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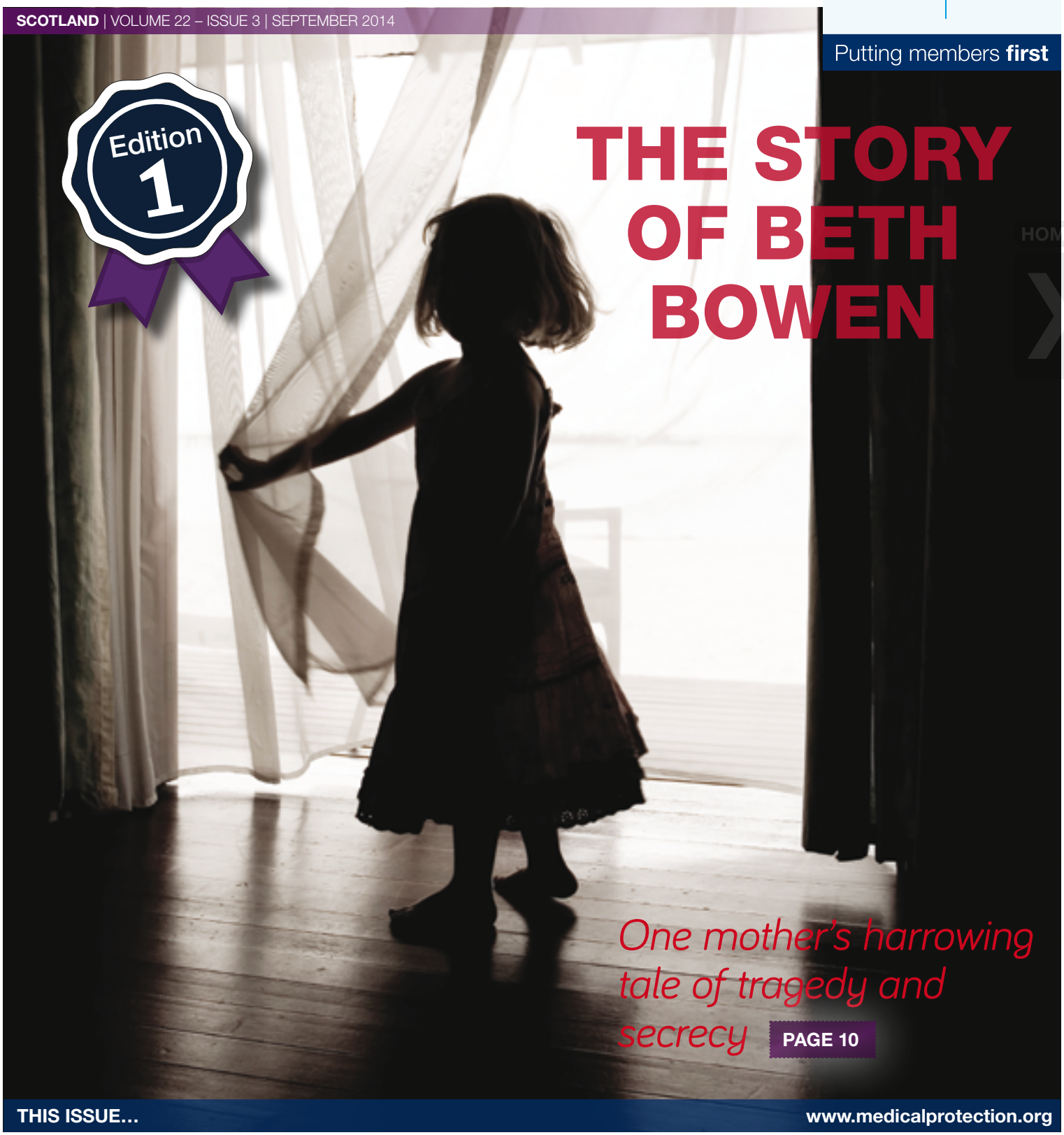
SCOTLAND | VOLUME 22 – ISSUE 3 | SEPTEMBER 2014



THE STORY OF BETH BOWEN

One mother's harrowing tale of tragedy and secrecy

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What's inside...

Every issue...

PRINT ISSN 2056-4449
ONLINE ISSN 2056-4457

Casebook is designed and produced three times a year by the Communications Department of the Medical Protection Society (MPS). Regional editions of each issue are mailed to all MPS members worldwide.

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Welcome

Dr Nick Clements – Editor-in-chief

I am pleased to welcome you to the first edition of Casebook Scotland, *which we are launching this month in recognition of the unique issues and topics affecting MPS members in Scotland.*

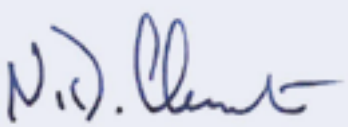
I should begin by acknowledging the input of my fellow medicolegal adviser Dr Gordon McDavid and the rest of the team in our Edinburgh office. They have helped to shape the content for this and upcoming editions of *Casebook Scotland* – and we will be giving readers the opportunity to find out more about the expertise of the MPS Scotland team in a future edition. In the meantime visit www.medicalprotection.org/uk/scotland to discover what else we are doing to assist members in Scotland.

You won't be surprised to know that a significant proportion of my work at MPS consists of assisting members who have been involved in an adverse event. We always advise members to be open about any errors made during the course of such an event – it is morally and ethically the correct thing to do, and can go a long way towards preventing a claim arising in the aftermath.

This is because we often find that claims derive from an angry or aggrieved (or both) patient or relative feeling they have been denied information and explanations – and, if appropriate, a simple apology – in the wake of an adverse outcome. Openness stands to benefit all parties and yet, quite understandably, there remains nervousness and uncertainty about delivering it.

Fear and anxiety over 'blaming and shaming' paralyses many healthcare professionals and prevents them from being open about mistakes that they may have made. This edition of *Casebook* features a truly harrowing first-hand account from Clare Bowen, a mother-of-two in England who lost her five-year-old daughter Beth in 2007 during surgery. A wall of silence from all involved in Beth's care prevented Mrs Bowen and her husband from getting a full explanation of the causes of the tragedy. Our article on page 10 will make sobering reading for anyone involved in healthcare today.

You will also be interested in our article on page 8, which looks at the Scottish Government's exploration of an alternative to the current system of litigation. Although the government is some way off firming up the details, the working group on no-fault compensation has been looking at the model in Sweden as the closest example of a new Scottish system. Our article looks in depth at how the no-fault scheme works in Sweden.



Guiding you through the claims process

Following your feedback, MPS has launched a new way of supporting you if you receive a clinical negligence claim. MPS medicolegal adviser *Dr Sam Godwin* explains what the changes mean

Receiving correspondence from a solicitor (or direct from a patient) in relation to a potential clinical negligence claim is a distressing experience for any MPS member. Most members start with little or no idea of what the process might involve for them, and what they need to do next.

Members can now benefit from a new way of dealing with claims, which MPS has introduced to:

- Individualise the experience – provide each member with the kind of support that they need, when and how they need it
- Provide members with information they need, when they need it most, and with the minimum of delay
- Make the process as smooth and efficient as possible, eliminating the uncertainty and stress of waiting for things to happen
- Explain in clear terms what is happening, what you need to do and when, and how you can help us to provide effective support.

Designed to provide you with an efficient and informative service, the new process will streamline the experience for members who find themselves on the receiving end of a claim. One of the problems traditionally associated with claims is the time it takes to resolve them, which in turn prolongs the potential for anxiety. We are doing everything we can to reduce that timescale, especially in the early stages before any formal legal proceedings have commenced.

The new Claims Guide

The process of a claim

Feedback indicates that you would appreciate more information about the claims process and what to expect. This new guide provides clear information about how MPS can help, and explains the legal process step by step.

Referring back to the document during the life of a claim will help you understand the stages and the timings you can expect between them. The guide will augment the ongoing support you will receive from your medicolegal adviser, together with a member of our legal team.

What you need to do

The guide provides a clear checklist of all of the information that we need from you to provide appropriate advice and support from the earliest stage. We need to gather together all the relevant information at the very outset and the *Claims Guide* will help us to do this, hastening our communication with the claimant/patient or their legal representatives.

Having a complete grasp of all the facts at an early stage helps us to assess your case more quickly and speed up decision-making. In a further response to member feedback we are now developing an online notification system for claims, so that you have the option of providing all of this in a way that suits you.

Robust and effective support

We are aware that subscriptions have been rising in recent years, and one of the main drivers for this has been the relentless increase in claims costs. This change is one of a series of measures designed to help stem the tide of rising costs and subscriptions, by continually reviewing and improving our internal processes. What we will not be compromising on, however, is our robust support for members.

We would greatly appreciate your feedback as we continue to roll out these developments. We are delighted that members have so far been telling us how impressed they have been with their experience of these new arrangements – so although we naturally hope that you will not be unfortunate enough to be on the receiving end of a claim, you can rest assured that you would be well supported and in expert, professional hands if this were to happen.

Some members find the experience of a claim particularly stressful. Members can access a free counselling service, which is provided independently and confidentially by Optum, who are respected experts in the provision of this kind of additional support. This service is explained to members in the new *Claims Guide*.

Claimants may get more time to sue

By Julia Bryden, MPS Claims Manager, Edinburgh

Claimants in Scotland currently have three years from the date of an incident to raise a court action seeking compensation for personal injury. Although there are some limited exceptions to this rule, a claimant generally loses the right to raise a court action after this period has expired.

Change is afoot, however, following a recent consultation by the Scottish Government regarding the civil law of damages. The government has now confirmed its intention to amend legislation to extend the limitation period from three to five years from the date of the incident.

The government has also signalled its intention to revise the current 'date of knowledge' test, which is objective and is based upon the principle of reasonable practicality. Although the exact wording still remains to be seen, initial indications suggest that courts will soon be entitled to take account of claimants' education, intelligence and occupation, and the clock will not run while a claimant was "excusably unaware" of the severity of the injury, or that it was caused by an act or omission of the defender. This will make it easier for the claimant to argue that the time limit to bring a claim should be pushed back further.

The key impetus underlying the above changes is a desire on the part of the government to ensure that claimants have sufficient time to investigate liability in more complex cases, such as industrial disease cases. It is considered that those cases require a higher degree of investigatory work and an increased number of expert reports may be necessary prior to raising proceedings.

The Scottish Government and the Scottish Law Commission are therefore of the view that these proposals will provide a better balance between the rights of the claimant and the defender.

From an MPS perspective, the extension of the limitation period in particular is a disappointing development. Generally, three years is sufficient to allow claimants to investigate and prepare clinical negligence court proceedings. In many cases, delays often stem from a failure on the part of the claimants to seek legal advice following the event, rather than because there was a lack of time to investigate matters. There is also a concern that the extension will reduce the quality of witness evidence due to the passage of time, and that it will generally encourage unnecessary delays.

On the plus side, we may well see fewer cases in which (often unfounded) "triennium buster" proceedings are raised before all the necessary investigations have been completed and before expert reports are available.

The draft Bill is due to be published later this year. Although there will be an opportunity for further comment as it passes through parliament, the reforms are expected to go ahead.

Notably, these developments mean that the position regarding clinical negligence claims arising in Scotland will be different to that in England and Wales, where the three-year limitation period will continue to apply.

***Note on terminology:** Once legal proceedings are raised in Scotland, a claimant becomes known as a 'pursuer'.*

NEWS UPDATE

Death certification: new MCCD forms go live

The Certification of Death (Scotland) Act 2011 will see significant changes to the arrangements for death certification and registration when it comes into full effect in April 2015. However, new MCCD forms went live in August – doctors should visit www.nes.scot.nhs.uk for comprehensive information from NHS Education for Scotland.

