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Casebook

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UNITED KINGDOM

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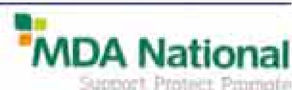

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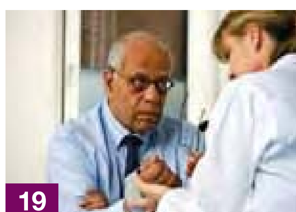

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Welcome

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

As this year marks 120 years since MPS was formed, we have provided an interesting account of our history on pages 4 and 5. Coincidentally, this year also marks the 20th anniversary of *Casebook*, and in keeping with the *Casebook* style we have published some excerpts from cases that MPS has been involved in over the years.

The 20th anniversary of *Casebook* is particularly significant because it represents a milestone in terms of the breadth of risk management advice and support that MPS now provides for members. I touched on the success of this material in the September 2011 edition of *Casebook*, after a survey of our members found that *Casebook* continued to play a key role in the safe practice of healthcare.

The range of benefits on offer to members now covers workshops, e-learning, conferences and lectures, while our suite of publications continues to be targeted at more specific areas of the MPS membership. This means that we can tailor our updates and advice to ensure you receive news that is directly relevant to your field of practice.

Reaching the 20th anniversary of publishing *Casebook* has reaffirmed to me the responsibility we have to protecting patient safety and in promoting effective risk management. I hope that this is a timely example of our commitment to supporting and guiding you in whatever way we can.

You can rest assured that we will continue to focus on ensuring our publications deliver medicolegal advice and support that is relevant, interesting and which you can rely on. As ever, please get in touch with any comments or suggestions; your feedback helps to shape our service to you.

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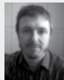

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120 years of MPS

Over a century of service

MPS Medical Director ***Dr Priya Singh*** pays tribute to the cornerstone of MPS's longevity – quality of service to members

This year marks the 120th anniversary of the founding of MPS. These two pages look back at how MPS has responded to member needs and legislative changes over this period by adapting and transforming services to become the world's leading medical defence organisation.

It is this commitment to service that I believe is the foundation on which MPS has been built. From the very start, as the London and Counties Medical Protection Society, the ethos has been focused on putting members' needs first, reflecting members' values and ensuring a personalised, proactive and professional service.

MPS is committed to providing the breadth of assistance that anticipates members' needs throughout a career and an indemnity that offers the best possible protection from the costs of clinical negligence claims. Together with the security offered by MPS's financial strength, this is a potent combination that gives confidence that MPS will be there for you when you need us, with the voice to protect and promote the interests of members and the wider profession.

The development of education and risk management tools has been designed to help avoid problems occurring and the collective expertise of MPS is now available to members in an unparalleled range of publications, workshops, e-bulletins and conferences, reflecting more than a century of experience.

As a mutual, not-for-profit organisation, MPS is owned by and accountable to members; your subscriptions do not go to shareholders or commercial partners – the mutual fund is there to provide the best protection for you. This financial strength has enabled MPS to remain independent: here solely to meet members' needs long into the future.

On 1 May 1892 the London and Counties Medical Protection Society was formed. ***Sarah Whitehouse*** looks back at 120 years of providing indemnity for doctors

In the 19th century, before medical defence organisations were established, local groups of doctors would subscribe to each other's legal costs to challenge defamation cases – in essence, working as local defence organisations. With membership costing around a guinea or less, this informal arrangement suited doctors whilst issues could be settled cheaply and easily. As legal costs and the value of claims began to rise, so too did the public's expectations of the medical profession. In 1858 the Medical Act laid down the basis for a minimum standard of medical education, leading to the formation of the General Medical Council (GMC).

> Between 1910 and 1923 MPS handled more than 50 cases of libel, slander and "patients grizzling about their doctors".

Amidst this evolving medical backdrop, 1885 saw the birth of the Medical Defence Union, a national rather than local organisation. But the union's turbulent early years, plagued by accusations of irregularity and lack of accountability to members, resulted in a breakaway group forming an alternative defence organisation; the London and Counties Medical Protection Society. The rest, as they say, is history.

Led by the surgeon Sir Jonathan Hutchinson and doctors George Heron, George Mead and Hugh Woods, the new society aimed to "support and safeguard the character

Above: 29 June 1926: a complimentary dinner to the President, Sir John Rose Bradford.

Left: The first New Zealand members recorded

of legally qualified practitioners and to advise and defend members when attacked". The society went from strength to strength. By 1894, the London and Counties Medical Protection Society had grown to 1,000 members – with an annual subscription rate of ten shillings. Premises were taken in Sloane Square, London, and Le Brasseur and Oakley were retained as solicitors – the start of a lasting association, as the firm's successor, Radcliffes LeBrasseur, remains one of MPS's panel law firms today.

Until 1910, MPS only bore its members' own legal costs, which could cause serious hardship for members if there was an adverse outcome. In 1911, MPS purchased collective insurance for members, to fund adverse costs and damages up to £2,000 for any individual member and up to £20,000 in any one year, at an additional cost of ten shillings.

By 1935, some hospitals and authorities had made membership of a defence organisation a compulsory pre-requirement to employment, which boosted MPS membership, and in 1939, MPS launched the Overseas Indemnity Scheme to afford protection to members practising outside the UK.

The "London and Counties" part of MPS's title was dropped in 1947, but it was still affectionately referred to as "the London and Counties" by older members. With the advent of the National Health Service in 1948 and the Legal Aid fund in 1950, costs to members began to rise substantially, as did requests for assistance.

In 1962, MPS introduced unlimited indemnity for overseas members, resulting in another substantial increase in membership. Schemes of co-operation were agreed with the Medical Defence Association of Western Australia, the Medical Defence Association of Tasmania, and the Trinidad and Tobago Medical Protection Society.

By 1985, MPS had established a general practice advisory board and had expanded its number of medicolegal advisers – dealing with more than 1,000 claims each year. The first £1 million claim was settled in the UK in 1986; a watershed moment in high claims.

Faced with such spiralling costs, an NHS indemnity scheme was introduced in the UK in 1990 to assume the costs of claims against hospital doctors. MPS membership remained strong, however, to ensure that hospital doctors had access to advice and assistance for a range of medicolegal matters not covered by the scheme, and to provide cover for GPs.

Today, MPS has offices in London, Leeds, Edinburgh, Brisbane, Wellington and Auckland, which provide assistance for more than 270,000 members in more than 40 countries, including the UK, Ireland, Hong Kong, Malaysia, New Zealand, Singapore, South Africa, and the Caribbean and Bermuda. MPS's most notable presence outside the UK is in South Africa, where it has been active for more than 50 years.

In its 120th year, MPS has chosen to hold its first international conference – Quality and Safety in Healthcare: Making a Difference – which will bring together international experts from around the world to share their knowledge, experience and expertise on quality and safety.

With an increasing focus on education and risk management, MPS looks set to remain at the heart of the medical profession for the next 120 years, responding to the needs of members in an ever-changing medicolegal climate.

Further details of the international conference are available on the MPS website.

In 1936, the first action was brought against the estate of a deceased doctor (Rubra Ats Connolly). Damages of £5,000 were awarded to the plaintiff and paid by MPS – the benefits of membership extend beyond the grave.

In the early days, challenges to the medical profession would often arise from quackery. MPS members would act as decoy patients to try and catch those posing as doctors with weird and wonderful treatments. A group of "Hindoo Oculists" boasted of a cure for blindness by excising the 'skin' over the cornea. They were driven out after MPS brought a prosecution against them for falsely styling themselves as doctors.

TIMELINE

- **1892** 1 May – London and Counties Medical Protection Society forms
- **1894** Sloane Square, London, office opens
- **1947** Name changes to Medical Protection Society
- **1947** First overseas scheme of co-operation (Medical Defence Society of Queensland)
- **1970** Leeds office opens in Park Square
- **1994** Leeds office relocates to Granary Wharf House
- **2007** Brisbane office opens (acquisition of Cognitive Institute)
- **2009** Edinburgh office opens
- **2011** Wellington office opens

Top: founder Dr George Heron

Bottom: former President Sir John Rose Bradford

MPS OPINION

Spreading the use of HIV testing

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Late diagnosis of HIV in adults continues to be an important issue in the UK but for too long it has been absent from healthcare's topical agenda. With national audit data showing that 24% of deaths of HIV-positive adults in the UK in 2006 were due to a diagnosis of HIV being made too late for effective treatment,[1] and further data showing that around one third of all HIV infections in UK adults remain undiagnosed, and approximately 25% of newly-diagnosed individuals have a CD4 count of less than 200 – an indicator of late diagnosis – there is clearly a lack of timely opportunity to improve early diagnosis.[2]

"Normalising" HIV testing in patients with clinical indicator diseases, by moving testing beyond the traditional antenatal and sexual health settings, is one way of tackling problems surrounding late diagnosis.

The benefits of early diagnosis of HIV go beyond the obvious, such as decreased mortality and morbidity. The chances of a more effective response to HAART (highly active antiretroviral therapy) treatment are increased[3] and there is a link between awareness of HIV status and a curb on risk behaviour,[4] suggesting that earlier diagnosis reduces the likelihood of further transmission.[5]

HIV testing is already a routine antenatal booking test and more than 95% of women in the UK accept this – and there is no extensive pre-test counselling carried out. The *UK National Guidelines for HIV Testing 2008*, which were released by the British HIV Association (BHIVA) to recommend expanding HIV testing beyond the antenatal and sexual health settings, list a number of clinical indicator diseases that should prompt a test for HIV infection in adults; these include tuberculosis, cervical cancer and cytomegalovirus retinitis – the full list is available at the BHIVA website, **www.bhiva.org**.

Undoubtedly, there are still barriers to encouraging the wider use of HIV testing. Even 30 years on, there are traces of the fear that was embedded in the nation's psyche by the infamous "tombstone" adverts of the 1980s. Sections of the community are still unaware of the enormous advances in effective treatment for HIV since those early days. The despondency around the prognosis for those who were diagnosed as HIV positive in the 1980s and early 1990s also discouraged individuals from testing.

Contact tracing helps identify if an individual's current or previous partners have contracted HIV but this has an obvious impact on relationships and puts an additional strain on an individual coming to terms with a new diagnosis. All of these factors are deterrents to undergoing a test. Patients can also be uncomfortable about attending their GP for testing, especially if they have personally known their doctor or practice staff for a number of years, and they may be embarrassed to provide a sexual history or have concerns over confidentiality.

