The ACCUSED

One doctor’s account of his trial by media

A PERSONAL FAILURE
Dr Dan Cohen on his own shortfall in reliability

CORPORATE INDEMNITY: ARE YOU PROTECTED?
Read two cases that underline its importance

OVER TO YOU
The place to debate hot topics

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Welcome

Dr Nick Clements – Editor-in-chief

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

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

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

Dr Bown worked at MPS for 19 years, beginning as a medicolegal adviser and becoming head of the Medical Services department in London soon after; this after spending more than 12 years as a doctor in acute hospital medicine, then obstetrics and gynaecology before moving into general practice. Dr Bown combined her editorial duties on Casebook and other MPS publications with high-profile external affairs work.

So it is with slight trepidation but great relish that I step into Dr Bown’s shoes, and build on her success with Casebook. Of course, I must also pay tribute to my predecessor Dr Stephanie Bown, who left MPS in February to become Director of the National Clinical Assessment Service (NCAS). Dr Bown has been involved with Casebook since the May 2006 issue, and oversaw numerous successful design upgrades and a renewed focus on producing truly topical content for all of our six regional editions.

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So it is with slight trepidation but great relish that I step into Dr Bown’s shoes, and build on her success with Casebook. My role as Head of Medical Services in the UK will continue, and I will try to use this experience to develop thought-provoking content that will be stimulating, informative and directly relevant to today’s doctor, wherever in the world you practise.

The keen-eyed among you will have spotted my name in Casebook before, so I am not entirely new to the magazine – in addition to occasionally introducing each edition’s collection of case reports, I have been on the editorial board for a number of years, helping to maintain the accuracy and educational value of each issue.

One thing will not change – and that is we continue to encourage your feedback, opinions and suggestions after each edition. Perhaps I will speak to some of you personally on our advice line…

The ACCUSED

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

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

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

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

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

Continued on page 6 >>
Investigation

We asked the patient to give consent so that we could send the complaint to be investigated thoroughly and in an unbiased way by the PCT (Primary Care Trust). After a delay the records were shared and I gave my witness statement. The local PCT determined that I should have a chaperone for every female consultation while the investigation was underway.

In spite of numerous attempts, Mrs B failed to engage with the PCT to give her version of events. The PCT felt they had no choice but to refer the case to the General Medical Council (GMC).

The GMC held an interim order panel meeting. Accompanied by an MPS solicitor, the panel listened to our case. They applied conditions to my registration that I was to have a chaperone for every intimate female examination, and to log each examination. The GMC’s investigation took more than a year to complete and a hearing date was set, 18 months after the initial allegation.

The hearing

The first day of the hearing didn’t go to plan. I arrived all geared up to defend my corner, but Mrs B did not turn up, so it was adjourned until the following day. When the hearing did commence Mrs B gave a witness statement, and there was a submission from my MPS-instructed barrister, then the panel went away to decide the next course of action. The next day the panel gave their decision that they found the allegation untrue, and the case was concluded.

Personal impact

The experience of having a patient make an unfounded allegation against you is devastating. I would not wish it on my worst enemy. The insecurity you feel day in and day out is worse than physical pain. There were days where I could not see any light at the end of the tunnel, like my head was under a guillotine. My mind was fractured. I kept thinking ‘why me, why did this happen to me?’

As a doctor this experience was earth-shattering: it’s the worst thing to be accused of – an allegation of sexual motivation; how can you prove you were acting appropriately? It’s their word against yours. If the GMC had found in Mrs B’s favour, my licence, my livelihood, my marriage, my social standing would have been demolished just like that.

During the investigation I went to work as normal. Every day I had to face the stigma around me of what I had allegedly done.

Impact on the practice

It was particularly hard on the practice, having to have a chaperone from beginning to end. We were not just employing a GP; but two healthcare professionals at the same time. This had huge financial and logistical implications for the practice. Not being a big practice we don’t have many nurses or staff, so it was difficult.

We had to consider the future of the business; if I were to be found guilty and forced to leave, how would the practice cope?

Handling the media was not something I really considered. I’d definitely never thought about being on the front page of a national newspaper.

Media coverage

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

Even abroad, it was all over the internet. The pressure was huge and so upsetting. My name was exposed, I’d lost my anonymity – I was breakfast gossip. There was a sense of bias – why was I stripped of my anonymity when the person who made the allegations enjoyed full anonymity? The media coverage added salt to my wounds.

Support

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

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

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

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

Legal opinion

By Dr Jo Galvin, MPS medicolegal adviser, who handled the case.

Unfortunately this case is not an isolated one. Mrs B came to the practice specifically asking for her chest to be examined thoroughly. During the examination she perceived that the actions of the GP in question, whom I shall refer to as Dr Z, were sexually motivated. Dr Z said that when he examined her, he explained what he was going to do and explained the depth and pattern of the breathing.

His situation was compounded when he locked the door to preserve her confidentiality, as the door had recently accidentally opened into the adjacent waiting room. Mrs B misconstrued this again to be sexually motivated.

Credibility

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

Chaperones

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

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

Good record-keeping

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

This raised questions around Mrs B’s recollection of the events. In contrast, Dr Z had documented everything contemporaneously. When there is a factual dispute, the credibility of a complainant is important. In this case there was a factual dispute and the weight of evidence was in Dr Z’s favour. His notes were further backed up by a GMC-obtained expert report about the correct standard of chest examinations; this proved that Dr Z’s standard of chest examinations was appropriate.

Professional challenges

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

Advice

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

Learning points

Always use chaperones for examinations that are perceived to be intimate examinations.

Good record-keeping is essential.

Communicate effectively with your practice team.

Develop good working relationships with your staff and patients.

Expert evidence is helpful in disputes around standard practice.

