VOLUME 23 ISSUE 2
NOVEMBER 2015
UK

Professional support and expert advice from your leading medicolegal journal

Medical Protection

CASEBOOK

I WILL SURVIVE
OVERCOMING ADDICTION

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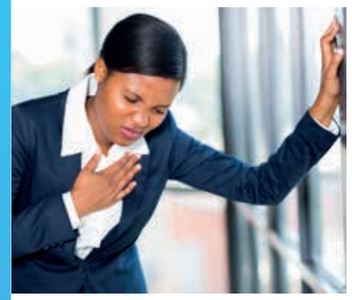
This issue...

WHAT'S INSIDE...



CASE REPORTS

Every issue...

FEATURES

FACTS AND OPINION

ISSN 1366 4409

Casebook is designed and produced twice 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

This edition of *Casebook* is one of welcomes and farewells. Dr Pardeep Sandhu is the new executive director for your professional services division, where he will be responsible for maintaining and building on the quality of the medicolegal advice and legal support that is available to you.

The appointment is a considerable boost to our aim of providing you with world class service. You can read more about Dr Sandhu on page 5, but in summary Dr Sandhu brings with him many years' experience of working within diverse healthcare environments around the world, and he has also worked extensively with governments to advise on health policy and clinical governance – something that is becoming increasingly important to Medical Protection as we seek to shape the clinical negligence landscape in many countries in which we have members.

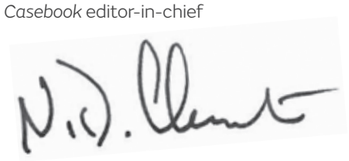
The cost of clinical negligence claims continues to rise in a number of countries around the world, and we are speaking regularly with relevant governments and policy-makers to find ways to control costs and simplify what can be long-running legal processes. More information about our work with the Department of Health can be found on page 6.

This edition of *Casebook* contains, as ever, our latest collection of case reports. Along with the usual salient learning points – and in this edition there is a general theme on the value of good record-keeping – you will also be interested to note some successful defences. As well as demonstrating the value of our legal expertise available to you, these cases also show how the clinicians involved were able to help their own position, be it through excellent documentation, a robust consent process or an articulate presentation of evidence at trial.

I mentioned at the beginning of this editorial that this edition of *Casebook* was one of welcomes and farewells. This is my last edition as editor-in-chief of *Casebook*, as I am moving into a new role within Medical Protection. I have greatly enjoyed my time in the position, especially as it has given me so many opportunities to hear your feedback directly.

I am happy to announce that Dr Marika Davies will be taking on the role, please do get in touch with any comments or suggestions that you wish Dr Davies to take on board.

Dr Nick Clements
Casebook editor-in-chief



FEATURE

NEW EXECUTIVE APPOINTMENT: DR PARDEEP SANDHU

Dr Pardeep Sandhu is the new executive director of your professional services division. Find out what Dr Sandhu brings to the role and how he plans to further improve your medicolegal support service.

Dr Sandhu joins us from Aetna International, a global health benefits provider in the USA, where he was medical director and head of business development.

Dr Sandhu spent more than seven years working with governments to create and expand robust healthcare systems. In this international role, Dr Sandhu worked across health policy, clinical governance, business development and strategy, as well as designing and launching Aetna's international care management programmes in multiple geographies.

Dr Sandhu trained at the University College London and was a GP before serving as a clinical adviser to the UK Department of Health. He also holds a MBA from Kellogg School of Management, Northwestern University, USA.

Simon Kayll, Chief Executive, said: "We are delighted to welcome Dr Pardeep Sandhu.

"We work in an increasingly challenging environment and one in which litigation, complaints and appearances before the regulator are now becoming more common. Dr Sandhu will head up a large team of more than 250 medical, dental and legal experts providing members with advice, support and protection tailored to their circumstances.

"He will also play a critical role as part of the Executive Committee, providing direction across the whole organisation. With his international experience and background as a physician and senior healthcare executive, Dr Sandhu will help strengthen our position as a world-class protection organisation."

Dr Sandhu said: "I am very excited to be joining a team of such talented individuals, and look forward to building on their established expertise to deliver an even better service to our members.

"With numerous challenges facing the medical and dental professions worldwide, it is vital that we are there for members in the right place, at the right time. As a former practising physician myself, I understand the unique dilemmas clinicians face on a daily basis – and I very much subscribe to the Medical Protection ethos that prevention is better than cure. Ensuring the expertise of my team benefits our membership is a key goal for me.

"Of particular interest to me is the challenge of meeting the needs of our members around the world. With so much variation from country to country, it is imperative that we tailor our services to meet everyone's requirements as fully as possible. I look forward to working with you and hearing your views on how we can improve even further."

NOTICEBOARD

DH ACCEPTS MEDICAL PROTECTION CALLS TO CAP LEGAL COSTS

The government has agreed with Medical Protection on the need to introduce a fixed costs regime for small value clinical negligence claims.

The Department of Health has stated that the fees some lawyers are charging are disproportionate and can outstrip the amount of compensation awarded to patients. In a recent cosmetic surgery case, damages of £17,500 were agreed; however, legal costs were claimed in excess of £50,000. The costs were finally settled at £36,000, which is still more than double the amount the patient received in compensation.

According to the NHS Litigation Authority (NHSLA),[1] in claims where compensation is less than £10,000, claimant lawyers recover almost three times more in costs on average.

For claims resolved for less than £100,000 damages, the percentage of claimant costs has increased from just over 30% to 50% over the last ten years and, as an absolute figure, has increased almost three-fold.

Approximately one third of the £1.1 billion paid out by the NHSLA last year went to the legal profession, most of which was paid to claimants' lawyers. The NHSLA has stated its support for a move to a position where legal costs are more proportionate to damages.

Health Minister Ben Gummer MP outlined the plans for the fixed costs regime in a letter to Lord Dyson, Master of the Rolls and Head of Civil Justice. The proposals include fixing legal costs to a percentage of the compensation won for patients in claims of up to £100,000.

Medical Protection has been calling on Government to introduce fixed costs as one way of helping to drive down the cost of clinical negligence.