Reservations among healthcare professionals were highlighted in a survey carried out by the Health Protection Agency (HPA) in 2010, which investigated awareness of the *UK National Guidelines for HIV Testing 2008*. Of the 17 medical royal colleges, faculties and professional organisations that responded, 11 reported awareness – but only four knew of any work being done in their own specialty to address HIV testing, and only five had covered HIV testing in their own clinical guidelines.[6]

Between 2009 and 2010, the Department of Health piloted the expansion of HIV testing outside traditional settings, by funding eight demonstration projects across primary and secondary care, and in community/outreach settings. In hospitals, the pilots were carried out in an emergency department, three acute admissions units and a dermatology outpatients department. The exercise was particularly interesting when measuring the shift in staff attitudes to testing before and after the pilots were conducted. Staff initially reported perceived barriers such as the need for additional training, the challenges of dealing with difficult questions from patients, and not having enough time to obtain informed consent for an HIV test.

Other concerns from secondary care staff related to the impact on service delivery. In primary care, some clinicians were anxious about managing reactive results. However, when analysing the results of the project, many of these concerns were unfounded. Testing was found to be operationally feasible and the majority of patients found the prospect of a routine test to be feasible. Staff training was acknowledged as an additional requirement, while in primary care there were still some concerns about the impact on consultation times. The full findings can be read in the HPA's report, *Time to Test for HIV: Expanding HIV Testing in Healthcare and Community Services in England*.

The Department of Health pilots demonstrated how misconceptions and anxieties can be challenged and overcome. With therapy to treat HIV more effective than ever before, it is important that we refocus our efforts to start the fight against HIV as early as possible.

Words: Gareth Gillespie and Dr Sonya McCullough

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For details of MPS events, courses and workshops visit **www.medicalprotection.org/uk/education**

For the latest NICE guidance visit **www.nice.org.uk**

Closing the loop: lessons from surgical cases

Dr Peter Mackenzie, Head of Membership Governance at MPS, looks at the reasons why claims in a range of surgical specialties are settled

This is the second in a series of articles looking at feedback from clinical negligence claims brought against MPS members across the world. This article highlights learning points from more than 800 such claims settled over the last four years on behalf of our members practising worldwide in a range of surgical specialties. As the number and size of claims continue to rise around the world, almost one in five requests for assistance from MPS members now arise from litigation. You may not be surprised to hear that for surgeons that figure is higher and nearer one in three requests.

Approximately half of surgical claims were settled because of problems relating to surgical technique (fairly equally spread between inadequate performance, causing collateral damage and poor cosmetic outcome) – the other half related to pre and postoperative issues. More worryingly, 44/805 (5.5%) of the settled claims relate to "never events" (wrong site surgery or retained equipment). "Never events" can be defined as "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented".[1] To help reduce the chances of being sued, surgeons should focus both on their surgical skills and on ensuring they periodically perform risk management assessments of their clinical support systems – such as chasing up pathology tests that have been ordered, or properly documenting risks of procedures in the patient's records.

Methodology

At MPS, we capture the reasons for recommending settlement to our members on each clinical negligence case.[2] For the purposes of this article, we have reviewed all those claims brought against our surgical members, worldwide, where we have had to recommend settlement since December 2007.

For reasons of commercial sensitivity, this article does not include information about the size of different specialty groups, so comparisons of relative claims rates between specialties cannot be made.

Results

MPS has recommended settlement on 805 surgical claim cases, worldwide, from members working in 29 different countries since December 2007.

The value of each claim varies enormously from £120 through to our highest surgical claim case (at the time of going to print) of £5.4 million. It should be remembered that this study looks primarily at frequency of reasons for settlement and that in terms of subscription setting for our members, the claim costs are an extremely important additional feature.

The distribution of the 805 claims by specialty can be seen in Chart 1.

Chart 1 – Number of surgical claim settlements worldwide by specialty:

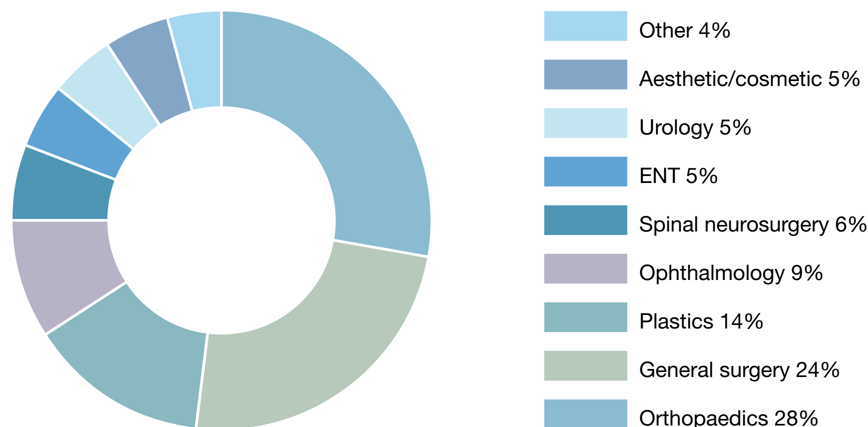
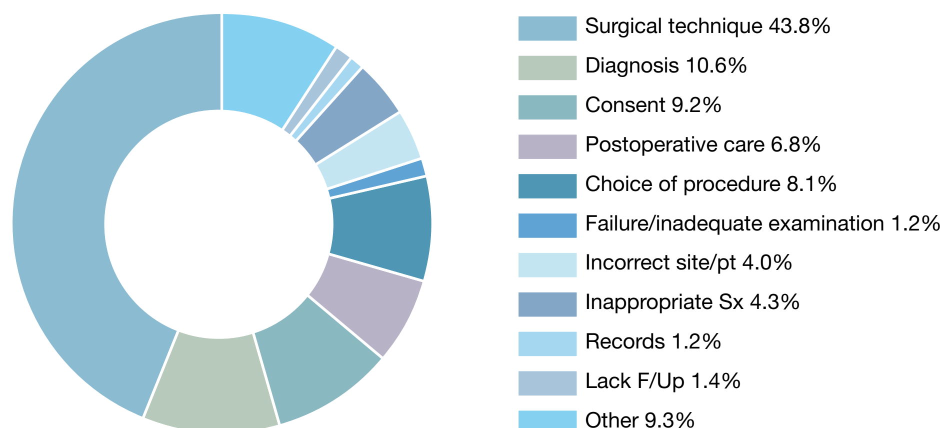


Chart 2 – Reasons for settlement:



About half of claims settled on behalf of surgeons can't be defended because of non-operative issues such as record-keeping, lack of follow-up, or not having adequate systems in place to chase up pathology tests ordered. We recommend all surgical members undertake regular reviews of their clinical support systems through risk assessments to help reduce these non-operative events from happening.

The commonest occurring contributory factor for deciding to settle claims is because of concern over the surgical technique used by the member (see Chart 2).

We note, however, that for plastic surgeons, inappropriate surgery is a more commonly occurring code than for other surgical specialties. This appears intuitively correct. Nevertheless, contributing factors to the settlement of plastic surgery claims include issues surrounding consent, postoperative care and choice of procedure.

Surgical technique

This occurs as a contributory factor in the reason for settlement in nearly half of all surgical claims and up to 62% depending on specialty. We studied in more detail a randomised sample of 100 of those claims. The reasons for concern over surgical technique can be broken down into six further causes:

- inadequate performance – 34%
- collateral injury – 27%
- cosmetic quality – 24%
- retained equipment – 8%
- incomplete procedure – 4%
- choice of implant – 3%

1. Inadequate performance

Inadequately performing surgical procedures affected virtually all the surgical specialties and simply meant that the particular method the surgeon had adopted couldn't be fully supported by his or her peers. Examples include not converting to an open cholecystectomy following significant blood loss in a patient with dense adhesions or poor suturing technique following a breast augmentation procedure.

RISK MANAGEMENT POINT 1

Ensure you perform a sufficient number of surgical procedures so as to maintain your skill level. If you were to experience difficulty in a procedure, is help available?

2. Collateral injury

Of particular interest are the 27% of settlements where some form of collateral injury has occurred. One third of these cases involved the use of some form of endoscope. Around a quarter of the collateral injury reasons involved laparoscopes; 6% endoscopes. Again, the range of surgical procedures involved fell across the breadth of surgical specialties varying from corneal burns during eyelid surgery, injuries to peripheral nerves during fracture manipulations and perforation of the bowel during liposuction.

RISK MANAGEMENT POINT 2

When using any form of invasive scope, you will be expected to have discussed the specific risks of collateral injury with your patient as part of the seeking of valid consent.

Do you have a sufficiently broad field of vision and can you interpret the anatomy correctly?

3. Cosmetic quality

Of those surgical technique cases settled because of an unsatisfactory cosmetic quality (the inference being the underlying technique was not satisfactory), all of these occurred in plastic/cosmetic practice. Nearly half were breast procedures and a third were facial operations. This reminds us to ensure patients having any form of surgical procedure (but in particular cosmetic procedures) must be allowed to make fully informed choices, and do not have unduly high expectations of outcome.

Ensure you have properly assessed your patient's expectations of the proposed surgical procedure and addressed any unrealistic outcomes. You must always ensure you have obtained and documented valid consent and advised your patient of the risks of the procedure they

CASE STUDY

For reasons of confidentiality, some facts have been changed in this case.

14/01/07 – 40yr patient presented with a 2-week history of intermittent right loin pain with associated haematuria. Investigation revealed a 2.5cm right renal stone. Patient advised to undergo percutaneous nephrolithotomy. Patient went home to consider advice.

25/01/07 – Patient re-presents with acute attack and requests PCNL. Patient otherwise fit. All appropriate blood tests taken preoperatively and the anaesthetist informed. Patient taken to theatre and general anaesthetic commenced. Nobody at that point had reviewed the preoperative blood tests results as they were not yet available. Urologist inserts ureteric catheter into left kidney via cystoscope. Patient becomes haemodynamically unstable. Cardiac arrest. Patient successfully resuscitated initially but remained unstable. Transferred to ITU.

26/01/07 – Patient dies. The postmortem was inconclusive. Cause of death classified as cardiac failure. It is alleged that neither doctor ensured the patient was sufficiently prepared preoperatively before the procedure went ahead.

The preoperative blood results showed low haemoglobin of 7.4 and abnormal liver function tests, the causes of which were both unknown. The exact causation of the patient's demise is unclear. Cardiac instability may have occurred due to some underlying pathology, which had not been diagnosed preoperatively in combination with the anaesthesia.

