RESPONDING TO COMPLAINTS
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A PERSONAL FAILURE
Dr Dan Cohen on his own shortfall in reliability

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The ACCUSED
One doctor’s account of his trial by media

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Dr Nick Clements is the new Editor-in-chief of Casebook – here he reflects on predecessor Dr Stephanie Bown’s time at the helm.

The accused
Public exposure from complaints and claims can cause doctors to face a trial by media. In 2011, a UK GP was accused of sexually motivated conduct when he examined a patient’s chest – he shares his experience with Sara Dawson.

High reliability in healthcare: a personal failure
In his follow-up to last edition’s article on high reliability organisations, Dr Dan Cohen revisits a personal experience that formed part of his own steep learning curve.

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Mastering your response to a complaint is key to ensuring a positive outcome for all involved. Dr Andrew Stacey, MPS medical adviser, talks you through the process.

Trial by media
Following our page 5 article “The accused”, Dr Alan Doris, MPS Head of Professional Services (New Zealand), looks at another recent MPS case involving a doctor who was unfairly treated by the media.

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Over to you
A sounding board for you, the reader – what did you think about the last issue of Casebook? All comments and suggestions welcome.

Reviews
In this issue Dr Omar Mukhtar reviews The Enemy Within, an hour-long documentary chronicling the last 50 years of the fight against cancer. Also, Dr Amir Forouzanfar reviews The Checklist Manifesto: How to Get Things Right, by Atul Gawande.

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Welcome

Dr Nick Clements – Editor-in-chief

Dr Nick Clements has taken over as Casebook Editor-in-chief from Dr Stephanie Bown, who left MPS in February 2014. Here, Dr Clements looks towards the task ahead.

As this is my first column as the new Editor-in-chief of Casebook, I would like to say how much I am looking forward to life at the helm of a publication with a prestigious history of some 20-plus years.

Of course, I must also pay tribute to my predecessor Dr Stephanie Bown, who left MPS in February to become Director of the National Clinical Assessment Service (NCAS). Dr Bown has been involved with Casebook since the May 2006 issue, and oversaw numerous successful design upgrades and a renewed focus on producing truly topical content for all of our six regional editions.

Dr Bown worked at MPS for 19 years, beginning as a medicolegal adviser and becoming head of the Medical Services department in London soon after; she has spent more than 12 years as a doctor in acute hospital medicine, then obstetrics and gynaecology before moving into general practice. Dr Bown combined her editorial duties on Casebook and other MPS publications with high-profile external affairs work.

So it is with slight trepidation but great relish that I step into Dr Bown’s shoes, and build on her success with Casebook. My role as Head of Medical Services in the UK will continue, and I will try to use this experience to develop thought-provoking content that will be stimulating, informative and directly relevant to today’s doctor, wherever in the world you practise.

The keen-eyed among you will have spotted my name in Casebook before, so I am not entirely new to the magazine – in addition to occasionally introducing each edition’s collection of case reports, I have been on the editorial board for a number of years, helping to maintain the accuracy and educational value of each issue.

One thing will not change – and that is we continue to encourage your feedback, opinions and suggestions after each edition. Perhaps I will speak to some of you personally on our advice line…

Public exposure from complaints and claims can cause doctors to face a trial by media. In 2011, a UK GP was accused of sexually motivated conduct when he examined a patient’s chest – he shares his experience with Sara Dawson

I seemed like a normal surgery day a couple of years ago. As I was signing scripts, my practice manager knocked on my door and brought in a brown envelope marked private and confidential. I opened it and read it – the contents were highly distressing. The letter contained details of allegations made by a female patient (Mrs B) that, two months previously, I had conducted a sexually motivated conduct when

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Investigation
We asked the patient to give consent so that we could send the complaint to be investigated thoroughly and in an unbiased way by the PCT (Primary Care Trust). After a delay the records were shared and I gave my witness statement. The local PCT determined that I should have a chaperone for every female consultation while the investigation was underway.

In spite of numerous attempts, Mrs B failed to engage with the PCT to give her version of events. The PCT felt they had no choice but to refer the case to the General Medical Council (GMC).

The GMC held an interim order panel meeting. Accompanied by an MPS solicitor, the panel listened to our case. They applied conditions to my registration that I was to have a chaperone for every intimate female examination, and to log each examination. The GMC’s investigation took more than a year to complete and a hearing date was set, 18 months after the initial allegation.

The hearing
The first day of the hearing didn’t go to plan. I arrived all geared up to defend my corner, but Mrs B did not turn up, so it was adjourned until the following day. When the hearing did commence Mrs B gave a witness statement, and there was a submission from my MPS-instructed barrister, then the panel went away to decide the next course of action. The next day the panel gave their decision that they found the allegation untrustworthy and uncorroborated, and the case was concluded.

Personal impact
The experience of having a patient make an unfounded allegation against you is devastating. I would not wish it on my worst enemy. The insecurity you feel day in and day out is worse than physical pain. There were days where I could not see any light at the end of the tunnel, like my head was under a guillotine. My mind was fractured. I kept thinking ‘why me? why did this happen to me?’

As a doctor this experience was earth-shattering; it’s the worst thing to be accused of – an allegation of sexual motivation; how can you prove you were acting appropriately? It’s their word against yours. If the GMC had found in Mrs B’s favour, a GMC-obtained expert report about the correct standard of chest examinations; this proved that Dr Z’s standard of chest examinations was appropriate.

Professional challenges
The situation presented professional challenges because Mrs B remained a patient at the practice. It is hard to justify removing a patient simply because they have made a complaint. Good practice management meant that Dr Z did not see Mrs B.

Advice
Dr Z was unlucky, but his contemporaneous note-keeping and good practice helped prove that he had not done anything wrong. He did everything he could to give himself the best protection.

Learning points
- Always use chaperones for examinations that are perceived to be intimate examinations.
- Good record-keeping is essential.
- Communicate effectively with your practice team.
- Develop good working relationships with your staff and patients.
- Expert evidence is helpful in disputes around standard practice.

For further information about chaperones and maintaining boundaries please visit the factsheets section of www.medicalprotection.org.

Ends
In his follow-up to last edition’s article on high reliability organisations, Dr Dan Cohen revisits a personal experience that formed part of his own steep learning curve.

