The ACCUSED

One doctor’s account of his trial by media

PAGE 5
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What’s inside…

FEATURES

04 Welcome
Dr Nick Clements is the new Editor-in-chief of Casebook – here he reflects on predecessor Dr Stephanie Bown’s time at the helm.

05 The accused
Public exposure from complaints and claims can cause doctors to face a trial by media. In 2011, a UK GP was accused of sexually motivated conduct when he examined a patient’s chest – he shares his experience with Sara Dawson.

08 High reliability in healthcare: a personal failure
In his follow-up to last edition’s article on high reliability organisations, Dr Dan Cohen revisits a personal experience that formed part of his own steep learning curve.

10 Medicine and manslaughter
Last year’s custodial sentence for surgeon David Selby, following a verdict of gross negligence manslaughter, raised concerns within the profession. Former Casebook Editor-in-chief Dr Stephanie Bown met with Professor Norman Williams, President of the Royal College of Surgeons, to discuss what the ruling means for healthcare professionals.

CASE REPORTS

08 High reliability in healthcare: a personal failure
In his follow-up to last edition’s article on high reliability organisations, Dr Dan Cohen revisits a personal experience that formed part of his own steep learning curve.

13 It’s your call
Take a look at our useful infographic to see what you called MPS about in 2013.

CASE REPORTS

14 Concealed sepsis
15 Headaches and hypertension
16 Nervous about neurosarcoidis
17 The Swiss cheese
18 Wrong drug, no negligence
20 No fundoscopy, no defence
21 Record your reasoning
22 Complications of colonoscopy

FEATURES

23 Over to you
A sounding board for you, the reader – what did you think about the last issue of Casebook? All comments and suggestions welcome

26 Reviews
In this issue Dr Omar Mukhtar reviews The Enemy Within, an hour-long documentary chronicling the last 50 years of the fight against cancer. Also, Dr Amir Forouzanfar reviews The Checklist Manifesto: How to Get Things Right, by Atul Gawande.

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Dr Nick Clements, MPS Head of Medical Services, has taken over as Casebook Editor-in-chief from Dr Stephanie Bown, who left MPS in February 2014. Here, Dr Clements looks towards the task ahead.

As this is my first column as the new Editor-in-chief of Casebook, I would like to say how much I am looking forward to life at the helm of a publication with a prestigious history of some 20-plus years.

Of course, I must also pay tribute to my predecessor Dr Stephanie Bown, who left MPS in February to become Director of the National Clinical Assessment Service (NCAS). Dr Bown has been involved with Casebook since the May 2006 issue, and oversaw numerous successful design upgrades and a renewed focus on producing truly topical content for all of our six regional editions.

Dr Bown worked at MPS for 19 years, beginning as a medicolegal adviser and becoming head of the Medical Services department in London soon after; this after spending more than 12 years as a doctor in acute hospital medicine, then obstetrics and gynaecology before moving into general practice. Combining her editorial duties on Casebook and other MPS publications with high-profile external affairs work, Dr Bown also regularly appeared on radio – and once on morning TV – to protect and promote the interests of you, the MPS member.

So it is with slight trepidation but great relish that I step into Dr Bown’s shoes, and build on her success with Casebook.

Dr Bown has been involved with Casebook before, so I am not entirely new to the magazine – in addition to occasionally introducing each edition’s collection of case reports, I have been on the editorial board for a number of years, helping to maintain the accuracy and educational value of each issue.

One thing will not change – and that is we continue to end with a personal contribution, as it is practice policy; she declined, so I performed a thorough chest examination and referred her for surgery.

Her complaint was that during the chest examination I squeezed her breast, and referred her for surgery.

As I was signing scripts, my practice manager knocked on my door and brought a brown envelope marked private and confidential. I opened it and read it – the contents were highly distressing. The letter contained details of allegations made by a female patient (Mrs B) that, two months previously, I had conducted a sexually motivated consultation.

I remember seeing Mrs B in early spring complaining of chest and stomach pain. Initially I offered her a chaperone, as it is practice policy; she declined, so I performed a thorough chest examination and referred her for surgery.

Her complaint was that during the chest examination I squeezed her breast, and behaved sexually while breathing heavily. She thought my front, back and side examination was inappropriate and not what she’d expected.

I was devastated to hear about the serious nature of the complaint, as it would have ramifications for me, as a doctor, and as a husband and a father, and as an upstanding member of society. My surgery staff were highly distressed and took it very seriously; I immediately contacted MPS.

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Media coverage
Handling the media was not something I’d really considered. I’d definitely never thought about being on the front page of a national newspaper. We were all worried about it: what would patients do? The stories were angled in a certain way that assumed I was guilty – it would have been nice to be captioned in a different way. I remember, during the hearing, getting messages from friends asking if I was ok, as they’d seen the coverage. Even abroad, it was all over the internet.

Support
Throughout the process I worked closely with the local medical committee, my MPS legal team, and the PCT. Without the understanding and professionalism of these people it would have been a much more difficult time. I drew strength from the fact that I knew I was professional and hadn’t done anything wrong – I believed the truth would come out in the end.

I’m most proud of the way the practice dealt with the whole thing – we pulled together like a family. From the first day, I was honest about the allegation and discussed it with my staff, my patients, my family and my colleagues; from then on I informed them of all the developments. I could not have survived the experience if they hadn’t supported me.

I always wanted to be a professional GP, dedicated to my practice and patients, and to be involved in the community as a doctor. Eighteen months have been wiped from my life and I will never get answers to why Mrs B did what she did. I take some comfort in that justice has been done and I was vindicated – life goes on and I have learnt in it.

Names have been withheld to protect the confidentiality of those involved.