Emma Hallinan, director of claims and litigation, said: "We have been calling for a fixed cost regime to help address the rising cost of clinical negligence, and it is fantastic to see that government plans to cap excessive legal fees that are placing such a burden on the public purse.

"There are further actions that can be taken to make the cost of clinical negligence more affordable for society, but this is an excellent start and we look forward to working with the Department of Health on the detail of their new approach."

Medical Protection is also currently engaging with the Government, MPs, Lords and key healthcare stakeholders to advocate further reform for members' benefit.

However, a fixed costs regime is only one reform, and more change is needed. The next and crucial step is to have a debate on the merits of limiting damages, in particular future loss of earnings and care.

In our experience, damages (in particular), future care costs and earnings have increased in recent years. We could learn from other countries: in some Australian states there are limits on the loss of earnings at, typically, a multiple of two or three times the average weekly earnings.

As difficult decisions are made about what the NHS can afford, it is crucial that we ask ourselves whether it is appropriate and affordable to continue to pay such large sums in damages and costs. Medical Protection believes that these funds could be better spent on patient care for all.

Other areas being pursued include reducing the burden of regulation on members. Medical Protection is seeking a moratorium on the introduction of new regulations on the healthcare profession, as we believe that a change in culture would be far more effective at promoting openness, professionalism and accountability amongst those working in healthcare. Focusing on legislation and regulation as the key methods of driving behavioural change will undermine this.

In our experience, a reliance on blunt legislative tools risks creating defensive behaviours, where self-preservation becomes a dominant influence, instead of a focus on the best interests of the patient.

A formal consultation on fixed costs for small value clinical negligence claims is due to take place in late 2015, which Medical Protection will respond to as part of our continued engagement with key policy-makers and stakeholders to drive proposals forward.

1. NHS Litigation Authority, Report and Accounts 2014/15

CPD APP LAUNCHED BY GMC

A new mobile app to help doctors manage their CPD has been launched by the GMC.

The app, "GMC My CPD", is available for Android and Apple devices and allows users to record their learning activities on the go, with one press of a button. The app also includes reminders for doctors to reflect on whether their CPD has changed their practice positively.

Niall Dickson, Chief Executive of the GMC, said: "CPD is an integral part of practising medicine and we very much hope this app will be a useful aid for front line doctors. We have developed and tested it with practising professionals – it should help doctors keep their learning records up to date, and reflect appropriately on their learning."

The app will allow doctors to record all aspects of their work wherever they are, including photographing learning certificates and voice recording ideas and thoughts.

It also provides advice and case studies, including planning, reflecting on points of learning, and how to prepare for appraisal.

NEW LEGAL TEST FOR GOOD SAMARITAN ACTS

In April, the Social Action, Responsibility and Heroism Act 2015 came into force in England and Wales. It sets out some additional factors that a court must consider when assessing a negligence claim or alleged breach of duty.

These factors essentially outline a new legal test that is especially pertinent in the case of a Good Samaritan act. They are:

Social action – whether the alleged negligence or breach of statutory duty occurred when the person was acting for the benefit of society or any of its members.

Responsibility – whether the person, in carrying out the activity in the course of which the alleged negligence or breach of statutory duty occurred, demonstrated a predominantly responsible approach towards protecting the safety or other interests of others.

Heroism – whether the alleged negligence or breach of statutory duty occurred when the person was acting heroically by intervening in an emergency to assist an individual in danger.

MEDICAL PROTECTION ADVICE

A Good Samaritan act is where medical assistance is given in a bona fide medical emergency, which a healthcare professional may happen upon in a personal rather than professional situation. While there is no legal duty to assist (in UK law), clinicians have an ethical and a professional duty to help.

As clinicians in such a situation, you should do the best you can in the circumstances with the resources available, working within the limits of your competence. Medical Protection will assist with any problems arising from a Good Samaritan act anywhere in the world.

When an emergency arises, it is vital to:

- Carefully consider your own competence and expertise, particularly if you are retired and/or no longer registered with the GMC:
  - Consider whether anyone else is better placed to assist, such as a currently practising/registered doctor
  - If retired, you should make clear you are no longer in practice
  - For those who no longer hold a license to practise, you must make this known.
  - Take a full history and carry out a full examination in order to make an informed assessment
- Suggest options for managing the situation (balance benefits and risks of treatment)
- Work within the confines of your expertise and training, except in a critical emergency
- Delegate and communicate appropriately.

FEMALE GENITAL MUTILATION GUIDELINES UPDATED

The Royal College of Obstetricians and Gynaecologists has updated its guidelines for healthcare professionals on how to best care for women with female genital mutilation (FGM). The green-top guideline no 53, *Female Genital Mutilation and its Management*, provides evidence-based advice on the clinical care of women with FGM before, during and after pregnancy, including legal and regulatory responsibilities. This is to understand the difference between recording FGM (for the purpose of the FGM enhanced dataset) and reporting FGM (making a referral to the police or social services) and a healthcare professional's responsibilities with respect to these.

For more information see the FGM Factsheet on our website: medicalprotection.org/uk/resources/factsheets

ACHIEVING SAFER AND RELIABLE PRACTICE

Medical Protection's Dr Suzy Jordache and Sam McCaffrey look at how a new workshop for members is making for a more reliable healthcare experience

Safe healthcare requires both the expert knowledge and technical skills of healthcare professionals as well as reliable delivery and application of that knowledge and skill.

In the new Medical Protection workshop Achieving Safer and Reliable Practice, reliability is defined as minimal unwanted variability in the care we have determined our patients should receive. Any figure below 90% reliability would be termed 'chaos' in other safety critical sectors, and yet in healthcare we regularly report 'success' rates of 80% or lower.

Examples of the variation in reliability in healthcare are readily available: the Health Foundation's report in 2010 found that in nearly one in five operations equipment was faulty, missing or used incorrectly; around one in seven prescriptions for hospital inpatients contained an error; and full clinical information was not available at just under one in seven outpatient appointments. The report also commented on the wide variations in reliability between and within organisations.

In addition, Medical Protection data gathered from visits to 778 GP practices in the UK and Ireland between 2008 and 2014 found that only 55.9% of practices had adequate processes for matching test requests and results received.

