This issue...

FROM THE CASE FILES
Our latest collection of case reports

RISK ALERT – MEDICATION ERRORS AND SAFER PRESCRIBING
Common problem areas in prescribing

RESPONDING TO COMPLAINTS
How to handle a complaint well

WHAT’S NEW IN THE UPDATED IMC ETHICAL GUIDE?
A PREVIEW OF THE CHANGES TO BE INCLUDED IN THE UPDATE

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DON’T LET RISKS DERAIL YOU

SPOTLIGHT ON RISK CONFERENCE 2016
THE CONVENTION CENTRE DUBLIN (CCD)
0900 – 1630
JUNIOR DOCTORS AND NCHDs

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am delighted to welcome you to this latest edition of Casebook and my first as Editor-in-Chief. I would like to express my thanks to my predecessor, Dr Nick Clements. For many years Nick has made an enormous contribution to both Casebook and to the work we do on behalf of members, and his considerable knowledge and experience have been invaluable resources. Fortunately he has not gone far, and we wish him all the best in his new role within Medical Protection.

Having been a medico-legal adviser at Medical Protection for over 12 years I have had the privilege to advise and assist many doctors going through difficulties in their professional lives. I am very aware of the stress and anxiety that doctors experience when they are the subject of criticism or an investigation, and the impact this can have on them both personally and professionally. Helping doctors to avoid such difficulties in the first place through education and awareness of risk is one of the key aims of Casebook, and I hope to continue the tradition of publishing informative, educational articles and case reports that help to improve practice and prompt discussion.

Later this year the Medical Council will launch the latest update to its Guide to Professional Conduct and Ethics for Registered Medical Practitioners. On page 6 Dr Audrey Dillon, Vice President of the Medical Council of Ireland and Chair of its Ethics and Professionalism Committee, previews what we can expect to see in the update, and our own Dr Sonya McCullough provides Medical Protection’s view on the changes.

Dealing with complaints can be stressful and time-consuming, but a good response can help to resolve a situation and may prevent it from escalating further. On page 10 we provide a guide to complaint handling and how to draft an appropriate response.

The case reports in this edition have a particular focus on conditions that can lead to claims of particularly high value. While some of these medical conditions may not be that common, they can lead to significant disabilities for the patient, unless diagnosed early and appropriate action is taken. One of the challenges for clinicians is identifying those patients that require further investigation in order to establish or rule out serious underlying pathology. As the cases demonstrate, good documentation is essential in order to justify your clinical decisions if there is an adverse outcome.

I hope you enjoy this edition. We welcome all feedback, so please do contact us with your comments or if you have any ideas for topics you’d like us to cover.
rescribing is one of the greatest risk areas for all clinicians and can be particularly hazardous for the inexperienced doctor. It is fraught with potential pitfalls, ranging from transcription errors and inadvertent dosage mistakes to overlooked drug interactions, allergies and side effects, the consequences of which may be profound both for the patient and the prescriber.

It is imperative that you have a good knowledge of the pharmacology and the legislation surrounding drugs, and any protocols and controlled drug routines that apply within your workplace – if unsure, ask.

To help members control their prescribing risks Medical Protection has developed a new online module on the subject, which can be found on our e-learning platform, Prism.

Below are two case reports highlighting some common potential hazards.

CASE 1

Mr A registered with a new GP practice and requested a repeat prescription for his regular medication, which included fluocinolone 0.025% cream (a potent topical steroid). He was asked to attend for a GP appointment with Dr B, who immediately noticed the patient’s “bright red shiny face”. Mr A explained that he had suffered from asthma and eczema for many years and that he had started using the fluocinolone on his face about two years earlier when his eczema had been bad. Although the eczema on his body and limbs had cleared up, he found that as soon as he stopped using the steroid on his face it became very uncomfortable, so he continued to use it.

Dr B discussed the risks of continuing to use the potent steroid on his face and referred him to a local dermatologist who initiated a regime to reduce gradually the strength of topical steroids before a review.

Discussion with Mr A and review of his records revealed that although he had attended for reviews at his previous GP, these had been at the asthma clinic. His records had been coded as “medication review done”. He had initially been prescribed hydrocortisone 1% ointment for his face but had stopped ordering this as well as his emollients when he found the stronger steroid more effective. The prescriptions for fluocinolone cream had simply stated “apply twice daily”.

LEARNING POINTS

- A change of GP practice is a good opportunity to review all medication.
- Medication reviews should encompass all items.
- Include relevant information on the prescription, such as the problem being treated and any monitoring requirements. This will appear on the label once the medication is dispensed and may improve adherence to treatment. For example, “apply twice daily to body, arms and legs for severe eczema only”.
- Consider restricting the number of issues allowable for certain drugs, such as potent topical steroids, before a review.
- In some cases it may be preferable not to add as repeat prescription until clear that the condition is responding as expected.
- Consider the use of patient information leaflets to explain the management of chronic conditions more clearly.

CASE 2

Mr C was on long-term immunosuppressive treatment when he visited his general practice for his annual flu vaccine. He asked if he could also be given the new shingles vaccine. The nurse said he was not sure and would check with one of the GPs. He waited outside one of the consulting rooms and quickly popped in between patients. Dr D was already running behind with her surgery and after a brief thought said, “Yes, that would be fine.”

Mr C was given the vaccine and unfortunately developed an atypical herpes zoster infection. A few months later a complaint and subsequently a claim were made against the GP practice.

A significant event analysis at the practice revealed that Dr D had not accessed the patient notes before giving advice. There was nothing in the clinical notes to record the discussion between the nurse and Dr D.

LEARNING POINTS

- Distractions and interruptions are a common cause of error.
- Vaccination errors are one of the most frequently reported medication safety incidents reported in primary care1.
- When prescribing or giving advice about a new or unfamiliar drug, be prepared to look up information on your clinical record system, in a formulary or in specific guidelines as appropriate.
- Make contemporaneous records of all contacts/discussions with colleagues about patients.
- Administration of a routine vaccination is not urgent and, although inconvenient for the patient, it may be safer to rebook, allowing time to check facts – particularly if, as here, the patient had a short appointment earmarked just for the flu vaccination.


The cases mentioned in this article are fictional and are used purely for illustrative purposes.

To take part in the Medical Protection Medication Errors and Safer Prescribing e-learning module and help lower your prescribing risk, visit: medicalprotection.org

and click on the e-learning link.
Professionalism is at the core of the patient/doctor relationship and is absolutely fundamental for patient safety and the delivery of high-quality healthcare. The Medical Council will shortly publish its 8th Guide to Professional Conduct and Ethics for Registered Medical Practitioners, wherein we have sought to clearly articulate the fundamental principles of professionalism, under the three pillars of partnership, practice and performance. These are values, principles and behaviours we expect of all doctors from the moment they enter medical school right through until retirement, so that the highest possible standard of care is provided to patients.

Having sought and received feedback from members of the public, the profession and our partner organisations within the health sector, and having reviewed five years of complaints to the Medical Council, we have updated our guidance to include the most pertinent issues affecting patients and doctors. As the last ethical guide was published in 2009, the updated guide reflects the evolving nature of medical practice. For example, it has been updated with some of the more contemporary issues of concern to patients and members of the profession.

Social media was in its infancy in 2009 when our last guide was published. Reflecting its pervading influence, it is prominent in this edition. During our consultation, doctors told us they wanted more guidance on this issue, and patients were clear on the impact that social media can have on their perception of their doctor, with three in four people agreeing that if their doctor posted personal information on social media such as Facebook or Twitter, it would make them think differently about his or her professionalism.

Our consultation showed that confidentiality is of the utmost importance to both patients and doctors, and when it comes to social media, 96% of patients agreed with the statement that a doctor should never share patient information on social media. Doctors should maintain the professional standards expected in other forms of communication, and while social media provides a new medium for communication and information sharing, it’s important that ethical values remain at the fore.

The significant role that doctors play in advocating for patients is another important area addressed in the new guide, and one that the Council wishes to emphasise strongly. Medical care must not be used as a tool of the State and doctors must be free to make judgements about their patients’ clinical needs and to give appropriate treatment without political pressure. This is particularly important for doctors in management roles, and we are providing new guidance for the particular challenges faced by doctors working as clinical directors and in other leadership positions.

Open disclosure is an issue that has been in the spotlight of late. We have expanded our guidance in this area, and this is informed by our experience in the handling of complaints. We know that many patients come to us and submit a complaint out of frustration when they have not been able to get answers as to what happened during the course of their care. Many complaints could be resolved to the satisfaction of both parties if doctors are honest, explain what happened and illustrate a commitment to learning from the incident. In many cases, patients simply want to have confidence that an adverse incident won’t be repeated. A culture within healthcare whereby adverse incidents are recorded and learned from is true to the values of medicine and in the best interests of doctors and their patients.

The Medical Council has worked closely with Medical Protection as one of our key stakeholders and their medicolegal expertise makes them an excellent source for advice and support in these issues, along with any others relating to values set out in the guide.