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

Ends

REFERENCES

Files for readers made possible through a grant from the National Health Service (NHS), responsible for commissioning primary, community and secondary health services from providers, and the Health Protection Agency. They were accessed in 2010.
In his follow-up to last edition’s article on high reliability organisations, Dr Dan Cohen revisits a personal experience that formed part of his own steep learning curve.

A ten-month-old girl, was admitted to an internationally prominent children’s hospital at the weekend for evaluation of a kidney mass, likely a Wilms’ Tumour, a highly curable childhood cancer. I was the paediatric oncology fellow (junior registrar) covering the service for the weekend. This institution’s Wilms’ Tumour protocol required the oncology fellow to administer Actinomycin-D intravenously as soon as the renal vein had been clamped at the time of surgical removal of the tumour. I wrote the orders correctly and logged using our standard double-check process and then things became complicated.

In addition to covering the inpatient oncology service (about 25 beds in this large centre), I had additional weekend obligations for the outpatient clinic and a two-day bone marrow transplant located in different, though adjacent, hospitals. Usually this multiple coverage obligation was not a problem, but on this particular weekend, two children with leukaemia were to receive outpatient L-asparaginase chemotherapy, and I had to be present in the clinic because of the substantial risk of allergic anaphylactic reactions. I could not be in clinic and the operating theatre at the same time. Recognising this dilemma, I arranged for the anaesthesiologist on A’s case to administer the Actinomycin-D, he sent up a syringe containing 190 micrograms. The substitute anaesthesiologist did not recognise the error. This massive overdose was administered intraoperatively.

It was not until several hours later that the error was identified. While I was making evening rounds, I saw the syringe that had contained the Actinomycin-D, still attached to A’s medical record (a standard procedure at that time), and the label revealed the dosage error; I was shocked! Although not immediately toxic, the effect on this child’s bone marrow would be profound, beginning about a week after administration. I was reasonably certain that this child was going to die – and I was ultimately responsible.

I called my consultant immediately and, after calming me down, he said some things that really resonated. “Dan, we do not know that A is going to die. We can expect that she will encounter severe bone marrow suppression and gastrointestinal toxicity, but we do not know the outcome of that, and we need to be factual when we talk with the family.”

The following morning we met with A’s parents. My consultant wanted to take the lead in the conversation but I insisted that as A was my patient, I wanted, and needed, to do the talking. I was the one who had originally met with the family and this was my responsibility, not his.

I carefully explained to the parents that A had received a higher than desired dose of medication and that we were very concerned about this. I apologised for this error and explained that we would investigate this further in order to ascertain how it had happened. I promised to correct any discrepancies in care identified in order to prevent this from ever happening again and then outlined the steps we would take to protect A.

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

Our investigation revealed the following:

- The protocol for intraoperative chemotherapy was not evidenced-based, it was anecdotal and experimental, and there was no informed consent for this.
- A single oncologist was responsible for coverage in multiple hospital settings, which, although usually manageable, set the stage for conflicting obligations.
- A cultural barrier forestalled calling for backup unless there was a dire emergency.
- Not all anaesthesiologists were qualified for all procedures.
- There was no pharmacy double-check process for chemotherapy orders.

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

Company directors and non-medical staff and institutions are sometimes named in clinical negligence claims, and the consequences of failing to arrange suitable indemnity protection can be serious. Gareth Gillespie looks at two recent MPS cases.

For clinicians in the Caribbean, the sense of awareness surrounding medicolegal pitfalls in their practice is generally high—however, for administrators of hospitals, clinics and general practices, this awareness has not always been at the same level. The same standards and duty of care are expected of the institution as of the clinicians. Adequate protocols, procedures and regulations should be in place to prevent allegations of negligence.

Medical indemnity for clinicians like MPS is available for doctors but what happens when the search for compensation extends beyond the limit of the individual practitioner? Who covers errors attributable to ancillary staff, the directors or the institution? How does a clinic administrator respond to alleged negligence when he/she may have had no training in medicine or the legal aspects of medicine?

Standard insurance policies usually cover such mishaps occurring from events related to the physical premises—for example, a slip on a wet floor where there is no appropriate signage—but they don’t extend to the operation of the practice itself or any act or omission that relate to clinical negligence. Shouldn’t the administration be afforded similar levels of comfort as the practitioners? The concept of corporate indemnity could fill such a need.

Dr Nancy Boddoh, MPS Head of Operations (Caribbean and Bermuda), says: “MPS has seen an increase in the corporate membership in the Caribbean, in terms of hospitals, small institutions and clinics.

“There has also been a steady increase in the types of cases where institutions or companies have been named defendants and corporate membership has been necessary or useful. Although the company or institution can often be taken out of the action, there can be considerable cost in legal fees in achieving this.”

MPS assists corporate members in establishing a robust and effective adverse incident reporting system. This provides very useful information for the institution in establishing where the shortfalls lie and where there are repeated problems. By efficient and careful analysis of this information, institutions with limited funding can direct their expenditure to areas where there will be maximum benefit. This might be simple systems such as prioritising where a limited number of available best beds are used—directing them to where there have been the greatest number of falls or using arm bands for patients with drug allergies.

“As medical practice in the region continues to grow—in the form of group practices, small institutions and specialist centres—corporate indemnity is more important than ever and should be given due consideration.”

Case 1

Miss T was a 30-year-old shop assistant who gave birth to a baby girl via a normal vaginal delivery at 39 weeks gestation. During the delivery, Mrs T required an episiotomy, which was performed and sutured by nurse Miss J. Mrs T’s antenatal care had been uncomplicated.