A, a ten-month-old girl, was admitted to an internationally prominent children’s hospital at the weekend for evaluation of a kidney mass, likely a Wilms’ Tumour, a highly curable childhood cancer. I was the paediatric oncology fellow (junior registrar) covering the service for the weekend. This institution’s Wilms’ Tumour protocol required the oncology fellow to administer Actinomycin-D intravenously as soon as the renal vein had been clamped at the time of surgical removal of the tumour. I wrote the protocol for intraoperative chemotherapy, being ‘jump qualified’, had to take responsibility for that case. She breifed a substitute anaesthetist and felt that the situation was well in hand. However, the pharmacist made a decimal point error and instead of preparing a dose of 97 micrograms of Actinomycin-D, he sent up a syringe containing 970 micrograms. The substitute anaesthetist did not recognise the error. This massive overdose was administered intraoperatively.

It was not until several hours later that the error was identified. While I was making evening rounds, I saw the syringe that had contained the Actinomycin-D, still attached to A’s medical record (a standard procedure at that time), and the label revealed the dosage error: I was shocked! Although not immediately toxic, the effect on this child’s bone marrow would be profound, beginning about a week after administration. I was reasonably certain that this child was going to die—and I was ultimately responsible. I called my consultant immediately and, after calming me down, he said some things that really resonated. ‘Dan, we do not know that A is going to die. We can expect that she will encounter severe bone marrow suppression and gastrointestinal toxicity, but we do not know the outcome of that, and we need to be factual when we talk with the family.”

The following morning I met with A’s parents. My consultant wanted to take the lead in the conversation but I insisted that as A was my patient I wanted, and needed, to do the talking. I was the one who had originally met with the family and this was my responsibility, not his. I carefully explained to the parents that A had received a higher than desired dose of medication and that we were very concerned about this. I apologised for this error and explained that we would investigate this further in order to ascertain how it had happened. I promised to correct any discrepancies in care identified in order to prevent this from ever happening again and then outlined the steps we would take to protect A. I promised the parents that the comprehensive resources of our institution would be mobilised to support A. I did not tell them that I thought she would die because her death was not a certainty, and voicing my concerns would have served little purpose.

High reliability in healthcare: a personal failure

With a steadily increasing focus on safety and risk-aversion in the healthcare industry, much attention, appropriately, has focused on the stories that patients and family members have shared about their experiences. We have learned much, although in some instances, especially early on, we may have been reluctant to listen. Sadly, in my view, we have not always equally valued the stories that clinicians may tell about their own experiences, challenges, and even their personal needs and shortcomings. As an example, I would like to ‘Tell’ myself and reveal a personal story that has affected me throughout my career. This is a story of multiple system and personal failures, fortunately embodied by transparency and honest disclosure long before these became everyday terms in our patient safety vernacular.

In addition to covering the inpatient oncology service (about 25 beds in this large centre), I had additional weekend obligations for the outpatient clinic and a two-bed bone marrow transplant unit located in different, though adjacent, hospitals. Usually this multiple coverage obligation was not a problem, but on this particular weekend, two children with leukaemia were to receive outpatient L-asparaginase chemotherapy, and I had to be present in the clinic because of the substantial risk of allergic anaphylactic reactions. I could not be in clinic and the operating theatre at the same time. Recognising this dilemma, I arranged for the anaesthetist on A’s case to administer the chemotherapy and briefed her thoroughly regarding the dosing, even providing a copy of the prescription. She and I had worked together for several years and I trusted her. She duly offered to administer the medication. Unfortunately, an emergent cardiac surgery case occurred on the same weekend and the anaesthetist, being ‘jump qualified’, had to take responsibility for that case. She briefed a substitute anaesthetist and felt that the situation was well in hand. However, the pharmacist made a decimal point error and instead of preparing a dose of 97 micrograms of Actinomycin-D, he sent up a syringe containing 970 micrograms. The substitute anaesthetist did not recognise the error. This massive overdose was administered intraoperatively.

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The incident

In his follow-up to last edition’s article on high reliability organisations, Dr Dan Cohen revisits a personal experience that formed part of his own steep learning curve.

Dr Dan Cohen is International Medical Director for Datix Ltd (www.datix.co.uk), a patient safety and risk management company whose software application enables users to spot trends as incidents/adverse events occur and reduce future harm by prioritising risks and putting in place corrective actions. Dr Cohen can be reached at dcohen@datix.co.uk.
Responding to complaints

Mastering your response to a complaint is key to ensuring a positive outcome for all involved. Dr Andrew Stacey, MPS medical adviser, talks you through the process

Despite their best efforts, many health professionals will receive a complaint about the care they provide. Receiving a complaint is always a stressful experience and clinicians react in different ways. It is advisable to discuss the clinical aspects of complaints with peers, both for educational purposes, as well as for collegial support. The Medical Assurance Society (MAS) and MPS also support access to a counselling service, which aims to provide immediate psychological support to members and assist in identifying useful resources for them in the longer term.

Right 10 of The Code of Health and Disability Services Consumers’ Rights (the Code of Rights) covers the right for a consumer to complain about a provider, and the duties that providers have in assisting with such complaints. Every provider, unless an employee of a provider, must have a complaints procedure and follow this when responding to a complaint. Complaints can be raised verbally or in writing. If received verbally, the discussion should be recorded in writing and agreed with the complainant. Check who is making the complaint – if it is not the patient, make sure you have consent to contain the patient’s health information in your response, or determine that consent is not required in the circumstances (such as a complaint from the spouse of a patient that you were rude to them).

What to do

It is a requirement of the Code of Rights that the complaint is acknowledged within five working days. It is also beneficial to offer to discuss with the complainant how their complaint will be handled. You should then undertake your investigation into the complaint and draw up a written response. Written responses not only enable you to carefully construct your reply, but also form the basis of any meetings you subsequently have with the complainant.

You should respond as soon as practicable. At ten working days following acknowledgement of the complaint, you should either have responded, or considered how much more time you will require. If the additional time required is 20 working days or more, then you must notify the complainant of the reasons for this. Where the complaint concerns a number of clinicians, aim for a co-ordinated response, with input from all the clinicians involved. Unfortunately it is not uncommon for members to come to MPS with a complaint that they have just been made aware of, and to whom others had previously responded on their behalf. Often, input from the individual at the start would have avoided misunderstandings that resulted in escalation of the complaint.

It is important to engage with the patient and attempt to resolve the complaint at an early stage. Not doing so risks the complaint being escalated, for example to the office of the Health and Disability Commissioner (HDC). Members have been criticised by the HDC for not attending to complaints in a timely fashion. This runs the risk of referral to a professional regulator such as the Medical Council or Psychologists Board for investigation of concerns arising from the professional’s conduct.

Structure of the response

Because complaints vary so much it is advisable to contact MPS at an early stage. On a number of occasions, MPS’s ability to assist members has been limited by prior responses submitted without our assistance. Be mindful when preparing your response that it may be read by more than the complainant, for example passed on to authorities such as the HDC.

Read the complaint and identify the issues raised. Often it is helpful to jot down a few words or a short phrase in the margin each time a new concern is mentioned.

