Charging for foreign patients

THE IMPLICATIONS FOR HUMAN RIGHTS

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Welcome

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

Wherever you are in the world, it is likely that you are working in an increasingly challenging environment. Financial constraints in your workplace and changes to how healthcare is delivered, and by whom, are complex issues affecting many of today’s doctors.

Globally the population is living longer and presenting with multiple comorbidities that demand increasingly complex interventions. Patient expectations are growing – rightly patients expect high quality, safe care, delivered in a respectful, clearly communicated manner – but there has been a change in the doctor–patient relationship and this is something MPS has written about extensively. The patient is now a consumer and the health service has had to adapt accordingly.

These higher expectations mean that patients are more likely to complain about their care. This is something we have been seeing in numerous reports of growing numbers of complaints against doctors; there is no other evidence that the profession’s standards are declining. I have personally heard concerns from our members that the gap between expectations and deliverables is widening, and that they are facing pressures to do more with less.

It is in times of great stress that your professional qualities come to the fore. Your sense of personal responsibility, pride in the care you deliver to patients, and your aspiration towards improvement are decisive attributes that can make all the difference when under pressure. In such moments your professionalism has never been more important.
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MPS Medical Director Dr Priya Singh shares her personal experiences of MPS’s international conference

MPS was delighted to welcome more than 250 delegates to our International Conference 2012 – Quality and Safety in Healthcare: Making a Difference. Throughout the conference, delegates heard from leading international experts about the importance of listening to patient feedback to improve quality, the need to be transparent and professional when things go wrong, and the cost, both to the doctor–patient relationship and to the doctor’s claims experience, in failing to do so.

I have been encouraged by the feedback from the conference so far – 100% of delegates who completed the post-conference evaluation form said that the programme of speakers met their expectations and they would recommend the conference to a colleague.

The real measure of the conference’s success, however, will be the extent to which delegates take home the key learning points about improving quality and patient safety – and put them into practice.

Ninety per cent of delegates agreed that they were likely to change something in their practice as a result of attending the conference. One delegate said: “We need to challenge the culture of resistance to openness”; another: “I have a much more positive attitude towards aspects of appraisal because I see the evidence behind it now. I feel confirmed and remotivated in what I do.”

I would be very interested to hear your thoughts on what we can do differently in our organisations to improve quality and safety in healthcare. If you have suggestions you would like to share, please do get in touch.

Making medicine safer

Healthcare in the 21st century has become highly effective, yet improvements in safety have lagged behind. MPS’s International Conference 2012 – Quality and Safety in Healthcare: Making a Difference moved the focus from making medicine better to making it safer.

By Sarah Whitehouse

Part of making medicine safer is listening to a patient’s experience. Patients are now very active consumers of healthcare, not just passive recipients. Described by conference speaker Dr Neil Bacon, founder of Doctors.net and iwantgreatcare.org, as “the smoke detector of patient safety”, patient experience captures both excellence and the potential for improvement.

As well as patient experience, MPS’s conference – held on 15-16 November 2012, at Church House Conference Centre, Westminster, London – addressed quality, safety culture, cost and professionalism. In partnership with the Canadian Medical Protective Association (CMPA) and MDA National, and key supporters CRICO and PIAA, MPS’s conference welcomed more than 250 international delegates from around the world, including Argentina, Australia, Canada, the USA, the Caribbean and Bermuda, Uruguay, Norway and Ireland, as well as the UK.

Dr Gerald Hickson, Assistant Vice Chancellor for Health Affairs, Vanderbilt University Medical Centre, and Director of Centre for Patient and Professional Advocacy, delivered the first keynote address on delivering quality and trust. Quality, he said, is about making medicine kinder and safer. Each doctor has a duty to address faulty systems;
To achieve a culture of safety, we first need to talk to each other. Quality is also about promoting reliability – doctors need to know they will be supported by their organisation if they raise any concerns. Similarly, organisations need to tackle unreasonable variations in the performance of healthcare professionals that threaten safety and quality.

Quality, however, means different things to different people. The pursuit of quality in challenging circumstances has one main goal for Dr Devi Prasad Shetty, Chairman, Narayana Hrudayalaya Group of Hospitals – to dissociate affluence from healthcare. Quality is being able to reduce the costs associated with cardiac surgery, by putting a price tag on human life out of necessity. Delivering cardiac surgery for $800 involves streamlining processes, reducing costs, and involving families as primary care providers.

Typically, it takes a catalyst for new aims to be set, or behaviours to alter.If something goes wrong, writing a policy to improve patient safety is the default mechanism, said keynote speaker Dr Carol Haraden, Vice President at the Institute for Healthcare Improvement (IHI). Yet often, there is no well-developed execution strategy – and so excellent ideas and aims to improve patient safety are lost in documentation. Most healthcare organisations have at least 250 guidelines; yet typically, healthcare professionals only put five into practice. To achieve a culture of safety, we first need a culture of improvement.

The shift needs to come from the top. In every healthcare organisation, there needs to be a board level commitment in everything to do with quality, stressed Professor Martin Elliott, Professor of Paediatric Cardiothoracic Surgery at Great Ormond Street Hospital. Talking about teamwork, leadership and professionalism, he said that leaders need to help define the goals of their organisations, set and maintain standards, and act as role models.

Force won’t work: the best leaders never bully, but lead by example.

Forecasting medicolegal risk would allow medicolegal institutions (eg, liability insurers, medical boards, hospital risk management departments) to become more proactive in quality and safety improvement efforts, argued Professor David Studdert, Professor and ARC Laureate Fellow at the University of Melbourne. His study is using a unique national dataset on patient complaints against Australian doctors to develop new methods and tools for predicting a clinician’s risk of a further complaint. Over a ten-year period, 18,900 complaints were received about 11,000 doctors in Australia. The research looked at practitioners’ sex, age, practice location and specialty. For all practitioners, standards of clinical care and communication were the main issues. The more complaints a doctor received, the more they were at risk of further complaints. Prof Studdert explained how the PRONE score (PRobability Of New Events) predicts doctors’ medicolegal risk, which could be used as a simple prediction tool for targeting interventions and reducing clinical negligence costs.

Tony Mason, former Chief Executive of MPS, explored the rise in negligence costs in a global context. For some doctors and hospitals, they have already proved to be unsustainable; in the UK, clinical negligence costs are the highest anywhere in the world, except the United States. The Panel Discussion provoked a lively debate about potential ways forward to address this unsustainable rise.

But the fallout from an adverse event is often not about the money, argued Dr Lucian Leape, Adjunct Professor of Health Policy at Harvard School of Public Health, in his keynote address on disclosure and apology. It is about communicating effectively when things go wrong. A serious preventable injury is devastating for the patient – they are doubly wounded. Not only do they suffer a physical wound (the adverse event), they also suffer an emotional wound, the betrayal and loss of trust in the healthcare professional. A serious preventable injury is a medical emergency. If a doctor does not act quickly, things become much worse. The necessary treatment is open,
Serious and sentinel events reporting aims to encourage transparency and a ‘no blame’ culture. This means we can have an accurate picture of where things are going wrong, and put in place systems to reduce harm.

It is also much more than that. It is a promise to patients that these tragic events will be robustly reviewed, to ensure appropriate care and treatment were provided and, where indicated, to improve systems and processes of care.

And this reporting is a safeguard for clinicians. By identifying and fixing systems failures we give clinicians greater confidence that they will be supported by the systems around them to practise safely.

For the 2011/12 year, DHBs reported 360 SSEs, 3% fewer than the 370 recorded in 2010/11. Ninety-one patients died (86 in 2010/11), although not necessarily as a result of the adverse event that occurred. SSEs included 170 falls, a 13% decrease from the 195 falls reported the previous year; 111 clinical management events, up from 105 in 2010/11; 18 medication errors, down from 25 the previous year; and 17 suspected inpatient suicides.

There was an overall decrease in SSEs and specifically falls for 2011/12. This is very good news and represents a lot of hard work by DHBs to both report and prevent adverse events. However, we have seen an increase in the number of cases of delayed treatment and suspected inpatient suicides.

In 2011/12, 17 suspected inpatient suicides were reported by DHBs. The Commission has looked at the DHBs’ reviews of these deaths and found there is no clear trend evident – either in terms of whether numbers are increasing, or common factors.

International evidence shows that despite the best efforts of family, friends, other social agencies and mental health staff, tragically, some patients will commit suicide.

However, it is important health services do everything they can to reduce these events and, when they occur, to investigate them. Each of these suicides has been subject to a robust process of review to ensure appropriate care and treatment were provided and to improve systems and processes of care to reduce the chances of such a tragedy occurring again.

The Commission is also working with the mental health sector to identify the best approach to reviewing and reporting serious incidents involving mental health service users. A working party of experts from the mental health sector (including consumer representation) has made recommendations to the Commission, and the Commission is discussing the implementation of these changes with the sector.

