CASE BOOK

Professional support and expert advice from your leading medicolegal journal

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IRELAND

CONTRACEPTION AND A CARDIAC ARREST

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Welcome

Dr Nick Clements
EDITOR-IN-CHIEF

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

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

The cost of clinical negligence claims continues to rise in a number of countries around the world, and we are speaking regularly with relevant governments and policymakers to find ways to control costs and simplify what can be long, running legal processes. It has now been a year since we launched our policy paper ‘Challenging the Cost of Clinical Negligence: The Case for Reform’ in Ireland and we recently held an event with key stakeholders, including the Medical Council, Irish Medical Organisation, Department of Health, HIQA, and several of the royal colleges to discuss the work we have done around that reform, and our next steps.

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

I mentioned at the beginning of this editorial that this edition of Casebook was one of welcomes and farewells. This is my last edition as editor-in-chief of Casebook, as I am moving into a new role within Medical Protection. I have greatly enjoyed my time in the position, especially as it has given me so many opportunities to hear your feedback directly.

I am happy to announce that Dr Marika Davies will be taking on the role, please do get in touch with any comments or suggestions that you wish Dr Davies to take on board.

Dr Nick Clements
Casebook editor-in-chief

WHAT TO DO WITH CLINICAL RECORDS

Clinical records are the cornerstone of patient confidentiality, so uncertainty over when you can or should disclose their details is understandable. Dr Sonya McCullough, Medical Protection medicolegal adviser, and Sam McCaffrey run through three common case studies

CASE 1: THIRD PARTY DISCLOSURE

Dr X was contacted by a patient’s wife to say that her husband was behaving in an odd manner. She considered that this was due to treatment, that the patient was prescribed by Dr X and resisted that he contact the patient to sort out the problem. She specifically said she didn’t want her husband to know that she had been in contact with him. Dr X recorded the conversation in the patient’s medical record.

The patient subsequently attended for a consultation and demanded a copy of his notes, but refused to provide Dr X with a reason when asked.

Dr X contacted Medical Protection to seek advice on whether the patient could have a copy of his records and whether or not the conversation with the wife should be redacted.

The medicolegal adviser referred Dr X to principle 11 of A Guide to Data Protection Legislation for Irish General Practitioners, which states that individuals are entitled to a copy of their personal data.

There are, however, a number of circumstances where a GP can legitimately refuse access to part or all of the medical record. These would include the following:

- Potential harm to patient – A patient can be refused access to their records if the disclosure “would be likely to cause serious harm to the physical or mental health of the data subject.”

- Third party information provided on a confidential basis – Certain personal health information may be withheld because of an unreasonable impact on the privacy of others. For example, where information was provided by another person whose disclosure to the individual seeking access could have serious consequences.

- Opinions given in confidence – If an opinion by a third party was given in confidence, the doctor can refuse access to the opinion if the person who provided that opinion does not consent to its release.

(Continued overleaf)
In any situation where access is denied the doctor should explain why to the patient. In addition, only the part of the medical record likely to cause harm can be withheld, the rest of the medical record should be released.

If a GP chooses to withhold information the patient can appeal this decision to the Data Protection Commissioner.

In the case of Dr X, the wife has provided him with information about her husband that is her opinion, and has specifically requested that the information be treated in confidence. If her husband applies for access to his records he is entitled to access them, but the opinion of his wife given in confidence should be redacted, unless Dr X were to obtain her consent to the disclosure.

**CASE 2: RECORDS AFTER RETIREMENT**

A six-month-old boy suffered with diarrhoea and vomiting. His GP was called and treatment was provided at home. Due to severe dehydration, the doctor’s estate had to be settled. Until the Health Information Bill is passed into law, there are no national guidelines for the retention of medical records. Without robust evidence to the contrary, the claim against the GP had died, leaving only minimal medical records. By this time, the GP had died, leaving only minimal medical records of his consultations. In the absence of any robust evidence to the contrary, the claim against the doctor’s estate had to be settled.

**LEARNING POINT**

Until the Health Information Bill is passed into law, there are no national guidelines for the retention of healthcare records other than those produced by the National Hospitals Office for public hospitals. These, however, are based on common sense principles that are equally applicable in the private sector.

**Recommended minimum retention periods:**

- Healthcare records of an adult – eight years after last treatment or death.
- Children and young people – until the patient’s 25th birthday, or 26th if the young person was 17 at the conclusion of treatment, or eight years after the patient’s death. Guidelines for public hospitals also recommend keeping records for longer periods if the contents have relevance to adult conditions or have genetic implications.
- Maternity records – 25 years after the birth of the last child.
- Records of a mentally disordered patient – 20 years after last treatment or eight years after death.

The value of retaining records for longer periods is so they can assist in responding to a complaint or claim. The recommended minimum retention periods are guidelines only and it may sometimes be necessary to retain some records for longer periods.

For more information on retaining records, how to dispose of or transfer them, see Medical Records in Ireland: An MPS Guide, which has detailed guidance on the subject.

**IF THE PATIENT WAS PRIVATE**

If he was a private patient then his records are not accessible under Freedom of Information or Data Protection legislation, as they apply only to living individuals. Therefore the question of whether, and to what extent, the records can be disclosed must be addressed in accordance with Dr U’s ethical duty of confidentiality to the deceased patient.

This duty is encapsulated in paragraph 24.2 of the Medical Council’s Guide to Professional Conduct and Ethics, which states the patient’s information remains confidential even after death. However, paragraph 24.2 also acknowledges that disclosure of a patient’s records might be released after death at a doctor’s discretion.

