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CASEBOOK

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NEW ZEALAND



Does my patient need to know?

LACK OF INFORMATION LEADS TO AN HDC INVESTIGATION

From the case files

FAILURE TO ACT ON LOWER BACK PAIN

What red flags were missed by both GP and hospital?

STRONG RECORD-KEEPING – STRONG DEFENCE

Alleged negligence leads to a claim and regulatory hearing.

NO RENAL REVIEW

Regular reviews are missed during long-term naproxen use.



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What's inside...

Every issue



Welcome

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



Over to you

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



Giving evidence

Being called as a witness in court can be a daunting proposition. Noon Sirisamphan and Adam Holloway, from DLA Piper, provide a practical guide to what you can expect.

Case reports



Wrongly reassured over swollen ankle

A patient claims his diagnosis was delayed – but was the GP in the clear?



Failure to act on lower back pain

What red flags were missed by both GP and hospital?



Does my patient need to know?

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No renal review

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Strong record-keeping – strong defence

Alleged negligence during surgery leads to both a claim and regulatory hearing.

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Welcome

DR MARIKA DAVIES
EDITOR-IN-CHIEF



Given the nature of our work, it is to be expected that the focus of Casebook over the years has been on medicolegal jeopardy, along with expert advice and guidance on how to avoid these pitfalls occurring in your own practice.

You are likely to be aware of some unwelcome developments in another area of medicolegal jeopardy over in the UK: gross negligence manslaughter, following the case of Dr Hadiza Bawa-Garba, the junior doctor struck off by the UK's General Medical Council (GMC).

For seven years, we supported Dr Bawa-Garba and fought hard against this decision by the GMC, which has caused shockwaves throughout the profession and is also being keenly watched by practising clinicians around the world.

We are continuing to fight hard against what is fast becoming an untenable level of scrutiny, blame and castigation for hard-working doctors. Of particular concern for both Medical Protection and the profession is the approach taken by the regulator in this case and the impact that the decision may have on creating an open, learning culture in healthcare, at a time when the profession is already marred by low morale and fear.

There are no such criminal charges arising in this edition's usual collection of case reports, which feature the customary mix of settled cases and successful defences. This latest set of reports – based on real Medical Protection cases, with some facts altered to preserve confidentiality – have been expanded in length, to allow for more detail

and greater exploration of the key issues and developments in each case.

In upcoming editions, we will also be expanding the case reports even further to provide you with more insight into the legal aspects of each case, to complement the clinical details that I know you enjoy reading. This wider focus on the complete narrative of a case has been prompted by your own feedback; many of you share a desire to get a more comprehensive understanding of the often complex and technical processes that comprise the passage of a case.

I hope you will enjoy this greater depth to your reading and I look forward to receiving your opinions. If you wish to get in touch on this or any other issue in Casebook, I would be happy to hear from you.

Dr Marika Davies
Editor-in-Chief

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Wrongly reassured over swollen ankle



BY DR ANNA FOX, GP

Mr E, a 50-year-old accountant, was playing squash with a colleague after work and hurt his left ankle. He couldn't keep playing but he was able to walk, so he went home. The next day his ankle became quite swollen, so Mr E kept it on ice and took some ibuprofen.

He did not see a GP at the time because he was busy at work. He was still able to walk, although he had pain around the back of his ankle and heel. A month later, the swelling and aching around his ankle did not seem to be settling down, so he made an appointment with his GP, Dr N.

Dr N noted that his ankle had been very painful and swollen after the injury, although overall it was significantly better. She examined Mr E and found that his gait was antalgic. She documented mild swelling but no tenderness to the ankle, and noted that his ankle had full range of movement. She diagnosed a sprain and advised Mr E to rest the ankle, elevate it when he was sitting and to use a compression bandage in the daytime.

Mr E followed the advice but was getting very frustrated since his pain and swelling failed to improve. Two months later his pain worsened and he was finding it hard to fully weight bear. He went to the Emergency Department (ED) to see if he needed an x-ray. He wondered if he could have broken a bone with the initial injury and that was why his symptoms were not settling down.

The ED doctor noticed a swelling over his Achilles tendon and a weak plantar response to a Simmond's test. It was also noted that he was unable to stand on tiptoe.

A review by the fracture clinic the following day considered the Simmond's calf squeeze test to be normal, but again noted Mr E's

inability to stand on tiptoes. A rupture of his Achilles tendon was suspected, and an ultrasound scan confirmed a complete tear with a significant gap.

Mr E's tendon healed but in an elongated fashion, affecting his ability to run and play sports. He made a complaint against his GP, Dr N, alleging failure to diagnose a ruptured Achilles tendon, thus delaying treatment and adversely affecting his recovery.

OUTCOME

In this case, based on the medical records, Medical Protection was able to defend the GP's management. In the letter of response it was argued that it was reasonable for Dr N to diagnose an ankle sprain based on the history and her clinical examination. The letter highlighted that as the Simmond's test performed at the fracture clinic was normal, it therefore would likely have also been normal at the time of Dr N's examination. The complaint was then withdrawn.

LEARNING POINTS

- Rupture of the Achilles tendon can be seen in sports such as squash, football and running, but can also occur as a result of missing a step when walking and a subsequent abrupt landing.
 - Prompt diagnosis of Achilles rupture is very important. A delay in treatment can lead to poorer outcomes, since a discontinuous or lengthened tendon can cause weak plantar flexion. The patient can be left with a limp and difficulty running, heel rising and stair
- climbing. More complicated surgery, with longer scars and higher risks of complications, may be needed, and return to sports may not always be possible.¹
 - In New Zealand, if the patient had complained to the HDC, they would have very likely severely criticised the doctor for not suspecting Achilles tendon injury: therefore, not performing the Simmond's test. The fact that it was normal later on would have been irrelevant, as the causal connection doesn't have to be established for the HDC to breach a doctor.
 - A delayed diagnosis of Achilles tendon rupture may be accepted as a claim under the ACC in New Zealand. If it was assessed by the ACC experts that Mr E had had the rupture at the time he saw Dr N, and that the delay of two months in him accessing treatment had a significant effect on his final outcome, then Mr E may have been eligible for some support from the ACC.
 - Examination details, including negative findings, should be clearly documented.
 - Achilles tendon rupture can be missed by non-specialists in about 20% of cases. It can be missed for multiple reasons that clinicians should be mindful of.^{1,2}

REFERENCES

1. Singh D, Acute Achilles tendon rupture, *BMJ* 351:h4722 (2015)
2. <https://cks.nice.org.uk/achilles-tendinopathy>



The medical world can be a mysterious and unsettling place; it has a bureaucracy and language all of its own. To a lesser extent, the same is true of the legal world. It is, therefore, understandable that some doctors will feel unsettled by receiving a formal notice requiring them to give evidence in a court: here, we take a practical look at giving evidence.

Leaving aside the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the field of forensic psychiatry, the most common reasons for doctors to give evidence are probably coroner's inquests and criminal prosecutions.