In view of the grossly abnormal blood tests, which had not been reviewed prior to surgery, a settlement was reached.

If you organise tests on a patient, ensure you have adequate clinical systems in place to review them.

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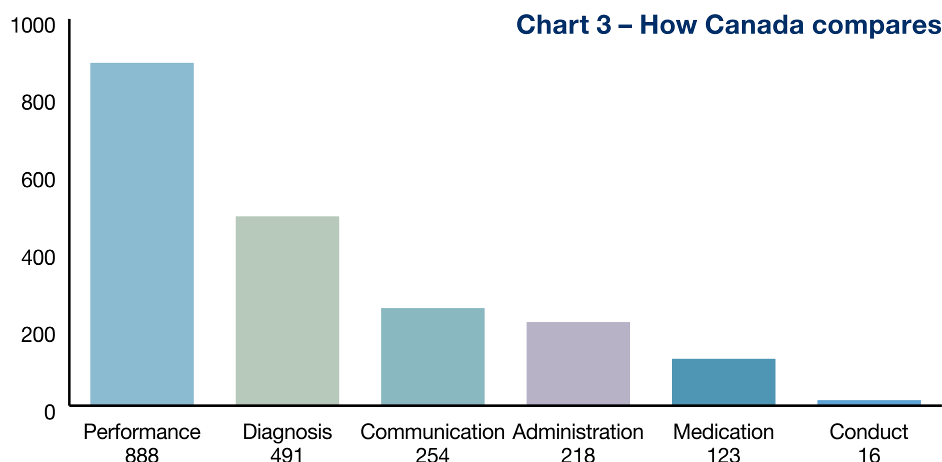

face. You should decide whether it is still appropriate to proceed if the patient remains unrealistic in his or her expectations.

Worldwide experience

What are the experiences of surgeons working elsewhere in the world where MPS does not operate? In Canada, for example, the CMPA (Canadian Medical Protective Association) reports that performance and diagnostic issues were the most problematic with preoperative evaluation sometimes leading to performing an inadequate procedure or failure to offer alternative treatments (Chart 3).[3] For general surgeons, the CMPA reports that common bile duct and vascular injuries during cholecystectomy were the most common issue. Damage to nerves and spinal cord were most frequent for orthopaedic surgeons. Consenting problems were encountered in 21% of all cases. These experiences are broadly similar to ours.

Summary

Our results highlight that issues around surgical technique are the commonest contributory factor for settling claims on behalf of our surgical members worldwide, with problems over inadequate surgical performance and collateral injury being particularly important. This highlights the importance of ensuring that surgical technique is regularly updated and in line with current best practice such that it would be supported by one's peers.

We have found that over half of claims that need to be settled on behalf of our surgical members are for reasons not directly related to surgical technique, such as issues surrounding consent or poor record-keeping. It is therefore extremely important for the surgeon to regularly review his clinical systems to help improve his treatments and thereby indirectly help his patients. Even the best surgeon in the world would still need to have claims settled on his behalf if his administrative or clinical support systems are found wanting.

Claims due to concerns about cosmetic outcome remind us that managing patient expectations and addressing unrealistic expectations is an important factor in reducing the risk of claims, particularly in plastic/aesthetic specialties. Asking the patient what would be a "good outcome" for them if they undergo the surgical procedure will help identify whether the patient's expectations are realistic and achievable.

Patients increasingly want to be involved in decisions about their care as part of a shared decision-making process. Patients who have been involved in a discussion about the advantages and disadvantages as well as the risks (including collateral injury) involved will have fewer grounds for a successful claim should an adverse outcome occur, particularly if these have been documented.

The overwhelming majority of healthcare is delivered to a high standard. When things go wrong, it is important to investigate, explain and apologise. Where substandard care results in avoidable harm, there should be an appropriate level of compensation. Every adverse event should be used as an opportunity to learn and improve care.

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2. The reason for settling a claim we record as a "Root Cause of Settlement" (RCS) code. We currently have 38 different such codes. There may be more than one RCS code per case and there may be more than one member recorded as involved in each case. For this reason, all of the statistics that follow have been adjusted so that where more than one RCS code is stored on a claim the codes are weighted so that the total value of codes per claim add up to 1.
3. Courtesy of the Research Department and Elise Amyot at the Canadian Medical Protective Association

Olympic dilemmas

Sara Williams **and** ***Sarah Whitehouse*** explore the medicolegal hoops doctors may have to jump through during the Games

The buzz of the Olympics will be felt throughout the UK this summer, not least in the Village itself and the surrounding London boroughs. With so many people attending as spectators, press, athletes and associated workers, the Games will require 5,000 medical volunteers, but the onus is on treating spectators rather than athletes.[1]

The NHS has made it clear that doctors are entitled to ask to attend the Olympics in a working capacity, but they do not have the right to be granted permission to do so. Those that do volunteer to work at the Games must do so in their own time.

The NHS has made it clear that doctors are entitled to ask to attend the Olympics in a working capacity, but they do not have the right to be granted permission to do so

Treating spectators

Most medical volunteers will be involved in providing medical care for the crowds, officials and the administrators, alongside St John Ambulance and paramedics when required. Effective triage and emergency medicine skills are essential.

Foundation doctors are not eligible to volunteer in a medical capacity at the Olympics. Dr Iain Barclay, Head of Medical Risk and Underwriting at MPS, explains: "We have been approached by a number of junior doctors who were hoping to volunteer. Unfortunately, owing to statutory restrictions, F1 and F2 grade doctors are unable to work at the Olympics as it is not an approved practice setting."

Indemnity

Doctors who have signed up to volunteer their services at the Games must ensure that they are properly trained and indemnified. Dr Barclay says: "MPS believes that doctors should only volunteer if they are able to do what they say they can do and work within the limits of their competence. They are also expected to abide by the protocols laid down by the London Committee of the Olympic Games (LOCOG) in respect of the provision of such services.

"Following discussions with LOCOG, MPS can confirm that if a member wishes to participate in this way, then he/she can look to MPS for advice and assistance in

the unlikely event of there being an adverse incident in respect of the provision of medical care. Such volunteer medical practitioners should, however, advise the MPS membership department of their participation."

Good Samaritan acts

MPS defines a Good Samaritan act as one in which medical assistance is given, free of charge, in a bona fide medical emergency upon which you may chance, in a personal as opposed to a professional capacity, eg, assisting a fellow spectator at an event.

For doctors, ignoring such a predicament is never an option. When called into action while off duty, you must remember to make a full clinical record after treatment. There will be millions of people at the Games and, in this scenario, you must assess your own competence in handling the situation – eg, you may be under the influence of alcohol – and proceed accordingly. Only intervene if the situation is an emergency.

Any situation that is beyond your competence may still benefit from your input, to a degree. For example, you can use your clinical skills to take a history, make an examination to reach a preliminary assessment, and give an indication of the likely differential diagnosis. You can also suggest options for the management of the situation pending arrival of support.

In the unlikely event that legal proceedings follow, members would be entitled to apply for assistance, no matter which country the legal proceedings are commenced in, which is important as many spectators will be drawn from around the world.

Treating overseas spectators in the community

The Olympics attracts huge numbers of visitors from all over the world. The majority will present with familiar problems: food poisoning, UTIs, chest infections, ankle sprains and mislaid medicines.[2] Large swathes of people also spread infectious disease, so doctors who offer their services will need to be aware of the prevalence of other illnesses abroad, eg, TB.

It is good practice when treating a foreign patient to consider writing a note for the patient's doctor back home so that it can be added to their medical records.

The myriad nationalities that will be present for the Games pose obvious concerns relating to language and culture. Dangers surrounding a consultation are magnified when there are different languages on either sides of the consultation.

You should make use of available translation services which should be sought if key messages cannot be received. If translation services are unavailable, translation tools may help.

© POPULOUS

Reciprocal arrangements

GP practices and emergency departments in close proximity to the Village may be hard pressed if waves of tourists turn up for treatment. Planning ahead and identifying who is eligible for NHS treatment will prevent confusion later on.

Patients from the EU and Commonwealth should be treated as UK citizens. If the patient is entitled to NHS treatment, you can issue them a normal NHS prescription. If you are in doubt, you can treat them as private patients. It is also possible to direct them to the local emergency department or NHS Walk-in Centre. Beware of the 'shopping list' where a foreign patient requests a list of drugs to send back to their family at home. A full list of reciprocal countries is available at: **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_064150.**

If a patient is from a country further afield, which does not have a reciprocal relationship entitling them to NHS treatment, they should be treated as a private patient.

One difficulty can arise with expatriates, who are not "ordinarily resident" in the UK. If such patients are not resident, then they are probably not covered by the NHS and may need to be treated as private patients. GPs should ensure that their practices provide receipts for fees paid to allow these patients to claim some of their treatment costs from their travel insurance.

The GMC advises that doctors must be honest and open in any financial arrangements with patients. Patients should be informed about fees and charges, wherever possible, before asking for their consent to treatment. In addition, you must not exploit patients' vulnerability or lack of medical knowledge when making charges for treatment or services.[3]

Planning ahead

Planning ahead, as best as possible, to ensure that you have adequate resources to deliver safe services and maintain service continuity during the peak of the Games is paramount. For example, a GP employer or emergency department in London may struggle if some of their workforce either request leave to watch the Games or call in sick. Be aware that both staff and patients may also experience transport problems in getting into the surgery.

To circumvent this, GP practice employers could plan ahead by considering building in flexible working options, such as giving staff time off in lieu, suggesting job-sharing or allowing staff to watch the Games online or listen to the radio.

Flexibility can also be built into the appointment system, so that there is extra cover to allow for any unforeseen circumstances. The Advisory, Conciliation

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LEARNING FROM THE BEIJING OLYMPIC GAMES

At the 2008 Olympic Games there were:

- 3,000 medical volunteers specially recruited to work at 227 Olympic medical stations
- A total of 22,137 medical encounters with staff, journalists, visitors and athletes
- A total of 128 people hospitalised, mostly for injuries
- 191 ambulances and 5,880 beds on standby in case of a mass casualty incident.[6]

and Arbitration Service (ACAS) has produced guidance on the issues affecting employees and employers arising from the Games: **www.acas.org.uk/index.aspx?articleid=3392**.

Treating athletes

It is unlikely that you will be asked to treat Canadian cyclists or Spanish divers as an addition to your day job. The vast majority of teams will bring their own experienced sports doctors to treat their athletes, who will have their own indemnity.

All doctors providing medical care at sports events in the UK in any capacity must be medically qualified and have a licence to practise from the GMC.

