Nasogastric tube errors
AVOIDING THE RISKS

Up in the air
WHEN YOUR PATIENT IS A PILOT

On the record
HOW TO HANDLE RECORDED CONSULTATIONS

MPS international conference
AN EVENT WITH A GLOBAL FOCUS
A new international conference focusing on quality, patient experience, safety culture, cost and professionalism

Keynote speakers include:

Dr Devi Prasad Shetty, Narayana Hrudayalaya Group of Hospitals, India

The Pursuit of Quality in Challenging Circumstances – Cardiac Surgery for $800

Dr Carol Haraden, Institute for Healthcare Improvement, USA

Dr Lucian Leape, Harvard School of Public Health, USA, looking at Disclosure and Apology – It’s not about the money

Dr Jason Leitch, Patient Safety Improvement Scotland, UK, addressing Safety and Outcomes

Professor David Studdert, University of Melbourne, Australia, on Reliable Predictions of Doctors’ Medicolegal Risks – Can it be done?

Key partners:

15-16 November 2012
Church House Conference Centre Westminster • London

www.mpsinternationalconference.org
ON THE COVER

10 Nasogastric tube errors
They are widely used across the world, but are still the source of patient fatalities; Sara Williams and Dr Gordon McDavid advise on avoiding the key risks.

6 Up in the air
Dr Dougal Watson of the Civil Aviation Authority explains the confidentiality issues when treating a patient who is also a pilot.

8 On the record
MPS has been contacted over a range of scenarios involving the recording of consultations. Dr Alan Doris resolves the dilemmas.

ALSO THIS ISSUE

4 Your MPS
In addition to MPS Medical Director Dr Priya Singh’s regular column, you can also read important updates from MPS.

5 Headlines and deadlines
The latest news on legislation, events and open consultations in New Zealand.

13 On the case
Dr Alison Metcalfe, MPS Head of Medical Services, introduces this issue’s selection of case reports.

14 Skipping over the details

15 A question of consent

16 A pain in the leg

17 Slipping through the cracks

18 Squash and a squeeze

19 An error that did not cause harm

20 A complication, not negligence

21 Missed ectopic pregnancy

22 Keeping watch

23 A frozen shoulder

24 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.

26 Reviews
Dr Emily Lees tests out the Medscape app, which is available on a range of devices. Dr Matthew Daunt takes the traditional route by reviewing the book The Rise & Fall of Modern Medicine, by Dr James Le Fanu.

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Providing a global perspective

MPS Medical Director Dr Priya Singh on MPS’s landmark conference

This November sees MPS host its two-day international conference on patient safety and risk – the first time we have held such an event for speakers and audiences from around the world.

A key part of MPS’s work, as the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and healthcare professionals, is informing and influencing the statutory and regulatory framework in which clinicians practise. Our aim in hosting the conference is to provide a platform to discuss international experience of how best to respond to the changing expectations surrounding healthcare.

The conference, Quality and Safety in Healthcare: Making a Difference, focuses on quality, safety culture, professionalism, cost and the patient experience. The latter is particularly pertinent in today’s climate as patient expectations continue to rise. There is perhaps no place where this has been more clearly demonstrated than in the increasing frequency, and associated cost, of clinical negligence claims.

We are delighted to welcome international experts in quality and safety from medicine and from other disciplines. The programme spans the breadth of policy and practical considerations, from questions such as what does quality mean, and is it affordable, to the implementation of tort reform and the management of adverse outcomes.

Speakers include Dr Lucian Leape, from the Harvard School of Public Health, who many will know and recognise as a leader of the patient safety movement. In particular, Dr Leape has been an outspoken advocate of the non-punitive systems approach to the prevention of error. We hope the conference will help to identify and share ways in which all in healthcare can be supported in achieving open and effective communication, even in the most challenging and stressful of circumstances in which we frequently practise.

A global perspective on safety and risk in healthcare gives us the best opportunity to pool learning and experience and to accelerate our progress. The first conference will be held in London on 15 and 16 November 2012, and we will look forward to hosting events around the world in the future, so if you have suggestions for conference content do please let us know.

To find out more about Quality and Safety in Healthcare: Making a Difference, and to book your place, visit http://mpsinternationalconference.org

IMPORTANT NEWS

Compounded life membership

In September last year, MPS’s previous Chief Executive, Tony Mason, announced a decision by MPS Council to discontinue Compounded Life Membership (CLM), in the interests of fairness to the wider membership.

This is a reminder that CLM will cease on 1 January 2014. Anyone who is a CLM member and still practising on 31 December 2013 will be required to pay the subscription appropriate for their grade and specialty to receive the benefits of MPS membership after that date.

CLM has been offered to members who have completed 40 years of paying membership, providing a waiver of the annual subscription for those still in practice. The decision to withdraw CLM was taken due to increased longevity and people working longer, therefore placing an unfair burden on paying members.

NEW COUNCIL CHAIR

Kay-Tee Khaw has been appointed the new Chair of the MPS Council. Kay-Tee has served on the Council since June 2011 and has a long and distinguished career.

Visit the MPS website and click on “About MPS” for more information on Kay-Tee.
New Zealand model to promote better care across Europe

A recent White Paper suggests that New Zealand can provide a model to improve healthcare across Europe. The White Paper, Better Information for Better Care – New Zealand’s Approach to Efficient and Affordable Care, commissioned by New Zealand Trade and Enterprise, explores how New Zealand has combined policy, system design and information technology to transform its healthcare system.

Malcolm Pollock, director of the National Institute for Health Innovation and author of the White Paper, commented: “New Zealand’s size has enabled a highly responsive approach to the development of sustainable healthcare systems. The country has pioneered advances in many areas of healthcare, ranging from medical devices and bio-pharmaceutical products to cost-saving IT solutions.”

“With a small, geographically dispersed population and remote locations, New Zealand has strong incentives to develop and implement new approaches to healthcare delivery using innovative health technology,” said Chai Chuah, National Director of the National Health Board, the New Zealand Ministry of Health.

“New Zealand is committed to improving its health system on a sustainable basis and realises that new approaches are required to increase quality cost effectively. We are currently focusing on more clinically-led innovative models of care; wider involvement of patients and consumers in designing our future health services and greater integration of investment in IT, workforce and infrastructure.”


For more information visit: www.newzealand.com/business

MINISTRY OF HEALTH PUBLISHES REPORT ON HEALTH STRATEGY

The Ministry of Health has published a report on the health strategy in New Zealand during the past year.

The report, Implementing the New Zealand Health Strategy 2011, details the actions taken through 2011 to progress priority areas that have been signalled to the sector. These priority areas are:

- Health targets
- Bringing services closer to home
- Health of older people
- Strengthening clinical leadership and the health workforce
- Financial management and sustainability
- Ensuring quality.

These priority areas remain consistent with the New Zealand Health Strategy and will continue to be priority areas for the medium term. For more information visit: www.health.govt.nz

Conferences and events

<table>
<thead>
<tr>
<th>Event</th>
<th>When</th>
<th>Where</th>
<th>Further information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilderness medicine</td>
<td>7-19 December</td>
<td>Antarctica</td>
<td><a href="http://www.expeditionmedicine.co.uk/index.php/products/event/p-009.html">www.expeditionmedicine.co.uk/index.php/products/event/p-009.html</a></td>
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The right of confidentiality is bound by the Privacy Act but, as doctors, you can disclose patient information in certain circumstances. One such area is aviation safety. Dr Dougal Watson explains your obligations.

Many doctors have pilots and air traffic controllers as patients. Few doctors are aware that in certain circumstances they also have public safety obligations to advise the aviation safety regulator – the Civil Aviation Authority (CAA) – concerning their patients. Even fewer doctors understand that those public safety obligations – to advise the CAA – are very well protected and are not overridden by privacy obligations.

This article explains some of the obligations and protections that apply to medical practitioners who have pilots and air traffic controllers as patients. This article also explains how those public safety obligations override your obligations under the Privacy Act.

The risks
As a medical practitioner, you will be aware of the potential for medical conditions to degrade aviation safety. Clearly it would be inappropriate for an epileptic patient to be flying an airliner carrying dozens, or hundreds, of passengers. What is not always clear, is just where the medical safety line lies. Epilepsy is relatively straightforward, along with some serious mental health problems, but what about migraines? What about after a myocardial infarct, head injury, or malignant disease? What about any of the many medical conditions that you routinely see in your day-to-day practice? What about prescribed medications?

It would not be reasonable to expect every medical practitioner to also be expert in the field of aviation medicine, or to also understand the safety thresholds that are applied by the CAA. To allow for this, and to help maintain aviation safety, the civil aviation legislation (Civil Aviation Act 1990) includes requirements for medical practitioners to report certain cases to the CAA. Those statutory requirements have a very low threshold for action, offer robust protection to the reporting medical practitioner, and ensure that it is the CAA's aviation medicine experts that make any final decisions concerning aviation medical safety.

Your obligations to report
Section 27C(3) of the Civil Aviation Act describes the circumstances and, if those circumstances are met, places a reporting obligation upon medical practitioners. There are three elements to the circumstances described: subject to General Directions issued by the Director of Civil Aviation; reasonable grounds to believe the patient is a pilot or air traffic controller; and reasonable grounds to suspect the patient has a medical condition that may interfere with aviation safety.