Include a sympathetic opening paragraph, placing the complaint in context. This may include an apology and acknowledgement of distress (condolences) if appropriate. Explain how the matter has been investigated and summarise the issues raised in the complaint.

Where responses are to an external authority such as the HDC, Medical Council, or Psychologists Board, it is useful to include a paragraph that paints a picture of you as a health professional. You should include details of your qualifications (where you graduated from and when), vocational registration, and current workplace and role.

Make sure you include a clear chronological account of the events in question, with an explanation of what happened and why. Many complaints arise from a consultation or series of consultations. A clear account of each consultation in terms of the history given by the patient, the examination findings, the results of investigations, the working diagnosis and differential diagnosis, and the management plan, goes a long way to addressing concerns about the clinical care provided.

Answer all the questions raised in the complaint or explain why you cannot answer a point. Some complaints can be lengthy, containing a large number of concerns. In this circumstance it may be more appropriate to group the concerns into themes and deal with them on this basis.

Draw conclusions and advise of any improvements or changes in practice that have been made as a result. The motivating factor for many patient complaints is a desire to stop the same thing happening to someone else. Being able to demonstrate that you have taken the complaint seriously and have made any appropriate changes in your practice may stop it going further.

Finish by providing details of the Office of the Health and Disability Commissioner and contact details of local advocacy services that can provide any further assistance desired by the complainant. It is often useful to offer an invitation to meet or to provide further information. Responses are better posted out than emailed, as emails tend to be sent with less consideration than conventional correspondences, and run the risk of ‘going ping’ of emails back and forwards. The issue of whether to store correspondence relating to a complaint in a patient’s file or separately depends on the nature of the complaint and should be considered on a case-by-case basis.

How can MPS help?

Complaints are unpleasant for all concerned and can be very time-consuming. MPS assists members in responding appropriately to a complaint, with the aim of resolving the matter quickly, effectively and at the lowest level possible. If you would like further MPS assistance, it would speed up our advice to you if you can forward the following information to us by email to advice@mps.org.nz or fax to 0800 677 329:

■ Copies of all the relevant complaint documentation to date.
■ Any relevant background information, including the dates on which you interacted with the patient(s) (if relevant). Please make sure all patient/complainant details are made anonymous.
■ A draft of your response to the current complaint.
■ Details of where and how you would like us to reply (including telephone/ fax numbers, email addresses etc).
■ Whether or not the complaint can be discussed with anyone in your absence.

A factsheet containing this information is also available on our website.

REFERENCES

1. www.medicalprotection.org/newzealand/factsheets/storage-of-patient-complaints
2. www.medicalprotection.org/newzealand/factsheets/storage-of-patient-complaints
3. www.medicalprotection.org/newzealand/factsheets/storage-guide-to-complaints

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Some people are comfortable in the media spotlight and others are desperate to attract it; for many health professionals media attention is intrusive, unwelcome and unpleasant. When the media coverage names individuals and is critical, it is particularly distressing as well as potentially damaging for the person’s professional standing, career and business.

As health stories are popular in the print and broadcast media, MPS is often asked to advise and assist members who are dealing with the media. When incorrect or misleading information is in the media, often a clarification, retraction or apology from the broadcaster is adequate to resolve the issue, though this is not always the case.

On 21 March 2013, Television New Zealand (TVNZ) broadcast a piece on its early evening current affairs programme Seven Sharp, regarding the healthcare provided to a young woman in Southland. The journalists involved made a number of comments and presented material in a way that greatly upset and alarmed a GP named in the programme, as well as members of the practice from which she worked, which was also identified. The doctor and the practice owner approached MPS for assistance in responding to what they believed to be an inaccurate and unfair portrayal of their care of the young woman.

The process that followed over the succeeding nine months was stressful and frustrating for the doctors, though ultimately successful. MPS arranged for a barrister with specialist skills in medical and media law to assist in pursuing whatever legal remedies were available in this situation for the members involved.

A complaint was laid with the Broadcasting Standards Authority (BSA) on the basis that the broadcast breached accepted standards of accuracy and fairness. Additionally, in June 2013 defamation proceedings were prepared with the assistance and support of MPS, and these were filed with the High Court in Auckland in July, alleging that TVNZ had defamed the GP in the broadcast. An expert opinion was commissioned by MPS, which was of the view that the doctor’s management of the case could not validly be criticised.

A jury trial was anticipated and prepared for, though before this commenced a negotiated settlement was reached with TVNZ, concluding matters in late December 2013. It was agreed that the doctor would cease the legal action against TVNZ and the complaint to the BSA would be withdrawn.

TVNZ did not admit liability but provided a written apology, in addition to a previously broadcast one. In addition, the original broadcast was not to be available for re-broadcast though the clarification and apology made on-air by TVNZ on 20 June 2013 would remain available online. TVNZ also agreed to pay a sum of money to the doctor, and the parties agreed that the actual sum paid would remain confidential, and that there would be no comment made that gave any indication of the payment amount or level.

When health professionals are in the media, either willingly or not, there is a risk that the experience may be unpleasant or harmful to them. MPS offers advice to members on engaging with the media to reduce the likelihood of difficulties arising and can assist members in taking appropriate steps where the coverage may have been in breach of journalistic standards or of the law.

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Learning points

- Good note-taking is essential. In this case, recording the vital signs and patterns mobility was essential. The case was an adequate assessment had been carried out and made the actions of the doctors involved easier to defend.

- Clinical presentation can change quickly. Expert opinion was critical of a lack of a plausible diagnosis. It is not clear from the note-taking how well Mr D was assessed by Dr A. It may have been the case that Mr D appeared so well that Dr A felt no need to document normally. However, without adequate information or a clear diagnosis to prove that a reasonable assessment was carried out, it is difficult to defend his actions. He may have been asymptomatic of polyarthralgia with patches of erythema suggestive of infection.

- Patients should be advised on the signs to look out for and when to seek further help.

- Identifying sepsis early can save lives. The diagnosis may not always be immediately obvious and a high index of suspicion is required to make the diagnosis and prevent fatalities. The surviving sepsis campaign, http://survivessps.org is an educational resource to train healthcare professionals in the recognition and immediate management of sepsis.

Learning points

- Tragic events don’t always equal to negligence. In this case, MPS successfully defended the claim by gaining expert opinion and wining the case.

- It is useful to remind ourselves of the stages of hypertensive crises. It is important to monitor blood pressure and advising the patient to take their medication. Dr A had not recorded anything like enough to show that her husband’s condition had been avoided.

