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HOW A HOSPITAL ASSESSMENT MISLED A GP – PAGE 16

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What can doctors expect from their legal advisers?

MANAGING THE GAP: PATIENT EXPECTATIONS AND REALITY
Dealing with the demands of today’s health service

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Welcome

Dr Nick Clements
Editor-in-Chief

Medical matters, unsurprisingly, continue to feature heavily in the headlines and the media in general. There seems to be an endless appetite among the public for such stories, whether they are announcing the arrival of new and better treatments or procedures, or reporting shortfalls, errors or even scandals. Politicians frequently feel obliged to step in, but their attempts to remedy things don't always have the desired response.

Inevitably this is felt by you on the wards or in your consulting rooms, with increasing patient expectations in the form of unrealistic demands or a raft of self-researched information from the internet. This can make for some challenging situations, at a time when workloads grow in intensity, perhaps due to budgetary cutbacks or other local factors.

It continues to be an important time to be part of an organisation like MPS. We work in partnership with you to protect and support your career at every stage, and this work takes many forms, beyond the litigation work that we are more traditionally associated with. This includes an extensive range of educational products such as online learning, and consultative work with governments and policy-makers worldwide.

Many of you got in touch with us following the last edition of Casebook, regarding our cover story on the case of Beth Bowen. While the emotional reaction from a number of correspondents was not surprising, I was heartened by the way the article made everyone think about their own approach to communication, openness and consent. Anger at the treatment of the Bowen family was palpable in some of your letters, and if this deeply tragic case results in reflection and changes in culture and practice, then something positive will have been achieved.

We have published a short response to this correspondence in our “Over to you” section on page 23. I hope you find this edition of Casebook an equally thought-provoking one and, as ever, I am keen to hear your feedback.

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Dr Nancy Boodhoo, MPS head of operations (Caribbean and Bermuda) and Dr Jonathan Bernstein, MPS medicolegal adviser, recently held a series of key meetings in Barbados, Jamaica, the Cayman Islands and the Bahamas.

The trip commenced with a discussion at the Barbados Association of Medical Practitioners (BAMP), to find out more about their role in handling patient complaints. BAMP receives a number of complaints from patients and they will either advise a patient to approach the Barbados Medical Council, or offer a conciliation service between the patient and the doctor involved. Advice to the doctor on improving aspects of their practice may, if appropriate, be offered.

Dr Boodhoo and Dr Bernstein closed their Barbados visit with a meeting with an MPS panel law firm, who handle local cases on behalf of MPS. Matters relating to specific cases were discussed, while solutions to the challenge of finding local experts for cases were also put forward and considered.

On travelling to Jamaica, Dr Boodhoo and Dr Bernstein presented to the Jamaica Dental Association on the importance of good documentation. The presentation was well-attended, with many delegates welcoming a rare dental-specific talk on this subject. A similar presentation took place soon after, with doctors of various grades in attendance. The audience was able to interact with the talk, and due to the level of discussion, the session overran its allotted time.

It was then on to the Cayman Islands, and numerous meetings with MPS panel law firms. Matters for discussion were specific to a number of cases. There were further presentations on disclosing medical records and a meeting with senior staff members. The trip ended with a visit to the Bahamas, where Dr Boodhoo and Dr Bernstein again presented to doctors on disclosing medical records, and met with an MPS panel law firm to review claims procedures in the Bahamas.

Overall it was another productive visit to the Caribbean and Bermuda region for MPS, and another valuable opportunity to share the benefits of education with MPS members.

BARBADOS, JAMAICA, CAYMAN ISLANDS, BAHAMAS
A CASE FOR THE DEFENCE

What can doctors expect from their legal advisers? Sophie Pearson, solicitor at MPS panel law firm Kennedys, argues the benefits of the ‘reality-testing’ role of the defence lawyer in clinical claims.

The litigation landscape continues its inexorable metamorphosis – thank goodness. From the bad old days of trial by ambush, posturing, brinkmanship and one-upmanship, we are lumbering towards a system in which early disclosure of relevant evidence followed by proper litigation risk assessments, mediation and negotiated settlements are the order of the day.

And not a moment too soon. In the notorious (and fictional, of course) case of Jarndyce v Jarndyce in the novel Bleak House, Dickens took the adversarial and bellicose approach to litigation to the extreme, wiping out the family’s entire inheritance in legal costs (when the preservation of that inheritance was the very reason for going to law in the first place) and killing the protagonist in the process. Nonetheless, there was more than a grain of truth in the utter devastation that the litigation left in its wake and important lessons to learn from it, even today.

Which brings me to what this article is about, namely, what is the role of the medical negligence defence lawyer in this day and age? How do our doctors best serve us in this climate of increasing medical negligence litigation and what more can we do to help?

First of all, the basic framework. When a doctor comes to us with a letter alleging negligence, there are, broadly speaking, four options: getting the case discontinued (because there is no merit in it); taking it to trial (because nothing will convince us that the claim has merit but the patient doesn’t see it that way); settling it – i.e., making an offer (without making any admissions of liability (because there just might be merit in it) and last but not least, settling it on a full admission basis (which hopefully requires no explanation).

To decide which avenue to take, we need to find out exactly what happened and then get independent expert evidence as to whether that particular medical practice was acceptable. We work hard with our doctors to establish what happened on that operating table or during that course of treatment. This is not always straightforward as memory can be unreliable, criticism is the finest way to put people on the defensive and doctors may simply be unclear how much information to share with us (the answer to that question: by the way, is share all of it – we are working with your best interests at heart, lawyer/client communications are entirely confidential and forewarned is forearmed). And, similarly, we work closely and determinedly with our experts to make sure that they have worked through their opinions thoroughly and logically. After all, if we don’t, the patient’s legal team is sure to do so at trial.

During the course of any case – and this is where the dynamic gets interesting – we wear two ‘hats’. The first is that of quasi-counsellor, the other that of reality-tester. In relation to the first, anyone facing criticism about the work they do with such dedication is likely to feel stung by it and doctors are no exception. Their role is to look after the health of their patients and at the core of the professional mentality is a desire for high standards. Criticism about an isolated incident is often seen as an attack on their general professional competence and can hugely undermine confidence. Similarly, doctors who have built up a rapport with a patient over a period of time can feel betrayed when the patient then turns round and criticises their management.

However, calm and collected doctors come across as a first meeting, they usually feel defensive, indignant, upset, vulnerable, angry or all of the above. A vitally important part of our job is to work with that emotional ‘fall-out’ and support the doctor throughout the litigation process. We spend our lives within the arena of dispute resolution, and have a profound understanding of the dynamics of conflict and how it feels to be on the receiving end of a claim.