In 2011/12, 17 cases were reported to the Commission describing events in which system failures resulted in delays in the diagnosis of cancer, or in a similar serious outcome. There were 13 such events in 2010/11, eight in 2009/10, nine in 2008/09 and seven in 2007/08 – indicating a likely increasing trend.

These cases of delays in treatment show how critical it is for clinicians to follow up when tests have been ordered, referrals made, or further treatment recommended. This is particularly important in today’s environment, in which people are increasingly seen by teams of health professionals.

The Commission will be looking at measures that can be put in place to reduce the likelihood of these sorts of events taking place. The importance of following up needs to be top-of-mind for clinicians at all times.

REFERENCES

1. A serious adverse event is one that leads to significant additional treatment but is not life-threatening, and has not resulted in a major loss of function. A sentinel adverse event is life-threatening or has led to an unexpected death or major loss of function.
This year, a national reportable events policy has introduced a change to the way SSEs are reported to the Commission. Previously, there was no requirement for DHBs to report the outcome of a review to the Commission, meaning lessons from events were often not shared. There is now a requirement for organisations to report to the Commission the key findings and recommendations of reviews of events that occurred from 1 July 2012. Future SSE reports will be able to discuss in greater detail issues such as contributory causes and what has been learnt from the events.

Several health and disability organisations other than DHBs are in discussion with the Commission about potentially reporting SSEs in the future. They include members of organisations such as the Disability Support Network, Care Association NZ, Hospice NZ and Ambulance NZ. Individual providers such as Mercy Hospital Dunedin are also in discussions with the Commission.

The Commission is working closely with the health and disability sector on a number of initiatives, including a national patient safety campaign to be launched in the first half of 2013. Initially the campaign will focus on preventing harm in the following areas:

- infection prevention and control
- surgery – reducing perioperative harm
- medication
- falls.

The full SSE report is available on the Commission’s website: www.hqsc.govt.nz.
The long arm of the law can have far-reaching consequences even for those who inadvertently breach its provisions. This is particularly so in the area of human rights discrimination. This article reviews an area of medical practice that can lend itself to complaints of breach of the Human Rights Act 1993 (“the Act”) and its anti-discriminatory provisions – in particular, we look at the practice of some medical centres that charge a higher fee for foreigners.

A case of discrimination?
A case that recently highlighted this involved a French student who was injured in a rugby match and required treatment by the local Accident & Emergency Medical Clinic. In keeping with its fee practices, the clinic charged him $98, whereas a New Zealand citizen or resident in comparable circumstances would have been charged $58. The student queried the increased charge. The clinic explained it justified this difference of fees because foreigners often take longer to consult or treat, due to language and other practical difficulties, such as locating the patient’s prior medical history.

The clinic also said its policy of charging foreigners a higher fee did not include travellers from the UK or Australia because of the reciprocal health agreement that New Zealand has with those countries. The question that emerges is whether or not the clinic’s fee structure practice is a breach of the Act, albeit an inadvertent or unintended one.

The Act: a closer look
The starting point is Section 21 of the Act. It lists those acts of discrimination that are prohibited – that is to say, not every act of discrimination (where one group of people is treated differently from another) is unlawful unless it is listed therein as a prohibited ground of discrimination. Discrimination or difference in treatment based on ethnic or national origin (which is said to also include nationality or citizenship) is one such prohibited ground. There are others, such as the more common ones of sex, race, colour or religious belief.

Section 44 of the Act then makes it unlawful for any person to supply services to the public, or any section of the public, whereby a person(s) is treated less favourably in connection with the provision of those services than would otherwise be the case “by reason of” any of the prohibited grounds of discrimination referred to in Section 21.

Undoubtedly on the facts of the above case, the clinic was indeed treating the French student less favourably (by charging him a higher consultation fee) for the provision of accident medical services than would otherwise be the case for a New Zealand national, or even a resident of Australia or the UK.

What then of the justification raised by the clinic in response to the fee policy it has adopted? The Act does provide statutory exceptions or excuses for conduct that would otherwise be unlawful and discriminatory. For example, the Act does permit differential charging where the fee being charged is a reduced one, based upon age, disability or employment status. Accordingly, the clinic would be quite entitled to charge a lower rate for students or retired persons or others who may be unemployed. But for the statutory exception provided in this regard, such a differential fee practice would be prohibited as unlawful discrimination. There are, however, no other statutory exceptions that apply, which would come to the aid of the clinic in the subject case.

Legitimising the policy
The clinic could, however, very easily amend its fee policy to remove the unlawful discriminatory component. For example, it could be amended to charge a lower fee for those foreigners who do have language problems.
Those who operate services, including medical practitioners, are bound to comply with the Human Rights Act and its provisions (hence requiring a longer consultation) this would not be discriminatory “by reason of” ethnic or national origin, but rather because their consultation will take longer. That assumes all persons, including those who are New Zealand residents who have language or other difficulties, thereby requiring a longer consultation, would all be charged on the same basis.

Recognising that funding availability in clinical practice, least of all primary care, is itself a complex topic – where different people may be entitled to different contributions or subsidies towards certain treatments – the clinic could also adopt a fee policy based upon the availability of subsidies or other fee contributions for eligible people. In such a way, that would indeed pay legitimate regard to the existence of any reciprocal health agreement between New Zealand and other countries.

**Conclusion**

Those who operate services, including medical practitioners, are bound to comply with the Human Rights Act and its provisions. Inadvertently policies may unlawfully discriminate on one of the prohibited grounds, including ethnic or national origin, or one of the other grounds such as disability, age or employment status. Practitioners should take care to evaluate their fee structures and other practices to ensure that no discrimination occurs by reason of one of the prohibited grounds of discrimination.

Unlawful conduct may occur even where the practitioner has no intention of so acting. Indeed, the Act also provides a long reach of the law where “indirect” discrimination may occur. That is where the policy in question has the effect of treating the patient differently on one of the prohibited grounds of discrimination unless the practitioner can establish good reason for the policy.

Unlawful discrimination is something of a minefield, through which practitioners should tread gently and with great care.
MPS has received a number of requests for assistance from GP members following enrolment audits. It is clear there are two distinct areas of the enrolment system that are causing members difficulties: one relates to eligibility for enrolment, and the other concerns actual enrolment processes. The issues relating to each practice’s audit is entirely fact-specific, so this article is a general commentary only.

Getting it right
Why should GPs be concerned about enrolment audits? Because for many, extrapolation of random audit findings across their entire Enrolment Register has proved very costly indeed when their District Health Board (DHB) seeks recovery.

Health providers are required by the Ministry of Health (Ministry) to take all reasonable steps to ensure that only eligible people are enrolled and included in the practice’s Primary Health Organisation (PHO) Enrolment Register. Currently, the Ministry, DHBs and PHOs are making a clear distinction between “invalid” enrolments (defined as no validly signed enrolment form at date of audit) and “ineligible” enrolments, in respect of whether extrapolation occurs or not.

Current and future policy
Importantly, GPs should be aware that the Ministry’s enrolment policy is regularly evolving, with input from DHBs, PHOs and providers. While it would be expected that a GP’s PHO would communicate changes in enrolment policy to them, it is nevertheless the GP’s responsibility to ensure they are aware of the current enrolment requirements and that their practice is compliant.

A new Enrolment Requirements for Providers and Primary Health Organisations Version 3.1 was published on 9 July 2012. GPs are also responsible for assessing the eligibility of a person for publicly-funded services against the criteria set out in the Eligibility Direction 2011. These two documents set the standard, and are incorporated into the DHB-PHO contracts. Via PHO-GP service or back-to-back agreements, members are also contractually obligated to comply. Both these “standards” documents are available on the Ministry’s website, as is the Primary Healthcare Audit Protocol (Audit Protocol).

GPs will be aware there was a moratorium (previously set out in Appendix 4 to the Audit Protocol) that applied to all audits conducted between 12 March 2010 and 28 February 2011. The purpose of the moratorium was to give PHOs and providers the opportunity to become fully compliant with enrolment requirements before they were due to submit their Enrolment Registers for the April-June 2011 period.

From 1 May 2011 to 30 April 2013 a quality improvement process applies (Quality Improvement Period). This is set out in the enrolment requirements document. GPs must be aware that after 28 February 2011, only one of the previous moratorium exception factors remained available: this relates to ineligible patients only. Ineligibility relates to whether a person is a New Zealand resident, holds valid
residential visas or work visas, etc. While it is the person’s responsibility to provide appropriate documentation evidencing eligibility, the GP practice is responsible for assessing the person’s eligibility, and they are expected to view and confirm the existence of relevant documentation to assess eligibility, and ideally take a copy and hold it with the person’s medical records. Under section 300 of the Immigration Act 2009 (which came into effect in November 2010), the Ministry and DHBs have access to eligibility data for overseas travellers and immigrants to determine eligibility to access publicly-funded health services. Similar disclosure is available to health providers under section 301 of the Immigration Act 2009.

