DEALING WITH ADVERSE INCIDENTS

MANAGING MISTAKES AND MISHAPS

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BEING OPEN AND HONEST
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CONSENT SUCCESS
Ten top tips

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We welcome contributions to New Doctor so if you want to get involved, please contact us on 0113 241 0836 or email: kirsty.plowman@medicalprotection.org

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Welcome

Welcome to the latest edition of New Doctor.

I would firstly like to introduce myself as the new Editor-in-Chief of this popular publication. My predecessor Dr Gordon McDavid has stepped aside and I would like to take this opportunity to thank him for the excellent job he has done since taking over in 2012. Here at Medical Protection, we appreciate the numerous challenges facing junior doctors and hope that you find the advice in this edition helpful in your day to day practice.

Putting pen to paper for my first article for New Doctor, I address the principle of probity. We frequently see cases arising from allegations which call a doctor’s honesty into question. This feature is not designed to frighten but rather serve as a vital reminder of your expectations – probity is central to the public trust placed in the medical profession and junior doctors should, through their actions, uphold this reputation.

Inside, you will also find some invaluable advice on how to deal with adverse incidents which can be particularly difficult to deal with when you are one of the more junior members of the team. If you do require advice then please contact us – you are not alone!

Our ‘From ward to world’ articles provide a wonderful insight into the overseas opportunities available to junior doctors. Dr Robert Molloy’s moving account on page 12 describes how the tragic Christchurch earthquake impacted on his time working in the city.

Also in this edition we provide you with top tips for consenting patients for procedures and a reminder on the importance of good handovers. In addition, Dr Nicky King explores the complex legal and ethical issues surrounding Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions.

I do hope you enjoy this edition of New Doctor. As always, we welcome your feedback and comments so please get in touch.

Dr James Thorpe
Editor-in-Chief

ARE YOU MISSING OUT?

If we haven’t seen you since you completed your Medical Protection renewal form back in medical school, you may need to update your details. To make sure your details are up-to-date and you are getting the most out of your membership, visit medicalprotection.org and log into My MPS.

You can access our popular CPD accredited e-learning modules and attend our workshops free of charge as a benefit of your membership so please take a look!

WE WANT TO HEAR FROM YOU!

Medical Protection is your organisation and we want you to be part of it. Do you have a dilemma and would like to see it addressed in New Doctor? Have you worked overseas and want to share your experiences with fellow foundation year colleagues? Getting research or writing published will make your CV stand out in whatever specialty you go into.

Tell us about your experiences on the wards and you could get published! We welcome contributions to New Doctor, so if you want to get involved, please email Kirsty Plowman, New Doctor Editor, at kirsty.plowman@medicalprotection.org
Medical Protection’s Senior Medicolegal Adviser Dr Pallavi Bradshaw forewarns foundation doctors about the prospect of facing criminal investigations during their career.

With the introduction of the new criminal offence of wilful neglect, there are now more criminal sanctions for doctors than ever before. There also seems to be more coverage of cases involving doctors which in my experience has all created a much greater awareness of, and fear about, the potential to end up in front of a judge. These cases dispel the myth that as a trainee you are somehow protected from the same levels of scrutiny as more senior doctors. What these cases also highlight is a willingness on the part of the CPS to prosecute healthcare professionals and an acceptance by society of this.

When I was a house officer the worst thing that I thought could happen to me was to face a complaint or be involved in a claim. Nowadays I advise foundation doctors that they should expect to be involved in significant events, inquests, receive complaints and even be referred to the GMC at some point in their career. As a medicolegal adviser I have to always bear in mind the risks of criminal investigation when advising members. Something as innocuous as being asked to write a report for a trust after an incident could lead to consequences far more significant.

It is not unheard of for doctors involved in inquests to be prosecuted if they are thought to have given untruthful evidence under oath and the Coroner Rules also imposes criminal sanctions should it be shown that a report sent is misleading or lacking in all relevant information. It is therefore imperative that when asked for a statement you ensure you have been through the contemporaneous notes and discussed the case with your education supervisor.

Another concern is the number of allegations of sexual assault made by patients against doctors. Doctors seem to have a false sense of security when performing physical examinations on the ward and often don’t offer chaperones. Although this may seem onerous it is something worth careful consideration, as is recording of when a chaperone is offered.

