

Casebook

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MPS



Putting members **first**

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AVOIDING THE RISKS

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Welcome



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

The level of performance a person is capable of attaining is dependent on finding the right balance between tension and support. Nowhere is this truer than in medicine, where high performance is expected and can literally be the difference between life and death.

No tension with no support creates a sense of apathy: excessive support alone can create complacency. Without urgency, determination and drive – why get out of bed in the morning?

On the other hand, high tension without adequate support creates high levels of stress, which we know can compromise performance.

In today's environment, tension is on the rise: most doctors are working in increasingly challenging environments and few experience a proportionate increase in support. But access to support that matches the level of stress in the job is what is needed if we, as doctors, are to maximise our potential and do the best we can for patients.

A year ago we wrote in *Casebook* about the cause and effect of stress in medicine ("The pressure point", *Casebook* 19(3)). The evidence is there to show that being involved in an adverse event, being sued for negligence, or having your professional conduct or competence brought into question is a source of the most severe tension for healthcare professionals. It is also associated with an increased risk of a second or third event. This issue of *Casebook* features many case reports that reflect these stressful situations.

At MPS we understand how important it is that the support we provide matches the tension caused by these events – it is at the core of what we do.

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Providing a global perspective

MPS Medical Director *Dr Priya Singh*
on MPS's landmark conference



This November sees MPS host its two-day international conference on patient safety and risk – the first time we have held such an event for speakers and audiences from around the world.

The conference, Quality and Safety in Healthcare: Making a Difference, focuses on quality, safety culture, professionalism, cost and the patient experience. The latter is particularly pertinent in today's climate as patient expectations continue to rise. There is perhaps no place where this has been more clearly demonstrated than in the increasing frequency, and associated cost, of clinical negligence claims.

Speakers include Dr Lucian Leape, from the Harvard School of Public Health, who many will know and recognise as a leader of the patient safety movement. In particular, Dr Leape has been an outspoken advocate of

the non-punitive systems approach to the prevention of error. We hope the conference will help to identify and share ways in which all in healthcare can be supported in achieving open and effective communication, even in the most challenging and stressful of circumstances in which we frequently practise.

A global perspective on safety and risk in healthcare gives us the best opportunity to pool learning and experience and to accelerate our progress. The first conference will be held in London on 15 and 16 November 2012, and we will look forward to hosting events around the world in the future, so if you have suggestions for conference content do please let us know.

To find out more about Quality and Safety in Healthcare: Making a Difference, and to book your place, visit <http://mpsinternationalconference.org>

MEDICOLEGAL EXPERTS

The determination in *Jones v Kaney* has removed experts' immunity from suit, and public awareness of the medicolegal expert role has grown. These developments have undoubtedly caused a deterioration in the risk profile of doctors who undertake medicolegal work and have prompted MPS to review our UK medicolegal grades.

On 1 August 2012, we removed the separate medicolegal grades and brought subscriptions into line with the rates applicable to doctors practising clinically in our lowest risk group.

Subscriptions are calculated based on income from medicolegal work, with an allowance of up to 25% for expenses, if incurred.

Members involved in medicolegal work in obstetrics, neurosurgery or spinal surgery will be assessed on the next higher grade, reflecting the higher risk. We hope that by adopting this approach we are more accurately reflecting the activity risk, as measured by income.

If you have any queries, please contact the Membership department.

IMPORTANT NEWS – COMPOUNDED LIFE MEMBERSHIP

In September last year, MPS's previous Chief Executive announced a decision by MPS Council to discontinue Compounded Life Membership (CLM), in the interests of fairness to the wider membership.

This is a reminder that CLM will cease on 1 January 2014. Anyone who is a CLM member and still practising on 31 December 2013 will be required to pay the subscription appropriate for their

grade and specialty to receive the benefits of MPS membership after that date.

CLM has been offered to members who have completed 40 years of paying membership, providing a waiver of the annual subscription for those still in practice. The decision to withdraw CLM was taken due to increased longevity and people working longer, therefore placing an unfair burden on paying members.

NEW MPS COUNCIL CHAIR

Kay-Tee Khaw has been appointed the new Chair of the MPS Council. Kay-Tee has served on the Council since June 2011 and has a long and distinguished career. Visit the MPS website and click on "About MPS" for more information.

MANAGING OBESITY

The management of obesity in the private sector has come under increasing scrutiny from the MHRA and GMC, resulting in regulatory action being taken against some doctors. For full details of the guidance, please visit: <http://tinyurl.com/d4sabye>.

OPINION

Getting the best out of online reviews

Dr Neil Bacon, founder of www.iwantgreatcare.org, discusses how to maximise the potential of patient feedback

A friend of mine, a surgical SpR, was breaking bad news to an 80-year-old patient and his elderly wife. A few months earlier the patient had undergone a Whipple's procedure, with all its associated pain, distress and decrease in quality of life. Despite this, the operation had sadly failed to remove the pancreatic cancer. My friend had to tell the patient and his wife that he had only a few months to live. Breaking such awful news made for an emotional and difficult consultation for all involved, and one that is all too common whichever area of medicine we practise in.

But what happened next was anything but usual. The patient's wife leant over and, putting her hand on the surgeon's arm, said: "Thank-you for telling us this awful news in such a kind and considerate way, but we knew you'd be excellent as we'd looked you up on the internet and saw what your patients said about you. We knew we were in the very best hands."

It is now common practice for patients to Google their doctor, whether they are registering with a new GP, being referred to secondary care, or seeing who will be caring for their relatives. At the same time more and more patients and their families are writing internet reviews of their care experience and online assessments of their doctor. It is clear that this is not a passing fad, but rather is here to stay, with healthcare – and all those who work in it – being rated and reviewed as is the norm in other service sectors.

Far from being a bad thing, many doctors have already realised that online reviews of

their care provide a range of powerful benefits for both their patients and themselves: as part of personal development, to meet the needs of revalidation and appraisal, to manage and enhance their professional reputation, and – as the example above shows – to build trust and confidence amongst those they care for.

But how can you ensure that you realise these benefits? How can you make it easy for your patients to provide the quantitative and qualitative feedback that you need? How can you prevent abuse or fraudulent reviews, and how can you know what is being said about your professional reputation on the internet?

Actively manage your online reputation

This is not complicated – many sites will already have a personal profile page for you – all you need to do is activate it and personalise it.

- Upload your picture, add a brief biography and a professional description.
- Ensure the site is secure, robust and has proven systems to prevent abuse or inappropriate comments.
- Encourage all your patients to leave feedback about your care – the most effective way is to give them a small card with the address of your personal profile page. Patients typically like being asked for their opinion and are usually grateful for this simple, easy way to say thank-you for the care they have received.

Ensure you know what is being said about you

Once you have asked your patients to provide feedback, it is important that you know

what is being said. Again this is not complicated – and doesn't require you to monitor numerous websites every week!

If you have chosen a professional organisation to collect the feedback on the care you personally deliver (as opposed to websites that collect general stories about your hospital or GP practice), then there should be the facility to receive an email alert when someone adds a review about you.

This ensures that you are the first to be informed when a new review is added, allows you to respond if necessary, and – with the vast majority of reviews being positive – provides good news in at least one of your daily torrent of emails!

Respond to comments by patients

You'll find that your patients will often leave detailed comments with a number of points in a few paragraphs. In the same way that you wouldn't ignore a letter from a patient, it is important that you can easily respond when you want or need to.

This needs to be simple for you to do, and your response must not breach confidentiality; it should also be fully compliant with GMC guidance – in particular, the GMC's specific guidance on social media use, which will be published in its revised *Good Medical Practice*, due by the end of 2012.

A carefully thought-out response can be a powerful and rapid way to ease a patient's concern, and prevent issues escalating into more formal procedures – saving you and your patient a lot of time and worry.

Make online patient reviews work for you

One of the most useful things about real-time, online patient feedback is that it helps you meet a whole range of professional needs.

Professional development, appraisals, job interviews and revalidation are a few of the instances where rigorous feedback from patients is required. For those doing private practice, online reviews are already proving to be a highly effective way to inform patients making choices about their care, whilst many other doctors just see this as a sensible, modern way to better understand the needs of those they care for, and they like getting regular feedback on their performance as judged by those they treat.

Enjoy it!

The vast majority of online feedback from patients is highly positive about their doctor. Typically, patients will provide detailed descriptions of just how and why their doctor made such a difference to them or their families. Of course, there is only one person who can tell you the experience you give to your patients and help you ensure it is as good as it can possibly be – and that is the patient themselves. Online reviews from your patients make it as easy for you to benefit from the wisdom of your patients, as it is for them to benefit from the wisdom of their physician.

- Dr Stephanie Bown, *Casebook* editor-in-chief, will feature in new educational videos from NHS Choices later this year. Visit www.nhs.uk

Dr Bacon is speaking at MPS's international conference, **Quality and Safety in Healthcare: Making a Difference**, in London on 15 and 16 November

An inconvenient truth

Over half of respondents to an MPS survey admitted to regret over their failure to raise concerns in the workplace. **Gareth Gillespie** looks at how obstacles to whistleblowing can be overcome

In the healthcare profession, raising concerns about colleagues or other workplace issues – ‘blowing the whistle’ – is a vital duty to be carried out if patient safety is to be safeguarded and professionalism maintained. Not optional; a duty – the GMC says “all doctors have a duty to act when they believe patients’ safety is at risk, or that patients’ care or dignity is being compromised”.¹

Potential whistleblowers may feel a sense of disloyalty – that they are landing colleagues in trouble, and ‘breaking rank’. Confidence in whistleblowing procedures – which the updated NHS Constitution says organisations must put in place – varies widely and many individuals have complained of ‘blame and shame’ cultures.



Perhaps unsurprisingly, would-be whistleblowers can also be deterred by fears that they will be ostracised by colleagues, or persecuted by senior management

Perhaps unsurprisingly, would-be whistleblowers can also be deterred by fears that they will be ostracised by colleagues, or persecuted by senior management – their careers clandestinely derailed in an effort to secure their silence and cover up undesirable issues.

For whistleblowers, the risks of encountering problems can be reduced by ensuring established processes and protocols are followed, which includes taking a step-by-step approach to escalating concerns. You should be able to demonstrate that your concerns are legitimate and be sure your response

is proportionate – and it is important to document each step you take in identifying and reporting your concern. Paragraphs 11-15 of the GMC’s *Raising and Acting on Concerns about Patient Safety* provide clear guidance on the correct approach.

In the line of fire

Protection exists in the form of the Public Interest Disclosure Act 1998 (PIDA), which states:

“A worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a protected disclosure.”²

According to the Act, a

“protected disclosure” means any disclosure of information that reveals the following:

- “(a) that a criminal offence has been committed, is being committed or is likely to be committed,
- (b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,
- (c) that a miscarriage of justice has occurred, is occurring or is likely to occur,
- (d) that the health or safety of any individual has been, is being or is likely to be endangered,
- (e) that the environment has been, is being or is likely to be damaged, or
- (f) that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.”³

MPS carried out a survey on whistleblowing in April 2012, asking 20,000 GPs, consultants and non-consultant hospital doctors in the UK for their views and personal experiences. The survey found that only 18% of respondents were aware of, or understood, PIDA. Elsewhere,

67% of respondents agreed that more training on whistleblowing should be offered to staff. Confidence in existing processes was very low, with 11% saying they had faith, while 52% of respondents were not even aware of their organisation’s policy on whistleblowing.

