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Welcome

Dr Stephanie Bown – Editor-in-chief
MPS Director of Policy and Communications

As this year marks 120 years since MPS was formed, we have provided an interesting account of our history on pages 4 and 5. Coincidentally, this year also marks the 20th anniversary of Casebook, and in keeping with the Casebook style we have published some excerpts from cases that MPS has been involved in over the years.

The 20th anniversary of Casebook is particularly significant because it represents a milestone in terms of the breadth of risk management advice and support that MPS now provides for members. I touched on the success of this material in the September 2011 edition of Casebook, after a survey of our members found that Casebook continued to play a key role in the safe practice of healthcare.

The range of benefits on offer to members now covers workshops, e-learning, conferences and lectures, while our suite of publications continues to be targeted at more specific areas of the MPS membership. This means that we can tailor our updates and advice to ensure you receive news that is directly relevant to your field of practice.

Reaching the 20th anniversary of publishing Casebook has reaffirmed to me the responsibility we have to protecting patient safety and in promoting effective risk management. I hope that this is a timely example of our commitment to supporting and guiding you in whatever way we can.

You can rest assured that we will continue to focus on ensuring our publications deliver medicolegal advice and support that is relevant, interesting and which you can rely on. As ever, please get in touch with any comments or suggestions; your feedback helps to shape our service to you.
120 years of MPS

Over a century of service

MPS Medical Director Dr Priya Singh pays tribute to the cornerstone of MPS’s longevity – quality of service to members

This year marks the 120th anniversary of the founding of MPS. These two pages look back at how MPS has responded to member needs and legislative changes over this period by adapting and transforming services to become the world’s leading medical defence organisation.

It is this commitment to service that I believe is the foundation on which MPS has been built. From the very start, as the London and Counties Medical Protection Society, the ethos has been focused on putting members’ needs first, reflecting members’ values and ensuring a personalised, proactive and professional service.

MPS is committed to providing the breadth of assistance that anticipates members’ needs throughout a career and an indemnity that offers the best possible protection from the costs of clinical negligence claims. Together with the security offered by MPS’s financial strength, this is a potent combination that gives confidence that MPS will be there for you when you need us, with the voice to protect and promote the interests of members and the wider profession.

The development of education and risk management tools has been designed to help avoid problems occurring and the collective expertise of MPS is now available to members in an unparalleled range of publications, workshops, e-bulletins and conferences, reflecting more than a century of experience.

As a mutual, not-for-profit organisation, MPS is owned by and accountable to members; your subscriptions do not go to shareholders or commercial partners – the mutual fund is there to provide the best protection for you. This financial strength has enabled MPS to remain independent: here solely to meet members’ needs long into the future.

On 1 May 1892 the London and Counties Medical Protection Society was formed. Sarah Whitehouse looks back at 120 years of providing indemnity for doctors.

In the 19th century, before medical defence organisations were established, local groups of doctors would subscribe to each other’s legal costs to challenge defamation cases – in essence, working as local defence organisations. With membership costing around a guinea or less, this informal arrangement suited doctors whilst issues could be settled cheaply and easily. As legal costs and the value of claims began to rise, so too did the public’s expectations of the medical profession. In 1858 the Medical Act laid down the basis for a minimum standard of medical education, leading to the formation of the General Medical Council (GMC).

Between 1910 and 1923 MPS handled more than 50 cases of libel, slander and “patients grizzling about their doctors”.

Amidst this evolving medical backdrop, 1885 saw the birth of the Medical Defence Union, a national rather than local organisation. But the union’s turbulent early years, plagued by accusations of irregularity and lack of accountability to members, resulted in a breakaway group forming an alternative defence organisation: the London and Counties Medical Protection Society. The rest, as they say, is history.

Led by the surgeon Sir Jonathan Hutchinson and doctors George Heron, George Mead and Hugh Woods, the new society aimed to “support and safeguard the character...
of legally qualified practitioners and to advise and defend members when attacked”. The Society went from strength to strength. By 1894, the London and Counties Medical Protection Society had grown to 1,000 members – with an annual subscription rate of ten shillings. Premises were taken in Sloane Square, London, and Le Brasseur and Oakley were retained as solicitors – the start of a lasting association, as the firm’s successor, Radcliffe LeBrasseur, remains one of MPS’s panel law firms today.

Until 1910, MPS only bore its members’ own legal costs, which could cause serious hardship for members if there was an adverse outcome. In 1911, MPS purchased collective insurance for members, to fund adverse costs and damages up to £2,000 for any individual member and up to £20,000 in any one year, at an additional cost of ten shillings.

By 1935, some hospitals and authorities had made membership of a defence organisation a compulsory pre-requisite to employment, which boosted MPS membership, and in 1939, MPS launched the Overseas Indemnity Scheme to afford protection to members practising outside the UK.

The “London and Counties” part of MPS’s title was dropped in 1947, but it was still affectionately referred to as “the London and Counties” by older members. With the advent of the National Health Service in 1948 and the Legal Aid fund in 1960, costs to members began to rise substantially, as did requests for assistance.

In 1962, MPS introduced unlimited indemnity for overseas members, resulting in another substantial increase in membership. Schemes of co-operation were agreed with the Medical Defence Association of Western Australia, the Medical Defence Association of Tasmania, and the Trinidad and Tobago Medical Protection Society.

By 1985, MPS had established a general practice advisory board and had expanded its number of medicolegal advisers – dealing with more than 1,000 claims each year. The first £1 million claim was settled in the UK in 1986; a watershed moment in high claims.

Faced with such spiralling costs, an NHS indemnity scheme was introduced in the UK in 1990 to assume the costs of claims against hospital doctors. MPS membership remained strong, however, to ensure that hospital doctors had access to advice and assistance for a range of medicolegal matters not covered by the scheme, and to provide cover for GPs.

Today, MPS has offices in London, Leeds, Edinburgh, Brisbane, Wellington and Auckland, which provide assistance for more than 270,000 members in more than 40 countries, including the UK, Ireland, Hong Kong, Malaysia, New Zealand, Singapore, South Africa, and the Caribbean and Bermuda. MPS’s most notable presence outside the UK is in South Africa, where it has been active for more than 50 years.

In its 120th year, MPS has chosen to hold its first international conference – Quality and Safety in Healthcare: Making a Difference – which will bring together international experts from around the world to share their knowledge, experience and expertise on quality and safety.

With an increasing focus on education and risk management, MPS looks set to remain at the heart of the medical profession for the next 120 years, responding to the needs of members in an ever-changing medicolegal climate.

Further details of the international conference are available on the MPS website.

In 1936, the first action was brought against the estate of a deceased doctor (Rubra Ats Connolly). Damages of £5,000 were awarded to the plaintiff and paid by MPS – the benefits of membership extend beyond the grave.

TIMELINE

1892 1 May – London and Counties Medical Protection Society forms
1894 Sloane Square, London, office opens
1947 Name changes to Medical Protection Society
1947 First overseas scheme of co-operation (Medical Defence Society of Queensland)
1970 Leeds office opens in Park Square
1994 Leeds office relocates to Granary Wharf House
2007 Brisbane office opens (acquisition of Cognitive Institute)
2009 Edinburgh office opens
2011 Wellington office opens
HEADLINES AND DEADLINES

Adverse events hit 377, reveals Commission

The Health Quality and Safety Commission has revealed that 377 serious and sentinel events occurred in New Zealand’s public hospitals in 2010/2011 – a rate of more than one a day.

The report, Making Our Hospitals Safer – Serious and Sentinel Events 2010/2011, reveals that of the 377 events reported, 86 patients died, although not necessarily as a result of the adverse event that occurred.

A serious or sentinel event has, or has the potential to result in, serious lasting disability or death not related to the natural course of the patient’s illness or underlying condition.

According to the figures, 195 falls were reported as serious and sentinel events in 2010/11, while 25 medication errors were reported. There were also 108 clinical management incidents, which included:

- Delays in responding to a patient’s condition
- Poor communication
- Delayed diagnoses.

Commission chair, Professor Alan Merry, urges health professionals to familiarise themselves with the report’s findings and to look at how they can make the services they provide safer for patients.

Professor Merry reflects on the report in more depth in this edition of Casebook www.hqsc.govt.nz

WORKSHOP SERIES A BIG HIT

MPS’s Essential Risk Management Workshop Series has proved extremely popular with members in New Zealand. Launched in 2009, by the end of 2011 over 160 workshops had taken place, with a total attendance of more than 2,800.

Feedback from members has been excellent. The figures in the table below show the percentage of attendees who agreed or strongly agreed with each statement.

