Cayman Islands National Healthcare Conference

Healthcare Economics: The Search for Quality and Affordability

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Ritz-Carlton, Grand Cayman, Cayman Islands

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Welcome

Dr Stephanie Bown – Editor-in-chief
MPS Director of Policy and Communications

Over the past few years, the volume of literature that MPS has produced for members worldwide has expanded significantly. Whether it be new serial publications, factsheets, booklets or email bulletins, the range of information now available to help support you in your practice covers many specialties and stages in your career.

With this in mind, we recently conducted a survey among our UK members to gauge their opinions on the quality of our material. MPS takes pride in offering so much more than medical indemnity: we consider it our duty to do as much as possible to guide, advise and support doctors to help prevent complaints and claims arising in the first place. Therefore it is important that we ensure our literature continues to be accurate, practical and relevant to you all.

I was pleased to discover that Casebook in particular continues to receive the strongest positive feedback, and clearly has a role to play in influencing the practice of its readers. One practice manager reported using material from Casebook to plan training.

Most attention was on the case reports, which seemed to draw a blend of reactions – from appreciation of their educational benefits to sheer terror. Either way, readers shape the decisions they make based on the learning points of each report, which is what Casebook sets out to accomplish as a risk management tool.

We are planning similar surveys in other countries in the future. But in the meantime, if anyone would like to submit their thoughts on the standard of all our medicolegal literature – including and beyond Casebook – we would welcome your feedback and ideas.

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Casebook is designed and produced three times a year by the Communications Department of the Medical Protection Society (MPS). Regional editions of each issue are mailed to all MPS members worldwide.

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MPS opened more than 13,000 new case files last year. Whilst the primary purpose of our files remains that of comprehensive support for members through high quality and effective management of those cases, we remain committed to feeding back issues from them that may help other members avoid harm or error in similar circumstances.

In doing so we try hard to avoid hindsight bias – the risk of knowing an adverse outcome has occurred can increase the potential for those reviewing or analysing cases to believe it was predictable and that it therefore could have been prevented.

To gain a broader perspective we look at groups or clusters of cases. The purpose is to draw out common themes and to identify trends, rather than to create specific clinical standards, guidelines or protocols, which would be inappropriate for MPS to do.

Case reviews can help to provide the type of information that can drive and compel changes to systems, behaviours and clinical skills. Unfortunately, many of the most helpful lessons come from cases involving a failure to meet the required standard of care, so you will tend to see and hear more about those cases than the ones that are discontinued against members or defended successfully to trial.

I remain of the view that simply counting errors will do little to support the conscientious clinician in reducing risk. We hope that these case reviews will continue to stimulate the type of debate between colleagues and within teams that encourages an environment receptive to understanding and reducing our risks.
Medical expert training course

On Saturday 2 – Sunday 3 July, MPS hosted a Training Course for Medical Experts at the Academy of Medicine of Malaysia, Kuala Lumpur. The event sold out, with more than 100 delegates attending.

Doctors are increasingly invited to act as experts and to provide an independent opinion in medical negligence litigation, MMC inquiries, personal injury court cases and other tribunals. The course provided experts with practical tips on enhancing their skills.

Presentations included: The Role of Medical Experts by MPS Head of Medical Services (Asia), Dr Ming-Keng Teoh; Expert Reports – the Good, the Bad and the Ugly by Emma Hallinan, MPS Director of Claims and Litigation; and Preparing for Trial and Appearance in Court – What to Expect by Muralee Nair, of Shearn Delamore and Co.

The course closed with a role play, Live in Court, looking at how to develop courtroom skills.

UK

In July, MPS held a parliamentary reception at the House of Commons to raise awareness about our Openness campaign, calling for doctors to be open and honest with patients when things go wrong. The reception launched our publication A Culture of Openness which is available on our website, and stimulated discussion about ways to achieve this openness in the NHS.

MPS has launched a Facebook page for medical students. The page contains information on e-learning resources and revision materials, sponsorship opportunities, MPS publications, events and student representatives. Visit Facebook and like “MPS” to access these resources.

IRELAND

MPS will be holding a Making the Most of Your Consultant Post conference, aimed at doctors preparing for their consultant post, at Croke Park, Dublin, on Friday 11 November 2011. For more information visit: www.medicalprotection.org/ireland/courses-and-events

SOUTH AFRICA

Chaired by MPS medicolegal consultants Dr Tony Behrman and Dr Liz Meyer, “Ethics for All”, the annual MPS ethics evening, will be held in Pretoria on Monday 21 November (CSIR International Conference Centre) and in Cape Town on Wednesday 30 November (Cape Town International Convention Centre). For more information visit: www.medicalprotection.org/southafrica/events-and-conferences/ethics-for-all

Dr Stephanie Bown, MPS Director of Policy and Communications, met with Dr Aaron Motsoaledi, Minister of Health, in June to discuss the rising cost of claims in South Africa and how this is affecting doctors and patients alike.

NEW ZEALAND

Reflecting our commitment to providing the best possible service to our growing membership, MPS will be opening a new branch office in Auckland in late September. The new office, based in Fort Street, will complement the existing Wellington office and will be staffed by highly experienced medical advisers. The existing contact number, 0800 225 5677, will be the single contact number for both offices.
HEADLINES AND DEADLINES

Healthcare achievements welcomed by CARICOM

Developments in healthcare across the Caribbean region over the last ten years have been welcomed by the incoming chairman of the Caribbean Community (CARICOM), Dr Denzil Douglas. Speaking before the 32nd annual meeting of the CARICOM Conference of Heads of Government, which opened on 1 July in St Kitts and Nevis, Dr Douglas listed a number of examples where notable developments had occurred.

He said that CARICOM was the first in the world to provide a response to the 2001 United Nations General Assembly special session on HIV and AIDS and its subsequent declaration, which led to the establishment of the Global Fund for HIV/AIDS, tuberculosis and malaria.

This response was the Nassau Declaration – the Health of the Region is the Wealth of the Region – which then helped establish PANCAP, the Pan Caribbean Partnership against HIV and AIDS, and the proposed Caribbean Regional Public Health Agency (CARPHA).

PANCAP has been acclaimed as international best practice by the United Nations, demonstrating progress in the response to HIV/AIDS with a significant reduction in the mortality rate, increased access to treatment for more than 50% of people living with AIDS, and a decrease in the prevalence rate of HIV infections.

Meanwhile, CARPHA was established as a legally-recognised entity, following a signing of an inter-governmental agreement at the annual meeting. The agency aims to improve the quality of healthcare delivery in the region by merging the core functions of the five regional health institutions: Caribbean Epidemiological Research Center (CAREC), Caribbean Health Research Council (CHRAC), Caribbean Food and Nutrition Institute (CFNI), Caribbean Environmental Health Institute (CEHI), and the Caribbean Drug Testing Regional Laboratory (CDTRL).

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CAYMAN ISLANDS

National risk survey planned

A national health risk factor survey, enabling the collection of baseline data for a number of health issues, is a step closer to reality in the Cayman Islands.

A meeting of the Ministry of Health’s Non-communicable Disease Risk Factor Survey Coordinating Committee established a clear plan for the survey, meaning vital information related to diabetes, cancer and heart disease could be gathered for the population.

Health Minister Mark Scotland said: “The meeting was an exciting step forward in getting the baseline health information necessary for future planning. Relevant, current and localised statistics are key ingredients in successful national prevention and treatment programmes, and this committee is about closing the information gap for us.

“Firstly, the work enables us to focus our resources for targeted interventions. Secondly, if we do nothing, heart disease, cancers and diabetes will spiral out of control.

“As for Cayman, already some 6% of our population suffers from diabetes and 12% have been diagnosed with high blood pressure. These are serious figures and we simply must address these issues as a matter of urgency.”

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BELIZE

Consultation over global AIDS responses

A worldwide study of AIDS responses by individual countries has seen Belize consulted, along with Malawi, Tanzania, India, Indonesia and El Salvador.

The study, which is supported by the United Nations Development Programme, focuses on leadership and structures of co-ordination, inclusive and multi-sector responses, financing of AIDS response, and the participation of civil society organisations.

For the past two years Belize has experienced lower numbers for new reported infections – a decrease of 14.1%, when compared with 2008.

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JAMAICA

Cashing in on medical tourism

Jamaica’s Tourism Minister, Edmund Bartlett, has revealed that efforts are underway to ensure Jamaica capitalises on the boom of medical tourism.

He said: “The growth of this form of tourism would lead to the development of new resorts that are conducive to recuperation and rejuvenation, present new possibilities for the employment of highly skilled and specialised health professionals locally, and recapture those health professionals who have migrated.”

