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

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

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

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

It is in times of great stress that your professional qualities come to the fore. Your sense of personal responsibility, pride in the care you deliver to patients, and your aspiration towards improvement are decisive attributes that can make all the difference when under pressure. In such moments your professionalism has never been more important.
MPS was delighted to welcome more than 250 delegates to our International Conference 2012, Quality and Safety in Healthcare: Making a Difference.

Throughout the conference, delegates heard from leading international experts about the importance of listening to patient feedback to improve quality, the need to be transparent and professional when things go wrong, and the cost, both to the doctor–patient relationship and to the doctor’s claims experience, in failing to do so.

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

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

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

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

Dr Priya Singh shares her personal experiences of MPS’s international conference

Making medicine safer

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

By Sarah Whitehouse

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

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

Dr Gerald Hickson, Assistant Vice Chancellor for Health Affairs, Vanderbilt University Medical Centre, and Director of Centre for Patient and Professional Advocacy, delivered the first keynote address on delivering quality and trust.

Quality, he said, is about making medicine kinder and safer. Each doctor has a duty to address faulty systems;
To achieve a culture of safety, we first need to talk to each other. Quality is also about promoting reliability – doctors need to know they will be supported by their organisation if they raise any concerns. Similarly, organisations need to tackle unreasonable variations in the performance of healthcare professionals that threaten safety and quality.

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

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

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

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

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

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

But the fallout from an adverse event is often not about the money, argued Dr Lucian Leape, Adjunct Professor of Health Policy at Harvard School of Public Health, in his keynote address on disclosure and apology. It is about communicating effectively when things go wrong. A serious preventable injury is devastating for the patient – they are doubly wounded. Not only do they suffer a physical wound (the adverse event), they also suffer an emotional wound, the betrayal and loss of trust in the healthcare professional. A serious preventable injury is a medical emergency. If a doctor does not act quickly, things become much worse. The necessary treatment is open, honest and full communication.

In this medical emergency, there is a second victim, the caregiver. Shame, guilt and fear can take over if the situation is ignored. Apologising or admitting something has gone wrong can be difficult, yet Dr Leape suggests it is essential for the caregiver to heal. Dr Stephanie Bown agreed, outlining MPS’s belief in the necessity of a culture of openness. Legislation cannot work: it only serves to encourage fearful behaviour.

Mistakes do occur. Quality, however, is never an accident: it is always the result of high intentions, said Dr Jason Leitch, Clinical Director at The Quality Unit, Scottish Government, in his keynote address on safety and outcomes. Safer care can only be delivered by frontline professionals doing common things uncommonly well.

To achieve a culture of safety, we need a culture of improvement. John Tiernan, Director of MPS Educational Services, closed the two-day conference with a question: “Delegates from around the world have come to the conference and will leave with great ideas. What will you do with the information you have learnt?”

Visit the MPS website to read the event summary report which features links to videos, podcasts and speaker presentations.
HEADLINES AND DEADLINES

248 doctors found guilty of delivering substandard care

The Health Professions Council of South Africa (HPCSA) has revealed that 248 health professionals have been found guilty of incompetence, insufficient treatment and misdiagnosis in 306 cases between 2008 and 2012.

During this time, the HPCSA also issued 283 fines and 137 suspensions to doctors for misconduct. Figures show that doctors were found guilty in 20 cases of misdiagnosis since 2008.

Cases of incompetence rose from 18 (in 2010-11) to 32 in 2011-12. The number of cases involving insufficient care and mismanagement of patients more than doubled, with 44 cases reported in 2011-12 compared to 20 in 2010-11.

HPCSA registrar and chief executive officer Buyiswa Mjamba-Matschoa said the increase in medical errors was a big concern that the HPCSA and the health department would be investigating.

www.sowetanlive.co.za

Doctors sceptical about insurance scheme

Some private doctors have voiced concerns about the Department of Health’s plans to enlist them to spend some time each week working in state clinics.

Since the National Health Insurance (NHI) system was launched in April 2012, Health Minister Dr Aaron Motsoaledi has been campaigning for private GPs to work at under-resourced state clinics in a bid to ease pressure on busy local practices.

However, some private doctors have raised concerns about the plans, saying they believe they are being implemented from policy makers’ perspectives without considering the point of view of communities. Some local doctors claim that plans under the NHI system would leave little opportunity to develop a “genuine relationship” with the Department of Health, leaving doctors feeling vulnerable to cuts.

These groups are instead campaigning for specialist teams to be appointed by local hospitals instead of health department headquarters, saying that hospitals are better placed to identify their own community challenges.

Dr Johan Olivier, a convener for an informal association of GPs in Knysna, said there was no clarity on how much doctors were to be paid or whether they would work from clinics or treat state patients in their rooms.

Dr Motsoaledi’s spokesman, Joe Maila, says that despite some concerns, most doctors are happy to co-operate with the plans. “The GPs are enlisting their names and we are consolidating them. We are further finalising the legal and contractual requirements to be entered into between the Department of Health and the practitioners,” he says.

www.iol.co.za

FEBRUARY DEADLINE FOR THE NON-REGISTERED

The deadline approaches for responding to an HPCSA warning, which was issued to unregistered medical practitioners – including corporate entities – regarding the employment of other medical practitioners.

To ensure compliance with the Health Professions Act, No 56 of 1974 (the Act), unregistered practitioners who are employing medical practitioners to provide medical services should “unbundle their structures” by February 2013.

Failure to do so will expose such medical practitioners to the risk of suspension and/or deregistration. It also potentially exposes anyone employing deregistered medical practitioners to criminal and civil liability.

www.hpcsa.co.za

HEALTH CLAIMS RISE TO R1.4 BILLION

The Gauteng Health Department has announced that it is currently dealing with medical negligence or misconduct claims worth R1.4 billion.

In 2011, it paid out R876 million in compensation for medical claims, up from R665m in 2010. In 2012, it paid R44m in compensation for just five claims.

