

# Casebook

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**MPS**



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## We need to talk about death

*Complaints about end of life care*

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How to balance the interests of patients and the public

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How to influence team behaviours and bring success

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After the landmark report, we ask what is next for the NHS?

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## Welcome

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

Scandals in healthcare have long been a staple ingredient in the diet of the media – I am sure that everyone reading this will have no difficulty recalling an event or events and the scathing criticism of those deemed to be responsible.

In the UK, the Francis report into the unnecessary deaths of more than 1,000 patients in the care of Stafford Hospital has led to renewed calls for the old days where care, compassion and humanity were the watchwords of professionalism. Have we lost our way by focusing on management and targets, guidelines, regulatory compliance and trying to dodge ambulance-chasing lawyers?

But we know that the issues are certainly not confined to this one hospital trust nor to the UK; in every country where MPS has members, similar themes emerge. Calls for a return to core professional values and strong leadership echo time and again. The case reports in *Casebook* also reflect that the same errors are repeated – but we have a better understanding now of the predisposing factors: poor communication and lack of empathy, which increase the chance of a claim after a precipitating event, such as an adverse outcome.

In this edition we take a look at leadership from a different direction – the skill of followership. It's not a term many doctors will embrace immediately – images of sheep certainly came to my mind when I first came across the term, but I am taken by the logical and accurate descriptions of how this skill can influence team behaviours and success.

The media coverage of healthcare recently has just felt like an endless catalogue of horror after horror and can be dispiriting; in *Casebook* we try not to focus overly on what went wrong, but what learning can be shared – and that not every allegation succeeds. As ever, we hope that this is a relevant and interesting insight into cases we have handled, and stimulates reflection on how to look after yourself and your patients in ever more challenging times.




## Practising in the Facebook world

MPS Medical Director Dr Rob Hendry warns of the challenges facing the healthcare profession in keeping pace with the information age



Medicine has always been quick to adopt and adapt new technologies and many advances in care have been due to utilising advances made in other branches of science.

As we enter the new information age, the phenomenon of social networking is changing the way doctors interact with their patients and wider society. Traditional boundaries between private and professional life are becoming blurred and the potential for members to inadvertently fall into medicolegal traps is increasing.

Professional bodies around the world have recognised both the potential for the good that social networking technologies offer and also the risks for the unwary.

Tweeting to one's friends after a bad day at work or posting details of what you got up to at a party at the weekend on Facebook can often be seen by patients, colleagues and managers. When comments are posted on the blogosphere all control is lost and they are less private than remarks made on the back of a postcard. The laws of defamation apply to comments that may have been originally designed to amuse your friends or written in the heat of the moment, but which end up being widely circulated just as much as more traditional channels of communication.

In the UK, the General Medical Council has recently published guidance on social media, which states that where doctors identify themselves as doctors in publicly accessible social media, they should also identify themselves by name because any written material by authors who represent themselves as doctors is likely to be taken on trust. This places an onus on doctors to be thoughtful in what they write.

The full impact of new social media technologies will inevitably develop over the coming years. It is important that the way in which the public can become engaged and informed about health issues is not inhibited. However, the regulation of the profession's use of new media opportunities may struggle to keep up with the pace of technological change and diverging social expectations of the profession.

MPS has always believed that our approach to indemnity allows us to provide the most flexible and adaptive support to our members, especially during times of rapid change in the world of medicine.

## OPINION

## Francis: what next?

Dr Stephanie Bown, *Casebook* Editor-in-Chief, on what the Francis report and the government response mean for healthcare

Everyone who has read or been involved in the Francis report into Mid-Staffordshire NHS Trust will be shocked and ashamed at the appalling standards of care, and how many turned a blind eye. The UK medical profession is now in an inescapable, undeniable position where it must reclaim its core professional values and uphold its duty of putting patient safety first.

This is also a wake-up call for the NHS to take more care of its staff, and ensure they are empowered to raise concerns. You can have the best individuals with the best intentions, but in the wrong environment they can succumb to what is the norm – even if that is a culture of complacency.

Delivering high quality communications with patients when something has gone wrong is a skill that should be part of every medical school's curriculum. This includes understanding the importance of responding in a timely way; the timeframe within which you respond (to an error) may have a profound impact on the ability to achieve resolution and affect the future relationship and trust with the patient or their family.

We were disappointed, then, that the Francis report recommended a statutory duty of candour for individuals, although the government is at least refraining from

making any hasty decisions on this. At MPS we continue to stress that the best way of achieving openness is by a cultural shift, rather than legislation.

We will be further highlighting to government that despite the understandable appeal of a legislated duty, this will not achieve the objective of effective open communication. The risk of any legislation is creating a 'tick-box' mentality, which does not support the intensely sensitive, personalised and patient-centred conversations that should happen with patients and their families when something has gone wrong.

Legislation whereby patients and their families are only informed when there is a serious injury or death would fail to address the learning opportunities from near misses, which are free smoke alarms for patient safety.

The sort of widespread failing that occurred at Stafford Hospital must never happen again, and it should be addressed at every level. It is the responsibility of every board to put patient safety at the top of their agenda. Understanding human error as an inherent risk in the practice of medicine, and how to identify and respond to it, should be built in as a core competency for every clinician. Errors are an opportunity to learn.



ABEL MITJA VARELA/ISTOCKPHOTO.COM

*Delivering high quality communications with patients when something has gone wrong is a skill that should be part of every medical school's curriculum*

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## Self-medication: a note from MPS

Doctors have long been warned about the pitfalls of prescribing for yourself in non-emergency situations: a lack of objectivity means you are not assured of safe and appropriate decision-making.

Worse still is stealing medication from your hospital or practice stores. It has recently come to the attention of MPS that the attitudes of both the law and medical regulators are hardening against medication theft, even common drugs such as paracetamol. Once seen as a fairly trivial matter, stealing medication has been seen by MPS to be treated as a criminal investigation.

The GMC says, in *Good Practice in Prescribing and Managing Medicines and Devices* (2013), para 17: "Wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship."

## MPS members and medicolegal work

Given the requirement to hold a licence to practise, in order to practise medicine in the UK, we have considered what are the appropriate criteria required by MPS of members who write medicolegal reports and/or act as a medicolegal expert.

Doctors producing medicolegal reports purely from records will not be required by MPS to have a licence to practise, but will be expected by MPS to act within the bounds of their competency and specialty and also will be required by MPS to inform the instructing solicitor whether or not they have a licence to practise and/or intention to maintain it in the future. It may well be that possession of a licence to practise in such a situation will

lend credibility in the provision of a report, but at the present time it is not a condition that MPS requires.

In addition to the requirement to advise the instructing solicitor whether or not they have a licence to practise and/or intend to maintain it in the future, MPS requires any doctor conducting a current condition and prognosis consultation/examination involving patient contact to maintain a licence to practise. Whilst this is not a current, explicit GMC requirement, MPS believes it is necessary in order to protect the position of the member should a complaint arise.

We hope that by introducing such criteria for members we will ensure the best possible protection for members carrying out such work.

# We need to talk about death

## *Complaints about end of life care*

When treating a patient who has reached the end of life, clear communication and collective decision-making are as important as any clinical intervention, says *Sarah Whitehouse*

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*"I don't want to achieve  
immortality through my work.  
I'd rather achieve it by not dying."*

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Woody Allen

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Death is the last great mystery. In modern society, so too is dying. In Victorian Britain, births, and deaths, took place in the home. Today, death is removed from the family sphere and many people do not experience the death of someone close to them until they are well into midlife. We do not discuss death and dying openly.<sup>1</sup> We go to extraordinary lengths to avoid referring directly to death; euphemisms such as "passed away" or "fallen asleep" shift our discomfort and allay our fears of upsetting relatives. Even the Liverpool Care Pathway, much vilified by the press, is named after the city it was developed in, rather than its intended purpose as a care plan for the dying.

Denying death, by being uncomfortable talking about it, means that it can be hard for healthcare professionals to have the difficult conversations with patients and their families that are necessary at the end of life. In the space of what is unsaid, confusion, uncertainty, and, ultimately, complaints about care can reside.

In April 2008, the Healthcare Commission reported that no less than 54% of complaints related in some way to end of life care.<sup>2</sup> The number of complaints received about end of life care can depend on where a patient dies. The National Bereavement Survey (2011) found that bereaved relatives felt 87% of hospice doctors and 80% of hospice nurses showed patients dignity and respect all the time, compared to 57% of hospital doctors and 48% of hospital nurses.<sup>3</sup> Perhaps this is to be expected: the whole purpose of a hospice is to provide specialist palliative care, tailored to an individual patient's needs.

### Communication with compassion

A survey of MPS hospital doctor members found that, of those who had received

complaints related to end of life care, 39% were related to poor communication: 32% of these were in general medicine and 26% in surgery.<sup>4</sup> Similarly, a study by the NHS National End of Life Care Programme into four hospital trusts over a six-month period found that complaints largely related to communication issues.<sup>5</sup> But a patient's death, if handled well, can be a rewarding experience for doctors and families are often very appreciative.

Dr Nicky King, MPS medicolegal adviser and former consultant in palliative medicine, says: "The major issue is always communication. If a patient has their original diagnosis – that first bit of communication – delivered badly, everything else seems to flow from there. When a complaint might come in related to end of life care, you can often look back and see that this particular family has had a bad journey; from the outset, they felt that no-one communicated with them properly. If there is good communication between a doctor, patient and their family, whatever the physical outcome, grief is usually handled better. The family have been communicated with and feel involved."

Poor communication at the outset can put pressure on colleagues dealing with a patient's care at a later stage. One MPS member describes their experience of receiving a complaint related to end of life care: "Unfortunately, the consultant had not explained the diagnosis or prognosis of this terminally ill patient very well, either to the patient or their family. They were very upset over how it had been explained and it fell to me as the junior doctor to do this." The EWTD means that the same doctor cannot be with the patient for any extended length of time. Strong handover procedures need to be in place to ensure good communication.

A doctor may believe he or she has communicated essential information, but it may have been done in such a way that patients and their families have not heard it, particularly if they are feeling distressed or vulnerable. Families often have unrealistic expectations of what can be achieved; not hearing may be a means of coping. It

is important to be aware of this, repeat information and check understanding. You should always make sure to document that such discussions have taken place in the patient's notes. Dr King says: "I think this is partly what is happening with the Liverpool Care Pathway (LCP); families are hearing that their relative is dying for the first time only when the LCP is mentioned, even though their relative's prognosis has been discussed with them before."

Much of the furore that surrounds the LCP in the national press is related to the lack of communication before its implementation. A national audit recently disclosed that almost half of all patients who were placed on the LCP were not told that life-saving treatment had been withdrawn. One in three families were never given the leaflet that they should have received, to explain the consent process.<sup>6</sup>

The GMC's *Treatment and Care Towards the End of Life* says: "It is important that you and other members of the healthcare team acknowledge the role and responsibilities of people close to the patient. You should make sure, as far as possible, that their needs for support are met and their feelings respected, although the focus of care must remain on the patient."<sup>7</sup> If death is imminent, the patient does not have capacity and the family are not around, however, it may not be possible to speak to family members before commencing the pathway. Ultimately, you must do what is best for the patient, after careful discussion with colleagues involved in their care.

### The blame game

Complaints usually stem from stressful events at a time when people are at their most vulnerable and scared.<sup>8</sup> In the anger of grief, families often look for someone to blame for the death of their loved one, but the problem often lies in the disparity between the family's expectations and the reality of the situation, and the gulf of poor communication that lies between.