Last year saw the introduction of the new criminal offence of ‘ill treatment or wilful neglect’ and a statutory duty of candour for healthcare providers in England. Whilst the latter does not apply directly to individual doctors, it is possible that hospital trusts may take action against healthcare professionals who fail to discharge their duty to be open and honest with patients when something goes wrong. The offence of wilful neglect on the other hand does not require harm to the patient and a doctor could potentially face prosecution where decisions taken owing to staffing levels and reasonable clinical judgement are investigated by police.

While the actual numbers of prosecutions remain relatively low and the conviction rate even smaller it does highlight the increasing minefield of modern day practice.
The word ‘probity’ is derived from the Latin for good, honest and upright. The GMC expects a doctor to be all of those things, as well as fair, law-abiding and of general good character. Probity is central to the public trust placed in the medical profession and junior doctors should, through their actions, uphold this reputation.

Here at Medical Protection, we frequently see cases arising from allegations calling a doctor’s probity into question. Although many of these result from clinical incidents, junior doctors are sometimes surprised by the interest that the GMC takes in their private lives.

The following cases are fictional but based on real events. They demonstrate a number of areas where it is important to ensure that you are completely open and honest. As we will see, failure to do so can potentially have a significant impact on your career.

**CASE 1 – CAUTIONS AND CONVICTIONS**

Dr A was working in her FY2 year and was late for a night shift. Whilst driving to work, she was caught by a mobile police safety camera driving at 82mph in a 50mph zone. The police notified her that, due to the severity of the offence, they intended to prosecute rather than offer a fixed penalty notice. She attended court and was given six penalty points and a 30 day driving ban.

Dr A was unaware of the GMC’s requirement that all doctors must self-refer in the event of a criminal conviction. When she applied for her GP training scheme, she was notified that her enhanced disclosure check had flagged her conviction for speeding. Dr A was referred to the GMC.

Dr A was a Medical Protection member and contacted our medicolegal advice line. With our assistance, Dr A submitted a statement detailing the circumstances of the conviction. Her case was closed with a letter of advice from the GMC.

**LEARNING POINTS**

The GMC make clear in Good Medical Practice (2013) that doctors are expected to inform them if, anywhere in the world, they are charged with, convicted or accept a caution for a criminal offence. This usually does not include fixed penalty notices for speeding but does include driving offences which result in a court appearance. Any doctor who finds themselves in a position where they are concerned that they should self-refer should seek advice from Medical Protection. Further information on the GMC guidance is available at:

gmc-uk.org/guidance/
CASE 2 – NOTE KEEPING

Dr B was a FY2 doctor in a major teaching hospital. He was asked to review a post-operative patient on the surgical ward during a busy night shift. He reviewed and examined the patient but was called to see another sick patient and made only a brief entry in the patient’s case notes.

The patient deteriorated suddenly the following day and died. The FY2 doctor was approached to contribute to the Trust Serious Untoward Incident (SUI) Investigation. On reviewing the notes, he realised that they did not accurately reflect his assessment of the patient and he amended his entry in the records. He did not make it clear that these additional notes were written in retrospect.

After being confronted by his consultant, he was reported to his educational supervisor and after an investigation, Dr B was referred to the GMC.

Dr B contacted Medical Protection and was assisted during the GMC investigation. The case was concluded with a warning.

LEARNING POINTS

The GMC will investigate any allegations relating to alleged dishonesty in your clinical work. Any retrospective entry made in a patient’s case notes should be clearly marked as such and the date and time when the entry was made clearly stated. Cases where notes have been changed have even resulted in doctors facing criminal charges for perverting the course of justice.

CASE 3 – STUDENT ASSESSMENTS

Dr C was working as a FY1 doctor in general medicine in a district general hospital. There were a number of final year medical students attached to the ward, many of whom he knew socially from his time at medical school. One student had been ill during their medical attachment and on the final day before rotating to surgery, approached Dr C and asked him to complete a number of compulsory assessments.

The other ward FY1 doctor was off sick and Dr C was extremely busy; despite not directly observing the student performing a respiratory or cardiovascular system examination, he completed and signed the assessments to say that the student’s clinical skills were appropriate.

