Professional support and expert advice from your leading medicolegal journal

This issue...

CONTRACEPTION AND CARDIAC ARREST
A case report on the risk of prescribing

RISK ALERT – RETAINED THROAT PACKS
Why you must remember the WHO checklist

ACHIEVING SAFER AND RELIABLE PRACTICE
Improve your safety and quality with our new workshop

OVER TO YOU
The place to debate hot topics

PAGE 10 VOLUME 23 ISSUE 2 NOVEMBER 2015
WHAT’S INSIDE...

05 New executive appointment – Dr Pardeep Sandhu
Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

06 Noticeboard – Capping legal costs
Find out how Medical Protection has shaped DH plans over the capping of legal costs for small claims; plus other medicolegal news.

08 Achieving safer and reliable practice
Dr Suzy Jordache and Sam McCaffrey look at how a new workshop for members is making for a more reliable healthcare experience.

10 I will survive – overcoming addiction
For one GP, stress and anxiety led to addictions that almost cost him his life. Read his personal account of how he not only saved his life, but also his career.

11 Mental health and doctors
A look at how doctors deal with their own mental health.

FACTS AND OPINION

04 Welcome
Dr Nick Clements, editor-in-chief of Casebook, comments on some topical issues affecting healthcare.

13 Risk Alert – Retained throat packs
Our medicolegal advisers warn of a recurring problem and remind doctors of the importance of the WHO surgical safety checklist.

14 From the case files
Dr Richard Stacey, senior medicolegal adviser, looks at what can be learned from this edition’s collection of case reports.
NEW EXECUTIVE APPOINTMENT: DR PARDEEP SANDHU

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division.

Dr Sandhu joins us from Aetna International, a global health benefits provider in the USA, where he was medical director and head of business development.

Dr Sandhu spent more than seven years working with governments to create and expand robust healthcare systems. In this international role, Dr Sandhu worked across health policy, clinical governance, business development and strategy, as well as designing and launching Aetna’s international care management programmes in multiple geographies.

Dr Sandhu trained at the University College London and was GP before serving as a clinical adviser to the UK Department of Health. He also holds a MBA from Kellogg School of Management, Northwestern University, USA.

Simon Kayll, Chief Executive, said: “We are delighted to welcome Dr Pardeep Sandhu.

“With numerous challenges facing the medical and dental professions worldwide, it is vital that we are there for members in the right place, at the right time. As a former practising physician myself, I understand the unique dilemmas clinicians face on a daily basis – and very much subscribe to the Medical Protection ethos that prevention is better than cure. Ensuring the expertise of my team benefits our membership is a key goal for me.

“Of particular interest to me is the challenge of meeting the needs of our members around the world. With so much variation from country to country, it is imperative that we tailor our services to meet everyone’s requirements as fully as possible. I look forward to working with you and hearing your views on how we can improve even further.”

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.
DH Accepts Medical Protection Calls to Cap Legal Costs

The government has agreed with Medical Protection on the need to introduce a fixed costs regime for small value clinical negligence claims. The Department of Health has stated that the fees some lawyers are charging are disproportionate and can outstrip the amount of compensation awarded to patients. In a recent surgical case, damages of £17,500 were awarded; however, legal costs were claimed in excess of £50,000. The costs were finally settled at £36,000, which is still more than double the amount the patient received in compensation.

According to the NHS Litigation Authority (NHSLA), in claims where compensation is less than £10,000, claimant lawyers recover almost three times more in costs on average. For claims resolved for less than £100,000 damages, the percentage of claimant costs has increased from just over 20% to 50% over the last ten years and, as an absolute percentage, increased by almost three times.

Approximately one third of the £1.1 billion paid out by the NHSLA last year went to the legal profession, most of which was paid to claimants’ lawyers. The NHSLA has stated its support for a move to a position where legal costs are more proportionate to damages.

Health Minister Ben Gummer MP outlined the plans for the fixed costs regime in a letter to Lord Dyson, Master of the Rolls and Head of Civil Justice. The proposals include fixing legal costs to a percentage of the compensation won for patients in claims of up to £100,000.

Medical Protection has been calling on Government to introduce fixed costs as one way of helping to drive down the cost of clinical negligence. Emma Hollinan, director of claims and litigation, said: “We have been calling for a fixed cost regime to help address the rising cost of clinical negligence, and it is fantastic to see that Government plans to cap excessive legal fees that are placing such a burden on the public purse.”

“Medical Protection believes that these funds could be better spent on patient care for all. Other areas being pursued include reducing the burden of regulation on members. Medical Protection is seeking a moratorium on the introduction of new regulations on the healthcare profession, as we believe that a change in culture would be far more effective at promoting openness, professionalism and accountability amongst those working in healthcare. Focusing on legislation and regulation as the key methods of driving behavioural change will undermine this.”

In our experience, damages (in particular), future care costs and earnings have increased in recent years. We could learn from other countries in some Australian states there are limits on the loss of earnings at, typically, a multiple of two or three times the average weekly earnings. As difficult decisions are made about what the NHS can afford, it is crucial that we ask ourselves whether it is appropriate to push forward and to pay such large sums in damages and costs. Medical Protection believes that any change is needed. The next and crucial step is to have a debate on the merits of limiting damages, in particular future loss of earnings and care.

In our experience, damages (in particular), future care costs and earnings have increased in recent years. We could learn from other countries in some Australian states there are limits on the loss of earnings at, typically, a multiple of two or three times the average weekly earnings. As difficult decisions are made about what the NHS can afford, it is crucial that we ask ourselves whether it is appropriate and affordable to continue to pay such large sums in damages and costs. Medical Protection believes that these funds could be better spent on patient care for all.

Other areas being pursued include reducing the burden of regulation on members. Medical Protection is seeking a moratorium on the introduction of new regulations on the healthcare profession, as we believe that a change in culture would be far more effective at promoting openness, professionalism and accountability amongst those working in healthcare. Focusing on legislation and regulation as the key methods of driving behavioural change will undermine this.

In our experience, damages (in particular), future care costs and earnings have increased in recent years. We could learn from other countries in some Australian states there are limits on the loss of earnings at, typically, a multiple of two or three times the average weekly earnings. As difficult decisions are made about what the NHS can afford, it is crucial that we ask ourselves whether it is appropriate and affordable to continue to pay such large sums in damages and costs. Medical Protection believes that these funds could be better spent on patient care for all.

Other areas being pursued include reducing the burden of regulation on members. Medical Protection is seeking a moratorium on the introduction of new regulations on the healthcare profession, as we believe that a change in culture would be far more effective at promoting openness, professionalism and accountability amongst those working in healthcare. Focusing on legislation and regulation as the key methods of driving behavioural change will undermine this.

In our experience, damages (in particular), future care costs and earnings have increased in recent years. We could learn from other countries in some Australian states there are limits on the loss of earnings at, typically, a multiple of two or three times the average weekly earnings. As difficult decisions are made about what the NHS can afford, it is crucial that we ask ourselves whether it is appropriate and affordable to continue to pay such large sums in damages and costs. Medical Protection believes that these funds could be better spent on patient care for all.
Achieving Safer and Reliable Practice

Medical Protection’s Dr Suzy Jordache and Sam McCaffrey look at how a new workshop for members is making for a more reliable healthcare experience.