Making a complaint can be a cathartic experience for the family. During the complaints process, families have to relive issues and write down facts and events; being able to tell and



*If there is good communication between a doctor, patient and their family, whatever the physical outcome, grief is usually handled better*

repeat their story allows them to work through their grief, knowing that someone is actively listening. “Resolution of grief creates a continuing bond that the survivors maintain with the deceased,” says Klass (1996).<sup>9</sup> Healthcare professionals should ensure that complainants do not become stuck in the process, and issues are resolved openly, honestly, professionally, and within an appropriate timeframe.

### What can doctors do to mitigate complaints?

Anticipating is the watchword in palliative care: anticipating what will happen and what to tell patients and their relatives. Just because you may have seen a certain condition or procedure many times before, it doesn’t mean that the patient or their relatives will know what may happen. Anticipatory prescribing is also important – perhaps getting drugs and prescriptions ready in anticipation of what will be needed in the coming days, or even hours.

Part of the anticipating process is discussing end of life care plans in advance, rather than when the patient is acutely unwell. Dr King says: “Patients are usually happy to have such a conversation – it can put their mind at rest and allow them some control. They can pack the information away until it is needed. Doctors often fear upsetting the patient and may be reluctant to initiate such a discussion in advance, but it does help.” A reluctance to discuss death within families can mean that often, if a patient loses capacity, their relatives are unaware of their wishes and how best to help and support them.<sup>10</sup>

If, in a hospital setting, the family hasn’t been prepared for their relative’s death, doctors can help allay concerns by taking time to offer a comprehensive debrief to the family soon after the death. Talking through the process and explaining in layman’s terms what happened, and answering any questions, may well avoid a complaint, but more importantly, it shows compassion and can allow families the chance to begin to make sense of what has happened, and gain some closure.

Relatives may associate a lack of compassion with poor clinical care, leading to complaints. Perceptions of brusqueness amongst staff, for example by quickly returning the deceased’s belongings to the family, or beginning to clear the room, can make the family feel that their experience is not valued, and the care their relative received suboptimal.

### Different cultures treat death differently

Some cultures are death accepting, some death denying, and some even death defying, using invasive medicine to defy death, whatever the cost to peaceful end of life care.<sup>11</sup> In the West, we often try to deny and defy death. Some relatives cannot accept that their elderly relative is at the end of life. One MPS member comments: “A common theme is a difficulty in



understanding that frail older people with multiple comorbidities and particularly dementia do die, even in the presence of optimum medical care.”

In some cultures, talking openly about death and dying is not acceptable – it is disrespectful, bad luck, or causes a loss of hope. Many cultures actively protect dying family members from knowing their prognosis.<sup>12</sup> For some families, talking about death is taboo and a religious leader may be needed to facilitate the conversation with the male family leader and the healthcare provider about end of life care. Anticipatory planning for end of life care cannot be done in such instances, which can make the healthcare professional's job even more difficult.

If there is a cultural mismatch between doctor and patient, the process of communicating about expectations surrounding end of life care can be even more fraught. Doctors may draw

### *Some cultures are death accepting, some death denying, and some even death defying*

upon their personal experiences, whereas they need to be aware of different cultural nuances and how these can influence expectations about end of life care. If reality does not meet expectation, and expectations are not discussed, the end result is quite often a complaint.

Even within Western cultures, there are differences as to how death and dying are viewed and accepted. In parts of Ireland, cultural norms such as the traditional wake make it easier for families to accept death as the body is laid out and death comes back into the family home. This can be compared with the modern rituals of death in hospital, which allow society to dissociate itself from death and dying.<sup>13</sup>

“End of life care is a very underrated aspect of care that we're not dealing with or teaching our doctors about very well,” says Dr King. Doctors should receive appropriate training so that they are better able to manage patient and family expectations, and are better able to view death as an inevitable consequence of life, rather than a failure of medicine.

Dr King concludes: “If both doctors and patients were more honest about the limitations of medicine, and more able to talk about death and dying at an earlier stage, a lot of complaints related to end of life could be avoided.”

Dame Cicely Saunders, founder of the modern hospice movement, said: “How people die remains in the memory of those who live on.” It is important as healthcare professionals to ensure quality end of life care.

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## Case study: *Professional communication matters*

Mr J, aged 67, had lung cancer with liver and brain metastases. A week previously he had been informed that his cancer was terminal. His family were made aware of the prognosis, but the oncologist, Mr M, seemed to suggest Mr J still had months to live. Mr M did not inform Mr J or his family that there was a possibility of rapid deterioration and sudden death or provide any advice on what to do if this happened. No advance care plan was discussed.

One Saturday evening, Mr J was watching TV at home with his son and daughter-in-law. He suddenly became drowsy and confused and his worried son rang the out-of-hours (OOH) doctor.

The OOH doctor arrived promptly. Without access to Mr J's notes he decided that he needed immediate hospital treatment and called an ambulance. In the Emergency Department (ED) the registrar, Ms H noted Mr J was now poorly responsive with erratic respiratory effort. Again, with no access to the medical records, she felt intubation and a head CT was needed but Mr J suffered a cardiorespiratory arrest before this could be done. Resuscitation was unsuccessful.

Mr J's son and daughter-in-law had been left in the busy and noisy waiting room. They were anxious and confused and wanted to be with Mr J. Fifteen minutes later Ms H came to inform them that Mr J had died.

Mr J's son was very traumatised. He initially complained that Ms H could have done more to save his father. When the extent of his father's cancer was fully explained to him, he complained instead about the lack of information that the family had been given and the lack of information sharing amongst health professionals that had prevented his father's death being peaceful or dignified.

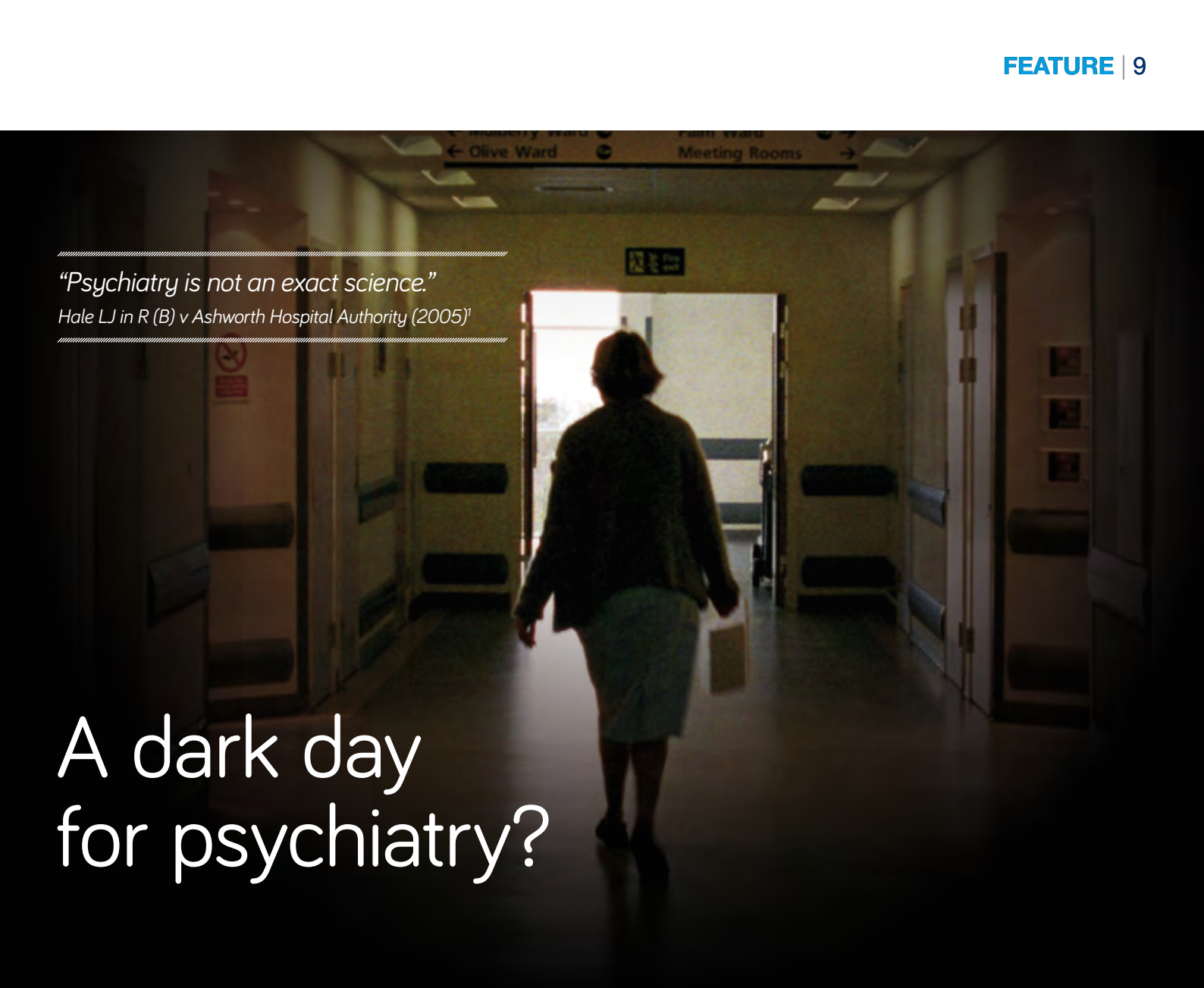
### Learning points

- If the oncologist had communicated clearly with Mr J and his family, they could have been made aware of the possibility of sudden death and planned for it accordingly.
- An Advanced Care Plan consisting of the right nursing support and the right drugs would have allowed Mr J's end of life care to be managed at home. With Mr J's consent, this could have been shared with his family, GP and OOH service.
- Check carefully to see whether an advance care plan is in place, and liaise with hospice colleagues if appropriate. Often, paramedics and OOH doctors do not have sufficient information as they cannot access medical records and this, combined with panicking relatives, can result in a terminally ill patient being admitted to the ED for active treatment.
- The relative might need reassurance and support that they can cope with a dying relative in a home setting, rather than admission to hospital being the answer.

MPS Educational Services runs a workshop, *Mastering Professional Interactions*, which covers specific strategies for clinical handovers: [www.medicalprotection.org/uk/education-and-events/Mastering-professional-interactions](http://www.medicalprotection.org/uk/education-and-events/Mastering-professional-interactions)







“Psychiatry is not an exact science.”

Hale LJ in *R (B) v Ashworth Hospital Authority* (2005)<sup>1</sup>

# A dark day for psychiatry?

Last year a French psychiatrist was charged with manslaughter after failing to recognise the danger posed by her patient. *Sara Williams* investigates how to balance the interests of risky patients and the public

Last year a French psychiatrist was found guilty of involuntary homicide after failing to recognise the danger posed by a schizophrenic patient, who went on to kill the elderly partner of his grandmother. This judgment was the first of its kind in France and potentially sets a precedent for future cases.

The psychiatrist, Dr Daniele Canarelli, was sentenced to a one-year suspended sentence as the court found that she had committed the “grave error” of failing to recognise the public danger posed by her patient, Joel Gaillard.

Gaillard, 43, escaped from a hospital consultation with Dr Canarelli in February 2004 and 20 days later he carried out his killing. Gaillard was a paranoid schizophrenic, who had been seeing Dr Canarelli for four years; he had already

been committed to a secure hospital on several occasions for a series of increasingly dangerous incidents.

The court found that Dr Canarelli should have requested that her patient be placed in a specialised medical unit or referred to another medical team, as one of her colleagues had suggested, and concluded that her refusal to do so equated to a form of “blindness”.

The SPEP, a union for French state psychiatrists, who backed Dr Canarelli during the trial, described the verdict as “worrying” as it risked scapegoating the profession over a complex case. They also argued that it could lead to the harsher treatment of patients as psychiatrists practise increasingly defensively.

The case of Daniele Canarelli raises serious questions as to how to

balance the interests of patients, of psychiatrists, and the safety of the general public.

