‘Having regard to the findings made by the referrer’: medicolegal implications of case SC (2020) for hospital clinicians

Abstract

A case concerning the management of a child with meningitis in a hospital paediatrics department provided a judgement that has significant potential implications for medical practice. The case establishes that the examination findings of a previous clinician must be taken into account when investigating and treating patients. This case is of medicolegal relevance to clinicians practising in tertiary centres and who receive patients from other hospitals. This article highlights the medicolegal implications of this case, using an example of cauda equina syndrome for neurosurgeons, a condition that can have fluctuating symptomatology and that already has a high burden of litigation.

Key words: Cauda equina; Law; Medicolegal

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Introduction

The NHS faced clinical negligence claims resulting from neurosurgery to the value of £213 million in the financial year 2020–21 (NHS Resolution, 2021). This represents just 3% of the total claims received by the NHS but places neurosurgery as the fourth leading litigated specialty by size of claim (obstetrics formed the bulk of the total claim value at 59%, followed by paediatrics at 6% and emergency medicine at 5%). Data from NHS Resolution’s annual reports suggest that the total size of claims for neurosurgery has increased by 65% since 2018, and evidence of ‘claim inflation’ is supported by retrospective analyses of NHS litigation claims (Machin et al, 2018; NHS Resolution, 2019), including that by Steele et al (2015) which found a 140% increase in the burden of claim size for the NHS from neurosurgery between 2002 and 2011. Similar trends have been seen in the USA, where a nationwide analysis of indemnity claims over a 15-year period suggested that neurosurgery carries the largest litigation burden by frequency of claims (Jena et al, 2011).

In this context, it is prudent for doctors practising in hospitals to understand the current medicolegal framework of practice, as well as being clear about how medical case law may direct future areas for claims in this field. This article presents a summary of a case concerning the management of a child with meningitis in a hospital paediatrics department (SC v University Hospital Southampton NHS Foundation Trust, 2020). The case involved documented examination findings of a referring GP, which were not replicated when the patient was examined in the secondary care setting. The implications of this case for future claims are considered, looking at the particular example of management of cauda equina syndrome in neurosurgery. Neurosurgery is a tertiary centre surgical specialty that frequently receives patients referred with information from examinations performed in secondary or primary care settings, and cauda equina syndrome often presents with fluctuating symptomatology and signs that may vary between examiners.

Case summary

SC was a 15-month old female infant, who was examined and referred to a paediatric unit by a GP, with a diagnosis of ‘?meningitis’.

The GP administered Calpol and intramuscular antibiotics, and directed that SC be transferred to the local hospital by ambulance. The GP telephoned the hospital, and wrote

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a referral letter recording vomiting, a high fever, tachycardia, lethargy, vacant expression, '?photophobia' and no neck stiffness.

SC was examined on admission by the paediatric senior house officer who identified swollen tonsils on examination and diagnosed tonsillitis. SC was then reviewed by a consultant paediatrician, who was in his first year of consultant practice. He also identified inflamed tonsils and found SC to be 'alert, miserable, walking around play area'. He agreed with an impression of tonsillitis and discharged SC home with her parents, for review the next day. At this review the consultant noted that the patient looked better but was still lethargic, concluding that this was consistent with a resolving viral illness which would require no further follow up. The patient deteriorated at home in the following days and was later diagnosed with partially treated meningitis. SC developed an infective cerebral vasculitis which has left her with significant neurological deficits.

The joint expert statement concluded that photophobia is a classic sign of bacterial meningitis, the symptoms of floppiness with a glazed expression were not consistent with tonsillitis, but were consistent with many serious conditions, and that the remainder of the symptoms were compatible with either meningitis and tonsillitis, or tonsillitis alone. Therefore the components of the GP's referral which had to be accorded weight to direct the hospital clinicians to consider meningitis were photophobia, floppiness with a glazed expression and the diagnosis being explicitly mentioned in the referral letter.

The judge concluded that SC's presentation at the time of the consultant assessment in hospital was consistent with tonsillitis but it was the findings and query noted by the GP which gave rise to the duty to rule out meningitis. The judge used the Bolam test (Bolam v Friern Hospital Management Committee, 1957) to define the relevant standard of care, which is that accepted as proper by a responsible body of professionals. However, the judge in SC's case clarified that it is part of the proper practice of a responsible group of professionals to consider not only their own examination findings, but also the documented findings of previous clinicians, even if such findings have not been replicated in their own examination.