Our other ‘hat’ is that of reality-tester. There comes a stage in every claim where in order to advise our client properly, we need to sit back, look at all the evidence rationally and dispassionately and advise our client on the most appropriate option. This objective analysis of the evidence is vital because it ensures the right decisions are taken at the right time and with the minimum disruption to our client’s lives, but can also be the most tricky moment in the lawyer/client relationship. How, after all, is the doctor supposed to believe that we are fully behind him if our advice is that the court will probably consider his actions negligent?

Controversial though it may sound, this stage of any claim is ripe with potential and the litigation process, if dealt with skillfully and constructively, has the power to transform. Once the initial horror of being accused of being negligent has subsided, the whole process of reality-testing the evidence and encouraging our clients to stand back and look at the care they provided rationally and objectively, can be very liberating and provide important lessons if they have the courage to look for them (and, ironically, it is only by looking at a sequence of events dispassionately that the defence lawyer will see where a true defence lies).

The exercise might move the doctor from a sense of outrage (if he thinks he has done nothing wrong) to an acceptance that things could have been done differently, or the doctor (who thinks he has) from feelings of vulnerability and despair to feelings of confidence in his decision-making processes or clinical skills and awareness that he needs to be more resilient in the face of criticism. And conversely for patients who are questioning the treatment they have received, it might actually be comforting – outlandish though this may sound to some in the claimant camp – to find out that the care they received was up to standard even if it did not result in the outcome hoped for. If there is anything worse than knowing that an injury was caused by carelessness?

But there is a further point. The adversarial approach to litigation often wreaks havoc on doctors’ lives. It puts them on hold and encourages an unhealthy preoccupation with how badly the other side is behaving, which leads to a gradual entrenchment of positions that, in turn, leads to an unwillingness to see when the other side might have a point. In short, it encourages a culture of not listening, not communicating and turning a blind eye to any middle ground that may exist. Sadly, this approach still lingers in some quarters, but those who espouse it do both patients and doctors a disservice.

In the words of one management guru, life is a corridor, we are tennis balls and by hitting the walls on either side we can change direction and make headway. Those walls, in this context, are the adverse outcomes that many doctors will come across at some point in their careers, and which, if they can learn from them, can propel them forward to new and better pastures.

The days of old-style, war-like litigation are on their way out and the days of forensic and objective analysis of this evidence and of dealing with the consequences sensibly – whatever that may mean – are in. We must continue to work hard with doctors to convince them that this new litigation landscape can be a good thing.
MANAGING THE GAP: PATIENT EXPECTATIONS AND REALITY

In a hectic clinical environment, patient loads are continually increasing and doctors can see many patients in a week. While focusing on trying to see and treat them all, one is also trying to meet many expectations—those of our patients and colleagues, as well as those outside work, including family and friends.

But when we have too many demands placed upon us, it can lead to gaps between meeting expectations and what is actually possible in reality. Unfortunately, and as most of us would have found out the hard way, this can cause patient resentments if and when expectations are not met.

The gap can be closed by taking the time to focus on the basics of expectation management—a process that begins and ends with good communication. Poor communication can be found in 70% of clinical negligence claims, and international research shows doctors have the potential to reduce the risk of litigation by improving their communication skills and better managing patient expectations.

The following tips reinforce how important good communication is before, during and after treatment.

BUILD GOOD RELATIONSHIPS WITH YOUR PATIENTS

While it’s tempting to spend more time with ‘happy’ patients, it is in your best interests to make an effort to build a good rapport with patients who seem unhappy or nervous. These are the patients who are more likely to make a complaint about you if something goes wrong down the track.

Greeting your patients warmly and treating them courteously and with empathy will help you form a positive connection. It will also encourage them to talk openly about any issues they have been experiencing with regards to their condition.

EMPPLOY TWO-WAY COMMUNICATION

Shared decision-making is where doctors and patients make decisions together, and is a widely regarded approach for patient communication. Patients are encouraged to engage with the healthcare process and consider the options to treat or manage their condition (and the likely benefits and harms of each) so that they can help select the best course of action.

Most patients will have an idea about what is wrong with them and what treatment they anticipate you will provide. It is recommended that you seek to understand what the patient already knows, what is important to them and what their expectations of treatment are.

Only then should you add your own views, based on their clinical assessment, as well as such information as is necessary to add to—or correct—the patient’s existing knowledge.

The next step is to discuss diagnosis and treatment options and address the patient’s expectations—even if the means explaining gently why they cannot be met. This is a very important step in preparing the patient for what is to come and could mean the difference between a happy patient and an unhappy patient after treatment. An excellent example is laparoscopic surgery.

Patients often have high expectations and work on the assumption that a brief hospital stay and small scar implies that it is complication-free.

The benefits and risks of all various options available should be discussed, including the option and possible consequences of no treatment. Allow the patient the no background knowledge whatsoever about their options and think about what you would want to know about the procedure if you were in their position. Certain information should also be shared including possible side effects, complications, and any considerations relating to their individual past medical and present social and occupational history.

Good medical practice requires you to check that the information you provide has been understood by the patient. This is especially pertinent in the Caribbean, where there are a number of official languages. The use of an interpreter should be considered where a language barrier exists.

As the discussion proceeds, the range of options will narrow as the patient or the doctor express a reluctance to proceed with some. This will usually lead to one, preferred and mutually agreed decision. Any recommendation made should take into account the preferences, values and expectations of the patient. If agreement cannot be reached, then it may be time to get a second opinion or otherwise stop the process.

BE PROACTIVE WHEN THINGS GO WRONG

When we hear the words: “I wanted... but...” it can be easy to feel stressed or overwhelmed and act in a defensive manner.

If you do find yourself being questioned after a clinical adverse event, mistake, delay, system error or provision of incorrect care, there are certain things you can do to improve the patient’s level of satisfaction, minimize the damage it has caused and reduce the risk of litigation.

The first step is to listen to your patient and understand why they are upset—they want to have their story heard and their distress acknowledged. Pay particular attention to non-verbal signs of feelings and emotions and attend to their comfort. This will go a long way in beginning to repair the emotional damage that has been caused.

Next, it is important to demonstrate an expression of regret or sorrow. You could use an apology of sympathy (for example, “I’m sorry this happened to you”) or an apology of responsibility (such as “I’m sorry I did this to you”). In some cases, an apology is all that unhappy patients seek from their doctor.