The survey also uncovered signs of inertia when faced with situations that caused concern. Of all respondents, 53% said they had experienced such a situation that they now wish they had done more to address; while 49% said that current whistleblowing processes discouraged efforts because the fear of consequences was too great.

Barriers, either real or imagined, undoubtedly block the path to – and can ultimately discourage – raising concerns. GMC guidance acknowledges this⁴ but stresses that patient safety – and your duty to maintain and protect it – overrides any such fears held about one’s own interests. Likewise, it says that the fear of inaccurately reporting a concern should not be a disincentive, provided it is raised “honestly, on the basis of reasonable belief and through appropriate channels”.⁵

Follow the leader

Strong leadership is essential, especially as it is more likely to be junior doctors who are fearful of the effects whistleblowing may have on their careers. It may be down to organisations to provide sufficiently robust whistleblowing policies and processes, but senior individuals need to provide support and mentorship to junior colleagues. In MPS’s survey, 76% of respondents said that supportive management is the best source of encouragement to raise concerns.

Dr Stephanie Bown, Director of Policy and Communications at MPS, said: “Doctors at

HOW TO REPORT A CONCERN

The GMC's *Raising and Acting on Concerns about Patient Safety* outlines the steps you should take if you have a concern you wish to raise:

"Wherever possible, you should first raise your concern with your manager or an appropriate officer of the organisation you have a contract with or which employs you – such as the consultant in charge of the team, the clinical or medical director or a practice partner. If your concern is about a partner, it may be appropriate to raise it outside the practice – for example, with the medical director or clinical governance lead responsible for your organisation. If you are a doctor in training, it may be appropriate to raise your concerns with a named person in the deanery – for example, the postgraduate dean or director of postgraduate general practice education.

"You must be clear, honest and objective about the reason for your concern. You should acknowledge any personal grievance that may arise from the situation, but focus on the issue of patient safety.

"You should also keep a record of your concern and any steps that you have taken to deal with it."⁶

You can also disclose concerns anonymously, or in confidence, to the Care Quality Commission (CQC) on **03000 616161**.

Independent and confidential advice is available from:

- The Whistleblowing Helpline for NHS and Social Care – **08000 724725**
- The charity, Public Concern at Work – **020 7404 6609**

The starting point must be that executive boards take responsibility for creating a culture in which raising concerns is a normal and integral part of providing healthcare

all stages of their career need to be supported to speak up, but none more so than junior doctors who will be shaping our hospitals and practices of tomorrow. This is why strong and open leadership by example is so important.

"The starting point must be that executive boards take responsibility for creating a culture in which raising concerns is a normal and integral part of providing healthcare. In addition, doctors and other healthcare professionals have to know and understand the right process. They also need to have confidence that their managers will support and enable them to fulfil their professional obligations – and they certainly can't do that if they work in a culture of blame and fear."

The bigger picture

MPS understands the anxieties and obstacles surrounding whistleblowing, and we have been active in seeking to influence organisations to do more

to entrench a culture of openness – across the healthcare profession. In May, we held a seminar to discuss ways of identifying and removing these obstacles, and to improve patient safety – representatives from a range of organisations including the RCGP, NMC, GMC, RCN and BMA were in attendance – and we will continue to engage with policy-makers on taking further action.

Patient safety is the ultimate goal for the healthcare profession, and this must be the deciding factor when facing a whistleblowing dilemma, as painful and difficult as it may be.

Strong leadership goes a long way to breaking down barriers; while leadership begins with executive boards, senior doctors can play their role by looking beyond their clinical specialty and taking responsibility for the wider interests of the patient. It is in leading by example that the necessary culture change can be brought about – and healthcare can begin to see a 'normalising' of the process.

People who have concerns in the workplace should ensure they follow the correct process. If they have any concerns about how to do this, contact MPS, but we would not normally become involved in any dispute surrounding whistleblowing.

REFERENCES

1. GMC, *Raising and Acting on Concerns about Patient Safety* (2012), para 1
2. www.legislation.gov.uk/ukpga/1998/23
3. *Ibid*
4. GMC, *Raising and Acting on Concerns about Patient Safety* (2012), para 9
5. GMC, *Raising and Acting on Concerns about Patient Safety* (2012), para 10c
6. GMC, *Raising and Acting on Concerns about Patient Safety* (2012), paras 13-15

Fairness to all: A look at Membership Governance

Many members of MPS will have very few medicolegal cases in the course of their career. But what happens to those who need assistance rather more frequently? **Sarah Whitehouse** finds out more

If you are a member who has had few, if any, cases in the past, you might look at your subscriptions increasing and find yourself asking: “Am I subsidising colleagues who need MPS’s services disproportionately?” Such a reaction is understandable.

Why do some doctors experience more claims than others?

There can be many reasons why doctors have a higher-than-average number of cases. Some doctors face additional problems largely because of where they practise, the patients they treat, or the specialty in which they work. Some doctors go through periods in their career where additional pressures are created by health problems, social or domestic upheavals, financial difficulties or other factors. Others, however, do need help to improve poor practice.

As a mutual organisation, our first instinct is to help and support members through such difficult times. We all appreciate how stressful it is to have even a single complaint and for those who are experiencing a lot of problems, we find that the impact on them is greater than just in their professional lives.

However, it makes little sense to wait until something bad happens and needs to be paid for – and more sense to invest in the prevention of problems

in the first place. As a responsible organisation, with a duty not only to an individual member but also the membership as a whole, we must be responsible in using the subscriptions paid by members. For this reason, MPS has developed educational programmes based on more than 100 years’ experience in this field, aimed both at helping all members and at providing that extra help that a small proportion of members will need.

Helping those in need

As part of our service, our medicolegal staff review every case and we aim to provide guidance to members if lessons can be learned from what has happened. If there are a number of repeat cases with a similar theme, we may recommend specific types of learning or training courses, which we believe will be of assistance to members in avoiding problems in the future.

In addition, there are a very small number of members who we invite to enter our Membership Governance Programme. These are members who have a significant adverse risk profile particularly in relation to claims. We aim to work with them to try to reduce the likelihood of future claims or complaints arising. Depending on an assessment of their individual needs, we may require compulsory attendance on

an intensive course, or we may place some restrictions on their benefits of membership in order that they can remain in MPS membership. Those in Membership Governance also pay an enhanced subscription, reviewed annually as part of continuing risk assessment. We believe that as these members are more likely to be at greater risk of future claims, they should contribute more to the mutual fund.

Through working with individuals on the Membership Governance Programme, we can try to mitigate risk for the whole of our membership. Those who refuse to accept the help offered will not be able to remain members of MPS. We expect that individual members experiencing difficulties should be prepared to take reasonable steps to work with MPS to help themselves. As in all walks of life, there will be a very small number of members who cannot, or will not, change their risk profile and in such circumstances may be unable to continue in MPS membership.

The overall aim of Membership Governance is to help the individual member suffering more problems than their colleagues, and to protect the assets of the mutual fund for which MPS is a custodian, so that members are not subsidising colleagues who need MPS’s services disproportionately.



We expect that individual members experiencing difficulties should be prepared to take reasonable steps to work with MPS to help themselves

EDUCATION AND RISK MANAGEMENT WORKSHOPS

Whilst MPS Educational Services offers help for those who have had a high level of claims and complaints, we also offer communication and interpersonal skills workshops for all members – helping you avoid problems before they arise.

Designed and facilitated by medical professionals, the Mastering workshop series is highly-interactive, with group discussions and activities, and is offered free of charge as a benefit of membership. It has proven to be popular with members.

Topics include: Mastering your Risk, Mastering Adverse Outcomes, Mastering Professional Interactions, Mastering Difficult Interactions with Patients and, new for 2012, Mastering Shared Decision Making.

For more information about dates, locations, and to book your place, visit:

www.medicalprotection.org

EDUCATION AS A HELPING HAND

An example of the type of course which a member may be asked to attend as part of the Membership Governance Programme is the three-day Clinical Communication Programme (CCP) workshop created by MPS Educational Services. The workshop focuses on improving communication skills and is followed-up with a six-month period of educational support.

Members who have attended the CCP have been encouragingly positive about the value of its content. Dr A said: “It made a real impression on me and made me aware of my shortcomings,” and surgeon Dr M said: “The CCP was very helpful; it points out the difference between real and perceived communication skills.” Other members revealed that the changes they have been able to implement in their communication with patients since attending the programme included moves to: “listen more”, “discuss various treatment options”, and “repeat, summarise, and question the patient to help with decision-making”.

Often, there may be a degree of anxiety, even resistance, amongst some members about being entered into the Membership Governance Programme. However, the intention of the programme is to work with members to mitigate potential future risk. Every member who is experiencing problems is encouraged to call and speak to our team about their cases and about any

special circumstances which may have given rise to them.

When providing feedback, one member was very honest about their initial – negative – response to the programme, which makes their eventual appreciation all the more positive: “I am sure I had the typical response and resistance to the programme. It is without doubt one of the most invaluable courses I have done that has probably had more impact on my practice than any other. In hindsight (the best sight), I am grateful for being awarded the opportunity to do the CCP.” The impact of the CCP is improved communications, a better identification of high-risk areas in clinical practice and, most importantly, an improved doctor–patient relationship.

GPs or others with an increased risk profile may be recommended to undergo a Member Risk Assessment, provided by MPS Educational Services. Here, the purpose is to assist in identifying existing and potential risks in their medical practice and throughout the surgery as a whole, and to make recommendations for change in line with national guidance and good practice. Following a recent Member Risk Assessment, where the test results system was found to be unsafe, recommendations were made, and the member wrote to inform MPS that their practice now had a computerised “tracking system” to ensure that patients do not get lost in the system and there is adequate follow-up.

For more detailed information on how the Membership Governance Programme works, see the article “Introducing Membership Governance” in *Casebook* (Vol 19 no 1 – January 2011): www.medicalprotection.org/uk/casebook-january-2011/introducing-membership-governance



Nasogastric tube errors

Nasogastric tubes are widely used in the world's hospitals, yet in spite of fierce campaigning to expose the dangers, patients are still dying from the complications of wrongful insertion. **Sara Williams** and MPS medicolegal adviser **Dr Gordon McDavid** explore how to avoid these risks

In 2010 75-year-old Maurice Murphy died in hospital as a result of a misplaced nasogastric tube. He was being treated for liver failure and required a nasogastric (NG) tube to be inserted. Unfortunately this ended up in his right lung instead of his stomach and feeding commenced, resulting in fatal pneumonia.

At the inquest it emerged that a junior doctor was challenged by a nurse to confirm that the tube was in the right place. The doctor in question overruled her, saying: "You don't have a brain to remember that I told you to start the feed as the tube is in the right position." It also emerged that there was an x-ray flagging the error.¹ So why hadn't anyone seen it?

It would appear that a combination of factors led to the death of Mr Murphy – the misplaced confidence of the junior doctor, the fact the standardised procedure for inserting a tube was not followed, and that the x-ray was not reviewed.

inadvertently caused a pneumothorax using an NG tube while working in a busy teaching hospital. "I was bleeped just before my shift ended and asked to check the position of an NG tube my consultant had inserted into a female patient who was nil by mouth due to an unsafe swallow post-stroke. The CXR showed that the tube was in the left bronchus.