FGM update published

The Chief Medical Officer has issued circular *SGHD/CMO(2014)19 Re: Female Genital Mutilation*. It provides an update on developments in Scotland related to Female Genital Mutilation (FGM) and asks healthcare professionals in NHS Scotland to record the diagnosis and types of FGM, together with any corrective procedures, in the relevant clinical records. This includes recording in the hospital discharge summary, and coding in GP practices.

Quality framework for general practice

Healthcare Improvement Scotland has published a report, *Developing a quality framework for general practice in Scotland*. The report is the outcome of a joint project between the Royal College of General Practitioners Scotland and Healthcare Improvement Scotland. The framework describes existing quality improvement activities within general practice in Scotland, determines where gaps currently are, and outlines recommendations and activities to be undertaken by a number of responsible bodies.

Reminder issued on DNACPR

The Chief Medical Officer has issued circular *SGHD/CMO(2014)17 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) – current position.* This reminder about the position in Scotland follows the recent Court of Appeal decision in *Tracey, R (on the application of) v Cambridge University Hospitals NHS Foundation Trust & Ors, Court of Appeal – Civil Division, January 24, 2014, [2014] EWCA Civ 33.* The Scottish Government considers that this recent judgment does not fundamentally change national good practice guidance issued in Scotland in 2010.

Inside... the Mental Welfare Commission

The Commission safeguards the interests of people with mental illness and learning disabilities, and earlier this year issued detailed guidance on the administration of covert medicine. Here *Lynn McBean*, communications manager, describes the work of the organisation

The Mental Welfare Commission (MWC) is an independent organisation set up by the Scottish Parliament, with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

What we do

Through our work, we aim to ensure that care, treatment and support are lawful, and that they respect the rights and promote the welfare of individuals with mental illness, learning disabilities and related conditions. We do this by empowering individuals and their carers, and influencing and challenging service providers and policy-makers.

Why we do it

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

We believe individuals with mental illness, learning disabilities and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible.

Our work in practice

Much of our work is at the complex interface between the individual's rights, the law and ethics, and the care the person is receiving. We work across the continuum of health and social care and:

- Find out whether individual care and treatment is in line with the law and good practice
- Challenge service providers to deliver best practice in mental health and learning disability care
- Follow up on individual cases where we have concerns and may investigate further
- Provide information, advice and guidance to individuals, carers and service providers
- Aim to have a strong and influential voice in service policy and development
- Promote best practice in applying mental health and incapacity law to individuals' care and treatment.

Covert medication – recent MWC guidance

One of the many ways in which we promote best practice is to produce good practice guides for practitioners.

We have recently updated our guidance, *Covert Medication*. It is a difficult and complex issue where our expertise in applying legal and ethical principles to individuals' care and treatment is often needed.

The use of covert medication appears to be increasing. It was therefore a good time to revise and reissue our guidance, with the valuable co-operation of the Care Inspectorate in the revision work.

Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the individual is unknowingly taking medication. This is likely to be due to a refusal to take medication when it is offered, but where treatment is necessary for the individual's physical or mental health.

We have developed our guidance from reading existing good practice statements and the requirements of the law in Scotland. We advise anyone considering covert medication to follow our guidance. It applies only to situations in which an individual lacks capacity to make a decision regarding medical treatment and refuses treatment. Covert medication must never be given to someone who is capable of deciding about medical treatment.

The practitioner with primary responsibility for the individual's medical treatment has the ultimate responsibility to decide whether or not to authorise covert administration of medication. This decision should be taken following consultation. Before deciding, the practitioner must:

- consider the necessity of giving the medication
- carefully assess the person's capacity to make a decision about the treatment
- apply the correct legal principles and procedures, in particular Part 5 of the Adults with Incapacity (Scotland) Act 2000.

There are occasions where covert administration of medication can be considered the best way to provide an individual with necessary medical treatment. It must be given safely and in accordance with the law. By following our guidance, practitioners will be able to demonstrate that they have done their best to comply with legal and ethical principles when giving treatment in this way.

A litigation alternative?

The Scottish Government is exploring the possibility of a no-fault compensation scheme – here *Gareth Gillespie* looks at how it works in Sweden

In 2009, the-then Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, set up the No-Fault Compensation Review Group, headed up by Professor Sheila McLean, director of the Institute of Law and Ethics in Medicine at Glasgow University. The aim was to assess the viability of a no-fault scheme as an alternative to costly legal fees and drawn-out clinical negligence cases, many of which can take years to conclude.

The review group published its report in February 2011, which provided advice on some key principles and design criteria. A year later, the Scottish Government consulted on the introduction of a no-fault compensation scheme, which MPS responded to, and on 4 April 2014, the government published a report on its consultation. The report revealed an intention to cautiously explore the complexities of the scope, shape and development of such a scheme.

What is no-fault compensation?

A no-fault system in healthcare is a method of compensating for injury received when undergoing treatment, without attributing fault or blame to any one individual or institution. There is still the need to establish proof of injury, and the causation connection between treatment and injury, but compensation is assessed and granted or denied based on the eligibility of the patient, rather than the 'negligence' of an individual or institution. The process is non-adversarial – there is no 'defence'.

Similar schemes already exist in other parts of the world, including Finland, Sweden and New Zealand; MPS's presence in New Zealand means we have some experience of the practicalities, which was useful in our response to the consultation, although the Scottish Government has indicated that any new scheme in Scotland would be based on the Swedish model.

The Swedish model

In Sweden, the system only applies to injuries sustained in the medical environment. It has been in place since January 1975, with conditions occasionally revised, and is now set down in statute.

Claimants who are unhappy with an award can appeal. They also retain the right to claim through traditional litigation through

the courts. However, you cannot 'double claim', as any award via the scheme would be deducted from the damages awarded by the court.

There is uncertainty over the transferability of the Swedish model to Scotland, specifically because of Sweden's different social welfare structure, which complements the no-fault model. Under their system, liability is borne by the healthcare providers, who pay compulsory premiums to a consortium of insurers. In Sweden, county councils bear most of these costs.

Compensation covers all medical care, pain and suffering, and earnings, with upper limits on payments that are updated from time to time. The procedure for making a claim omits the need for a lawyer, and involves the claimant filling in a form that is sent to a medical assessor at the insurance company. Claims can be brought up to three years from the injury becoming apparent. The claim is decided on the basis of notes and medical reports, unless more information is needed on medical condition and prognosis, and a report is sent to the patient.

If compensation is denied, the patient is advised of their right of appeal. The appeal panel meets 12 times a year, and the patient can have legal representation at this appeal. Legal aid is available for qualifying individuals who are unable to fund their own legal costs. Cases can go to arbitration by a judge of the Swedish Court of Appeal, whose decision is final.

What is a successful claim?

In Sweden, the injury must be the result of a decision, act or omission on the part of someone engaged in health or medical care. As with any system of compensation, there is the need to define a precise delineation: if the injury was unrelated to the medical care, it is not reasonable to expect compensation. However, if it was preventable, it is reasonable to provide compensation. A caveat to this rule is that it does not apply in circumstances in which the risk taken was medically indicated because of the threat of death or disability.

The no-fault system applies only to injuries not already covered by other forms of insurance, either from the state or held personally. Payments are subject to the exhaustion of all other avenues, claim sources, policies or entitlements (such as third party motor insurance, workers' compensation, national health treatment, private medical insurance, etc).

Nothing is paid for minor injuries. Injuries worthy of compensation must result in a permanent disability or disfigurement of significance, or sick leave of a particular length of time. The philosophy is to draw a clear distinction between injuries worthy of compensation and those which are not, rather than establishing whether or not the medical practitioner is at fault.

What factors influence payments?

Decisions under the Swedish model are reached via the influence of certain questions, such as:

- Was a better or less risky treatment available, which should have been chosen?
- Was injury caused by treatment later shown to have been unnecessary?
- Would it have been hypothetically possible to avoid the injury by performing the treatment differently?

However, the Swedish system is not entirely without some difficulties. Some cases of injury may be impossible to ascertain whether the injury was caused by the actions of the healthcare provider or the patient. Each case is considered on its merits, meaning there may be inconsistencies.

When is compensation not paid?

- Cosmetic surgery for reasons of vanity (though the right to sue remains)
- Emergency or life-saving treatment, unless negligently performed: the more serious the condition, the more serious the level of acceptable risk
- Psychological injury that is not organically based (because, under Swedish law, this is a response to the natural condition rather than to the treatment), but neuroses and nerve damage may be compensated
- Risks assumed by the patient to prevent death or disability
- Where the treatment was reasonable in the circumstances
- Pharmaceutical injuries, which are covered by other collective insurance arrangements taken out by manufacturers and importers (unless hospital staff administered them improperly).

What types of injury are covered?

Four groups of injury are covered:

- Genuine injuries arising in connection with medical interventions will be covered.
- Diagnostic injuries: if a correct diagnosis should have been made, compensation is payable for lack of or delay in correct diagnosis. Incorrect lab results are compensated, as is (formerly) negligent interpretation of results.
- Accidental injuries are covered on the ground that a sick person is more susceptible and requires a greater degree of care. The injury must be related to the equipment and/or the premises used for healthcare and not due (directly) to the basic illness.
- Injury arising from infection. This is effectively a 'complication insurance' where the principle is that no compensation is paid if the patient's own bacteria is causal. If it is equally likely that infection is from treatment, then compensation is payable. For example, unless the procedure is incorrectly performed, no compensation is paid for infection after operating on an abscess or a ruptured appendix, or for surgery on colon or lungs, where the probability of infection is high. Here the system retains some negligence principles.

The Scottish model

The publication of the Scottish Government's consultation report in April has left a number of areas still to explore, particularly with regard to the projected cost and eligibility criteria of such a scheme. The report is quite conclusive about the government's ultimate goal: "We are still committed to ensuring that patients who have been harmed as a result of clinical treatment have access to redress in the form of compensation, where this is appropriate and that they have access to this without the need to go through lengthy court processes. We will continue to work towards developing a fair system and in doing so will aim to ensure that this will not be at the expense of other essential NHS services."[1]

As expected from an exercise that has such potentially far-reaching changes, there remain many complexities to address before any binding decisions are made. This article has looked at the system in Sweden; it has perhaps only served to temper any expectation of a straightforward port over from Sweden to Scotland.

In conclusion

No-fault compensation is an alternative under consideration in Scotland. This article has looked in depth at the system in Sweden; readers should bear in mind that this is not intended to indicate what might also be introduced in Scotland. MPS would like any proposed system to be carefully trialled and, given that there are questions that still need answering over how the scheme will be funded, it would be sensible for any initial trial to take place in the hospital sector. As with any system, it has downsides. Inconsistencies or lower level of compensation could be a deterrent and the complexity of predicting costs presents a phenomenal challenge.

The current system of clinical negligence claims through the courts necessitates a detailed assessment of any case where injury is alleged. As well as payment of damages, patients will often express a sense of vindication when an error has occurred as someone has been held to account.

The question is whether a no-fault system can offer sufficient compensation but also if this can tie into other forms of healthcare regulation. It is vital that any amended system does not lose the ability to identify system or individual failures, enabling improvements.