Doctors’ low morale and poor working conditions were cited as the main reasons why errors occurred leading to a claim, although the HPCSA also recognize patients’ growing understanding of their rights as a contributing factor.

www.timeslive.co.za

HPCSA REMINDS DOCTORS OF DUTIES IN EMERGENCY SITUATIONS

The Health Professions Council of South Africa (HPCSA) has issued a reminder to all healthcare practitioners of their obligations during an emergency situation with a patient.

Its statement says that doctors must first stabilise the patient and then arrange for an appropriate referral to another practitioner or facility if they feel they are unable to provide further treatment. It also says that a healthcare professional must not refuse a patient medical treatment in an emergency situation. This advice is in line with Section 27 of the Constitution, the National Health Act, and the HPCSA’s ethical guidelines.

www.hpcsa.co.za
EVENT SPECIAL

Ethics 4 All

The largest gathering of MPS members anywhere in the world assembled in South Africa last November, as MPS’s annual Ethics 4 All event took place. Held over three locations, the event in total attracted around 2,500 delegates – with 450 attendees in Durban, nearly 400 in Pretoria and more than 1,600 in Cape Town. The event is now in its fifth year but was making its debut in Durban.

The conferences, which support doctors faced with ethical challenges and enable them to obtain CPD/CME points for the ethical component of their professional development, had a different high-profile chairperson at each event. These were:

- **Durban:** Professor Morgan Chetty, Professor of Managed Care and Health Services Management, University of KwaZulu-Natal and Chairperson, South African Managed Care Coalition Ltd.
- **Pretoria:** Professor Ames Dhai, Director of the Steve Biko Centre for Bioethics and Co-Chair of the Human Research Ethics Committee, University of Witwatersrand.
- **Cape Town:** Professor Zephne van der Spuy, Professor of Obstetrics and Gynaecology, University of Cape Town.

There was the usual series of presentations at each of the events. In Pretoria and Cape Town, MPS Chief Executive Simon Kayll opened proceedings with a talk that provided an overview of MPS in South Africa, which included a look at current membership numbers; an overview of MPS’s service delivery in the country, and what this says about our ongoing commitment to South Africa; finally, Mr Kayll identified the challenges facing MPS in South Africa.

In Durban, the event was opened by Dr Stephanie Bown, MPS Director of Policy and Communications, and Editor-in-Chief of *Casebook*. Subsequent presentations were:

- **Special Investigations – Avoiding Complaints:** Consent and Context, delivered by Dr Graham Howarth, MPS Head of Medical Services (Africa).
- **Balancing Resources,** by Professor Martin Veller, Professor and Head, Department of Surgery, University of Witwatersrand.
- **Why do Patients Sue?** by John Tiernan, Director of MPS Educational Services.
- **The Trouble with Being Human – The Role of Effective Teams in Creating a Just Culture,** by Guy Hirst, British Airways Training Captain (retired) and Human Factors Consultant.

Dr Howarth said: “Set against the backdrop of an adverse claims environment and increasing complaints to the HPCSA, providing support and guidance to doctors about ethical issues by way of these conferences is both timely and fulfils a key educational need. We know that issues surrounding ethics and professionalism can be challenging for doctors to navigate and, although we’re here for doctors when things go wrong, we very much want to help them get it right in the first place. It’s about preventing pain for doctors and their patients. “Helping doctors understand why patients complain – for example, poor communication skills or not managing patient expectations – can minimise potential complaints as well as improve the doctor–patient relationship. “MPS’s membership – and with it our commitment to South Africa – is growing, which is why we have extended the conference over three sites and continue to provide workshops across South Africa on specialised communication techniques for a range of situations. “The feedback we have received from delegates has been overwhelming; we have had so many messages of support and encouragement – we really look forward to delivering these conferences again in 2013.”

Video accounts of the event in Cape Town are available on the MPS website, together with a more comprehensive report on all three conferences. The growing success of Ethics 4 All means MPS is hopeful of repeating – and building on – its positive reception in 2013.
Although most doctors will avoid claims for clinical negligence during their careers, the possibility of receiving one remains. Large claims in particular are on the rise, with MPS seeing an increase of 250% in the number of reported claims valued at over R2.5 million over the past five years. Because of this, we thought it useful to provide members with a step-by-step account of how a civil claim progresses – while also emphasising what you can do to assist MPS at each step, to ensure as swift and robust a response as possible.

Warning shots
Because a claim for clinical negligence can arise many years after an adverse event took place, you may not see a claim coming – but at other times you will be aware that something has gone wrong, in which case you should notify MPS at the earliest opportunity. The earlier we are in receipt of the facts, the sooner we can start looking into how we can best provide assistance.

Another indication that a claim is imminent is a request for a patient's records. This should not be ignored; as above, it is an ideal time to contact MPS. There may also be a fee payable to you to cover any costs, and we can find out exactly what that is. Disclosing medical records has been covered in more detail in the Casebook article “Disclosing patient records” (Vol 20 No 3, September 2012), but essentially any request for records from a solicitor needs the consent of the patient. If the solicitor is acting on behalf of the patient, it is usually safe to assume the request is being made on the patient’s instructions – but a signed consent form is still preferred.

When responding to the request, it is vital that you:
- Send a copy of the contemporaneous records
- Do not modify the records in any way
- Do not just send out a summary of the records.

The claim is made
The claim officially begins with the issuing of a Letter of Demand. The flowchart (right) sets out the steps of the ensuing claim; this article will then discuss the process in more detail and describe how MPS can assist.

The Letter of Demand sets out what the claimant wants, and gives a time frame in which to satisfy their demand. The letter also serves as a warning that you will be taken to court if you do not comply within said time frame. If you haven’t already informed MPS, you should do so upon receipt of a Letter of Demand.

If there is no reply to the Letter of Demand, the claimant will issue a Summons, which is a document that is stamped by the court and which lays out the details of the claim.

