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Medical Protection

Casebook

Volume 30 | Issue 2 | **November 2022** Asia

An allegation of sexual assault

We step in when the police investigate

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From the case files

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What's inside...

Every issue

Article

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Casebook publishes medicolegal reports as an educational aid to Medical Protection members and to act as a risk management tool. The reports are based on issues arising in Medical Protection cases from around the world. Facts have been altered to preserve confidentiality.

Case reports

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Welcome

Dr Rob **Hendry**
Editor-in-Chief

With many of the effects of the pandemic still being felt across healthcare globally, I hope this edition of *Casebook* provides you with timely guidance on safe practice. I also want this publication to underline the level of support provided to you by Medical Protection, in the shape of some robust defences of members that we have captured in this new collection of case reports.

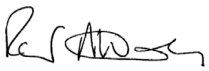
Another strand to this, of course, is the oft-quoted statement that prevention is better than cure, and nowhere is this better demonstrated at Medical Protection at the moment than in our ongoing development of the MPS Foundation. Established to fund valued initiatives on patient safety, the MPS Foundation is progressing well to its next stage and we are issuing periodical updates along the way.

Also underpinning this philosophy of supporting safe practice in medicine is our comprehensive free risk management CPD, which utilises our cases experience and research to help colleagues to minimise the risk of professional challenge, but at the same time – and through the same processes – develop their skills.

Feedback suggests members value the content and we always invite any feedback we receive, good or bad, so please let us know what you think. I'd always encourage those of you who have not used the online learning hub to give it a go.

As has become the norm now in *Casebook*, in among the collection of case reports is a varied list of authors taken from across the Medical Protection medicolegal teams – underlining the breadth of experience you have access to as a member. Whomever you speak to from our multidisciplinary team – medicolegal consultants, solicitors, case managers – you are guaranteed to get expertise and quality advice and support.

I hope you find this edition interesting and helpful, and do get in touch with any thoughts, comments or suggestions via **casebook@medicalprotection.org**.



Dr Rob Hendry
Medical Director, Medical Protection and Editor-in-Chief, *Casebook*

Obituary

Dr John Bradley FRCP FRCPsych (1930-2022)

Dr John Bradley, who recently passed away aged 92, was the Chair of MPS Council between 1987 and 1997. He qualified from the Middlesex Hospital in 1953 and specialised in psychiatry, and was a consultant at the Whittington Hospital for many years.

Dr Bradley was initially invited to join the Cases Committee of MPS and was later elected on to the Council in 1983, serving as Chair during a time that included overseeing the advent of Crown indemnity in the UK, the precursor to the current NHS clinical negligence compensation arrangements. He was a wise and courteous chairman, helping to steer MPS through a time of considerable change.

This change involved a highly commercial climate of rapidly increasing litigation and Dr Bradley oversaw the restructuring of MPS's governance, setting the company on its way to becoming the world's largest medical indemnity organisation. This was very much down to Dr Bradley's quiet 'political' skill, perhaps acquired from his training in psychiatry and an understanding of the need to listen.

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How to be...an expert witness

*Gareth **Gillespie** looks at what it takes to be an expert witness*

Expert witness work is rife with myths and misconceptions. For some doctors, accepting instructions to act as an expert – be it for a claim, disciplinary hearing or coroner's inquest – may be driven by the payment on offer; others might see it as a curio, an interesting diversion from the day-to-day duties of clinical work.

Considering what is often at stake – a doctor's livelihood, perhaps a patient's hopes for compensation – it is dangerous for anyone to accept expert work with either of the above reasons as the primary goal. Budding experts must approach their duty with a clear understanding of what is expected of them – and of the consequences of failing to meet these expectations. Any expert delivering substandard work may find themselves falling foul of the same sanctions they were originally assisting with.

In the course of Medical Protection's work, we instruct experts around the world on a regular basis. To help maintain and improve the skills of experts – and potential experts – in Hong Kong, Singapore and Malaysia, Medical Protection runs expert training days. A hugely experienced team of clinical and legal professionals from across all three countries are on hand at each event to outline the practicalities – and pitfalls – of working as an expert witness.

What is an expert witness?

An expert witness is hired based on their expertise – based on education, training, skill or experience (or all four) – in a particular subject. This specialist knowledge is relied upon when they are asked to provide an expert opinion on the facts of a case.

Above all an expert witness must maintain the confidentiality of any information they receive on the case – resist the temptation to discuss it with colleagues – and must be:

- Impartial – the expert witness must only comment on the facts they know about a case and must not speculate: opinions must be based on the facts only and should not be preferential or disparaging towards any doctor involved
- Competent – an expert witness should not stray outside the boundaries of their own expertise.
- Adequately trained to understand:
  - their duty to the court
  - appropriate standard of proof
  - rules of the court
  - the litigation process and pre-action protocol
  - how to prepare an expert report
  - how to give oral evidence in court.

If you are instructed to act as an expert witness, ensure you read the instructions fully and consider:

- Who is instructing me?
- In what capacity am I being asked to provide a report? Clarify it is as an expert witness
- Am I the right person to do this report?
  - Do I have the appropriate expertise?
  - Is there a conflict? Do I know the doctor involved, or perhaps the patient or close family?
  - Do I have the time?

The last point is particularly important, because expert witness work is not solely writing a report. Accepting instructions to be an expert witness means you are committing to a range of other duties, which can involve:

- Attending meetings with solicitors or doctors involved
- Attending meetings with other experts
- Attending court. You may be cross-examined about your expert evidence and this can be daunting. You must be alert to the possibility of being summoned to court – there is no 'opting out' because it may seem unappealing.