The student and Dr C were reported to the medical school by a fellow FY1 doctor. After an investigation, Dr C was reported to his educational supervisor and subsequently to the GMC. Dr C contacted Medical Protection and was supported through the GMC investigation and Fitness to Practice (FTP) hearing. The sanction imposed by the FTP panel was a short period of suspension from the medical register.

LEARNING POINTS

It is important to remember that probity extends to the assessments you must complete during your training and to any assessments you complete for others. You must also be completely honest in any CV or job application that you submit.

CASE 4 – MAINTAINING PROFESSIONAL BOUNDARIES

Dr D was working in A&E as a FY2. He reviewed a 19-year-old female patient who had broken her ankle whilst playing sport. She was discharged but then contacted Dr D via Facebook having noted his name from his identity badge. She invited Dr D out for a drink which he accepted. Thereafter, they had a short sexual relationship. Dr D then ended the relationship and the patient complained to the GMC that Dr D had abused his position as a doctor.

Dr D initially denied having a sexual relationship with the patient and denied any wrongdoing in several investigatory meetings. During the subsequent GMC investigation, text and social media messages were recovered which demonstrated that Dr D had lied during the initial stages of the investigation. This was considered an exacerbating factor and Dr D was suspended from the medical register for one year.

LEARNING POINTS

The GMC make it clear in Good Medical Practice (2013) that you must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them. Further guidance on this issue is available through the GMC supplementary guidance Maintaining a professional boundary between you and your patient. In this case, the outcome for Dr D’s lack of probity was considered a significant exacerbating factor by the GMC.

Further information on the GMC guidance is available at gmc-uk.org/guidance/
DEALING WITH ADVERSE INCIDENTS

Dr Clare Redmond, Medical Protection’s Medicolegal Adviser, reflects on how junior doctors can manage mistakes and mishaps

The world of hospital medicine is challenging, varied, stimulating and sometimes terrifying. It can be immensely rewarding to work as part of a team, contribute to a patient’s diagnosis and watch as their clinical condition improves. But, of course, not every day goes well, not every patient improves and sometimes mistakes are made. One of the greatest challenges a doctor will face during their career is in ensuring they respond well when things go wrong. Even the most experienced doctors make mistakes but it can be particularly difficult to deal with when you are one of the more junior members of the team.

The impact on doctors of making an error has been recently demonstrated by Harrison et al (2014) in their online survey of members and Fellows of the Royal College of Physicians. Of 1,755 respondents, the survey found that 76% felt personally or professionally affected by adverse patient safety events and 25% reported that they did not report an incident when they knew they should have done so. The impact of an adverse event included an increase in stress and anxiety, disturbance in sleep, reduced satisfaction at work and a fear of punitive action.

So how should you deal with an adverse incident? What are your professional obligations when a mistake is made? How is your hospital likely to investigate and where can you go for support when something goes wrong?

GMC guidance

The GMC sets out in Good Medical Practice (2013), the need to be open and honest with patients when things go wrong, to put matters right (where possible) and offer an apology with a full and prompt explanation.

More recently, the GMC has set out new guidance in Openness and Honesty when things go wrong which highlights that all healthcare professionals have a duty of candour. You have a duty to be open and honest with patients in your care, or those close to them, if something goes wrong and to apologise when this occurs.

As a junior member of the team it can be daunting to consider trying to explain when something goes wrong. The GMC states: “We don’t expect every team member to take responsibility for reporting adverse incidents and speaking to patients if things go wrong. However we do expect you to make sure that someone in the team has taken on responsibility for each of these tasks, and we expect you to support them as needed.”

It is recognised that the lead clinician is likely to be best placed to speak to the patient, and that this conversation should take place as soon after the mistake comes to light as possible. The patient should have a friend, relative or professional colleague present to support them and if the consequences of the mistake are not yet clear, this should be communicated to the patient. You may well be asked to accompany a more senior colleague to discuss an incident, and if you have been personally involved in making a mistake, should apologise for this during the conversation.

Where the harm caused has been so serious as to cause incapacity or death then the GMC states you must be open and honest with those close to the patient, answering any questions they may have and providing details of support available.

When near misses occur, you are obliged to consider whether it would be beneficial to the patient, or cause them harm, before discussing this with them. Seek advice from a senior colleague if you are unclear.
The apology

When apologising, as well as saying “sorry” the apology should include an explanation of events and provide information to the patient about how any harm will be dealt with. The GMC states patients should also be told “what will be done to prevent someone else being harmed”.