Dr U is obliged to consider whether the patient consented to disclosure after his death, along with other factors, including:

- How the disclosure of the medical records benefits or causes distress to the patient’s family or carers
- The effect of the disclosure on the reputation of the deceased
- The purpose of disclosure.

Disclosure of confidential medical information about a deceased private patient should only be done at the request, or with the consent, of the deceased’s personal representative. Where the personal representative requests such information, or consents to its disclosure to a named third party, then Dr U should consider disclosure under the parameters of paragraph 24.2.

Paragraph 24.2 also acknowledges that a deceased person’s confidential information can be referred to in the context of acknowledging, explaining and apologising for an adverse event.

In summary, if the deceased was a private patient:

1. Dr U should prepare a full and complete set of all medical records held at the practice about the patient so that he can fully review it.
2. Dr U should consider each individual entry and report/letter in the chart. It may be the case that certain parts of the chart should be withheld while others are disclosed.
3. He should ascertain whether Mr Y’s wife is the deceased’s personal representative and, if not, he should advise her to obtain the personal representative’s consent to the disclosure. He will require this in writing.
4. He should inform Mr Y’s wife that he has to consider whether he can release the record to her without breaching his duty of confidentiality he still owes to the patient. He should also ask her why she wants the records.
5. He should consider liaising with other colleagues in the practice who may have treated the patient.
6. He should seek the record of the decision he has made and why, so that he has evidence that he complied with the Guide if it is taken with the disclosure.

**IF THE DECEASED WAS A GMS PATIENT**

The Freedom of Information Acts govern access to records held by public bodies. If the deceased was a GMS patient then his records are deemed to be held by the Health Service Executive, although Dr U has custody of them as an agent of the HSE. The decision on whether or not to grant access to the deceased’s records does not fall to Dr U but rather to the HSE, and he should immediately transfer the request for access to his local area HSE office.

For the case of Dr U, if the deceased is a GMS patient:

1. Mr Y’s wife can apply under the FOI Acts for access to the medical records, although her right of access is not absolute.
2. Dr U is not the appropriate person to make the decision on whether or not to disclose the records, and he should therefore immediately send Mr Y’s wife’s FOI request to the HSE. Medical Protection recommends that he contacts Mr Y’s wife to explain this to her.
3. He should get ready a full and complete copy of all of the patient’s records so that he can send this to the HSE as soon as they look for it. They are entitled to this under section 6(9) of the FOI Acts.
4. He should also be ready to provide his comments on disclosure if requested by the HSE to do so. Accordingly, he should carry out the same exercise as recommended in respect of a private patient’s records.

**CASE 3: RECORDS OF A DEAD SPOUSE**

Dr U received a request for all medical records relating to Mr Y, one of his patients who had recently died. The request was made by the patient’s wife.

Dr U was not sure if the deceased’s wife was entitled to a copy of the records so he called Medical Protection for advice. He wanted to know in what circumstances access should be granted and what information, if any, should be redacted.

If the patient’s wife requested “all medical records” in relation to her husband then this includes not only clinical notes but also all incoming and outgoing correspondence relating to the patient’s treatment, all laboratory reports, all radiology reports, all X-rays and so on. A full and complete set of the medical records relating to the deceased should be assembled to analyse whether and to what extent a copy can be disclosed to the patient’s wife.

However, what should be considered before disclosing the medical records differs depending on whether the patient was treated publicly or privately.

He should consider liaising with other colleagues in the practice who may have treated the patient. He should also ask her why she wants the records.
and explains plans to expand unannounced inspections

Mary Dunnion, Director of Regulation at the Health Information and Quality Authority (HIQA), describes how new guidance will build a link between inspection findings and national standards – and explains plans to expand unannounced inspections.

With new guidance recently published, the Health Information and Quality Authority (HIQA) is taking extra steps towards improving quality and safety within the Irish health service.

The publication of Linking Learning to National Standards is aimed at helping hospitals and healthcare providers achieve these improvements, by linking 232 recommendations from seven HIQA reports with overarching National Standards for Safer Better Healthcare that they are expected to meet.

These recommendations were drawn from investigation, statutory inquiry and reviews reports published since 2009. Our National Standards for Safer Better Healthcare were mandated by the Minister for Health in 2012, and describe a vision for high quality and safe healthcare. It is internationally recognised that setting, implementing and monitoring compliance with standards are important factors in making improvements in quality and safety in healthcare.

Linking Learning to National Standards connects National Standards to real-world care delivery by matching these recommendations to identified Standards. In implementing the recommendations of national reports, it is important for each service provider to look at the National Standards or Standards associated with the recommendation to ensure their service meets the particular National Standard.

Established in 2007, their mandate extends across the quality and safety of the public healthcare service, and public, private and voluntary sectors within our social care function. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, HIQA has various statutory responsibilities, including the lead role for developing and monitoring National Standards for the quality and safety of services.

When reviewing these in their totality, a number of common issues emerge in relation to services provided in public acute hospitals. Because high quality, safe and reliable healthcare is best supported by good governance, performance should be monitored continuously to check if a service meets National Standards. When things go wrong, or desired outcomes are not achieved, there need to be systems in place to collect, analyse, investigate and learn so that care is improved and mistakes are not repeated.

ABOUT HIQA

The Health Information and Quality Authority (HIQA) publishes a vast array of inspection and other regulatory reports on Ireland’s health and social care services.