An open and truthful discussion should follow, including a factual explanation of what happened and any anticipated consequences so the patient is prepared for what to expect going forward. If required, propose a management plan for ongoing care. If you can’t provide this, explain how the patient can obtain further help and assist with arrangements by providing contacts and resources.

Finally, offer some comments on what has been learnt from the incident, as well as information on how recurrences will be prevented in the future.

If the patient is still unhappy and you suspect they will make a complaint, contact MPS as soon as possible. A medicolegal adviser will be able to provide you with advice specific to your individual situation.

While these recommendations may seem basic, the current litigation environment is such that good communication and expectation management are now more important than ever. They are some of the most important risk management tools a doctor can employ.

REFERENCES

While precise settlement figures can be affected by technical issues such as misdiagnosing a condition, which can lead to a chain of events set in motion by cumulative errors. This then leads to the whole picture with all the missing pieces and an adverse outcome. A judge will use the experts to inform him on medical issues and assess the issues objectively, the chain of events could have stopped being debated.

Interestingly, having had the opportunity to discuss this with my colleagues who deal with matters before the regulator, ‘reflection’ and ‘insight’ are words that are used repeatedly in that arena. Again, reflection can be the key to a successful outcome.

As a final thought, I can see how some may wonder why compensation is still paid even though there was no obvious outcome for the patient or any potential for a future period of low back pain. The decision of not to award compensation even though a causal link could not be established is challenging. However, I believe it is important to consider the potential for future pain and disability that could arise as a result of the injury.

Mrs. J returned later for the second diagnostic injection. Mrs. J was placed in the prone position and local anaesthetic infiltrated into the skin. Using fluoroscopy, the spine was visualized and the needle tip was confirmed to be at the correct level. Unfortunately, as soon as Dr. M started the injection, the patient jumped with pain and her left arm twitched. The procedure was abandoned.

Despite a normal neurological examination immediately after the procedure, the patient later that same day developed numbness in her left arm and right leg. She also complained of headache when sitting up, as well as pain in her left neck and shoulder. As she felt dizzy on standing, Dr. M decided to admit Mrs. J for overnight monitoring and analgesia.

The next morning, Mrs. J was no better. She felt unstable on her feet and complained of a burning sensation in her right leg, as well as weakness and shooting pains in her left arm. Dr. M decided that a second opinion was required and referred Mrs. J to a neurological colleague. An MRI was arranged, which unfortunately demonstrated signal change in the cord at a level consistent with the intended facet joint injection.

Over time, the MRI changes improved but Mrs. J continued to suffer from incapacitating lower back pain and at times radiating from the cord into her back. As a result of further investigations, Dr. M decided to bring a claim against Dr. M.

Mrs. J subsequently lost her job and, following unsuccessful and was later removed.

Dr. F concluded that insufficient images were taken to satisfactorily position the needles. She also noted that only 40 seconds had passed between the images taken for the first and second needle insertions, inferring that the procedure had been carried out with some haste.

MPS then instructed a causation expert to comment on Mrs. J’s progression of symptoms. Professor D concluded that the development of neuropathic pain in the right arm was understandable, although the disabling effects were more than he would have expected. Whilst the patient did have a history of neck pain, the patient’s symptoms were consistent with a lesion affecting the spinal tracts on the contralateral side of the cervical spine.

The case was considered indefensible and was settled for a high sum.
Mr S was a 60-year-old lorry driver. He was overweight and smoked, and couldn’t walk because he suffered pain in his calves. During a long drive he became aware of pain in his right calf and foot. This became so severe that he attended the on-call-hours service that evening. The GP measured both calves and found them to be the same. A history of foot pain but no calf tenderness was noted and a DVT was excluded. He told Mr S he likely had a problem with his circulation. Mr S was prescribed aspirin and advised to visit with his own GP for further follow-up.

Mr S struggled to sleep for the next two nights because he had a burning sensation in his right foot and lower leg, which felt cold and numb. He had gone to see the practice nurse to relieve the pain. He made an appointment with his own GP, Dr A, the next day. Dr A noted the history of numbness and rest pain. He documented that his right foot was pale and felt cold. He requested a non-urgent Doppler assessment because he could not detect any pulses in his right foot and described the pain as ‘thunderclap’ in the calf.

Mr S’s Doppler scan was arranged for the following week but he rang his GP surgery three days later because the pain in his foot had worsened. He was given an appointment with Dr A the next day to discuss the results.

Dr A discussed the Doppler results and documented that his right foot was cold. He made the diagnosis of ‘worsening peripheral limb insufficiency’ and arranged for Mr S to attend the surgical assessment unit the following day.

Mr S was admitted urgently from the ED. He had right calf and foot pain with his own GP, Dr A, the next day. Dr A noted the history of numbness and rest pain. He documented that his right foot was pale and cold. He requested a non-urgent Doppler assessment because he could not detect any pulses in his right foot and prescribed quinine sulphate.

Dr A advised him to go straight to the Emergency Department (ED). The ED doctor sent him home despite documentation of rest pain and a cool, pale right foot with weak pulses. The diagnosis of arterial insufficiency rather than acute limb ischaemia was made. Mr S was advised to stop smoking and to attend his Doppler assessment in four days’ time.

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A baby was born by caesarean section at 27 weeks gestation. The baby was intubated, ventilated and endotracheal surfactant was administered.

During the first four hours of life, the baby’s oxygen saturations were recorded as ranging between 95-97%. A blood gas taken five hours after delivery showed a pH of 7.48 (normal 7.3-7.4), a PaO2 of 35.8kPa (normal 8-10), a PaCO2 of 35.8kPa (normal 5-8) and a bicarbonate level of 24.6mmol/L (normal 18-24). This demonstrated the baby was being over-ventilated.

The baby was ventilated for three days, placed on continuous positive airway pressure (CPAP), and then placed on 0.5L nasal cannula oxygen due to recurrent apnoeic spells. Overall the baby received 204 hours of oxygen with oxygen saturation levels of 96-100% throughout.

The baby was not referred at four to six weeks of age for retinopathy of prematurity (ROP) screening, and was first seen by an ophthalmologist at the age of seven months when a diagnosis of irretrievable retinal (ROP) causing blindness, was made.

The baby’s parents made a claim against the consultant paediatrician who handled the baby’s care.