Under Section 27B of the Medical Act (1983), introduced in 2007, any overseas doctor who is, or intends to be, in the United Kingdom temporarily for the purposes of providing particular medical services to non-UK nationals can apply to the GMC to be registered temporarily as a fully registered medical practitioner. For example, overseas doctors can treat their athletes only, for the duration of the games, if registered.[4]

If an athlete suffers an injury, there is a possibility that they may be taken to NHS facilities to receive treatment. However, it is likely they will already have their own arrangements for treating acute injuries. If you do treat an athlete, your arrangements should just be between you and that athlete – do not enter into a contract with a third party, eg, a sporting body without taking any specific advice.

Performance enhancing drugs

Be aware, too, that certain medications can enhance performance. If you are asked to prescribe for an athlete who is taking part in the games, don't do it unless you have a detailed knowledge of the rules and regulations surrounding the sport. Athletes have the responsibility for ensuring that they do not take anything which could be seen as a performance-enhancing drug. Some over-the-counter cold medicines, steroids, or drugs such as ephedrine can give a boost in performance. Similarly, all athletes are advised not to buy over-the-counter drugs, in case they accidentally enhance their performance.

The issue of athletes taking prohibited substances is complicated and is fraught with dangers for the unwary; it is an area best left to those with special expertise and training in the World Anti-Doping Code, which may, subject to certain provisions, allow an intrusion into the private life of an athlete. In general, athletes have exactly the same rights and expectations as any other patient in respect of confidentiality, consent and the right to refuse a medical intervention. Further information is contained in the Olympic Movement Medical Code.

Conclusion

Whilst London 2012 is a once in a lifetime experience, the medicolegal risks remain the same as any other clinical encounter. Be sure to work within the limits of your competence, ensure good communication with overseas patients and make sure you document any treatment given or decisions made. Domhnall MacAuley, Primary Care Editor of the *BMJ*, sums up the role of the medical volunteer: "Like many of the backroom staff, their success is measured in how little you see of them."[5] You should be prepared and well-equipped to help immediately in those rare instances that you are needed.

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5. MacAuley D, GMC and the Olympics, *BMJ Group Blogs* **http://blogs.bmj.com/bmj/2011/08/08/domhnall-macauley-gmc-and-the-olympics/**
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On the case

Dr Nick Clements, Head of Medical Services, introduces this issue's round-up of case reports, a number of which focus on missed infections

In "Where is the consultant?" on page 17, Mr W's endocarditis was missed by the cardiologist Dr H, who only saw him once during his inpatient stay. Mr W was not consulted about his progress, results of investigations or plans for discharge or follow-up. In this case, team working and fractured continuity of care created an "I thought you did it" situation; required tasks were not completed and an outpatient clinic appointment was not arranged. Safe systems should be in place to ensure that results are acted upon and that the relevant investigations are carried out.

Similarly, there was poor continuity of care in "A pain in the neck", on page 19. Mr P was not fully examined on any subsequent visits to his GP, Dr W, despite progression of his neurological symptoms. The problem here was Mr P's hostile and challenging behaviour, which meant that clinical examination was usually difficult. All the healthcare professionals involved in his care missed the large tubercular abscess in his neck, which resulted in Mr P becoming tetraplegic. This case is a pertinent reminder that despite an aggressive or difficult patient, you should maintain a professional approach and rule out any underlying pathology. To do otherwise is indefensible – expert opinion found Mr P was not examined early enough, despite repeatedly attending with his symptoms.

Preconceptions of a particular patient can hinder diagnosis. In "Crying wolf" on page 15 Mrs Z's multiple calls went unheeded, and similarly, in "Suffer the little children" on page 21, M's generally unhealthy demeanour and frequent contact with the GP masked the extent of her symptoms. Her puffy eyes were put down to "looking rather ill, as usual," rather than the severe bilateral orbital cellulitis she was eventually diagnosed with and which resulted in her becoming blind. Extra care should be taken with frequent attenders, particularly if there are repeated calls – always revisit your diagnosis if symptoms persist or appear to be getting worse. You should have a low threshold for examination when conducting telephone consultations, and, as this case shows, effective triage is essential. Non-clinical staff should be educated to recognise potential red flag symptoms and pass on vital information to the healthcare team.

CASE REPORTS

Casebook publishes medicolegal reports as an educational aid to MPS members and to act as a risk management tool. The reports are based on issues arising in MPS cases from around the world. Unless otherwise stated, facts have been altered to preserve confidentiality.

CASE REPORT INDEX

PAGE	TITLE	SPECIALTY	SUBJECT AREA
14	Oh by the way, doctor	GENERAL PRACTICE	DIAGNOSIS/RECORD-KEEPING
15	Crying wolf	OOH/GENERAL PRACTICE	DIAGNOSIS/SYSTEMS ERRORS
16	A dangerous cough	ANAESTHETICS	COMMUNICATION/RECORD-KEEPING
17	Where is the consultant?	CARDIOLOGY	INVESTIGATIONS/SYSTEMS ERRORS
18	A normal appendix	GENERAL SURGERY	COMMUNICATION/CONSENT
19	A pain in the neck	GENERAL PRACTICE	COMMUNICATION/INVESTIGATIONS
20	Trouble behind her back	GENERAL PRACTICE	SUCCESSFUL DEFENCE
21	Suffer the little children	GENERAL PRACTICE	INVESTIGATIONS
22	Too much bleeding	OBSTETRICS	INVESTIGATIONS/PROFESSIONALISM
23	A friend in need	GENERAL PRACTICE	RECORD-KEEPING/PROFESSIONALISM

WHAT'S IT WORTH?

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 £1,000,000+
Substantial £100,000+
Moderate £10,000+
Low £1,000+
Negligible <£1,000

FRED GOLDSTEIN/SHUTTERSTOCK

Oh by the way, doctor

Mrs R was a receptionist in a local estate agent's office. One evening, she noticed that her 11-year-old son, Y, was limping as he walked towards her in the kitchen. Y was overweight and had been grumbling to his mother about his left knee hurting intermittently for the previous month. On this occasion, when she asked why he was limping, Y told his mother he had slipped on ice in the playground earlier in the day. The fall had caused his leg to be sore. He had pointed at his thigh and said his knee was hurting again. The following day, Mrs R was booked to visit her GP, Dr G, to review her contraceptive medication. She decided to bring her son along with her, without an appointment.

At the end of her consultation, Mrs R asked the doctor if he would take a look at her son. She explained what had happened yesterday and told Dr G that Y had been limping at home. There was a computer record of the consultation with Mrs R, but not with Y.

Mrs R reported that Dr G carried out a cursory examination of Y, while Y was sitting in the chair. She said that the doctor told them this was most likely a hip sprain, but to come back if the pain did not settle.

Dr G remembered Mrs R attending for a review of her medication, and then asking for her son to be seen at the same time. He recalled feeling rushed and that Mrs R was quite insistent that Y be examined. Dr G could not remember carrying out the examination and thought he had asked Mrs R to rebook an appointment for Y. As there was no formal record of this, there was therefore no note of such a request, or an examination being performed.

When they returned home, the boy continued to complain of pain in his leg. Mrs R decided to bring Y to the local Emergency Department (ED) three weeks later, where a doctor requested bilateral hip x-rays and subsequently diagnosed slipped upper femoral epiphysis (SUFE). The case was discussed with the orthopaedic team on call and Y was admitted immediately for internal fixation.

After his treatment, Y's legs were of unequal length and one year later, he still walked with a persistent limp, which he found extremely distressing. The family had learnt it was likely that Y would require an early hip replacement in the future.

Mrs R made a claim against Dr G.

As there were no records of the consultation, experts found it difficult to make a definitive assessment of the case, but they did find that Dr G's management had not been appropriate. The case was settled for a high sum.

GMcK

LEARNING POINTS

- Remember the importance of contemporaneous record-keeping. Good documentation is the basis of good medical practice, and can help to defend a claim. Even if Y's problem was mentioned by Mrs R as a "by-the-by", Dr G should have made a clinical record of the events.
- If you are going to assess a patient, even in someone else's appointment, the history and examination should be carried out appropriately. Had Dr G done it at the time, he may have realised that there was a significant problem with the child's leg. Otherwise, Dr G should have asked Mrs R to wait until the end of surgery for Y to be seen if urgent, or rebook an appointment for Y at a later date, when a more thorough history and examination could be carried out, if the problem could wait. Dr G should have made a record of this discussion.
- A limp in a child can have multiple aetiologies: Perthes' disease/trauma/transient synovitis/septic arthritis/osteomeylitis. Slipped upper femoral epiphysis usually affects boys aged 10-15 years old. Incidence is 1:100,000 and is bilateral in 20% of cases. It occurs more frequently in obese children with delayed secondary sexual development and tall thin boys.
- Remember referred pain to the knee as an early clinical symptom of SUFE.
- Examine both hips and check for restricted movement, particularly internal rotation.

FURTHER INFORMATION

- Lalanda M, A Limping Child, *Casebook* 15(2)
- Lalanda M, Alonso JA, Improving the Management of the Child with an Unexplained Limp, *Clinical Governance: An International Journal* 11(4) 308–15 (2006)
- Anthony S, Getting to Grips with Children's Hips, *Casebook* 12(3)

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Crying wolf

Mrs Z was a 34-year-old mother of four who smoked 20 cigarettes a day. She had recently been under investigation for central chest pain related to minimal exertion. Her GP, Dr B, had arranged an ECG, which had been normal, and done some blood tests, which showed raised cholesterol. He had also found her to be hypertensive. He had made no firm diagnosis regarding her central chest pain but was considering a referral to cardiology.

Mrs Z developed what she thought was indigestion, which was also causing aching in both her arms. When she started feeling unwell with it she rang the out-of-hours (OOHs) service complaining that in addition to the indigestion she also felt hot and sweaty. Mrs Z was very well-known to the OOHs staff because she used the service very regularly for herself and her children. The triage nurses advised her to take some antacid or milk for the indigestion. The nurse had failed to get a past history for Mrs Z's cardiac symptoms.

Mrs Z waited for an hour after drinking some milk but felt worse. She was still feeling sweaty and hot with the chest pain and rang the OOHs service again to explain this. She asked to speak to the doctor but the triage nurses remarked that "the doctor would not be able to do much more for that kind of problem". That evening she became really concerned after several hours of pain were showing no signs of remitting. She had managed to get all her children to bed but was feeling like something awful was going to happen. She rang the OOHs services again but was given the same advice by the triage nurses.