Assessing eligibility

Eligibility has to be determined at the point the patient is being enrolled, and when the services are actually being provided. If the person’s eligibility is unlikely to change (eg, New Zealand citizens and permanent residents), the GP may need to only assess eligibility once, but for individuals who qualify under other eligibility criteria, they will need to be periodically reassessed before services are provided. There are also circumstances where even a New Zealand citizen, for example, may become ineligible to be enrolled, such as if they declare an intention to live overseas for 12 months or longer, or if there has been no entry in their medical records within the previous three years.

During the Quality Improvement Period, audit reports will continue to give advice on enrolled patients who are not eligible, and those individuals will be removed from the register, with no further capitation payments being made for them. Practices will not face extrapolation across the whole Enrolment Register for ineligible enrolments.

GPs reading the enrolment requirements need to be aware that while the words “invalid enrolments found in the sample” could initially be read more widely, taken in context they refer only to ineligible enrolments. This has been confirmed by the PHO Service Agreement Amendment Protocol Group (PSAAP).

Assessing validity

While eligibility is a prerequisite, it is not necessarily determinative of a patient being entitled to be enrolled – for example, the patient may live overseas and the general practice would not be their regular and ongoing primary healthcare provider. For purposes of valid enrolments, the person must be intending to live permanently in New Zealand for a period of two or more years. Further, three years is the maximum period a person in New Zealand can be enrolled with a PHO without a first level service consultation being recorded, a new enrolment form signed, or auditable contact with the person that confirms continued enrolment.

Signing of enrolment forms became mandatory on 1 April 2004. Patients validly enrolled with a practice prior to that date – as long as there is at least one first level service consultation recorded in the medical records within each three-year period – were not required to be re-enrolled.

For an enrolment form to be considered valid on the day of audit a number of criteria must be met. It is beyond this article to outline all of these, but three that GPs should watch out for are:
- The person’s enrolment details must comply with the mandatory minimum dataset, which is outlined in Appendix Two of the enrolment requirements document.
- The person must sign the enrolment form. The date on which the enrolment form was actually signed must be the date that is recorded on the Enrolment Register. Some practices, whether due to administrative procedures or software design, record the enrolment date as the date it is entered on their patient management system. Such enrolments are audited as being invalid and extrapolation will apply.
- If the person is a child under the age of 16 years, a parent or guardian must sign a separate enrolment form in the name of the infant; the child cannot be enrolled under the parent or guardian’s enrolment form. Once a dependent child reaches 16 years of age, a new enrolment form does not need to be signed if he/she remains with the same provider of first level services. The criterion of consulting the provider at least once in a three-year period or reconfirming enrolment applies.

The enrolment requirements document notes that in January/February 2013, PSAAP (or parties to the PHO agreements if PSAAP no longer exists) will review progress and any final requirements for the enrolment standards to be fully met.

GPs are therefore recommended and encouraged to liaise with their PHO and/or check the Ministry’s website to ensure they are aware of any changes to enrolment and eligibility criteria. It is likely that, from 1 May 2013, extrapolation across the member’s Enrolment Register will apply for both invalid and ineligible enrolments.

Signing of enrolment forms became mandatory on 1 April 2004. Patients validly enrolled with a practice prior to that date – as long as there is at least one first level service consultation recorded in the medical records within each three-year period – were not required to be re-enrolled.
GPs top complaints figures

A freedom of information request by the Waikato Times has revealed that between August 2010 to July 2012, 362 separate health providers were complained about in the wider Waikato region.

Complaints to the Health and Disability Commissioner included delays in treatment, wrong site surgery, misdiagnosis, unexpected outcomes and poorly co-ordinated care.

Of the 362 complaints, 214 were made about group providers, such as medical centres and hospitals. The remaining 148 were made against individual registered and unregistered providers.

The complaints figures included:
- GPs – 37
- Dentists – 20
- Physicians – 10
- Orthopaedic surgeons – 9
- Midwives – 9
- Nurses – 6
- Psychiatrists – 5
- Other – 52.

Royal New Zealand College of General Practitioners chief executive Helen Morgan-Banda said GPs were at the forefront of primary medicine and saw, on average, more patients than other medical practitioners.

The region’s public hospitals received the most complaints for a group provider with 104, followed by medical centres (25), rest homes (21) and accident and emergency clinics (7).

This builds on the Commissioner’s Annual Report (2011) which identified treatment as the primary issue in half of all complaints received.

Source: Waikato Times

Inquiry into hospital death

The police are investigating the death of a patient after surgery at Waiau Hospital last year.

Detective Sergeant Jason Hillgrove, of Blenheim, reported they were in the very early stages of investigating the death at the request of the coroner.

This investigation is being completed alongside an investigation by the Health and Disability Commissioner.

The patient’s family went to the Health and Disability Commissioner within three months of the death last year and the commissioner accepted the complaint after a meeting with them.

Health board chief medical officer Heather McPherson said the board had started an investigation after it received a complaint from two women who had surgery at Waiau Hospital in December 2010 and February 2011.

The investigation was prompted by two cases of a “known but uncommon complication” during the same procedure within a relatively short time.

The two women had also complained to the Health and Disability Commissioner, who said in a letter last year she had referred the complaint to the Medical Council after a preliminary assessment.

Source: Marlborough Express

CHANGES FOR REPORTING A DEATH TO THE CORONER

The Ministry of Justice has ushered in changes to the coronial services unit, affecting how doctors should report a death to the coroner.

Doctor should no longer ring their regional office to report all deaths from around the country during the week, and direct all calls to the Coronial Services centralised National Initial Investigation Office (NIIO) using 0800 266 800 to report a death to the coroner on a 24/7 basis.

The following sudden deaths should be reported:
- if it was without known cause, suicide, unnatural or violent
- where a medical certificate of the cause of death cannot be issued
- if it occurred during or as a result of a medical, surgical or dental procedure
- if it occurred while a woman was giving birth
- if it occurred while the deceased was in custody.

For more information contact: www.justice.govt.nz

PATIENTS UNAWARE OF TRUE COST OF SURGERY

A survey by Southern Cross Healthcare Group found that most New Zealanders are unaware of the cost of elective (non-urgent surgery).

According to the healthcare group, only a third of the 2,000 New Zealanders surveyed believed they had an understanding of how much three common surgical procedures cost.

Those who indicated they did have an idea were asked to estimate the cost of those surgeries in the private sector – the majority cited prices that were a small percentage of the real cost.

- 21% believed the cost of a knee replacement was $2,500 or under (actual cost $19,000) (including prosthetic), only 15% of people estimated that this procedure cost more than $15,000.
- 27% believed the cost of a hip replacement to be under $5,000; 45% suggested it was between $5,000-$15,000 (actual cost in excess of $18,250).
- Though 28% believed a single cataract replacement cost under $1,000, 37% believed it cost between $2,000 and $5,000 (in excess of $3,500).

The survey found that those from higher income households tended to have a better understanding of the cost of healthcare.

Southern Cross Healthcare Group CEO Ian McPherson said: “Already around half of all elective surgeries are funded privately. As the population ages, it is highly likely New Zealanders are going to be asked to fund an increasing portion of their non-urgent healthcare costs in the future in order to keep the country solvent.”

Source: Southern Cross Healthcare
On the case

Dr Rob Hendry, Deputy Medical Director, introduces this issue’s round-up of case reports.

When treating patients who attend the surgery frequently, especially within a short space of time, it can be all too easy to be blinded by a familiar diagnosis based on pattern recognition, particularly if it is a commonplace, and seemingly innocuous, condition. The safest approach when treating frequent attenders is to go back to basics: document a thorough history and be prepared to re-examine the patient if their symptoms change.

Back pain is one of the most common complaints seen in general practice. Doctors may easily discount it, but it is important to remember that a small proportion of such cases mean serious or life-threatening pathologies. In “Back with back pain” on page 16, Mrs S’s recurrent urine infections and back pain were found to be co-existing with non-Hodgkins lymphoma. Despite a claim being made against Dr F for failing to refer Mrs S earlier, Dr F’s good documentation of the history and each examination meant that this was discontinued. Experts found that there was a careful, well-documented assessment of Mrs S on every occasion, which showed that at no time was an emergency referral warranted.

In direct contrast, a claim against Dr W for a missed SAH in “Take me seriously” (page 14) had to be settled for a high sum. There was no evidence in the records that Dr W had taken any history or performed an examination. As a result, Mrs T’s fatal SAH was missed. One consultation was recorded simply as “Migraine. Prescribed some painkillers.” Despite Mrs T returning to the surgery several times with recurrent headaches, and later with pain shooting down the back of her neck, the potentially life-threatening causes of her recurrent headaches were not considered.

