

Learning from other people's mistakes

Clinical negligence claims are a rich source of risk management material. Although medical practice varies to some extent around the globe, familiar themes can be identified from the cases reported to the Medical Protection Society's (MPS) Claims Committee. Case reports inevitably focus on the lessons that can be learnt and so tend to be reports where the errors in management are unequivocal. However, this should not be seen as a reflection of all the claims reported or even settled by the MPS. The dividing line between accepted medical practice and negligence can be exceptionally fine, and in some otherwise defensible cases, settlement has to be made simply for want of relevant evidence, such as adequate medical records.

The following cases are just a few examples from Hong Kong and other jurisdictions which make a particular point and serve as a useful reminder of the essentials of good practice.

Making a diagnosis

A patient consulted a general practitioner over a period of 8 years, complaining mainly of tiredness and loss of weight. There were numerous consultations, the records of which amount to the list of medicines prescribed with an occasional blood pressure reading but no other clinical findings. Finally, a visit to another doctor led to a diagnosis of renal stones and hydronephrosis. There is no hint within the records that either of these diagnoses were at any time entertained by the general practitioner.

An expert reviewing the case concluded that the quality of care provided by the doctor fell well below that to which the patient was entitled. Specifically, there was failure to assess the patient's condition adequately, failure to control the patient's blood pressure, failure to undertake routine urinalysis and other basic investigations, and failure to refer for an expert opinion.

Misdiagnosis

Doctors are always advised to listen very carefully to their patients but just occasionally that advice may be followed too closely. A 48-year-old man suffering with chest pain was seen by his family doctor. He described central chest pain associated with nausea, feeling generally unwell, and lethargy. He described how this had come on after eating a spicy meal and reassured the doctor that it was another bout of indigestion and that it just needed time to settle. The patient was prescribed antacids and died during the night.

In the subsequent claim, the doctor's conduct was considered open to some criticism for failure to carry out a

full assessment. Experts who examined the case had every sympathy with the doctor. However, they advised that he was vulnerable to adverse criticism for failing to take a full history, failing to examine the patient adequately, and failing to advise the patient that further investigations were necessary to rule out the diagnosis of myocardial infarction. Consequently the claim was settled.

Ignoring someone else's diagnosis

A 13-year-old boy woke with a sharp pain in his right testicle and vomited. He was seen urgently by the duty general practitioner who diagnosed torsion of the testis and advised the parents that urgent surgery was necessary. His parents took him to the local hospital where he was seen by the surgeon on call. The surgeon noted a painful right hemi-scrotum with a tender and hard epididymis, made a diagnosis of epididymitis and sent him home.

The patient returned to the Accident and Emergency Department the same evening and was seen by a different doctor who, like the general practitioner, suspected torsion of the testis. The claimant was then reviewed by the same surgeon who confirmed his previous diagnosis and discharged the patient for a second time. Seven days later, the child was seen at the hospital again and taken to theatre, where a gangrenous testicle was found. There was no evidence of epididymitis.

Expert opinion resulted in speedy settlement on the basis that there were no grounds to make such a confident diagnosis of epididymitis and that in these circumstances, exploration of the scrotum should have been undertaken as soon as possible.

Failure to refer

A worried female patient in her forties reported the presence of a breast lump to her general practitioner. On examination, the general practitioner was not convinced that there was a discrete lump and therefore suggested that the patient returned following her next menstrual cycle. On the second occasion, examination was again inconclusive and so a further follow-up appointment was made. On the third occasion, there appeared to be no change and the patient was anxious to be reassured so it was decided to take no further action unless the lump changed.

Some months later, the patient was referred by another doctor to a consultant surgeon and a diagnosis of breast carcinoma confirmed by histology. The failure here to take further action to establish the diagnosis led to an inevitable admission of breach of duty of care by the general practitioner.

Technical errors

A young woman presented to her general practitioner with fever, headache, bone pain, and cough of 1 day's duration. Her medical history was unremarkable. Examination revealed a congested throat and slightly raised temperature. An upper respiratory tract infection was diagnosed. Prescribed treatment included amoxicillin, paracetamol, chlorpheniramine, and a cough syrup. In view of the fever, the doctor also administered an intramuscular injection of diclofenac into the right buttock. The patient was sitting at the time the injection was given and did not complain of any pain or numbness at the time. She was apparently able to walk out of the room without limping. Approximately 1 week later, the patient returned to see the doctor about her upper respiratory tract infection but complaining now of pain in the right buttock and numbness in the right leg which failed to resolve over a further 3 weeks. The patient was referred to a hospital where an electromyogram showed impairment of sensory nerve conduction of both peroneal and sural nerves, with normal motor conduction studies—a picture consistent with right sciatic nerve injury, affecting the sensory component.

While injections are given into the buttock with the patient sitting, the landmarks for injection may be distorted in this position, and in this case resulted in an injection into the sciatic nerve. Had the injection been given with the patient standing or lying prone, the landmarks would have been more easily defined and this problem avoided.

In another case, a young child presented to a local hospital with symptoms suggestive of appendicitis. The surgeon arranged to operate immediately. On entering the abdominal cavity, turbid fluid was encountered so that the appendix was not easily visible. The surgeon then identified a tubular structure that was indurated, attached at its base to a pinkish structure, identified as the caecum. The histology report revealed that the excised structure was in fact a fallopian tube, not the appendix. Subsequent analysis by experts threw doubt on the accuracy of the diagnosis of appendicitis and concluded that there was no excuse for the error which had been made.