Dr Audrey Dillon, Vice President of the Medical Council of Ireland and Chair of its Ethics and Professionalism Committee, highlights some of the issues that will be prominent in its new Guide to Professional Conduct and Ethics for Registered Medical Practitioners.
Recent social changes, such as the use of social media, can have ramifications for doctors not only on how they must act professionally, but also increasingly in relation to how they conduct themselves in their personal lives.

Social media channels can offer many new opportunities as effective outlets to promote healthcare, but they also present many new challenges for healthcare professionals.

Patient confidentiality is a key issue – the very public nature of social media means doctors must take care to avoid unintentional disclosures. A doctor’s professionalism also faces new challenges when communicating via social media, as any comments made relating to patients, colleagues or employers can be unintentionally published to a wider audience with sometimes devastating consequences.

Our advice to all members is to have a full and open communication with the patient, as soon as practically possible, once sufficient facts have been established about any adverse incident. An open explanation may be all that is needed to reassure a patient about what happened, thus avoiding unnecessary escalation of the matter.

Patient confidentiality is a key issue – the very public nature of social media means doctors must take care to avoid unintentional disclosures. A doctor’s professionalism also faces new challenges when communicating via social media, as any comments made relating to patients, colleagues or employers can be unintentionally published to a wider audience with sometimes devastating consequences.

Medical Protection has a range of advice available on social media, including factsheets and articles on how doctors should conduct themselves online. We will be updating this guidance once the new IMC ethical guide is published and will highlight any key issues for members in the coming editions of Casebook.

Open disclosure is an issue that Medical Protection has worked on with both the Medical Council and the Government. We highlighted it as a key issue in our 2014 policy paper, Challenging the cost of clinical negligence: The case for reform.

Our advice to all members is to have a full and open communication with the patient, as soon as practically possible, once sufficient facts have been established about any adverse incident. An open explanation may be all that is needed to reassure a patient about what happened, thus avoiding unnecessary escalation of the matter.

When organisations embrace open disclosure it can benefit all concerned. We have seen many complaints and claims escalate following poor communication after an adverse outcome. We were pleased to see that our ASSIST framework model, utilised in our educational workshops, now forms part of the HSE’s Open Disclosure guidelines.

We strongly believe that a change in culture is the best way to achieve openness in medicine. Healthcare organisations need to facilitate and promote a culture of candour, where healthcare professionals willingly give patients an open and honest explanation when something has gone wrong, as well as an apology where appropriate. For a cultural shift to be effective and far-reaching, the Government and healthcare managers need to encourage organisations to support open communication and the notification of adverse events and near misses. This should include ongoing support, training, mentorship and investment in leadership by example. This will enable staff to effectively participate in open discussions and fulfil their existing professional obligations.

This article highlights a small number of the changes contained in the updated guide and in the coming months we will be reviewing much of our own guidance to members to reflect these. Our medicolegal advice team remains at hand to assist members with any claims, complaints or concerns. If you need to contact us please call +44 113 241 0200 or email querydoc@medicalprotection.org.

REFERENCES
1. Challenging the cost of clinical negligence: The case for reform, 2014: medicalprotection.org/ireland/about/our-policy-work
2. MPS workshop, Mastering Adverse Outcomes: medicalprotection.org/ireland/education-and-events/workshops/workshops/ire-mastering-adverse-outcomes-workshop
3. HSE, Open disclosure: hse.ie/opendisclosure

WHAT DO YOU THINK?
We want to hear from you. Send your comments to: casebook@medicalprotection.org
Meet Your Medical Protection Team

Rachel Lynch, your membership co-ordinator, outlines the medicolegal and educational service available to members in Ireland.

As I travel across the country and talk to members, I’m often told that whilst working in healthcare is rewarding, it’s also a very challenging time to be a doctor in Ireland right now. It’s not surprising then that I’m frequently asked for more information about what Medical Protection does day-to-day and what our team can offer should the worst happen.

**On Your Side**

In challenging times it’s good to know that there’s someone on your side. As a Medical Protection member, you have access to a wide range of specialist support and advice. Every day our team of medicolegal advisers (qualified doctors who are specialists in legal medicine) help members in Ireland deal with difficult issues arising from their clinical practice. They can provide expertise on a wide variety of medicolegal and ethical issues and help navigate through the relevant processes to reach a resolution.

This can include (but is by no means limited to) support and representation with IMC matters, dealing with disciplinary matters, assistance with drafting reports and providing guidance on handling complaints.

We’re proud to have supported healthcare professionals in Ireland for many years and plan on continuing to do so long into the future. Given our long history, we’ve gained extensive experience of dealing with clinical negligence claims and are very familiar with the many nuances specific to medicolegal issues in Ireland.

You can find our claims advisers, for example, regularly meeting with members across the country together with commissioning experts to provide medicolegal reports and working closely with leading clinical negligence barristers, plaintiff and defence firms.

Our team can also frequently be seen presenting at or attending various seminars and conferences to keep abreast of developments in the Irish healthcare system.

**Campaigning for Change**

On your behalf, our policy team works with the government and other decision-makers in Ireland to help shape reform and regulation. In 2014, for example, Medical Protection released proposals for the introduction of a Pre-Action Protocol to promote openness and transparency between solicitors acting on behalf of plaintiffs and defendants. In 2015 the Government introduced legislation to enable the introduction of a pre-action protocol and we are now turning our attentions to the implementation.

**Case Study 1**

Dr X contacted the Medical Protection medicolegal telephone advice line after receiving a letter from the Dublin City Coroner inviting him to submit a deposition. The request was in respect of a patient that he had seen and treated a number of months previously.

Dr X spoke to a medicolegal adviser (MLA), a former practising physician with additional law qualifications, regarding the case. She asked him to submit further information, including anonymised records regarding his consultations with the patient. She also referred him to the factsheets on the website with regard to writing reports, giving evidence and attending a Coroner’s Inquest.

After reviewing the submitted information, the MLA contacted Dr X to provide further advice. In this case, where the member had seen the patient very close to the date of death and was the last practitioner to see the patient alive, and where the medical records were very brief, the MLA considered that there were some vulnerabilities for Dr X. Additionally, it was understood the family were not happy with his management of the patient and Dr X knew that they had instructed solicitors to attend the Inquest. With these particular circumstances, the MLA thought it best that one of the panel firm solicitors be instructed. She arranged to meet with the member and the solicitor to review the relevant documentation and to assist him in drafting a deposition to the Coroner. At the conclusion of that meeting it was decided it would be prudent for the solicitor to go on record with the Coroner (thus enabling the team to have sight of all the relevant statements and a copy of the post mortem report prior to the Inquest). It was agreed that a solicitor would attend with Dr X on the day of the Inquest. Both the MLA and the panel firm solicitor offered the member advice on the purpose of an Inquest, took him through giving evidence, and supported him through the process.

Dr X confessed that he was not sleeping, had lost his confidence in the clinic and had found the whole process very difficult. The MLA spoke to him on the telephone a number of times about this to provide him with background support and also gave him details of the Medical Protection counselling service should he wish to discuss his concerns further with a qualified counsellor.
FEATURE

SUPPORTING MEMBERS TO REDUCE RISK
One of our goals is to work with members to help reduce medicolegal risks and prevent adverse incidents for occurring.

We regularly run workshops facilitated by our local accredited experts in Cork and Dublin. We offer a comprehensive portfolio of GP and specialty-specific workshops, free as a benefit of membership, that are fully accredited by the Irish College of GPs and Royal College of Surgeons of Ireland. We also offer a range of master classes and risk assessment tools for primary care organisations that can help practices and out-of-hours organisations to improve the quality of patient care, minimise risk and comply with national standards.

You can also access an e-learning platform, Prism, that provides an online programme of interactive modules to help you keep your knowledge up to date.

MEET THE TEAM
Many people across Medical Protection are involved in supporting members in Ireland – too many to list here. Below is a selection of the team that can offer advice, support and defence to members in Ireland.

DR SONYA MCCULLOUGH
Country Lead for Ireland

DR ANGELIQUE MASTIHI
Senior Medicolegal Adviser

DR RACHEL BIRCH
Medicolegal Adviser

DR GORDON MCDAVID
Medicolegal Adviser

DR ANDY POWER
Medicolegal Adviser

DR JAMES LUCAS
Medicolegal Adviser

DR JAMES THORPE
Medicolegal Adviser

MEET YOUR REGIONAL MEMBERSHIP CO-ORDINATOR
If you’ve got any questions about Medical Protection or want to know more about how our team can support you, then please get in touch. I can be contacted on 087 2867491 or Rachel.Lynch@medicalprotection.org. You can also come to see me at one of the events below:

- College of Anaesthetics AGM – 19-20 May
- Future Health Summit – 26-27 May
- ICSI AGM – 11 June
- ICGP Summer School – 24-25 June.