EXPERT OPINION

The baby had inappropriately high blood oxygen saturation levels and PaO2 levels for a period of 204 hours. During oxygen administration to premature infants, very high blood oxygen levels can develop if saturation levels rise above 96%. Weaning of the Fraction of Inspired Oxygen (FiO2) seldom occurred despite oxygen saturation levels of between 96 and 100%, indicating that the nursing staff had no protocol for weaning of oxygen according to oxygen saturation.

There was no record that an ophthalmological appointment for the screening of ROP was made at the recommended four to six weeks of age. The baby developed severe ROP and blindness due to excessive oxygen administration. The opportunity to limit the condition and save the infant’s vision was missed due to the fact that the child was not referred for screening for ROP.

There was negligence on the part of the paediatrician and nursing, in allowing the baby to be exposed to unnecessarily high oxygen levels in his blood over a four-day period, and failing to refer the child at the appropriate time for an eye examination.

The case was settled for a substantial sum.

Learning points

- Neonatal units should have written guidelines for oxygen saturation levels during the administration of oxygen to very low birth weight premature infants, and these must be adhered to.
- Attention should be paid to weaning oxygen when the saturation levels are more than 95%. The recommended safe levels of both weight infants are between 85% and 94%, irrespective of the prolonged oxygen exposure in very low birth weight infants in ROP.
- ROP is a relatable disease that affects premature infants, and can be limited by adhering to the specific guidelines for preventing prematurity infants at four to seven weeks of age by an ophthalmologist experienced in the identification and treatment of ROP.

Mr S was a 35-year-old taxi driver who was visiting his extended family abroad. While he was there he decided to have a routine health check in a private clinic. He told the doctor in the health clinic that he had noticed some rectal bleeding over the previous four months. The doctor did a digital rectal examination and proctoscopy and saw two rectal polyps. He gave Mr S a letter to take to his GP at home, explaining the findings and recommending a colonoscopy to further investigate his bowel.

Mr S returned from overseas a week later and made an appointment with Dr A. He gave Dr A the letter from the overseas health clinic and explained that he had noticed occasional rectal bleeding over the last four months. He said that he had seen one of his colleagues a month before who had seen external haemorrhoids that were bleeding slightly. Dr A advised Mr S to avoid constipation to help with his haemorrhoids. He filed the letter from the health clinic but did not act on it.

The following year Mr S was still bleeding occasionally. He remembered the concerns of the overseas doctor and rang his GP surgery. He was given an appointment with Dr B. He explained that he had seen manor blood on the toilet paper and in his stool for months and was concerned about the cause. Dr B examined him externally and noticed some small haemorrhoids. He advised that Mr S was not keen on medical intervention and suggested that he drink more fluids and increase his fibre intake. The bleeding persisted for six months, but the bleeding persisted so he visited Dr B again. Dr B did a purely external examination again and documented “simple external piles”. He prescribed anusol suppositories.

Over the next three months Mr S began to lose weight and feel very tired. His wife was concerned that he looked pale. He still had the bleeding and was having episodes of diarrhoea and constipation. He made an appointment with Dr C, another GP from his practice, who arranged for some blood tests, which showed significant iron deficiency anaemia. She referred Mr S to the colorectal team, who diagnosed rectal carcinoma.

He had a panproctocolectomy and the histological diagnosis was of two synchronous rectal carcinomas, Duke’s stage C1. Multiple adenomas were found, some with high grade dysplasia, and it was considered that Mr S had Attenuated Polyposis Syndrome.

Mr S and his family were devastated. He struggled through chemotherapy and radiotherapy. He was told that it was not possible to reverse his ileostomy and that his five-year survival rate was 45-55%. He was very angry and made a claim against Dr A for not referring him earlier or taking notice of the overseas health clinic’s recommendations.

EXPERT OPINION

Mr S’s case shows the importance of referring suspected cancer cases and the need to assess patients appropriately. Mr S’s case was unique as he was a 35-year-old man who had never had any significant bowel symptoms before he was referred.

Mr S was referred for bowel screening by his GP, but the decision to refer Mr S to a specialist gastroenterologist was made by his GP. The GP did not inform Mr S about the recommendation for a colonoscopy and did not raise any concerns about his symptoms.

The GP decided not to refer Mr S for a colonoscopy and instead arranged for the patient to be referred to a colorectal surgeon.

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Miss A, a 40-year-old IT consultant, was talking to a colleague at work when she developed a headache, along with blurred vision and nausea. Her symptoms worsened as she ran to the nearest Emergency Department (ED). Miss A was triaged as moderate urgency and examined by Dr X who recorded that her head felt “heavy” at work and she’d felt herself breaking out in a cold sweat, with a throbbing frontal headache radiating to each temple. The notes describe Miss A lying on a trolley covering her eyes with her hands, with temperature of 35.4, blood pressure 152/96, pulse rate 58/min, and tenderness over her temporal muscles. Her neurological examination was essentially normal. Kernig’s sign was negative and she had no sinus tenderness or neck stiffness. There was no past medical history of migraine or family history of note. She was given IM metoclopramide and diclofenac.

A record followed of a telephone discussion with another doctor, who requested that Miss A have hourly neurological observations, be given analgesics and be reviewed in the emergency observation unit. Miss A received intravenous fluid and analgesia. She had a normal full blood count, electrolytes, liver function tests, bone profile and C-reactive protein. ESR was mildly raised at 30mm/hr. Two hours later, Miss A was assessed and, although the headache was still present, she was feeling better and the blurred vision and dazzle had resolved. The raised ESR was noted with a comment that it was unlikely to represent giant cell arteritis. Following a diagnosis of migraine headache, she was discharged with analgesia and advised to return if the symptoms worsened.

Two days later, Miss A returned to work, though she still had the headache and preferred to be in a dark room. The next week she attended her GP, Dr X, who listened to her history and read the hospital letter, noting that she still had a throbbing bi-temporal headache worse on movement and relieved by being in a dark room. He recorded a blood pressure of 120/80, no carotid bruits on auscultation, and a normal neurological examination with recorded a blood pressure of 130/80, no carotid bruits on auscultation, and a normal neurological examination with.

The following day, Miss A phoned to report that her headache was much better. Dr X recorded a discussion about a possible ophthalmology opinion and follow up.

Over the next three weeks, Miss A continued to have a headache, which varied in severity. She didn’t seek further medical advice because she expected the headache to pass, after being investigated at hospital and attending her GP. Her partner said later she had no reason to doubt the advice she had been given.