Hong Kong

Experts have an overriding duty to the court to help on matters within his expertise. The duty to the court overrides any duty to the person who has instructed him/her or pays him/her. *Order 38, Rule 35A, Rules of the High Court (Cap 4)*

Singapore

***Supreme Court of Judicature Act, Rules of Court (2006), Order 40 and 40A* provides for the rules on experts in Singapore.**

Malaysia

It is the duty of an expert to assist the court on the matters within his expertise. This duty overrides any obligation to the person from whom he has received instructions or by whom he is paid. *Order 40A, Rule 2, Rules of Court 2012*

The role of an expert

An expert witness can be involved in various scenarios:

1) Medical Council disciplinary hearings

This depends on the charge against the doctor; usually no expert is needed for hearings concerning dangerous drugs records, prescription labelling, sick leave certificate management, or practice promotion.

An expert may be needed for situations involving informed consent issues, management decisions, unconventional treatment, 'over-service', and indecent assault.

2) Coroner's inquest

Here the role of expert is to:

- Give an opinion on the medical cause of death and management issues, on the basis of available evidence – medical records/ reports, autopsy report, witness statements
- Make suggestions to prevent future risks: identify any errors in the system, without opining on an individual doctor's clinical judgment/decision.

3) Personal injury claims and mediation

- Expert opinion required to ascertain position in negligence (ie, whether there was breach of duty or causation)
- Experts can also examine patients to give opinion on condition and prognosis, which lawyers use to decide the value of any payout (this often involves orthopaedic surgeons, neurologists or psychiatrists, etc).

4) Test of testamentary capacity

Expert to give opinion on whether the testator:

- understood the nature of the act and its effect
- understood the extent of the property being disposed
- is of sufficiently sound mind to be capable of forming the testamentary intentions embodied in the will
- is affected by any disorder or disease of the mind which would influence his decisions.

Expert reports

A comprehensive guide to writing expert reports is available in the advice section on the Medical Protection website. Essentially the report should include:

- A title page
- The author's personal details, name, current post and summary of previous experience
- Statement of the opinion asked to provide and details of relevant knowledge/ experience enabling the author to comment on the issues
- List of documentation considered and relied upon in reaching the opinion on the case
- Chronology and summary of the relevant evidence
- Details of any examination undertaken or any other investigations performed
- The opinion – including your reasons, with evidence
- The concluding paragraph, summarising the opinions reached and concluding with a statement of truth.

What not to say...

- *"The patient's version of events is barely credible..."*
- *"This is a recognised treatment option which is well documented in the literature [no references]."*
- *"Dr Y is clearly not guilty of negligence..."*

Expert immunity

Experts are not immune from sanctions themselves. In the UK, the case *Meadow v General Medical Council (2006)* CA saw Professor Roy Meadow's evidence at a murder trial subsequently found to be "seriously flawed". The defendant, who had initially been convicted, appealed and was acquitted, while a complaint was lodged about Professor Meadow to the UK's General Medical Council (GMC). He was found guilty of misconduct and erased from the medical register; although further appeals saw this decision overturned, Professor Meadow voluntarily relinquished his registration in 2009.

In 2011, the case *Jones v Kaney* concluded with the UK Supreme Court decision that experts were no longer entitled to immunity from claims in negligence. The case involved a motorcyclist, Paul Jones, injured by a car. An expert he instructed, the clinical psychologist Sue Kaney, changed her mind about whether he had suffered post-traumatic stress, which resulted in Mr Jones receiving less compensation – and so he sued Ms Kaney. In doing so, the Supreme Court made its landmark ruling to remove expert immunity from negligence claims.

CASE STUDY 1

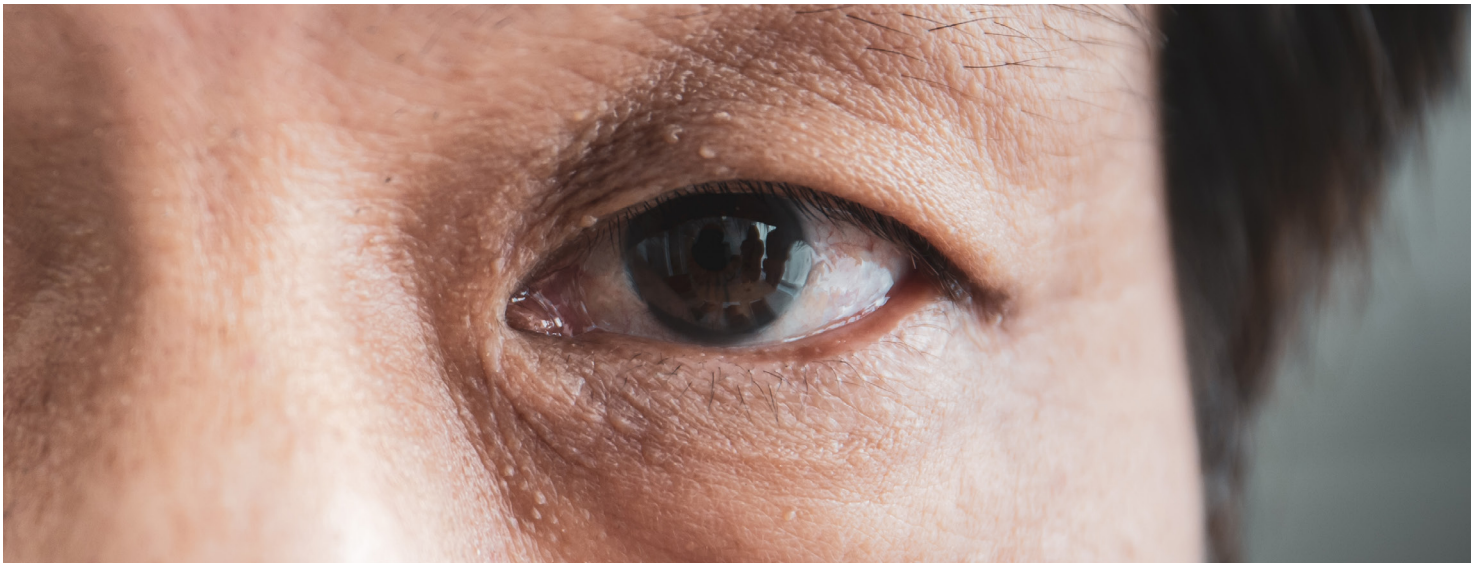
GP Dr A had been treating his colleague Dr P informally for anxiety. He was asked by Dr P to provide an expert report to say Dr P was unfit to appear at his upcoming fitness-to-practise hearing. Dr A provided the report "because he wanted to help a colleague", and afterwards he was called to give evidence. When Dr A was cross-examined, no records of his consultations with Dr P were found, and the content of his report was found to be beyond his expertise. Dr A was referred to the Singapore Medical Council, where he became the subject of a fitness-to-practise hearing in his own right. Dr A was suspended for six months..

