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His edition of Casebook is one of welcomes and farewells. Dr Pardeep Sandhu is the new executive director of your professional services division, where he will be responsible for maintaining and building on the quality of the medicolegal advice and legal support that is available to you.

The appointment is a considerable boost to our aim of providing you with world class service. You can read more about Dr Sandhu on page 5, but in summary he brings with him many years’ experience of working within diverse healthcare environments around the world, and he has also worked extensively with governments to advise on health policy and clinical governance – something that is becoming increasingly important to Medical Protection as we seek to shape the clinical negligence landscape in many countries in which we have members.

This edition of Casebook contains, as ever, our latest collection of case reports. Along with the usual salient learning points – and in this edition there is a general theme on the value of good record-keeping – you will also be interested to note some successful defences. As well as demonstrating the value of the Medical Protection legal expertise available to you, these cases also show how the clinicians involved were able to help their own position, be it through excellent documentation, a robust consent process or an articulate presentation of evidence at trial.

I mentioned at the beginning of this editorial that this edition of Casebook was one of welcomes and farewells. This is my last edition as editor-in-chief of Casebook, as I am moving into a new role within Medical Protection. I have greatly enjoyed my time in the position, especially as it has given me so many opportunities to hear your views on how we can improve our services. I am happy to announce that Dr Marika Davies will be taking on the role, please do get in touch with any comments or suggestions that you wish Dr Davies to take on board.

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 a GP before serving as a clinical advisor 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. Of particular interest to me is the challenge of building on our established expertise to deliver an even better service to our members. Of particular interest to me is the challenge of building on their established expertise to deliver an even better service to our members. We work in an increasingly challenging environment and one in which litigation, complaints and appearances before the regulator are now becoming more common. Dr Sandhu will head up a large team of more than 250 medical, dental and legal experts providing members with advice, support and protection tailored to their circumstances.

“He will also play a critical role as part of the Executive Committee, providing direction across the whole organisation. With his international experience and background as a physicist and senior healthcare executive, Dr Sandhu will help strengthen our position as a world-class protection organisation.”

Dr Sandhu said: “I am very excited to be joining a team of such talented individuals, and look forward to building on their established expertise to deliver an even better service to our members. 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 I 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.”

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Dr Nick Clements
Casebook editor-in-chief

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.
The event, which took place on 5 September, provided an opportunity for delegates to walk through the current challenges and complaints landscape in Singapore. It was hosted at Farrer Park Conference Centre, a state of the art conference space attached to a purpose built hospital and medical centre that was opened in 2014.

The conference was the finale to a wider trip across Hong Kong and Singapore, which included a number of stakeholder meetings and receptions, and expert training for members in Hong Kong.

The conference was broken down into five main themes:

• The changing medicolegal landscape
• The doctor as a professional
• Challenges of new communication and information technology
• Increasing public interest and scrutiny
• Medico-legal and ethical issues.

The conference concluded with a panel discussion where a number of anonymous real life cases. These included situations where doctors had breached patient confidentiality on Facebook, Twitter and WhatsApp. At the end of Dr Bradshaw’s session, the audience was asked to vote on whether or not doctors can be safe on Facebook, with the audience overwhelmingly voting red – no!

Shelley McNicoll, director of communications and policy at Medical Protection, spoke about the internet and social media, covering some of the pitfalls for doctors and referring to a number of anonymised real life cases. These included situations where doctors had breached patient confidentiality on Facebook, Twitter and WhatsApp. At the end of Dr Bradshaw’s session, the audience was asked to vote on whether or not doctors can be safe on Facebook, with the audience overwhelmingly voting red – no!

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RED FLAGS: CASE A

- Multiple surgeries
- Other clinicians refusing to operate
- The patient’s unfounded criticisms of other doctors
- Patient’s demands on Mr P
- Fixation on surgery being the solution

In some cases a patient’s expectations that are apparent from the outset as being unrealistic are not actively managed, and this can lead to the doctor facing unfair complaints.