Hospital incident reporting

All hospitals have processes for reporting incidents and you should know how to use these systems (which include reporting near misses). If a serious incident occurs, then hospitals in England and Wales are required to investigate these and produce a report within a 60 day period.

A serious incident involves those where an error results in unexpected or avoidable death, unexpected or avoidable injury (resulting in serious harm) and other incidents such as abuse and Never Events.

Duty of candour

The new statutory duty of candour came into force for hospital trusts in England and Wales in November 2014 and for all organisations registered with the CQC in April 2015. This followed the external inquiries into the Mid-Staffordshire NHS Trust scandal with Sir Robert Francis QC describing an NHS culture of cover up and denial when medical errors occurred.

Your GMC obligations require you to cooperate with this duty to be candid when your employer requests this. The duty of candour requires an organisation to ascertain whether a ‘notifiable safety incident’ has occurred (see Medical Protection: Duty of Candour), and if so, a process of discussion with the patient and documentation of the investigation and outcome of the incident must be completed. You could be asked to participate in this process, alongside the hospital investigation.

Practical steps & support:

As soon as you become aware you have made a mistake (whatever its magnitude) or been involved in a serious incident, you should:

- Stop, acknowledge the mistake, decide whether you need to seek the advice of a senior colleague immediately to ensure the necessary steps are taken to minimise patient harm and investigate the error.

- Report the error using your hospital incident reporting systems if this has not already been done.

- Speak to the patient (and/or relatives) if you feel competent to do so and the error is minor, or with a senior colleague, if this is more appropriate (and in all cases where more complex discussion is likely to be needed). Remember the patient should have someone present to support them.

- Ensure you, or your senior colleague have apologised, both for any mistake made and/or any distress caused, have explained what has occurred and what is likely to occur next. Explain who the patient can approach if they have further questions and how the investigation will proceed.

- Document any discussion within the medical records.

- Discuss the incident with your educational and clinical supervisor and try to identify any learning points.

- Comply with your employer’s request to fulfil their obligations under their duty of candour, discuss this with a senior colleague if you are unsure.

- If the incident is serious and your involvement may be questioned, you should immediately draft a statement which factually sets out your involvement (see our factsheet on report writing for more information). Make sure you have access to the medical records when writing your statement and ensure it is factual and clearly sets out your involvement.

- Contact Medical Protection to discuss the incident and ask for review of your statement prior to submission to any incident investigation, or if you are asked to attend an investigation interview.

- Seek out supportive colleagues and discuss what has arisen (being aware of the need to maintain confidentiality). Avoid any temptation to minimise or cover up a mistake, even if suggested by others.

- Recognise that it is normal to find these incidents stressful and difficult to manage, look after your own health and see your GP if you are struggling to cope.

- Remember that Medical Protection can provide you the details of their counselling service.

REFERENCES

2. medicalprotection.org/about-mps/our-policy-work/duty-of-candour
4. Health & Social Care Act 2008 (regulation 20)
6. medicalprotection.org/about-mps/our-policy-work/duty-of-candour
7. medicalprotection.org/resources/factsheets/england/england-factsheets/uk-eng-report-writing

To book or view dates to attend a Medical Protection Mastering Adverse Outcomes workshop, visit medicalprotection.org/uk/education-and-events/workshops

If you are involved in an adverse incident and require advice, you can contact our team of medicolegal advisers on our telephone advice line: 0800 561 9090
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TURN TO OUR ARTICLE ON P8–9
CONSENT SUCCESS

Top ten tips to assist foundation doctors when consenting a patient for a procedure

1. Never obtain consent for a procedure that you are not familiar with. Foundation doctors should not feel pressured by experienced doctors or other staff to do anything beyond their knowledge, experience and competence.

2. Record in the notes what a patient has been told. The presence of a signed consent form does not in itself prove valid consent to treatment – keep contemporaneous notes which record the key points discussed and relevant warnings given to the patient.

3. Use your common sense – consent is patient-specific and depends on the individual’s circumstances, including age, lifestyle, occupation, expectations etc. If you are uncomfortable consenting a particular patient, always discuss with a senior colleague.