One month after the headache started, Miss A left work early because of another severe headache. While brushing her teeth, she lost consciousness and collapsed. She vomited twice before an ambulance took her to the hospital. Miss A’s headache was so severe that hospital admission was essential that day to exclude a diagnosis. She vomited twice before an ambulance took her to the hospital. Miss A’s headache was so severe that hospital admission was essential that day to exclude a diagnosis. Dr X had based his own diagnosis on the reported pulsating headache lasting 4-72 hours of moderate to severe intensity, aggravated by routine exertion and associated photophobia. Miss A had worked stress, which may have precipitated a migraine and reinforced the diagnosis. Migraines usually present as unilateral headaches, but bilateral headaches can also occur. Miss A’s headache was frontal to begin with and then bi-temporal when she’d attended Dr X. Although she had no history of aura, migraines without aura are more common. In Dr X’s opinion, it did not matter if Miss A had no past history of migraine – not all patients are aware they may have experienced migraines in the past.

The claim was settled against both Dr X and the hospital for a moderate sum.
of squamous cell or “more likely a malignant
removed as the doctor noted the possibility
earlier. Only the crust of the lesion was
The day after the urgent referral was made,
Mr M was referred urgently to
prescribed flucloxacillin as he felt the lesion
was infected. Mr M was referred urgently to
metastatic disease, despite
He died in July of progressive
malignant melanoma. Can you see him as a matter
of how the lesion looked and no action was
The following month, a third doctor in the
practice about the skin lesion – it had
symptoms and Mr M also mentioned the
appearance. When referring, it is helpful
to detail how the lesion looks in terms of
whether they are growing or changing in
the lesion. What had changed about the
lesion that Mr M referred the surgery for
examination in the first place? This
should have been documented further and
a full history documented.
Mr M’s widow made a claim against the
doctors at the practice for failing to
diagnose the lesion as malignant
sooner.
Mr M underwent wide excision and
One month later, in March, Mr M
underwent wide excision and
axillary dissection, but his condition
deteriorated. Unfortunately, he had
developed brain metastasis by April
and stage 4 malignant melanoma.
He died in July of progressive
metastatic disease, despite
Mr M’s widow made a claim against the
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Mr H is a 45-year-old solicitor and father of three, visited his GP for a persistent headache. He described two months of symptoms, occurring up to six times per week, mainly in the mornings and with associated nausea. Dr P took a thorough history and neurological examination, including fundoscopy. He excluded alcohol, stress or carbon monoxide poisoning as potential precipitants, and found no other ‘red flag’ symptoms. Mr H mentioned that a close friend had been diagnosed with a brain tumour a few years ago. He was not particularly worried about this, but Dr P decided it should be excluded and referred him for an early neurological opinion.

As part of his examination, Dr P checked the patient’s blood pressure and found it to be elevated. Mr H had been attending the practice for a few years. He had been arranged with the practice nurse a few days later and this had reduced to 132/72. No further action was taken.

Mr H was seen by neurologist Dr B some six months after his initial GP presentation, and underwent an MRI scan. The scan was normal and Dr B advised Mr H that his headaches were likely to be related to muscle tension. Mr H didn’t see Dr P again for another two years. When he re-presented to Dr P, it was mentioned by Mr H that he had returned to work and was feeling better. Mr H mentioned that the headaches had been ongoing for two years and were still associated with what he described as an MSU and bloods to be taken (CRP, LFTs, PV and PSA) and commenced a referral to an orthopaedic surgeon for further evaluation. Mr H was referred for an MRI scan. The scan was normal and Mr H had a follow-up appointment with Dr B who noted tenderness over the medial side of the knee and a 1.5 degree fixed flexion deformity. He advised an arthroscopy for further evaluation. This confirmed the presence of multiple loose bodies and attached soft tissue structures. Mr B made a provisional diagnosis of a foreign body reaction and took biopsies for histology.

Expert opinion
Expert opinion was supportive of Dr P’s initial management. When Mr H first presented with headaches he had a single mildly elevated blood pressure reading followed by two normal results, which would not be consistent with a headache secondary to malignant hypertension or renal disease. Although outside his area of expertise to comment on a GP’s standard of care, he did comment on Dr P’s failure to follow up Mr H more intensively once his hypertension was diagnosed and for failing to assess baseline renal function in conjunction with starting lisinopril. However, since the treatment to delay renal deterioration is to use an ACE inhibitor, experts agreed that on the balance of probabilities, earlier intervention is unlikely to have significantly affected Mr H’s long-term renal prognosis.

Mr H subsequently discontinued his claim.

Learning points
• When starting new anti-hypertensives it is important to have a baseline measurement of renal function, and ongoing monitoring of renal function thereafter. The NICE guidelines on Clinical Management of Primary Hypertension in Adults: See guide page 19. Clinical vigilance is important.
• In the minute GP consultation, blood pressure should be checked, but it may not be the main focus of the consultation. It is important to not overlook monitoring of hypertension when dealing with multiple other compliance and educational systems in play to ensure this is followed up.

CASE REPORTS

A PERSISTENT HEADACHE

SPECIALTY GENERAL PRACTICE
SUCCESSFUL DEFENCE

THE SWOLLEN KNEE

SPECIALTY RADIOLOGY
THEME DIAGNOSIS

SUBSTANTIAL US$200,000+

In the opinion of the MPS radiology expert, Dr J, Dr A had underreported the MRI scans in that he had failed to mention the presence of a joint effusion with non-specific tissue followed in the supra-patellar pouch. In his opinion, however, it would have been inappropriate on this evidence to consider a sarcoma in the differential diagnosis. In the context of a recurrent acute episode these findings were likely to represent breakdown products of blood.

Further investigation would have been dictated by the subsequent clinical course of events, albeit that this may have been influenced by the MRI findings. Mr K, the orthopaedic expert, agreed with Dr J that the MRI findings were non-specific and not indicative of malignancy. Had the MRI been reported in the terms suggested by Dr J, Mr K considered it likely that the GP would have reassured Ms M and treated her conservatively with physiotherapy, which was, in fact, what happened.

Had Ms M’s symptoms not settled down following the first MRI scan it is likely the GP would have referred Ms M to an orthopaedic surgeon who would probably have arranged an arthroscopy, and biopsied the lesion. This would have resulted in the same course of action and outcome as that which subsequently transpired. The treatment options that would have been offered would have been above knee amputation or tumour resection followed by radiotherapy. The prospects of success for the latter option would have been low, with a high risk of recurrence. In Mr K’s opinion, the only safe option was above knee amputation. He disagreed with the claimant’s expert, Mr C, that amputation would have been avoided had the diagnosis been made 14 months earlier.