CASE B

Mr C, 65 years old, was diagnosed with bilateral cataracts and referred for surgical removal. He had been short-sighted all his life and stated that he was told that the operation would leave him free of glasses, which he was very happy about. Mr F explained that while he would aim for emmetropia (20/20 vision) he could not guarantee this. Mr C was excited about the prospect of not having to wear glasses all the time and explained this to the clinic’s optometrists who took his measurements for the surgery.

On the day of surgery Mr F reconfirmed that while he hoped Mr C would not need glasses again; there was a possibility of over or under correction – Mr C did not seem to appreciate that the primary purpose of the surgery was to remove the cataract.

Mr C later rang Mr F’s clinic, angrily stating that he could not see properly and that the surgery had failed. When seen by Mr F it was noted that the patient was able to see well without glasses but that his right eye was slightly under corrected, and this was causing a blurring of his vision as this was the dominant eye. He had been advised by an optometrist that he should consider glasses. Mr C was very aggressive, stating that the surgery had been performed negligently and demanded his money back and cover for the future cost of glasses.

Despite Mr F showing Mr C the consent form, which included the risk of over or under correction, the patient remained dissatisfied and complained to the local consumer council. It was apparent that the patient had been told of the risks and agreed to them, and that to all intents and purposes the surgery had achieved the primary aim of cataract removal. The complaint was dismissed.

Mr F had further opportunities to address this issue and be firmer about his advice, and to clearly document the patient’s desire to not wear glasses.

CASE C

A 23-year-old patient, Miss V, attended Mr G’s clinic seeking a rhinoplasty and fat removal.

She explained to theatre staff that he would be saving a fortune now that he didn’t have to purchase glasses.

Mr G consulted with Miss V and told her that he could make her nose smaller.

The procedure was uneventful and Miss V initially appeared happy. A month later she returned, stating that she had some scarring and that she was upset with the cosmetic outcome. Mr G showed her before and after pictures to demonstrate the difference in appearance. Miss V agreed that the look had improved but she was annoyed that it didn’t look like Zhang Ziyi, and there was some scarring that had left a small pigmented area. Miss V had been rejected by modelling agencies and blamed Mr G for not doing the operation as she requested.

In this instance, Mr G had not clearly explained the risk of scarring although minimal in this case, it was a material risk to the patient and Mr G knew Miss V wanted to be a model. Medical Protection had to settle the case at a moderate amount.

CONCLUSION

Doctors must be alive to the fact that patients may have unrealistic expectations of what can be achieved from medical intervention. If you are concerned that a patient has not appreciated the limitations of treatment, it is important to document the discussions in as much detail as possible within the medical record. It may be helpful to suggest that they return with family members for further discussions.

You may also want to be very direct and ask the patient what they are expecting from the consultation. You may want to offer them a second opinion, discuss the case with colleagues or simply conclude that you are unable to treat them. With cosmetic procedures, where the patient may be vulnerable or have had multiple surgeries, consideration may be given to psychological input or support.

Most importantly, you should never feel pressured by the patient into embarking on a course of treatment or intervention that you do not believe is necessarily in the patient’s best interest, or where the outcome may not satisfy the patient’s expectation.

The three cases in this article are based on real Medical Protection cases, but some facts and details have been altered to preserve confidentiality.
HOW TO BE...AN EXPERT WITNESS

Gareth Gillespie looks at what it takes to be an expert witness

WHAT IS AN EXPERT WITNESS?

An expert witness is hired based on their expertise – education, training, skill or experience (or all four) – in a particular subject. This specialist knowledge is relied upon when they are asked to provide an expert opinion on the facts of a case.

Above all an expert witness must maintain the confidentiality of any information they receive on the case – resist the temptation to discuss it with colleagues – and must be:

- Impartial – the expert witness must only comment on the facts they know about, and must not speculate. Opinions must be based on the facts only and should not be preferential or disparaging towards any doctor involved.
- Competent – an expert witness should not stray outside the boundaries of their own expertise.
- Adequately trained to understand: their duty to the court – appropriate standard of proof – rules of the court – the litigation process and pre-action protocol – how to prepare an expert report – how to give oral evidence in court.