## An imprecise science

The late Dr Patrick McGrath, for many years physician superintendent at Broadmoor Hospital, once said that half of his patients could be discharged, but the problem is knowing which half.

We cannot completely remove risk from psychiatry for it is not an exact science; risk is a fundamental component of psychiatry, as in all medicine. Unfortunately, there is no risk instrument that predicts homicidal behaviour. Incarcerating all risky patients would reduce risk and protect the public, but it would be wholly defensive and inhumane to do so.

### Best practice

MPS regularly receives calls from psychiatrists seeking medicolegal advice about the decisions they are taking about patients and the risks they present.

In Dr Canarelli's case it has been proposed that she had not taken into account the views of her colleagues, and hadn't fully considered the previous violent history. Good practice involves taking therapeutic risks based on thorough risk assessments involving the whole multidisciplinary team (MDT). They back up these discussions with comprehensive notes, which are of course the cornerstone of your defence should your care be questioned.

Professor Keith Rix is a consultant forensic psychiatrist with more than 30 years' experience working in the medicolegal field. He says that if psychiatrists practise competently they will not end up in the same situation as Dr Canarelli. "The fact that the court found Dr Canarelli responsible for a 'grave error' suggests that she was convicted of the equivalent of manslaughter on the grounds of 'gross negligence'. Not every negligent act of a doctor that results in the death of a patient has the potential to lead to a conviction for manslaughter."

The degree of responsibility in medical negligence depends on the foreseeability and severity of the consequences of the breach of duty. If it is determined that the breach was serious enough to constitute gross negligence, a doctor could be charged with manslaughter. The seminal case here, *R v Adomako*, happened in the United Kingdom in 1994. An anaesthetist did not notice that a ventilator had been disconnected for six minutes; a result of which was that the patient suffered a cardiac arrest and died. The conduct of the defendant was regarded as so far below the standard of a reasonable practitioner that it amounted to a criminal act.<sup>2</sup>

In order to secure a conviction for manslaughter the conduct must have:

- Fallen far below the standard to be expected of a reasonable doctor
- Involved a risk of death
- Constituted a breach of duty so serious that it amounts to a crime.

### The Rabone case

In 2005, in the UK, 24-year-old Melanie Rabone was admitted to hospital as an emergency following a suicide attempt. She was assessed as being at high risk of a further suicide



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*"The fact that the court found Dr Canarelli responsible for a 'grave error' suggests that she was convicted of the equivalent of manslaughter on the grounds of 'gross negligence'"*

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attempt, but was not detained under the Mental Health Act 1983. She remained a voluntary or "informal" patient, so when she requested a brief period of home leave, her doctor agreed. The following day, while on leave, she killed herself.<sup>3</sup>

The Supreme Court held that the treating hospital had a duty to take reasonable steps to avert the risk to life in circumstances where they knew (or ought to have known) of a "real and immediate" threat to that individual. In the specific circumstances of the case, the court held that the hospital involved had violated the positive duty that it had, under Article 2 of the European Convention on Human Rights – the right to life – to protect a voluntary patient from the risk of suicide.

Professor Rix observed that this case has caused some anxiety amongst psychiatrists. He points out that the court defined a "real" risk as "a substantial or significant risk and not a remote or fanciful one", which is a low threshold. The court defined "immediate" as meaning "present and continuing". He says that there is an understandable concern that if a patient has an antisocial personality

disorder and has a history of causing serious harm, a court will deem them as posing a "real and immediate" risk to the public, if allowed to be at large, and so psychiatrists will detain, or seek to detain, such patients longer, if not indefinitely.

Likewise he says that there are similar concerns that depressed patients who are at risk of suicide will be detained longer or not granted leave even when there is only a low likelihood of suicide. However, this duty should not persuade professionals to behave any more cautiously or defensively than they are already persuaded to do by the ordinary law of negligence.<sup>4</sup>

### Balancing the risks

Professor Rix advocates using thorough risk assessments to balance risks. He says: "You need to assess the likelihood of something happening, using all information available to identify what might go wrong, and how serious the consequences would be. This information falls into two categories: historical and dynamic factors. A dynamic factor would be the mental state of the person at the time.

## *A patient having a heart attack will not make the front pages, but a patient attacking a member of the public most certainly will*

This information should then be used to work out possible scenarios, eg, who might be at risk, what harm might they suffer?"

When using such methods Professor Rix warns practitioners to be wary of tick-box risk assessments. "I have seen a suicide risk assessment instrument that involves putting a tick in a box if the patient is 'unemployed' on the basis that this is associated with an increased risk of suicide. But what about the person who has worked all their life, is still employed, but faces almost certain redundancy in the coming weeks or months? It is necessary to think outside the box in order to identify this person probably being at greater risk of suicide than someone who has been unemployed for years and has adjusted to this state."

Writing in the *British Medical Journal*, Dr John Morgan, who chairs a patient safety steering group, made an interesting point. He contended that we need to ensure

that common psychiatric risks are not overshadowed by rare ones. He added that the emphasis needs to return to managing risk with clinical examinations, by systematic evaluations of signs and symptoms, thus returning to our enduring duties as doctors.<sup>5</sup> Given that in psychiatry the therapeutic and prognostic implications of diagnoses are relatively weak, and the diagnoses themselves relatively unreliable, he has a point.<sup>6</sup>

### Raising concerns

Many calls to MPS's advice line are from psychiatrists who are being pulled in two directions by their employers and their patients; on the one hand they are caught between what is in the patient's best interests, and on the other, their employer's needs, such as financial and organisational constraints.

Psychiatrists should always be mindful of what is in the best interests of their patients. Medical councils across the world advise that doctors have a duty to raise concerns where they believe that patient safety is being compromised by the practice of colleagues, or the systems, policies and procedures in the organisation in which they work.

This applies equally to psychiatrists, who may become aware that their employer is applying undue pressure to follow through with action that may put patient safety at risk, or

compromise a patient's care or dignity.

Steps to raise a concern:

- Follow the local procedures for reporting near misses and incidents
- Raise concerns with a manager or an appropriate officer, eg, team leader
- If patients are, or may be, at risk of death or serious harm, immediately report those concerns to the appropriate person or organisation
- Be clear, honest and objective about the reason for those concerns
- Keep a record of any steps that have been taken to deal with it.

### The future

A patient having a heart attack will not make the front pages, but a patient attacking a member of the public most certainly will. The challenge for psychiatrists is to avoid practising defensively, so as not to undermine the therapeutic privileges afforded to psychiatrists.

The message from the Canarelli case is that it should not change psychiatric practice – psychiatrists should continue to practise competently and learn how to balance the risks in order to safeguard their practice for the future.

Professor Keith Rix is a consultant forensic psychiatrist, with more than 30 years' medicolegal experience, including a Master of Laws in medical law and ethics. His current clinical responsibilities involve caring for particularly disturbed and potentially dangerous patients.



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# Followership: the forgotten part of leadership

It goes without saying that strong leadership is vital to ensuring the stability and success of healthcare systems. But the value of followers in challenging this leadership is just as great, say *Mr Andrew Gibbons* and *Ms Danielle Bryant*

Doctors are seen by society as leaders and frequently take on leadership roles both at work and in the community. Nevertheless, doctors spend a large part of their careers in training as followers, accountable to a more senior doctor. Even when fully registered as consultants or general medical practitioners, doctors will not always be the leader. When acting in committees or teams they will still often be required to follow.

The concept of followership has a very important part to play in the success of any group task. However, this is often forgotten.

This reflects modern culture's emphasis on leadership and its tendency to overlook the less glamorous but vital role of followership. Unfortunately advertising ascribes leadership with all the positive aspects of success and falsely depicts followers as docile and impotent. "Always be a leader, never a follower" is emblazoned on one leading cyclist's shoes.

Bill Gates may have founded and led Microsoft but could not have achieved success without the followers that worked for him. Health services around the world would not function without the support of the majority of their staff who are not in leadership positions.

## What is followership?

Followership is the response of people in subordinate positions to those in senior ones.

It is a social relationship between the leader, followers and the group. It is not subservience or passive obedience to orders. Rather it is a process whereby followers engage in constructively critical thinking, and interact with and support the leader to help achieve a task.

Good followers are accountable for their actions. They can also influence and mould the leader's views. When

necessary they can even substitute for the leader.

Members of any team should be aware of their own and each other's followership style as set out in Figure 1. This illustrates the two dimensions that are fundamental in determining an individual's style of followership (independent thinking and active engagement) and the five followership styles that result from them.

Followers who are not engaged with their organisation or task and do not apply independent critical thinking are passive followers. These individuals require constant motivation and direction and, consequently, can be a drain on the leader and the team.

Those that support the task and are motivated but do not critically appraise what they are doing are conformist followers. They will always support the team leader and may work hard but they do not consider alternate options and may not make decisions without guidance from the leader.

Alienated followers have high levels of critical thinking but are disengaged from their organisation and task. These followers usually come across as sceptical or cynical. When the leader, or team, tries to move forward, they will voice the reasons why it shouldn't happen. They may have good ideas but do not put these forward. Indeed, they may be negative and undermine the group.

In comparison, the exemplary follower will apply constructive critical thinking and interact with the group and the leader. If they agree with the current course of action, they will back the leader 100%. Alternatively, if they disagree, they will challenge the leader, offering constructive alternatives in order to help the leader and organisation achieve their aims.

Some people are pragmatists and move between the boxes in their

followership style over the duration of the task.

## Avoiding 'group think'

It is important when working in a group that leaders and followers do not succumb to 'group think'. This is where the culture of the group lends itself to thinking about and analysing things in the same way. Similar views, and a desire for unanimity, lead the group to concur too easily and overlook potential problems and alternative ideas or options.

Many modern businesses appoint one or two board members from successful organisations that have a completely different field of interest to prevent group think. Many clinicians will have experienced group think in hospital practice. For example, a surgeons' meeting on theatre policy without an anaesthetist present will be very different to a meeting with anaesthetist representation.

Followership styles can have an important part to play in the onset of group think within teams. Within a group, passive followers agree and go along with the flow just because they think this is the group's view. Conformist followers will actively support any group decision and act on it as they don't have the independent level of thinking required to consider the options. Both these styles of followership predispose a group to group think.

Alienated followers demonstrate critical thinking, crucial for the prevention of group think, but due to their lack of participation in the group they may not be listened to and this again can allow group think from the other members. In contrast, an exemplary follower will question the status quo, and critically evaluate the facts and options before making a decision.

Consequently, exemplary followers provide a level of independent thinking





*Even when fully registered as consultants or general medical practitioners, doctors will not always be the leader. When acting in committees or teams they will still often be required to follow*

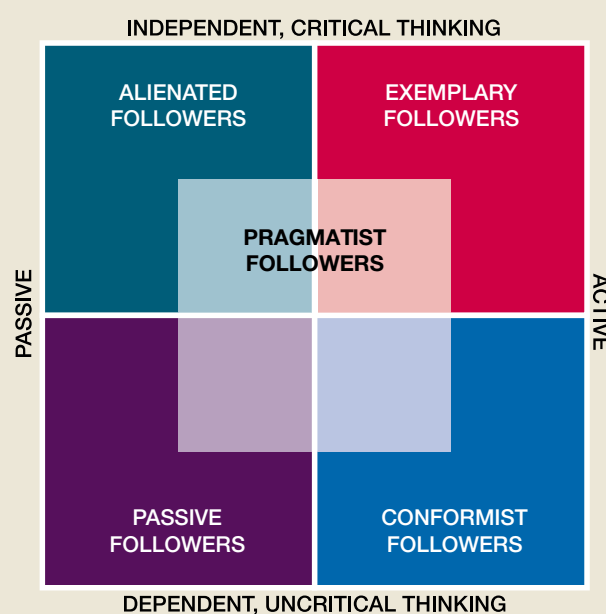


Figure 1: Robert Kelley's Followership dimensions and styles, adapted from Kellerman (2008)<sup>1</sup>

that is crucial to preventing group think, but they also bring a high level of energy to the group so are motivated to help see the best decision made and the best job done.

