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Medical Protection

CASEBOOK

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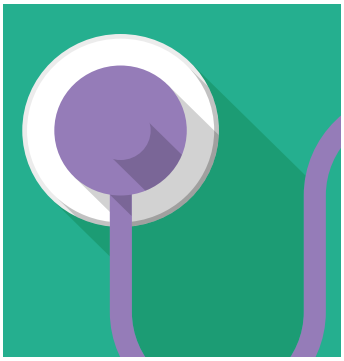

CASE REPORTS

Every issue...

FEATURES

FACTS AND OPINION

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WELCOME

Dr Marika Davies
EDITOR-IN-CHIEF

In *Casebook* we have always had a focus on the risks that are inherent to the practice of medicine. We hope that by raising awareness of the risks, and providing techniques and strategies to mitigate them, we can help to reduce the likelihood of adverse incidents for patients and the potential consequences for our members.

In this issue we take a look at patient expectations. Unmanaged expectations can lead to a patient unsatisfied with their outcome and possibly a complaint or a claim. Dr Vanessa Perrott examines this issue on page 10, providing advice on how to manage patient expectations.

Meanwhile, on page 6, Dr Rachel Birch looks at communication between hospital doctors and their primary care colleagues, with a focus on test results and patient follow-up after a patient is discharged from hospital. This interaction is fraught with risky assumptions regarding who is responsible for what, and the article provides practical advice to overcome these risks.

The case reports in this issue demonstrate yet again the importance of good history taking, performing appropriate examinations, communicating well with colleagues, and keeping full and complete clinical records. These themes are almost a permanent feature of our case reports, but this is because every day we see cases where a failure to do one or all of these has made it difficult for us to defend a claim brought against a member.

I hope you enjoy this edition. We welcome all feedback, so please do contact us with your comments or if you have any ideas for topics you'd like us to cover.

Dr Marika Davies
***Casebook* Editor-in-Chief**
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NOTICEBOARD

NEWS & UPDATES FROM THE *CASEBOOK* TEAM

GUIDANCE ON FITNESS TO DRIVE

A new DVLA publication, *Assessing fitness to drive – a guide for medical professionals*, offers guidance on the requirements of competent driving.

Practitioners can refer to the document for information on conditions that affect patients' fitness to drive and the assessment of this ability.

To see the full guide, visit **http://goo.gl/ynCza3**

GUIDANCE ON CAUDA EQUINA SYNDROME

Following coverage of Cauda Equina Syndrome (CES) in the last edition of *Casebook* the NHS Litigation Authority (NHSLA) has published its own factsheet on CES.

In 2015, 13% of the high value claims that Medical Protection handled were related to CES, and the NHSLA information comes to a similar conclusion. The cases handled by Medical Protection show that delay in diagnosis, referral and treatment can contribute to an adverse outcome. Early diagnosis and treatment of CES is likely to lead to a better outcome for the patient.

To see the NHSLA information, visit **http://goo.gl/oKoyzR**

WRITE FOR *CASEBOOK*

Medical Protection is your organisation and we want you to be part of it. We are currently seeking new contributors to submit well-crafted and informative feature articles for *Casebook*. If you would like to have your writing published or if you have any ideas for content, contact the *Casebook* editorial team at **casebook@medicalprotection.org.**

GMC LAUNCHES PILOT SCHEMES FOR CHANGES TO FITNESS TO PRACTISE

Two new pilot schemes are being launched to improve the process of fitness to practise investigations to reduce the impact on doctors.

One of the pilots will involve cases in which doctor faces an allegation of a one-off mistake involving poor clinical care. Rather than opening a full investigation the GMC will gather key information, such as medical records and incident reports, and then make a decision whether a full investigation is required. If not, it will refer the case to the doctor's responsible officer or close it with no further action.

The second scheme incorporates a recommendation from Sir Anthony Hooper's review of whistle-blowing procedures for the GMC. Designated bodies, such as NHS organisations and independent healthcare providers, will need to disclose whether the doctor being complained about has previously raised any patient safety issues. The person referring the concerns will also have to make a declaration that the complaint is being made in good faith, and that it is fair and accurate.

The GMC says this will help to assess if an investigation is needed and avoid whistle-blowers facing retaliatory attacks or complaints.

The schemes are being rolled out across the UK and will be reviewed after six months.

NEW GMC CHIEF EXECUTIVE APPOINTED

The GMC has announced its new chief executive will be Charlie Massey. He will replace the outgoing Niall Dickson, who leaves his post after seven years in the role.

Mr Massey worked previously as a director general at the Department of Health. Before that he occupied senior roles at the Department for Work and Pensions, HM Treasury and as an executive director at the Pensions Regulator.

He will take up his new role towards the end of 2016.

A TESTING PROBLEM

Medicolegal Adviser Dr Rachel Birch explores why effective communication between hospital doctors and GPs is essential for the safe handover of test results

From the patient's point of view, there have been many improvements to healthcare services in recent years, including shorter hospital stays, clearer referral pathways and the use of electronic communication methods between primary and secondary care.

However, such improvements often come with new risks. For example, when a patient is discharged from hospital without all the test results being back, there may be uncertainty as to who will be following up those outstanding results. If a consultant asks for blood test monitoring, the GP requests the tests and copies the consultant into the results – who then should be taking any appropriate action?

An analysis of data from Medical Protection's Clinical Risk Self Assessments (CRSAs) showed that 83.2% of practices had potential risks associated with test ordering and results management.[1] Although corresponding data for secondary care are lacking, there may be pitfalls in the test-result systems of many hospitals.

This article outlines two case studies and provides practical advice on how to mitigate such risks.

CASE STUDY 1

At Main Street Medical Practice, Dr G was checking all the incoming test results at 5.40pm on Friday. He came across a mid-stream urine (MSU) result for Mrs A, demonstrating that she had a urinary tract infection (UTI). He looked in her medical record and saw that no test had been requested by the practice. On closer inspection of the result, he found that it had been ordered in the gynaecology clinic, but the result had been sent to the GP practice.

He telephoned Mrs A to inform her of the result. She told him that Dr T, the consultant gynaecologist, had treated her for thrush and had told her that "someone would be in touch" regarding her urine result.

Mrs A's symptoms had worsened since the clinic appointment. Dr G felt that the infection required treatment, but was not clear whether Dr T was planning to be in touch with Mrs A about the result. He attempted to telephone Dr T, but received only the answer-phone because it was now 6pm on a Friday.

He felt that it was in Mrs A's best interests to prescribe antibiotics rather than delay treatment over the weekend. He told her to tell Dr T if he contacted her, that she was already on treatment for her UTI.

LEARNING POINTS

This case illustrates the confusion that can occur when a GP receives a result from secondary care. It can take extra time to try to clarify who should be dealing with the result. There is also the possibility that the patient is treated twice, which is a potential safety issue.

In this situation, Dr G took appropriate action by:

- speaking to the patient
- trying to liaise with the consultant
- considering the best interests of the patient
- treating the infection.

The BMA advises[2] that there may also be potential safety issues if GPs are asked by hospital doctors to find out test results which the hospital had ordered. Both the General Practitioner Committee and the Consultants Committee of the BMA, in accordance with National Patient Safety Agency guidance, have agreed the following:

- the ultimate responsibility for ensuring that results are acted upon rests with the person requesting the test
- that responsibility can only be delegated to someone else if they accept by prior agreement
- handover of responsibility has to be a joint consensual decision between the hospital team and the GP. If the GP hasn't accepted that role, the person requesting the test must retain responsibility.

NHS England has developed a set of standards[3] for the communication of diagnostic test results when patients are discharged from hospital. Although not mandatory standards, they are designed to improve systems in both hospitals and primary care relating to handover of patients' test results.

RECOMMENDATIONS INCLUDE:

- Patients, and if appropriate, families and carers, should be given sufficient information about received and pending test results at discharge.
- This should include details of follow-up arrangements and contact details if there are any concerns.
- At discharge, hospital teams should have a system to ensure that test results are seen, acted on and communicated to GPs and patients in a timely manner. Consultants should ensure their team members understand and comply with this process.
- Primary and secondary care should have a mutually agreed system for safe handover of test results, including any outstanding actions where appropriate.
- GP teams should have a system to ensure that any discharge information they receive is seen and acted on in a timely manner. If a practice receives a test result, it should be reviewed and, where necessary, acted on by the GP, even if the GP did not order the test.

Whilst developed for England, these principles are equally applicable in Scotland, Wales and Northern Ireland.

REFERENCES:

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2. BMA, *Duty of Care to Patients Regarding Test Results* www.bma.org.uk/advice/employment/gp-practices/service-provision/duty-of-care-to-patients-regarding-test-results
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CASE STUDY 2

Mr D had been seen regularly by consultant urologist, Professor H, for the last two years. He had undergone two previous prostatic biopsies for a moderately raised PSA. The biopsies had been normal and Professor H recommended the PSA was monitored every six months.

He discharged the patient from his clinic and asked the GP, Dr M, to arrange the blood tests and copy the results to Professor H. He wrote that Mr D would need a further prostate biopsy if the PSA started to rise.

For the first year Mr D's PSA remained stable and, although raised, remained around the previous level of 9 ng/ml. However, the third PSA test demonstrated a PSA of 13 ng/ml.

Dr M considered this result, noted that the PSA had increased, but felt reassured that Professor H was copied into the result. She assumed that a prostate biopsy would be arranged for the patient and she filed the result.

Six months later the patient's PSA result was 28 ng/ml. At this stage Dr M reviewed Mr D and he told her he had not had any contact from the urology department. She referred him urgently under the two-week suspected cancer pathway. Mr D was found to have prostate cancer and required an urgent radical prostatectomy.

Mr D made a complaint to both Dr M and Professor H, as he felt there had been an opportunity to treat the cancer six months earlier.

LEARNING POINTS

It is clear from this case that the two doctors had different expectations of what would happen if the patient's PSA started to rise. Dr M assumed that, because the results were being copied to Professor H, that he would arrange further follow-up for the patient. Professor H had believed that Dr M would contact him if the patient's PSA started to rise.

In future similar cases:

- Professor H should adhere to agreed shared care arrangements in the local area and make it clear on the discharge letter whether he will be reviewing or actioning the PSA result. He should also outline at what PSA result he would wish to see the patient again.
- Dr M should clarify whether she is expected to re-refer the patient back to the urology clinic if the PSA level rises.
- It would be helpful to have a clear agreed protocol outlining the respective agreed responsibilities.
- Any new team members should be made aware of the arrangements and Dr M may wish to put an alert on patients' notes in such a situation.