Safe healthcare requires both the expert knowledge and technical skills of healthcare professionals as well as reliable delivery and application of that knowledge and skill.

In the new Medical Protection workshop Achieving Safer and Reliable Practice, reliability is defined as minimal unwanted variability in the care we have determined our patients should receive. Any figure below 90% reliability would be termed, ‘chaotic’ in other safety critical sectors, and yet in healthcare we regularly report ‘success’ rates of 80% or lower.

Examples of the variation in reliability in healthcare are readily available: the Health Foundation’s report in 2010 found that in nearly one in five operation procedures there were faulty, missing or used incorrectly; around one in seven prescriptions for hospital inpatients contained an error; and full clinical information was not available at just under one in seven outpatient appointments. The report also commented on the wide variations in reliability between and within organisations.

In addition, Medical Protection data gathered from visits to 778 GP practices in the UK in 2008 and 2010 found that only 55.9% of practices had adequate processes for matching test requests and results received.

Reliability is defined as minimal unwanted variability in the care we have determined our patients should receive.

WHAT LEVEL IS ACHIEVABLE?

Research suggests that implementation rates in healthcare for standard procedures that impact on patient safety are between 50% and 70%, or >1 x 10⁻². Other industries such as aviation and nuclear power have achieved reliability levels of 10⁻¹ in critical processes. In healthcare anaesthetics has been successful in achieving this level of reliability during the induction of anaesthesia. This and other reliable practices, such as blood transfusions and pathology labelling, can inspire and lead the way for all of us, whether practising in primary or secondary care.

HUMAN FACTORS

The science of human factors examines the relationship between people and the systems with which they interact, with the goal of minimising errors. In healthcare, human factors knowledge can help design processes that make it easier for doctors and nurses to do their job right.

Some of the factors that have been identified that can impede human performance include:

- Perceptual deficits under stress
- Fatigue
- Physical Decisinal
- Poor interpersonal communication
- Transmission/reception
- Challenge
- Poor understanding of the nature of human error
- Causes Extent
- The weakness of 10⁻¹ strategies in prevention.

Processes and systems inadequate:
- Structured decisional support and checking tools
- Measurement, feedback and accountability mechanisms
- Briefing and simulation
- Environmental design and control
- Equipment design

Perhaps the most important strategy is that of ‘speaking up’ – safe cultures train and insist on respectful assertive communication. In healthcare, we often find that following an error, one member of the team had ‘seen it coming’, but felt unable to say anything. There are complex reasons for this and simple steps by individual clinicians can transform safety.

Moving to 10⁻²

The MPS AlwaysChecking™ approach

Always Checking

In order to mitigate the risks from these factors Medical Protection advocates the AlwaysChecking™ approach, which offers five manageable, evidence-based steps to raise reliability in any healthcare setting.

Always means always

Always means always means always.

In healthcare, ‘always means always’ around handwashing.

The results achieved in 2009 (>1 x 10⁻²) were achieved using strategies based on individual memory, diligence and vigilance. In 2010 the centre moved to a detailed monitoring and individualised clinician and team benchmark feedback process, leading to 10⁻¹ levels of reliability.

Since 2011 the level of compliance has been maintained (and even increased again) to 10⁻².

The benefits to patients, in terms of morbidity and mortality reduction, along with the economic benefits to the hospital and the decreased risk of complaint and claim for the clinicians employed by Vanderbuilt, is a testament to the value of measurement and accountability in achieving 10⁻² reliability.

CHECKLISTS

The use of checklists in healthcare has been demonstrated in numerous studies to improve reliability and outcomes for patients; yet they are still resisted in some in the profession and are often hotly debated during the workshop.

Some of the benefits of using a checklist include:

- Reduce cognitive work
- Facilitate concentration on first order concerns
- Critical in preventing “never events”
- Change the culture of a team

Always checking tools

The workshop includes a guide on how to develop effective checklists and implement them in organisations.

Example: Hand Washing Programme

Processes and systems inadequate:
- Structured decisional support and checking tools
- Measurement, feedback and accountability mechanisms
- Briefing and simulation
- Environmental design and control
- Equipment design

30% reduction in serious hospital infections

Estimated annual net savings of $4.5m

Ten fold reduction in ICU central line infection rate (new one quarter of national benchmark)

Vanderbuilt U.M.C.
I have always felt restless, irritable and discontent. As a child I was uncomfortable in my own skin and never felt like I fitted in. Alcohol was the only thing that calmed down my over-analytical teenage head. I remember thinking: “Wow – this is how normal people feel.”

My addiction continued when I got into university and became a regular recreational drug user. I would use one drug or combination of drugs, until it caused a problem – a fight, a missed session or so I would have to stop it, but then I would move on to something else. I had to have something to put into my system to make me feel “normal”.

ANXIETY AND DEPRESSION

Throughout this time, I felt anxious and depressed. I saw my own GP, and rebuked his questions around alcohol. He didn’t ask me about drugs, and I had no insight into what all this pharmacology was doing to my brain. I was learning about drugs and justifying their use – addiction couldn’t happen to me…I was sure I had learnt from my mistakes, over and over again, and expecting a different result each time.

I wrote the goodbye, cruel world letters, stating it was everyone else’s fault, not mine, and I tried to take my own life. Twice. When I woke up the second time I realised that I had two choices: live or die. I had to find a new way of living. I was making the same mistakes, over and over again, and expecting a different result each time.

I had a sort of epiphany. I decided: “I will survive.”

SURRENDER

I was so full of shame and guilt that I didn’t feel I deserved a detox.

I asked for help. I got in touch with the Sick Doctors Trust and the Practitioner’s Health Programme. I was advised to self-refer to the GMC, which was probably the best thing I ever did, as it saved my life. The GMC put enough barriers in place to stop me from using again.

I went to rehab, which was like pressing fast forward on my recovery. Being a patient is very difficult for doctors. I had to let go of my arrogance and false pride.

By going to ‘mutual aid’ meetings I identified with other people’s addiction stories. “I feel and think like that. I do act and behave like that.” And I got hope from their recovery. I will always remember the quote: “A clever man learns from his own mistakes – a wise man learns from other people.”

ACCEPTANCE

Admitting I was an addict was hard enough, but accepting it was extremely difficult. Accepting that is who you are is a struggle. Once I did, I realised that I’d never have to use drugs again.

LIVING

I didn’t get into recovery to be miserable. Recovery is fun.

I retrained in addictions, doing the RCGP Substance Misuse Part 2, and became a GPwSI. I told my story on the RCGP Health for Healthcare Professionals course and became a trainer, acquiring a Certificate in Practitioner Health. I sat on the Scottish Government’s National Forum on Drug-Related Deaths.

I got back to work, unpaid initially, but now I’ve got my dream job. I still do some GP work, but also work with alcoholics and addicts, including those in the prison system.