4. Ensure you have documented consent for taking photographs and making recordings. Trusts will usually have specific consent forms that should be used or medical photography departments who can guide you through the process. Do not take photographs on your personal smartphone.

5. Remember there are circumstances where a child can give consent without reference to a parent – if they are Gillick competent they should be considered competent to provide consent. If in doubt consult a senior colleague.

6. Remember, the patient must be competent. The starting point in the case of adults is always to presume that the patient has capacity until it is shown otherwise.

7. The law concerning incompetent adults, who are unable to give valid consent, is more complicated. If you are in doubt consult senior colleagues.

8. Allow the patient to give their consent freely – pressuring patients into consenting to treatment invalidates the consent. Where possible, patients should be given time to consider their options before deciding to proceed with a proposed treatment.

9. Always remember that consent is a process, not a one-off event – it is important to maintain a continuing discussion to reflect the evolving nature of treatment.

10. Ideally consent should be obtained well in advance so that there is time to respond to a patient’s questions and provide adequate information on the procedure is planned. If you are asked to consent a patient immediately before an intervention and are uncomfortable to do so, you must seek advice from more senior members of the medical team.
was firmly undecided about career choices as I neared the end of my foundation year jobs. I had actually applied for Core Medical Training but withdrew my application the day before my interview as I wasn’t sure it was for me. I wanted adventure. At that point in my training I wasn’t ready to commit to at least another two years of rotations in the UK, so instead I opted for what has now become the ‘F3’ year.

I applied through a locum agency in New Zealand that had been recommended and sent all of my paperwork to them. This was 2010 and the mass exodus of doctors to the antipodes was only just getting started. Without as much as a telephone interview I was offered five jobs across New Zealand in various hospitals. I eventually opted for Christchurch, based purely on its proximity to the beach and the mountains. About 10 months after starting applications I landed in New Zealand to start work.

Work in Christchurch’s Emergency Department was great, but to be honest, not very different from being at home. In fact, many of the department’s doctors were British. I loved the consultant support and on the job teaching. I felt free to work up patients to a much greater extent than back at home, rather than doing everything to the four hour clock. During my time there I was encouraged to do as much as possible before referring to inpatient teams — intubating in resus, reducing dislocated joints and performing lumbar punctures to investigate subarachnoid haemorrhages. It was all very rewarding and brought a shy young doctor out of his shell.

Kiwi patients are a tough bunch, whose casual understatement of often quite serious medical problems always made me smile. On one shift I saw a 96-year-old with chest pain. “What were you doing when your chest pain came on?” I asked. He said: “I was out chain-sawing.” One man presented a day late into a stroke as he wanted to finish clearing his garden. Of course, New Zealand sporting traditions dictate that Saturday and Sunday afternoons should be dedicated to a seemingly endless list of rugby injuries — I gained lots of experience in pulling shoulders and clearing c-spines.

Life outside of work was wonderful. Life in New Zealand is definitely about living and not working. With the local and ex-pat doctors I surfed, cycled and kayaked in every spare moment. If you haven’t been to New Zealand, then I’m sorry, but you’ve really let yourself down — it is easily one of the most beautiful places on earth.

I’d be lying if I said I was a hero when 12.51 on 22 February 2011 came around. Many of my friends and colleagues certainly were heroes that day. I was actually on holiday near Lake Taupo when Christchurch was hit
by a magnitude 6.3 earthquake. It killed 185 people and injured many more. I returned to a city in shock and ruin the next day. Following the day of the earthquake itself, the hospital became eerily quiet as the city evacuated. Extra personnel volunteered to work extra shifts over the next few days, anticipating numerous injuries to present as the rescue effort went on. They were not needed – no one came from the rubble alive after the first 24 hours.

The next few weeks were scary and sad. Dozens of junior doctors and I moved into a building the hospital had commandeered nearby as the roads out to our homes were badly damaged. The earthquake had however, brought out the best in the community – showing their resilience and their kindness. Locals sent food to the emergency department so that the staff wouldn’t go hungry. Drivers would stop as you walked home to offer a lift to make sure you got home safe. A few afternoons after the earthquake I watched a lady drive up to the military cordon around the most damaged part of the city centre; the soldier politely turning her away. She’d had no intention of passing through; instead she passed a flask of tea and box of sandwiches from her window to keep the soldiers going and turned around. I forget how many hundreds of aftershocks we endured over the weeks and months that followed, but watching the people of Christchurch come together through all of it was one of the most life-affirming things I have experienced.