"Unfortunately, I had to free the tube from the bridle it had been attached to before removing it. To reinsert the tube I couldn't use the standard technique of having the patient swallow and so went blindly. The first time it coiled in her mouth, the second time it inserted smoothly without any resistance. As we were unable to aspirate any contents she went for a further chest x-ray to confirm the position.

"I came in after the weekend to find that I had unwittingly caused a pneumothorax and still have no idea how. Fortunately the patient received no lasting damage."

RISKS OF NASOGASTRIC TUBES

The 'whoosh' or 'blow' test

The UK's National Patient Safety Agency (NPSA) issued guidance in 2005 highlighting the unreliability of certain tests to detect the placement of NG tubes, such as the 'whoosh' test (listening for bubbling sounds after blowing air through the NG tube with a syringe) and pH testing by non-quantitative, coloured litmus paper.² The NPSA recommend pH testing using pH indicator paper as a first-line check – pH levels between 1 and 5.5 are safe.

Misinterpretation of x-rays

Between 2005 and March 2011 the NPSA was notified of 21 deaths and 79 cases of harm due to misplaced NG tubes. The single greatest cause of harm was due to misinterpretation of x-rays, accounting for about half of all incidents and deaths. A chest x-ray is required if the first-line check fails to prove the NG tube is safe for use.

Flushing nasogastric tubes

The NPSA recently highlighted the deaths of two patients, where staff had flushed NG tubes with water before the initial placement. The mix of water and



Many practitioners may not have considered the real potential for harm that these innocent-looking plastic tubes may present, particularly if they are misplaced in the patient's oesophagus or, worse, a bronchus

NG tubes are commonly used across the world to treat stroke patients with dysphagia or those on ventilators, and are generally accepted as being safe pieces of equipment. They are used in the short to medium term (six weeks); longer term feeding usually requires insertion of gastrostomy or jejunostomy tubes (PEG or PEJ). Although feeding by NG tubes is not routinely captured in activity data, in the UK alone around 170,000 tubes are supplied to the NHS each year.

Many practitioners may not have considered the real potential for harm that these innocent-looking plastic tubes may present, particularly if they are misplaced in the patient's oesophagus or, worse, a bronchus. If not detected before feeding, patients can suffer complications like pneumonia, which can be fatal.

Junior cardiology trainee doctor Dr Owen Bebb

CASE REPORT

Think before you sleep



Between 2005 and March 2011 the NPSA was notified of 21 deaths and 79 cases of harm due to misplaced NG tubes

lubricant gave a pH reading below 5.5, so practitioners assumed that the NG tubes were correctly placed, when they were not.³

Recurring problems

According to Sir Liam Donaldson, Patient Safety Envoy for the World Health Organisation, recent findings indicate that NPSA guidance is not being heeded, such as feeding despite obtaining nasogastric aspirates with pH between 6 and 8, instilling water down the tube before obtaining an aspirate, not checking tube placement or not recording written confirmation of such checks.

Sir Liam said: “An NPSA audit suggested great variation among 166 junior doctors at five pilot hospital sites in England and Wales, with low awareness of harm and continued use of checks, such as the ‘whoosh test’ or blue litmus paper, as bad practice. Fewer than a quarter were aware of existing guidance and less than a third of the junior staff had received formal training on x-ray interpretation.

“Because of the preventable nature of this harm, last year misplaced nasogastric tubes were confirmed by the Department of Health in England as a ‘never event’, one of a restricted list of serious avoidable events that could incur financial penalties for providers.”⁴

England and Wales are not alone; other countries such as Malaysia routinely use the ‘whoosh test’ to detect the placement of NG tubes. »

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Mr S was a 70-year-old librarian who had a long history of recurrent colitis due to Crohn’s disease. Despite maximal medical treatment, he experienced recurring symptoms of severe abdominal pain and rectal bleeding, so was admitted to hospital. Following a period of parenteral steroid therapy, Mr S’s bleeding continued and he required an exploratory laparotomy. Prior to surgery a barium enema revealed a discrete area of abnormal bowel, which was felt to be responsible for his symptoms. It was hoped that the inflamed section of bowel could be surgically resected. Mr S underwent a pre-op assessment by senior anaesthetic trainee, Dr P. He was noted to have a history of angina and COPD, but these chronic conditions were stable.

On the day of surgery, the operation took place without complication and Dr P inserted a NG tube. As Mr S was intubated, Dr P used a laryngoscope and Magill’s forceps to insert the NG tube. Dr P had performed this procedure many times before and felt confident to do it independently. During the insertion, Dr P found it difficult to visualise the proximal end of the oesophagus, but based on the smooth insertion assumed the NG tube was in place.

On arrival in ICU, Dr P still needed to confirm the position of the NG tube. Unable to aspirate fluid, he wanted to auscultate the stomach while instilling air through the NG tube (the ‘whoosh’ or ‘blow’ test) – this was in line with the local protocols at the time. As Mr S had had a laparotomy, Dr P was unable to access the epigastrium to carry out this manoeuvre due to a large wound pad covering the area.

Dr P decided to arrange a chest x-ray. Due to a backlog in the radiology department, the x-ray was not carried out before the end of Dr P’s shift. Dr P handed over the task of reviewing the film to the nightshift trainee, Dr A. Unfortunately, Dr P failed to inform Dr A that the x-ray was to check the position of the NG tube. Dr P had not documented the NG tube insertion.

Following the handover, Dr A noticed a leak from Mr S’s endotracheal tube and injected approximately 1ml of air into the tube’s cuff. Dr A was called away to an emergency, but instructed

one of the nurses to observe Mr S. The results of Mr S’s chest x-ray arrived, but Dr A was very busy. She glanced at the x-ray, verbally informing the nurses that it “looked ok”, referring to the ET position as “satisfactory” and the lungs looking “grossly normal”. She did not document this in the notes.

Unfortunately, Mr S had to return to theatre for an anastomotic leak repair and subsequently required prolonged intubation, blood transfusions, IV fluids and inotropic support after the second surgery. With treatment Mr S’s haemodynamic parameters stabilised although he began to develop renal failure. Consultant anaesthetist Dr W took the decision to begin feeding. During this time, the original NG tube remained in-situ and no-one realised the initial chest x-ray had not been formally reviewed.

About 12 hours later, Mr S’s nurse aspirated feed-like material from his ET tube and feeding was immediately stopped. Dr A was asked to review the patient. Radiology then phoned to advise that the chest x-ray taken before the weekend showed the NG tube was positioned incorrectly. Despite aggressive treatment for aspiration pneumonia, unfortunately Mr S died two days later.

The outcome

The postmortem outlined the cause of death as aspiration pneumonia due to a misplaced nasogastric tube in right main bronchus, left hemicolectomy for intestinal haemorrhage, ischemic heart disease and chronic obstructive airways disease. Dr P and the nurses involved were interviewed by the police under caution, but following an investigation it was agreed that the level of care, although suboptimal, did not meet the necessary criteria for a criminal offence.

Two years later, the practitioners involved were called to an inquest and MPS arranged legal representation for Dr P. Dr P accepted that it was his omission not to have specifically recorded the NG insertion in the notes. The coroner took no further action, as she was satisfied that preventative systems had been implemented by the hospital. Mr S’s wife subsequently launched a claim against the hospital, which was settled for a moderate sum.



MPS strongly advocates mandatory documentation of the method by which the NG tube's position is confirmed

AVOIDING THE RISKS

Individual clinicians should consider the following:

- **Is nasogastric feeding right for this patient?** – Seek specialist advice if the patient has a high risk of aspiration or any deviation to normal anatomy, such as pharyngeal pouch, strictures or facial trauma, in which cases fluoroscopic guidance can often be used. The decision to feed should be agreed by two competent professionals and recorded.
- **Does this need to be done now?** – Risks are greater during the night.
- **Am I competent to do this?** – Ensure you have had training in safe insertion and checking, including interpretation of x-rays.
- **How can I check the right amount of tube has been inserted?** – Use “NEX” measurement (by placing exit port of tube at tip of Nose, stretching to Earlobe and then down to Xiphisternum) to guide insertion. The tube length should be confirmed and recorded before each feed to check it has not moved.
- **Do I know how to test for correct placement?** – Do not flush tubes or start feeding until you can confirm by testing with quantitative pH indicator paper.
- **What is a safe pH level?** – Obtain a nasogastric aspirate (pH levels between 1 and 5.5 are safe). Double-check with another person if you are unsure. Always record the result and the decision to start feeding.
- **When should I get an x-ray?** – If no aspirate can be obtained or the pH reading is above 5.5, request an x-ray specifying the purpose so the radiographer knows the tip of the NG tube should be visible.
- **What should I look for on the x-ray?** – That the tube is in the correct position (see guide in Figure 1).
- **What about repeat checks?** – Tubes can be dislodged so they should be checked every time they are used, by aspirating and confirming a low pH, and only x-raying if this is not the case.

Organisations and managers can make systems safer by:

- identifying a clinical lead to implement actions
- reviewing existing policies and training and competency frameworks (eg, ensure a doctor with sufficient seniority is responsible for signing off the use of NG tubes)
- ensuring stock of correct equipment (approved pH indicator paper and radio-opaque tubes with clear length markings)
- restricting procedures done out-of-hours.

MPS strongly advocates mandatory documentation of the method by which the NG tube's position is confirmed. Documenting confirmation of correct placement should safeguard against accidental and potentially catastrophic use of NG tubes.

New developments

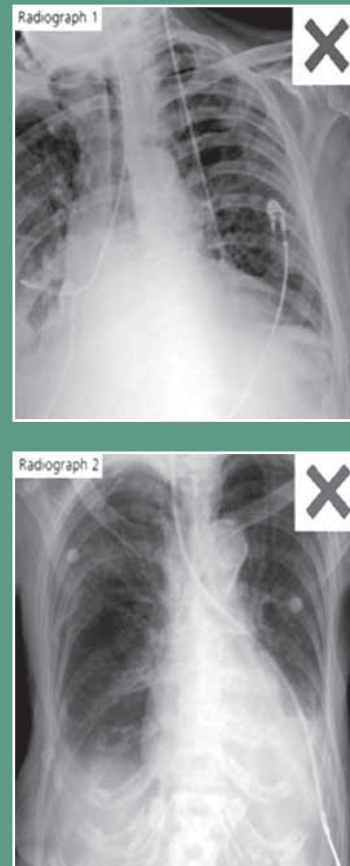
Further clinical research is needed in this area, but small studies have suggested that magnet-tracking devices, where a magnet is inserted into the tube tip, may hold promise for the future.⁵ In the meantime, no existing bedside methods are completely reliable in testing the position of NTs, so being mindful of the complications will mitigate the dangers.

Thanks to Sir Liam Donaldson and Dr Sukhmeet Panesar from the NPSA for their help with this feature.

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5. Bercik P, Schlageter V, Maruo M, Rawlinson J, Kucera P, Armstrong D, Non-invasive Verification of Nasogastric Tube Placement Using a Magnet-Tracking System, *JPEN J Parenter Enteral Nutr* (2005, 29(4):305-10)

FIGURE 1



Radiograph 1 shows the tip of an NG tube above the diaphragm and on the right-hand side of the thorax. The presence of ECG leads makes the interpretation of the radiograph more difficult.