### Being a good follower

Good followers must have the moral courage to express concerns. They should question why and understand the reason they do things. In doing so it is important to not undermine the leader's authority. This can mean asking the leader to step away from the group to present your views to them on a one-to-one basis.

Effective followers should be able to reflect, adapt and take responsibility for their own actions. Once the follower has understood a decision and had their questions answered satisfactorily, they should back the decision of the leader or group wholeheartedly.

However, followership is not only about the individuals who follow within a team; it is about the relationship between these individuals and their

leader. A good leader is responsible for creating an environment conducive to an exemplary followership style. In creating such an environment the leader should be prepared to:

- Explain why
- Welcome challenging questions
- Seek regular feedback from members of their team
- Delegate responsibility
- Utilise the expertise within their team
- Lead by example
- Know their team
- Share the credit with the entire team.

Mutual respect between leader and follower is a key prerequisite to success.

There are many opportunities in clinical practice for doctors to show good followership and good leadership. A junior doctor can tactfully question his seniors as to why a decision is taken, understand it and then convey this with a sense of purpose to the nursing staff. Poor followers take negative attributes into their leadership styles.

360 degree feedbacks from juniors,

nurses or administrative staff, a key aspect of doctors' appraisal and future revalidation, will often reveal this. Exemplary followers, when leaders, are more able to appreciate the concerns of their followers and to set the tone and vision that others will follow willingly.

Throughout their careers doctors will be both leaders and followers. By understanding these roles they can better influence decisions and ultimately be more effective.

This piece is based on an article first published in *BMJ Careers*.<sup>2</sup>

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# From the case files

*Dr Nick Clements, Head of Medical Services,*  
introduces this issue's round-up of case reports

After listening to your feedback, we have made some changes to the format of this edition's case reports, expanding the narrative to make the clinical detail clearer and including more details of the expert opinion provided for each case. Expert opinion plays a key role when handling claims for clinical negligence, as it considers whether there was a breach of duty and causation present. By covering this in more detail here, we can further explore why a case was defended or settled. As a result some of the case reports are a little longer, but we hope that the extra reading will prove not only to be interesting, but invaluable in terms of risk management.

A recurring learning point from the following selection of cases is the need to be aware of the risks associated with diagnostic testing. Not only is it important to offer the relevant tests where clinically appropriate, you must record that you have done so in the patient's notes. The reasons for the test should be clearly explained to the patient when taking informed consent, as should the outcomes and their implications when results become available.

In "Suspected epilepsy: when to warn" on page 16, L's parents were not made

aware of the possibility of a diagnosis of epilepsy following their daughter's fit. They failed to attend for an EEG appointment and they claimed it was not clearly explained to them what the test was for. Expert opinion found that had L's parents been made aware of the possibility of epilepsy, and been given appropriate advice, they would have prioritised their daughter's EEG appointment.

Similarly, poor communication in "When normal is wrong" on page 23 resulted in a claim that could not be defended. When Mr B rang the urology clinic for his results following a vasectomy, Dr X's secretary informed him that the report was "normal". Dr X had forgotten to label Mr B's path lab test as post-vasectomy, leading to miscommunication and Mrs B's unwanted pregnancy. Test results should not be given over the telephone by non-medically trained staff to avoid the potential for incorrect information being given or for misunderstandings, as happened here.

Good communication extends to detailed patient notes. A lack of clear documentation made the case "A failure to monitor" (page 21) difficult to defend. Remember, if an investigation is not written down, it is hard to prove that it took place.



## CASE REPORTS

*Casebook* aims to promote safer practice by sharing experiences that we hope you will find helpful. MPS publishes medicolegal reports as an educational aid to MPS members and as a risk management tool.

The case reports are based on MPS experience from around the world and are anonymised to preserve the confidentiality of those involved.

The cases described are historic and the expert opinions that follow in specific cases reflect accepted practice at the time. The learning points are applicable today.

If you would like to comment on a case, please email [casebook@mps.org.uk](mailto:casebook@mps.org.uk).

## CASE REPORT INDEX

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## 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



# A case of renal failure

Mrs B was a 44-year-old teacher with two children. She smoked ten cigarettes a day and was overweight. She saw her GP, Dr T, about knee pain and he prescribed ibuprofen and advised her to lose weight. The ibuprofen helped so she continued to take it long-term.

Later that year she saw Dr T again, complaining of itching. Dr T thought the likely issue was a change in washing powder so prescribed antihistamines and suggested she switched brands. He also requested some blood tests including renal function. Her creatinine was slightly raised at 138 and her eGFR (estimated glomerular filtration rate) was 38 (indicative of chronic kidney disease stage 3b). Dr T had documented "blood tests OK, repeat in three months".

Mrs B forgot to have her repeat blood tests but saw the nurse and different GPs several times over the next few years with minor ailments. The issue was not raised again by any of the health professionals. A nurse had documented her BP as 125/80 when she had attended for travel vaccinations. Three years later, she consulted Dr R, another GP at the practice, complaining of breast tenderness. His notes remarked on a diagnosis of CKD stage 3 but Mrs B was not informed of the diagnosis and no investigation or further follow-up was made.

Another year later, Mrs B made an appointment with Dr R because she was struggling with anxiety and was concerned about palpitations. She was stressed at work and was waiting for some cosmetic surgery that she was nervous about. Dr R checked her BP and found it greatly elevated at 216/107. He prescribed her diazepam and propranolol and arranged an ECG on the same day, which showed ventricular hypertrophy. Dr R arranged blood tests the following day and rechecked her blood pressure. Her eGFR was 21, indicative of CKD stage 4. Her creatinine

was 226 and urea 10.6. Mrs B was informed about a problem with her kidney function and was referred and seen the same day by a nephrologist, Dr W.

Dr W started treatment with amlodipine, bisoprolol, alphacalcidol, simvastatin, ranitidine and aspirin. He informed Mrs B that she had renal failure and accelerated hypertension. Mrs B underwent detailed investigation with blood tests, urinalysis and ultrasound. In Dr W's opinion, her chronic renal failure was caused by a combination of smoking, a bad family history of vascular disease (and possibly renal disease), and hypercholesterolaemia, which, combined with the adverse effects of NSAIDs, produced an ischaemic interstitial disease that became rapidly worse with the sudden development of severe uncontrolled hypertension.

Mrs B was told that progression to end-stage renal failure was almost certain and that she would require dialysis or transplantation within five to ten years. She was told that her life expectancy with dialysis could be 10-15 years and 15-20 years with transplantation. She would need a complex drug regime, dietary restrictions and indefinite outpatient follow-up.

Mrs B was devastated and felt that the diagnosis and treatment of her renal failure had been delayed. She was struggling with fatigue and was unable to cope at work. She made a claim against both GPs.

Expert GP opinion acknowledged that there had been a big shift in clinical practice since the case took place. Guidance has changed regarding the recognition and labelling of chronic kidney disease. Expert opinion considered that at the time, few GPs would have recognised that the slightly elevated creatinine and the eGFR of 38 were likely to represent significant renal disease.

Dr T's actions in arranging to repeat the test in three months were found to be very reasonable, but expert opinion would have been critical if this had not been communicated to the patient. Dr T was criticised for failing to notice that Mrs B's renal function had not been rechecked, as repeat testing could have led to an inquiry about potentially nephrotoxic drugs such



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as NSAIDs, and a timely referral to the nephrologists.

Dr R was criticised for failing to identify the low eGFR and raised serum creatinine and that the plan to repeat the renal function tests had not occurred. Repeat testing and non-urgent referral should have taken place.

Renal physician opinion was also sought, which found that an urgent repeat/confirmatory test should have been ordered. Mrs B should have been examined for potential causes and complications of renal disease. The GP should have sent urine for culture and ACR (albumin: creatinine ratio) estimation and carried out dipstick testing for blood. Blood tests should have been arranged to exclude diabetes, anaemia and nephrotic syndrome. Expert opinion also suggested that an urgent referral within a week should have been made if the hypertension was marked and the rise in creatinine rapid. In the absence of a rising creatinine and in the presence of a normal blood pressure, the patient would normally have been seen within two months. Had this been done, the severe episode of hypertension could have been avoided and renal function preserved. The timely withdrawal of NSAIDs would have been of some benefit. As a result of missed opportunities for referral and intervention, progression to end-stage renal failure was almost certain and dialysis or transplantation would be required.

The claim was settled for a substantial sum.

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## Learning points

- This case occurred before 2008 and the expert opinion follows practice that was current at the time. Guidelines surrounding the management of CKD have since been updated – see NICE, *Chronic kidney disease – Early identification and management of chronic kidney disease in adults in primary and secondary care*. [www.nice.org.uk/CG73](http://www.nice.org.uk/CG73)
- Good note-keeping is important. The GMC requires doctors to "keep clear, accurate and legible records" including the information given to patients. [www.gmc-uk.org/guidance/good\\_medical\\_practice/good\\_clinical\\_care\\_index.asp](http://www.gmc-uk.org/guidance/good_medical_practice/good_clinical_care_index.asp)
- This is vital for a good defence. It was useful that Dr T documented that he had advised Mrs B to return for blood tests in three months.
- Steps to ensure continuity of care would have made it easier to notice that Mrs B had not returned for the planned follow-up. GPs should review previous notes when seeing patients, to put the consultation into context and continue with existing management plans.
- It is important to keep up-to-date and be familiar with guidelines and developments that affect your work.

# Suspected epilepsy: when to warn

A girl of eight, L, was brought by ambulance to the Emergency Department (ED) with a history of a fit during a lesson in school. There was no reliable history: according to friends who had been playing with L, she had touched an electrical socket, fallen, and then had a fit lasting about five minutes, from which she spontaneously recovered.

Shortly after L's parents had arrived in the ED, she was seen by the on-call paediatric team. By this stage she had fully recovered. Her parents were keen to take her home. The on-call paediatrician noted that there were no signs of any acute infectious aetiology for the fit, and no evidence of any burn injury associated with an electrical discharge.

It was unclear whether a head injury had been sustained either before or during the incident. Because of uncertainty around the aetiology, a CT brain scan was performed. This was reported as normal. L's parents were advised that further investigations would be organised as an outpatient, and to bring L back if any further episodes occurred. However: there was nothing in the notes to suggest the hospital intended

from her school. On this occasion the history was a little vague; it seemed that L had fallen to the ground, possibly as a result of a faint. It was unclear whether she had hit her head on a desk or on the floor. When on the floor, she had been noted to have some persistent blinking and unusual side-to-side movements of the head and one hand.

When examined in the ED about one hour after the episode, L was alert and co-operative. Neurological examination was unremarkable. A further CT brain scan was performed, and again reported as normal. On this occasion L's parents were advised that further investigations including an echocardiogram and an EEG were necessary, that these would be arranged as an outpatient and that she would be seen in the paediatric department with the results of these. She was discharged home with planned EEG and follow-up appointment booked for two weeks and four weeks respectively.

Ten days later, L was found drowned in the bath at home.

L's parents made a claim against the hospital treating L. Expert evidence on behalf of

*The hospital did not have a 'Did not attend' policy in place, and no further action was taken as a result of this*

to rule out anything serious, like epilepsy. An electroencephalogram (EEG) was arranged for two weeks and a follow-up appointment was made for the paediatric outpatient clinic in six weeks in order to discuss the results of the EEG.

Unfortunately, L did not attend for her EEG. The hospital did not have a 'Did not attend' policy in place, and no further action was taken by medical staff as a result of this.

