Medical records
WHY POOR RECORDS CAN END YOUR CAREER

In the spotlight
ON-SITE PERFORMANCE ASSESSMENTS

One step at a time
HOW TO IMPROVE COMMUNICATION

120 years of MPS
LOOKING BACK AT THE MILESTONES

CASE REPORTS PAGE 13
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ON THE COVER

7 Medical records
Failing to keep accurate medical records can have grave consequences for your career. Dr Sonya McCullough and Gareth Gillespie present some scenarios that demonstrate how.

10 In the spotlight: your performance
Dr Muiris Houston looks at the Medical Council’s new initiative for on-site performance assessments.

12 One step at a time
Dr Mark O’Brien describes how a step-by-step approach can mitigate the risks posed by poor communication.

ALSO THIS ISSUE

4 Your MPS
In addition to MPS Medical Director Dr Priya Singh’s regular column, you can also explore MPS’s history as the organisation celebrates 120 years.

6 Headlines and deadlines
The latest news on legislation, events and open consultations in Ireland.

13 On the case
Dr George Fernie, Senior Medicolegal Adviser, introduces this issue’s selection of case reports.

14 Case reports
14 Oh by the way, doctor
15 Crying wolf
16 A dangerous cough
17 Where is the consultant?
18 A normal appendix
19 A pain in the neck
20 Trouble behind her back
21 Suffer the little children
22 Too much bleeding
23 A friend in need

24 Over to you
A sounding board for you, the reader – what did you think about the last issue of Casebook? All comments and suggestions welcome.

26 Book reviews
This issue, Dr Mike Baxter reviews If Disney Ran Your Hospital: 9½ Things You Would Do Differently, by Fred Lee, while Dr Rebecca Smith and Dr Chris Jones review The Wisdom of Whores: Bureaucrats, Brothels and the Business of AIDS, by Elizabeth Pisani.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Amidst this evolving medical backdrop, 1885 saw the birth of the Medical Defence Union, a national rather than local organisation. But the union’s turbulent early years, plagued by accusations of irregularity and lack of accountability to members, resulted in a breakaway group forming an alternative defence organisation; the London and Counties Medical Protection Society. The rest, as they say, is history. Led by the surgeon Sir Jonathan Hutchinson and doctors George Heron, George Mead and Hugh Woods, the new society aimed to “support and safeguard the character
of legally qualified practitioners and to advise and defend members when attacked”. The society went from strength to strength. By 1894, the London and Counties Medical Protection Society had grown to 1,000 members – with an annual subscription rate of ten shillings. Premises were taken in Sloane Square, London, and Le Brasseur and Oakley were retained as solicitors – the start of a lasting association, as the firm’s successor, Radcliffe LeBrasseur, remains one of MPS’s panel law firms today.

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

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

The “London and Counties” part of MPS’s title was dropped in 1947, but it was still affectionately referred to as “the London and Counties” by older members. With the advent of the National Health Service in 1948 and the Legal Aid fund in 1960, costs to members began to rise substantially, as did requests for assistance.

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

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

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

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

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

With an increasing focus on education and risk management, MPS looks set to remain at the heart of the medical profession for the next 120 years, responding to the needs of members in an ever-changing medicolegal climate. Further details of the international conference are available on the MPS website.
THE DETERIORATING CLAIMS ENVIRONMENT CONTINUES TO DETERIORATE

The deteriorating claims environment in Ireland was the subject of much discussion at an MPS reception in Dublin, held in February.

The event, held at the Royal College of Physicians of Ireland, had more than 70 figures from the healthcare and legal fields in attendance. It was hosted by new MPS Chief Executive Simon Kayll and focused on the medicolegal challenges facing Ireland now and in the future.

Dr Stephanie Bown, MPS Director of Policy and Communications, and Editor-in-chief of Casebook, said at the event: “These are turbulent times. In the past five years, we have seen medical claims costs increase by 26% per annum. And for dental claims, the numbers are escalating – last year there were three times as many claims as five years ago.

“We are pleased that the Legal Services Regulation Bill will give rise to greater transparency for legal costs. Legal fees are often disproportionate to what patients receive in compensation, which is wrong and plainly unfair.”

Meanwhile, the Health Service Executive (HSE) has revealed that it paid out over €81 million in 2011 for clinical negligence claims, compared to €49m in 2009.

Jerry Buttimer, Chairman of the Oireachtas Health Committee, said: “The figure of €81m is worrying. The figures are startling and they reveal an ongoing issue that needs to be addressed.”

Legal Services Regulation Bill

Status: The Bill is now in its second stage in the Dáil

Aim: The Bill makes provision for three key entities:

- A new, independent, Legal Services Regulatory Authority with responsibility for oversight of both of the legal professions.
- An Office of the Legal Costs Adjudicator to assume the role of the existing Office of the Taxing-Master, which will be conferred with enhanced transparency in its functions. The legal costs regime will be brought out into the open with better public awareness and entitlement to legal costs information.
- An independent complaints structure to deal with complaints about professional misconduct – this will be supported by an independent Legal Practitioners Disciplinary Tribunal.