CASE STUDY 2

Radiologist Dr T accepted instructions to act as an expert for a patient. She worked across several different sites and the documents were sent to one site where Dr T only attended one half-day a week. The instructions were overlooked, and when they were eventually found, Dr T was travelling overseas for a conference, which meant the report would be late. A complaint was made to the Malaysian Medical Council and Dr T received a warning.

Not winning, not losing

Managing a claim is not about winning or losing; it is about establishing facts to resolve the dispute. Here both doctors and patients share a common aim – a fair and speedy resolution of the claim, and it is the same for complaints, inquests and any situation where a doctor's practice is under the spotlight. Good expert opinions expedite resolution of such matters, and ensure fairer decisions while limiting costs. Working as an expert witness is anything but an easy way to make money but, if approached in the right way, it is an important part of an efficient process for doctor and patient alike.



Corneal graft surgery leads to claim

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

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

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

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

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

Expert opinion

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

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

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

Learning points

- **When providing important information in a written format, the patient must be made aware of its importance. Consider providing verbal information as well as written information for important matters. When giving written information to sight-impaired patients, the format and font should be suitable for their visual ability. When applicable, consider adjunctive methods to deliver information such as audio or video formats.**
- **Although the primary purpose of medical records is to ensure continuity of patient care, medical records are used as evidence of care when dealing with complaints and medicolegal claims. Therefore, clear and detailed medical records are in both the patient's and the doctor's best interest.**

Sympathectomy claim centred around consent

Thirty-year-old Mr P had suffered from facial and palmar hyperhidrosis and blushing since he was 14. Over the years, he had tried various over-the-counter remedies and a period of psychotherapy with no success. Although he had learned to live with his condition to some extent, he found it socially inhibiting and believed that it was preventing him from progressing in his career as an accountant.

Having researched a on the internet, Mr P was attracted to the potentially permanent solution offered by a sympathectomy and asked his GP to refer him to a suitably trained surgeon.

Three weeks later he saw Dr R, a consultant surgeon, at his clinic and requested an endoscopic transthoracic sympathectomy, telling Dr R that he had conducted detailed research on the internet and therefore had a good understanding of what the surgery entailed. Although Mr P had clearly done his research and had already concluded that surgery was his best option, Dr R nevertheless explained the operation and its risks and benefits to him in detail, emphasising the well-known side effect of compensatory sweating.

After discussing the implications, Mr P was still intent on undergoing the surgery, indicating that he considered compensatory sweating an acceptable risk outweighed by the benefits of the operation. Dr R therefore agreed to perform the surgery, but gave Mr P a patient information leaflet to take home with him, asking him to read it and telephone him if he had any further questions.

Mr P was admitted as a day patient a month later for the surgery. Dr R performed endoscopic transthoracic sympathectomies on both sides at T2. The operation was uneventful and Mr P was discharged home later the same day.

The operation had the desired effect of eliminating Mr P's problems with blushing and his facial and palmar hyperhidrosis, but it did result in compensatory sweating on his trunk and thighs. Unfortunately, this failed to resolve itself and increased in severity over the next 18 months, to the point where Mr P had to change his clothes several times a day. This was extremely distressing to Mr P. He deeply regretted having the operation and became profoundly depressed, unable to work and socially withdrawn.

Two years later, Dr R received a letter from Mr P's solicitors requesting a copy of Mr P's medical records. He alerted Medical Protection to the possibility that a claim would be made against him and sent copies of the records to the solicitors and Medical Protection. Fortunately, Dr R had documented the substance of Mr P's preoperative consultation in the medical records and, furthermore, had followed up the consultation with a letter to Mr P (with a copy to his GP), in which he reiterated the risks and benefits of the operation.

In our opinion, Dr R was in a strong position to defend an allegation of negligence on the basis of failure to secure adequate consent for the operation. Mr P's solicitors evidently agreed with our assessment as no further action was taken.

Learning points

- **The "well-informed patient" is a common phenomenon in countries with widespread access to the internet. Although these patients may claim that they've thoroughly researched their treatment options and thought it all through, their doctors should still ensure that patients are given all the necessary information to make a properly informed choice.**
- **Doctors might also consider familiarising themselves with sources that are available.**
- **Patients requesting specific surgical procedures often have unreasonably high expectations about outcomes. They may be so focused on the perceived benefits of the surgery that they don't give due regard to the risks.**

Pulled in all directions

By Dr Dudley ***Bush*** *and Dr John* ***Adams***

Mrs J was a 32-year-old female patient with a long history of neck pain following a road traffic accident. The pain was localised to the left side of the neck and left shoulder, with only very occasional paraesthesia in her left hand. Despite regular analgesics and exercises, the pain was still troublesome and she was keen for a specialist opinion.

Mrs J was referred to Dr M, a pain consultant. Dr M noted slight restriction in neck movement on the affected side and elicited tenderness over the left C5/6 and C6/7 facet joints. Imaging revealed fusion of the C3 and C4 vertebrae and some loss of normal cervical spine curvature, but the vertebral bodies and spaces remained otherwise well-preserved.