CORONERS' JURISDICTION

Coroners are judicial officers equivalent to district court judges. The primary function of a coroner is that of a fact-finder: they decide whether to direct a post-mortem, authorise the release of the body, and determine whether an inquiry is to be opened. A coroner must open an inquiry into self-inflicted deaths, deaths in official custody or care, and unexplained deaths. A discretion exists in other cases. As part of an inquiry, a coroner may also decide to hold an inquest, which is a formal hearing of evidence.

The coroner can require a witness to attend an inquest by issuing a summons.

CRIMINAL JURISDICTION

The criminal jurisdiction is adversarial rather than inquisitorial, so it is up to the prosecution and defence (not the judge) to decide what evidence to call. Either side can obtain a summons calling a person to appear as a witness at a hearing in relation to a charge.

RECEIVING A SUMMONS — WHAT HAPPENS NEXT?

A summons can't be ignored. It is a criminal offence to not appear when required (the

penalty being a fine up to \$1,000), and the coroner or judge may issue a warrant for you to be arrested and brought to court.

LIAISING WITH THE PARTY CALLING YOU AS A WITNESS

An important question is: "Do I need to give evidence at all?" Sometimes witnesses are summoned when they don't need to be. Your evidence may be uncontroversial and could be given in writing, or the person calling you could be mistaken about the relevance or potential helpfulness of your evidence. It is therefore sensible to liaise as soon as possible with the person wanting to call you. Ask questions and try to find out why you are being called and what evidence you are expected to give.

If there are dates that will be difficult for you to attend court, make this known as soon as possible. In the coroner's jurisdiction, tell the relevant coronial case manager. In criminal proceedings, write to the registrar as well as telling the lawyer who wants to call your evidence. While there are no guarantees, courts will generally try to accommodate witness availability where they can. If a court appearance can't be changed and you had planned to be out of town, ask the coronial case manager/registrar about the possibility of giving evidence by video link.

PREPARATION AND WHAT TO EXPECT ON THE DAY

The process of giving evidence is made up of four parts:

- Evidence in chief (for example, reading out your statement/brief of evidence or report for the coroner)
- Cross-examination
- Questions from the coroner or judge
- Re-examination.

Evidence in chief

The person who is calling you as a witness asks you to come forward to the witness box. After you have taken an oath, the person calling will lead your 'evidence in chief' – this is your opportunity to tell your part of the story, which usually involves you reading out your brief of evidence. You may also be asked some supplementary questions.

Cross-examination

Cross-examination is when other parties are given the opportunity to scrutinise and test your evidence in chief by asking questions. It is often the process that witnesses are most apprehensive about, but it is rarely as dramatic as television portrayals.

The best way to relieve nervousness, and be good at cross-examination, is preparation:

Know the courtroom – the layout and etiquette. It is a good idea to come to part of the hearing before your turn to give evidence, so that you can get used to the layout and personalities in the room. Sometimes, the coroner/judge makes witness exclusion orders: if you are arriving at court after a hearing has started, it is important to check whether a witness exclusion order is in place and whether it applies to you.

Be controlled and measured in your responses. Listen to the question and consider it before responding, to avoid appearing uncertain or giving an unconsidered answer too quickly. Body language needs to be kept in check, as do impressions of arrogance, aggression or irritation.

Confidence is also important, as it reinforces your expertise and knowledge of the area. This comes with preparation and knowing the facts and relevant documents.

After cross-examination has started, you are not permitted to talk to anyone else about

Giving evidence

Being called as a witness in court can be a daunting proposition. *Noon Sirisamphan*, senior solicitor at DLA Piper, and *Adam Holloway*, partner at DLA Piper, provide a practical guide to what you can expect

the proceeding (whether they are involved in it or not). This means you cannot talk to other people about the proceeding during adjournments – including adjournments that run overnight.

Questions from the coroner/judge

The coroner/judge can ask you questions on any topic or subject of interest. If you don't know the answer to a particular question, it best to say so.

Re-examination

After cross-examination, there is an opportunity for the person who called you to ask further questions on matters arising from cross-examination. If you are re-examined by your lawyer, it is usually for a reason – typically to correct or clarify something you said in cross-examination. When you hear the question, listen carefully and try to think of the reason behind it.

Other tips for cross-examination

- Always be honest.
- If you do not know an answer to a question, say so. Do not guess the answer if you are unsure. Similarly, if you are unsure or don't understand a question, say so: the question will then be restated or rephrased. You will not be criticised for making sure that you understand the question before answering it.
- After listening to a question, direct your answer to the coroner/judge. Turn to face the fact-finder/decision-maker and make eye contact.
- Tell the truth in a simple, straightforward way. Short and concise answers are the best. Whenever possible, answer questions with a 'yes' or a 'no'. Giving an imprecise or complicated explanation to a simple question can appear evasive and uncertain; resist letting the cross-examiner rush you.

- Listen and take your time over questions and give considered answers. There is no rush when giving evidence and a witness will never be criticised for taking time to give accurate and precise answers. In order to be accurate, make sure that you concentrate and fully understand each question put to you before providing an answer. If you need to refer to a document before answering, ask to do so.
- Treat each question on its own merit. Do not try and predict where the line of questioning is heading, as this will distract you.
- If you are asked to read a document, make sure that you do read it carefully, even if the document is very familiar to you.
- Once you have said everything you have to say in response to a particular question, be quiet and comfortable waiting as long as is necessary for the next question. Do not feel obliged to fill the silence.
- If answering a question requires you to be critical about another person, ensure that the tone of that evidence is objective. The best impression you can create is one of objectivity and candour.
- On the other hand, if a question invites a strong answer and you have a strong view, give it. You are entitled to and should be forthright in your evidence where necessary, but refrain from becoming over-emotive.
- You may not ask questions yourself, except to request that a question be repeated or clarified where you did not hear or understand it. Challenging counsel by responding with a question of your own is inappropriate.
- If you have any doubt about your answer, you can say "I am not sure I remember everything, but my best memory/what