Unfortunately during the late hours of the evening, Mrs Z collapsed at home. One of her children called an ambulance but attempts by the paramedics to resuscitate her were unsuccessful. She was pronounced dead. The postmortem confirmed that the cause of death was an acute MI.

Mrs Z's relatives made a claim against the triage nurses and the on-call doctors that night. The doctors denied having any knowledge about her. There were long discussions about the standards of training and support for the triage nurses and the levels of GP cover. The case was settled for a high amount.

AF

LEARNING POINTS

- It is important to listen to patients who make recurrent calls regarding the same problem. Mrs Z had contacted the OOHs team and the GP surgery on multiple occasions. Doctors must not let an element of "crying wolf" blind their judgment.
- There are risks associated with telephone triage and information not being appropriately passed on to the medical team. It is harder to make a diagnosis without the visual information from a patient's appearance, behaviour and non-verbal cues so great care must be taken.
- Written protocols should exist for the management of chest pain with clear guidance about when to pass on information to doctors. Although protocols often lack the "intuition" of experience, it would have been helpful if one had been adhered to in Mrs Z's case.
- Ischaemic heart disease is rare in younger women, but not impossible, particularly when associated with risk factors. It is important to consider this diagnosis in the differential even if it is uncommon.

KATHERINE MOFFITT/ISTOCKPHOTO.COM

A dangerous cough

Mrs T, a 58-year-old music teacher, was admitted to her local hospital for an elective total abdominal hysterectomy for post-menopausal bleeding. She was seen on the day of surgery by consultant anaesthetist Dr Q, who noticed she had a cough. Mrs T said she had recently had a chest infection and had been prescribed a course of antibiotics from her GP. However, she was vague about how long she had had her cough, and whether she had finished the antibiotics. She dismissed her symptoms as a "smoker's cough" and was insistent that the operation should go ahead, as she wanted it to be "all over and done with" in time for her son's wedding a few weeks later. She also requested a general anaesthetic.

Dr Q did not discuss the case with the consultant gynaecologist Ms R. Later it was revealed that they had "fallen out following a disagreement". Dr Q agreed to proceed with general anaesthesia.

Dr Q induced general anaesthesia using a standard technique and intubated the trachea. However, he found the airway pressures unexpectedly high. He reasoned that the cause was bronchospasm. He adjusted the ventilator settings, deepened anaesthesia and administered intravenous salbutamol to relieve the spasm. After a few minutes, things seemed to improve and the operation went ahead. Mrs T was coughing on the tube at the end of the operation, but was extubated. However, she continued to cough vigorously in the recovery area and was clearly in difficulty, with very low oxygen saturations and a high respiratory rate.

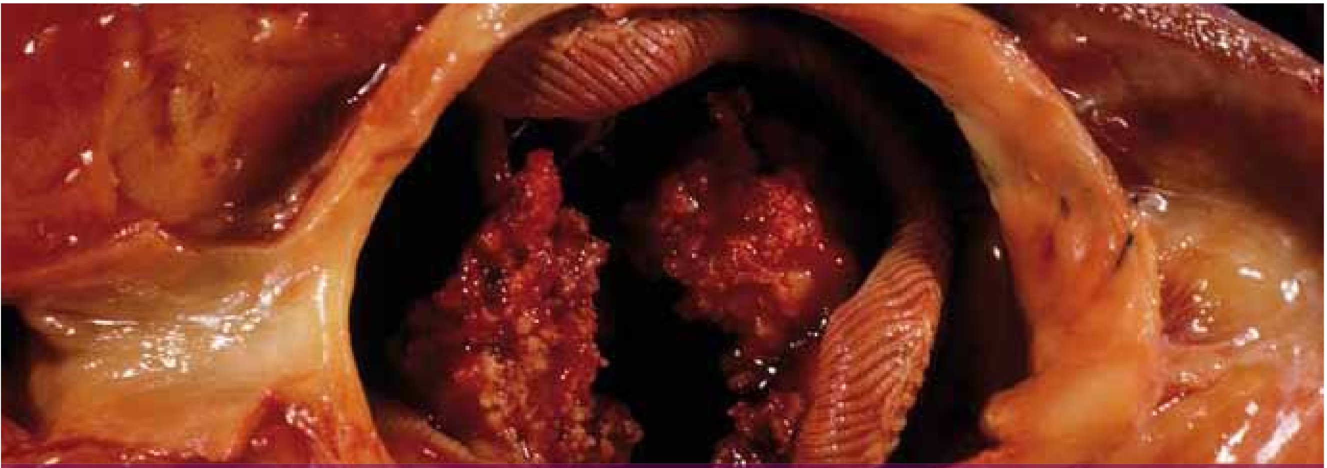
Shortly afterwards Mrs T rapidly developed subcutaneous surgical emphysema and suffered a cardiac arrest. Cardiac compressions were performed and intravenous adrenaline was administered. A circulation returned, although she remained very unstable. A chest x-ray was performed, which showed a tension pneumothorax. A chest drain was inserted, which improved stability, and she was reintubated. She was transferred to the intensive care unit, where she was found to have signs of a right lower lobar pneumonia. Oxygenation was very difficult. She had a prolonged and turbulent course in intensive care, complicated by pneumonitis and multi-organ failure, and was eventually found to have cognitive impairment consistent with hypoxic brain injury.

There were limited records of what happened during induction, anaesthesia and recovery, and most of the medical record was found to have gone missing. The recovery nursing notes included an incident form for "difficult airway maintenance" and she was noted to have arrived in recovery in a "very poor state". A claim was brought on Mrs T's behalf against Dr Q, which was settled for a high sum.

AOD

LEARNING POINTS

- Your first obligation is to act in the patient's best interests and you should not be pressurised by the patient into doing anything that is counter to this. In elective surgery, it is important to avoid pressure to proceed. In this case, finding out that Mrs T had pneumonia might have prevented this outcome.
- When administering anaesthesia during an elective procedure, it is preferable to stop should you encounter difficulties and reassess for surgery another time.
- Good communication between professionals is essential in patient care. Had the anaesthetist and the surgeon discussed this patient, it might have been possible to perform a vaginal hysterectomy under spinal anaesthesia, or the case could have been postponed until later.
- Good, careful, well-kept records help provide a good defence. In this case, the nursing records and their understanding of the events were the only written documents to go by. Safeguarding the integrity of records is even more important after an adverse event.
- Bronchospasm is an important and treatable cause of high airway pressures and tension pneumothorax during ventilation, but not the only one. The differential diagnosis includes endobronchial intubation, foreign body in the airway, and equipment problems such as kinks and obstructions.



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Where is the consultant?

A 48-year-old driver, Mr W, was sent to hospital by his GP with a one-week history of unremitting back pain and associated mild shortness of breath. On direct questioning, he also reported non-specific malaise for at least three months with half a stone weight loss but no symptoms of fever. There was no previous history of cardiac problems and no recent dental or other invasive procedures.

Initial investigations demonstrated a mild leucocytosis with normal biochemistry. The ECG and chest x-ray were normal and there was no elevation of troponin, BNP or D-dimers. There was some concern about the possibility of an aortic dissection but a CT scan of the chest was also normal. Inflammatory markers were not measured.

The consultant cardiologist Dr H saw Mr W only once – on the post-take ward round after being admitted – and requested an echocardiogram after hearing "an aortic murmur". The medical records indicate that he did not see Mr W again during his in-patient stay – nor was he consulted about his progress, results of investigations or plans for discharge or follow-up. Mr W's temperature was recorded once daily. The echocardiogram demonstrated a bicuspid aortic valve with moderate aortic regurgitation and no other abnormality. The template report included the statement: "endocarditis is not excluded". He was discharged directly from the medical assessment unit without senior review, with a diagnosis of musculoskeletal back pain and possible atypical pneumonia, with a plan for outpatient follow-up in four weeks' time to assess progress and review the results of the echocardiogram. The GP received only an interim discharge summary, which did not show an appointment had been arranged.

Eight weeks later, Mr W was readmitted to hospital with a high temperature, further weight loss, and shortness of breath secondary to pulmonary oedema. He was anaemic with an ESR of 104mm/hr and six out of six blood cultures were positive for Streptococcus mutans. A clinical diagnosis of infective endocarditis was made and confirmed by echocardiography, which demonstrated a large vegetation on the aortic valve with destruction of the non-coronary cusp and severe aortic regurgitation. He was treated appropriately after microbiological consultation with intravenous benzylpenicillin and gentamicin and his case discussed with the local cardiothoracic surgical centre. Unfortunately, within 24 hours, and before he could be transferred, Mr W deteriorated acutely with hypotension and pulmonary oedema refractory to diuretics and could not be resuscitated. The postmortem showed large vegetations on the aortic valve and extensive destruction of both leaflets of the bicuspid aortic valve secondary to bacterial endocarditis.

The case was settled for a moderate amount.
BP

LEARNING POINTS

- The diagnosis of infective endocarditis is difficult and depends upon a low threshold of suspicion (see Beynon R, Bahl VK, Prendergast BD, Infective endocarditis, *BMJ* 333:334-339(2006)). The disease may present in a variety of forms to a variety of clinical specialties.
- Senior medical input to the care of seriously ill patients is important.
- There is little purpose in requesting investigations if the results are not carefully reviewed and acted upon at an appropriately early stage. There were several diagnostic clues in this particular case, which should have alerted the clinical team to the earlier diagnosis and management of infective endocarditis.
- The pressure to discharge patients and create beds for further admissions means that the results of important investigations are easily overlooked.
- Clear and comprehensive communication with the patient and GP is essential.
- Team working and fractured continuity of care can easily create "I thought you did it" situations where required tasks are not completed. The outcome for this unfortunate patient may have been different had an early follow-up appointment been arranged.
- Safe systems should be in place to check that outpatient clinics are arranged. It is worthwhile telling the patient that they should get in touch if plans are not confirmed.

HTTP://COMMONS.WIKIMEDIA.ORG/WIKI/FILE:BLINDDARM-01.JPG

A normal appendix

Mr A, a 35-year-old accountant, was admitted to hospital overnight as an emergency under the care of consultant general surgeon Ms Q. He described an acute onset of severe right iliac fossa pain. Clinical examination revealed lower abdominal tenderness with localised peritonism in the right iliac fossa. Routine blood tests revealed an elevated white cell count whilst urinalysis was negative. A provisional diagnosis of appendicitis was made and the patient was commenced on intravenous antibiotics, and kept nil by mouth pending review by Ms Q in the morning.