<table>
<thead>
<tr>
<th>Workshop worthwhile attending</th>
<th>Recommend to colleague</th>
<th>Consider further MPS activities</th>
<th>Will change practice as a result</th>
</tr>
</thead>
<tbody>
<tr>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>84%</td>
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</tbody>
</table>

NEWS IN BRIEF

Recertification programme for doctors registered in a general scope of practice

The New Zealand Medical Council, in partnership with Bpacnz Ltd, has issued a guide to the recertification programme.

The guide, In Practice: Bpacnz Recertification Programme for Doctors Registered in a General Scope, aims to provide doctors registered in a general scope of practice with a framework for their continuing professional development.

The Council will use the programme to ensure doctors are competent and practicing within the scope of their registration.

More information on the Bpacnz Recertification Programme can be found online at www.inpractice.org.nz.

A fond farewell to Dr Aine McCoy

Dr Aine McCoy has bid MPS farewell after nine years as a medical consultant based in the Wellington office.

“I have thoroughly enjoyed being part of the MPS team both in New Zealand and internationally and I value the friendships I have made over the years,” says Aine. “It has been a rewarding experience dealing with our members and providing assistance during what was, for some, a very stressful time in their professional careers.”

Aine now intends to concentrate on her busy general practice and her golf handicap.

Correction

In the article “Prescribing phentermine” (Casebook 20(1), January 2012), the standard daily dose is 30mg daily, not 30mg twice daily as stated. We are sorry for any misunderstandings caused by this error.
Safe care through strong systems

Each year, a report is released on the serious and sentinel events that occur in our hospitals. The Health Quality & Safety Commission has taken over responsibility for reporting this information. Chair Professor Alan Merry takes a look at the 2010/11 figures, and how we can learn from them.

No clinician goes to work wanting to make a mistake, but as annual serious and sentinel events reporting shows, mistakes do happen. It is generally accepted that even the most careful and caring of clinicians will make errors in practice, and at times these errors will result in harm to patients. Often, the root cause can be traced back to a systems failure – which is why making systems as safe as possible is a priority for the Health Quality & Safety Commission.

For the 2010/11 year, District Health Boards (DHBs) reported 377 serious and sentinel events. This included 195 falls (up from 130 falls reported for the previous year), 108 clinical management incidents, and 25 medication errors. There were 86 deaths, although not necessarily as a result of the event.

These events are tragedies for patients and their families. They also often greatly affect the medical professionals involved. It is important we learn from them, to increase patient safety and to give clinicians confidence that they will be supported by the systems around them to practise safety. The publishing of serious and sentinel events data must therefore be more than a recitation of numbers.

The latest event findings have several recurring themes:
- Poor communication between health professionals, resulting in harm to a patient
- Delayed diagnoses due to failings in referral processes and the reporting of investigation results.
- Medication errors, including incorrect doses and administration of drugs to which a patient was known to be allergic
- Delays in responding to a patient’s changing or deteriorating condition
- Medication errors, including incorrect doses and administration of drugs to which a patient was known to be allergic

The Commission is concentrating on a number of specific work programmes to support the health and disability sector to reduce the incidence of harm from preventable events by making systems safer.

These include the development of a central repository for serious and sentinel events; development of strategies to reduce harm from falls; the continued and enhanced use of the World Health Organisation’s Safe Surgery Checklist; the development of a national reportable events policy; promoting the use of the national medication chart, medication reconciliation and electronic medicines management, and improving infection prevention and control measures.

Until now, only DHBs have reported serious and sentinel events, and only those events that occurred in public hospitals. We all know, however, that adverse events can happen in any health and disability setting. The Commission hopes that eventually all health and disability providers, whether public or private, will report serious and sentinel events that occurred in public hospitals.

For the 2010/11 year, District Health Boards (DHBs) reported 377 serious and sentinel events.

The report Making Our Hospitals Safer: Serious and Sentinel Events reported by District Health Boards 2010/11, as well as a separate document with information on individual cases, is available at www.hqsc.govt.nz.
With increasing frequency, doctors are approached by the police seeking information about a patient. There are two quite distinct circumstances: on the one hand the enquiry from the police may not concern or be about the doctor; in other circumstances the police investigation may be a result of a complaint by a third party (usually a patient) about you. Both call for caution – particularly in the latter case.

This article attempts to provide some general guidance for doctors in the event they are approached by the police for a statement and/or copies of records containing health information. In providing this guidance no criticism is intended of the police, who commonly act in good faith when seeking comment or records or when following up a complaint.

You must ascertain from the police why you are being asked to provide the information and/or give a statement. For example, are the police investigating a complaint? What is the nature of the complaint? Are you the subject of or in any way implicated in the complaint? If not, are the police able to obtain the information from another, perhaps more appropriate, source? Such detail is important to enable you to make an informed and considered choice as to whether or not you should comply with the police request.

If you are in any way implicated in the complaint, do not comply without firstly obtaining legal advice. See the further guidance provided below.

Where you are the subject of the police enquiry
Regrettably, innocent doctors are not uncommonly the subject of complaints that the police will investigate. Clinical practice is such that at times the patient will misunderstand the purpose or conduct of the doctor. Serious criminal offences are sometimes alleged out of consultations undertaken for proper purpose. It is naive to say this only happens to the guilty doctor, or will only happen to others.

There are some golden rules:

■ You should never try and handle the situation without medicolegal advice. At the first opportunity seek advice.

■ Do not be drawn into making any comment or statement until you have seen complete disclosure from the police. This will include what it is you are being criticised for and what evidence the police have, to date, obtained. As a matter of routine the police will not provide disclosure when investigating a complaint or potential offence.

What do you do if you are asked for patient information by the police? Barrister Aimee Credin looks at the legal position

Saying ‘no’ to the police

Act complaint or otherwise is ever-present in this situation – hence the need for guidance.
You must ascertain from the police why you are being asked to provide the information and/or give a statement.

Experience has shown, however, that it is extremely unwise to offer any comment or statement at all until that has happened. Note – this is imperative, irrespective of whether the doctor is innocent or guilty.

- The police will routinely provide you with a “caution” before conducting an enquiry of you. This caution is to the effect you have the right to remain silent but that anything said by you may be used against you. The caution means exactly what it says. Properly advised, it will be a rare circumstance where you should choose not to exercise that right to silence during the police investigation phase. There is plenty of opportunity to make a comment or statement once you have seen the information comprising the police investigation to that point in time.

- Do not voluntarily accompany the police to the police station if they ask you to do so. You are not required to and generally the sensible course of action is to politely decline.

- If, notwithstanding the above, you end up at the police station, be sensible – exercise your right to silence. Do not agree to make a statement and most certainly do not agree to be videoed. Even the entirely innocent doctor, outside his/her comfort zone, in these circumstances, has a demeanour that understandably does not come across well in a videoed interview. If you do get drawn into making a statement (not to be recommended), follow the advice given in Box A, regarding it being accurate. Signing it means you are happy that the content is a fair and accurate record of your knowledge. Do not sign a statement if you feel that you have been bullied, forced, cajoled or in any way made to say what you did not mean to say, or where words may have been put in your mouth. Only sign the statement when you have checked it carefully.

- Do not comment on matters that you do not know the answer to, or be drawn into giving evidence outside your scope of expertise.

- Do not sign a statement if you are not happy with the statement, do not sign it.

Aimee Credin is a Barrister at Quay Chambers, Auckland.

**BOX A: REQUEST FOR A STATEMENT OR COMMENT**

- Importantly, and surprisingly not widely known, you are not obligated to provide a verbal or a written statement to the police, no matter what the situation is.

- Remember that “helping with enquiries” is only a half answer. The police do not have to provide an explanation and if they refuse to do so, then it is surely easier and appropriate to decline the request.

- Alternatively, rather than providing a verbal statement you can ask the police to put their questions in writing and provide a written response once you have had time to consider the matter and/or seek advice. This will also give you the opportunity to, in appropriate circumstances, advise the patient of what you intend to do.

- If you decide to provide a statement make sure you report known facts. Expressions of opinion, speculation or hypothesis are best avoided (unless you are being asked to act as an expert witness, but in that event you certainly must not do so unless full details/disclosure are firstly provided to you).

- Do not comment on matters that you do not know the answer to, or be drawn into giving evidence outside your scope of expertise.

**BOX B: REQUEST FOR HEALTH INFORMATION BY THE POLICE**

- The Health Act allows the police to request access to health information when they need it to investigate an offence. It is within your discretion whether or not to provide the health information, and factors such as the gravity of the alleged offence and the sensitivity of the health information sought are matters to be taken into consideration.

- In some situations it may not be feasible to discuss the request with the patient but, where at all possible or appropriate, you are wise to do so even if merely to advise the patient you propose to disclose the information.

- Disclosure of health information without the consent of the patient is provided for in Rules 10 and 11 of the Health Information Privacy Code. This is usually a high threshold to meet and doctors are advised to seek medicolegal advice before doing so.