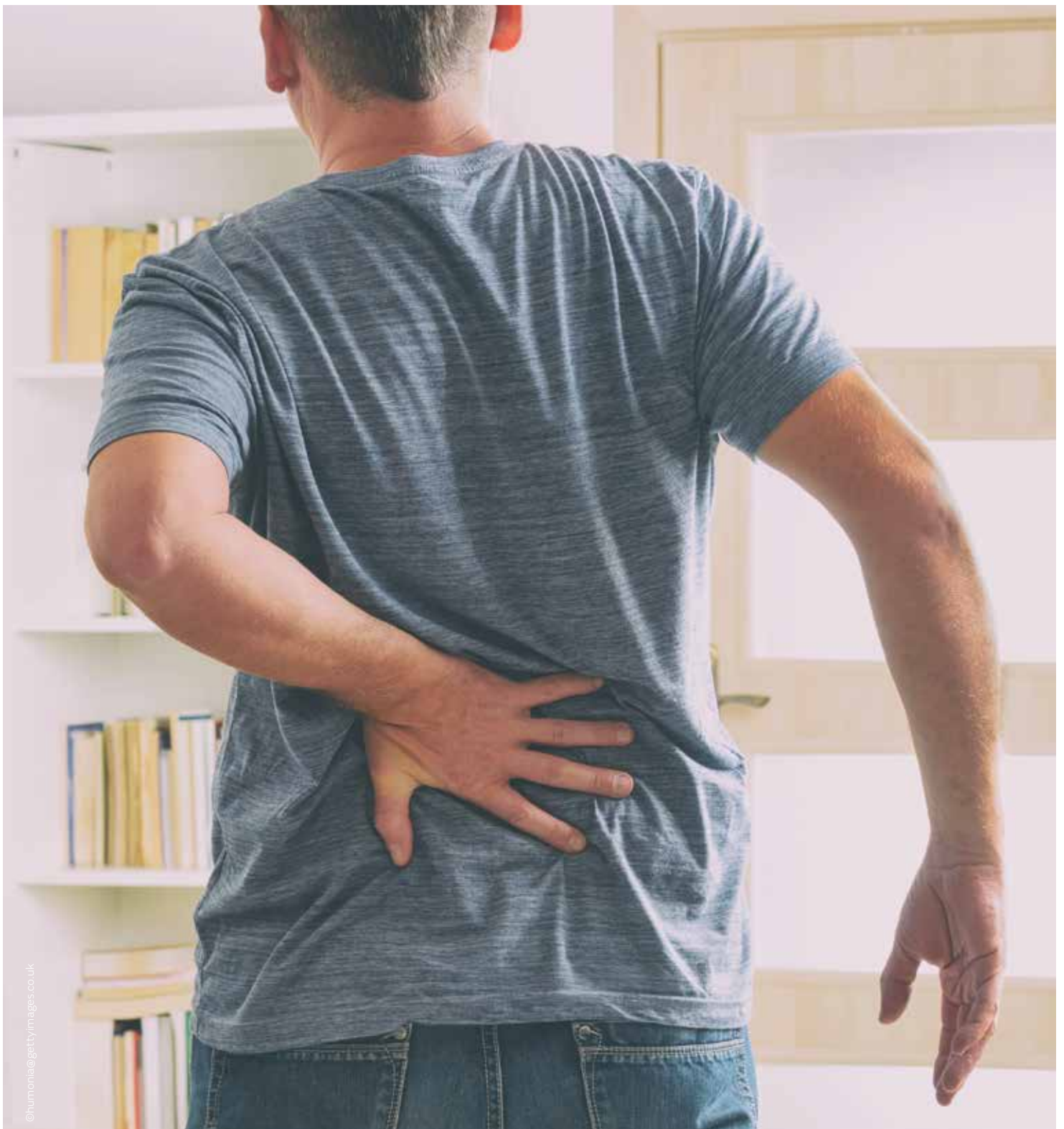
I do recall is..." Give the best answer you can in the circumstances.

- If your honest view is that what has been put to you is correct, you must agree. However, you may sometimes feel that a straight 'yes' or a straight 'no' is an insufficient answer. The best way to deal with this is to say 'Yes, but...' or 'No, but...' and then give your qualification.

There is much that could be said about the art of giving evidence as a witness in court. While there is no substitute for the real thing, some colleges (such as the Australasian College of Legal Medicine) run training programs for giving expert evidence in court, including a mock trial.

Noon Sirisamphan has a number of years of experience in regulatory and professional disciplinary frameworks, and specialises in healthcare law. She has appeared in the Coroners Court and Health Practitioners Disciplinary Tribunal, and regularly assists Medical Protection members in responding to complaints, inquiries and other investigations.

Adam Holloway specialises in healthcare, public law and civil litigation. He regularly acts for Medical Protection members in relation to a wide range of medicolegal, professional misconduct and privacy matters, including inquests.



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Failure to act on lower back pain



BY DR ELLEN WELCH, GP

Mr X, a 25-year-old fit and active man, was reviewed by his GP, Dr A, with a recurrence of lower back pain. He had noticed lumbar back pain intermittently throughout his 20s, but played a lot of sports to which he attributed his symptoms. On this occasion, he described lumbar back pain radiating into both thighs, along with cramping in both feet. He had no other worrying features, so a repeat prescription for his usual analgesia was given.

Six months later, he returned to see Dr A, this time complaining of difficulty passing urine. Mr X recalled telling Dr A about his ongoing back problems, but this was not documented and Dr A did not recollect any back pain being mentioned. A urinalysis was negative and Mr X was given antibiotics for a presumed urinary tract infection.

Two months later, Mr X collapsed whilst playing football, complaining of a sudden onset headache. He was admitted under the care of Mr B's neurosurgical team and assessed by the locum doctor on duty. His head CT was unremarkable so a lumbar puncture was carried out, which showed blood in his CSF. The locum diagnosed a migraine. While in hospital, Mr X went into urinary retention and required catheterisation. The patient decided to discharge himself and left the hospital with the catheter still in situ, removing it himself at home the following day.

“ ”

Mr X returned to the GP surgery to consult again with Dr A. He complained this time of both lumbar back pain and difficulty passing urine

His symptoms persisted and, a week later, Mr X returned to the GP surgery to consult again with Dr A. He complained this time of both lumbar back pain and difficulty passing urine, which prompted Dr A to arrange an urgent MRI scan of his lumbar spine. This was carried out two weeks later and revealed an arterio-venous malformation (AVM) in the lumbar region, with a normal spinal cord and no evidence of nerve root compression.

Dr A wrote to Mr B to advise him of the MRI result, and Mr X was seen in the outpatient clinic three weeks later, by which time he had saddle anaesthesia and numb, weak legs, and was incontinent of urine and faeces. He underwent embolisation of his AVM, but unfortunately his symptoms did not resolve.

Mr X made a claim against both Dr A and the hospital.

EXPERT OPINION

Expert opinion was critical of all involved in the case. The hospital breached their duty of care by failing to suspect, detect and treat the spinal pathology during the hospital admission. The GP experts agreed that Dr A had failed to diagnose bilateral sciatica when Mr X first presented. They agreed that bilateral sciatica is a red flag symptom that warrants urgent referral to the back clinic. They criticised Dr A's failure to document a physical examination, including straight leg raise and neurological testing.

Dr A and Mr X had different recollections of what was discussed during the second presentation at the surgery. The GP experts agreed that regardless of whether or not Mr X mentioned his back pain, Dr A should have explored potential neurological causes for Mr X's urinary symptoms, including specific enquiries regarding the back pain he mentioned in the previous consultation. Furthermore, they agreed that it is unusual for a UTI to be present with a negative urine dip test, and they criticised Dr A's failure to recognise urinary retention with back pain, and admit Mr X to hospital that same day to exclude cauda equina syndrome.