Similarly, in “Where the heart is” on page 21, Mr R’s high blood pressure was attributed to anxiety before more sinister pathologies were excluded. His risk factors for cardiopulmonary disease should have been considered when taking the history, examining and arranging follow up tests.

The learning points from all these cases are that potentially serious pathologies should never be discounted before a proper assessment has been made and a detailed history taken. Comprehensive records should be made of both.

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

High $3,000,000+
Substantial $300,000+
Moderate $30,000+
Low $3,000+
Negligible <$3,000
Forty-year-old hairdresser and mother-of-three Mrs T had long-term problems with neck pains and migraines. She had seen her own GP Dr W, and many of the partners in the practice, several times over the years with the same complaint. Her symptoms had been largely attributed to muscular spasms due to her job.

One day, Mrs T attended Dr W’s surgery with a headache she felt was much worse than usual. She had also experienced several episodes of vomiting that morning. Although the history of migraine was well-established, the symptoms she presented with “felt different to her usual migraine”. She described pain shooting down the back of her neck, which had never happened before. Dr W documented the consultation with one line in the notes, stating: “Migraine. Prescribed some painkillers.” There was no evidence in the records about any history taken or examination performed.

Over the next three weeks, Mrs T attended four more times with ongoing symptoms, seeing different partners each time. She asked for a private referral to a chiropractor as she thought she had “wry neck” and simple analgesia was providing no relief. Frustrated with the ongoing headache, she even attended the Emergency Department once but no investigations were carried out, based on the chronicity of her symptoms and her long history of migraines. Four weeks from the onset of this latest, severe headache, Mrs T had a seizure followed by a fatal cardiorespiratory arrest. The postmortem showed that she had suffered a subarachnoid haemorrhage.

Mrs T’s family made claims against all the doctors involved in her care, including hospital doctors, and the case was settled for a high sum.

LEARNING POINTS

- Those who reattend frequently with the same complaint might be seriously ill. A safe approach is to go back to basics, by documenting a thorough history and examination of the problem.
- Listening to what the patients tell you remains one of the best medical tools. A patient with chronic migraine who describes her headache as different to previous ones deserves careful attention. Try not to allow a consultation to be prejudiced by what has happened before and do not let the patient’s self-diagnosis prevent you from keeping an open mind as to the cause of their symptoms.
- NICE have similar guidance: Headaches: Diagnosis and management of headaches in young people and adults http://publications.nice.org.uk/headsches-cg150
- Headache is a common symptom and missed SAH is a frequent source of litigation. Casebook has featured similar presentations of SAH in the past, which may be of interest:
  - MPS Casebook, Not just another headache, 17 (3) (2009)
  - MPS Casebook, Sudden (1) (2008)
  - MPS Casebook, Sudden, first and worst again, 16 (2) (2008)
  - MPS Casebook, Sudden, first and worst again, 16 (2) (2008)
- If aneurysmal SAH is treated urgently, complications can be reduced. Kowalski et al noted that misdiagnosis of SAH in patients who initially present in good condition is associated with an increased mortality and morbidity. They suggest a low threshold for CT scanning and highlight the importance of immediate aneurysm repair – stating that rebleeding occurs in 26%-73% of patients within days or weeks if left untreated. Kowalski R et al, Initial misdiagnosis and outcome after subarachnoid haemorrhage, JAMA 291(7):866-869 (2004) http://jama.jamanetwork.com/article.aspx?articleid=198199
- Remember the importance of lumbar puncture – CT scans may often come back negative.
- Ensure that you keep accurate records, as when a claim is made, evidence is collected from a number of different sources and records may be cross-referenced. For example, hospital records on admission may contain a history that is very relevant in a claim relating to a GP’s earlier actions.
Mrs B was a 35-year-old housewife with two children. She was well-known at her GP surgery since childhood and had needed support with a troubled past. She had suffered abuse as a child and domestic violence in her first marriage. She attended the surgery very frequently with anxiety issues and lots of minor ailments. She would have a list of things that she wanted to discuss each time she attended and consultations would frequently take a long time. Some years ago, Mrs B had been referred to the breast clinic and was diagnosed with fibrocystic disease. Mrs B mentioned several times on her way out of the doctor’s room of having sore and lumpy breasts. Several of the GPs she had seen had documented this as part of her lengthy consultations and she was examined several times. This, however, always seemed to be part of a “by-the-way” mention rather than a full and detailed examination. Mrs B felt anxious about her breasts and continued to report this when she saw her GP about other things. Dr T knew Mrs B well and found her to be a challenging patient. He struggled to be able to separate her physical and psychological issues, which were often intertwined. Mrs B always seemed very emotional about her personal problems and Dr T knew he would always run late after he had seen her. He found her increasing breast discomfort difficult to assess. Dr T had wanted to give fuller attention to Mrs B’s breast symptoms and had asked her to return on another day for a new assessment, but she had failed to attend. Dr T’s partners also saw Mrs B many times with multiple symptoms and issues. A breast examination had been documented several times by different GPs and always mentioned lumpy breast tissue. Fibrocystic breast disease was mentioned on each occasion. After 12 months she was eventually referred to breast clinic with her persistent symptoms. She was diagnosed with breast cancer. Unfortunately, her disease was quite advanced and she needed a mastectomy and chemotherapy. Mrs B made a claim against the doctors at her surgery for the delayed diagnosis. The case was settled for a moderate sum.

LEARNING POINTS

1. Fibrocystic breast disease is a diagnosis of exclusion. If symptoms persist the diagnosis needs to be challenged on a regular basis. The initial diagnosis could have been wrong or it may have evolved into something else.
2. Continuity of care is important, especially in reviewing the nature of a breast lump over time. This can be difficult in busy surgeries with many GPs but it is good practice to ensure that it is the same doctor each time in order to make the comparison objective. As more healthcare professionals are involved in a patient’s care, comprehensive notes and good communication are important.
3. NICE has published guidance on Improving Outcomes in Breast Cancer (28 August 2002). It has a useful section on managing breast lumps which GPs should be familiar with. The document makes several recommendations, some of which are outlined below:
   1. All patients with possible or suspected breast cancer should be referred to a breast clinic without delay.
   2. Urgent referral (within two weeks) should be arranged for:
      - Patients aged 30 or over with a discrete lump in the breast
      - Patients with breast signs or symptoms which are highly suggestive of cancer. These include ulceration, skin nodules, skin distortion, nipple eczema, recent nipple retraction or distortion (<3 months) or unilateral nipple discharge which stains clothes.
3. Breast lumps in the following patients or of the following types should be referred but not necessarily urgently:
   - Discrete lump in a younger woman (<30 years)
   - Asymmetrical nodularity that persists at review after menstruation
   - Abscess
   - Persistently refilling or recurrent cyst.
   - Beware of “by-the-way” mentions from patients on their way out of the surgery. Sometimes they hide serious pathology. If there is no time for a full assessment, arrange a new, later appointment.
   - Challenging patients may require particular care. Patients with complex psychological, social and psychiatric needs can, and often do, have physical problems. There is an interesting article about challenging patients in Casebook (May 2009).
   - It has some insightful case reports and tips on management.
   - Patients that don’t attend their appointments raise several issues. Where does the doctor’s responsibility end? What should GPs do about it? It may be useful to have a practice meeting to discuss this and consider developing some practice guidelines about safety netting for did not attend patients.

www.medicalprotection.org
Mrs S was a 35-year-old shopkeeper with an established history of recurrent UTIs, which had responded well to antibiotics. An ultrasound in the past had confirmed kidney stones.

She presented to her GP, Dr F, complaining of back pain for the past six weeks and tingling in her right leg, which was relieved by lying down. Dr F took a full history and examined her back, including a neurological examination. Dr F diagnosed Mrs S as having sciatica, exacerbated by lifting heavy boxes in the shop. Dr F prescribed regular analgesia and advised her about careful lifting and gentle exercises.

However, the pain continued to worsen. Dr F saw her again four weeks later and this time was concerned as Mrs S was having difficulty walking. She was referred for physiotherapy.

Whilst waiting for the physiotherapy appointment Dr F saw Mrs S again, this time with symptoms of a urinary tract infection including frequency and urge incontinence. Again a urine sample was sent to the lab and confirmed a urinary tract infection, which was treated successfully with antibiotics.

Mrs S’s back pain and right leg sciatica continued to deteriorate to the extent that she could not sit and she returned to the surgery again. Dr F was concerned about the repeated urine infections in association with back pain and the recent onset of incontinence, and informed Mrs S that she felt an ultrasound scan of her urinary tract system would be prudent. A urology referral was made and a CT scan confirmed a renal stone and a retroperitoneal mass. Mrs S had further investigations for the mass and was eventually diagnosed with non-Hodgkins lymphoma.