HILARY STEELE
Claims Lead for Ireland

JULIA BRYDEN
Claims Manager

CATHERINE HIBBERD
Claims Manager

Should the worst happen, our claims managers will co-ordinate and manage your case. They provide a balance of legal and professional qualifications and expertise in clinical negligence claims.

The cases mentioned in this article are fictional and are used purely for illustrative purposes.

To sign up for one of our conferences or workshops, or take part in one of our e-learning modules, visit: medicalprotection.org and click on ‘Education and Events’.

CASE STUDY 2
Dr F attended the Medical Protection General Practice Conference: Spotlight on Risk where he listened to a series of talks from leading figures in general practice and Medical Protection medicolegal specialists providing advice on different areas of risk. During the day-long conference he took part in a workshop on reducing the risks around repeat prescribing.

Upon returning to his practice Dr F was inspired by the workshop and performed an audit of his practice’s repeat prescribing processes. He found that many of the risks highlighted at the conference were present in his practice’s procedures.

He arranged for Medical Protection to come into the practice and conduct a whole practice workshop on reducing the risks around repeat prescribing. Following on from this, the practice appointed a new repeat prescribing lead and changed its processes to address the concerns raised in the workshop.
Responding to Complaints

Medical Protection’s Pippa Weeks looks at the complaints process and provides advice on how to handle a complaint well.

In a local level, responding to patient complaints can be difficult and, when they are handled poorly, can result in escalation to the Health Service Executive or the Medical Council. While our medicolegal advisers are on hand to provide expert advice and support for members who receive a complaint, an understanding of the complaints process, and how to handle a complaint well, could prove useful to all clinicians who find themselves in this position.

Why do complaints occur?

There are many different reasons why a patient might complain, but they usually fall into one of five different categories:

- Medical error.
- Grief.
- Patient’s poor understanding or clinician’s poor explanation.
- Unrealistic expectations.
- Failure to appreciate needs/wishes of the patient.

Regardless of the triggering event, the vast majority of patient complaints can be resolved at the local level when appropriately managed. Often patients, regardless of the original incident, can be assured by knowing that you are listening to their concerns, that you understand them and that you are working with them to resolve any outstanding issues.

Good complaints handling

Complaints are usually perceived as negative experiences. However, a good local complaints protocol can assist in the doctor/patient relationship whilst reflecting on what has gone wrong, and changing practices accordingly can help to improve services. Dealing with complaints in a constructive manner can result in a complaints process that is beneficial for both the patient and the surgery.

Box A outlines elements of a good complaints handling system.

**Box A**

A good complaints handling system should be:

- well-publicised;
- easy to access;
- simple to understand;
- confidential;
- sensitive to the needs of both the complainant and the practice;
- effective – providing suitable and flexible remedies;
- well-resourced;
- regularly reviewed and adjusted as necessary;
- supported by management;
- constructive;
- focused on quick effective resolutions to the satisfaction of all concerned.

---

**PUBLIC PATIENTS**

Option 1: Complain locally
Option 2: Request a Health Service Executive (HSE) review
Option 3: Complain to the Ombudsman or the Ombudsman for Children
Option 4: Contact a regulator
Option 5: Obtain legal advice

**PRIVATE PATIENTS**

Option 1: Complain locally
Option 2: Contact a regulator
Option 3: Obtain legal advice
MAKE A PLAN
Good complaints handling will include a plan. This plan should be discussed and agreed with the complainant, and should include the details listed in Box B.

Box B
Elements to be agreed with the complainant at the outset:

- details of the complainant;
- parties to the complaint;
- a summary of issues;
- the agreed outcome aimed for;
- the type of investigation/action required;
- the timescale for a response and timing of any progress reports;
- details of any support being provided to the complainant.

You may wish to simply confirm these details verbally with the complainant. However, ensure that you record what has been agreed and that you meet any relevant time frames. Be realistic when agreeing to time frames – although there is often pressure to resolve the dissatisfaction immediately, you will only further alienate the complainant by promising something you cannot deliver.

HOW DO YOU INVESTIGATE A COMPLAINT?
It is important to take the concerns raised by patients seriously, and to use the feedback constructively to improve your services. You may wish to appoint a certain person to conduct an investigation into the circumstances of the event.

See Box C for what you might consider in investigating a complaint.

Box C
When investigating a complaint you should:

- talk to those involved to get a comprehensive understanding of what happened;
- perform an objective assessment of the systems involved;
- put yourself in the patient’s shoes and imagine the circumstances from their perspective;
- look for learning points or any improvements that can be made;
- share the results with your staff and discuss how to improve services for the future.

OFFERING AN APOLOGY
In the current climate, where there is a culture of litigation, we are often reluctant to offer apologies because they are associated with an admission of liability. However, apologising for a patient experiencing distress or dissatisfaction does not equate to admitting a mistake or accepting liability. An immediate and genuine apology can go a long way to resolving a complaint before it progresses. An apology demonstrates respect for the patient and can ease the patient’s hostility, no matter what the issue.

It is worth remembering that a genuine apology for frustration and distress caused as a result of the complaint being made does not constitute an admission of liability.

PROVIDING A RESPONSE
In most cases you will be asked to provide a written response to the complainant. The aim of this response should be to resolve concerns, and is not an exercise in establishing who is right or wrong. The response should directly address the questions or concerns raised by the complainant. It is often useful to summarise the complainant’s concerns at the beginning of the response, to assure the complainant that you have received and understood the concerns, and that you are responding to each.

The content ought to be factual, and provide the chronology of events, the clinical findings, the actions taken and the justification for the management decisions. Where appropriate, you should reflect on lessons learned, or comment on any aspects that you will seek to improve in the future. It may also be appropriate to apologise for any misunderstandings or distress caused.

The tone of the response should be non-confrontational and sympathetic. Try to avoid drafting a response that comes across as defensive or accusatory.

See Box D for a blueprint of a good complaint response.

Box D
A good complaint response will:

- recite the list of concerns;
- detail a chronology of events;
- address each concern;
- highlight what the practice can do better in the future;
- where appropriate, offer an apology for any misunderstanding or distress caused;
- offer a meeting to discuss any outstanding concerns on receipt of the response.

An effective protocol and positive approach can turn a complaint into a constructive and useful exercise that strengthens rather than harms your relationship of trust with the patient. It may also prevent the matter escalating.

Medical Protection’s workshop on Mastering Adverse Outcomes helps members develop skills to effectively communicate with a patient when something has gone wrong. The workshop can help reduce your exposure to risk of complaints or claims. To find out more and book a place, please visit:

medicalprotection.org/ireland/education-and-events
More support for your professional development

FACE-TO-FACE LEARNING

The Mastering workshops should be compulsory. Very informative.

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- Achieving safer and reliable practice
- Medical records
- Medication errors and safer prescribing

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When I was at medical school, I recall being admonished for suggesting an esoteric cause for a presentation of acute renal failure (or acute kidney injury as it is now known), under the explanation from the consultant that common things are common and that when providing a differential diagnosis, I should start by providing a list of the common causes. Then, without a hint of irony, the consultant suggested that I might wish to see a patient who had been admitted overnight with acute renal failure as a consequence of Wegener’s Granulomatosis.

This edition of Casebook highlights a number of cases in which allegations have arisen as a consequence of a missed and/or delayed diagnosis of serious underlying pathology: in the case of Mr B it was alleged that the severity of his symptoms was underestimated and that a home visit should have been arranged; there are two paediatric cases in which the allegations related to a missed/delayed diagnosis of meningitis/meningococcal septicaemia; there is a case in which there was a missed diagnosis of pre-eclampsia with catastrophic consequences for the baby; and there is a case in which there is an unusual presentation of renal disease, which was subsequently complicated by a subarachnoid haemorrhage.

The difficulty that a clinician faces when assessing a patient is that, by definition, common things are common and (usually, but not always) are either benign and/or self-limiting in their nature. For example, most children who present with coryzal symptoms will not have serious underlying pathology; most pregnant patients who develop ankle swelling will not have pre-eclampsia; most patients who present with headache will not have serious underlying pathology etc. One of the challenges for clinicians is identifying those patients that require further investigation (and/or treatment) in order to establish or rule out serious underlying pathology and arranging for that investigation (and/or treatment) to be undertaken within a reasonable time frame (which, depending on the circumstances, may be on an emergency basis). There is an abundance of diagnostic algorithms, standards and guidance available, and whilst it is not always easy to access them in the midst of a consultation, if there is an adverse outcome, your care will be judged to the relevant standards and guidance (that prevailed at the time of the incident).

In circumstances when you have made a diagnosis of a common benign and/or self-limiting illness, it is useful to ask yourself the following check questions:

1. Have I advised the patient of red flag symptoms to look out for and explained what they should do in the event that these develop?
2. Have I informed the patient as to what should prompt them to return for review?
3. If the diagnosis subsequently turns out to represent serious underlying pathology, would I be in a position to justify not making (or contemplating) that diagnosis based on the information available to me?