Once the AVM had been discovered on the MRI ordered by Dr A, the consensus among the experts was that the GP should have urgently sought the advice of a neurosurgeon, rather than leaving Mr X a further three weeks to have an outpatient appointment.

The experts conceded that on the balance of probability, there would have been no neurological findings the first two occasions Mr X consulted Dr A. It was also agreed that, had the AVM been detected and treated before Mr X collapsed, or even during his hospital admission, it is likely that he would not have been left with persisting neurological deficits.

OUTCOME

The case was settled for a high sum, with a 25% contribution from Medical Protection on behalf of Dr A.

LEARNING POINTS

- Missed cauda equina syndrome comes up again and again in *Casebook*. The presence of red flag symptoms in back pain indicates the need for further investigations and specialist referral.
- Think twice before attributing urinary symptoms to infection where presentation is atypical. Even when there is urine dip evidence of infection, consider that infection can co-exist with retention and specifically enquire about the presence of other neurological symptoms.
- When tests reveal unfamiliar pathology outside your scope of knowledge, it is prudent to seek advice from the relevant specialist sooner rather than later.
- Unfortunately, we can't always rely on our colleagues to have done the right thing. If a patient presents with concerning symptoms that persist after specialist investigations, take any action necessary to ensure the patient is reassessed with the appropriate degree of urgency.
- In New Zealand, instead of a claim against Dr A and the hospital, Mr X would be able to make an ACC "treatment injury" claim due to the potential delayed diagnosis. The main ACC entitlements include the costs of treatment and rehabilitation, weekly compensation for lost wages or salary, and lump sum compensation for permanent impairment. ACC may consider that there was sufficient risk of harm to the public to notify either the Director General of Health or the Medical Council. The Medical Council may then forward the notification on to the HDC.



Does my patient need to know?



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

Mr K, 49 years old, dislocated his right shoulder when he fell off his motocross bike. He presented to the Emergency Department (ED), where he was seen by the triage nurse and an x-ray was arranged.

The x-ray showed that the shoulder was dislocated, and Mr K was then seen by a clinical nurse specialist (CNS) who, after several unsuccessful attempts, requested that ED consultant Dr U provide procedural sedation so that the shoulder could be reduced.

The CNS ordered a post-reduction x-ray, which confirmed that the relocation had been successful. Mr K's discharge summary stated: "Discharge Plan/Advice: Follow up with [general practitioner] GP..."

The day following Mr K's discharge, the x-rays were reported on formally. The pre-reduction report stated: "...There is a 1 X 0.2mm bone fragment posterior to the humeral head... Summary: Anterior fracture..."

The post-reduction report stated: "...Discrete humeral head fracture is not identified, though subtle Hill-Sachs deformity is not easily excluded on this exam. I also question subtle bony deformity of the scapula inferior to the glenoid...if indicated this can be better evaluated by CT." Dr U viewed and signed those x-ray reports and did not feel that any further action was required.

Three days later, Mr K attended his GP practice because of ongoing shoulder pains. Neither the x-ray report nor the discharge summary were available to that doctor at the time. He was referred to see an orthopaedic surgeon, whom he saw some five weeks later.

Mr K subsequently made a complaint to the HDC: in part, that the orthopaedic surgeon had diagnosed him with a fracture (a Bankart lesion) and advised him that this should have been addressed "right away". Mr K had a series of clinic appointments and further investigations, and was considered for surgery to repair his torn rotator cuff. However, surgery was not performed owing to a lack of movement in his shoulder. Mr K told the HDC that he was now faced with a permanent disability due to a severe lack of movement in his shoulder. The HDC opened an investigation.

THE INVESTIGATION

Dr U advised the HDC that he did not feel that the abnormality as described in the x-ray report required him to take any further immediate action, and he was reassured by the knowledge that Mr K would be following up with his GP, as recorded in the notes. He further advised that, routinely, all x-ray reports were sent to the patient's GP. The

HDC noted, however, that on Mr K's report the GP was listed as "Dr A unknown" and the reports were not sent to his GP.

While Dr U acknowledged that there would be occasions where recognition of an abnormality required notifying a patient of the abnormal result, provision of the report, and ensuring that appropriate follow-up had been arranged, he did not feel that this was one of these cases. Further support came from a senior orthopaedic surgeon, who advised in an email to Dr U that: "[T]he radiology report suggests a tiny avulsion fracture and I don't feel there would be any need to inform a patient of that. They are quite common and often not even spotted...I don't think there was anything wrong with the way this was handled."

The DHB advised the HDC that Mr K would have been advised to take a copy of his notes and x-ray to his GP, but the HDC noted that he didn't recall this. The DHB also stated that while it did not view the fracture as a clinically significant bone deformity, it did accept that it was good practice to communicate this to the patient.

EXPERT OPINION

The HDC obtained expert opinion from an ED specialist, who felt that it was a major departure from the expected standard of care that the abnormalities documented by the reporting radiologist were not passed on to the patient or the patient's GP. The expert felt that because the ED did not have the patient's GP's details, Mr K should have been contacted to inform him of the findings, and either he or his GP be provided with a copy of the report so that appropriate and timely follow-up could be arranged.

The Commissioner acknowledged Dr U's opinion that the abnormality identified in the x-ray report was not one that required reporting to the patient or his GP, and that the end process would have been the same even if the information had been provided. However, in the HDC's view, even though the abnormality was small, Mr K had the right to receive available information in relation to it.

The Commissioner made reference to Right 6(1)(f) of the Code of Rights, which states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive..." This included the results of tests, and the HDC was critical that Dr U did not inform Mr K of the abnormality seen on the x-ray, especially in light of the fact that the x-ray reports were not copied to Mr K's GP.

OUTCOME

The Commissioner found Dr U in breach of Right 6(1)(f) of the Code and recommended that he apologise to Mr K for the failings that had been identified.

The Commissioner also found the DHB in breach for not providing Mr K with reasonable care and skill (Right 4(1) of the Code); in part for not capturing his GP details on their system. The HDC acknowledged changes the DHB had made, including the development of a letter to be sent to all patients with a condition or injury identified on an x-ray report that was not seen at the time of their presentation. This was to be used when the injury/condition was of a nature that did not require the patient to be recalled to the department, but would advise the patient to discuss the problem with their GP. It was recommended that the DHB also apologised for its failings and report back to the HDC with evidence that this new letter was being used in practice.

The HDC advised the Medical Council of Dr U's name and the outcome of their investigation. The Medical Council was reassured by the changes he had made to his practice and did not feel that any further action was required.

LEARNING POINTS

- The information that a "reasonable consumer, in that consumer's circumstances, would expect to receive" is always going to be a very subjective test. Based on this decision, the HDC appears to have a very low threshold and practitioners should be in the habit of advising patients of all abnormal test results, irrespective of how abnormal or clinically significant they may be.
- Systems and processes can be developed to facilitate this (such as the letter devised by the ED department in this case).
- Organisations should ensure that systems are in place for capturing patients' GP details and populating these on all correspondence to ensure continuity of care.