Dr M recommended C5/6 and C6/7 facet joint treatment and told Mrs J that there was a 50% chance of getting long-term pain relief. He suggested two diagnostic injections with local anaesthetic followed by radiofrequency lesioning if benefit was felt. Dr M went through the risks of the procedure with Mrs J, including lack of benefit, relapse of pain, infection and damage to nerves.

Mrs J returned for the first of the two diagnostic blocks. The block was performed in the lateral position and Dr M injected a mixture of 0.5% levobupivacaine and triamcinolone. The block provided good pain relief and Mrs J felt it was easier to move her neck.

Mrs J later returned for the second diagnostic injection. Mrs J was placed in the prone position and local anaesthetic infiltrated into the skin. Using biplanar fluoroscopy, 22G spinal needles were inserted toward the C5/6 and C6/7 facet joints. Dr M then attempted to inject a mixture of lignocaine and triamcinolone at the lower level. Unfortunately, as soon as Dr M started the injection the patient jumped with pain and her left arm twitched. The procedure was abandoned.

Despite a normal neurological examination immediately after the procedure, the patient later the same day developed numbness in her left arm and right leg. She also complained of headache when sitting up, as well as pain in her left neck and shoulder. As she felt dizzy on standing, Dr M decided to admit Mrs J for overnight monitoring and analgesia.

The next morning Mrs J was no better. She felt unsteady on her feet and complained of a burning sensation in her right leg, as well as weakness and shooting pains in her left arm. Dr M decided that a second opinion was required and referred Mrs J to a neurosurgical colleague. An MRI was arranged, which unfortunately demonstrated signal change in the cord at a level consistent with the intended facet joint injection.

Over time, the MRI changes improved but Mrs J continued to suffer from terrible neuropathic pain. It affected many aspects of her daily life and she found it difficult to return to work as she was not able to sit for any length of time. A spinal cord stimulator was inserted by another pain specialist to try and help with the pain, but this was largely unsuccessful and was later removed.

Mrs J subsequently lost her job and, following that, decided to bring a claim against Dr M.

Expert opinion

The case was reviewed for Medical Protection by Dr F, a specialist in pain management. Dr F was of the opinion that the initial assessment and management plan were entirely appropriate. She was somewhat critical of the approach used by Dr M for the diagnostic injection as it was not consistent with the planned approach for the radiofrequency lesioning and, in her opinion, more likely to be associated with the possibility of damage to the spinal cord. She also felt that the use of triamcinolone in the diagnostic injections could be criticised, as injection of particulate matter into the spinal cord is known to be associated with a higher risk of cord damage.

Dr W, an expert neuroradiologist, was concerned about the images he reviewed from the second diagnostic injection. He concluded that neither needle was within the respective facet joint and that the lower needle tip was within the spinal canal at the level of C5, less than 1cm from the midline. Dr W also confirmed that the MRI abnormality corresponded with the position of the lower needle tip.

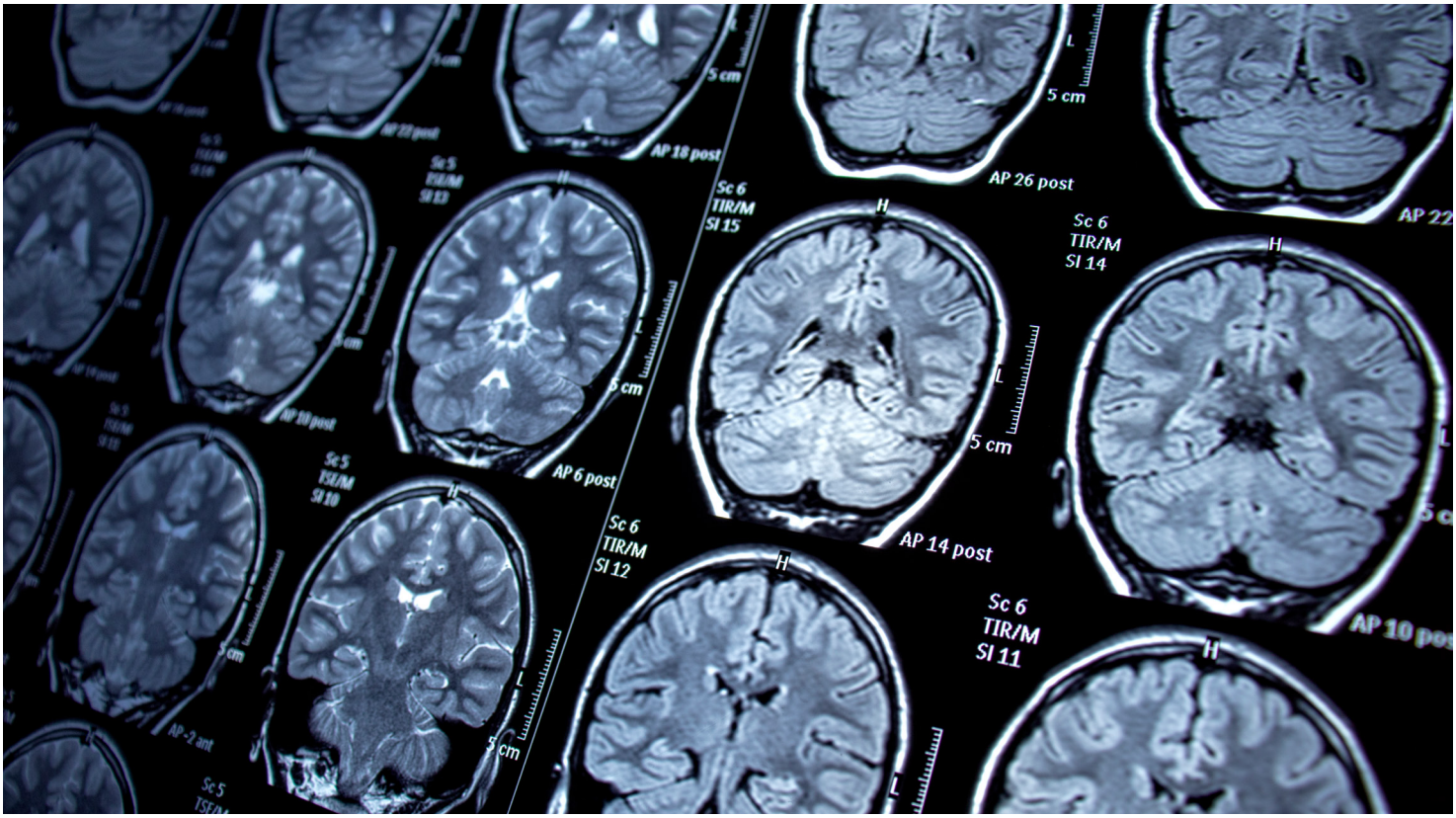
Dr F concluded that insufficient images were taken to satisfactorily position the needles. She also noted that only 40 seconds had passed between the images taken for the first and second needle insertions, inferring that the procedure had been carried out with some haste.