The GMC’s bad. It’s the only reason I’ve got a job. But being in recovery is the best thing I’ve ever done, as it saved my life. The GMC put enough barriers in place to stop me from using again.

I went to rehab, which was like pressing fast forward on my recovery. Being a patient is very difficult for doctors. I had to let go of my arrogance and false pride.

Words: Sara Dawson

Medical Protection surveyed UK members across all specialties to find out about their personal experiences of mental health issues. It ran from 18 June to 3 July 2015 and received 631 responses.

Mental health issues impacted on:

- Depression: 59%
- Low self-esteem: 59%
- Stress: 57%
- Sleep disturbance: 52%
- Suicidal feelings: 17%
- Anxiety: 52%
- Low self-esteem: 57%
- Stress: 47%
- Sleep disturbance: 49%
- Suicidal feelings: 17%

Reasons doctors didn’t discuss mental health issues with anyone:

- Stigma attached to mental health issues: 40%
- Worried about the professional implications: 39%
- Had not had the support: 25%
- Did not feel comfortable: 21%
- Did not feel ready to disclose: 23%
- Did not feel it was their business: 18%
- Did not feel it was a personal issue: 4%

Have you personally experienced any of the following mental health issues during your medical career?

- Stress: 75%
- Depression: 32%
- Anxiety: 49%
- Low self-esteem: 35%
- Sleep disturbance: 57%
- Suicidal feelings: 13%
Doctors help their patients with mental health problems, but they often suffer alone. Being a doctor is not only physically and intellectually demanding, but also emotionally draining.

The largest study of its kind ever conducted in the UK among GPs was published in BMJ Open. It surveyed 564 general practitioners and reported that 46% of respondents reported emotional exhaustion, 42% reported depersonalisation and 34% reported low levels of personal accomplishment.

In 2015 the BMA reported that 39% of doctors admitted to frequently feeling drained, exhausted, overloaded, tired, low and lacking energy. Furthermore, 43% admitted that they were at high risk of suffering burnout in the near future.

Dr Clare Gerada, from the Practitioner Health Program, a confidential service for those with mental health and addiction problems but who are unable to access standard NHS services, likens the experience of doctors to the armed forces: “Of the doctors we’ve seen over the last eight years, two thirds have mental health problems. The vast majority of those have depression or anxiety, but increasing numbers have obsessionl behaviour, panic disorder and eating disorders. The remaining third have addiction problems.

“We are a group of professionals who have high expectations of ourselves and the public have incredibly high expectations of us. There is very little room for error. At the same time there are enormous barriers to us receiving help: some are self-barriers, self-stigmatisation others are enforced upon us by society – doctors don’t get ill.”

Dr Mike Peters, who has run the BMA’s Doctors for Doctors support unit for a number of years, describes mental health problems and work-related stress as the biggest problems facing doctors today. He estimates that one in ten doctors consult a psychiatrist each year. Of those, around one third have a mental health problem.

“If a doctor had a mental health issue, the pattern of their clinic would be disrupted by emotional exhaustion, low self-esteem and depression. Doctors can combat the negative effects of working in a high pressure environment in a number of ways – one of which is opening up to others and talking about their problems. According to Dr Peters, Doctors for Doctors takes 200 calls a month from doctors in trouble. “We encourage doctors to talk to colleagues, to their friends and family, many of them feel that they can just lock it up and it is going to go away and, of course, it doesn’t.”

Dr Gerada said: “My role is to be an advocate for those who may be vulnerable and in the interest of providing the best care to their patients; doctors must seek help as soon as they experience mental health difficulties.”

Doctors for Doctors support unit for a number of years, two thirds have mental health problems. The vast majority of those have depression or anxiety, but increasing numbers have obsessionl behaviour, panic disorder and eating disorders. The remaining third have addiction problems.

The work of the organisations of Dr Gerada and Peters is testament to the fact that if you build a confidential, accessible, good quality mental health service, then people will come, and they will access it.

“Mental health issues are still taboo in some areas of the medical community. One of the most powerful ways to break that taboo is for doctors to talk about it and to admit that we are human, like our patients. We can get through this if we admit it and get the appropriate support.”

Dr Gerada said: “My role is to be an advocate on behalf of doctors, and make sure that they are not their own worst enemy. The shame that surrounds a doctor admitting that they have got problems is so deep rooted it probably goes way back before they got to medical school.”

In this short video Dr Michael Blackmore describes his 20-year battle with addiction. He is joined by Dr Clare Gerada, from the NHS’s Practitioner Health Program, and Dr Mike Peters, from the BMA’s Doctors for Doctors Unit, both have years of experience working with doctors with mental health issues.

Medical Protection | Mental Health and Addiction

Medical Protection urges colleagues of doctors to look out for signs of mental health problems and offer support, such as talking through issues or helping to balance their workload.

“Important is that doctors know that seeing help will not automatically lead to a referral to the GMC or put their careers at risk. Colleagues should provide support to those who may be vulnerable and in the interests of providing the best care to their patients, doctors must seek help as soon as they experience mental health difficulties.”

Doctors have experienced mental health issues, such as stress, anxiety, low self-esteem and depression. When used properly, the WHO Checklist prompts effective team communication to eradicate avoidable risks, such as retained throat packs. Proper usage of the Checklist requires the following:

• All three phases of the list must be performed — Sign-in, time out, Sign-out
• The anaesthetist must be present for all stages.

There were three cases on the list that afternoon. A briefing took place before the list, and the WHO checklist sign-in was performed. The insertion of the throat packs was discussed, however, the plan for their removal was not.

Dr D inserted the throat pack for the first patient on the list but at the end of surgery it was removed by a junior surgeon. Dr D therefore inserted a nasopharyngeal airway. This created some confusion. Miss C was second on the list and, although Dr D inserted her throat pack, he was not under the impression that its removal was his responsibility.

Further, this throat pack had been obtained from the anaesthetic room, and as such did not form part of the scrub nurse’s swab count. Dr D did, however, place a sticker on Miss C’s head notifying that a throat pack had been used.

The surgery proceeded uneventfully. However, immediately after waking up, Miss C experienced some difficulty breathing. The issue of the throat pack was raised by nursing staff and Dr D mistakenly asserted that it had already been removed. The nursing staff therefore removed the sticker that had been placed on Miss C’s head. A laryngeal mask airway (LMA) was inserted, which improved Miss C’s oxygen saturation levels.

30 min removal of the LMA, around 30 minutes later, Miss C coughed up the throat pack. She also made a full recovery.

The WHO CHECKLIST

When used properly, the WHO Checklist prompts effective basic communication to eradicate avoidable risks, such as retained throat packs. Proper usage of the Checklist requires the following:

• All three phases of the list must be performed — Sign-in, time out, Sign-out

The anaesthetist must be present for all stages. Best practice is to have all members of the surgical team present for all three phases, although the WHO advises that the Sign-in may take place without the anaesthetist.

• At Sign-in, responsibility for both insertion and removal of throat packs must be assigned.