Four weeks later, L was again brought into the ED by a teacher

the parents advised that had the parents been made aware of the possibility of epilepsy as a diagnosis, and been given appropriate advice, that they would have prioritised the EEG appointment; and they would have followed standard advice given to parents of children with a diagnosis of epilepsy, ie, to ensure that she was supervised during baths, or to take only showers.

The claim was settled for a moderate sum.

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## Learning points

- Doctors may be faced with a dilemma when counselling parents about conditions in their child that are unconfirmed and still under investigation. There is a delicate balance to be found between causing undue anxiety if the condition is subsequently not diagnosed, and failing to provide parents with sufficient information for them to take appropriate precautions. In the case of a child who has had two episodes that are suggestive of a fit over a short period of time and in which investigations for epilepsy are underway, it would be prudent both to offer some precautionary advice to parents and to document the advice given.
- In the UK, NICE's clinical guideline 137 *The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care*, issued in January 2012, states that:
  1. All children, young people and adults with a recent onset suspected seizure should be seen urgently (ie, within two weeks) by a specialist (ie, a paediatrician with training and expertise in epilepsy). This is to ensure precise and early diagnosis and initiation of therapy as appropriate to their needs.
  2. Following a first seizure, essential information on how to recognise a seizure, first aid, and the importance of reporting further attacks should be provided to a child, young person or adult who has experienced a possible first seizure, and their family/carer/parent as appropriate. This information should be provided while the child, young person or adult is awaiting a diagnosis and should also be provided to their family and/or carers.
  3. Children, young people and adults with epilepsy and their families and/or carers should be given information to include (where appropriate):
    - epilepsy in general
    - risk management
    - first aid, safety and injury prevention at home and at school or work.
  4. The time at which this information should be given will depend on the certainty of the diagnosis, and the need for confirmatory investigations.
- In this instance, the parents' failure to bring the child for the initial investigation may have been a contributory factor. Had a 'Did not attend' policy been in place, there would have been an opportunity to review the records and to establish whether further efforts should have been made to ensure that the child was brought for medical assessment or treatment.

# Mishandling major surgery

Mr A, a 63-year-old retired farmer, had suffered from severe gastro-oesophageal reflux disease for many years. His symptoms were partially controlled with long-term anti-secretory medication but after a number of years he had reached the point where his gastroenterologist recommended anti-reflux surgery. He saw Mr X, an upper gastrointestinal surgeon, who arranged a repeat endoscopy. This demonstrated a 10cm area of Barrett's oesophagus with no obvious macroscopic abnormality above a 5cm sliding hiatus hernia. Mr X went on to perform a laparoscopic Nissen fundoplication, after which the patient made an uneventful recovery.

At a review appointment three months later Mr A reported a significant improvement in his symptoms and no longer required his medication. He next saw Mr X for a surveillance endoscopy seven months later. The fundoplication was intact and the long segment of Barrett's appeared unchanged. On this occasion multiple biopsies were taken and were subsequently reported by pathologist Dr H as demonstrating high grade dysplasia (HGD). Mr X reviewed the patient shortly thereafter and explained that the findings were likely to indicate the development of cancer. He recommended that Mr A should undergo an oesophagectomy.

Postoperatively the patient was managed jointly by Dr N, a respiratory physician, and Mr X on the intensive care unit. Mr X had arranged to go on holiday the day after the procedure and spoke to a colleague, Mr B, about managing the patient in his absence. Details regarding the handover and cover arrangements were subsequently disputed. Specifically Mr B allegedly told Mr X that he could not look after the patient until the following day.

In the afternoon after Mr X had departed, the patient developed intra-thoracic haemorrhage. Another surgeon, Mr F, was called to perform an emergency right thoracotomy and successfully stopped the bleeding by ligating an aortic bleeding point. Postoperatively, the patient developed severe gastric distension and pneumonia. Mr B (who was now available) inserted an NG tube to decompress the stomach, confirming its position by chest x-ray. However the NG tube failed to drain any fluid and Dr N subsequently discovered that it had been placed in the right main bronchus when performing a bronchoscopy. Dr N placed it correctly into the stomach under direct vision.

There then ensued a protracted period of ventilation and multi-organ support on the intensive care unit. Mr X returned from leave and continued the patient's care. A stepwise deterioration occurred with worsening pneumonia, sepsis and multi-organ failure and Mr A died on the intensive care unit 14 weeks after the operation. The final pathology report from the specimen demonstrated multi-focal HGD with no signs of invasive carcinoma and all margins clear.

Mr A's family made several claims of negligence by the clinicians involved in his care. They alleged

that Mr X had failed to biopsy the Barrett's segment at the patient's initial endoscopy leading to an unnecessary fundoplication and delay in the finding of high grade dysplasia. They also complained that Mr X had failed to adequately discuss alternative management options for HGD other than surgery and that he had also not arranged adequate cover for his planned absence after the operation. Allegations of negligence also centred on Dr H and Mr X relying on a single pathologist's assessment for the diagnosis of HGD. Criticism was made of the other surgeons involved in Mr A's care for failing to place a nasogastric (NG) tube at the time of each operation to prevent gastric distension.

Expert opinions for MPS and the claimant agreed that biopsies of the Barrett's segment should have been obtained at the initial endoscopy performed by Mr X, although they accepted that previous endoscopic biopsies did demonstrate entirely benign Barrett's epithelium. They also agreed that the standard approach to the finding of HGD should warrant further independent pathological review and assessment of biopsy material before acting upon the findings. However, it was noted that the diagnosis here was correct, as several pathologists confirmed the findings of HGD in the resected oesophageal specimen.

*Expert opinions for MPS and the claimant agreed that biopsies of the Barrett's segment should have been obtained at the initial endoscopy performed by Mr X*

It was accepted that at the time the case occurred, the finding of HGD in Barrett's in a fit patient was an indication for consideration of oesophagectomy. Other therapies, including endoscopic mucosal resection and radiofrequency ablation, have now become more accepted treatments as an alternative to surgery. There was considerable criticism of Mr X's decision to schedule such major surgery a day before he was on holiday and his subsequent arrangements for colleagues to cover. The absence of an NG tube placement at the initial operation and subsequent procedure was also criticised, as was Mr B's misplacement of the tube and his misinterpretation of the X-ray findings.

The case was eventually settled for a moderate sum.

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## Learning points

- The diagnosis and management of HGD in Barrett's oesophagus remains a controversial area with a number of different therapies available. It is now common practice for specialist multidisciplinary teams that include surgeons, gastroenterologists and pathologists to manage these patients. This approach may improve the accuracy of diagnosis and staging, and facilitates a consensus on the optimum management for each patient.
- It is not always possible for a surgeon to be constantly available for the postoperative management of a patient. In periods of extended absence, robust arrangements must be made for adequately qualified colleagues to cover the care of a patient. The patient, relatives and all relevant staff involved should be informed. Even so surgeons undertaking major or high risk elective surgery before a planned holiday are likely to be at risk of criticism when something goes wrong in their absence. The duration of time that can elapse between events and subsequent litigation, as highlighted in this case, demonstrates the need to maintain accurate and detailed notes as the cornerstone to any medicolegal defence. See GMC guidance on good medical practice: [www.gmc-uk.org/guidance/good\\_medical\\_practice/working\\_with\\_colleagues\\_arranging\\_cover.asp](http://www.gmc-uk.org/guidance/good_medical_practice/working_with_colleagues_arranging_cover.asp)
- It is common practice to place an NG tube after oesophagectomy. In this case it may have prevented gastric distension, aspiration and pneumonia. Misplacement of an NG tube is a common error and a potential source of morbidity, mortality and medicolegal problems. See *Casebook* 20(3), September 2012, for an article on NG tube errors.



# The cost of invalid consent

Ms M, a 38-year-old woman, consulted Mr F, an ophthalmologist, for surgical correction of high hypermetropia. Mr F recommended clear lens extraction and intraocular lens implantation with subsequent excimer laser treatment to correct any residual refractive error. There was no record of any consent process describing the complications of intraocular lens implantation. Ms M underwent uncomplicated clear lens extraction and a silicone intraocular lens was implanted. She was not given any postoperative anti-inflammatory treatment.

On the fourth day post-surgery, Ms M was reviewed and was noted to have moderate postoperative uveitis. She was started on Maxitrol (dexamethasone, polymyxin B and neomycin) and cyclopentolate eye drops and was managed as an outpatient. Over the next two days, Ms M was

*Ms M made a claim alleging that she was not given informed consent prior to the surgical procedure, that the postoperative treatment of the infection was poor and that she suffered a period of reduced visual acuity*

reviewed daily and some improvement was noted, but a 'tiny hypopyon' persisted.

On the seventh day post-surgery, Ms M presented to the Emergency Department of another hospital with pain and reduced vision. A diagnosis of endophthalmitis was made. The endophthalmitis was treated according to local protocol and Ms M improved. She eventually regained excellent vision and had good binocular vision at final follow-up. Mild posterior capsular opacification was noted, but she remained asymptomatic.

Ms M made a claim alleging that she was not given informed consent prior to the surgical procedure, that the postoperative treatment of the infection was poor and that she suffered a period of reduced visual acuity.

Expert opinion found that the postoperative care of Ms M was suboptimal and resulted in a prolonged course to recovery. The absence of detailed informed consent in the patient's notes made the case indefensible.

The case was settled for a moderate sum.

AK



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## Learning points

- Even though the final visual outcome was excellent, failure to take informed consent made this case indefensible. Ample guidance on taking consent is available from professional bodies, employers and the Department of Health. The UK's General Medical Council provides the following professional guidance to doctors [www.gmc-uk.org/guidance/ethical\\_guidance/consent\\_guidance\\_index.asp](http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp)
- In this case, inappropriate postoperative prophylaxis for uveitis and infection compounded the problem. The Royal College of Ophthalmologists provides guidelines on prophylaxis to prevent endophthalmitis [www.rcophth.ac.uk/page.asp?section=451&sectionTitle=Clinical+Guidelines](http://www.rcophth.ac.uk/page.asp?section=451&sectionTitle=Clinical+Guidelines) (See *Cataract Surgery Guideline*, 2010). Following lens extraction surgery, the majority of ophthalmologists would prescribe topical antibiotics as prophylaxis against infection and topical corticosteroid therapy as prophylaxis against uveitis. Furthermore, older generation silicone intraocular lenses have been associated with a higher incidence of postoperative uveitis. In the absence of strong evidence to support alternative practice, it would have been prudent to use prophylactic anti-inflammatory treatment in this patient.
- Postoperative adverse incidents should be treated promptly and mitigated immediately. Endophthalmitis is a sight-threatening emergency that should be evaluated and treated promptly and usually requires in-patient care and monitoring. The presence of a hypopyon and the failure of rapid resolution should alert the ophthalmologist to the possibility of endophthalmitis.
- This case was identified as being indefensible at an early stage – so MPS did all it could to ensure a swift settlement to keep legal costs controlled.

# Managing patient expectations

Mr G was admitted to hospital under Mr R, consultant orthopaedic surgeon, complaining of severe right leg pain. Mr G had a long history of back pain and had already undergone a disc removal at L5/S1 some years earlier. On this occasion, Mr G was complaining of severe back pain and radiating pain down the right leg for about two weeks. His pain was very severe and he was unable to work.

An MRI scan was obtained, which showed a large recurrent disc prolapse at L5/S1 with a retrolisthesis and end plate oedema at that level. In hospital, conservative treatment was begun, but after five days there was no improvement.

Mr R suggested a revisional discectomy and pedicle screw fusion at L5/S1. He carefully explained and documented the uncertainty about the results of such surgery and the increased risks because of the previous procedure at that level. Mr G wished to go ahead.