Highlighting the example of India, which is estimated to be due to earn US$2 billion from medical tourism in 2012, Mr Bartlett said that medical tourism would help enhance Jamaica’s health infrastructure and boost the island’s reputation as a safe tourist destination.

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Destination Moscow for regional health ministers

Two CARICOM health ministers were in Moscow recently to attend a number of large-scale global events aimed at tackling non-communicable diseases (NCDs).

Dr Leslie Ramsammy, Guyana’s Minister of Health, and Donville Innis, Barbados Minister of Health, joined another 100+ health ministers at the events, in preparation for a United Nations high level meeting on chronic disease prevention in New York in late September.

One of the events saw the launch of the World Health Organisation’s (WHO) Global Status Report on NCDs, which cites NCDs as the leading causes of death in the world and notes that 36.1 million people died in 2008 from conditions such as heart disease, strokes, chronic lung diseases, cancers and diabetes. Nearly 80% of these deaths occurred in low- and middle-income countries.

The attendance of the two CARICOM ministers is crucial, in that it aims to ensure that the priorities of the Caribbean region are taken into account at the UN meeting in New York.

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Learning from clinical claims in primary care

Dr Peter Mackenzie, head of membership governance at MPS, looks at the reasons why claims in primary care are settled

Following on from the last edition of Casebook, in which we looked at diagnostic errors,1 we are running a series of articles that provide an overview of why clinical negligence claims are settled. We start by looking at general practice and over the next few issues, we will look at cases across the spectrum of specialties.

Almost half of all claims in primary care are able to be defended successfully. If a decision is made that we will be unable to defend a case successfully, we record the reasons why a settlement needs to be made and we have aggregated that information as a guide to common pitfalls in primary care.

The top four reasons for settling claims in primary care are set out below in chart 1. Considering each in turn:

Failure or delay in making the correct diagnosis (FTD)

We know from a previous MPS study that 50% of delays in diagnosis in primary care relate to surgical conditions, 32% to medical and 18% to obstetrics/gynaecology.2 Malignant neoplasms are the largest category of claims where there was an alleged delay in diagnosis. Of claims brought against UK GPs in 2009, in one in five the allegations related to the investigation, diagnosis or treatment of cancer.

Delays in making a diagnosis can arise for a number of reasons, and can involve the actions of the doctor, the patient or the healthcare system itself. Recent articles have looked at issues within healthcare systems, such as the impact of easier access to diagnostics in primary care, particularly in conditions where early diagnosis can be critical to the outcome, such as oesophageal, pancreatic and bladder cancers.3

Failure to diagnose breast cancer is the commonest cancer claim in general practice, whilst missed rectal carcinoma is the commonest digestive tract claim. Missed breast carcinoma, melanoma and rectal carcinoma make up nearly one third of all cancer claims in primary care.

So why do claims for diagnostic problems occur in cancer cases? The most common reason is because there has been a failure to consider referral or to perform a crucial test. In these cases, the GP has taken an adequate history, performed an appropriate examination when indicated, but the penny simply has not dropped that the patient might have cancer. Based on the history and examination findings, there should have been a referral or more tests to have excluded serious pathology, as it is commonplace to have more than one working diagnosis.

Once cancer was considered, referral was usually prompt. An example of failure to refer promptly when serious pathology was a consideration involved a 65-year-old who, as a result of previous symptoms, was on a waiting list for colonoscopy and polypectomy. After six months on the waiting list, he returned to his GP with continuing intermittent bowel symptoms, but now with a recent episode of passing blood PR and a two stone weight loss. Unfortunately, he was advised to await his appointment and although the GP’s care had been exemplary until then, the resulting delay in diagnosis and consequent poor prognosis could not be defended.

Risk Management Point

Be prepared to revisit the previous diagnosis. The preliminary diagnosis made here was of an intestinal polyp. With the change in symptoms, a more serious pathology was not properly considered, resulting in a delay in diagnosis.

Failure to diagnose serious illness can also occur because of systems failures. Consider the following case:

A young male patient attended...
his GP’s minor surgery clinic to have a mole removed from his upper arm. Histology received by the practice confirmed a malignant melanoma that required a wider margin of excision. The report was promptly actioned to indicate that the patient should be asked to return for an appointment. Unfortunately, the system then broke down and the report was filed, only to be revisited to the horror of all concerned two years later when the patient returned with an axillary lump and metastatic disease.

RISK MANAGEMENT POINT

You are responsible for ensuring proper follow-up for the tests and investigations you are aware of. Consider whether the system you work in or are responsible for adequately supports you and your colleagues to do this.

Prescribing and medication errors

The second most common area for settlement of claims in primary care is that of prescribing and medication errors. Of the prescribing errors, the most frequent involved a contraindicated drug (most commonly antibiotics), followed by choosing the wrong drug (e.g., unsuitable choice of antibiotic for wound infection) and selecting the incorrect dose of the correct drug (most commonly opiates).

Failure to assess adequately

This is of particular importance in the out-of-hours setting, where inadequate assessment led to the greatest number of indefensible cases. These cases tended to occur where there had been purely telephone contact and triage.

A particular example involved a young male patient who called the out-of-hours service, reporting to the GP a short history of pain and swelling in the right testicle. The GP (GP1) took a history, which included the absence of trauma and a previous similar history, when the pain had resolved within a day. GP1 advised the patient to take pain relief, apply heat and see his own GP in the morning. Four hours later the patient rang again and spoke to another GP (GP2), reporting that he now felt feverish and that the pain continued. GP2 reiterated the earlier advice.

On attending his own GP’s surgery the next morning, he was admitted as an emergency. As by then the testis was gangrenous, he underwent an orchidectomy. The case was settled against both doctors, following expert opinion that concluded: “The history given by the claimant and recorded in the triage system on two occasions in the OOHs service is of acute testicular condition requiring prompt surgical review.”

RISK MANAGEMENT POINT

■ Based on the history taken, an acute surgical problem cannot reasonably be excluded. An urgent surgical review should have occurred.
■ Each GP is expected to ensure they take an adequate history and perform an appropriate examination where required.

Surgical technique

The most common problems arising from minor surgical procedures carried out by GPs included burns from cryotherapy, and nerve damage following excisions of skin lesions.

RISK MANAGEMENT POINT

Ensure you follow the manufacturer’s instructions when using cryotherapy, particularly with reference to skin contact times.

What about the experiences of GPs working elsewhere in the world?

In Canada, for example, the three most commonly missed or delayed diagnosis cases involved cancer, fractures and diseases of the circulatory system (mainly myocardial infarction
and cerebral haemorrhage). These are shown in chart 2.

Summary
From analysis of the last three years of claims, MPS has found that the four most common reasons for indefensibility of claims in primary care are:

- A failure or delay in diagnosis, particularly breast, bowel and skin cancers
- Prescribing and medication errors
- Failure or inadequate assessment, particularly in the out-of-hours setting
- Minor surgery – cryotherapy burns and nerve damage.

Ensure your practice has a safe system for both chasing up tests you have ordered, and properly actioning them when you receive the results. We have also seen an increasing number of complaints in the out-of-hours setting, mainly due to inadequate assessment of the patient – particularly over the phone. You should be prepared to revisit both your and a colleague’s earlier diagnosis, especially when further symptoms and signs are available.

Patients are also more likely to sue their doctor if they have experienced poor interpersonal communication. The communication involves not only the individual doctor but also any members of the practice team with whom they have had contact.

MPS has developed a number of focused educational and risk management programmes that could assist you in these areas – and which you can access free as a member, so do have a look at the MPS website and visit the Education section.

A successful defence
Finally, I started this article by saying that almost half of all claims in primary care are discontinued or successfully defended. Whilst failure to diagnose and telephone triage remain amongst the most common pitfalls, they were also both crucial elements of a successfully defended claim in primary care. That claim involved alleged failures by a GP to diagnose premature labour, to undertake a vaginal examination and to admit a 31-week pregnant mother to hospital immediately.

The baby was born at home and was subsequently diagnosed with cerebral palsy due to a lack of appropriate resuscitation until she arrived at hospital 45 minutes after delivery, giving rise to a claim in clinical negligence for approximately £6 million. The GP was initially contacted by a relative on behalf of the patient, the patient having experienced a short history of lower abdominal pain at 31 weeks of pregnancy. The GP asked about the nature of the pain, any vaginal discharge and whether the patient’s waters had broken.

The relative was relaying the questions to the patient and the patient’s answers back to the GP, and although the GP felt reasonably confident that the answers that he had received over the telephone did not suggest labour, he nevertheless felt that this was not a satisfactory way of taking a medical history, and arranged to visit the patient after surgery, arriving just over an hour after the telephone call.