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No renal review



BY DR ELLEN WELCH, GP

Mr J, a 63-year-old gardener, visited Dr C for his annual health check and routine bloods were requested. Dr A, another GP in the surgery, reviewed the results and noted that Mr J had moderate renal impairment, with an eGFR of 59 ml/min/1.73m² and he coded Mr J as having chronic kidney disease stage 3.

The laboratory recommended that the blood test should be repeated within the next five days. Dr A assumed that Dr C would follow his patient up since he was the doctor who requested the initial blood tests.

A week later, Mr J was seen again by Dr C. He had a sore finger after pruning some trees, and this was the focus of the consultation. The blood results were not discussed and a repeat test was not mentioned as Dr C assumed that Dr A, as the doctor who reviewed the blood results, would have arranged subsequent testing and follow up.

Six months later, Mr J had an appointment with Dr A regarding his painful osteoarthritis. Naproxen was prescribed and placed on repeat prescription. The patient's previous blood results were overlooked and a repeat renal function was not requested.

Another year passed and Mr J consulted this time with an episode of diarrhoea and vomiting. Bloods were checked and showed an eGFR of 50 ml/min/1.73m². The result was recorded by the duty doctor as being consistent with moderate renal impairment, but no further action was taken.

Mr J continued to receive naproxen on repeat prescription for a further two years, and during this time had documented medication reviews by both Dr A and Dr C. He was then reviewed by a locum doctor at the surgery, who noted a degree of renal impairment and stopped the naproxen. Blood tests had not been carried out for a two-year period, so the locum requested a renal function test, which showed a deteriorating eGFR of 44 ml/min/1.73m². Mr J was referred to the nephrology team for review, and his renal function gradually improved after the naproxen was discontinued.

A claim was brought against Dr C and Dr A for continuing to prescribe naproxen despite evidence of renal impairment, and for failing to monitor Mr J's renal function, which had an adverse impact on Mr J's prognosis.

EXPERT OPINION

Medical Protection investigated the claim and instructed experts in general practice and nephrology. The GP expert reviewing this case criticised the failure of both doctors to initially recheck Mr J's renal function in order to confirm or refute a diagnosis of chronic kidney disease. He noted several missed opportunities to act on the abnormal blood results, and was critical of the GPs for prescribing naproxen on a repeat basis without checking Mr J's renal function initially and at least on an annual basis.

The expert nephrologist considered that although the continued prescription of naproxen was likely to have contributed to Mr J's deterioration in renal function, most of the kidney damage occurred prior to the medication being commenced. He agreed that Mr J should have undergone further investigation after the second eGFR result showed a deterioration, and felt it was likely that the naproxen would have been withdrawn at this point. He felt the naproxen was unlikely to have had a clinically significant effect on Mr J's long-term prognosis. The claim was subsequently discontinued.

THE NEW ZEALAND POSITION

As we are a no-fault jurisdiction, with the Accident Compensation Corporation (ACC) covering treatment injury claims, it is very rare for a claim to be brought against a health provider.

A similar situation as the case described above was investigated by the Health and Disability Commissioner (HDC). In this New Zealand case (13HDC01041), an elderly patient was prescribed a non-steroidal anti-inflammatory (NSAID) for musculoskeletal pain and gout. The patient had multiple co-morbidities and known chronic kidney disease. An alert had been placed in the file regarding a previous reaction to an NSAID.

The GP was not cognisant of this alert when the anti-inflammatory was prescribed. Sadly, the patient died from multi-organ failure secondary to acute on chronic renal failure. Following the HDC investigation, the HDC was unable to determine whether or to what degree the prescribing of the NSAID to the patient had contributed to the patient's death. Regardless, the GP was found in breach of The Code of Patient Rights. The GP was required to provide a written apology to the patient's wife and undergo further training on good prescribing practice. The GP was referred to the New Zealand Medical Council.

LEARNING POINTS

- Safety nets should be in place to ensure abnormal blood results are appropriately followed up – at both a practice and individual level. GP surgeries differ in their approach to following up results, but the requesting and reviewing clinicians should know where their own responsibilities lie. In this situation, both Dr A and Dr C assumed the other was managing Mr J with respect to his renal function, as a result of which his follow up was missed.
- Patients taking potentially nephrotoxic medication on a long-term basis should be regularly reviewed and consideration should be given to the need to monitor renal function. Electronic records allow this to be done at a practice level, by conducting clinical audits of all patients coded with chronic kidney disease to ensure they are managed appropriately.



A nitrofurantoin problem



BY DR ANNA FOX, GP

Mrs A was a 70-year-old retired teacher. She had struggled with recurrent urinary tract infections for many years so her GP, Dr G, decided to start her on prophylactic antibiotics. He prescribed nitrofurantoin 50mg once daily, which worked well for her.

Mrs A had her liver function tests checked approximately 14 months after starting the nitrofurantoin and they were normal. Subsequent testing ten months later revealed a slightly raised ALT of 54. Dr G considered the results and decided that no further action was required. He knew that Mrs A was overweight and thought the slightly raised ALT was probably due to a fatty liver.

Five months later, now three years after the initiation of nitrofurantoin, Mrs A went to see her GP with a rash on her legs. It was unlike any rash she had had before and looked like lots of small bruises. Dr G was not sure what was causing the rash so he arranged some blood tests and referred her to hospital.

Liver function tests revealed a significantly raised ALT of 161. The rash was diagnosed as possible leucocytoclastic vasculitis. It was suggested that the rash and the raised liver enzymes were caused by the nitrofurantoin. The drug was stopped, Mrs A's rash resolved and her ALT returned to normal.

Mrs A made a claim against Dr G, alleging a failure to perform medication reviews, a failure to arrange repeat testing when the ALT was noted to be mildly abnormal, and a failure to stop nitrofurantoin at an earlier stage.

EXPERT OPINION

Medical Protection sought expert opinion from a GP and a rheumatologist. The expert GP was critical of Dr G for failing to repeat the liver function tests following the initial, slightly abnormal result. It was felt that Dr G should have considered other possible causes for the raised ALT, including nitrofurantoin, and not simply assumed it was due to a fatty liver. Had this been done, it is likely that nitrofurantoin would have been stopped approximately one year earlier than it actually was.

The rheumatologist's opinion was that Mrs A's raised liver enzymes and rash would be consistent with the use of nitrofurantoin, and on the balance of probability would not have occurred had the drug been stopped an earlier stage.