Following surgery, Mr G was still in a lot of pain. A CT scan was performed, which showed that the right sided pedicle screws were too long and had protruded beyond the front walls of both the L5 and S1 vertebrae. The tips of the screws were reasonably close to the iliac artery and vein. However, there was no evidence of intra-abdominal injury or haematoma. Because Mr G's pain

was continuing, a further operation was performed and the screws were replaced. During surgery, the bone at S1 was found to be osteoporotic and an oversized screw was required to gain purchase. Mr G improved for a few days but then his pain returned and continued unabated. Further scanning showed no complications.

Mr G was dissatisfied and began a claim against Mr R. He felt that Mr R had not examined him properly and had failed to discuss the problems that could be caused by a weak vertebra, or the nerve damage that could result.

Expert opinion found that Mr R had adequately explained all the risks of the operation, and had tried a reasonable period of conservative treatment before surgery was undertaken. The inappropriate initial placement of the pedicle screws on the right was unfortunate, but there was no evidence that this had injured the patient. Expert opinion also found that the manipulation of the L5 roots at the initial surgery was the cause of the continuing pain, but this can occur in the best of circumstances and did not constitute negligence. There was no way to predict the osteoporotic nature of the S1 vertebra preoperatively.

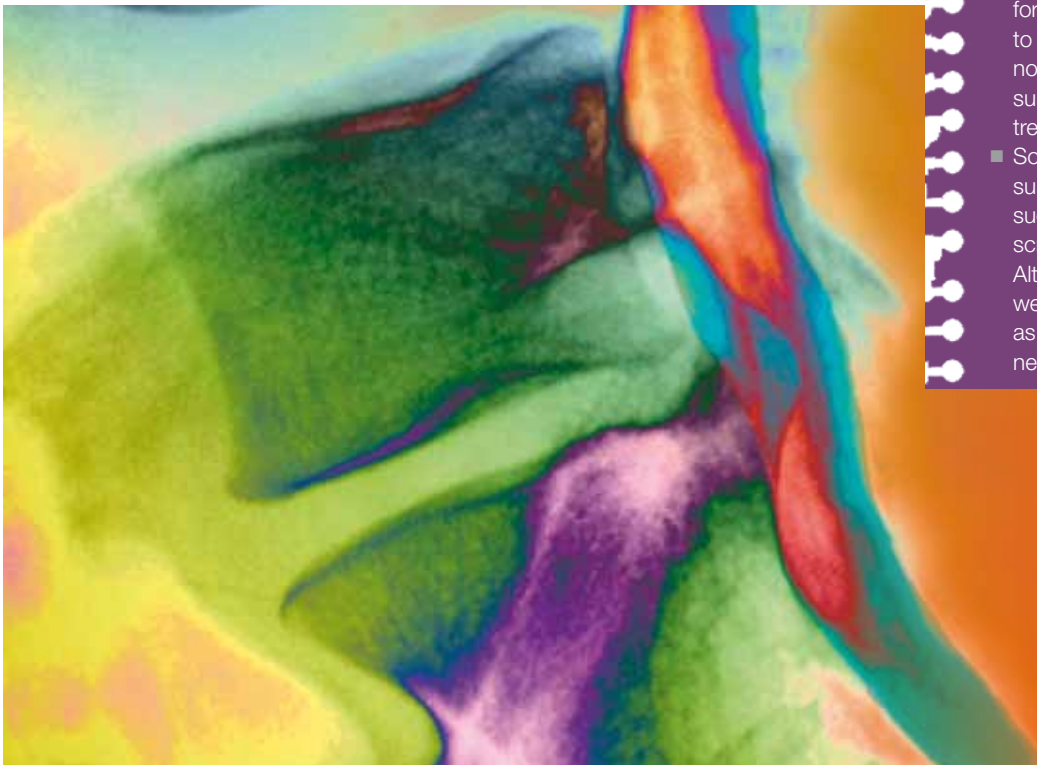
A detailed letter of response was sent and the claim was successfully defended.

LP

*Expert opinion found that Mr R had adequately explained all the risks of the operation, and had tried a reasonable period of conservative treatment before surgery was undertaken*

## Learning points

- Patient expectations must be carefully managed. Under ideal conditions, lumbar surgery has an approximate 80% success rate. In situations such as this case, where there has been previous surgery and instrumented procedures are contemplated, the overall results may not be quite that good. Patients must always be informed of these facts and of the risks to neurological structures, and this must be well documented.
- A failure to resolve the patient's symptoms does not constitute negligence.
- When proposing surgery on the spine for benign conditions, it is important to first explore the possible benefit of non-surgical treatments. Very rarely is surgery appropriate as the first line of treatment.
- Sometimes things happen during surgery that are less than ideal, such as in this case, where pedicle screws were used that were too long. Although these screw placements were inappropriate, no harm occurred as a result, and so a claim of negligence was unsuccessful.



# A rash oversight

Mrs B was a housewife with a four-year-old son. She had been trying to have a second child for some time and eventually conceived. She rang Dr L, senior partner at her practice, to inform him of her positive pregnancy test.

Her son developed chickenpox and seemed “under the weather” so Mrs B phoned her surgery to make an appointment with his GP. While she was talking to the receptionist she asked if she was at any risk from chickenpox since she was eight weeks pregnant. The receptionist tried to be reassuring and told Mrs B that there was no risk from chickenpox and that only German measles or rubella would cause concern.

Mrs B's husband took their son to the appointment with GP Dr Y the next day. Dr Y confirmed the diagnosis of chickenpox by inspecting his widespread vesicles. He had noted that examination of his ears, nose and throat had been acceptable and that his chest was “fine”. His management notes were very minimal and just stated “advice given”.

On a separate occasion, Mrs B visited Dr Y to arrange antenatal care. She did not mention her son's chickenpox because she had felt reassured by the advice he had given her husband when he had attended with their son. Dr Y made no notes of this consultation although he arranged a dating ultrasound scan and an appointment at the antenatal clinic.

Mrs B developed the same spots as her son and immediately panicked about her pregnancy. She became anxious that the baby could be harmed so rang her surgery to make an appointment with her GP. The receptionist informed her that only emergency appointments were available so she could not get an appointment that day. She also told Mrs B that “nothing could really be done for chickenpox”. Mrs B was still anxious so the receptionist agreed to put her through to the practice nurse. The nurse also tried to reassure her and reiterated the

receptionist's advice.

Mrs B, who had had two miscarriages in the past, still felt very anxious about her pregnancy. She felt upset and rang her husband at work. He rang the surgery and demanded that his wife should have an appointment with a GP that day. An appointment was eventually made with Dr L who made no notes of the consultation. Mrs B stated that Dr L said there was “no need to worry about any risks to her pregnancy with respect to her chickenpox”.

Mrs B went on to have a normal dating and 20 week scan. Her chickenpox was never discussed in her antenatal appointments. She had a normal delivery at term. Her baby, CB, was 4.54kg and breast fed well.

When CB was three months old, the health visitor noticed a squint and a referral was made to a paediatrician. At five months old it became evident that CB had an abnormal posture. Mrs B's chickenpox at eight weeks

*The opinion of a GP expert was sought. He thought the standard of care was indefensible because the receptionists had provided clinical advice without discussing it with a doctor first*

gestation was noted by the paediatricians and congenital varicella syndrome (CVS) was diagnosed. CB had severe visual impairment, asymmetrical 4 limb motor disorder, scoliosis and learning difficulties.

Mrs B was completely devastated that her chickenpox had not been managed while she was pregnant and she made a claim against her GP, Dr L.

The opinion of a GP expert was sought. He thought the standard of care was indefensible because the receptionists had provided clinical advice without discussing it with a doctor first. He felt that Mrs B should have been able to speak to a doctor. Had a doctor seen Mrs B when she had the chickenpox contact, he stated that varicella antibody testing should have been arranged. If

varicella IgG had been negative then Mrs B should have been offered varicella zoster immune globulin (VZIG). It was his opinion that a “reasonable GP” would have concluded that there was no benefit in giving VZIG when Mrs B was seen with the rash.

The claim was settled for a high amount. Dr L was criticised in his capacity as senior partner in the practice for allowing administrative and nursing staff to provide negligent medical advice. It was also agreed that he had personally provided negligent advice to Mrs B concerning the risks to her and her unborn baby resulting from exposure to the varicella virus. He had also failed to test Mrs B for immunity to the varicella virus and administer VZIG once the results were known.

AF

## Learning points

- Clear and accurate note-keeping is an important aspect of providing good clinical care. It is also vital when trying to defend a case. Dr Y's records were very minimal and some consultation notes were completely missing. The case was consequently impossible to defend.
- Reception staff should not provide medical advice. It could be easy for them to act outside their competence so clear roles and responsibilities should be set. GMC guidance states that you should “make sure that your patients and colleagues understand your role and responsibilities in the team and who is responsible for each aspect of patient care”.<sup>1</sup>
- The *Green Book (Immunisation against Infectious Diseases)*<sup>2</sup> gives clear guidance on the investigation and management of varicella in pregnancy. A recent *BMJ* article also discusses the investigation of a pregnant woman exposed to a child with a rash.<sup>3</sup> If a pregnant woman consults you worried about a chickenpox contact:
  - Define “contact”. Significant contact usually means face to face contact in the same room for 15 minutes or more.
  - Ask the woman if she has had chickenpox. If she has a negative history or is unsure, test for varicella zoster IgG urgently.
  - Consider her susceptible if IgG is not detected.
  - Post-exposure prophylaxis with VZIG can be given if susceptible within ten days of the exposure and may attenuate the disease in pregnant women.
  - If the woman is antibody negative with significant contact or if she has the vesicular rash then expert advice should be sought.

## REFERENCES

1. [www.gmc-uk.org/guidance/good\\_medical\\_practice/working\\_with\\_colleagues\\_working\\_in\\_teams.asp](http://www.gmc-uk.org/guidance/good_medical_practice/working_with_colleagues_working_in_teams.asp)
2. [www.wp.dh.gov.uk/immunisation/files/2012/07/Green-Book-Chapter-34-v2\\_0.pdf](http://www.wp.dh.gov.uk/immunisation/files/2012/07/Green-Book-Chapter-34-v2_0.pdf)
3. Investigating the pregnant woman exposed to a child with a rash, *BMJ* 2012;344:e1790



# A failure to monitor

Retired engineer Mr S, 77, went to see his GP, Dr J, with symptoms of dizziness. He had returned from a pacemaker check at the hospital that morning and while travelling home on the train he had started to feel off-balance. He managed to get an emergency appointment to see Dr J, by which time the symptoms were resolving. Dr J noted that the pacemaker had been fitted for complete heart block six years ago, and had remained in situ without any problems since then. Mr S reported no chest pain or palpitations and Dr J, feeling reassured by the recent pacemaker check and a normal examination, attributed the symptoms to motion sickness and prescribed cinnarizine.

Despite taking the medication regularly, Mr S's dizziness continued, so he returned to the practice two days later to see Dr A, his usual GP. Dr A recorded his BP as 140/50 and attributed the symptoms to benign paroxysmal positional vertigo. No record was made of Mr S's pulse. Dr A advised Mr S to continue the medication prescribed by Dr J.

pacing but no ventricular spikes, and his symptoms were attributed to a malfunctioning pacemaker. He was admitted to hospital, and while being monitored on telemetry, the pacemaker activity resumed without intervention. Mr S became acutely confused after admission to the ward. He was treated for a urinary tract infection, and underwent a full confusion screen, which was unremarkable. A CT scan of his brain showed small vessel disease. The patient continued to deteriorate, leading to him becoming fully dependant. He was discharged into a care home following a prolonged admission.