Radiograph 2 shows the tip of the nasogastric tube apparently below the left hemidiaphragm, but the tube clearly follows the contours of the left bronchus. In fact, the tube is positioned in the left lower lobe of the lung.

Suggested questions to ask yourself when interpreting an x-ray.

1. Can you see the tube?
2. Does the tube path follow the oesophagus?
3. Can you see the tube bisect the carina?
4. Can you see the tube cross the diaphragm in the midline?
5. Does the tube then deviate immediately to the left?
6. Can you see the tip of the tube clearly below the left hemi-diaphragm?
7. Does the length of tube inserted suggest it should be in the stomach?
8. Does the x-ray cover enough of the area below the diaphragm to see the tube clearly or does it need to be repeated? Note that if the image is not clear, you can manipulate the PACS windows to improve contrast and visualisation.

On the case

Dr Alison Metcalfe, Head of Medical Services, introduces this issue's round-up of case reports.



CASE REPORTS

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

the parents were fully aware of the potential for neurological damage. "A frozen shoulder" rounds off this issue's case reports on page 23, showing how adverse outcomes are not always necessarily negligent.

"Skipping over the details", on page 14, carries a warning about the dangers of falling foul of the 'HALT' mnemonic – Hungry, Angry, Late, Tired. Dr G was reported by his patient, and the patient's wife, to be tired and dismissive during his consultation, and it appears that this may have played a part in Dr G failing to fully engage with his patient, Mr K, and his presentation, and falsely reassuring him. He also failed to keep an adequate note of the consultation, leaving little opportunity to resolve the factual dispute.

Poor testing and investigations were the cause of a delayed diagnosis in "Squash and a squeeze", on page 18. The failure by GP Dr V to carry out a squeeze test on the patient's calf was considered to have led to a delay in diagnosis of an Achilles tendon rupture – a diagnosis that was only made following referral to an orthopaedic consultant. In "Missed ectopic pregnancy", on page 21, an ectopic pregnancy was missed after a junior doctor in the emergency department, Dr Y, failed to request pregnancy tests on two occasions. Dr Y also failed to seek assistance

from the on-call gynaecology team, despite the patient presenting with abdominal pains having undergone a recent termination of pregnancy.

Amid the steady stream of costly settlements in *Casebook*, it can be easy to forget the instances where we successfully defend our members from claims of negligence. Discovering where the doctor went right is often as valuable a learning tool as discovering where the doctor went wrong, and in "A pain in the leg" on page 16, we demonstrate the value of good record-keeping. Dr C's failure to diagnose DVT was defended by her excellent clinical records, which revealed that she had done everything she could possibly have done.

Similarly, in "A complication, not negligence" on page 20, record-keeping again allowed us to defend our member from a claim. The allegation of bad management following the unfortunate neurological complication suffered by Baby R was refuted by comprehensive clinical notes, which clearly described the level of observation of Baby R post-surgery. The consent process was also well-documented, which showed

CASE REPORT INDEX

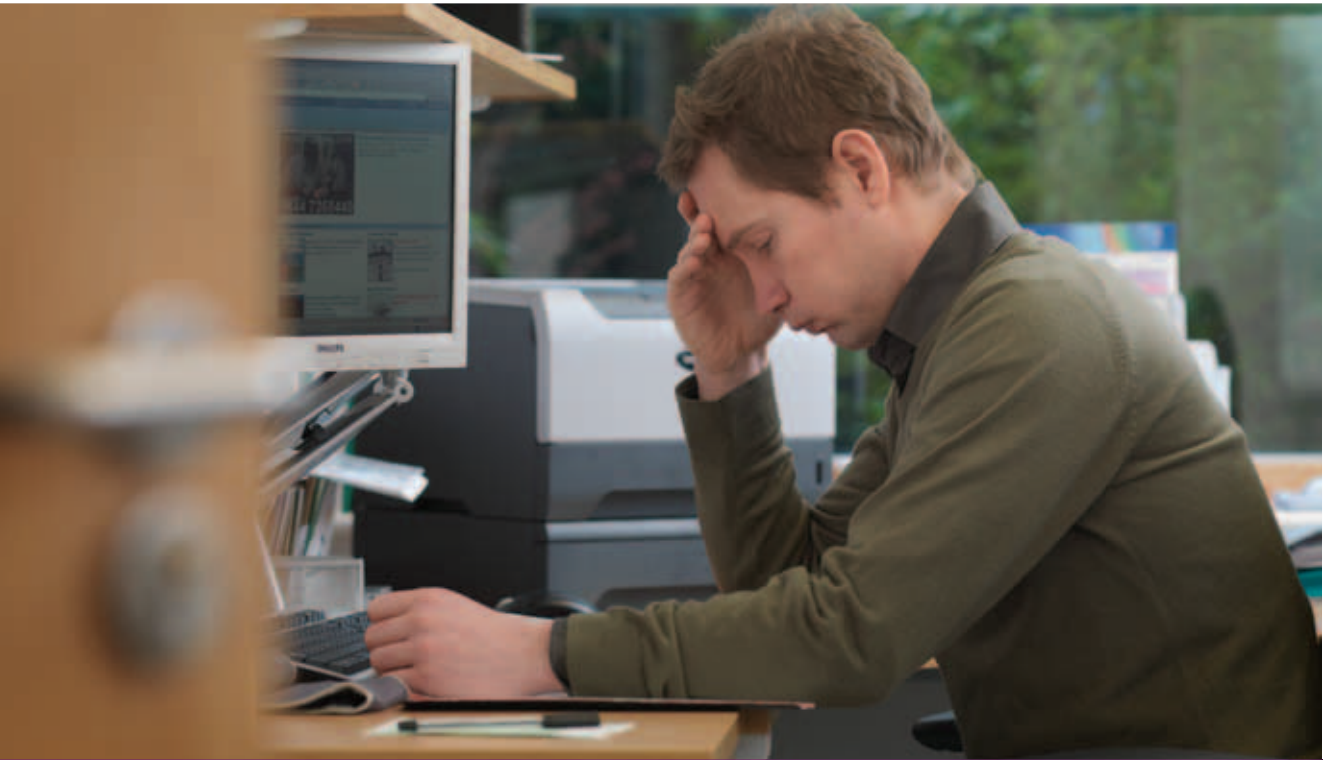
PAGE	TITLE	SPECIALTY	SUBJECT AREA
14	Skipping over the details	GENERAL PRACTICE	INVESTIGATIONS/DIAGNOSIS
15	A question of consent	GENERAL SURGERY	CONSENT
16	A pain in the leg	GENERAL PRACTICE	SUCCESSFUL DEFENCE
17	Slipping through the cracks	GENERAL PRACTICE	SYSTEM ERRORS
18	Squash and a squeeze	GENERAL PRACTICE	INVESTIGATIONS/DIAGNOSIS
19	An error that did not cause harm	GENERAL PRACTICE	SUCCESSFUL DEFENCE
20	A complication, not negligence	NEUROSURGERY	SUCCESSFUL DEFENCE
21	Missed ectopic pregnancy	GYNAECOLOGY/EMERGENCY MEDICINE	INVESTIGATIONS
22	Keeping watch	PSYCHIATRY	SYSTEM ERRORS
23	A frozen shoulder	ORTHOPAEDICS	SUCCESSFUL DEFENCE

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





Skipping over the details

One night Mr K, a 37-year-old bricklayer, felt a lump in his testicle. Worried, he decided to attend the emergency surgery on Saturday with his wife to have it checked.

When Mr K arrived at the surgery, he was seen by Dr G as his last patient. The consultation was short, only lasting a few minutes. Dr G

examined Mr K briefly and reported his finding to them as “just a little gristle that will go away with time”. He did not give any particular advice. He added that there was “nothing to worry about” and he wrote in his medical notes “testicular examination: NAD”. Dr G appeared disgruntled that Mr K had used the emergency appointment for a routine check-up. Mr and

Mrs K later reported that Dr G had appeared dismissive and tired throughout the brief consultation.

One year later, Mr K attended his GP surgery with a painless hard lump in his neck. Further investigations and referrals led to Mr K being diagnosed with a testicular choriocarcinoma. Despite treatment Mr K died two years after the diagnosis.

A claim was made against Dr G regarding his management of Mr K. The experts agreed that earlier diagnosis would have improved Mr K’s prospects and they were very critical that Dr G didn’t advise on any further follow-up or investigations; the case was therefore settled for a substantial sum.

EL

LEARNING POINTS

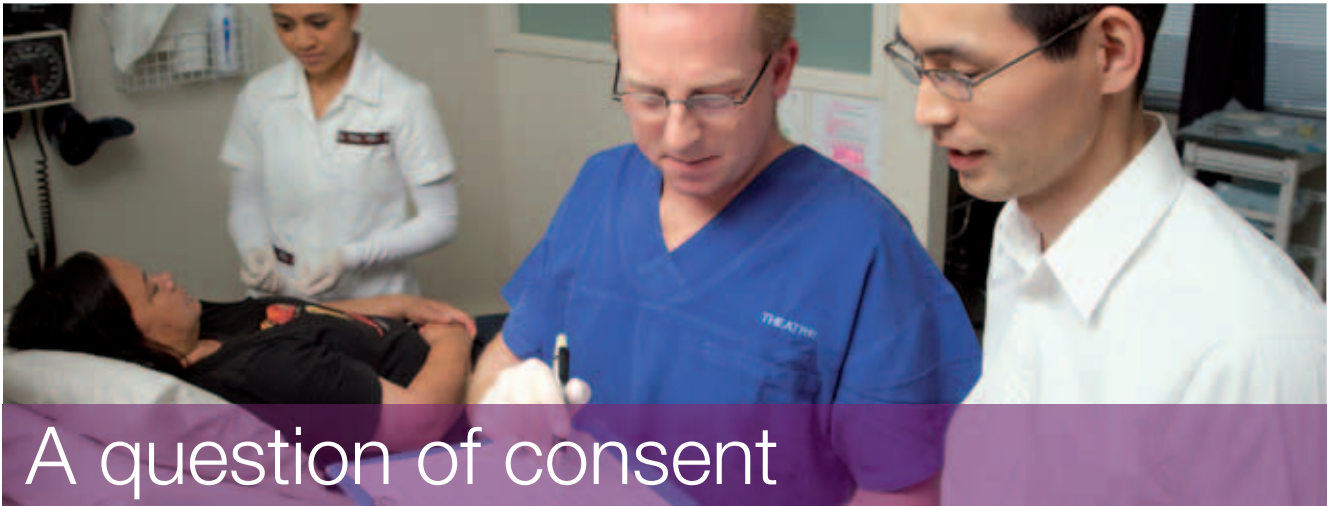
- Unplanned appointments are inherently high risk, so writing good notes is even more important in this setting. On this occasion the records did not help resolve the factual dispute in the case. The medical notes should always reflect the clinical findings. If there was a palpable lump described as “gristle” to the patient, the clinical notes should have made a mention of it.
- MPS has considerable experience of claims that have arisen from factual disputes between patients and doctors. This case emphasises the importance of making as full a note as you can, particularly if you cannot find what the patient is reporting.
- In this case the patient presented as an emergency, which would have

been taken into account in assessing the honesty of his assertion that he was acutely worried.