The first circumstance is very straightforward. The Director of Civil Aviation has not issued any General Directions that specifically relate to medical practitioners’ responsibilities under this legislation. The second circumstance simply requires the medical practitioner to have reasonable grounds to believe that the patient is a pilot or air traffic controller. In most cases that information will have come to your awareness from the occupational or recreational aspects of the history you’ve taken. In some other cases you may have been told by family members or others. If you suspect your patient may be a pilot or air traffic controller, but are not satisfied you have “reasonable grounds to believe” then you can always contact the CAA to check.

The third circumstance is based on a “reasonable grounds to suspect” requirement, which is a relatively low burden of proof. This is entirely appropriate in a public safety situation where many people can be placed at risk from the actions of one person. As a medical practitioner, you do not need to be certain that your patient’s medical condition may interfere with aviation safety; you merely need to have reasonable grounds to suspect. Similarly you are not required to believe that aviation safety will be adversely affected, but just that it may. What you must then do is also described in the legislation. Once the circumstances described above have been met, your responsibilities are relatively straightforward. You have an obligation to advise the CAA (the Director) and an obligation to inform the pilot/air traffic controller that the CAA will be advised.

The civil aviation legislation (Civil Aviation Act 1990) includes requirements for medical practitioners to report certain cases to the CAA

Informing your patient
How you do this will depend on the circumstances at the time. During a consultation this will usually take the form of verbal advice and an entry in the patient’s notes. At other times it may take the form of a brief letter to the patient.

The CAA website (www.caa.govt.nz) includes a pair of Medical Information Sheets (MISs) designed to assist medical practitioners in this area. MIS 2 describes your obligations. MIS 3 is intended to be a handout that you can
give to your patients, and again describes your obligations along with theirs. If you are experiencing any difficulty, or if your patient is resisting your informing the CAA and you are not confident of your obligations, then you may wish to seek advice from MPS or from the CAA Medical Unit.

Aiding the CAA
The legislation requires a timeline of “as soon as practicable” and the fastest way to advise the CAA is to telephone and talk with a CAA staff medical officer or medical adviser. If that is not convenient you can email, fax or write. Prompt advice is desirable and it would be inappropriate to delay advising the CAA of a safety relevant medical condition.

In advising the CAA you should provide the name of the patient, their date of birth is often helpful to identify similarly named individuals, and a basic description of the medical condition that has triggered your concern. You do not need to provide great detail at that time. Once aware of the basic issue, the CAA has responsibilities and powers to obtain additional details as necessary. You should also make a note, in the patient’s records, of your having advised the CAA.

If you are not sure whether your patient’s medical condition warrants reporting, especially if you are not expert in aviation medical matters, then you should contact the CAA Medical Unit and discuss the condition with one of their medical staff.

Protection
The Civil Aviation Act also provides robust protection for medical practitioners who make reports to the CAA under s27C(3). A medical practitioner is “not subject to any civil or criminal liability” for a good faith report to the CAA that a pilot or air traffic controller may be unsafe.

The CAA is not aware of any medical practitioner having faced court proceedings, civil or criminal, as a result of complying with their obligations to report such medical matters to the CAA.

Privacy
Some medical practitioners are uncomfortable reporting a patient to another agency and sometimes (incorrectly) believe they are unable to do so because of privacy legislation. On some occasions the patient may try to dissuade the medical practitioner from advising the CAA.

Your public safety responsibility to advise the CAA overrides your obligations under the Privacy Act 1993. You must advise the CAA, even if your patient does not want you to.

The reason that this obligation trumps your privacy obligations is contained in section 7 of the Privacy Act. The first provision of that section provides for another “enactment” (in this case the Civil Aviation Act) to not be derogated (overridden) by privacy principles 6 or 11. This means that your aviation safety obligations outweigh the privacy principles 6 and 11.

No medical practitioner has faced prosecution or privacy commissioner sanction as a result of complying with their obligations to report such medical matters to the CAA.

The pilot or air traffic controller must also report
The fact that the pilot or air traffic controller also has an obligation to report their medical situation to the CAA does not remove the obligation of a medical practitioner. You must still advise the CAA.

Failure to report
In the past some medical practitioners have felt, despite advice to the contrary, that the Privacy Act prevented them from advising the CAA concerning their patient. In those cases the CAA chose not to pursue prosecution of the medical practitioners but instead advised the Medical Council of New Zealand of the medical practitioner’s failure. Without exception the proper advice was provided soon after.

Dr Dougal Watson is Principal Medical Officer at the Central Medical Unit of the Civil Aviation Authority

In advising the CAA you should provide the name of the patient, their date of birth is often helpful to identify similarly named individuals, and a basic description of the medical condition

PILOTS AND AIR TRAFFIC CONTROLLERS
These obligations apply to all air traffic controllers and many, but not all, pilots. The pilots who are covered by these requirements include:
■ All airline pilots
■ All other professional pilots
■ All private pilots
■ Some parachutists, hang-glider pilots, microlight pilots, home-built aircraft pilots, glider pilots, parapente pilots etc.

If you are unsure if your pilot patient is included in these groups then you can telephone the CAA Medical Unit to seek guidance.

SECTION 27C(3) OF THE CIVIL AVIATION ACT 1990
Subject to any directions that the Director may issue under section 27G(1)(b), if a medical practitioner has reasonable grounds to believe that a person is a licence holder and is aware, or has reasonable grounds to suspect, that the licence holder has a medical condition that may interfere with the safe exercise of the privileges to which the licence holder’s medical certificate relates, the medical practitioner must, as soon as practicable:
(a) inform the licence holder that the Director will be advised of the condition
(b) advise the Director of the condition.

FURTHER INFORMATION ONLINE


Civil Aviation Authority Medical Information Sheets – www.caa.govt.nz/medical/Med_Info_Sheets/Med_info_sheets.htm

CONTACTING THE CAA

Address: Level 15, 55 Featherston Street, Wellington 6011. PO Box 3555, Wellington, 6140.

Phone: 04 560-9400 and ask to be put through to the Medical Unit.

Fax: 04 560-9470

Email: Med@caa.govt.nz

Website: www.caa.govt.nz/about_caa/contact_us.htm
Modern technology makes audio and video recording of dialogue and behaviour extremely easy. There have been many recent examples in the general media where supposedly private or personal material has been brought into the public domain, causing considerable distress and problems for those involved.1,2

Increasingly, MPS is being contacted by members who seek advice in circumstances where recordings have been made or are proposed in clinical settings. Managing the situation depends greatly on who is intending to make the recording, how this is done, and for what purpose. We will look at a range of scenarios below:

**A clinician wishes to make an audio or video recording**

The Health Information Privacy Code 1994 (the Code) was established to ensure that health agencies (including individual practitioners) abide by strict rules when handling information about patients. This is in recognition of the confidential and often sensitive nature of health information. If a health provider decided to record a clinical interaction then they must ensure that their actions comply with the Code.

The Code is “technology neutral” and so information in the form of an audio or video recording must be managed by the health agency in the same way as if the information was recorded in a traditional paper record or an electronic medical record.

The information collected must be necessary for a lawful purpose or function of the health agency.3 Patients must know that information is being collected, why it is being collected and what is going to happen to the information.

Patients are also entitled to request a copy of any recording that is collected or used on the basis that it is part of their health information.

Health information must not be collected by a health agency by unlawful means or by means that, in the circumstances of the case, are unfair; or intrude to an unreasonable extent upon the personal affairs of the individual concerned.4 Making an audio or video recording without the patient’s knowledge is an example of where collection would be unfair.

In some circumstances, additional safeguards require that explicit consent is gained from the patient before a video or audio recording is made, such as Section 68 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and section 52 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

A successful complaint that a health agency has breached one of the rules of the Code can lead to proceedings in the Human Rights Review Tribunal, with possible penalties including an award of damages of up to $200,000.

**A patient asks to make an audio or video recording**

The Code only applies to health agencies and so does not have any role where a recording has been made by a patient. It is possible that the Privacy Act
could apply in circumstances where some personal information of the doctor was included in the recording, though this would be unusual. Patients may ask to record a clinical interaction for a variety of reasons. When the assessment is for a medicolegal purpose, such as an insurance or ACC claim, the patient may wish to have their own record of what occurred.

The Medical Council of New Zealand (MCNZ) refers to this issue in its statement on Non-Treating Doctors Performing Medical Assessments of Patients for Third Parties Doctors (Dec 2010): “Recording a consultation
11. A patient may want to record the consultation by video or audio tape. You should consider such a request carefully and, if you do not consent, ask the third-party to arrange for another doctor to conduct the assessment.”

The MCNZ refers to the case of Jackson v ACC, which upheld the patient’s privilege to record a consultation, though also acknowledged that doctors have a privilege in deciding what way a medical assessment should take place. The doctor must be able to reasonably justify a refusal to allow recording in these circumstances.

Therefore, you should be clear about the reasons why you refuse to permit a patient to record a consultation. The reasons should stand up to scrutiny if the patient complained about your refusal. Reasons to refuse to consent to recording might include concerns that:

- The presence of a recording device will hinder the open sharing of information and views
- A recording cannot convey relevant non-verbal cues that affect an assessment
- The recording (or a transcript) may be edited in ways that alter its significance
- The subsequent use of the recording will be outside your control and could be used to misrepresent your actions or views.

MPS is aware of cases involving members where each of these problems has arisen.