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HIQA aims to provide greater assurance to the public about the safety and quality of those services, it operates an independent regulatory model that is designed to listen to and act on the views and experiences of people using and providing services. The objective is to propel improvement by sharing learning, and publicly highlighting good and poor practice in their reports.

INFECTION PREVENTION AND CONTROL

Throughout 2015, HIQA has been expanding the scope of its unannounced inspections against the National Standards for the Prevention and Control of Healthcare Associated Infections. We believe all hospitals should work together to better facilitate the sharing of good practice in infection prevention and control, and the benefits of all patients nationally. This year, we have published a revised guide to these inspections, which will focus on the following three areas:

- Hand hygiene compliance
- Cleanliness of the environment and equipment
- Effectiveness in implementation and monitoring of Infection prevention care bundles

We are monitoring how hospitals implement those infection prevention care bundles that have been recommended in national guidelines. For example, we will inspect hospitals’ progress in introducing and monitoring the effectiveness of care bundles designed to prevent infections caused by the use of intravenous lines (drip lines) or urinary catheter use. Re-inspections are carried out within six weeks of the first inspection if performance is deemed to be sufficiently poor during the initial inspection, and re-inspection aims to rapidly improve care.

This programme aims to promote a culture of responsibility and accountability among all staff involved in the management and delivery of healthcare services; with the findings of each inspection publicly available on the HIQA website, www.hiqa.ie.

NUTRITION AND HYDRATION

In a related development, and in line with our responsibility for checking compliance against the Infection Prevention and Control Standards, we have developed an inspection programme focused specifically on antimicrobial stewardship in public acute hospitals. This is a critically important aspect of care. The inspection programme will consist of two parts: a process of self-assessment followed by announced inspections in a selection of hospitals.

Antimicrobial resistance in healthcare is an international challenge. Effective antimicrobial stewardship aims to improve the quality of antibiotic usage, thereby:

- Improving patient treatment outcomes
- Reducing adverse effects
- Prolonging the value of existing antimicrobial agents
- Reducing overall treatment costs

All public acute hospitals — which should have good governance structures in place — will be expected to complete a self-assessment and submit it to HIQA.

The completed self-assessments will give HIQA baseline information about nutrition and hydration care in Irish hospitals and inform our programme of unannounced inspections, due to start later in 2016. We will inspect approximately 13 hospitals to verify results. A national overview report will be published in 2016 to promote a process of continuous improvement.

NEXT STEPS

The government has indicated that HIQA’s remit in healthcare will be extended to the private healthcare sector. The extent and type of private facilities to be brought within HIQA’s remit will be determined during the revision of the relevant legislation.

In the meantime, there are a number of ongoing initiatives underway to promote the quality and safety of public healthcare services. Findings and recommendations from our investigation reports and other reports are intended to be used by all healthcare services to inform and improve practice. It is vital that lessons learned should be shared between hospitals within the new hospital groupstructure, between hospital groups and nationally throughout the wider healthcare system.
Kevin Murphy, a student at UCC, died needlessly at just 21 years of age. In this article his mother, Margaret, presents what should be a call to action for all healthcare professionals. Kevin’s death signalled the end of multiple opportunities to intervene and save his life, all missed by his many physicians. The errors involved primary and secondary care, poor communication and, ultimately, lethally inadequate management of investigation results.

The everyday management of investigation results may appear mundane. Ignore these lessons at your peril.

It provides an invaluable learning opportunity for clinicians to take note of what went wrong and ensure that it never happens in their own practice. In her pursuit of the facts of what led to her son’s untimely passing Margaret has been motivated by a desire to not just have the truth acknowledged but to have doctors learn from it so that no other patients or their families need go through the same experience.

This is a difficult case to recall for all who were involved in it, the patient’s family and those doctors responsible for his care. However, the family and the doctors involved have not forgotten what happened. They have been by their own words “shattered and that is why we undertook litigation.”

Almost five years later, a judge of the High Court declared: “It is very clear to me that Kevin Murphy should not have died.” Two GPs, a private consultant, a hospital consultant and a hospital admissions department admitted liability, expressed their regret at Kevin’s death and apologised.

The errors involved primary and secondary care, poor communication and, ultimately, lethally inadequate management of investigation results. This has led to patient harm.

The procedure has a 96% success rate with 1% complication rate.

The World Health Organisation (WHO) has recognised Kevin’s patient journey as a learning tool and has included me as external lead adviser of the Patients for Patient Safety Programme, which has allowed me to engage collaboratively with healthcare at local, national and international levels.

I fully subscribe to declaration of Sir Liam Donaldson: “To err is human, to cover up is unforgiveable, but to refuse to learn is inexcusable.”

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THE PATIENT EXPERIENCE:
A CATALYST FOR CHANGE

BY MARGARET MURPHY

Large numbers of patients have successful and uneventful healthcare encounters but it is also a fact that a significant number of patients experience preventable adverse events that impact on their quality of life and, all too often, result in loss of life itself.

As patients we do urge that past experience be used to inform the present so we can work together in the present to influence a better future. It is a heartfelt call to give meaning to tragedy by acknowledging that something happened that should not have happened, extracting the learning and, importantly, doing everything possible to prevent recurrence.

One such tragedy relates to the needless death of my own 21-year-old son, Kevin. Every point of contact within the Irish healthcare system failed him and that injury was compounded by the very real fact that learning opportunities were frustrated by corporate damage limitation efforts after his death.