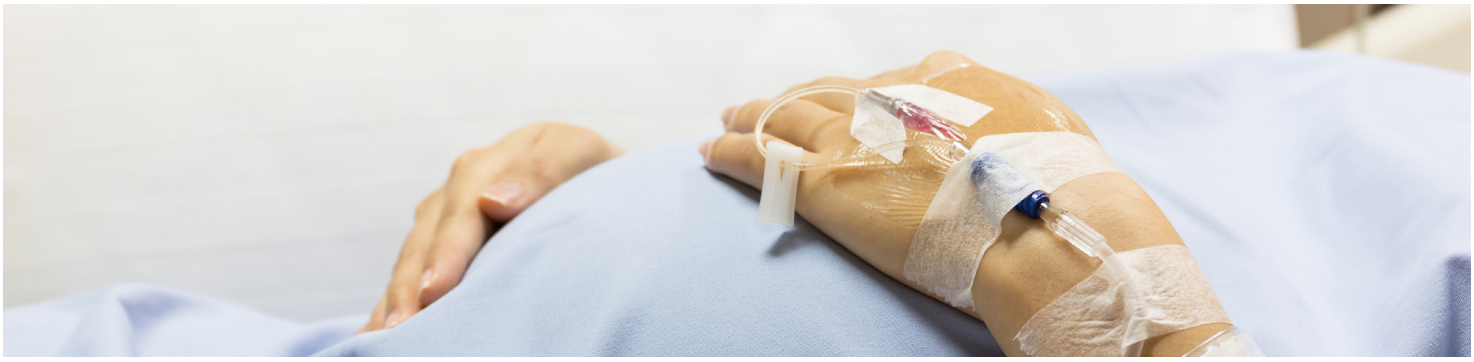
Medical Protection then instructed a causation expert to comment on Mrs J'sprogression of symptoms. Professor I concluded that the development of neuropathic pain in the right limb was understandable, although the disabling effects were more than he would have expected. Whilst the patient did have a history of neck pain, the patient's symptoms were consistent with a lesion affecting the spinothalamic tract on the contralateral side of the cervical spinal cord.

The case was considered indefensible and was settled for a high sum.

Learning points

- **Although it is commonplace for a doctor to assume multiple roles, this case highlights the risks during an individual procedure. Dr M was acting as an anaesthetist providing sedation, analgesia and reassurance, whilst at the same time carrying out the facet joint injections.**
- **Although Dr M warned the claimant about the possibility of nerve damage, this does not mean that a defence can necessarily be made. Both the expert pain consultant and radiologist concluded that neither needle was positioned as tended prior to the injection and that the lower needle tip was clearly within the spinal canal and thus potentially within the substance of the cord.**
- **The experts were of the opinion that a pain medicine consultant should be confident in interpretation of live radiological imaging including needle trajectory and accurately determine needle trajectory and position prior to performing the procedure. It is important to allow the necessary time regardless of other pressures and to follow guidelines published by professional societies/bodies, eg, International Spinal Injection Society. There is a body of opinion that advises against the use of particulate steroid injections in the cervical area.**
- **When an elective procedure or service has been offered to a patient, the practitioner may feel an obligation to fulfil this, even when they may not be entirely confident about doing so. Where there is any doubt or concern, it is far better to abandon the procedure or seek a second opinion, particularly where a mistake may lead to a serious complication.**





Cumulative errors

By Dr David ***D'Souza***

Mrs G, 34, presented to the delivery suite at 12pm, 38 weeks into her first pregnancy.

Her antenatal care had been uneventful apart from measuring slightly "large for dates". She was found to have a longitudinal lie with a cephalic presentation, and was experiencing three contractions every ten minutes. The midwife examined her and found her to be 2cm dilated with a fully effaced cervix and "intact membranes".

At 3.30pm she was re-examined and found to be 3cm dilated and was given 100mg pethidine IM.

At 8.30pm she was examined by the midwife again and still found to be 3cm dilated. The cardiotocograph (CTG), which had been started one hour before, was normal, with a baseline of 140b/min and good variability and good reactivity. Mrs G was now experiencing more painful contractions and an epidural was sited.

At 10pm, she was found to be 3cm dilated and the "membranes were still intact", despite still having regular contractions of three every ten minutes. No artificial membrane rupture was carried out; however, Mrs G was started on a syntocinon regime by the midwife. There was no documentation as to whether this was carried out after verbal advice from the doctor or not, but no written prescription could be found on the drug chart, when the notes were reviewed retrospectively.