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Settle or defend
There are two choices in how to respond to the Summons – settle the case out of court, or defend to trial. This is not a decision to be taken lightly; settle too easily and get a reputation as a soft touch or defend unnecessarily and accumulate costs. As a result MPS takes this decision very seriously and inevitably the claim is investigated. This means obtaining all the factual information, which will include a copy of the patient’s records and possibly an interview with the doctor concerned. Once the facts have been ascertained, expert opinion on whether the case is defensible or not can be sought. If MPS is assisting you with the claim and a decision to settle is taken, we will contact the claimant’s legal team to agree on a settlement figure. If the case is being defended, the Notice of Intention to Defend – the form for which is on the rear of the
Summons – is completed and submitted to the claimant’s lawyer. Following this, a documentary exchange takes place between both parties – this phase is called the Pleadings. The legal documents involved are prepared according to the rules of court. During this stage it is still possible for both parties to agree on a settlement out of court. But if the case is heading to court, MPS will at this stage seek the opinion of an independent expert. It is important to note that this expert is neither for or against the doctor in question; the expert is for the court, and is there to provide a reflective opinion on the specifics of the case. Sometimes this will mean the expert making criticisms of you, the defendant. However, it is much better to have this criticism given to your defence team at this stage than have it played out in open court. Your defence team will be better placed to prepare for the case if it has all the facts and potential vulnerabilities to hand.

A pre-trial meeting will be held, which brings together all experts involved in the case. Often this meeting also sees a final offer made to the claimant.

At trial
The trial plays out in customary fashion, with both claimant and defendant lawyers presenting their side of the case. Evidence is presented and witnesses are called and they can be cross-examined. The ensuing judgment can then be followed by a review or appeal.

In South Africa, trials are normally split into liability and quantum. This means that in the case of the former, the onus is on the claimant to prove the negligence of you, the defendant. If they are successful in their claim, the next issue is to decide on the quantum of the claim – here the claimant must prove how much compensation the defendant is liable to pay to the claimant.

Feeling the pressure
If all this sounds stressful, then that’s because it is – and in MPS’s experience the stress of going to trial is a common reason for doctors wishing to settle privately, avoiding the battleground of the courtroom. But whether a claim goes to trial or not, there can be no doubt that being in receipt of a clinical negligence claim is a highly stressful and anxious time for any doctor.

MPS has a counselling service that is available to members who have experienced an adverse incident or medicolegal issue, and are experiencing emotional or psychological difficulties. Access to the service is obtained through the individual’s medicolegal case handler. The service is available 24 hours a day, seven days a week, with face-to-face counselling sessions available at a convenient time and place – all funded by MPS.

In our next edition of Casebook, we will take a more detailed look at MPS’s recent experience in South Africa, including our own approach to handling a member’s case, and a comparison of the number of cases we settle with the number of those that we defend to trial.
The worst of times

Medicolegal implications of the recession

Unemployment reduces wellbeing. Recession raises the demands on healthcare systems and makes it harder to pay for them. Doctors worldwide are having to adapt and change to cope with these additional pressures, says Sarah Whitehouse

Pro Sano Medical Scheme has noted a significant increase in serious ailments requiring hospitalisation, such as cardiovascular illness, hypertension, strokes and heart attacks, as well as psychiatric conditions such as depression. Many of these conditions are stress-related and are being seen across the board, in people of all ages and income levels.¹ Most dispiringly, international research suggests that for every 1% increase in the unemployment rate, there is a 0.78% increase in the rate of suicide.²

The impact on doctors

But what does all this mean for doctors? In the UK, the Insight Research Group has reported that 77% of GPs feel there has been an increase in new cases of mental health conditions in the last four years directly linked to the economic climate.³

Secondary care, too, has been affected, as many patients go directly to a specialist to reduce the costs of additional primary care. Hospitals are run as businesses, as are some medical aids, where they are mutuals and are accountable to their members. As these businesses become increasingly overstretched, tensions can begin to arise between treating escalating patient numbers, reducing costs, and maintaining patient safety. Dr Graham Howarth, Head of Medical Services (Africa) explains: “We have heard that some private hospital groups, in an attempt to save money, employ nurses rather than midwives on their labour wards, but we cannot comment on the truthfulness of these claims. A lack of specialisation can lead to increased intrapartum problems and the potential for increased complaints or claims.”

Acting within your competence is important. MPS has received a number of calls from hospital doctors who feel uncomfortable at being asked to provide cover for an area they do not normally specialise in because of staff shortages.

Dr Ming-Keng Teoh, MPS Head of Medical Services (Asia), explains that some medical private practitioners choose to maintain their income (as patients turn to the public sector) by taking on a wider range of treatments (eg, GPs undertaking cosmetic procedures), as well as patients (paediatricians seeing adult patients, obs and gynae consultants examining patients with breast lumps). Doctors who choose to do this are practising in areas beyond their expertise and may fail to
If you find that you are so overstretched that the situation is in danger of putting patient safety at risk, or your health begins to suffer, you should raise your concerns within the appropriate channels.

Maintaining standards
In South Africa, there has been speculation that the recession has led to an increase in fraudulent claims. These could be patient or doctor-related. Dr James Arens, Clinical Operations Executive of Pro Sano, says: “A practitioner might load their bill, so that a legitimate procedure is padded with all sorts of additional codes, which patients often do not understand or think to question.” Remember your professional obligations to be open and honest at all times.

Despite an increase in patient numbers, you should always take a thorough medical history and an examination if necessary – and document both. Record-keeping standards can easily slip if a consultation overruns, but it is important to stop and make notes before rushing to see the next patient. Be aware too of “by the way” comments, where symptoms might be mentioned in passing as the patient is on their way out of the door. These symptoms can often be the real reason behind an appointment, so make sure you record them. If it is not urgent, or you do not have sufficient time to give the patient your full attention, you should ask them to rebook.