Legal opinion
By Dr Jo Galvin, MPS medico-legal adviser, who handled the case.

Unfortunately this case was not an isolated one. Mrs B came to the practice specifically asking for her chest to be examined thoroughly. During the examination she perceived that the actions of the GP in question, whom I shall refer to as Dr Z, were sexually motivated. Dr Z said that when he examined her, he explained what he was going to do and explained the depth and pattern of the breathing. His situation was compounded when he locked the door to preserve her confidentiality, as the door had recently accidentally opened into the adjacent waiting room. Mrs B misconstrued this again to be sexually motivated.

Credibility
The credibility of Mrs B was undermined when she did not turn up for the first day of the hearing – she claimed that her father was in hospital. MPS requested full disclosure of the reasons for her absence. It came to light that she had sent the text message explaining her absence from her sister’s house, and her father was not in fact in hospital.

Chaperones
Doctors are alive to the fact that they need to use a chaperone when performing intimate examinations, but they aren’t always alive to the dangers of some examinations; for example, an accidental brush of the chest can get doctors into difficulty. An important point to make is that Mrs B’s consultation was not an intimate examination – it was a chest examination – but Dr Z still offered Mrs B a chaperone.

MPS conducted an audit of Dr Z’s previous consultations, and were able to prove that it was his consistent practice to offer a chaperone and document it. He’d documented contemporaneously in the notes that he had offered a chaperone to Mrs B and that she had declined – this helped his defence.

Good record-keeping
There were several important factors that further undermined Mrs B’s version of events. During the consultation Dr Z also referred Mrs B to hospital to be treated for a different condition; Mrs B had no recollection of this or of visiting Dr Z a couple of weeks later about a different matter. It is unlikely that you would come back voluntarily and visit your GP after you perceived him to have acted inappropriately.

This raised questions around Mrs B’s recollection of the events. In contrast, Dr Z had documented everything contemporaneously. When there is a factual dispute, the credibility of a complainant is important. In this case there was a factual dispute and the weight of evidence was in Dr Z’s favour.

His notes were further backed up by a GMC-obtained expert report about the correct standard of chest examinations; this proved that Dr Z’s standard of chest examinations was appropriate.

Professional challenges
The situation presented professional challenges because Mrs B remained a patient at the practice. It is hard to justify removing a patient simply because they have made a complaint. Good practice management meant that Dr Z did not see Mrs B.

Advice
Dr Z was unlucky, but his contemporaneous note-keeping and good practice helped prove that he had not done anything wrong. He did decide that he could give himself the best protection.

Learning points
- Always use a chaperone for examinations that are perceived to be intimate examinations.
- Good record-keeping is essential.
- Communicate effectively with your practice team.
- Develop good working relationships with your staff and patients.
- Expert evidence is helpful in disputes around standard practice.

For further information about chaperones and maintaining boundaries please visit the factsheets section of www.medicalprotection.org.

Ends

References
- Notes for readers outside England: Primary Care Trusts were administrative bodies within the National Health Service (NHS), responsible for commissioning primary and community care services from providers, and providing funding for those services. They were abolished in 2013.
- For readers outside England: Local PCTs were directly involved in the investigation, since the GMC-obtained expert report about the correct standard of chest examinations was appropriate.
With a steadily increasing focus on safety and risk-aversion in the healthcare industry, much attention, appropriately, has focused on the stories that patients and family members have shared about their experiences. We have learned much, although in some instances, especially daily on, we may have been reluctant to listen. Sadly, in my view, we have that formed part of his own steep learning curve.

In his follow-up to last edition’s article on high reliability organisations, Dr Dan Cohen revisits a personal experience that formed part of his own steep learning curve.

A, a ten-month-old girl, was admitted to an internationally prominent children’s hospital at the weekend for evaluation of a kidney mass, likely a Wilms’ Tumour, a highly curable childhood cancer. I was the paediatric oncology fellow [junior registrar] covering the service for the weekend. This institution’s Wilms’ Tumour protocol required the oncology fellow to administer Actinomycin-D intravenously as soon as the renal vein had been clamped at the time of surgical removal of the tumour. I wrote the orders correctly and legally using our standard double-check process and had previously administered this drug without incident.

In addition to covering the inpatient oncology service (about 25 beds in this large centre), I had additional weekend obligations for the outpatient clinic and a two-bed bone marrow transplant unit located in different, though adjacent, hospitals. Usually this multiple coverage obligation was not a problem, but on this particular weekend, two children with leukaemia were to receive outpatient L-asparaginase chemotherapy, and I had to be present in the clinic because of the substantial risk of allergic anaphylactic reactions. I could not be in clinic and the operating room because of the substantial risk of leukaemia were to receive outpatient L-asparaginase chemotherapy, and I had to be present in the clinic because of the substantial risk of allergic anaphylactic reactions. I could not be in clinic and the operating room because of the substantial risk of leukaemia were to receive outpatient L-asparaginase chemotherapy.

The incident

It was not until several hours later that the error was identified. While I was making evening rounds, I saw the syringe that had contained the Actinomycin-D, still attached to A’s medical record (a standard procedure at that time), and the label revealed the dosage error. I was shocked! Although not immediately toxic, the effect on this child’s bone marrow would be profound, beginning about a week after administration. I was reasonably certain that this child was going to die – and I was ultimately responsible! I called my consultant immediately and, after calming me down, he said some things that really resonated. “Dan, we do not know that A is going to die. We can expect that she will encounter severe bone marrow suppression and gastrointestinal toxicity, but we do not know the outcome of that, and we need to be factual when we talk with the family.”