• At Sign-out, removal of the throat pack must be checked, either as part of the swab count exercise, or as a distinct part of the checklist.
before joining Medical Protection in 2003, I was a GP and always enjoyed reading the cases in Casebook, irrespective of whether they related to primary or secondary care cases. In my role at Medical Protection I meet many doctors from different specialties and when I introduce myself, invariably the first thing they say is that they enjoy reading the cases in Casebook – with the caveat that it often causes them to reflect on their own practice (which, of course, is one of the reasons why the particular cases are chosen).

In this edition of Casebook there is the usual array of thought-provoking cases, with varying outcomes and learning points. A common issue is that of record-keeping; in the case ‘Poor notes, fatal consequences’, Dr A is criticised for not documenting a thorough history or the fact that Mrs Y was reluctant to be admitted to hospital; and in the case “Elbow arthroscopy – radial nerve injury”, the operation note was not deemed to be of an acceptable standard. Conversely, in the case “Alleged anticoagulation failure”, the fact that the consultant cardiologist had specifically stated that anticoagulation was not indicated on the advice slip to Dr B was an important feature in defending the claim.

There is a real tension in the context of a busy surgery or outpatient clinic, and other clinical settings, in that patients can perceive that the making of records intrudes into the consultation – yet the records provide the basis of your defence in the event of an adverse outcome. I have often heard it said by patients “the doctor did not pay attention to me as they were far too busy tapping into their computer”. The likelihood is that, in fact, the doctor was making a thorough contemporaneous record, hence there is a real art to being able to take thorough and contemporaneous notes without appearing to disengage from the consultation (or without missing what could be very important non-verbal clues).

There are several strategies that may be deployed to provide the patient with the reassurances that you remain engaged, whilst allowing an opportunity to make a record of the consultation:

- At the start of the consultation, it is often helpful to maintain eye contact and to listen carefully to what the patient says before making an entry in the records
- At an appropriate point in the consultation, it may help to introduce the fact that it is your intention to make a record of what has been discussed
- In making the record, it is often a helpful opportunity to summarise your understanding of the problem; this can be useful in reaching shared understanding of the issues and demonstrating empathy
- Whilst making the record, it is important to keep glancing in order to make eye contact and to demonstrate to the patient that you remain engaged in the consultation
- When the record has been made, there is an opportunity to explain to the patient (or even show the patient) what you had recorded, which is once more helpful in terms of summarising the concerns and ensuring that both you and the patient are content that the record is accurate
- You might wish to consider developing macros (a standard form of text that can be inserted into the record) or templates for common scenarios pertaining to your particular area of practice, to ease the recording of the consultation (I appreciate that this may not be possible in relation to handwritten notes).

I hope that you find the cases thought-provoking and that they provide you with an opportunity to reflect (amongst other things) on your approach to record-keeping.

What’s it worth?

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 £1,000,000+
- SUBSTANTIAL £100,000+
- MODERATE £10,000+
- LOW £1,000+
- NEGLIGIBLE <£1,000
Mrs S was a 51-year-old teacher. At the start of term Mrs S developed a troublesome cough and went to see her GP, Dr B, about it. Dr B diagnosed a chest infection and prescribed antibiotics but also noted that she had an irregular pulse. An ECG was performed at the surgery the same day, which showed that Mr S was in atrial fibrillation. Dr B sent Mrs S to the medical assessment unit for urgent review.

The hospital doctors confirmed the diagnosis of atrial fibrillation and prescribed warfarin to reduce her risk of thromboembolic stroke and bisoprolol to slow her heart rate. They put Mrs S on the waiting list for a cardioversion procedure and discharged her home.

Mrs S attended for her cardioversion procedure but was found to be in sinus rhythm. The cardiologist (Dr T) advised Mrs S to stop taking her warfarin and to reduce her bisoprolol. Dr T gave Mrs S a medication slip to take to her GP, which detailed his advice, and told her that she would be called back to clinic for follow-up.

Dr B saw Mrs S again with the cardiologist’s advice slip. Dr B documented that her pulse was regular now (although she was slightly bradycardic). Dr B arranged a further ECG for the following week and reduced her bisoprolol dose further. Dr B documented that Mrs S was “awaiting cardiology follow-up” and that she had had a chest infection when the atrial fibrillation was initially diagnosed.

The ECG the following week showed sinus rhythm with a rate of 60 bpm. Dr B saw Mrs S again to inform her that her ECG was normal. Dr B noted her pulse on that day was regular and that she was waiting for cardiology review.

Soon after, Mrs S received a letter asking her to return for another cardioversion procedure. Mrs S rang the cardiologist’s secretary to explain that she had been advised that this was not necessary but that she was waiting for an outpatient appointment.

Dr B received a letter from the warfarin clinic stating that she had not attended for INR testing for at least four weeks.

Dr B circled the response “no longer requires anticoagulation”.

A month later, Mrs S suffered a stroke. There were no other risk factors for stroke identified other than atrial fibrillation, thus the likely cause of Mrs S’s stroke was an embolic event arising as a consequence of thrombus formation within the atrium.

As a result of the stroke, Mrs S felt unsteady and hesitant every time she walked. Despite rehabilitation, her writing was slow and clumsy and she slurred her words. Sadly, teaching was no longer possible and Mrs S had to retire early on grounds of ill health.

Mrs S was devastated. She felt that her stroke could have been prevented if she had been anticoagulated. Mrs S made a claim in negligence against Dr B. It was alleged that Dr B should have prescribed some form of anticoagulation and that he should have contacted the hospital to query the medication position, especially in light of the non-attendance letter from the anticoagulation clinic.

EXPERT OPINION

Medical Protection sought the advice of an expert GP, Dr H. Dr H felt that the care given by Dr B was of a reasonable standard. Dr H did not consider that Dr B had a mandatory duty to prescribe anticoagulation or that he should have contacted the hospital to query the medication position. Dr H noted that the decision to stop anticoagulation had been clearly relayed on an advice slip from a cardiologist. Mrs S had also told Dr B that she was waiting for cardiology review and her subsequent ECG had shown sinus rhythm.

The opinion of a professor in stroke medicine (Professor G) was also obtained by Medical Protection. Professor G confirmed that the likely cause of Mrs S’s stroke was thromboembolic. Professor G pointed out that some patients develop atrial fibrillation secondary to other illness such as chest disease. In such a setting, if the atrial fibrillation resolves when the underlying cause has been treated, and the clinician feels that there is a low risk of it recurring, then it is reasonable not to anticoagulate. Mrs S would have had a CHA2DS2-VASc score of 1 because of her sex but an absence of congestive heart failure, hypertension, diabetes, stroke or vascular disease and age below 75 years, Professor G felt that it would have been quite reasonable not to anticoagulate in this context.

Medical Protection served a letter of response denying liability and Mrs S did not pursue the claim any further.

Learning points

- NICE, Atrial fibrillation: the management of atrial fibrillation (June 2014) state that doctors should consider anticoagulation for men with a CHA2DS2-VASc score of 1 and to offer anticoagulation to people with a CHA2DS2-VASc score of 2 or above, taking bleeding risk into account.