If you are instructed to act as an expert witness, ensure you read the instructions fully and consider:

- Who is instructing me?
- In what capacity am I being asked to provide a report? Clarify it is as an expert witness
- Am I the right person to do this report?
- In what capacity am I being asked to provide a report? Clarify it is as an expert witness.
- Is there a conflict? Do I know the doctor involved, or perhaps the patient or close family?
- Do I have the time?

The last point is particularly important, because expert witness work is not solely writing a report. Accepting instructions to be an expert witness means you are committing to a range of other duties, which can involve:

- Attending meetings with solicitors or doctors involved
- Attending meetings with other experts
- Attending court. You may be cross-examined about your expert evidence and this can be daunting. You must be alert to the possibility of being summoned to court – there is no ‘opting out’ because it may seem unappealing.

THE ROLE OF AN EXPERT

An expert witness can be involved in various scenarios:

1) Medical Council disciplinary hearings

This depends on the charge against the doctor, usually no expert is needed for hearings concerning dangerous drugs records, prescription labelling, sick leave certificate management, or practice promotion. An expert may be needed for situations involving informed consent issues, management decisions, unconventional treatment, ‘over-service’, and indecent assault.

2) Coroner’s inquest

Here the role of expert is to:

- Give an opinion on the medical cause of death and management issues, on the basis of available evidence – medical records/reports, autopsy report, witness statements
- Make suggestions to prevent future risks: identify any errors in the system, without opining on an individual doctor’s clinical judgment/decision.

3) Personal injury claims and mediation

- Expert opinion required to ascertain position in negligence (ie, whether there was breach of duty or causation)
- Experts can also examine patients to give opinion on condition and prognosis, which lawyers use to decide the value of any payout (this often involves orthopaedic surgeons, neurologists or psychiatrists, etc).

4) Test of testamentary capacity

Expert to give opinion on whether the testator:

- understood the nature of the act and its effects
- understood the extent of the property being disposed of
- is of sufficiently sound mind to be capable of forming the testamentary intentions embodied in the will
- is affected by any disorder or disease of the mind which would influence his decisions.

HONG KONG

Experts have an overriding duty to the court to help on matters within their expertise. The duty to the court overrides any duty to the person who has instructed him/her or pays him/her. Order 38, Rule 35A, Rules of the High Court (Cap 4)

SINGAPORE

Supreme Court of Judicature Act, Rules of Court (2006), Order 40 and 40A provides for the rules on experts in Singapore.

MALAYSIA

It is the duty of an expert to assist the court on the matters within his expertise. This duty overrides any obligation to the person from whom he has received instructions or by whom he is paid. Order 40A, Rule 2, Rules of Court 2012

Continued...
FEATURE

• “This is a recognised treatment option which is well documented in the literature [no references].”

• “The patient’s version of events is barely credible…”

• The concluding paragraph, summarising the opinions reached and concluding with a statement of truth.

What not to say...

• “The patient’s version of events is barely credible…”

• “This is a recognised treatment option which is well documented in the literature (no references)”

• “Dr Y is clearly not guilty of negligence…”

EXPERT IMMUNITY

Experts are not immune from sanctions themselves. In the UK, the case Meadow v General Medical Council (2006) CA saw Professor Roy Meadow’s evidence at a murder trial subsequently found to be “seriously flawed”. The defendant, who had initially been convicted, appealed and was acquitted, while a complaint was lodged about Professor Meadow to the UK’s General Medical Council (GMC). He was found guilty of misconduct and erased from the medical register; although further appeals saw this decision overturned, Professor Meadow voluntarily relinquished his registration in 2009.

In 2011, the case Jones v Kaney concluded with the UK Supreme Court decision that experts were no longer entitled to immunity from claims in negligence. The case involved a motorcyclist, Paul Jones, injured by a car. An expert he instructed, the clinical psychologist Sue Kaney, changed her mind about whether he had suffered post-traumatic stress, which resulted in Mr Jones receiving less compensation—and so he sued Miss Kaney. In doing so, the Supreme Court made its landmark ruling to remove expert immunity from negligence claims.

CASE 1: MRS A

Mrs A opted to undergo facelift surgery. Dr B was the consultant anaesthetist for the procedure and used a throat pack in order to stabilise Mrs A’s airway.