After a further history and abdominal examination, which found a soft, non-tender uterus, the GP concluded that these were non-specific stretching pains rather than the onset of labour, and advised rest, paracetamol and to call again if necessary. Approximately 40 minutes later, the patient’s membranes ruptured and she gave birth at home.

The obstetric experts agreed that this was a tragic case in which the birth did not follow the regular, frequent and painful contractions of labour normally encountered after a full term pregnancy, but instead a particular condition of pre-term birth where there is a slow and insidious labour followed by a precipitate delivery. The GP experts agreed that a reasonably competent GP could neither be expected to

Ensure your practice has a safe system for both chasing up tests you have ordered, and properly actioning them when you receive the results have encountered, nor to be aware of, this extremely unusual presentation of pre-term labour.

The court accepted the GP’s clear and consistent evidence that there were no signs of labour at the time of the visit, and that neither vaginal examination nor emergency admission to hospital were indicated. The judge therefore found in the favour of the GP, who had undertaken an adequate assessment in the circumstances, and the claim against him was dismissed.

Thanks to Dr Mark Dinwoodie, MPS Education and Risk Management and Elise Amyot, and the Research Department, Canadian Medical Protective Association, for their contributions.

Chart 2: Critical incident groupings, family, practitioner settlement cases, CMPA 2006 – 2010

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3. Various articles on cancer, B&GP (61) (May 2011)
4. Courtesy of the Research Department, Canadian Medical Protective Association
The pressure point

MPS has launched a worldwide counselling service for members, to provide support in times of work-related stress. **Gareth Gillespie** and **Sara Williams** look at the possible causes of stress and the potential consequences for doctors and patients.

Modern society is becoming increasingly frantic. If we are not rushing to get somewhere, we are reading headline news or replying to text messages, in between preparing our next tweet and Facebook post, while planning how we can afford an iPad, get fit, feed the family, advance our careers and see our friends; we could go on. Stress has become an acceptable cliché, ignored by most and discarded as normal by many.

In this all-action world, patience is not often regarded as a virtue; it is a hindrance. This modern attitude is becoming increasingly evident in medicine, where the business of running a successful and profitable hospital or surgery increasingly becomes the focus. Doctors are under increasing pressure, with increasing demands on their time.

Doctors are no strangers to stress, but these attitudes certainly do not make their jobs easier: stress needs to be tackled effectively or it will lead to burn-out. Not only can stress eat away at a doctor’s physical and emotional health, but the impact on patient safety is potentially severe. The association between stress levels and clinical negligence claims has been demonstrated in studies in the US, while the intervention of stress prevention programmes has also been shown to reduce the likelihood of errors and ensuing clinical negligence claims.

Prevalence

In the United Kingdom, studies have determined that the proportion of medical professionals demonstrating above-threshold levels of stress is around 28%, compared to around 18% in the general working population. The British Medical Association (BMA) has estimated that one doctor in 15 could develop a dependency on alcohol or drugs at some point in their career. The most disturbing statistics, however, come from the Working Group on the Health of Health Professionals, who prepared a report in 2010 for the UK Department of Health – these statistics showed that rates of suicidal thoughts and suicides, and those of substance misuse, are considerably higher among health professionals than in any other group of workers.

Similarly, in New Zealand, studies of stress among doctors in 2000 and 2001 revealed that 30% of doctors had significant psychological symptoms, and around 10% of GPs, physicians and surgeons had symptoms of significant psychological distress. In Hong Kong, stress in doctors is such a prevailing issue that the Hospital Authority set up Oasis in 2002, a “Centre for Personal Growth and Crisis Intervention”, which, among other services, provides treatment by clinical psychologists for healthcare workers in situations including the occurrence of a medical error.

Cause and effect

There are many causes of stress in doctors, and not all of them are work-related. A study of the usage of the MPS counselling service in New Zealand – which is jointly-funded by the Medical Assurance Society and has been in existence since 2006 – revealed that many doctors had “home-based” issues related to their spouse or alcohol use, or problems adapting to new cultures. For the workplace, the Firth-Cozens view was compelling evidence that high levels of stress impair a doctor’s performance, by affecting memory, concentration and attention, and decision-making ability. Firth-Cozens’ view was that individual and organisational factors are involved in the potential compromising of patient care, which can create a vicious circle. Evidence of this process exists in a review carried out in the US of a large number of claims reported to a leading malpractice insurer. These claims were analysed to ascertain the period between the notification date of a first claim and the incident date of a second claim against the same doctor. The results showed that in any given quarter, a doctor’s average risk of being named in a clinical negligence claim was 5% – but during the three months following notification of a first
claim, the likelihood of a doctor being involved in an adverse incident leading to a second claim increased to 14.4%. An increased risk of being involved in a successive clinical negligence claim was found to remain so for a two-year period.

It is also interesting to look at which specialties are worst affected by stress. According to the BMA’s Doctors for Doctors, the most frequent calls come from GPs, followed by those working in psychiatry, general medicine, surgery and anaesthetics. Users of the MPS/MAS counselling service in New Zealand were, again, predominantly GPs. Dr Mike Peters, who is the head of Doctors for Doctors and also a GP, said that GPs work in a unique set of circumstances.

He said: “General practice is demand led: it is difficult to say that, within a day, ‘I am going to be free for myself’. The stresses may not be patients, as practice staff are used to dealing with them, it might be that a GP has put half an hour aside to perform personal tasks, and the nurse tells them there’s an urgent visit required – that would be the stress of the day. The other thing is that if you are continually over-running surgeries this can become a real problem.

“I think one of the main problems is that there often isn’t compassion from colleagues because they are working at the ‘coal face’ and it’s difficult: everyone is under stress. Organising time for reflection with colleagues is really important.”

A professional view

MPS has launched its new counselling service worldwide after similar services in New Zealand and South Africa received positive feedback from those who used them. The current service in South Africa will be staying the same. Professional help with stress and anxiety is often the best way of rooting out the issues that are at the core of the problem. Jenny Lanyon is Head of Clinical and Service Development at PPC Worldwide, who are facilitating the counselling service for MPS. Ms Lanyon says that counselling can be an “enormously liberating” experience.

She said: “Counselling is a ‘stress-busting’ activity. Talking to a neutral but caring person allows clients to be open about the stressful situation, without losing face. Also, as counselling services are available on both a telephone and a face-to-face basis, it is possible to speak to a counsellor at the time which is most convenient. Telephone counselling is a 24/7 service, and it fits particularly well into busy lives. Online counselling – a real-time, ‘chat’-based service – is an alternative way of seeking help and support at any time, day or night.

“PPC’s counselling focuses on seeking practical solutions to issues, rather than unravelling the past. It is helpful to look at the reasons for the development of the stressful situation, but always with a view to replacing a ‘vicious’ with a ‘virtuous’ circle. In practice, this takes the form of replacing emotional symptoms with behavioural tasks. So, for a client who feels tired and anxious 80% of the time, the aim would be to begin to reduce – rather than eliminate – that high percentage. Monitoring stress symptoms on a daily basis would therefore be an important part of the process, so that even small changes can be registered as progress.

“The counselling process might continue to look at sleep patterns and, particularly, sleep deficit – a very common cause of stress. The counselling would then focus on putting in place a plan to remedy the poor sleep pattern. This would need to be realistic and gradual – behavioural change takes time. It might begin with the client setting an alarm to remind him/herself to go to bed at an agreed time every night. The following week might introduce a period of relaxation before bed – a walk with the dog, a conversation with a partner, reading a book, or use of a relaxation tape.
“Depending on the client’s needs, the counselling might then look at exercise patterns and increasing the time spent on enjoyable leisure pursuits. Scales of 0-10 are used to assess progress at every stage, and counsellors will always discuss with clients how they will handle setbacks. It is normal for progress to be ‘stop-start’, and it is important not to become demoralised, so that the whole project is abandoned.”

Dr Fiona Donnelly is the chairman of the Doctors Support Network in the UK, an online forum that acts as a peer support group for doctors. Dr Donnelly established the service after suffering stress and depression in her own life. While her story demonstrates how a problem like stress can be turned into a positive action, it showcases the perils of leaving stress unchecked.

Dr Donnelly said: “I got involved in this group because I experienced stress and depression in my own life. It was brought on by a series of events that occurred in a short period of time. I got married, bought my first house, started my first psychiatry post doing the job of a higher level trainee as my consultant was off sick, and then I was assaulted by a patient.”

“I left my illness for a very long time. I had no idea how ill I was. I felt very guilty, as there was a perception that people made things like this up to get out of work. I could do the job fine, but when I got home I wouldn’t leave the sofa or speak to my husband.”

“How effective stress management is depends on the local culture of where someone is working: some areas take a hard line on illness, and offer support and encourage staff to take time off. However, I know of other areas where the attitude is old-fashioned – if you can’t take the stress you shouldn’t be doing the job.”