Managing expectations
Speaking this year at an MPS conference for newly-qualified consultants, MPS Head of Medical Services Dr Nick Clements said: “There has to be a balance between the patient’s interests, the need to control budgets and where the doctor’s duty lies in these difficult circumstances. Often, the buck seems to stop with you, the doctor. If a patient cannot get the treatment they want, or the drugs they want, they will blame the doctor who is saying no. Doctors need to have the right communication skills to handle these situations carefully and manage patient expectations.”

Some patients see making a claim as a financial opportunity in these tough times. In Ireland, the average size of claims against doctors has increased by 37% between 2007 and 2011. Dr George Fernie, MPS Senior Medicolegal Adviser, says: “There has always been tension in Ireland with the public and private mix, but it’s been magnified with the recession. We have seen a case where a doctor reasonably asked a patient on long-term prescription to come in for a review, but the patient felt that this was financially motivated and lodged a complaint.” You should always explain your reasons for calling a patient in for a review, clearly explaining the health benefits and the need for follow-up.

Delaying a visit to the doctor
In South Africa, the loss of medical aid usually follows job losses, and so unemployed patients defer healthcare treatment and only seek help when acutely ill. This has resulted in patients presenting to primary care physicians later in the course of their illness, with more complications. Sometimes, patients go to see their GP with a medical aid card that they have borrowed from a friend or family member. GPs need to be vigilant and check that the card belongs to the patient in front of them.

In Ireland, those without Medical Cards are increasingly putting off making an appointment, which can have an impact on early diagnosis and the treatment of long-term conditions. Requests for telephone consultations are on the rise and, with them, the risks of potential missed diagnosis. Failure to diagnose can lead to a complaint or a claim, so it is important to have a low threshold for inviting the patient in for a review.

Despite the impact of the recession being less marked in Hong Kong, Malaysia and Singapore, which generally have more private practices and less welfare spending, Dr Teoh...
Yet doctors must retain a degree of realism. They cannot be responsible for putting right the social and financial woes of all their patients, as well as their ill health.

A reduction in patient numbers has also led to many doctors in private practice resorting to longer opening hours, more practice promotion activities and more turf battles between doctors. The respective medical councils do not permit doctors to promote their practice or advertise or canvass for patients, and so doctors may find themselves in murky medicolegal waters if they do try to seek new patients in this way. They are advised to consult and seek legal advice if unsure.

**Where does a doctor’s duty lie?**

The conflict between a doctor’s duty to their patient, and the patient’s ability to pay, can be all too real. An MPS GP, based in Ireland, describes a case where a patient with depression wanted to wait to pick up his anti-depressant prescription until he was paid. The GP was concerned – the patient had severe depression and was at risk if he did not take his medication. The GP spoke to the pharmacist and agreed to postpone the fees for a few days until the patient was able to pay.

Dr Brian Charles, Emergency Physician and MPS Consultant, based in Barbados, says that in the Caribbean: “Private practitioners are frequently faced with the ill patient who cannot pay (or at least, cannot pay at the time of the encounter), and they too must be compassionate and not put that patient at harm by denying appropriate care. All must be done to ensure that these patients are stabilised and properly referred onwards for the complete care they need.”

Yet doctors must retain a degree of realism. They cannot be responsible for putting right the social and financial woes of all their patients, as well as their ill health. To do otherwise may well result in burnout for the already overstretched doctor. In the UK, the GMC, in *Good Medical Practice*, states that good doctors: “Make the care of their patients their first concern”, but “must make good use of the resources available”. Unfortunately, these are not finite.

**Conclusion**

One small positive can be gleaned from the UK GP research into the effects of the recession on healthcare: 38% of GPs believe that patients who smoke are giving up or cutting down to save money. However, the pressure cooker of reduced health and increased demand for healthcare continues to affect most doctors. Dr Clements sums up: “Do the best you can with the resources available. Make sure that any resource-related decisions are fair and based on clinical need and remember to be open and honest with patients about the constraints.”

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On the case

Dr Graham Howarth, Head of Medical Services (Africa), introduces this issue’s round-up of case reports.

When treating patients who attend the surgery frequently, especially within a short space of time, it can be all too easy to be blinded by a familiar diagnosis based on pattern recognition, particularly if it is a commonplace, and seemingly innocuous, condition.

The safest approach when treating these patients is to go back to basics: document a thorough history and be prepared to re-examine the patient if their symptoms change.

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

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

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

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

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

- High R15,000,000+
- Substantial R1,500,000+
- Moderate R150,000+
- Low R15,000+
- Negligible <R15,000
Forty-year-old hairdresser and mother-of-three Mrs T had long-term problems with neck pains and migraines. She had seen her own GP Dr W, and many of the partners in the practice, several times over the years with the same complaint. Her symptoms had been largely attributed to muscular spasms due to her job.

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

Over the next three weeks, Mrs T attended four more times with ongoing symptoms, seeing different partners each time. She asked for a private referral to a chiropractor as she thought she had “wry neck” and simple analgesia was providing no relief.

Frustrated with the ongoing headache, she even attended casualty once but no investigations were carried out, based on the chronicity of her symptoms and her long history of migraines.

Four weeks from the onset of this latest, severe headache, Mrs T had a seizure followed by a fatal cardiorespiratory arrest. The postmortem showed that she had suffered a subarachnoid haemorrhage.