Repeated consultations and blood tests taken two years before Kevin’s death revealed calcium levels at 3.51mmol, together with plasma creatinine levels indicating 50% loss of overall renal function. Flawed communication between consultant and GP meant that the necessary referral to an endocrinologist did not happen, the diagnosis of primary hyperparathyroidism was not made and hypercalcaemia was allowed to progress for a further year and ten months.

In the week before his death, Kevin attended his GP complaining of lethargy, occasional vomiting and continuing bone pain. Blood and urine samples were taken, with test results being telephoned to the GP for surgery the next day and written on a Post-It note by the practice nurse, who drew attention to the high calcium level (now at 5.73).

However, a key point of contact failed Kevin when the GP, ignoring the high calcium levels, only included in his letter of referral to the hospital those elements of the blood test results that supported his own diagnosis of leptospirosis – although he did send the Post-It with the letter.

When compiling the file in the hospital, that Post-It note containing those vital calcium results was stuck to the back of the letter and was not seen until six weeks after Kevin’s death. The standard blood test in that particular hospital did not include for calcium. So, throughout his time there, they remained unaware of Kevin’s dangerously high calcium levels; a diagnosis of nephritis was made.

It was a weekend admission and Kevin was managed at registrar level. On-call senior personnel were not advised of his deteriorating condition, with calcium readings now at 6.21mmol. The following day, and without warning, Kevin suffered a heart attack as his sister and I sat at the bedside.

Attempts at resuscitation failed. I asked about organ donation as Kevin carried a donor card. The doctor shook his head – Kevin had been allowed to deteriorate to the point where his organs were of no use to any other human being. That was very difficult to hear: it was almost like Kevin dying twice. The doctor then asked if we would like him to enquire about Kevin’s eyes. So Kevin’s corneas were donated and we later learned that two people – a 42-year-old woman and a 60-year-old man – now have sight.

We met with those responsible for Kevin’s care. One doctor described his dilemma as an issue with “loyalty to colleagues”. Another suggested, in relation to the Post-It, that even if it had been seen by his consultant colleague, it would not have meant anything to him. He said this was because it was not written as they would write it – in scientific notation. It was at that point that I lost faith. Our confidence in any hope of ascertaining the truth through honest dialogue was shattered and that is why we undertook litigation.

After the Moyse/Ornstein case, it is also a fact that a significant number of patients have successful and uneventful healthcare encounters but it is also a fact that a significant number of patients experience preventable adverse events that impact on their quality of life and, all too often, result in loss of life itself.

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Almost five years later, a judge of the High Court declared: “It is very clear to me that Kevin Murphy should not have died.” Two GPs, a private consultant, a hospital consultant and a hospital admissions department admitted liability, expressed their regret at Kevin’s death and sympathised with the family. The conclusion of peer review was that “all the evidence indicates that the patient was suffering from a solitary parathyroid adenoma at that time and removal would have been curative with a normal life expectancy.”

This procedure has a 96% success rate with 1% complication rate.

The World Health Organisation (WHO) has recognised Kevin’s patient journey as a learning tool and has included me as external lead adviser of the Patients for Patient Safety Programme, which has allowed me to engage collaboratively with healthcare at local, national and international levels. I fully subscribe to declaration of Sir Liam Donaldson: “To err is human, to cover up is unforgiveable, but to refuse to learn is inexcusable.”

Learning from mistakes

This tragic case highlights significant problems in test handling procedures in both hospitals and practices. Make sure it doesn’t happen to you by taking the time to review your own protocols and procedures.

System errors are the cause of many claims relating to failure to diagnose, as shown by Medical Protection research. Such errors include results scanned to incorrect patient files, failure to notify the patient of an abnormal result, or result mismanagement during annual leave.

An effective system to manage results will help reduce the likelihood of adverse events, trap errors and help improve patient safety. Investigations, processing results and “actions arising” are three key areas where weak systems may lead to patient harm.

Table 1 shows the number of Medical Protection risk assessments conducted in UK and Ireland practices by year, and the proportion with test results system risks highlighted by clinical assessors.

<table>
<thead>
<tr>
<th>Year</th>
<th>CRSA general practice visits</th>
<th>Proportion of practices with identified test result system issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>163</td>
<td>85.1</td>
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<tr>
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<td>153</td>
<td>88.2</td>
</tr>
<tr>
<td>2014</td>
<td>107</td>
<td>72.0</td>
</tr>
</tbody>
</table>

RISK: NO TEST RESULT PROTOCOL

A robust practice protocol for management of investigation results is crucial for patient safety. Investigation, processing results and actions outcomes are the key areas to consider. With investigation results arriving from a multiplicity of sources, the challenges of investigation, processing of results and Actions outcomes are fraught, with a high volume of results returning to already busy clinicians. It is all too easy for important results to go astray in such complex busy systems.

Consider undertaking a rigorous analysis of your test result systems. Involve all staff, as administrative staff are often very busy. It can be easy to view the everyday management of test results as a mundane task, but a failure to do so can have tragic consequences.

Cork GP Dr Diarmuid Quinlan, a Medical Protection educational services facilitator, offers guidance on some common pitfalls.

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RISK: NO RECORD OF INVESTIGATIONS REQUESTED, AND NO CHECK THAT ALL RESULTS HAVE RETURNED
It is important to document what investigations have been ordered. Many doctors now record a list of blood tests requested. It’s prudent to carefully check that all results have returned, especially as some results are back within a few days, while others may take much longer. Try to avoid that awful scenario where the patient is advised that all results are normal, only for a very abnormal result to subsequently return.
In an ideal world we would have reliable automated tracking of investigations out/results back. Such a system would regularly identify ‘missing’ results. A simple audit of investigations out/results back will verify whether all results return. Such an audit might also fulfill your Medical Council audit requirement: a win-win situation.