REFERENCES

1. Scottish Government, *Consultation Report – Consultation on recommendations for no-fault compensation in Scotland for injuries resulting from clinical treatment* (April 2014)

THE STORY OF BETH BOWEN

In 2007 Clare Bowen's five-year-old daughter Beth died during surgery at a hospital in the UK. Here she tells her story to *Sara Dawson* – and relays her hopes that it will reduce the likelihood of such an incident happening again

I'm a mum to three small children who all have spherocytosis, which causes them to become very anaemic and require blood transfusions. The condition made my middle child William very poorly, so in January 2006 a decision was made to remove his spleen – it made a massive difference to his quality of life.

So the following July, we decided that Beth, my eldest daughter, would have the same operation – she had just started school and couldn't keep up with the other children. We felt confident, as the same team that operated on William would be treating Beth. I remember talking with the doctors beforehand about possible scars on Beth's tummy, so the spleen would be removed through a lower incision.

We had all the pre-op stuff done and chatted to all the doctors, before arriving at the hospital on 27 July. She went down for her operation at 1pm – we didn't hear from the doctors for several hours. At 4pm we spoke to a nurse, asking her why it was taking longer than it should. The nurse said it was fine as these operations take a long time.

Just after 6pm, the surgeons, the anaesthetist and the nurses came into our tiny waiting room – without any warning they said something awful had happened. The doctors seemed unable to comprehend what had happened. I asked one doctor: "Is she dead?" He said "yes", adding that she'd lost a lot of blood during the operation as a blood vessel had been cut and she hadn't survived. He said they'd been trying to save her for an hour and half prior to coming to see us, but she hadn't survived – she'd lost too much blood.

The immediate aftermath

In the weeks after Beth's death we received no answers from the hospital – it was very difficult to get them to talk to us. Slowly we gathered bits of information. We found out that at the last minute a new piece of equipment was used called a morcellator – like an apple corer – that removes chunks of flesh through laparoscopic portholes.

It emerged that the surgeons hadn't used the equipment before, they hadn't received any training and no risk assessments on the equipment had been undertaken.

It was an adult piece of equipment that was not meant to be used on a child.

The damage to Beth's body was extensive; they made cuts to her aorta, her stomach, her intestines – she had massive trauma to her body.

Searching for answers

It was only when we enlisted help from a friend with a medical background that we started asking questions that really needed asking.

Why did the hospital throw away all the equipment they used that night? Why didn't they keep the blood that Beth lost? Why didn't they try and retrieve the items when we'd asked them, even though they were still at the hospital? Everything that could have given us clear answers was disposed of immediately. It didn't allow us to get the answers we so needed.

It surfaced that the surgeon who carried out Beth's operation had only ever done three laparoscopic surgeries before – William had been her first. In her head she deemed it ok to try to operate that piece of equipment on my daughter.

Confusion

That was something we as parents could never understand – why would a doctor allow themselves to operate a new piece of equipment that they weren't comfortable with, while their senior was in the room? I don't think any of the surgeons understood that there was a technique to what they were doing, one that had to be learned.

They had no formal training on how to use the morcellator; a five-minute talk was judged to be enough training. The nurse who was asked to put the morcellator together had never seen it before. No-one felt they had the authority or the ability to halt the operation. If only someone in the theatre that day had said can we stop a minute, can we take a step back, we've had no training, we've not done a risk assessment, we've not really thought this through, is this a good idea?

The inquest

We did not receive an apology before or after the inquest. The hospital admitted they had failed in their duty of care and they were sorry that they had failed to prevent Beth's death. They didn't fail to prevent Beth's death – they caused it.

The three-day inquest took place 18 months after Beth died. Unfortunately, the only way we could afford a

Photos courtesy of Clare Bowen

Download the tablet edition of *Casebook* to see a video interview with Clare Bowen, as she describes her fight for the truth behind the tragedy.

solicitor was to take legal action against the hospital, which is something we never really wanted to do. For us it was never about money; it was about answers.

The only way I can describe the inquest from a parent's point of view is that it's like being tortured and you can't escape. We had to listen to different stories about Beth's last hours, while trying to fit it all together in our heads – it was horrible. Information that came out in the inquest was contrary to what the hospital had been telling us in the months previously.

Photographs were revealed of the theatre and information was shared on Beth's medication, which she'd been given but we were unaware of. A trainee surgeon was the one specifically holding the morcellator – they had never used it before and she was not allowed to perform surgery on her own.

During the inquest the hospital admitted that they had not received consent from us to carry out the operation on Beth.

I left the inquest room while they showed pictures of Beth's autopsy, but my husband Richard felt he had failed Beth by allowing the hospital to do the operation, so he remained in the room – the pictures destroyed him. No-one should have to see their child cut up on an autopsy table.

The striking thing during the inquest was the arrogance and complete disregard by the medical professionals in the room for our feelings, and for the part that they played in Beth's death.

In the months after the inquest, Richard suffered a massive heart attack and died – he was only 31 years old.

On a national level

Beth's death was reported widely in the media and the UK government became interested in what happened. The Health Select Committee[1] started looking at many incidents where hospitals hadn't been open and honest with parents and relatives after operations or treatment that had gone wrong.

The Committee published a report about the death of Beth. It generated a lot of dialogue and interest in the subject that wasn't there before – it was a catalyst for change. That said, I do think there is still a long way to go.

The Committee came up with some good ideas for ways to drive things forward, but it's not always about rules and making people do things; it's about a change in culture. Bringing in a law to enforce open candour and openness is not necessarily the right way forward.

Reflections

Attitudes need to change. Some medical professionals are too arrogant to believe they can be any better and that they can make mistakes. With this attitude you blind yourself to mistakes, and you won't see one heading straight for you.

Medical professionals should be confident in their ability, but they should understand their limitations – "I'm good, but I can be better". Beth may still be alive if the surgical team's mindset had been different going into the operation.

Change has to come from the top and the bottom – openness and candour must be championed by everyone but, ultimately, it is the board and the senior doctors who are the ones that need to facilitate the changes.

Commentary – Being open

By John Tiernan, MPS Executive Director, Member Engagement

Sadly things do go wrong in medicine. We can't be totally confident about how frequently things go wrong, but they are not a rare occurrence.

For many years a culture of denial existed, where doctors were heroes who never have adverse outcomes. These expectations led patients to demand perfection and perceive adverse outcomes as unacceptable even when the literature suggests that as many as 50% are not avoidable. The fear of openness is often driven by a blame culture where the doctor is disproportionally singled out for sanction, regardless of the multifactorial causes of some of these events.

The real challenge is how to change this culture to one where we move from disproportionate blame to one of fair accountability or a just culture, where the emphasis is on learning from adverse events rather than finding someone to blame. The learning culture is balanced by the profession taking accountability when mistakes are made.

A good starting point is encouraging openness after an adverse event has occurred. When something has gone wrong be open and candid with the patient – it is part of the ongoing therapeutic relationship. Say sorry for what has happened and talk honestly with them – don't run away or deny what's happened. It isn't always easy but it is the right thing to do.

Examining significant events and exploring adverse outcomes is not always an admission of bad practice – it is, however, an essential part of good practice.

Being open can also reduce the risk of complaints and claims. For many patients who have suffered an injury, turning to the law is often a last resort; patients go down this route because they feel it is the only way to have their questions answered.

There is a large amount of evidence that suggests that people lodge a complaint or a claim against a doctor, not primarily because of their injury, but because they're angry at what happened and want answers.

Which is more professional? To refuse to acknowledge an adverse outcome and cling to the belief that you are incapable of having one, or to acknowledge it, manage it ethically and professionally and, most of all, learn from it?

Which sort of professional would you rather be treated by?

HOME

Junior doctors should feel empowered to stand up to cultures that threaten patient safety. They should be able to speak out and be supported by their seniors. They may not be correct all the time, but that should be ok – they shouldn't be berated for being wrong; they should be rewarded for asking questions and having the courage to say "can we stop; can we check this is right?" Seniors should not view this as frustrating but as affording an opportunity to rethink what they are doing.

Learning to live again

I can't do anything to bring my daughter back. My daughter has gone – I can't do anything for her now; I can't help her. But I can encourage doctors to be safer, to work as a team and to speak out. I want people to understand that once you've made a mistake or done something wrong, or been in a situation out of your control where something has gone dreadfully wrong, then you should be open and honest about what's happened. Allow yourself to be found at fault because that is the only way that people can improve.

No-one can truly understand the pain of losing a child unless you've been there, but if you can think – even for a second – that you're putting someone's life at risk, stop and consider the pain that I feel every single day. Then I know you'll do the right thing.

Lucian L Leape MD

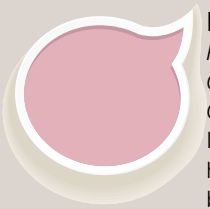
Adjunct Professor, Health Policy, Harvard School of Public Health

We're moving from paternalism with patients – let the doctor tell you what's right for you – to an openness and a patient partnering, where the patient not only has a right to know, but we want them to know.

Dr Donald Berwick

MD, MPP, President Emeritus and Senior Fellow, Institute for Healthcare Improvement

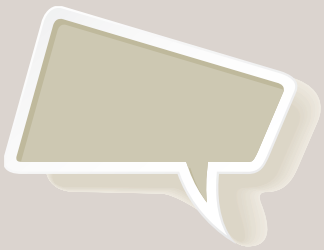
Don't think we can become safer secretly. There's some very inescapable connection between openness and honesty and disclosure and involvement, confession, apology... all acts of openness in building a safe culture. I think this idea of transparency and openness is an essential part of our future.



Professor Charles Vincent

Professor of Psychology, Emeritus Professor of Clinical Safety at Imperial College London, Imperial College, London

Information about errors and adverse events, harmful outcomes in healthcare, has very seldom been studied openly; it's been treated as a nuisance, something we don't want to know about, an occasion for shame, guilt, and other sorts of problems. In the last few years in healthcare we've come to realise that it can also be – if treated properly – a resource, and an essential way of achieving a safe culture.



Professor Mayur Lakhani

GP and Chairman of the National Council for Palliative Care, UK

When something goes wrong, you need to lose sleep over it. Why did it happen? Do I understand what happened here? Have I made sure that I know the reasons this happened? What can I do to prevent it? Have I said sorry to the patient? Have I involved the patient in this situation? Have I talked to staff? I think that's a really important obligation of doctors.

Guy Hirst

Former British Airways training captain and human factors expert

Medical teams are human. Medical teams are driven to succeed and have the needs of the patient at heart. They need to be pre-occupied with the possibility that they will make errors. The team leaders, usually consultants, must understand that they will make mistakes and try to break rules in order to achieve results. The safety net is their team who must trap or mitigate the consequences of such errors or violations. Research shows that if the leader briefs the team in an open, interactive and inclusive manner then team members will speak up in an assertive manner when the situation demands.

REFERENCES

1. Note to non-UK readers: the Health Select Committee is part of the UK parliament, and oversees the operations of the UK Department of Health. Here is a link to the Health Select Committee report – www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/151/151we22.htm

From the case files

This edition *Dr Mark Dinwoodie*, head of member education at MPS, assesses the key learning from the latest collection of case reports

I'm delighted to have the opportunity to reflect on the cases in this edition of *Casebook* from an educational and risk management perspective.

The cases of Mr D, with his osteoarthritic knees ("A pain in the knee", page 14), and Mrs H, with her neuropraxia following cannula insertion ("A cannula complication", page 21), remind us how record-keeping can contribute to an effective defence against allegations of negligence. Of course, good documentation is also increasingly essential to support good clinical care and enable continuity to be delivered by an increasing range and number of involved healthcare professionals.