Mediation and Conciliation Bill

Status: The Bill provides for implementation of recommendations of the Law Reform Commission and is expected in 2012.

Aim: MPS is interested in the Mediation and Conciliation Bill as we strongly support measures that could resolve disputes more efficiently and reduce the cost of legal proceedings. Although we welcome plans to incorporate the use of mediation, our experience shows that some cases are better suited for mediation than others and careful consideration needs to be given to which cases should be the focus of any new dispute resolution system.

The Medical Council has published details of new procedures for assessing doctors’ performance when their professional competence is subject to investigation. The new procedures will involve on-site assessments of doctors’ performance for the first time.

Doctors selected for participation in the procedures will be assessed by an independent team of two medical doctors and one patient representative, who will conduct on-site assessments, observe interactions with patients and review performance in practice. The new rules are pursuant to the provisions of Section 11 and Part 11 of the Medical Practitioners Act 2007.

For an in-depth feature on these new procedures, read Dr Muiris Houston’s article in this edition of Casebook, www.medicalcouncil.ie

GP guidance on referrals

A national referral template has been launched by the ICGP and National GPIT Group. Two pages long and very easy to complete, software packages Health One, Socrates, Helix Practice Manager and Complete GP can now generate the national referral template with large parts of the form completed using information already stored with the electronic patient record. For GPs not using certified GP software the referral template can be downloaded from www.icgp.ie.

The first page of the form seeks information regarding the specialty being referred to, the reason for referral and the GP’s impression of whether the referral is urgent or routine. The patient’s demographic information and GP details make up the rest of page one. The second page contains a “Symptom” section for examination findings. The rest of page two allows the GP software to list past medical history, medications and allergies, as well as relevant social and family history.

Time to scrub up

Doctors are the least likely hospital staff members to wash their hands, according to the latest Health Service Executive (HSE) report on hand hygiene compliance.

In an audit of hand hygiene in 42 acute hospitals carried out last October, doctors washed their hands on 68% of the opportunities open to them. Auxiliary staff, such as healthcare assistants and porters, washed their hands 79% of the time and nurses and midwives were compliant almost 84% of the time.

The survey showed hand hygiene compliance at seven hospitals had disimproved since the previous audit. The HSE said the report showed an overall compliance rate of 79.6%, above the 75% target for 2011. The target for this year is 85%. Assistant national director of health protection with the HSE Dr Kevin Kelleher said improving hand hygiene compliance was a priority.
Medical records: which path will you take?

MPS medicolegal adviser
Dr Sonya McCullough and
Gareth Gillespie show how the
course of your career can hinge
on your record-keeping

It is, perhaps, easy to be flippant about a medical record. You may think of it as a bureaucratic sideline to the buzz and unpredictability of practising medicine; a tiresome, superfluous chore that is carried out to keep the suits in the Medical Council happy.

But to underestimate or disregard altogether the importance of keeping good medical records is to potentially deal a severely damaging blow to your career. Whether you have received a complaint or a claim for clinical negligence, or you are at an inquest, the presence of a complete, up-to-date and accurate medical record can make all the difference to the outcome. In this article, we have drawn on three real MPS cases in Ireland (with some facts altered to preserve confidentiality) to demonstrate how good record-keeping can shape your professional future.

CASE 1: NO INFORMED CONSENT

Miss A was referred to Mrs B, consultant gynaecologist, with a diagnosis of ovarian cancer. Mrs B, in that initial consultation, explained that she would admit Miss A for a course of chemotherapy. She gave Miss A some indication of the prognosis but did not elaborate. Miss A made a complaint to the Medical Council, saying that she had received no information about alternative regimens of treatment and there had been no discussion about future fertility or prognosis. Mrs B had not kept a record of the consultation and could not recollect much of what had been said.

Learning points
Patients are better informed in the era of advances in IT and they wish to have adequate information on which to base their decisions. Consent should be informed to be valid and medicine has moved away from a paternalistic to an autonomous approach. Mrs B had not recorded her decisions or conversation during the consultation, thus making it difficult to assist her in providing a robust response to the letter of complaint to the Medical Council. Good record-keeping is essential during vital consultations in a patient’s management, where important decisions are being made about the patient’s care.
**SPECIAL FEATURE**

**IRELAND CASEBOOK | VOLUME 20 | ISSUE 2 | MAY 2012**

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**CASE 2: RELEVANT NEGATIVES**

Mr F attended his GP, Dr L. He had noted a chest discomfort over the last two days, eased by antacids. Dr L asked him about type, duration and radiation of the pain, and about precipitating factors and relieving factors. He recalls asking him about shortness of breath and cardiac risk factors. However, he did not record these relevant negatives in the notes. Given that the history did not indicate a cardiac aetiology, Dr L prescribed further antacids and asked the patient to attend for review in one week, sooner if his symptoms did not settle. The patient died subsequent to a myocardial infarct three days later. His widow made a complaint to the Medical Council and the matter was referred on to a fitness to practise panel.