HOW RELIABILITY IS QUANTIFIED

Reliability is often expressed in terms of failure rate as a power of 10. For example, a procedure that is reliable nine times out of ten fails 10% of the time, or has 10^{-1} reliability. A procedure that fails 20% of the time has a reliability of $>10^{-1}$.

Systems that fall below 10^{-1} reliability are generally considered 'chaotic'.

WHAT LEVEL IS ACHIEVABLE?

Research suggests that implementation rates in healthcare for standard procedures that impact on patient safety are between 50% and 70%, or $>10^{-1}$.

Other industries such as aviation and nuclear power have achieved reliability levels of 10^{-6} in critical processes. In healthcare anaesthetics has been successful in achieving this level of reliability during the induction of anaesthesia. This and other reliable practices, such as blood transfusions and pathology labelling, can inspire and lead the way for all of us, whether practising in primary or secondary care.

HUMAN FACTORS

The science of human factors examines the relationship between people and the systems with which they interact, with the goal of minimising errors. In healthcare, human factors knowledge can help design processes that make it easier for doctors and nurses to do the job right.

Some of the factors that have been identified that can impede human performance include:

People

- Perceptual deficits under stress
- Fatigue
  - Physical
  - Decisional
- Poor interpersonal communication
  - Transmission/reception
  - Challenge
- Poor understanding of the nature of human error
  - Causes
  - Extent
  - The weakness of 10^{-1} strategies in prevention.

Processes and systems

Inadequate:

- Structured decisional support and checking tools
- Measurement, feedback and accountability mechanisms
- Briefing and simulation
- Environmental design and control
- Equipment design

ALWAYS CHECKING

In order to mitigate the risks from these factors Medical Protection advocates the AlwaysChecking™ approach, which offers five manageable, evidence-based steps to raise reliability in any healthcare setting:

Moving to 10^{-2}

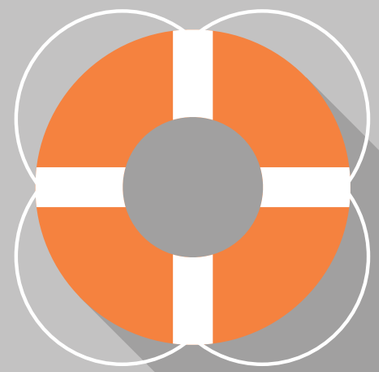
The MPS *Always*Checking™ approach

PRINCIPLE *WE ALWAYS CHECK*	STRATEGY
each other and welcome being checked	Speaking up
what we've agreed should be done	Checklists
message sent is message received	Repeatback/ Readback
we know how to work together	Briefing and Simulation
always means always	Measurements and Accountability

Perhaps the most important strategy is that of 'speaking up' – safe cultures train and insist on respectful assertive communication. In healthcare, we often find that following an error, one member of the team had 'seen it coming', but felt unable to say anything. There are complex reasons for this and simple steps by individual clinicians can transform safety.

Speaking up is only possible in a culture that accepts that everyone will make mistakes. In many teams the perceived negative consequences of speaking up can be greater than those of not speaking up. Explicitly telling others of your expectation that they will speak up and 'have your back' and thanking anyone who challenges you – especially when they are wrong – can help change this perception.

Engaging with those in your team who are reluctant to speak up is also essential. This may require training to ensure that the necessary skills are taught and learnt. The Medical Protection Speaking Up for Safety workshop is a one-hour session designed to introduce a common method of 'speaking up' within organisations. For further information go to: medicalprotection.org/uk/education-and-events.



CHECKLISTS

The use of checklists in healthcare has been demonstrated in numerous studies to improve reliability and outcomes for patients, yet they are still resisted by some in the profession and are often hotly debated during the workshop.

Some of the benefits of using a checklist include:

- Reduce cognitive work
- Facilitate concentration on first order concerns
- Critical in preventing "never events"
- Change the culture of a team
  - Validate the importance of a safe process
  - Empower team members to challenge.

In one example the successful implementation of a checklist saved lives and millions of dollars by eliminating central venous line infections.

The intervention involved the education of staff, creating a dedicated catheter insertion cart, daily assessment as to whether catheters could be removed, implementing a checklist to ensure guidelines for preventing infections were followed, and training and empowering nurses to challenge colleagues if they were not following the checklist.

It resulted in the infection rate falling from 11.3/1000 to 0/1000 catheter days, as well as 43 infections and eight deaths being prevented.

The workshop includes a guide on how to develop effective checklists and implement them in organisations.

MEASUREMENT AND ACCOUNTABILITY

Another key aspect of the AlwaysChecking™ approach is "Measurement and Accountability". Within many organisations and teams there will be some clinicians who do not conform to agreed safety procedures. Allowing 'special rules' for some is toxic and can sabotage success.

Challenging these individuals can be diffi cult but without doing so high reliability and safety cannot be achieved. The success story from Vanderbilt University Hospital system in the USA demonstrates the importance of measurement, feedback and accountability – highlighting the power of insisting that "always means always" around handwashing.

The results achieved in 2009 ($>10^{-1}$) were achieved using strategies based on individual memory, diligence and vigilance. In 2010 the centre moved to a detailed monitoring and individualised clinician and team benchmark feedback process, leading to 10^{-1} levels of reliability.

Since 2011 the level of compliance has been maintained (and even increased again) to 10^{-2}.

The benefits to patients, in terms of morbidity and mortality reduction, along with the economic benefits to the hospital and the decreased risk of complaint and claim for the clinicians employed by Vanderbilt, is a testament to the value of measurement and accountability in achieving 10^{-2} reliability.

EXAMPLE: HAND WASHING PROGRAMME

YEAR	HAND WASHING RATE
2009	58%
2010	80%
2011	92%

30% reduction in serious hospital infections

Estimated annual net savings of $4.5m

Ten fold reduction in ICU central line infection rate (now one quarter of national benchmark)

Vanderbuilt U.M.C

I WILL SURVIVE
- OVERCOMING ADDICTION

Doctors help their patients with mental health problems, but often suffer alone. Dr Michael Blackmore has battled with drug and alcohol addiction for more than 20 years. How did a doctor working in the NHS become an addict? He shares his story

I have always felt restless, irritable and discontent. As a child I was uncomfortable in my own skin and never felt like I fitted in. Alcohol was the only thing that calmed down my over-analytical teenage head. I remember thinking: "Wow – this is how normal people feel".