In situations where a doctor agrees to the recording of a consultation, it is suggested that the doctor consider making an agreement with the patient, prior to any recording, to receive a copy of the whole recording from the patient. Alternatively, a doctor could seek the patient’s agreement to make his or her own separate recording of the consultation.

A clinical assessment is covertly recorded by the patient
Occasionally clinicians discover after a consultation that the patient has made a recording without their knowledge. As it is the patient’s health information that has been recorded, and it is in the possession of the patient, the doctor has very little influence over what is done with the recording.

MPS has been asked to assist members who have discovered audio recordings or transcripts of consultations that have appeared on the internet. This material is usually placed in the public arena by the patient seeking to make a particular point and may be edited or altered in some way.

As it is often impossible to know whether a consultation is being recorded it may be prudent to assume that it is, in a similar way to assuming that all your written entries in a medical record will be read by the patient.

If a health assessment, then before considering information obtained in this way, it is important to ascertain from the information provider whether the patient is aware that this information has been provided to you

Material recorded covertly is provided to the doctor
Investigators working for insurance companies or ACC occasionally present covertly obtained video recordings of claimants to doctors; for example, where there are concerns of fraud. The steps required on the receipt of such unsolicited information will differ depending on whether the assessment is purely about the health of the patient or whether it is required for legal proceedings.

If a health assessment, then before considering information obtained in this way, it is important to ascertain from the information provider whether the patient is aware that this information has been provided to you. If the patient is not aware of the material then it may be difficult to form a valid medical opinion on a video or audio recording that has been made without the knowledge of the patient, in non-clinical circumstances and without the opportunity to ask the patient questions arising from examining the recording.

You may decide to return such information as you may need to show why it was necessary to use it without the patient’s knowledge and response, if a complaint resulted. If there are legal proceedings in existence or anticipated, different considerations apply. Please consult MPS with any queries.

A person masquerades as a patient and records the interaction
MPS is aware of cases where individuals have presented to doctors with factitious complaints for the purpose of manipulating and covertly recording the consultation for their own purposes. A member was recently assisted by MPS after a complaint had been made to the MCNZ alleging inappropriate prescribing.

A journalist pretending to be a patient had presented to several GPs seeking to obtain medication with the potential of abuse by deception and, at least in one case, intimidation. This was done to form the basis of a newspaper article. A covert recording of one consultation was used by him in his subsequent complaint to the MCNZ. After considering the response from

REFERENCES
1. Election tea tape leaked online, www.stuff.co.nz/auckland/local-news/6317929/Election-tea-tape-leaked-online
2. www.levesoninquiry.org.uk
3. Health Information Privacy Code 1994, Rule 1
Nasogastric tubes are widely used in the world’s hospitals, yet in spite of fierce campaigning to expose the dangers, patients are still dying from the complications of wrongful insertion. **Sara Williams** and MPS medicolegal adviser **Dr Gordon McDavid** explore how to avoid these risks.

Many practitioners may not have considered the real potential for harm that these innocent-looking plastic tubes may present, particularly if they are misplaced in the patient’s oesophagus or, worse, a bronchus.

NG tubes are commonly used across the world to treat stroke patients with dysphagia or those on ventilators, and are generally accepted as being safe pieces of equipment. They are used in the short to medium term (six weeks); longer term feeding usually requires insertion of gastrostomy or jejunostomy tubes (PEG or PEJ). Although feeding by NG tubes is not routinely captured in activity data, in the UK alone around 170,000 tubes are supplied to the NHS each year.

Many practitioners may not have considered the real potential for harm that these innocent-looking plastic tubes may present, particularly if they are misplaced in the patient’s oesophagus or, worse, a bronchus. If not detected before feeding, patients can suffer complications like pneumonia, which can be fatal. Junior cardiology trainee doctor Dr Owen Bebb inadvertently caused a pneumothorax using an NG tube while working in a busy teaching hospital. “I was bleeped just before my shift ended and asked to check the position of an NG tube my consultant had inserted into a female patient who was nil by mouth due to an unsafe swallow post-stroke. The CXR showed that the tube was in the left bronchus. “Unfortunately, I had to free the tube from the bridle it had been attached to before removing it. To reinsert the tube I couldn’t use the standard technique of having the patient swallow and so went blindly. The first time it coiled in her mouth, the second time it inserted smoothly without any resistance. As we were unable to aspirate any contents she went for a further chest x-ray to confirm the position.

“I came in after the weekend to find that I had unwittingly caused a pneumothorax and still have no idea how. Fortunately the patient received no lasting damage.”

**RISKS OF NASOGASTRIC TUBES**

The ‘whoosh’ or ‘blow’ test

The UK’s National Patient Safety Agency (NPSA) issued guidance in 2005 highlighting the unreliability of certain tests to detect the placement of NG tubes, such as the ‘whoosh’ test (listening for bubbling sounds after blowing air through the NG tube with a syringe) and pH testing by non-quantitative, coloured litmus paper. The NPSA recommend pH testing using pH indicator paper as a first-line check – pH levels between 1 and 5.5 are safe.

Misinterpretation of x-rays

Between 2005 and March 2011 the NPSA was notified of 21 deaths and 79 cases of harm due to misplaced NG tubes. The single greatest cause of harm was due to misinterpretation of x-rays, accounting for about half of all incidents and deaths. A chest x-ray is required if the first-line check fails to prove the NG tube is safe for use.

Flushng nasogastric tubes

The NPSA recently highlighted the deaths of two patients, where staff had flushed NG tubes with water before the initial placement. The mix of water and
Between 2005 and March 2011 the NPSA was notified of 21 deaths and 79 cases of harm due to misplaced NG tubes.

Recurring problems
According to Sir Liam Donaldson, Recurring problems
According to Sir Liam Donaldson, P a Patient Safety Envoy for the World Health Organisation, recent findings indicate that NPSA guidance is not being heeded, such as feeding despite obtaining nasogastric aspirates with pH between 6 and 8; instilling water down the tube before obtaining an aspirate, not checking tube placement or not recording written confirmation of such checks.

Sir Liam said: “An NPSA audit suggested great variation among 166 junior doctors at five pilot hospital sites in England and Wales, with low awareness of harm and continued use of checks, such as the ‘whoosh test’ or blue litmus paper, as bad practice. Fewer than a quarter were aware of existing guidance and less than a third of the junior staff had received formal training on x-ray interpretation.

“Because of the preventable nature of this harm, last year misplaced nasogastric tubes were confirmed by the Department of Health in England as a ‘never event’, one of a restricted list of serious avoidable events that could incur financial penalties for providers.”

England and Wales are not alone; other countries such as Malaysia routinely use the ‘whoosh test’ to detect the placement of NG tubes.

Mr S was a 70-year-old librarian who had a long history of recurrent colitis due to Crohn’s disease. Despite maximal medical treatment, he experienced recurring symptoms of severe abdominal pain and rectal bleeding, so was admitted to hospital. Following a period of parenteral steroid therapy, Mr S’s bleeding continued and he required an exploratory laparotomy. Prior to surgery a barium enema revealed a discrete area of abnormal bowel, which was felt to be responsible for his symptoms. It was hoped that the inflamed section of bowel could be surgically resected. Mr S underwent a pre-op assessment by senior anaesthetic trainee, Dr P. He was noted to have a history of angina and COPD, but these chronic conditions were stable.

On the day of surgery, the operation took place without complication and Dr P inserted a NG tube. As Mr S was intubated, Dr P used a laryngoscope and Magill’s forceps to insert the NG tube. Dr P had performed this procedure many times before and felt confident to do it independently. During the insertion, Dr P found it difficult to visualise the proximal end of the oesophagus, but based on the smooth insertion assumed the NG tube was in place.

On arrival in ICU, Dr P still needed to confirm the position of the NG tube. Unable to aspirate fluid, he wanted to auscultate the stomach while instilling air through the NG tube (the ‘whoosh’ or ‘blow’ test) – this was in line with the local protocols at the time. As Mr S had had a laparotomy, Dr P was unable to access the epigastrium to carry out this manoeuvre due to a large wound pad covering the area. Dr P decided to arrange a chest x-ray. Due to a backlog in the radiology department, the x-ray was not carried out before the end of Dr P’s shift. Dr P handed over the task of reviewing the film to the nightshift trainee, Dr A. Unfortunately, Dr P failed to inform Dr A that the x-ray was to check the position of the NG tube. Dr P had not documented the NG tube insertion.

Following the handover, Dr A noticed a leak from Mr S’s endotracheal tube and injected approximately 1ml of air into the tube’s cuff. Dr A was called away to an emergency, but instructed one of the nurses to observe Mr S. The results of Mr S’s chest x-ray arrived, but Dr A was very busy. She glanced at the x-ray, verbally informing the nurses that it “looked ok”, referring to the ET position as “satisfactory” and the lungs looking “grossly normal”. She did not document this in the notes.

Unfortunately, Mr S had to return to theatre for an anastomotic leak repair and subsequently required prolonged intubation, blood transfusions, IV fluids and inotropic support after the second surgery. With treatment Mr S’s haemodynamic parameters stabilised although he began to develop renal failure. Consultant anaesthetist Dr W took the decision to begin feeding. During this time, the original NG tube remained in-situ and no-one realised the initial chest x-ray had not been formally reviewed.

About 12 hours later, Mr S’s nurse aspirated feed-like material from his ET tube and feeding was immediately stopped. Dr A was asked to review the patient. Radiology then phoned to advise that the chest x-ray taken before the weekend showed the NG tube was positioned incorrectly. Despite aggressive treatment for aspiration pneumonitis, unfortunately Mr S died two days later.

