for anything that has an impact on day-to-day living.



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