Two weeks later, Mrs T presented to Dr D, consultant in obstetrics and gynaecology. She complained of severe pelvic pain and difficulty walking. On examination, Dr D noted dehiscence of the left mediolateral aspect of the episiotomy and bacterial vaginitis. Mrs T was prescribed a course of oral antibiotics and was instructed to continue sitz baths; a follow-up examination showed resolution of the vaginal infection but the dehiscence persisted. The edges were reapproximated and stitched. Mrs T further noticed another dehiscence at the proximal third aspect of the episiotomy, which was managed conservatively with sitz baths.

A further follow-up examination revealed complete closure of the episiotomy incision but a small painful nodule on the left labia minora. Dr D cauterised the nodule and Mrs T reported that she was able to walk without difficulty.

Two months later, Mrs T made a claim against the hospital for what she alleged was negligent treatment by Miss J. Mrs T claimed that Miss J’s execution of the episiotomy was negligent and the source of the various complications that arose afterwards. Mrs T further claimed post-traumatic stress disorder—for which she had to pay for psychotherapy—loss of bonding with her baby, temporary disability and loss of earnings.

MPS resolved to defend the case at trial. At court, the MPS legal team applied to have the claim struck out because of the expiration of the six-month limitation period. The judge accepted the application and MPS was able to recover its costs from the claimant.

Case 2

Miss R was admitted to hospital with a history of vomiting; she also had a previous history of diabetes and hypertension. On admission she was diagnosed with uncomplicated diabetes and hypertension, and ketoadosisis was ruled out. She was treated with IV fluids and other medication as her diagnosis warranted. Miss R was noted to have an IV infiuison in her right arm after a few days but it is unclear how long this was in place.

Two days later, Miss R visited the Emergency Department (ED), complaining of pain and swelling in her right forearm, which reportedly occurred after she was administered an IV infusion during her previous admission. She was treated with IV fluids, insulin and a Voltaren injection for the pain. She also had an x-ray of the affected arm and was kept for observation.

Miss R was referred to the Internal Medicine Department, where Dr V diagnosed cellulitis of the right forearm and hand. Miss R was prescribed Voltaren for the pain, antibiotics, aspirin, Liptor, Zestril, sliding scale insulin and vitamin C. She was then transferred to the Female Medical Unit for further management.

A day later, Miss R’s condition was recorded as stable but she continued to complain of pain to the affected arm, which remained swollen. Her previously prescribed insulin dosage increased almost daily due to persistently elevated blood sugars. However, a few days later, Dr V recorded that Miss R was not receiving her correct dose of insulin. Some discrepancies were observed between the dosages of insulin ordered and the amount administered.

Two days later, Miss R was seen by the surgical team. Her right arm was described as oedematous and tender up to the proximal third aspect of the forearm. Radial pulse was not felt and there were no active finger movements. Following the fasciotomy, Miss R’s blood sugar remained elevated.

Miss R was then reviewed by Dr M, orthopaedic consultant, who noted partial necrosis of the right forearm and no sensation or pulsation in the affected arm. The prescribed treatment continued and Miss R was monitored by doctors from the internal medicine and surgery departments.

Miss R’s blood glucose remained uncontrolled. An arterial Doppler examination was performed, followed by an exploration of the brachial-radial artery. There were further surgical interventions carried out on Miss R’s arm over the next month: three debridements and a secondary suturing of the forearm.

The general condition of Miss R’s arm continued to deteriorate. She had regular dressing changes and prescribed medication inclusive of insulin and antibiotics continued. Her blood glucose levels continued to fluctuate. The condition of the wound also fluctuated—between a red and healthy appearance to sloughy.

Miss R then developed pseudomomas infection to the wound, which was treated with the required antibiotics. The wound healed gradually and glucose levels finally became controlled. She was discharged from surgery and her treatment continued in internal medicine.

Following satisfactory control of Miss R’s blood glucose levels and the healing of the wound, she was discharged from hospital, after which she received physiotherapy as an outpatient.

Miss R lodged a claim against the hospital for various aspects of her treatment. She alleged that her infections and subsequent surgical interventions could have been avoided with more timely administration of her antibiotics. Miss R also claimed that incorrect dosages of insulin worsened her infection, and that there were delays in her admission to internal medicine and the surgical department.

As with the previous case, there was a delay in the claim being served—therefore, the MPS legal team applied to have the claim struck out. This application was successful.

With thanks to Dr Jonathan Bernstein for his assistance with this article.
Dates for your diary

**MAY 2014**
- **39th Annual Spring Meeting of International Society of Aquatic Medicine (ISAM)**
  - Location: Roseau, Dominica
  - More information: www.divingdocs.org

**JUNE 2014**
- **World Congress on Age Management Medicine**
  - Location: Palm Beach, Aruba
  - More information: https://agorned.org
- **2014 College on Problems of Drug Dependence Annual Meeting**
  - Location: San Juan, Puerto Rico
  - More information: www.cpdd.vcu.edu
- **Exploring Cuban Healthcare & Culture/Cuba: People to People**
  - Location: Havana, Cuba
  - More information: www.pets-travel.com

**JULY 2014**
- **Cardiology Review for Primary Care Medicine**
  - Location: Paradise Island, Bahamas
  - More information: www.mceconferences.com

**AUGUST 2014**
- **NYU’s Summer Radiology Symposium in Aruba**
  - Location: Oranjestad, Aruba
  - More information: https://tools.med.nyu.edu
- **16th Annual Summer Conference on Paediatrics**
  - Location: Atlantis Resort, Bahamas
  - More information: http://sympsiamedicus.org

**It’s your call**

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

- **Advice**: 4,128
- **Complaint**: 3,067
- **Confidentiality**: 1,964
- **Disclosure of records**: 1,250
- **Inquest (or Fatal Accident Inquiry in Scotland)**: 758
- **Medical or Dental Council matter**: 998
- **Ethics**: 448
- **Disciplinary**: 312
- **Consent**: 359
- **Criminal investigation**: 60
- **Adverse incident**: 707
- **Report writing**: 1,378
- **Claim**: 1,522
- **Confidentiality**: 1,964
- **Medical or Dental Council matter**: 998
- **Inquest (or Fatal Accident Inquiry in Scotland)**: 758
- **Criminal investigation**: 60
Concealed sepsis