- Expert opinion also felt that the very high blood pressure readings at the time of the stroke represented the usual physiological reaction to a cerebral bleed and did not represent the true ongoing level of hypertension. He discounted the relevance of headaches only which usually causes headache if it is malignant or accelerated hypertension.

- He thought that hypertension usually only causes headache if it is malignant or accelerated hypertension, which was not the case. His hypertension had been well controlled and the delay in treatment had caused his brain haemorrhage. He was alleged that Dr A had failed to take his blood pressure despite persistent headaches and haematuria. He believed that Dr A had diagnosed somatisation hypertension, but failed to examine him. Expert GP opinion had only one criticism of Dr A, in that he failed to examine his optic fundi when he presented with headaches in the morning. The opinion of a professor of cardiovascular medicine was also gained. He concluded that the intracerebral bleed was likely to be due to a small vascular abnormality rather than due to malignant or accelerated hypertension. He thought that he probably had only mild to moderate hypertension before his bleed because he had been found to have only grade 2 hypertensive retinopathy. There was no proteinuria, haematuria or oedema which accompany accelerated or malignant hypertension.
Nervous about neurosarcoidosis

Mrs W was a 44-year-old French teacher who was usually fit and well. She had two children and enjoyed walking to the same school together in the mornings. On one of these walks Mrs W was troubled by aching in her right buttock and some tingling in her right calf. She mentioned this to her GP, who noted that there had been no acute injury and that she was still managing to walk to school. He advised her to take paracetamol and ibuprofen and suggested some exercises.

A week later the pain was worse so Mrs W made an appointment to see Dr G, another GP. Dr G documented that she had acute backache with right-sided sciatica and paraesthesia with a one-day history of retention of urine and inability to pass stool. Examination revealed weakness and diminished sensation in Mrs W’s right leg but normal findings on the left. There was reduced anal tone and sensation over the saddle area. She was catheterised and one litre of urine was drained. Shortly after, records stated that she had complained of numbness and weakness in her left leg and that power had been found to be reduced in her left leg. Ten minutes later Mrs W had found to have no power in both legs.

Mrs W was commenced on a three-day course of intravenous steroids, followed by a further two-day course. An MRI confirmed an extensive high signal throughout the thoracic cord, suggestive of either inflammation or infarction; a plasma exchange was begun. There was no change to Mrs W’s condition and doctors noted her developing upper limb symptoms, a 6th nerve palsy and papilloedema. She was therefore treated on the basis that she had neurosarcoidosis, and Mrs W was recommenced on high dose steroids and started on intravenous cyclophosphamide.

Her condition stabilised and the 6th nerve palsy and papilloedema resolved. However, she was left with clumsy hands and paraesthesia of both lower limbs. Methotrexate was tried, but there was no substantial change to her clinical condition. She did report some improvement in the function of her hands.

Mrs W was left with flaccid paralysis in her lower limbs, rendering her unable to move either leg or stand. Her upper limbs were weak. She had a suprapubic catheter and was incontinent of her bowels. Mrs W was devastated and made a claim against Dr G.

Mrs W alleged that she had told the GP of her difficulties in passing urine and opening her bowels several times prior to her admission. She claimed that her GP had failed to examine her adequately and had not referred her urgently. She believed that her disabilities would have been less severe if she had been diagnosed and treated earlier.

MPS’s GP expert reviewed the notes from Dr G, the physiotherapist and the hospital. He felt that there were some vulnerabilities in Dr G’s notes from the second and third consultations because they were rather brief, but considered her examination and management to be reasonable. He noted that Dr G prescribed senocitol for constipation but thought it understandable for a patient taking diclofenac to be constipated.

He felt that constipation in itself was not sufficiently discriminatory to be a red flag necessitating urgent neurosurgical referral. He commented that the physiotherapy notes were clear and that the patient had been specifically asked about bladder or bowel symptoms and that there were none. The hospital notes stated that urinary symptoms only occurred on the day of admission. The records from all the clinicians involved pointed to Mrs W’s bladder and significant bowel symptoms starting on the day she was admitted, and not before as Mrs W claimed.

MPS also sought the opinion of a professor in neurology. He concurred with the rare diagnosis of neurosarcoidosis. He felt that Mrs W’s acute deterioration was a consequence of cord ischaemia and infarction resulting from inflammatory or granulomatous involvement of the arterial supply to the cord. This would explain the sub-acute illness with a rapid evolutionary phase to the point of severe neurological disability. It was his opinion that there is no proven effective treatment for neurosarcoidosis and that earlier treatment would not have altered the outcome. He noted that it is well recognised that cranial neuropathies, such as Mrs W’s 6th nerve palsy, can resolve spontaneously without treatment, and the improvement in Mrs W’s upper limbs was consistent with the variable natural history of neurosarcoidosis. The cord dysfunction that she had developed remained unchanged despite treatment.

MPS decided to defend the case to trial denying liability, supported by expert evidence. Mrs W discontinued proceedings two weeks before the trial, and MPS is now seeking recovery of all costs.

Learning points

- Good note-keeping is important in patient care but also when defending a claim. Clinical records should include relevant clinical findings, negative findings and relevant negatives when excluding red flags, such as the absence of bladater or bowel symptoms.
- MPS carefully reviewed the records of the GP, the physiotherapists and the hospital doctors to see how the notes supported each other to aid the defence.
- It is useful to be reminded of the referral guidelines from primary care for lower back pain.1 Repeated examination is needed to check that there is no progression of neurological deficit.
- This case highlights the value of revisiting your diagnosis and not making assumptions when a patient re-presents.

REFERENCES

1. www.gpnotebook.co.uk/simplepage.cfm?ID=-1227882441

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Ms X gave birth to J, a healthy baby boy. J was discharged, with a note in the records stating he was a “normal healthy infant”; a further note stated that, on examination, there was a bilateral red reflex. At four weeks, the health visitor’s notes showed that J’s parents were concerned that J’s left eye was smaller than the right, and the health visitor referred the baby to a community paediatrician. A couple of weeks later, the health visitor documented the left eye as being open, but the referral was cancelled. J was then seen by the family’s GP, Dr A, for a six-week check-up; his vision and hearing were recorded as being “satisfactory”. At three months, Dr A referred J to the ophthalmology department after noticing a squint in his left eye; the left pupil was also smaller than the right pupil. Six weeks later – before the ophthalmology consultation took place – J was admitted to hospital as an emergency via Dr A, with cornea, vomiting and poor feeding. J was transferred to the paediatric department, but there was no record from this admission of any examination of J’s eyes.

At six months, J’s ophthalmology appointment took place. He saw a consultant ophthalmologist, Dr H, who noted that she could not detect any visual acuity in the left eye and that the eye was microphthalmic. She also noted a central cataract on the left side. J eventually became blind in his left eye.