The outcome
The postmortem outlined the cause of death as aspiration pneumonia due to a misplaced nasogastric tube in right main bronchus, left hemicolecotomy for intestinal haemorrhage, ischemic heart disease and chronic obstructive airways disease. Dr P and the nurses involved were interviewed by the police under caution, but following an investigation it was agreed that the level of care, although suboptimal, did not meet the necessary criteria for a criminal offence.

Two years later, the practitioners involved were called to an inquest and MPS arranged legal representation for Dr P. Dr P accepted that it was his omission not to have specifically recorded the NG insertion in the notes. The coroner took no further action, as she was satisfied that preventative systems had been implemented by the hospital. Mr S’s wife subsequently launched a claim against the hospital, which was settled for a moderate sum.
MPS strongly advocates mandatory documentation of the method by which the NG tube’s position is confirmed

AVOIDING THE RISKS

Individual clinicians should consider the following:

- Is nasogastric feeding right for this patient? – Seek specialist advice if the patient has a high risk of aspiration or any deviation to normal anatomy, such as pharyngeal pouch, strictures or facial trauma, in which cases fluoroscopic guidance can often be used. The decision to feed should be agreed by two competent professionals and recorded.
- Does this need to be done now? – Risks are greater during the night.
- Am I competent to do this? – Ensure you have had training in safe insertion and checking, including interpretation of x-rays.
- How can I check the right amount of tube has been inserted? – Use “NEX” measurement (by placing exit port of tube at tip of Nose, stretching to Earlobe and then down to Xiphisternum) to guide insertion. The tube length should be confirmed and recorded before each feed to check it has not moved.
- Do I know how to test for correct placement? – Do not flush tubes or start feeding until you can confirm by testing with quantitative pH indicator paper.
- What is a safe pH level? – Obtain a nasogastric aspirate (pH levels between 1 and 5.5 are safe). Double-check with another person if you are unsure. Always record the result and the decision to start feeding.
- When should I get an x-ray? – If no aspirate can be obtained or the pH reading is above 5.5, request an x-ray specifying the purpose so the radiographer knows the tip of the NG tube should be visible.
- What should I look for on the x-ray? – That the tube is in the correct position (see guide in Figure 1).
- What about repeat checks? – Tubes can be dislodged so they should be checked every time they are used, by aspirating and confirming a low pH, and only x-raying if this is not the case.

Organisations and managers can make systems safer by:

- identifying a clinical lead to implement actions
- reviewing existing policies and training and competency frameworks (eg, ensure a doctor with sufficient seniority is responsible for signing off the use of NG tubes)
- ensuring stock of correct equipment (approved pH indicator paper and radio-opaque tubes with clear length markings)
- restricting procedures done out-of-hours.

MPS strongly advocates mandatory documentation of the method by which the NG tube’s position is confirmed. Documenting confirmation of correct placement should safeguard against accidental and potentially catastrophic use of NG tubes.

New developments

Further clinical research is needed in this area, but small studies have suggested that magnet-tracking devices, where a magnet is inserted into the tube tip, may hold promise for the future. In the meantime, no existing bedside methods are completely reliable in testing the position of NTs, so being mindful of the complications that may result is wise.

Thanks to Sir Liam Donaldson and Dr Sukhmeet Panesar from the NPSA for their help with this feature.

REFERENCES

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3. NPSA, Harm from Flushing of Nasogastric Tubes Before Confirmation of Placement (March 2012) – www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=133441
4. Mayor S, NHS extends never events list and introduces cost penalties, BMJ (2011;342:d1263)
Dr Alison Metcalfe, Head of Medical Services, introduces this issue’s round-up of case reports.

“Skipping over the details”, on page 14, carries a warning about the dangers of falling foul of the ‘HALT’ mnemonic – Hungry, Angry, Late, Tired. Dr G was reported by his patient, and the patient’s wife, to be tired and dismissive during his consultation, and it appears that this may have played a part in Dr G failing to fully engage with his patient, Mr K, and his presentation, and falsely reassuring him. He also failed to keep an adequate note of the consultation, leaving little opportunity to resolve the factual dispute.

Poor testing and investigations were the cause of a delayed diagnosis in “Squash and a squeeze”, on page 18. The failure by GP Dr V to carry out a squeeze test on the patient’s calf was considered to have led to a delay in diagnosis of an Achilles tendon rupture – a diagnosis that was only made following referral to an orthopaedic consultant. In “Missed ectopic pregnancy”, on page 21, an ectopic pregnancy was missed after a junior doctor in the emergency department, Dr Y, failed to request pregnancy tests on two occasions. Dr Y also failed to seek assistance from the on-call gynaecology team, despite the patient presenting with abdominal pains having undergone a recent termination of pregnancy.

Amid the steady stream of costly settlements in Casebook, it can be easy to forget the instances where we successfully defend our members from claims of negligence. Discovering where the doctor went right is often as valuable a learning tool as discovering where the doctor went wrong, and in “A pain in the leg” on page 16, we demonstrate the value of good record-keeping. Dr C’s failure to diagnose DVT was defended by her excellent clinical records, which revealed that she had done everything she could possibly have done.

Similarly, in “A complication, not negligence” on page 20, record-keeping again allowed us to defend our member from a claim. The allegation of bad management following the unfortunate neurological complication suffered by Baby R was refuted by comprehensive clinical notes, which clearly described the level of observation of Baby R post-surgery. The consent process was also well-documented, which showed the parents were fully aware of the potential for neurological damage. “A frozen shoulder” rounds off this issue’s case reports on page 23, showing how adverse outcomes are not always necessarily negligent.

CASE REPORT INDEX

<table>
<thead>
<tr>
<th>PAGE</th>
<th>TITLE</th>
<th>SPECIALTY</th>
<th>SUBJECT AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Skipping over the details</td>
<td>GENERAL PRACTICE</td>
<td>INVESTIGATIONS/DIAGNOSIS</td>
</tr>
<tr>
<td>15</td>
<td>A question of consent</td>
<td>GENERAL SURGERY</td>
<td>CONSENT</td>
</tr>
<tr>
<td>16</td>
<td>A pain in the leg</td>
<td>GENERAL PRACTICE</td>
<td>SUCCESSFUL DEFENCE</td>
</tr>
<tr>
<td>17</td>
<td>Slipping through the cracks</td>
<td>GENERAL PRACTICE</td>
<td>SYSTEM ERRORS</td>
</tr>
<tr>
<td>18</td>
<td>Squash and a squeeze</td>
<td>GENERAL PRACTICE</td>
<td>INVESTIGATIONS/DIAGNOSIS</td>
</tr>
<tr>
<td>19</td>
<td>An error that did not cause harm</td>
<td>GENERAL PRACTICE</td>
<td>SUCCESSFUL DEFENCE</td>
</tr>
<tr>
<td>20</td>
<td>A complication, not negligence</td>
<td>NEUROSURGERY</td>
<td>SUCCESSFUL DEFENCE</td>
</tr>
<tr>
<td>21</td>
<td>Missed ectopic pregnancy</td>
<td>GYNAECOLOGY/EMERGENCY MEDICINE</td>
<td>INVESTIGATIONS</td>
</tr>
<tr>
<td>22</td>
<td>Keeping watch</td>
<td>PSYCHIATRY</td>
<td>SYSTEM ERRORS</td>
</tr>
<tr>
<td>23</td>
<td>A frozen shoulder</td>
<td>ORTHOPAEDICS</td>
<td>SUCCESSFUL DEFENCE</td>
</tr>
</tbody>
</table>

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
One night Mr K, a 37-year-old bricklayer, felt a lump in his testicle. Worried, he decided to attend the emergency surgery on Saturday with his wife to have it checked.

When Mr K arrived at the surgery, he was seen by Dr G as his last patient. The consultation was short, only lasting a few minutes. Dr G examined Mr K briefly and reported his finding to them as “just a little gristle that will go away with time”. He did not give any particular advice. He added that there was “nothing to worry about” and he wrote in his medical notes “testicular examination: NAD”. Dr G appeared disgruntled that Mr K had used the emergency appointment for a routine check-up. Mr and Mrs K later reported that Dr G had appeared dismissive and tired throughout the brief consultation.

One year later, Mr K attended his GP surgery with a painless hard lump in his neck. Further investigations and referrals led to Mr K being diagnosed with a testicular choriocarcinoma. Despite treatment Mr K died two years after the diagnosis.

A claim was made against Dr G regarding his management of Mr K. The experts agreed that earlier diagnosis would have improved Mr K’s prospects and they were very critical that Dr G didn’t advise on any further follow-up or investigations; the case was therefore settled for a substantial sum.