The following morning we met with A’s parents. My consultant wanted to take the lead in the conversation but insisted that as A was my patient, I wanted, and needed, to do the talking. I was the one who had originally met with the family and this was my responsibility, not his. I carefully explained to the parents that A had received a higher than desired dose of medication and that we were very concerned about this. I apologised for this error and explained that we would investigate this further in order to ascertain how it had happened. I promised to correct any discrepancies in care identified in order to prevent this from ever happening again and then outlined the steps we would take to protect A.

I promised the parents that the comprehensive resources of our institution would be mobilized to support A. I did not tell them that I thought she would die because her death was not a certainty, and voicing my concerns would have served little purpose.

The lessons

1. If the healthcare industry is to truly function as a highly reliable organisation, then the kinds of challenges and variables portrayed above must be anticipated beforehand so that appropriate failsafe mechanisms can be established to provide for all contingencies. This child deserved better from the system, from me, and from others. The Swiss cheese barriers hadn’t worked.

2. Transparent and timely disclosure should be the gold standard for patient care. We are obligated to tell our patients the truth when things are good... and when things are bad.

3. Clinicians are often collateral or “second victims” of patient safety incidents and principles of high-reliability require that hospitals provide necessary support within a just culture framework.

Doctors and nurses do not wake up in the morning intending to harm patients. We go to work each day with every intention of helping our patients. We expect the systems and processes in our workplace to support us in achieving that goal; in other words, we want to work in highly reliable, safe, collaborative and just organisations.

Dr Dan Cohen is International Medical Director for Datix Ltd (www.datix.co.uk), a patient safety and risk management company whose software application enables users to spot trends as incidents/ adverse events occur and reduce future harm by prioritising risks and putting in place corrective actions. Dr Cohen can be reached at dcohen@datix.co.uk.

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As an example, I would like to “lift” myself and reveal a personal story that has affected me throughout my career. This is a story of multiple system personal failures, fortunately embellished by transparency and honest disclosure long before these became everyday terms in our patient safety vernacular.

High reliability in healthcare: a personal failure

With a steadily increasing focus on safety and risk-aversion in the healthcare industry, much attention, appropriately, has focused on the stories that patients and family members have shared about their experiences. We have learned much, although in some instances, especially daily on, we may have been reluctant to listen. Sadly, in my view, we have.

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Medical manslaughter – the background

The law, as it stands, was stated in the case of Kilmulo (1996) 1 AC 171. In this case the defendant, an anaesthetist, failed to notice for six minutes during an operation that the oxygen supply to the patient had become disconnected from the ventilator. As a result the patient suffered a cardiac arrest and died.

The House of Lords affirmed the conviction, and the elements of the offence were specified as:
- The defendant owed the victim a duty of care
- The defendant breached that duty
- The breach caused (or significantly contributed to) the victim’s death
- The breach was grossly negligent.

The key point is that it is a matter for the jury to determine whether the breach was grossly negligent.

In summing up, Lord MacKay stated: “The jury will have to consider whether the extent to which the defendant’s conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal…The essence of the matter…is whether having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgment to a criminal act of omission.”

The law as it stands has been criticised on a number of counts, but particularly because the reach of the criminal law in this area is left to be determined by the jury.

When parliament enacted the Coroners and Justice Act 2009, no change was made to involuntary manslaughter; the reforms being confined to voluntary manslaughter. Observers at the time thought it unlikely any further reform of homicide would take place in the foreseeable future.

Doctors in the dock

In 2006, a paper published in the Journal of the Royal Society of Medicine by Ferner and McDowell looked at the number of doctors charged with medical manslaughter between 1795 and 2005. The review found that 85 doctors had been charged with manslaughter in the UK since 1795, 38 of them since 1990. Of these 60 were acquitted, compared to 22 recorded convictions and three guilty pleas.

Other widely-reported cases include:

- Dr Feda Mulhem (2003)
- Wayne Jowett, 18, was in remission from acute lymphoblastic leukaemia, and had entered the maintenance phase of his treatment. In January 2001 he was inadvertently given vincristine intrathecally.
- The sequence of events leading to this were complex and involved multiple errors and breaches of protocol by a number of staff. An analysis of the circumstances can be found online.
- Despite this, the registrar, Dr Mulhem, was charged and convicted of manslaughter in 2003. He was sentenced to eight months, and a further ten months on unrelated assault charges. As he had already served 11 months on remand, he was released from custody. The GMC subsequently suspended him for 12 months.

- Mr Steven Walker (2004)
- Mr Steven Walker was found guilty in 2004, after changing his plea to guilty, of the manslaughter of a female patient who suffered catastrophic blood loss during an operation to remove a liver tumour in 1995. He admitted he should have stopped the operation after finding the tumour was double the expected size and close to key blood vessels. Mr Walker received a 2½ month suspended jail sentence and was erased from the medical register in 2005.

- In November 2013 the case again hit the headlines when Mr Walker applied for restoration to the register. Following adverse opinion, he withdrew his application.

- Dr Michael Stevenson (2007)
- A 54-year-old GP, Dr Stevenson admitted manslaughter after a patient died in 2005 when he injected six times the required dose of diamorphine for migraine. He made the same error on his next visit, but the second patient survived. He received a suspended sentence of 15 months in 2007. The GMC erased him from the register in September 2009.

- Dr Bala Kovvali (2013)
- Dr Kovvali diagnosed depression in a middle-aged patient who died shortly afterwards from diabetic ketoacidosis. He pleaded guilty to manslaughter and received a two-and-a-half year custodial sentence. An appeal against the length of sentence was unsuccessful, and he was subsequently erased from the medical register.