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

LEARNING POINTS

- In a New Zealand setting, if this had been a complaint to the HDC, it is likely that the GP would be criticised for the failure to follow up on the raised ALT, and if there had been no monitoring of respiratory function this might also have been criticised. There would also be the question of fully informed consent with treatment beyond six months.
- Hepatotoxicity is a potentially serious side effect of a number of drugs including nitrofurantoin. Clinicians should weigh up the risks and benefits of nitrofurantoin before initiating treatment, especially with long-term use in high risk patients.¹
- Annual medication reviews provide an opportunity to assess the need for any monitoring and to determine what, if any, action needs to be taken regarding a specific drug. It is important to have robust systems in place to ensure that annual medication reviews are performed, particularly in patients on long term medication.
- New Zealand guidance on long-term nitrofurantoin is that "its use is associated with the development of interstitial lung disease and pulmonary fibrosis, particularly in elderly people and with longer courses".²

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Sciatic nerve injury but was it negligent?



BY DR ELLEN WELCH, GP

Mrs D, a 68-year-old housewife, had consulted her GP, Dr L, regularly over a number of years for various minor musculoskeletal complaints. She complained intermittently of low back pain, for which she typically received an intramuscular injection of diclofenac. Over a five-year period, it was documented that she had received five intramuscular injections from Dr L without any problems.

On one occasion, Mrs D visited Dr L complaining of severe dizziness, vomiting and headache. Dr L diagnosed her with likely vestibular neuronitis and offered her an intramuscular injection of dimenhydrinate to improve her symptoms. Dr L carried out the procedure as he had many times before, by asking Mrs D to lie in the left lateral position. He injected 1ml of the antihistamine into the dorsogluteal site at the upper, outer quadrant of her right buttock. She did not complain of any excessive pain following the injection.

Almost two weeks later, Mrs D returned to see Dr L, complaining of swelling at the injection site, associated with pain and numbness over her right leg. She reported that these symptoms had started soon after leaving Dr L's clinic, and she had continued to experience pain and numbness extending from the injection site, all the way down the lateral aspect of her right leg to her toes. Dr L explained that the pain could be caused by chemical irritation from the injected medication, and he prescribed anti-inflammatories.

Mrs D continued to experience these symptoms and consulted with Dr L several times. A month later, she decided to seek a second opinion from another GP, Dr U, who raised the possibility that she had sustained an injury of the right sciatic nerve due to the injection she had received. He referred her to see Dr P, an orthopaedic surgeon, who reviewed her in the outpatient clinic a month later. Dr P examined Mrs D and documented good range of motion in her hip, with no muscle wasting, normal power and normal lower limb reflexes. Diffuse numbness was found from the groin to the toes, which did not correspond to the distribution of any known spinal nerve root or peripheral nerve. Dr P reported that in his opinion, her condition was unlikely to be caused by any injury to the sciatic nerve, and she was treated for lumbar spondylosis.

Mrs D continued to consult with Dr L for another four months with persisting symptoms, and the clinical findings remained unchanged. He referred her for a neurological opinion, documenting in his referral notes that she was experiencing "numbness after injection three months ago with upper thigh muscle atrophy".



After his initial consultations with Mrs D, Dr L continued to consult with her on several occasions, but did not write down any of his physical examination findings

Mrs D made a complaint against Dr L, alleging iatrogenic nerve damage.

EXPERT OPINION

As part of the neurologist's investigation, Mrs D underwent an electrophysiological study, which showed a slight reduced recruitment ratio over her right inferior gluteal nerve suggestive of chronic denervation.

Expert witnesses on both sides agreed that the results of this study could not fully account for Mrs D's clinical symptoms, since the inferior gluteal nerve is a purely motor nerve and would therefore not cause sensory symptoms. Her diffuse numbness did not correspond to the distribution of any known spinal or peripheral nerve.

Concerns were raised by the expert witnesses regarding Dr L's documentation of the case. After his initial consultations with Mrs D, Dr L continued to consult with her on several occasions, but did not write down any of his physical examination findings. He documented that she complained of 'muscle atrophy', but this was not confirmed on examination. Dr L stated that he wrote the words 'muscle atrophy' because these were the words Mrs D had used, and the problem

she complained of, but he himself did not find any objective evidence of atrophy.

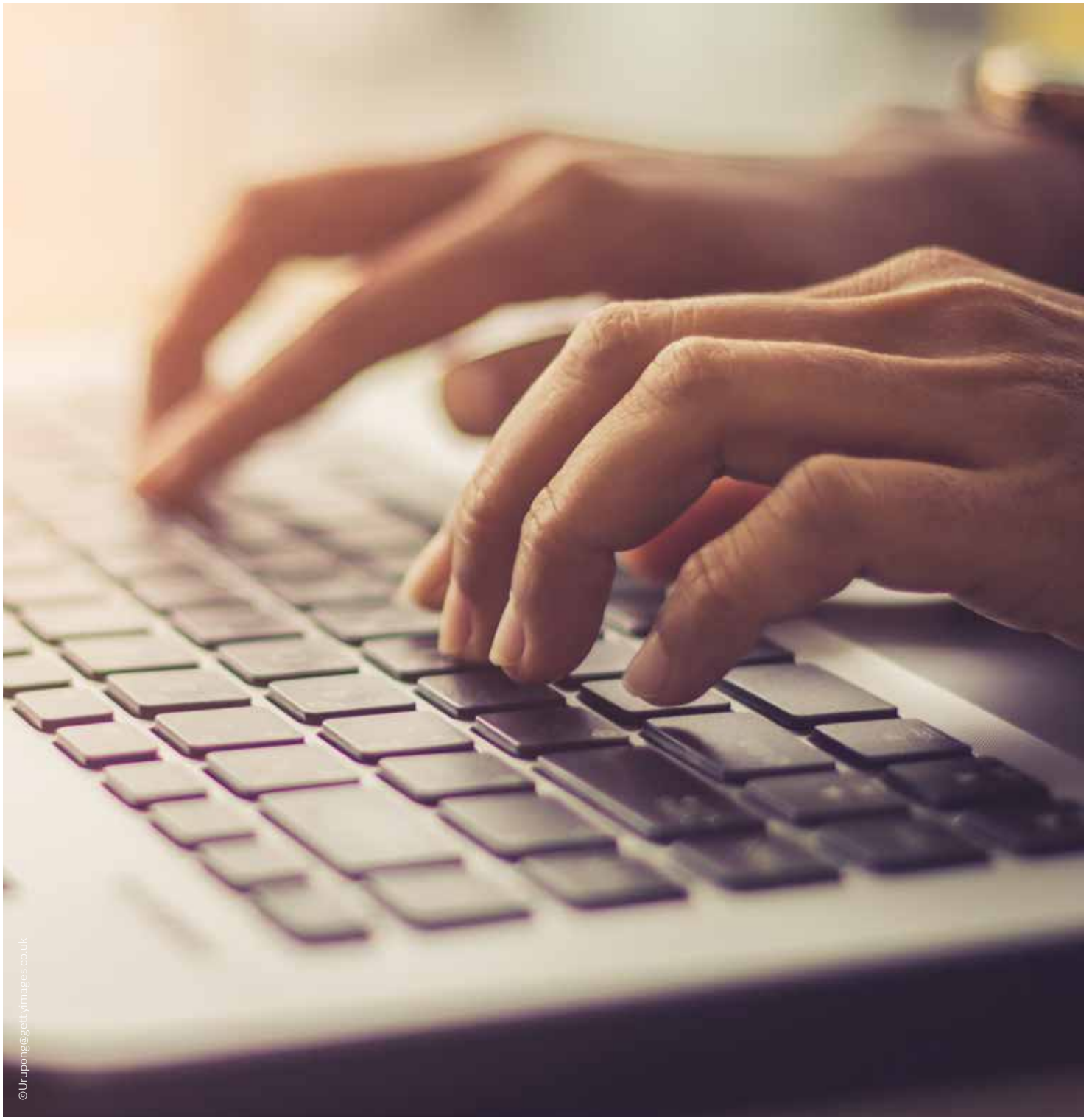
However, neither the distribution nor the timing of the onset of Mrs D's symptoms fit the typical distribution for sciatic nerve injury, and there was no other documented neurological abnormality. Medical Protection provided a letter of response, and no further action was taken.