My addiction continued when I got into university and became a regular recreational drug user. I would use one drug, or combination of drugs, until it caused a problem – a fight, mood swing – so I would have to stop it, but then I would move on to something else. I had to have something to put into my system to make me feel "normal".

ANXIETY AND DEPRESSION

Throughout this time, I felt anxious and depressed. I saw my own GP, and rebuked his questions around alcohol. He didn't ask about drugs, and I had no insight into what all this pharmacology was doing to my brain. I was learning about drugs and justified their use –addiction couldn't happen to me...I was wrong.

This started a 20-year trial of various antidepressants, analgesics anxiolytics and sleep medications. None of them really worked because I was still using recreational drugs. Passing my finals and becoming a trainee doctor meant long stressful hours, and I continued taking medication to help me get through.

ISOLATION

Throughout my GP training I would justify my medication abuse, using my childhood, bullying at school, family life and my job as an excuse – I was in denial. My use of drugs and tolerance was progressing.

During that time I pushed my friends and family away so I didn't have to remember whom I'd told what lie to. I tried stopping many times, through a variety of methods, but nothing ever worked.

NIHILISM

Things progressed to the point where I couldn't see a way out and I didn't really care if I didn't wake up each morning. It got to the point where I was sick and tired of feeling sick and tired. I was consumed with overwhelming despair.

I wrote the 'goodbye, cruel world' letters, stating it was everyone else's fault, not mine, and I tried to take my own life. Twice. When I woke up the second time, I realised that I had two choices: live or die. I had to find a new way of living. I was making the same mistakes, over and over again, and expecting a different result each time.

I had a sort of epiphany. I decided: "I will survive."

SURRENDER

I was so full of shame and guilt that I didn't feel I deserved a detox.

I asked for help. I got in touch with the Sick Doctors Trust and the Practitioner's Health Programme in London. I was advised to self-refer to the GMC, which was probably the best thing I've ever done, as it saved my life. The GMC put enough barriers in place to stop me from using again.

I went to rehab, which was like pressing fast forward on my recovery. Being a patient is very difficult for doctors. I had to let go of my arrogance and false pride.

By going to 'mutual aid' meetings I identified with other people's addiction stories: "I feel and think like that. I do act and behave like that." And I got hope from their recovery. I will always remember the quote: "A clever man learns from his own mistakes – a wise man learns from other people."

ACCEPTANCE

Admitting I was an addict was hard enough, but accepting it was extremely difficult. Accepting that is who you are is a struggle. Once I did, I realised that I'd never have to use drugs again.

LIVING

I didn't get into recovery to be miserable. Recovery is fun.

I retrained in addictions, doing the RCGP Substance Misuse Part 2, and became a GPwSI. I told my story on the RCGP Health for Healthcare Professionals course and became a trainer, acquiring a Certificate in Practitioner Health. I sat on the Scottish Government's National Forum on Drug-Related Deaths.

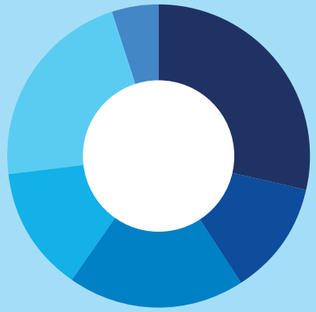
I got back to work, unpaid initially, but now I've got my dream job. I still do some GP work, but I also work with alcoholics and addicts, including those in the prison system.

I've told my story to nursing students, medical students, trainee doctors, hospital consultants and GPs. I've helped other doctors get into recovery, via the British Doctors and Dentists Group (BDDG), and even paid employment. Around 50% of the team I work in are doctors in recovery.

Words: Sara Dawson

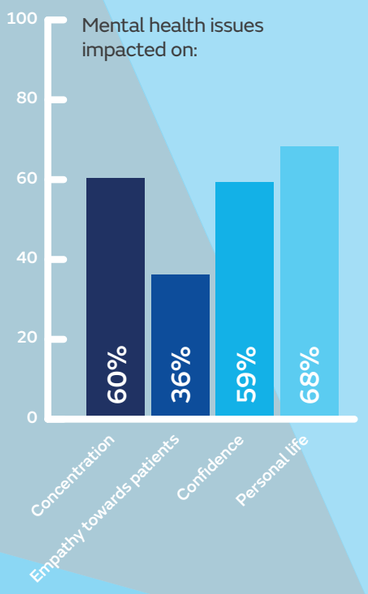
MENTAL HEALTH AND DOCTORS

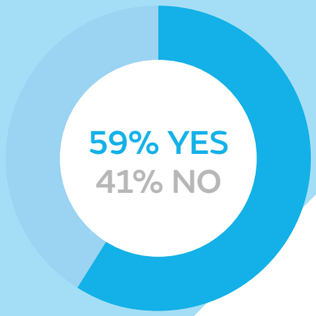
Medical Protection surveyed UK members across all specialties to find out about their personal experiences of mental health issues. It ran from 18 June to 3 July 2015 and received 631 responses

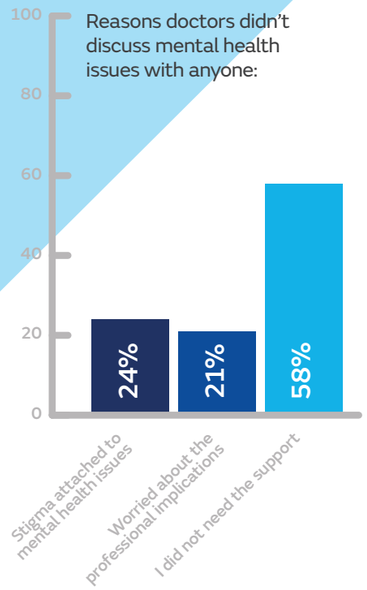


Have you personally experienced any of the following mental health issues during your medical career?