Mrs S was very upset when she was diagnosed, as she felt the back pain had always been due to the mass, and she made a claim against Dr F for failing to refer her earlier.

Experts who looked into the case agreed that the management had been appropriate and Dr F had acted like any other reasonable GP would have at the time. The experts also found that although some of the examinations weren’t examples of best practice, they were not below an unacceptable level. At no time was an urgent or emergency referral warranted.

The case was discontinued after a detailed letter of response was sent.

MR

Back with back pain

Leaving home with back pain

Back pain is one of the commonest complaints seen in general practice. Doctors may easily disregard back pain but it is important to keep in mind that a small proportion of them mean serious or life-threatening pathologies.

Taking a good history and examining the patient regularly when they attend without a firm diagnosis with back pain is important, even if they come with a recurrent complaint. Re-examine if there is any change in symptoms. Good documentation of history and examination is safe practice. This helps other clinicians to understand the history of a complaint better. It can be the basis of a good defence if a case ever becomes a claim.

When patients attend with different symptoms and illnesses at the same consultation, differential diagnosis can be more complex and therefore greater awareness is necessary. Keep up-to-date with guidelines on best practice for back pain. The NICE guidelines for low back pain can be downloaded here: www.nice.org.uk/CG88quickrefguide. This covers management of musculoskeletal back pain but not malignancy, infection, fracture and inflammatory conditions such as ankylosing spondylitis. Remember these alternative differential diagnoses when assessing a person with back pain.

Failure to diagnose is not inevitably negligent. There was a careful, well-documented assessment of the patient on every occasion.

Learning points

- Back pain is one of the commonest complaints seen in general practice. Doctors may easily disregard back pain but it is important to keep in mind that a small proportion of them mean serious or life-threatening pathologies.
- Taking a good history and examining the patient regularly when they attend without a firm diagnosis with back pain is important, even if they come with a recurrent complaint. Re-examine if there is any change in symptoms. Good documentation of history and examination is safe practice. This helps other clinicians to understand the history of a complaint better. It can be the basis of a good defence if a case ever becomes a claim.
- When patients attend with different symptoms and illnesses at the same consultation, differential diagnosis can be more complex and therefore greater awareness is necessary.
- Keep up-to-date with guidelines on best practice for back pain. The NICE guidelines for low back pain can be downloaded here: www.nice.org.uk/CG88quickrefguide. This covers management of musculoskeletal back pain but not malignancy, infection, fracture and inflammatory conditions such as ankylosing spondylitis. Remember these alternative differential diagnoses when assessing a person with back pain.
- Failure to diagnose is not inevitably negligent. There was a careful, well-documented assessment of the patient on every occasion.
Mrs H, a 23-year-old professional photographer in her first pregnancy, was pregnant with twins. The pregnancy progressed without any complication, until week 36 when she went into preterm labour. Dr L was the obstetrician on duty. As the first twin was a breech presentation, an emergency caesarean section was performed under spinal anaesthetic and both twins were delivered in good condition.

Soon after the procedure, whilst still in the recovery room, Mrs H began bleeding steadily vaginally and became hypotensive. She was resuscitated with intravenous fluids. Dr L administered oxytocin with little effect, followed by insertion of misoprostol per rectum. He did not follow hospital protocol for postpartum haemorrhage which advised the administration of ergometrine and carboprost if the bleeding continued despite the use of oxytocin. As the bleeding continued, Dr L decided to take Mrs H to theatre for an examination under general anaesthesia to identify the source of bleeding. In the meantime, resuscitation continued with blood products. During laparotomy, the uterus was found to be atonic, but there was no rupture or evidence of any retained products of conception.

Unfortunately, Mrs H’s condition deteriorated and she began to develop disseminated intravascular coagulation. Dr L reported this to the patient’s husband, informing him that “there were no options” other than removing the uterus. It was impossible to gain informed consent from the patient as a consequence of her clinical condition at that time. Dr L proceeded to perform a hysterectomy. Mrs H made a satisfactory recovery from her surgery, but made a claim against Dr L for his management. Experts were critical of Dr L, as he had failed to follow the hospital guidelines on the management of postpartum haemorrhage and secondly by not considering alternative surgical options such as internal iliac artery ligation or ligation of the uterine and ovarian arteries. Furthermore, Dr L had not documented why he had not considered less radical intervention before resorting to a hysterectomy in such a young woman in her first pregnancy.

The case was settled for a moderate sum.

GM

LEARNING POINTS

- Postpartum haemorrhage remains a leading cause of maternal morbidity and mortality.
- As part of good clinical governance, obstetric departments will have guidelines on the management of massive haemorrhage.
- The management of massive obstetric haemorrhage should be included when practising emergency drills on the labour ward, as well as forming part of regular education for all staff that look after pregnant women. This would help ensure staff are familiar with local guidelines.
- It may be justifiable to deviate from local guidelines in an emergency, but it is very important to document any reasons for doing so.
- Women at high risk of postpartum haemorrhage should have a written management plan, including any prophylactic measures that need to be implemented. Multiple pregnancy is a risk factor for postpartum haemorrhage as a result of uterine atony.
- The decision to perform a postpartum hysterectomy can be a difficult one to make as it will have irreversible consequences. It is good practice to discuss the decision with an experienced consultant colleague.
- Women who have suffered a major obstetric complication should be offered the opportunity to discuss the events with a consultant obstetrician and senior midwife and be offered the necessary support.
Mr P, a 49-year-old taxi driver, had recently visited his local Emergency Department (ED) with chest pain. He ended up being transferred to the regional cardiac unit where, according to his brief discharge advice note, he had “emergency coronary bypass surgery (full discharge letter to follow)”. Three days later after getting home he developed aching discomfort in his right lower leg and reattended his local ED, taking the discharge note with him. He was seen by junior doctor Dr B. Dr B examined his lower leg and noted that the wound from his saphenous vein harvest site looked inflamed. He documented that there were no clinical signs of a deep venous thrombosis and discharged Mr P home with a course of oral flucloxacillin.

The following evening Mr P reattended the ED as he was still getting intermittent pain and was seen by Dr A, a more experienced junior doctor. After examining him Dr A obtained the notes from the previous day’s visit and felt able to reassure Mr P that he simply had not given enough time for the antibiotics to work. Mr P specifically asked about the possibility of deep vein thrombosis, but Dr A advised him that her senior colleague had considered that on his previous visit and felt it was very unlikely. Dr A noted in a statement she wrote for the subsequent investigation that she did not bother her senior on the evening of Mr P’s second visit as “he’d only just gone for a break”. She discharged Mr P with some stronger painkillers.

During the next two days, Mr P rang his GP Dr X on two occasions. Dr X went through his symptoms on the phone and noted that the ED had “excluded a DVT” (he had not received any communication from the ED and had not yet received a full discharge summary from the tertiary unit). He reassured Mr P that he was happy with the assessment in the ED and that he should continue taking the antibiotics and the painkillers prescribed. The following night Mr P, unable to sleep because of the pain, reattended the ED. By now his leg was cold, pale and mottled. Further investigation identified an embolus occluding his femoral artery, which had arisen from the site of coronary angiography he had had performed via the right groin. Despite the best efforts of the vascular surgical team he went on to require an above knee amputation.

Mr P made a claim against all the doctors who had been involved in his care prior to his last ED attendance. The claim was settled for a substantial sum.

LEARNING POINTS

- Examine your patient properly and fully – had the entire leg been assessed the femoral arterial puncture site would have been seen and may have led to earlier diagnosis of arterial problems.
- Earlier and fuller discharge letters might have similarly alerted the doctors involved to the fact that coronary angiography had been carried out.
- Reattending patients can easily be perceived as a nuisance, but should instead prompt consideration of why they are reattending.
- Do not rely on a colleague’s earlier diagnosis – they may have been wrong or things may have developed further, providing clues that they did not benefit from when they assessed the patient.
- You should always seek senior input, even if it is inconvenient.
- Beware of blinkered decision-making. Doctors often use heuristic pattern recognition to make rapid diagnoses, eg, one’s intuition, but this can lead to errors if the wrong pattern is recognised and alternate diagnoses are not considered.
- Pain out of keeping with the clinical findings or diagnosis should always prompt review – and merits more than telephone advice, especially when a patient has undergone major surgery.
Mr C, a 40-year-old carpenter, attended his local Emergency Department (ED) with a severe headache, vomiting, blurred vision and photophobia. These symptoms responded to analgesics and antiemetics. History and examination suggested possible intracranial pathology. The CT scan performed showed no evidence of a subarachnoid haemorrhage but did show a large tumour in the pituitary fossa. Recently appointed consultant neurosurgeon Mr Y was soon involved in Mr C’s care. He requested immediate ophthalmology assessment and a visual field defect was excluded. Mr Y arranged a pituitary function test but proceeded before the result was available. Mr Y discussed the problem with Mr C and informed him that due to possible pituitary pressure on the optic nerves there was a high risk of blindness, and growth of the tumour might affect the function of the pituitary. Mr C agreed to immediate surgery. Mr Y had very little experience of pituitary gland surgery. He chose a surgical approach that he felt familiar with, a left-sided fronto-temporal craniotomy, adopting a subfrontal and transsylvian approach to remove the tumour. The procedure was complicated as the tumour was very friable. Postoperatively Mr C had a dense hemiparesis. A repeat CT scan revealed extensive capsular infarct on the left side of the brain and a lacuna infarct on the right. It took several months for Mr C to recover any independence and he was left with right-sided permanent neurological damage with hemiparesis. Subsequently he was also found to have raised prolactin levels and ACTH and gonadotropin deficiencies requiring hydrocortisone and testosterone. He made a claim against Mr Y.