It wasn’t the year I had set out to have, but I loved life in New Zealand all the same and made some great friends. I still feel that working at Christchurch Emergency Department was one of the best, most satisfying jobs I’ve ever had. It made me a better doctor and definitely made me a more confident person, but, if anything, working away had made me even more indecisive about my career plans. I’d learnt that career plans weren’t as important as I’d thought they were. The one thing I was sure of was that I wanted more time to travel and work overseas.

In the end there were a couple of reasons I came home. For starters, New Zealand is a really long way away and it’s hard work being in a relationship where the other person is almost exactly on the other side of the planet. (We’re getting married next year, so I think I probably made the right decision to come back). Also, Skype doesn’t quite cut it when a family member is unwell and you want to be next to them. I also wanted to keep going – to keep travelling and working in new places. I wasn’t sure I would have that opportunity from New Zealand. Since leaving I’ve worked back in the UK, volunteered in some of the remotest parts of Zambia and helped at a clinic in East Timor – stories for another occasion perhaps.

If in doubt, go. Do it. Take the step, apply for a job and see where it takes you.

Dr Robert Molloy is a GP VTS first year trainee in central Birmingham.
When it comes to Do Not Attempt Cardiopulmonary Resuscitation, Medical Protection’s Medicolegal Adviser Dr Nicky King reflects on a junior doctor’s position

Patients fear that a DNACPR order means all care is withdrawn and it is important to have been clear regarding what measures are in place for actively managing symptoms and reversible conditions.

The second area which causes problems seems to arise from the public misconception regarding the success of CPR. There is a lack of understanding that the heart will stop as part of the process of dying and attempting to restart the heart with CPR would provide no benefit in such situations. The success of CPR is also over estimated, probably based on TV soaps and dramas where considerably more patients make a full successful recovery than in reality. The GMC End of Life Care guidance points out the low success rate of CPR and the risks involved, and that inappropriately attempting CPR may result in the patient dying in an undignified and traumatic manner.

A further recent legal case has confirmed that the duty to consult applies in cases both of capacity and absence of capacity.

For patients who lack capacity a family member or person representing the patient’s interests should be consulted before a DNACPR decision is put in place. Families often need the reassurance that the clinicians are not ‘giving up’ on their loved one.

The BMA have recently launched a project to examine both the public and medical professionals’ attitudes on aspects of end of life care. The outcome of the project will hopefully improve the way these difficult situations are managed and discussed, resulting in improved experiences of end of life care.

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1. resus.org.uk/statements/emergency-care-and-cpr-decision-making/
2. R (Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors [2014] EWCA Civ 822
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5. Mental Capacity Act 2005 s4(7)
6. bma.org.uk/endoflifecare
**GOOD HANDOVERS**

A good handover should be a two-way process where information is exchanged and opportunities are given to ask questions and reaffirm that the exchange has been successful. It should be structured and focused on making suitable arrangements for the patient’s medical care, with minimal interruptions.

Checklists can help with the management of common conditions. For example, a successful handover requires:

- A senior clinician to lead the handover
- A shared understanding of the plan of action, who is responsible for each aspect of the patient’s care and exactly what is required
- Designated handover time within working hours (at least 30 minutes for large hospitals)
- Involvement of all relevant health professionals, as more information is needed for high-risk patients
- A clear method of contacting the doctor responsible for a particular patient
- Awareness of potential risks
- Information for the patient as to who will be responsible for their care going forward
- Clear documentation.

**REFERENCES**

3. A version of this case study first appeared in Casebook, September 2008 at: www.medicalprotection.org/hongkong/casebook-resources/case-reports/case-reports/row-fatal-communication-failure

**Case study**

Mrs D, a 60-year-old lawyer, was admitted to her local hospital after a short illness characterised by anorexia, vomiting and severe colicky abdominal pain.

She was assessed in the emergency department by Dr L, an emergency medicine doctor. Dr L felt that Mrs D was suffering from sub-acute small intestinal obstruction of uncertain aetiology, but that her condition was not life-threatening. He thought that Mrs D was stable and suitable for observation and conservative management on a surgical ward. Dr L referred Mrs D to the on-call surgeon, Dr A. The handover was brief, informal and conducted by telephone, as Dr A was in theatre.