“GPs struggle because in comparison to a hospital, it is harder for a GP to go off sick as they feel they are letting their business down. So their stress builds up. Also it is harder for them to access occupational health facilities compared to hospitals, which have designated departments.”

Dr Donnelly was an in-patient for six months. Following this, she rescued her career and has since had two children – successes that she puts down to sharing her feelings and dealing with them.

Accessing the MPS counselling service

The MPS counselling service is available to members who have experienced an adverse incident or medicolegal issue and are experiencing emotional or psychological difficulties.

If you feel you might benefit from accessing the counselling service, simply contact your medicolegal case handler, who will provide you with the appropriate contact details. If you have not reported a medicolegal matter to MPS, but are suffering from stress due to an adverse incident or medicolegal issue, contact MPS and ask to speak with a medicolegal adviser.

PPC Worldwide offers a service tailored to the individual’s requirements and it is delivered by fully trained, qualified and registered psychologists and counsellors. PPC’s in-house telephone counselling provides immediate access to support 24 hours a day, seven days a week, and face-to-face counselling sessions can be arranged near to you and at your convenience, all funded by MPS. The service provided by PPC is entirely independent and confidential – MPS will not be informed of any contact with PPC.

With thanks to Dr Tony Behrman and Mr Al Neaber for their help with this article.

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CASE STUDY: DR A

Dr A, a GP based in South Africa, recently sought assistance from the MPS counselling service. Although MPS’s counselling services are completely confidential, Dr A wished to share his story and this case study is published with his full consent.

Dr A is now retired but was in practice for 40 years. He was named in a clinical negligence claim and his case took five years – during that time Dr A fell ill with stress. He couldn’t sleep; his ability to concentrate at work was affected. Dr A developed an acute peptic ulcer that eroded a blood vessel, leaving him in hospital, vomiting blood.

The Health Professions Council of South Africa (HPCSA) wrote to Dr A, summoning him for a consultation surrounding a complaint of alleged misconduct. Following a difficult experience at the HPCSA, Dr A broke down and was unable to work. To make matters worse the patient contacted the local press. It was at this stage that Dr A considered taking his life.

Dr A’s wife contacted MPS and said that her husband had made up his mind to kill himself. MPS arranged for assistance for Dr A – an intervention that Dr A attributes to saving his life.
Not only is reporting your concerns the ethical thing to do, it is also your professional obligation – ignoring system failures or incompetent colleagues can have a profound impact on patient safety. The World Medical Association, in its *International Code of Medical Ethics*, says that “a physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception”.1

All doctors must learn how to recognise when a situation will start affecting patient care.

**Checking your tools**
The procedure is fairly straightforward when you suspect that a piece of equipment is not fit for use.

In a hospital setting, overlooking the availability of consumables such as cartridges for blood gas machines or pads for ECG machines can be the problem, rather than the functionality of the medical device itself. If you notice that stocks and supplies are running low, it is your responsibility to ensure that more equipment is ordered. You should also document that concerns have been raised.

When the hospital is stocked with new equipment, comprehensive training must be available for everyone who might need to use it. If you feel the training is inadequate, request some refresher courses – the chances are that others will also benefit from the training.

In all other situations, you must always alert your employer as soon as you notice or suspect that a piece of equipment needs replacing. The sooner you can raise the alarm, the fewer patients will be at risk.

**All systems go**
Most doctors will be able to recall a time where they have noticed a failure in the way things are run. Perhaps you have noticed gaps in the handover procedure at your hospital, or delays in delivering urgent test results or a lack of communication among the medical team when discharging patients?

The first thing to do is assess who was responsible for implementing the system in the first place. Is it unique to your hospital, or was it brought in to follow regulations or guidance issued by the Medical Council?

If the system is specific to your hospital, contact the Chief Medical Officer of the hospital. If you have your own ideas about how the situation could be improved, put your suggestions down in writing. There is no guarantee that your employer will implement your ideas, but it may help when they begin to look at developing a solution.

If your concerns relate to a system that lies outside the realm of your individual hospital – for example, legislation or regulations – you should contact your local Medical Council and explain why you think the regulations

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**CASE STUDY 1**

Dr X notices that the defibrillator is often used and then not put back on to recharge ready for future use. He frequently vents his frustration with colleagues about the situation and makes a mental note to tell his employers about the system failure when he has time.

Later that week, a patient arrives at the hospital having suffered a sudden cardiac arrest. Dr X reaches for the defibrillator and again finds it uncharged, and therefore unavailable for use. Subsequently, there is a delay in treating the patient, which leads to a formal complaint being made against the hospital. Dr X is also criticised on the basis that he knowingly failed to ensure the appropriate equipment is readily available for use.
need to be reviewed. See the Caribbean Association of Medical Councils’ website for more information on how to contact your local Medical Council.

Fit to practise?
The situation becomes more complicated when you have concerns about a colleague. Whilst your overriding loyalty lies with the patient, you must also treat colleagues in the same way you would wish to be treated – this means showing respect by raising concerns with the individuals themselves first.

The guidance from the Medical Council of Jamaica is clear. It says doctors have a fundamental obligation to “work with colleagues in the ways that best serve patients’ interests [and] to act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practice, or may be endangering the interest of patients”.

Senior doctors who harbour concerns about a junior colleague should be well-versed in voicing concerns early. Junior doctors who are still developing their skills and learning about accepted practices will usually be receptive to advice from their seniors. Telling them when they are doing something wrong means you are stopping a potentially dangerous situation from escalating.

However, it can be difficult when the situation is reversed. Junior doctors who hold concerns about the medical ability or ethical stance of senior colleagues can feel anxious about speaking out – particularly if they have been asked by a senior doctor to carry out a procedure in a manner which they believe to be outdated.

In this situation, junior doctors must find a way of speaking directly to their colleague. Ask them why the procedure must be done in that particular way – and if possible, suggest an alternative method which you believe to be safer or more effective.

MPS Medicolegal Adviser Dr Lyn Griffiths explains: “In some cases, you may find there is a valid explanation for their actions. Not only will your concerns be allayed, but you will also learn something new. In other cases, where the doctor in question cannot validate their actions, raising the issue will help your colleague to face up to gaps in their skills, and highlight areas where they would benefit from further training.”

You have an obligation to take the necessary action when you think a colleague is working under the influence of alcohol or drugs, as this poses an immediate risk to patients they come into contact with. If you harbour doubts about a colleague’s clinical capabilities and fail to tell the appropriate authorities, then you could be criticised if a claim is later brought against your colleague.

Delegate with care
The assistance provided by nurse practitioners and other medical staff can lighten the load of busy doctors, but when does help become a hindrance?

The following situation is fairly commonplace:

Dr B notices that Nurse G is attempting to carry out a task that he suspects she has not been trained to do. He decides to ask her directly about how she is going about the task to ascertain her level of knowledge and experience.

It becomes clear that Nurse G has not been adequately trained, so the onus is on Dr B to put patient safety first and conduct the procedure himself. He discusses his reasons to Nurse G and agrees to arrange the appropriate training to allow her to do the procedure in future. This helped to maintain a good working relationship with Nurse G and demonstrated that he appreciated her efforts to help.

HAZARDS TO WATCH OUT FOR

- Colleagues acting outside their areas of expertise
- Colleagues repeatedly making mistakes, eg, not checking prescriptions/dosages
- Colleagues working when you suspect they are under the influence of alcohol or drugs
- Equipment that is starting to show signs of malfunction
- Shortage or lack of equipment
- New equipment being introduced without the offer of training.
The Bahamas Medical Council offers some helpful guidance on how to deal with delegation: “A doctor who delegates treatment or other procedures must be satisfied that the person to whom they are delegated is competent to carry them out. “It is also important that the doctor should retain ultimate responsibility for the management of his patients because the doctor has received the necessary training to undertake this responsibility.”

If doctors choose to delegate a task to a nurse practitioner or allow them to carry out a procedure they have not been formally trained to do, and a mistake is subsequently made that leads to a complaint, they are responsible for their actions just as much as the nurse and can face disciplinary proceedings. Be prepared to justify your actions in case they are later called into question.

Don’t turn a blind eye
If you have raised your concerns directly with the colleague in question and you still see them making mistakes or performing outside their expertise, then it is time to alert your employer.

Keep the following checklist in mind:
- Raise any concerns about colleagues, equipment or systems with your employer at the earliest opportunity
- Alert higher authorities when you have serious concerns about standard practices
- Put all concerns in writing (either formally in a letter or simply via email)
- Keep your own record of the concerns you hold and the actions you have taken to try to improve the situation
- By following these simple steps, you will protect your own professional integrity, even if someone else’s is later called into question.