Dr H’s parents made a claim against Dr A and the hospital for the delay in the diagnosis of the congenital cataract.

Expert opinion
Expert GP opinion on breach of duty stated that Dr A had not been diligent when initially examining J’s eyes at the time of the six-week check. By that time the health visitor had listed initial concerns about the size of J’s eyes, which should have prompted Dr A to be meticulous in his examination of the eyes; had the red reflex been absent, referral to a specialist should have occurred immediately. Prompt and appropriate referral would have led to a 25% chance of restoring J’s visual acuity to a level adequate for driving.

Another expert report, provided by a consultant ophthalmologist, also stated this examination was inadequate, as an abnormal red reflex would almost certainly have been present: this would have allowed for appropriate surgical intervention of the cataract that was later diagnosed. This report also criticised the hospital paediatric department for failing to communicate the concerns in J’s records about his eye size to the appropriate colleagues.

The case was settled for a substantial sum.

Wrong drug, no negligence
Mrs M was a 64-year-old care assistant in a retirement home. She visited her GP with a two-month history of blood in her stools, altered bowel habit, and intermittent lower abdominal discomfort. On examination the GP found haemorrhoids, and referred her to her local hospital to see Dr P, a gastrointestinal surgeon. Mrs M was found to be overweight, with a BMI of 32, and was a smoker. Dr P performed routine blood tests, and booked Mrs M to undergo gastroscopy, proctoscopy, colonoscopy, biopsies, and injection of haemorrhoids, under general anaesthesia. She was seen preoperatively by Dr D, consultant anaesthetist. Dr D noted Mrs M was on a number of medications, including metoprolol and quinapril for hypertension; simvastatin for raised lipids, and inhalers for a diagnosis of chronic obstructive airways disease. She was documented to be allergic to the antibiotic augmentin, which she had taken some years previously, and had caused a rash and wheeze. Mrs M reported that her brother had suffered a severe reaction to general anaesthesia, and had spent two days in intensive care following a hernia operation. However, she was unable to provide more details, and her brother had subsequently moved overseas. Mrs M had undergone two uneventful general anaesthetics at that hospital.

Dr D decided to proceed with general anaesthesia. The procedure was uneventful, but at one point, Dr D administered 1.25g of augmentin. In the recovery area, Mrs M was noted to have a widespread itchy rash and was complaining of wheeze. However, her pulse, blood pressure, saturations and conscious level remained normal. She was treated with antihistamines and hydrocortisone. As a precaution she was admitted to hospital overnight, where the rash and wheeze resolved, and she was discharged the following day following a further set of blood tests.

During her stay, she was visited by Dr D, who documented that he had apologised to her for the accidental administration of augmentin. Dr D wrote a letter to the surgeon, Dr P. Mrs M had been allergic to augmentin. However, Dr P stated that he had left it up to Dr D to choose which antibiotic to give. The expert concluded that there had been a clear lapse in standards, where it had been documented that the patient was allergic to augmentin. Mrs M brought a claim against Dr D and Dr P, alleging that the incorrect administration of augmentin had brought about her cholecystitis as part of an allergic reaction. Dr D, the anaesthetist, stated that he had given the antibiotic on the directions of the surgeon, Dr P. However, Dr P stated that he had left it up to Dr D to choose which antibiotic to give. The expert concluded that there had been a clear lapse in standards, where it had been documented that the patient was allergic to augmentin. Mrs M was found to be overweight, with a BMI of 32, and was a smoker. Dr P performed routine blood tests, and booked Mrs M to undergo gastroscopy, proctoscopy, colonoscopy, biopsies, and injection of haemorrhoids, under general anaesthesia.

Learning points
- Adherence to simple protocols, such as the WHO Surgical Safety Checklist, can help prevent problems of this kind, where a known and documented allergy was overlooked. See www.who.int/patientsafety/safesurgery/ls_checklist/en/
- In choosing a TIVA technique for the anaesthesia, Dr D was attempting to avoid a rare but dramatic problem, malignant hyperthermia: Mrs M might have been at risk given what happened to her brother. However, this may have distracted his attention from a much commoner problem, which is allergy to antibiotics. Take extra care when performing a technique that is unusual for you.
- Good documentation is the cornerstone of your defence. In this case Dr D didn’t document anything that had been discussed or shared. If a junior doctor is making the notes, ensure you check their entries.
- Human error is inevitable in medicine, but doctors should always be open with patients and their families following an adverse event. An open and frank apology can often help to diffuse anger. In this case, Dr D was praised for his handling of the incident afterwards.
CASEBOOK

No fundoscopy, no defence

Miss Z, a 17-year-old with ongoing headaches, neck pain and headaches. She also noticed that her vision was ‘blanking out’ every few days. Dr G documented a normal pulse and blood pressure at this time. However, despite resolution of the symptoms all subsiding she was felt to be unwell with a sore throat and vomiting. Dr B reassured her that she was probably run down following her exams, and she was likely to have picked up a virus. She had planned to go to America with her family over the summer, so he advised her to return to the surgery if her symptoms persisted when she came home.

A month later, Miss Z felt no better and returned to the surgery, this time seeing Dr Q. She complained of ongoing nausea, neck pain and headaches. She was also noted that her vision was ‘blanking out’ every few days. Dr G documented a normal pulse and blood pressure at this time. However, despite resolution of the symptoms all subsiding she was felt to be unwell with a sore throat and vomiting. Dr B reassured her that she was probably run down following her exams, and she was likely to have picked up a virus. She had planned to go to America with her family over the summer, so he advised her to return to the surgery if her symptoms persisted when she came home.

The next day (17 weeks after first presentation) Miss Z was seen by an ophthalmologist and an immediate hospital admission was arranged. An astrocytoma of the third ventricle was diagnosed and a shunt inserted that day to relieve the pressure. The tumour was subsequently excised.

However, despite resolution of the papilloedema, her vision deteriorated further. She was left with perception of light at first and eye movement vision in the right, and registered as severely sight-impaired.

Expert opinion agreed that the delayed referral led to Miss Z’s visual loss. If an appropriate referral had been initiated when the visual symptoms were first described, then it is likely that the visual symptoms would have been avoided. The case was settled for a high sum.

Learning points

■ As ever, clear documentation of a consultation is essential. Your standard of note-keeping says a lot about your practice. If you can demonstrate that your notes are generally of a high standard, it may assist you if you haven’t mentioned something in the notes.

■ Dr Q had recorded the patient to have “no visual disturbance” and later “normal fundoscopy,” that would have been more convincing than no mention of symptoms at all, when the patient clearly recalled reporting problems.