**Learning points**

Dr L had actually taken a full history and, based on the negative features for ischaemic heart disease, had diagnosed a gastric cause for the symptoms. However, he had simply written “seems gastric – Rx Gaviscon” in the notes. This did not reflect the care and attention paid to the patient during the consultation or support and justify his decision on management, making the case more difficult to defend when it went before the fitness to practise panel.

**Why are medical records important?**

The Medical Council says: “You have a duty to maintain accurate and up-to-date patient records either in manual or electronic form.”

The main reason for maintaining medical records is to ensure continuity of care for the patient. They may also be required for legal purposes if, for example, the patient pursues a claim following a road traffic accident or an injury at work. For health professionals, good medical records are vital for defending a complaint or clinical negligence claim; they provide a window on the clinical judgment being exercised at the time.

**What are medical records?**

This probably sounds like an obvious question. However, medical records cover an array of documents that are generated as a result of patient care. This includes:

- Handwritten notes
- Computerised records
- Correspondence between health professionals
- Laboratory reports
- Imaging records, including x-rays
- Photographs
- Video and other recordings
- Printouts from monitoring equipment
- Text messages
- Emails.

**The essentials**

Good medical records summarise the key details of every patient contact. On the first occasion a patient is seen, records should include:

- Relevant details of the history, including important negatives
- Examination findings, including important negatives
- Differential diagnosis
- Details of any investigations requested and any treatment provided
- Follow-up arrangements

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**CASE 3: RETROSPECTIVE NOTES**

Mr J was admitted to a psychiatric unit on 2 February 2012. He was seen by the junior doctor, Dr X, on arrival. She took a full psychiatric history, including a discussion about suicidal ideation. However, she did not record this conversation in the notes. Mr J was discharged from hospital on 6 February 2012, and hanged himself two days later. Dr X went back to the medical records on 8 February 2012 and, in a different coloured pen, under the entry she had made for 2 February 2012 wrote “no suicidal ideation” – she made a retrospective note. This was picked up by the coroner during the inquest and the matter was referred to the Medical Council. This was considered a matter of probity and the Preliminary Proceedings Committee referred the matter to a fitness to practise hearing.

**Learning points**

All records should be contemporaneous. If you do add to a record, date and sign it and make it clear that you are adding it retrospectively. In the above scenario, Dr X, when she was made aware of what had happened, should simply have made an entry on 8 February 2012 indicating that she was aware of the suicide, and that she recollected that the patient had no suicidal ideation when she clerked him in on 2 February 2012, although she did not record this at the time.
What you have discussed with the patient. This is particularly important regarding management options and the taking and documentation of consent.

On subsequent occasions, you should also note the patient’s progress, findings on examination, monitoring and follow-up arrangements, details of telephone consultations, details about chaperones present, and any instance in which the patient has refused to be examined or comply with treatment. It is also important to record your opinion at the time regarding, for example, diagnosis. Medical records must be:

- Objective recordings of what you have been told or discovered through investigation or examination
- Clear and legible
- Made contemporaneously, signed and dated
- Kept securely.

Abbreviations

The National Hospitals Office Code of Practice for Healthcare Records Management states:

35. Abbreviations shall not be used. In the event of abbreviations being utilised, only abbreviations approved by the National Hospitals Office may be permitted.

36. All approved abbreviations shall be written in higher case (capital) BLOCK letters and not in a cursive script and/or in lower case.

37. Other than the abbreviations approved by the National Hospitals Office, on each side of each page the full term shall be used, followed by the abbreviation in brackets. Thereafter the abbreviation may be used on that page.

38. Abbreviations shall not be used on documentation which is used for transfer, discharge or external referral letters.

39. Abbreviations shall not be used on consent forms, death certificates, incident report forms and communications sent from the hospital.

Note: Drugs names shall not be abbreviated."

Be aware, also, that patients may access their records – it is essential that you avoid insulting or derogatory remarks.

Additions or alterations

If you need to add something to a medical record or make a correction, make sure you enter the date of the amendment and include your name, so no-one can accuse you of trying to pass off the amended entry as contemporaneous. Do not obliterate an entry that you wish to correct – run a single line through it so it can still be read. Finally, there is only one thing more damaging than absent or poor notes and that is fabricated notes.

Occasionally, when sued, a doctor will forget, or be unaware, that a copy of the records has already been disclosed to the patient’s legal team. When he becomes aware he is to be sued, he reviews his notes and realises that the care or notes are suboptimal and then amends the records. We then prepare a defence based on the records disclosed to us and our case collapses when we compare our “original” records to the claimant’s copy of the true original records – copied before summons was issued.

Keeping good records

You are obliged by the Medical Council to keep good medical records – whether electronic or handwritten – as they are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should, therefore, be comprehensive enough to allow a colleague to carry on where you left off.

Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory
The regulatory landscape in which doctors in Ireland practise continues its rapid pace of change. Following on from making fitness to practise hearings public events, the Medical Council has just introduced on-site practice assessments of doctors’ performance for the first time. It means a small number of doctors can expect their standard of patient care to be looked at as they actually go about their daily work; their interaction with patients and how they perform clinically will now be closely examined.