Expert opinion was critical of Mr Y’s management on various counts. Preoperatively Mr C had normal vision so he was not at immediate risk of blindness as a consequence of pressure on the optic nerve. However as the tumour enlarged he may have been at risk of pituitary infarction (apoplexy), further affecting the hormonal function of the pituitary gland. Cases such as this are usually managed jointly with an endocrinologist who will assess the function of the anterior and posterior pituitary, by appropriate biochemical tests, such as stimulatory hormonal testing, and for posterior pituitary, a prolactin level. Medical management could delay surgical intervention if the optic nerves were not at risk and the tumour size did not suggest a risk of infarction. The experts were also critical of the surgical approach, which was not in line with usual practice. They agreed that there was no clinical indication for the urgency with which this procedure was undertaken; had an MDT assessment been undertaken he wouldn’t have had surgery. The case had to be settled for a high sum.

LEARNING POINTS

- Patience and an awareness of one’s own expertise and knowledge are vital to practise safe surgery. It is rarely appropriate to rush into a procedure, particularly if this means there is a risk of taking an incorrect or risky approach.
- A surgeon may need to take rapid and difficult decisions intraoperatively; however, preoperatively it is important to take appropriate time to review all investigation and treatment options to ensure the best outcome for the patient.
- In medical practice recognising one’s limits (cognisance) and accepting that something may go beyond one’s expertise and training is essential for good medical practice. This might be particularly hard for newly-appointed consultants eager to establish their clinical practice and expertise to their senior colleagues.
- It is important to gather all the facts available to define the clinical situation of the patient before deciding on any management plan. It is here that joint or team working may be appropriate and helpful. In retrospect, in this patient, there were a number of unanswered questions such as the precise nature of the lesion; whether more tests should have been carried out to define the situation; whether the surgery was needed at that time; and whether the patient was at risk of pituitary apoplexy.
- Working as a team provides an extra safety net to medical practice. In areas such as pituitary surgery, it is common practice nowadays to work in conjunction with the endocrinology team, who can give advice on the medical investigations to define the patient’s problem and assist in postoperative hormone replacement as appropriate.
Ms W, a 45-year-old secretary, had poliomyelitis as a child, which left her with a leg length discrepancy, the right leg being several cm shorter than the left. Despite the obvious cosmetic appearance and impaired functional mobility, she had never thought of having any form of treatment. However, one day she watched a programme on TV about surgery to lengthen limbs, so she asked her GP to get her an appointment to see the surgeon involved in the programme, Mr A. Mr A saw Ms W in clinic; soon after she had a date for her surgery. Mr A did not document any counselling of the potentially serious side-effects or the intensive physical therapy that would be required after the surgery. All the people in the TV programme had had great results. Mr A did not explain that this was not always the case, nor was the risk that she may be worse off after surgery explored. Mr A only made brief notes at the initial consultation, the operation and follow-up with no documentation about explanation of risks and complications. Unfortunately, the postoperative progress was not good and Ms W suffered incapacitating pain.

Over the course of a few months Ms W experienced progressive stiffening of the ankle and was subsequently left with an equinus contracture. During the next few years she also developed a valgus deformity of her proximal tibia with some procurvatum. Her mobility deteriorated. The cosmetic appearance of her leg, although longer, was no better and overall her clinical condition was worse than before the operation. Eventually Ms W made a claim against Mr A. The experts involved thought it was difficult to decide how much of her subsequent problems were due to the surgery and poor quality of follow-up, or because of post-polio syndrome. However, due to lack of adequate medical notes, to demonstrate adequate warning of risks, the case could not be defended and was settled for a substantial sum.

RM

LEARNING POINTS

- Patients can often take away unrealistic expectations from what they see or read about in the media, and increasingly in social media. In these circumstances it is even more important to explore expectations about realistic outcomes, take proper consent and document appropriately. Remember good notes at all stages are the cornerstone of your defence.
- It is important that the patient fully appreciates all that is involved, not just in the surgery but in the follow-up. This can sometimes influence the final outcome as much as the operation itself.
- This case highlights the importance of a robust consent process when using innovative techniques.
- Limb lengthening surgery is highly specialised and complex. There are numerous recognised complications and these must be made clear to the patient.
- It can sometimes take more than one discussion before the patient is able to make a fully-informed decision to proceed with surgery.
- It is important to make timely decisions.
- MPS’s workshop Mastering Shared Decision Making is available via the MPS website.
Fifty-five-year-old Mr R had a history of hypertension for which he was taking an ACE inhibitor. He attended his GP, Dr S, with intermittent tightening of the chest and a sense of breathlessness. He did not have any symptoms of nausea or pins and needles. Mr R felt that he was suffering panic attacks, especially as he had recently been made redundant and was experiencing financial difficulties. On examination, Mr R’s blood pressure was found to be high and Dr S attributed these symptoms to anxiety. However, he arranged an ECG and routine blood tests and asked Mr R to return to discuss the results.

When the results were available, Dr S considered the ECG for any abnormalities of rate, rhythm or appearance, and looked for changes suggestive of myocardial ischaemia or infarction. He felt that the ECG was essentially normal, aside from mild tachycardia, and did not see any gross abnormality requiring emergency admission.

Two days later, Mr R attended the surgery as an emergency, complaining of chest pain, shortness of breath and nausea over the weekend. Dr S saw him before surgery began in the morning and arranged for emergency admission to hospital. The ECG and blood test results were sent along with a handwritten referral letter. Upon admission to hospital, Mr R clinically deteriorated and CPR was given; however, Mr R died within an hour of admission. The postmortem found that Mr R had a large saddle embolus in the pulmonary artery causing complete obstruction of the lumen. The left popliteal vein showed residual deep venous thrombosis and that this was the likely source of the fatal embolism.

Mr R’s widow made a claim against Dr S. Expert opinion criticised Dr S for his initial diagnosis of anxiety, his failure to consider that Mr R’s symptoms were potentially life-threatening and for failing to note that the ECG showed right bundle branch block and right axis deviation compatible with pulmonary embolism. Mr R should have been referred to hospital when he initially presented with chest discomfort, where a cardiologist would have diagnosed him and Mr R would have survived.

The claim was settled for a moderate sum.

— General practice investigations —

LEARNING POINTS

- Mr R had a number of risk factors for cardiovascular disease, including his age, high blood pressure and other symptoms that could possibly relate to circulatory problems. In any patient with chest discomfort you need to rule out serious cardiopulmonary causes with a careful history, examination and ongoing referral if warranted.
- You should refer a patient for further assessment if an ECG is abnormal if they have risk factors for cardiovascular disease. Mr R should have been admitted to hospital to exclude an MI, even if Dr S was unsure of the diagnosis, because of his risk factors for cardiovascular disease.
- Be aware of non-cardiac causes of chest pain. In this case, the history, in combination with tachycardia, pointed towards pulmonary embolism. However, the doctor only excluded a cardiac cause without considering embolism.
- Anxiety symptoms can be very similar to symptoms of more sinister pathologies. When assessing someone with a history of or new presentation with anxiety symptoms, consider risk factors for cardiopulmonary disease when taking the history, examining and arranging follow-up tests.
Mr Y was a 21-year-old unemployed man who lived with his mother. He was a heroin addict and in the last few months, he had started injecting into his groin. Each day he was buying heroin and cocaine and had recently served a prison sentence for burglary to fund his habit. Mr Y was well-known at the practice as he had attended since his childhood. The practice had supported him and his mother with some behavioural problems at school and with issues around domestic violence before his father had left home. His mother had schizophrenia and was also a regular attender at the practice.