It is important that not only should the clinical assessment and any procedure be adequately documented, but also the discussion behind any decision made regarding treatment. It is, of course, a matter of judgment regarding how much to write in the notes and, inevitably, time pressures will contribute to that consideration.

"The elusive diagnosis" for Mr M (page 15) turned out to be diabetes in a patient who had repeatedly attended the GP surgery for several infections. While MPS successfully defended this case, it reminds us of the importance of reconsidering the diagnosis in patients who represent with recurring symptoms or signs. There can be a temptation when a patient returns with no improvement to keep adjusting the treatment, whereas sometimes what is needed is a review of the original diagnosis and adjustment of the treatment to match the reviewed diagnosis.

The system errors of Mrs Y and the blood transfusion ("Transfusion confusion", page 19) highlight the importance of someone taking responsibility when the patient has suffered an adverse outcome and, following an apology, having an open and honest discussion with the patient, explaining what has happened. It is always appropriate to say that you are sorry for what the patient has experienced. It also shows how patients themselves can make a valuable contribution to patient safety.

I hope that you find reading the cases to be interesting and informative. Our range of education risk management products can help you address some of these challenges, and I encourage you to visit www.medicalprotection.org and click on the Education tab for more information.

CASE REPORTS

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

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

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

If you would like to comment on a case, please email casebook@mps.org.uk.

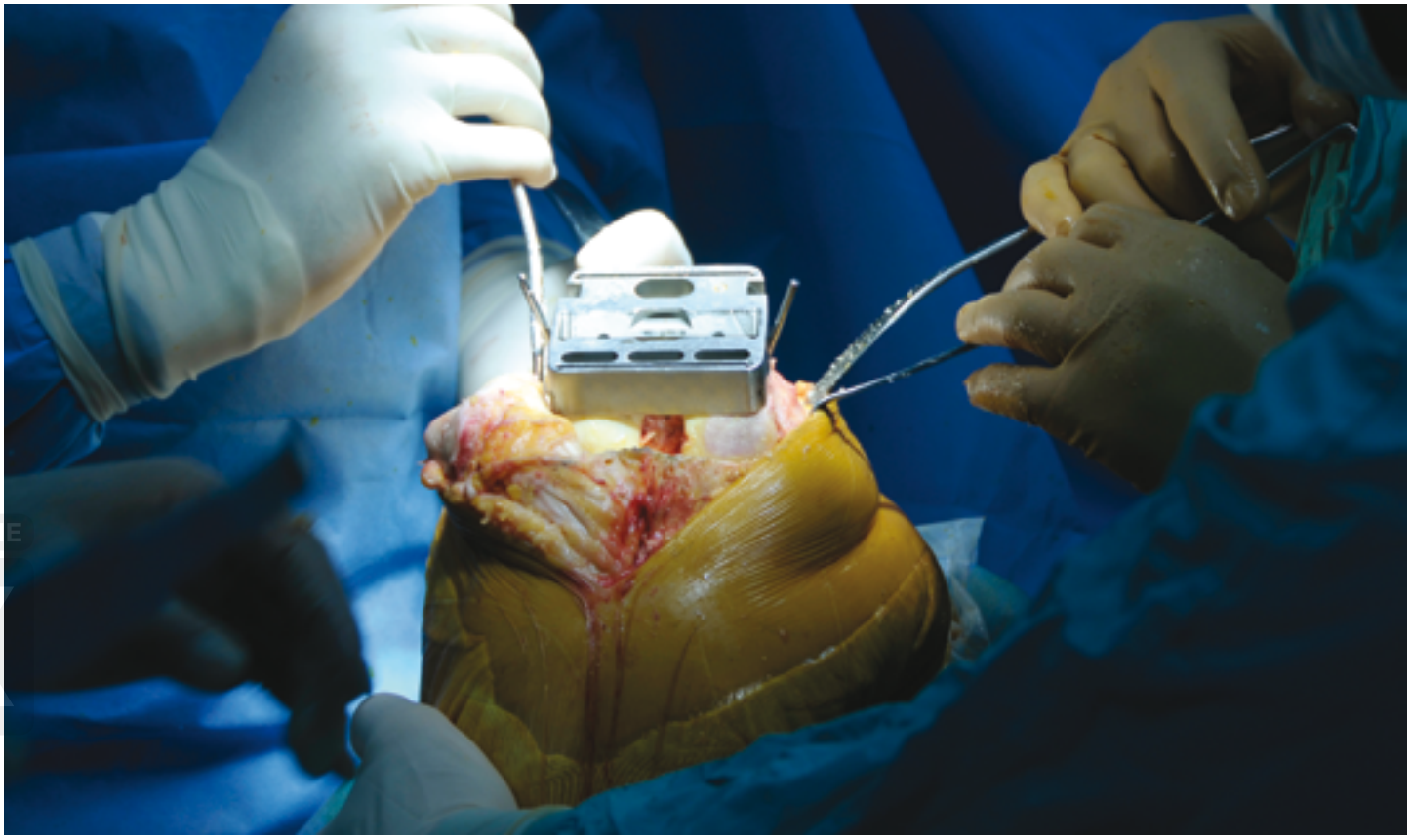
CASE REPORT INDEX

PAGE	TITLE	SPECIALTY	SUBJECT AREA
14	A pain in the knee	**ORTHOPAEDICS**	SUCCESSFUL DEFENCE
15	The elusive diagnosis	**GENERAL PRACTICE**	SUCCESSFUL DEFENCE
16	Who's to blame?	**GASTROENTEROLOGY/ ENDOCRINOLOGY/OPHTHALMOLOGY**	SUCCESSFUL DEFENCE
17	Missing cauda equina	**GENERAL PRACTICE**	INTERVENTION AND MANAGEMENT/RECORD-KEEPING
18	An unwanted pregnancy	**GYNAECOLOGY**	SAFETY-NETTING
19	Transfusion confusion	**GENERAL MEDICINE**	SYSTEM ERRORS
20	Eyes of the storm	**OPHTHALMOLOGY**	INTERVENTION AND MANAGEMENT
21	A cannula complication	**ANAESTHETICS**	SUCCESSFUL DEFENCE
22	High expectations	**GENERAL PRACTICE**	SUCCESSFUL DEFENCE

WHAT'S IT WORTH?

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

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



A pain in the knee

Mr D, a 62-year-old manager, had severe pain in both knees, which caused him trouble walking more than 200 yards. He was referred to an orthopaedic clinic for assessment.

At the assessment, consultant Mr M diagnosed bilateral osteoarthritis of his knees. Two weeks later bilateral knee arthroscopies were carried out. At follow-up clinic a week later, Mr D felt his knees had improved.

However, two months later Mr D complained of extreme pain in the left knee and it was decided he should undergo total left knee replacement.

Following the knee replacement, Mr D had physiotherapy. Two months post-surgery, Mr D was happy with his knee replacement. He had returned to work, was driving, and playing golf.

Four months post-surgery, Mr D was reviewed by Mr M after he complained of developing difficulties flexing his knee. Mr M thought Mr D had developed fibrotic changes within the joint and, as a result, manipulation was undertaken under anaesthetic a few months later. The day after the manipulation, Mr D had a disagreement with one of the physiotherapists and discharged himself from hospital. He declined in and out-patient physiotherapy and arrangements for physiotherapy elsewhere.

Early the following year, Mr M saw Mr D and noted that he had benefited from having later physiotherapy, with movement of 100º. However, a number of months later, Mr D had subsequent difficulties and pain. A second opinion obtained from surgeon Ms H stated that the femoral component was too large and a revision knee replacement was carried out. Mr D claimed his pain had been eradicated.

Mr D made a claim against Mr M, stating that he had failed to recognise, from postoperative x-ray, that the femoral implant of the first knee replacement was too large, failed to advise of the need for a revision procedure, and failed to carry out a revision procedure, or refer Mr D to another surgeon. He also claimed a pointless manipulation was carried out under anaesthetic and he had suffered unnecessary pain and inconvenience for more than two years.

Expert opinion

Expert opinion was supportive and there was no criticism of the initial procedure carried out by Mr M. The femoral component was found to be in reasonable size limits and it was stressed that the management of painful stiff knee post-replacement is notoriously difficult – many factors can come into play. During the revision procedure, significant soft tissue release would have been required and this alone may have been responsible for an increased range of motion in Mr D's knee. However, experts were critical of the fact that as Mr D was not happy with the result of the knee replacement, the reasons why should have been investigated.

The case was successfully defended at trial and nearly all costs were recovered.

SW

Learning points

- A poor outcome doesn't necessarily mean negligence. There was no criticism of the procedure itself by experts.
- Supportive expert opinion of the technique used in the procedure meant that the case could be defended to trial.
- Mr M had well-documented the procedure and detailed medical records helped in defence of the case.

The elusive diagnosis

Mr M, 50 years old, suffered chronic ill-health due to spinal fusion, chronic bronchitis and asthma. He was a regular attendee at the surgery of Drs C and D, with sinusitis. In March 2005, Mr M saw Dr D with a similar complaint and she administered him with a flu jab, particularly as Mr M often failed to attend chronic monitoring clinics. The notes from the consultation said: *"Upper respiratory tract infection NOS. Catarrh following URTI 2/52 ago is well. O/E ENT NAD chest flu jab given."*

A year later, Mr M saw Dr D and the notes said: *"Acute sinusitis chest clear. Prescription for doxycycline 100 mg (8)."* Dr D advised Mr M how to take the doxycycline and told him to return if the symptoms did not resolve. Three months later, in June 2006, Mr M attended the surgery again, this time as an emergency, and saw Dr C. Dr C's notes said: *"[SO] penis. Cough. EM-Cough prod of green sputum and sore scratch of L-side of corona of penis ? infected. Chest clear. RV PRN."* Dr C prescribed Mr M some antibiotics to cover the possibility of both skin and chest infections, and asked Mr M to return if either problem did not clear up.

Three months later, Mr M was again seen by Dr C as an emergency appointment. Mr M presented with a productive cough and a high temperature, and, on examination, there were signs of chest infection at the base of the right lung. Mr M was prescribed antibiotics for a lower respiratory tract infection. Six months later, in February 2007, Mr M saw Dr C with a rash on his glans penis and also on his left hand. Dr C considered that the rash looked like a bacterial infection rather than a fungal infection. He prescribed an antibacterial steroid cream.

Five months later, Mr M consulted Dr C over the phone. Mr M said he was coughing up phlegm and that his ears felt blocked. With Mr M's previous presentations with chest infections in mind, Dr C prescribed an antibiotic suitable for respiratory tract infections. Six months later, in January 2008, Mr M suffered a stroke. Upon admission to hospital, diabetes was diagnosed. Mr M remained in hospital for three months and afterwards continued to suffer pain and restrictions to his mobility.

Mr M made a claim against Dr C and Dr D, alleging that over the course of his numerous consultations, they had failed to diagnose, treat and monitor his diabetes; failed to diagnose, treat and monitor his hypercholesterolaemia; and failed to monitor his blood pressure.

Expert opinion

MPS instructed GP expert Dr K to report on breach of duty. Dr K raised no criticisms of the care provided by either Dr C or Dr D, and did not consider either to be in breach of duty. However, Dr K did warn that a lack of a screening programme at the surgery, to screen for diabetes in at-risk patients, posed a litigation risk.

Professor V, a consultant physician, reported on causation for MPS. He said that had the diabetes been diagnosed and controlled, together with treatment of his blood pressure and cholesterol, on the balance of probabilities Mr M's stroke would have been prevented or, at least, delayed for a few years. Professor V deferred to Dr K's view that there had been no breach in the duty of care.