Lead by example
By acting ethically and reporting concerns when you have them, you will encourage other members of your team to follow suit. Dr Brian Charles, consultant for MPS based in Barbados, says: “Members should report first in-house to address any concerns regarding medical ethics or misconduct. If these are not satisfactorily dealt with, then recourse is available through the local medical councils. Members can also contact MPS for advice. The issue of confidentiality, reprisal and discrimination is very real, especially in small communities. Practitioners need to remember that patients’ wellbeing is paramount and that not reporting misconduct may be detrimental to the patients and the practitioner involved.”

If you have raised your concerns directly with the colleague in question and you still see them making mistakes or performing outside their expertise, then it is time to alert your employer.

USEFUL LINKS
- Caribbean Association of Medical Councils www.camcweb.org
- Medical Council of Jamaica www.medicalcounciljamaica.org
- Bahamas Medical Council http://bahamasmedicalecouncil.net

REFERENCES
4. Medical Professions Act 2010, section 32.2a
On the case

Dr Nancy Boodhoo, Head of Operations, Caribbean and Bermuda, introduces this issue’s round-up of case reports, many of which highlight the importance of working with others.

Working effectively with others to ensure patient safety involves thorough handovers, careful delegation and a willingness to revisit colleagues’ decisions or diagnoses, where appropriate.

“Minor operation – major problem” on page 17 shows how important it is that when delegating, you must be satisfied that the other doctor has the experience, skills and knowledge needed to provide good clinical care.

Similarly, if a task has been delegated to you and you feel concerned about the appropriateness of the treatment, as Dr Q did in this case, you should raise this with your senior colleagues before proceeding – and document this. Challenging a colleague’s diagnosis or treatment plan can be daunting, particularly for junior doctors. However, it is imperative to do so if you feel patient care may be compromised.

Poorly-managed delegation can lead to adverse outcomes not only when performing clinical procedures, but when taking informed consent. In “Jotting it all down” on page 18, expert opinion did not find Mr Y negligent as a result of Mrs T’s ureteric injury during the hysterectomy, but he was found liable for failing to warn Mrs T of the potential complications involved. Taking consent was delegated to a junior who did not have sufficient knowledge of the procedure. A junior doctor should only be asked to take the consent if they have enough knowledge of the procedure, especially if it is a specialised complicated procedure, to be able to answer the patient’s questions. Mrs T was not warned of the possibility of postoperative loin pain and so did not report it straight away, leading to further complications.

Although you may not be accountable for the decisions and actions of those to whom you delegate, you are still responsible for the overall management of the patient and accountable for your decision to delegate.

Sometimes, it is important to refer upwards; in “Mother knows best” on page 22, Dr Y did not refer baby T to a senior colleague, despite the mother and baby re-presenting at the Emergency Department (ED) shortly after discharge, and the receptionist in “An age-old problem” (page 23) did not approach the doctors in the surgery for advice because they were busy.

Doctors need to be aware of their own limitations, but also need to ensure that all staff are aware of their individual role and limitations.

### CASE REPORT INDEX

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Since precise settlement figures can be affected by issues that are not directly relevant to the learning points of the case (such as the claimant’s job or the number of children they have) this figure can sometimes be misleading. For case reports in Casebook, we simply give a broad indication of the settlement figure, based on the following scale:

- **High US$2,000,000+**
- **Substantial US$200,000+**
- **Moderate US$20,000+**
- **Low US$2,000+**
- **Negligible <US$2,000**
Mrs W, a 25-year-old secretary, was referred by her GP to a local general surgeon, Mr D, with troublesome warts on the middle finger of her dominant hand. On the day of the consultation, there were pressures in the consultant’s outpatient clinic as one of his juniors had unexpectedly gone off sick. In the event, he did not make any record of the consultation, but completed a booking form for Mrs W to have “diathermy of warts” on the minor surgery list delegated to junior doctor Dr Q.

On the day of the procedure, Dr Q was unsupervised for this list. He searched the notes for some advice or indications by way of an entry or letter to the GP, but could find none. Being relatively experienced at his level, he was concerned with the appropriateness of the prescribed treatment, but felt uncomfortable contradicting his senior so, after asking the patient to sign the form of consent, proceeded nevertheless.

Some days later, the patient returned with a black sloughy wound over a 1.5cm area on the dorsum of the PIP joint, which went on to become infected despite the prescription of antibiotics. Another member of the team subsequently saw Mrs W and realised that the developing wound was exposing the extensor tendons and asked an orthopaedic colleague if she would perform a skin graft to get the wound healed. This was done under local anaesthetic, using skin harvested from the patient’s chest wall. Unfortunately, the graft didn’t “take” well and the finger wound proceeded to heal slowly by scar formation.

Mrs W went on to need several months’ physiotherapy to her hand, but was left with very significant stiffness in the finger. She also unfortunately developed a nasty scar on her chest at the site of skin graft harvest.

After returning to her job she found herself only able to type at much reduced levels of efficiency and lost her job in a subsequent staff review at her firm. She became very depressed.

Mrs W made a claim against both Mr D and Dr Q. Expert opinion was sought during the process and it was agreed that there was neither adequate informed consent nor appropriate primary treatment for the condition. The claim was settled for a moderate sum.

**LEARNING POINTS**

- There is no such thing as a “minor operation”. As this case demonstrates, all procedures have the potential to produce complications, which may escalate. Sometimes the effect of such complications can be magnified, particularly in the area of the human hand, which a patient’s livelihood could depend on.

- When you delegate care or treatment you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved. Although you will not be accountable for the decisions and actions of those to whom you delegate, you will still be responsible for the overall management of the patient, and accountable for your decision to delegate.

- If there are complications requiring specialist input, then that expertise should be sought. In this case, the patient had a skin graft harvested from her chest wall and ended up with a large scar. It is almost always inappropriate to harvest skin grafts from the chest wall and a plastic surgeon’s opinion would most likely have prevented this.

- Clinical misfortunes are extremely difficult to defend without good record-keeping.

- In today’s increasingly cost-conscious and frenetic health service, there are more and more pressures on doctors to take short cuts and minimise costs. The experienced clinician needs to know when these pressures should be resisted to avoid a fall in standards of good care.

- Referrals to hospital specialists should be as clinically appropriate as possible. Where hospital specialists receive what appear to be referrals outside their sphere of expertise, they should triage them accordingly.
Jotting it all down

Mrs T, a 40-year-old mother of one with an extensive gynaecological history, had suffered with menorrhagia secondary to fibroids for most of her adult life. This had failed to respond to both medical treatment and a myomectomy. Mrs T’s one pregnancy was uneventful, but she elected for a caesarean section in view of her persistent problems with fibroids. Following the birth of her son, her menorrhagia returned and she began to experience more persistent abdominal and pelvic pain, which was investigated and attributed to postoperative adhesions. After several years of discomfort, she approached her GP for advice regarding surgery and he referred her to consultant gynaecologist Mr Y. Mr Y discussed the options with her and she decided that, as she no longer wished to have any more children, an abdominal hysterectomy offered a more definitive approach and was the best method for her to relieve the continued symptoms.

Mrs T attended Mr Y’s preoperative clinic, where she was assessed by the nursing staff and given an explanation of the procedure by one of the junior doctors. Mr Y performed the operation a week later. It was a difficult procedure due to inflammation, adhesions, and large and friable blood vessels around the bladder, due in part to her previous history. However, no immediate complications were noted intraoperatively. Mr Y ensured he had carefully documented the procedure and had included a detailed description of his findings, with clear writing and diagrams. Mr Y had not checked the notes prior to the operation regarding what complications had been discussed or what consent had been taken. There was no documentation regarding identification of the ureter.

Mrs T started suffering from dysuria almost immediately, but didn’t report it straight away. Further investigations, including an IV pyelogram, demonstrated a blocked ureter which had led to hydronephrosis. The urology team on call took Mrs T to theatre and successfully reimplanted the ureter onto the bladder, restoring urine flow. There were no long-term consequences.

Mrs T made a claim against Mr Y for damaging her ureter during the hysterectomy. The experts reviewed the notes and did not consider that there was negligence, since ureteric injuries are a recognised complication of hysterectomy, especially when previous pathology may alter the expected anatomical course of the ureter. However, they did agree that Mr Y was liable for a failure to warn the patient of the risk of this complication.

It was also argued that this led to a delay in diagnosis and that if the patient was aware of the possibility of ureteric damage then she would have reported her urinary symptoms earlier. The claim was settled for a moderate sum.