Mr S's family made a claim against Dr A, stating that the confusion and memory loss developed as a result of hypoxia, linked to the malfunctioning pacemaker. Experts agreed that a competent GP would rethink the diagnosis of vertigo and carry out a cardiovascular examination, including an ECG. Dr A defended his actions by stating that by taking a manual blood pressure reading, he would have listened to the pulse

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*Experts agreed that a competent GP would rethink the diagnosis of vertigo and carry out a cardiovascular examination*

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During the next six weeks, Mr S consulted with Dr A on three further occasions with ongoing symptoms of intermittent dizziness. Note-keeping from all three consultations was sparse, with no defined cause of the symptoms documented, and no further cardiovascular examination or ECG performed. Mr S was given a trial of betahistine for presumed Meniere's disease.

Two months after his initial presentation, Mr S was taken into the Emergency Department after collapsing on the street when out shopping. He was found to be in complete heart block, with a pulse rate of 32 beats per minute. The admission ECG showed atrial

and been aware of any significant irregularity or abnormal rate.

However, opinion was divided on the causation of Mr S's decline. Experts found no evidence to support an episode of circulatory failure significant enough to cause prolonged hypoxic damage. The general deterioration was considered to be due to a pre-existing cognitive impairment, which was exacerbated by the hospital environment and the bradycardia – which experts agreed, would have occurred in any event with an earlier hospital admission.

The case was settled for a low sum to reflect the partial causation defence.

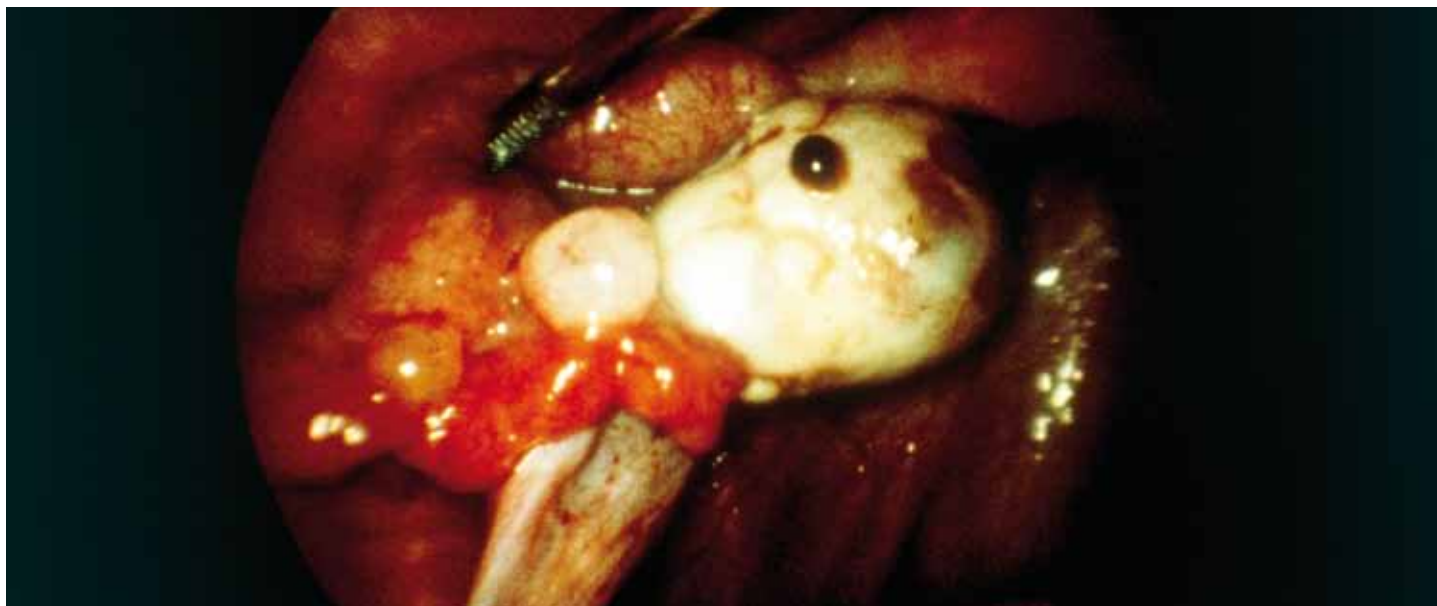
**EW**



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## Learning points

- Lack of clear documentation makes a case difficult to defend. In this scenario, there was no record in the notes that the patient's pulse had been taken. If an investigation is not written down, it is hard to prove that it took place.
- The allegation in this instance was of memory loss as a result of hypoxia. Ultimately, the deterioration of the patient was attributed to pre-existing cognitive impairment, hence the low settlement. From a medicolegal standpoint, this highlights the importance of fully investigating claims, since taking the claim at face value may have resulted in payment of long-term care costs.
- Be wary of repeat consultations. Dizziness is common, but revisiting a diagnosis and carrying out a basic examination, especially in a patient with a cardiac history, is essential to ensure that good quality care is provided.



## A retained swab

Miss Y, 37 years old, was known to have bilateral ovarian endometrial cysts treated at the time of a laparotomy by Mr D, consultant gynaecologist. For several years she had been regularly followed up and repeat scans had showed recurrence of her cysts, which were managed with dydrogesterone. She subsequently presented as an emergency, complaining of severe dysmenorrhoea for three days. Further bilateral ovarian cysts were confirmed on a trans-vaginal ultrasound scan and a decision was made for her to undergo further surgery.

Mr D performed a further laparotomy and found recurrent bilateral ovarian cysts stuck down in the Pouch of Douglas and adherent to the back of the broad ligament. Both tubes were dilated but otherwise normal. Mr D recorded that the right ovary was freed and chocolate coloured material aspirated. The left ovary was drained in situ, but no attempt was made to free it. Before the operation, Mr D inserted a small pack into the posterior fornix in an attempt to keep the uterus and ovaries elevated. Miss Y had never been sexually active.

Miss Y made an uneventful recovery and was discharged from hospital on day four. Three weeks later she was referred back to the gynaecology department with increasing pain and urinary incontinence. Clinical examination demonstrated left iliac fossa tenderness but an ultrasound scan was negative. A diagnosis of dysmenorrhoea, secondary to endometriosis, was made as the patient had begun menstruating two days earlier. The patient declined admission to hospital as she was anxious to go home. Mefenamic acid was prescribed and she was reviewed by Mr D two weeks later.

At this stage she continued to complain of a foul vaginal discharge although her pain and urinary symptoms had settled. A high vaginal swab was taken and the patient was given continuous progesterone

for three months and doxycycline for ten days. At a further review two weeks later the patient was well with no evidence of discharge, but an offensive odour was detected. Betadine vaginal pessaries were prescribed and Miss Y was asked to reattend in three weeks. Upon reattendance, it was found that the foul smelling discharge had resumed. Further swabs revealed the presence of faecal organisms and the betadine pessaries were continued.

The patient's problems persisted. Eight months after the original operation she was reviewed again by Mr D who performed a speculum examination. This revealed the pack in the posterior fornix, which was removed, and the vagina was washed with more betadine. Some oestrogen cream was inserted and she was put on further antibiotics. The patient subsequently made a full recovery.

The patient initiated proceedings against Mr D, citing negligence in failing to remove the swab during the operation. A further complaint was also made that Mr D failed to suspect or locate the swab after surgery by not taking reasonable steps to heed or investigate her complaints. Responsibility for not removing the pack and failing to diagnose its presence for several months was accepted and the case was settled for a moderate sum.

**SD**

*A further complaint was also made that Mr D failed to suspect or locate the swab after surgery by not taking reasonable steps to heed or investigate her complaints*

### Learning points

- Such incidents as described in this case report continue to occur after operative procedures with variable degrees of subsequent harm. Each organisation and individual surgical team need to implement safety checks and take responsibility for ensuring that all surgical instruments and swabs used in an operation are counted in and counted out. The World Health Organisation Surgical Safety Checklist has been widely implemented and has specific elements to help reduce the risk of such events. See [www.who.int](http://www.who.int).

# When normal is wrong

Mr B, a 35-year-old businessman, consulted Mr L, a urologist, over the telephone requesting a vasectomy. Mr B had been married for 12 years and had three children with his wife, aged seven, four and two. Mr L explained the procedure briefly over the telephone to Mr B, stating that there was a slight risk of infection and bleeding from the procedure and a very slight risk of chronic scrotal pain. Mr L then sent Mr B the hospital admission form and the consent form, to bring back with him on the day of the operation.

Mr B was admitted to the

ward and only met Ms Q, the urologist who would perform the operation. In that short visit, Ms Q introduced herself to Mr B, checked his signature on the consent form, and told Mr B he should be out of hospital in a few hours' time.

On discharge later that day, Mr B was advised to get a sperm count organised by his doctor in 12 weeks' time. He claimed later that he was not given any practical advice on contraception, nor told that there

was a risk that the vasectomy might not have worked. Ms Q did not see Mr B after the operation; instead it was the nursing staff that discharged Mr B and gave him advice regarding his sperm count check.

GP Dr X saw Mr B in clinic and was surprised to hear about the operation but still requested a path lab test for his semen analysis, although he failed to label that it was post-vasectomy. Dr X advised Mr B to contact the urology clinic for the results.

Mr B contacted the clinic but could not get hold of any of the doctors. The secretary mentioned that the report said "normal", which Mr B interpreted as meaning that the operation had been successful.

Unfortunately, Mrs B became pregnant and only then it was made clear that Mr B's sperm count was normal. Mr B made a claim against all doctors involved. The case could not be defended and it was settled for a moderate sum.

**PS**

*He claimed later that he was not given any practical advice on contraception, nor told that there was a risk that the vasectomy might not have worked*



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## Learning points

- Vasectomy is one of the technically simplest urological procedures and yet one of the most litigious. While the procedure might be simple, the consent process is not. Informed consent is best gained in person rather than over the telephone and ideally should be performed by the person performing the operation. If it is gained a few days or more before the procedure, consent should be confirmed on the day of the procedure by verifying the patient's understanding of the procedure. Going through the operative risks of the procedure is not sufficient. The failure rate of vasectomy, either due to failure to remove adequate sections of both vasa or recanalisation, albeit small, is of crucial significance, and must be mentioned and documented.
- The patient must also be told that it takes around 12-14 weeks on average for the sperm to be non-motile or absent after vasectomy, and thus two separate sperm samples should be provided at these time intervals, and contraception used until the patient receives the 'all-clear' from these samples. These sperm samples should be marked as post-vasectomy so the processing laboratory understands that the desired result would be to have no sperm or few non-motile sperm. If the patient's GP is expected to send these samples then a discharge letter explaining this plus the procedure should be sent to him/her, so that he/she is aware of the situation. The results of the sperm samples should also be sent in writing to the patient's GP as well as the patient with a letter from the urologist who performed the procedure stating the 'all-clear' or otherwise. If viable sperm are still present, the patient should be advised to continue contraception and provide a further sample four weeks later.
- Results should not be given over the telephone by non-medically-trained staff, to avoid potential miscommunications as happened in this case.
- This case illustrates the commonest reason for medical claims – poor communication. There was poor communication at multiple stages: during the consent process, between urologist and patient after the operation, between urologist and GP after the operation, between GP and sperm laboratory, and between patient and urology secretary. While each of these errors might appear small in isolation, together they added up to an undesired outcome.



# Over to you

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

Please address correspondence to: Casebook, MPS, Victoria House, 2 Victoria Place, Leeds LS11 5AE, UK. Email: casebook@mps.org.uk

## Ignoring the guidelines

Re: The case report "Ignoring the guidelines", *Casebook* 21(1), January 2013

» I have some years' experience with a medicolegal practice in obstetrics and gynaecology and as a trainer for the Inner Temple. I read this article with some degree of incredulity.

Personally, I would find it very difficult to criticise many of the actions of the obstetrician involved and indeed to follow the guidelines in the particular case with a poor outcome could be considered to be negligent. In many emergency cases it is entirely appropriate for the clinician concerned to act within their abilities. Even if the guidelines make particular recommendation, it would be unwise to adhere to it in an emergency situation if they have no experience of using a particular drug or a technique. In the situation you describe it would not be appropriate for the individual to do anything other than what they are familiar with. At no point does anyone question the validity of the guideline.