- It has been recognised that delay in presentation is an important factor in men with tumours. Even if the clinical findings are clear then men should be given advice, which is documented in the notes, to seek attention again if they have any concerns.
- Always be mindful of how human factors can affect your performance. Remember the HALT mnemonic (Hungry, Angry, Late, Tired); where possible anticipate these and take action to mitigate their impact. Where they are unexpected then be prepared to seek the opinion of your colleagues or bring patients back at the earliest opportunity

to fully address their needs.

- Most patients present with a painless, solid, unilateral mass in the scrotum or an enlarged testicle. However, it is worth being aware that there can, rarely, be a decrease in testicular size. Around one in five men with tumours will have pain at presentation. The SIGN guidance *Management of Adult Testicular Germ Tumours* provides advice on the diagnosis and presentation of testicular tumours – www.sign.ac.uk/pdf/sign124.pdf. The guidelines recommend that anyone with a lump or doubtful epididymo-orchitis or orchitis not resolving within two to three weeks should be referred urgently for urological assessment.



A question of consent

A 45-year-old woman, Ms B, suffered from severe heartburn and was referred to consultant general surgeon Mr X. He undertook an upper gastrointestinal endoscopy, which demonstrated erosive oesophagitis above a large sliding hiatus hernia. Ms B's symptoms were not controlled with maximal medical therapy and therefore Mr X recommended anti-reflux surgery. He subsequently performed a laparoscopic fundoplication, but Ms B continued to have significant reflux symptoms and was unhappy with the results of her operation. At two years after the initial surgery, Ms B was desperate for further intervention but had now started smoking and had put weight on to the point that her BMI > 40.

A further consultation with Mr X resulted in a repeat endoscopy, a barium swallow, oesophageal manometry and 24-hour pH monitoring. These investigations demonstrated a recurrent hiatus hernia with a breakdown in the fundoplication resulting in marked recurrent gastro-oesophageal reflux disease. Ms B agreed to a further revision laparoscopic fundoplication but Mr X was unable to complete the procedure laparoscopically due to the presence of multiple adhesions. Mr X decided against an immediate conversion to open surgery as he had

not discussed this with the patient or documented it on her consent form.

Three days later, after further discussion with Ms B and completion of a more detailed consent form, Mr X performed a laparotomy and a difficult revision anti-reflux operation requiring partial resection of the gastric fundus. Ms B developed a severe abdominal wound infection and experienced a stormy and prolonged postoperative recovery. There then followed several readmissions, culminating

in a major plastic surgical procedure to reconstruct her abdominal wall.

Ms B made a claim against Mr X, alleging negligence in the management of her case.

Expert opinion was obtained and there was agreement that the indication for revision anti-reflux surgery and preoperative work-up had been satisfactory. However, the process of consent was criticised in several areas. The failure to warn Ms B of the possibility of an open conversion was felt to be a significant

failure, causing a three-day delay and requiring another operation and anaesthetic. There was also no evidence of any preoperative discussion regarding the risks of infection or gastric resection, even before the second procedure. It was additionally felt that Mr X should have given more consideration to Ms B's high BMI and smoking habits as potentially reversible risk factors for postoperative complications. The case was settled for a moderate amount.

SD

LEARNING POINTS

- The process of consent for any operation should be a detailed conversation between clinician and patient with documented evidence. The incidence and potential impact of any common and potentially serious complications should always be discussed and documented.
- Patients should be made aware of any aspect of their health or lifestyle that may adversely affect the outcome of an operation, particularly where action could be taken to optimise such conditions before surgery. In this case, preoperative weight loss and smoking cessation may have averted or lessened the extent of the subsequent complications.
- Postoperative infection is not necessarily a sign of negligence or substandard care. In this case, although some responsibility for the infection could be attributed to the patient's body habitus and smoking, it was the failure by the surgeon to specifically warn Ms B of this risk that may have constituted substandard care in the quality of consent taken.
- Any laparoscopic operation, no matter how minor, may not go to plan, necessitating an open conversion. Patients should always be made aware of this with any consent form clearly reflecting the discussion.
- Consent for procedures should be a personalised discussion so that the information given to patients includes not only the general and procedure-specific risks, but is also tailored to the specific values held by the individual patient. With revision anti-reflux surgery, adhesions and scarring from the original surgery may increase the risk of damage to organs such as the liver, spleen or stomach (as in this case) with a variety of clinical consequences, including resection. Mr X should have warned Ms B about this.
- Detailed information regarding MPS and GMC guidance for consent can be found on these websites:
 - www.medicalprotection.org/uk/education-and-events/Mastering-shared-decision-making
 - www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_contents.asp



A pain in the leg

Miss Y was a 36-year-old housewife with three children. She presented at her GP surgery with spontaneous pain in the leg, which was associated with a cramping sensation and pins and needles in her left foot.

Miss Y saw her GP Dr C, and upon entering the consultation room raised the possibility of DVT, as she had been recently reading about DVTs in the news and her symptoms appeared similar. Dr C took a careful history and, with Miss Y's suggestion in her mind, concentrated particularly on the possibility of a DVT. She asked if there was any swelling of the legs, shortness of breath, chest pain or haemoptysis. Miss Y had confirmed that she had none of these symptoms.

She asked if there was any personal or family history of thromboembolism, which there was not. She also asked about smoking history and Miss Y had stated that she had never smoked. Dr C also examined Miss Y thoroughly. She had found her pulse to be 70 beats per minute and her respiratory rate to be 12 breaths per minute. She noted that Miss Y's chest was "clear to auscultation". She had measured calf circumferences and found them to be equal. She had also documented that she could palpate normal pulses in both her legs and feet. Dr C could not find anything wrong but had written that she had told Miss Y to reattend if she developed any swelling in the legs, shortness of breath, chest pain or haemoptysis.

Ten days later, Miss Y collapsed suddenly and was found dead at home. The postmortem found the cause of death to be a pulmonary embolus secondary to a DVT. Her family were devastated and brought a claim against Dr C because of failure to diagnose.

Dr C could not remember the case but her note-

keeping was excellent. She had documented a thorough history, a full examination and sensible safety-netting advice. Despite the fact that she did not make a diagnosis of the DVT, the case was found to be defensible because Dr C had done everything she could and should have done.

The case was successfully defended.

AF

LEARNING POINTS

- Good note-keeping is not only good practice,¹ but it will make a possible defence much easier if needed.
- A DVT can be difficult to diagnose clinically and GPs should have a low threshold for referring patients for ultrasound scanning to either confirm or refute the diagnosis. Recent (June 2012) NICE guidance on managing venous thromboembolic diseases can be found here: <http://guidance.nice.org.uk/CG144>.

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Slipping through the cracks

Mr F, a 45-year-old executive manager in a major sales company, saw his GP, Dr D, for a cold. The GP noted from the records that Mr F had attended the Emergency Department three times prior to this for minor ailments. His blood pressure that day was 150/90mmHg and his BMI was 36. Dr D arranged a cholesterol test, gave some lifestyle advice and asked him to reattend to recheck his blood pressure. Mr F did not attend the follow up appointment with the healthcare assistant for a blood pressure check.

Six months later, Mr F attended surgery again and was seen by a different doctor in the same practice. Looking at the notes, the patient had attended multiple walk-in centres and received treatment for minor ailments six times since his last attendance at the practice. His cholesterol was significantly raised on the blood test taken six months ago and it appeared a note had been sent to the patient to come in to discuss the result.

When asked about this, Mr F explained that he had received the note but that he

had had the same test done at his in-house occupational health department, with whom he had discussed the result, and that he had been also seeing them for minor ailments. Once again, Mr F's BP was raised but was significantly higher than before and the GP was concerned, despite Mr F's protests that it was likely because he was a "bit stressed". The GP and Mr F discussed the best management option and the GP decided to refer Mr F to cardiology based on this high reading, and started

Mr F on an antihypertensive. Mr F failed to attend the outpatient appointment.

Two months later, Mr F had an episode of indigestion. At the consultation with his occupational health doctor, when asked whether he was on any medication, Mr F said he was taking none. He was given antacids. However, he continued to have pain for three days on and off. He then suffered a cardiac arrest and unfortunately could not be resuscitated. The postmortem showed myocardial infarction.

Looking back over his

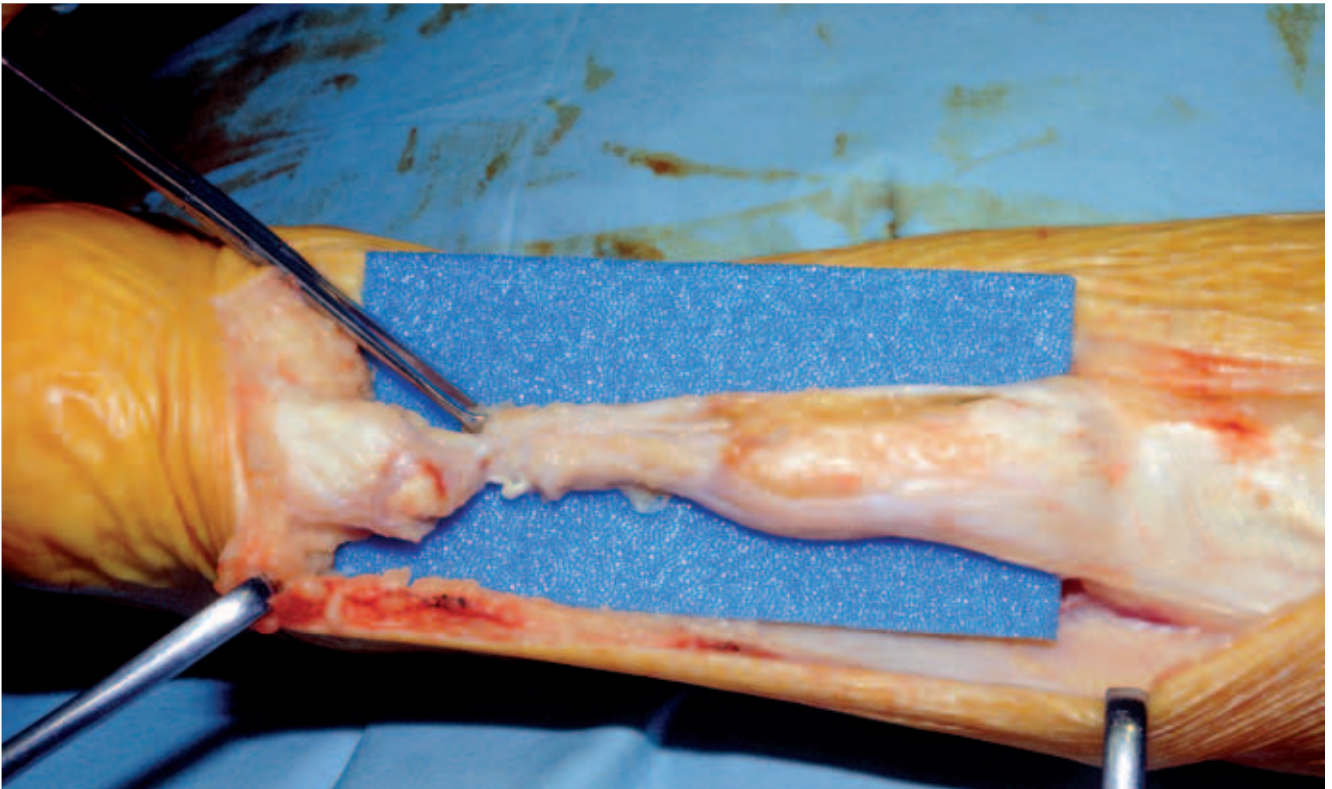
notes, there had been repeated blood pressures recorded in his notes from various appointments at the practice, the occupational health department, emergency and out of hours services, and readings had been steadily increasing, without the instigation of a proper management plan and with inadequate follow up.