**LEARNING POINTS**

- Unplanned appointments are inherently high risk, so writing good notes is even more important in this setting. On this occasion the records did not help resolve the factual dispute in the case. The medical notes should always reflect the clinical findings. If there was a palpable lump described as “gristle” to the patient, the clinical notes should have made a mention of it.
- MPS has considerable experience of claims that have arisen from factual disputes between patients and doctors. This case emphasises the importance of making as full a note as you can, particularly if you cannot find what the patient is reporting.
- In this case the patient presented as an emergency, which would have been taken into account in assessing the honesty of his assertion that he was acutely worried.
- It has been recognised that delay in presentation is an important factor in men with tumours. Even if the clinical findings are clear then men should be given advice, which is documented in the notes, to seek attention again if they have any concerns.
- Always be mindful of how human factors can affect your performance. Remember the HALT mnemonic (Hungry, Angry, Late, Tired); where possible anticipate these and take action to mitigate their impact. Where they are unexpected then be prepared to seek the opinion of your colleagues or bring patients back at the earliest opportunity to fully address their needs.
- Most patients present with a painless, solid, unilateral mass in the scrotum or an enlarged testicle. However, it is worth being aware that there can, rarely, be a decrease in testicular size. Around one in five men with tumours will have pain at presentation. The SIGN guidance Management of Adult Testicular Germ Tumours provides advice on the diagnosis and presentation of testicular tumours – www.sign.ac.uk/pdf/sign124.pdf. The guidelines recommend that anyone with a lump or doubtful epididymo-orchitis or orchitis not resolving within two to three weeks should be referred urgently for urological assessment.
A 45-year-old woman, Ms B, suffered from severe heartburn and was referred to consultant general surgeon Dr X. He undertook an upper gastro-intestinal endoscopy, which demonstrated erosive oesophagitis above a large sliding hiatus hernia. Ms B’s symptoms were not controlled with maximal medical therapy and therefore Dr X recommended anti-reflux surgery. He subsequently performed a laparoscopic fundoplication, but Ms B continued to have significant reflux symptoms and was unhappy with the results of her operation. At two years after the initial surgery, Ms B was desperate for further intervention but had now started smoking and had put weight on to the point that her BMI > 40.

A further consultation with Dr X resulted in a repeat endoscopy, a barium swallow, oesophageal manometry and 24-hour pH monitoring. These investigations demonstrated a recurrent hiatus hernia with a breakdown in the fundoplication resulting in marked recurrent gastro-oesophageal reflux disease. Ms B agreed to a further revision laparoscopic fundoplication but Dr X was unable to complete the procedure laparoscopically due to the presence of multiple adhesions. Dr X decided against an immediate conversion to open surgery as he had not discussed this with the patient or documented it on her consent form.

Three days later, after further discussion with Ms B and completion of a more detailed consent form, Dr X performed a laparotomy and a difficult revision anti-reflux operation requiring partial resection of the gastric fundus. Ms B developed a severe abdominal wound infection and experienced a stormy and prolonged postoperative recovery. There then followed several readmissions, culminating in a major plastic surgical procedure to reconstruct her abdominal wall.

Ms B made a claim against Dr X, alleging negligence in the management of her case. Expert opinion was obtained and there was agreement that the indication for revision anti-reflux surgery and preoperative work-up had been satisfactory. However, the process of consent was criticised in several areas. The failure to warn Ms B of the possibility of an open conversion was felt to be a significant failing, causing a three-day delay and requiring another operation and anaesthetic. There was also no evidence of any preoperative discussion regarding the risks of infection or gastric resection, even before the second procedure. It was additionally felt that Dr X should have given more consideration to Ms B’s high BMI and smoking habits as potentially reversible risk factors for postoperative complications. The case was settled for a moderate amount.

**LEARNING POINTS**

- The process of consent for any operation should be a detailed conversation between clinician and patient with documented evidence. The incidence and potential impact of any common and potentially serious complications should always be discussed and documented.
- Patients should be made aware of any aspect of their health or lifestyle that may adversely affect the outcome of an operation, particularly where action could be taken to optimise such conditions before surgery. In this case, preoperative weight loss and smoking cessation may have averted or lessened the extent of the subsequent complications.
- Postoperative infection is not necessarily a sign of negligence or substandard care. In this case, although some responsibility for the infection could be attributed to the patient’s body habitus and smoking, it was the failure by the surgeon to specifically warn Ms B of this risk that may have constituted substandard care in the quality of consent taken.
- Any laparoscopic operation, no matter how minor, may not go to plan, necessitating an open conversion. Patients should always be made aware of this and any consent form clearly reflecting the discussion.
- Consent for procedures should be a personalised discussion so that the information given to patients includes not only the general and procedure-specific risks, but is also tailored to the specific values held by the individual patient. With revision anti-reflux surgery, adhesions and scarring from the original surgery may increase the risk of damage to organs such as the liver, spleen or stomach (as in this case) with a variety of clinical consequences, including resection. Dr X should have warned Ms B about this.
Miss Y was a 36-year-old housewife with three children. She presented at her GP surgery with spontaneous pain in the leg, which was associated with a cramping sensation and pins and needles in her left foot. Miss Y saw her GP Dr C, and upon entering the consultation room raised the possibility of DVT, as she had been recently reading about DVTs in the news and her symptoms appeared similar. Dr C took a careful history and, with Miss Y’s suggestion in mind, concentrated particularly on the possibility of a DVT. She asked if there was any swelling of the legs, shortness of breath, chest pain or haemoptysis. Miss Y had confirmed that she had none of these symptoms. She asked if there was any personal or family history of thromboembolism, which there was not. She also asked about smoking history and Miss Y had stated that she had never smoked. Dr C also examined Miss Y thoroughly. She had found her pulse to be 70 beats per minute and her respiratory rate to be 12 breaths per minute. She noted that Miss Y’s chest was “clear to auscultation”. She had measured calf circumferences and found them to be equal. She had also documented that she could palpate normal pulses in both her legs and feet. Dr C could not find anything wrong but had written that she had told Miss Y to reattend if she developed any swelling in the legs, shortness of breath, chest pain or haemoptysis.

Ten days later, Miss Y collapsed suddenly and was found dead at home. The postmortem found the cause of death to be a pulmonary embolus secondary to a DVT. Her family were devastated and brought a claim against Dr C because of failure to diagnose. Dr C could not remember the case but her note-keeping was excellent. She had documented a thorough history, a full examination and sensible safety-netting advice. Despite the fact that she did not make a diagnosis of the DVT, the case was found to be defensible because Dr C had done everything she could and should have done.

The case was successfully defended.

LEARNING POINTS

- Good note-keeping is not only good practice, but it will make a possible defence much easier if needed.
- A DVT can be difficult to diagnose clinically and GPs should have a low threshold for referring patients for ultrasound scanning to either confirm or refute the diagnosis.
Mr F, a 45-year-old executive manager in a major sales company, saw his GP, Dr D, for a cold. The GP noted from the records that Mr F had attended the Emergency Department three times prior to this for minor ailments. His blood pressure that day was 150/90mmHg and his BMI was 36. Dr D arranged a cholesterol test, gave some lifestyle advice and asked him to reattend to recheck his blood pressure. Mr F did not attend the follow up appointment with the healthcare assistant for a blood pressure check.

Six months later, Mr F attended surgery again and was seen by a different doctor in the same practice. Looking at the notes, the patient had attended multiple walk-in centres and received treatment for minor ailments six times since his last attendance at the practice. His cholesterol was significantly raised on the blood test taken six months ago and it appeared a note had been sent to the patient to come in to discuss the result. When asked about this, Mr F explained that he had received the note but that he had had the same test done at his in-house occupational health department, with whom he had discussed the result, and that he had been also seeing them for minor ailments. Once again, Mr F’s BP was raised but was significantly higher than before and the GP was concerned, despite Mr F’s protests that it was likely because he was a “bit stressed”. The GP and Mr F discussed the best management option and the GP decided to refer Mr F to cardiology based on this high reading, and started Mr F on an antihypertensive.

Two months later, Mr F had an episode of indigestion. At the consultation with his occupational health doctor, when asked whether he was on any medication, Mr F said he was taking none. He was given antacids. However, he continued to have pain for three days on and off. He then suffered a cardiac arrest and unfortunately could not be resuscitated. The postmortem showed myocardial infarction. Looking back over his notes, there had been repeated blood pressures recorded in his notes from various appointments at the practice, the occupational health department, emergency and out of hours services, and readings had been steadily increasing, without the instigation of a proper management plan and with inadequate follow up.

A claim was made against all doctors involved. The case was settled for a substantial sum reflecting Mr F’s age and the fact he was a high earner.

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A claim was made against all doctors involved. The case was settled for a substantial sum reflecting Mr F’s age and the fact he was a high earner.

LEARNING POINTS

- When patients use multiple health systems for care, there is a risk of concern for their symptoms being diluted by spreading the consultations across a number of healthcare providers. This can be a particular problem with people with demanding jobs, and where employers provide a work-based health service. It is important to work together and communicate with colleagues. The occupational health service should inform the patient’s GP, with the patient’s consent, and it should be clear who will be following up – usually the GP.
- When patients attend the ED multiple times for minor ailments, it may be worth addressing this in the consultation and explaining alternatives, to avoid a lack of continuity of care.
- Any advice given to non-compliant patients should include the risks of failing to take medication or attend appointments, and should be documented.
- Arranging follow-up for any appointments missed or medication started makes practice safer. In this particular case, the patient missed an outpatient appointment and a GP appointment and was not followed up for either non-attendance to find out what happened.
- With poorly compliant patients, or those who are difficult to track, it is important to take advantage of opportunistic follow-up, and perform routine checks, such as blood pressure.
Forty-seven-year old shop assistant Mr U had noticed a persistent pain in his heel for several months, which deteriorated suddenly whilst playing his weekly game of squash. It took him two weeks before he attended his local Emergency Department, where he was x-rayed and diagnosed with a bony spur on his calcaneus. He was advised to rest and to follow-up with his own GP if it did not resolve.