Mr D, 53, had suffered with gouty arthritis in his right knee since turning 50. This had been confirmed with arthroscopy. He continued to work as a PE teacher. He experienced a flare-up of knee pain at the start of the autumn term but this settled quickly with analgesia. He contacted his GP out-of-hours service on the first weekend of the Christmas holidays, complaining of two days of bilateral knee pain, which was unrelied by his usual (Glyceryl) aspirin. A home visit was arranged. He was seen by Dr C, who documented a normal right knee on examination, but limited movement in the left knee, with positive meniscal signs and no effusion. Dr C also noticed that Mr D had a painful, swollen left little finger, which he had jammed in the door two weeks earlier. Since he was ambulant, Dr C attributed the symptoms to OA and advised Mr D should also arrange to get an X-ray of his fracture. She provided him with naproxen analgesia. The pain continued after the weekend and Mr D had been unable to leave the house to arrange the X-ray. He spoke to Dr V at his own surgery and an appointment was arranged for the next morning. The following day, Mr D was still unable to get to his car and called the surgery again, this time speaking to Dr A, who agreed to a home visit.

Dr A recorded an effusion and worsening right knee pain now radiating to the calf and hip. He also mentioned that Mr D now had swelling over the dorsum of his injured hand, and he also spotted two erythematous patches on the right elbow and left foot. Mr D had not reported feeling feverish and so vital signs were not recorded. Dr A prescribed a course of antibiotics to cover possible infection in the left wrist. He also documented that the knee pain was likely to be a strain. She quizzed gout as a possible cause and recorded that she was uncertain what the satellite lesions represented. She advised Mr D to check his X-ray of the surgery again the next day.

The next day was Christmas Eve and Dr B was on duty for the day. He visited Mr D at home as requested by Dr A. By now he was feeling better, and the swelling in his hand had reduced, but he was feeling ‘space out’ on the corticosteroid he was taking. Mr D’s wife recalled the doctor taking her husband’s blood pressure and advising him to omit his antihypertensive medication. Dr B made no record of this examination. He later recalled that he examined the patient fully, including his temperature, and he found nothing of concern he did not make a note of this. His advice was to complete the course of antibiotics and increase his fluid intake.

Mrs D recalled that her husband became worse towards the end of the day, with slurred speech and generalised weakness. He made an attempt to go to the toilet with the assistance of his son and it took him 40 minutes. Mr D died the next morning to find his wife dead. The pathologist who carried out the postmortem concluded that Mr D had died from complications of septicemia, but the focus of the infection remained uncertain. He noted splenomegaly but no lymphadenopathy. Experts agreed that the cause of death was overwhelming but that the knee was the least likely site.

Learning points

- Good note-keeping is essential. In this case, recording the vital signs and patient’s mobility would have demonstrated that an adequate assessment had been carried out and made the actions of the doctors involved easier to defend.
- Clinical presentation can change quickly. Expert opinion was that if intravenous antibiotics had been given earlier, Mr D’s head would have been saved.
- Good note-keeping is essential. In this case, recording the vital signs and patient’s mobility would have demonstrated that an adequate assessment had been carried out and made the actions of the doctors involved easier to defend.
- Critical illness can change quickly. Expert opinion was that if intravenous antibiotics had been given earlier, Mr D’s head would have been saved.
- Learning points

Heads of hypertension

Mr J was 43 and unemployed. He developed headaches and a GP complained that that sunshine hurt his eyes and he was bothered by noise. He was diagnosed with pre-tension and had been referred to a consultant oral maxillofacial surgeon. He thought his headaches were coming from tempo-mandibular joint dysfunction, possibly secondary to a tenderness wisdom tooth. He had his wisdom tooth extracted under sedation. His blood pressure was not taken at this time. At his review, it was noted that his headaches had improved and could be managed with paracetamol alone. Mr J felt better and had been able to fit in a job in a supermarket.

The same year Mr J became concerned because he saw blood in his urine. He made an urgent appointment with his GP. Dr A documented that he had no dysuria or suprapubic pain. He noted that Mr J was very anxious about it and referred him to urology to investigate his painless haematuria. There was no mention of headaches at this consultation and his blood pressure was not taken.

A month later, Mr J fell whilst stacking shelves at work. He complained of neck pain. He suggested some exercises for cervicalgia. Mr J visited his dentist who referred him to a consultant oral maxillofacial surgeon. He thought his headaches were coming from tempo-mandibular joint dysfunction, possibly secondary to a tenderness wisdom tooth. He had his wisdom tooth extracted under sedation. His blood pressure was not taken at this time. At his review, it was noted that his headaches had improved and could be managed with paracetamol alone. Mr J felt better and had been able to fit in a job in a supermarket.

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A month later, Mr J fell whilst stacking shelves at work. He complained of neck pain. He suggested some exercises for cervicalgia. Mr J visited his dentist who referred him to a consultant oral maxillofacial surgeon. He thought his headaches were coming from tempo-mandibular joint dysfunction, possibly secondary to a tenderness wisdom tooth. He had his wisdom tooth extracted under sedation. His blood pressure was not taken at this time. At his review, it was noted that his headaches had improved and could be managed with paracetamol alone. Mr J felt better and had been able to fit in a job in a supermarket.
Mrs W was a 44-year-old French teacher who was usually fit and well. She had two children and they enjoyed walking to the same school together in the mornings. On one of these walks Mrs W was troubled by indigestion with the diclofenac so Dr G prescribed senokot instead. She gave Mrs W a sick note so she couldn’t work. Dr G noted back pain with right-sided sciatica and paraesthesia in the right calf. She mentioned this to her GP, who noted that there had been no acute injury and that she should take paracetamol and ibuprofen and suggested some exercises.