Due to supportive expert evidence, MPS resolved to defend the case; Mr M's legal team discontinued the claim and MPS was able to recover some of its costs.

GG

Learning points

- The NICE guidelines *Preventing Type 2 Diabetes: Risk Identification and Interventions for Individuals at High Risk* (2012) are aimed at identifying people at a potential high risk of developing the condition; assessing their individual risk with testing; and, if necessary, offering lifestyle advice (such as advice on diet and exercise), to help prevent the condition in people who are at high risk. The guidelines are available at www.nice.org.uk/guidance/PH38
- It is important to listen to patients who reattend with recurring problems. Doctors must not let an element of "crying wolf" blind their judgment. Maintain an open mind and be willing to revise an initial diagnosis.
- A long-running scenario such as this one is ideal for discussion at a 'significant event' meeting, to identify whether anything could have been done differently at each stage of Mr M's treatment.

SPECIALTY GASTROENTEROLOGY/ENDOCRINOLOGY/OPHTHALMOLOGY **THEME** SUCCESSFUL DEFENCE

Who's to blame?

Mrs B, 40 years old, was referred by her optician to see an ophthalmologist, Mr F, because of concerns about possible raised intraocular pressure and right-sided amblyopia. Mr F confirmed the diagnosis of right-sided amblyopia, found her to have normal intraocular pressure and documented some visual field loss in both eyes, which he considered was performance-related. He advised reassessment in six months but the patient did not attend for follow-up. Mr A attempted to conduct further follow-up consultations on a number of occasions but Mrs B failed to attend.

Ten years later Mrs B was admitted to hospital with smoke inhalation after an accidental house fire. Her only significant past medical history was a hysterectomy for menstrual disturbance some years previously. The medical consultant on call was an endocrinologist, Dr Y, and she was discharged after two days under his care.

A year later she was seen by consultant gastroenterologist, Dr Z, with hepatomegaly due to alcoholic hepatitis. Soon after, Mrs B was admitted under Dr Z's care after taking an overdose of chlordiazepoxide. A junior doctor commented in the notes that she had "noticed a change in her appearance" that was "interesting, but not classically like acromegaly" and recommended further investigation. Dr Z had no recollection of hearing such comments and no further investigations were carried out.

Over three years later a brain MRI scan was carried out to investigate mild neurological symptoms and memory impairment following a fall. The MRI scan showed an abnormality in the pituitary gland and a subsequent pituitary MRI scan showed a pituitary macroadenoma measuring 1.5cm. Mrs B was found to have a hoarse voice caused by oedematous vocal cords, and a large tongue, nose and hands. Her prolactin level was elevated and a diagnosis of acromegaly was made. Mrs B underwent uncomplicated transphenoidal surgery to remove the pituitary tumour.

Following surgery Mrs B had numerous medical problems caused by late stage acromegaly and other problems related to the hormonal disturbances brought on by removal of the pituitary gland. An MRI scan the following year showed no signs of tumour recurrence.

Mrs B brought a claim against Mr F, Dr Y and Dr Z, alleging that on three occasions opportunities to diagnose her pituitary tumour were missed.

Expert opinion

Most of Mrs B's medical problems were the direct effect of undiagnosed acromegaly. The acromegaly could also have contributed to depression, consequent alcoholism and memory loss. The menstrual disturbance may have been due to the hyperprolactinaemia. Early diagnosis and treatment would have given Mrs B a substantially better quality of life.

The claimant's expert considered that Mr F, Dr Y and Dr Z had "missed opportunities" for making the diagnosis. Significantly, a consultant endocrinologist examined Mrs B when she was admitted with smoke inhalation. The expert commented that it is not unreasonable to expect an endocrinologist to detect the clinical signs of acromegaly during a routine clinical examination.

However, experts instructed by MPS were supportive of the care provided by the doctors. The physical changes of acromegaly are slow to develop and the diagnosis is notoriously difficult to make in the early stages. Mrs B's alcoholism could also have contributed to the changes in her facial appearance, making the acromegalic features more difficult to pick up.

MPS issued a robust defence to the allegations. Eventually, Mrs B discontinued her claim.

AK

SPECIALTY GENERAL PRACTICE **THEME** INTERVENTION AND MANAGEMENT/RECORD-KEEPING **HIGH** £1,000,000+

Missing cauda equina

Ms E, a 29-year-old mother, had suffered with ongoing low back pain since the birth of her second child two years ago, which had failed to improve with physiotherapy. She was assessed in orthopaedic outpatients and diagnosed with an L5 disc prolapse and listed for microdiscectomy.

A week after her orthopaedic consultation, she called her local GP surgery and spoke to Dr A, complaining that she was still in pain, and was unable to come down to the surgery to be seen. Dr A noted she was waiting for an operation and gave further analgesia and muscle relaxants.

The following day, Ms E called the out-of-hours service reporting ongoing pain, despite taking the analgesia prescribed by her GP. She also mentioned numbness in her left leg. The triage nurse she spoke to advised her to try an anti-inflammatory and to seek further advice if her symptoms worsened or if she continued to be worried.

Ms E continued to have symptoms so booked an appointment to see Dr A, and was seen three days later. Her pain was ongoing and she had now developed urinary symptoms; Dr A added in naproxen and started antibiotics for a suspected UTI.

The prescribed medication made no difference to her symptoms, and the following evening Ms E presented to her local emergency department, and was diagnosed with cauda equina syndrome. She was transferred to the care of the neurosurgeons and had an urgent MRI. She underwent an L4 laminectomy the following afternoon, but was left with irreversible disturbance of bladder and bowel function and a persisting numbness in both the left leg and the perineal region.

Ms E pursued a claim against Dr A, alleging that he had failed to warn her about the seriousness of red flag symptoms in his first two consultations with her. She also claimed that he had failed to carry out any clinical assessment or suspect cauda equina syndrome and refer appropriately when she had presented at the surgery.

Expert opinion

MPS experts reviewed Dr A's case notes. The GP expert felt that Dr A had not breached his duty in his initial telephone consultation by failing to warn Ms E about red flag symptoms, on the basis that she was under the care of the orthopaedic team and it was reasonable to assume that they had advised her about cauda equina syndrome and its symptoms. However, his subsequent consultations were viewed as substandard. His note-taking was poor and he failed to document any enquiry about red flag symptoms when the patient presented with urinary symptoms on a background of back pain. Dr A conceded that his usual practice was to document a lack of red flag symptoms if he asks about them and, therefore, it was likely he did not ask and that his diagnosis of a UTI would be difficult to defend.

The neurosurgical expert felt that the onset of cauda equina began with the urinary disturbance, which Ms E consulted Dr A about, and that an urgent referral for surgery within 48 hours of the onset of symptoms would have resulted in a more favourable outcome. He stated that the claimant was likely to have been left with residual low backache without bladder and bowel symptoms or neurological symptoms, and that Dr A's failure to diagnose cauda equina syndrome led to a significantly less favourable outcome for Ms E.

The claim was settled for a high sum.

EW

Learning points

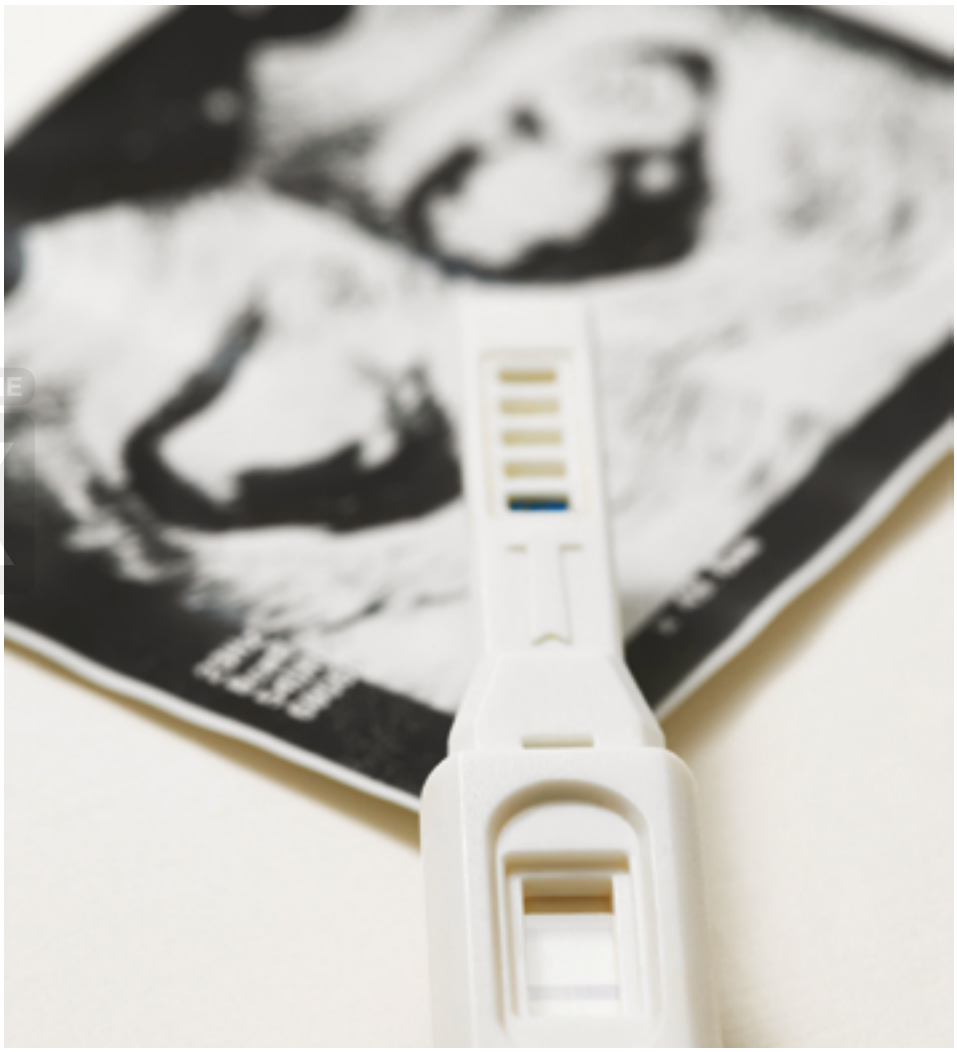
- As always, good note-keeping is essential – not only for patient care, but when defending a claim. When assessing any patient, negative findings should be routinely documented, and in cases of back pain, repeated examination is often necessary to ensure there are no developing or progressing neurological symptoms.
- Cauda equina syndrome comes up repeatedly in *Casebook*. Be wary of patients who re-present with ongoing pain and never forget to ask about red flag symptoms (see useful links). In the setting of acute back pain, bowel and bladder symptoms should always prompt careful consideration of a neurological cause.
- It is easy to be reassured when a patient has seen a specialist and is awaiting further treatment, but symptoms can change, and an enquiry should be made about any deterioration in each new contact with the patient.

USEFUL LINKS

www.sheffieldbackpain.com/professional-resources/learning/in-detail/red-flags-in-back-pain

SPECIALTY GYNAECOLOGY **THEME** SAFETY-NETTING **MODERATE** £10,000+

An unwanted pregnancy



Learning points

- Make sure adequate safety-netting is in place for follow-up of patients. Ms S was advised by Dr F to contact the clinic 48 hours later but did not do so. Follow-up may have made a difference to the outcome.
- Clear communication and sharing information is important when handling complaints, especially when a claim involves more than one healthcare professional. In this case, Dr F was not informed the clinic had admitted liability.
- It is important to carefully consider scans – in this case the ultrasound scan found no evidence of a gestational sac, but this was not acted upon.
- For more information see the RCOG's guidance, *The Care of Women Requesting Induced Abortion*: **www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion**

Ms S, a 44-year-old shop assistant, was seven weeks pregnant. She didn't feel able to continue with the pregnancy and booked an appointment at a clinic for a termination of pregnancy (TOP).