The actions of disgraced medical practitioners such as Harold Shipman and Michael Neary were rare and exceptional; nonetheless they caused the public to re-evaluate their trust in all doctors. A possible reflection of this trend is the MPS experience of the past five years, which has seen medical claims costs increase by 26% per annum in Ireland.

In turn, politicians took steps to tighten oversight of doctors’ professional activities. In the Republic a new Medical Practitioners Act came into force: among many changes it increased lay representation on the Medical Council; fitness to practise proceedings now take place in public unless the complainant specifies otherwise; and it strengthened the oversight of doctors’ continuing medical education.

Not least, the new Act made it easier to detect and help doctors who were underperforming because of personal illness or addiction. And new performance assessments will now further strengthen the Medical Council’s regulatory role.

In the run-up to the new procedures, a consultation process invited views on each of the individual draft rules governing performance assessment; the Medical Council then invited comments on the proposed performance procedures.

Approximately 25 organisations and individuals provided feedback with three main issues emerging as areas of concern:

- The standard against which doctors will be assessed
- The timeliness and confidentiality of the procedures
- Processes for communication with the employer.

Some 355 doctors were surveyed last September, with the following among the opinions expressed about performance assessment: respondents would like to see the process record areas of satisfactory practice as well as those requiring improvement; and they want the process to record health and structural issues within the health service that may be preventing the doctor from engaging in good practice.

Anecdotally, there is concern among practitioners as to who will be responsible for the not insubstantial costs of what may be a 2/3 day on-site visit. The Medical Council reserves the position that it may levy fees and expenses for the performance procedures and activities. It is currently determining policy in relation to how it will exercise this position, which it says “includes engagement with indemnifiers and the Department of Health and Children”.

“It is in everybody’s interest that the Medical Council has a robust process in place to ensure patients receive a high standard of professional care from their doctors,” said John Delap, Chairman of the Irish College of General Practitioners.

“It will be important that the standards set are based on the highest quality for patients within the level of resources available in our health system. The College will have a role in providing opportunities and support for doctors to meet
Both staff and patients will be canvassed for their views on a wide range of issues concerning the doctor’s professional abilities and attributes.

Their educational needs.

Medical Council President Prof Kieran Murphy told Casebook: “New performance procedures will further enhance the Medical Council’s processes in protecting the public. This marks the culmination of a number of years of development work and is a further safeguard, which will help to both protect patients and to promote good professional practice among doctors.

“While doctors endeavour to provide safe, high quality care, sometimes performance problems may arise. Performance assessment will not replace other procedures that the Medical Council already has in place, but will allow us to work in a more targeted and effective way with doctors who are experiencing problems in some aspects of their practice.”

So how many assessments does the Medical Council expect to carry out per annum? “It is difficult to predict the number of assessments that will be conducted in the first year as it will depend on the number of instances that arise where Council feels it needs assurances about the quality of a doctor’s practice,” Prof Murphy said.

But he points to New Zealand as a country with a similar population, and using similar procedures – it conducted about 20 performance assessments in 2010. In half of these cases, doctors were formally required to engage in further education to maintain their knowledge and skills.

The new assessors include both medically-qualified individuals as well as non-medical assessors to represent the views of patients. A team of three assessors will conduct the assessment visit, which will be timetabled over a number of days. Even before the visit the team will have gathered together, in some depth, information about the practice. Both staff and patients will be canvassed for their views on a wide range of issues concerning the doctor’s professional abilities and attributes. A sample of the practice’s patient records will be looked at to assess their quality, and the doctor may be asked to demonstrate his clinical skills to the assessors.

At the end of the process a report will be considered by the Medical Council, who will then decide what action (if any) is necessary to ensure the ongoing competence of the doctor who has been assessed. Prof Murphy sees the latest development as a key element in the overall package of protecting the public.

He said: “It’s important that the public is aware that these procedures will be used when Council feels it needs assurances about the overall quality of a doctor’s practice. While this situation may arise following a complaint about an isolated incident, in general these new procedures will be triggered by the Council in response to information about the overall pattern of a doctor’s performance rather than how the doctor performed in relation to an isolated incident.”

In other words, fitness to practise inquiries will remain the principal mechanism through which the Council investigates a doctor whose care in a specific case is alleged to have fallen below an acceptable standard.

Where the Medical Council identifies resource or systems failures as part of a visit or investigation it will write formally to the Health Service Executive or the Health Information and Quality Authority to tell them about the problem. In turn, these agencies are expected to communicate with the Council about any concerns that arise about the performance of individual doctors. It’s all part of an intricate jigsaw with patient safety at its centre.

Dr Muiris Houston is a medical journalist and part-time GP from Co Galway, Ireland.

MPS has considerable expertise in assisting doctors with performance assessments in other jurisdictions and whilst the Medical Council is quite different to its UK counterpart, the experience gleaned by MPS makes us better able to support Irish doctors with this new element of accountability, which, in some circumstances, may be quite a daunting procedure.
Most colleagues will be aware from reading previous Casebook articles that poor communication contributes to approximately 70% of clinical negligence claims against doctors. Nevertheless, communication issues continue to surface, with depressing regularity, with each new series of claims and complaints assisted by MPS.