- Documentation of the reasons behind the decision-making was invaluable in defending this case.

AF
Miss F, an 18-year-old university student, had been taking the combined oral contraceptive pill microgynon for 18 months for dysmenorrhoea, when she presented to her GP. Dr K, worried about acne on her back, Miss F had heard from her flatmate that dianette is a better pill to take for acne because microgynon reduced the speed of processing information. Miss F was a non-smoker with normal BMI and BP, and switched her pill to dianette, advising her to start it when her microgynon cycle finished in another fortnight.

Two weeks after commencing the dianette, Miss F was rushed into hospital with sudden onset chest pain and acute distress. Miss F was diagnosed with a pulmonary embolism and went on to have a cardiac arrest in the emergency department. Miss F was thrombolysed, which resulted in return of spontaneous circulation, and she was transferred to intensive care. On waking she reported reduced vision and was found to have left hemianopia.

Imaging of Miss F’s brain revealed oedema suggestive of a cerebral infarction and a small subdural haemorrhage. Miss F’s treating haematologist commented that the dianette definitely made a contribution to the blood clot Miss F suffered, but considered the cerebral infarction to be more likely due to thrombolysis given to appropriately treat this. Miss F spent over a month recovering in hospital and her vision improved. Long-term warfarin was initiated and she was discharged with no focal limb deficits or neurological symptoms. Twice weekly physiotherapy and occupational therapy was commenced.

Two months after discharge, a formal physiotherapy and occupational therapy was discharged with no focal limb deficits or neurological symptoms. Twice weekly physiotherapy and occupational therapy was commenced.

Dr K recorded that Miss F was a non-smoker with normal BMI and BP, and switched her pill to dianette, advising her to start it when her microgynon cycle finished in another fortnight.

A claim was made against Dr K stating that he prescribed dianette to Miss F when she was not suffering with severe acne. He failed to advise Miss F regarding the increased risk of venous thromboembolism, and did not try alternate treatments for her acne such as topical therapies or oral antibiotics. The claim stated that had Miss F’s not been exposed to dianette, she would not have suffered the massive PE that led to her suffering anoxic brain damage.

EXPERT OPINION

Expert GP Dr C was unsupportive of Dr K’s action, stating that acne is usually a second or third line treatment for acne, and with no evidence that the acne was severe and in the absence of a trial of alternate therapies first, the prescription was indefensible.

Dr E, expert consultant in pharmacology, was also supportive of Dr K, stating that although there is probably an increased risk with dianette, the size of this increase is small, and the risk appears to peak between four months and one year of use. The timing of Miss F’s PE appeared to be close to that episode of spontaneous circulation, and the balance of probabilities, he was likely to have still suffered her PE had she continued on microgynon.

Medical Protection defended this case and prior to trial made a deep hands-off offer – Miss F to discontinue her claim, with each party to bear their own costs. This was accepted by Miss F’s solicitors. This is largely because it cannot be entirely accepted that it was wrong to prescribe dianette to the claimant, and perhaps more importantly, the claimant would have suffered the PE in any event – considering Miss F had only just been prescribed the dianette.

Mr B was a 27-year-old secretary with a ten-year-old daughter. She had just enjoyed a trip to Pakistan, where she had been visiting relations. Three days after her return she developed profuse, watery diarrhoea. She made an appointment with her GP, Dr A, because she was opening her bowels seven times a day and couldn’t face eating anything.

Dr A noted that Mrs B had recently returned from Pakistan and that she had diarrhoea. Dr A was happy with Mrs B’s pulse and blood pressure and documented her temperature as 37.7°C. Dr A advised her to be soft and non-tender. Dr A prescribed some paracetamol and co-phenotrope and advised her to return if there was no improvement.

Mrs B waited for a week but she began to feel worse – she was so nausaeus that she still couldn’t eat and the diarrhoea had been relentless for ten days. Mrs B was feeling rather weak so she made another appointment with Dr A. Dr A’s notes were brief, just stating “diarrhoea”. Dr A noted that Mrs B was apyrexial with a satisfactory pulse and blood pressure. Dr A examined Mrs B’s abdomen again and found it to be soft and non-tender. She prescribed some codeine linctus and loperamide.

Two days later Mrs B began to feel very faint and lethargic with ongoing diarrhoea. She had been staying with her mother-in-law who was really worried about her. Her mother-in-law drove Mrs B to her GP surgery where she was given an emergency appointment. Dr A saw her again and found her restless and sweating with a tender abdomen, which was recorded in the notes. He admitted her to hospital with possible enteritis or malaria.

Medical Protection commissioned a report from a GP expert, Dr S. Dr S was critical of Dr A’s first consultation with Mrs B. At that time Mrs B had a three-day history of diarrhoea. Dr S explained that viral gastroenteritis is the commonest cause of diarrhoea and that traveller’s diarrhoea is an extremely common presenting complaint.

Even in cases of bacterial infection, antibiotic treatment is not usually required. As traveller’s diarrhoea is self-limiting in the majority of cases, Dr S felt that few GPs would have requested a stool sample on that occasion.

Dr S was, however, critical of Dr A’s second consultation. At that time Mrs B had complained of significant diarrhoea for ten days. Dr S felt the clinical records were very brief and did not include a record of the presence or absence of blood in the stool or abdominal pain.

Dr S thought that the patient’s ongoing symptoms at this consultation required the identification of a causative organism and that a stool culture should have been arranged. It was his view that the failure to do so represented an unreasonable standard of care. He postulated that if a stool sample had been taken, this would have led to the causative organism being known within four to seven days.

The case was settled for a moderate sum.
Mr K was a 36-year-old man who ran a pub. Mr K smoked and drank heavily. Mr K’s dentist noticed a painless swelling on the right side of his neck during a routine check-up and asked him to see his GP. Mr K was seen by Dr A, one of the GPs at his surgery, who noted that Mr K was unsure how long the lump had been there, and referred him to the ENT outpatient department.

A letter came back to the practice confirming the presence of a lymph node in the anterior triangle of Mr K’s neck, which was felt to be innocuous. The plan was for Mr K to be reviewed in six weeks’ time and said if any investigations were to be pursued if the node was still present.

Mr K was busy at work and did not feel too concerned about the lump because it was not painful. He did not attend his follow-up appointment, and a letter stating this was sent from the hospital to his GP.

Eight months later, Mr K began to get some discomfort in the neck swelling so decided to see his GP again. This time he was seen by Dr B, who was the ENT surgeon at the surgery. Dr B noticed a swelling and also a history of chronic tonsillitis and one of the GPs had documented an examination of the mouth, tongue or throat. Dr B ordered a CT scan so that he could clearly see the node in his neck.

Mr K’s neck lump subsequently proved to be malignant. As a result he had to have neck surgery and resection of a primary in his tonsil. He had a course of radiotherapy and since has not had recurrence of his disease. Unfortunately he was left with shoulder weakness and a dry mouth, which he found difficult to cope with.

Mr K was angry with Dr B and felt that he caused a delay in his diagnosis. He brought a claim for negligence against Dr B because he felt the delay had necessitated more radical surgery, leaving him with debilitating symptoms.