Dr A asked Dr L to pass on a message to the ward staff to request that the surgical ward doctor assess Mrs D and pass a nasogastric tube when she arrived on the ward. However, Mrs D was not seen by the surgical ward doctor on her arrival on the ward, as Dr L forgot to impart this information to the nursing staff on the handover form on the front of her notes.

Mrs D suffered a cardiac arrest shortly afterwards and could not be resuscitated. A post-mortem revealed a right-sided obstructed, necrotic femoral hernia. Mrs D’s family launched a legal claim against Dr A, Dr L and the nursing staff on the surgical ward, alleging negligence through insufficient assessment and observation.

This case demonstrates the importance of an effective, formalised handover procedure being conducted between departments when patients are admitted to hospital. It resulted in incomplete observations and lacked an ongoing management plan that unfortunately had fatal consequences for Mrs D.

GOOD HANDOVERS

The Importance of Passing the Baton:

**When handing a patient over to another doctor for treatment – either between shifts, between phases of care, or between community and hospital care – problems can occur which can put the patient’s safety at risk. The effectiveness of handovers will depend on the timeliness, accuracy and completeness of the information given, and whether it is understood by your colleagues.**

Inconsistent processes, absence of best practice guidelines and limited use of protocols mean that handovers can be fraught with risk. Poor handovers can result in adverse events, avoidable harm and complaints.

**A poor handover can have a significant impact on the quality of care of a patient, and complaints can arise from this. The following risk areas can often contribute to complaints about handovers:**

- Lack of clear leadership or responsibility when complications arise
- Failure to effectively communicate a patient’s condition when seeking advice from a colleague
- Inappropriate delegation, for example to a doctor without sufficient expertise
- Lack of an agreed care plan

Most handovers are done with the best intentions, but quite informally. People are often distracted and trying to do several things at once, which can affect levels of concentration.

**Case study**

Mrs D, a 60-year-old lawyer, was admitted to her local hospital after a short illness characterised by anorexia, vomiting and severe colicky abdominal pain.

She was assessed in the emergency department by Dr L, an emergency medicine doctor. Dr L felt that Mrs D was suffering from sub-acute small intestinal obstruction of uncertain aetiology, but that her condition was not life-threatening. He thought that Mrs D was stable and suitable for observation and conservative management on a surgical ward. Dr L referred Mrs D to the on-call surgeon, Dr A. The handover was brief, informal and conducted by telephone, as Dr A was in theatre.

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This case demonstrates the importance of an effective, formalised handover procedure being conducted between departments when patients are admitted to hospital. It resulted in incomplete observations and lacked an ongoing management plan that unfortunately had fatal consequences for Mrs D.

Good handovers provide continuity of care and can help to avoid errors, says Medical Protection’s Dr Ming-Keng Teoh.

Inconsistent processes, absence of best practice guidelines and limited use of protocols mean that handovers can be fraught with risk. Poor handovers can result in adverse events, avoidable harm and complaints. They can be associated with:

- Inaccurate clinical assessment and diagnosis
- Delays in diagnosis and treatment
- Delays in ordering investigations
- Medication errors
- Inconsistent or incorrect translation of results
- Duplication of investigations
- Increased length of stay
- Increased in-hospital complications
- Low patient satisfaction.

A poor handover can have a significant impact on the quality of care of a patient, and complaints can arise from this. The following risk areas can often contribute to complaints about handovers:

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Checklists can help with the management of common conditions. For example, a successful handover requires:

- A senior clinician to lead the handover
- A shared understanding of the plan of action, who is responsible for each aspect of the patient’s care and exactly what is required
- Designated handover time within working hours (at least 30 minutes for large hospitals)
- Involvement of all relevant health professionals, as more information is needed for high-risk patients
- A clear method of contacting the doctor responsible for a particular patient
- Awareness of potential risks
- Information for the patient as to who will be responsible for their care going forward
- Clear documentation.

**REFERENCES**

3. A version of this case study first appeared in Casebook, September 2008 at: www.medicalprotection.org/hongkong/casebook-resources/case-reports/case-reports/row-fatal-communication-failure
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