Dr G noted that Mrs W’s right leg felt numb and weak, and that she felt like she needed to pass urine but couldn’t. An ambulance was called and records in the Emergency Department noted a five-week history of right-sided leg pain and paraesthesia with a one-day history of retention of urine and inability to pass stool. Examination revealed weakness and diminished sensation in Mrs W’s right leg but normal findings on the left. There was reduced anal tone and sensation over the saddle area. She was catheterised and one litre of urine was drained. Shortly after, records stated that she had complained of numbness and weakness in her left leg and that power had been found to be reduced in her left leg. Ten minutes later Mrs W was found to have no power in both legs.

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

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

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

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

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

He felt that constipation in itself was not sufficiently discriminatory to be a red flag necessitating urgent neurosurgical referral. He commented that the physiotherapy notes were clear and that the patient had been specifically asked about bladder or bowel symptoms and that there were none. The hospital notes stated that urinary symptoms only occurred on the day of admission. The records from all the clinicians involved point to Mrs W’s bladder and significant bowel symptoms starting on the day she was admitted, and not before as Mrs W claimed. MPS also sought the opinion of a professor in neurology. He concurred with the rare diagnosis of neurosarcoidosis. He felt that Mrs W’s acute deterioration was a consequence of cord ischaemia and infarction resulting from inflammatory or granulomatous involvement of the arterial supply to the cord. This would explain the sub-acute illness with a rapid evolutionary phase to the point of severe neurological disability. It was his opinion that there is no proven effective treatment for neurosarcoidosis and that earlier treatment would not have altered the outcome. He noted that it is well recognised that cranial neuropathies, such as Mrs W’s 6th nerve palsy, can resolve spontaneously without treatment, and the improvement in Mrs W’s upper limbs was consistent with the variable natural history of neurosarcoidosis. The cord dysfunction that she had developed remained unchanged despite treatment. MPS decided to defend the case to trial denying liability, supported by expert evidence. Mrs W discontinued proceedings two weeks before the trial, and MPS is now seeking recovery of all costs.

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

**References**
- [www.gpnotebook.co.uk/simplepage.cfm?ID=-1227882441](http://www.gpnotebook.co.uk/simplepage.cfm?ID=-1227882441)
The Swiss cheese

Mr X gave birth to J, a healthy baby boy. J was discharged, with a note in the records stating he was a “normal healthy infant”; a further note stated that, on examination, there was a bilateral red reflex.

At four weeks, the health visitor’s notes showed that J’s parents were concerned that J’s left eye was smaller than the right, and the health visitor referred the baby to a community paediatrician. A couple of weeks later, the health visitor documented the left eye as being more open, and the referral was cancelled. J was then seen by the family’s GP, Dr A, for a six-week check-up; his vision and hearing were recorded as being “satisfactory”. At three months, Dr A referred J to the ophthalmology department after noticing a squint in his left eye; the left pupil was also smaller than the right pupil. Six weeks later – before the ophthalmology consultation took place – J was admitted to hospital as an emergency via Dr A, with coryza, vomiting and poor feeding. J was transferred to the paediatric department, but there was no record from this admission of any examination of J’s eyes.

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

Dr H’s parents made a claim against Dr A and the hospital for the delay in the diagnosis of the congenital cataract.

Expert opinion

Expert GP opinion on breach of duty stated that Dr A “should have recognised the symptoms of a microphthalmia” at six weeks. By that time, it was “too late to perform any surgical intervention”. A further expert report, provided by a consultant ophthalmologist, also stated this examination was inadequate, as an abnormal red reflex would almost certainly have been present. This would have allowed for appropriate surgical intervention of the cataract that was later diagnosed.

Another expert report, provided by a consultant ophthalmologist, also stated this examination was inadequate, as the hospital paediatric department for failing to communicate the concerns in J’s records about his eye size to the appropriate colleagues.

The case was settled for a substantial sum.

Wrong drug, no negligence

Mrs M was a 64-year-old care assistant in a retirement home. She visited her GP with a two-month history of blood in her stools, altered bowel habit, and intermittent lower abdominal discomfort. On examination the GP found haemorrhoids, and referred her to her local hospital to see Dr P, a gastrointestinal surgeon.

Mrs M was found to be overweight, with a BMI of 32, and was a smoker. Dr P performed routine blood tests, and booked Mrs M to undergo gastroscopy, proctoscopy, colonoscopy, biopsies, and injection of haemorrhoids, under general anaesthesia.

She was seen preoperatively by Dr D, consultant anaesthetist. Dr D noted Mrs M was on a number of medications, including metoprolol and quinapril for hypertension; simvastatin for raised lipids, and inhalers for a diagnosis of chronic obstructive airways disease. She was documented to be allergic to the antibiotic augmentin, which she had taken some years previously, and had caused a rash and wheeze. Mrs M reported that her brother had suffered a severe reaction to general anaesthesia, and had spent two days in intensive care following a hernia operation. However, she was unable to provide more details, and her brother had subsequently moved overseas. Mrs M had undergone two uneventful general anaesthetics at that hospital.

Dr D decided to proceed with general anaesthesia. The procedure was uneventful, but at one point, Dr D administered 1.25g of augmentin. In the recovery area, Mrs M was noted to have a widespread itchy rash and was complaining of wheeze. However, her pulse, blood pressure, saturations and conscious level remained normal. She was treated with antihistamines and hydrocortisone. As a precaution she was admitted to the hospital overnight, where the rash and wheeze resolved, and she was discharged the following day following a further set of blood tests.