Legal points arising

1. Clinicians are judged according to the standard expected of someone occupying their post, no allowance is made for relative inexperience (para 44, 96).
2. The hospital clinicians had to consider both the presentation of the patient, as well as the findings that had been made and communicated by previous clinicians. The fact that a hospital clinician has carried out their own examination does not mean they can safely disregard the findings of the referring clinician (para 106).
3. The assessment of previous clinicians needs to be afforded weight, in the context of events (in this case administration of Calpol and antibiotics) which have occurred between assessments (para 88).
4. Hospital clinicians do not have to explicitly note, re-record or recite the findings made by previous clinicians (para 85).

Implications for clinical practice

The legal precedent arising from this case is potentially applicable to a variety of hospital specialists who receive urgent referrals by letter. For those conditions in which symptoms may fluctuate, it is not sufficient for a clinician to direct their history, examination and investigations solely according to the patient in front of them. A specialist must also consider the documented findings and provisional diagnoses of the non-specialist referrer. The authors feel that this case is particularly relevant for neurosurgeons assessing and managing degenerative spinal disease and cauda equina syndrome – for which a delay in treatment is the single most common cause of a successful claim in NHS neurosurgery (Hamdan et al, 2015).

The natural history of cauda equina syndrome being caused by degenerative disease typically leads to symptoms progressing from back pain and sciatica (which may be bilateral), to more specific signs of lumbosacral nerve root involvement, including saddle anaesthesia and urinary retention. Outcomes after decompressive surgery for cauda equina

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Key points

- For conditions with fluctuating signs and symptoms, the documented findings and provisional diagnoses of the referring clinician need to be considered with the same weight as one's own findings.
- Clinicians should not automatically be reassured if their own examination yields milder signs than those elicited by previous clinicians. A cause should be sought.
- Clinicians do not have to re-cite all of the previous documentation that they have considered in forming their clinical impression and plan, if the material reviewed is available to all subsequent clinicians. However, they should make explicit reference to findings, diagnoses or plans that they are discounting, excluding or altering.

syndrome are more likely to be favourable if the patient has not progressed to painless urinary retention (ie remains as cauda equina syndrome-incomplete) (Gardner et al, 2011). Prompt diagnosis of cauda equina syndrome-incomplete and stratification from more common syndromes of lower back pain and sciatica is thus vitally important.

Referrals for '?cauda equina' may be received by tertiary neuroscience centres from both primary care and secondary care (which may lack spinal surgery services for treatment or, in some cases, out-of-hours magnetic resonance imaging scanning for diagnosis). A significant period of time may have passed between the patient's first presentation to a clinician and their arrival at a neurosurgical centre. Importantly, during this period, patients may have received initial management with analgesia, multiple clinical neurological assessments and urinary catheterisation. Upon arrival, the neurosurgeon will no doubt take the patient's history and conduct their own clinical examination to decide whether there is a need for magnetic resonance imaging or operative management (if the imaging received from secondary care was sufficient to allow this). Any incongruous findings when compared to the original referral (eg improvement in pain or resolution of urinary disturbance) might be put down to the natural fluctuating course of the condition, an anomalous or suboptimal examination by the referring clinician, or even an example of referrers deliberately 'overselling' a referral, leaving the clinical decision making to be based solely on one's own history and examination.

The judgement in SC v University Hospital Southampton NHS Foundation Trust [2020] suggests that the provisional diagnosis of the referrer must be explicitly ruled out, even if the patient's presentation to the hospital clinician would not ordinarily have required this approach. In the example of a referral of '?cauda equina', the patient would need to be treated as having cauda equina notwithstanding the absence of signs on presentation to hospital. Put another way, two patients attending hospital with identical symptoms, non-concerning to the neurosurgical specialist, would need to be treated differently if one had been referred by their GP with a diagnosis of '?cauda equina' on the basis of the GP's examination. For the patient who self-presented, the non-concerning nature of the presentation to a specialist clinician would mean that magnetic resonance imaging was not indicated. For the patient referred '?cauda equina', the syndrome would need to be excluded first. The fluctuating course of the condition means that it could not be excluded by the current examination, increasing the likelihood of a magnetic resonance imaging investigation for the referred patient, but not for the self-presenting patient.

Conclusions

Although the clinical facts in the case of SC relate to paediatrics, the medicolegal implications are pertinent to all specialist clinicians receiving referrals. For conditions characterised by fluctuating symptoms and signs, the specialist must give the same weight to the examination findings and provisional diagnoses of the referring clinician as to their own examination findings and diagnoses. Any deviation from the appropriate management that would be indicated by the referrer's findings or provisional diagnosis should be documented, with a clear explanation of the rationale for this, and with specific reference to the previous findings or diagnosis.

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These suggestions are likely to be the mode of practice among most neurosurgeons, who will be aware of the medicolegal minefield of cauda equina syndrome, but SC sets a clear precedent to support this practice in the management of patients with any pathology that has fluctuating symptomatology.

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Conflicts of interest

The authors declare that there are no conflicts of interest.

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