- Mr David Sellu (2013)
- This recent case resulted in a custodial sentence of two and a half years.
- The case involved a patient admitted to a private unit for a knee replacement. Postoperatively the patient developed abdominal symptoms and Mr Sellu was asked to review the patient.
- The patient subsequently died following a laparotomy, and it was alleged that there had been an inappropriate delay in the diagnosis and treatment of a perforated bowel.
- The experts for the prosecution and the defence disagreed over whether Mr Sellu’s actions were reasonable in the circumstances. The conclusion was that there was a lack of urgency in the investigation and treatment of the patient.

Medical and manslaughter

Last year’s custodial sentence for surgeon David Sellu, following a verdict of gross negligence manslaughter, raised concerns within the profession. Former Casebook Editor-in-chief Dr Stephanie Bown met with Professor Norman Williams, President of the Royal College of Surgeons, to discuss what the ruling means for healthcare professionals.
The custodial sentence imposed on Mr Sellu has caused surprise and consternation among the medical profession. As President of the Royal College of Surgeons, Professor Norman Williams has been uniquely placed to hear the concerns of Mr Sellu’s wider surgical fraternity.

On the defensive

Although one can reasonably observe that the David Sellu case simply reflects the times in which we live – and more specifically the level of expectations patients have of us – the consequences mean that there is a real risk for doctors to practise defensive medicine. This is, of course, the pursuit of unnecessary investigations – the ordering of tests, treatments, etc, that help protect the doctor rather than to further the patient’s diagnosis.

Dr David Studdert identified two types of defensive medicine:

■ Assurance behaviour (positive defensive medicine) – providing services of no medical value with the aim of reducing adverse outcomes, or persuading the legal system that the standard of care was met, eg, ordering tests, referring patients, increased follow up, prescribing unnecessary drugs.

■ Avoidance behaviour (negative defensive medicine) – reflects doctors’ attempts to distance themselves from sources of legal risk, eg, forgoing invasive procedures, removing high-risk patients from lists.

Defensive medicine can make your practice more risky.

Unnecessary treatment – particularly invasive procedures – could actually increase the risk of litigation. Some tests have their own inherent risks and doctors could potentially be criticised for ordering investigations that are not in patients’ best interests (eg, if the risks associated with the procedure outweigh any potential benefit to the patient).

Professor Williams says: “I suppose patients have always expected very high standards but they also had a high level of trust in us and that trust has been eroded in recent years, with the expected very high standards but they also had a high level of expectations patients have of us – the consequences mean that there is a real risk for doctors to practise defensive medicine. This is, of course, the pursuit of unnecessary investigations – the ordering of tests, treatments, etc, that help protect the doctor rather than to further the patient’s diagnosis.

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It’s your call

Members call the MPS advice line about a wide range of issues. Our useful infographic reveals what you have been calling us about, and how often. The figures are taken from calls made by MPS members around the world, between January and October 2013.

What lies ahead

A change in the law on gross negligence manslaughter is highly unlikely in the current climate. The Law Commission has reviewed the law twice, with the most recent review not recommending any change. The Coroners and Justice Act 2009, which was the most recent review of the law, left the law on gross negligence manslaughter unchanged.

Changes to some other aspects of cases might gain more traction, such as pushing for a specific offence of medical manslaughter, with a more appropriate definition. How the law will evolve in relation to gross negligence manslaughter in the future is uncertain, but MPS will continue to monitor events – and the potential impact on the medical profession – closely.

Words: Gareth Gillespie

REFERENCES


4,128 Advice
1,378 Report writing
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1,378 Report writing
3,067 Complaint
1,250 Disclosure of records
1,964 Confidentiality
998 Medical or Dental Council matter
1,522 Claim
758 Inquest (or Fatal Accident Inquiry in Scotland)
Concealed sepsis

Mr D. 53, suffered with osteoarthritis in his right knee since turning 50. This had been confirmed with arthroscopy. He rarely bothered him and he had settled quickly with analgesia. It continued to work as a PE teacher. He had experienced a flare-up of knee pain at the start of the autumn term but this settled quickly with analgesia. He contacted Dr V by GP out-of-hours service on the first weekend of the Christmas holidays, complaining of two days of bilateral knee pain, which was unrelated by his usual (Gyldysh). A home visit was arranged. He was seen by Dr C, who documented a normal right knee on examination, but limited movement in the left knee, with positive meniscal signs and no effusion. Dr C also noticed that Mr D had a painful hamstring and mentioned the symptoms to OA and advised Mr D should also arrange to get the symptoms to OA and advised Mr D should also arrange to get it to cover for possible infection in the hand. Mr D was told to rest and return via the door two weeks earlier. Since then, Mr D had been unrelieved by his usual medication. Dr B made no record of this examination. He noted splenomegaly but recorded anything like enough to risk the fatal episode of sepsis could have been avoided.

Expert opinion was that hypertension was present with presentations with some features of migraine and prescribed some tramadol. Five years later, Mr D was still unable to get to his local surgery and an oral maxillofacial surgeon. He had his wisdom tooth extracted under sedation. His blood pressure was not taken. Extracted under sedation. His blood pressure was not taken. His blood pressure was not taken. His blood pressure was not taken.
Nervous about neurosarcoidosis

Mrs W was a 44-year-old French teacher who was usually fit and well. She had two children and they enjoyed walking to the same school together in the mornings. On one of these walks Mrs W was troubled by aching in her right buttock and some tingling in her right calf. She mentioned this to her GP, who noted that there had been no acute injury and that she was still managing to walk to school. He advised her to take paracetamol and ibuprofen and suggested some exercises.