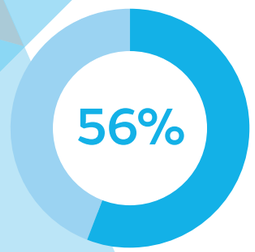
Stress	75%
Depression	32%
Anxiety	49%
Low self-esteem	35%
Sleep disturbance	57%
Suicidal feelings	13%







of doctors would inform their GP if they had a significant mental health issue



of doctors would not feel at all confident about informing the GMC

1869: 07/15

DISCUSSION

By Sara Dawson

Doctors help their patients with mental health problems, but they often suffer alone. Being a doctor is not only physically and intellectually demanding, but also emotionally draining.

The largest study of its kind ever conducted in the UK among GPs was published in BMJ Open. It surveyed 564 general practicioners and reported that 46% of respondents reported emotional exhaustion, 42% reported depersonalisation and 34% reported low levels of personal accomplishment. [1]

In 2015 the BMA reported that 39% of doctors admitted to frequently feeling drained, exhausted, overloaded, tired, low and lacking energy. Furthermore, 41% admitted that they were at high risk of suffering burnout in the near future. [2]

Dr Clare Gerada, from the Practitioner Health Program, a confidential service for those with mental health and addiction problems but who are unable to access standard NHS services, likens the experience of doctors to those in the armed forces: "Of the doctors we've seen over the last eight years, two thirds have mental health problems. The vast majority of those have depression or anxiety, but increasing numbers have obsessional behaviour, panic disorder and eating disorders. The remaining third have addiction problems.

"We are a group of professionals who have high expectations of ourselves and the public have incredibly high expectations of us; there is very little room for error. At the same time there are enormous barriers to us receiving help: some are self-barriers, self-stigmatisation; others are enforced upon us by society – doctors don't get ill."

Dr Mike Peters, who has run the BMA's Doctors for Doctors support unit for a decade, echoes Dr Gerada's sentiments: "Doctors catastrophise; they think they've got the worst form of everything, so they will keep putting their condition off in the hope that it will go away. This is why doctors present late. Doctors are professionals with a deep sense of integrity: they will go to work in their surgery, or in their hospital, and perform as normal, ignoring the problems underneath."

In this climate, where difficult decisions have to be made daily, alongside rising expectations and fewer resources, doctors can feel isolated and are vulnerable to burnout and emotional exhaustion.

A Medical Protection survey of more than 600 UK doctors revealed that 85% had experienced mental health issues, with common issues being stress (75%), anxiety (49%) and low self-esteem (36%).[3] A third (32%) had depression during their medical career, while one in ten (13%) stated they had experienced suicidal feelings.

Respondents cited heavy workloads, long working hours, high levels of regulation and scrutiny, and experience of negligence claims as reasons. The effect on their professional life is striking: 60% believed their mental health issues had an impact on their concentration and 36% felt it impacted on their empathy towards patients.

Forty one per cent of those affected did not discuss their issues with anyone, with 58% of those believing they did not need support, and a quarter (24%) felt there is a stigma attached to mental health issues.

Dr Pallavi Bradshaw, senior medicolegal adviser, said: "Medical Protection urges colleagues of doctors to look out for signs of mental health problems and offer support, such as talking through issues or helping to balance their workload.

"It is important that doctors know that seeking help will not automatically lead to a referral to the GMC or put their careers at risk. Colleagues should provide support to those who may be vulnerable and in the interests of providing the best care to their patients; doctors must seek help as soon as they experience mental health difficulties."

Doctors can combat the negative effects of working in a high pressure environment in a number of ways – one of which is opening up to others and talking about their problems.

According to Dr Peters, Doctors for Doctors takes 200 calls a month from doctors in trouble. "We encourage doctors to talk to colleagues, to their friends and family; many of them feel that they can just lock it up and it is going to go away and, of course, it doesn't.

"Mental health issues are still taboo in some areas of the medical community. One of the most powerful ways to break that taboo is for doctors to talk about it and to admit that we're human, like our patients. We can get through this if we admit it and get the appropriate support."

Dr Gerada said: "My role is to be an advocate on behalf of doctors and make sure that they are not their own worst enemy. The shame that surrounds a doctor admitting that they have got problems is so deep-rooted. It probably goes way back before they get to medical school."

The work of the organisations of Drs Gerada and Peters is testament to the fact that if you build a confidential, accessible, good quality mental health service, then people will come, and they will access it.

WATCH

In this short video Dr Michael Blackmore describes his 20-year battle with addiction. He is joined by Dr Clare Gerada, from the NHS's Practitioner Health Program, and Dr Mike Peters, from the BMA's Doctors for Doctors Unit; both have years of experience working with doctors with mental health issues.

medicalprotection.org/mental-health-and-addiction

VISIT

If you feel you are experiencing issues with mental health issues, such as stress, anxiety, low self-esteem and depression, visit the dedicated section on our website:

medicalprotection.org/uk/help-advice/mental-health-and-doctors-what-do-you-need-to-know

1. Orton P et al, Depersonalised doctors: A cross-sectional study of 534 doctors, 760 consultations and 1876 patient reports in UK general practice, BMJ Open (2012 2)
2. BMA, Quarterly Tracker Survey (April 2015)
3. Medical Protection, 85% of doctors have experienced mental health issues, reveals Medical Protection survey (16 July 2015)

RETAINED THROAT PACKS

Medicolegal advisers Dr Helen Hartley and Professor Carol Seymour examine two recent Medical Protection cases, which demonstrate that the risk of retained throat packs has survived the introduction of the WHO checklist

Throat packs are used commonly in oral and maxillofacial surgery for a number of purposes, including the prevention of unwanted material from entering a patient's oesophagus or trachea. The packs themselves, however, are capable of causing serious injury by obstructing patients' airways if they are not removed after surgery.

The WHO Surgical Safety Checklist was launched in 2008 to improve teamwork and thus combat avoidable complications in surgery, such as retained swabs and instruments. Two recent Medical Protection cases, however, demonstrate that the problem of retained throat packs persists, notwithstanding the introduction of the WHO Checklist.

CASE 1: MRS A

Mrs A opted to undergo facelift surgery. Dr B was the consultant anaesthetist for the procedure and used a throat pack in order to stabilise Mrs A's airway.