The GMC states[4] that:

- There must be safe transfer of care between doctors, all relevant information should be shared and an agreement reached on the responsibility for the care when a doctor's role in providing care ends.
- Doctors should raise concerns if they believe that patient safety may be compromised by inadequate policies or systems. They should put the matter right, if possible.

It is important for both Professor H and Dr M to reflect on the incident and determine why it occurred. They both made assumptions that did not reflect the reality of the arrangement.

The cases mentioned in this article are fictional and are used purely for illustrative purposes.

CHALLENGING INTERACTIONS WITH COLLEAGUES

Poor communication between doctors lies at the heart of many complaints, claims, and disciplinary actions. Dr Mark Dinwoodie, Director of Education, explains the importance of maintaining good relationships with colleagues and communicating effectively with other health professionals

Interactions with colleagues can be one of the most challenging aspects of medicine. The people you work with have a profound effect on how you practise – colleague interactions can lighten the burden, or make it infinitely heavier.

Our experience is that poor communication between two or more doctors providing care to patients lies at the heart of many complaints, claims and disciplinary actions.

It is inevitable at some point throughout your career as a doctor that you will come across at least one colleague with whom you have issues working. It is therefore important to be aware of different strategies and techniques you can use to deal with this situation.

IDENTIFYING RISKS

There are many reasons why doctors may not communicate sufficient clinical information to their colleagues about patients under their care. These can include pressures of time, difficulty in accessing colleagues, and difficult relationships with them.

Changes in working patterns and the resultant increase in shift work and cross cover mean that more doctors may be involved in a patient's care. This has increased the risk of failures in communication because passing care between doctors (in a referral or a handover) increases the possibility that patient information will not be shared optimally. As a result, abnormal investigation results may be missed, treatments may be monitored inadequately, or important comorbidities may not be taken into account, which all put the patient at risk of harm.

So what can you do to reduce the risk around interactions with difficult colleagues?

PICK YOUR BATTLES

Use your energy wisely – you might have several issues with colleagues but some will generate more risk to patients and yourself than others. It is wise to concentrate your efforts and energy on high risk areas with the best interests of the patient at the centre of discussions.

CATCH AND STOP RISKY ASSUMPTIONS

Assumptions are a common human error that we all make. They are especially prevalent when dealing with colleagues we dislike or find challenging. We can be more likely to make an assumption relating to clinical communication rather than check with that colleague. This generates a variety of risks that can lead to catastrophic outcomes.

Checklists can reduce this type of risk. They are a useful method of ensuring completeness of communication when referring a patient, and they can be used as memory aids or integrated into the records or correspondence. They also enable doctors to focus on more complex tasks by reducing the amount of information they need to remember and process at one time.

HANDOVER

Where all responsibility for patient care is being handed over – for example, to the hospital night team or to a GP colleague when going on leave – a handover model such as SBAR (situation, background, assessment, recommendation) or the MPS SHIFT© model (status of patient, history, investigations pending, fears of what may unfold, treatment planned) can be used to ensure all relevant information is passed on and recorded.

It can be useful to ask the recipient to repeat back a summary of what they have understood to confirm the accuracy of information transfer.

Other ways to reduce risk when passing care to a colleague include the use of information technology systems to automate information transfer, as well as tracking systems for referrals, investigations and follow-up to ensure safe completion of processes. Patients may also be recruited to "check" the communication between colleagues – for example, a referral letter can be dictated in their presence or they can be given a copy of their discharge summary or clinic letter. Doctors should take action if the communication they receive about a patient is inadequate.

ACTIVELY MANAGE DISAGREEMENTS

Differences of opinion between doctors also pose a risk. Disagreements may arise over diagnosis, treatment and management, as well as interpretation of investigations, resource allocation, and end of life issues. The breakdown of a working relationship between doctors can have a detrimental effect on colleagues and patient care. When raising concerns with colleagues over disagreement about patient care, you should emphasise the importance of achieving the best outcome for the patient, while maintaining dignity and respect for your colleague, and attempt to negotiate a mutually agreeable resolution.

If you think that a colleague is routinely putting you or your patient at risk through inadequate communication and your attempts to give subtle feedback have not been effective, you should raise your concerns with the colleague directly, making suggestions for improvements to enhance clinical communication and framing the conversation in terms of the risk to everyone concerned. You should emphasise that you are committed to taking action, document your concerns, and explain what you have done to tackle them. If that does not work you should discuss the matter with your clinical lead or defence organisation for support and advice on what to do next.

CASE REPORT

WE DON'T TALK ANYMORE

Mr Y, a 35-year-old marine engineer, was undergoing surgery to treat a congenital vascular lesion in the posterior compartment of the thigh. Mr O, consultant vascular surgeon, was carrying out the procedure. The lesion was closely related to the sciatic nerve and some of its branches, and Mr O was aware of the risk of damaging the sciatic bundle.

The anaesthetic was given by Dr A, consultant anaesthetist. During the induction phase Mr Y had suffered repeated generalised muscular spasms, so Dr A had given a muscle relaxant to prevent intraoperative movement of the surgical field.

Intraoperatively, Mr O used tactile stimulation to ascertain if a nerve that was likely to be compromised by his surgical approach was the sciatic nerve, or a branch of the peroneal nerve. Reassured by a lack of contraction of relevant muscle groups, he continued to operate under the impression that the structure about which he was concerned was not the sciatic nerve.

Unfortunately, in the context of neuromuscular blockade, there was no rationale for this approach. It transpired that Mr Y suffered severe foot drop as a result of extensive damage to the sciatic nerve. Mr Y sued Mr O as a result of his injuries.

The case hinged on whether Mr O had taken sufficient care in establishing the relevant anatomy during surgery. Dr A had documented in the anaesthetic record that he had given the muscle relaxant, and was adamant that he had told Mr O this fact. Mr O was insistent that Dr A had not informed him about the administration of the drug and so had left him open to the error that he made.

During an investigation of events surrounding the case it emerged there were unresolved investigations into allegations of bullying and harassment between Mr O and Dr A. In the context of how Mr Y suffered his injury, and the clinicians' apparent failure to communicate, it was impossible to defend the case, which was settled for a moderate sum with liability shared equally between the two doctors.

LEARNING POINTS

- Effective clinical communication between healthcare professionals is essential for safe patient care. In the context of an operating theatre, where there are anaesthetic factors that may have an impact on the surgical outcome (and vice versa), it is vital that this information is shared.
- Unresolved personal or professional disagreements between healthcare professionals who share responsibility for patients is potentially prejudicial to patient care. It is the responsibility of all who work in the clinical team, and those who manage them, to make sure that patients are protected from any adverse outcome that results from doctors not working together properly. The wellbeing of patients must always significantly outweigh the personal disagreements of doctors.
- The rights and wrongs of any argument come second to their conduct. Both individuals could find themselves the subject of investigation by the regulatory authorities.
- Independent, external professional assistance with conflict resolution may sometimes be necessary and can be extremely effective.

For more help in dealing with clinical communication between colleagues why not try our FREE workshops on *Mastering Professional Interactions*? To find out more and book a place, go to: **medicalprotection.org/uk/education-and-events**

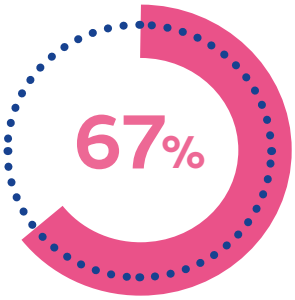
GREAT EXPECTATIONS

Managing patient expectations well is essential for an effective consultation. A disconnect between the doctor and the patient in this regard can lead to a dissatisfied patient and possibly a complaint or a claim.

A survey by Medical Protection and YouGov in 2015 measured the opinions of over 2000 patients and compared them with the opinions of 707 of our GP members. The results showed that 67% of the public believe that their expectations of their GP are lower now, compared with five years ago, whereas 88% of the GPs thought public expectations had increased.

More information about patients' expectations came from the Picker Institute's 2015 NHS adult inpatient survey (carried out on behalf of the Care Quality Commission), which found that only 60% of respondents felt they were definitely involved as much as they wanted to be in decisions about their care and treatment.

The inpatient survey implies that a lot of assumptions are being made about what is best for patients. At the same time, the differing perception between doctors and patients around rising expectations shows that we may be wrong in assuming we know what patient expectations are.



67% of the public believe that their expectations of their GP are lower.

88% of GPs thought public expectations had increased.

DISAPPOINTMENT GAP

If we fall into the trap of making assumptions we may be at risk of not meeting an un-elicited expectation or not appreciating and managing an unrealistic one. Patients themselves do not differentiate whether their expectations are realistic or not, they just have expectations and if they aren't met, that can lead to disappointment. The term "disappointment gap" is often used to describe the difference between their expectations and their subsequent experience.

One of the challenges is that meeting expectations can become an upward spiral as meeting higher expectations becomes the new expected norm, which may explain some of the discrepancies in the survey between members and their patients about changing levels of expectations.

There is a significant amount of research evidence linking this dissatisfaction to the subsequent likelihood that a patient will take further action in terms of a complaint or negligence claim. Of course, the patient's reflection and assessment of their own experience may differ from our own but it is the patient's perception that matters when it comes to expectation management. It, therefore, follows that doctors need to have strategies in place to elicit expectations and then to manage them.

We suggest that there are at least two points in the consultation where expectations should explicitly be elicited. The first occasion is the expectation regarding the appointment itself in terms of what the patient is hoping to achieve from it and the second is establishing the patient's expectation of the clinical management and outcomes.

EXPECTATIONS OF THE APPOINTMENT

Explicitly asking about the expectations of the appointment using phrases such as, "what were you hoping to discuss in today's appointment?" or "what were you hoping I might do for you today?" are examples but you will need to refine them for your own use. The exact phrase you use may depend on whether it is a new problem, a review or follow-up.

Dr Vanessa Perrott, Medical Protection's Head of Education Development and Delivery, explores the importance of patient expectations and how doctors can manage them

We recommend eliciting this expectation early on to avoid the problem of the "hand on the door-handle" comment. These comments typically come at the end of a consultation, just as patients are leaving, when they raise a new issue or symptom not previously discussed. Even worse is the scenario where they leave dissatisfied because their unvoiced expectation was not met.