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

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**LEARNING POINTS**

- Those who reattend frequently with the same complaint might be seriously ill. A safe approach is to go back to basics, by documenting a thorough history and examination of the problem.
- Listening to what the patients tell you remains one of the best medical tools. A patient with chronic migraine who describes her headache as different to previous ones deserves careful attention. Try not to allow a consultation to be prejudiced by what has happened before and do not let the patient’s self-diagnosis prevent you from keeping an open mind as to the cause of their symptoms.
- SIGN have produced comprehensive guidelines: Diagnosis and Management of Headache in Adults – A National Clinical Guideline (2008) [www.sign.ac.uk/pdf/sign107.pdf](http://www.sign.ac.uk/pdf/sign107.pdf)
- NICE have similar guidance: Headaches: Diagnosis and management of headaches in young people and adults [http://publications.nice.org.uk/headaches-cg150](http://publications.nice.org.uk/headaches-cg150)
- Headache is a common symptom and missed SAH is a frequent source of litigation. Casebook has featured similar presentations of SAH in the past, which may be of interest:
  - MPS Casebook, Not just another headache, 17 (3) (2009)
  - MPS Casebook, Sudden first and worst, 16 (1) (2008)
  - MPS Casebook, Sudden first and worst again, 16 (2) (2008)
- If aneurysmal SAH is treated urgently, complications can be reduced. Kowalski et al noted that misdiagnosis of SAH in patients who initially present in good condition is associated with an increased mortality and morbidity. They suggest a low threshold for CT scanning and highlight the importance of immediate aneurysm repair – stating that rebleeding occurs in 26%-73% of patients within days or weeks if left untreated. Kowalski R et al, Initial misdiagnosis and outcome after subarachnoid haemorrhage, JAMA 291(7):866-869 (2004) [http://jama.jamanetwork.com/article.aspx?articleid=198199](http://jama.jamanetwork.com/article.aspx?articleid=198199)
- Remember the importance of lumbar puncture – CT scans may often come back negative.
- Ensure that you keep accurate records, as when a claim is made, evidence is collected from a number of different sources and records may be cross-referenced. For example, hospital records on admission may contain a history that is very relevant in a claim relating to a GP’s earlier actions.
**Missed breast cancer**

Mrs B was a 35-year-old housewife with two children. She was well-known at her GP surgery since childhood and had needed support with a troubled past. She had suffered abuse as a child and domestic violence in her first marriage. She attended the surgery very frequently with anxiety issues and lots of minor ailments. She would have a list of things that she wanted to discuss each time she attended and consultations would frequently take a long time.

Some years ago, Mrs B had been referred to the breast clinic and was diagnosed with fibrocystic disease. Mrs B mentioned several times on her way out of the doctor’s room of having sore and lumpy breasts. Several of the GPs she had seen had documented this as part of her lengthy consultations and she was examined several times. This, however, always seemed to be part of a “by-the-way” mention rather than a full and detailed examination. Mrs B felt anxious about her breasts and continued to report this when she saw her GP about other things.

Dr T knew Mrs B well and found her to be a challenging patient. He struggled to be able to separate her physical and psychological issues, which were often intertwined. Mrs B always seemed very emotional about her personal problems and Dr T knew he would always run late after he had seen her. He found her increasing breast discomfort was difficult to assess. Dr T had wanted to give fuller attention to Mrs B’s breast symptoms and had asked her to return on another day for a new assessment, but she had failed to attend.

Dr T’s partners also saw Mrs B many times and reported this when she saw them. Mrs B made a claim against the doctors at her surgery for the delayed diagnosis. The case was settled for a moderate sum.

**LEARNING POINTS**

- Fibrocystic breast disease is a diagnosis of exclusion. If symptoms persist the diagnosis needs to be challenged on a regular basis. The initial diagnosis could have been wrong or it may have evolved into something else.
- Continuity of care is important, especially in reviewing the nature of a breast lump over time. This can be difficult in busy surgeries with many GPs but it is good practice to ensure that it is the same doctor each time in order to make the comparison objective. As more healthcare professionals are involved in a patient’s care, comprehensive notes and good communication are important.
- NICE has published guidance on Improving Outcomes in Breast Cancer (28 August 2002). It has a useful section on managing breast lumps which GPs should be familiar with. The document makes several recommendations, some of which are outlined below:
  1. All patients with possible or suspected breast cancer should be referred to a breast clinic without delay.
  2. Urgent referral (within two weeks) should be arranged for:
     - Patients aged 30 or over with a discrete lump in the breast
     - Patients with breast signs or symptoms which are highly suggestive of cancer. These include ulceration, skin nodules, skin distortion, nipple eczema, recent nipple retraction or distortion (<3 months) or unilateral nipple discharge which stains clothes.
  3. Breast lumps in the following patients or of the following types should be referred but not necessarily urgently:
     - Discrete lump in a younger woman (<30 years)
     - Asymmetrical nodularity that persists at review after menstruation
     - Abscess
     - Persistently refilling or recurrent cyst.
     - Beware of “by-the-way” mentions from patients on their way out of the surgery. Sometimes they hide serious pathology. If there is no time for a full assessment, arrange a new, later appointment.
     - Challenging patients may require particular care. Patients with complex psychological, social and psychiatric needs can, and often do, have physical problems. There is an interesting article about challenging patients in Casebook (May 2009). It has some insightful case reports and tips on management.
     - Patients that don’t attend their appointments raise several issues. Where does the doctor’s responsibility end? What should GPs do about it? It may be useful to have a practice meeting to discuss this and consider developing some practice guidelines about safety netting for did not attend patients.
Mrs S was a 35-year-old shopkeeper with an established history of recurrent UTIs, which had responded well to antibiotics. An ultrasound in the past had confirmed kidney stones.

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

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

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

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

Mrs S was very upset when she was diagnosed, as she felt the back pain had always been due to the mass, and she made a claim against Dr F for failing to refer her earlier. Experts who looked into the case agreed that the management had been appropriate and Dr F had acted like any other reasonable GP would have at the time. The experts also found that although some of the examinations weren’t examples of best practice, they were not below an unacceptable level. At no time was an urgent or emergency referral warranted.

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

Back with back pain

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

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

When patients attend with different symptoms and illnesses at the same consultation, differential diagnosis can be more complex and therefore greater awareness is necessary.

Keep up-to-date with guidelines on best practice for back pain. The NICE guidelines for low back pain can be downloaded here: www.nice.org.uk/CG88quickrefguide. This covers management of musculoskeletal back pain but not malignancy, infection, fracture and inflammatory conditions such as ankylosing spondylitis. Remember these alternative differential diagnoses when assessing a person with back pain.