MPS argued that although there was a breach of duty by Dr A in failing to report the presence of an effusion and soft tissue within the knee joint, this would not have altered the outcome. Had Dr A reported the MRI scan correctly, management would have been dictated by the subsequent clinical course and would most likely have been conservative in the first instance. From the outset, above knee amputation would have remained the only curative treatment option, and hence the amputation could not be attributed to any failure on Dr A’s part to report the abnormalities on the original MRI scan and so causation could not be established.

Although the claimant could not be persuaded to discontinue on the causation defence alone, it enabled MPS to settle the case for a reduced amount, based on the patient’s additional pain and suffering.

The Swollen Knee

A forty-four-year-old Ms M presented to her GP with pain and swelling of her right knee. She had experienced similar symptoms three years earlier whilst pregnant but had not undergone any investigations at the time. The GP made a provisional clinical diagnosis of recurrent meniscal injury and referred Ms M for an MRI scan.

The radiologist, Dr A, reported the scan as normal. Plain films taken at the same time showed evidence of mild degenerative change and several small loose bodies above and below the joint, which were not considered significant. Ms M underwent a course of physiotherapy. Fourteen months later she presented with acute locking of the knee after an aerobics class. She was experiencing difficulty sleeping and reduced movement in the knee joint and was referred to Mr B, who noted tenderness over the medial side of the joint and a 1.5 degree fixed flexion deformity. He advised an arthroscopy for further evaluation. This confirmed the presence of multiple loose bodies and attached soft tissue structures. Mr B made a provisional diagnosis of a foreign body reaction and took biopsies for histology.

Interpretation of the histology proved extremely challenging and the specimens were sent to a number of eminent pathologists. The consensus was that this was a high grade, undifferentiated soft tissue sarcoma, although malignant pigmented villonodular synovitis (PVNS) could not be entirely excluded.

A further MRI scan was carried out, which identified a residual soft tissue mass that was also biopsied and confirmed to be consistent with the initial histology. Ms M underwent an above knee amputation followed by chemotherapy.

She subsequently made a claim against Dr A for alleged failure to properly interpret and report on the original MRI scan, thus leading to a delay in diagnosis of synovial sarcoma, which necessitated an above knee amputation.
Miss C’s 30-year-old accountant, developed an asymptomatic left-sided neck lump. A scan revealed a 23 x 17 x 27mm mass at the carotid bifurcation consistent with a carotid body tumour. Miss C was referred to the vascular surgeon, Professor A, who noted there was no significant medical or family history and confirmed that she was normotensive with no neurological signs. He explained that this was a rare tumour with the potential for malignancy and recommended surgical excision, which he undertook the following day. Miss C signed a consent form completed by Professor A for ‘medical excision of left carotid body tumour’.

During surgery, the carotid bifurcation was damaged, resulting in rapid blood loss of approximately 3,100mls. Professor A recorded that the bleeding was controlled by clamping the common carotid artery three times for a total of 16 minutes. The injury was repaired with ‘difficulty’ using a 5/0 prolene suture and at the end of the procedure there was good flow in the internal carotid artery.

Postoperatively, Miss C was transferred to the ICU where she was extubated and transferred to the ward. Miss C initially appeared drowsy, but had no obvious neurological deficit. She remained stable overnight but the following morning appeared drowsy and was noted by the nursing staff to have profound right-sided weakness. Dr B, ICU anaesthetist, reviewed Miss C and attributed her drowsiness to oligaemic toxicity and presumed neurological deficit. This diagnosis did not improve and when Professor A saw her, he arranged an urgent MRI scan. The diagnosis was confirmed: a middle cerebral artery territory infarction with complete occlusion of the entire extra-cranial left internal carotid artery. Miss C was taken to theatre for urgent carotid clamping.

Postoperatively, Miss C initially appeared neurologically intact and experts therefore felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also agreed that while anti-coagulation may have prevented thrombus formation, such a trauma was at high risk of major haemorrhage and was contraindicated.

The experts raised concerns regarding the failure of the nursing staff to inform the medical team immediately when Miss C demonstrated neurological deterioration. Dr B was also criticised for not performing a full neurological evaluation and wrongly attributing the decreased conscious level simply to oligaemic toxicity. It was speculated that the resulting delay in the diagnosis and treatment of Miss C’s stroke may have led to a worse neurological outcome.

However, the main focus of criticism centred on the consent process. Experts acknowledged that Professor A carried out surgery the day after the initial consultation, given the slow growing nature of carotid body tumours. Miss C’s family felt the process had been rushed and that she had not fully understood the magnitude of the risks of surgery. Indeed, there was no documented evidence that any of the major complications had ever been discussed and Professor A accepted that the process of informed consent had been inadequate.

The case was settled for a small sum, reflecting the severe neurological outcome and the need for continuous care.

Expert opinion
Miss C’s family felt that the process had been rushed and that she had not fully understood the magnitude of the risks of surgery. Indeed, there was no documented evidence that any of the major complications had ever been discussed and Professor A accepted that the process of informed consent had been inadequate.

The case was settled for a small sum, reflecting the severe neurological outcome and the need for continuous care.

Expert opinion
Expert opinion agreed that arterial bleeding from excision of a carotid body tumour is a well-recognised and inherent potential risk of such surgery and Professor A handled this complication in an appropriate and timely manner. Although questioning the need for three periods of carotid clamping, it was felt that the total time of potential cerebral ischaemia was relatively short and the alternative approach of arterial shunting carried its own additional risks.

Learning points

- Communicating within the team is important – the nursing staff did not inform the medical team of the patient’s deterioration – consider a team approach for raising concerns.
- Good communication and documentation are essential in the process of consent. Patients must be made aware of the risks of surgery and their implications. This would include common complications as well as any serious adverse outcomes, including reoperations, which may result in permanent disability or death. Patients need to be able to weigh up the benefits and risks of an intervention so that they can make an informed decision as to whether they want to proceed.
- Comprehension can wax and wane and are not necessarily a sign of negligence.
- Litigation can be prevented successfully if patients are educated about the risks in advance and this discussion is recorded.

SD

The story of Beth Bowen

Our cover story in the previous edition of Casebook, “The Story of Beth Bowen”, drew a powerful and emotional response from many readers – indeed your letters were so numerous that we can only print a small selection in this edition.

The two letters below capture many common themes: respect and admiration for Claire Bowen in speaking openly about her diagnosis, loss and anger and disbelieving at Mr’s Bowen’s struggle to obtain answers and information.