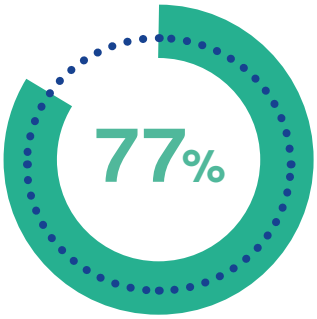
EXPECTATIONS OF MANAGEMENT

Establishing patient expectations of treatment by asking will help ensure that your treatment is directed towards meeting their realistic expectations and will also help identify any that are unrealistic. What often happens, if we don't ask, is that we make assumptions that can often be wrong. For example, we might assume that cosmetic appearance is the most important patient expectation or priority whereas, it might be symptom control. Proceeding with an intervention in the presence of unmanaged and unrealistic expectations will likely lead to disappointment when these are inevitably unmet.

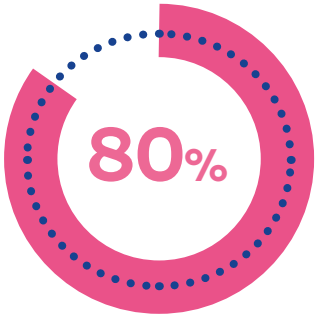
Shared decision making is the widely accepted model of involving patients in decisions about their care. The challenge for many of us is that a wise decision isn't dictated by science and clinical expertise alone, but requires consideration of the patient's perspective. It also requires clinicians to move from the "general" (what might be the right decision for the majority of patients), to the "individual" (what is the right decision for this individual). The only way to achieve the latter is to ask the patients what matters to them and involve them. Some useful phrases could include: "What would be a good result for you?" or "What are you hoping treatment will achieve?"

These will minimise the likelihood of a disappointment gap and increase the likelihood that that the treatment you are proposing will meet patient expectations.

One point from the survey where doctors and patients are of one voice is, reassuringly, around trust. Some 77% of GPs surveyed think that their patients still trust them and 80% of patients agreed they do trust their doctors. However, in the current medicolegal climate, it would be unwise to rely on this trust alone. Specific questions aimed at overtly eliciting expectations from patients and then managing those expectations can help improve consultations and lead to more satisfied patients.



Some 77% of GPs surveyed think that their patients still trust them.



80% of patients agreed they do trust their doctors.

MORE SUPPORT FROM MEDICAL PROTECTION

Two workshops in the Mastering series (Mastering your Risk and Mastering Shared Decision Making) look at communication models where expectations are a key element. These are FREE for members and you can EARN 3 CPD POINTS. To find out more and book a place visit: **medicalprotection.org/workshops**

ON THE POLICY FRONT

Thomas Reynolds, Medical Protection's Public Affairs and Policy Manager, provides a round-up of what our policy team is doing for members

The Scottish government is exploring the merits and limitations of a 'no-fault' compensation system of redress for harm resulting from clinical treatment, and earlier this year draft proposals were published for consultation on a 'No-Blame Redress' (NBR) scheme.

Since the Scottish government formally instigated these discussions, back in 2009, we have sought to share our experience and expertise. Medical Protection has a long history in New Zealand, where the 'no-fault' principle sits at the centre of compensation for injuries resulting from clinical treatment. We have more than 17,000 members in New Zealand and, based upon our experience in representing them, it is evident that the detail of such a compensation system is open to considerable legal argument.

In June 2016, we responded to the consultation on the draft proposals for a NBR scheme. Below are some of the key points about the new proposed scheme, and our view on them.

AVOIDABILITY

It is proposed that the new scheme would apply only if the harm was "avoidable", but the definition of this remains unclear.

We have called on the Scottish government to provide a clear definition of what precisely constitutes "avoidable" harm. Of particular importance is whether the definition would exclude known complications. If that were the case, the question is raised as to what would happen when a known complication does indeed occur, but the procedure may have been done poorly and that led to the complication?

For instance, the risk of post-operative deep vein thrombosis (DVT) is a well-known complication for patients undergoing surgery. Depending on risks factors, good practice directs that the healthcare team responsible ensures appropriate venous thromboembolism (VTE) prophylaxis. DVT can occur despite exemplary care as an inherent risk of surgery, however, it is also a potential complication of negligent treatment. It is, therefore, unclear whether this postoperative complication would be excluded from the remit of the NBR scheme

'FAST TRACK' CLAIMS

The Scottish government is also proposing that claims going through the NBR scheme should be 'fast tracked'. Given that this has the potential to keep disruption to a minimum for the healthcare professionals involved, we are predominantly supportive, however the Scottish Government needs to supply much more detail.

We expect those assessing 'fast track' claims to be independent medical experts who are currently in clinical practice. Furthermore, by the standards of a responsible body of medical opinion, they should also be suitably experienced to comment upon the cases they are being asked to review.

We are continuing to impress the importance of this on the Scottish government. It is a vitally important element of the scheme.

INTEGRATION OF PROCESSES

A specific proposal underpinning the draft scheme is for the redress to be integrated with incident investigation, the duty of candour, and the complaints process. The Scottish government's stated aim in this proposal is to improve consistency and shared learning.

We fully support a culture of openness in healthcare, and have long called on government and regulators to play their part in advancing a cultural shift towards openness and learning. While there are potential benefits for a unified system akin to that described in the consultation, the Scottish government must recognise that each of the processes has a different objective.

Combining governance processes with a component of financial redress could undermine the principle of openness and learning when things go wrong. While the duty of candour and complaints process are largely about reflection and learning, adding this extra dynamic of financial redress is likely to lead to 'blame', in the context of what should be a no-fault governance system.

If done incorrectly, this integration could also lead to healthcare professionals feeling the system is punitive rather than open with learning at its core. We believe this would be regrettable and so will continue to actively engage with the Scottish Government and other stakeholders on this issue.

A final, and important point, in these proposals is that of patient expectations. It is foreseeable that integration, as outlined in the proposals, could give rise to incorrect expectations on the part of the patient that any adverse event will lead to financial redress. The Scottish government must give careful consideration to how this can be addressed.

The proposals for this new compensation scheme are in their infancy. From the limited detail that has already been made available by the Scottish government, there a number of questions about how the scheme can work in practice.

As always, when government is considering medicolegal issues, we will ensure that your perspective is properly reflected in the debates to come.

WHAT DO YOU THINK?

We would like to hear from you. Send your comments to **casebook@medicalprotection.org**

FROM THE CASE FILES

Dr Janet Page, Medical Claims Adviser, introduces this edition's case reports

Join the discussion about this edition's case reports. Visit **medicalprotection.org** and click on the 'Casebook and Resources' tab

In a world in which technological advances and medical innovation abound, it is very easy to overlook the importance of the fundamental clinical skills of history taking and clinical examination. Yet, as some of the cases you will be reading about in this edition illustrate, a few extra minutes taken to ask pertinent questions and perform relevant examinations pays dividends. Not only may it result in an earlier diagnosis and improved outcome for the patient, but it could also reduce the risk of a complaint or a claim of clinical negligence.

In 'Tunnel vision', having failed to take a proper history at the first consultation, Mrs O's doctors fell into the trap of going along with the earlier presumptive diagnosis. Despite repeated attendances by the patient with worsening symptoms, no further history was elicited and no examination undertaken. The correct diagnosis was ultimately made when Mrs O collapsed resulting in an emergency admission to the local hospital.

In 'Tripped up', Master Y was reviewed twice by his GPs, Dr E and Dr B, three and seven weeks after his fall when he was still complaining of unremitting pain, despite which there was no attempt to revisit the history and review the original diagnosis. It was only by chance that an unrelated abnormality on a knee x-ray prompted orthopaedic referral which led to the correct diagnosis being made.

Making a diagnosis is particularly challenging for patients with more than one co-existing condition, as illustrated in 'Back to front'. In this case, a careful review of the character of Mr W's pain after he failed to respond to treatment may have prompted consideration of alternative diagnoses.

Communication and process errors are other themes emerging from this edition's case reports. In Mr T's case an abnormal MSU result was marked as "normal" and filed in the records without action. Notwithstanding that Dr W had no record of having received the health screener's letter, the practice's failure to communicate the abnormal result to the patient or to flag it up in the records led to further actions which compounded the problem and was indefensible. 'Turning a blind eye' is another example of how a failure to communicate an abnormal result to a patient can have devastating consequences. In this case, Dr L, in his desire not to alarm the patient or to disclose sensitive information in a letter, failed to convey to Mrs R the urgency of his request such that she chose to ignore it. In such circumstances it is imperative that the request is followed up if the patient fails to attend within the anticipated timeframe.

Poor communication between healthcare providers can also lead to problems, as illustrated by 'A risk of harm' and 'Paediatric brain injury'. In both cases the failure to give clear, explicit and documented instructions to nursing staff led to a misunderstanding as to the level of observation required, which contributed to a delay in treatment of a postoperative complication in BC's case and to Miss A suffering serious harm.

Finally, time and time again, we see the impact of poor record keeping on our ability to defend our members' actions, particularly when it comes to issues of consent and providing evidence of discussions of risks and complications. The case of Mrs W and Mr D is no exception. Master Y's doctors, Dr E and Dr B, are also criticised for their poor record keeping, and our GP expert in that case remarks on the discrepancy between their described usual practice and the paucity of the records. Today's doctors are practising in an increasingly pressured and challenging environment in which the temptation to take shortcuts is a strong one. By continuing to practise those core skills of history taking, clinical examination and communication, doctors can reduce substantially the risk of a successful claim of clinical negligence being brought against them.

At Medical Protection we are proud to say that we were able to successfully defend 74% of medical claims (and potential claims) worldwide between 2011 and 2015. We believe that through our risk management advice, and the learning taken from case reports such as these, we can help members lower their risk, and improve that figure even further.

What's it worth?

Since precise settlement figures can be affected by issues that are not directly relevant to the learning points of the case (such as the claimant's job or the number of children they have), this figure can sometimes be misleading. For case reports in *Casebook*, we simply give a broad indication of the settlement figure, based on the following scale:

- HIGH £1,000,000+
- SUBSTANTIAL £100,000+
- MODERATE £10,000+
- LOW £1,000+
- NEGLIGIBLE <£1,000

A HIDDEN PROBLEM

A failure to act on an abnormal test result means a serious diagnosis is missed

Mr T, a 40-year-old accountant, attended a private health check under his employer's healthcare scheme. Blood and protein were noted on urinalysis and his eGFR was found to be 45 ml/min/1.73 m^2. He was asked to make an appointment with his GP and was given a letter highlighting the abnormal results to take with him.