During her stay, she was visited by Dr D, who documented that he had apologised to her for the accidental administration of augmentin. Dr D wrote a letter to the hospital explaining what had happened, and gave Mrs M a copy. Dr P was also noted to have visited her, but did not document his visit or discussion.

Approximately one week later, Mrs M developed a high fever and abdominal pain and was admitted to the hospital under Dr P. She was noted to be jaundiced and her other liver function tests were deranged. Investigations suggested a diagnosis of acute cholecystitis, and she was treated with antibiotics. The episode was sent home with an appointment for an elective laparoscopic cholecystectomy.

Mrs M brought a claim against Dr D and Dr P, alleging that the incorrect administration of augmentin had brought about her cholecystitis as part of an allergic reaction. Dr D, the anaesthetist stated that he had given the antibiotic on the directions of the surgeon, Dr P. However, Dr P stated that he had left it up to Dr D to choose which antibiotic to give.

The experts concluded that there had been a clear lapse in standards, where it had been an allergic reaction. Mrs M might have been at risk given what happened to her brother. However, this may have distracted his attention from a much commoner problem, which is allergy to antibiotics. Take extra care when performing a technique that is unusual for you.

Dr D was attempting to avoid a rare but dramatic problem, malignant hyperthermia; Mrs M might have been at risk given what happened to her brother. However, this may have distracted his attention from a much commoner problem, which is allergy to antibiotics. Take extra care when performing a technique that is unusual for you.

Dr P didn’t document anything that had been discussed or shared. If a junior doctor is making the notes, ensure you check their entries.

Dr P didn’t document anything that had been discussed or shared. If a junior doctor is making the notes, ensure you check their entries.

Good documentation is the cornerstone of your defence. In this case Dr D didn’t document anything that had been discussed or shared. If a junior doctor is making the notes, ensure you check their entries.
No fundoscopy, no defence

M iss Z, a 17-year-old with a form student, visited Dr B at the end of the summer term of school after a stressful exam period. She was feeling generally unwell with a sore throat and some vomiting. Dr B reassured her that she was probably run down following her exams, and she was likely to have picked up a virus. She had planned to go to America with her family over the summer, so he advised her to return to the surgery if her symptoms persisted when she came home.

A month later, Miss Z felt no better and returned to the surgery, this time seeing Dr Q. She complained of ongoing nausea, neck pain and headaches. She also noticed that her vision was ‘blinking out’ every few days. Dr Q documented a normal pulse and blood pressure, and noted that he was aware of the symptoms and felt that they might be related to a virus. Miss Z had planned to go on holiday after a stressful exam period, so he advised her to return to the surgery if her symptoms persisted when she came home.

Over the next month, Miss Z consulted Dr Q twice, and on both occasions the weight loss was the focus of the consultations. Dr Q attributed the symptoms to stress as deadlines for coursework were looming. On their last meeting, Miss Z complained of vacant episodes where she described a complete loss of vision. Experts commented that if an appropriate referral were not made in the absence of these key documents, we would be indefensible.

M iss Z was seen at 36 weeks gestation in an uncomplicated pregnancy. The consultant, Dr A, documented this consultation and the mode and timing of delivery. The cervix was noted to be thin, and Dr A discussed the increased risk of instrumental delivery and caesarean section as a result. Miss Z saw Dr A again two weeks later. Delivery by induction was revisited and agreed upon. Dr A made arrangements with the labour ward and used the indication ‘reduced fluid around the baby’, though he explained to Miss Z that this was to keep the midwife happy. An ultrasound scan reassured Mrs G that all was well with the baby.

Mrs G was admitted for induction of labour at 37 weeks gestation. On examination by Dr A the cervix was found to be soft, posterior and partially effaced. Induction by 24mg intravaginal Prostaglandin G2 was commenced at 09:30. An amniotomy was performed seven hours later and labour ensued within two hours. The first stage of labour was completed at 00:05 and pushing commenced 45 minutes later. Progress was slow, Mrs G’s temperature increased and the foetus developed a tachycardia. The midwife requested a consultant review and Dr A assessed the patient. The baby’s head was in an occiput posterior position but low in the pelvis. There was discussion with the parents about the possibility of ventouse extraction, initially they were reluctant, having seen the effects of ventouse delivery on head shape and facial bruising before. However they consented and the procedure went ahead.

A Kiwi cup was used with positive pressure over two contractions to effect delivery. The perineum stretched well and episiotomy was not deemed necessary. A second degree tear was sustained with laceration and was repaired with vicryl under local anaesthesia due to pain.

Later, both the midwife and Dr A noted the perineum to be swollen. Mrs G questioned the possibility of prolapse but this was excluded by Dr A. Soon after, relations with Dr A deteriorated for unknown reasons and Mrs G refused to see him again.

She remained in hospital and saw other doctors and a physiotherapist. Each clinician acknowledged that she had ongoing pain, urinary and faecal incontinence, but none identified a problem with the repair. There was no presence of infection but the anal sphincter was intact. Mrs G was discharged six days following delivery and was improving.

Dr B saw the patient 11 days post-discharge and noted constiction of the introitus that was thought to be self-limiting (the risk of requiring surgery being 2%). The following week, there was no improvement: pain persisted locally, there was difficulty recognising feelings in the bladder and intercourse was impossible. Examination revealed a very tight asymmetrical introitus.

A second opinion gynaecologist, Dr F, recommended a Fenton’s procedure, which was undertaken with ease and without complications ten weeks after delivery.

A claim was made against Dr A, alleging breach of duty for using oxytocin inappropriately, failing to rotate the head prior to delivery, using ventouse inappropriately, failing to perform an episiotomy, substandard repair of the perineum and failing to provide adequate postnatal care.