Failure to warn

A 45-year-old man was referred to hospital with a history of a change in bowel habit and intermittent abdominal pain. Abdominal examination revealed mild tenderness of the lower abdomen but nothing else of note. The patient was advised to undergo a colonoscopy but was not warned of the risk of perforation with that procedure.

The colonoscopy was performed on the next day. The rectum was found to be inflamed. As the colonoscope turned into the sigmoid colon, the patient complained of increased pain. The abdomen then appeared distended and the lumen

collapsed, despite air insufflation. Perforation of the colon was immediately suspected and a plain X-ray of the abdomen revealed a pneumoperitoneum. A laparotomy was then undertaken, the perforation found, repaired, and the patient discharged home some days later.

Experts advised that perforation of the colon or rectum is a well-recognised risk of colonoscopy—the frequency being perhaps one or two times in a thousand cases. Although there was no criticism of the way the colonoscopy itself was conducted, or the subsequent management, the failure to warn of the chance of perforation rendered the claim indefensible.

In virtually every jurisdiction in which MPS operates, informed consent theory is now the rule, requiring clinicians to provide patients with all material information so that they are empowered to accept or refuse treatment as they see fit.

Medication errors

Medication errors account for approximately 20% of all claims in both general practice and secondary care. Two examples of recent claims in relation to medication errors are presented.

A patient in her twenties sought advice from her doctor on malaria prophylaxis. The doctor identified mefloquine as the drug of choice for the area the patient was about to travel to. Although he took a history of drug allergy, he did not specifically ask the patient about any previous psychiatric illness, and did not notice on her medical records that she had a history of anxiety and depression. Mefloquine is contra-indicated in such circumstances, and the doctor had to admit subsequently that had he read the medical records or taken a full history, he would not have prescribed it. Two days after prescribing mefloquine, the patient suffered an acute psychotic episode which necessitated her being admitted to hospital and the subsequent claim being settled for a very substantial sum.

A patient stabilised on warfarin developed joint pain over a weekend and was seen in an emergency clinic where the patient's notes were not available. The doctor did not elicit a full drug history and, unaware that the patient was taking warfarin, prescribed a non-steroidal anti-inflammatory drug. Three days later, the patient suffered an acute intracerebral bleed resulting in a dense right hemiplegia and dysphasia. The case was deemed indefensible due to the failure to take a full drug history.

Administrative failure

A woman in her early forties attended her general practitioner complaining of inter-menstrual bleeding. In preparing the referral letter, the doctor came across a cervical smear test taken two and a half years before, which showed some abnormal cells and advised a repeated smear.

Although that report was signed as having been seen, no action had been taken and the patient's condition had been left to deteriorate over the intervening period.

Conclusion

Good medical practice is defensible medical practice and the first rule of avoiding being sued is to keep within the limits of your own expertise. This may sound self-evident but as the above case histories demonstrate, there are cases where people who thought they knew what they were doing clearly did not.

The expertise or competence issue extends to delegation. When delegating tasks to others, whether or not medically qualified, the delegating doctor should always check that the individual is competent to complete the task to a reasonable standard. Equally, delegated duties should not be accepted if they cannot be completed to a reasonable standard.

Keeping up-to-date is another important and related issue. Medical practice is constantly evolving. Using out-dated techniques inevitably makes a practitioner vulnerable to criticism. Having the right facilities and necessary help at hand is a further prerequisite for providing adequate care. Any shortfall which might jeopardise patient care should lead to delaying the procedure unless doing so would, on balance, be more hazardous for the patient.

No matter how good the clinician may be in any given team, adverse incidents are inevitable if there is administrative chaos. There must be systems in place to ensure that patients are not lost to follow-up, referrals are made, test results are reviewed, and abnormalities acted upon.

Good communication lies at the centre of medical practice. Establishing rapport and gathering sufficient information are clearly essential, as is explaining clearly what management is proposed and why—failure to do so inevitably results in poor compliance. Communication also lies at the heart of obtaining valid consent, as a patient who is inadequately counselled may simply not be in a position to give valid consent. Continuity of care requires clear communication between members of multi-disciplinary teams and between different clinical teams. In this context, it is the written communication contained in clinical records and correspondence which must set out clearly the management plan and who is responsible for each aspect of its delivery.

G Panting, FRCGP, DMJ
(e-mail: gerard.panting@mps.org.uk)
Communications and Policy Director
The Medical Protection Society
London
W1G 0PS
United Kingdom

Answers to CME Programme *Hong Kong Medical Journal* December 2003 issue

HKMJ 2003;9:407-14

I. Status of obstetric epidural analgesia service in Hong Kong public hospitals: postal questionnaire survey

- | | | | | | |
|---|----------|----------|----------|----------|----------|
| A | 1. False | 2. True | 3. False | 4. False | 5. False |
| B | 1. True | 2. False | 3. True | 4. False | 5. False |
| C | 1. True | 2. False | 3. True | 4. True | 5. True |
| D | 1. True | 2. True | 3. False | 4. False | 5. True |

HKMJ 2003;9:415-8

II. Penicillin and vancomycin tolerance among clinical isolates of *Streptococcus pneumoniae* in Hong Kong

- | | | | | | |
|---|----------|----------|----------|---------|----------|
| A | 1. False | 2. True | 3. False | 4. True | 5. False |
| B | 1. False | 2. False | 3. False | 4. True | 5. True |
| C | 1. True | 2. False | 3. False | 4. True | 5. True |