The WHO Checklist Sign-in was performed and the surgery proceeded uneventfully. However, the WHO Checklist Sign-out did not take place. Dr B reversed muscle paralysis, applied suction to the airway and intubated Mrs A. Dr B would usually perform a laryngoscopy at this point but did not on this occasion, as it was difficult to open the patient’s mouth.

Mrs A was handed over to the recovery staff where slightly obstructed respiratory movements were noted. Dr B attributed these symptoms to emergence delirium, and therefore inserted a nasopharyngeal airway. On examination around 20 minutes later, Mrs A was awake, the artificial airway had been removed and she indicated to Dr B that she was not in any discomfort.

Around three further hours passed before the throat pack was discovered, during which time she experienced significant respiratory distress. The throat pack was removed and Mrs A made a full recovery.

Mrs A was referred to the Singapore Medical Council, where she became the subject of a fitness-to-practise hearing in November 2014. It was determined that Dr B should be warned.

CASE 2: MISS C

Miss C was admitted to hospital for the routine excision of a benign palatal lump. Dr D was the anaesthetist for the procedure, although it was the first time that he had worked in this hospital.

There were three cases on the list that afternoon. A briefing took place before the list started, and the WHO Checklist Sign-in was performed. The insertion of the throat pack 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 the junior surgical doctor. 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.

On removal of the LMA around 35 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 team communication to eradicate avoidable risks, such as retained throat packs. Proper usage of the Checklist requires the following:

- At three phases of the list must be performed: Sign-in, Time out, Sign-out
- The anaesthetist must be present for all three 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 surgeon.
- 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.

XPERT REPORTS

A comprehensive guide to writing expert reports is available in the advice section on medicalprotection.org.

• A little page
• The author’s personal details, name, current post and summary of previous experience
• Statement of the opinion asked to provide and details of relevant knowledge/experience enabling the author to comment on the issues
• List of documentation considered and relied upon in reaching the opinion on the case
• Chronology and summary of the relevant evidence
• Details of any examination undertaken or any other investigations performed
• The opinion — including your reasons, with evidence
• The concluding paragraph, summarising the opinions reached and concluding with a statement of truth.

FEATURE

RETIRED THROAT PACKS

Medicolegal advisers Dr Helen Hartley and Professor Carol Seymour examine two recent Medical Protection cases, which demonstrate that the risk of retained throat packs has survived the introduction of the WHO checklist.

CASEBOOK | VOLUME 23 ISSUE 2 | NOVEMBER 2015 | medicalprotection.org
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:
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.
Miss F, an 18-year-old university student, had been taking the combined oral contraceptive pill microgynon for 18 months for dysmenorrhea. When she presented to her GP, Dr K, worried about acne on her back, Miss F had heard from her flatmate that dienette is a better pill to take for acne than microgynon and wanted to give it a try. Dr K recorded that Miss F was a non-smoker with a normal BMI and BP and switched her pill to dienette, advising her to start it when her microgynon cycle finished in another fortnight.

Two weeks after commencing the dienette, Miss F was rushed into hospital with sudden onset chest pain, shock, and respiratory 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 speed of processing information. Three more months later, Miss F was discharged from physiotherapy and occupational therapy. Miss F was discharged with no focal limb deficits and the cerebral bleed to be a result of the 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 speed of processing information.

Dr E, expert consultant in pharmacology, was also supportive of Dr K, stating that although there is probably an increased risk of VTE with dienette, 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 closely linked to switched contraception; however, on the balance of probabilities, she was likely to have still suffered the massive PE that led to her suffering axonic brain damage.

Dr E, expert consultant in pharmacology, was also supportive of Dr K, stating that although there is probably an increased risk of VTE with dienette, 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 closely linked to switched contraception; however, on the balance of probabilities, she was likely to have still suffered the massive PE that led to her suffering axonic brain damage.

Miss F 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 at 37.7°C. She guessed it was most likely to be soft and non-tender. Dr A prescribed some paracetamol and co-phenotrope and advised her to return if there was no improvement.

Dr B waited for a week but she began to feel worse – she was so nauseous 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 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’s daughter to school, then took 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, this was recorded in the notes. He admitted her to hospital with possible enteritis or malaria.