Doctors clearly do not communicate poorly on purpose. As a group, we have a strong ethical drive of wanting to do the best for the patient and this is combined with a pragmatic desire to avoid being sued.

Why do communication failures persist?

A report by the British Medical Association’s (BMA) Board of Education has highlighted key barriers to effective communication. Several of these barriers link to personal traits and attitudes. Such barriers include:

- Negative attitudes towards communication. Doctors give it a low priority, preferring to focus on treating an illness rather than the patient’s overall needs.
- A lack of inclination to communicate with a patient, especially when a doctor doesn’t have a lot of time, is dealing with an uncomfortable subject or is lacking in confidence.
- Doctors having personality differences compared to their patients. Research in the UK suggests that doctors may differ significantly to adult population norms in the areas of personality related to preferred mode of understanding. This opens up the possibility of misunderstandings in communication between doctors and patients.
- Undervaluing the importance of communications: doctors may not appreciate the importance of keeping patients informed. This may reflect a wider imbalance in the doctor–patient relationship.
- A lack of understanding of the communication process, such as the need to provide information in language that a patient understands, or listening to a patient’s views, to encourage two-way communications.
- A lack of knowledge or training in communication skills, especially in non-verbal communication, such as body language.

The same report recommended that more communication skills training programmes should be developed for doctors. MPS Educational Services offers members a number of three-hour workshops that aim to support doctors’ communication skills.

Small interactive workshops, like those offered by MPS, have been shown to be effective in changing doctors’ behaviours. And after attending a workshop, 80% of participants say they will change their practice.

As doctors, we know from our own experiences of supporting patients with behaviour change, such as quitting smoking or addressing weight problems, that good intentions on their own often aren’t enough. Overcoming barriers, especially when they are related to attitudes or personal traits, requires support, reflection and reinforcement.

It is for this reason that MPS offers members a series of communication skills workshops. The workshops each focus on a different area of communication. This was another recommendation of the BMA’s Board of Medical Education.

The areas covered by the workshops include:
- Basic communication skills
- Non-verbal communications
- Communicating after an adverse outcome
- Inter-professional communications
- Difficult interactions
- Shared decision-making.

Different techniques and skills are provided for each area but all the workshops share key themes. Starting with Mastering Your Risk and working through Mastering Adverse Outcomes, Mastering Professional Interactions, Mastering Difficult Interactions with Patients and the new Mastering Shared Decision-Making, the workshops build upon one another.

They each offer participants the chance to rehearse communication techniques, while revisiting key ideas and refreshing skills. Each workshop also encourages doctors to reflect on their own actions and behaviours.

The aim is that over time, by gradually helping members challenge and change their attitudes towards communications, the workshop will ultimately produce a step change in their communication skills. This will lead to a reduction in risk for the doctor and an improved patient experience.

REFERENCES

1. BMA Board of Medical Education, Communication Skills Education for Doctors: an Update (November 2004)
On the case

Dr George Fernie, Senior Medicolegal Adviser, introduces this issue’s round-up of case reports, a number of which focus on missed infections.

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

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

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

CASE REPORT INDEX

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

Since precise settlement figures can be affected by issues that are not directly relevant to the learning points of the case (such as the claimant’s job or the number of children they have) this figure can sometimes be misleading. For case reports in Casebook, we simply give a broad indication of the settlement figure, based on the following scale:
Mrs R was a receptionist in a local estate agent’s office. One evening, she noticed that her 11-year-old son, Y, was limping as he walked towards her in the kitchen. Y was overweight and had been grumbling to his mother about his left knee hurting intermittently for the previous month. On this occasion, when she asked why he was limping, Y told his mother he had slipped on ice in the playground earlier in the day. The fall had caused his leg to be sore. He had pointed at his thigh and said his knee was hurting again. The following day, Mrs R was booked to visit her GP, Dr G, to review her contraceptive medication. She decided to bring her son along with her, without an appointment. At the end of her consultation, Mrs R asked the doctor if he would take a look at her son. She explained what had happened yesterday and told Dr G that Y had been limping at home. There was a computer record of the consultation with Mrs R, but not with Y. Mrs R reported that Dr G carried out a cursory examination of Y, while Y was sitting in the chair. She said that the doctor told them this was most likely a hip sprain, but to come back if the pain did not settle.

When they returned home, the boy continued to complain of pain in his leg. Mrs R decided to bring Y to the local Emergency Department (ED) three weeks later, where a doctor requested bilateral hip x-rays and subsequently diagnosed slipped upper femoral epiphysis (SUFE). The case was discussed with the orthopaedic team on call and Y was admitted immediately for internal fixation. After his treatment, Y’s legs were of unequal length and one year later, he still walked with a persistent limp, which he found extremely distressing. The family had learnt it was likely that Y would require an early hip replacement in the future. Mrs R made a claim against Dr G.