When Ms Q saw Mr A she was unconvinced by his physical signs and organised an ultrasound scan, which did not demonstrate any abnormality. The appendix was not visualised. Twenty-four hours later the patient's condition had not improved and Ms Q made a decision to perform an appendicectomy.

Open surgery was carried out by an experienced surgical trainee on behalf of Ms Q, who found no sign of any intra-abdominal pathology to account for Mr A's symptoms. Ms Q attended the operation and confirmed that there was no peritoneal contamination and that the appendix, terminal ileum, gall bladder, duodenum and remaining accessible small bowel and colon all appeared normal. An appendicectomy was performed and the wound was closed. Postoperatively Mr A made an unremarkable recovery and was discharged home one day later. Neither Ms Q nor the surgical trainee who performed the operation saw Mr A prior to discharge. The junior staff caring for Mr A simply informed him that an appendicectomy had been carried out and he left hospital under the impression that he had had an inflamed appendix removed. Subsequent histopathological examination of the appendix showed no evidence of inflammation.

Over the next few weeks and months Mr A continued to suffer from intermittent abdominal pain. He consulted his GP on numerous occasions and also attended the Emergency Department (ED) at times when the pain was severe. He received antibiotic treatment for a proven urinary tract infection on two occasions but his symptoms persisted. Further blood tests and a urological assessment (including a cystocopy) all proved to be negative. Mr A was eventually referred to another surgeon, Mr B, who arranged a CT scan, which suggested there was a Meckel's diverticulum in the terminal ileum. A subsequent radio-nucleotide scan confirmed evidence of active disease at this site. Mr B recommended a further operation and Mr A underwent a laparotomy, division of adhesions and Meckel's diverticulectomy.

Mr A made a claim against Ms Q for performing an unnecessary appendicectomy and for failing to identify the Meckel's diverticulum.

The opinion of the experts consulted on behalf of MPS was supportive of Ms Q's decision to remove the appendix at the time of surgery. They were, however, critical of the failure by Ms Q and her team to adequately communicate to the patient the operative findings and the subsequent negative histology and were critical of the consent process. The failure to identify the diverticulum at the first operation was also criticised but it was pointed out that in the absence of a perforation it was not certain that the diverticulum was the cause of Mr A's initial presentation. The case was subsequently discontinued.

SD

LEARNING POINTS

- In the consent process for appendicectomy it is important to warn patients that the appendix may be normal and other causes for the pain may (or may not) be identified.
- 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 and occasionally other pathology may be found in the appendix at the time of histopathological examination.
- A Meckel's diverticulum is a common congenital abnormality and may be found in up to 2% of the population. It can contain ectopic gastric mucosa, which can occasionally bleed or ulcerate causing pain or perforation. In the absence of obvious appendicitis at the time of an operation the terminal ileum should be thoroughly inspected and if a Meckel's diverticulum is found (typically two feet from the ileo-caecal valve) a diverticulectomy can easily be performed.
- Good communication between clinicians and a patient is essential. Ideally, the operating surgeon should discuss a procedure directly with the patient. This should be supported by clear written instructions to all staff involved in the patient's care. In this case, had the patient understood that he did not have appendicitis and the rationale behind his appendicectomy, he may have been less likely to pursue a claim.
- Although in this case the experts found the communication to be sub-optimal, it did not amount to negligence.

WILLIE B. THOMAS/ISTOCKPHOTO.COM

A pain in the neck

Fifty-five-year old Mr P moved to the UK ten years ago from overseas and secured a job as an administrator in a factory just outside London. He registered with GP Dr W soon after arriving in the UK and mentioned during his first appointment that he had suffered with long-standing back pain for over a decade.

Mr P became well-known at the surgery, as he was often argumentative and confrontational towards staff. Over a period of three months, Mr P attended his GP several times complaining of neck pain, stiffness and loss of strength in both arms. It was documented that he would routinely demand sick notes from Dr W in an aggressive manner and was adamant that the doctor didn't like him. He repeatedly insisted that he should be provided with an orthopaedic chair for work, to ease his neck.

The hostile behaviour of the patient meant that clinical examination was usually difficult and Dr W would try to keep the consultations as short as possible. Full neurological examination was only performed once when Mr P first presented and it appeared normal at this time. Despite reported progression of his neurological symptoms, examination was never repeated in subsequent consultations. Mr P began to complain of increased heaviness in his arm, which prompted Dr W to request a cervical x-ray, which showed some age-related degenerative changes. A routine referral was then made to rheumatology. Once again, no neurological examination was conducted.

While awaiting his appointment with the rheumatologists, Mr P was admitted to hospital after a fall; he was found to be tetraplegic. Further investigations confirmed his symptoms were due to a large tubercular abscess in the neck with destruction of the C4 vertebrae and pus in the epidural space. Mr P required extensive treatment and following a long hospital stay, he remained tetraplegic on discharge and required help with all normal activities of daily living.

The case could not be defended as expert opinion found that Mr P was not examined early enough, despite repeatedly attending with his symptoms. It is likely that a full recovery would have been made if diagnosis had been made sooner.

The case was settled for a high sum.

EW

LEARNING POINTS

- Management of challenging patients can be very complicated and in cases like this can have devastating results. Despite the multitude of negative emotions introduced by an aggressive patient, it is important to maintain a professional approach and rule out any underlying pathology. Neglecting basics such as physical examination and reassessing for evolving signs is indefensible.
- Dr Monica Lalanda's article on "The challenging patient" offers advice on dealing with these difficult encounters and reflects on the elements that often contribute to a patient's behaviour.
- An estimated one third of the world's population is infected with latent tuberculosis, and although once uncommon in the UK, cases have increased markedly over the last 20 years, particularly among ethnic minority communities from countries where TB is widespread, and in patients with HIV. This increasing prevalence makes it a diagnosis that should be considered.
- It is important to revisit your diagnosis and examination for evolving signs. See the *Casebook* article "Tunnel Vision" for more information: **www.medicalprotection.org/uk/casebook-may-2011/tunnel-vision**
- Dealing with conflict from aggressive patients can be a significant source of stress for doctors and can lead to a breakdown in the therapeutic relationship. Training in communication skills can be helpful in dealing with challenging scenarios. MPS runs a workshop, Mastering Difficult Interactions with Patients; visit **www.medicalprotection.org** and click on the Education tab.

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3. Williams S, Tunnel Vision, *Casebook* 19 (2) (2011)

MONKEY BUSINESS IMAGES/SHUTTERSTOCK

Trouble behind her back

Housekeeper Mrs L, 58, was a poorly-controlled diabetic patient who was well-known to her GP, Dr V. One day, she presented with a swollen foot, and Dr V discovered an extensive area of skin breakdown on the ball of the foot discharging purulent fluid. He diagnosed an infected diabetic ulcer and referred her immediately to hospital.

At hospital the ulcer was debrided and she was treated with intravenous antibiotics. The diabetes multidisciplinary team reviewed her diabetes management and warned her several times that she might need an amputation. Fortunately, the infection was controlled, the tissues remained viable and amputation was not needed. She was then discharged for ongoing care in the community.

Mrs L continued to make progress as the ulcer gradually resolved, but during the recovery period she developed pleuritic chest and back pain. Dr V saw Mrs L several times at home and in surgery and diagnosed this as a chest infection. Each time he took time to carefully document Mrs L's symptoms and his management.

One month following her hospital admission, Mrs L developed severe back pain and acute urinary retention. She was admitted as an emergency admission to hospital, where investigations revealed vertebral osteomyelitis at T10 with spinal cord compression and an epidural abscess. In spite of aggressive treatment Mrs L was left with paraplegia.

Mrs L made a claim against the hospital and Dr V for a delay in diagnosis of the abscess, which caused her paralysis.

Expert opinion reviewed the medical notes, which included details of every visit, and were strongly supportive of Dr V's management. The case was successfully defended.

TM

LEARNING POINTS

- Complications can, and do, occur in almost any clinical scenario, even when treatment is meticulous.
- Comprehensive and contemporaneous notekeeping is vital and the foundation of good practice.
- Infections are a significant problem in diabetes, especially when their control is poor. Microvascular and macrovascular complications of diabetes, as well as defects in cell-mediated immunity, increase with age, so increasing the risk of infection. Infections may also disrupt metabolic homeostasis and glycaemic control, so prompt recognition and treatment is therefore critical. Access a good overview here: **http://enotes.tripod.com/dm_infections.pdf**
- The importance of good foot care should be emphasised to patients – diabetic foot complications are the most common cause of non-traumatic lower extremity amputations in the industrialised world. Early detection and appropriate treatment of diabetic ulcers may prevent up to 85% of amputations. There is useful advice at:
  - The prevention, diagnosis and classification of diabetic foot ulcers – **www.aafp.org/afp/1998/0315/p1325.html**
  - Evaluation and Treatment of Diabetic Foot Ulcers – **http://clinical.diabetesjournals.org/content/24/2/91.full**
  - ABC of Diabetes – **www.bmj.com/content/326/7396/977.full**
- There may be an identifiable nidus from which the infection seeds through the blood stream, but 30-70% of patients with vertebral osteomyelitis have no obvious prior infection. Read more on the management of spinal infections at: **http://emedicine.medscape.com/article/1266702-overview#aw2aab6b2b1aa**
- Medicines used to treat the primary infection can obscure the presentation of symptoms from complications elsewhere, eg, a prolonged course of antibiotics and painkillers used to treat an infected diabetic foot ulcer may temper signs of infection elsewhere, rendering the secondary infection occult.

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Suffer the little children

M had always been a rather sickly child who missed a lot of school through minor illness. Her mother brought her to see the GP frequently with her asthma, eczema and possible food intolerances. Most of the entries in her medical records had remarks about her low weight, small size and generally unhealthy appearance. M's mother would often request home visits and they were regular users of the surgery.

When M was 12 years old she became unwell with a cold. Her mother requested a home visit. This was declined and standard advice for a non-specific viral illness was given. Over the following ten days M's mother rang the surgery several times to report what appeared to be minor influenza symptoms. She described a mild fever, a runny nose and aching muscles. She spoke to her GP Dr T and several of the other partners who documented this and advised giving paracetamol and plenty of fluids.

M's mother became increasingly anxious because she felt her daughter was not improving and "just didn't seem right". She started to ring the surgery more often. She spoke to different GPs and reported new symptoms of swollen eyes, severe headache and general weakness. She felt frustrated because she had the impression that the GPs were not listening to her concerns. She stated later that the doctor on the other end of the line would keep saying "aha" or "I see" and seem disinterested in her worries.