At the clinic, Ms S was seen by Dr F where a full history was taken – Ms S mentioned she had had one miscarriage – before tests were carried out. A pregnancy test proved positive, but an ultrasound scan showed no evidence of a gestation sac. Ms S was treated with mifepristone orally, followed by misoprostol (inserted vaginally) several hours later. Later that day, Ms S was discharged and given a post-treatment leaflet for reference. She was advised to contact the clinic 48 hours later to discuss her treatment, though she did not do so. She assumed that the termination had occurred by the next day.

Three weeks later, Ms S woke in extreme pain and was taken by ambulance to the local Emergency Department (ED). Here, it was discovered that Ms S had an ectopic pregnancy, which had ruptured. As a result, her left fallopian tube had to be removed.

Ms S brought a claim against both the clinic and Dr F, stating that she had been unable to conceive since the event, which had exacerbated her pre-existing depressive disorder. Ms S alleged that Dr F was negligent in failing to investigate the fact that no gestation sac could be seen on the scan prior to performing early medical abortion. She also alleged Dr F was negligent in failing to consider the possibility of ectopic pregnancy and refer her to hospital for further investigation.

Expert opinion

The clinic admitted liability to Ms S at the complaints stage, without contacting Dr F or seeking his opinion. MPS sought expert opinion on behalf of Dr F, which concluded Dr F's actions were likely to have caused, or materially contributed to, Ms S suffering the loss of her left fallopian tube with some consequent pain and suffering.

However, expert opinion maintained that the loss of one fallopian tube does not necessarily prevent conception, as the probability of pregnancy is not substantially reduced. GP records confirmed that Ms S had been trying to conceive for 18 months and she was still ovulating. Her inability to conceive would at least partly be due to her age (44). Dr F's actions did not necessarily cause Ms S's infertility.

GP records indicated that Ms S had an extremely complex, long-standing psychiatric history. She had been taking antidepressants for more than ten years, and had been diagnosed with a mild form of bipolar disorder three years previously. Expert opinion suggested that Dr F's breach of duty in his actions may have exacerbated Ms S's long-standing psychiatric condition.

The claim was therefore settled for a moderate sum.

SW

SPECIALTY GENERAL MEDICINE **THEME** SYSTEM ERRORS **LOW** £1000+

Transfusion confusion

Mrs Y, 38, was admitted to hospital under the care of consultant Dr F for treatment of anaemia due to excessive menstrual bleeding. A sample of her blood was taken for grouping and cross-matching, for the purpose of a blood transfusion; a pack of compatible A-positive donor blood was sent to the ward for this purpose.

After the transfusion began, Mrs Y asked about the blood grouping, telling the nurse that she thought she might be A-negative. The nurse immediately stopped the transfusion and reported this to the laboratory technician – by which time, three to four drops of blood had already been transfused. However, the technician replied that the cross-matching was compatible, and advised that the transfusion should continue while he rechecked the cross-matching.

A short time later, the technician informed the nurse that Mrs Y was in fact A-negative and that the transfusion should stop; by this time, another six to seven drops of blood had been transfused. A blood sample was taken from Mrs Y and she was immediately administered dextrose saline and hydrocortisone intravenously.

Upon clinical examination and observation, Mrs Y's condition was normal. Both the pre and post-transfusion blood samples had been tested for haemolysis and antigen-antibody reaction (Coomb's test), and both tests had shown as negative for any reaction. A day later, Mrs Y was referred to a consultant obstetrician and gynaecologist for a full review of her menorrhagia, and a vial of anti-D was administered to Mrs Y. The following day, Mrs Y was discharged from hospital.

Mrs Y attended the hospital two weeks later where her condition was found to have improved – her haemoglobin level had increased, she was feeling less tired and there were no more palpitations. Mrs Y was asked to attend a further follow-up a month later, but did not attend. She made a claim against both Dr F and the hospital for the errors in her blood transfusion, alleging pain and suffering, and emotional stress and psychiatric injury.

Expert opinion

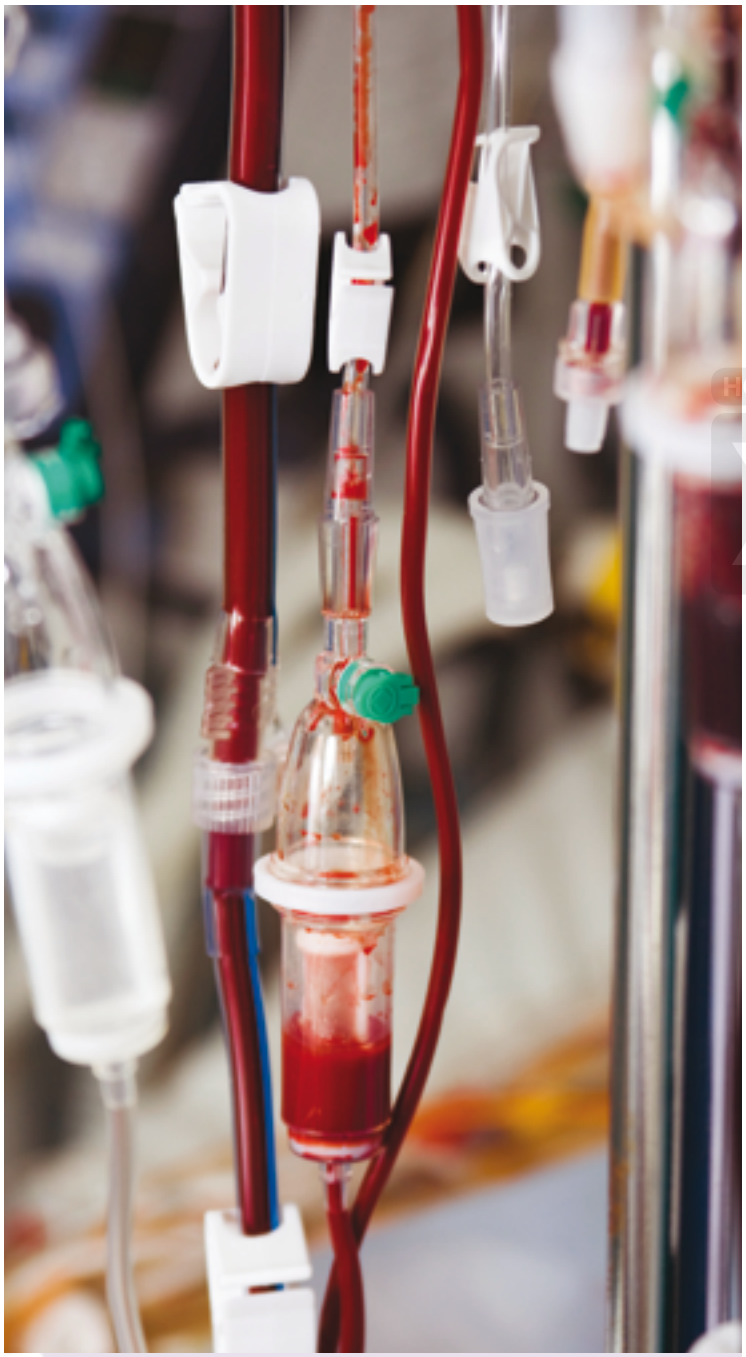
Although there had been a clear breach of duty in the error made during the blood transfusion, the experts for both MPS and Mrs Y disagreed over causation. Although Mrs Y had suffered no adverse reactions as a result of the transfusion, and had been administered with the necessary remedial measures, she alleged psychiatric injury; the experts instructed by Mrs Y's legal team stated that she was indeed suffering from major depressive disorder with psychosis, as a result of the erroneous transfusion.

The expert instructed by MPS, a consultant psychiatrist, said that the 17-month period between the blood transfusion and the alleged diagnosis of major depressive disorder was rather prolonged for a connection to be drawn between the two incidents.

MPS denied any liability on the part of Dr F in the claim, stating that although he ordered the blood transfusion and had overall responsibility for the care of Mrs Y, he could not be held accountable for the mistake of the hospital's laboratory technician.

The allegations against Dr F were subsequently dropped and the hospital accepted full liability for the incident and Mrs Y's psychiatric injury, settling the case for a low sum.

GG



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Learning points

- Being open about errors following an adverse event is important – in paragraph 61 of *Good Medical Practice*, the GMC says: "You must respond promptly, fully and honestly to complaints and apologise when appropriate."
- Listen carefully to the history given by the patient, and don't hesitate to query a course of treatment even after it has started.

SPECIALTY OPHTHALMOLOGY **THEME** INTERVENTION AND MANAGEMENT **MODERATE** £10,000+

Eyes of the storm

Mr Q, 40 years old, consulted Miss A, a consultant ophthalmologist, with lesions affecting his eyelids. Mr Q's complex medical history included antiphospholipid syndrome and his drug therapy included anticoagulant and antiplatelet agents, oral corticosteroids and ocular surface lubricants.

Miss A documented lesions on the left upper and lower eyelid margins resembling papillomas. No corneal or tear film abnormality was noted. She advised upper and lower full thickness wedge excision of the lesions under general anaesthesia. Consent was obtained and Mr Q was warned of the risks of bruising, infection, scarring and revision surgery. The surgery was performed a month later and was uncomplicated.

Mr Q reported severe pain in the eye shortly following surgery. Review the next day identified a small central corneal abrasion and two lashes on the lower lid in contact with the cornea. The corneal abrasion was fully healed on the fourth postoperative day and the lid sutures were removed. Ten days postoperatively there was complete dehiscence of the lower lid wound that was repaired under local anaesthesia. Subsequent eye examinations revealed persistent punctate corneal erosions affecting the lower cornea. Mr Q also experienced painful recurrent corneal erosions and a bandage contact lens did not help to alleviate the pain. Over the months that followed, Mr Q continued to experience episodic pain in the left eye despite regular topical therapy. Two years after the initial surgery, worsening symptoms prompted epithelial debridement, stromal puncture and placement of a bandage contact lens but the discomfort persisted.

A subsequent entry in Miss A's private notes, noted a notch in the centre of the upper eyelid and a note that further surgery may be needed. Her letter to the GP made reference to ocular dryness causing discomfort.

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On 24 August 2010, Mr Q saw Mr B, another consultant ophthalmologist, on account of increasing pain in the left eye. He noted a central corneal opacity reducing vision to 6/12 and an overlying area of epithelial loss. Mr B felt the lid notching with central corneal exposure and a deficient tear film were contributing to his corneal problem and referred Mr Q to oculoplastic surgeon, Mr C, for further management.

Mr Q was seen by Mr C in November 2010, who noted a noticeable notch of the upper lid and a subtle notch affecting the lower lid with corneal exposure. He advised surgical correction of the upper lid notch under general anaesthesia.

Mr Q made a claim against Miss A. He alleged that Miss A failed to carry out the first operation correctly, failed to provide adequate aftercare, failed to inform Mr Q of the notches on his eyelids caused by the removal of the warts, and failed to make a proper or adequate examination of Mr Q.

Expert opinion

The expert ophthalmologist was critical of Miss A's operative technique and aftercare. He also said that during the initial consultation Miss A failed to enquire about dry eye and diseases that can be associated with this. The expert was further critical that Miss A failed to complete consent forms adequately.