Both Mr Y and his mother had been a case for discussion as practice staff were finding them increasingly difficult to manage. Lately, they had both been regularly missing appointments and were rude to staff. Mr Y frequently requested appointments for minor ailments, such as lower back pain and colds, yet upon attending he asked for methadone or pethidine. His behaviour was rather manipulative and consultations were often challenging.

During one month, Mr Y attended several times complaining of back pain and feeling unwell with flu-like symptoms. Dr S and his partners saw him and documented their history and examination. It was recorded that he was suffering with severe back pain and feeling “hot and cold”. His temperature had been recorded as 38.9 degrees. Notes also stated that he had symptoms of severe constipation and difficulty passing urine. A blood test had been arranged, which showed a significantly raised ESR and white cell count – the results were not acted upon.

Mr Y began to feel worse and was struggling to get out of bed due to the severity of his back pain. His mother attended the surgery on her son’s behalf to ask for a home visit, but one of the receptionists refused the request and asked the patient to attend surgery. She mentioned later that Dr S had said previously that “he couldn’t do any more for the family” and that she was trying to help. The next day Mr Y felt very weak. He tried to get out of bed and collapsed. His mother called an ambulance and he was rushed to hospital. He was diagnosed with endocarditis and discitis. Despite intravenous antibiotics he died of overwhelming sepsis. His mother was devastated and made a claim against Dr S’s surgery. The case could not be defended and was settled for a moderate amount.

**LEARNING POINTS**

- Frequent attenders can and do have serious illnesses; doctors must not let an element of “crying wolf” blind their judgment. It is important to keep this awareness and objectivity when seeing patients.
- When investigations are requested it is important to have a system in place to ensure they are acted upon if necessary.
- Effective triage is an integral part of general practice and is better based on clinical need rather than catering to the most persuasive or demanding patients. An effective triage system could help direct patients to the most appropriate appointment at the most appropriate time, and identify patients who have an immediate medical need.
- The management of patients who are drug users raises issues that may need discussing within the practice to offer better care. For examples, there should be an awareness of the guidelines to support patients with addiction including where and how to refer patients for support and/or detoxification, and offer “shared care” for the management of drug misuse.
Slipping through the cracks

We received a large amount of correspondence regarding last issue’s case, “Slipping through the cracks”. We have published the letter below as an example of the concerns raised, which were similar across all the letters we received. MPS’s response is also below.

I have read and generally agreed with most of Casebook’s reports over the years; however, I really do not understand the outcome here. My husband (a GP) and I (an emergency physician) cannot fathom how the GPs are involved in this case. They tried their utmost to engage this patient by recalling him, starting an anti-hypertensive and making an outpatient appointment.

If a patient does not follow up any leads offered by a GP, denies any medication/health issues and uses multiple health services, it’s very difficult to see how else he could have been helped.

We understand there are many more unknown details to this case but patients have to take some responsibility for their health too. Drs Sally and Jonathan O’Keefe, UK

Response

Many thanks for your recent correspondence about the case report, “Slipping through the cracks”. We have, perhaps unsurprisingly, received many letters and emails from members working in different specialties and different countries, expressing similar views: Why was the case settled? What more could the GP have done? Where does the patient’s responsibility lie?

On reviewing the claim, there are a number of differences between the facts of that case and the facts described in Casebook, such that the material omissions (failure to adequately monitor or manage significant hypertension in presence of multiple cardiovascular risk factors) which led to expert criticism in the case, do not appear in the account given in Casebook.

I offer my personal apology for this – we do change details of cases prior to publication so that anonymity of the parties is preserved, but on this occasion the changes severely compromised the credibility of the case and this was not picked up by our editorial process. Indeed, it is your MPS Editor-in-Chief who has ‘slipped through the cracks’ on this occasion. And we have some learning points to ensure that this does not happen again.

I am heartened to some extent that so many of you have taken the trouble to put us right, but am extremely sorry if the report caused unnecessary anxiety. Dr Stephanie Bow, Editor-in-chief

A pain in the leg

I cannot disagree more strongly with your conclusion that Dr C had done everything she could and should have done. Clinical examination along with “Homans sign” should be consigned to the clinical dustbin. How many people will die from undiagnosed DVT causing a massive PE through a clear lack of understanding? You should be shouting the message loud and clear that a normal clinical examination has absolutely no predictive value in excluding a DVT whatsoever. It is useless!

Even a Wells score of 0, which it would have been in this lady, places her in the “Low risk” group. This is not the same as no risk.

What Dr C should have done is a d-dimer. Forget her fabulous documentation. There is no clinical finding that excludes a DVT. That you defended the claim successfully is a travesty. A life was lost. A positive result would have led to a Doppler USS, which may just have saved her life.

Dr S J Wallace, UK

Nasogastric tube errors – 1

The article relating to errors surrounding nasogastric tube placement (Casebook 20 (3)) raised several important issues pertinent to both junior doctors and also radiology performance and interpretation. The article mentions specifically the timing of tube placement and imaging – as far as possible this should be done in working hours when senior doctors and radiologists are available to assist with image evaluation.

Junior doctors will need training in chest radiograph interpretation, but often these radiographs are done in sick patients and image quality is poor, making assessment difficult even for more experienced doctors. Junior doctors must be able to appreciate when they need help and should ask for senior advice if there is any doubt; all decisions and consultations must be clearly documented in the patient record.

The article covers also in some detail how to approach a chest radiograph following tube placement – it does not mention some crucial points, namely that before any attempt at image interpretation is made the reviewing doctor must check that the film is of the correct patient done at the correct time and date. This is essential, especially on ITU for example, where a patient may have multiple chest radiographs in a day – errors are still made when the incorrect film is reviewed and cleared.

There is also the issue, alluded to in the article, of getting radiographs formally reported by a radiologist, ideally on the same day for inpatient work. This is a problem area in many trusts, with often long delays in getting inpatient films reported, or in some cases not reporting them.
Primary postoperative care

There’s a theme running throughout increasing numbers of recent medical incidents reported in Casebook that does not entirely seem to have been picked up by your case report writers and I believe is worthy of discussion. This revolves around the increasing pressure on hospital doctors and medical teams to discharge patients as rapidly as possible back to primary care.

A case in point was in the article “A normal appendix” in the May 2012 issue, where a patient subsequently found to have a Meckel’s diverticulum as the source of problems was discharged one day after appendectomy in such apparent haste that neither the consultant nor the trainee saw him, and the article also makes clear that no follow-up appointment was offered. Subsequently the patient made numerous visits to his GP and to hospital Emergency Departments before the real reason for the problem was identified.

This pressure on hospital doctors to ‘get rid’ of their patients back to the community is encapsulated in a set of rules known as NTFUR (new to follow-up ratios) and is being applied ever more ruthlessly across the country. A figure for the average ideal number of times a patient should be seen by a certain specialty (and not by pathology) is devised without published evidence and imposed upon specialty departments. Often the ratio is well under one to two. Lead clinicians whose departments do not stick to the figures are called in by administrators (as I have found myself) and pressured to comply.

Clearly, because hospital care is seen (often wrongly) as expensive, the stimulus for this is cost-savings. However, it should fail us as medical professionals to point out the very considerable dangers and indeed false economies. Firstly there is often no continuity of care because GPs understandably often feel unable or unwilling to deal with the nuances of postoperative care. Patients such as that in “A normal appendix” suffer needless delays and sometimes injury in reaching the real diagnosis. Finally, over a longer period there’s a massive loss of skill, experience and learning because surgery does not end at the door of the operating theatre or ward. It ends when the specialist discharges the patient from the follow-up clinic cured of his/her symptoms, and it’s often during that follow-up that as a surgeon one realises one has missed something or perhaps done something less well than one might have. The changes now being forced away from us by NTFUR reduce the experience and excellence of doctors, nursing and clinical support staff. The problem applies equally in public and private practice where insurers are starting to apply the same pressures. Professional organisations and indeed our indemnity providers need to support doctors in dealing with this.

Mr Peter Mahaffey, UK

Nasogastric tube errors – 2

We write in reference to the special feature article regarding nasogastric (NG) tube errors.

The guidance that you quote from the NPSA is very difficult to implement in practice in many clinical circumstances. There are unintended consequences that expose patients to risks from repeated doses of radiation with multiple x-rays and failure of delivery of nutrition or medication for long periods; as well as increasing healthcare costs. The evidence quoted in the NPSA guidance is weak and focuses on small numbers of serious adverse events, while ignoring very large denominator numbers of tens of thousands of patients who receive NG feed to put numbers into perspective.