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

GMcK

LEARNING POINTS

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

FURTHER INFORMATION

- Lalanda M, A Limping Child, Casebook 15(2)
- Anthony S, Getting to Grips with Children’s Hips, Casebook 12(3)
Mrs Z was a 34-year-old mother of four who smoked 20 cigarettes a day. She had recently been under investigation for central chest pain related to minimal exertion. Her GP, Dr B, had arranged an ECG, which had been normal, and done some blood tests, which showed raised cholesterol. He had also found her to be hypertensive. He had made no firm diagnosis regarding her central chest pain but was considering a referral to cardiology.

Mrs Z developed what she thought was indigestion, which was also causing aching in both her arms. When she started feeling unwell with it she rang the out-of-hours (OOHs) service complaining that in addition to the indigestion she also felt hot and sweaty. Mrs Z was very well-known to the OOHs staff because she used the service very regularly for herself and her children. The triage nurses advised her to take some antacid or milk for the indigestion. The nurse had failed to get a past history for Mrs Z’s cardiac symptoms. Mrs Z waited for an hour after drinking some milk but felt worse. She was still feeling sweaty and hot with the chest pain and rang the OOHs service again to explain this. She asked to speak to the doctor but the triage nurses remarked that “the doctor would not be able to do much more for that kind of problem”. That evening she became really concerned after several hours of pain were showing no signs of remitting. She had managed to get all her children to bed but was feeling like something awful was going to happen. She rang the OOHs services again but was given the same advice by the triage nurses.

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

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

**LEARNING POINTS**

- It is important to listen to patients who make recurrent calls regarding the same problem. Mrs Z had contacted the OOHs team and the GP surgery on multiple occasions. Doctors must not let an element of “crying wolf” blind their judgment.
- There are risks associated with telephone triage and information not being appropriately passed on to the medical team. It is harder to make a diagnosis without the visual information from a patient’s appearance, behaviour and non-verbal cues so great care must be taken.
- Written protocols should exist for the management of chest pain with clear guidance about when to pass on information to doctors. Although protocols often lack the “intuition” of experience, it would have been helpful if one had been adhered to in Mrs Z’s case.
- Ischaemic heart disease is rare in younger women, but not impossible, particularly when associated with risk factors. It is important to consider this diagnosis in the differential even if it is uncommon.
Mrs T, a 58-year-old music teacher, was admitted to her local hospital for an elective total abdominal hysterectomy for post-menopausal bleeding. She was seen on the day of surgery by consultant anaesthetist Dr Q, who noticed she had a cough. Mrs T said she had recently had a chest infection and had been prescribed a course of antibiotics from her GP. However, she was vague about how long she had had her cough, and whether she had finished the antibiotics. She dismissed her symptoms as a “smoker's cough” and was insistent that the operation should go ahead, as she wanted it to be “all over and done with” in time for her son’s wedding a few weeks later. She also requested a general anaesthetic.

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

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

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

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

LEARNING POINTS

- Your first obligation is to act in the patient’s best interests and you should not be pressurised by the patient into doing anything that is counter to this. In elective surgery, it is important to avoid pressure to proceed. In this case, finding out that Mrs T had pneumonia might have prevented this outcome.
- When administering anaesthesia during an elective procedure, it is preferable to stop should you encounter difficulties and reassess for surgery another time.
- Good communication between professionals is essential in patient care. Had the anaesthetist and the surgeon discussed this patient, it might have been possible to perform a vaginal hysterectomy under spinal anaesthesia, or the case could have been postponed until later.
- Good, careful, well-kept records help provide a good defence. In this case, the nursing records and their understanding of the events were the only written documents to go by. Safeguarding the integrity of records is even more important after an adverse event.
- Bronchospasm is an important and treatable cause of high airway pressures and tension pneumothorax during ventilation, but not the only one. The differential diagnosis includes endobronchial intubation, foreign body in the airway, and equipment problems such as kinks and obstructions.
A 48-year-old driver, Mr W, was sent to hospital by his GP with a one-week history of unremitting back pain and associated mild shortness of breath. On direct questioning, he also reported non-specific malaise for at least three months with half a stone weight loss but no symptoms of fever. There was no previous history of cardiac problems and no recent dental or other invasive procedures.

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

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

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

The case was settled for a moderate amount.

**LEARNING POINTS**

- The diagnosis of infective endocarditis is difficult and depends upon a low threshold of suspicion (see Beynon R, Bahl VK, Prendergast BD, Infective endocarditis, BMJ 333:334-339(2006)). The disease may present in a variety of forms to a variety of clinical specialties.
- Senior medical input to the care of seriously ill patients is important.
- There is little purpose in requesting investigations if the results are not carefully reviewed and acted upon at an appropriately early stage. There were several diagnostic clues in this particular case, which should have alerted the clinical team to the earlier diagnosis and management of infective endocarditis.
- The pressure to discharge patients and create beds for further admissions means that the results of important investigations are easily overlooked.
- Clear and comprehensive communication with the patient and GP is essential.
- Team working and fractured continuity of care can easily create “I thought you did it” situations where required tasks are not completed. The outcome for this unfortunate patient may have been different had an early follow-up appointment been arranged.
- Safe systems should be in place to check that outpatient clinics are arranged. It is worthwhile telling the patient that they should get in touch if plans are not confirmed.
Mr A, a 35-year-old accountant, was admitted to hospital overnight as an emergency under the care of consultant general surgeon Ms Q. He described an acute onset of severe right iliac fossa pain. Clinical examination revealed lower abdominal tenderness with localised peritonism in the right iliac fossa. Routine blood tests did not demonstrate any abnormality. The appendix was not visualised. Twenty-four hours later the patient’s condition had not improved and Ms Q made a decision to perform an appendicectomy.