A claim was made against all doctors involved. The case was settled for a substantial sum reflecting Mr F's age and the fact he was a high earner.

MR

LEARNING POINTS

- When patients use multiple health systems for care, there is a risk of concern for their symptoms being diluted by spreading the consultations across a number of healthcare providers. This can be a particular problem with people with demanding jobs, and where employers provide a work-based health service. It is important to work together and communicate with colleagues. The occupational health service should inform the patient's GP, with the patient's consent, and it should be clear who will be following up – usually the GP.
- When patients attend the ED multiple times for minor ailments, it may be worth addressing this in the consultation and explaining alternatives, to avoid a lack of continuity of care.
- Any advice given to non-compliant patients should include the risks of failing to take medication or attend appointments, and should be documented.
- Arranging follow-up for any appointments missed or medication started makes practice safer. In this particular case, the patient missed an outpatient appointment and a GP appointment and was not followed up for either non-attendance to find out what happened.
- With poorly compliant patients, or those who are difficult to track, it is important to take advantage of opportunistic follow-up, and perform routine checks, such as blood pressure.



Squash and a squeeze

Forty-seven-year old shop assistant Mr U had noticed a persistent pain in his heel for several months, which deteriorated suddenly whilst playing his weekly game of squash. It took him two weeks before he attended his local Emergency Department, where he was x-rayed and diagnosed with a bony spur on his calcaneus. He was advised to rest and to follow-up with his own GP if it did not resolve.

For the next three months, the symptoms continued and Mr U saw his GP Dr V on several occasions to have his leg examined. He distinctly recalled two separate episodes of acute heel pain when he was playing squash, which he felt had precipitated his ongoing symptoms. No weakness or immobility was noted, and the pain appeared to be isolated to the heel only. Reassured by the normal x-ray and unremarkable examination, Dr V recommended further conservative treatment.

Unfortunately, Mr U's heel pain did not resolve and he reattended a few weeks later complaining of swelling and erythema of the calf on the affected side. A definitive diagnosis was not obtained, and over the course of several weeks he was investigated for DVT on two occasions and commenced on antibiotics for suspected cellulitis. Three months after the initial event, symptoms remained much the same and Dr V sent Mr U to see an orthopaedic consultant in clinic. The orthopaedic surgeon made a clinical diagnosis of an Achilles tendon rupture, which was then confirmed with a soft tissue ultrasound. Mr U required surgical repair of his injury and made a very slow recovery with various complications. He made a claim against Dr V for the delay in diagnosis.

The case was complex since it was considered that it was not a case of sudden rupture of the Achilles, with the more recognisable associated signs, and it would have been very

difficult for the GP to make an early diagnosis, especially as the patient did not present immediately following injury. It was further complicated by the fact that there was no mention at all of a calf squeeze test having been performed, so it was difficult to judge at what point the tendon finally snapped.

Expert evidence was sympathetic to the unusual presentation of the case, but felt that there were weaknesses in the case because there was no documentation of the squeeze test. The case was therefore settled for a moderate sum.

EW

LEARNING POINTS

- No matter how careful you are and how much effort you take on dealing with your patients in an appropriate manner, things sometimes do go wrong. Most doctors will have at least one claim against them during their practising lives.
- Documenting consultations thoroughly is essential. Keep records of any specific test or examination carried out – “whatever is not written has not happened” is a good safety motto.
- The calf squeeze test is used to examine the integrity of the Achilles tendon. The patient lies prone with the foot extended beyond the edge of the examination couch. The examiner squeezes the calf and watches the foot for mild plantarflexion in a normal exam. Lack of ankle movement can indicate rupture of the Achilles tendon. A useful link to a reminder about the squeeze test can be found here: www.cks.nhs.uk/achilles_tendinopathy/management/scenario_diagnosis/diagnosis_of_achilles_tendon_rupture/tests_for_rupture_of_the_achilles_tendon



An error that did not cause harm

Mr T was a 50-year-old successful interior designer. He was taking 5mg of warfarin daily for recurrent DVTs and regularly visited the warfarin clinic for INR checks. The clinic found his INR to be above target and he was advised to omit the following day's medication and then go back to his usual dose. He was asked to return for an INR check after ten days.

Three days later Mr T started suffering with neck and back pain, which was very unusual for him. He was an enthusiastic cyclist and was used to "aches and pains". The pain became quite severe quickly and he didn't feel able to cycle to his GP's surgery so he rang his GP to request a home visit, which was arranged for the same day. Dr B saw Mr T at his apartment and took a history of his complaint. He had developed back pain quickly and she thought this was due to muscular spasm triggered by a particularly long bike ride. She had considered his past medical history of DVT. She had documented that he had not complained of weakness, numbness or pins and needles in his legs and that he had had no problems with his bladder or bowel function. She examined Mr T fully and noted that his gait was

normal and that he had full range of movement in his back and neck. She also documented that his tone, power, sensation and reflexes were normal in both legs. Dr B gave Mr T some diclofenac to ease the pain and spasm but advised him to contact the surgery if things did not improve.

Mr T felt reassured but within a couple of hours of Dr B's departure his back pain became even more severe. He panicked when he suddenly lost sensation in his legs and was incontinent of urine. He called an ambulance, which took him straight to the Emergency Department (ED).

The doctors at the ED did some urgent investigations and found his INR to be 10. Scans showed an extensive extra-dural haematoma. Mr T had to have emergency surgery to remove the haematoma within the vertebral canal but outside the dura which was causing compression of his spinal cord. Despite the surgery Mr T was left in a wheelchair and needed extensive rehabilitation.

Mr T was understandably devastated because he would never walk or cycle again. He made a claim against the clinic and also Dr B for having contributed to the high INR

causing the haematoma and for not recognising his neurological symptoms.

During the case Dr B admitted that prescribing diclofenac to a patient on warfarin is contraindicated, but the experts commented that the INR could not have been affected that quickly by the diclofenac, so Dr B's error did not cause the injury. Dr B's notes were very comprehensive and aided her defence regarding the lack of neurological symptoms and signs.

The case was settled by the clinic, but the allegations against Dr B were successfully defended.

AF

LEARNING POINTS

- Home visits can be particularly tricky since you do not have the usual tools to elicit information about the patient. If possible, read patients' notes carefully before setting off on a visit and take a printout with you, listing past medical history and the patient's medications and allergies.
- Full examination, including a neurological assessment, should be undertaken in all patients with severe back pain to exclude cord compression. Spinal cord compression is a surgical emergency. The outcome of treatment depends on a timely diagnosis.
- As the proportion of older people grows, there will be more patients on multiple medications. Polypharmacy goes hand in hand with the increasing risk of drug interactions. Be aware of the risks of patients on anticoagulants.
- Tony Avery's recent study, *The PRACtICE Study Report* (May 2012), investigates the prevalence and causes of prescribing errors in general practice. It highlights that prescribing errors in general practice are very common, although severe errors are unusual. His work discusses strategies for reducing the prevalence of error, including having a reporting system for reporting and learning from adverse incidents.
- MPS has published a useful factsheet on prescribing, outlining the importance of checking the dose and contraindications of a medication, gaining patients' informed consent, writing clear and accurate prescriptions and making a record of this in patients' notes. It also discusses issues about prescribing on the recommendation of a specialist.



A complication, not negligence

Baby R presented at 18 months of age with a fit. He seemed otherwise healthy, but a CT scan was performed, which showed a Sylvian fissure arachnoid cyst with a shift of midline structures. After careful discussion with the parents, it was agreed that the baby would have a craniotomy and fenestration of the cyst into the subarachnoid space. Following this procedure, carried out by consultant neurosurgeon Mr F, Baby R began to do well and had no further fits.

A few months later he was re-referred by the GP because he had become increasingly lethargic and off his food. A CT scan demonstrated that the cyst had recurred and was now bigger than it had been originally. Mr F again discussed with the parents the various options and their potential complications; these were documented in a clinic letter. In the end, it was agreed that Mr F would take Baby R back to theatre and perform a

cysto-peritoneal shunt.

During the insertion of the shunt, fresh blood began to appear in the proximal catheter. Mr F flushed the tubing with sterile water until the cerebro-spinal fluid became clear. After waiting a short period, more blood began to appear in the tubing and Mr F decided to open the dura to find the bleeding point. After reopening the craniotomy, Mr F found that the shunt had penetrated the brain tissue, causing bleeding from a vein on the cortical surface. The bleeding was stopped and the shunt procedure completed.

Baby R was taken from the operating theatre for a CT scan, which showed a slight brain contusion at the site of the cortical puncture and shrinkage of the cyst. He was then extubated and taken to the paediatric intensive care unit where he was closely watched by Mr F and the paediatric intensive care consultant. Mr F informed the parents about what had happened in the operating theatre but said

that he felt everything would now be fine. For the next couple of hours, there were entries in the clinical notes every few minutes and initially all was well. Unfortunately, four hours following the operation, Baby R developed a dilated pupil and a bradycardia. He was taken back for a CT. The scan showed a large haematoma had developed at the site of the cortical puncture and the baby was taken immediately to theatre for drainage of the clot. In spite of the surgery, Baby R was left with a severe neurological impairment.

A claim was made against Mr F by Baby R's family, alleging bad management both during and after the operation.

Experts reviewed all the notes and concluded that the management had been careful and appropriate. In particular, the consent process was well documented and it was clear that the parents knew about the possibility of bleeding and the potential consequent neurologic damage. The case was successfully defended.

LP

LEARNING POINTS

- In particularly complicated cases, the more detailed the medical records, the more robust the defence. As this case demonstrates, documenting the time of the notation can be very important. It was clear from the medical records that Baby R had been observed very closely in the hours following his surgery and therefore the postoperative care could not be criticised.
- Complications are unfortunate but do happen and, in some cases, can have terrible and lifelong effects on patients. The medical records are clearly vital in documenting the consent process, which is at the heart of patient-centred medical care.



Missed ectopic pregnancy

Miss G was a 33-year-old single parent who had two children, aged 4 and 6. She had previously had chlamydia and three weeks ago had had unprotected sexual intercourse. Her periods were overdue by four days, so she had a pregnancy test, which was positive. She made an urgent appointment at a clinic to discuss the possibility of a termination.

When she was first seen in the clinic, she was scanned and they were unable to identify an intrauterine sac. She was therefore asked to come back ten days later. When she returned, the scan showed what was reported as "...an 8.5mm intrauterine sac compatible with five weeks gestation". The gynaecologist, Mr W, warned Miss G of the risks of having such an early termination, but she insisted that they went ahead with the procedure as soon as possible. Mr W agreed and carried out a surgical termination under local anaesthesia. The procedure was deemed to be uneventful and no histology was requested.

Ten days later, Miss G attended her local Emergency Department with nausea, dizziness and abdominal pains. She was fully examined by junior doctor Dr Y, who thought she had endometritis and gave her some antibiotics, reassured her and sent her home.