Failure to diagnose is not inevitably negligent. There was a careful, well-documented assessment of the patient on every occasion.
Mrs H, a 23-year-old professional photographer in her first pregnancy, was pregnant with twins. The pregnancy progressed without any complication, until week 36 when she went into preterm labour. Dr L was the obstetrician on duty. As the first twin was a breech presentation, an emergency caesarean section was performed under spinal anaesthetic and both twins were delivered in good condition.

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

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

The case was settled for a moderate sum.

**LEARNING POINTS**

- Postpartum haemorrhage remains a leading cause of maternal morbidity and mortality.
- As part of good clinical governance, obstetric departments will have guidelines on the management of massive haemorrhage.
- The management of massive obstetric haemorrhage should be included when practising emergency drills on the labour ward, as well as forming part of regular education for all staff that look after pregnant women. This would help ensure staff are familiar with local guidelines.
- It may be justifiable to deviate from local guidelines in an emergency, but it is very important to document any reasons for doing so.
- Women at high risk of postpartum haemorrhage should have a written management plan, including any prophylactic measures that need to be implemented. Multiple pregnancy is a risk factor for postpartum haemorrhage as a result of uterine atony.
- The decision to perform a postpartum hysterectomy can be a difficult one to make as it will have irreversible consequences. It is good practice to discuss the decision with an experienced consultant colleague.
- Women who have suffered a major obstetric complication should be offered the opportunity to discuss the events with a consultant obstetrician and senior midwife and be offered the necessary support.

GM
Mr P, a 49-year-old taxi driver, had recently visited casualty with chest pain. He ended up being transferred to the local cardiac unit where, according to his brief discharge advice note, he had "emergency coronary bypass surgery (full discharge letter to follow)".

Three days later after getting home he developed aching discomfort in his right lower leg and reattended casualty, taking the discharge note with him. He was seen by Dr B. Dr B examined his lower leg and noted that the wound from his saphenous vein harvest site looked inflamed. He documented that there were no clinical signs of a deep venous thrombosis and discharged Mr P home with a course of oral flucloxacillin.

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

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

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

No leg to stand on

Mr P, a 49-year-old taxi driver, had recently visited casualty with chest pain. He ended up being transferred to the local cardiac unit where, according to his brief discharge advice note, he had “emergency coronary bypass surgery (full discharge letter to follow)”. Three days later after getting home he developed aching discomfort in his right lower leg and reattended casualty, taking the discharge note with him. He was seen by Dr B. Dr B examined his lower leg and noted that the wound from his saphenous vein harvest site looked inflamed. He documented that there were no clinical signs of a deep venous thrombosis and discharged Mr P home with a course of oral flucloxacillin.

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

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Mr P made a claim against all the doctors who had been involved in his care prior to his last casualty attendance. The claim was settled for a substantial sum.
Mr C, a 40-year-old carpenter, attended casualty with a severe headache, vomiting, blurred vision and photophobia. These symptoms responded to analgesics and antiemetics. History and examination suggested possible intracranial pathology. The CT scan performed showed no evidence of a subarachnoid haemorrhage but did show a large tumour in the pituitary fossa.

Recently appointed consultant neurosurgeon Dr Y was soon involved in Mr C’s care. He requested immediate ophthalmology assessment and a visual field defect was excluded. Dr Y arranged a pituitary function test but proceeded before the result was available. Dr Y discussed the problem with Mr C and informed him that due to possible pituitary pressure on the optic nerves there was a high risk of blindness, and growth of the tumour might affect the function of the pituitary. Mr C agreed to immediate surgery.

Dr Y had very little experience of pituitary gland surgery. He chose a surgical approach that he felt familiar with, a left-sided fronto-temporal craniotomy, adopting a subfrontal and transylvanian approach to remove the tumour. The procedure was complicated as the tumour was very friable.

Postoperatively Mr C had a dense hemiparesis. A repeat CT scan revealed extensive capsular infarct on the left side of the brain and a lacuna infarct on the right. It took several months for Mr C to recover any independence and he was left with right-sided permanent neurological damage with hemiparesis. Subsequently he was also found to have raised prolactin levels and ACTH and gonadotropin deficiencies requiring hydrocortisone and testosterone. He made a claim against Dr Y.

Expert opinion was critical of Dr Y’s management on various counts. Preoperatively Mr C had normal vision so he was not at immediate risk of blindness as a consequence of pressure on the optic nerve. However as the tumour enlarged he may have been at risk of pituitary infarction (apoplexy), further affecting the hormonal function of the pituitary gland. Cases such as this are usually managed jointly with an endocrinologist who will assess the function of the anterior and posterior pituitary, by appropriate biochemical tests, such as stimulatory hormonal testing, and for posterior pituitary, a prolactin level.

Medical management could delay surgical intervention if the optic nerves were not at risk and the tumour size did not suggest a risk of infarction. The experts were also critical of the surgical approach, which was not in line with usual practice. They agreed that there was no clinical indication for the urgency with which this procedure was undertaken; had an MDT assessment been undertaken he wouldn’t have had surgery.

The case had to be settled for a high sum.

LEARNING POINTS

- Patience and an awareness of one’s own expertise and knowledge are vital to practise safe surgery. It is rarely appropriate to rush into a procedure, particularly if this means there is a risk of taking an incorrect or risky approach.
- A surgeon may need to take rapid and difficult decisions intraoperatively; however, preoperatively it is important to take appropriate time to review all investigation and treatment options to ensure the best outcome for the patient.
- In medical practice recognising one’s limits (cognisance) and accepting that something may go beyond one’s expertise and training is essential for good medical practice. This might be particularly hard for newly-appointed consultants eager to establish their clinical practice and expertise to their senior colleagues.
- It is important to gather all the facts available to define the clinical situation of the patient before deciding on any management plan. It is here that joint or team working may be appropriate and helpful. In retrospect, in this patient, there were a number of unanswered questions such as the precise nature of the lesion; whether more tests should have been carried out to define the situation; whether the surgery was needed at that time; and whether the patient was at risk of pituitary apoplexy.
- Working as a team provides an extra safety net to medical practice. In areas such as pituitary surgery, it is common practice nowadays to work in conjunction with the endocrinology team, who can give advice on the medical investigations to define the patient’s problem and assist in postoperative hormone replacement as appropriate.
Ms W, a 45-year-old secretary, had poliomyelitis as a child, which left her with a leg length discrepancy, the right leg being several cm shorter than the left. Despite the obvious cosmetic appearance and impaired functional mobility, she had never thought of having any form of treatment. However, one day she watched a programme on TV about surgery to lengthen limbs, so she asked her GP to get her an appointment to see the surgeon involved in the programme, Dr A.