RISK: TRACKING SYSTEM TO ENSURE FOLLOW-UP
The doctor has identified an abnormality, or may wish to repeat an important blood test, or re-examine the patient with results to hand. Such planned review of the file may be crucial to enable timely diagnosis. You may decide to issue a prescription for potentially toxic medication (methotrexate, lithium, DMARDs), only once blood monitoring results have returned.
Have you a reliable system to ensure such follow-up actually occur? Are you just hoping that the patient will phone if or return? An electronic or paper tracking system is actually very easy to initiate. It’s simple to make an electronic task: “Has Mrs Ryan’s MRI brain scan returned?” and date it for two weeks later. The task will pop up in your ‘to-do’ list two weeks later.
Similarly, a paper-based tracking system can be easily implemented, although the use of loose sheets of Post-its should be avoided: they are easily lost, may breach confidentiality and may be unacceptable as part of an evidential paper trail.

RISK: PATIENT NOT INFORMED OF IMPORTANT ABNORMAL RESULT
Responsibility for appropriate actioning of results lies with the requesting clinician. You must therefore assume the patient will phone the practice to obtain results, and undertake any necessary follow-up. Many patients will be unaware of the importance of consultation with their GP if results are of particular significance. If so, setting up a buddy system to check on all abnormal results may help. This is clearly unsafe, as apparently normal results can indicate evolving clinical situations.

RISK: A BUDDY SYSTEM IS IMPORTANT!
What happens in your practice when you have a day off, are sick or go on holiday? A buddy system should be in place to guarantee timely review of all investigation results. This will ensure no important results are overlooked, and that urgent management is not compromised. Consider a system where each buddy electronically signs the results, which are then stored in a ‘review’ file, pending final verification by the absent clinician.

RISK: NON-CLINICAL STAFF INTERPRETING PATIENT RESULTS
If reception staff are permitted to give results, they should solely read out the clinician’s comments which should be clear and unambiguous. Reception staff should never enter into clinical discussion about investigation results. If the patient has further questions, then a telephone conversation with the relevant clinician should be arranged. It is obvious that some results (HIV, malignancy) should only be given by a clinician. Nursing and reception staff may, with training, be permitted to convey some less critical results.

RISK: CLINICAL STAFF REVIEW ONLY “ABNORMAL” RESULTS
In a small minority of settings, clinicians review only those results flagged as abnormal. The remaining results are simply filed without review or electronic signature. This is clearly unsafe, as apparently normal results can indicate evolving clinical situations. Seemingly normal test results often warrant clinical action: a rising PSA, falling ferritin, haemoglobin or variable thyroid result may need action, while still within normal range. It is unsafe to delegate responsibility for checking apparently normal results. A clinician should always review all investigation results.

RISK: GIVING OUT THE TEST RESULT
Giving the result from a different date or the wrong patient can happen easily. Having several files open on the computer may predispose to such errors. Prior to giving a result, verify the patient’s identity, ideally using three identification markers: name, address and date of birth.

ANYTHING THAT CAN GO WRONG...
In busy healthcare settings it is inevitable that errors will occasionally occur. In such circumstances, consider sharing learning outcomes with relevant staff and hold a significant event analysis. Lessons should be learned and shared, and protocols amended, to prevent similar errors recurring. Suboptimal management of investigation results can be lethal.

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

CASE 1: MRS A
MRS A opted to undergo facelift surgery. Dr B was the consultant anaesthetist for the procedure and used a throat pack in order to stabilise Mrs A’s airway.
The WHO Checklist: Sign-in was performed and the surgery proceeded uneventfully. However, the WHO Checklist: Sign-out did not take place. Dr B reversed muscle paralysis, applied suction to the airway and extubated Mrs A. Dr B would usually perform a laryngoscopy at this point but did not on this occasion, as it was difficult to open the patient’s mouth.
Mrs A was handed over to the recovery staffing, where slightly obstructed respiratory movements were noted. Dr B attributed these symptoms to emergence delirium, and therefore removed a nasopharyngeal airway. On examination around 20 minutes later, Mrs A was awake, the artificial airway had been removed and she indicated to Dr B that she was not in any discomfort.
Around three further hours passed before the throat pack was discovered, during which time she experienced significant respiratory distress. The throat pack was removed and Mrs A made a full recovery.

CASE 2: MISS C
Miss C was admitted to hospital for the routine excision of a benign palatal lump. Dr D was the consultant anaesthetist for the procedure, although it was the first time that he had worked in this hospital.
There were three cases on the list that afternoon. A briefing took place before the list started, and the WHO Checklist: Sign-out was performed. The insertion of the throat packs was discussed, however, the plan for their removal was not.
Dr D inserted the throat pack for the first patient on the list but at the end of surgery it was removed by the junior surgical doctor. This created some confusion. Miss C was second on the list and, although Dr D inserted her throat pack, he was not under the impression that its removal was his responsibility.
Further, this throat pack had been obtained from the anaesthetic room, and as such did not form part of the scrub nurse’s swab count. Dr D did however, place a sticker on Miss C’s head noting that a throat pack had been used.
The surgery proceeded uneventfully. However, immediately after waking up, Miss C experienced some difficulty breathing. The issue of the throat pack was raised by nursing staff and Dr D mistakenly asserted that it had already been removed. The nursing staff therefore removed the sticker that had been placed on Miss C’s head. A laryngeal mask airway (LMA) was inserted, which improved Miss C’s oxygen saturation levels.
On removal of the LMA around 35 minutes later, Miss C coughed up the throat pack. She also made a full recovery.