Although mistakes in medicine are unavoidable, many issues in this case combined to contribute to the tragedy and its aftermath: from the surgical team’s misplaced confidence (in terms of the equipment used), to the lack of an appropriate and valid consent process. This was only exacerbated by the institutional behaviour of the hospital, which made it so difficult for the Bowen family to get the explanations and apologies that were their basic right.

MPS has long campaigned for greater openness in healthcare, particularly when things go wrong. This is a challenging and difficult process, which needs the support of culture, colleagues and organisations. The story of Beth Bowen as narrated by her mother, in Casebook (2014: 22:3), pp 10-11, I wish to express my deepest sympathy to the Bowen family and concur with Mrs Bowen that the medical profession fell short of expectations in this case and much needs to be done.

The irony was that the child would not have died 30 years ago, before the widespread introduction of laparoscopic surgery if she had open splenectomy, a properly qualified surgeon could have completed the operation with minimal risk. Even if a major blood vessel is torn, it could have been controlled without delay. Laparoscopic surgery denies the surgeon the important faculty of tactile sensation and stereoscopic vision. It also denies the surgeon rapid response to accidental tear of major blood vessels and organs as illustrated in this case. Worst of all, it opens a floodgate and permits the introduction of high-risk instruments like the morcellator, which has killed other patients including adults, children, and not young surgeons that are dangerous. Senior surgeons trained in the open classical procedures are even more dangerous if they try their hands on laparoscopic procedure without proper retraining. It is very important to have a small scar that we should compromise safety standards?

John SM Leung, FRCS(Ed), Hong Kong

Casebook 22(3), September 2014

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MISSED CAUDA EQUINA

You report a case of a GP missing a cauda equina syndrome in a patient with a slipped disc (page 17, Casebook September 2014). I do not believe this is within the expertise of a GP and is not even within the expertise of many specialists. I have seen several of these cases not from slipped disc but from anaesthesia either by inserting a needle into the lumbar spine or from the insertion of a plastic catheter to anaesthetise the abdomen or legs. Most anaesthetists claim the procedure is harmless and that ‘soft’ catheters can’t harm. It may be rare but it is completely false to assume it is harmless.

HIGH EXPECTATIONS

I am rather puzzled by “High Expectations”, on pages 22 to 23 of the September 2014 issue. From the description of the case, it sounds very likely that this was indeed a case of post viral fatigue syndrome (also known as Myalgic encephalomyelitis or chronic fatigue syndrome). No diagnosis is given and I believe it could be a possible diagnosis of chronic fatigue or what management was given for the condition.

Post viral fatigue syndrome is a common condition probably affecting about 1% of the population. It is not difficult to diagnose as there are clear diagnostic criteria available today and it would be interesting to know whether the patient fitted the diagnostic criteria or not. They did indeed seem so bizarre to doctors that I feel a misdiagnosis would be unlikely if the criteria were properly used. In addition, in the following paragraph it is stated that the patient “…was convinced that there was a physical cause for his symptoms…” as if this rebutted the specialist opinion. However it is well known today that chronic fatigue is indeed an organically-based physical condition. The weakness was clearly shown at the last conference of 2014 in the United States and it is no longer considered acceptable to consider a non-organic basis for the disease. It is probably a chronic encephalitis but this has not been definitively proven. There is management available for chronic fatigue syndrome.

In my opinion, it is indeed negligent to miss this diagnosis in a patient who fits the criteria for it (eg, Carruthers et al 2003 and 2011 – these are the criteria). In addition the patient’s prognosis can be adversely affected if proper management including management of activity scheduling is not instituted as soon as possible.

Unfortunately, at least in South Africa, this disease now occupies the same space as mental illnesses did in the dark ages and as multiple sclerosis did at the turn of the last century (“Fisher’s Disease”). Patients generally do not have the energy or financial means to pursue their cases against doctors regarding their diagnosis but in my opinion it certainly should be a source of litigation because of the poor diagnostic skills of most practitioners. In regard to the ignorance about management and the stigma which doctors attach to this disease, greatly increasing the significant suffering of patients.

Dr Elizabeth Murray, Rondesbuche Medical Centre, Mediclinic Constantiaberg, UCT Private Academic Hospital, South Africa

Response

Thank you for your letter of 21 September, regarding the case report “High Expectations”. By necessity, our case reports are a summarisation of the actual case, where the diagnosis was made in a few days or weeks, not a few months or even hundreds of pages. This does mean that we are only able to focus on the most salient features of the case from a medical/legal perspective.

In this particular case, even after the involvement of a number of specialists, the diagnosis was not completely certain. The claimant alleged a failure to make the diagnosis (probably a variant of chronic fatigue syndrome), as well as a failure to arrange vestibular rehabilitation. This will have been based on the advice of his solicitors and, in all probability, an expert opinion.

However, the expert opinion obtained on behalf of our member was supportive, as explained at the end of the article. It is important to bear in mind that the standard to be applied here is that of a responsible body of general practitioners, and not any higher or different, standard. It is also the case that where there might be more than one school of thought on a particular issue, a doctor will not be negligent for choosing one over the other, as long as the option he chooses is supported by a responsible body of practitioners, skilled in that particular specialty, even if that is a minority opinion.

In this case, the claimant withdrew their claim before the matter came to court, which generally indicates that their solicitors considered the strength of this expert opinion had advised them that their case is unlikely to succeed.

Of course, medicine is constantly changing and advancing, and what would have been acceptable practice five years ago may no longer be supportable. In the context of medical negligence litigation, the standard which applies is, of course, that which applied at the time in question.

Thank you once again for your comments.

THE ELUSIVE DIAGNOSIS

Re: “The elusive diagnosis”, Casebook September 2014. I am very surprised from the evidence given that the claim for late diagnosis of diabetes (presumably mellitus) was successfully defended. The failure to test the plaintiff’s urine is irreconcilable.

Many years ago the late Professor Peter Jackson estimated that in Cape Town there were an estimated 20,000 asymptomatic people with undiagnosed diabetes mellitus. Since then the provincial facility at which I used to practise has tested the urine of every new and returning patient for glucose et al. We were newly diagnosing two to three diabetes mellitus patients every week.

Dr Stephen A Crowen, Hon Lecturer in Family Medicine, University of Cape Town, South Africa

I read “The elusive diagnosis” (Casebook 22(2), September 2013) with great interest, in particular the mention during two presentations of penile symptoms, described as “sore scratch on L-side of penis” and “a rash on the glans penis”.