While we were pleased to see an article highlighting this important and preventable cause of morbidity and mortality in healthcare, there was a vital omission in the discussion: the implications of acid suppressing drugs for confirmation of NG tube position. Many critical incidents occurring with misplaced NG feeding tubes occur in ventilated critically ill patients. This group of patients frequently receive prophylaxis against stress ulceration with either an H2 antagonist or proton pump inhibitor, in line with national and international standards of care for ventilated patients. The administration of these drugs frequently results in gastric aspirate that is above pH 5.5, necessitating a chest x-ray as proof of correct NG placement. The bullet point relating to repeat checks states that NG tubes “can be dislodged so they should be checked every time they are used, by aspirating and confirming a low pH, and only x-ray if this is not the case” – this needs further clarification.

A group with increased gastric pH this would mean a chest x-ray every time an NG drug is administered – possibly multiple times over the course of a day. We would suggest that
There are many patients receiving concurrent feeding tubes and multiple x-rays on a daily basis who are impossible to sustain. In many of these units there may not be direct access to x-ray facilities available. The guidance makes the maintenance of regular adequate enteral nutrition administration impossible for large groups of patients, and should be revised. The major difficulty with that is that the NPSA was abolished last year and there is no mechanism for revision.

Dr Neil Young and Dr Brian Cook, UK

Skipping over the details

“Skipping over the details” (Casebook Vol 20(3), p14) raises an interesting point. It was a year from the first consultation to the next. At first sight this seems surprising; why ever did the patient not come back sooner; is the doctor really so responsible for the late presentation? After all, doctors can only ever offer reassurance and not that there will not be a problem later.

Indeed the observation of illness over time is an essential part of our trainee GPs’ learning experience.

Patients on the other hand seem to treat the reassurance as not anchored in time as it were, and treat it as if it could be considered as ongoing: “The doctor told me it was alright six months ago, so it’s ok now…” It seems that the lay belief is that all problems are obvious from first presentation. Perhaps patients also underestimate the time it was since they last consulted about the problem and thus falsely believe that the reassurance is more recent than it actually was. From our point of view it all seems so unfair.

While this might raise the possibility that patients could consult too soon and be given false reassurance before the problem becomes clearer, the issue for us is to communicate the need to reattend if the problem gets worse, or other symptoms develop. So: are we approached?

Can we somehow give permission in advance to come back as well as showing a personal interest? A phrase offered to our trainees to adapt is something along the lines of: “If this thing misbehaves itself in any way I want to know about it…” Trainee GPs would be asked to record a contingency plan (in this case an ultrasound scan) to give some idea of what is expected. Another possible technique is to inject some deliberate uncertainty such as “I think that’s OK, but you must let me know if…” Dr Paul Vincent, UK

The internet: target practice?

This letter refers to an article that was in our UK edition only. To read it, visit: www.medicalprotection.org/uk/casebook-september-2012/getting-the-best-out-of-online-reviews.

The suggestions in the article “Getting the best out of online reviews” by Neil Bacon surprised me since they are the exact opposite of what I’d advise. I’m not aware of “powerful benefits” of online reviews. What is possible is that anyone may write anything they like about a doctor. There is no peer editing, there is no restriction, the writer cannot be identified (they might not be who they say they are) and there is no sanction against a derogatory or even malicious review.

Dr Bacon says that reviews are the norm in other service sectors. There have been documented cases of damaging reviews written by rivals of commercial organisations, the writer never having partaken of the service on which they are commenting. The motive is plain: to put a competitor out of business. Tracking these people down requires cyber detective work and there is no guarantee of success. The derogatory information might even be passed through a server in another country so it becomes difficult to invoke UK law – which itself offers scant protection anyway.

Hoping that a site is “secure, robust and has proven systems to prevent abuse” is no more than wishful thinking. Nothing on the internet is that secure. How does a doctor “ensure” that a site is secure, anyway? How many of us would understand the security measures in place, let alone be allowed to know their exact nature and function?

Information on one website quickly spreads and copies appear on others. Look at how social networks have become the new playground for school bullies. It just takes one disgruntled patient to ruin your reputation through the web – and you can’t stop it. The greatest difficulty is removing adverse comments. There is no enforcement to make sure this happens. Many websites have no direct means of contacting their operators, there’s no compulsion to reply to any email you might send them. Finally, what if you disagree with something an identifiable patient says about you? Any reply would be breach of confidence; it’s the same problem as when trying to handle adverse newspaper publicity.

There are various branches of engineering – civil, mechanical, electronic, etc. The new discipline of socially-appropriate engineering is now becoming recognised. Of any technical achievement, it asks not can we do it, but should we do it? Yes, you can hand out cards to encourage patients (or anyone) to publish comments about you on the internet. Should you do it? Of course not. You can stick your head over the parapet if you want, but when they start to shoot, you can’t stop them.

Dr Godfrey Manning, UK

Dr Neil Young and Dr Brian Cook, UK

The guidance also has implications that extend far beyond critical care. There are many patients in community hospitals and rehabilitation units who will be receiving concurrent acid suppressing drugs.

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Dr Godfrey Manning, UK
The Creative Destruction of Medicine by Eric Topol
Reviewed by Dr Marien Houston, medical journalist and health analyst

Not that long ago a discussion about “digital medicine” could only be construed as a reference to rectal examination. Such has been the pace of technological change and of the digital revolution, that an updated form of digital medicine is now unquestioningly seen as part of modern medicine’s cutting edge.

In his book, The Creative Destruction of Medicine: How the Digital Revolution will Create Better Health Care, Eric Topol, chief academic officer for Scripps Health, a non-profit healthcare system based in San Diego, argues that the digital revolution can democratise medical systems in a groundbreaking way. The creative destruction in the book’s title comes from Austrian economist Joseph Schumpeter, who popularised the term “creative destruction” to denote transformation that accompanies radical innovation.

Topol boldly predicts the end of ‘one-size-fits-all’ medicine; instead patients can look forward to personalised and customised solutions for their health problems. It is almost Nirvana-like: as we collect ever more complex medical data about ourselves we can look forward to more personalised care at the point of delivery.

Informed consumers will be in the driving seat, controlling their own healthcare based on genomic information and real-time data obtained wirelessly through nanosensors.

Social networking will play a major role as ever-widening online health communities provide us with peers whom we never meet but who become crucial guides as we come to terms with our illness.

Topol really is convincing on the technological aspects of this coming revolution. But readers may have greater difficulty envisaging the consultation of the future. What will happen in the valuable crucible of the doctor–patient interaction?

In the years ahead Topol says he expects up to 70% of office/surgery visits will become redundant, “replaced by remote monitoring, digital health records and virtual house calls”. But there is no convincing narrative to back this up, leading this reviewer wanting a follow-up volume in order to be entirely convinced that Topol’s transformation can work in the trenches of frontline medicine.

Thinking Fast, and Slow, by Daniel Kahneman
Reviewed by Dr Mareeni Raymond, GP in London

Daniel Kahneman’s book was recommended to me at my GP study group, my colleague telling me it was a must-read for any doctor. The book has been a bestseller since it was published in 2011 and having just read it I can see why; I couldn’t put it down.

Kahneman is an Israeli American psychologist who has published some of the most well known and important papers on the subject of behavioural psychology. This book covers some of his and his colleagues’ most notable ideas, experiments and theories about decision-making, behaviour and judgment.

Although his book may at first glance appear to be aimed at business people and economists it gradually becomes obvious that absolutely anyone could relate to the book’s principal ideas, and could benefit from an understanding of the psychological theories described. As doctors we need to make quick decisions about patients as well as the interpretation of clinical information and statistics. We expect our decisions to be based on experience, intuition and knowledge. However the conclusions each person draws are different and this book clearly describes the possible reasons why.

Our brains are tainted by presumptions and are subconsciously influenced by what we are exposed to in our daily lives. This is partly about cognitive bias, which Kahneman describes in the first part of this book. If you are a person who questions what is happening around you, and is interested in understanding your own thought processes with a view to improving judgment, you will be enlightened. Take for example the effect of cognitive bias; it can lead to mistakes, inaccurate judgments, irrational behaviour and illogical conclusions. Perhaps we know that we are influenced by what is around us – that isn’t a new idea – but what is so powerful about this book is that it points out totally unexpected and unpredictable influences on our state of mind. When a patient walks into a room there are hundreds of reasons why you may come to a conclusion – by understanding those reasons perhaps you can check yourself – that is, think slow, rather than fast, and make better judgments.

The reader may be put off by the potential of complex ‘science bits’ and long words – this is not something to be worried about. It is a bestseller because it is accessible, written in an informal way, each chapter peppered with example questions, scenarios, and details of experiments that clarify the arguments made for each of the theories. Today our minds are heavily bombarded by mass media and marketing, and Kahneman’s book also helps us unravel the decisions we make outside the workplace. After reading the book perhaps having an understanding of these shortcomings will make us question our decision-making, our behavioural responses and our confidence in judgments, but hopefully in a positive way.
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