A. Front Sheet

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Generalist Medico-Legal Expert
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LIABILITY AND CAUSATION REPORT ON ALLEGED CLINICAL NEGLIGENCE TO THE COURT PREPARED ON:

Name:	Minnie Mouse
Address	56 Hollywood Blv Drinking XX1 1XX
Date of Birth:	Saturday 8 March 1986
Occupation:	Teacher
Report Requested By:	Sue Grabbit and Run
Solicitor's Reference:	xxx.xxx
Documentation Available:	General Practitioner Medical Records
Date of Report:	Wednesday 8 January 2014

Special Instructions: I have been instructed to write a report without sight of the claimant.

B. Contents

C. Introduction.

1 Summary of the instructions.

I have been instructed by Sue Grabbit and Run to prepare a Liability and Causation report to the court considering alleged negligence of a General Medical Practitioner.

2 Summary of case.

This case involves the alleged failure to properly assess abdominal pain by a Generalist Doctor in a patient that was diagnosed with perforated appendicitis and peritonitis.

3 Material issues. (Suggested level of decision).

Was the pain less than moderately severe?	(Lay).
Was the consultation satisfactory?	(Generalist).
Was the presentation typical or atypical?	(Generalist).
What date did the Appendix perforate?	(Generalist).
What is the difference between surgery for appendix which has burst and one that is intact?	(Generalist).
What disabilities are present and expected long term?	(Generalist).
Scar cosmetic significance and prognosis?	(Generalist).

Is there is a chance that at some definite or indefinite time in the future the injured person will develop some serious disease or some serious deterioration in her physical or mental condition as a result of this particular accident?

Specifically is there a risk to the fertility of this patient or of obstruction? (Specialist)

4 Limitations of Evidence.

The surgeon's operation records and any imaging are not available and these records will be required to determine the *risk of serious deterioration* question.

I have not reviewed the statement from the defendant Doctor Y, X.

No examination has been performed.

5 Summary of conclusions.

The history, examination and investigations were only of satisfactory standard.

The management of red flags was below the standard expected of the reasonable generalist medical practitioner.

6 Expertise – Qualifications and experience.

I am Dr Mark Burgin (BM BCh MRCGP) and have been working as a Medical-Legal expert and produced medical-legal reports regularly since 2000.

I have been involved in 6 previous clinical negligence cases.

As a doctor a basic qualification is the Bachelor of Surgery covering assessment of abdominal pain.

I have worked as a General Surgery junior doctor for 6 months assessing abdominal pain about 40 patients a week.

I have worked as a Gynaecology junior doctor for 6 months assessing abdominal pain about 10 patients per week.

I have worked as an Accident and Emergency doctor for 6 months assessing abdominal pain about 20 patients per week.

I have worked as a General Practitioner training doctor for 12 months assessing abdominal pain about 3 patients per week.

I was in active clinical practice as a General Practitioner from 1995 until 2011 seeing patients on a regular basis about 2 patients per week.

Since 2011 I have been working as a Disability Analyst seeing claimants and preparing reports on the level of disability. The problems these patients present with include the type of medical problems in this report in particular the assessment of the disabling long term effects of abdominal pain.

I sat examinations - clinical skills assessments in 2009 and 2011, both included assessing abdominal pain

This report is intended to be entirely independent and I am aware that my duty as an expert is to the Court.

D. Technical Details

7 Glossary and Abbreviations.

Appendix – a small tubular like extension of the caecum.

Caecum – first part of the large bowel.

Guarding – muscle spasm in the abdominal wall muscles e.g. over an inflamed appendix.

Abdominal movement – alternative test for guarding.

Peritoneum – the lining of the abdominal cavity.

Peritonism - inflammation affecting the peritoneum.

Peritonitis – bacteria growing in the abdominal cavity, can be local or generalised.

Rebound tenderness – the classic sign of inflammation affecting the peritoneum Peritonitis.

Percussion tenderness – alternative test for Peritonitis.

Press on the opposite side from the pain – alternative test for Peritonitis.

Cough tenderness – alternative test for Peritonitis.

Somatic nerves – give exact location of the pain.

Autonomic nerves – pain is referred to the origin of the nerves e.g. the umbilicus.

Umbilicus – tummy button.

Abdominal cavity – large space lined with peritoneum, abdominal wall muscles to the front, Retroperitoneal structures to the rear, thin muscle diaphragm above and continuous with the pelvis below. Contains bowels, spleen and liver.

Retroperitoneal – behind the peritoneum, kidneys, spine, spinal muscles and nerves.

Names of the parts of the abdominal wall - Both hypochondrium, epigastrium, both lumbar, umbilical, both iliac fossa and hypogastric (suprapubic) areas.

8SG – trade name for a urine testing strip for urine infections.

UTI - urine tract infection

N – Nausea

T – Pyrexia (has a temperature)

NAD – No Abnormality Detected.

Read Code – a list of codes used in computer systems to code diagnoses.
PU – pass urine.
O/E – On examination.
Adv – Advised
IV – intravenous
Po – Oral
tds – three times daily.