EXPERT OPINION

Medical Protection sought the advice of an expert GP (Dr F). Dr F felt that Dr B bore liability for the delayed diagnosis. He was critical of Dr B’s history-taking and record-keeping.

Dr F commented that Dr B had responsibility for establishing the history of his previous referral to the surgical assessment unit. Had Dr B known of that referral, then the duration and the continuing nature of the lymph node would have necessitated immediate re-referral back to that team. Dr F also criticised Dr B’s inadequate examinations, stating that he should have documented an examination of the patient’s neck, mouth, tongue and throat.

The opinion of a professor of oto-rhinolaryngology (Professor Y) and head and neck surgery was also obtained. Professor Y commented that there was an earlier diagnosis in this case and the opinion of his team was that had Mr K been referred back then, the need for surgery may not have been as pronounced. Professor Y also stated that had there been a more complete examination of the neck, the presence of a lymph node would have been identified.

In addition, Professor Y considered that it may have been possible to spare radiotherapy if he had been treated earlier. The need for radiotherapy in this case was due to the size of the lymph node in the final specimen and the positive margins, which was evident following removal of the tumour.

Due to expert opinion finding Dr B to be in breach of his duty, the claim was settled for a high amount.

Mr P, a right-handed project manager, developed a stiff right elbow following a previous injury and had reached the limit of his progress with physiotherapy. X-rays showed degenerative changes and he was referred to an orthopaedic consultant, Mr A, who diagnosed osteoarthritis of his left elbow. He advised Mr P that as he had chronic anterior and posterior osteoarthritis, he may need multiple arthroscopic debridements to achieve a good outcome.

After an arthroscopic anterior debridement, there was still minimal improvement and further surgery was planned. There were another two debridements, the third one being more than six months after the initial procedure, before Mr A was happy with the result.

Two months later Mr P returned with a reduced range of movement in his elbow. X-rays confirmed the presence of massive heterotopic ossification (‘bone growth’), which was confirmed on CT. Mr A planned a fourth arthroscopic debridement two months later. No discussion relating to the risks and complications of surgery was documented. The limited operation note for this complex arthroscopic debridement described significant bone removal and a full range of movement at the end of the procedure.

In clinic two days later Mr P was noted to have a radial nerve palsy but Mr A felt that some nerve conduction was present and that this was a neuropaedic nerve injury, which should recover completely. He commented that the procedure had been lengthy at over an hour and ten minutes. Mr P returned two days later as there was no change in his symptoms, but Mr A was reassured by the presence of a positive Tinel’s test and felt the nerve palsy would recover. He planned for review in six weeks, which was then three months post-surgery, but again there was little improvement. Mr A commented that the positive Tinel’s could now be felt up to the fingertips. An appointment for three months later was made, but still there was no improvement.

Six months post-surgery, Mr A now requested nerve conduction studies, which were performed within six days, and reported the presence of a severe radial nerve injury. Plans were then made for surgical exploration of the nerve with possible repair, grafting or neurolysis as necessary.

Mr P made a claim against Mr A, stating that his nerve injury had left him with a permanent disability including restricted grip and manual dexterity, plus an inability to extend his fingers. He believed that the surgery should have been an open procedure rather than arthroscopic, and that had his injury been diagnosed sooner, and not presumed to be a neuropaedia, then he would have had a better outcome.

On review of the case, an expert felt that as long as Mr A had the necessary experience it was not negligent to carry out the surgery arthroscopically. There is still a risk of radial nerve injury when carrying out this surgery with an open technique. However, Mr A was found to be negligent in causing the nerve injury, keeping poor documentation, and delaying arraigning nerve conduction studies. The lack of any documented discussions about the risks of the surgery was also a factor in the outcome of the case.

The case was settled for a substantial sum.
Mrs Y, a 39-year-old chef, opted to see consultant obstetrician Mr B for private antenatal care. It was her first pregnancy and other than a BMI of 30 she had no previous medical problems. She was reviewed regularly throughout her pregnancy and noted to have elevated blood pressure through the first trimester, between 126/83 – 157/90. Methyldopa had been considered at 23 weeks but not initiated since a pre eclampsia screen was negative, and close monitoring continued.

At 36 weeks Mrs Y presented to the emergency department complaining of a headache and feeling generally unwell. Her BP was 170/120 and she was admitted to hospital. Two days later and provided telephone advice to continue antihypertensive medication. The following morning the decision was made to deliver by cesarean section on a semi-urgent basis, and Mrs Y gave birth to a healthy baby. She was discharged on oxprenolol to control her blood pressure.

A week following delivery Mrs Y continued to have elevated BP readings of 140/90. Mr B asked her to see GP Dr A. Dr A arranged a routine home visit two days later and found Mrs Y had a headache and a raised blood pressure of 180/90. He treated her with tolvaptal and made a diagnosis of a combination of biotinidase and isebutin.

Three days later Mrs Y was unchanged and Dr A visited her at home again. Her BP remained elevated at 160/90. He issued a New Mother's Health Handbook and wrote to consultant neurologist Dr D requesting a second opinion. He described her headaches as “severe” with some photophobia and dizziness and a degree of meningeal irritation from a small bleed versus a subarachnoid hemorrhage. He thought Mrs Y would have had the Cairo scan a confirmed a cerebral haemorrhage. She died four days later.

**EXPERT OPINION**

Experts were critical of Mr B, commenting that it was unacceptable for him to fail to visit Mrs Y when called by the ward team regarding her symptoms. Mrs Y’s persistently elevated BP warranted urgent management with half hourly BP and hourly urine output measurements, which Mr B should have initiated.

Dr A was also criticised by the experts, particularly regarding his consultation notes, which were lacking in a clear description of the headache and its associated symptoms. The BP was recorded but there was no evidence of any further examination including fundoscopy. The expert felt on the basis of the letter Dr A wrote requesting a second opinion, the patient was displaying red flag symptoms but a reasonably competent GP would have made arrangements to admit Mrs Y as an emergency to exclude intracranial haemorrhage.

Expert neurosurgeon Mr G commented that diagnosis was difficult to determine it was possible that Mrs Y could have had the cerebral haemorrhage before, during or after delivery. He noted that the hypertension during pregnancy could have been responsible for the development and subsequent rupture of the intracranial aneurysm. Mr G commented that although based on the information available there was no evidence that the outcome would have been different, earlier admission to hospital would have been preferable.

Mrs Y was a 27-year-old Romanian woman who lived with her husband in the UK, became pregnant and presented to her local GP surgery to commence antenatal care. Mrs S’s Y did not speak English and usually brought a family member with her to interpret. Mrs S’s presented to the emergency department at six weeks gestation and since she had previously suffered with a hydatidiform mole an early scan was carried out, which confirmed a viable pregnancy. Mrs S received IV hydration and was discharged with oral cyclizine to use if the vomiting persisted.

A month later, she was feeling better. The vomiting had resolved and she was no longer using the pessaries. She was discharged by GP Dr A, who noted “had Down’s scan, family member interpreter present, review at 16 weeks”.