LEARNING POINTS

- The dorsogluteal site or the 'upper, outer, quadrant' is the traditional IM injection site of choice, but it has been associated with injury to the sciatic nerve. The ventrogluteal region is now preferred as the first choice injection site despite having a shallower muscle depth as it is farther from neurovascular structures.
- Good clinical documentation, as always, is an essential part of the consultation, and should a patient take legal action, a defence will be built on the clinical notes. It is easy to become relaxed about documentation with patients who present often and/or are well known to the doctor, but examination findings, including significant negatives, should always be recorded.

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Strong record-keeping – strong defence



BY MR SAM **DRESNER**, GENERAL SURGEON

Ms Q, 58 years old, consulted Dr G, a gastroenterologist, with a history of dyspepsia, early satiety and altered bowel habit. Clinical examination, including digital rectal examination, was recorded as normal.

Dr G requested a full set of routine bloods and a chest x-ray (Ms Q had a long history of asthma), all of which were normal. Ms Q was advised that an upper gastrointestinal endoscopy and colonoscopy were required to further investigate the cause of her symptoms. Dr G documented that he had discussed the nature of the investigations, the possible need to take biopsies or remove polyps for histopathological examination and the risks involved. He provided standard hospital information booklets about the endoscopic procedures and obtained written consent from Ms Q. Specifically, he advised her that there was a very small risk of perforation (of the order of less than 0.01% for an upper gastrointestinal endoscopy and 0.1-0.5% for a colonoscopy), which might require emergency surgery.

Dr G provided Ms Q with bowel preparation and scheduled her appointment for a bidirectional endoscopy a few days later. When she attended for the investigations, Dr G reviewed her again in the presence of an endoscopy nurse. He went over the procedures once more and the risks involved, and obtained further written confirmation of her consent.

The hospital records indicate that the patient entered the endoscopy room at 12pm and was provided with conscious sedation using intravenous midazolam and fentanyl. Her blood pressure was recorded as 130/60, oxygen was supplied via nasal cannula and her saturations noted as >98% throughout the procedure. The initial upper gastrointestinal endoscopy demonstrated some mild antral gastritis but no other abnormalities. A helicobacter pylori test was negative.

Antral biopsies were taken, which later confirmed acute-on-chronic gastritis and intestinal metaplasia. Attention then turned to the colonoscopy. Dr G recorded that the colonoscope was inserted up to 25cm, where extensive diverticular disease was evident. Dr G encountered difficulty in negotiating this segment of the colon, noting diminished insufflation and that Ms Q was experiencing pain. A colonic perforation was suspected, and the procedure was therefore immediately abandoned.

Dr G noted that Ms Q's abdomen was distended, with lower abdominal tenderness but no peritonism. He prescribed broad spectrum intravenous antibiotics, intravenous fluids and more opiate analgesia, and advised

that she should be kept 'nil by mouth'. Ms Q remained stable and was transferred directly to the radiology department for an urgent CT scan of the abdomen and pelvis, and afterwards was moved to a ward at 1.05pm.

Dr G attended Ms Q at 1.40pm and informed her and her relatives that a perforation of the colon had been identified on the CT scan, with extensive retroperitoneal gas but also some possible intraperitoneal free gas and fluid. By this stage Ms Q's abdomen had become more distended, her pain was worse and she had a tachycardia >100bpm. Dr G advised that in view of her clinical deterioration and the CT findings, surgery would probably be required. After discussion with Ms Q and her relatives, he arranged transfer to a nearby emergency hospital facility.

Dr G contacted the on-call surgical team at the nearby hospital, prepared a referral letter and escorted the patient during her transfer, briefing the receiving staff on her condition upon arrival. Emergency surgery was performed later that day with resection of the perforated diverticular segment and primary anastomosis. Dr G contacted the surgeon the following morning, who confirmed that the prompt action had minimised the contamination seen in the abdominal cavity at the time of surgery, allowing him to perform a primary anastomosis. Dr G visited the patient several times during her admission and subsequently saw her in his clinic for review after discharge, noting that she had made a full recovery.

Three years later just before the end of the limitation period for bringing a claim in the UK, Ms Q decided to pursue a claim against Dr G.

EXPERT OPINION

This was a UK Medical Protection case but the principles are the same for New Zealand. It was clear from the detailed documentation that Dr G provided to his Medical Protection legal team that he had acted entirely appropriately in response to a well-recognised but rare complication. Ms Q had been clearly warned about and understood the risks prior to the procedure. As a result, expert advice for Medical Protection concluded that the patient's solicitors were unlikely to pursue their claim and, indeed, the case was subsequently dropped.

However, Ms Q went on to complain about Dr G to his Medical Council. Medical Protection again assisted Dr G by providing further reassurance and advice, confirming that their independent expert opinion felt his actions had been entirely appropriate. They helped him compile an appropriate response to the investigation, which demonstrated reflection and insight but robustly defended

his communication with the patient and the subsequent handling of this well recognised complication. The complaint was dismissed without further action.

LEARNING POINTS

- Accurate and clear documentation, which often may need to be relied upon years after the event, are the cornerstone of any medicolegal defence. In this case, there was a thorough process of consent, recording the risks of the colonoscopy and the potential consequences of any complications. When it became apparent that a perforation had occurred, Dr Q was able to rely on his detailed notes, which confirmed his prompt and appropriate actions and his clear communication with the patient and her relatives.
- The development of a complication is not necessarily evidence of negligence, provided the patient has been warned of the risks, the procedure has been carried out to an acceptable standard and all reasonable steps have been taken to minimise the effects of the complication. In this case Dr Q's prompt and appropriate actions may have prevented further contamination of the abdomen and the severity of sepsis. Although ultimately this may not prevent a complaint, it helped contribute to a robust defence.
- This case also highlights the necessity to be open and honest when complications develop. All healthcare professionals have a professional responsibility to be honest with a patient when things go wrong: this was exemplified by Dr G's prompt and clearly documented communication with Ms Q and her relatives. This was not a medical mistake but a recognised complication about which Ms Q had been warned. Although Dr G's open and honest approach did not prevent the complaint to his Medical Council, it helped contribute to the dismissal of the complaint as he was able to demonstrate that he had carried out professional duties promptly and appropriately.