Check questions 1 and 2 amount to the provision of safety-netting advice and if the answer to check question 3 is ‘no’ then this should prompt consideration as to whether further investigation is indicated.

I hope that you find both the cases and the above suggestions thought-provoking and draw your attention to the fact that the cases have common themes relating to both communication and 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
C was a 20-month-old boy who had been up all night with a fever. It was the weekend so his mother rang the out-of-hours GP. She explained that his temperature was 39.4 degrees and that he was clingy and sleepy. Dr R assessed him at the out-of-hours centre and documented that there was no rash, vomiting or diarrhoea. His examination recorded the absence of photophobia and neck stiffness. He stated “nothing to suggest meningitis”. Examination of the ears, throat and chest were documented as normal. He noted that his feet were cool but he appeared hydrated. Dr R diagnosed a viral illness and advised paracetamol and fluids. He advised JC’s mother to make contact if he developed a rash, vomiting, or if she was concerned.

JC’s mother felt reassured so she took him home and followed the GP’s advice. JC remained tired and off his food over the next two days. The following day he began vomiting and mum could not get his temperature down. He seemed drowsy and was just lying in her arms. She took him straight to A+E.

He was very unwell by the time he was assessed in A+E. The doctors noted that he was pale, drowsy, and only responding to pain. His temperature was 38 degrees and his pulse was 160bpm. A diagnosis of “sepsis” was made. Full examination revealed neck stiffness and he went on to have a lumbar puncture. This confirmed meningitis with Haemophilus influenzae.

JC was treated with IV fluids, ceftriaxone and dexamethasone and showed great improvement. Four days later he developed a septic hip needling aspiration and arthroscopy. The aspirate revealed Haemophilus influenzae. A month later he was assessed at a fracture clinic and documented that there was no rash, vomiting or diarrhoea. An x-ray eight years later showed that the right femoral capital epiphysis was slightly larger than the left. His mother claimed that he complained of daily hip pain, giving way and morning stiffness.

Two months after his illness JC had a hearing test that showed moderately severe sensorineural hearing loss. Despite hearing aids JC had delayed speech and language development. His mother was upset because he struggled with poor concentration at school and found it difficult to interact in groups.

JC’s mother made a claim against Dr R, alleging that he failed to diagnose meningitis and admit her son. She felt that if his meningitis had been treated earlier his hearing could have been saved and he would not be at risk of arthritis in his hip in later life.

EXPERT OPINION
Medical Protection obtained expert opinion from a GP, a professor in infectious diseases, an orthopaedic surgeon and a consultant in ENT.

The GP thought Dr R had made a comprehensive examination of a febrile child and had demonstrated an active consideration of the possibility of meningitis. He commented that the features of many childhood viral illnesses are indistinguishable from the very early stages of meningitis. He noted that Dr R had advised JC’s mother to make contact if he deteriorated. He was a little critical of Dr R for not recording JC’s vital signs such as pulse and temperature. He felt this was an important part of determining a child’s risk of having a serious illness.

The professor of infectious diseases thought that JC did not have meningitis when he saw Dr R but was likely to be in the bacteraemic phase of the illness. This phase shares features with many other more trivial infections. He explained that Haemophilus influenzae meningitis can present in an insidious fashion over several days. He felt that the vomiting three days later may have signified cerebral irritation due to meningitis.

The orthopaedic surgeon noted the minor x-ray changes it was difficult to explain the alleged hip symptoms as children with coxa magna generally have no symptoms even with contact sports. He thought that JC would have a lifetime risk of needing hip replacement of 12-20% due to past septic arthritis.

The ENT consultant concluded that JC would need to use hearing aids for the rest of his life. He felt that his speech and language development had also been compromised by poor hearing aid usage.

In response to the Letter of Claim from the claimant’s solicitors, Medical Protection issued a letter of response denying liability based on the supportive expert opinion and the claim was discontinued.

Learning points

• NICE have a useful traffic light system for identifying risk of serious illness in febrile children under five. Along with other clinical signs, it requires GPs to check pulse, respiratory rate, temperature and capillary refill time in order to categorise them into groups of low, medium or high risk of having serious illness.

• Safety netting is an important part of a consultation. In this case Dr R advised the mother to contact services again if he deteriorated. This helped Medical Protection defend his case.

• In some cases claims can be brought many years after the events. This makes good note-keeping essential as medical records will often be the only reliable record of what occurred.

REFERENCES

Mrs B was a 57-year-old lady with a past history of breast cancer treated with mastectomy and adjuvant therapy. She re-presented to her consultant breast surgeon, Mr F, three years after the original surgery with a worrying 2cm lump in the vicinity of her mastectomy scar. Mr F recommended an urgent excision biopsy of the lump under general anaesthetic.

On the day of surgery, Mrs B was reviewed by consultant anaesthetist Dr S. She told Dr S that she had been fine with her previous anaesthetic and that she had no new health problems. Dr S reassured Mrs B that it should be a routine procedure and that he anticipated no problems. He warned her about the possibility of dental damage and sore throat and promised that he would not use her left arm for IV access or blood pressure readings, because of the previous lymph node dissection on that side.

In the anaesthetic room, Dr S reviewed the anaesthetic chart for Mrs B’s mastectomy procedure. He saw that Mrs B had received a general anaesthetic along with a paravertebral block for post-operative analgesia, and this technique appeared to have worked well. He did not, however, discuss this with Mrs B.

Dr S inserted a cannula in Mrs B’s right arm and induced anaesthesia with fentanyl and propofol. He inserted a laryngeal mask airway and anaesthesia was maintained with sevoflurane in an air/oxygen mixture. Mrs B was then turned on her side and Dr S proceeded to insert left-sided paravertebral blocks at C7 and T6. Although Dr S used a stimulating needle and a current of 3mA, he had difficulty eliciting a motor response at either level. At T6, Dr S finally saw intercostal muscle twitching after a number of needle passes. Twitches were still just visible when the current was reduced to 0.5mA and Dr S treated with boluses of ephedrine and metaraminol.

Dr S then administered atracurium 30mg and Mrs B was ventilated for the duration of the operation. The operation was largely uneventful apart from modest hypotension, which Dr S treated with boluses of ephedrine and metaraminol.

At the end of surgery, Dr S reversed the neuromuscular blockade and attempted to wake Mrs B. However, Mrs B’s respiratory effort was poor and she was not able to move her limbs. Dr S diagnosed an epidural block caused by spread of the local anaesthetic. He reassured Mrs B and then re-sedated her for approximately 40 minutes. Following that she was woken again and her airway was removed. Weakness of all four limbs was still noted.

Over the next five hours Mrs B regained normal sensation and power in her lower limbs and left arm. However, her right arm remained weak, with an absence of voluntary hand movements. She also had gait ataxia on attempting to mobilise. An MRI was performed the following day, which demonstrated signal change and subdural haemorrhage in the spinal cord at a level consistent with her persistent symptoms.

Mrs B remained in hospital for physiotherapy and rehabilitation. Her walking and right hand function gradually improved and she was discharged three weeks after her operation. Six months later, Dr S received a solicitor’s letter stating that Mrs B was still having problems with her hand and was seeking compensation.

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EXPERT OPINION
Medical Protection instructed Dr M, a consultant anaesthetist, to comment on the standard of care. Dr M was critical of Dr S for four major reasons:

1. Dr S had failed to inform Mrs B that he intended to perform a paravertebral block and failed to discuss the risks and benefits of such a technique.

2. He was somewhat critical of the decision to perform the block with Mrs B anaesthetised. He opined that had Mrs B been conscious or lightly sedated, she would have alerted Dr S when the needle was in proximity to nerve tissue. However, Dr M did concede that there was a body of responsible anaesthetists who would support the notion of performing a paravertebral block with the patient anaesthetised.

3. He was critical of Dr S’s decision to keep persisting with the block when he was struggling to locate the correct needle position. He felt that Dr S should have abandoned the block or called for help. He also concluded that the technique used by Dr S was very poor given the complications that followed.

4. Dr M was critical of the levels chosen by Dr S to perform the block. He felt that C7 was too high, given that the dermatomal level of the surgery was approximately T4. He also felt that the surgery was very minor and did not warrant the paravertebral block. Dr M was of the opinion that infiltration of local anaesthetic by the surgeon, combined with simple analgesics, would have sufficed.

On the basis of the expert evidence Medical Protection concluded that there was no reasonable prospect of defending the claim. The case was eventually settled for a substantial sum.
Following a hospital admission for status epilepticus, which was attributed to a previous cerebral insult, Mr G, a 35-year-old clerical officer, was started on an anticonvulsant regime of phenytoin and sodium valproate. Over the next few years, the medication was changed by the hospital several times in response to the patient's concerns that his epilepsy was getting worse. After a further seizure led to hospital admission, the patient was discharged on vigabatrin on the advice of the treating neurologist, Dr W. Readmission for presumed status epilepticus a short while later led the hospital to conclude that there might be a functional element to the seizures. This was supported by psychiatric evaluation. The patient was discharged to psychology follow-up with a recommendation at the end of the discharge summary to gradually tail off and stop the vigabatrin. This advice was overlooked by Mr G's GP, Dr L, who continued to prescribe as before. The error was not picked up by either Dr L or the hospital despite multiple contacts and several hospital admissions over the next five years, for the first three years of which Mr G remained under the care of Dr W.