Mrs S visited Romania for a holiday to see her family. While she was there she presented to hospital complaining of possible kidney problems with a secondary concern over recent foetal movements. Mrs S underwent a pelvic ultrasound scan, which appeared to have shown a growth on her right kidney. Mrs S also claimed she underwent a triple test at this point.

After returning to the UK, Mrs S attended her routine 16-week check with Dr A. The practice antenatal template was completed and Dr A ticked that the Down’s screening test had been done. A month later Mrs S visited the results of her Romanian triple test, which allegedly gave a risk of Down’s Syndrome of 1 in 67. Her combined test in the UK was much lower at 1 in 383. Based on her age, Mrs S had a background risk of 1.800 therefore a risk of 1.67 would represent a significantly increased risk.

Dr S reached term and gave birth to her son by emergency caesarean section due to fetal distress. The baby was born with Down’s Syndrome and patent ductus arteriosis and developed septicaemia and pulmonary hypertension.

Mrs S made a claim against Dr A, stating that she had been given false reassurance regarding her test results, which had also failed to be documented adequately in her notes. It was alleged that she had been referred to an obstetrician for amniocentesis, then she would have chosen to undergo a termination of pregnancy.

**EXPERT OPINION**

Expert GP Dr C maintained that Dr A’s standard of care did not fall below that expected of a GP. Dr C felt that Dr A was entitled to rely on the screening performed in the local secondary care setting, which indicated a low risk of Down’s Syndrome with no need for further investigations. Dr C’s account was that he was not told of the Romanian result, so was unable to take into consideration. Dr C maintained that it would have been prudent to refer if this conflict had been made clear, however, if this result had been available, given that it was carried out at 16 weeks – at a time when it would be less sensitive – it would have been reasonable for Dr A to have made a request for the local test to carried out at the appropriate time.
Mrs L, a teacher, was first prescribed the oral contraceptive pill, microgynon, by her GP, Dr F, when she was 23. Her blood pressure was taken and recorded as normal. At this time, no other mention was made in the records of her risk profile or family history. Later, Mrs L’s medical records showed that she had been queried on an ovary and then ovarectomy, but this was normal. There was no explanation why these changes were made. Mrs L was changed again to ovulen SG. The reasoning this time was due to “excessive bleeding on ovarenette.” At her review consultation, Mrs L’s blood pressure was taken and recorded as normal.

When she was 26, Mrs L was seen by her GP for antenatal care, where it was noted that she was smoking 20 cigarettes per day. Mrs L was pregnant again and before she changed to the combined pill.

Three years later, Mrs L consulted her GP as she was under significant stress. Her records showed that she had increased her smoking to 25 cigarettes per day and did not exercise. Counselling was offered, but she admitted she was still smoking. 50mg was prescribed and exercise was advised. In addition, a prescription for a combined contraceptive pill was also issued.

For the next six years, Mrs L was given repeat prescriptions of the microgynon without any record of her blood pressure being taken or her risk factors being assessed. Mrs L was now 35, but the records show that Dr F did not say whether she was still smoking, under a lot of stress, or whether or not she was still exercising.

Four months after her last repeat script, aged 35, Mrs L presented to the same practice with central chest pain and a second GP, Dr G, was seen. She had been under a lot of stress, but a few months before, she had been to the GP, and her blood pressure was stable. No further imaging was performed at this stage. The inflation device was exchanged for a syringe with a three-way tap to facilitate deflation of the balloon to the orthopaedic team. The right common femoral artery was accessed and at laparotomy a large retro-peritoneal haematoma was discovered secondary to a 2.5cm tear in the anterior aorta. The aorta was surgically repaired but after release of the clamps, Mrs S’s abdomen was severely injured and she died.

Mrs S was also reviewed by Mr B, consultant vascular surgeon, who planned to introduce an aortic balloon through the femoral artery prior to the tumour resection. If required, the balloon was to be inflated during the surgical resection in order to reduce blood loss. Mr B sought consent for aortic balloon occlusion and documented that the risks included “femoral artery injury, limb ischaemia and bleeding from rupture.” Separate consent was obtained by the orthopaedic team.

The case was settled for a substantial sum.
MISSED CRITICAL LIMB ISCHAEMIA

I don’t understand why the out-of-hours GP faced with rest pain in a foot he thought had circulation problems was not involved in the litigation. He missed the problem and failed to act properly by admitting straight away. I was left with the rather depressing notion after reading all the cases that we should not trust anyone.

It is interesting that the drive from the NHS is to be more streamlined and use records to improve contingency of care, and prevent patients having to repeat themselves at every point on their illness pathway — and yet the legal drive is to treat each appointment as an individual legal entity that will be judged in isolation.

Dr James A H Cave
Berkshire
UK

Response

Your assessment of the legal situation is quite right. Each professional involved in the care of a patient is responsible for their own actions, and can be held negligent for their actions or omissions. Every consultation will turn upon its own facts, and that will include what information the clinician has at hand, both from their own history and examination, and from any information in the records, or conveyed by others involved in the case.

Whether any individual has been negligent will depend on whether they have breached their duty of care, and whether the alleged injury was caused by or materially contributed to, by the breach of duty (causation).

The claimant and his or her legal advisers will determine which individual actions and decisions (which is responsible for the actions of all its staff), but for GPs or those in private practice the claim is usually aimed at individual clinicians.

It is sometimes the case that the defendant or defendants in a case will wish to bring additional parties into the case (again usually based on expert opinion), but would need good grounds for doing so.

In this case neither the claimant nor the defendant sought to involve the out-of-hours service, based on the above principles. I hope this helps clarify the issues you raise about this case.

A PROBLEM WITH POLYPS

LETTER 1

Thank you for another stimulating and informative Casebook. In the case ‘A problem with polyps’, you quote your GP expert as saying: “A digital rectal examination would have revealed the polyps and thus prompted a more timely referral.” Really? This suggests that your GP expert’s opinion is that rectal polyps are all detectable on DRE, which is hardly the case.

It seems to me that the crucial error in this case was failing to refer in the knowledge that another doctor had seen two rectal polyps and had recommended further investigation (even if this information came by an unconventional route). A normal DRE, while contributing to a comprehensive assessment, would not influence that decision.

It is difficult to see what Dr A could have learned from history or examination that would have trumped the clear recommendation from the overseas clinic. An element of irritation, perhaps understandable, at 5%’s deviation from standard procedure could have clouded Dr A’s judgement.

In most of your GP cases, I can identify with the doctors involved, to the extent that I can envisage circumstances where I might have acted as the involved doctor did, and this is the great value of Casebook: this was not such a case.

Dr Aidan Finnegan
Waterford
Ireland

Response

Thank you for contacting us with your comments on this case.

Upon looking more closely at this case, the view of the expert GP was not that all polyps are detectable on DRE — they are not — but that, on the facts of this particular case, a DRE would have detected them. This view was echoed by the comments of our other expert, a professor of colorectal surgery.