The age of information

I read with interest your case report on the pulmonary complications of nitrofurantoin.

Every prescription dispensed to me has always contained an information leaflet saying in bold: "Read all of this leaflet carefully before you start using this medicine." In this particular instance, the leaflet then goes on to say that the lungs may react to this drug causing breathlessness, "especially in elderly patients".

All the drugs I have ever received contain this type of information leaflet. This leaflet is clearly meant for the patient, and I assume its distribution is standard practice. Whatever the perceived failings of the doctor, does the patient not bear some responsibility in this age when patients can often arrive at the doctor with volumes of downloaded information?

Gerald McEnery
Retired paediatrician

Why no colonoscopy?

I am an inveterate reader of your journal, which I find most instructive not only from the medicolegal aspect but from a clinical perspective. Thus I find your article on bleeding haemorrhoids extremely puzzling and perplexing.

Firstly, the diagnosis is made on the history and rectal palpation. The history is excellent but a conclusive diagnosis cannot be made on the history alone. Rectal palpation also cannot suffice. A simple and conclusive examination is proctoscopy. Visualising the haemorrhoids is conclusive and, in the absence of such visualisation, irrespective of the age of the patient, colonoscopy is mandatory.

Secondly, colonoscopy would have revealed the cause of the bleeding and, at this stage, the tumour may well have been contained and thus totally curable. In other words, this young man may well have been alive and well today.

Dr Leslie Hotz

I was appalled when I read this case. I do not agree with the outcome and it is my opinion that the standard of care was very poor. Subsequently, this case is indefensible.

I cannot believe that a GP expert would defend this case by stating that the history of straining with fresh blood on defecation would be consistent with a diagnosis of haemorrhoids. The latter can also be consistent with the diagnosis of colorectal cancer. That is why you may never assume that rectal bleeding is due to haemorrhoids: this is a very basic rule that I was taught in medical school almost 30 years ago.

The patient had a six-month history of abdominal pain and rectal bleeding when he presented to his GP. He should have immediately



These are interesting points. The amount of information you give to each patient will vary according to the nature of their condition, the potential risks and side effects and the patient's needs and wishes. You should check that the patient has understood the information, and encourage them to ask questions to clarify any concerns or uncertainty. Patient information leaflets are useful supplements to the information you give patients about their medicines, but they are not a substitute for that information.

In answer to your question, if a patient is already well informed about a particular drug from their online research the discussion can of course be tailored to their 'needs and wishes', but ultimately it is the responsibility of the doctor to ensure that the patient has been given (and has understood) the information they need to make a decision.

been referred for further assessment – there is no excuse. The fact that Dr B felt that this was most likely haemorrhoids secondary to constipation is on its own also a reason for further investigation. Any adult with a change in bowel habits (without an obvious reason) should also be investigated further.

Students and young doctors should not be taught that this standard of care is acceptable by any means. We cannot condone what happened here. I feel that the GP expert in this case should be held liable.

Dr Debbie Bekker



Thank you for your comments on the case report on haemorrhoids that appeared in the latest edition of Casebook.

I appreciate your concern, and should first of all clarify that the cases we publish are taken from around the world in the countries in which we support members, where local practices and guidelines may vary. Cases may also take a number of years to resolve, and so accepted best practice and guidelines can change in that time. In this case our member had asked the deceased to attend for blood tests and to return in four weeks for review. Had the bleeding been reported to be continuing, our member would have referred the deceased for further investigations in secondary care. This plan was clearly documented in the medical records.

The claim was successfully defended at an early stage in the litigation process on the basis of a supportive expert report, which was a good outcome for our member. However, we recognise that in reporting this case we should have taken the opportunity, as we usually do, to illustrate current good practice by reference to up-to-date guidelines.

Antibiotic allegations

In the last issue of *Casebook*, in the case “Antibiotic allegations”, patient G gave a history of cough and fever for four days and, in the next paragraph, it was recorded that she “was on day four of a five day course of amoxicillin prescribed by her dentist”. It seems that she did not see any connection between going to the dentist and her cough. Normally one does not go to a dentist for a viral respiratory infection, and a dentist usually prescribes amoxicillin for a dental procedure on an infected (or potentially infected) tooth condition. Could it be that her fever and cough started or deteriorated after the dental procedure? Could she have choked and aspirated some of the oral fluid during the procedure?

As a thoracic surgeon, I have seen quite a few cases of cough and fever following dental procedures, some developing into pneumonia, probably due to aspiration. These cases were confirmed by a CT scan and bronchoscopy. A bronchoscopy would help to confirm the diagnosis, identify the offending organism (which is often resistant to the penicillins including amoxicillin) and, by clearing the bronchus and starting the correct antibiotics, set the pace to recovery.

Perhaps we should look deep through the stories the patients try to tell us. Sometimes we need to view the various facts from another angle. Perhaps we should be more aggressive or defensive or thorough in our investigations. Our patients’ demand for perfection in medical service is ever-growing. Unless we can meet such challenges, our list of litigation will keep growing.

John SM Leung MB, BS, FRCSEd



Thank you for your email regarding the case report “Antibiotic allegations”. Your observations on this case are interesting and identify common themes that we see arising from our cases, such as the need to take a detailed history, revisit a diagnosis when a patient does not improve, and carefully manage the expectations of patients.

Antibiotics: to complete or not?

I notice in your case entitled “Antibiotic allegations”, your expert comments: “Incomplete antibiotic courses promote the growing problem of antibiotic resistance.” However, my understanding is that the latest evidence has turned this old adage upside down, and suggests that completing courses of antibiotics may actually contribute to antibiotic resistance. I have been told by some senior colleagues that we ought to be advising patients to cease taking antibiotics when they become asymptomatic, rather than advise them to ‘complete the course’.

Are you able to get a microbiologist to comment on this? I would hate your fine publication to be encouraging inappropriate antibiotic stewardship.

Dr David Jonathan Jones



I note your concerns about the case report “Antibiotic allegations”, specifically whether the advice from our expert that “incomplete antibiotic courses promote the growing problem of antibiotic resistance” may no longer be correct.

I have asked a microbiologist to comment on this, who has advised me that the recent debate on the subject of completing a course of antibiotics was initiated by an article in the BMJ in July 2017. There is apparently no new guidance for clinicians and the matter is still being debated among the experts.

*We will keep an eye on developments in this area and bear this in mind for future case reports. Although the experts we instruct must provide their opinion on the standard of care according to accepted practice at the time of the incident giving rise to a claim, we also want to ensure that the advice given in *Casebook* is up to date.*



**We welcome all contributions to Over to you.
We reserve the right to edit submissions.**



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