THE WHO CHECKLIST
When used properly, the WHO Checklist prompts effective team communication to eradicate avoidable risks, such as retained throat packs. Proprietary usage of the Checklist requires the following:
• As three phases of the list must be performed: Sign-in, Time-out, Sign-out.
• All three phases of the list must be assigned.
• Each phase must be checked, either as part of the swab count exercise, or as a distinct part of the checklist.

throat packs are used commonly in oral and maxillofacial surgery for a number of purposes, including the prevention of unwanted material from entering a patient’s oesophagus or trachea. The packs themselves, however, are capable of causing serious injury by obstructing patients’ airways if they are not removed after surgery.

The WHO Surgical Safety Checklist was launched in 2008 to improve teamwork and thus combat avoidable complications in surgery, such as retained swabs and instruments. Two recent Medical Protection cases, however, demonstrate that the problem of retained throat packs persists, notwithstanding the introduction of the WHO Checklist.
Before joining Medical Protection in 2003, I was a GP and always enjoyed reading the cases in Casebook, irrespective of whether they related to primary or secondary care. In my role at Medical Protection I meet many doctors from different specialties and when I introduce myself, invariably the first thing they say is that they enjoy reading the cases in Casebook – with the caveat that it often causes them to reflect on their own practice (which, of course, is one of the reasons why the particular cases are chosen).

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

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

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

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

What’s it worth?

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

- HIGH €1,500,000+
- SUBSTANTIAL €150,000+
- MODERATE €15,000+
- LOW €1,500+
- NEGLIGIBLE <€1,500
Mrs S was a 51-year-old teacher. At the start of term Mrs S developed a troublesome cough and went to see her GP, Dr B, about it. Dr B diagnosed a chest infection and prescribed antibiotics but also noted that she had an irregular pulse. An ECG was performed at the surgery the same day, which showed that Mrs S was in atrial fibrillation. Dr B sent Mrs S to the medical assessment unit for urgent review.

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

Mrs S attended for her cardioversion procedure but was found to be in sinus rhythm. The cardiologist (Dr T) advised Mrs S to stop taking her warfarin and to reduce her bisoprolol dose further. Dr B arranged a further ECG for the following week and reduced her bisoprolol dose completely. Dr B documented that Mrs S was “waiting cardiology follow-up” and that she had had a chest infection when the atrial fibrillation was initially diagnosed.

The ECG the following week showed sinus rhythm with a rate of 60 bpm. Dr B saw Mrs S again with the cardiologist’s advice slip. Dr B documented that her pulse was regular now (although she was slightly bradycardic). Dr B arranged a further ECG for the following week and reduced her bisoprolol dose further. Dr B documented that Mrs S was “awaiting cardiology follow-up” and that she had had a chest infection when the atrial fibrillation was initially diagnosed.

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

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

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

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

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

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

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

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

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

**Learning points**

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

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

**AF**
**CASE REPORTS**

**CONTRACEPTION AND A CARDIAC ARREST**

**SPECIALTY: GENERAL PRACTICE**

**THEME: SUCCESSFUL DEFENCE**

**CASE REPORT**

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

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

Imaging of Miss F’s brain revealed oedema suggestive of a cerebral infarction and a small subdural haematoma. Miss F’s treating haematologist commented that the dianette definitely made a contribution to the blood clot Miss F suffered, but considered the cerebral haematoma to be thrombolysis given to appropriately treat this. Miss F spent a month recovering in hospital and her visual symptoms resolved.

Long-term warfarin was initiated and she was discharged with no focal limb deficits or cognitive symptoms. Twice weekly physiotherapy and occupational therapy was commenced.

Two months after discharge, a formal cognitive assessment revealed ongoing difficulties with verbal and visual recall and reduced speed of processing information. Three more months later, Miss F was discharged from physiotherapy and occupational therapy and returned to her part-time job. Miss F had returned to the gym and was making plans to resume her university studies, which she did at the beginning of the new autumn term. A year after the event, Miss F was back to her studies and happy with her progress and the support she had been given.

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

**EXPERT OPINION**

Expert GP Dr C was unsupportive of Dr K’s action, stating that dianette is usually the first-line treatment for acne and that the size of this increase in risk is small, and the risk appears to peak between four months and one year of use. The timing of Miss F’s PE appeared to be closely linked to switching off the dianette, she would not have suffered the massive PE that led to her suffering from ischaemic brain damage.

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

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

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

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

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

The case was settled for a moderate sum.

**LEARNING POINTS**

- Poor record keeping is a major factor in litigation cases brought against healthcare professionals. Good medical records are not only essential for the provision of quality care but for defending yourself if you face a complaint or clinical negligence claim.
- Doctors should take and document a detailed history to help identify possible causes. Common symptoms can usually be categorized as those related to gastroenteritides or to viral illnesses.
- It’s important to reassess patients if they don’t behave as expected.
- There are some useful UK guidelines from the Health Protection Agency (HPA) about infectious diarhoea, detailing what to send to a stool culture for which there is a moderate sum.
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**CASE REPORTS**

**DEATH BY DIARRHOEA**

**SPECIALTY: GENERAL PRACTICE**

**THEME: DIAGNOSIS/RECORD-KEEPING**

**CASE REPORT**

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

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

Miss F’s family were devastated and made a claim against Dr A. They felt that her death could have been avoided if Dr A had investigated and treated her diarrhoea earlier.