EW

LEARNING POINTS

- Appropriate informed consent should include: an explanation of the investigation, diagnosis or treatment; an explanation of the probabilities of success, the risk of failure; side effects and complications.
- Valid consent is the responsibility of the health professional who is undertaking the procedure; this can be delegated to a member of staff who has sufficient knowledge to give the patient all the information they need to make an informed choice. Mr Y should have checked what was documented in terms of the scope of consent preoperatively and addressed any gaps.
- Good quality notekeeping is essential, and this must include all aspects of the consultation including consent.
- Surgical complications happen. Damaging the ureter during hysterectomy is a recognised complication of the procedure with an incidence around 1%. The occurrence of a complication does not necessarily equate to negligence.
- When things do go wrong it is important to deal with the situation in the right way as quickly and efficiently as possible. Provide the best possible care to resolve the problem and be open and transparent with the patient.

REFERENCES

Miss W was a 20-year-old shop assistant who lived at home with her parents. She had to go home from work because she felt dizzy and nauseous. She went home and was sick, and developed earache, so she made an appointment with her GP. Her GP diagnosed an ear infection and prescribed her some antibiotics.

A week later she was much worse. She was vomiting several times a day and the dizziness was becoming intolerable. She also had a ringing in her ears that would not cease. Her mother was concerned and rang her GP, Dr T, who agreed to visit the same day. Dr T noted the dizziness and tinnitus, and documented that her pulse and blood pressure were normal. He also noted that there was no nystagmus or signs of dehydration. He diagnosed vestibulo-neuritis and prescribed some stemetil to help with the dizziness. Dr T made clear and comprehensive notes following the visit and asked Miss W to ring if the situation did not improve with the treatment.

Miss W's mother rang the GP surgery the following day requesting a visit because her daughter had made no improvement at all. She was feeling very weak and it was the fifth day that she had been bed bound. Dr T spoke with her mother over the telephone rather than arranging a home visit. Dr T was concerned that the continued vomiting could be causing dehydration so asked about her urine output. Her mother answered that she was passing “a huge amount of urine and she was drinking a lot”. Dr T recorded: “Good urine output, drinking well, not dehydrated. Continue treatment.”

Miss W deteriorated over the next two days. She became confused at times and felt an incredible thirst that seemed unquenchable. Her mother continued giving her the stemetil, hoping that she would improve with time as the GP had said. Miss W slept most of the day and when her mother tried to remind her to take her medication, she was unable to wake her. She phoned the emergency services in panic. Once in hospital the doctors noticed a smell of ketones on her breath and her severely dehydrated state. She was diagnosed with diabetic ketoacidosis. Despite all appropriate treatment she was left with some serious neurological impairment.

Miss W and her mother made a claim against Dr T. The experts considered that although the initial assessment was reasonable, the telephone consultation should have alerted Dr T to the possibility of diabetes, given the history of polyuria and polydipsia. The case was settled for a high amount, reflecting the level of harm to the patient.

Diagnosis is a dynamic process that needs revisiting with an open mind. Had Dr T noted the information about Miss W drinking excessively and passing a lot of urine prior to the “label” of vestibulo-neuritis, he might have considered diabetes. His own diagnosis prevented him from seeing the full picture.

It is important to remember that patients with diabetic ketoacidosis can deteriorate very quickly. Any patient with deteriorating symptoms needs reviewing. Young healthy people with minor complaints tend to recover fairly quickly. If this does not occur, alarm bells should ring.

Telephone consultations have inherent risks; if you decline a home visit you should be satisfied that you’ve taken a thorough history. The diagnosis might have been aided by an examination revealing the smell of ketones and signs of severe dehydration. It is important to try to speak directly with the patient and if they are not well enough to talk to you, this should raise concerns.
Mr M, a 23-year-old builder, went on holiday to Thailand. His flatmate had been there and recommended that Mr M take malaria prophylaxis. Mr M went to a travel clinic to get some antimalarials and started to take them as prescribed before travelling. However, a few days after starting the course, he felt nauseous and unwell and decided to stop taking the medication.

He had an uneventful trip and returned home after a two-week holiday. One month later Mr M had a bad bout of diarrhoea. He then began to vomit and felt feverish. He put it down to having a fast food meal the previous evening but as things didn’t seem to be getting better 24 hours later, he made an emergency appointment to see his GP.

The GP, Dr H, took a history and ascertained that Mr M had eaten fast food 2 days previously, which could explain his diarrhoea and vomiting. Mr M mentioned to Dr H that he had been on holiday in Thailand a month before; however, Dr H didn’t make a note of the recent travel in the medical records. Dr H recorded that Mr M had a fever of 38.9° and a clear chest, and was coughing. Dr J explained management of an upper respiratory infection to Mr M and documented: “Flu-like symptoms. Increase fluids; add paracetamol.”

Ten days after the symptoms started, Mr M became more unwell and his flatmate called an ambulance for him. In hospital his flatmate mentioned the recent trip to Thailand and investigations were carried out accordingly. A diagnosis of falciparum malaria was made. Unfortunately Mr M did not respond to treatment, deteriorated and died within a few days of admission. His family made a successful claim against both doctors involved for failing to establish the history of recent travel. It was settled for a moderate amount.

LEARNING POINTS

- Ask the right questions for the presenting complaint. Patients need to be guided into giving a relevant history. A patient who was on a trip and develops symptoms a month later is unlikely to make an association.
- Dr H recalled Mr M mentioning his holiday to Thailand, but he pursued a different diagnosis. When symptoms do not respond as expected, it is worth starting afresh with the history and considering alternative diagnoses.
- Always be aware of tropical diseases when seeing a patient with fever and ask about recent foreign travel; nowadays exotic holiday destinations are common and tropical illness may present at any surgery.
- Consider malaria in every febrile patient returning from a malaria-endemic area within the last year, especially in the previous three months, regardless of whether they have taken prophylaxis. Early treatment will improve prognosis and prevent deaths.
- Even in countries where malaria is not endemic and the patient has not travelled, you should bear in mind that a patient need not have travelled abroad to become infected.

USEFUL LINKS

- National Travel Health Network and Centre – www.nathnac.org
- TRAVAX – www.travax.scot.nhs.uk
- Health Protection Agency information on malaria – www.malaria-reference.co.uk
Mr G, a 40-year-old manager, saw Mr S, a spinal surgeon, in his consultation room with a short history of sciatica. Mr G presented with two weeks of back pain and pain radiating down the front of the left thigh to just below the knee. The pain was not responding well to NSAIDs, but no other treatments had been tried. Mr G was still working full-time, but his symptoms were interfering with his weekly squash match. He was having minor trouble sleeping. In addition, Mr G was due to be best man at a friend’s wedding in two months’ time and was very keen to be fit for the nine-hour flight to the Caribbean.

On examination, there was no weakness but there was dulling to pinprick in the left anterior thigh. The knee reflex on the left was diminished but still present. Straight leg raising was normal but there was minor restriction to femoral stretch.

An MRI was arranged and showed that the L4/L5 disc was prolapsed laterally.

Mr S discussed surgery with Mr G but no other options for treatment were mentioned. Mr G agreed to have the surgery and he was properly consented for the operation by Mr S himself. Although the surgery was uneventful, Mr G was thoroughly dissatisfied with the standards of nursing care he received and wrote a formal complaint. He felt that the nurses were abrupt and uncaring. He had to wait a long time for pain relief and was given no apology or explanation why.

Mr G’s symptoms persisted after the surgery and a new MRI showed that there was still a lateral disc protrusion compressing L4 root.

Mr G made a claim against Mr S. Expert opinion was critical of the choice of surgical treatment in this case. The expert felt that Mr G’s symptoms were not severe enough, nor had they been present long enough, to consider surgery as a first option. It was felt that a reasonable body of his peers would have suggested that conservative measures should have been tried first prior to consideration of surgery. In addition, Mr S’s surgical approach was incorrect for this particular patient’s unusual herniation. The far lateral component of the disc was unreachable through the usual medial fenestration approach.

The case was settled for a moderate sum.

LEARNING POINTS

- Spinal surgery at the wrong level is, unfortunately, a fairly common error. This particular case is slightly more unusual since the level was right but the surgery was performed medially, not laterally, making it impossible to remove the offending disc fragment.
- Familiarity with different surgical approaches to the spine is crucial so that the procedure can be tailored to the patient’s particular anatomical problem.
- The indications for surgery should be the same, regardless of whether treatment is privately or publicly funded. Up to 80% of lumbar disc prolapses will resolve with conservative treatment. As a general rule, unless there are red flag signs (bladder involvement or weakness), many surgeons would allow a period of four to six weeks to pass to allow the disc prolapse to resolve spontaneously before considering surgery.1
- It is important to take informed consent and explore all treatment options. The risks and benefits of all possible treatments, including doing nothing, should be explained.
- Be aware of the predisposing factors in claims, eg, poor communication and staff attitudes. This can cause patients to complain before anything goes wrong. Claims usually arise from a combination of predisposing and precipitating factors. Mr G was thoroughly dissatisfied with the care he received and so when his recovery from surgery was slow he was motivated to make a claim.