The WHO Checklist Sign-in was performed and the surgery proceeded uneventfully; however, the WHO Checklist Sign-out did not take place. Dr B reversed muscle paralysis, applied suction to the airway and extubated Mrs A. Dr B would usually perform a laryngoscopy at this point but did not on this occasion, as it was difficult to open the patient's mouth.

Mrs A was handed over to the recovery staff, where slightly obstructed respiratory movements were noted. Dr B attributed these symptoms to emergence delirium, and therefore inserted a nasopharyngeal airway. On examination around 20 minutes later, Mrs A was awake, the artificial airway had been removed and she indicated to Dr B that she was not in any discomfort.

Around three further hours passed before the throat pack was discovered, during which time she experienced significant respiratory distress. The throat pack was removed and Mrs A made a full recovery.

CASE 2: MISS C

Miss C was admitted to hospital for the routine excision of a benign palatal lump. Dr D was the anaesthetist for the procedure, although it was the first time that he had worked in this hospital.

There were three cases on the list that afternoon. A briefing took place before the list was started, and the WHO Checklist Sign-in was performed. The insertion of the throat packs was discussed; however, the plan for their removal was not.

Dr D inserted the throat pack for the first patient on the list but at the end of surgery it was removed by the junior surgical doctor. This created some confusion. Miss C was second on the list and, although Dr D inserted her throat pack, he was not under the impression that its removal was his responsibility.

Further, this throat pack had been obtained from the anaesthetic room, and as such did not form part of the scrub nurse's swab count. Dr D did, however, place a sticker on Miss C's head notifying that a throat pack had been used.

The surgery proceeded uneventfully. However, immediately after waking up, Miss C experienced some difficulty breathing. The issue of the throat pack was raised by nursing staff and Dr D mistakenly asserted that it had already been removed. The nursing staff therefore removed the sticker that had been placed on Miss C's head. A laryngeal mask airway (LMA) was inserted, which improved Miss C's oxygen saturation levels.

On removal of the LMA around 15 minutes later, Miss C coughed up the throat pack. She also made a full recovery.

THE WHO CHECKLIST

When used properly, the WHO Checklist prompts effective team communication to eradicate avoidable risks, such as retained throat packs. Proper usage of the Checklist requires the following:

- All three phases of the list must be performed: Sign-in, Time out, Sign-out
- The anaesthetist must be present for all three stages. Best practice is to have all members of the surgical team present for all three phases, although the WHO advises that the Sign-in may take place without the surgeon.
- At Sign-in, responsibility for both insertion and removal of throat packs must be assigned.
- At Sign-out, removal of the throat pack must be checked, either as part of the swab count exercise, or as a distinct part of the checklist.

FROM THE CASE FILES

Dr Richard Stacey, senior medicolegal adviser, introduces this edition's collection of case reports and reminds readers of the importance of good note-keeping

Want to join the discussion about this edition's case reports? Visit medicalprotection.org and click on the "Casebook and Resources" tab.

Before joining Medical Protection in 2003, I was a GP and always enjoyed reading the cases in *Casebook*, irrespective of whether they related to primary or secondary care cases. In my role at Medical Protection I meet many doctors from different specialties and when I introduce myself, invariably the first thing they say is that they enjoy reading the cases in *Casebook* – with the caveat that it often causes them to reflect on their own practice (which, of course, is one of the reasons why the particular cases are chosen).

In this edition of *Casebook* there is the usual array of thought-provoking cases, with varying outcomes and learning points. A common issue is that of record-keeping; in the case 'Poor notes, fatal consequences', Dr A is criticised for not documenting a thorough history or the fact that Mrs Y was reluctant to be admitted to hospital; and in the case "Elbow arthroscopy – radial nerve injury", the operation note was not deemed to be of an acceptable standard. Conversely, in the case "Alleged anticoagulation failure", the fact that the consultant cardiologist had specifically stated that anticoagulation was not indicated on the advice slip to Dr B was an important feature in defending the claim.

There is a real tension in the context of a busy surgery or outpatient clinic, and other clinical settings, in that patients can perceive that the making of records intrudes into the consultation – yet the records provide the basis of your defence in the event of an adverse outcome. I have often heard it said by patients "the doctor did not pay attention to me as they were far too busy tapping into their computer". The likelihood is that, in fact, the doctor was making a thorough contemporaneous record, hence there is a real art to being able to take thorough and contemporaneous notes without appearing to disengage from the consultation (or without missing what could be very important non-verbal clues).

There are several strategies that may be deployed to provide the patient with the reassurances that you remain engaged, whilst allowing an opportunity to make a record of the consultation:

- At the start of the consultation, it is often helpful to maintain eye contact and to listen carefully to what the patient says before making an entry in the records
- At an appropriate point in the consultation, it may help to introduce the fact that it is your intention to make a record of what has been discussed
- In making the record, it is often a helpful opportunity to summarise your understanding of the problem; this can be useful in reaching shared understanding of the issues and demonstrating empathy
- Whilst making the record, it is important to keep glancing in order to make eye contact and to demonstrate to the patient that you remain engaged in the consultation
- When the record has been made, there is an opportunity to explain to the patient (or even show the patient) what you had recorded, which is once more helpful in terms of summarising the concerns and ensuring that both you and the patient are content that the record is accurate
- You might wish to consider developing macros (a standard form of text that can be inserted into the record) or templates for common scenarios pertaining to your particular area of practice, to ease the recording of the consultation (I appreciate that this may not be possible in relation to handwritten notes).

I hope that you find the cases thought-provoking and that they provide you with an opportunity to reflect (amongst other things) on your approach to record-keeping.

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

ALLEGED ANTICOAGULATION FAILURE

SPECIALTY GENERAL PRACTICE
THEME SUCCESSFUL DEFENCE

Mrs S was a 51-year-old teacher. At the start of term Mrs S developed a troublesome cough and went to see her GP, Dr B, about it. Dr B diagnosed a chest infection and prescribed antibiotics but also noted that she had an irregular pulse. An ECG was performed at the surgery the same day, which showed that Mr S was in atrial fibrillation. Dr B sent Mrs S to the medical assessment unit for urgent review.

The hospital doctors confirmed the diagnosis of atrial fibrillation and prescribed warfarin to reduce her risk of thromboembolic stroke and bisoprolol to slow her heart rate. They put Mrs S on the waiting list for a cardioversion procedure and discharged her home.