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

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

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

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

**LEARNING POINTS**

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

Fifty-five-year-old Mr P emigrated from his home country ten years ago and secured a job as an administrator in a factory. He went to see GP Dr W soon after arriving in the country and mentioned during his first appointment that he had suffered with long-standing back pain for over a decade. Mr P became well-known at the surgery, as he was often argumentative and confrontational towards staff. Over a period of three months, Mr P attended his GP several times complaining of neck pain, stiffness and loss of strength in both arms. It was documented that he would routinely demand sick notes from Dr W in an aggressive manner and was adamant that the doctor didn’t like him. He repeatedly insisted that he should be provided with an orthopaedic chair for work, to ease his neck.

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

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

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

The case was settled for a high sum.

LEARNING POINTS

- Management of challenging patients can be very complicated and in cases like this can have devastating results. Despite the multitude of negative emotions introduced by an aggressive patient, it is important to maintain a professional approach and rule out any underlying pathology. Neglecting basics such as physical examination and reassessing for evolving signs is indefensible.

- Dr Monica Lalanda’s article on “The challenging patient” offers advice on dealing with these difficult encounters and reflects on the elements that often contribute to a patient’s behaviour.

- It is important to revisit your diagnosis and examination for evolving signs. See the Casebook article “Tunnel Vision” for more information.

- Dealing with conflict from aggressive patients can be a significant source of stress for doctors and can lead to a breakdown in the therapeutic relationship. Training in communication skills can be helpful in dealing with challenging scenarios. MPS runs a workshop, Mastering Difficult Interactions with Patients; visit www.medicalprotection.org and click on the Education tab.

REFERENCES

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

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

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

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

Mrs L made a claim against the hospital and Dr V for a delay in diagnosis of the abscess, which caused her paralysis. Expert opinion reviewed the medical notes, which included details of every visit, and were strongly supportive of Dr V's management. The case was successfully defended.

LEARNING POINTS

- Complications can, and do, occur in almost any clinical scenario, even when treatment is meticulous.
- Comprehensive and contemporaneous notekeeping is vital and the foundation of good practice.
- Infections are a significant problem in diabetes, especially when their control is poor. Microvascular and macrovascular complications of diabetes, as well as defects in cell-mediated immunity, increase with age, so increasing the risk of infection. Infections may also disrupt metabolic homeostasis and glycaemic control, so prompt recognition and treatment is therefore critical. Access a good overview here: http://enotes.tripod.com/dm_infections.pdf
- The importance of good foot care should be emphasised to patients – diabetic foot complications are the most common cause of non-traumatic lower extremity amputations in the industrialised world. Early detection and appropriate treatment of diabetic ulcers may prevent up to 85% of amputations. There is useful advice at:
  - Evaluation and Treatment of Diabetic Foot Ulcers – http://clinical.diabetesjournals.org/content/24/2/91.full
  - ABC of Diabetes – www.bmj.com/content/326/7396/977.full
- There may be an identifiable nidus from which the infection seeds through the blood stream, but 30-70% of patients with vertebral osteomyelitis have no obvious prior infection. Read more on the management of spinal infections at: http://emedicine.medscape.com/article/1266702-overview#aw2aab6b2b1aa
- Medicines used to treat the primary infection can obscure the presentation of symptoms from complications elsewhere, eg, a prolonged course of antibiotics and painkillers used to treat an infected diabetic foot ulcer may temper signs of infection elsewhere, rendering the secondary infection occult.
M had always been a rather sickly child who missed a lot of school through minor illness. Her mother brought her to see the GP frequently with her asthma, eczema and possible food intolerances. Most of the entries in her medical records had remarks about her low weight, small size and generally unhealthy appearance. M’s mother would often request home visits and they were regular users of the surgery.

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

M’s mother became increasingly anxious because she felt her daughter was not improving and “just didn’t seem right”. She started to ring the surgery more often. She spoke to different GPs and reported new symptoms of swollen eyes, severe headache and general weakness. She felt frustrated because she had the impression that the GPs were not listening to her concerns. She stated later that the doctor on the other end of the line would keep saying “aha” or “I see” and seem disinterested in her worries. The GPs asked her to bring M down to the surgery but her mother said she was too ill to leave the house so a home visit was arranged by Dr C. His notes from the visit described M as “looking rather ill, as usual” and the puffy eyes were put down to a flare up of her longstanding eczema. Dr C prescribed some hydrocortisone cream for use around her eyes and advised M to get out of bed and try to get back to normal.