Mr T saw his GP, Dr W, shortly after and told her that blood had been found in his urine on dip testing during a health check. Dr W arranged for an MSU to be sent to the laboratory. The MSU showed no infection or raised white cells but did confirm the presence of red blood cells. Unfortunately the result was marked as "normal" and filed in the notes without any action.

One year later Mr T saw Dr W again with a painful neck following a road-traffic accident. Dr W prescribed diclofenac tablets to help with the discomfort. One week later he booked an urgent appointment because he had developed a severe headache and felt very lethargic and breathless. He was seen by Dr A, who diagnosed a chest infection and prescribed a course of amoxicillin.

Mr T went home but was taken to hospital later the same day following a fit. He was subsequently diagnosed with malignant hypertension and severe renal failure with pulmonary oedema. Again, blood and protein were found in his urine but this time his eGFR was 12 ml/min/1.73 m^2. Mr T stabilised but needed assessment for possible kidney transplantation.

Mr T was angry and upset about the care he had received from his GP. He alleged that he had given Dr W a letter from the healthcare assessment when he consulted with her and that she had failed to act on it. He also alleged that Dr W had failed to diagnose his renal disease or refer him to the renal team. He claimed that this delay had resulted in progression of his condition to end stage renal failure.

EXPERT OPINION

Medical Protection sought the advice of a consultant nephrologist, Dr B. Dr B was of the opinion that Mr T's renal impairment was probably due to glomerusclerotic disease rather than hypertension at the time of the health check. He felt that the diclofenac prescribed caused the clinical situation to deteriorate, leading to the acute presentation of severe hypertension and renal failure. He advised that if Mr T's condition had been diagnosed earlier, this would have allowed monitoring and control of his blood pressure. It would also have been unlikely that NSAIDs would have been prescribed, thus avoiding the acute presentation. It was Dr B's opinion that earlier diagnosis and treatment would have delayed the need for renal transplant by a period of between two to four years.

Dr W specifically denied that she had been given the letter from the private health check and indeed there was no evidence of it within the GP records. She did, however, accept that she had erroneously marked the MSU result as normal and had thus not taken any action. In view of this, it was agreed that Dr W was in breach of duty in this matter and the case was settled for a high sum.

Learning points

- This case raises issues about communication between healthcare providers. The GMC states that "you must contribute to the safe transfer of patients between healthcare providers and between health and social care providers".[1] Doctors need to consider whether their systems for receiving and recording information, written or verbal, from other healthcare providers are sufficiently robust.
- Mistakes can be easily made when working under stress with high workloads. It is important, however, to be thorough and to ensure that all elements of a test result are reviewed before marking the result as 'normal'.
- The assessment and management of non-visible haematuria in primary care is discussed in a useful clinical review published by *The BMJ* in 2009.[2]

AF

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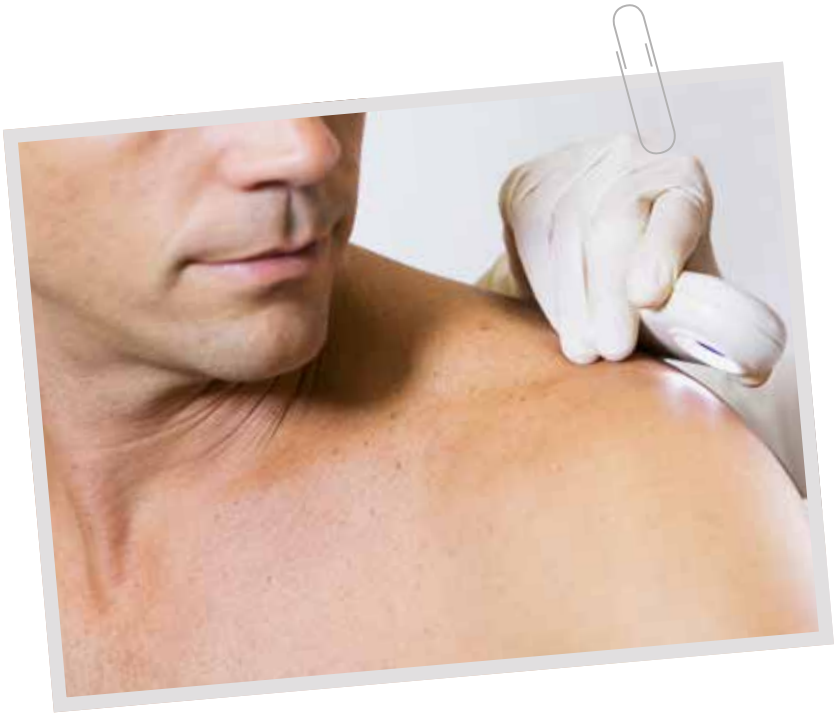
2. Kelly JD, Fawcett DP and Goldberg LC, Assessment and Management of Non-visible Haematuria in Primary Care, *BMJ* 338: a3021(2009)

DIATHERMY DRAMA

Minor surgery to remove a skin tag is complicated by an unexpected event



Mr P was a 32-year-old runner. He had a skin tag on his back that kept catching on his clothes when he ran. It had become quite sore on a few occasions and he was keen to have it removed. He saw his GP, Dr N, who offered to remove the skin tag in one of his minor surgery sessions.

The following week, Mr P attended the minor-surgery clinic at his GP practice. Dr N explained that he was going to use diathermy to remove the skin tag and Mr P signed a consent form.

Mr P lay on the couch and a sterile paper sheet was tucked under him. The assisting nurse sprayed his skin with Cryogesic, a topical cryo-analgesic. The spray pooled on his back and soaked into the paper sheet. No time was left for the alcohol-based spray to evaporate. Mr P's back was still wet when Dr N began the diathermy to remove the skin tag. Unfortunately, the paper sheet caught fire along with the pooled spray on his back. Mr P suffered a superficial burn. Dr N and the nurse apologised immediately and applied wet towels and an ice pack. The burn area was treated with Flamazine cream and dressings. Mr P was left with a burn the size of a palm on his back which took two months to heal fully.

Mr P made a claim against Dr N, alleging that his painful burn had been the result of medical negligence. It is well known that alcohol-based solutions pose a risk of fire when diathermy is used, and in failing to ensure the area was dry before applying the diathermy Dr N was clearly in breach of his duty of care. Medical Protection was able to settle the claim quickly, thus avoiding unnecessary escalation of legal costs.

Learning Points

- Flammable fluids employed for skin preparation must be used with caution. GP practices should refer to safety data sheets before using these products. The data sheet for Cryogesic states that it "may form a flammable/explosive vapour–air mixture " and that one should "ensure good ventilation and avoid any kind of ignition source".[1]
- The Medicines and Healthcare products Regulatory Agency (MHRA) warns that "spirit-based skin preparation fluid should not be allowed to pool and should be dry or dried before electrosurgery commences".[2]
- The fire triangle is a simple model illustrating the three necessary ingredients for most fires to ignite: heat, fuel, and oxygen. In clinical situations such as the one described above, diathermy provides the heat and skin preparation fluids provide the fuel.[3]
- According to the the National Patient Safety Agency (NPSA), when a medical error occurs it is important to document the incident as soon as possible after it has happened. This should include the date, time and location of events. It also advises that it is best practice to apologise because openness and honesty can help to prevent formal complaints and litigation. Doctors should also report incidents via local reporting systems to help improve patient safety and to discuss adverse incidents with colleagues to learn lessons and create solutions to improve future care.[4]

AF

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2. Medicines and Healthcare Products Regulatory Agency, SN 2000(17)–*Use of Spirit-based Solutions During Surgical Procedures Requiring the use of Electrosurgical Equipment*, London: MHRA (2000)
3. Rocos B and Donaldson L, Alcohol Skin Preparation Causes Surgical Fires, *Ann R Coll Surg* Engl 94(2):87–9 (2012)
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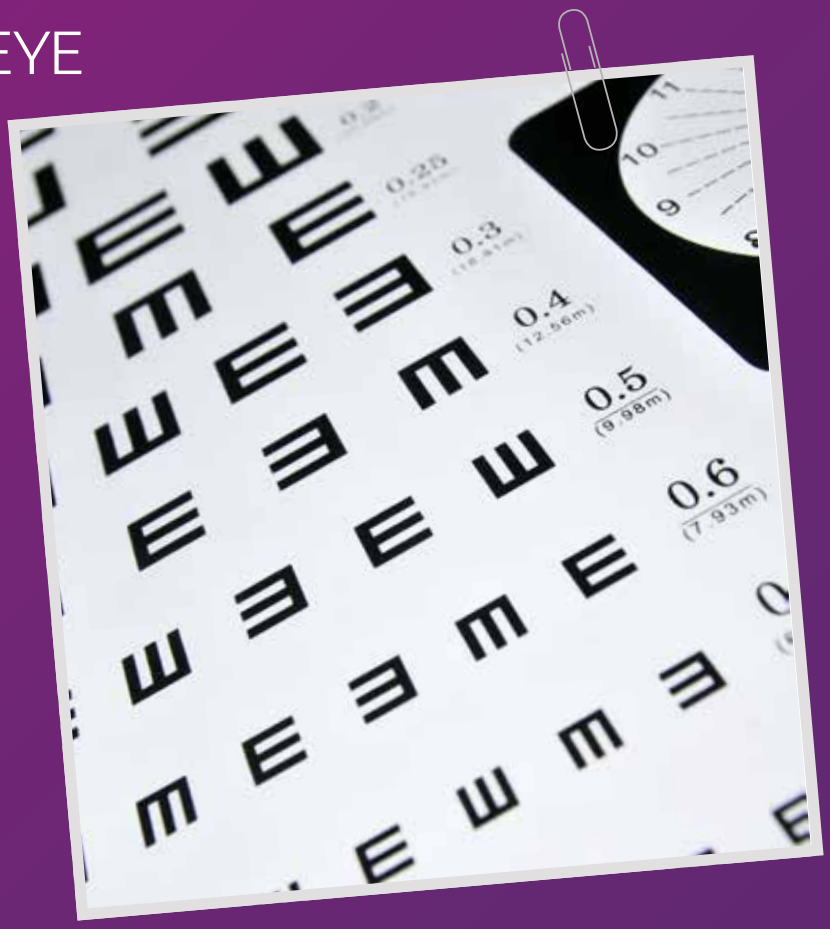
TURNING A BLIND EYE

A delay in sharing an urgent result with a patient results in a loss of vision



Mrs R, a 56-year-old freelance journalist, became aware she had reduced vision in her right eye. She saw her optician who noted that her visual acuity was 6/18 in the right eye and 6/6 in the left eye. Examination confirmed a nasal visual field defect in the right eye with a normal visual field in the left eye. The right optic disc was atrophic but the left appeared normal. Mrs R's optician referred her to the local ophthalmology emergency unit, where Dr S confirmed his findings and also detected a right afferent pupillary defect, and reduced colour vision in the right eye. He made a diagnosis of right optic atrophy and arranged blood tests to investigate this further.