Subsequently, Mr G was seen by both Dr L and his optician, complaining of tired, heavy eyes. No visual field check was carried out on either occasion. Nine months later Mr G returned to see Dr L, requesting a referral to the epilepsy clinic as he had read a newspaper report about the visual side effects of vigabatrin. An appointment was made at the clinic but Mr G failed to attend on two occasions. An urgent referral was ultimately made by Mr G's optician several months later following detection of a visual field defect on a routine examination. The ophthalmic surgeon, Mr D, noted that Mr G had been on vigabatrin for in excess of 11 years during which time he had not been monitored. His visual fields were noted to be markedly constricted, which was attributed to the vigabatrin. Mr G was referred to another neurologist who recommended a change of anticonvulsant. Mr G was gradually weaned off the vigabatrin.

As a result of the damage to his eyesight, Mr G brought a claim against the hospital for negligent prescription of vigabatrin and failure to warn the claimant of the side effects. Mr G also brought a claim against Dr L for continuing to prescribe vigabatrin against the advice of the neurologist, failing to review the medication at regular intervals, and failing to refer to an ophthalmologist.

EXPERT OPINION
Medical Protection's GP expert was critical of Dr L's failure to act on the neurologist's advice to tail off the vigabatrin and for the absence of any record that Dr L monitored the patient or reviewed his medication. Dr L's decision to refer Mr G to an epilepsy specialist once he was alerted to the potential side effects was appropriate and Dr L could not be held accountable for Mr G's failure to attend a number of hospital appointments, which may have contributed to the delay in diagnosing the visual field defect. The claim was settled on behalf of Dr L and the Trust for a reduced but still substantial sum.

Learning points
- If a doctor signs a prescription, they take responsibility for it – even if it is on the advice of a specialist. Good communication between primary and secondary care is vital to ensure patients receive the appropriate treatment.
- Patients should be informed if there is a need for monitoring or regular review of long-term medications. Where there is shared care with another clinician, agreement should be sought as to the most appropriate arrangements for monitoring. All advice should be clearly documented.
- When alerted to a potentially serious side effect of medication, prompt arrangements for review should be made, with a specialist if appropriate.
aby LM was taken to see his GP, Dr E, for his six-week check. During this examination Dr E noted that his left testis was in the scrotum but his right testis was palpable in the canal. He asked LM’s mother to bring him back for review in a month.

Two weeks later his mother brought him to see Dr E because he had been more colicky and had been screaming a lot in the night. As part of that consultation, Dr E documented that both testes were in the scrotum.

LM was brought for his planned review with Dr E in another two weeks. Both testes were noted to be in the scrotum although this time the left testis was noted to be slightly higher than the right. His mother was reassured.

When LM was 16-months-old he appeared to be in some discomfort in the groin when climbing stairs. His mother was worried so she took him back to Dr E for a check-up. Dr E examined him carefully and documented that both testes felt normal and were palpated in the descended position. He also noted the absence of herniae on both sides. He advised some paracetamol and advised his mother to bring him back if he did not improve.

When LM was 15-years-old he noticed that one of his testicles felt different to the other. At that time he was found to have a left undescended testis which was excised during surgical exploration.

LM’s mother felt that Dr E had missed signs of his undescended testis when he was younger. A claim was brought against Dr E, alleging that he had failed to carry out adequate examinations and that she should have referred to the paediatric team earlier. It was claimed that if Dr E had referred to paediatrics earlier then this would have resulted in a left orchidopexy, placing the testis normally in the scrotum before the age of two years and thus avoiding removal of the testis.

**EXPERT OPINION**

Medical Protection obtained expert opinions from a GP and a consultant in paediatric surgery. Both were supportive of Dr E’s examination and management. The consultant in paediatric surgery thought that LM had an ascending testis. This is a testis which is either normally situated in the scrotum or is found to be retractile during infancy, and later ascends. He thought that even if LM had been referred in infancy, it would have been likely that examination would have found the testes to be either normal or retractile and he would have been discharged with reassurance. He explained that it is thought that in cases of ascending testsis testicular ascent occurs around the age of five years. Therefore, on the balance of probabilities, referral to paediatrics before the age of four would not have led to diagnosis of an undescended testis.

This claim was dropped after Medical Protection issued a letter of response to the claimant’s legal team which carefully explained the expert opinion.

**Learning points**

- Medical Protection were able to defend Dr E in light of his appropriate clinical management, good note-keeping and the expert advice.
- Good documentation helped Medical Protection to defend Dr E’s case. Doctors should always document the presence or absence of both testes in the scrotum at the six-week check.
- A testis that is retractile or normally situated in the scrotum in infancy can ascend later. NHS-choices have a useful leaflet for parents outlining that “retractile testicles in young boys aren’t a cause for concern, as the affected testicles often settle permanently in the scrotum as they get older. However, they may need to be monitored during childhood, because they sometimes don’t descend naturally and treatment may be required”1.

- NICE have published a Clinical Knowledge Summary that covers the primary care management of unilateral and bilateral undescended testes, including referral. It can be found here: cks.nice.org.uk/undescended-testes

**REFERENCES**

1. nhs.uk/conditions/undescendedtesticles/Pages/Introduction.aspx

AF
Mr B was a 31-year-old man with three children. His mother was staying with him over the weekend because he was in bed coughing and shivering. On Saturday he complained of chest pains so his mother rang an ambulance. The paramedic recorded a temperature of 39 degrees, oxygen saturations of 94%, pulse 134, respiratory rate of 16 and a blood pressure of 120/75. An ECG was done and noted to be normal. The paramedic explained to Mr B that he should be taken to hospital. Mr B declined and was considered to have capacity so the ambulance left.

The ambulance crew called their control centre who in turn contacted an out-of-hours GP, Dr Z. The control centre left a verbal message for Dr Z, explaining the situation, but did not hand over details of Mr B’s vital signs including his oxygen saturations and pulse rate.

Dr Z rang Mr B and noted his history of chest pain triggered by coughing and the normal ECG. She noted his temperature of 39 degrees and that he had taken some ibuprofen to help. She documented “no shortness of breath” and advised some cough linctus and paracetamol. She offered him an appointment at the out-of-hours centre, which he declined, but he did agree to ring back if he was worse. She documented that her advice had been accepted and understood.

Mr B was no better on Sunday so his mother rang the out-of-hours centre again. This time a nurse spoke to Mr B and noted his history of productive cough, fever and aching chest pain. She documented that he had some difficulty in breathing on exertion but that he could speak in sentences over the telephone. Again she offered him an appointment at the out-of-hours centre but he refused, saying he would prefer to see his own GP on Monday.

Three days later Dr B’s mother took him to see his own GP. He found coarse crepitations in his right upper and mid chest but with good air entry. He noted that Mr B was not unduly distressed and had no shortness of breath so opted for oral antibiotics and a review in two days.

Later the same day Mr B’s breathing became rasping and very laboured. He collapsed and an ambulance took him to A&E. Cardiopulmonary resuscitation was attempted but sadly failed. A post mortem was performed, giving the cause of death as “right-sided lobar pneumonia and bilateral pleural effusions”.

Mr B’s mother was distraught and brought a claim against the out-of-hours GP, Dr Z. She claimed that her son had been extremely short of breath on the telephone and that she had not paid adequate attention to this. She was upset that Dr Z had not arranged to visit her son at home and had incorrectly diagnosed a simple chest infection.

EXPERT OPINION

Medical Protection obtained expert opinions from a GP and a respiratory specialist. The GP was supportive of Dr Z. He noted that cough, fever and malaise are very common symptoms in a young adult. He listened to the recorded consultation and considered Mr B to have been only mildly short of breath and showing no verbal signs of delirium. He felt it was reasonable for Dr Z to suggest attendance at the primary care centre. He also noted that if Mr B had been well enough to attend his own GP four days later, then he could probably have travelled to see Dr Z on the day she spoke to him. He felt it had been neither possible nor necessary to define the diagnosis beyond a respiratory tract infection.
during their telephone consultation. He thought it was unhelpful that Dr Z had not received Mr B’s oxygen saturations or pulse rate from the ambulance crew.

The respiratory specialist noted that Mr B was assessed by the ambulance crew on the same day he consulted with Dr Z on the telephone. At that time he was not confused, his respiratory rate was 16 and his blood pressure was satisfactory. This would have given him a CRB65 score of 0, which is associated with a good prognosis. He commented that this, along with clinical judgement, would have supported home-based care for this patient rather than the need for hospital assessment.