REFERENCES

Mother knows best

Miss T was 17 years old and still at college when she became pregnant with her first child. She gave birth to a healthy baby boy at term, and was discharged the following day, with planned midwifery follow-up at home.

At one month old, Miss T became concerned that her infant, baby T, appeared to be having occasional odd movements of his left hand. She contacted her community midwife, who advised her to take the infant straight to the Emergency Department (ED) of her local hospital.

At the ED, baby T was seen by the junior doctor on-call for paediatrics, Dr Y. Miss T told Dr Y that she had noticed a bit of twitching, and that examination was otherwise unremarkable. Dr Y organised some blood tests and arranged for baby T to be brought back to the department’s Rapid Access Clinic in the morning. Dr Y noted Miss T’s young age and her exhaustion, which he put down to caring for a new infant. He wrote in the record: “over-anxious mum – almost a child herself.”

The following morning, baby T was seen in the Rapid Access Clinic by a registrar, Dr B. She noted that the infant was hot, more sleepy than usual, and had not fed overnight. On examination, baby T was noted to be febrile and listless with a mottled appearance and a high-pitched cry when examined. Occasional brief twitches of the left arm and leg were observed. Dr B made a presumptive diagnosis of bacterial meningitis, arranged a full septic screen, and started baby T on intravenous antibiotics.

Shortly after commencing treatment, baby T’s condition deteriorated, necessitating resuscitation and ventilation. He was transferred to the regional Paediatric Intensive Care Unit where he spent a further two weeks recovering.

The bacterial meningitis was confirmed and treated appropriately, but he was left with significant neurological impairment.

Baby T’s mother made a claim against Dr Y. Expert opinion was that the initial symptom of twitching should have prompted a full septic screen, including a lumbar puncture. The decision to discharge the infant after the second presentation to the ED was indefensible. Earlier treatment might have impacted on the outcome. The case was settled for a substantial sum.

LEARNING POINTS

- Babies can be difficult to assess; seek senior advice if you are unsure.
- Meningitis can present in a number of non-specific ways, including with twitching. Signs of meningitis should be actively looked for in any acutely unwell infant. Any infant presenting with symptoms where bacterial meningitis is a part of the differential diagnosis should have an immediate septic screen. This should include a lumbar puncture unless there are contraindications, such as evidence of raised intracranial pressure.
- Listening to the parents is always the safest option. If a mother thinks that there is something not right with her baby, she may well be right.
- If a patient re-presents to the ED shortly after discharge, they need to be re-assessed carefully, preferably involving a more senior or experienced colleague.
- Patients don’t use textbook language to describe their concerns and may require further exploration; if you don’t fully understand what the patient is saying, let them explain in detail in their language.
- Always write records with the expectation that patients, relatives or other third parties may read them. Remain professional in all that you write.
The following case occurred in the UK in 1983, when it was common practice for patients to contact their GP for antenatal advice rather than their maternity unit. The practice was able to settle the claim 28 years later as a result of occurrence-based indemnity, which can meet claims arising from treatment carried out by a member, regardless of when the claim is brought, without the need for any further payment to be made. Standards of care are assessed by the standards at the time of the incident, rather than at the time a claim is brought.

The doctor’s surgery was extremely busy and all of the urgent appointments for the morning session were booked. A telephone call came through from Mrs P, a 29-year-old who was 30 weeks pregnant. Mrs P was pregnant for the first time, and had been seeing her doctor for routine antenatal care. So far, she had had an uneventful pregnancy. Mrs P had become worried by what felt like strong contractions and she had called her husband at work in a fluster. She had tried the surgery a couple of times and eventually got through to a receptionist. Ms A, the receptionist, had been working at the surgery for one year, but had been working in other surgeries for more than 15 years. She felt she was an experienced receptionist. Mrs P described the contractions to Ms A and how she and her husband had become increasingly worried and would like to speak to a doctor. Ms A, a mother of three, listened to the story and immediately reassured Mrs P, explaining that these were likely to be “training contractions” she herself had experienced in all of her pregnancies. Ms A also reassured Mrs P that it was too soon for these to be birth pains.

A few hours later, another call came through to the phones, this time from Mrs P’s husband. He had come home from work and found that rather than getting better, his wife seemed to be in worsening pain. He asked for a GP to visit them at home. The receptionist Ms A explained that unfortunately, all the urgent slots for patients had been taken and the doctors were all busy at that time, but the doctor would visit after surgery.

Two hours later, Mrs P had a breach delivery at home. Her husband had called an ambulance that arrived a couple of minutes later. However, the baby suffered hypoxic brain damage, and as a consequence required long-term care.

A claim against the surgery was settled for a very high sum.

**LEARNING POINTS**

- GPs and practice managers need to ensure that all staff are aware of their roles and responsibilities within the practice and their limitations.
- Reception staff who are responsible for dealing with patients on the phone or in person should not give medical advice to patients.
- In this case, when the patient first called they should have been given an urgent appointment with a doctor or been put through to speak on the phone. When doctors are busy or there are no appointments, reception staff should inform the doctor of the patient’s request and the doctor can then arrange appropriate action.
- When doctors’ surgeries are busy it can be difficult for reception staff to approach doctors. Measures must be taken to make sure that at all times reception has at least one doctor to deal with queries from reception staff who are booking appointments.
- Doctors need to be accessible and approachable to their fellow staff in order to avoid errors such as the above.
- Reception staff should have regular and appropriate training to fulfil their role. Practice protocols should be kept up-to-date and all staff should be familiar with what’s expected of them.
Repeat offender
I refer to the case report “Repeat offender” (Casebook 19(1)). It’s always very sad when a patient has been harmed, though one goes to work to see and help patients harbouring no bad intent or motivation.

In the end it seems the practice was found liable even though it was initially issued by the locum. That, perhaps, would be because whenever a doctor signs a script, it is his responsibility to check what he/she is signing is safe and appropriate etc.

I often labour this point to those who “shove” a wad of repeat scripts in front of me in surgery; I tell them that it takes much longer for a locum to go through them and delve into the patient records as appropriate, before signing off these scripts. I have been told that the patients’ usual doctor can often simply sign them off quickly without due deliberation, because they “know their patients”.

As the father of risk management Professor James Reason once said, it’s important to have the vigilance of a squirrel – I find extremely daunting the responsibility of junior doctors, a task which can take up a significant amount of time, or as an architect designed to be vigilant all life and health. That said, it’s important to have the due deliberation, because it is always wise to re-examine their history and double check even the most apparent, even if you are familiar with the relevant specialist to ascertain whether the prescription is indeed correct or still required.

This is a situation where I greatly sympathise with doctors, and especially GPs. In the current climate of medicine, there are new drugs being introduced all the time. Whilst it appears easy to say that all GPs should check prescriptions they are unfamiliar with, I think this places a huge burden on primary care physicians.

This is a situation that I find extremely daunting as a medical student, and it highlights to me the need to keep informed with publications such as Casebook, as well as ensuring better education and training of both medical students and junior doctors.

Nuru Noor, medical student, UK

Missed opportunities
I am interested in your comment (Casebook 19(2)) that any woman referred for an IUD fitting (or TOP) “should have an STD screen plus or minus antibiotic cover as appropriate”.

My impression is that the majority of such women do not have any tests for STDs (based on risk assessment). Those who do usually have a test only for chlamydia. Few of those are given antibiotics contemporaneously with the IUD insertion. The regimen chosen is generally one recommended for uncomplicated chlamydia, which may not be effective repeat medication list from the patients’ GPs will help identify any discrepancy and possibly point towards yet undiagnosed cognitive or social issues.

Dr Yaasir Mamoojee, junior doctor, UK

A dosing disaster
Thank you for the last edition of Casebook, which was an interesting and informative read. The case report “A dosing disaster” (Casebook 19(2)) was particularly relevant to me as a junior doctor. You also mentioned that 11% of patient safety incidents occurring between April and September 2010 were medication related (Casebook 19(2)).

Writing up drug charts is usually the responsibility of junior doctors, a task which can take up a significant amount of time, especially for elderly patients with multiple co-morbidities being on a long list of medications. Often I find myself being interrupted in this task for various reasons and surely your case report highlights the importance of concentrating on the task at hand. Although most hospitals will have pharmacists checking patients’ drug charts, there are few simple means that we junior doctors can implement in our routine practice to prevent these errors.