Two weeks later Dr S received a telephone call from the virology department informing him that Mrs R had tested positive for syphilis. Dr S immediately contacted Mrs R's GP, Dr L, informing him of the result and the need for urgent treatment.

On the same day, Dr L wrote a letter to Mrs R asking her to book an appointment. His letter said: "Please be advised that this is a routine appointment, and there is no need for you to be alarmed."

Mrs R did not take this letter seriously and no appointment was made. Dr L did not pursue the matter.

Seven months later, Mrs R was referred to Dr D in the neuro-ophthalmology clinic for deteriorating vision affecting both eyes. Dr D diagnosed bilateral optic atrophy and repeated the blood tests for syphilis. He arranged for Mrs R to be admitted to hospital, where lumbar puncture and examination of the cerebrospinal fluid confirmed the diagnosis of neuro-syphilis.

Mrs R was treated with penicillin and corticosteroids, which cleared the infection. Post-treatment visual acuity in the left eye was 6/5 but she had a severely reduced field of vision. In the right eye her visual acuity was light perception only. Although these changes had stabilised, Mrs R was assessed as legally blind.

Mrs R brought a case against her GP alleging that the delay in treatment led to her losing her sight. Due to this she had lost her driving licence, which reduced her earning capacity substantially.

EXPERT OPINION

A GP expert considered that, in failing to follow-up an important laboratory result, Dr L was in breach of his duty of care. Ophthalmology expert opinion concluded that the delay in treatment resulted in loss of the remaining 50% of vision in the right eye and 80% of vision in the left eye. The loss of sight impacted substantially on Mrs R's lifestyle and earning capacity. Both the virology department and the ophthalmologist were deemed to have acted appropriately and promptly.

The case was settled for a substantial sum on behalf of Dr L.

Learning points

- When faced with a serious condition requiring urgent treatment you should be diligent in your attempts to communicate this to the patient promptly and sensitively.
- When communicating urgent information to colleagues, direct conversations are the most effective. It may be useful to follow a conversation with a letter because this may reinforce a point and prompt further action. A letter on its own may be insufficient in that it may be mislaid, misfiled or the importance not understood.
- When communicating sensitive information to patients, a face-to-face consultation is most appropriate. Communicating such information in writing could lead to misunderstanding, a breach of confidentiality, or may downplay the urgency of the matter.
- Be aware of local practice: the management of neuro-syphilis is often initiated through neurology or medical teams and the ophthalmologist should consider direct referral when the condition is sight-threatening. Ophthalmologists should also be prepared to discuss laboratory results with patients and, where appropriate, emphasise the need for prompt treatment.

AK

TRIPPED UP

A child is unable to weight bear after a fall

Master Y, aged nine, was walking home from school when he tripped over and fell. He was usually very stoical but after the fall he cried with pain when he tried to stand on his right leg. His mother took him into the local A&E department where, after a brief examination, he was discharged home with a diagnosis of a torn quadriceps muscle. No x-rays were taken. He was advised to avoid weight bearing for two weeks.

Master Y was no better three weeks later. His mother rang their GP, Dr E, who saw him the same day. Dr E noted the history of a fall and recorded only "tenderness" and "advised NSAID gel and paracetamol".

Master Y continued to complain of pain in his thigh and also his knee. One month later, he saw another GP, Dr B, who assessed him and diagnosed "musculoskeletal pain". There was no record of any examination. Master Y's knee pain continued over the next month. Dr B reviewed him and arranged an x-ray of his knee. The only entry on the records was "pain and swelling right knee".

The x-ray showed signs of osteoporosis and features consistent with possible traumatic injury to the right proximal tibial growth plate. The report advised an urgent orthopaedic opinion, which Dr B arranged .

The orthopaedic surgeon noted an externally rotated and shortened right leg. An urgent MRI revealed a right-sided slipped upper femoral epiphysis and Master Y underwent surgery to stabilise it. The displacement was such that an osteotomy was required later to address residual deformity.

Despite extensive surgery Master Y was left with a short-legged gait and by the age of 16 he was increasingly incapacitated by pain in his right hip. Surgeons considered that he would need a total hip replacement within ten years, and that a revision procedure would almost certainly be required approximately 20 years after that.

A claim was brought against GPs Dr E and Dr B, and the hospital for failing to diagnose his slipped upper femoral epiphysis. It was alleged that they failed to conduct sufficiently thorough examinations, arrange imaging and refer for timely orthopaedic assessment.

EXPERT OPINION

Medical Protection instructed a GP expert who was critical of both GPs' unacceptably brief documentation. He noted the discrepancy between what was actually written down by the GPs in the contemporaneous records and their subsequent recollection of their normal practice. The expert felt that their care fell below a reasonable standard.

Medical Protection also obtained an opinion from a consultant orthopaedic surgeon. The expert was critical of the assessment undertaken in the A&E department and advised that knee pain can be a feature of a slipped upper femoral epiphysis. The expert considered that the fall caused a minor slippage of the right upper femoral epiphysis, which was a surgical emergency and the appropriate management would have been admission for pinning of the epiphysis *in situ*. In the presence of a slight slip and subsequent fusion of the epiphysis, recovery without functional disability would have been expected. As a consequence of failure to diagnose an early slip, Master Y lost the chance of early correction. Instead, he developed a chronic slippage with associated disability that necessitated osteotomy.

The case was settled for a high sum, with a contribution from the hospital.

Learning points

- A slipped upper femoral epiphysis is a rare condition in general practice. It usually occurs between the ages of eight and 15 and is more common in obese children. It should be considered in the differential diagnosis of hip and knee pain in this age group.
- Because patients often present with poorly localised pain in the hip, groin, thigh, or knee, it is one of the most commonly missed diagnoses in children.[1] In 15% of cases, knee or distal thigh pain is the presenting feature. Referred pain can cause diagnostic error and orthopaedic examination should include examination of the joints above and below the symptomatic joint.
- The medical records were inconsistent with the GPs' accounts. When records are poor it is very difficult to defend a doctor's care successfully. The GMC requires doctors to ensure consultations are recorded "clearly, accurately and legibly".[2]
- Safety-netting is important and follow-up should be arranged if patients are not improving or responding to treatment. This should prompt a thorough review and reconsideration of the original diagnosis.

AF

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2. General Medical Council, *Good Medical Practice* (2013)

TUNNEL VISION

A patient presents several times with a worrying vaginal discharge

Mrs O, a 34-year-old mother of three, visited her GP with a two-month history of worsening vaginal discharge which had become malodorous recently. Her husband had urged her to see the doctor because he was particularly concerned when she had admitted to the discharge being blood stained.

The first GP she saw, Dr A, took a cursory history and simply suggested she should make an appointment with the local GUM clinic. Of note, Dr A didn't enquire about the nature of the discharge, associated symptoms or note that she had not attended for a smear for over five years, despite invitations to do so. Dr A did not examine Mrs O, nor did he arrange investigations or appropriate follow-up. Mrs O was deeply offended that Dr A had implied the discharge was likely to be secondary to a sexually transmitted infection and did not feel the need to attend a GUM clinic.

She re-presented to another GP, Dr B, several months later, complaining that her discharge had worsened. Dr B reviewed the previous notes and encouraged her to make an appointment with the GUM clinic as recommended previously by Dr A. There was no evidence from the notes that a fresh review of the history had been undertaken. No examination was performed and Dr B did not arrange vaginal swabs or scans despite Mrs O's continued discharge.

One week later, Mrs O re-attended the surgery where Dr B agreed to try empirical clotrimazole on the premise she may be suffering from thrush. Again, no examination or investigations were discussed, and there was no evidence of safety netting advice documented in the records.

Two months later, Mrs O saw a third GP, Dr C, because the clotrimazole had failed to resolve her worsening symptoms. By now she had started to lose weight, had developed urinary symptoms, and her bloody vaginal discharge had worsened. Despite her malaise and pallor, Dr C again failed to take an adequate history or examine Mrs O and further reinforced the original advice that Mrs O attend the GUM clinic.

Mrs O collapsed later that week and was taken by ambulance to the A&E department of her local hospital. She was found to have urosepsis and was profoundly anaemic with a haemoglobin of 60 g/l. Examination by the A&E team revealed a hard, irregular malignant-looking cervix and a large pelvic mass. She was admitted under the gynaecology team, who arranged an urgent scan. The scan revealed an advanced cervical cancer with significant pelvic spread and bulky lymphadenopathy.

After an MDT meeting and a long discussion with her oncologist, Mrs O and her husband elected to try a course of neoadjuvant chemotherapy and debulking surgery. Unfortunately, prior to surgery, she experienced severe pleuritic chest pain and a working diagnosis of pulmonary embolism was made. Further investigations excluded embolic disease but confirmed tumour deposits in the lung and liver.

It was agreed she would forego chemotherapy and Mrs O was referred to the palliative care team. Her symptoms were managed in the community until her death at home two months later.

Learning points

- Failure to take an adequate history and examination will make any case difficult to defend.
- It is not advisable to reinforce a colleague's diagnosis or management advice without first conducting your own assessment of the patient's symptoms.
- Alarm bells should ring if patients return multiple times for the same problem.
- Where clinically relevant, a screening test should be offered opportunistically to patients who fail to respond to routine invitations.

RT

EXPERT OPINION

A claim was brought against all three GPs for failure to take adequate histories, failure to examine, failure to accurately diagnose and failure to safety net. An expert witness was highly critical of the care Mrs O received from all the GPs involved and advised that her death was potentially avoidable with better care and a more robust system for smear recall. Breach of duty and causation were admitted and the family's claim was settled for a high amount.

AN UNLUCKY TUMMY TUCK

A patient is unhappy with the outcome of cosmetic surgery

A 34-year-old lady, Mrs C, consulted a private plastic surgeon, Mr Q, about her lax abdominal skin. Nine days later, she was admitted under his care for an abdominoplasty ("tummy tuck"). The procedure was uneventful and the patient was discharged after 24 hours.