At 12.30am the CTG had become "suspicious", with the baseline 150b/min and typical variable decelerations and the contractions were coming five every ten minutes. Dr A, the staff grade obstetrician on-call, was notified and he advised "verbally" to stop the syntocinon infusion, change the position of Mrs G and give her oxygen. The midwife felt the CTG improved after this.

At 3am, Mrs G was re-examined and her cervix was found to be 6cm dilated with "bulging membranes". These were artificially ruptured and she was found to have grade II meconium. The CTG baseline had risen to 180b/min and there were deep late decelerations and the contractions were still strong, coming four every ten minutes, despite having stopped the syntocinon. Dr A was informed, but he was "busy" and had still not arrived to review the CTG by 3.35am.

He was re-contacted and came to assess Mrs G at 4am. He felt she was now "fully dilated" with the head at the level of the ischial spines. He decided to carry out a ventouse delivery, which was started at 4.15am. This was recorded as a "difficult delivery", but no other documentation was made. The 3.9kg baby girl was delivered at 4.35am with an Apgar score of 3 at one minute after birth, and 6 at five minutes. The cord gases showed severe metabolic acidosis with a pH 6.9 and BE-18 (arterial). The paediatricians were called subsequently and the baby was transferred to NICU. Although the baby survived, she had significant hypoxic ischaemic encephalopathy and severe cerebral palsy as a result.

Mrs G made a claim against Dr A and his team for their failure to adequately monitor her baby and recognise signs of fetal distress. This lack of communication between the teams and lack of recognition of the severity of the condition resulted in the infant having severe cerebral palsy, requiring lifelong care.

The claim was settled for a substantial sum.

Learning points

- **When things go wrong it is rarely because of a single isolated event. Errors and incidents occur within a system and usually there is a sequence of events that occur before an accident happens.**
- **Although the mother and the fetus were "adequately" monitored throughout the whole labour, the expert witnesses felt that there was significant substandard care in the interpretation of this CTG and the communication of the findings with the doctor involved.**
- **In this case the handover was poor throughout. A recognised handover model is a useful way of ensuring good communication and effective handover between health professionals and teams.**
- **All verbal advice about the proposed procedures should be carefully documented in the notes, eg, position of suction cup over the flexion point on the occiput, number of pulls (ideally less than three) and time for completion (less than 15 minutes). In this case there was a 20-minute time from application to delivery.**
- **If there is any delay in a patient being assessed by one member of a team, seek advice from a higher level to get this expedited (eg, supervisor of midwives, consultant).**

Further reading

Patterson-Brown S, Howell C, *The MOET Course Manual* (3rd edition), Cambridge University Press (2014)

Multidisciplinary care leads to inquest

*By Mohammad **Shahid**, Legal Adviser, Medical Protection*

Dr S, a GP, appeared before a coroner in relation to the death of a 13-year-old boy, D.

D suffered from morbid obesity from a young age. He was later diagnosed with dilated cardiomyopathy. As a result of his morbid obesity, D was not eligible to undergo heart transplantation or any interim measures pending transplantation, until his weight reduced to a transplantable level.

D was hospitalised and was diagnosed with heparin induced thrombocytopenia, which was a further factor in D not being eligible for interim measures, including mechanical support of his heart. D sadly died two months later.

Dr S appeared before the coroner, along with other GPs and a wider multidisciplinary care cohort, including D's school, his family and relevant state departments.

The inquest was complex not only because of the breadth of the parties involved, but also given the possible interplay between morbid obesity and cardiomyopathy and the issues of neglect and safeguarding, and the role of children's services, which formed the crux of the coroner's considerations.

How did Medical Protection assist?

We supported Dr S by explaining the inquest process: the nature of the coroner's remit and the scope of his considerations, and Dr S's role in the process. We explored Dr S's involvement in detail, with the benefit of both the medical records and our in-house clinical expertise. We were able to advise on possible risks, explore how Dr S and her practice fitted into the wider multidisciplinary picture, and how she might present her position.

With Dr S's instructions to hand, we were also able to contribute to the coroner's consideration of the scope of the inquest, in terms of the issues and the witnesses that it would consider.

The Medical Protection legal team also used experienced counsel to assist with strategy discussions and preparations, and to represent Dr S's best interests at the inquest.

Outcome

The coroner concluded that D died from natural causes, contributed to by his longstanding morbid obesity, which itself significantly contributed to his death in that it rendered him ineligible to receive appropriate treatment.

In respect of the GPs in particular, the coroner found that appropriate care was given by the GPs, but that a failure to engage in weight management should have led to a referral to children's services.

Throughout the inquest hearing, the coroner expressed his concern about the absence of a specific reference to 'obesity' in national guidance relating to signs and symptoms of neglect in children. The absence of such a reference was a matter of concern as to how obesity in children is viewed as a public health issue in comparison to malnourished or underweight children (which are both referenced as signs and symptoms of neglect). The consensus from the public health witnesses was that obesity should be included within national guidance as a sign and symptom of neglect in order to protect children at risk.

Learning points

While a coroner's findings do not equate to civil or criminal liability, they are significant, statutory, fact-finding processes that require careful consideration and preparation.

This inquest in particular took a considerable amount of time to reach a final hearing, not least because of the breadth and complexity of the issues. Understanding how you fit into this often complex process and how you might best navigate it requires careful preparation, and indeed experience. We would encourage you to contact us if a coroner asks you to take part in an inquest, whether that is as a witness of fact (somebody who may be said to be more peripherally involved in the circumstances of an individual's death) or whether, in the first instance, it is considered that you may play a more significant role in helping the coroner determine who died, when, where and how.

An allegation of sexual assault

By Dr Heidi **Mounsey**, *Medicolegal Consultant, Medical Protection*

Dr B was an obstetric and gynaecology registrar covering the labour suite during an overnight on-call shift.