Dr A saw Ms W in clinic; soon after she had a date for her surgery. Dr A did not document any counselling of the potentially serious side-effects or the intensive physical therapy that would be required after the surgery. The possibility of subsequent surgery was not mentioned, nor was the risk that she may be worse off after surgery explained.

Dr A only made brief notes at the initial consultation, the operation and follow-up, with no documentation about explanation of risks and complications. Unfortunately, the postoperative progress was not good and Ms W suffered incapacitating pain. Over the course of a few months Ms W experienced progressive stiffening of the ankle and was subsequently left with an equinus contracture. During the next few years she also developed a valgus deformity of her proximal tibia with some procurvatum. Her mobility deteriorated. The cosmetic appearance of her leg, although longer, was no better and overall her clinical condition was worse than before the operation.

Eventually Ms W made a claim against Dr A. The experts involved thought it was difficult to decide how much of her subsequent problems were due to the surgery and poor quality of follow-up, or because of post-polio syndrome. However, due to lack of adequate medical notes, to demonstrate adequate warning of risks, the case could not be defended and was settled for a substantial sum.

**Learning Points**

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

When the results were available, Dr S considered the ECG for any abnormalities of rate, rhythm or appearance, and looked for changes suggestive of myocardial ischaemia or infarction. He felt that the ECG was essentially normal, aside from mild tachycardia, and did not see any gross abnormality requiring emergency admission. Two days later, Mr R attended the surgery as an emergency, complaining of chest pain, shortness of breath and nausea over the weekend. Dr S saw him before surgery began in the morning and arranged for emergency admission to hospital. The ECG and blood test results were sent along with a handwritten referral letter. Upon admission to hospital, Mr R clinically deteriorated and CPR was given; however, Mr R died within an hour of admission. The postmortem found that Mr R had a large saddle embolus in the pulmonary artery causing complete obstruction of the lumen. The left popliteal vein showed residual deep venous thrombosis and that this was the likely source of the fatal embolism.

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

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

Mr Y was well-known at the practice as he had attended since his childhood. The practice had supported him and his mother with some behavioural problems at school and with issues around domestic violence before his father had left home. His mother had schizophrenia and was also a regular attender at the practice.

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

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

Mr Y began to feel worse and was struggling to get out of bed due to the severity of his back pain. His mother attended the surgery on his behalf to ask for a home visit, but one of the receptionists refused the request and asked the patient to attend surgery. She mentioned later that Dr S had said previously that “he couldn’t do any more for the family” and that she was trying to help.

The next day Mr Y felt very weak. He tried to get out of bed and collapsed. His mother called an ambulance and he was rushed to hospital. He was diagnosed with endocarditis and discitis. Despite intravenous antibiotics he died of overwhelming sepsis. His mother was devastated and made a claim against Dr S’s surgery. The case could not be defended and was settled for a moderate amount.

LEARNING POINTS

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

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

Response

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

On reviewing the claim, there are a number of differences between the facts of that case and the facts described in Casebook, such that the material omissions (failure to adequately monitor or manage significant hypertension in presence of multiple cardiovascular risk factors) which led to expert criticism in the case, do not appear in the account given in Casebook. I offer my personal apology for this – we do change details of cases prior to publication so that anonymity of the parties is preserved, but on this occasion the changes severely compromised the credibility of the case and this was not picked up by our editorial process. Indeed, it is your MPS Editor-in-Chief who has ‘slipped through the cracks’ on this occasion. And we have a few learning points to ensure that this does not happen again.

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

Dr Stephanie Bown, Editor-in-chief

A pain in the leg

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

Even a Wells score of 0, which it would have been in this lady, places her in the “Low risk” group. This is not the same as no risk. What Dr C should have done is a d-dimer. Forget her fabulous documentation. There is no clinical finding that excludes a DVT. That you defended the claim successfully is a travesty. A life was lost. A positive result would have led to a Doppler USS, which may just have saved her life.

Dr S J Wallace, UK

Nasogastric tube errors – 1

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

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

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

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

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

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

This pressure on hospital doctors to ‘get rid’ of their patients back to the community is encapsulated in a set of rules known as NTFUR (new to follow-up ratios) and is being applied ever more ruthlessly across the country. A figure for the average ideal number of times a patient should be seen by a certain specialty (and not by pathology) is devised with published evidence and imposed upon specialty departments.

Often the ratio is well under one to two. Lead clinicians whose departments do not stick to the figures are called in by administrators (as I have found myself) and pressured to comply.

Clearly, because hospital care is seen (often wrongly) as expensive, the stimulus for this is cost-savings. However, it should fall to us as medical professionals to point out the very considerable dangers and indeed false economies.

Firstly there is often no continuity of care because GPs understandably often feel unable or unwilling to deal with the nuances of postoperative care.

Patients such as that in “A normal appendix” suffer needless delays and sometimes injury in reaching the real diagnosis.

Finally, over a longer period there’s a massive loss of skill, experience and learning because surgery does not end at the door of the operating theatre or ward. It ends when the specialist discharges the patient from the follow-up clinic cured of his/her symptoms, and it’s often during that follow-up that as a surgeon one realises one has missed something or perhaps done something less well than one might have. The changes now being forced away from us by NTFUR reduce the experience and excellence of doctors, nursing and clinical support staff. The problem applies equally in public and private practice where insurers are starting to apply the same pressures. Professional organisations and indeed our indemnity providers need to support doctors in dealing with this.