- Importantly, the only way the police can demand clinical records is by way of a search warrant, so unless there is a warrant you do not have to release the health information.

- If in doubt it is advisable to seek medicolegal advice.
Silent witness

Sara Williams explores how using chaperones for particular consultations can protect your practice

The challenge for today’s doctors is to show their human face while maintaining clear professional boundaries. Using a chaperone is not only an effective safeguard against unfounded accusations; it will help put a patient at ease.

Respect for a patient’s autonomy is expressed in many different ways. On an overt level, it is conveyed by seeking consent, conducting open discussions and working in partnership with patients. On a more subtle level, it requires a sensitive recognition of the power differentials that exist between doctors and their patients, and the vulnerability patients may feel. Using a chaperone is both an added layer of protection and an acknowledgement of a patient’s vulnerability.

The Code of Health and Disability Services Consumers’ Rights provides that: “Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer’s rights unreasonably infringed.”

Defining the third person
For particular consultations, doctors may want another person present. The role they will play will depend on the individual circumstances of the consultation. The function of the third person should be clearly understood by all parties, so it is necessary to obtain informed consent beforehand.

A third person may be present to participate in one of the following five roles as defined in this statement:

- a support person for the patient – Patients have the right to request one or more support people for consultations that might cause discomfort or confusion. Their presence focuses on the needs of the patient.
- an interpreter for the patient – This is...
the patient’s right under Right 5(1) of the Code of Health and Disability Services Consumers’ Rights. An interpreter may assist with translating a different language or with the understanding of someone with a disability or alternative form of communication (ie, sign language).

- **an observer for the doctor**
  - This person is present at the doctor’s request for a number of reasons, eg, part of CPD to assess the doctor.

- **a student or trainee**
  - Participation in teaching is covered by the Code of Health and Disability Services Consumers’ Rights. If a student or trainee is present during a consultation, an explanation should be provided before the consultation and consent obtained.

- **the doctor’s chaperone**
  - A chaperone is a person who, at the invitation of the doctor and with the patient’s informed consent, is present during a specific examination or treatment procedure. This could be part of an internal practice policy. If a patient or doctor refuses the attendance of a third person, they have the right to withdraw from the consultation until a mutually acceptable third person is available. Alternatively, the patient may be referred to another doctor.

Using chaperones

“The use or offer of a chaperone should be routinely annotated in the clinical record, even if this is declined by the patient (eg, COD – Chaperone offered: declined, or CP – Chaperone present).”

The use of chaperones should not be restricted to male doctors and female patients, or when a physical or internal examination is carried out. Be aware of grey areas of vulnerability where an inadvertent breach may occur. Examples include listening to the chest, taking the blood pressure cuff and palpating the apex beat – all could involve touching the breast area.

When choosing a chaperone, consider that:

- Chaperones should have the knowledge to assess the appropriateness of an examination and/or procedure as well as the way in which an examination and/or procedure is carried out.
- Receptorists are not generally considered acceptable.
- The most appropriate person would be a member of the clinical team, but the patient must be introduced to them and told what their position is beforehand.
- Potential inadvertent breaches of confidentiality make friends and relatives poor choices of chaperones.

Doctors with conditions on registration

Some doctors have conditions on their registration that require a chaperone to be present at certain types of consultation. Doctors who have this condition on their practice should inform their employer of the condition, as it is usually the result of past disciplinary action.

For such doctors, the presence of a chaperone is not optional and if a patient does not feel comfortable, they should be referred to another doctor.

According to the Medical Council of New Zealand, doctors who have chaperone conditions should disclose the reason behind the requirement if they are questioned by a patient. The only exception to the chaperone condition is in an emergency situation. A doctor with a chaperone condition may attend an emergency, even when a chaperone cannot be located.

Summary

There is a real risk in practice of patients mistaking your intentions, so respectful two-way communication and the judicious use of chaperones are your best protection from false or unfounded allegations.

SCENARIO A

Locum GP Dr A is seeing a patient, Miss F, who is complaining of a problem in her right eye. Dr A explains that “he will need to look at the back of the eye”. He promptly turns out the light in the consulting room and proceeds to perform a fundoscopy. Whilst Dr A is leaning forward, his tie inadvertently (and unbeknown to Dr A) comes into contact with Miss F’s blouse. She leaves the consultation thinking that Dr A has touched her inappropriately and makes a complaint.

Advice

Dr A should have given a clear explanation as to what the examination entailed and confirmed the patient was content for him to proceed before going ahead. Inadvertent contact of this nature can easily be misconstrued, especially in this particular context. Dr A should have been alive to this possibility and taken reasonable steps to minimise such risks (for example, by explaining why he turned the light out, why he had to be so close and tucking his tie in). If any inadvertent contact does occur during the course of an examination, an apology and an acknowledgement should be offered immediately.

Key points

- Third person policies should be displayed in the practice waiting and examination areas.
- Arrangements for the presence of a third person should be in place prior to the start of the consultation.
- All parties involved in the consultation must understand the role of the third person, and the patient must give informed consent for a third person to be present and the role they will take.
- The Medical Council of New Zealand advises that the doctor speak with the patient about the presence of a third person in private, away from the nominated third person.
- If a doctor requires a third person to attend a consultation they should preferably be another health professional.
- Third persons should be made aware of the confidential nature of the consultation.

REFERENCES

3. The Health and Disability Commissioner, report on opinion – case642dc2761, September 1997
Most colleagues will be aware from reading previous Casebook articles that poor communication contributes to approximately 70% of clinical negligence claims against doctors. Nevertheless, communication issues continue to surface, with depressing regularity, with each new series of claims and complaints assisted by MPS.

Doctors clearly do not communicate poorly on purpose. As a group, we have a strong ethical drive of wanting to do the best for the patient and this is combined with a pragmatic desire to avoid being sued.

**Why do communication failures persist?**

A report by the British Medical Association’s (BMA) Board of Education has highlighted key barriers to effective communication.1 Several of these barriers link to personal traits and attitudes. Such barriers include:

- **Negative attitudes towards communication.** Doctors give it a low priority, preferring to focus on treating an illness rather than the patient’s overall needs.
- **A lack of inclination to communicate with a patient, especially when a doctor doesn’t have a lot of time, is dealing with an uncomfortable subject or is lacking in confidence.**
- **Doctors having personality differences compared to their patients.** Research in the UK suggests that doctors may differ significantly to adult population norms in the areas of personality related to preferred mode of understanding. This opens up the possibility of misunderstandings in communication between doctors and patients.
- **Undervaluing the importance of communications:** doctors may not appreciate the importance of keeping patients informed. This may reflect a wider imbalance in the doctor–patient relationship.
- **A lack of understanding of the communication process, such as the need to provide information in language that a patient understands, or listening to a patient’s views, to encourage two-way communications.**
- **A lack of knowledge or training in communication skills, especially in non-verbal communication, such as body language.**

The same report recommended that more communication skills training programmes should be developed for doctors. MPS Educational Services offers members a number of three-hour workshops that aim to support doctors’ communication skills.

Small interactive workshops, like those offered by MPS, have been shown to be effective in changing doctors’ behaviours.2 And after attending a workshop, 80% of participants say they will change their practice.

As doctors, we know from our own experiences of supporting patients with behaviour change, such as quitting smoking or addressing weight problems, that good intentions on their own often aren’t enough. Overcoming barriers, especially when they are related to attitudes or personal traits, requires support, reflection and reinforcement.

It is for this reason that MPS offers members a series of communication skills workshops. The workshops each focus on a different area of communication. This was another recommendation of the BMA’s Board of Medical Education.

The areas covered by the workshops include:

- Basic communication skills
- Non-verbal communications
- Communicating after an adverse outcome
- Inter-professional communications
- Difficult interactions
- Shared decision-making.

Different techniques and skills are provided for each area but all the workshops share key themes. Starting with Mastering Your Risk and working through Mastering Adverse Outcomes, Mastering Professional Interactions, Mastering Difficult Interactions with Patients and the new Mastering Shared Decision-Making, the workshops build upon one another.

They each offer participants the chance to rehearse communication techniques, while revisiting key ideas and refreshing skills. Each workshop also encourages doctors to reflect on their own actions and behaviours.

The aim is that over time, by gradually helping members challenge and change their attitudes towards communications, the workshop will ultimately produce a step change in their communication skills. This will lead to a reduction in risk for the doctor and an improved patient experience.

**REFERENCES**

1. BMA Board of Medical Education, Communication Skills Education for Doctors: an Update (November 2004)
On the case

Dr Nick Clements, Head of Medical Services, introduces this issue’s round-up of case reports, a number of which focus on missed infections.