For the next three months, the symptoms continued and Mr U saw his GP Dr V on several occasions to have his leg examined. He distinctly recalled two separate episodes of acute heel pain when he was playing squash, which he felt had precipitated his ongoing symptoms. No weakness or immobility was noted, and the pain appeared to be isolated to the heel only. Reassured by the normal x-ray and unremarkable examination, Dr V recommended further conservative treatment.

Unfortunately, Mr U’s heel pain did not resolve and he reattended a few weeks later complaining of swelling and erythema of the calf on the affected side. A definitive diagnosis was not obtained, and over the course of several weeks he was investigated for DVT on two occasions and commenced on antibiotics for suspected cellulitis. Three months after the initial event, symptoms remained much the same and Dr V sent Mr U to see an orthopaedic consultant in clinic. The orthopaedic surgeon made a clinical diagnosis of an Achilles tendon rupture, which was then confirmed with a soft tissue ultrasound. Mr U required surgical repair of his injury and made a very slow recovery with various complications. He made a claim against Dr V for the delay in diagnosis.

Expert evidence was sympathetic to the unusual presentation of the case, but felt that there were weaknesses in the case because there was no mention at all of a calf squeeze test having been performed, so it was difficult to judge at what point the tendon finally snapped.

Learning Points

- No matter how careful you are and how much effort you take on dealing with your patients in an appropriate manner, things sometimes do go wrong. Most doctors will have at least one claim against them during their practising lives.
- Documenting consultations thoroughly is essential. Keep records of any specific test or examination carried out – “whatever is not written has not happened” is a good safety motto.
- The calf squeeze test is used to examine the integrity of the Achilles tendon. The patient lies prone with the foot extended beyond the edge of the examination couch. The examiner squeezes the calf and watches the foot for mild plantarflexion in a normal exam. Lack of ankle movement can indicate rupture of the Achilles tendon. A useful link to a reminder about the squeeze test can be found here: [www.cks.nhs.uk/achilles_tendinopathy/management/scenario_diagnosis/diagnosis_of_achilles_tendon_rupture/tests_for_rupture_of_the_achilles_tendon](www.cks.nhs.uk/achilles_tendinopathy/management/scenario_diagnosis/diagnosis_of_achilles_tendon_rupture/tests_for_rupture_of_the_achilles_tendon)
Mr T was a 50-year-old successful interior designer. He was taking 5mg of warfarin daily for recurrent DVTs and regularly visited the warfarin clinic for INR checks. The clinic found his INR to be above target and he was advised to omit the following day’s medication and then go back to his usual dose. He was asked to return for an INR check after ten days.

Three days later Mr T started suffering with neck and back pain, which was very unusual for him. He was an enthusiastic cyclist and was used to ‘aches and pains’. The pain became quite severe quickly and he didn’t feel able to cycle to his GP’s surgery so he rang his GP to request a home visit, which was arranged for the same day. Dr B saw Mr T at his apartment and took a history of his complaint. He had developed back pain quickly and he didn’t feel able to cycle to his GP’s surgery so he rang his GP to request a home visit, which was arranged for the same day.

Dr B examined Mr T fully and noted that his gait was normal and that he had full range of movement in his back and neck. She also documented that his tone, power, sensation and reflexes were normal in both legs. Dr B gave Mr T some diclofenac to ease the pain and spasm but advised him to contact the surgery if things did not improve.

Mr T felt reassured but within a couple of hours of Dr B’s departure his back pain became even more severe. He panicked when he suddenly lost sensation in his legs and was incontinent of urine. He called an ambulance, which took him straight to casualty. The doctors at casualty did some urgent investigations and found his INR to be 10. Scans showed an extensive extradural haematoma. Mr T had to have emergency surgery to remove the haematoma within the vertebral canal but outside the dura which was causing compression of his spinal cord. Despite the surgery Mr T was left in a wheelchair and needed extensive rehabilitation. Mr T was understandably devastated because he would never walk or cycle again.

Mr T was understandably devastated because he would never walk or cycle again. He made a claim against the clinic and also Dr B for having contributed to the high INR causing the haematoma and for not recognising his neurological symptoms.

During the case Dr B admitted that prescribing diclofenac to a patient on warfarin is contraindicated, but the experts commented that the INR could not have been affected that quickly by the diclofenac, so Dr B’s error did not cause the injury. Dr B’s notes were very comprehensive and aided her defence regarding the lack of neurological symptoms and signs.

The case was settled by the clinic, but the allegations against Dr B were successfully defended.

**LEARNING POINTS**

- Home visits can be particularly tricky since you do not have the usual tools to elicit information about the patient. If possible, read patients’ notes carefully before setting off on a visit and take a printout with you, listing past medical history and the patient’s medications and allergies.

- Full examination, including a neurological assessment, should be undertaken in all patients with severe back pain to exclude cord compression. Spinal cord compression is a surgical emergency. The outcome of treatment depends on a timely diagnosis.

- As the proportion of older people grows, there will be more patients on multiple medications. Polypharmacy goes hand in hand with the increasing risk of drug interactions. Be aware of the risks of patients on anticoagulants.
Baby R presented at 18 months of age with a fit. He seemed otherwise healthy, but a CT scan was performed, which showed a Sylvian fissure arachnoid cyst with a shift of midline structures. After careful discussion with the parents, it was agreed that the baby would have a craniotomy and fenestration of the cyst into the subarachnoid space.

Following this procedure, carried out by consultant neurosurgeon Mr F, Baby R began to do well and had no further fits.

A few months later he was re-referred by the GP because he had become increasingly lethargic and off his food. A CT scan demonstrated that the cyst had recurred and was now bigger than it had been originally. Mr F again discussed with the parents the various options and their potential complications; these were documented in a clinic letter. In the end, it was agreed that Mr F would take Baby R back to theatre and perform a cysto-peritoneal shunt.

During the insertion of the shunt, fresh blood began to appear in the proximal catheter. Mr F flushed the tubing with sterile water until the cerebro-spinal fluid became clear. After waiting a short period, more blood began to appear in the tubing and Mr F decided to open the dura to find the bleeding point. After reopening the craniotomy, Mr F found that the shunt had penetrated the brain tissue, causing bleeding from a vein on the cortical surface. The bleeding was stopped and the shunt procedure completed.

Baby R was taken from the operating theatre for a CT scan, which showed a slight brain contusion at the site of the cortical puncture and shrinkage of the cyst. He was then extubated and taken to the paediatric intensive care unit where he was closely watched by Mr F and the paediatric intensive care consultant. Mr F informed the parents about what had happened in the operating theatre but said that he felt everything would now be fine. For the next couple of hours, there were entries in the clinical notes every few minutes and initially all was well. Unfortunately, four hours following the operation, Baby R developed a dilated pupil and a bradycardia. He was taken back for a CT. The scan showed a large haematoma had developed at the site of the cortical puncture and the baby was taken immediately to theatre for drainage of the clot. In spite of the surgery, Baby R was left with a severe neurological impairment.

A claim was made against Mr F by Baby R’s family, alleging bad management both during and after the operation. Experts reviewed all the notes and concluded that the management had been careful and appropriate. In particular, the consent process was well documented and it was clear that the parents knew about the possibility of bleeding and the potential consequent neurologic damage. The case was successfully defended.

In particularly complicated cases, the more detailed the medical records, the more robust the defence. As this case demonstrates, documenting the time of the notation can be very important. It was clear from the medical records that Baby R had been observed very closely in the hours following his surgery and therefore the postoperative care could not be criticised.

Complications are unfortunate but do happen and, in some cases, can have terrible and lifelong effects on patients. The medical records are clearly vital in documenting the consent process, which is at the heart of patient-centred medical care.
Missed ectopic pregnancy

Miss G was a 33-year-old single parent who had two children, aged 4 and 6. She had previously had chlamydia and three weeks ago had had unprotected sexual intercourse. Her periods were overdue by four days, so she had a pregnancy test, which was positive. She made an urgent appointment at a clinic to discuss the possibility of a termination.

When she was first seen in the clinic, she was scanned and they were unable to identify an intrauterine sac. She was therefore asked to come back ten days later. When she returned, the scan showed what was reported as “…an 8.5mm intrauterine sac compatible with five weeks gestation”. The gynaecologist, Mr W, warned Miss G of the risks of having such an early termination, but she insisted that they went ahead with the procedure as soon as possible. Mr W agreed and carried out a surgical termination under local anaesthesia. The procedure was deemed to be uneventful and no histology was requested.

Ten days later, Miss G attended her local Emergency Department with nausea, dizziness and abdominal pains. She was fully examined by junior doctor Dr Y, who thought she had endometritis and gave her some antibiotics, reassured her and sent her home.

A week later Miss G collapsed at home with severe right iliac fossa pain. She was brought back into the hospital by ambulance, hypotensive (BP90/50) and tachycardic (P 120). She was seen again by Dr Y who suspected appendicitis and requested an abdominal USS and routine bloods (FBC, U&Es). The USS showed a large amount of fluid in the pelvis and abdomen and an empty uterus, and the radiologist suggested carrying out an urgent pregnancy test. This was indeed positive and the gynaecologists were called to carry out an urgent laparoscopy. Two litres of blood were found in Miss G’s abdominal cavity and a ruptured ectopic pregnancy on the right side was confirmed. Miss G required a laparotomy and right salpingectomy. Her left fallopian tube had scarring from her previous chlamydial infection; regrettably, the right tube could not be conserved.