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

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**Casebook**

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Mr K was a 36-year-old man who ran a pub. Mr K drank heavily. Mr K's dentist had noticed a painless swelling on the right side of his neck during a routine check-up and asked him to see his GP.

Mr K was seen by Dr A, one of the GPs at his surgery, who noted that Mr K was unsure how long the lump had been there, and referred him to the ENT outpatient department.

A letter came back to the practice confirming the presence of a lymph node in the anterior triangle of Mr K's neck, which was felt to be innocuous. The plan was for Mr K to be reviewed in six weeks' time. Mr K was asked to refer all future swellings to be pursued if the node was still present.

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

Eight months later, Mr K began to get some discomfort in the neck swelling so decided to see his GP again. This time he was seen by Dr B at the surgery. Dr B noted his painful swelling and also a history of chronic tympanic membrane perforations. Dr B did not document his previous referral to the ENT department regarding the same lump or the intended follow up.

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

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

**EXPERT OPINION**

Medical Protection sought the advice of an expert GP (Dr F). Dr F felt that Dr B bore liability for the delayed diagnosis. He was critical of Dr B's history-taking and record-keeping. Dr F commented that Dr B had responsibility for establishing the history of his previous referral to the surgical assessment unit. Had Dr B known of that referral, then the duration and the continuing nature of the lymph node would have necessitated immediate re-referral back to that team. Dr F also criticised Dr B's inadequate examinations, stating that he should have documented an examination of the patient's neck, mouth, tongue and throat.

The opinion of a professor of oto-otology (Professor Y) and head and neck surgery was also obtained. Professor Y commented that there was a need for an earlier presentation and initial presentation and the final treatment. Professor Y thought that an earlier diagnosis may have allowed a less radical neck dissection and it may have been possible to spare the accessory nerve, which controls the muscles of the trapezius and sternocleidomastoid muscle. This would have resulted in less dysfunction to the shoulder and neck.

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

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

Six months later, Mr K was still struggling with his symptoms and went again to see Dr B. This time Dr B made a referral to head and neck surgery. His referral letter stated “intermittent chronic right sided neck swelling in the pre-auricular and submandibular area”. There was no mention of any previous referral in his letter.

Dr B documented a differential diagnosis of a possible parotid lesion or salivary gland stone. Mr K’s neck lump subsequently proved to be malignant. As a result he had to have neck surgery and resection of a primary in his tonsil. He had a course of radiotherapy and since has not had recurrence of his disease. Unfortunately he was left with shoulder weakness and a dry mouth, which he found difficult to cope with.

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

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

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

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

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

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

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

The case was settled for a substantial sum.
Ms S, a 27-year-old Romanian woman who lived with her husband in the UK, became pregnant and presented to her local GP surgery to commence antenatal care. Ms S’s dressing was clean and photophobia, and queried a degree of meningeal irritation from a small bleed versus cerebral haemorrhage before, during or after delivery. She was referred to consultant neurologist Dr A requesting a second opinion, the result of her Romanian triple test, which allegedly gave a risk of Down’s Syndrome of 1 in 67. Her combined test in the UK gave a much lower risk of 1:835. Based on these results, Dr A’s account was that he was not told of the Down’s screening but had recommended an amniocentesis, which was declined by Ms S. Ms S reached term and gave birth to her son by emergency caesarean section due to fetal distress. The baby was born with Down’s Syndrome and patent ductus arteriosis and developed septicaemia and pulmonary hypertension.

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

EXPERT OPINION
Expert GP C maintained that Dr A’s standard of care did not fall below that expected of a GP. Dr C felt that Dr A was entitled to rely on the screening performed in the local secondary care setting, which indicated a low risk of Down’s Syndrome with no need for further investigations. Dr C’s account was that he was not told of the Romanian result, so was unable to take this into consideration. Dr C maintained that it would have been prudent to refer if this result had been available, given that it would be carried out at 16 weeks – at a time when it would be less sensitive – it would have been reasonable for Dr A to have terminated the pregnancy.

Dr D, expert in foetal-maternal medicine, stated that had Dr A been made aware of the test from Romania, it would have been a breach of duty to discount it. Assuming that Ms S would have accepted the offer of amniocentesis, based on the timings, the diagnosis of Down’s would have been made between 22 and 24 weeks gestation, at which point a late termination of pregnancy could have been contemplated.

The case went to trial. Dr A proved to be a credible witness and set out his evidence well, which helped in the claim being dismissed.

Learning points
- Consent/confidentiality with patients who do not speak the same language presents a significant challenge for all healthcare professionals. If your patient cannot understand the procedure you are putting both yourself and the patient at risk.
- If possible, try to use an interpreter rather than a family member if possible, unless a patient presents acutely.
- Patients who undergo investigations over weeks rather than hours for ongoing care and if you present a challenge to GPs, it is advisable to refer to a specialist who may be the best course of action.