In “Where is the consultant?” on page 17, Mr W’s endocarditis was missed by the cardiologist Dr H, who only saw him once during his inpatient stay. Mr W was not consulted about his progress, results of investigations or plans for discharge or follow-up. In this case, team working and fractured continuity of care created an “I thought you did it” situation; required tasks were not completed and an outpatient clinic appointment was not arranged. Safe systems should be in place to ensure that results are acted upon and that the relevant investigations are carried out.

Similarly, there was poor continuity of care in “A pain in the neck”, on page 19. Mr P was not fully examined on any subsequent visits to his GP, Dr W, despite progression of his neurological symptoms. The problem here was Mr P’s hostile and challenging behaviour, which meant that clinical examination was usually difficult. All the healthcare professionals involved in his care missed the large tubercular abscess in his neck, which resulted in Mr P becoming tetraplegic. This case is a pertinent reminder that despite an aggressive or difficult patient, you should maintain a professional approach and rule out any underlying pathology. To do otherwise is indefensible – expert opinion found Mr P was not examined early enough, despite repeatedly attending with his symptoms.

Preconceptions of a particular patient can hinder diagnosis. In “Crying wolf” on page 15 Mrs Z’s multiple calls went unheeded, and similarly, in “Suffer the little children” on page 21, M’s generally unhealthy demeanour and frequent contact with the GP masked the extent of her symptoms. Her puffy eyes were put down to “looking rather ill, as usual,” rather than the severe bilateral orbital cellulitis she was eventually diagnosed with and which resulted in her becoming blind. Extra care should be taken with frequent attenders, particularly if there are repeated calls – always revisit your diagnosis if symptoms persist or appear to be getting worse. You should have a low threshold for examination when conducting telephone consultations, and, as this case shows, effective triage is essential. Non-clinical staff should be educated to recognise potential red flag symptoms and pass on vital information to the healthcare team.

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Since precise settlement figures can be affected by issues that are not directly relevant to the learning points of the case (such as the claimant’s job or the number of children they have) this figure can sometimes be misleading. For case reports in Casebook, we simply give a broad indication of the settlement figure, based on the following scale:

- High $3,000,000+
- Substantial $300,000+
- Moderate $30,000+
- Low $3,000+
- Negligible <$3,000
Mrs R was a receptionist in a local estate agent’s office. One evening, she noticed that her 11-year-old son, Y, was limping as he walked towards her in the kitchen. Y was overweight and had been grumbling to his mother about his left knee hurting intermittently for the previous month. On this occasion, when she asked why he was limping, Y told his mother he had slipped on ice in the playground earlier in the day. The fall had caused his leg to be sore. He had pointed at his thigh and said his knee was hurting again. The following day, Mrs R was booked to visit her GP, Dr G, to review her contraceptive medication. She decided to bring her son along with her, without an appointment.

At the end of her consultation, Mrs R asked the doctor if he would take a look at her son. She explained what had happened yesterday and told Dr G that Y had been limping at home. There was a computer record of the consultation with Mrs R, but not with Y. Mrs R reported that Dr G carried out a cursory examination of Y, while Y was sitting in the chair. She said that the doctor told them this was most likely a hip sprain, but to come back if the pain did not settle.

Dr G remembered Mrs R attending for a review of her medication, and then asking for her son to be seen at the same time. He recalled feeling rushed and that Mrs R was quite insistent that Y be examined. Dr G could not remember carrying out the examination and thought he had asked Mrs R to rebook an appointment for Y. As there was no formal record of this, there was therefore no note of such a request, or an examination being performed.

When they returned home, the boy continued to complain of pain in his leg. Mrs R decided to bring Y to the local Emergency Department (ED) three weeks later, where a doctor requested bilateral hilar x-rays and subsequently diagnosed slipped upper femoral epiphysis (SUFE). The case was discussed with the orthopaedic team on call and Y was admitted immediately for internal fixation.

After his treatment, Y’s legs were of unequal length and one year later, he still walked with a persistent limp, which he found extremely distressing. The family had learnt it was likely that Y would require an early hip replacement in the future.

Mrs R made a claim against Dr G. As there were no records of the consultation, experts found it difficult to make a definitive assessment of the case, but they did find that Dr G’s management had not been appropriate. The case was settled for a high sum.

GMcK

LEARNING POINTS

- Remember the importance of contemporaneous record-keeping. Good documentation is the basis of good medical practice, and can help to defend a claim. Even if Y’s problem was mentioned by Mrs R as a ‘by-the-by’, Dr G should have made a clinical record of the events.
- If you are going to assess a patient, even in someone else’s appointment, the history and examination should be carried out appropriately. Had Dr G done it at the time, he may have realised that there was a significant problem with the child’s leg. Otherwise, Dr G should have asked Mrs R to wait until the end of surgery for Y to be seen if urgent, or rebook an appointment for Y at a later date, when a more thorough history and examination could be carried out, if the problem could wait. Dr G should have made a record of this discussion.
- A limp in a child can have multiple aetiologies: Perthes’ disease/trauma/transient synovitis/septic arthritis/osteomyelitis. Slipped upper femoral epiphysis usually affects boys aged 10-15 years old. Incidence is 1:100,000 and is bilateral in 20% of cases. It occurs more frequently in obese children with delayed secondary sexual development and tall thin boys.
- Remember referred pain to the knee as an early clinical symptom of SUFE.
- Examine both hips and check for restricted movement, particularly internal rotation.

FURTHER INFORMATION

- Lalanda M, A Limping Child, Casebook 15(2)
- Anthony S, Getting to Grips with Children’s Hips, Casebook 12(3)
Mrs Z was a 34-year-old mother of four who smoked 20 cigarettes a day. She had recently been under investigation for central chest pain related to minimal exertion. Her GP, Dr B, had arranged an ECG, which had been normal, and done some blood tests, which showed raised cholesterol. He had also found her to be hypertensive. He had made no firm diagnosis regarding her central chest pain but was considering a referral to cardiology.

Mrs Z developed what she thought was indigestion, which was also causing aching in both her arms. When she started feeling unwell with it she rang the out-of-hours (OOHs) service complaining that in addition to the indigestion she also felt hot and sweaty. Mrs Z was very well-known to the OOHs staff because she used the service very regularly for herself and her children. The triage nurses advised her to take some antacid or milk for the indigestion. The nurse had failed to get a past history for Mrs Z’s cardiac symptoms. Mrs Z waited for an hour after drinking some milk but felt worse. She was still feeling sweaty and hot with the chest pain and rang the OOHs service again to explain this. She asked to speak to the doctor but the triage nurses remarked that “the doctor would not be able to do much more for that kind of problem”. That evening she became really concerned after several hours of pain were showing no signs of remitting. She had managed to get all her children to bed but was feeling like something awful was going to happen. She rang the OOHs service again but was given the same advice by the triage nurses.

Unfortunately during the late hours of the evening, Mrs Z collapsed at home. One of her children called an ambulance but attempts by the paramedics to resuscitate her were unsuccessful. She was pronounced dead. The postmortem confirmed that the cause of death was an acute MI.

Mrs Z’s relatives made a claim against the triage nurses and the on-call doctors that night. The doctors denied having any knowledge about her. There were long discussions about the standards of training and support for the triage nurses and the levels of GP cover. The case was settled for a high amount.

LEARNING POINTS

- It is important to listen to patients who make recurrent calls regarding the same problem. Mrs Z had contacted the OOHs team and the GP surgery on multiple occasions. Doctors must not let an element of “crying wolf” blind their judgment.
- There are risks associated with telephone triage and information not being appropriately passed on to the medical team. It is harder to make a diagnosis without the visual information from a patient’s appearance, behaviour and non-verbal cues so great care must be taken.
- Written protocols should exist for the management of chest pain with clear guidance about when to pass on information to doctors. Although protocols often lack the “intuition” of experience, it would have been helpful if one had been adhered to in Mrs Z’s case.
- Ischaemic heart disease is rare in younger women, but not impossible, particularly when associated with risk factors. It is important to consider this diagnosis in the differential even if it is uncommon.
Mrs T, a 58-year-old music teacher, was admitted to her local hospital for an elective total abdominal hysterectomy for post-menopausal bleeding. She was seen on the day of surgery by consultant anaesthetist Dr Q, who noticed she had a cough. Mrs T said she had recently had a chest infection and had been prescribed a course of antibiotics from her GP. However, she was vague about how long she had had her cough, and whether she had finished the antibiotics. She dismissed her symptoms as a “smoker’s cough” and was insistent that the operation should go ahead, as she wanted it to be “all over and done with” in time for her son’s wedding a few weeks later. She also requested a general anaesthetic.