The GPs asked her to bring M down to the surgery but her mother said she was too ill to leave the house so a home visit was arranged by Dr C. His notes from the visit described M as "looking rather ill, as usual" and the puffy eyes were put down to a flare up of her longstanding eczema. Dr C prescribed some hydrocortisone cream for use around her eyes and advised M to get out of bed and try to get back to normal.

The next day M felt very weak but her mother tried to get her out of bed, like the GP had suggested. She collapsed on the floor and her mother called an ambulance that took her to the emergency department. She was diagnosed with severe bilateral orbital cellulitis and scans showed bilateral cavernous sinus thrombosis. Unfortunately, in spite of aggressive treatment, M became blind.

M's mum made a claim against all the GPs involved. Experts could not support the GPs' treatment. The case was settled for a moderate amount.

AF

LEARNING POINTS

- Patients who see their doctors with minor ailments all the time may eventually present with a serious complaint. It is important to be mindful of frequent attenders whose serious symptoms can be missed. Extra care should be taken.
- Repeated calls should be a red flag. They should always make doctors stop and think.
- Doctors must always be able to justify any decisions they make and have a low threshold for having a face-to-face consultation.
- Telephone consultations are challenging where it is hard to make a proper assessment of the patient. Effective telephone triage is essential. Listen to a podcast on how to improve your patient triage over the telephone – **www.medicalprotection.org/uk/podcasts/Telephone-triage-managing-uncertainty**.

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Too much bleeding

Mrs C, a 25-year-old mother of two, had an elective caesarean with her first pregnancy as that baby was breech, and she experienced a failed attempt at a VBAC (Vaginal Birth After Caesarean) with her second pregnancy.

Her third pregnancy was uneventful and she was booked in for an elective caesarean section at 39 weeks. Mr A, a staff grade obstetrician, carried out the operation under spinal anaesthetic. The operation was felt to be "routine" and there was minimal scarring from the previous caesareans. After initial observations concluded that everything was normal, the patient and her 3.5kg baby girl were returned to the postnatal ward.

Three hours later, Mrs C started to feel unwell with dizziness. Mr A was called by the midwifery staff, but as he was busy in the delivery suite, he sent his specialty trainee, Dr Q, to check on Mrs C.

On examination, she looked pale and sweaty, although the visible blood loss per vaginum was minimal and the uterus appeared to be well contracted. She was, however, tachycardic (P110) and hypotensive (BP100/70 mm Hg). Dr Q started appropriate fluid resuscitation, cross-matched blood and set up an oxytocin infusion and arranged for her to be transferred back to the delivery suite.

As Dr Q was keen to get to his "protected teaching" session in the afternoon his notes were brief, but he had informed Mr A of his findings. As the midwifery staff were delayed by a change of shift, Mrs C was not taken back to the delivery suite for another hour and a half.

As soon as she was reassessed on the delivery suite, she had become more tachycardic (P120) with profound hypotension (BP70/50 mm Hg), and tachypnoeic with a respiratory rate of 28/min. Only minimal urine was noted in the catheter bag and a decision for an immediate laparotomy was made. Mr A found 1.5l of blood within the peritoneal cavity and a tear at the left extremity of the uterine incision, extending into the broad ligament. This was successfully repaired, but Mrs C required a transfusion of three units of blood and stayed in the high dependency unit for 24 hours.

Both Mrs C and her baby were discharged home a week later and physically recovered well. However, Mrs C made a complaint against Mr A and his team for poor management of her condition. An internal investigation was begun.

Expert opinion on the issue was sought and there was agreement that although this was an unusual complication, it can be caused by the angle at which the baby's head was delivered, and it should have been recognised and treated at the time of the initial caesarean section. There was also considerable criticism regarding the delay in taking the patient back to theatre and the documentation that had been made in the notes.

Following a face-to-face meeting where the case was discussed in detail, the complaint was resolved and no further action ensued.

DS

LEARNING POINTS

- Although a caesarean section is a common operation nowadays, it is still a major surgical procedure. Mistakes do happen and complications do occur, even if you have done the same procedure thousands of times before.
- The operating surgeon takes the ultimate responsibility for the patient's outcome. Although it may be appropriate to delegate suitably trained personnel to review some patients, cases of pre-imminent shock need urgent assessment by appropriately experienced staff at the most senior level available.
- Postpartum haemorrhage is an obstetric emergency.
- It is important to remember the physiological changes that occur during a normal pregnancy (eg, increased circulating volume, increased cardiac output etc), such that the common signs of hypovolaemia (ie, tachycardia, increased respiratory rate, oliguria, narrowed pulse pressure, etc) may not become apparent until a significant amount of blood has been lost.
- The abdomen can act as a "silent reservoir", so the visible blood loss (ie, per vaginum) may not be apparent and hypotension is often a very late sign.
- Postpartum haemorrhage may be caused by the 4Ts:
  - **Tone** – atonic uterus accounts for 70% of cases and should be treated with uterotonic agents
  - **Tissue** – check the notes that the placenta and membranes were "complete" during the delivery
  - **Trauma** – cervical/vaginal tears, ruptured uterus from previous scars, extension of uterine angles at time of caesarean section
  - **Thrombin** – clotting problems – often this can be a late complication after significant blood loss.
- Although administrative procedures and teaching are important they should not be allowed to interfere with patient care.

FATIHHOCA/ISTOCKPHOTO.COM

A friend in need

Mr A was a 55-year-old newsagent who had smoked 20 cigarettes a day for 30 years. He had been good friends with his GP, Dr B, for years – since they were children playing in the same football team. Mr A had suffered with asthma since childhood. He visited Dr B regularly with exacerbations causing wheeziness and coughing, especially during the winter months. The visits were always kept very informal since they were friends, and Dr B's medical notes were very brief, with minimal entries regarding Mr A's presenting complaints or clinical examinations. Entries often comprised only the date and the prescription of inhalers.

Mr A had started suffering with back pain, which had not responded adequately to analgesia. It became severe enough to require hospital admission. A hospital CT scan revealed extensive mediastinal lymphadenopathy and parenchymal lung deposits. Mr A underwent bronchoscopy with biopsy, which confirmed the diagnosis of non-small cell carcinoma of the bronchus. Further scanning showed his disease to be metastatic involving his thoracic and lumbar spine, with a very poor prognosis. Unfortunately, Mr A deteriorated very rapidly, becoming very dyspnoeic and cachexic. He died just a few weeks after the diagnosis.

Mr A's widow was devastated and made a claim against Dr B. She thought that her husband should have been investigated much earlier for severe breathing difficulties and weight loss. Dr B claimed from memory that Mr A had remained in good health with no breathing difficulties or weight loss till the weeks prior to his death. Dr B's notes were so minimal it would have been impossible to confirm this. Experts looking into the case reviewed Dr B's minimal notes but also, fortunately, had the benefit of the hospital notes. The hospital notes confirmed that Mr A's symptoms of weight loss and severe dyspnoea started after his hospital admission.

There was heavy criticism of Dr B for his poor documentation. However, it was also agreed that since Mr A's tumour was rapidly growing and aggressive, earlier diagnosis would not have improved his prognosis. The case was settled for a low amount.

AF

LEARNING POINTS

- Clear and comprehensive notes are your defence when things go wrong. In this particular case the claims made by the deceased's wife that the patient had been ill for a long time, could only be confirmed because of someone else's medical records.
- Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship. When treating those close to you, it could be easy to make assumptions, eg, regarding the way a patient is feeling if a doctor knows them already and does not ask the relevant questions, or it could be possible to over-identify with patients and lose objectivity.

FURTHER INFORMATION

- Rourke L, Rourke J, Close friends as patients in rural practice, *Can Fam Physician* (June 1998)
- GMC, *Good Medical Practice* (2011)

Over to you...

We welcome all contributions to ***Over to you***. We reserve the right to edit submissions. Please address correspondence to: *Casebook*, MPS, Granary Wharf House, Leeds LS11 5PY, UK
Email: casebook@mps.org.uk

Debating DNAR orders

(Note – this response refers to an article that appeared in the UK edition of *Casebook* – non-UK readers can access it here: ***www.medicalprotection.org/uk/casebook-january-2012/debating-DNR-orders)***

We have received a number of letters from readers about this article, in particular the statement: "If, after careful consideration, clinical evidence suggests that it is not in the patient's best interests to perform CPR should it be needed, this must be discussed fully with the patient." We accept the criticisms raised that the use of the phrase "must be discussed" is incorrect and does not apply to every clinical situation.

The purpose of the article was to emphasise the need for good communication in this area, given the rising number of complaints about DNACPR decisions being made without the knowledge of patients or their families, and the generally accepted best practice approach of involving patients in decisions about their care ("no decision about me, without me"). However, there are situations where clinical judgment will determine that such discussions are not appropriate, or timely – for example, in the case of the dying patient.

For clarification we set out below the relevant section from the GMC guidance *Treatment and Care towards the End of Life: Good Practice in Decision Making*, which states:

134. "If a patient is at foreseeable risk of cardiac or respiratory arrest and you judge that CPR should not be attempted, because it will not be successful in restarting the patient's heart and breathing and restoring circulation, you must carefully consider whether it is necessary or appropriate to tell the patient that a DNACPR decision has been made. You should not make assumptions about a patient's wishes, but should explore in a sensitive way how willing they might be to know about a DNACPR decision. While some patients may want to be told, others may find discussion about interventions that would not be clinically appropriate, burdensome and of little or no value. You should not withhold information simply because conveying it is difficult or uncomfortable for you or the healthcare team."

Guidance published by the BMA/RCN/Resuscitation Council in 2007 on this issue also states: "In considering this clinicians need to take account of the fact that patients are legally entitled to see and have a copy of their health records, so it may be preferable for them to be informed of the existence of a DNAR decision and have it explained to them rather than for them to find it by chance. It may be distressing for them to find out by chance that a DNAR decision has been made without them being involved in the decision or being informed of it."

The guidance goes on to advise doctors to record the reasons why a patient has not been informed about a DNACPR order if the decision is made not to inform the patient.

We are pleased to respond to the concerns raised by readers, and welcome all feedback.

›› With regards to "Debating DNAR orders" (*Casebook* 20(1)). The comment from Dr Davies, your adviser, was appropriate – the real issue is whether comprehensive discussion of management options has taken place. Unfortunately, the medical profession has been guilty of placing almost all the emphasis on the isolated issue of cardio pulmonary resuscitation, which, of course, is an entirely inappropriate form of management for the majority of patients dying from progressive illness in medical wards up and down the country. The relevant discussion is about "ceiling of treatment" – what treatment approaches are and are not appropriate for a given clinical picture. Thus, for example, if intensive care management would not be appropriate for a patient with progressive respiratory failure, CPR would automatically be inappropriate.