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**Learning points**

**EXPERT OPINION**

- Consent/confidentiality with patients who do not speak the same language presents a significant challenge for all healthcare professionals. If your patient cannot understand the procedure you are putting both yourself and the patient at risk.
- If possible, try to use an interpreter rather than a family member if possible, unless a patient presents acutely.
- Patients who undergo investigations over weeks rather than hours for ongoing care and if you present a challenge to GPs, it is advisable to refer to a specialist who may be the best course of action.
Mrs L, a teacher, was first prescribed the oral contraceptive pill microgynon by her GP, Dr G, when she was 22. Her blood pressure was taken and recorded as normal. At this time, no other mention was made in the records of her risk profile or family history. Later, Mrs L’s medical records showed that she was changed to ovulen 50. The reasoning this time was due to “excessive bleeding on ovranette”. At her review consultation, Mrs L’s blood pressure was taken and recorded as normal.

When she was 26, Mrs L was seen by her GP for antenatal care, where it was recorded that she was smoking 20 cigarettes per day. Her blood pressure was recorded as normal. After her first child had been born, Mrs L was prescribed ovranette, before she changed to the combined pill.

Three years later, Mrs L consulted her GP as she was under significant stress. Her records showed that she had increased her smoking to 25 cigarettes per day and did not exercise. Counseling was started and advice given that smoking should be reduced. 50mg was prescribed and exercise was advised. In addition, a prescription of progesterone-only pill (or at least have alternative options). Mrs L’s notes show that she was advised that she should also have revisited the prescription as the risk factors involved in prescribing the pill were not being assessed.

Mrs L was seen on a number of occasions in the practice for a repeat prescription for microgynon and other matters, including further chest pain, collapse and migraine.

Aged 41, Mrs L collapsed and was admitted to the Emergency Department, where investigations found that she had had a stroke. She was unable to return to work due to paralysis affecting her left side.

Mrs L made a claim against Dr F. She alleged that he had been negligent in continuing to prescribe microgynon after she was 35 years old when she had three risk factors: a family history of heart attack, smoking and being over the age of 35. Mrs L was advised to refer to paralysis affecting her left side.

Two years later, Mrs L fell to the floor with severe chest pain and attended her GP surgery the next day. Mrs L had been getting palpitations once every two weeks that lasted for two hours to two days, over the previous two years. These were accompanied by sharp chest pains. Mrs L was noted to be under less stress now and was smoking slightly less at 20 per day. She was advised about smoking. Mrs L was referred to the chest clinic, where she was diagnosed with non-cardiac chest pain.

Mrs L was seen on a number of occasions in the practice for a repeat prescription for microgynon and other matters, including further chest pain, collapse and migraine.

Four months after her last repeat script, aged 35, Mrs L presented to the same practice with central chest pain and was seen by Dr F. Dr F noted that Mrs L was now smoking 30 cigarettes a day and did not exercise. Dr F noted that Mrs L was advised to consider what drugs are on your practice’s repeat-prescribing list. She was prescribed paracetamol 200mg six times daily and a sleeping tablet for two weeks. However, Dr F noted that Mrs L was advised to call the emergency services if the pain became worse.

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The case was settled for a substantial sum.

EXPERT OPINION

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

The case was settled for a substantial sum.

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

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

Learning points

- Dr F should have considered all the risk factors involved in prescribing the contraceptive pill to Mrs L. He should also have revisited the prescription at the clinic appointment 35 days and documentation placed. For more information on prescribing the combined pill see: Faculty of Sexual and Reproductive Healthcare - Clinical Guidance, Combined Hormonal Contraception (August 2012) www.fsrh.org.
- Remember to exercise clinical judgment when prescribing - be careful not to just accept a patient's request for a repeat prescription if it is not in their best interests.
- Consider what drugs are on your practice’s repeat-prescription list. It is having a monitoring strategy is helpful in prescribing a protocol. Clinical notes should show the reasoning behind your decision, as well as the clinical evidence. The records here did not reflect any further history had been taken.

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EXPERT OPINION

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

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

The case was settled for a high sum.
MISSED CRITICAL LIMP ISCHAEMIA

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

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

Dr. James A H Cave
Berkshire
UK

Response

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

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

The claimant and his or her legal advisers will determine which individuals to claim against, based on their understanding of the facts and the opinion of their experts. Of course in the case of an NHS hospital, the claim will be against the organisation itself (which is responsible for the actions of all its staff), but for GPs or those in private practice the claim is usually aimed at individual clinicians.

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

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

A PROBLEM WITH POLYPS

LETTER 2

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

It seems to me that the crucial error in this case was failing to refer in the knowledge that another doctor had seen two rectal polyps and had recommended further investigation (even if this information came by an unconventional route). A normal DRE, while contributing to a comprehensive assessment, would not influence that decision. It is difficult to see what Dr A could have learned from history or examination that would have trumped the clear recommendation from the overseas clinic. An element of irrefutable, perhaps understandable, at 97.5% deviation from standard procedure could have clouded Dr A’s judgement.

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

Dr Aidan Finnegan
Waterford
Ireland

Response

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

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

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

A PROBLEM WITH POLYPS

LETTER 1

Thank you for your helpful comments.

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

TOO MUCH OXYGEN

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

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

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

Dr. Jane Alsweiler
Neonatal paediatrician
Auckland
New Zealand

Response

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

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

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

REFERENCES

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

by Kevin Pho and Susan Gay

Dr Aidan O’Donnell, consultant anaesthetist, New Zealand

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

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

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

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

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

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

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

Edited by Colin Brewer and Michael Irwin

Reviewed by Dr Ellen Welch – GP, London

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

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

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

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

A major limitation of this book is that it only presents one side of the argument on the debate and it would certainly provide more of a balanced read if there had been contributors from those who oppose assisted dying. Whatever your view may be, it does provide an interesting and comprehensive read in support of the issue.
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