Some years ago I submitted with a medical student a paper to the BMJ on the hope it would be published as “Lesson of the week”. We reported case histories of four men, aged 26, 34, 51 and 51 years, who presented to our department of geriatric medicine in the month of July 2008 and were found on examination to have balanoposthitis, while three of them also had fissuring of the penile skin. All gave a history of or had a tight prepuce presentation. None have the previous diagnosis of diabetes but all four were found at their first attendance to have glycosuria, with random blood sugars of 28.8 mmol/L, 14.3 mmol/L and 175 mmol/L in order of their ages as above. The 26-year-old gave a ten-month history of balanoposthitis and was subsequently diagnosed with Type 2 diabetes requiring insulin. All four had their diabetes managed by their GPs and at least two were prescribed metformin.

These patients all presented with balanoposthitis and at some stage appeared to have associated phimosis. It has been previously suggested that the sudden appearance of these symptoms in a patient without a prior history justifies investigating such patients for possible diabetes.

The paper was not accepted for publication as it was felt that the association with balanoposthitis and diabetes was well known, although interestingly the 40 and 51-year-old had been advised to attend our department by their GPs.

It is difficult from the description of the penile symptoms in the case presented in “The elusive diagnosis” to fully assess their relevance in regard to missing the diagnosis of diabetes in this case but balanoposthitis (and vulitis particularly when recurrent) certainly warrant at least checking the patient’s urine for glycosuria.

Dr Mike Wolfman, Consultant in Genitourinary Medicine, George Eliot Hospital, Nuneaton, UK

Response (to both letters):

Thank you for your correspondence about this case.

The chronology of the symptoms relating to the skin in this case was a sore scratch to the penis (possibly infected) in June 2006, and of a rash on the hand and penis eight months later, in February 2007.

Whether a doctor would be considered negligent in not considering diabetes in such circumstances revolves around whether their actions would be supported by a responsible body of medical opinion, skilled in the relevant specialty. In this case, the relevant specialty is general practice, and the GP expert instructed by MPS was supportive of our member’s actions.

It is important to realise that where there might be differing views as to the appropriate steps to take in an individual case, a doctor is not negligent for choosing one option over another, as long as the option chosen would be supported by a responsible body of opinion.

It was on the basis of the supportive opinion that MPS decided to defend the case.

Subsequently, the claimant discontinued his case, presumably on the advice of his solicitors and any expert opinions they had obtained.

CORRECTION

The following correction relates to a photo accompanying the case “A cannuia complication” in the previous issue of Casebook. Our photographs are taken from stock image libraries and are chosen to reflect the general theme of an article or case. Here, the case related to the potential risks associated with cannulation, specifically necrotic damage to the radial nerve, and the image was chosen to reflect that theme. In this case a picture of venous cannulation would have been better, and we apologise for any confusion caused by this error.

REFERENCES

1. Hershfield M, Dahlen CP, Phimosis with balanoposthitis in previously undiagnosed diabetes mellitus, QJM 1993; 86: 85-89
BEING MORTAL

Atul Gawande

Review by Dr Sam Dawson
(Specialty trainee, anaesthetics, Northern Ireland)

Atul Gawande barely needs an introduction. He is the author of three bestselling books, winner of multiple awards for writing and Professor at Harvard Medical School. He was also a key figure in the implementation of the WHO checklist revolution.

His new book Being Mortal is a compassionate yet unfurling look at what mortality means in the 21st century. In it, he explores the way in which modern medicine is letting our patients down at the ends of their lives whether in nursing homes, hospitals or hospices. At the same time, he reveals the people and institutions redeeming the situation with unparalleled passion and creativity.

Gawande does this by telling the stories of his patients facing cancer, of his neighbours and, most movingly, of his own family, as they face old age, decline and death. He weaves together research, philosophy, historical study and personal anecdotes to show that many of us are neither living well in our last days nor dying the way we want.

Most damning of all, however, is the realisation that the medical profession is not only hapless in the face of this suffering but acting harmfully as a result of paternalism, lack of imagination and fear. Gawande’s previous book The Checklist Manifesto ushered in a new global paradigm of perioperative safety with a simple, yet radical idea. Being Mortal could do the same for end-of-life care.

I read most of this book in my on-call room, pausing to attend the critically ill in the wards, theatre and emergency department in which I work. This added extra poignancy to what is already an emotional, compelling and challenging book. It isn’t perfect – at times the interlinking of stories is disorientating and the section on assisted dying appears somewhat tacked on. However, this book is for anyone who has ever stared speechlessly into the eyes of someone who knows they are dying, or who has had the difficult task of counselling their relatives. In fact, it is for anyone who wants to live well, help others live well and, in the end, die as well as they can.

What would a new era of ingenuity, empathy and dignity look like for our patients as they approach the end of their lives? It is obvious Gawande is not entirely sure, but in Being Mortal he is asking the right questions and exploring novel solutions to a situation we desperately need to improve.

POSTMORTEM: THE DOCTOR WHO WALKED AWAY

Maria Phalime

Review by Dr Anand Narabhai
(Intern at New Somerset Hospital, Western Cape, South Africa)

After practising clinical medicine for four years, Maria Phalime decided to stop. Postmortem: The Doctor Who Walked Away tells the story of her search for an introduction. He is the author of three bestselling books, winner of multiple awards for writing and Professor at Harvard Medical School. He was also a key figure in the implementation of the WHO checklist revolution.

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After practising clinical medicine for four years, Maria Phalime decided to stop. Postmortem: The Doctor Who Walked Away tells the story of her search for an explanation and provides a useful commentary on the profession.

The book is divided into two parts. In the first part, Phalime searches within herself for reasons why she left. She tells of her life growing up in Soweto and high school years. From then on the cliches and anecdotes were unoriginal to my ears, but often benignly accepted issues that we face in the medical profession. In the end, Phalime’s decision to leave is multifaceted. She concludes: “It was tough, it was sad, and I left, that’s all.”

She practised medicine during the dark age of HIV-daniolism, and in the often frustrating, pressured and disheartening South African public health sector.

There is a bigger lesson in the book: in an interview with Stellenbosch University Dean of Health Sciences, Professor Jimmy Volmink, Phalime is told “We are all on a journey, and sometimes that journey takes us overseas, into the private sector, or even out of the profession altogether. People have got to be allowed to take that journey.” Phalime is on her journey, each of us is on our own, and for our patients, maybe the point of what we do by caring for their health, is to give them an opportunity to take their own journey.

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