On reflection, we could perhaps have made this clearer in the narrative. Thank you once again for drawing my attention to this point.

A PROBLEM WITH POLYPS

LETTER 2

I always enjoy reading Casebook and have often thought: “there but for the grace of God…”

However, reading the report “A problem with polyps”, I do find it extraordinary that MPS took this case to court. In the first paragraph a colonoscopy was properly recommended. Not arranging this is, to my mind, completely irresponsible, and the professor’s comment about repeating the rectal examination just ignores the previous proctoscopic findings. The patient’s lawyers must have enjoyed the grace of God…"

A B Richards
Tedley
UK

Response

I regret to say that this is an error on our part, and that this case did not, in fact, go to court. It was settled without matters going this far – as you correctly point out, there was no doubt that an error had been made by Dr A.

I am not entirely sure how our mistake slipped through but we will correct our online version.

Thank-you for your email. We have discussed your comments with the author of the case report in question.

He has confirmed that the oxygen range quoted was from guidelines issued in 2010 and that a more recent meta-analysis has found that the lower range of oxygen saturations are associated with higher mortality at a later stage.

We are happy to correct this point and would like to thank you for your helpful comments.

TOO MUCH OXYGEN

I read with interest your case report of an extremely preterm baby with high oxygen saturations, who was not screened for retinopathy of prematurity (ROP) and who subsequently developed severe ROP, causing blindness.

However, the learning point that safe levels of oxygen saturation in low birth weight infants are between 86-92% is incorrect. In two large, multi-centre trials a targeted oxygen saturation level of 85-89% increased infant mortality compared with an oxygen saturation target level of 91-95%.

While the incidence of ROP was lower with lower oxygen saturation target levels, this does not outweigh the increased risk of babies dying. It is recommended that extremely preterm babies should have target oxygen saturations levels between 91-95%.

Dr Jane Atsweiler
Neonatal paediatrician
Auckland
New Zealand

Response

Thank you for your email. We have discussed your comments with the author of the case report in question.

He has confirmed that the oxygen range quoted was from guidelines issued in 2010 and that a more recent meta-analysis has found that the lower range of oxygen saturations are associated with higher mortality at a later stage.

We are happy to correct this point and would like to thank you for your helpful comments.

REFERENCES

ESTABLISHING, MANAGING AND PROTECTING YOUR ONLINE REPUTATION – A SOCIAL MEDIA GUIDE FOR PHYSICIANS AND MEDICAL PRACTICES

by Kevin Pho and Susan Gay

How social media savvy are you? If you are a medical student, the chances are that you are online more or less permanently. If, like me, you are a practising doctor who qualified in the last century (read ‘dinosaur’), you might be a bit less comfortable. I’ve been using computers since you could measure the pixels with a ruler, and I carry my smartphone as if it were grafted onto my hand, but even I admit I am feeling a little left behind by the social media tsunami that has arisen around us. Social media is becoming increasingly popular among doctors and patients alike.

Where clear ethical and behavioural boundaries are well-established in traditional face-to-face relationships, the online community has developed so rapidly that the medical profession is finding itself in uncharted waters. How do you respond when a patient wants to “friend” you on Facebook? Or when someone harshly criticises your doctoring on a public forum?

My organisation has released guidelines about how to behave online, but they are a series of don’ts. Don’t publish pictures of yourself drunkenly incapacitated on your Facebook page, where employers and patients can see them.

Into this environment come Kevin Pho and Susan Gay, with their book, Establishing, Managing and Protecting your Online Reputation. Pho is himself a doctor, writing for doctors, which gives him immediate authority. His blog, www.kevinmd.com, is well-known and successful.

The central theme of the book is that doctors’ online reputation is just as important as their real-life one. Whether we like it or not, our basic information is already out there, but we usually don’t take any ownership of it. Done properly, we can establish and cultivate an online reputation, which can be professionally and personally rewarding. In short, we can use social media to our professional advantage. To quote: “First, do no harm; second, get an online profile.” Rather than don’ts, this book is full of dos.

The book is informal and readable, and covers the absolute basics well: techno-novices need have no fear. My main criticism is the book’s overwhelmingly American perspective. Patterns of work and ethos of practice are very different where I work, and I don’t need to build myself – or my practice – as a brand, or attract my paying customers. Social media is here to stay, and need not be a threat. We can ignore it, or use it to our advantage, and this book goes a long way toward telling us how.

I’LL SEE MYSELF OUT, THANK YOU: THIRTY PERSONAL VIEWS IN SUPPORT OF ASSISTED SUICIDE

Edited by Colin Brewer and Michael Irwin

Reviewed by Dr Ellen Welch – GP, London

Following the recent rejection of the Assisted Dying Bill in the UK House of Commons by an overwhelming majority of 330 against to 118 in favour, this collection of essays in support of the issue provides the reader with some of the key arguments in the debate for the legalisation of what the authors term medically assisted rational suicide (MARS).

The book has been compiled by former psychiatrist Colin Brewer and former medical director of the United Nations Michael Irwin, with essays contributed by doctors, priests, politicians, philosophers and, most poignantly, from people suffering with terminal illness.

The writers discuss the facts and the law surrounding the subject in both the UK and overseas, with both ethical and religious perspective offered. Dignitas writes a chapter on their experiences in Switzerland over the last 16 years of their existence. And a chapter is dedicated to palliative care – both its promises and its limitations.

Perhaps the most thought-provoking stories come from people who have been faced with the reality of a painful, undignified death. They tell of their struggle, their pain, the frustration that they feel in a life they no longer want to live, but are unable to end. Several quotes are given from the 2014 House of Lords debate which sum up some of the main arguments.

A major limitation of this book is that it only presents one side of the argument on the debate and it would certainly provide more of a balanced read if there had been contributors from those who oppose assisted dying. Whatever your view may be, it does provide an interesting and comprehensive read in support of the issue.
DOWNLOAD THE MEDICAL PROTECTION PUBLICATIONS APP TO ACCESS OUR RANGE OF JOURNALS ON YOUR TABLET DEVICE
How to contact us

**MEDICAL PROTECTION**

33 Cavendish Square
London, W1G 0PS
United Kingdom

[medicalprotection.org](http://medicalprotection.org)

Please direct all comments, questions or suggestions about our service, policy and operations to:

Chief Executive
Medical Protection Society
33 Cavendish Square
London W1G 0PS
United Kingdom

info@medicalprotection.org

In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

**UK MEDICO LEGAL ADVICE**

Tel 0800 561 9090
Fax 0113 241 0500
querydoc@medicalprotection.org

**UK MEMBERSHIP ENQUIRIES**

Tel 0800 561 9000
Fax 0113 241 0500
member.help@medicalprotection.org

MPS is the world’s leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Our benefits include access to indemnity, expert advice and peace of mind. Highly qualified advisers are on hand to talk through a question or concern at any time.

The Medical Protection Society Limited (MPS) is a company limited by guarantee registered in England with company number 36142 at 33 Cavendish Square, London, W1G 0PS.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association. MPS is a registered trademark and ‘Medical Protection’ is a trading name of MPS.