Mrs S attended for her cardioversion procedure but was found to be in sinus rhythm. The cardiologist (Dr T) advised Mrs S to stop taking her warfarin and to reduce her bisoprolol. Dr T gave Mrs S a medication slip to take to her GP, which detailed his advice, and told her that she would be called back to clinic for follow-up.

Dr B saw Mrs S again with the cardiologist's advice slip. Dr B documented that her pulse was regular now (although she was slightly bradycardic). Dr B arranged a further ECG for the following week and reduced her bisoprolol dose further. Dr B documented that Mrs S was "awaiting cardiology follow-up" and that she had had a chest infection when the atrial fibrillation was initially diagnosed.

The ECG the following week showed sinus rhythm with a rate of 60 bpm. Dr B saw Mrs S again to inform her that her ECG was normal. Dr B noted her pulse on that day was regular and that she was waiting for cardiology review.

Soon after, Mrs S received a letter asking her to return for another cardioversion procedure. Mrs S rang the cardiologist's secretary to explain that she had been advised that this was not necessary but that she was waiting for an outpatient appointment.

Dr B received a letter from the warfarin clinic stating that she had not attended for INR testing for at least four weeks.

Dr B circled the response "no longer requires anticoagulation".

A month later, Mrs S suffered a stroke. There were no other risk factors for stroke identified other than atrial fibrillation, thus the likely cause of Mrs S's stroke was an embolic event arising as a consequence of thrombus formation within the atrium.

As a result of the stroke, Mrs S felt unsteady and hesitant every time she walked. Despite rehabilitation, her writing was slow and clumsy and she slurred her words. Sadly, teaching was no longer possible and Mrs S had to retire early on grounds of ill health.

Mrs S was devastated. She felt that her stroke could have been prevented if she had been anticoagulated. Mrs S made a claim in negligence against Dr B. It was alleged that Dr B should have prescribed some form of anticoagulation and that he should have contacted the hospital to query the medication position, especially in light of the non-attendance letter from the anticoagulation clinic.

EXPERT OPINION

Medical Protection sought the advice of an expert GP, Dr H. Dr H felt that the care given by Dr B was of a reasonable standard. Dr H did not consider that Dr B had a mandatory duty to prescribe anticoagulation or that he should have contacted the hospital to query the medication position. Dr H noted that the decision to stop anticoagulation had been clearly relayed on an advice slip from a cardiologist. Mrs S had also told Dr B that she was waiting for cardiology review and her subsequent ECG had shown sinus rhythm.

The opinion of a professor in stroke medicine (Professor G) was also obtained by Medical Protection. Professor G confirmed that the likely cause of Mrs S's stroke was thromboembolic. Professor G pointed out that some patients develop atrial fibrillation secondary to other illness such as chest disease. In such a setting, if the atrial fibrillation resolves when the underlying cause has been treated, and the clinician feels that there is a low risk of it recurring, then it is reasonable not to anticoagulate. Mrs S would have had a CHA2DS2-VASc score of 1 because of her sex but an absence of congestive heart failure, hypertension, diabetes, stroke or vascular disease and age below 75 years, Professor G felt that it would have been quite reasonable not to anticoagulate in this context.

Medical Protection served a letter of response denying liability and Mrs S did not pursue the claim any further.

Learning points

- NICE, Atrial fibrillation: the management of atrial fibrillation (June 2014) state that doctors should consider anticoagulation for men with a CHA2DS2-VASc score of 1 and to offer anticoagulation to people with a CHA2DS2-VASc score of 2 or above, taking bleeding risk into account.
- Documentation of the reasons behind the decision-making was invaluable in defending this case.

AF

CONTRACEPTION AND A CARDIAC ARREST

SPECIALTY GENERAL PRACTICE
THEME SUCCESSFUL DEFENCE

Miss F, an 18-year-old university student, had been taking the combined oral contraceptive pill microgynon for 18 months for dysmenorrhoea, when she presented to her GP Dr K worried about acne on her back. Miss F had heard from her flatmate that dianette is a better pill to take for acne than microgynon and wanted to give it a try. Dr K recorded that Miss F was a non-smoker with a normal BMI and BP, and switched her pill to dianette, advising her to start it when her microgynon cycle finished in another fortnight.

Two weeks after commencing the dianette, Miss F was rushed into hospital with sudden onset chest pain and respiratory distress. Miss F was diagnosed with a pulmonary embolism and went on to have a cardiac arrest in the emergency department. Miss F was thrombolysed, which resulted in return of spontaneous circulation, and she was transferred to intensive care. On waking she reported reduced vision and was found to have a left homonymous heminaopia.

Imaging of Miss F's brain revealed oedema suggestive of a cerebral infarction and a small subdural haemorrhage. Miss F's treating haematologist commented that the dianette definitely made a contribution to the blood clot Miss F suffered, but considered the cerebral bleed to be a result of the thrombolysis given to appropriately treat this. Miss F spent over a month recovering in hospital and her visual symptoms resolved. Long-term warfarin was initiated and she was discharged with no focal limb deficits or neurological symptoms. Twice weekly physiotherapy and occupational therapy was commenced.

Two months after discharge, a formal cognitive assessment revealed ongoing difficulties with verbal and visual recall and reduced speed of processing information. Three more months later, Miss F was discharged from physiotherapy and had returned to her part-time job in a bar. Miss F had returned to the gym and was making plans to resume her university studies, which she did at the beginning of the new autumn term. A year after the event, Miss F was back to her studies and happy with her progress and the support she had been given.

A claim was made against Dr K stating that he prescribed dianette to Miss F when she was not suffering with severe acne. He failed to advise Miss F regarding the increased risk of venous thromboembolism, and did not try alternate treatments for her acne such as topical therapies or oral antibiotics. The claim stated that had Miss F not been exposed to dianette, she would not have suffered the massive PE that led to her suffering anoxic brain damage.

EXPERT OPINION

Expert GP Dr C was unsupportive of Dr K's action, stating that dianette is usually a second or third line treatment for acne, and with no evidence that the acne was severe and in the absence of a trial of alternate therapies first, the prescription was indefensible.