8 Relevant Pathological Processes.

Perforation – about 24 hours after the start of appendicitis the appendix can burst releasing the bacteria inside the appendix.
Appendicitis – inflammation of the appendix due to obstruction to the entrance causing swelling.
Omentum - an apron like structure in the abdominal cavity whose purpose is to seal off peritonitis.
Abscess – bacteria in a cavity that is sealed off from the rest of the body.
Bacteraemia – bacteria spreading in the blood stream.
Septicaemia - bacteria growing in the blood stream associated with shock collapse and death.

9 Differential Diagnoses.

Typical presentation as vague central abdominal ache in the area of the umbilicus then later pain in the right iliac fossa. Association with anorexia, foetor oris and pain with movement.

Atypical presentation depends on where the appendix is lying and can appear to be a UTI (next to the bladder, ureter or kidney), diarrhoea predominant gastroenteritis (behind the caecum retrocaecal) pregnancy related (in pelvis).

10 Quotes from Key Published Sources.

Patient.co.uk

Patient Plus articles are written by UK doctors and are based on research evidence, UK and European Guidelines.

Red flags that raise suspicion of serious pathology

Systemically unwell/septic-looking.
Signs of dehydration.
Marked involuntary guarding/rebound tenderness.
Tenderness to percussion.

British Medical Journal BMJ

Abdominal pain lasting more than 48 hours is less likely to require surgery than pain of shorter duration.

Oxford Handbook of General Practice.

Most common surgical emergency in the UK – lifetime incidence about 6%. Peak age 10 to 30 years.

(If suspect appendix) - Admit as surgical emergency expect to be wrong half the time.

Procedures and Guidelines

There are no relevant guidelines for the management of acute abdominal pain in General Practice from NICE or SIGN.

11 Medical Uncertainly and Controversies.

Diagnosis of Appendicitis is recognised to be difficult and missing the diagnosis can be reasonable if the presentation is atypical.

There is a balance to be struck in practice between referring all abdominal pain which would result in overloading the system and not referring enough so that acute surgical conditions are missed.

E. Medical Records Review

12 Transcribed records.

28/12/2012 GP Surgery Dr Y. X. Gastroenteritis viral 12 h abdo pain loose stool N, PU OK periods OK O/E T tender lower abdo *SG-NAD Adv fluids.

01/01/2013 Hospital Admission ward 18 from A and E diagnosis Perforated Appendicitis, Laparotomy and Appendicectomy, IV antibiotics, drains out 2 days, discharged 03/01/2013 Cephalexin 500mg tds po 21 tablets, Metronidazole 400mg tds po 21 tablets. No Follow.

13 Medical procedures.

The Consultation is the medical procedure that was used by the doctor in this case.

The Consultation is made up of various parts which are well recognised.

History, examination, investigation, differential diagnosis, red flags, management treatment referral.

History.

The history considers the three positive symptoms of loose stools, abdominal pain, nausea and the negative symptoms of no problems with the periods or passing water.

The history confirms the onset as 12 hours prior to the consultation.

The history does not confirm the severity of the pain or the date of the patient's last menstrual period.

Examination.

The examination confirms there is tenderness in the lower abdomen and the patient has a temperature.

The examination does not confirm the absence of guarding or rebound tenderness.

The examination does not indicate whether the patient is well or ill looking.

Range of opinion.

Testing for rebound tenderness remains an area where different opinions are present.

Some doctors feel that whilst in surgical practice the tests for rebound are useful in General Practice they are not specific enough to be useful if used in all patients.

Other doctors feel that the tests require skills that can quickly be lost and are anyway unpleasant for the patient.

On the other extreme there are doctors that believe every abdominal examination should be performed in a systematic way as they were taught at medical school.

My opinion is that without specific guidance from a source such as NICE this variation of practice will remain.

Investigation

The Investigation confirms that the patient does not have a urine infection but does not give the results of the 8 tests on the 8SG (Leuks, Nitrites, RBC, Protein, Ketones, Glucose pH and SG).

No pregnancy test is carried out.

No blood tests or imaging is requested.

Differential diagnosis

Differential diagnosis shows that a positive diagnosis of Viral Gastroenteritis is made and no other diagnosis is considered. This is indicated by the choice of a READ code and by the advice to take fluids which is the treatment recommended for that diagnosis.

Red flags.

There are concerning features of nausea, temperature, abdominal tenderness and short history but these have not been investigated for the presence of red flags.

The claimant states that the pain was ‘awful’ which suggests the red flag of severe pain.

The red flag of looking ill was not noted in the positive or negative.

There are no records of whether the symptoms of nausea are causing the red flag of anorexia - where no food or drink can be tolerated.

Management

The management is appropriate for the diagnosis but there is no follow up arranged.

Prescription

No prescription is offered – there is a range of opinion between offering symptomatic treatments or no treatments.

Referral

No referral is appropriate on the diagnosis given.

F. Examination

I have been instructed not to perform an examination of the claimant for this report.