She required a blood transfusion, but made a full physical recovery, although she was quite traumatised by the events that had occurred and was upset by the advice that she might have problems conceiving naturally in the future. Miss G made a claim against both Mr W and Dr Y. It was deemed that Mr W had offered appropriate counselling to the patient with regards to the risks of the procedure at such an early stage of the pregnancy, although he was criticised for not requesting histology in this case. Dr Y was felt to have been negligent in not requesting a pregnancy test on each occasion she attended and not requesting advice from the on-call gynaecology team, especially in view of her recent gynaecological surgery.

The claim was settled for a moderate sum on behalf of both clinicians.

LEARNING POINTS

- When undertaking early terminations at less than seven weeks gestation, it is possible that only decidual endometrium is aspirated rather than the actual gestational sac. As such these procedures must be performed with the appropriate safeguards to ensure that the abortion is complete. Visual inspection of the tissue aspirated is of utmost importance. See: RCOG, The Care of Women Requesting Induced Abortion. Evidence-based clinical Guideline Number 7, London: RCOG (November 2011) – www.rcog.org.uk/womens-health/clinical-guidance/care-women-requestinginduced-abortion

- Although terminations are common procedures, as with all surgical procedures, all the common and significant complications must be fully explained to the patients and documented carefully in their notes – www.bpas.org/bpasknowledge.php?page=154-13k

- Even in the presence of a small uterine sac (eg, pseudosac), an ectopic pregnancy cannot always be excluded. See: 2011 Centre for Maternal and Child Enquiries (CMACE), BJOG 118 (Suppl 1), 1–203.
Mr L, a 22-year-old unemployed man, presented with his parents to the Emergency Department complaining of low mood and thoughts of suicide. He was assessed by Dr P, a junior hospital doctor on-call for psychiatry.

Mr L told Dr P that he had recently experienced the acrimonious break-up of a long-term relationship. He also volunteered a psychiatric history of ongoing treatment for depression starting as a teenager. He said he currently attended regular appointments with a community psychiatrist and was prescribed antidepressant medication. In the past he had once been admitted to hospital following a deliberate large overdose of paracetamol.

During the interview Mr L said he had not written a suicide note but that he had a plan for his suicide. He would not disclose what this was, but said that he was very likely to enact it soon. In view of his current presentation and history Dr P documented that Mr L was at high risk of a further suicide attempt. Dr P agreed with Mr L and his parents that Mr L should be admitted voluntarily to a psychiatric ward.

Mr L arrived at the ward and was seen for a ward clerking by Dr Q, a psychiatry trainee. Dr Q read Dr P’s assessment and also talked to Mr L about his intentions. Dr Q relayed to the nursing staff that Mr L’s supervision on the ward should consist of observations at 15-minute intervals.

That night Mr L went to bed. The next morning he kept a low profile and did not give the nursing staff any cause for concern. There was no ward round that day and the frequency of his nursing staff observations was not reviewed.

In the afternoon Mr L received several visitors. As they were leaving he mentioned to them that he was desperate for a cigarette. They were not aware that any items were restricted on the ward and left him with a packet of cigarettes and a lighter. Later that evening Mr L set his clothing on fire. Although this was quickly extinguished, he nevertheless received serious burns to his legs that required skin grafting.

Mr L’s family started a claim against Dr Q, stating that the level of supervision Dr Q recommended for Mr L was inappropriate in light of his suicide risk. Dr Q said that at the time he had seen Mr L he was keen to recommend constant ‘one-to-one’ nursing supervision. However, he did not as he had recently been told that this level of supervision was only appropriate in exceptional circumstances due to its high cost. No mention of this restriction was made in the notes. The claim was settled for a moderate amount.

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**LEARNING POINTS**

- All psychiatric patients require a suicide risk assessment on admission. This should be particularly detailed if a patient has a history of suicidal actions. Some patients, especially those at high risk, will require one-to-one nursing.
- In times of increasing pressure on finite resources, it is likely that hospital managers and clinicians will be under increasing pressure to keep expenditure under control. However, a doctor’s first responsibility is towards patient safety, so potentially dangerous policies should be clarified with management.
- If the patient management you consider clinically appropriate is blocked make sure this is clearly documented. If on-call trainees feel their clinical decisions are being inappropriately restricted they should alert the senior who is on-call.
- For reasons of safety, some items are restricted on psychiatric wards. Transgressions like this should not be possible and appropriate safeguards should be in place. If necessary, at-risk patients should have their visitors restricted.
Mrs H, a 54-year-old gardener, had been complaining of left shoulder pain for several weeks. It had become gradually worse, affecting her normal daily activities and causing her significant sleep disturbance. As Mrs H’s shoulder became progressively stiffer, she was referred to Mr Z, consultant orthopaedic surgeon.

Mr Z made a diagnosis of frozen shoulder, and sought to manage this conservatively with nonsteroidal analgesia and physiotherapy treatment. Unfortunately, after three months, Mrs H’s symptoms had not improved. After suitable verbal counselling, Mr Z administered an intra-articular steroid injection and reviewed Mrs H two weeks later. Again, Mrs H’s pain had not improved, and her range of movement remained severely restricted.

Mr Z discussed the option of surgical management with Mrs H, explaining that he could perform a shoulder arthroscopy and manipulation under anaesthesia. Mr Z documented in the hospital notes that he had a “long chat” with Mrs H as a way of informing her of the implications of the planned procedures, although he did not write down what possible complications were discussed.

The patient underwent the combined procedure. Mr Z confirmed the diagnosis of frozen shoulder, also identifying some rotator cuff degeneration. He performed a debridement of the rotator cuff as well as a subacromial decompression, injecting a mixture of local anaesthetic and adrenaline as part of his standard practice for this procedure. It all went uneventfully and the patient was discharged home the following day.

Although the mobility on the affected shoulder improved, the pain became worse. Mr Z suspected a possible injury to the axillary nerve that could have occurred at the time of the manipulation under anaesthesia or during the arthroscopy. He asked Dr N, a colleague neurologist with special interest in nerve injuries, to review Mrs H. Dr N could not find any neuropathy or evidence of nerve injury to explain the increasingly severe shoulder pain.

Mrs H made a claim against Mr Z on the basis that there had been nerve damage during the operation, causing her worsening pain. She alleged that Mr Z had not warned her that this was a possible complication of the surgery. She also claimed that had she known of this surgical risk, she would not have had the procedure.

An expert commissioned by Mrs H supported the thesis that during the manipulation under anaesthesia an excessive force was used, resulting in nerve injury. The expert also stated that on the balance of probabilities, had the patient known this risk, she would not have had the procedure. He supported this on the fact that no written consent, including risks, benefits and alternatives, was given to the patient. He concluded that Mr Z had acted negligently.

On the other hand, an expert on behalf of MPS stated that if the patient had a nerve lesion, this was most likely to have been present prior to surgery. He said that even if this injury occurred during the procedure, this was such a rare event that Mr Z could not be found negligent.

Given the strength of our defence expert’s opinion the case was taken to trial and the court found in favour of Mr Z. He was able to rely on a causation defence.

LEARNING POINTS

- Unforeseeable adverse outcomes, while deeply regrettable, are not always negligent.
- Informed consent is a fundamental part of the decision-making process between the doctor and the patient regarding treatment options. Most regulatory bodies across the world have specific guidance on consent. To ensure consistency in practice, it may be worth considering the use of informed consent templates for specific procedures. A template for a specific procedure may be helpful as an aide memoire, but it is not a substitute for a conversation with the patient.
A dangerous cough

I must take issue with one of the usually excellent learning points associated with a case report published in Casebook 20(2) entitled “A dangerous cough”. You recommend: “When administering anaesthesia during an elective procedure, it is preferable to stop should you encounter difficulties and reassess for surgery at another time.” Although it is apparent that this would have been the correct course of action in the case described, this is not always so.

Can I suggest the slightly more verbose but much more accurate:

If you encounter problems that you cannot be completely confident you have diagnosed accurately, and resolved fully when a patient is under general anaesthesia for an elective procedure that has not yet started, you should consider abandoning the procedure and waking the patient up.

Dr William Harrop-Griffiths, Consultant anaesthetist, UK

All in the detail

I am having increasing difficulty relying on Casebook for considered advice. The editorial standard is at odds with the excellent verbal advice I have received from the organisation over the last 20 years or so. What amounts to an apology regarding poor DNACPR advice given in January this year appears in the same edition as the following example of clumsiness:

“Your first obligation is to act in the patient’s best interests and you should not be pressured by the patient into doing anything that is counter to this” (learning points, “A dangerous cough”, Casebook 20(2), May 2012.). This seems to suggest that the patient does not know what their best interests are but the doctor does. Modern medical ethics tend more towards the notion that if a patient is able to make a decision regarding their own best interests it is not for the doctor to paternalistically impose their own views of best interests on them:

“A person is not to be treated as unable to make a decision merely because he makes an unwise decision.” s1(4) Mental Capacity Act 2005.

In the instant case I would have hoped that the advice given by the MPS would have been along the lines of:

Your first obligation is to act in the patient’s best interests and you should not be pressured by anyone else into doing something that is counter to this. In this case, more comprehensive preoperative assessment may have led the anaesthetist (in consultation with the surgeon) into concluding that the surgery would be safer once the chest infection had fully cleared. Presented with this information the patient would very likely agree to the postponement. If she felt her best interests were served by proceeding anyway the anaesthetist and surgeon would have the opportunity to seek second opinions from colleagues. A doctor is under no obligation to provide treatment he feels would be detrimental to the patient’s health simply because the patient demands it.