A week later the pain was worse so Mrs W made an appointment to see Dr G, another GP. Dr G documented that she had acute backache with right-sided sciatica and paraesthesia in the right lateral leg. She noted that there were no bladder or bowel symptoms and documented that tone, power and reflexes were normal in both legs. Dr G’s notes stated that she had discussed warning signs that needed review. She prescribed diclofenac and referred Mrs W to physiotherapy.

Three weeks later Mrs W saw Dr G again, complaining that the pain was so bad that she couldn’t work. Dr G noted back pain with right-sided sciatica and paraesthesia but, again, found the power in her legs to be normal. Mrs W was getting indigestion with the diclofenac so Dr G prescribed codeine instead. She gave Mrs W a sick note.

Mrs W was struggling to sleep with pain so made another appointment with Dr G. She documented that Mrs W was tearful but keeping active, doing jobs round the house. Dr G prescribed some senokot to help with “codeine related constipation” and a trial of amitriptyline.

Two days later Mrs W fell at home and rang the out-of-hours GP service. She told the triage nurse that her right leg felt numb and weak, and that she felt like she needed to pass urine but couldn’t. An ambulance was called and records in the Emergency Department noted a five-week-history of right-sided leg pain and paraesthesia with a one-day-history of retention of urine and inability to pass stool. Examination revealed weakness and diminished sensation in Mrs W’s right leg but normal findings on the left. There was reduced anal tone and sensation over the saddle area. She was catheterised and one litre of urine was drained. Shortly after, she needed to pass urine but couldn’t. She was referred to physiotherapy.

Mrs W was seen in physiotherapy a week later. The physiotherapist in the meantime had confirmed an extensive high signal on the right leg and that power had been found to be reduced in her left leg. Ten minutes later Mrs W was found to have no power in both legs.

Mrs W was commenced on a three-day course of intravenous steroids, followed by a further two-day course. An MRI confirmed an extensive high signal throughout the thoracic cord, suggestive of either inflammation or infection; a plasma exchange was begun. There was no change to Mrs W’s condition and doctors noted her developing upper limb symptoms, a 6th nerve palsy and papilloedema. She was therefore treated on the basis that she had neurosarcoidosis, and Mrs W was recommenced on high dose steroids and started on intravenous cyclophosphamide.

Her condition stabilised and the 6th nerve palsy and papilloedema resolved. However, she was left with clumsy hands and paralysis of both lower limbs. Methotrexate was tried, but there was no substantial change to her clinical condition. She did report some improvement in the function of her hands.

Mrs W was left with faecal incontinence in her lower limbs, rendering her unable to move either leg or stand. Her upper limbs were weak. She had a suprapubic catheter and was incontinent of her bowels. Mrs W was devastated and made a claim against Dr G.

Mrs G alleged that she had told the GP of her difficulties in passing urine and opening her bowels several times prior to her admission. She claimed that her GP had failed to examine her adequately and had not referred her urgently. She believed that her disabilities would have been less severe if she had been diagnosed and treated earlier.

MPS carefully reviewed the notes from Dr G, the physiotherapist and the hospital. He felt that there were some vulnerabilities in Dr G’s notes from the second and third consultations because they were rather brief, but considered her examination and management to be reasonable. He noted that Dr G prescribed senokot for constipation but thought it understandable for a patient taking codeine to be constipated.

He felt that constipation in itself was not sufficiently discriminatory to be a red flag necessitating urgent neurosurgical referral. He commented that the physiotherapy notes were clear and that the patient had been specifically asked about bladder or bowel symptoms and that there were none. The hospital notes stated that urinary symptoms only occurred on the day of admission. The records from all the clinicians involved point to Mrs W’s bladder and significant bowel symptoms starting on the day she was admitted, and not before as Mrs W claimed.

MPS also sought the opinion of a professor in neurology. He concurred with the rare diagnosis of neurosarcoidosis. He felt that Mrs W’s acute deterioration was a consequence of cord ischaemia and infarction resulting from inflammatory or granulomatous involvement of the arterial supply to the cord. This would explain the sub-acute illness with a rapid evolutionary phase to the point of severe neurological disability. He noted that there is no proven effective treatment for neurosarcoidosis and that earlier treatment would not have altered the outcome. He noted that it is well recognised that cranial neuropathies, such as Mrs W’s 6th nerve palsy, can resolve spontaneously without treatment, and the improvement in Mrs W’s upper limbs was consistent with the variable natural history of neurosarcoidosis. The cord dysfunction that she had developed remained unchanged despite treatment.

MPS decided to defend the case to trial denying liability, supported by expert evidence. Mrs W discontinued proceedings two weeks before the trial, and MPS is now seeking recovery of all costs.

Learning points

- Good note-keeping is important in patient care but also when defending a claim. Clinical records should include relevant clinical findings, negative findings and relevant negatives when excluding red flags, such as the absence of bladder or bowel symptoms.
- MPS carefully reviewed the records of the GP, the physiotherapists and the hospital. Doctors to see how the notes supported each other to aid the defence.
- It is useful to be reminded of the referral guidelines from primary care for lower back pain. Repeated examination is needed to check that there is no progression of neurological deficit.
- This case highlights the value of revisiting your diagnosis and not making assumptions when a patient re-presents.

REFERENCES

1. www.gpnotebook.co.uk/simplepage.cfm?ID=-1227882441
Mrs X gave birth to J, a healthy baby boy. J was discharged, with a note in the records stating he was a “normal healthy infant”; a further note stated that, on examination, there was a bilateral red reflex. At four weeks, the health visitor’s notes showed that J’s parents were concerned that J’s left eye was smaller than the right, and the health visitor referred the baby to a community paediatrician. A couple of weeks later, the health visitor documented the left eye as being more open and the referral was cancelled. J was then seen by the family’s GP, Dr A, for a six-week check-up; his vision and hearing were recorded as being “satisfactory”. At three months, Dr A referred J to the ophthalmology department after noting a squint in his left eye; the left pupil was also smaller than the right pupil. Six weeks later – before the ophthalmology consultation took place – J was admitted to hospital as an emergency via Dr A, with coryza, vomiting and poor feeding. J was transferred to the paediatric department, but there was no record from this admission of any examination of J’s eyes.