He was asked to urgently attend a patient, Mrs T, who had delivered her baby approximately 30 minutes earlier, and who had ongoing brisk bleeding following the delivery. The midwife reviewing Mrs T was concerned, and sounded the emergency buzzer to summon Dr B to review urgently.

Dr B attended Mrs T and introduced himself prior to taking a brief medical history and seeking verbal consent to examine her, which was granted. Dr B explained that the purpose of the examination would be to try to identify the cause of the bleeding and, if necessary, take steps to stop it.

In the presence of the midwife, Dr B conducted a vaginal examination, removed a number of clots, and applied bimanual compression to stem the bleeding. A junior doctor, Dr F, was present on the labour suite and had also attended upon hearing the emergency buzzer, and they obtained intravenous access while the examination was occurring to allow fluids and additional medication to be administered.

After approximately 15 minutes, the bleeding was controlled and Dr B sought further consent from Mrs T to conduct an examination of her external genitalia and perineum to ensure there were no tears or other sources of bleeding.

No further issues were identified and Dr B, after a brief discussion with Mrs T, left the room with Dr F. Dr B was then bleeped to attend the emergency department and asked Dr F to write in Mrs T's notes to document the interaction.

Three days later, Dr B was contacted by the hospital's deputy medical director and informed a patient had made a complaint against him of inappropriate physical contact. Dr B was informed that while the matter was investigated, he was to be excluded from any patient contact, although he was permitted to conduct non patient facing work such as audit. He was requested to provide a written statement to the hospital.

The following day, Dr B was contacted by a police officer requesting to interview him in relation to an allegation of sexual assault made by Mrs T. Mrs T alleged that during Dr B's examination he had repeatedly rubbed her clitoris.

How did Medical Protection assist?

Dr B contacted Medical Protection for advice and was assigned a medicolegal consultant (MLC) who instructed a solicitor and arranged for a conference with Dr B to discuss the matter in detail. Dr B initially stated this was completely unnecessary as he felt it was obvious the patient had misinterpreted the examination and the requirement for it. He felt that the police would simply close the matter without the need for him to be further involved, and wanted to know whether he could sue the patient for defamation. The MLC explained to Dr B that allegations such as this are usually taken extremely seriously by the police and the hospital, and the consequences of not responding in a robust and detailed matter may mean that he was faced with a criminal charge and the consequences of this.

At the conference, Dr B explained the circumstances and the conduct of his examination to the MLC and the instructed solicitor. He was clear that at no point had he deliberately touched the patient's clitoris nor was there any sexual motivation for the examination he had conducted. He did state that there would have been a possibility he inadvertently made contact with the patient's clitoris during the examination and management of her bleeding, but if that had occurred it would have been accidental and very fleeting.

The patient's notes were reviewed and it was observed that Dr F had made only a very brief entry in relation to the discussion with the patient and the examinations performed, without making it clear why Dr B's intervention had been necessary and that consent had been verbally obtained from the patient. However, Dr B had a good memory of his interaction with the patient, primarily because the allegations had arisen so quickly after the consultation.

On behalf of Dr B, the instructed solicitor drafted a statement for the police incorporating a detailed description of Dr B's examination, elicited by thorough questioning from the medicolegal consultant.

The statement was submitted to the police, and although the police still arranged to interview Dr B about the matter, this was purely to confirm that Dr B agreed the contents of the statement were true.

The police closed the matter with no further action and the hospital, on being informed that the police were taking no further action, conducted their own investigation, which also closed with no findings against Dr B. He was permitted to return to work with no restrictions imposed on his practice.

Learning points

- **The documentation in this case by Dr F on Dr B's behalf was poor, and had the allegations arisen some time later it is likely Dr B would have had little recollection of the case and would not have easily been able to rely on the medical records. If the task of documenting a consultation is delegated, it is prudent for the clinician conducting the examination to ensure they subsequently review the notes to confirm all the relevant information has been included.**
- **Allegations such as this must be taken seriously, even if the clinician feels that they are unfounded.**
- **Involve Medical Protection at an early stage (even if it felt that there is no substance to the allegations) to ensure the first statement provided is of a high quality – this can help resolve the matter more rapidly and reduce the need for additional questioning by the police.**

Equipment shortage and a delayed reaction

*By Nicole **Xashimba**, Case Manager, Medical Protection*

Mr M, a 38-year-old financial adviser, was an existing patient of Dr V, a dermatologist. He had a history of acne keloidalis nuchae. Besides the skin disorder, he was a healthy individual with no known co-morbidities or allergies. There was no pre-existing surgical history, or family history of cancer.

The keloids in the occipital region of his scalp were secondary to his existing skin condition, for which he was treated with a combination of antibiotics and topical ointments daily.

Mr M received further treatment in the form of intralesional corticosteroids in January and February 2015 respectively. Mr M had returned for his third treatment at Dr V's rooms in April 2015. Because the administration of the corticosteroids had proven painful during previous visits, Dr V decided to use local anaesthetic before proceeding on this occasion.

The procedure was explained by Dr V to the patient before commencing. Due to the nature and presentation of the keloid, the insertion of the needle was difficult. It was asked whether the patient could feel anything, to which he replied that he could not feel any pain but he was not feeling well. The procedure was immediately halted and Mr M was asked once more how he felt. At this point he began to breathe heavily, subsequently becoming unresponsive.

When the procedure was halted, the time noted was 10:12. Mr M was placed into the recovery position while help was called for. Mr M was transported on an emergency trolley to the operating theatre, one floor down from Dr V's rooms, by Dr V, the hospital matron, an anaesthetist and an ENT surgeon.

At approximately 10:16, Mr M was still unresponsive, with no pulse detected.

He was intubated, a drip inserted and 1ml of adrenalin was administered intravenously. Chest compressions began at about 10:19, followed by defibrillation. Further adrenalin infusions up to 5ml and atropine 1mg were administered intravenously.

Mr M was sadly declared dead by the anaesthetist at about 10:28.