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

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

**LEARNING POINTS**

- Patients who see their doctors with minor ailments all the time may eventually present with a serious complaint. It is important to be mindful of frequent attenders whose serious symptoms can be missed. Extra care should be taken.
- Repeated calls should be a red flag. They should always make doctors stop and think.
- Doctors must always be able to justify any decisions they make and have a low threshold for having a face-to-face consultation.
- Telephone consultations are challenging where it is hard to make a proper assessment of the patient. Effective telephone triage is essential. Listen to a podcast on how to improve your patient triage over the telephone – www.medicalprotection.org.uk/podcasts/Telephone-triage-managing-uncertainty.
Mrs C, a 25-year-old mother of two, had an elective caesarean with her first pregnancy as that baby was breech, and she experienced a failed attempt at a VBAC (Vaginal Birth After Caesarean) with her second pregnancy. Her third pregnancy was uneventful and she was booked in for an elective caesarean section at 39 weeks. Mr A, a staff grade obstetrician, carried out the operation under spinal anaesthetic. The operation was felt to be “routine” and there was minimal scarring from the previous caesareans. After initial observations concluded that everything was normal, the patient and her 3.5kg baby girl were returned to the postnatal ward. Three hours later, Mrs C started to feel unwell and was taken to the delivery suite. On examination, she was noted in the catheter bag and a decision for an immediate laparotomy was made. Mr A found 1.5l of blood within the peritoneal cavity and a tear at the left extremity of the uterine incision, extending into the broad ligament. This was successfully repaired, but Mrs C required a transfusion of three units of blood and stayed in the high dependency unit for 24 hours. Both Mrs C and her baby were discharged home a week later and physically recovered well. However, Mrs C made a complaint against Mr A and his team for poor management of her condition. An internal investigation was begun. Expert opinion on the issue was sought and there was agreement that although this was an unusual complication, it can be caused by the angle at which the baby’s head was delivered, and it should have been recognised and treated at the time of the initial caesarean section. There was also considerable criticism regarding the delay in taking the patient back to theatre and the documentation that had been made in the notes. Following a face-to-face meeting where the case was discussed in detail, the complaint was resolved and no further action ensued.

LEARNING POINTS

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

Although administrative procedures and teaching are important they should not be allowed to interfere with patient care.
Mr A was a 55-year-old newsagent who had smoked 20 cigarettes a day for 30 years. He had been good friends with his GP, Dr B, for years – since they were children playing in the same football team. Mr A had suffered with asthma since childhood. He visited Dr B regularly with exacerbations causing wheeziness and coughing, especially during the winter months. The visits were always kept very informal since they were friends, and Dr B’s medical notes were very brief, with minimal entries regarding Mr A’s presenting complaints or clinical examinations. Entries often comprised only the date and the prescription of inhalers.

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

Mr A’s widow was devastated and made a claim against Dr B. She thought that her husband should have been investigated much earlier for severe breathing difficulties and weight loss. Dr B claimed from memory that Mr A had remained in good health with no breathing difficulties or weight loss till the weeks prior to his death. Dr B’s notes were so minimal it would have been impossible to confirm this. Experts looking into the case reviewed Dr B’s minimal notes but also, fortunately, had the benefit of the hospital notes. The hospital notes confirmed that Mr A’s symptoms of weight loss and severe dyspnoea started after his hospital admission. There was heavy criticism of Dr B for his poor documentation. However, it was also agreed that since Mr A’s tumour was rapidly growing and aggressive, earlier diagnosis would not have improved his prognosis. The case was settled for a low amount.

**LEARNING POINTS**

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

**FURTHER INFORMATION**

- Rourke L, Rourke J, Close friends as patients in rural practice, *Can Fam Physician* (June 1998)
Debating DNAR orders

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

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

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

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

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

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

The guidance goes on to advise doctors to record the reasons why a patient has not been informed about a DNACPR order if the decision is made not to inform the patient. We are pleased to respond to the concerns raised by readers, and welcome all feedback.

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

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

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

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

Randall Morton, professor of otolaryngology – head and neck surgery, University of Auckland, New Zealand
The Wisdom of Whores: Bureaucrats, Brothels and the Business of AIDS
By Elizabeth Pisani
(Granta Books, 2008)
Reviewed by Dr Rebecca Smith
(Granta Books, 2008)

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

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

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

Pisani brings home the lesson that there is no purity in science. Epidemiological facts are distorted by a smokescreen of money, power, politics, religion and the media. It’s unfashionable and unpopular to dedicate money to prostitutes and junkies – it won’t win you votes in elections. This book is dedicated to realism. It is an abrasive and raw account of the battle between science and politics. It is a disturbing read, but a must for any enquiring mind.

If Disney Ran Your Hospital: 9½ Things You Would Do Differently
By Fred Lee (Second River Healthcare Press, 2004)
Reviewed by Dr Mike Baxter, independent medical consultant and former Medical Director at Ashford and St Peter’s Hospitals NHS Foundation Trust

If Disney Ran Your Hospital changed my view of how hospitals should work and the correct avenues to pursue to deliver effective change and improvement. This book also reads very well in the context of current definitions of quality, where outcome, safety and experience are given equal weighting. Whilst outcomes and safety are familiar currencies that we easily understand, experience is less comfortable and much more alien to the medical community.

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

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

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

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

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

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