I would be disappointed if this case was not robustly defended. In my own experience I have made the mistake of relying on RCOG (Royal College of Obstetricians and Gynaecologists) guidelines in the past, only to be demolished and humiliated by the opposing side when they have pointed out their inconsistencies.

I would draw your attention to the fact that guidelines are indeed just that

and that they are not tramlines, and that in such a case any clinician should have the intellectual rigour to base any actions on their own knowledge, experience and abilities. Thankfully, in most cases guidelines are based on good evidence and there is little dispute.

However, I think it is an exceptionally worrying development if one merely judges a colleague's actions by comparing it with a guideline checklist that has been produced by a committee. Often the most sensible opinion is based on experience, meticulous research of the literature and careful thought. Unfortunately there is a paucity of all three in many reports I see today.

Dr Mike Bowen, UK

## Response

*We would agree that strict adherence to guidelines is not mandatory, and that circumstances will arise where this strict adherence is not inevitably in the patient's best interests. Guidelines are intended to represent pooled experience of best practice, and so if a decision is made to depart from them, the clinician doing so has the burden of being able to explain and justify why that decision was appropriate – and document the reasoning.*

*You will have noted that there were other criticisms in the case – failing to attempt less radical procedures before proceeding to hysterectomy and lack of documentation.*

## Ignoring the guidelines 2

» I read with interest the report on "Ignoring the guidelines" in the January 2013 case of postpartum haemorrhage (*Casebook* 21(1)). Whilst I agree that the ultimate decision on the most appropriate surgical management of this patient lay with the obstetrician on-call, it is important to point out that the medical management of the patient up to that point (including maternal resuscitation, and the correct implementation of the local massive obstetric haemorrhage guidelines) was the joint responsibility of the obstetrician and the obstetric anaesthetist on-call covering the labour ward.

Generally, when a massive obstetric haemorrhage occurs, in most obstetric units, the anaesthetist should take the lead with the administration of intravenous syntocinon (+/- infusion), im/iv ergometrine, im carbaprost, intravenous fluid resuscitation and administering packed red cells/blood products, since they are most familiar with these drugs and in those specific aspects of maternal resuscitation; the obstetrician (assisted by the midwifery team) should take the lead with the usage of pr misoprostol and im syntometrine, external uterine massage and bimanual compression, since they are most accustomed to using these particular drugs/techniques.

Once the decision to go to theatre has been made (jointly), whilst the anaesthetist should mainly concern themselves with continued maternal

## Where the heart is

» I read with interest the last issue's compendium of mishaps. I would like to point out that in "Where the heart is", the statement "Mr R's symptoms were potentially life-threatening" is inaccurate. In fact, those symptoms can and often do represent life-threatening conditions, but they are not in themselves fatal.

My main gripe however is with the statement "...where a cardiologist would have diagnosed him and Mr R would have survived".

It certainly isn't the case in my (A&E/ITU-bearing) hospital in rural West Wales that Mr R would have been guaranteed to be seen by the only cardiologist on staff. Nor could we have guaranteed that the large saddle embolus in his pulmonary artery would not have killed him.

A small point perhaps, but definitely one to reflect on.

Dr Gavin Ross, Haverfordwest, Pembrokeshire, UK



resuscitation, they still have a duty to discuss/remind the obstetrician of their available surgical options (B-Lynch suture, internal iliac/uterine/ovarian arterial ligation, packing of the abdomen as a holding measure or to enable angiography +/- embolisation, hysterectomy, cross clamping the aorta etc, depending on the clinical scenario and cardiovascular/haematological stability), particularly if there is perceived deviation from local/national guidelines.

Massive obstetric haemorrhage is an extremely stressful clinical situation, particularly for the obstetrician, therefore the anaesthetist plays a crucial role in ensuring that logical sensible decisions are still being made amidst the mayhem, which includes insisting that the obstetrician calls for further assistance/senior help/consultant advice/consultant to come in, if the clinical situation warrants it.

Maternal resuscitation in massive obstetric haemorrhage is most effective when the labour ward obstetricians, anaesthetists and midwives work together as a team, so that the guidelines are followed and the appropriate decisions are made at the appropriate times, to achieve the best maternal outcome (which may still unfortunately be a hysterectomy, but at least the appropriate steps to justify that decision will have been taken along the way).

Dr Patrick Ward, specialty trainee, anaesthetics, UK

#### Note from Casebook:

*Effective teamworking is part of the training offered on behalf of MPS by Atrainability, an organisation that specialises in the roles human factors and situational awareness play in risk and patient safety. Visit [www.atrainability.co.uk/](http://www.atrainability.co.uk/) for more information.*

### Ignoring the guidelines 3

Re: The case report "Ignoring the guidelines", Casebook 21(1), January 2013

>> I think MPS should push for clarity regarding what is meant by the term "guideline", particularly in the context of "NICE guidelines". Vociferous lawyers

often pursue doctors for not following NICE guidelines (which they see as rules), yet we are taught as doctors to 'think outside the box' and beware exceptional/atypical patients. Moreover there is very little evidence for many of the NICE guidelines (some are graded low level of evidence and often simply considered as good professional practice).

My belief is true guidelines represent more generic guidance that apply to the majority of patients with that condition, and provide a fallback when you may be otherwise unclear how to treat a condition. In the case you presented there was a lack of adherence to basic common sense and it should have been called "Ignoring the protocol". In fact in that article the author loosely switches between the terms "protocol" and "guideline".

I am happy to be pursued by a lawyer for not following a protocol, but would expect to be supported by MPS for not following a guideline – could MPS explain the different terms to our legal friends and fight for tighter use of the correct terminology?

Dr John Hewertson, UK

#### Response

*We agree with your comments; guidelines tend to be based on pooled experience and opinion of best practice and can be used to standardise care and improve quality of care. Healthcare providers should know about the guidelines relevant to their field of practice, and then be able to decide whether or not to follow them for an individual patient. The weight attached to a guideline will be influenced by the authority of the issuing body; for example, it might be a challenge to successfully argue against following some regulatory guidance.*

*Protocols are built on a set of rules which healthcare providers are expected to follow, and in some contexts are stricter than guidelines and so carry more legal weight. In clinical practice the terms are often used interchangeably, as you have observed. The terminology used would be but one consideration of what constitutes practice that would be supported as reasonable by a*

*responsible body of the profession working in that field. And MPS would be very clear in explaining that to a claimant lawyer, where it was necessary to do so, in the defence of a claim.*

### More on primary postoperative care

>> I found the letter from a consultant surgeon on this matter in the January 2013 Casebook ("Primary postoperative care", Over to You) very interesting – but it does not complete the picture on the whole issue of secondary care discharges to primary care. As a manager who has to deal increasingly with patient complaints in a general practice, the discharge process and continuity of care does give a great deal of disquiet.

I fully understand the pressures to discharge quickly from secondary care – as GPs take on the financial responsibility for the cost of referrals [in the UK] this is only going to increase.

### The problem I see is in the quality of discharge notifications and how timely they are

The problem I see is in the quality of discharge notifications and how timely they are. There is no common format for discharge information being provided and important facts are never highlighted in the same place in the variety of documents that drop into our inboxes from hospitals. This places the GP in danger of missing some important detail and joining both the GP and the consultant at risk of legal action.

To round off the point, if a discharge is made "in haste", then flagging up such issues as the need for the follow-up to take place in primary care and making sure the GP gets this information is even more important.

Alan Moore, Group Manager, Great Sutton Medical Centre, UK

# Reviews

If you would like to suggest an app, website or book for review, or write a review, please email [sara.williams@mps.org.uk](mailto:sara.williams@mps.org.uk)

## Medical Law

By Jo Samanta and Ash Samanta (£24.95, Palgrave Macmillan, 2011)

Reviewed by Dr Simon Paul, Consultant Rheumatologist, Kingston Upon Thames

If you have ever looked for a book on medical law that manages to balance an exposition of historical medical jurisprudence and ethics, academic debate, insightful critiques of the contemporary UK healthcare situation, a thorough exploration of current medical law and future challenges, all interwoven with stimulating discussions using real-life practical dilemmas, then this book might be for you! *Medical Law*, written by a husband and wife couple, stands out from most recent medical law texts in many respects. Firstly, the authors come from nursing and medical backgrounds, but are also law lecturers.

Undoubtedly, their practical experience of healthcare settings, enhanced by their legal backgrounds, provides a unique insight into medical law. The authors illustrate topics with authoritative case law and, where relevant, primary and secondary

there are areas of medical law that overlap chapters (eg, consent in chapters on mental health law, ethics and research) but topic analyses are not duplicated in the chapters; if anything, they are developed in subsequent sections. I found it more helpful to read the end of chapter summaries at the beginning to help signpost how the chapters evolve, but that is only a personal preference.

The authors develop the reader's understanding using practical scenarios to illustrate important but not straightforward principles. Key terms are expanded for the reader with little background knowledge, but these are also useful for those with more experience in the area as aide memoires. A minor criticism is I found the text blocks a little hard to wade through in places – this is not unusual in books that tackle medical law and ethics, but in general, good use is made of headings and subheadings

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*Undoubtedly, their practical experience of healthcare settings, enhanced by their legal backgrounds, provides a unique insight into medical law*

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legislation. Refreshingly, the authors also manage to discuss obiter dicta (persuasive statements made in passing by judges, which, although not binding, may be influential on later decisions), something that many other books sadly fail to do. It was nice to see comparative analyses of case law and legislation from other (non-UK) jurisdictions, eg, in the section on assisted dying, and also discussion on relevant EU law.

Each chapter begins with a topic map and this serves to put subjects into neat headings. As expected,

to break up the text. The book is sufficiently indexed and suggestions for further reading are provided, which mostly appeared relevant.

Overall, I would highly recommend *Medical Law*, a book that manages to bridge the gap between an introductory and more substantive textbook. It will appeal to law and medical students who have chosen medical law modules, but will also appeal to postgraduate medical and other healthcare practitioners. Lawyers with an interest in medical law will find this a useful general textbook.



## CliniCalc app

Reviewed by Dr Laura Davison, GP in Milton Keynes

Have you ever been clerking in a patient and just cannot remember what the four E's of the Glasgow Coma Scale are, or remember which dermatome those shingle-like vesicles seem to be following? Ever needed to urgently calculate The Delta Gap and Ratio... well, probably not that last one, but the point of new app, CliniCalc, is that if you wanted to, you could.

This very thorough and clever little app covers a multitude of clinical scoring systems, risk evaluators and physiological calculations. Its breadth should mean it applies to both primary and secondary care doctors, from junior to consultant level. The coverage is wide ranging, from the bamboozling anaesthetic and nephrology calculators, to the simplicity of BMI and GCS.

There are numerous lifestyle and cardiac risk categories too, applicable to general practice; however, the majority of modern operating systems for GPs now have these already incorporated.

There are so many calculations on this app, to be honest I had not heard of half of them, and as good as the program is at telling you how it worked it out, it cannot tell you what to do with the results at the end of it. But I guess that is why we went to medical school. The only obvious omission I've noted is the Rockall Score for gastrointestinal bleeds, but perhaps this could be included in a future upgrade.

My only concern is that you can waste minutes flicking through the various category screens hunting for the calculator you need. There is an option on the app to save certain calculations to your "Favourites".

Overall a useful application to put on your smartphone, to whip out for patient care decisions or showing off your thoroughness on the ward round, and if you do not use it in the end, who cares, it is free to download from the Apple App Store. So if it is no use to your practice, just delete and replace it with another upgrade of Angry Birds.

CliniCalc is yet to be released for the Android market.



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