A fortnight later, at a postoperative nurse-led clinic, Mrs C complained of lower abdominal swelling. This was identified as a seroma and she was briefly admitted for aspiration by Mr Q.

Three months later she was seen again at a nurse-led clinic, on this occasion complaining of peri-umbilical pain. She was reviewed two days later by Mr Q himself, whose examination noted nothing amiss. Her symptoms continued and four months later her GP referred her to the local general hospital, raising the possibility of an incisional hernia. Mr Q was contacted by the hospital and reviewed Mrs C again. He offered to perform a scar revision and to waive his fee.

Three months after this revision surgery was performed, Mrs C had further problems around the scar site, this time manifesting itself as an infection, which developed into an abscess. Initially her GP treated this with antibiotics and dressings. However, despite this intervention, she was seen again by Mr Q, who re-admitted Mrs C for drainage of the abscess and revision surgery to the scarring around the umbilicus.

Mrs C was unhappy with the cosmetic result, and after her discharge from hospital, Mr Q referred her to a colleague, Mr H, for a further opinion. Mr H reviewed Mrs C and replied that in his view the umbilicus and the horizontal scar were placed too high, and he recommended a further revision. Subsequently, Mr Q received a letter of claim from Mrs C's solicitors alleging that the surgery had been carried out negligently and she had been left with an unsatisfactory cosmetic outcome requiring further surgery.

EXPERT OPINION

An expert opinion obtained by Medical Protection was critical of a number of aspects of Mr Q's management, including the positioning of the incision line, consent issues around scarring, and some technical aspects of Mr Q's wound closure methods.

In the light of the expert's comments the case was settled for a moderate amount.

Learning points

A patient's decision to make a claim against his or her clinician often reflects more than one point of dissatisfaction or poor performance. Some of the important points in this case include:

- The interval between Mrs C having her first consultation with her surgeon and the subsequent operation was just nine days. When cosmetic surgery is being considered it is good practice to allow a cooling-off period of at least two weeks before the surgery. The patient should be provided with, or directed to, sources of information about the proposed procedure. It is also best practice to offer patients a second consultation, which allows the patient to discuss any doubts or questions which may have arisen. Patients should be under no pressure to proceed with aesthetic surgery.
- Complications can occur after any surgery. In abdominoplasty, issues of scarring and the formation of seromas can occur. It is vital that these possibilities are discussed during the pre-procedure consultations. It is insufficient to simply list them on a consent form, signed in a rush on the morning of operation by a nervous patient.
- It is vital to ensure careful documentation of the pre-procedure consultations. This should outline what has been discussed, including the alternatives, potential outcomes and possible risks associated with any procedure. You should also document any literature that has been supplied to the patient or sources of information that were signposted.
- Aesthetic surgery requires a strong element of psychological understanding of the patient, and patients need to feel supported by their surgeon. Good communication and timely reviews are essential in maintaining a good relationship.
- Being asked to provide a second opinion can be an extremely challenging task, particularly if you may disagree with the original doctor. In this case, Mr H was critical of the repeat surgery carried out by Mr Q. Doctors should always convey their honest opinion to patients. However, you should consider the effect that the manner you express an opinion can have. Excessive or derogatory comments to a patient about a colleague are unlikely to be helpful and may encourage a patient to complain or pursue a claim.

PM

A RISK OF HARM

A psychiatric patient is placed under close observation

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Miss A, a 30-year-old teacher, saw Dr W, a consultant psychiatrist, in the outpatient clinic. Dr W noted Miss A's diagnosis of bipolar affective disorder, her previous hospital admission for depression and her history of a significant overdose of antidepressant medication. Dr W found Miss A to be severely depressed with psychotic symptoms. Miss A reported thoughts of taking a further overdose and Dr W arranged her admission informally to hospital.

During Miss A's admission Dr W stopped her antidepressant medication, allowing a wash-out period before commencing a new antidepressant and titrating up the dose. He increased Miss A's antipsychotic medication and recommended she be placed on close observations due to continued expression of suicidal ideation. He documented that Miss A appeared guarded and perplexed, did not interact with staff or other patients on the ward, and spent long periods in her nightwear, lying on her bed. He did not document the content of her suicidal thoughts. Dr W reiterated to nursing staff that close observations should continue.

During the third week of her admission, Miss A asked to go home. Miss A's named nurse left Miss A alone to contact the team doctor to ask whether Miss A required assessment. While alone in her room, Miss A set fire to her night clothes with a cigarette lighter and sustained burns to her neck, chest and abdomen. She was transferred to the A&E department and then to the plastic surgical team. She remained an inpatient on the burns unit for three months, requiring skin grafts to 20% of her body.

Miss A made a good recovery from this incident and subsequently brought a claim against Dr W and the hospital. She alleged Dr W had failed to prescribe adequate doses of medication to ensure the optimal level of improvement in her mental health symptoms, failed to adequately assess the level of risk she posed, and failed to ensure constant specialist nursing care was provided to supervise her adequately during her hospital stay. She also alleged the hospital had failed to ensure she did not have access to a cigarette lighter. Miss A claimed that she would not have suffered the severe burns and subsequent post-traumatic stress disorder if not for these failings.

EXPERT OPINION

An expert opinion was sought from a psychiatrist. The expert made no criticism of the medication regime or changes to it, but was critical of the communication between Dr W and nursing staff over the meaning of the words "close observation", and the lack of a policy setting this out. She was also of the view that additional nursing staff should have been requested to ensure one-to-one nursing of the patient during her admission. She was critical of the hospital for allowing the patient access to a lighter on the ward, and concluded that the incident could have been avoided if these failures had not occurred.

Dr W acknowledged Miss A had been the most unwell patient on the ward at the time and in hindsight agreed that additional nursing staff should have been requested. Dr W highlighted that there was pressure on consultants not to request additional nursing staff due to cost implications. He also acknowledged that by "close observations" he had expected the patient to be within sight of a member of nursing staff at all times but had not ever communicated this specifically to the ward staff.

The claim was settled for a substantial sum, with the hospital contributing to the settlement.

Learning points

- Mental health units should have clear policies regarding observation levels and all staff should be aware of these. The observation level deemed appropriate for each patient should be clearly discussed with ward staff and documented within the notes, both on admission and whenever changes are made. The justification for any changes in the level of observation should be clearly documented.
- Robust risk assessment is always important. Risk assessment tools are available, and you should be familiar with any relevant local policies regarding these. Decisions made about the risk posed by a patient to themselves or others should be clearly documented and communicated.
- Mental health units should also have policies surrounding the requirement to check patient's belongings when they are admitted and for removing any items that may pose a risk, including lighters and any sharp implements.
- If a lack of resources results in concerns regarding patient safety, these should be raised by the clinician involved, following guidance set out by the GMC in *Raising and Acting on Concerns About Patient Safety*.

CNR

Further Reading

Royal College of Psychiatrists, Self-harm, Suicide and Risk: a Summary (2010) rcpsych.ac.uk/pdf/ps03-2010x.pdf

PAEDIATRIC BRAIN INJURY

Surgery for an arachnoid cyst is complicated by an intracranial bleed

A three-year-old child, BC, was admitted to hospital for investigation following an epileptic fit. A CT scan demonstrated a left-sided Sylvian fissure arachnoid cyst with bulging of the overlying temporal bone (but no midline shift).

BC underwent cyst drainage with insertion of a shunt under the care of Mr S, a consultant paediatric neurosurgeon, but it was complicated by an intracranial bleed. Intraoperative exploration revealed that there had been an injury to the temporal lobe that was likely to have been associated with the insertion of the ventricular catheter (which was not inserted entirely under direct vision). The haemorrhage was under control when the operation was concluded.

Following the surgery, BC was transferred to the paediatric ward as a high care patient. Mr S left the hospital having handed over care to Dr K, a consultant paediatrician, and Mr P, a consultant neurosurgeon. Mr S explained that BC had had an intraoperative bleed, that a clotting screen should be checked (to exclude an underlying bleeding disorder) and that regular neurological observations should be undertaken. Unfortunately the handover discussions were not documented in the records.

BC remained stable until early evening when Dr K was asked by the nursing staff to review her because she had started to vomit and had developed a dilated left pupil. A repeat scan demonstrated a haematoma in the Sylvian fissure with consequent displacement of the shunt, impingement of both the temporal and parietal lobes, together with a midline shift. Mr P was called and immediately returned BC to theatre to evacuate the haematoma.

Unfortunately BC sustained a neurological injury, which left her with a right-sided hemiparesis, cognitive difficulties and ongoing epilepsy.

The parents pursued a claim alleging:

- the original procedure was not indicated (and that non-surgical approaches were not considered);
- the shunt was inserted negligently, which led to the bleeding and associated brain injury;
- the bleeding was not adequately controlled in the context of the first procedure; and
- BC should have been transferred to a paediatric intensive care facility so that her neurological condition could have been monitored intensively.

EXPERT OPINION

Medical Protection sought an expert opinion from a consultant paediatric neurosurgeon, who was not critical of Mr S' decision to drain the cyst and insert a shunt. However, concerns were raised in relation to the operative technique which, the expert said, was not according to standard practice. The expert indicated that the preferred approach would be to insert the ventricular catheter under direct vision and postulated that there may have been damage to one of the branches of the middle cerebral artery.

The expert was not critical of the decision to transfer BC to a paediatric ward (on the basis that she did not require ventilation and that the monitoring facilities on the ward were appropriate) but was concerned about the lack of written and verbal instructions (particularly directed towards the nursing staff) relating to the postoperative care and neurological observations. In addition, the expert was of the opinion Mr S should have reviewed BC on the ward given that he had performed a surgical procedure on her that had been complicated by bleeding.

In light of the vulnerabilities highlighted by the expert, the claim was resolved by way of a negotiated settlement.

Learning points

- The allegations were wide-ranging and although the expert was supportive of some aspects of Mr S' involvement in BC's care, the concerns in relation to the operative technique and handover meant that there was no realistic prospect of defending the case successfully.
- The case emphasises the importance of communication and record keeping, particularly with reference to providing clear verbal and written handover to all relevant staff.
- It may be entirely appropriate to leave the care of a patient in the hands of colleagues at the end of a shift but it would have assisted Mr S's defence if he had reviewed BC on the ward postoperatively in light of the fact that the neurosurgical procedure had been complicated by bleeding.