Dr Q did not discuss the case with the consultant gynaecologist Ms R. Later it was revealed that they had “fallen out following a disagreement”. Dr Q agreed to proceed with general anaesthesia. Dr Q induced general anaesthesia using a standard technique and intubated the trachea. However, he found the airway pressures unexpectedly high. He reasoned that the cause was bronchospasm. He adjusted the ventilator settings, deepened anaesthesia and administered intravenous salbutamol to relieve the spasm. After a few minutes, things seemed to improve and the operation went ahead. Mrs T was coughing on the tube at the end of the operation, but was extubated. However, she continued to cough vigorously in the recovery area and was clearly in difficulty, with very low oxygen saturations and a high respiratory rate.

Shortly afterwards Mrs T rapidly developed subcutaneous surgical emphysema and suffered a cardiac arrest. Cardiac compressions were performed and intravenous adrenaline was administered. A circulation returned, although she remained very unstable. A chest x-ray was performed and intravenous adrenaline was administered. A circulation returned, although she remained very unstable. A chest x-ray was performed, which showed a tension pneumothorax. A chest drain was inserted, which improved stability, and she was reintubated. She was transferred to the intensive care unit, where she was found to have signs of a right lower lobar pneumonia. Oxygenation was very difficult. She had a prolonged and turbulent course in intensive care, complicated by pneumonitis and multi-organ failure, and was eventually found to have cognitive impairment consistent with hypoxic brain injury.

There were limited records of what happened during induction, anaesthesia and recovery, and most of the medical record was found to have gone missing. The recovery nursing notes included an incident form for “difficult airway maintenance” and she was noted to have arrived in recovery in a “very poor state”. A claim was brought on Mrs T’s behalf against Dr Q, which was settled for a high sum.

**LEARNING POINTS**

- Your first obligation is to act in the patient’s best interests and you should not be pressurised by the patient into doing anything that is counter to this. In elective surgery, it is important to avoid pressure to proceed. In this case, finding out that Mrs T had pneumonia might have prevented this outcome.
- When administering anaesthesia during an elective procedure, it is preferable to stop should you encounter difficulties and reassess for surgery another time.
- Good communication between professionals is essential in patient care. Had the anaesthetist and the surgeon discussed this patient, it might have been possible to perform a vaginal hysterectomy under spinal anaesthesia, or the case could have been postponed until later.
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- Bronchospasm is an important and treatable cause of high airway pressures and tension pneumothorax during ventilation, but not the only one. The differential diagnosis includes endobronchial intubation, foreign body in the airway, and equipment problems such as kinks and obstructions.
A 48-year-old driver, Mr W, was sent to hospital by his GP with a one-week history of unremitting back pain and associated mild shortness of breath. On direct questioning, he also reported non-specific malaise for at least three months with half a stone weight loss but no symptoms of fever. There was no previous history of cardiac problems and no recent dental or other invasive procedures.

Initial investigations demonstrated a mild leucocytosis with normal biochemistry. The ECG and chest x-ray were normal and there was no elevation of troponin, BNP or D-dimers. There was some concern about the possibility of an aortic dissection but a CT scan of the chest was also normal. Inflammatory markers were not measured.

The consultant cardiologist Dr H saw Mr W only once – on the post-take ward round after being admitted – and requested an echocardiogram after hearing “an aortic murmur”. The medical records indicate that he did not see Mr W again during his in-patient stay – nor was he consulted about his progress, results of investigations or plans for discharge or follow-up. Mr W’s temperature was recorded once daily. The echocardiogram demonstrated a bicuspid aortic valve with moderate aortic regurgitation and no other abnormality. The template report included the statement: “endocarditis is not excluded”. He was discharged directly from the medical assessment unit without senior review, with a diagnosis of musculoskeletal back pain and possible atypical pneumonia, with a plan for outpatient follow-up in four weeks’ time to assess progress and review the results of the echocardiogram. The GP received only an interim discharge summary, which did not show an appointment had been arranged.

Eight weeks later, Mr W was readmitted to hospital with a high temperature, further weight loss, and shortness of breath secondary to pulmonary oedema. He was anaemic with an ESR of 104mm/hr and six out of six blood cultures were positive for Streptococcus mutans. A clinical diagnosis of infective endocarditis was made and confirmed by echocardiography, which demonstrated a large vegetation on the aortic valve with destruction of the non-coronary cusp and severe aortic regurgitation. He was treated appropriately after microbiological consultation with intravenous benzylpenicillin and gentamicin and his case discussed with the local cardiothoracic surgical centre. Unfortunately, within 24 hours, and before he could be transferred, Mr W deteriorated acutely with hypotension and pulmonary oedema refractory to diuretics and could not be resuscitated. The postmortem showed large vegetations on the aortic valve and extensive destruction of both leaflets of the bicuspid aortic valve secondary to bacterial endocarditis. The case was settled for a moderate amount.

**LEARNING POINTS**

- The diagnosis of infective endocarditis is difficult and depends upon a low threshold of suspicion (see Beynon R, Bahl VK, Prendergast BD, Infective endocarditis, BMJ 333:334-339(2006)). The disease may present in a variety of forms to a variety of clinical specialties.
- Senior medical input to the care of seriously ill patients is important.
- There is little purpose in requesting investigations if the results are not carefully reviewed and acted upon at an appropriately early stage. There were several diagnostic clues in this particular case, which should have alerted the clinical team to the earlier diagnosis and management of infective endocarditis.
- The pressure to discharge patients and create beds for further admissions means that the results of important investigations are easily overlooked.
- Clear and comprehensive communication with the patient and GP is essential.
- Team working and fractured continuity of care can easily create “I thought you did it” situations where required tasks are not completed. The outcome for this unfortunate patient may have been different had an early follow-up appointment been arranged.
- Safe systems should be in place to check that outpatient clinics are arranged. It is worthwhile telling the patient that they should get in touch if plans are not confirmed.
Mr A, a 35-year-old accountant, was admitted to hospital overnight as an emergency under the care of consultant general surgeon Ms Q. He described an acute onset of severe right iliac fossa pain. Clinical examination revealed lower abdominal tenderness with localised peritonism in the right iliac fossa. Routine blood tests revealed an elevated white cell count whilst urinalysis was negative. A provisional diagnosis of appendicitis was made and the patient was commenced on intravenous antibiotics, and kept nil by mouth pending review by Ms Q in the morning.

When Ms Q saw Mr A she was unconvinced by his physical signs and organised an ultrasound scan, which did not demonstrate any abnormality. The appendix was not visualised. Twenty-four hours later the patient’s condition had not improved and Ms Q made a decision to perform an appendicectomy.

Open surgery was carried out by an experienced surgical trainee on behalf of Ms Q, who found no sign of any intra-abdominal pathology to account for Mr A’s symptoms. Ms Q attended the operation and confirmed that there was no peritoneal contamination and that the appendix, terminal ileum, gall bladder, duodenum and remaining accessible small bowel and colon all appeared normal. An appendicectomy was performed and the wound was closed. Postoperatively Mr A made an unremarkable recovery and was discharged home one day later. Neither Ms Q nor the surgical trainee who performed the operation saw Mr A prior to discharge. The junior staff caring for Mr A simply informed him that an appendicectomy had been carried out and he left hospital under the impression that he had had an inflamed appendix removed. Subsequent histopathological examination of the appendix showed no evidence of inflammation.

Over the next few weeks and months Mr A continued to suffer from intermittent abdominal pain. He consulted his GP on numerous occasions and also attended the Emergency Department (ED) at times when the pain was severe. He received antibiotic treatment for a proven urinary tract infection on two occasions but his symptoms persisted. Further blood tests and a urological assessment (including a cystoscopy) all proved to be negative. Mr A was eventually referred to another surgeon, Mr B, who arranged a CT scan, which suggested there was a Meckel’s diverticulum in the terminal ileum. A subsequent radio-nuclide scan confirmed evidence of active disease at this site. Mr B recommended a further operation and Mr A underwent a laparotomy, division of adhesions and Meckel’s diverticulectomy.

Mr A made a claim against Ms Q for performing an unnecessary appendicectomy and for failing to identify the Meckel’s diverticulum. The opinion of the experts consulted on behalf of MPS was supportive of Ms Q’s decision to remove the appendix at the time of surgery. They were, however, critical of the failure by Ms Q and her team to adequately communicate to the patient the operative findings and the subsequent negative histology and were critical of the consent process. The failure to identify the diverticulum at the first operation was also criticised but it was pointed out that in the absence of a perforation it was not certain that the diverticulum was the cause of Mr A’s initial presentation. The case was subsequently discontinued.