The notion that a vaginal hysterectomy under spinal anaesthesia might have been a reasonable alternative in the presence of pneumonia is a contentious point (particularly in an elective setting) that detracts from the otherwise sound advice regarding good communication.

Also, condensing what appears to be a very complicated case into a single glossy page might look attractive but for those experienced professionals reading the piece it usually leaves more questions than it provides answers. The poor writer has a Herculean task on his hands. Perhaps a much fuller summary could be provided online as might be found on Westlaw.

I do feel that the glossy Casebook does something of a disservice to MPS. There should be greater use of references and quotations from statute, case law and guidelines from professional bodies and considerably less reliance on well meaning, but sometimes ill-considered, bullet points.

Response

Regarding your point about patients’ best interests, from a medicolegal standpoint you are of course correct – and no authority can impose treatment on them against their wishes, save under the provisions of mental health legislation. However, the principle applies to the patient’s rights, and not the doctor’s responsibility; in other words, the patient cannot insist on being provided with inappropriate or negligent treatment simply because they believe it will be in their best interests to have it. The doctor has responsibilities and duties both in law and – in the UK at least – as imposed by the GMC to exercise their judgment and professionalism in assessing what treatment options are appropriate for the patient’s condition. After a proper informed discussion it is then for the patient to decide which option is best for them. I agree with your comment about the wording of the first learning point; precision and detail can be lost at the expense of limitations on space. I also recognise that in seeking to provide material that is interesting, practical and relevant to the very wide range of doctors who receive Casebook, we do not always provide the level of detail in case reports which an experienced specialist in your position might wish.

We have recently started publishing more specialty specific material, including an anaesthetic e-bulletin, and would welcome ideas for topical issues to cover in future editions. Casebook does not purport to be an academic or peer-reviewed journal; the case reports are based on MPS cases from around the world but, unless otherwise stated,
**HIV testing**

(please note – this article appeared in the UK version of Casebook. To read it on the UK MPS website, click here: www.medicalprotection.org/uk/casebook-may-2012/MP5-opinion-spradling-the-use-of-HIV-testing)

I read with interest the article “Spreading the use of HIV testing”, and entirely agree with the need for “normalisation” of the investigation of this virus. Encouragement to present to healthcare services and the stage at which patients present may be outside our control, but from their point of contact with healthcare professionals we have a window of opportunity to modify their prognosis.

Proactive consideration of the condition among our differential diagnoses of patients presenting with signs of immunosuppression (recurrent infections, atypical infections), PUO, obscure dermatological changes and non-specific signs (weight loss), should prompt investigation at the time of disease consideration, like any condition.

The demonstration projects clearly identify key educational needs among practitioners to dispel the myths around investigation and build professional confidence (consent, results management, insurance fallacies). Empowerment of junior doctors to consider the disease in their diagnoses and to elucidate risk factors among patients they encounter on the acute take or new outpatient referrals could improve early investigation. Through junior doctors presenting their reasons for investigation choice to senior clinicians, as any investigation with significant implications (genetic testing tumour markers, radiation exposure, invasive procedures), test appropriateness could be confirmed or refuted.

Also teaching communication skills to develop patient rapport prior to enquiring into the sexual history may assist clinicians.

If the barriers are not in diagnosis consideration, but clinician fears in discussing the investigation – what will the patient think? What if I cannot answer their questions? How do I tell them they have a positive result? – we are failing patients by potentially delaying diagnosis and thus denying life-preserving treatment at the earliest interval. Any concern regarding managing the results is our responsibility, to nurture the working relationship with sexual health services.

By the time the doctor with all the answers is encountered, it may be too late.

Dr Claire Brough, specialty trainee, cardiology, UK

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**Oh by the way, doctor**

I would like to offer a comment on your latest “Oh by the way, doctor” in Casebook 20(2), May 2012. Fair enough, the GP did miss the SUFE and didn’t make any notes, but when you examine the structure of the consultation, there would be few GPs in any country who couldn’t have ended up in the same unpleasant situation. The advice about the limping child is all apt but, just as importantly, there needs to be training and advice about managing the structure of consultations and demands that you cannot meet in a busy day that is already fully booked.

For example, the GP could have made a one-line entry in the mother’s notes about the request and then insisted she book in for a proper consultation for the child. Yes, she might have been angry and demanding, but it is ok to set boundaries with patients: “I’m sorry Mrs Smith, but assessment of a limp in children is not a quick thing and I really want to do my best for Johnny, I can give you an appointment tomorrow.”

Or: “I’m sorry Mrs Smith, but I am heavily booked today, and in fairness to the booked patients who are already waiting I cannot provide you with a double appointment.”

Better to weather some short-term annoyance from the patient and create a long-term understanding with the patient that you practise good medicine, and that off-the-cuff double bookings are not part of that practice.

In my own practice I will oblige with minor “quick look” things, eg, checking the child’s tonsils for which I gave antibiotics last week when he accompanies mum for her appointment. This sort of quick follow-up is useful for me and creates goodwill, but new assessments, of the type above with the limping child, should be deferred.

It is also important that both your reception and nursing staff have clear guidance about what is acceptable to double-book and that you should be consulted about double bookings. This creates a consistent culture across the practice, which prevents the doctor being overloaded and resentments developing within the practice team.

Dr Philippa Story, GP, New Zealand
As a newcomer to the world of smartphones, I was astonished by the number of medical apps available and the vast array of functions they serve. From Shiftworker (creates attractive calendars documenting your shift patterns), to PaedsED (provides rapid drug-dose calculations and a pain scale containing cute animal pictures) – there is something to suit every specialty and taste.

Of all the apps I discovered, Medscape stands out as being an incredibly versatile and useful tool, containing abundant functions, which I’ll highlight below. There is also a mind-bending back catalogue of evidence available for download, all more incredible for the fact that it is free. All that is required of you is an email address with which to set up an account.

Medscape ranks in Apple’s top app downloads, and it is easy to determine why. The app can be downloaded on to many devices, eg, iPhones, iPods, Blackberrys, Androids and Kindlefires, and has an easily navigable format, with large enough icons that you won’t forever be hitting the wrong button.

Medscape is developed by WebMD, the group responsible for various online medical resources, including eMedicine and Rxlist. The Medscape app is constantly developing with frequent evidence updates and an ever-expanding number of conditions covered (currently 4,000+). The content is written and peer-reviewed by 7,000 physicians representing numerous institutions, so somewhat more reliable than the good doctors Google and Wiki. Many articles also come with illustrations and videos, which are particularly handy for the anatomy segments and the section giving step-by-step instructions for 600-plus clinical procedures – an improvement on the ‘see one, do one’ ethos.

Medscape’s drug reference contains detailed prescribing information for more than 8,000 drugs (prescription, OTC and supplements). The only downfall is that some of the drugs are not listed in their English format (eg, Acetaminophen is listed for Paracetamol). There is also a drug interaction checker that allows the user to cross-check multiple drugs/supplements against each other to ensure they’re prescribing safely.

Not only that, Medscape incorporates numerous medical calculator tools, relevant to each specialty. I’ve highlighted some of my favourite aspects of the app, but there’s much more to take advantage of including daily news updates, 100-plus clinical protocols, monthly hot topics with latest practice updates, and the ability to carry out Medline searches within the app.

I’d thoroughly recommend adding Medscape to your device, and whilst you may not be fast enough to impress your senior by looking up the answers to ward round questions, you can enter each on-call, whatever your specialty, armed with the wisdom of 100 textbooks in your back pocket.

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**The Rise & Fall of Modern Medicine (2nd edition)**

*By James Le Fanu (Abacus Books, 2011)*

Reviewed by Dr Matthew Daunt, specialist registrar in anaesthesia at Nottingham University Hospitals NHS Trust

This new version has been updated to include the changes in the decade since its first release. It is essentially divided into two parts, a superb historical narrative of medicine’s greatest achievements in the post-war years, followed by a somewhat cynical review of the current medical world.

The first part – the “Twelve definitive moments of modern medicine” – is a must-read for all doctors and medical students. Covering the 45 years from the beginning of World War II, Le Fanu articulately describes the most significant developments of modern medicine, recounting details that are both entertaining and enlightening. The well-researched and heavily-referenced chapters depict events such as the discovery of penicillin, the birth of intensive care, open heart surgery and the first test-tube baby. This section of the book alone is enough for me to recommend it.

The uplifting book goes on to describe the development of newly-qualified doctors, from the 1930s when they had “a dozen or so proven remedies” at their disposal, to the end of their career when they have “over 2,000”. Le Fanu reveals in telling the reader that these discoveries were fortuitous, and often accidental. The change in the way research occurs is one of his reasons for the “fall” in modern medicine.

The second half of the book tackles the reasons behind the relative dearth of significant breakthroughs. The subsequent decline in new discoveries in the last 30 years is attributed mostly to the overwhelming impact of the human genome project, and the pharmaceutical companies whose interest in profit-making prohibits the effects of individual research. The latter half of the book is quite depressing, but ends with a sense of optimism overall as to what the future may hold.

This fascinating book gives an expert account of how modern medicine affects us all as doctors and patients, whilst also calling for change in order to prevent stagnation in the field of research.
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