G. Review of Statements.

14 Claimant's Statement

undated

I went to see Dr Y, X on 28/12/2012 in the morning and she said that I had a tummy bug. She did not examine me. She checked a urine sample and said it was ok. The pain was awful I could hardly stand; I was sweating and felt sick. When I went to A and E they said it was classic appendicitis and sent to ward 18 and I had an operation. They took the drains out after 2 days because there was not much coming out. The said Dr Y, X has missed appendicitis before and it is a basis diagnosis she should get right. I have a horrible scar and it still hurts. I am feeling very tired and depressed.

15 Defendant Doctor's Statement

No statement from the Defendant Doctor has been received.

H. Liability

16 General Performance in the Consultation.

The defendant doctor has only performed a brief history, examination and investigations.

On a scale of unsatisfactory, satisfactory, good and outstanding the history, examination and investigations were only of satisfactory standard.

On balance the general performance in the consultation was not below the standard of the reasonable GP.

17 Rebound tenderness

There is a range of opinion of the testing for rebound tenderness and I accept that other doctors would act in the same way by not performing any of the rebound tenderness tests. It is for the court to decide whether failure to perform testing for rebound in patients presenting with abdominal pain is a logically reasonable approach.

18 Red flags.

The claimant states that her pain was awful

If she had moderate-severe or worse pain and this would be a red flag.

The doctor has not documented the severity of the pain in this case.

It is for the court to determine whether the claimant's version of the severity of the pain is consistent with a red flag.

The doctor has not documented whether the claimant looked ill or well however the claimant has not alleged this red flag was present.

The doctor has not documented whether anorexia was present or not however the claimant has not alleged this red flag was present.

The doctor has not documented whether the abdominal wall felt hard (guarding) however the claimant has not alleged this red flag was present.

On balance the management (asking about, documentation and further checking) of red flags was below the standard expected of the reasonable generalist medical practitioner.

I. Causation

19 Atypical or typical?

No atypical features have been made in the claimant's statement or have been documented in the medical records.

*28/12/2012 GP Surgery Dr Y. X. Gastroenteritis viral 12 h abdo pain loose stool N, PU OK periods OK O/E T tender lower abdo *SG-NAD Adv fluids.*

It is likely that the presentation was typical and had the consultation been performed reasonably the claimant would have been referred promptly for surgery.

20 Appendix perforation

Appendix perforation is variable but about 24 hours from first symptoms is common.

It is likely that the Appendix perforated on the 29 December 2012.

21 Surgery for appendicitis.

The surgery for appendix on the 28 December 2012 would have been a smaller operation with a quicker recovery and a small scar with minimal cosmetically significance, the surgery for the perforated appendix caused a larger scar of cosmetically significance and a slower recovery.

On balance a failure to properly assess the claimant lead to the delay in diagnosis.

This delay lead to the appendix perforating on the 29 December 2012 rather than being removed on the 28 December 2012.

The perforation caused bacteria and other contents of the bowel to enter the abdominal cavity causing local peritonitis.

This local peritonitis lead to the need for a larger surgical scar and drains and worse pain than would have occurred with an earlier surgery.

The recovery from such surgery is likely to be longer and would be expected to include symptoms such as tiredness and feeling depressed.

The area of local peritonitis is likely to have given rise to a larger area of scarring and an increased risk of long term consequences.

The presence of drains, on its own, after the operation does not indicate the claimant suffered an abscess complication.

There is no evidence of the claimant having suffered septicaemia complication.

There is no evidence of the claimant having continuing infection in the area of the surgery.

J. Condition

The following issues can be determined by a Generalist medical report at examination.

22 Typical day

Not assessed.

23 Functional restrictions.

Not assessed.

24 What disabilities are present?

Cosmetic significance of the scar?

K. Prognosis

25 Generalist Issues.

The following issues can be determined by a Generalist medical report at examination.

What long term disabilities are expected?

Scar cosmetic prognosis?

26 Specialist Issues.

The following issue can be determined by a Specialist medical report from review of the surgical documentation especially the operation records and the imaging.

Specifically is there a risk to the fertility of this patient or of future bowel obstruction?

L. Recommendations.

27 Recommendations

There are no recommendations at the present time on the evidence available as to rehabilitation, aids or adaption.

There are no recommendations at the present time on the evidence available as to further tests or treatments.

M. Declaration of Truth

(i) I understand my duty to the court and have complied and will continue to comply with it; and (ii) I am aware of the requirements of Part 35 and practice direction 35, this protocol and the practice direction on pre-action conduct.

I have endeavoured in my report to be accurate and I have covered all the relevant issues.

I have included in my report all matters which I have knowledge of, or which I have been made aware of, that might adversely affect the validity of my report.

I have indicated the sources of information that I have used.

I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

I will notify those instructing me immediately if for any reason my existing report requires correction or clarification.

I understand that:

a My report, subject to any corrections before swearing as to its correctness, will form the evidence to be given under oath or affirmation.

b I may be cross-examined on my report by a cross-examiner assisted by an expert witness.

c I am likely to be subject to adverse criticism by the judge if the Court concludes that I have not taken reasonable care in trying to meet the standards set out above.

I confirm that I have not entered into any arrangement where my fee is in any way dependent on the outcome of the case.

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Dr M Burgin BM, BCh (Oxon), MRCGP

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