**LEARNING POINTS**

- In the consent process for appendicectomy it is important to warn patients that the appendix may be normal and other causes for the pain may (or may not) be identified.
- When open surgery is performed it is common surgical practice to remove the appendix even if it is not inflamed. This prevents the lifetime risk of future appendicitis and occasionally other pathology may be found in the appendix at the time of histopathological examination.
- A Meckel’s diverticulum is a common congenital abnormality and may be found in up to 2% of the population. It can contain ectopic gastric mucosa, which can occasionally bleed or ulcerate causing pain or perforation. In the absence of obvious appendicitis at the time of operation the terminal ileum should be thoroughly inspected and if a Meckel’s diverticulum is found (typically two feet from the ileo-caecal valve) a diverticulectomy can easily be performed.
- Good communication between clinicians and a patient is essential. Ideally, the operating surgeon should discuss a procedure directly with the patient. This should be supported by clear written instructions to all staff involved in the patient’s care. In this case, had the patient understood that he did not have appendicitis and the rationale behind his appendicectomy, he may have been less likely to pursue a claim.
- Although in this case the experts found the communication to be sub-optimal, it did not amount to negligence.
A pain in the neck

Fifty-five-year-old Mr P emigrated from his home country ten years ago and secured a job as an administrator in a factory. He went to see GP Dr W soon after arriving in the country and mentioned during his first appointment that he had suffered with long-standing back pain for over a decade. Mr P became well-known at the surgery, as he was often argumentative and confrontational towards staff. Over a period of three months, Mr P attended his GP several times complaining of neck pain, stiffness and loss of strength in both arms. It was documented that he would routinely demand sick notes from Dr W in an aggressive manner and was adamant that the doctor didn’t like him. He repeatedly insisted that he should be provided with an orthopaedic chair for work, to ease his neck. The hostile behaviour of the patient meant that clinical examination was usually difficult and Dr W would try to keep the consultations as short as possible. Full neurological examination was only performed once when Mr P first presented and it appeared normal at this time. Despite reported progression of his neurological symptoms, examination was never repeated again in subsequent consultations. Mr P began to complain of increased heaviness in his arm, which prompted Dr W to request a cervical x-ray, which showed some age-related degenerative changes. A routine referral was then made to rheumatology. Once again, no neurological examination was conducted.

While awaiting his appointment with the rheumatologists, Mr P was admitted to hospital after a fall; he was found to be tetraplegic. Further investigations confirmed his symptoms were due to a large tubercular abscess in the neck with destruction of the C4 vertebrae and pus in the epidural space. Mr P required extensive treatment and following a long hospital stay, he remained tetraplegic on discharge and required help with all normal activities of daily living.

The case could not be defended as expert opinion found that Mr P was not examined early enough, despite repeatedly attending with his symptoms. It is likely that a full recovery would have been made if diagnosis had been made sooner. The case was settled for a high sum.

LEARNING POINTS

- Management of challenging patients can be very complicated and in cases like this can have devastating results. Despite the multitude of negative emotions introduced by an aggressive patient, it is important to maintain a professional approach and rule out any underlying pathology. Neglecting basics such as physical examination and reassessing for evolving signs is indefensible.
- Dr Monica Lalanda’s article on “The challenging patient” offers advice on dealing with these difficult encounters and reflects on the elements that often contribute to a patient’s behaviour.
- It is important to revisit your diagnosis and examination for evolving signs. See the Casebook article “Tunnel Vision” for more information.
- Dealing with conflict from aggressive patients can be a significant source of stress for doctors and can lead to a breakdown in the therapeutic relationship. Training in communication skills can be helpful in dealing with challenging scenarios. MPS runs a workshop, Mastering Difficult Interactions with Patients; visit www.medicalprotection.org and click on the Education tab.

REFERENCES


EW
Housekeeper Mrs L, 58, was a poorly-controlled diabetic patient who was well-known to her GP, Dr V. One day, she presented with a swollen foot, and Dr V discovered an extensive area of skin breakdown on the ball of the foot discharging purulent fluid. He diagnosed an infected diabetic ulcer and referred her immediately to hospital.

At hospital the ulcer was debrided and she was treated with intravenous antibiotics. The diabetes multidisciplinary team reviewed her diabetes management and warned her several times that she might need an amputation. Fortunately, the infection was controlled, the tissues remained viable and amputation was not needed. She was then discharged for ongoing care in the community.

Mrs L continued to make progress as the ulcer gradually resolved, but during the recovery period she developed pleuritic chest and back pain. Dr V saw Mrs L several times at home and in surgery and diagnosed this as a chest infection. Each time he took time to carefully document Mrs L’s symptoms and his management.

One month following her hospital admission, Mrs L developed severe back pain and acute urinary retention. She was admitted as an emergency admission to hospital, where investigations revealed vertebral osteomyelitis at T10 with spinal cord compression and an epidural abscess. In spite of aggressive treatment Mrs L was left with paraplegia. Mrs L made a claim against the hospital and Dr V for a delay in diagnosis of the abscess, which caused her paralysis.

Expert opinion reviewed the medical notes, which included details of every visit, and were strongly supportive of Dr V’s management. The case was successfully defended.

LEARNING POINTS

- Complications can, and do, occur in almost any clinical scenario, even when treatment is meticulous.
- Comprehensive and contemporaneous notekeeping is vital and the foundation of good practice.
- Infections are a significant problem in diabetes, especially when their control is poor. Microvascular and macrovascular complications of diabetes, as well as defects in cell-mediated immunity, increase with age, so increasing the risk of infection. Infections may also disrupt metabolic homeostasis and glycaemic control, so prompt recognition and treatment is therefore critical. Access a good overview here: http://enotes.tripod.com/dm_infections.pdf
- The importance of good foot care should be emphasised to patients – diabetic foot complications are the most common cause of non-traumatic lower extremity amputations in the industrialised world. Early detection and appropriate treatment of diabetic ulcers may prevent up to 85% of amputations. There is useful advice at:
  - Evaluation and Treatment of Diabetic Foot Ulcers – http://clinical.diabetesjournals.org/content/24/2/91.full
  - ABC of Diabetes – www.bmj.com/content/326/7396/977.full
- There may be an identifiable nidus from which the infection seeds through the blood stream, but 30-70% of patients with vertebral osteomyelitis have no obvious prior infection. Read more on the management of spinal infections at: http://emedicine.medscape.com/article/1266702-overview#aw2aab6b2b1aa
- Medicines used to treat the primary infection can obscure the presentation of symptoms from complications elsewhere, eg, a prolonged course of antibiotics and painkillers used to treat an infected diabetic foot ulcer may temper signs of infection elsewhere, rendering the secondary infection occult.
M had always been a rather sickly child who missed a lot of school through minor illness. Her mother brought her to see the GP frequently with her asthma, eczema and possible food intolerances. Most of the entries in her medical records had remarks about her low weight, small size and generally unhealthy appearance. M’s mother would often request home visits and they were regular users of the surgery. When M was 12 years old she became unwell with a cold. Her mother requested a home visit. This was declined and standard advice for a non-specific viral illness was given. Over the following ten days M’s mother rang the surgery several times to report what appeared to be minor influenza symptoms. She described a mild fever, a runny nose and aching muscles. She spoke to different GPs and reported new symptoms of swollen eyes, severe headache and general weakness. She felt frustrated because she had the impression that the GPs were not listening to her concerns. She stated later that the doctor on the other end of the line would keep saying “aha” or “I see” and seem disinterested in her worries. The GPs asked her to bring M down to the surgery but her mother said she was too ill to leave the house so a home visit was arranged by Dr C. His notes from the visit described M as “looking rather ill, as usual” and the puffy eyes were put down to a flare up of her longstanding eczema. Dr C prescribed some hydrocortisone cream for use around her eyes and advised M to get out of bed and try to get back to normal. The next day M felt very weak but her mother tried to get her out of bed, like the GP had suggested. She collapsed on the floor and her mother called an ambulance that took her to the emergency department. She was diagnosed with severe bilateral orbital cellulitis and scans showed bilateral cavernous sinus thrombosis. Unfortunately, in spite of aggressive treatment, M became blind. M’s mum made a claim against all the GPs involved. Experts could not support the GPs’ treatment. The case was settled for a moderate amount.

LEARNING POINTS

- Patients who see their doctors with minor ailments all the time may eventually present with a serious complaint. It is important to be mindful of frequent attenders whose serious symptoms can be missed. Extra care should be taken.
- Repeated calls should be a red flag. They should always make doctors stop and think. Doctors must always be able to justify any decisions they make and have a low threshold for having a face-to-face consultation.
- Telephone consultations are challenging where it is hard to make a proper assessment of the patient. Effective telephone triage is essential. Listen to a podcast on how to improve your patient triage over the telephone – www.medicalprotection.org/uk/podcasts/Telephone-triage-managing-uncertainty.
Mr C, a 25-year-old mother of two, had an elective caesarean with her first pregnancy as that baby was breech, and she experienced a failed attempt at a VBAC (Vaginal Birth After Caesarean) with her second pregnancy.