The discussion of do not resuscitate orders at a relatively early stage in a progressive illness inevitably risks concerns for patient or family about the approach to overall care. It also raised a genuine difficulty in distinguishing an acute unexpected event from progression of the underlying disease. As a patient's clinical state deteriorates it often becomes obvious when DNAR is appropriate and in reality not something that is a realistic discussion. The resuscitation issue lies between these points, when it is apparent that a clinical picture is deteriorating and possible management options such as treatment change or involvement of intensive care need to be considered. At this juncture the focus of discussion should be on these management options with the issue of DNAR being a secondary consequence from this discussion.

There will, of course, be the occasional patient with a chronic illness who does not want CPR under any circumstance. We should be sensitive enough to pick up on that. However, those cases are an exception.

Duncan Macintyre, consultant physician in respiratory medicine, Scotland

›› This disagreement has been publicly discussed for many years, and screams "communication failure" between hospital staff and patients, and their relatives – particularly their relatives.

But also, sadly, between hospital workers and the president of the Royal College of GPs. Resuscitation is not for patients to opt in or opt out, like breast enhancement or a facelift. It is the dramatic last stand in a provision of circulatory and respiratory support offered to some patients. Patients can choose to refuse any treatment at any time, but appreciation of medical limits increases confidence and trust.

About 50 years ago DNR (Do Not Resuscitate) labels were placed on some patients' notes by doctors to stop the cardiac arrest team being called out for every death. The team, called to treat an unfamiliar patient, would have to read

Double problem, double risk

Double problem, double risk

The report on the patient with tonsillar cancer surprises me; it is hard to believe that an ENT surgeon consulted about "a recurrent sinus problem" does not perform a full ear nose and throat examination, or at the very least an inspection of the oral cavity and pharynx. To read that the patient mentioned "ongoing ... sore throat" and that the ENT surgeon suggested that the patient get his GP to check it reflects professional laziness or incompetence on the part of the specialist.

If indeed the specialist did examine the throat, it seems likely that it was not a competent examination, as within a month there was an obvious tonsillar carcinoma evident on inspection, and accompanying metastases in the cervical nodes.

I am also surprised that the learning points did not conclude that the initial ENT assessment was inadequate, and that the specialist's response to the patient's expressed concern about his throat was unacceptable. At the very least the specialist should have examined the throat in the light of the information provided. Given the findings one month later, an adequate initial specialist assessment, in all probability, should have raised the alarm at that time.

Randall Morton, professor of otolaryngology – head and neck surgery, University of Auckland, New Zealand

Response

The points you make about the consultation are very valid, and it is only a limitation on space that means we are unable to include all of the learning points from every case. The focus of this case report was to highlight the need for vigilance when patients present with more than one complaint, but there were clearly other issues of concern, as you have pointed out, that led to this claim being settled. Thank you for taking the time to share your views on this article with us.

the notes in detail, by which time the treatment would be too late. This precaution allowed the nurses to avoid mistakes that would waste valuable staff time and energy, valuable blood and expensive disposable equipment and materials.

Patients need to understand that when all definitive treatment for a disease has failed, and the circulation ceases, this is not the time to start treating the disease, because everything possible has already been done. If it is known that the cause of death cannot be reversed, nothing more can be achieved. This should be the basis for any discussion, if discussion is sought. There are a few circumstances in which it may be reversed, when the lethal blow was so sudden that earlier support could not be given, then it may be possible to help a patient whose heart has stopped; including coronary occlusion, electric shock, embolism, suffocation, drowning, haemorrhage, hypothermia, poisoning (including gas), severe head or chest injury and a few other recent insults.

Explaining to a patient that resuscitation is "not in your best interests" will not soothe a suspicious patient; it will make him very cross!

Dr CJF Potter, retired, UK

"Just a quick look" can be costly

As a recently graduated doctor, I read "'Just a quick look' can be costly" (*Casebook* 20(1), p19) with interest. Despite my relative inexperience, I am frequently asked to review other hospital staff who drop into my ward 'as a favour'. My initial instinct is to accommodate such requests out of a sense of professional courtesy and fear of being labelled a jobsworth should I decline. After all, we are all very busy people working to help others and taking a quick look for a colleague very often seems like the right thing to do.

However, I am increasingly concerned that such behaviour represents neither best practice nor a good use of NHS time and resources. Requests for advice or review are rarely accompanied by paperwork highlighting past medical history, allergies or current medications and there is no pathway in place to allow for vital communication back to the individual's GP. Additionally the pressure to arrive at a quick decision often leaves minimal time to take a history and form a considered diagnosis.

Since recently starting a new rotation, I have found the problem to be more of an issue in otolaryngology, perhaps as examination often necessitates more specialist equipment often not found on other wards. Although I am becoming more proficient in many ENT investigations and procedures, diagnoses are not always the most obvious or easily formulated, which can lead to disappointment, uncertainty or even anxiety.

Worryingly neither my department nor hospital has a defined policy of how to handle these cases of "quick looks". The GMC stipulates that contemporaneous notes should be kept in keeping with good medical practice but offers little other advice. Although my trust has no guidelines on the subject and seems to take a neutral attitude to the issue, I have come across areas where such impromptu consultations are tacitly encouraged if they reduce time taken off work.

Given the potential medicolegal pitfalls and consequences highlighted when dealing with such cases, I feel I would benefit from greater guidance either from individual hospital trusts or the GMC on how to manage such cases, so that I am able to alleviate and reduce any anxiety both for me or my unsolicited patients.

Timothy Batten, junior doctor, UK

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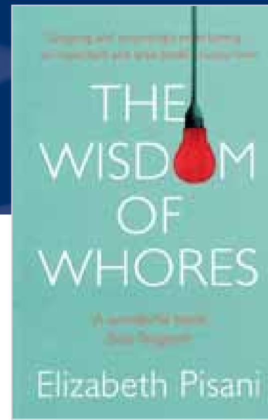
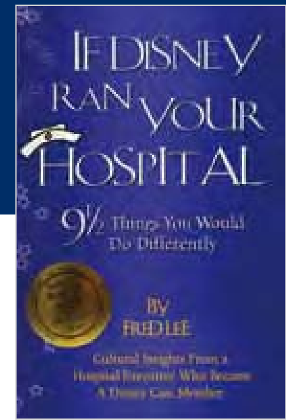
If you would like to suggest a book for review, or write a review, please email sara.williams@mps.org.uk

Reviews





The Wisdom of Whores: Bureaucrats, Brothels and the Business of Aids

By Elizabeth Pisani
(Granta Books, 2008)
Reviewed by Dr Rebecca Smith and Dr Chris Jones, specialist registrars in Anaesthesia.

Elizabeth Pisani set out on an unusual path towards a career in sex and drugs, and she achieved it.

The Wisdom of Whores is a passionate debate, dedicated to unmasking the HIV epidemic in Asia. The winding tale leads you through a murky world of brothels, public needle exchange services, boardrooms and international conference centres. You will learn a new language on your journey, of MARPS (Most At Risk Populations), FSWs (Female Sex Workers) and Waria (male sex workers that are culturally considered to be female). At every turn you will be shocked by chilling statistics and controversial comments.

Surprisingly, the book is fairly humorous. It pokes fun at some of the governments' initiatives, for example, peer outreach – in a competitive industry, like prostitution, where rivals have to covet each others' clients in order to survive – whoever thought this could work?! Some of the difficulties faced in accurate data collection are also revealed – it must be challenging to gather meaningful statistics when you are asking an intoxicated prostitute questions in a poorly lit nightclub in the early hours.

Having read Classical Chinese at University, Pisani first worked as a foreign correspondent in Hong Kong. She then undertook a Masters degree at the London School of Hygiene and Tropical Medicine, and entered into a career of Epidemiology. Transferring to Family Health International in Jakarta, Indonesia in 2001, Pisani became part of the "HIV surveillance mafia", dedicating her time to building international surveillance systems to help develop HIV prevention programmes. What may have started off as a mere intellectual pursuit became an intensely personal battle as she met the faces behind the statistics, and fought to save her friends.

Pisani brings home the lesson that there is no purity in science. Epidemiological facts are distorted by a smokescreen of money, power, politics, religion and the media. It's unfashionable and unpopular to dedicate money to prostitutes and junkies – it won't win you votes in elections.

This book is dedicated to realism. It is an abrasive and raw account of the battle between science and politics. It is a disturbing read, but a must for any enquiring mind.

If Disney Ran Your Hospital: 9½ Things You Would Do Differently

By Fred Lee (Second River Healthcare Press, 2004)
Reviewed by Dr Mike Baxter, independent medical consultant and former Medical Director at Ashford and St Peter's Hospitals NHS Foundation Trust

If Disney Ran Your Hospital changed my view of how hospitals should work and the correct avenues to pursue to deliver effective change and improvement.

This book also reads very well in the context of current definitions of quality, where outcome, safety and experience are given equal weighting. Whilst outcomes and safety are familiar currencies that we easily understand, experience is less comfortable and much more alien to the medical community.

Indeed, we have been drawn into the world of "customer satisfaction" and have been persuaded that service delivery models aimed at high levels of patient satisfaction represent the desired goals in healthcare.

However, Fred Lee makes the case that it is so much more than this. Experience is about how you are made to feel: it is an emotional interface that relies on genuine human interaction with spontaneous and reflex elements that make it real and unique for each patient. He makes it clear that the generation of an experience is how you make lasting impressions and, if good, generates loyalty and trust.

He reminds us that the single most important element to all successful human relationships, especially in healthcare, is compassion. Until we recognise, develop and reward compassion, we are destined to have services that may be good, but are vulnerable to veering into average or poor, consistently underwhelming in terms of experience.

Fred describes, for me, what was a confirmation of my own anxiety – that process redesign does not take into account this human element/ emotion and, although it can deliver efficient care process, it cannot deliver great care because ultimately it does not create an emotional and therefore memorable experience.

If, like the Disney Corporation, we aspire to deliver excellence in our hospitals, we must create a truly unforgettable experience where compassion is a core value and all staff provide predictive, selfless care.

I do believe that this book is the potential guide to a better land. I believe if we were run by Disney that the values of compassion delivered by naturally talented and/ or appropriately motivated staff would create an environment for a safe service with good outcomes, which would also deliver the elusive goal of a great experience.

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