Expert opinion was supportive regarding breach of duty on all counts. Induction on psychological grounds was said to be reasonable, as was the use of oxytocin. Ventouse delivery without head rotation was cited as normal practice, as was allowing the perineum to stretch, avoiding the need for episiotomy. The expert stated that it would be unusual that a consultant of Dr A’s standing would refute the labia together. The tissues were likely to have healed incorrectly rather than the repair having been performed in a substandard fashion. Induction of labour had no bearing on the need for instrumental delivery.

Unfortunately, several key documents were missing from the notes and could not be traced. Despite the supportive expert opinion, because of the absence of these key documents, we were advised it would be very difficult to defend the case. Accordingly it was settled for a modest sum.

Learning points

- When inducing labour, documentation regarding the counselling and consent process must be robust. The notes in this case were lost, which resulted in the case being indefensible.
- Good record-keeping is imperative throughout pregnancy, but especially so in the intrapartum phase.
- Delivery by ventouse is acceptable for most positions of the foetal head and is preferable to Kiellands forceps, which should not be used for rotational deliveries except in the most experienced hands.
- Postnatal care is as important as antenatal and intrapartum care and should not be dismissed. The care of Mrs G in the postnatal period seems to have been adequate but for reasons that are not clear she refused to see Dr A.
- When things go wrong it is important to be open, honest, conciliatory and empathic to the patient.

Learning points

- As ever, clear documentation of a consultation is essential.
- Your standard of note-taking says a lot about your practice. If you can demonstrate that your notes are generally of a high standard, it may assist you if you have not mentioned something in the notes.
- If Dr Q had recorded the patient to have ‘no visual disturbance’ and later ‘normal fundoscopy’, that would have been more convincing than no mention of symptoms at all, when the patient clearly recalled reporting problems.
- Fundoscopy is an essential examination and can assist in the diagnosis of many diseases. In this particular case, early fundoscopy could have prevented loss of vision.
- Experts commented that if Dr Q had carried out fundoscopy in his initial consult (as he said he did as part of a cranial nerve exam) then he failed to identify papilloedema, as it is likely to have been present at this time.
- If you do suggest a patient consults an optician to obtain a more thorough and immediate check-up, you should ensure that safety-netting is in place by arranging a follow-up consultation.
- Remember red flag symptoms, especially in patients who may be presenting with vague non-specific symptoms. Ask the important questions, document what has been done and record any important negatives.

REFERENCES

Complications of colonoscopy

A 40 year-old accountant, Mrs A, developed altered bowel habit and rectal bleeding. She saw consultant colorectal surgeon Dr C, who found large prolapsing haemorrhoids and recommended a haemorrhoidectomy and colonoscopy. Dr C removed a 5mm polyp in the caecum with a snare and then went on to perform a haemorrhoidectomy. Both procedures were described as uneventful and Mrs A was stable throughout the anaesthetic.

A few hours later, after the operation, Dr C noted Mrs A was well and ready for discharge. She subsequently developed minor rectal bleeding and abdominal discomfort, and was kept in overnight. The following morning, her routine blood tests were normal and her observation chart had been unremarkable, but the abdominal pain persisted. A chest x-ray revealed bilateral sub-diaphragmatic free gas. Dr C prescribed broad-spectrum antibiotics, intravenous fluids and normal saline and kept Mrs A’s abdomen intact. She was discharged home with Mrs A initially developed pain. It was also alleged that Dr C had selected inappropriate antibiotics and had discharged her too early, allowing the development of her abscess. It was suggested that these acts of negligence had delayed appropriate surgical treatment and directly led to Mrs A’s subsequent complications.

Expert opinion for MPS is well known and the claimant’s defence was that the antibiotics prescribed were inappropriate and the length of the antibiotics were sufficient. Dr C was able to produce audit evidence of his colonoscopy practice, demonstrating a high volume (400 per annum) with a very low complication rate.

MPS defended the case and the claimant discontinued the first day of trial, with full recovery of costs.

Learning points
- Complications after procedures can occur and are not necessarily the result of negligence. Claims can be defended if clinicians are able to demonstrate that they acted appropriately in the detection and subsequent management of complications. Evidence of a high volume practice with a low complication rate (as in this case) can strengthen the defence. If claims arise many years after the event, the careful documentation of events and discussions with the patient two years earlier enabled the facts of the case to be established, and a successful defence of the allegations to have sealed. The CT result, together with the carefully documented clinical findings, nursing charts, and operative notes was accepted by the expert panel.

Over to you

We welcome all contributors to Over to you. We reserve the right to edit submissions.
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What an assessment at the beginning of the process by a specialist might potentially have resulted in an earlier diagnosis (depending on what symptoms were actually presented), the standard to be applied is that of the reasonable GP, and our expert was clear that doctors A, B and C had reached that standard.

Consent templates?
This is the question of adequate consent and the preparatory documentation of possible risks and complications frequently appear in Casebook. Are there any templates of consent forms available for gynaecological procedures (especially laparoscopic procedures)? Is it not something that MPS should be involved in creating or developing?

Response
Thank you for your observations and comments.

Dr AA Carlessen, Gynaecologist, South Africa

MPS does not produce specific templates or forms for use in the consent process. Consent is a process that will vary depending on the circumstances. Although there are some specific exceptions in relation to certain procedures, interventions and circumstances (e.g., sterilization and termination of pregnancy, which require the completion of statutory forms), the actual format of the consent is less important than the accurate documentation of the process. MPS has produced a comprehensive guide – Consent to Medical Treatment in South Africa – which is available on our website.

Controlled drugs
This letter refers to an article in the New Zealand edition of Casebook – consultants can read it here: www.medicalprotection.org/newzealand/casebook-january-2014/controlled-drugs-what-you-need-to-know

Response
Thank you for an informative article. I am writing to Helen Monirian’s article on controlled drugs – “Controlled drugs – what you need to know”, Casebook 22(1) in New Zealand.