■ Fundoscopy is an essential examination and can assist in the diagnosis of many diseases. In this particular case, early fundoscopy could have prevented loss of vision. Experts commented that if Dr Q had carried out fundoscopy in his initial consult (as he said he did as part of a cranial nerve exam) then he failed to identify papilloedema, as it is likely to have been present at this time.

■ If you do suggest a patient consult an optician to expedite the referral during their busy on-call. He had several home visits and admissions so it was a day later when he managed to write the referral letter. He documented that Miss Z’s vision had markedly worsened over the weekend, and after a period of the symptoms all subsiding she was now waking each day with headaches and nausea.

References


Record your reasoning

Miss G was seen at 35 weeks gestation in an uncomplicated pregnancy. The consultant, Dr A, documented this consultation and the mode and timing of delivery. The patient clearly recalled that she had been anxious as she had had two miscarriages and Dr A counselled her regarding induction of labour, and the due date. He discussed the increased risk of instrumental delivery and caesarian section as a result.

Mrs G saw Dr A again two weeks later. Delivery by induction was revisited and agreed upon. Dr A made arrangements with the labour ward and used the indication “reduced fluid around the baby”, though he explained to Mrs G that this was to keep the midwife “happy”. An ultrasound scan reassured Mrs G that all was well with the baby.

Mrs G was admitted for induction of labour at 37 weeks gestation. On examination by Dr A the cervix was found to be soft, posterior and partially effaced. Induction by 2mg intravaginal Prostin gel was commenced at 09:30. An amniotomy was performed by the midwife and labour ensued within two hours. The first stage of labour was completed at 00:30 and pushing commenced 45 minutes later.

Progress was slow, Mrs G’s temperature increased and the foetus developed a tachycardia. The midwife requested consultant review and Dr A assessed the patient. The baby’s head was in an occiput posterior position but low in the pelvis. There was discussion with the parents about the possibility of ventouse extraction, initially they were reluctant, having seen the effects of ventouse delivery on head shape and facial bruising before. However they consented and the procedure went ahead as planned.

A Kiwi cup was used with positive pressure over two contractions to effect delivery. The perineum stretched well and episiotomy was not deemed necessary. A second degree tear was sustained with latal bruising and was repaired with vicryl under local anaesthesia due to pain.

Later, both the midwife and Dr A noted the perineum to be swollen. Mrs G questioned the possibility of prolapse but this was excluded by Dr A. Soon after, relations with Dr A deteriorated for unknown reasons and Mrs G refused to see him again.

She remained in hospital and saw other doctors and a physiotherapist. Each clinician acknowledged that she had ongoing pain, urinary and faecal incontinence, but none identified a problem with the repair. There was no antenatal or infection but the anal sphincter was intact. Mrs G was discharged six days following delivery and was improving.

Dr B saw Mrs G 11 days post-discharge and noted constriiction of the introitus that was thought to be self-limiting (the risk of requiring surgery being 25%). The following week there was no improvement; pain persisted locally, there was difficulty recognising feelings in the bladder and intercourse was impossible. Examination revealed a very tight symmetrical introitus.

A second opinion gynaecologist, Dr F, recommended a Fenton’s procedure, which was undertaken with ease and without complications ten weeks after delivery.

A claim was made against Dr A, alleging breach of duty for using oxytocin inappropriately, failing to rotate the head prior to delivery, using ventouse inappropriately, failing to perform an episiotomy, substandard repair of the perineum and failing to provide adequate postnatal care.

Expert opinion was supportive regarding breach of duty on all counts. Induction on psychological grounds was said to be reasonable, as was the use of oxytocin. Ventouse delivery without head rotation was cited as normal practice, as was allowing the perineum to stretch, avoiding the need for episiotomy. The expert stated that it would not be unusual that a consultant of Dr A’s standing would suture the labia together. The tissues were likely to have healed incorrectly rather than the repair having been performed in a substandard fashion. Induction of labour had no bearing on the need for instrumental delivery.

Unfortunately, several key documents were missing from the notes and could not be traced. Despite the supportive expert opinion, the claim proceeded. In the absence of these key documents, we were advised it would be very difficult to defend the case. Accordingly it was settled for a moderate sum.

KE
Complications of colonoscopy

As an orthopaedic surgeon, I was concerned about the number of cases related to orthopaedic surgeons in Casebook 22(1), January 2014. I was pleased to see, however, that many of these have been defended. What surprised me was the case “A catalogue of errors”. In that case, a lady underwent a knee replacement that appears to have been mis-positioned, which caused pain in the knee and the need for a revision procedure to be carried out at an early stage. At that revision, carried out by a different surgeon, swabs were taken showing coagulase negative staphylococcus, but this was not thought to be significant. Subsequently, the patient developed an infected knee replacement and staphylococcus epidermidis was grown (the same bacteria as coagulase negative staphylococcus). This pattern of late clinical symptoms from infection is not at all unusual with this low virulence organism.

The importance of this, of course, is that the infection was clearly in the knee following surgery and would have become symptomatic in due course in any event. The patient would therefore have required a revision knee replacement for this infection, even if the original components had been perfectly placed. I note that the first surgeon was sued and the claim was settled because of the poor technical skill exhibited in carrying out the original knee replacement, and your expert, Mr D, felt that this was a breach of duty which indeed it may well have been. However, the infection would not have been a breach of duty as it is a well-recognised risk following any knee replacement, and this would have required a two-stage revision in any event.

I note that the claim was settled for a substantial sum but it would seem that the patient had an acute medical condition (the original component and then one revision procedure, rather than the eventual poor result with post-operative infection) which was certainly due to the infection and consequence of scarring rather than anything to do with the original surgical procedure.

We welcome all contributions to Over to you. We reserve the right to edit submissions.

Professor Robert J Grimer, Consultant orthopaedic surgeon, Honorary professor, University of Birmingham, UK

Response
Thank-you for your observations on this case.

The expert in this case did carefully consider the issue of causation, and in particular the question of the infection that developed in the knee. His opinion was that the infection would not have developed if the patient had not required early revision surgery due to the sub-standard index operation. He was also of the opinion that had the initial procedure been carried out appropriately, the prosthesis would not have required revision until it failed – in approximately 15 to 20 years.

The settlement in this case reflected these issues.

Anatomy of a claim

In Casebook 22(1), January 2014, the feature “Anatomy of a claim” tells a depressingly familiar story. Frequently and incompletely termed “dislocated”discography of the vertebral bodies are commonly missed clinically. The vascular anatomy in the iata-discal area shows a pattern of end vessels throughout life – hence a vulnerability to infection. The disc is avascular and infection can only occur by direct inoculation, eg, during surgery or discography.