At six months, J’s ophthalmology appointment took place. He saw a consultant ophthalmologist, Dr H, who noted that she could not detect any visual acuity in the left eye and that the eye was microphthalmic. She also noted a central cataract on the left side. J eventually became blind in his left eye.

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Dr A referred J to Dr H and said that J’s parents were concerned that J’s left eye was smaller than the right.

Another expert report, provided by a congenital cataract expert, stated that this examination was inadequate, as the health visitor had listed initial concerns about the size of the eyes, which should have prompted Dr A to be meticulous in his examination of the eyes; had the red reflex been absent, referral to a specialist should have occurred immediately. Prompt and appropriate referral would have led to a 25% chance of restoring J’s visual acuity to a level adequate for driving.

Another expert report, provided by a congenital cataract expert, stated that this examination was inadequate, as an abnormal red reflex would almost certainly have been present; this would have allowed for appropriate surgical intervention of the cataract that was later diagnosed. This report also criticised the hospital paediatric department for failing to communicate the concerns in J’s records about his eye size to the appropriate colleagues.

The case was settled for a substantial sum.

Learning points
- Poor communication leads to poor treatment. Here there is poor communication at various stages, between GP and hospital and within the hospital itself.
- Congenital cataract has a finite time period in which surgical intervention is beneficial.
- J was not seen by a consultant ophthalmologist until he was six months old; this delay highlights failings at both ends. Dr A’s referral letter did not make the urgency of the appointment clear but, also, the recognised association of microphthalmia with congenital cataract should have prompted the consultant reading the letter to offer an urgent outpatient appointment.

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Learning points
- Adherence to simple protocols, such as the WHO Surgical Safety Checklist, can help prevent problems of this kind, where a known and documented allergy was overlooked. See www.who.int/patientafety/safesurgery/ss_checklist/en/
- In choosing a TIVA technique for anaesthesia, Dr D was attempting to avoid a rare but dramatic problem, malignant hyperthermia. Mrs M might have been at risk given what happened to her brother. However, this may have distracted his attention from a much commoner problem, which is allergy to antibiotics. Take extra care when performing a technique that is unusual for you.
- Good documentation is the cornerstone of your defence. In this case Mr P didn’t document anything that had been discussed or shared. If a junior doctor is made to keep the notes, ensure you check their entries.
- Human error is inevitable in medicine, but doctors should always be open with patients and their families following an adverse event. An open and frank apology can often help to defuse anger. In this case, Dr D was praised for his handling of the incident afterwards.
No fundoscopy, no defence

Miss Z, a 17-year-old sixth form student, visited Dr B at the end of the summer term of school after a stressful exam period. She was feeling generally unwell with a sore throat and nausea and had ongoing nausea, neck pain and headaches. She also noticed that her vision was ‘blanking out’ every few days. Dr B documented a normal pulse and blood pressure and noted “normal cranials”. Miss Z did not recall an eye examination taking place; however, Dr B maintained that fundoscopy would have been part of his cranial nerve examination. He arranged some blood tests and a review with the results.

The next day, Miss Z’s vision had markedly worsened over the summer, so he advised her to return to the surgery, this time seeing Dr Q. She complained of ongoing nausea, neck pain and headaches. Dr Q attributed the symptoms to stress as deadlines for exams were approaching. He documented “no visual disturbance” and later “normal fundoscopy”, that would have been more convincing than no mention of symptoms at all, when the patient clearly recollected reporting problems.

Fundoscopy is an essential examination and can assist in the diagnosis of many diseases. In this particular case, early fundoscopy could have prevented loss of vision. Experts commented that if Dr Q had sent Miss Z for an ophthalmology appointment and an immediate hospital admission was arranged, an astrocystoma of the third ventricle was diagnosed and a shunt inserted that day to relieve the pressure. The tumour was subsequently excised.

Over the next month, Miss Z consulted Dr Q twice, and on both occasions the weight loss was the focus of the consultations. Dr Q attributed the symptoms to stress as deadlines for coursework were looming. On their last meeting, Miss Z complained of a number of episodes where she described a complete loss of vision. This prompted Dr Q to make an urgent referral to the local neurology service, but there was no documentation that an eye examination was performed.

After five days of waiting for the neurology appointment, Miss Z was taken to an optometrist by her mother due to ongoing visual disturbance. The optician found severe optic neuropathy in both eyes, complete loss of disc margins and turuous blood vessels with dot haemorrhages. An urgent referral was made to ophthalmology. Dr Q received a phone call from the optometrist to expedite the referral during his busy on-call. He has several home visits and admissions so it was a day later when he managed to write the referral letter. He documented that Miss Z’s vision had markedly worsened over the weekend, and after a period of the symptoms all subsiding she was now waking each day with headaches and nausea.

The next day (17 weeks after first presentation) Miss Z was seen by an ophthalmologist and an immediate hospital admission was arranged. An astrocystoma of the third ventricle was diagnosed and a shunt inserted that day to relieve the pressure. The tumour was subsequently excised.

However, despite resolution of the papilloedema, her vision deteriorated further. She was left with peripapillary haemorrhage and optic atrophy.