The expert believed that a shave excision would have been more appropriate and has fewer risks, so was further critical of the wedge excision of both the upper and lower eyelids, as it was unnecessary and undertaken without careful counselling of the claimant with regard to the effect on the ocular surface disease.

The claim was settled for a moderate sum.

AK

Learning points

- Careful discussion with the patient of the treatment options and potential complications is important, as is a record of the conversation, decision and consent process. This should include a discussion about the possible interaction(s) with any pre-existing condition.

A cannula complication

Mrs H, a 28-year-old massage therapist, was admitted to hospital for laparoscopic tubal ligation. Dr T was the anaesthetist for this surgery.

Before the surgery, Dr T placed a cannula in Mrs H's right wrist and, after surgery, a patient-controlled analgesia (PCA) was commenced through this cannula. According to the cannula chart, a cannula was also placed in Mrs H's left hand, although this was not in place following surgery. Mrs H also recalled a cannula site in the left forearm and a further cannula site in the right forearm following surgery, although these were not recorded on the cannula chart.

Records show that a day later, slight blood staining was present at the cannula site in Mrs H's right wrist. The following day, Mrs H reported the site of the cannula being painful so it was removed. No further problems were recorded and Mrs H left hospital a day later.

A month later, Mrs H attended the hospital in relation to umbilical wound oozing; she also complained of altered sensation in her left thumb and for this was referred back to Dr T. He noted that Mrs H had had two cannula sites over her left arm where she had developed a haematoma and now had paraesthesia over her distal thumb; Dr T referred Mrs H to Dr Q, a consultant orthopaedic surgeon.

Dr Q noted neurapraxic damage to the dorsal branch of the radial nerve, and advised desensitisation exercises. A month later, improvement was noted and Dr Q noted the hyperaesthesia had settled. He further noted that there was 40% function in the dorsal branch of the radial nerve and that there was a reasonable chance that this would recover, at least to a degree.

Mrs H made a claim against Dr T for alleged substandard technique during cannulation, also alleging poor record-keeping in his failure to record two cannula insertions on the cannula chart. Mrs H claimed that when the needle was inserted into her vein, poor technique was employed, resulting in the bevel of the needle cutting through nerves and creating neuromas, causing neurological damage. Mrs H also claimed that the sensory injury had left her disabled, in that she found it extremely difficult to carry out her job.

Expert opinion

MPS obtained an expert report on breach a short time after the letter of claim was received. Professor I, a consultant in anaesthesia and intensive care, produced the report and was robust in his defence of Dr T. Professor I stated that he considered Dr T's technique to be entirely appropriate and that he could not see any evidence of substandard care. He considered it likely that the nerve damage did arise from the unsuccessful cannulation but did not in any way reflect bad technique. Professor I also found Dr T's record-keeping to be appropriate, as he would not expect failed cannulations to be documented.

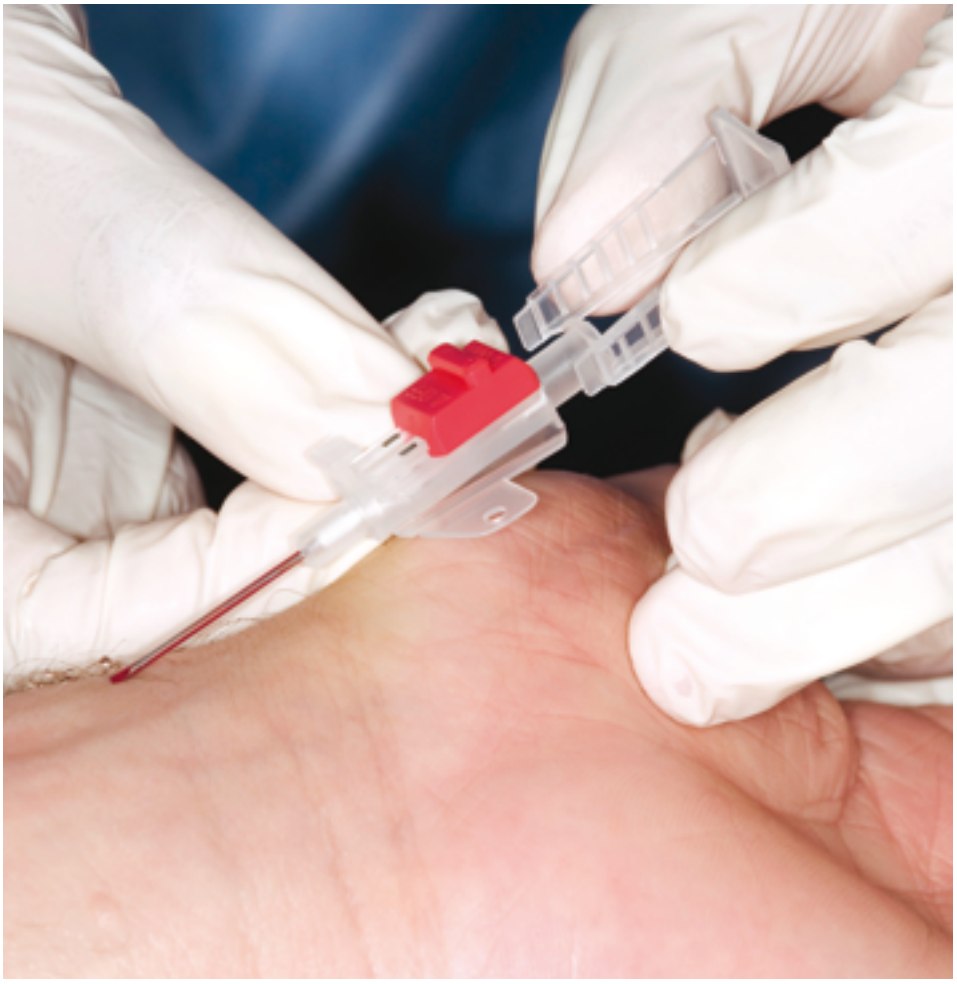
The MPS legal team was aware that Mrs H's own legal advisers were still to obtain their report on breach of duty, and considered that issuing them with a quick response that was supportive of Dr T would dissuade them from pursuing the matter. MPS served its expert evidence along with the letter of response a short time after the letter of claim was received.

Mrs H withdrew her allegations and the claim was discontinued.

GG

Learning points

- Good record-keeping is essential for continuity of care – therefore, the medical records you keep should provide a window on the clinical judgment being exercised at the time.
- When inserting a cannula, consider using the patient's non-dominant hand if possible.
- It is helpful to write a report soon after an adverse event, because of the lengthy time that can sometimes pass before a related complaint or claim arises.
- This case is a reminder that not every adverse outcome is negligent. MPS's robust approach meant the case was dropped and the allegation withdrawn very quickly.



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SPECIALTY GENERAL PRACTICE **THEME** SUCCESSFUL DEFENCE

High expectations

Mr O was a 24-year-old man who had just enjoyed a holiday overseas. On the return journey he started vomiting. The nausea and vomiting continued after he arrived home and he began to lose weight because of it. When his symptoms did not abate he made an appointment with his GP.

His GP documented a four-week history of nausea and vomiting and, after reviewing normal blood tests, referred him to gastroenterology. The gastroenterologist wrote back concluding that he had found no significant pathology on endoscopy or ultrasound, and that he thought that anxiety was contributing to his ongoing symptoms. Irritable bowel syndrome was also considered to be a factor.

Mr O asked his GP for a private referral to neurology, which he agreed to. The neurologist arranged an MRI scan, which was normal, and felt that Mr O was suffering from a significant depressive illness from which he had partly recovered. Mr O did not agree with this diagnosis and felt that his symptoms had a physical rather than a psychological cause. He did, however, agree to see a psychiatrist, who concurred that his symptoms were due to anxiety and depression. He prescribed venlafaxine and arranged CBT.

Mr O was struggling with fatigue in addition to the nausea and was not coping at work, so he visited his GP again. His GP referred him to a specialist in chronic fatigue who wondered if he may be suffering with post-viral fatigue syndrome.

Mr O was convinced that there was a physical cause for his symptoms and demanded a second neurological opinion. This was sought but nothing abnormal was found on examination, repeat MRI or lumbar puncture. He had mentioned some dizziness and had an audiometric assessment showing abnormal canal paresis to the right. The neurologist concluded in a letter to the GP that “the only abnormality found in spite of extensive investigations was a mild peripheral vestibular disorder”. The letter detailed that he had been seen by a physiotherapist who had instructed him in Cawthorne-Cooksey exercises and that he had been asked to continue these at home.

Despite doing the vestibular rehabilitation exercises at home, Mr O failed to improve. He still felt weak and light-headed and had moved back in with his parents who were worried about him. They made him another appointment with his GP who referred him for an ENT opinion.

The ENT consultant took a detailed history and noted the absence of tinnitus, vertigo or deafness. She could not find anything abnormal on examination and thought that a labyrinthine

problem was unlikely to be the problem. She repeated the balance tests, which were normal.

Years went by and Mr O became very focused on his symptoms, feeling sure that a diagnosis had been missed. Opinions were sought from an endocrinologist, a professor in tropical diseases and a private GP. Nothing abnormal could be found and no firm diagnosis was made. A neuro-otologist thought that his symptoms were due to a combination of "anxiety with an associated breathing pattern disorder, a migraine variant and physical de-conditioning". A joint neuro-otology/psychiatry clinic concluded that it was "a confusing story with nebulous symptoms but it was probably a variant of fatigue disorder with a depressive element and derealisation".

Mr O was very frustrated at the lack of diagnosis or improvement in his symptoms. He felt that the sole cause of his symptoms was a peripheral vestibular disorder. He made a claim against his GP, alleging that he had failed to make the diagnosis and that he had also failed to arrange vestibular rehabilitation.

MPS instructed expert opinion from a GP and a professor in audiovestibular medicine. The experts felt that Mr O's GP had not been at fault.

The professor in audiovestibular medicine was sceptical regarding the diagnosis of a vestibular disorder. He noted that repeat audiograms and tympanograms had been normal and felt there was no robust evidence that he had a peripheral vestibular disorder. He stated that there was no clinical history suggestive of vestibular pathology at the onset of Mr O's illness. He also commented that there had been no consensus amongst various specialists as to the true cause of Mr O's symptoms and that to claim that a peripheral vestibular disorder was the sole cause was an overly simplistic view.

The GP expert noted that the neurologist's letter to the GP referred to Mr O having been instructed by the physiotherapists in Cawthorne-Cooksey exercises. These are vestibular rehabilitation exercises so it was wrong to say that there had been a failure to arrange the exercises or that this was the responsibility of the GP. The expert explained that GPs are not trained to instruct a patient in vestibular rehabilitation exercises and are not likely to have direct access to specialist physiotherapists who could arrange these. The expert noted that a large number of specialists saw Mr O over a prolonged period, all of whom failed to reach a consensus on the cause of his symptoms. The expert's view was that the treatment provided was reasonable and that the standard that the claimant sought to apply was too high.

Mr O withdrew his claim before it went to court.

AF

HOME

Learning points

- The defence of this claim was helped by the contents of the correspondence to and from specialists, which were relied upon to disprove some of the allegations made. It is important to take the time to write comprehensive referral letters and to read letters from specialists carefully. Correspondence is an important part of the medical record, as well as being important communication between clinicians.
- Mr O clearly had a very difficult time. There had been a protracted period of time with no clear diagnosis. However, in the circumstances of this case, this did not equate to negligence.
- This case highlights the standard doctors must meet in order to refute negligence claims – that of a responsible body of their peers (GPs in this case), rather than a specialist in the condition in question.