In cases of chronic spinal infection and in my experience of more than 35 years as a spinal surgeon, careful clinical examination of the spine will invariably disclose clear evidence. Pain and tenderness on local pressure will always be associated with the back pain history. Chest pain or radiculopathy may also be present. The ESR is invariably raised.

Given the typical history given by Mr P, Dr C’s conclusion that the symptoms represented “muscular back pain” was made on the basis of symptoms that must have been present for more than ten days’ duration, and this was Mr P’s third consultation. Events showed this to be a serious misjudgment. Dr A’s second consultation (Mr P’s fourth) 25 days after his original assessment, with an increase in symptomatology and in the absence of a diagnosis, resulted in an entirely inappropriate referral for phsyiotherapy.

This treatment is likely to have caused the onset of neurological symptoms six days later.

Mr P was noted to have a loss of sensation in his legs at the time of hospital admission. An MRI scan undertaken at another hospital disclosed an “infective discitis at T5-6”.

Two laminectomies were undertaken, following which Mr P was rendered paraplegic.

Laminectomy has been recognised as contraindicated as a surgical procedure for infections of the thoracic vertebral bodies for over 100 years. The history indicates that the laminectomy directly resulted in the complete spinal cord injury in Mr P at T4 (at least one level higher than the bony pathology). If the indication for surgery existed, a closed biopsy followed by an anterior debridement via a thoracotomy or an approach via a costo-transversectomy should have been undertaken. A majority of cases can be managed by appropriate antibiotic treatment.

If Mr P’s legal advisers had instructed experts who were familiar with the presentation and appropriate treatment of spinal infections, the outcome would have been very different. On the basis of the history, the claim that Drs A and C failed to suspect a spinal infection or arrange correct investigation that should have necessitated an urgent referral meant that Mr P’s claim is self-evidently correct. This was a failure of duty of care. The subsequent surgical investigation and operative treatment was both inappropriate and negligent, and therein lay the liability and causation. This should have been proved by Drs D, E, F, and G, and Mr F, had they been familiar with the extensive surgical literature on the subject, the catastrophic outcome was avoidable. The case may represent a satisfactory outcome for Mr P but it was definitely not an unfair outcome for the patient/claimant.

Alistair G Thompson, Consultant Orthopaedic Spinal Surgeon, Birmingham, UK

Learning points

- Complications after procedures can occur and are not necessarily the result of negligence. Claims can be defended if clinicians are able to demonstrate that they acted appropriately in the detection and subsequent management of complications. Evidence of a high volume practice with a low complication rate (as in this case) can strengthen the defence.
- If claims often arise many years after the event. The careful documentation of events and discussions with the patient two years earlier enabled the facts of the case to be established, and a successful defence of the allegations.

- The CT result, together with the carefully documented clinical findings, nursing charts, and medical records were used to substantiate any of these claims.
- Dr C provided appropriate surgical treatment and directly led to Mrs A’s subsequent complications.
- Dr A was also able to produce audit evidence of his colonoscopy practice, demonstrating a high volume (400 per annum) with a very low complication rate.
- Mrs A’s case involved the need for a revision procedure to be carried out at an early stage.
- Both procedures were carried out appropriately, and the length of administration support was sufficient.
- Dr C’s conclusion that the symptoms represented “muscular back pain” was made on the basis of symptoms that must have been present for more than ten days’ duration, and this was Mr P’s third consultation. Events showed this to be a serious misjudgment.
- Dr A’s second consultation (Mr P’s fourth) 25 days after his original assessment, with an increase in symptomatology and in the absence of a diagnosis, resulted in an entirely inappropriate referral for physiotherapy.
- This treatment is likely to have caused the onset of neurological symptoms six days later.
- Mr P was noted to have a loss of sensation in his legs at the time of hospital admission. An MRI scan undertaken at another hospital disclosed an “infective discitis at T5-6”.
- Two laminectomies were undertaken, following which Mr P was rendered paraplegic.
- Laminectomy has been recognised as contraindicated as a surgical procedure for infections of the thoracic vertebral bodies for over 100 years. The history indicates that the laminectomy directly resulted in the complete spinal cord injury in Mr P at T4 (at least one level higher than the bony pathology). If the indication for surgery existed, a closed biopsy followed by an anterior debridement via a thoracotomy or an approach via a costo-transversectomy should have been undertaken. A majority of cases can be managed by appropriate antibiotic treatment.
- If Mr P’s legal advisers had instructed experts who were familiar with the presentation and appropriate treatment of spinal infections, the outcome would have been very different. On the basis of the history, the claim that Drs A and C failed to suspect a spinal infection or arrange correct investigation that should have necessitated an urgent referral meant that Mr P’s claim is self-evidently correct. This was a failure of duty of care. The subsequent surgical investigation and operative treatment was both inappropriate and negligent, and therein lay the liability and causation. This should have been proved by Drs D, E, F, and G, and Mr F, had they been familiar with the extensive surgical literature on the subject, the catastrophic outcome was avoidable. The case may represent a satisfactory outcome for Mr P but it was definitely not an unfair outcome for the patient/claimant.
Over to you

We welcome all contributions to Over to you. We reserve the right to edit submissions.

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REFERENCES


Response

Thank you for your comments on this article.

In this case it is important to note that the case the claimant did not bring any allegations in respect of the surgical treatment provided. The allegations were in respect of Drs A, B and C who saw Mr P at the GP surgery. In accordance with the general principles of medical negligence, the standard on which the three doctors are judged is that of the reasonable general practitioner.

On the doctors’ account of the case the GP expert evidence was supportive. Although there was a potential conflict of factual evidence (ie, what actually happened in the consultations), it is clear that Mr P had no real recollection of what he told the GPs about his symptoms during the various consultations.

Consent templates?

The question of adequate consent and the preoperative discussion of possible risks and complications frequently appear in Casebook. Are there any templates of consent forms available for gynaecological procedures (especially laparoscopic procedures)? Is it not something that MPS should be involved in creating or developing?

Response

Thank you for your observations and comments. MPS does not produce specific templates or forms for use in the consent process. Consent is a process that will vary depending on the circumstances. Although there are some specific exceptions in relation to certain procedures, interventions and circumstances (eg, sterilisation and termination of pregnancy, which require the completion of statutory forms), the actual form of the consent is less important than the accurate documentation of the process.

Controlled drugs

This (letter refers to an article in the New Zealand edition of Casebook - Consultations, which can be read here: www.medicalprotection.org/ newszeland/casebook-january-2014/ controlled-drugs-what-you-need-to-know)

Response

Thank you for another informative issue of Casebook. I am responding to Helen Moriarty’s article on controlled drugs – what you need to know'. Casebook 22(1) in New Zealand.