Expert opinion agreed that the delayed referral led to Miss Z’s visual loss. If an appropriate referral had been initiated when the visual symptoms were first described, then it is likely that significant loss of vision would have been avoided. It was settled for a high sum. EW

Learning points

As ever, clear documentation of a consultation is essential. Your standard of note-keeping says a lot about your practice. If you can demonstrate that your notes are generally of a high standard, it may assist you if you haven’t mentioned something in the notes.

If Dr Q had recorded the patient to have “no visual disturbance” and later “normal fundoscopy”, that would have been more convincing than no mention of symptoms at all, when the patient clearly recollected reporting problems.

Fundoscopy is an essential examination and can assist in the diagnosis of many diseases. In this particular case, early fundoscopy could have prevented loss of vision. Experts commented that if Dr Q had carried out fundoscopy in his initial consult (as he said he did as part of a cranial nerve exam) then he failed to identify papilloedema, as it likely had been present at this time.

If you do suggest a patient consults an optician to obtain a more thorough and immediate check-up, you should ensure that safety-netting is in place by arranging a follow-up consultation.

Remember red flag symptoms, especially in patients who may be presenting with vague non-specific symptoms. Ask the important questions, document what has been done and record any important negatives.

Learning points

Indications for induction of labour are set out in NICE guidelines as well as the ROOG red top guides. Psychological reasons and maternal choice are acceptable but documentation regarding the counselling and consent process must be robust. The notes in this case were lost, which resulted in the case being indefensible.

Good record-keeping is imperative throughout pregnancy, especially so in the intrapartum phase.

Delivery by ventouse is acceptable for most positions of the fetal head and is preferable to Kolffmans forceps, which should not be used for rotational deliveries except in the most experienced hands.

Postnatal care is important as antenatal and intrapartum care and should not be dismissed. The care of Mrs G in the postnatal period seems to have been adequate but for reasons that are not clear she refused to see Mr A.

When things go wrong it is important to be open, honest, conciliatory and empathic to the patient.

No fundoscopy, no defence

Miss G was seen at 35 weeks gestation with uncomplicated pregnancy. The consultant, Mr A, documented the mode and timing of delivery was discussed. Mrs G was naturally anxious as she had had two miscarriages and Mr A counselled her regarding induction of labour around the due date. He discussed the increased risk of instrumental delivery and caesarean section as a result.

Mrs G saw Mr A again two weeks later. Delivery by induction was resisted and agreed upon. Mr A made arrangements with the labour ward and used the indication “reduced fluid around the baby”, though he explained to Mrs G that this was to keep the middle “happy”. An ultrasound scan confirmed that Mrs G that all was well with the baby.

Mrs G was admitted for induction of labour at 37 weeks gestation. Examination by Mr A the cervix was found to be soft, posterior and partially everted. Induction by 2mg intravenous Prostin gel was commenced at 09:30. An amniotomy was performed seven hours later and labour ensued within two hours.

The first stage of labour was completed at 00:05 and pushing commenced 45 minutes later. Progress was slow. Mrs G’s temperature increased and the foetus developed a tachycardia. The midwife requested a consultant review and Mr A assessed the patient. The baby’s head was in an occiput posterior position but low in the pelvis. There was discussion with the parents about the possibility of ventouse extraction. Initially they were reluctant, having seen the effects of ventouse delivery on head shape and facial bruising before. However they consented and the procedure went ahead.

A Kiwi cup was used with positive pressure over two contractions to effect delivery. The perineum stretched well and episiotomy was not deemed necessary. A second degree tear was sustained with labial bruising and was repaired with vicryl under local anaesthesia due to pain. Both the midwife and Mr A noted the perineum to be swollen. Mrs G questioned the possibility of prolapse but this was excluded by Mr A. Soon after, Mrs G’s temperature increased and the foetus developed a tachycardia. The midwife requested a consultant review and Mr A assessed the patient. The baby’s head was in an occiput posterior position but low in the pelvis. There was discussion with the parents about the possibility of ventouse extraction. Initially they were reluctant, having seen the effects of ventouse delivery on head shape and facial bruising before. However they consented and the procedure went ahead.

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Complications of colonoscopy

A 50-year-old accountant, Mrs A, developed altered bowel habit and rectal bleeding. She saw consultant colorectal surgeon Mr C, who found large protruding haemorrhoids and recommended a haemorrhoidectomy and colonoscopy. Mr C removed a 5mm polyp in the rectum with a snare and then went on to perform a haemorrhoidectomy. Both procedures were described as uneventful and Mrs A was stable throughout the procedure.

A few hours later, after the operation, Mr C noted Mrs A was well and ready for discharge. She subsequently developed minimal rectal bleeding and abdominal discomfort, and was kept in overnight. The following morning, her routine blood tests were normal and her operation chart had been unremarkable, but the abdominal pain persisted. A chest x-ray revealed bilateral sub-diaphragmatic free gas. Mr C prescribed broad-spectrum antibiotics, intravenous fluids and kept Mrs A ‘nil by mouth’.

An urgent CT scan confirmed an extensive pneumo-peritoneum but no signs of any fluid collection. Mr C examined Mrs A and found a ‘completely soft abdomen with no peritonism or bowel sounds’. He explained that the perforation had probably occurred at the polypectomy site, but appeared to have sealed. Two weeks later Mrs A contacted Mr C complaining of right shoulder, abdominal pain and vomiting. He saw her immediately and arranged an ultrasound scan, which revealed a large pelvic abscess. Mr C organised her admission to a hospital for radical guided drainage of the abscess, but this proved unsuccessful. Her condition deteriorated and Mr B, the consultant surgeon on-call at this hospital, undertook an emergency laparatomy to drain the abscess and performed a defunctioning ileostomy.

