

Pitfalls in practice

There are now approximately 7000 Medical Protection Society (MPS) medical members in Hong Kong generating, in 2002, 250 new files of which 20% were clinical negligence claims. The remainder comprised complaints, Medical Council inquiries, inquests, and a variety of other cases including criminal prosecutions for indecent assault and manslaughter.

Claim frequency has risen markedly in the last 10 years (Fig 1) with a commensurate increase in the payments made in Hong Kong (Fig 2). Currently, MPS has just over 100 outstanding claims in Hong Kong with a total reserve in excess of HK\$100 million.

The vast majority of clinical negligence cases turn on just one or two key elements in the chronology, but the theme

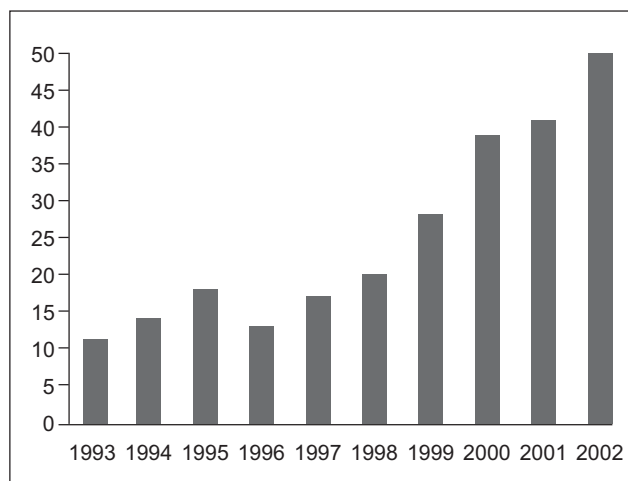


Fig 1. Number of claims, 1993-2002, Hong Kong

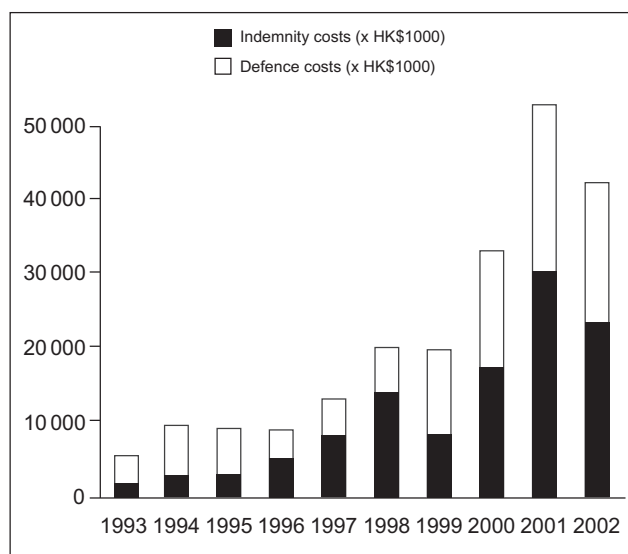


Fig 2. Payments arising from claims, 1993-2002, Hong Kong

for these errors may well have been set by a long sequence of events culminating in one poor decision, often in an attempt to serve the best interests of the patient.

System failures

A 23-year-old woman was referred by her general practitioner to a consultant neurologist following a series of syncopal attacks which the general practitioner suspected to be epileptic fits.

She was seen by the hospital and further investigations were instituted but because of the convincing nature of the history, anti-epileptic medication was started.

The general practitioner's letter had not stated that she was taking the oral contraceptive pill and the hospital consultant had not enquired about this.

For reasons which are unclear, the patient missed the next out-patient appointment at the hospital and she was sent a letter with a further appointment. However, by the time of that appointment she had fallen pregnant and was referred for a termination of pregnancy. As a result, she missed the next appointment. The consultant wrote to the general practitioner indicating that she was probably not epileptic and suggesting the withdrawal of anti-epileptic medication.

That letter was received by the general practitioner but was filed away without action being taken and as a result, the patient continued to receive anti-epileptic medication for a further 7 years before the error was discovered.

This case serves as a graphic illustration of how system failures combined to result in the patient suffering avoidable harm, first in relation to the unwanted pregnancy and secondly, from the side-effects of medication over a prolonged period with all the psychological and social consequences of being diagnosed as epileptic when in fact she was not. Primarily, administrative and system failures pave the way for adverse events culminating in clinical negligence claims. But few chronologies are so complex, the next example being far more typical.

A simple administrative oversight

A patient attended his doctor complaining of discomfort in the right side of his scrotum for just 1 week. On examination, there was tenderness on palpation of the right testicle but there was no swelling, irregularity, or any other abnormality detected.

Two years later the patient returned, again complaining

of pain and swelling in his right testicle. Examination on this occasion revealed inflammation of the scrotum with swelling and redness. A diagnosis of epididymo-orchitis was made and antibiotics prescribed. The patient was told that he could expect to get better over a few days and should return if there was no improvement after 1 week. The patient did not return for another 4 months when the patient was re-examined and the doctor noted that the swelling had not decreased in size. The patient was referred to hospital where a right orchidectomy was performed. The excised testis was examined by the pathologist who diagnosed a mixed germ cell tumour. This report was sent to the surgeon who concluded that there was no malignancy and reassured the patient that the tumour was benign. Consequently, no further investigations or management were advised.