Her third pregnancy was uneventful and she was booked in for an elective caesarean section at 39 weeks. Mr A, a staff grade obstetrician, carried out the operation under spinal anaesthetic. The operation was felt to be “routine” and there was minimal scarring from the previous caesareans. After initial observations concluded that everything was normal, the patient and her 3.5kg baby girl were returned to the postnatal ward.

Three hours later, Mrs C started to feel unwell with dizziness. Mr A was called by the midwifery staff, but as he was busy in the delivery suite, he sent his specialty trainee, Dr Q, to check on Mrs C. On examination, she looked pale and sweaty, although the visible blood loss per vagina was minimal and the uterus appeared to be well contracted. She was, however, tachycardic (P110) and hypotensive (BP100/70 mm Hg), Dr Q noted in the catheter bag and a decision for an immediate laparotomy was made. Mr A found 1.5l of blood within the peritoneal cavity and a tear at the left extremity of the uterine incision, extending into the broad ligament. This was successfully repaired, but Mrs C required a transfusion of three units of blood and stayed in the high dependency unit for 24 hours.

Both Mrs C and her baby were discharged home a week later and physically recovered well. However, Mrs C made a complaint against Mr A and his team for poor management of her condition. An internal investigation was begun. Expert opinion on the issue was sought and there was agreement that although this was an unusual complication, it can be caused by the angle at which the baby’s head was delivered, and it should have been recognised and treated at the time of the initial caesarean section. There was also considerable criticism regarding the delay in taking the patient back to theatre and the documentation that had been made in the notes.

Following a face-to-face meeting where the case was discussed in detail, the complaint was resolved and no further action ensued.

DS

LEARNING POINTS

- Although a caesarean section is a common operation nowadays, it is still a major surgical procedure. Mistakes do happen and complications do occur, even if you have done the same procedure thousands of times before.
- The operating surgeon takes the ultimate responsibility for the patient’s outcome. Although it may be appropriate to delegate suitably trained personnel to review some patients, cases of pre-imminent shock need urgent assessment by appropriately experienced staff at the most senior level available.
- Postpartum haemorrhage is an obstetric emergency.
- It is important to remember the physiological changes that occur during a normal pregnancy (eg, increased circulating volume, increased cardiac output etc), such that the common signs of hypovolaemia (ie, tachycardia, increased respiratory rate, oliguria, narrowed pulse pressure, etc) may not become apparent until a significant amount of blood has been lost.
- The abdomen can act as a “silent reservoir”, so the visible blood loss (ie, per vagina) may not be apparent and hypotension is often a very late sign.
- Postpartum haemorrhage may be caused by the 4Ts:
  - Tone – atonic uterus accounts for 70% of cases and should be treated with uterotonic agents
  - Tissue – check the notes that the placenta and membranes were “complete” during the delivery
  - Trauma – cervical/vaginal tears, ruptured uterus from previous scars, extension of uterine angles at time of caesarean section
  - Thrombin – clotting problems – often this can be a late complication after significant blood loss.
- Although administrative procedures and teaching are important they should not be allowed to interfere with patient care.
Mr A was a 55-year-old newsagent who had smoked 20 cigarettes a day for 30 years. He had been good friends with his GP, Dr B, for years – since they were children playing in the same football team. Mr A had suffered with asthma since childhood. He visited Dr B regularly with exacerbations causing wheeziness and coughing, especially during the winter months. The visits were always kept very informal since they were friends, and Dr B’s medical notes were very brief, with minimal entries regarding Mr A’s presenting complaints or clinical examinations. Entries often comprised only the date and the prescription of inhalers.

Mr A had started suffering with back pain, which had not responded adequately to analgesia. It became severe enough to require hospital admission. A hospital CT scan revealed extensive mediastinal lymphadenopathy and parenchymal lung deposits. Mr A underwent bronchoscopy with biopsy, which confirmed the diagnosis of non-small cell carcinoma of the bronchus. Further scanning showed his disease to be metastatic involving his thoracic and lumbar spine, with a very poor prognosis. Unfortunately, Mr A deteriorated very rapidly, becoming very dyspnoeic and cachexic. He died just a few weeks after the diagnosis.

Mr A’s widow was devastated and made a claim against Dr B. She thought that her husband should have been investigated much earlier for severe breathing difficulties and weight loss. Dr B claimed from memory that Mr A had remained in good health with no breathing difficulties or weight loss till the weeks prior to his death. Dr B’s notes were so minimal it would have been impossible to confirm this. Experts looking into the case reviewed Dr B’s minimal notes but also, fortunately, had the benefit of the hospital notes. The hospital notes confirmed that Mr A’s symptoms of weight loss and severe dyspnoea started after his hospital admission.

There was heavy criticism of Dr B for his poor documentation. However, it was also agreed that since Mr A’s tumour was rapidly growing and aggressive, earlier diagnosis would not have improved his prognosis. The case was settled for a low amount.

**LEARNING POINTS**

- Clear and comprehensive notes are your defence when things go wrong. In this particular case the claims made by the deceased’s wife that the patient had been ill for a long time, could only be confirmed because of someone else’s medical records.
- Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship. When treating those close to you, it could be easy to make assumptions, eg, regarding the way a patient is feeling if a doctor knows them already and does not ask the relevant questions, or it could be possible to over-identify with patients and lose objectivity.
- Mr A had remained in good health with no breathing difficulties or weight loss till the weeks prior to his death. Dr B’s notes were so minimal it would have been impossible to confirm this. Experts looking into the case reviewed Dr B’s minimal notes but also, fortunately, had the benefit of the hospital notes. The hospital notes confirmed that Mr A’s symptoms of weight loss and severe dyspnoea started after his hospital admission.

**FURTHER INFORMATION**

- Rourke L, Rourke J, Close friends as patients in rural practice, *Can Fam Physician* (June 1998)
Debating DNAR orders
(Note – this response refers to an article that appeared in the UK edition of Casebook – non-UK readers can access it here: www.medicalprotection.org.uk/casebook-january-2012/debating-DNAR-orders)

We have received a number of letters from readers about this article, in particular the statement: “If, after careful consideration, clinical evidence suggests that it is not in the patient’s best interests to perform CPR should it be needed, this must be discussed fully with the patient.”

We accept the criticisms raised that the use of the phrase “must be discussed” is incorrect and does not apply to every clinical situation.

The purpose of the article was to emphasise the need for good communication in this area, given the rising number of complaints about DNACPR decisions being made without the knowledge of patients or their families, and the generally accepted best practice approach of involving patients in decisions about their care (“no decision about me, without me”). However, there are situations where clinical judgment will determine that such discussions are not appropriate, or timely – for example, in the case of the dying patient.

For clarification we set out below the relevant section from the GMC guidance Treatment and Care towards the End of Life: Good Practice in Decision Making, which states:

134. “If a patient is at foreseeable risk of cardiac or respiratory arrest and you judge that CPR should not be attempted, because it will not be successful in restarting the patient’s heart and breathing and restoring circulation, you must carefully consider whether it is necessary or appropriate to tell the patient that a DNACPR decision has been made. You should not make assumptions about a patient’s wishes, but should explore in a sensitive way how willing they might be to know about a DNACPR decision. While some patients may want to be told, others may find discussion about interventions that would not be clinically appropriate, burdensome and of little or no value. You should not withhold information simply because conveying it is difficult or uncomfortable for you or the healthcare team.”

Guidance published by the BMA/RCN/Resuscitation Council in 2007 on this issue also states: “In considering this clinicians need to take account of the fact that patients are legally entitled to see and have a copy of their health records, so it may be preferable for them to be informed of the existence of a DNAR decision and have it explained to them rather than for them to find it by chance. It may be distressing for them to find out by chance that a DNAR decision has been made without them being involved in the decision or being informed of it.”

The guidance goes on to advise doctors to record the reasons why a patient has not been informed about a DNACPR order if the decision is made not to inform the patient.

We are pleased to respond to the concerns raised by readers, and welcome all feedback.

With regards to “Debating DNAR orders” (Casebook 20(1)). The comment from Dr Davies, your adviser, was appropriate – the real issue is whether comprehensive discussion of management options has taken place. Unfortunately, the medical profession has been guilty of placing almost all the emphasis on the isolated issue of cardio pulmonary resuscitation, which, of course, is an entirely inappropriate form of management for the majority of patients dying from progressive illness in medical wards up and down the country. The relevant discussion is about “ceiling of treatment” – what treatment approaches are and are not appropriate for a given clinical picture. Thus, for example, if intensive care management would not be appropriate for a patient with progressive respiratory failure, CPR would automatically be inappropriate.

The discussion of do not resuscitate orders at a relatively early stage in a progressive illness inevitably risks concerns for patient or family about the approach to overall care. It also raised a genuine difficulty in distinguishing an acute unexpected event from progression of the underlying disease. As a patient’s clinical state deteriorates it often becomes obvious when DNAR is appropriate and in reality not something that is a realistic discussion.