Mr Peter Mahaffey, UK

Learning points

- In the current case, Ms Q appendicectomy was done for an appendix thought to be inflamed, which on further investigation was found to be a Meckel’s diverticulum, which is an infrequent cause of postoperative care.
- When open surgery is performed it is common surgical practice to remove the appendix even if it is not inflamed. This prevents the lifetime risk of future appendicitis.
- Appendicectomy for a Meckel’s diverticulum is not recommended. This should be undertaken only in the case of active disease at this site.
- It is the responsibility of the operating surgeon to discuss the procedure directly with the patient, as a failure to do so may result in a claim being made. This should be recorded and signed by the patient in the patient’s notes.
- The changes in primary postoperative care have led to a reduction in the experience and excellence of doctors, nursing and clinical support staff.

Nasogastric tube errors – 2

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

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

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

In a group with increased gastric pH this would mean a chest x-ray every time an NG drug is administered – possibly multiple times over the course of a day. We would suggest that
for ventilated critically ill patients the wording should be changed from “every time they are used” to “if there is any suspicion of displacement”. This can be aided by ensuring that the cm marker at the nostril following insertion is clearly documented and checked every time the NG tube is used.

The guidance also has implications that extend far beyond critical care. There are many patients in community hospitals and rehabilitation units receiving NG feeding, who will be receiving concurrent acid suppressing drugs. There are large numbers of confused patients who repeatedly pull out NG feeding tubes and multiple x-rays on a daily basis and who are impossible to sustain. In many of these units there may not be direct access to x-ray facilities available. The guidance makes the maintenance of regular adequate enteral nutrition and medication administration impossible for large groups of patients, and should be revised. The major difficulty with that is that the NPSA was abolished last year and there is no mechanism for revision.

Dr Neil Young and Dr Brian Cook, UK

The internet: target practice?

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

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

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

While this might raise the possibility that patients could consult too soon and be given false reassurance before the problem becomes clearer, the issue for us is to communicate the need to reattend if the problem gets worse, or other symptoms develop. So: are we approachable? Can we somehow give permission in advance to come back as well as showing a personal interest? A phrase offered to our trainees to adapt is something along the lines of: “If this thing misbehaves itself in any way I want you to know about it…” Trainee GPs would be asked to record a contingency plan (in this case an ultrasound scan) to give some idea of what is expected. Another possible technique is to inject some deliberate uncertainty such as “I think that’s OK, but you must let me know if…”

Dr Paul Vincent, UK

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

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

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

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

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

Dr Godfrey Manning, UK

Skipping over the details

“ Skipping over the details” (Casebook Vol 20(3), p14) raises an interesting point. It was a year from the first consultation to the next. At first sight this seems surprising; why ever did the patient not come back sooner; is the doctor really so responsible for the late presentation? After all, doctors can only ever offer reassurance that is relevant at the moment in time it is given, not that there will not be a problem later. GPs are well aware of how presentations may change over time; that a significant diagnosis may not be obvious at first presentation.

Dr Neil Young and Dr Brian Cook, UK
Reviews

The Creative Destruction of Medicine by Eric Topol
Reviewed by Dr Muiris Houston, medical journalist and health analyst

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

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

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

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

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

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

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

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

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

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

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

Our brains are tainted by presumptions and are subconsciously influenced by what we are exposed to in our daily lives. This is partly about cognitive bias, which Kahneman describes in the first part of this book.

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

The reader may be put off by the potential of complex ‘science bits’ and long words – this is not something to be worried about. It is a bestseller because it is accessible, written in an informal way, each chapter peppered with example questions, scenarios, and details of experiments that clarify the arguments made for each of the theories.

Today our minds are heavily bombarded by mass media and marketing, and Kahneman’s book also helps us unravel the decisions we make outside the workplace. After reading the book perhaps having an understanding of these shortcomings will make us question our decision-making, our behavioural responses and our confidence in judgments, but hopefully in a positive way.
1. There can be no doubt that professional standards are declining in South Africa. True or false

2. Doctors may be employed by unregistered practitioners. True or false

3. Doctors are not obliged to assist in medical emergencies. True or false

4. Improving communications skills is unlikely to help decrease complaints. True or false

5. If a solicitor requests a copy of a patient’s records there is no need for the patient to consent. True or false

6. If there is a request for records, in anticipation of litigation, do not send a summary of the records. True or false

7. If a patient’s solicitor requests a copy of your records do not modify them in any way. True or false

8. A Letter of Demand is usually the first formal indication that litigation is to follow. True or false

9. You ignore a Summons a case against you cannot be progressed. True or false

10. A Default Judgement is a judgment against you and you may end up having to compensate the claimant. True or false

11. The primary role of the defence expert is to give an opinion that will defend the defendant. True or false

12. A critical defence expert opinion necessarily shows that the expert is biased against you. True or false

13. In South Africa cases sometimes go to trial on both liability and quantum. True or false

14. Healthcare is impervious to recession. True or false

15. Regular attenders with the same problem are seldom ill. True or false

16. Appropriate special investigations are inevitably a better tool than a good history. True or false

17. Newspaper and other media articles foster realistic expectations in patients. True or false

18. Consent for innovative techniques does not need to be as robust as for tried and tested techniques. True or false

19. Money and not communication is the essence when managing a complaint. True or false

20. There is no correlation between unemployment and wellbeing. True or false
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In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

AFRICA MEDICOLEGAL ADVICE
www.mps-group.org/za-mla

To help us to provide you with assistance as quickly as possible please use the medicolegal contact form on our website.

The form is secure and confidential – allowing you to give us your MPS membership details and provide a brief explanation of an incident. The information you provide comes directly to MPS and the receipt of the form will be acknowledged by email immediately.

On the next working day we will open a new case for you and we will contact you as soon as possible to discuss the matter.

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