Over to you

We welcome all contributions to Over to you. We reserve the right to edit submissions.
Please address correspondence to: *Casebook*, MPS, Victoria House, 2 Victoria Place, Leeds LS11 5AE, UK. Email: casebook@mps.org.uk

Wrong drug, no negligence

›› I enjoyed reading your article "Wrong drug, no negligence" in the May 2014 edition of *Casebook*. As a trainee anaesthetist I can remember making exactly the same mistake during my first month of training, ie, administering a full dose of co-amoxiclav to a patient with penicillin allergy whilst under anaesthesia. Fortunately the patient suffered no ill-effects whatsoever, and postoperatively she admitted she was sceptical about whether she had a true allergy or not, and was glad that we had inadvertently found out.

Drug administration errors in anaesthesia are common, with some studies suggesting one error in every 133 anaesthetics.[1] In your article you state the anaesthetist may have been distracted by the use of the total intravenous anaesthesia technique. This is probably not the only factor, as observational studies have shown that on average an anaesthetist is distracted once every four to five minutes during a routine list.[2]

Thus the propensity for making errors is huge and it would seem only a matter of time before an error leads to a catastrophe that makes headline news. On wards and on intensive care units, nurses have long ago moved to using a two-person check system prior to the administration of harmful medication. Since anaesthetists have access to some of the most dangerous medications in the whole hospital, how vulnerable are we to litigation claims, given that we still use a single-person check? Should we be pushing to implement a two-person check as well, to protect both us and our patients?

Dr Nikhail Murli Balani
ST4 Anaesthesia and Intensive Care Medicine
Guy's and St Thomas' NHS Trust, London

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Response

Thank-you for your letter about this case, and for sharing your own experiences. Your suggestion about the introduction of two-person checking certainly seems to make sense, and steps that may reduce avoidable errors should be encouraged.

Perhaps a discussion with your trust is worthwhile, to consider introducing or trialling such measures.

Photo criticism

›› I just wanted to let you know that I find *Casebook* really helpful, well-presented and useful (if a little frightening at times!). I also wanted to make a small criticism about some of the photos that let down the otherwise professional approach.

I am a bit behind on reading them but a case in point was the Jan 2014 edition (volume 22), page 14, which showed an otoscope being held completely wrongly, in the wrong hand and without an earpiece. I suspect

Manslaughter

›› I enjoy *Casebook,* which reminds us that there are always new errors, and that old errors are easily repeated.

You kindly refer on page 11 ("Medicine and manslaughter", *Casebook* UK only) to the review that Sarah McDowell and I wrote of medical manslaughter between 1795 and 2005. But you then state that "other widely-reported cases include" and cite Mulhem (2003) and Walker (2004). This might unintentionally suggest that we omitted these from our review. They are, respectively, cases 7 and 14.

Incidentally, the trend towards long prison sentences for surgeons started with *R v Garg*, which seems to have attracted little attention; and the verdict in the Sellu case was reached in spite of the fact that the judge was reported to have said that the patient might have died even if he had received the proper treatment promptly.

Professor Robin Ferner, Consultant Physician and Clinical Pharmacologist , West Midlands Centre for Adverse Drug Reactions, City Hospital, Birmingham, UK

Response

Thank-you for your letter about the case report "Wrong drug, no negligence" in the last issue of Casebook.

The terminology used in the case may have inadvertently led to some confusion. From a legal perspective, in order for a case to be established in negligence, the claimant has to establish certain key elements: that the defendant owed the claimant a duty of care, that there was a breach of that duty of care, and that the breach of duty was the cause of the loss or harm complained of.

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any lay person would not notice but it would be worthwhile getting a doctor to check the photos before publication to avoid similar errors, which look terrible to doctors.

I hope you understand that I am making the point to improve the journal rather than be overly critical.

Dr Samantha Dunnet
GP, UK

Response

Thank-you for your letter about the photograph on page 14 of the January 2014 edition of Casebook.

The pictures used in Casebook *are not accurate representations of clinical situations, but rather to illustrate the general theme of the case report or article. We do have a notice to this effect at the foot of the* Casebook *contents page, although the font is rather small and might benefit from being a little more prominent.*

The content of each issue of Casebook *is reviewed in its final form in our layout board meetings, and these always include a number of doctors from a variety of clinical backgrounds. Whilst no comment was passed about the use of the picture in question, your comments will be a timely reminder for the board members.*

The accused

›› I was shocked by the account of a patient making a spurious claim against the GP in your recent edition of *Casebook*.

The story left me feeling quite angry at the fact that the patient in the matter was able to simply shrug off an apparent malicious claim against the GP without any consequence. I can completely understand the professional reluctance to do so, but would there be an argument in this case to pursue a civil claim of libel, given the significant impact this claim has had on the doctor both professionally, emotionally and undoubtedly financially?

Dr T Broughton
Consultant Forensic Psychiatrist
Norfolk, UK

Response

Whilst it might seem an attractive proposition to contemplate some form of legal redress in these circumstances, there are a number of significant practical issues to consider.

Firstly, MPS experience is that nearly all complaints of this type are made by genuine complainants who have misunderstood or misinterpreted a clinically appropriate examination carried out in a reasonable and responsible manner.

The second point to consider is that as a matter of public policy, most legal systems provide some form of protection against allegations of defamation for complainants who take their concerns through appropriate channels. This is because otherwise there would be a very chilling effect on the ability of members of the public to raise concerns, particularly where a defendant may be able to access much greater resources than the complainant.

Additionally, in criminal cases, the decision to prosecute rests with the prosecuting authority rather than the complainant. In England and Wales, for example, this rests with the Crown Prosecution Service, who will weigh up the issues before deciding to proceed with a case. This includes assessing whether there is sufficient evidence, whether the evidence is reliable and credible, and whether a prosecution is in the public interest.

Finally, even if there were no other hurdles, and it was possible to consider an action in an individual case, it would be an unattractive case, which would be liable to attract adverse publicity, and in the event of success, given the financial position of most complainants, a doctor (or their MDO had they agreed to undertake the matter) would be unlikely to recover their costs, let alone any damages actually awarded.

Realistically speaking therefore, it is unlikely that we will see cases of this sort being brought.

The accused

›› The excellent article "The Accused" (*Casebook* 22(2), May 2014) leaves an obvious question, which would be valuable to consider…

What is MPS's advice for the doctor when the patient declines the chaperone? Is the doctor at risk if they refuse to proceed with an examination without a chaperone? What should they do, in that event?

Other readers may also wish to know your response – it seems important.

Dr Mark Davis
New Zealand

Response

Thank-you for your letter, which raises a very important issue.

Generally speaking, if a chaperone is declined by the patient, and you don't want to go ahead without one, you should clearly explain why you would like one to be present. You could also consider referring the patient to a colleague who would be willing to examine without a chaperone. However, the patient's clinical needs must come first, and any such arrangements should not result in delays that affect the patient's health.

The discussion about chaperones, together with the outcome, should be recorded in the medical record. If a chaperone is present, record that fact, and their identity. If the patient refuses a chaperone, make a note that the offer was made and declined.

There are often local guidelines or protocols that cover this issue, and members should make sure they are aware of these and follow them.

Readers in New Zealand can access the MPS factsheet on chaperones at the MPS website: www.medicalprotection.org/newzealand/factsheets/chaperones

HOME

★★★★★

Reviews

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

Do No Harm: Stories of Life, Death and Brain Surgery

Henry Marsh, Reviewed by Dr John Gilbey, Core Trainee – Anaesthetics, North Western Deanery, UK

Do No Harm: Stories of Life, Death and Brain Surgery is the memoir of Henry Marsh, a senior consultant neurosurgeon who has previously had his work featured in two television documentaries. In this book he reflects on the events and experiences that have shaped his professional life.

The sentiment of a quote by René Leriche at the start, "Every surgeon carries within himself a small cemetery, where from time to time he goes to pray – a place of bitterness and regret, where he must look for an explanation for his failures", resonates loudly throughout the book. Difficult decision-making and dealing with mistakes are themes that repeatedly arise. Other topics are also covered including modern medical training, the reality of consent, being ill as a doctor, the modern health service and the meaning of success.

Each chapter presents either clinical cases or other events from Marsh's life. These are then interspersed with his thoughts on the events. He does mention some success through the book and describes achieving most "when our patients recover completely and forget us completely". Difficult decision-making and dealing with mistakes is most explicitly demonstrated when recalling a visit to a Catholic nursing home where he finds patients he had previously forgotten and at least one who "I had wrecked".

The book is written in a way to inform the lay reader of the deepest thoughts of a neurosurgeon. Medical terminology is used throughout, with meanings clearly explained. This is not to say that it does not appeal to a medical audience as simultaneously. The writing style is matter-of-fact without being dry. His stories are moving and in places brutally honest.

Do No Harm certainly gives an insight into the reality of life as a neurosurgeon in a modern hospital. For patients, it provides an insight into the fallibilities and difficulties of being a doctor. For students, it is a must-read if you are considering a career in neurosurgery. For doctors, it is a fantastic example of reflection.

★★★½

Forks in the Road: A Life In and Out of the NHS

Leslie Turnberg, Reviewed by Dr Behrad Baharlo (Specialty trainee, anaesthetics, Imperial School of Anaesthesia)

Charting the life and times of Lord Leslie Turnberg of Cheadle, this candid and eloquently written autobiography gives the reader insight into some of the most defining events affecting not only the medical profession, but also healthcare in the United Kingdom over the last 40 years. To say that the author bore witness to such events would be underestimating the active role he clearly executed not only in postgraduate training but also healthcare policy.

Detailing his life from humble beginnings in Lancashire, the former President of the Royal College of Physicians and of MPS takes the reader through his childhood and formative years with humility, which is a consistent theme throughout the book. He charts his many achievements from qualification then into academia, medical politics, the presidency of the RCP and culminating in his nomination as a peer of the realm.

Notably describing his role in the advent of the university department at Salford Hospital "from scratch" along with its initial shortcomings, as well as comments regarding research (and how not to do it) and the changes in postgraduate medical training of the 1990s, the reader is given a front seat with this account of aspects of the profession that can often seem peculiar if not mysterious. Discussion is made of contemporary issues affecting NHS politics especially pertinent to the New Labour years, and the author is not afraid of casting an opinion or giving fair reflection with the benefit of hindsight.

I found the descriptions around medical training (the eventual establishment of the Academy of Medical Royal Colleges and Postgraduate Medical Education and Training Board) and issues surrounding reform of the NHS of particular interest and found food for thought in aspects concerning financing and NHS interaction with politics and politicians. I couldn't help feeling that a number of these issues described, including attempts at reform, would have been equally valid when the author commenced his career in the NHS. On matters of NHS reform, financing and political pressures the author clearly had a privileged insight, especially during the term of the Labour government. I would commend the author's views to anyone interested in such matters.

Reflecting his privileged title, the author visits a number of topics of interest that he has spoken about at the House of Lords, and unashamedly bestows opinions ranging from assisted suicide to anonymity in sperm donation. The importance of the author's Jewish faith is identifiable and his subsequent interest in Middle Eastern politics results in an attempt at summarising and digesting this complex and otherwise problematic issue with numerous good opinions.

The book concludes with a moving tribute to Daniel, the author's late son, the impact of his passing being vividly and eloquently described, leaving the reader sharing a sense of melancholy if not shedding tears in sympathy with the author's tragedy.

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