The resuscitation issue lies between these points, when it is apparent that a clinical picture is deteriorating and possible management options such as treatment change or involvement of intensive care need to be considered. At this juncture the focus of discussion should be on these management options with the issue of DNAR being a secondary consequence from this discussion.

There will, of course, be the occasional patient with a chronic illness who does not want CPR under any circumstance. We should be sensitive enough to pick up on that. However, those cases are an exception.

Duncan Macintyre, consultant physician in respiratory medicine, Scotland

This disagreement has been publicly discussed for many years, and screams “communication failure” between hospital staff and patients, and their relatives – particularly their relatives.

But also, sadly, between hospital workers and the president of the Royal College of GPs. Resuscitation is not for patients to opt in or opt out, like breast enhancement or a facelift. It is the dramatic last stand in a provision of circulatory and respiratory support offered to some patients. Patients can choose to refuse any treatment at any time, but appreciation of medical limits increases confidence and trust.

About 50 years ago DNR (Do Not Resuscitate) labels were placed on some patients’ notes by doctors to stop the cardiac arrest team being called out for every death. The team, called to treat an unfamiliar patient, would have to read
Double problem, double risk

The report on the patient with tonsillar cancer surprises me; it is hard to believe that an ENT surgeon consulted about “a recurrent sinus problem” does not perform a full ear nose and throat examination, or at the very least an inspection of the oral cavity and pharynx. To read that the patient mentioned “ongoing ... sore throat” and that the ENT surgeon suggested that the patient get his GP to check it reflects professional laziness or incompetence on the part of the specialist.

If indeed the specialist did examine the throat, it seems likely that it was not a competent examination, as within a month there was an obvious tonsillar carcinoma evident on inspection, and accompanying metastases in the cervical nodes.

I am also surprised that the learning points did not conclude that the initial ENT assessment was inadequate, and that the specialist’s response to the patient’s expressed concern about his throat was unacceptable. At the very least the specialist should have examined the throat in the light of the information provided. Given the findings one month later, an adequate initial specialist assessment, in all probability, should have raised the alarm at that time.

Randall Morton, professor of otolaryngology – head and neck surgery, University of Auckland, New Zealand

Response

The points you make about the consultation are very valid, and it is only a limitation on space that means we are unable to include all of the learning points from every case. The focus of this case report was to highlight the need for vigilance when patients present with more than one complaint, but there were clearly other issues of concern, as you have pointed out, that led to this claim being settled. Thank you for taking the time to share your views on this article with us.

Dr C J F Potter, retired, UK

“Just a quick look” can be costly

As a recently graduated doctor, I read “Just a quick look’ can be costly” (Casebook 20(1), p19) with interest. Despite my relative inexperience, I am frequently asked to review other hospital staff who drop into my ward ‘as a favour’. My initial instinct is to accommodate such requests out of a sense of professional courtesy and fear of being labelled a jobsworth should I decline. After all, we are all very busy people working to help others and taking a quick look for a colleague very often seems like the right thing to do.

However, I am increasingly concerned that such behaviour represents neither best practice nor a good use of NHS time and resources. Requests for advice or review are rarely accompanied by paperwork highlighting past medical history, allergies or current medications and there is no pathway in place to allow for vital communication back to the individual’s GP. Additionally the pressure to arrive at a quick decision often leaves minimal time to take a history and form a considered diagnosis.

Since recently starting a new rotation, I have found the problem to be more of an issue in otolaryngology, perhaps as examination often necessitates more specialist equipment often not found on other wards. Although I am becoming more proficient in many ENT investigations and procedures, diagnoses are not always the most obvious or easily formulated, which can lead to disappointment, uncertainty or even anxiety.

Worryingly neither my department nor hospital has a defined policy of how to handle these cases of “quick looks”. The GMC stipulates that contemporaneous notes should be kept in keeping with good medical practice but offers little other advice. Although my trust has no guidelines on the subject and seems to take a neutral attitude to the issue, I have come across areas where such impromptu consultations are tacitly encouraged if they reduce time taken off work.

Given the potential medicolegal pitfalls and consequences highlighted when dealing with such cases, I feel I would benefit from greater guidance either from individual hospital trusts or the GMC on how to manage such cases, so that I am able to alleviate and reduce any anxiety both for me or my unsolicited patients.

Timothy Batten, junior doctor, UK

Casebook and other publications from MPS are also available to download in digital format from our website at:

www.medicalprotection.org
The Wisdom of Whores: Bureaucrats, Brothels and the Business of Aids
By Elizabeth Pisani
(Granta Books, 2008)
Reviewed by Dr Rebecca Smith
and Dr Chris Jones, specialist registrars in Anaesthesia.

Elizabeth Pisani set out on an unusual path towards a career in sex and drugs, and she achieved it. The Wisdom of Whores is a passionate debate, dedicated to unmasking the HIV epidemic in Asia. The winding tale leads you through a murky world of brothels, public needle exchange services, boardrooms and international conference centres. You will learn a new language on your journey, of MARPS (Most At Risk Populations), FSWs (Female Sex Workers) and Waria (male sex workers that are culturally considered to be female). At every turn you will be shocked by chilling statistics and controversial comments.

Surprisingly, the book is fairly humorous. It pokes fun at some of the governments’ initiatives, for example, peer outreach – in a competitive industry, like prostitution, where rivals have to covet each others’ clients in order to survive – whoever thought this could work?! Some of the difficulties faced in accurate data collection are also revealed – it must be challenging to gather meaningful statistics when you are asking an intoxicated prostitute questions in a poorly lit nightclub in the early hours.

Having read Classical Chinese at University, Pisani first worked as a foreign correspondent and later started programmes. What may have started off as a mere intellectual pursuit became an intensely personal battle as she met the faces of MARPS (Most At Risk Populations), FSWs (Female Sex Workers) and Waria (male sex workers that are culturally considered to be female). At every turn you will be shocked by chilling statistics and controversial comments.

In Hong Kong, she then undertook a Masters degree at the London School of Hygiene and Tropical Medicine, and entered into a career of Epidemiology. Transferring to Family Health International in Jakarta, Indonesia in 2001, Pisani became part of the “HIV surveillance mafia”, dedicating her time to building international surveillance systems to help develop HIV prevention programmes. What may have started off as a mere intellectual pursuit became an intensely personal battle as she met the faces behind the statistics, and fought to save her friends.

Pisani brings home the lesson that there is no purity in science. Epidemiological facts are distorted by a smokescreen of money, power, politics, religion and the media. It’s unfashionable and unpopular to dedicate money to prostitutes and junkies – it won’t win you votes in elections.

This book is dedicated to realism. It is an abrasive and raw account of the battle between science and politics. It is a disturbing read, but a must for any enquiring mind.

If Disney Ran Your Hospital: 9½ Things You Would Do Differently
By Fred Lee (Second River Healthcare Press, 2004)
Reviewed by Dr Mike Baxter, independent medical consultant and former Medical Director at Ashford and St Peter’s Hospitals NHS Foundation Trust.

If Disney Ran Your Hospital changed my view of how hospitals should work and the correct avenues to pursue to deliver effective change and improvement.

This book also reads very well in the context of current definitions of quality, where outcome, safety and experience are given equal weighting. Whilst outcomes and safety are familiar currencies that we easily understand, experience is less comfortable and much more alien to the medical community.

Indeed, we have been drawn into the world of “customer satisfaction” and have been persuaded that service delivery models aimed at high levels of patient satisfaction represent the desired goals in healthcare.

However, Fred Lee makes the case that it is so much more than this. Experience is about how you are made to feel: it is an emotional interface that relies on genuine human interaction with spontaneous and reflex elements that make it real and unique for each patient. He makes it clear that the generation of an experience is how you make lasting impressions and, if good, generates loyalty and trust.

He reminds us that the single most important element to all successful human relationships, especially in healthcare, is compassion. Until we recognise, develop and reward compassion, we are destined to have services that may be good, but are vulnerable to veering into average or poor, consistently underwhelming in terms of experience.

Fred describes, for me, what was a confirmation of my own anxiety – that process redesign does not take into account this human element/emotion and, although it can deliver efficient care process, it cannot deliver great care because ultimately it does not create an emotional and therefore memorable experience.

If, like the Disney Corporation, we aspire to deliver excellence in our hospitals, we must create a truly unforgettable experience where compassion is a core value and all staff provide predictive, selfless care.

I do believe that this book is the potential guide to a better land. I believe if we were run by Disney that the values of compassion delivered by naturally talented and/or appropriately motivated staff would create an environment for a safe service with good outcomes, which would also deliver the elusive goal of a great experience.
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