It was highlighted that Mr B had refused to go to hospital with the ambulance crew and to attend the out-of-hours centre. This and the supportive expert opinion helped Medical Protection to successfully defend Dr Z.

Learning points

• Medical Protection can use recorded data as evidence to support members who are the subject of a claim. GPs working out-of-hours should be aware that a telephone recording is an additional record of the consultation when speaking to patients on the telephone.

• According to NICE guidance, after diagnosing pneumonia GPs should use the CRB65 score to determine the level of risk and help guide decisions on where to manage a patient. One point is given for confusion (AMTS 8 or less or new disorientation in person, place or time), raised respiratory rate (30 breaths per minute or more), low blood pressure (systolic <90mmHg or diastolic <60mmHg), age 65 years or more. A score of 0 is classed as low risk and is associated with less than 1% mortality. A score of 1 or 2 is classed as intermediate risk and is associated with 1-10% mortality. A score of 3 or 4 is classed as high risk and is associated with more than 10% mortality.

• When communicating between healthcare services, it is important to hand over all relevant information. In this case the ambulance crew did not pass on the patient’s low oxygen saturations or his raised pulse rate. These vital signs could have conveyed the severity of the patient’s illness to the out-of-hours GP.

REFERENCES

1. nice.org.uk/guidance/cg191/chapter/1-recommendations

AF
S, a four-month-old baby, was felt by his mother to be developing a cold and was given oral paracetamol solution, which was effective. The following day his mother noted he was warm and snuffly. His breathing was laboured and he was making moaning noises. He was not feeding well, although he was taking some milk. He apparently had a rash on his back. JS was given oral paracetamol solution but it now had no effect and as his condition was worsening an appointment was made for him to be seen by the GP.

Dr D reviewed the baby at around 2-3pm that day, stating in his notes that the baby had been unwell and tachypnoeic since the morning, but drinking. The examination findings that Dr D recorded were that the baby felt hot, was alert, had a soft fontanelle and equal and reactive pupils. No abnormality was recorded on examination of the throat, ears, chest and abdomen and there was no photophobia or neck stiffness. A diagnosis of a virus was made and regular oral paracetamol solution recommended, with advice to return if JS did not improve.

Dr D stated that if he had confirmed an abnormally high respiration rate when examining the baby he would have noted it. He was confident he was not told of or shown any rash, and would have noted any history or examination findings in relation to it.

The mother stated that when JS did not improve she sent her other son (aged 11-years-old) to explain that she was concerned that the oral paracetamol solution was not working. The son apparently spoke to the receptionist who advised that “the oral paracetamol solution needed time to work”. No doctor was spoken to although the receptionists that were working at the time stated that they did not recall the son attending or providing such advice.

JS is said to have remained unwell during the evening and the mother awoke at 6:30am the following day to find that JS had developed large purple spots. She contacted the doctor, Dr W, who was on call for the practice, arrived at about 8am. On arrival it was immediately apparent to him that the baby was very unwell as he was very drowsy, greyish in colour and also exhibiting a purpuric rash. He immediately took the child to hospital in his car and stated that he administered an intramuscular injection of benzylpenicillin.

Meningococcal septicaemia was diagnosed and following treatment JS was found to be profoundly brain damaged. He was later diagnosed with severe microcephaly, cognitive impairment, poor vision and intractable epilepsy.

His mother brought a claim alleging that Dr D failed to take an adequate history and perform an adequate examination, give adequate consideration to the age of the child and the risk of rapid deterioration in his condition, failed to observe and act in the presence of a rash and to consider diagnoses other than a viral infection and failed to refer the baby to hospital. It was also alleged that the practice reception staff failed to seek medical advice and that they provided inappropriate advice to the 11-year-old son about treatment with oral paracetamol solution.

Learning points
- Good clinical records are essential for the resolution of factual disputes.
- Non-clinical staff (such as receptionists) should not provide clinical advice.
- Although the outcome was tragic, this does not always equal negligence.
- Parents should be advised on the signs to look for and when to seek further help, and this should be documented.

EXPERT OPINION
Medical Protection sought expert opinion from a GP, a paediatric neurologist, a paediatric infectious diseases specialist and a medical microbiologist. The expert GP’s opinion on breach of duty stated that if the mother’s account of the consultation with Dr D was accepted, the standard of care was unreasonable. However, on the basis of the records and witness statement, and having seen the member in conference, the expert was satisfied that the doctor’s actions were reasonable. The paediatric infectious diseases expert report on causation indicated that if the baby had been admitted by Dr D and treated in hospital with intravenous antibiotics immediately, his opinion was that JS would have made a full recovery.

On the basis of the supportive expert GP report Medical Protection opted to defend the case at trial. The claimant discontinued three days into the trial.
CASE REPORTS

STRETCH MARKS AND STEROIDS

SPECIALTY: GENERAL PRACTICE/ ENDOCRINOLOGY

THEME: PRESCRIBING

Mr A was a 25-year-old man who was on lifelong steroid medication for congenital adrenal hyperplasia. He was under the care of Dr F, a consultant endocrinologist. Dr F advised him to change his steroid medication from hydrocortisone to prednisolone, 7.5mg in the mornings and 5mg in the evenings. He gave him a prescription and wrote to Mr A’s GP to advise him of the steroid dose change.

A few weeks later Mr A had run out of prednisolone and went to see his GP, Dr S. He was prescribed 12.5mg prednisolone in the mornings and 10mg in the evenings. Dr S told him he had recently received a letter from Dr F about this dose.

Three weeks later Mr A started experiencing muscle cramps and mood swings. A few weeks after this his friends commented that his face was becoming swollen. In the subsequent weeks Mr A noticed he felt weaker and was not able to exercise as much at the local gym. He noticed he was bruising more easily.

Four weeks later he noticed he was developing large unsightly stretch marks on his body, especially around his back and abdomen. He consulted with another GP, Dr T, as he was concerned these, and his other symptoms, could be related to his steroid medication. Dr T examined him but advised him to wait and discuss his concerns with his endocrinologist at his appointment two months later.

At his endocrinology review Dr F advised him that all his recent symptoms were attributable to being on too high a dose of prednisolone. He reduced the steroid dose to 5mg prednisolone in the mornings and 2.5mg in the evenings.

Over the next few weeks most of the symptoms resolved, but Mr A was left with stretch marks that he found unsightly and embarrassing. He became very self-conscious and felt he could only go swimming with a T-shirt on. The stretch marks were itchy and uncomfortable, requiring frequent application of emollient, and he was advised that, although they would fade, they would never go away.

A DEXA scan revealed a decreased bone density and Mr A was commenced on Calcium tablets.

Mr A made a clinical negligence claim for undue suffering against Dr S and Dr T.

EXPERT OPINION

The GP expert was critical of both Dr S and Dr T’s actions and felt this constituted a breach of duty.

It appeared that Dr S had misread Dr F’s letter and prescribed an excessively high dose of prednisolone. Mr A continued to receive prescriptions for this medication every 28 days and Dr S and Dr T continued to issue the prescriptions without querying the dose.

He was particularly critical of Dr T for not questioning the dose of steroid when the patient presented with a multitude of steroid-related symptoms as well as new stretch marks.

The endocrinology expert felt that all the symptoms were attributable to an excess prednisolone dose over a five-month period. He advised that most of the symptoms would be reversible, including the decreased bone density. However, he felt that the stretch marks would be permanent, although would fade to a certain extent over time.

The case was settled for a moderate sum.

Learning points

- Side effects of corticosteroids are dose-related. Doctors should be alert to the potential side effects of long-term corticosteroids. These include all of the symptoms that Mr A was experiencing.
- If a patient complains of new symptoms while on corticosteroid medication, review the current dose and ensure the patient is taking the medication correctly.
- If there is any doubt about a patient’s dose of corticosteroid, have a low threshold for discussing the matter with the patient’s endocrinologist. If Dr T had telephoned Dr F for advice, the excess steroid dose would have been picked up two months earlier and might have reduced the severity of the stretch marks that the patient developed.
- If a patient is receiving long-term corticosteroid treatment, it would be helpful for them to carry a steroid treatment card. This gives clear guidance on the precautions to be taken to minimise the risks of adverse effects, and provides details of the prescriber, drug, dosage, and duration of treatment.
- The National Institute for Health and Care Excellence (NICE) has a useful resource addressing the management of patients receiving oral corticosteroids in primary care: “Clinical Knowledge Summary. Corticosteroids-oral. August 2015”.
  cks.nice.org.uk/corticosteroids-oral.
M, aged 39, presented initially to the Emergency Department with headaches, limb weakness and a drooping eyelid, but took his discharge before full investigations were completed. He was reviewed two weeks later by a neurologist who noted numbness in the arm and unsteadiness. He arranged for a CT scan which was normal. The patient did not attend for an MRI scan.

Three months later, Mr M presented to an ophthalmologist with blurred vision. Examination showed retrobulbar neuritis and he was referred to a neurologist.