The article is clear and helpful, and the message that prescribing to any dependant person must be by a gazetted practitioner (and sometimes location) or under the specific written authority of such a practitioner, is clear.

However, the article does not address the question of colleague or locum prescribing, and I have wondered about this in the past. Specifically, if the duly gazetted authorised practitioner is away/unavailable (not just fully booked that day), does a colleague from the practice, or a locum, have the legal right to prescribe for dependant patients?

It is a widespread convention that locums (if not colleagues) are authorised to do all that the doctor they are replacing would normally manage, including prescribing to this category of patient.

I shall be grateful for Dr Monirian’s further advice.

Dr Craig Downey, Wairakei, New Zealand

How reliable is healthcare?
I’d just like to comment on the excellent article “How Reliable is Healthcare?” by Dr Dan Cohen in the current January 2014 issue of Casebook. As both an airline captain and former surgeon, I have a view from both sides of the debate. I’d like to agree with his views on complacency leading to errors but must disagree on two points.

While I agree that patients are initially more worthy than aeroplanes, the important point is that aeroplanes (patients) generally don’t cause accidents – it’s caused by human error due to the operator (healthcare professional or pilot). Therefore this is where we need to focus our energies, namely in human factors training for staff to help recognise and deal with errors. Also, as in healthcare, we consider our passengers (patients) an integral part of our safety awareness system. Any issue brought to the attention of our cabin crew, such as unusual smells, sounds, ice on the wings or leaks from engines (both of which are much more easily seen by our passengers due to their better view of that area of the aeroplane), are brought immediately to the attention of the captain as part of our crew resource management information gathering system, ie, communication, leadership, situational awareness, leading to decision-making. We regard passengers as much more as active, passive consumers of our service. Captain Niall Downey FFRCS, Managing Director, Framework Health, Ireland

Response
Capt Downey makes some excellent points and his thoughts are aligned with mine. It is certainly true that aeroplane safety relies to some extent on passengers alerting crew to potential problems, and in adopting a healthcare outcomes paradigm, similarly relying on patients for their expertise is crucial. A difference is that the passengers on an aeroplane, except perhaps in the case of a mid-air emergency, do not rely on the crew to instruct them how to be successful passengers (after the initial safety instructions prior to takeoff), whereas achieving healthcare outcomes uniquely requires clinicians and patients to work very hard together across all aspects of care planning to achieve successful care implementation. One of the reasons that 20-25% of elderly patients discharged from hospital with a diagnosis of congestive heart failure are readmitted within 30 days is because patients are not viewed as components of the healthcare system in a high-reliability model. Many clinicians have no real window on the challenges that patients face once discharged and back in their homes. Every preventable readmission is a failure of our system and a cause of physical, psychological and financial harm; the antithesis of a high-reliability system.

Clinicians and patients are both encumbered with many human factors liabilities and training or interventions for both are likely to serve good purpose.

The processes of diagnosis, therapeutics and of care plan implementation present numerous human factors challenges. If the goal is preventing readmission then planning for that should begin at the time of admission with defining, and then modulating, the human factors that confound success.

Dr Cohen, MD, FRCPCH, FAAP, International Medical Director, Daft UK Ltd and Daft (USA Inc) Drchen@datix.co.uk

REFERENCES

Response
Thank you for your comments on this article.

In this case it is important to note that the case the claimant did not bring any allegations in respect of the surgical treatment provided. The allegations were in respect of Drs A, B and C who saw Mr P at the GP surgery. In accordance with Drs A, B and C who saw Mr P at the GP surgery. In accordance with
FILM: The Enemy Within (50 Years of Fighting Cancer)

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

The Enemy Within is an hour-long film presented by Vivienne Parry – it tells the story of the human fight against cancer over the last 50 years. Contributors include the great and the good of cancer research – Professors Robert Weinberg and Umberto Veronesi, Lord Ara Darzi, Professor David Nathan, Professor Brian Druker and many more. Equally, there are contributions from a number of patients, including Karen Lord, a survivor of childhood leukaemia, Julian Tutty, one of many patients who benefited from the development of Gleevec, and Bobbie Araudo, who eventually succumbed to pancreatic cancer.

In chronicling the fight against cancer, it describes any number of important events – be that the debate surrounding combination versus sequential, single agent chemotherapy, the provision of palliative care or the realisation that a conservative surgical approach, as opposed to radical mastectomy, might be equally beneficial and less disfiguring for patients with breast cancer.

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

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

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

The Checklist Manifesto: How to Get Things Right

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

Atul Gawande has written an insightful, in-depth and stimulating book about the challenges of modern medicine. His honest reporting of challenging medical scenarios including personal mistakes, combined with stories from other professions, certainly convinced me that surgical checklists are a good thing.

I work as a specialist registrar and we now routinely undertake the WHO operating checklist. I’ve noticed an increase in its uptake and implementation, which can only be a good thing. I see errors picked up on a weekly basis simply by having an easy-to-follow checklist for the whole team to follow.

Gawande distinguishes between errors of ignorance and errors of inaptitude – the most common and relevant in today’s medical world being the latter. He explains that the high pressured and intense environment that is prevalent in the medical world means mistakes are inevitable.

He borrowed a concept from the aviation industry: the checklist, similar to the checklists used by pilots before take-off, and applied it to medicine. He then argues that implementing checklists that walk surgeons through procedures actively prevents mistakes. Good checklists and clear communication amongst the team can significantly reduce errors.

For those among the medical profession who are sceptical about using checklists, or are interested in how the WHO operative checklist came about, I suggest you read this book, as it is powerful enough to make you rethink your ideas. I’ve found myself using examples of Gawande’s book to inform my operating staff of the origins of the checklist, while stressing its importance to us all.

Surgeon or paediatrician, GP or psychiatrist – I encourage every doctor to read this well-crafted and fascinating book – it will change the way you think.
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