The article is clear and helpful, and the message that prescribing to any dependent person must be by a gazetted practitioner (and sometimes locum) or under the specific written authority of such a practitioner, is clear. However, the article does not address the question of colleague or locum prescribing, and I have wondered about this in the past. Specifically, if the duly gazetted authorised practitioner is away/ unavailable (not just fully booked that day), does a colleague from the practice, or a locum, have the legal right to prescribe for dependent patients?

It is a widespread convention that locums (if not colleagues) are authorised to do all that the doctor they are replacing would normally manage, including prescribing to this category of patient.

I shall be grateful for Dr Moriarty’s further advice.

Response

Restriction Notices always specify “Doctor (name) or Locum” for this specific reason. You should find that this is the standard wording on Restriction Notices held in the practices that you work in.

How reliable is healthcare?

I was interested to read the excellent article “How Reliable is Healthcare?” by Dr Dan Cohen in the current (January 2014) issue of Casebook. As both an airline captain and former surgeon, I have a view from both sides of the debate. I’d like to agree with his views on complacency leading to errors but must disagree on two points.

While I agree that patients are initially more tolerant of aeroplanes, the important point is that aeroplanes (patients) generally don’t cause accidents – it is caused by human error due to the operator (healthcare professional or pilot). Therefore this is where we need to focus our energies, namely in human factors training for staff to help recognise and deal with error. Also, as in healthcare, we consider our passengers (patients) an integral part of our safety awareness system. Any issue brought to the attention of our cabin crew, such as unusual smells, sounds, ice on the wings or leaks from engines (both of which are much more easily seen by our passengers due to their better view of that area of the aeroplane), are brought immediately to the attention of the captain as part of our crew resource management information gathering system, ie, communication, leadership, situational awareness, leading to decision-making. We regard passengers as much more than passive consumers of our service. Captain Nick Downey FRCS, Managing Director, Framework Health, Ireland.

Response

Capt Downey makes some excellent points and his thoughts are aligned with mine. It is certainly true that aeroplane safety relies to some extent on passengers alerting the crew to potential problems, and in adopting a healthcare outcomes paradigm, similarly relying on patients for their expertise is crucial. A difference is that the passengers on an aeroplane, of course, are not in the case of a mid-air emergency, do not rely on the crew to instruct them how to be successful passengers (after the initial safety instructions prior to takeoff!), whereas achieving healthcare outcomes uniquely requires clinicians and patients to work very hard together across all aspects of care planning to achieve successful care implementation. One of the reasons that 20-25% of elderly patients discharged from hospital with a diagnosis of congestive heart failure are re-admitted within 30 days is because patients are not viewed as components of the healthcare system in a high-reliability model. Many clinicians have no real window on the challenges that patients face once discharged and back in their homes. Every preventable readmission is a failure of our system and a cause of physical, psychological and financial harm; the antithesis of a high-reliability system.

Clinicians and patients are both encumbered with many human factors liabilities and training or interventions for both are likely to serve good purpose. The processes of diagnosis, therapeutics and of care plan implementation present numerous human factors challenges. If the goal is preventing readmission then planning for that should begin at the time of admission with defining, and then modulating, the human factors that confound success.

Dr Cohen, MD, FRCPCH, FAAP, International Medical Director, Delta UK Ltd and Delta (USA) Inc. Dcohen@deltax.co.uk

Cutting corners

As an anaesthetist, I was interested to read the case report “Cutting corners”, describing the severe brain damage that befell a four-year-old boy following an anaesthetic mishap (Casebook 22(1)).

The anaesthetist, Dr B, was criticised on several aspects of his care, including failing to warn the parents, without alarming them unnecessarily, of the risks associated with an anaesthetic mishap (eg, sterilisation and termination of pregnancy, which require the completion of statutory forms), the actual form of the consent is less important than the accurate documentation of the process. MPS has produced a comprehensive guide – Consent to Medical Treatment in South Africa – which is available on our website.

Response

I’d like to agree with his views on complacency leading to errors but must disagree on two points.
ul Gawande has written an insightful, in-depth book titled "The Checklist Manifesto: How to Get Things Right". The book focuses on the importance of checklists in reducing errors and improving outcomes in healthcare. Gawande, a surgeon and writer, draws on real-life examples of medical errors to argue for the use of checklists to prevent mistakes in medical procedures and beyond.

In his book, Gawande presents checklists as a simple yet powerful tool to ensure that medical professionals do not overlook important steps in complex procedures. He uses the example of the WHO operating room checklist to illustrate how such tools can prevent errors and improve patient safety.

Gawande’s book also explores the history of checklists and their origins in the aviation industry. He discusses how checklists were developed to prevent errors in space shuttle launches and how they can be applied to other high-stakes environments.

The book contains numerous personal anecdotes and stories from other medical professionals who have used checklists to improve patient care. Gawande’s writing is both accessible and thought-provoking, making it an essential read for anyone interested in improving medical safety and outcomes.

In summary, "The Checklist Manifesto: How to Get Things Right" is a well-written, important book that argues for the use of checklists in medicine and other fields. It is a call to action for all medical professionals who want to improve patient care and reduce errors.

Reviews

The Checklist Manifesto: How to Get Things Right
Review by Dr Arif Forouzanfar, surgical specialist registrar, Doncaster, United Kingdom

**stars out of 5**

The Checklist Manifesto has been praised for its clarity and accessibility. Gawande’s writing is engaging and easy to follow, making complex concepts understandable to readers with a variety of backgrounds.

The book is especially useful for medical professionals who are interested in improving patient safety and reducing errors. The examples and anecdotes provided throughout the book make it a valuable resource for anyone working in healthcare.

Overall, "The Checklist Manifesto: How to Get Things Right" is a must-read for anyone interested in improving medical safety and outcomes. It is a thought-provoking and accessible book that offers practical solutions for reducing errors in healthcare.

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**Films: The Enemy Within (50 Years of Fighting Cancer)**

By Dr Omar Mukhtar, ‘Darzi’ Fellow, Health Education South London, UK

Films like The Enemy Within (50 Years of Fighting Cancer) provide a high level overview of the human story, the story of those who have achieved that failure to diagnose and treat virulent cancers, especially pancreatic and thoracic disease, the inadequacy of treatment in the non-industrialised world, and the considerable costs arising from non-achievement.

This is a non-commercial, editorially independent piece, supported by Cancer Research UK and funded by an educational grant from Roche. The film-makers set out to educate and inform those who are affected by cancer.

Whether they have achieved that, as the focus and language is largely directed towards the medical fraternity. However, in a little over an hour, this film provides a high level overview of what has been achieved in 50 years, which will be enjoyed by many a clinician.

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In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

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