A few months later the patient was seen by a neurologist, Dr P, who wrote a letter to the patient’s GP, Dr O, indicating a possible diagnosis of multiple sclerosis (MS). She said that an MRI scan had been organised. Mr M was reviewed by the neurologist four months later when he was started on oral methylprednisolone and referred to support services. Dr P wrote that she would review the patient in two months, but no indication was given of the dose or duration of the course of steroids. Five days later, the GP pharmacy records indicate dispensing of the prescription of methylprednisolone as “150 methylprednisolone tablets 16 mg. 5 tablets to be taken daily as directed by your doctor”. The signature of the doctor was not a known doctor at the Practice. There were no entries in the records corresponding to this or in the computerised prescribing records.

The patient received repeat prescriptions of methylprednisolone from Dr O. Four months later, Mr M was admitted to hospital with back pain after lifting a heavy object. He was diagnosed with a fractured T6 secondary to osteoporosis (due to high-dose steroids). The expert believed that the over-prescribing of high prednisolone doses was largely the responsibility of Dr P, who gave insufficient information about the initiation dosage and duration of the initial steroid dose. It would be a not unreasonable assumption by the GP that treatment commenced by the consultant was to be continued until the patient saw the consultant again. Clearly there was delay as the patient did not attend regularly. When the over-prescribing was identified, Dr P failed to put in place a clear management plan with appropriate guidance to Dr O.

The steroids caused severe osteoporosis, resulting in multiple vertebral crush fractures and collapse of the vertebral bodies and myopathy. These problems aggravated the disability attributed to the patient’s MS and interfered with his rehabilitation.

The standard of record-keeping made this a difficult claim to defend. It was settled for a small sum with a contribution from the hospital.

There is no further record of methylprednisolone in the GP records, although in a consultation with a Dr P the long-term steroid regimen was picked up. She recorded the patient should only have taken a single four-day high-dose methylprednisolone course.

Eighteen months after his presentation with fractures Mr M suffered further falls. Suspicions of spinal cord compromise at that time were not confirmed on MRI. His underlying disease and associated disability had progressed steadily. He had not walked independently for over two and a half years and suffered urinary incontinence requiring an indwelling catheter. He had poor feeling in both hands, with coordination, visual and swallowing problems and mid-thoracic pain.

Mr M brought a claim against Dr O and the hospital, alleging that both Dr O and Dr P had allowed the continued repeat prescription of high-dose steroids, which had caused his severe osteoporosis.

EXPERT OPINION
The case was reviewed for Medical Protection by an expert GP. He considered Dr O’s records inadequate, with insufficient details of the patient’s problems, particularly related to his MS. Care was substandard in respect that prescriptions were issued in respect that prescriptions were issued and not recorded. Furthermore, steroid prescription should never have been on a repeat basis. Lack of records about specific details of the patient’s problems, particularly related to his MS.

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Learning points
• When a patient registers at a new Practice, this is an important opportunity to review their notes and medication.
• Careful documentation in clinical records is essential, particularly with chronic disease.
• Good communication with secondary care is vital in relation to patient management.
• Be clear as to who prescribes for the patient who regularly attends secondary care.
• Regular review of repeat prescriptions should be routine.

CS
Ms C, a 43-year-old smoker who was otherwise well, presented to her GP, Dr Q, complaining of a few days’ discoloration to the tip of her right index finger. She explained that her fingers had always felt cold and often turned white and went numb when she was outside. When Dr Q examined the finger, there was purplish discoloration of the tip and it felt cold. He noted the presence of good peripheral pulses. Dr Q advised her to stop smoking and made a non-urgent referral to the vascular team.

Nine days later, the patient consulted a second GP, Dr P, as the fingertip had become painful. The records of this consultation were limited, but he diagnosed cellulitis and prescribed flucloxacillin, with an appointment for review in 10 days.

When Ms C returned for review, her finger was much better but she now complained of tiredness with some back pain, which she thought was related to her periods. Dr P arranged some investigations, including full blood count, urea and electrolytes (U&Es), liver and thyroid function tests and planned a further review with the results.

The next day, the results were available and alarmingly revealed some abnormalities. Her eGFR was just 22; urea 14 (2.8–7.2); creatinine 211 (58–96); albumin 33 (35–52). The results were reviewed by a third doctor, Dr Q, who arranged to see Ms C the next day. As there were no previous U&Es, Dr B arranged for a repeat set of bloods, including an ESR. He also arranged an urgent renal ultrasound scan.

The repeat bloods showed creatinine 216, urea 10.7 and ESR 104. These were reviewed by Dr P, who took no action as the renal ultrasound scan was to be carried out three days after that and the patient was due to be seen by Dr B for review thereafter.

At that review, eight days later, Dr B noted the U&Es were still abnormal and decided to await the results of the ultrasound scan. The ultrasound result was delivered the next day, which stated that “both kidneys demonstrate slight increase in cortical brightness; otherwise both kidneys are normal size, shape and morphology with no pelvi-calycetal dilatation”. The results were filed by Dr P as no major abnormality was demonstrated.

One and a half months later, Ms C was admitted to hospital with a subarachnoid haemorrhage. On admission, her GCS was 11, BP 175/103, and the creatinine 573, urea 50 and albumin 29. The patient was referred to a neurosurgeon who organised a CT scan, which confirmed blood in the interventricular systems. An angiogram was performed, which revealed a left pericallosal aneurysm, which was successfully embolised. There were also noted to be other aneurysms. Ms C was initially aphasic with significant neurological impairment after the first procedure.

Ms C was also seen by a nephrologist in light of her significant renal impairment. She was found to have +++proteinuria and +++blood in her urine. Further investigation revealed raised inflammatory markers, mild anaemia and the presence of antinuclear antibody. A repeat renal ultrasound showed two normal kidneys. A renal biopsy was performed, which revealed acute necrotising glomerulonephritis.

A potential diagnosis of systemic vasculitis was made. She was commenced on peritoneal dialysis, high-dose oral prednisolone and cyclophosphamide. Ms C eventually required renal transplantation, three months after the presentation with subarachnoid haemorrhage. Her kidney function stabilised thereafter.

In conjunction with renal support, Ms C was successfully treated for the multiple aneurysms, and recovered from her aphasia. Her neurological deficit improved, such that she was able to mobilise, albeit with assistance.

Following discharge from hospital, Ms C brought a claim against Dr P and Dr B, alleging they failed to refer her to a renal specialist when the abnormal U&E results were initially found.

Medical Protection instructed experts in general practice, nephrology, neurology and radiology to assist in managing the claim.

EXPERT OPINION

The GP expert opined that a reasonably competent GP should have checked the patient’s urine on the first consultation after the increased creatinine was noted, as proteinuria and blood in the urine would more than likely have been present. Urgent referral to a renal specialist would have been appropriate at that stage. He was critical of Dr B for waiting for a second blood sample and ultrasound. Furthermore, when the second set of blood results was reviewed and then the ultrasound report received, Dr P should have referred the patient.

The nephrologist expert considered that end stage renal failure would have been deferred but not avoided if the patient had been appropriately diagnosed and treated earlier. As there was no evidence of polycystic renal disease, he did not consider there was any connection between the kidney disease and the cerebral aneurysms. However, it is noted that although the pre-subarachnoid haemorrhage blood pressure was not available, the blood pressures at the time of the haemorrhage were elevated. It was felt that if Ms C had been referred earlier, any hypertension would have been treated aggressively. The neurologist expert considered that strict control of blood pressure would have been sufficient to prevent the subarachnoid haemorrhage.

On the basis of the critical expert reports the case was settled for a substantial sum.
Ms B was 28 weeks pregnant with her first child. She became acutely unwell and requested a visit from her GP. Dr M attended the patient, who gave a short history of nausea and headache. She also complained of swollen ankles and puffiness of her fingers and face. Dr M did not have access to the patient’s GP records at the time and did not subsequently make a note of the consultation. However, Ms B showed him her antenatal record card, which documented a weight gain of 25kg. Dr M took Ms B’s blood pressure but performed no other examination. Dr M prescribed Gaviscon and a diuretic and advised Ms B to rest.

A few hours later Ms B developed epigastric pain and loss of vision, followed 20 minutes later by a grand mal seizure. An ambulance was called. During the transfer Ms B suffered two further grand mal seizures, which were treated with IV diazepam. On arrival at hospital the eclampsia protocol was initiated and Ms B underwent an emergency caesarean section. The baby was resuscitated and transferred to SCBU, where she was subsequently noted to have spastic quadriplegic cerebral palsy with dystonia.

Ms B subsequently brought a claim against Dr M for failing to diagnose pre-eclampsia.

EXPERT OPINION
According to our GP expert, a history of nausea, headache and oedema, coupled with the likelihood she had a mildly elevated blood pressure, should have suggested the possibility of pre-eclampsia, and urinalysis to exclude proteinuria was mandatory. In failing to perform this test, or alternatively to arrange it by referral to hospital, Dr M breached his duty of care to Ms B.