A week later Miss G collapsed at home with severe right iliac fossa pain. She was brought back into the hospital by ambulance, hypotensive (BP90/50) and tachycardic (P 120). She was seen again by Dr Y who suspected appendicitis and requested an abdominal USS and routine bloods (FBC, U&Es). The USS showed a large amount of fluid in the pelvis and abdomen and an empty uterus, and the radiologist suggested carrying out an urgent pregnancy test.

This was indeed positive and the gynaecologists were called to carry out an urgent laparoscopy. Two

litres of blood were found in Miss G's abdominal cavity and a ruptured ectopic pregnancy on the right side was confirmed. Miss G required a laparotomy and right salpingectomy. Her left fallopian tube had scarring from her previous chlamydial infection; regrettably, the right tube could not be conserved. She required a blood transfusion, but made a full physical recovery, although she was quite traumatised by the events that had occurred and was upset by the advice that she might have problems conceiving naturally in the future.

Miss G made a claim

against both Mr W and Dr Y. It was deemed that Mr W had offered appropriate counselling to the patient with regards to the risks of the procedure at such an early stage of the pregnancy, although he was criticised for not requesting histology in this case. Dr Y was felt to have been negligent in not requesting a pregnancy test on each occasion she attended and not requesting advice from the on-call gynaecology team, especially in view of her recent gynaecological surgery.

The claim was settled for a moderate sum on behalf of both clinicians.

DD

LEARNING POINTS

- When undertaking early terminations at less than seven weeks gestation, it is possible that only decidual endometrium is aspirated rather than the actual gestational sac. As such these procedures must be performed with the appropriate safeguards to ensure that the abortion is complete. Visual inspection of the tissue aspirated is of utmost importance. See: RCOG, *The Care of Women Requesting Induced Abortion. Evidence-based clinical Guideline Number 7*, London: RCOG (November 2011) – www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion
- Although terminations are common procedures, as with all surgical procedures, all the common and significant complications must be fully explained to the patients and documented carefully in their notes – www.bpas.org/bpasknowledge.php?page=154-13k
- Although urinary pregnancy tests may stay positive for two weeks following any miscarriage or termination, they should be requested on any female of reproductive age attending ED with gastrointestinal symptoms or unexplained abdominal pain. Gastrointestinal symptoms, particularly diarrhoea and dizziness, in early gestation can be important indicators of ectopic pregnancy.
- An early pregnancy ultrasound that fails to identify a definite intrauterine sac should stimulate active exclusion of tubal pregnancy. Dr Y had two opportunities to keep a broad differential diagnosis and should have requested a urinary pregnancy test +/- and an ultrasound, and sought advice from the gynaecology on-call team, to exclude an ectopic pregnancy.
- Even in the presence of a small uterine sac (eg, pseudosac), an ectopic pregnancy cannot always be excluded. See: 2011 Centre for Maternal and Child Enquiries (CMACE), *BJOG* 118 (Suppl 1), 1–203.



Keeping watch

Mr L, a 22-year-old unemployed man, presented with his parents to the Emergency Department complaining of low mood and thoughts of suicide. He was assessed by Dr P, a junior hospital doctor on-call for psychiatry.

Mr L told Dr P that he had recently experienced the acrimonious break-up of a long-term relationship. He also volunteered a psychiatric history of ongoing treatment for depression starting as a teenager. He said he currently attended regular appointments with a community psychiatrist and was prescribed antidepressant medication. In the past he had once been admitted to hospital following a deliberate large overdose of paracetamol.

During the interview Mr L said he had not written a suicide note but that he had a plan for his suicide. He would not disclose what this was, but said that he was very likely to enact it soon. In view of his current presentation and history Dr P documented that Mr L was at high risk of a further suicide attempt. Dr P agreed with Mr L and his

parents that Mr L should be admitted voluntarily to a psychiatric ward.

Mr L arrived at the ward and was seen for a ward clerking by Dr Q, a psychiatry trainee. Dr Q read Dr P's assessment and also talked to Mr L about his intentions. Dr Q relayed to the nursing staff that Mr L's supervision on the ward should consist of observations at 15-minute intervals.

That night Mr L went to bed. The next morning he kept a low profile and did not give the nursing staff any cause for concern. There was

no ward round that day and the frequency of his nursing staff observations was not reviewed.

In the afternoon Mr L received several visitors. As they were leaving he mentioned to them that he was desperate for a cigarette. They were not aware that any items were restricted on the ward and left him with a packet of cigarettes and a lighter. Later that evening Mr L set his clothing on fire. Although this was quickly extinguished, he nevertheless received serious burns to his legs that required skin grafting.

Mr L's family started a claim against Dr Q, stating that the level of supervision Dr Q recommended for Mr L was inappropriate in light of his suicide risk. Dr Q said that at the time he had seen Mr L he was keen to recommend constant 'one-to-one' nursing supervision. However, he did not as he had recently been told that this level of supervision was only appropriate in exceptional circumstances due to its high cost. No mention of this restriction was made in the notes.

The claim was settled for a moderate amount.

SG

LEARNING POINTS

- All psychiatric patients require a suicide risk assessment on admission. This should be particularly detailed if a patient has a history of suicidal actions. Some patients, especially those at high risk, will require one-to-one nursing.
- In times of increasing pressure on finite resources, it is likely that hospital managers and clinicians will be under increasing pressure to keep expenditure under control. However, a doctor's first responsibility is towards patient safety, so potentially dangerous policies should be clarified with management.
- If the patient management you consider clinically appropriate is blocked make sure this is clearly documented. If on-call trainees feel their clinical decisions are being inappropriately restricted they should alert the senior who is on-call.
- For reasons of safety, some items are restricted on psychiatric wards. Transgressions like this should not be possible and appropriate safeguards should be in place. If necessary, at-risk patients should have their visitors restricted.
- More information about suicide risk management can be found here: <http://bestpractice.bmj.com/best-practice/monograph/1016/treatment/step-by-step.html>



A frozen shoulder

Mrs H, a 54-year-old gardener, had been complaining of left shoulder pain for several weeks. It had become gradually worse, affecting her normal daily activities and causing her significant sleep disturbance. As Mrs H's shoulder became progressively stiffer, she was referred to Mr Z, consultant orthopaedic surgeon.

Mr Z made a diagnosis of frozen shoulder, and sought to manage this conservatively with nonsteroidal analgesia and physiotherapy treatment. Unfortunately, after three months, Mrs H's symptoms had not improved. After suitable verbal counselling, Mr Z administered an intra-articular steroid injection and reviewed Mrs H two weeks later. Again, Mrs H's pain had not improved, and her range of movement remained severely restricted.

Mr Z discussed the option of surgical management with Mrs H, explaining that he could perform a shoulder arthroscopy and manipulation under anaesthesia. Mr Z documented in the hospital notes that he had a "long chat" with Mrs H as a way

of informing her of the implications of the planned procedures, although he did not write down what possible complications were discussed.

The patient underwent the combined procedure. Mr Z confirmed the diagnosis of frozen shoulder, also identifying some rotator cuff degeneration. He performed a debridement of the rotator cuff as well as a subacromial decompression, injecting a mixture of local anaesthetic and adrenalin as part of his standard practice for this procedure. It all went uneventfully and the patient was discharged home the following day.

Although the mobility on the affected shoulder improved, the pain became worse. Mr Z suspected a possible injury to the axillary nerve that could have occurred at the time of the manipulation under anaesthesia or during the arthroscopy. He asked Dr N, a colleague neurologist with special interest in nerve injuries, to review Mrs H. Dr N could not find any neuropathy or evidence of nerve injury to explain the increasingly severe shoulder pain.

Mrs H made a claim against Mr Z on the basis that there had been nerve damage during the operation, causing her worsening pain. She alleged that Mr Z had not warned her that this was a possible complication of the surgery. She also claimed that had she known of this surgical risk, she would not have had the procedure.

An expert commissioned by Mrs H supported the thesis that during the manipulation under anaesthesia an excessive force was used, resulting in nerve injury. The expert also stated that on the balance of probabilities, had the patient known this risk, she would not have had the procedure. He supported this on

the fact that no written consent, including risks, benefits and alternatives, was given to the patient. He concluded that Mr Z had acted negligently.

On the other hand, an expert on behalf of MPS stated that if the patient had a nerve lesion, this was most likely to have been present prior to surgery. He said that even if this injury occurred during the procedure, this was such a rare event that Mr Z could not be found negligent.

Given the strength of our defence expert's opinion the case was taken to trial and the court found in favour of Mr Z. He was able to rely on a causation defence.

AA

LEARNING POINTS

- Unforeseeable adverse outcomes, while deeply regrettable, are not always negligent.
- Informed consent is a fundamental part of the decision-making process between the doctor and the patient regarding treatment options. Most regulatory bodies across the world have specific guidance on consent. To ensure consistency in practice, it may be worth considering the use of informed consent templates for specific procedures. A template for a specific procedure may be helpful as an aide memoire, but it is not a substitute for a conversation with the patient.

Over to you . . .

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

A dangerous cough

» I must take issue with one of the usually excellent learning points associated with a case report published in *Casebook* 20(2) entitled "A dangerous cough". You recommend: "When administering anaesthesia during an elective procedure, it is preferable to stop should you encounter difficulties and reassess for surgery at another time." Although it is apparent that this would have been the correct course of action in the case described, this is not always so.

Can I suggest the slightly more verbose but much more accurate:

If you encounter problems that you cannot be completely confident you have diagnosed accurately, and resolved fully when a patient is under general anaesthesia for an elective procedure that has not yet started, you should consider abandoning the procedure and waking the patient up.

Dr William Harrop-Griffiths,
Consultant anaesthetist, UK

All in the detail

» I am having increasing difficulty relying on *Casebook* for considered advice. The editorial standard is at odds with the excellent verbal advice I have received from the organisation over the last 20 years or so. What amounts to an apology regarding poor DNACPR advice given in January this year appears in the same edition as the following example of clumsiness:

"Your first obligation is to act in the patient's best interests and you should not be pressured by the patient into doing anything that is counter to this" (learning

points, "A dangerous cough", *Casebook* 20(2), May 2012.). This seems to suggest that the patient does not know what their best interests are but the doctor does. Modern medical ethics tend more towards the notion that if a patient is able to make a decision regarding their own best interests it is not for the doctor to paternalistically impose their own views of best interests on them:

"A person is not to be treated as unable to make a decision merely because he makes an unwise decision." s1(4) Mental Capacity Act 2005.

In the instant case I would have hoped that the advice given by the MPS would have been along the lines of:

Your first obligation is to act in the patient's best interests and you should not be pressured by anyone else into doing something that is counter to this. In this case, more comprehensive preoperative assessment may have led the anaesthetist (in consultation with the surgeon) into concluding that the surgery would be safer once the chest infection had fully cleared. Presented with this information the patient would very likely agree to the postponement. If she felt her best interests were served by proceeding anyway the anaesthetist and surgeon would have the opportunity to seek second opinions from colleagues.

A doctor is under no obligation to provide treatment he feels would be detrimental to the patient's health simply because the patient demands it.

The notion that a vaginal hysterectomy under spinal anaesthesia might have been a reasonable

alternative in the presence of pneumonia is a contentious point (particularly in an elective setting) that detracts from the otherwise sound advice regarding good communication.