It is both quick and easy to cross-check the newly written-up drug chart against the patients’ brought-in medications or list again at the end, especially if we have been interrupted during our task. It is also not uncommon for elderly patients to bring in medications that have been stopped a long time ago. Requesting a
in these circumstances, still less if antibiotics are only given when the results of tests are available.

In view of your comment, I wonder if current practice is digging a medicolegal minefield? Dr Humphrey Bridle, GUM physician, Wales.

In the recent volume (Casebook 19(2)) you have a comment on “Missed Opportunities” in your Over to You section. I’d like to query your response: “In any situation where a woman is being referred for a TOP or for the fitting of an IUD, she should have an STD screen plus or minus prophylactic antibiotic”. Can please I refer you to FFPRHC guidance November 2007: www.ffprhc.org.uk/admin/uploads/ CEUGuidanceIntrauterine ContraceptionNov07.pdf

This says that prior to fitting an IUD, consideration of STD must be done; sexual history should be taken and some women may be higher risk, but that STD screen isn’t necessarily required.

Is it therefore just a question of documenting that sexual history has been taken? Dr Conrine Shepherd, GP, UK

Response

Many thanks for your comments and also for drawing our attention to other information relevant to the case report “Missed opportunities” (Casebook 19(1)) and our response to Dr Stevens’ letter about the same report (Casebook 19(2)).

It is not the place of Casebook to provide comment on specific clinical aspects of case reports; rather we seek to highlight potential medicolegal pitfalls in practice. In this particular case, failure to carry out an appropriate examination and relevant investigations according to the patient’s history led to an adverse outcome for the patient. The patient had a past history of PID and was intending to have a TOP; therefore, STI screening should have been considered.

We acknowledge that practice varies in different settings and that the approach may need to be tailored to the particular circumstances, but the key medicolegal learning points to come out of this case remain the same – document relevant history and carry out the appropriate investigations.

More on “A dosing disaster”

Like most of your readers, although I enjoy reading the case presentations, this enjoyment is always tempered by the thought “there but for the grace of God go I”. I most sincerely hope never to play a starring role in any future case presentation.

Now to the meat of the matter.

In many of the cases I can understand what might have gone wrong but in the case of “A dosing disaster” (Casebook 19(2)) I confess that I am more than a little perplexed.

In the first part of the story:

1. Although the admitting doctor was unfamiliar with the drugs he/she was prescribing, a BNF or its equivalent was not available somewhere in the ward nor in the doctor’s pocket.
2. The nurses doing the drug round had read the prescription at least five to six times before delivery without noticing the mistake. It used to be (still is?) normal nursing practice to record the medications on admission in the nursing notes. This discrepancy should have been noted there.
3. The patient herself failed to notice the incorrect dosing and draw it to anyone’s attention.
4. The admitting consultant and/or the registrar overlooked this mistake when they did a ward round of the new patients the day of or after admission.

In the second part of the story:

1. The psych trainee failed to read the drug chart.
2. The patient was never reviewed by a psych doctor other than the trainee.
3. In the third part of the story:
   a. The nurses and the admitting consultant’s team (including the consultant) failed to read the drug chart for almost two weeks.
   b. The doses of medication were increased – by whom? – but the remainder of the drug chart seems not to have been read.

The commentary does draw attention to the fact that the prescriptions were not reviewed by a pharmacist. While this may be desirable, I am not sure how common this practice may be.

The story sounds like it may have occurred in a large teaching hospital (a presumed centre of excellence) as it is unlikely that there would be an on-call neurologist in any smaller unit. Given the presumed superiority of such institutions it seems difficult to understand that no-one seems to review the drug charts of patients who have been admitted or who are unwell.

While it has been some time since I worked in obstetrics I can recall my professor insisting on reviewing every drug chart of all patients under his care on every ward round. Given the case here I can appreciate the wisdom in his approach even further. As he would explain, this practice is “basic medicine” – a sentiment with which I fully concur.

I am also disturbed that the patient was never reviewed by a consultant other than the admitting one. While many trainees may be excellent at their jobs surely a patient requiring a consultation deserves an expert opinion?

I think your commentary may be too narrowly focused and unfairly so on the initial prescriber. Those who were responsible for her continuing care share at least some of the blame, if not the majority of the blame. Suggesting that the review of drug charts is the responsibility of the pharmacist rather than that of the admitting consultant seems a little odd.

My impression here is that this particular institution may have a number of deep-seated problems. I sincerely hope that this impression is incorrect.

David Mitchell, UK
**Caribbean and Bermuda Casebook**

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**The Mind's Eye**

By Oliver Sacks

Reviewed by Joanna Jastrzebska, consultant psychiatrist, New Zealand

Have you ever got lost in a familiar place or failed to recognise an acquaintance’s face? What if it happened to you every day? How would you live with it? How would you adapt?

In his newest book *The Mind's Eye*, Oliver Sacks tells stories of people who struggle with prosopagnosia (face blindness) and other vision problems. We have a concert pianist who loses her ability to read music and recognise everyday objects. We meet an aphasic woman who masters her ability to express herself through gesture and mime. We are told a story of a man of letters who finds a way around his post-stroke alexia to continue to read and write. We also learn how prosopagnosia has affected the lives of many people, including Sacks himself.

Sacks is a great neurologist and his knowledge shows in the ease with which he presents the complexity of our vision. Moreover, he goes beyond the mechanics of the eye and visual cortex and demonstrates how problems with vision affect people’s lives, and how human adaptability can overcome the blow. He makes us realise how much we take for granted and how plastic our brains are.

Sacks is a great storyteller, too (does his psychiatry background help here?). His essays are not only interesting but also touching, particularly where he shares his personal struggles with prosopagnosia and ocular melanoma. Even through the most difficult moments, Sacks doesn’t stop being a scientist and continues illustrating psychophysiology behind the phenomena he’s experiencing. I admit, I found the entries from Sacks’ journal a little disturbing. Although emotional and full of tension (I was skipping descriptive bits to see what happened next), they are somehow mechanical and lacking human aspect. The question of how having a cancer and losing his beloved stereoscopy have affected Sacks as a person and a doctor is left unanswered.

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**Taking the Medicine**

By Druin Burch

(£9.99, Vintage, 2010) Reviewed by Dr Aidan M O’Connell, consultant anaesthetist, New Zealand. He can be contacted through his website – www.aidanmconnell.info.

Imagine yourself in 1610, standing on a balcony at night overlooking the sleeping town of Padua. Beside you is Galileo, his telescope pointed at the stars. He whispers to you that he has calculated that the Earth, like the other planets, is moving around the Sun. As you feel the cool stone beneath your feet, it is clear – obvious! – that the balcony, Padua, and the Earth are completely still, not whizzing round in space at enormous speed, and you would be forgiven for thinking that Galileo was profoundly deluded.

We forget how difficult it was to accept the heliocentric solar system in the first place. This is just one illustration of how hard it can be for any scientist to disregard what common sense dictates is obvious, in favour of what rational intellect insists must be true.

Druin Burch’s book, *Taking the Medicine*, is a detailed and powerful account of a truth which is, in its way, as hard to accept as the heliocentric solar system: the truth of evidence-based medicine. Hailed at by Hippocrates (“experience is fallacious”), it has taken millennia to be understood. Put simply, doctors cannot reliably tell for themselves which treatments are best for their patients, no matter how great their expertise, or how good their intentions, without randomised controlled trials to eliminate their inadvertent biases and prejudices.

Burch writes passionately, but with plenty of scholastic wallop. The first section of the book is a history both of medical treatments and of experimental methods, and is full of fascinating detail. The second section involves a colourful biography of Archie Cochrane, the feisty pioneer of evidence-based medicine. The book reaches its peak in the final section, and deals with several powerful themes: thalidomide, cancer in children, and the introduction of anti-HIV drugs. I found it as compelling as a thriller.

Burch’s writing is uncompromising and unforgiving. A unifying theme is the seductive illusion of medical certainty. He writes: “...With the most advanced molecular underpinnings, the best laboratory scientists, with superb and highly motivated doctors and researchers, extensive trials in cancer models, then in animal models, then on a small scale in actual children – with all of this, the greatest cancer experts in the world were unable to predict what worked and what did not without actually doing a trial.” A secondary theme is that many medical treatments make only modest improvements in individuals, yet when applied to populations, they can provide enormous benefits.

I first came across Druin Burch’s writing on a well-known doctors’ internet service. I found his clarity of thought and his uncompromising viewpoint extraordinary. This book has changed both the way I practise and the way I think about my job. It should be read, not just by medical students and doctors, but by anyone who has ever swallowed a tablet. The truth of evidence-based medicine may be hard to swallow, but at least it won’t get you in trouble with the Inquisition.
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