The obstetric expert advised that prodromal symptoms such as headache and nausea are more prominent in ante-partum eclampsia than signs, and blood pressure is often not dramatically increased, hence it is possible that the patient would not have had significant hypertension and/or proteinuria when seen by Dr M. However, the absence of any clinical record of the home visit made it difficult to rebut the claimant’s allegation that she should have been admitted to hospital.

Had Ms B been admitted to hospital at the time and proteinuria detected, it is likely she would have been observed, and antihypertensive treatment would probably have been initiated if the diastolic blood pressure exceeded 110mm/Hg. By the time she complained of epigastric pain, the window of opportunity to alter the outcome would have been missed.

Expert opinion from a paediatric neurologist concluded that the marked neurological injury sustained by the baby most likely resulted from an acute severe hypoxic ischaemic insult to the thalamus at or around the time of the seizures and a more chronic hypoxic ischaemic insult prior to delivery, rather than as a consequence of premature delivery at 29 weeks gestation. It is likely on the balance of probabilities that had the baby been delivered prior to the onset of maternal seizures she would have sustained mild neurological injury, at most.

Given the absence of GP records for the crucial consultation, it was difficult to rebut the allegations. The claim was therefore settled for a moderate sum.

Learning points
• It is difficult to defend a case without adequate records and it is important that doctors document home visit consultations in the patient’s notes at the earliest opportunity. This is essential for good communication with others caring for the patient, and can prove invaluable should a complaint or claim arise.
• A failure to carry out or record simple bedside tests (e.g. urine dipstix) and temperature can also make a case difficult to defend, especially where they can help to make a serious diagnosis.
• Prodromal symptoms may be more prominent than signs in the immediate pre-eclamptic state. BP readings in particular may not be dramatically raised.
• Delivery before the onset of eclampsia can have a marked effect on outcome and substantially reduce the risk of cerebral injury.

JP
RISK ALERT – RETAINED THROAT PACKS

I read with interest the article regarding throat packs. In both cases measures were taken to prevent error yet error still occurred. I think that as practitioners need to have a more sophisticated understanding of error and our own fallibility.

Firstly, this article illustrates the danger of presumption – the doctor presumed the surgeon removed the throat pack, the doctor presumed delirium (and we may all do the same). If in doubt, check it out, test the hypothesis.

Secondly, a checklist, briefing or standard operating procedure does not in and of itself eradicate error. In fact regular, repeated, routine skills and checks can become so familiar they are performed with little attention thus becoming a potential source of error.

Thirdly, we do not know the details of the WHO checks in these cases but distractions, interruptions or team changes all diminish the effectiveness of the checklist. It is also influenced by culture and belief – if practitioners do not value the tool it has little power to change practice.

I believe that we need to learn how to identify potential error and use the tools available to manage error.

If we use the WHO checklist in terms of threat and error management, we are actively evaluating the case in question, this requires attention. For example, in case 2 the anaesthetist was new to the hospital; this is a “threat” to performance because the team and the routine practices of that department are unknown. This should be stated during the team brief with the request that the team keep the new doctor informed regarding their normal practices.

The use of a throat pack is an “airway threat” and should be stated as such. The anaesthetist should inform the rest of the team how they plan to manage this. This includes the team directly in the management plan promoting team situation awareness and vigilance.

Maybe what is required is a shift in attitude, a change in “mind-set” from a passive “tick box exercise” to an active evaluation for error management, a point when all team members are united and engaged in planning their workload.

Dr Heather Gallie
Salford
UK

ELBOW ARTHROSCOPY AND RADIAL NERVE PALSY

I read with some distress the case regarding elbow arthroscopy and radial nerve palsy. I am an upper limb surgeon who does perform elbow arthroscopy for arthritis.

What bothers me about this case is the management plan where it appears that the surgeon had planned multiple arthroscopic operations to debride an arthritic elbow. Leaving the radial nerve palsy aside, this decision was negligent from the start. This was not an acceptable management plan. One elbow arthroscopy has its risks and planning multiple procedures would certainly increase the risks to the surrounding nerves and vessels.

I feel this point is lost in the summary.

Many of the cases in your magazine are unfortunate and do lack evidence of documentation, which Medical Protection has repeatedly highlighted the importance of. Thus they come to litigation, but this is different.

Dr Cormac Kelly
Shoulder and Elbow surgeon
UK

Response

Thank you for your letter. I note your concerns about the management plan in this particular case. As you may know, our case reports are based on cases in which Medical Protection has assisted members around the world. Interestingly, the allegations in this case, as set out by the claimant’s solicitors, focused solely on the operation that caused the radial nerve injury, the post-operative care, and the delay in diagnosis of the nerve injury. The claimant did not allege that there had been any negligence prior to this and as such this was not a point that our expert or Medical Protection had to address.

POOR NOTES, FATAL CONSEQUENCES

I can see a few pitfalls in the management of Mrs Y. First, I would have considered a low dose aspirin as she was at risk of developing early-onset pre-eclampsia. Second, her blood pressure was moderately elevated in the second trimester (where BP is at its lowest). However, methyldopa was considered but never initiated! Third, when she was admitted with severe pre-eclampsia, she was commenced on methyldopa and nifedipine. Methyldopa is known to have a slow onset of action that could last a few hours, and although her BP was never controlled, she was not offered a second-line therapy (e.g. IV hydralazine or labetalol) to control the BP before the delivery, which was conducted the next day semi-urgently.

All of the above are basics in the management of hypertension in pregnancy as recommended by NICE guidelines (CG107) published August 2010.

Dr T Hamouda
Consultant O&G,
New Zealand

REFERENCES

1. nice.org.uk/guidance/cg107
**GOING INTO HOSPITAL? A GUIDE FOR PATIENTS, CARERS AND FAMILIES**  
by Oliver Warren, Bryony Dean and Charles Vincent

Review by: Dr Timothy Knowles (ST2) and Dr Rebecca Smith (Consultant), Department of Anaesthesia, Chelsea and Westminster Hospital, London

Going into Hospital is the collaborative work of three well-respected healthcare professionals – a surgeon, a pharmacist and a psychologist. This book is the first of its kind, providing a road map to help patients, relatives and carers to navigate the complex world of hospital medicine.

The book is designed in a similar fashion to a travel guide, allowing the reader to dip in and out of relevant chapters. It describes the culture of modern healthcare, the roles of various health professionals, and the diverse wards and experiences encountered during a typical patient’s journey.

Throughout the book practical advice is offered to reduce the anxiety often encountered by patients. Checklists are frequently provided, covering topics such as “Questions to consider asking during your outpatient appointment” and “Reducing your risk of deep vein thrombosis while in hospital”. Wherever possible, authentic patient stories and experiences are included. These powerful messages portray the vulnerability and loss of dignity that many people experience when admitted to hospital.

To a doctor, this book serves as a stark reminder of how debilitating an overwhelmingly unfamiliar environment can be. With the demise of paternalistic medicine, it is our responsibility to ensure patients are enlightened and able to participate in their care. Going into Hospital will empower patients to make informed, collaborative decisions with their healthcare team. The book seeks to dispel many of the myths obtained from the media. It helpfully lists reliable, useful sources of information accessible on the internet.

The anxiety of being in hospital for a prolonged period of time can be compounded by the frustration and stress of trying to understand the complex way in which hospital care is delivered. We would encourage anyone being admitted to hospital, or those close to someone going into hospital, to read this book.

For healthcare professionals this book is an eloquent reminder of how we all can play our part in reassuring patients on their hospital journey.

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**BETTER – A SURGEON’S NOTES ON PERFORMANCE**  
By Atul Gawande

Review by: Dr Rebecca Aning, Medical Protection Medicolegal Adviser

“Good, better, best, never will I rest, until my good is better and my better is best.” I don’t know a single doctor who wants to be average! But, if you measure our success, it is probable that most of us would hover around the peak of the bell curve. To replicate the positive deviants, we need to know who is at the top. But is anyone willing to be at the bottom, in order that we could all learn to be closer to the best?

Who would have thought that handwashing gurus would take guidance from those encouraging better nutrition in malnourished African children? Or that army medics could find the time to capture 75 pieces of information on every patient to reduce the Golden Hour of Trauma Medicine to the golden five minutes? Do we really need more expensive cures to do the best for our patients? What if doing what we know, well, and making a science out of performance could further improve the care that we offer? Is money important to medics? Does the modern trend towards informality by doctors blur the lines for patients and effectively encourage claims of misconduct? Should we extend compassion and competency to those on death row?

Gawande is a Harvard professor and highly acclaimed. But above all, he has listened to those around him and those that no one cares much to listen to. He trusts that his audience is intelligent enough to understand the points illustrated, consider their importance and be changed by what they read. Not once will you feel lectured, but if you have not reconsidered a single part of your practice or been inspired to improve anything by the end, then I urge you to read this book again.
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