Mrs A had a stormy postoperative recovery, initially requiring ITU support, and spent three weeks in hospital. Mr B subsequently reversed her ileostomy but Mrs A developed problems with an incisional hernia, necessitating several attempts at repair. She also needed psychological support for post-traumatic stress disorder, resulting in prolonged absences from work.

Two years later, Mrs A brought negligence proceedings against Mr C. It was claimed that Mr C should not have proceeded with the polypectomy, as evidenced by perforation or by performing an X-ray and CT scan on the evening when Mrs A initially developed pain. It was also alleged that Mr C had selected inappropriate antibiotics and had discharged her too early, allowing the development of her abscess. It was suggested that these acts of negligence had delayed appropriate surgical treatment and directly led to all Mrs A’s subsequent complications.

Expert opinion for MPS did not substantiate any of these claims. It was agreed that non-operative management for perforations after colonoscopy was an acceptable practice if the patient was stable, exhibited no signs of sepsis and the perforation appeared to have sealed. The CT result, together with this carefully-documented clinical findings, nursing charts, and absence of a rise in the patient’s inflammatory markers over several days, all supported this approach. Microbiology experts agreed that the antibiotics prescribed were appropriate and the length of administration sufficient. Mr C was also able to produce audit evidence of his colonoscopy practice, demonstrating a high volume of his colonoscopy practice, demonstrating a high volume of his colonoscopy practice, demonstrating a high volume of his colonoscopy practice, demonstrating a high volume of his colonoscopy practice, demonstrating a high volume of his colonoscopy practice.

Both procedures were discharged home with antibiotics, intravenous fluids and abdominal discomfort, and was kept in overnight. The following morning, her routine blood tests were normal and her operation chart had been unremarkable, but the abdominal pain persisted. A chest x-ray revealed bilateral sub-diaphragmatic free gas. Mr C prescribed broad-spectrum antibiotics, intravenous fluids and kept Mrs A ‘nil by mouth’.

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FILM: The Enemy Within (50 Years of Fighting Cancer)

By Dr Omar Mukhtar, ‘Darzi’ Fellow, Health Education South London, UK

The Enemy Within is a two-part programme on cancer, produced by the British Broadcasting Corporation and is directed by Vivienne Parry. It tells the story of the human fight against cancer over the last 50 years. Contributions include the great and good of cancer research – Professors Robert Weinberg and Umberto Veronesi, Lord Ara Darzi, Professor David Nathan, Professor Brian Druker and many more.

Equally, there are contributions from a number of patients, including Karen Lord, a survivor of childhood leukaemia, Julian Tutty, one of many patients who benefited from the development of Gleevec, and Bobbie Arnaudo, who eventually succumbed to pancreatic cancer. In chronicling the fight against cancer, it describes any number of important events – be that the debate surrounding combination versus sequential, single agent chemotherapy, the provision of palliative care or the realisation that a conservative surgical approach, as opposed to radical mastectomy, might be equally beneficial and less disfiguring for patients with breast cancer.

It also focuses on achievements further afield that have helped improve survival rates for many cancers – the vast technological advances that have led to the development of CT, MRI and PET imaging, the sequencing of the human genome and the realisation that environmental exposures (smoking, alcohol, obesity and sunbeds) are significant causative factors that need to be addressed. In doing so, it tells a calm and sober story of human endeavour.

Whilst the film also acknowledges the role of survivors, politics and ‘people power’, you sense that the nod to these groups is simply that – a nod. The power of the human story, the story of those who have succumbed to cancer and those who have survived, feels sanitised – devoid of the emotion of those who have fought their cancer and those who have survived, feels sanitized – devoid of the emotion that might invigorate this short film. Moreover, you can’t help but feel that it glosses over many of the challenges that remain – the failure to diagnose and treat virulent cancers, especially pancreatic and thoracic disease, the inadequacy of treatment in the non-industrialised world, and the considerable costs arising from non-adherence.

This is a non-commercial, editorially independent piece, supported by Cancer Research UK and funded by an educational grant from Roche. The film-makers set out to educate and inform those who are affected by cancer. Whether they have achieved that is questionable, as the focus and language is largely directed towards the medical fraternity. However, in a little over an hour, this film provides a high level overview of what has been achieved in 50 years, which will be enjoyed by many a clinician.

The Checklist Manifesto: How to Get Things Right

Review by Dr Amir Forouzanfar, surgical specialist registrar, Doncaster, United Kingdom

A tul Gawande has written an insightful, in-depth and stimulating book about the challenges of modern medicine. His honest reporting of challenging medical scenarios including personal mistakes, combined with stories from other professionals, certainly convinced me that surgical checklists are a good thing. I work as a specialist registrar and we now routinely undertake the WHO operating checklist. I’ve noticed an increase in its uptake and implementation, which can only be a good thing. I see errors picked up on a weekly basis simply by having an easy-to-follow checklist for the whole team to follow.

Gawande distinguishes between errors of ignorance and errors of inexperience – the most common and relevant in today’s medical world being the latter. He explains that the high pressured and intense environment that is prevalent in the medical world means mistakes are inevitable. He borrowed a concept from the aviation industry: the checklist, similar to the checklists used by pilots before take-off, and applied it to medicine. He then argues that implementing checklists that walk surgeons through procedures actively prevent mistakes. Good checklists and clear communication amongst the team can significantly reduce errors. For those among the medical profession who are sceptical about using checklists, or are interested in how the WHO operative checklist came about, I suggest you read this book, as it is powerful enough to make you rethink your ideas.

I’ve found myself using examples of Gawande’s book to inform my operating staff of the origins of the checklist, while stressing its importance to us all. Surgeon or paediatrician, GP or psychiatrist – I encourage every doctor to read this well-crafted and fascinating book – it will change the way you think.

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