Also, condensing what appears to be a very complicated case into a single glossy page might look attractive but for those experienced professionals reading the piece it usually leaves more questions than it provides answers. The poor writer has a Herculean task on his hands. Perhaps a much fuller summary could be provided online as might be found on Westlaw.

I do feel that the glossy *Casebook* does something of a disservice to MPS. There should be greater use of references and quotations from statute, case law and guidelines from professional bodies and considerably less reliance on well meaning, but sometimes ill-considered, bullet points.

Name and address supplied

Response

Regarding your point about patients' best interests, from a medicolegal standpoint you are of course correct – and no authority can impose treatment on them against their wishes, save under the provisions of mental health legislation. However, the principle applies to the patient's rights, and not

*the doctor's responsibility; in other words, the patient cannot insist on being provided with inappropriate or negligent treatment simply because they believe it will be in their best interests to have it. The doctor has responsibilities and duties both in law and – in the UK at least – as imposed by the GMC to exercise their judgment and professionalism in assessing what treatment options are appropriate for the patient's condition. After a proper informed discussion it is then for the patient to decide which option is best for them. I agree with your comment about the wording of the first learning point; precision and detail can be lost at the expense of limitations on space. I also recognise that in seeking to provide material that is interesting, practical and relevant to the very wide range of doctors who receive *Casebook*, we do not always provide the level of detail in case reports which an experienced specialist in your position might wish. We have recently started publishing more specialty specific material, including an anaesthetic e- bulletin, and would welcome ideas for topical issues to cover in future editions. *Casebook* does not purport to be an academic or peer-reviewed journal; the case reports are based on MPS cases from around the world but, unless otherwise stated,*

CORRECTION

A normal appendix

In the third column of the case report "A normal appendix" (*Casebook* 20(2)), it is stated that: "A subsequent radio-nucleotide scan confirmed evidence of active disease at this site".

Nuclear medicine diagnostic imaging procedures do not use radio-nucleotides, but rather radio-nuclides. *Casebook* is happy to point out this error.

Thank-you to Professor Iturralde for this information.

HIV testing

(Please note – this article appeared in the UK version of *Casebook*. To read it on the UK MPS website, click here: www.medicalprotection.org/uk/casebook-may-2012/MPS-opinion-spreading-the-use-of-HIV-testing)

» I read with interest the article “Spreading the use of HIV testing”, and entirely agree with the need for “normalisation” of the investigation of this virus. Encouragement to present to healthcare services and the stage at which patients present may be outside our control, but from their point of contact with healthcare professionals we have a window of opportunity to modify their prognosis. Proactive consideration of the condition among our differential diagnoses of patients presenting with signs of immunosuppression (recurrent infections, atypical infections), PUO, obscure dermatological changes and non-specific signs (weight loss), should prompt investigation at the time of disease consideration, like any condition.

The demonstration projects clearly identify key educational needs among practitioners to dispel the myths around investigation and build professional confidence (consent,

results management, insurance fallacies). Empowerment of junior doctors to consider the disease in their diagnoses and to elucidate risk factors among patients they encounter on the acute take or new outpatient referrals could improve early investigation. Through junior doctors presenting their reasons for investigation choice to senior clinicians, as any investigation with significant implications (genetic testing tumour markers, radiation exposure, invasive procedures), test appropriateness could be confirmed or refuted. Also teaching communication skills to develop patient rapport prior to enquiring into the sexual history may assist clinicians.

If the barriers are not in diagnosis consideration, but clinician fears in discussing the investigation – what will the patient think? What if I cannot answer their questions? How do I tell them they have a positive result? – we are failing patients by potentially delaying diagnosis and thus denying life-preserving treatment at the earliest interval. Any concern



regarding managing the results is our responsibility, to nurture the working relationship with sexual health services.

By the time the doctor with all the answers is encountered, it may be too late.
Dr Claire Brough, specialty trainee, cardiology, UK

facts are altered to preserve confidentiality and to focus on generic learning to be gained rather than clinical detail. We do include some links to relevant reference material and guidelines (bearing in mind the worldwide spread of members) but quotes from statute and case law have not been considered to be a natural fit with the overall nature and purpose of this publication. We do publish a wide range of country specific factsheets, available on the website, which include greater reference to statute and guidelines.

Dr Stephanie Bown, Editor-in-Chief

ended up in the same unpleasant situation. The advice about the limping child is all apt but, just as importantly, there needs to be training and advice about managing the structure of consultations and demands that you cannot meet in a busy day that is already fully booked.

For example, the GP could have made a one-line entry in the mother's notes about the request and then insisted she book in for a proper consultation for the child. Yes, she might have been angry and demanding, but it is ok to set boundaries with patients: “I’m sorry Mrs Smith, but assessment of a limp in children is not a quick thing and I really want to do my best for Johnny, I can give you an appointment tomorrow.” Or: “I’m sorry Mrs Smith, but I am heavily booked today, and in fairness to the booked patients who are already waiting I cannot provide you with

a double appointment.” Better to weather some short-term annoyance from the patient and create a long-term understanding with the patient that you practise good medicine, and that off-the-cuff double bookings are not part of that practice.

In my own practice I will oblige with minor “quick look” things, eg, checking the child's tonsils for which I gave antibiotics last week when he accompanies mum for her appointment. This sort of quick follow-up is useful for me and creates goodwill, but new assessments, of the type

above with the limping child, should be deferred. It is also important that both your reception and nursing staff have clear guidance about what is acceptable to double-book and that you should be consulted about double bookings. This creates a consistent culture across the practice, which prevents the doctor being overloaded and resentments developing within the practice team.

Dr Philippa Story, GP, New Zealand

Oh by the way, doctor

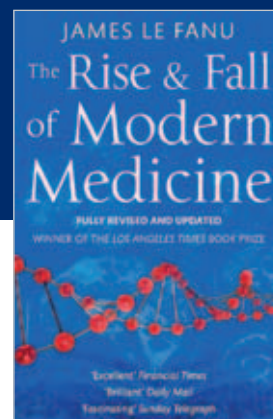
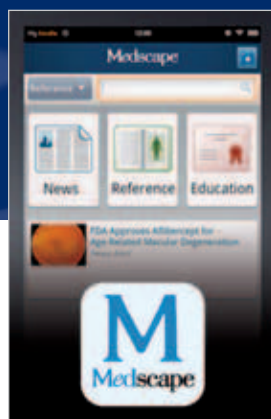
» I would like to offer a comment on your latest “Oh by the way, doctor” in *Casebook* 20(2), May 2012. Fair enough, the GP did miss the SUFE and didn't make any notes, but when you examine the structure of the consultation, there would be few GPs in any country who couldn't have

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www.medicalprotection.org

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

Reviews



Medscape app

Reviewed by Dr Emily Lees, Academic Clinical Fellowship Year 1 in Paediatrics at Alder Hey Hospital in Liverpool, UK

As a newcomer to the world of smartphones, I was astonished by the number of medical apps available and the vast array of functions they serve. From Shiftworker (creates attractive calendars documenting your shift patterns), to PaedsED (provides rapid drug-dose calculations and a pain scale containing cute animal pictures) – there is something to suit every specialty and taste.

Of all the apps I discovered, Medscape stands out as being an incredibly versatile and useful tool, containing abundant functions, which I'll highlight below. There is also a mind-bending back catalogue of evidence available for download, all the more incredible for the fact that it is free. All that is required of you is an email address with which to set up an account.

Medscape ranks in Apple's top app downloads, and it is easy to determine why. The app can be downloaded on to many devices, eg, iPhones, iPods, Blackberrys, Androids and Kindlefires, and has an easily navigable format, with large enough icons that you won't forever be hitting the wrong button.

Medscape is developed by WebMD, the group responsible for various online medical resources, including eMedicine and Rxlist. The Medscape app is constantly developing with frequent evidence updates and an ever-expanding number of conditions covered (currently 4,000+). The content is written and peer-reviewed by 7,000 physicians representing numerous institutions, so somewhat more reliable than the good doctors Google and Wiki. Many articles also come with illustrations and videos, which are particularly handy for the anatomy segments and the section giving

step-by-step instructions for 600-plus clinical procedures – an improvement on the 'see one, do one' ethos.

Medscape's drug reference contains detailed prescribing information for more than 8,000 drugs (prescription, OTC and supplements). The only downfall is that some of the drugs are not listed in their English format (eg, Acetaminophen is listed for Paracetamol). There is also a drug interaction checker that allows the user to cross-check multiple drugs/supplements against each other to ensure they're prescribing safely. Not only that, Medscape incorporates numerous medical calculator tools,

relevant to each specialty.

I've highlighted some of my favourite aspects of the app, but there's much more to take advantage of including daily news updates, 100-plus clinical protocols, monthly hot topics with latest practice updates, and the ability to carry out Medline searches within the app.

I'd thoroughly recommend adding Medscape to your device, and whilst you may not be fast enough to impress your senior by looking up the answers to ward round questions, you can enter each on-call, whatever your specialty, armed with the wisdom of 100 textbooks in your back pocket.

The Rise & Fall of Modern Medicine (2nd edition)

By James Le Fanu
(Abacus Books, 2011)

Reviewed by Dr Matthew Daunt, specialist registrar in anaesthesia at Nottingham University Hospitals NHS Trust

This new version has been updated to include the changes in the decade since its first release. It is essentially divided into two parts, a superb historical narrative of medicine's greatest achievements in the post-war years, followed by a somewhat cynical review of the current medical world.

The first part – the "Twelve definitive moments of modern medicine" – is a must-read for all doctors and medical students. Covering the 45 years from the beginning of World War II, Le Fanu articulately describes the most significant developments of modern

medicine, recounting details that are both entertaining and enlightening. The well-researched and heavily-referenced chapters depict events such as the discovery of penicillin, the birth of intensive care, open heart surgery and the first test-tube baby. This section of the book alone is enough for me to recommend it.

The uplifting book goes on to describe the development of newly-qualified doctors, from the 1930s when they had "a dozen or so proven remedies" at their disposal, to the end of their career when they have "over 2,000". Le Fanu revels in telling the reader that these discoveries were fortuitous, and often accidental. The change in the way research occurs is one of his reasons for the 'fall' in modern medicine.

The second half of the book tackles the reasons behind the relative dearth of significant breakthroughs. The subsequent decline in new discoveries in the last 30 years are attributed mostly to the underwhelming impact of the human genome project, and the pharmaceutical companies whose interest in profit-making prohibits the effects of individual research. The latter half of the book is quite depressing, but ends with a sense of optimism overall as to what the future may hold.

This fascinating book gives an expert account of how modern medicine affects us all as doctors and patients, whilst also calling for change in order to prevent stagnation in the field of research.

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chief.executive@mps.org.uk

In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

UK medicolegal advice

T 0845 605 4000
F 0113 241 0500
E querydoc@mps.org.uk

UK membership enquiries

T 0845 718 7187
F 0113 241 0500
E member.help@mps.org.uk

Calls to Membership Services may be recorded for monitoring and training purposes.

UK student membership enquiries

T 0845 900 0022
F 0113 241 0500
E student@mps.org.uk

UK GP Practice Package enquiries

T 0845 456 7767
F 0113 241 0500
E gppractice@mps.org.uk

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

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