Mrs B was investigated in hospital with thick and sticky films, blood cultures, and a stool culture. Mrs B was commenced on empirical oral ciprofloxacin and intravenous fluids. An early report from the microbiologists stated that her blood cultures had grown a gram negative rod, likely to be salmonella and that ciprofloxacin was the appropriate therapy. After two days of treatment Mrs B refused to take any more tablets because her nausea was so severe and she was commenced on intravenous ciprofloxacin.

The following day Mrs B had a cardiac arrest and despite adrenaline and DC cardioversion she died. A postmortem report showed she had died of a gram negative septicemia and gastroenteritis with salmonella paratyphi A.

Mrs B’s family were devastated and made a claim against Dr A. They felt that her death could have been avoided. A claim investigator and treated her diarrhoea earlier.

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 had 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 innocent. The plan was for Mr K to be reviewed in six weeks' time and significant delay in follow-up 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 to 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. Dr B noted Mr K's pain and swelling and also a history of chronic systemic Raynaud's phenomenon. Dr B did not document his previous referral to the ENT department regarding the same lump or any mention of any significant delay in follow-up. In his brief examination notes, Dr B described Mr K's pain as "intermittent chronic right sided neck swelling in the preauricular and submandibular area". There was no mention of any previous referral in his letter. Dr B documented a differential diagnosis of a possible parotid lesion or salivary gland stone.

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 of negligence against Dr B because he felt the delay had necessitated more radical surgery, leaving him with debilitating symptoms.

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 elbow. He advised Mr P that as he had significant anterior and posterior osteoarthritis he may need multiple arthroscopic debridements to achieve a good outcome.

After an arthroscopic anterior debridement, there was no 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 (new bone growth), which was confirmed on CT. Mr A planned a fourth arthroscopic debridement two months later. No discussion relating to the possible 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 ten 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 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.

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 failing to ensure a proper 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.
Ms Y, a 32-year-old Romanian patient living with her husband in the UK, became pregnant and presented to her local GP surgery to commence antenatal care. Ms Y’s blood pressure was persistently elevated at 160/90. G was asked to review her, as she had a history of hypertension. Ms Y visited Dr A at home again. Her BP was recorded but it was not documented. Ms Y was discharged on an outpatient basis and close monitoring continued.

Learning points

- It is important to have back-up options in place for patients who do not speak the same language.
- If you cannot understand a patient’s history or symptoms, you should not provide medical care.
- It is important to try to use an interpreter when a patient does not speak the same language.
- Patients who undergo investigations overseas often return home for ongoing care and you may be asked to provide a second opinion.

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. Her BP was followed closely for the next 2 days and it remained elevated at 160/90. Methyldopa was considered at 23 weeks but not initiated as a trial. Mrs Y gave birth to a healthy son. She was discharged on an urgent basis, and Mrs Y was given the option of a Caesarean section on a semi-urgent basis, and Mrs Y gave birth to a healthy son. She was discharged from hospital and remained well.

A week following delivery Mrs Y continued to monitor her BP and was referred to the hospital’s high-dependency unit. She was reviewed regularly throughout the postnatal period. Mrs Y had no pre-existing medical problems.

The following morning, with no relief of her symptoms, Mrs Y was admitted to hospital. She was discharged on an outpatient basis and close monitoring continued.

Learning points

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Mrs Y had a headache and a raised blood pressure with proteinuria in spite of ongoing antihypertensive therapy. Mr B was contacted by the ward team and provided telephone advice to continue antihypertensives. The following morning the decision was made to deliver Mrs Y by Caesarean section on a semi-urgent basis, according to the hospital’s high-dependency unit. Mrs Y was discharged on an outpatient basis and she continued to monitor her BP through the first trimester, between 126/83 – 157/90. Methyldopa was considered at 23 weeks but not initiated as a trial. Mrs Y gave birth to a healthy son. She was discharged from hospital and remained well.

A second opinion. He described her headaches as “vigorous” with some neck stiffness. Mrs Y was discharged on oral antihypertensives and a combination of bisoprolol and irbesartan.