A claim against Dr V

Mr M's wife sued Dr V, alleging that Dr V was negligent and that this led to Mr M's untimely death. It was alleged that the cause of death was anaphylaxis due to the anaesthetic used during the procedure. Among other things, it was alleged that Dr V failed to warn Mr M that the local anaesthetic could be fatal. It was further alleged that Dr V failed to obtain informed consent for the procedure.

Expert opinion

Dr S, an emergency medicine practitioner, provided the following expert opinion:

Adrenaline is a critical medication in the treatment of anaphylaxis and is found to be ineffective in only 10% of most cases. It appears that there was a significant delay in the administration of intramuscular adrenaline, and delayed administration is often associated with a poor outcome. Adrenaline should have been administered at the earliest possible time, which would have been around 10:13, had the ampoule and other stock (ie needle and syringe) been readily available in Dr V's rooms.

It was not established exactly when Mr M was noted to be pulseless. This should have been among the first diagnostic tests performed in order to proceed with the correct protocol for the treatment of cardiac arrest, which is to immediately begin chest compressions. As per Dr V's chronology of events, this commencement of chest compressions had begun in theatre.

Considering that fatality as a result of medicine-induced anaphylaxis is rare and often difficult to predict, it is reasonable to expect a practitioner to be adequately prepared should this type of complication occur.

Mr M could have potentially had a 90% chance of responding to early adrenaline administration, but it was impossible to accurately opine on Mr M's statistical chances of survival since there was no data to show that the delay specifically would have led to death from anaphylaxis. There was nothing in Mr M's medical history to identify him as a high-risk patient for anaphylaxis. He gave verbal consent to the procedure, and Dr V could not have predicted this outcome. That said, every procedural practitioner is reasonably expected to be prepared for anaphylaxis.

Outcome

Dr V was vulnerable to criticism by a court on the basis that she did not have the necessary resuscitation equipment in her rooms when she should have. Given expert opinion that Mr M potentially would have had a 90% chance of survival had the adrenaline been administered sooner, it was agreed that the matter should be settled. The attorneys appointed by Medical Protection to represent Dr V negotiated a settlement with the plaintiff's attorneys.

Learning points

When undertaking to perform procedures within the practice, it is prudent to obtain written consent from the patient, which clearly states the name of the procedure, what it is for, how the procedure will be conducted and what the potential side effects could be.

Adequate emergency equipment should be available as the reasonable practitioner should be prepared for any reasonably expected adverse events. Emergency stock should be readily available and kept as close as possible to the procedural area. Emergency stock should be checked daily for expiry dates and should be replaced immediately if used. Stock should be stored appropriately and at the correct temperatures.

Practitioners should always keep abreast of current protocols and procedures, in order to act efficiently and appropriately should an emergency arise.

Basic preoperative examinations should be carried out in order to have a baseline of the patient's condition before the procedure, as this could be an early indicator of any abnormality present, which would directly influence the outcome of the procedure.

Expert challenged over delayed diagnosis report

*By Lisa **Jones**, Legal Adviser, Medical Protection*

Dr M, a consultant oncoplastic breast surgeon, was referred to his regulator by a patient following a late diagnosis of breast cancer.

Dr M had seen this patient on a private basis following an urgent referral made by the patient's GP after the identification of a lump in her right breast. The patient was later diagnosed with breast cancer.

It was alleged that there was a failure to carry out appropriate investigations of the patient's right breast, and examinations and investigations of the patient's left breast, and a failure to ensure the support of the breast cancer nurse during or after the consultations had taken place. It was also alleged that there was a failure to provisionally diagnose the patient's left breast cancer following the finding of an alleged abnormality in the CT scan, which led to a delay in diagnosis. There were also allegations concerning record keeping and failure to provide appropriate information to the patient's GP.

The clinical allegations were supported by an expert report obtained by the regulator that was extremely critical of Dr M.

The discrepancies between Dr M's recollection of the appointments in comparison to the patient's recollection were dealt with by their respective witness evidence and also with reference to the clinical notes.

How did Medical Protection assist?

Dr M requested assistance from Medical Protection in respect of the regulator's investigation, which culminated in a fitness to practise hearing.

Throughout the investigation and hearing process we assisted and supported Dr M by explaining the relevant processes, understanding key terminology and principles and the importance of reflection and remediation.

One of the most important steps taken in this case was the instruction of our own independent expert to challenge the regulator's expert witness report, as we had concerns about the validity of the opinion provided by their expert. The defence expert was wholly supportive of Dr M's position and a joint expert meeting took place in advance of the hearing; unfortunately, the regulator's expert did not rescind their opinions.

Both experts were required to give evidence at the hearing.

Outcome

A number of facts were admitted at the first stage of the hearing and the panel subsequently found some of the outstanding allegations proved. In respect of the expert evidence the panel preferred the evidence of the defence expert in all areas of dispute between the two experts and, as a result, a number of allegations were found not proved.

The panel then went on to consider misconduct and impairment, and determined that there was no evidence of serious misconduct in this case. In the circumstances, it was not necessary to then consider impairment and the case concluded with no action being taken against Dr M's registration. The panel did not consider the issue of a warning either as no misconduct had been found.

Learning points

This case highlights the importance of doctors having the benefit of considered and informed advice during a regulatory investigation and hearing. It also highlighted the importance of having a defence expert to challenge expert evidence.

Instruction of an independent expert is something that an unrepresented registrant would be unlikely to be able to do. Without the benefit of an expert report in this case it is likely that more of the unadmitted allegations would have been found proved and this could have potentially had more serious consequences for Dr M, which may have included a potential finding of misconduct and impairment – and a sanction imposed on his registration, including the possibility of a warning.

Contacts

You can contact Medical Protection for assistance

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Calls to Membership Services may be recorded for monitoring and training purposes.

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

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