RS

Further reading

GMC, *Good Medical Practice*, paragraphs 44 and 45, 'Continuity and Coordination of Care'.

BACK TO FRONT

An unusual presentation masks a significant underlying diagnosis

Mr W was a 55-year-old diabetic who worked in a warehouse. He began to get pain across his shoulders when he was lifting boxes and walking home. He saw his GP, Dr I, who noted a nine-month history of pain in his upper back and around his chest on certain movements. She documented that the pain came on after walking and was relieved by rest. Her examination found tenderness in the mid-thoracic spine. Dr I considered that the pain was musculoskeletal in nature and advised anti-inflammatory medication and one week off work.

Two weeks later Mr W returned to his GP because the pain had not improved. This time Dr I referred him to physiotherapy. Mr W did not find the physiotherapy helpful and four months later saw another GP, Dr J, who diagnosed thoracic root pain and prescribed dothiepin. He also requested an x-ray of the patient's spine, which was normal, and referred him to the pain clinic. The referral letter described pain worse on the left side that was brought on by physical activity and stress.

At the pain clinic, a consultant documented a two-year history of pain between the shoulder blades. The examination notes stated that direct pressure to a point lateral to the thoracic spine at T6 could produce most of the pain. Myofascial pain was diagnosed and injections at trigger points were administered.

Three months later Mr W was still struggling with intermittent pain in his upper back. He went back to see Dr J, who referred him to orthopaedics. His referral letter described pain in the upper thoracic region with radiation to the left side, aggravated by strenuous activity and stress. Again, it was recorded that the pain was reproduced by pressure to the left thoracic soft tissues.

Two months later Mr W was assessed by an orthopaedic surgeon who diagnosed ligamentous laxity and offered him sclerosant injections.

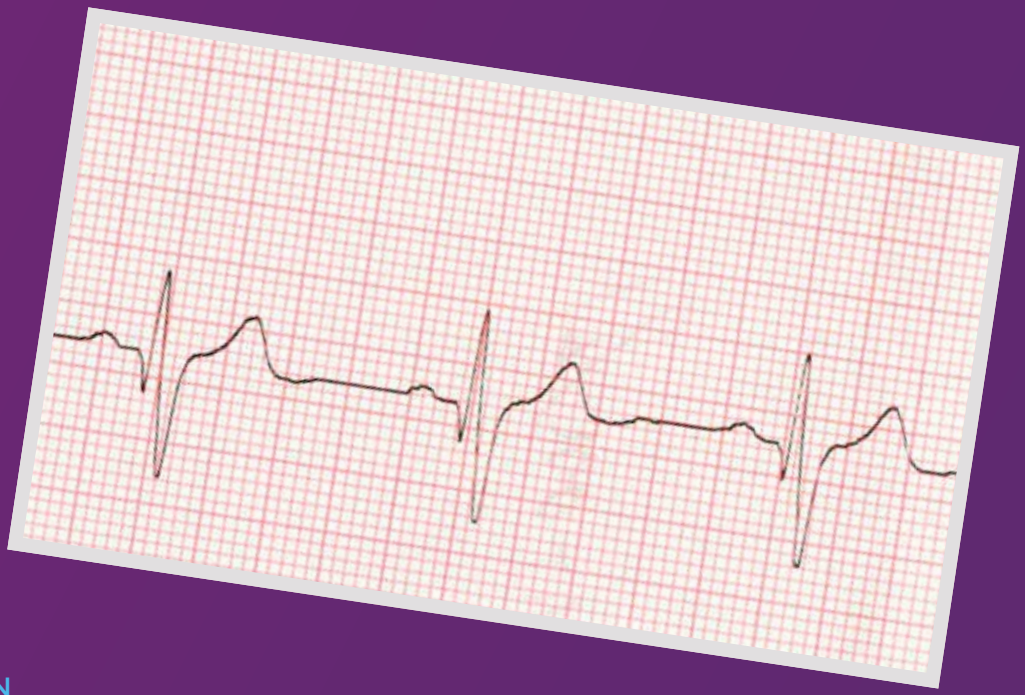
Mr W took on a less physically demanding role and the pain came on less often. After one year, however, his discomfort increased and his GP referred him back to the orthopaedic team.

A consultant orthopaedic surgeon found nothing of concern in his musculoskeletal or neurological examination. X-rays were repeated and reported as normal. It was thought that his symptoms were psychosomatic and he was discharged.

Six months later, Mr W was struggling to work at all. He rang his GP surgery and was given an appointment with a locum GP, Dr R. Her notes detailed a several-year history of chest and back pain on lifting and exercise that had worsened recently. Pain was recorded as occurring every day and being "tight" in character. It was also noted that he was diabetic, smoked heavily and that his mother had died of a myocardial infarction at the age of 58. Dr R referred him to the rapid access chest pain clinic.

Angina pectoris was diagnosed and an ECG indicated a previous inferior myocardial infarction. Mr W was found to have severe three-vessel disease and underwent coronary artery bypass grafting, from which he made an uncomplicated recovery. He was followed up in the cardiology clinic and continued to be troubled by some back pain.

Mr W brought a claim against GPs Dr I and Dr J for the delay in diagnosis of his angina.



EXPERT OPINION

Medical Protection sought the advice of an expert GP, Dr U. Dr U pointed out that Mr W appeared to have two chest pain syndromes. That is, coronary artery disease, which caused angina, and chronic musculoskeletal pain, which caused back and chest pain (as evidenced by continuing musculoskeletal pain even after coronary surgery). She thought that his angina had presented in a very atypical manner with features that had reasonably dissuaded the GPs and specialists from making the diagnosis. She supported the GPs' early management but believed that angina should have been considered when Mr W failed to respond to treatment. Dr U commented that pain brought on by stress and exertion should have raised suspicions of angina. She also felt that the GPs should have assessed cardiovascular risk factors sooner.

An opinion from a consultant cardiologist, Dr M, was also sought. Dr M explained that diabetic patients are more likely to have atypical presentations of angina and that, depending on which part of the heart is deprived of blood supply, the pain can sometimes be situated more posteriorly. He commented that if Mr W had been diagnosed earlier he would have commenced aspirin, statin, and beta-blocker therapy and been advised to stop smoking. This would have reduced his risk of myocardial infarction. Dr M believed that if this had been prevented Mr W's life expectancy could have been improved.

Based on the expert opinion, the case was deemed indefensible and was settled for a high amount.

Learning points

- Pain that is precipitated by exertion should always raise suspicion of angina pectoris. NICE[1] defines stable angina symptoms as being:
  - constricting discomfort in the front of the chest, in the neck, shoulders, jaw, or arms;
  - precipitated by physical exertion; and
  - relieved by rest or glyceryl trinitrate within about five minutes.
- People with typical angina have all three of the above features. People with atypical angina have two of the above features.
- Angina can present in uncharacteristic ways. There can be vague chest discomfort or pain not located in the chest (including the neck, back, arms, epigastrium or shoulder), shortness of breath, fatigue, nausea, or indigestion-like symptoms. Atypical presentations are more frequently seen in women, older patients and diabetics.[2]
- Multiple conditions can run alongside each other and we must try to untangle them by careful questioning and listening. Stepping back and looking at the bigger picture can help if a patient's symptoms are persistent.
- Confirmation bias can lead to medical error. The interpretation of information acquired later in a medical work-up might be biased by earlier judgments. When we take medical histories it can be tempting to ask questions that seek information confirming earlier judgements, thus failing to discover key facts. We also can stop asking questions because we have reached an early conclusion. *The BMJ* published an article about the cognitive processes involved in decision making and the pitfalls that can lead to medical error.[3]

AF

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2. Abrams J, Chronic Stable Angina, *N Engl J Med* 352:2524–33 (2005)
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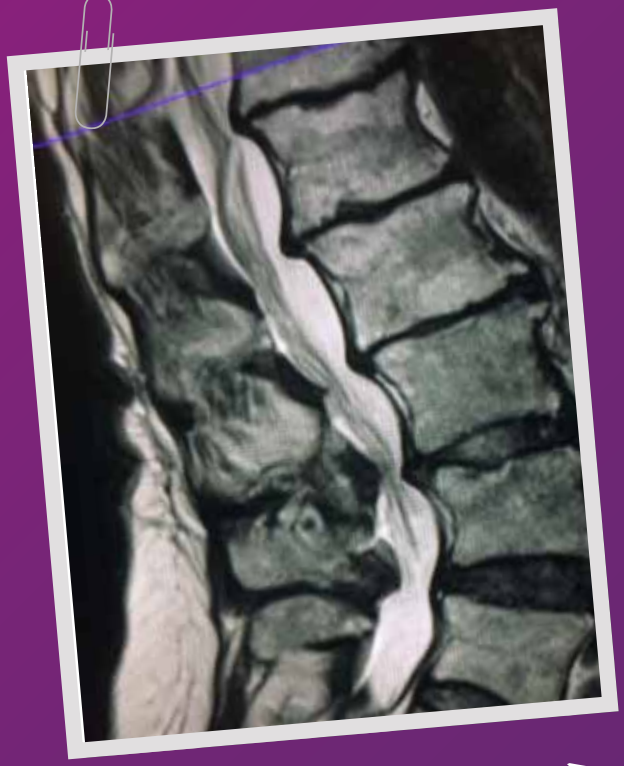
A MISSED OPPORTUNITY?

A patient suffers complications following spinal surgery



Mrs W, a 58-year-old business manager, consulted Mr D, an orthopaedic surgeon, with exacerbation of her chronic back pain. She had a history of abnormal clotting and had declined surgery three years earlier because of the attendant risks. An MRI scan confirmed degenerative spinal stenosis for which Mr D recommended an undercutting facetectomy to decompress the spinal canal while preserving stability. On this occasion, Mrs W agreed to the proposed procedure. Surgery was uneventful, and she was discharged home on the fourth postoperative day.

At her outpatient review 11 days later, Mrs W complained that she had been unable to open her bowels and that she had also developed a swelling at the wound site, from which Mr D aspirated "turbid reddish fluid". Suspecting a dural leak, Mr D undertook a wound exploration, which confirmed that the dura was intact. At the same time, a sacral haematoma was evacuated. In the two years following surgery, Mrs W was seen by Mr D and several other specialists complaining of ongoing constipation, urinary incontinence and reduced mobility which, although atypical, was thought to be due to cauda equina syndrome.