The pathologist had also taken some additional sections for treatment with special stains. The results of this further examination were not available until later but a second report revealed that, in addition to the non-seminomatous germ cell tumour, there were also immature teratoma and embryonal carcinoma forming major components. However, this second report was not seen by the surgeon until the patient was re-admitted with lung metastases some months later.

The failure to take appropriate action in the light of the second pathology report could clearly not be defended, making this case an inevitable settler.

Another problem with this case related to the follow-up arrangements when the patient re-presented after a 2-year interval. The patient was properly assessed, given appropriate advice and treatment but the experts concluded that more positive steps were required to secure follow-up so any question over whether the swelling had failed to resolve completely could have immediately triggered further investigation.

Medication errors

Medication errors are a common cause of clinical negligence claims in Hong Kong as elsewhere, the more common errors being administration of a drug which the patient is known to be allergic to, prescribing or dispensing the wrong drug, prescribing contra-indicated drugs, failure to warn of adverse effects or alarm symptoms requiring immediate reporting, failure to monitor adequately, and excessively prolonged administration.

The classic allergy case is the administration of penicillin to a patient known to be sensitive to it, often with a clear statement to that effect on the medical records. But this category also includes claims where there is a cross-reaction, for example between penicillin and the cephalosporins.

There are numerous examples of patients being given

the wrong drugs and patients being prescribed or dispensed the wrong drugs because of similar sounding names. Looking back over the MPS annual reports, the most commonly cited example is the prescription of chlorpropramide instead of chlorpromazine, resulting in profound hypoglycaemia and brain damage. In one case in England, a doctor prescribed Amoxil for his patient. The handwritten prescription was taken to the pharmacy where it was misread as Daonil, another hypoglycaemia drug. The patient suffered profound hypoglycaemia, brain damage and sued both the pharmacist and doctor. Very substantial damages were awarded, 75% against the pharmacist for failing to check something that he was not sure about and 25% against the doctor for bad handwriting.

In another case, again in the United Kingdom, a patient who had undergone a hysterectomy was written up for epidural diamorphine, 3 mg as required. When the patient complained of pain, the ward staff nurse called the duty doctor who misread the prescription as 30 rather than 3 mg and administered 30 mg. Soon after, the patient collapsed, was resuscitated but remained in a coma, dying some days later. That case was subsequently analysed in great detail as criminal charges were brought against the doctor who administered the fatal dose. He in fact came from New Zealand where diamorphine cannot be prescribed or used. He was therefore totally unfamiliar with the drug and the sorts of doses that might be used by various routes of administration. He had only recently arrived in the country. As Resident Medical Officer (RMO), his role was to provide any medical care required by patients when their own consultants were not immediately available. The anaesthetist in this case did not check with the RMO to ensure that he was familiar with the use of epidural postoperative pain relief and was competent to administer epidural diamorphine. Furthermore, there had been no induction training for the new doctor who had been expected simply to pick up the hospital protocols and procedures as he went along. One of those procedures required any dose of diamorphine to be checked by the nursing staff on the ward. But that did not happen in this case, firstly because the RMO did not know that that was required and secondly because the staff nurse was a temporary agency nurse who was also unfamiliar with the rule. Although the RMO was culpable for failing to check the dosage of a drug that he was unfamiliar with, via a route of administration which he had never used before, there are other obvious failures in this scenario which set the scene for the ultimate tragedy.

Prescribing contra-indicated drugs is another familiar theme found in MPS cases. For example, the use of some non-steroidal anti-inflammatory drugs in patients with a known history of peptic ulceration has cropped up a number of times. In one case, a 77-year-old man with a known history of duodenal ulcer complained of pain in his knees and hips. The doctor who saw him took a history, but was reassured that the patient had been asymp-

tomatic for several years. He prescribed Peroxicam. Five days later, the patient was admitted to hospital following a severe haematemesis and required urgent surgery. In this particular case, the patient was warned to stop taking the drug and to return to the doctor immediately if he suffered indigestion. Unfortunately, these events took place so quickly that the warning was to no avail.

Prolonged use of steroids may result in a number of very well-documented adverse effects. One indefensible claim resulted from the prescription of prednisolone and betamethasone over a prolonged period as treatment for psoriasis by a practitioner apparently ignorant of the various complications that might ensue. From the medical records there is clear evidence of Cushing's syndrome after several years' treatment. The following year, the patient com-

plained of pain in the left hip. That pain was attributed to bad weather. The patient was continued on steroids and analgesics. The joint deterioration was rapid and a total left hip replacement was necessary just 6 months after the initial symptoms.

The expert reports in this case confirmed the use of systemic steroids to treat mild psoriasis is inappropriate and that avascular necrosis of the femoral head is a likely consequence of that treatment.

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