Ms S underwent a pelvic ultrasound scan, which appeared to show a growth on her right kidney. Ms S also claimed she underwent a triple test at 16 weeks.

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- Patients who undergo investigations overseas often return home for ongoing care and you may be asked to provide a second opinion.
Mrs L, a teacher, was first prescribed the oral contraceptive pill microgynon by her GP Dr G, when she was 26. 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 was changed to ovran and then ovranette, but there was no explanation why these changes were made. Mrs L was changed again to ovulan 50. The reasoning this time was due to “excessive bleeding on ovranette”. 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 recorded that she smoked one pack of cigarettes a day. Her blood pressure was recorded as normal. After her first child had been born, Mrs L was prescribed minulet, before she changed to the combined pill.

Four months after her last repeat script, Mrs L was reviewed consultation, Mrs L’s blood pressure was recorded as normal. At this time, no mention was made in the records of anxiety or depression. Later Mrs L’s medical records showed that she was changed to progesterone-only pill or at least have warned Mrs L of the increased risks in order that she could have considered the alternative options. Mrs L’s notes show that the practice knew of Mrs L’s family history and her smoking, but despite these risks continued to prescribe the pill.

The case was settled for a substantial sum.

**EXPERT OPINION**

Expert opinion found that a reasonably competent GP would have stopped prescribing microgynon from the age of 35 onwards and changed Mrs L to a progesterone-only pill or at least have warned Mrs L of the increased risks in order that she could have considered the alternative options. Mrs L’s notes show that the practice knew of Mrs L’s family history and her smoking, but despite these risks continued to prescribe the pill.

The case was settled for a substantial sum.

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Mrs S was a 36-year-old patient diagnosed with a benign giant cell tumour of the sacrum. She was seen by Mr A, consultant in orthopaedic oncology, and listed for resection of the lesion. Prior to surgery Mrs S underwent preoperative embolisation.

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 would 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.

Surgery was initially performed in the supine position to allow access to the femoral vessels. The right common femoral artery was cannulated and a 6Fr sheath inserted. This was exchanged for a 14Fr sheath under radiological control. A 40mm aortic balloon was introduced to the level of L3, its position being confirmed in fluoroscopy.

Mrs S was then turned to the prone position to allow tumour resection. The balloon position was re-imaged and found to be unchanged. Mr B left the operating theatre.

After two hours, Mr B was called back to the theatre to inflate the aortic balloon as haemostasis was required. The balloon was inflated by Mr B using an inflation device. Haemostasis was improved and the blood pressure stable. No further imaging was performed. 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.

Mr B received a telephone call to inform him the operation was finishing and he should return in order to remove the sheath and aortic balloon. Prior to him arriving at the operating theatre, the patient suffered a cardiac arrest and CPR was commenced.

Mrs S had an unrecorded blood pressure 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 suffered a further cardiac arrest and died.

Mrs S’s family made a claim against Mr B. It was alleged that consent was inadequate as the risk of death was not specifically mentioned. It was also alleged that the aortic balloon used was inappropriate and that it was inappropriate to inflate the balloon without radiological guidance. In addition, it was alleged that delegation of the deflation of the balloon to the orthopaedic team was unacceptable.

**EXPERT OPINION**

Medical Protection sought an expert vascular surgery opinion from Professor T. Although the risk of vessel rupture and bleeding was discussed, he was critical of the failure to warn of the small risk of death from aortic balloon inflation.

Whilst acknowledging that re-inflating the aortic balloon without guidance may have been acceptable as a last-ditch effort to save the patient’s life under extreme circumstances, the decision to initially inflate the balloon without radiological guidance and to delegate deflation to the orthopaedic team was also critiqued.

The case was settled for a high 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 problem 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 continuity 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 individuals to claim against, based on their understanding of the facts and the opinion of their experts. Of course in the case of an NHS hospital, the claim will be against the organisation itself (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 inertia, perhaps understandable, at 95%’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 wrongly 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 case at great legal expense to MPS.

A B Richards
Tadley
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 getting in touch and drawing our attention to it.

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 Alsweiler
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

Dr Aidan O’Donnell, consultant anaesthetist, New Zealand

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.
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