Mrs W brought a claim against Mr D, alleging that she had not been advised of the risks of the surgery and that no alternative options were offered to her. Furthermore, she claimed that had she been properly advised, she would have declined surgery, as indeed she had done in the past. She also alleged that Mr D failed to arrange appropriate postoperative monitoring such that her developing neurological symptoms were not acted on, and that she should have undergone an urgent MRI, which would have revealed a sacral haematoma requiring immediate evacuation.

EXPERT OPINION

An orthopaedic expert instructed by Medical Protection made no criticism of the conduct of the surgery, but was very critical of the poor quality of Mr D's clinical records. Although Mr D was adamant that the risks of surgery and alternative treatment options were discussed with Mrs W, he made no note of this in the patient's records nor did he make reference to any such discussions in his letter to the GP. Furthermore, despite Mr D's assertions that he reviewed Mrs W every day postoperatively prior to her discharge, he made no entries in the records to this effect, stating that he had relied on the nurses to do so. The nursing records did not corroborate this.

The claim was predicated on the basis that Mrs W suffered from cauda equina syndrome and that earlier intervention to evacuate the haematoma would have improved the outcome. In the expert's opinion, there was insufficient evidence to support a diagnosis of cauda equina syndrome, hence it was unlikely that earlier decompression would have made a difference. However, the absence of documentary evidence of her postoperative condition made it very difficult, if not impossible, to rebut this claim.

In any event, Mrs W would have been successful in her claim if she could establish that she was not properly advised of the risks and alternative options, and that if she had been she would have not proceeded with the surgery. This is because, on the balance of probabilities, the complications she suffered would not have occurred had she been counselled properly. The absence of any record of the advice given, coupled with the documented reasons for her earlier refusal of surgery lent significant weight to Mrs W's claim.

On the basis of the critical expert report, the claim was settled for a substantial sum.

Learning points

- Good clinical records are essential to the ability to defend a doctor's actions in the event of a claim.
- An appropriate clinical note should be made by the attending doctor or explicitly delegated to another appropriately skilled healthcare professional.
- Patients are entitled to expect they will be advised of all relevant and material risks of a proposed treatment and of any alternative treatment options (including no treatment). Any advice given should be clearly documented.

JP

Further Reading

Medical Protection: An Essential Guide to Medical Records
medicalprotection.org/uk/advice-booklets

Medical Protection: Consent-the Basics
medicalprotection.org/ factsheets

GMC Consent Guidance
gmc-uk.org

OVER TO YOU

DIAGNOSING PNEUMONIA OUT OF HOURS – CORRECTION

Thank you for the latest edition of *Casebook* which I found informative. However, I would like to draw your attention to what I believe are a couple of mistakes in the learning points to your article 'Diagnosing pneumonia out of hours'.

The second paragraph of the advice given states: "According to NICE guidance...GPs should use the CURB65 score to determine the level of risk...One point is given for confusion (MMSE 8 or less ...)".

I believe that NICE's guidance for GPs is to use the CRB65 algorithm, and this appears to be the algorithm referred to in the rest of the article. The CURB is slightly different, includes a blood test for urea and is intended mainly for hospital use.

More importantly, NICE advises doctors to assess confusion using the Abbreviated Mental Test Score (AMTS),[1] not the Mini Mental State Examination (MMSE)[2] as stated in the article. The AMTS is scored out of 10, the MMSE out of 30; so whilst a score of 8/10 on the AMTS is consistent with mild confusion (allowing for the crudity of the AMTS), a score of 8/30 on the MMSE would be indicative of very severe confusion. Use of the MMSE in an acute respiratory infection would be time-consuming and could give false assurance.

Dr Brian Murray

Response

Thank you for pointing out the two errors in the case report from the last edition. You are correct that it should have been the CRB65 algorithm, and the AMTS that were referred to. We regret that these were not picked up on clinical review and we apologise for any confusion caused.

FAILURE TO DIAGNOSE PRE-ECLAMPSIA

The learning points arising from this case missed arguably the most important learning point – that both patients and doctors are more likely to experience adverse outcomes if patients are seen at home rather than in surgery.

The GP involved was criticised for failing to keep adequate records, an outcome far more likely after a home visit than after an attendance at the surgery, where the computer records system is accessible immediately.

The GP was also criticised for failing to test urine; obtaining a urine sample from patients is far easier to manage in surgery, where the delays involved can be mitigated by seeing other patients whilst the specimen is produced, and where specimen pots and urine test sticks are immediately to hand. A busy GP will simply not have the time for a prolonged wait in a patient's home until the specimen is eventually produced.

Finally, the decision-making capacity of the doctor will be impaired if in an unfamiliar location and stressed by congestion and route finding whilst travelling to a patient's home, as well as consulting without immediate access to the full medical record.

Dr Douglas Salmon

A FAMILY MATTER

I read the case study regarding the doctor prescribing an antibiotic for her daughter. Having retired recently after 25 years as a GP partner it surprises me that common sense is not applied by the GMC in such circumstances.

How can this ever be considered a serious complaint baffles me. Being a GP is stressful enough and cases like these make me angry that as a profession we have to suffer such indignity when we can't be trusted to treat our families for minor illnesses.

Dr M Shah

PROBLEMATIC ANAESTHETIC

I read with interest the unfortunate case of neurological injury following attempted paravertebral blockade.

What the learning points do not mention is the expert opinion that this procedure should have been performed awake or under light sedation. There is a large body of anaesthetists who do perform this procedure under anaesthesia with exemplary results, but I have to agree with the expert opinion. When struggling with a procedure we can sometimes get too preoccupied with succeeding. Awake patients do not like needles in places where they should not be and this helps prevent multiple attempts by the operator. In this case it may have led to the doctor abandoning this unnecessary procedure.

Dr Mohammed Akuji

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1. Qureshi KN and Hodkinson HM, Evaluation of a Ten-question Mental Test in the Institutionalized Elderly. *Age Ageing* 3(3):152–7 (1974)
2. Folstein, MF, Folstein SE and McHugh PR, "Mini-mental State". A Practical Method for Grading the Cognitive State of Patients for the Clinician. *J Psychiatr Res* 12(3): 189–98 (1975)

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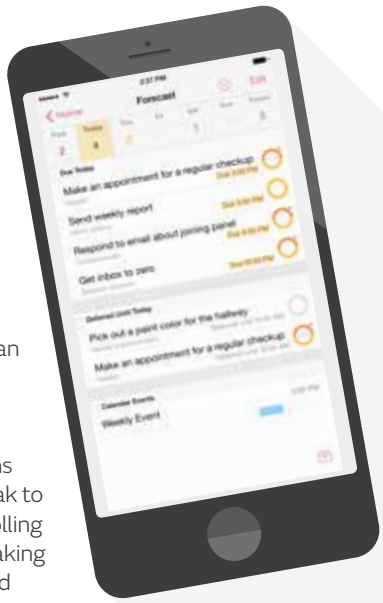
REVIEWS

From books to apps, podcasts to training courses, we invite doctors to review what has helped them improve their practice

OMNIFOCUS (IOS, MAC) OMNI GROUP

omnigroup.com/omnifocus

Review by: Dr Jennifer Munroe-Birt



The Omnifocus app can't technically grant you the extra ten hours a day that everyone wishes they had, but what it can do is focus you, organise you, and maximise your productivity so you do in fact seem to end up with more time. At first glance it doesn't seem much of an upgrade on a to-do list – albeit a rather expensive one – but further inspection reveals an intuitive, multi-level application that will afford you levels of organisation you always assumed were beyond you.

For doctors, the app is useful to arrange and categorise the abundance of tasks at hand (projects, meetings, CV, CPD). You can easily categorise individual tasks into bigger projects (holiday, that audit you've been meaning to finish all year) and assign deadlines to each task. Being able to break each 'project' into smaller, more manageable chunks will appeal to anyone who's sat down to start a big piece of work and found themselves still on Facebook half an hour later because they are too daunted to take the first step.

Each project can be contextualised to various aspects of your life, and each 'context' can be location-based using GPS. This way Omnifocus knows when you're at home ('paint shelves'), when you're at work ('arrange educational supervisor meeting'), or even when you're walking past the supermarket ('buy mustard').

One of my favourite features is the ability to defer certain tasks once they are out of your control (for example, if you've sent an email and are waiting for a reply) and bring them back into view again once you're required to respond. It seems obvious, but this minor tweak to the interface saves you scrolling through irrelevant tasks, making you feel more motivated and focused on the things that you are able to control.

Currently the app is limited in a clinical setting primarily due to confidentiality issues. Perhaps one day our archaic bleeps will be replaced with hospital-issue encrypted smartphones with apps such as Omnifocus to help co-ordinate the tasks... but I won't hold my breath.

DECISION MAKING WHEN PATIENTS MAY LACK CAPACITY TOOLKIT – GENERAL MEDICAL COUNCIL

www.gmc-uk.org/Mental_Capacity_flow chart

Review by: Dr Rosemarie Anthony-Pillai

The toolkit is intended to identify how to manage situations in which there is concern about an adult patient's mental capacity. It is based on the GMC guidance on 'Consent' and 'Treatment and care towards the end of life: good practice in decision making'. There is a flowchart summarising the information in the tool and a link to a reflection log that can completed and used for appraisal.

The interactive tool engages clinicians via a series of questions, each with key points of information to consider. The structure avoids upfront information overload. However, you need to be mindful that the tool covers various jurisdictions across the UK and, therefore, should be not seen as a summary of the law in any one region. For example, under the Mental Capacity Act, identifying lack of capacity is a two-step process that requires recognition there is a disorder of the brain and mind before you proceed further. The tool also makes no reference to the statutory requirement for Independent Mental Capacity Advocates for patients who are unbefriended. The caveat needs to be that text in the information boxes should be seen more as 'pointers' or 'tasters' to what needs to be considered, and you need to engage with the linked resources for a more complete understanding of the subject. What the tool does provide is an invaluable hub of topic specific information and links to the excellent GMC case scenarios pertinent to the subject.

The section setting out the four elements of capacity provides an innovative and useful amalgamation of key concepts: the 'Consent' guidance is used to identify how you can support patients in their decision making regardless of whether their capacity is in question. The tool steers you into taking wider advice if uncertainty about capacity exists; it reminds clinicians to consider advance decisions; the presence of potential proxy decision makers and the need to ultimately pursue consensus.

Decision making for patients who lack capacity and especially those at the end of life is complex, and can be a source of conflict. Anything that helps clinicians approach this issue systematically can only help, and this tool presents the key considerations in a user-friendly way with all the resources you need available at the click of the mouse.

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