

ORIGINAL ARTICLES

Negligence Claims for Treatment of Neurological Disease: Cases from the Medical and Dental Defence Union of Scotland

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Abstract

There is no detailed description of negligence claims made against clinicians treating neurological disease in the U.K. Here negligence claims concerning treatment of neurological disease, which were handled by the Medical and Dental Defence Union of Scotland (MDDUS), were audited. Sixty-two cases were identified; in 38 cases the clinician was a neurosurgeon, in 16 a neurologist and in 8 a General Practitioner (G.P.). The most common conditions were inter-vertebral disc disease and neoplasia, the most common misadventure was improper performance of procedure and most of the cases resulted in severe permanent disability.

Introduction

In the UK clinical negligence claims which arise during NHS work are covered by the NHS indemnity schemes, while claims which relate to private practice are indemnified by medical defence organisations. Around 6000 – 8000 clinical negligence claims are made every year in the English NHS, and such claims cost £432 million in 2003 – 2004.¹ The specialties which face the greatest cost and frequency of litigation are obstetrics and surgical specialties.¹ Neurosurgery is at high risk for litigation, while medical neurology is one of the lowest risk specialties in the UK.¹ In the United States, the Physician Insurers Association of America (PIAA) publishes data on malpractice claims in each specialty, detailing the pathology, misadventure and injury severity.² The NHS litigation authority audits NHS negligence claims in England, but does not publish information comparable to that provided by the PIAA. Hence there is no detailed description of neurology claims which arise from UK clinical practice. In this report, clinical negligence claims handled by the Medical and Dental Defence Union of Scotland (MDDUS) were examined in order to provide a description of instances of alleged negligence relating to treatment of neurological disease in UK private hospital practice and primary care.

Materials and Methods

The private and locum practice records of the MDDUS were searched to identify clinical negligence claims made regarding the treatment of neurological disorders over the period 1980 – 2004. Cases which involved neurological sequelae of birth injury were excluded. For each case the specialty of the clinician, pathology involved, type of misadventure and severity of injury were extracted by analysing contemporaneous medical records, expert witness statements and summary data compiled by the MDDUS. The misadventure and injury severity were assigned by one investigator (AM) according to the PIAA criteria. The Lothian Research Ethics Committee asserted that this project was audit and thus did not require full ethics approval.

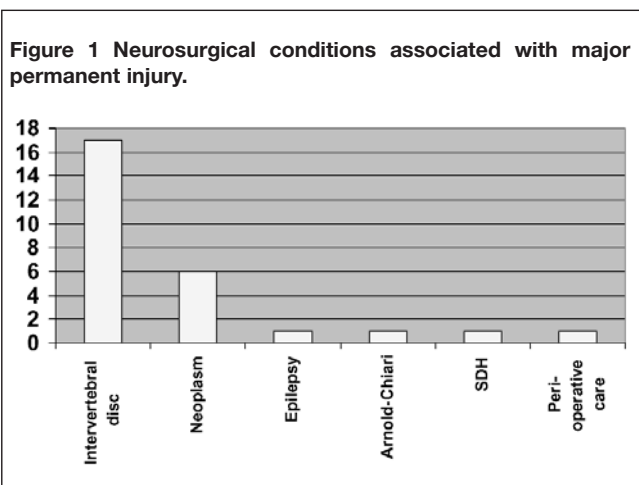
Results

Sixty-two cases were identified; in 38 cases the clinician was a neurosurgeon, in 16 a neurologist and in 8 a general practitioner (GP). Of these cases 50 were closed and 12 ongoing, but data on how the closed cases were settled was not available. The most common pathologies were intervertebral disc disease (20/62 cases), neoplasia (16/62 cases), stroke (4/62 cases) and bacterial meningitis (5/62 cases). There were 2 cases of epilepsy, 1 subdural haematoma, 1 Chiari malformation, 2 cases of viral encephalitis, 3 head injuries, 3 neurodegenerative disorders and 2 encephalopathies. Three of the neurosurgical cases involved poor peri-operative care leading to pressure sores, which led to limb amputation in 1 case.

The most common misadventure was “improper performance of procedure” (32 cases); concerning surgery for disc disease (17 cases), neoplasia (8 cases), Chiari malformation (1 case) and epilepsy (1 case). Improper post-operative care (2 cases) and negligent expert opinion

on head injury (3 cases) also occurred. "Error in diagnosis" was cited in 26 cases; the most frequent condition being neoplasia (8 cases), followed by meningitis (5 cases), stroke (3 cases) and neurodegenerative disease (3 cases). The remaining misadventures were "procedure not indicated" for surgery in 2 cases of disc disease, "delayed performance" (1 case) for drainage of a subdural haematoma, and a single case of "medication error" for epilepsy.

Injury severity was most frequently rated as "major permanent" (38 cases). These resulted from 27 neurosurgical procedures (Figure 1) and delayed diagnosis of 11 neurological cases, chiefly meningitis and stroke.



Death occurred in 6 cases, from 2 operations and delayed diagnosis in 4 cases. "Emotional injury" occurred in 10 cases, from diagnostic error (7 cases), negligent expert opinions (2 cases) and a medication error.

Discussion

This study provides a description of negligence claims occurring in private neurological practice in the UK. It is informative to compare the results presented here with those from the PIAA study. In both studies intervertebral disc disorders were the most common pathology, but while stroke was the second most common diagnosis in the PIAA report, there were only 4 cases (6.4 %) in the current study. This probably reflects organisation of UK services whereby strokes are primarily managed by general or stroke physicians and not neurologists.

In both studies, the most common misadventures, accounting for over 3 quarters of cases, were "error in diagnosis" and "improper performance of procedure". A prominent group in which diagnostic error resulted in

major injury was that of 4 paediatric meningitis cases seen by GPs. It is well recognised that atypical clinical presentations of childhood meningitis pose diagnostic difficulties.³ However, in 2 of the cases in this study, the GPs commented that the home circumstances and behaviour of adults in the child's home hindered their evaluation of the patient. This suggests that distracting factors in the environment should be recognised as possibly predisposing to sub-optimal clinical assessment during a home visit.

The most common injury severities in the PIAA study were "major permanent injury" (23 %) followed by death (17 %). In the present study 61 % of injuries were rated "major permanent" while only 9.5 % of cases resulted in death. The predominance of "major permanent" injuries in this study reflects the high proportion of neurosurgical cases in the cohort (61 % vs 13.9 % in PIAA), while the lower prevalence of deaths reflects the lack of acute neurology and emergency neurosurgery in our private practice cohort. There are fundamental differences between the cohorts studied in this paper and the PIAA report. Nevertheless, it can be broadly concluded that negligence claims against neurologists and neurosurgeons chiefly involve errors in diagnosis and surgical technique respectively, which frequently result in grave injury to the patient.

This study provides preliminary data on negligence claims occurring in neurological practice in the UK, but several limitations temper our conclusions. The study was restricted to claims made in private and locum practice handled by one defence organisation; clearly this means our study is not representative of UK wide neurological practice. In particular, acute neurological conditions managed as emergencies by the NHS were absent from this research. A large scale study of NHS claims is needed to furnish a definitive description of neurological negligence in the UK and inform specialty specific risk reduction strategies.

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