Dr D, another expert GP, disagreed and felt the standard of care was reasonable – prescribing dianette to an 18-year-old, non-smoking patient for the management of both acne and contraception was conventional and supported by published guidelines. Standard textbooks do not require the acne to be severe for other treatments to be tried in the first instance, but it would have been expected of Dr K to have discussed the slightly higher thromboembolic risk with the patient.

Dr E, expert consultant in pharmacology, was also supportive of Dr K, stating that although there is probably an increased risk of VTE with dianette, the size of this increase is small, and the risk appears to peak between four months and one year of use. The timing of Miss F's PE appeared to be closely linked to switching contraception; however, on the balance of probabilities, she was likely to have still suffered her PE had she continued on microgynon.

Medical Protection defended this case and prior to trial made a drop hands offer – Miss F to discontinue her claim, with each party to bear their own costs. This was accepted by Miss F's solicitors. This is largely because it cannot be entirely accepted that it was wrong to prescribe dianette to the claimant; and perhaps more importantly, the claimant would have suffered the PE in any event – considering Miss F had only just been prescribed the dianette.

Learning points

- Consultations for 'repeat pills' are commonly seen as an easy consultation amid a busy surgery, but it's important to ensure women are screened for risk factors adequately and that it is safe to prescribe. Risks and benefits should be routinely discussed, even if the patient has been taking the pill for years, as these issues may not have been raised before. Document that this discussion has taken place.

Further reading

Clinical Guidelines from the Faculty of Sexual and Reproductive Health: www.fsrh.org/pages/Clinical_Guidance_2.asp

EW

DEATH BY DIARRHOEA

SPECIALTY GENERAL PRACTICE
THEME DIAGNOSIS/RECORD-KEEPING

MODERATE

Mrs B was a 27-year-old secretary with a ten-year-old daughter. She had just enjoyed a trip to Pakistan where she had been visiting relations. Three days after her return she developed profuse, watery diarrhoea. She made an appointment with her GP, Dr A, because she was opening her bowels seven times a day and couldn't face eating anything.

Dr A noted that Mrs B had recently returned from Pakistan and that she had diarrhoea. Dr A was happy with Mrs B's pulse and blood pressure and documented her temperature as 37 degrees. Dr A found Mrs B's abdomen to be soft and non-tender. Dr A prescribed some paracetamol and co-phenotrope and advised her to return if there was no improvement.

Mrs B waited for a week but she began to feel worse – she was so nauseous that she still couldn't eat and the diarrhoea had been relentless for ten days. Mrs B was feeling rather weak so she made another appointment with Dr A. Dr A's notes were brief, just stating "diarrhoea". Dr A noted that Mrs B was apyrexial with a satisfactory pulse and blood pressure. Dr A examined Mrs B's abdomen again and found it to be soft, he prescribed some codeine linctus and loperamide.

Two days later Mrs B began to feel very faint and lethargic with ongoing diarrhoea. She had been staying with her mother-in-law who was really worried about her. Her mother-in-law drove Mrs B's daughter to school, then took Mrs B to her GP surgery where she was given an emergency appointment. Dr A saw her again and found her restless and sweating with a tender abdomen, this was recorded in the notes. He admitted her to hospital with possible enteritis or malaria.

Mrs B was investigated in hospital with thick and thin films, blood cultures, and a stool culture. Mrs B was commenced on empirical oral ciprofloxacin and intravenous fluids. An early report from the microbiologists stated that her blood cultures had grown a gram negative rod, likely to be salmonella and that ciprofloxacin was the appropriate therapy. After two days of treatment Mrs B refused to take any more tablets because her nausea was so severe and she was commenced on intravenous ciprofloxacin.

The following day Mrs B had a cardiac arrest and despite adrenaline and DC cardioversion she died. A postmortem report showed she had died of a gram negative septicaemia and gastroenteritis with salmonella paratyphi A.

Mrs B's family were devastated and made a claim against Dr A. They felt that her death could have been avoided if Dr A had investigated and treated her diarrhoea earlier.

EXPERT OPINION

Medical Protection commissioned a report from a GP expert, Dr S. Dr S was not critical of Dr A's first consultation with Mrs B. At that time Mrs B had a three-day history of diarrhoea. Dr S explained that viral gastroenteritis is the commonest cause of diarrhoea and that traveller's diarrhoea is an extremely common presenting complaint.

Even in cases of bacterial infection, antibiotic treatment is not usually required. As traveller's diarrhoea is self-limiting in the majority of cases, Dr S felt that few GPs would have requested a stool sample on that occasion.

Dr S was, however, critical of Dr A's second consultation. At that time Mrs B had complained of significant diarrhoea for ten days. Dr S felt the clinical records were very brief and did not include a record of the presence or absence of blood in the stool or abdominal pain.

Dr S thought that the patient's ongoing symptoms at this consultation required the identification of a causative organism and that a stool culture should have been arranged. It was his view that the failure to do so represented an unreasonable standard of care. He postulated that if a stool sample had been taken, this would have led to the causative organism being known within four to seven days.

The case was settled for a moderate sum.

Learning points

- Poor record keeping is a major factor in litigation cases brought against healthcare professionals. Good medical records are not only essential for continuity of patient care, they are also vital for defending you if you face a complaint or clinical negligence claim.
- Doctors should take and document a detailed history to help differentiate between benign and more serious conditions. Common symptoms can occasionally point to serious pathology.
- It is important to reassess patients carefully if they are not improving.
- GPs see a lot of patients with diarrhoea. It is worth remembered what on the face of it could be a benign condition, can catch you out if you don't take a proper history and look at the whole patient. Common conditions usually follow the expected course, but you must be alive to those that don't behave as expected.
- There are some useful UK guidelines from the Health Protection Agency (HPA) about infectious diarrhoea, detailing when to send a stool for culture.

www.gov.uk/government/uploads/system/uploads/attachment_data/file/345392/Infectious_diarrhoea_lab_use_guidance.pdf

AF

FAILING TO ACT ON TONSILLAR CANCER

SPECIALTY GENERAL PRACTICE
THEME INVESTIGATIONS

HIGH

Mr K was a 36-year-old man who ran a pub. Mr K smoked and drank heavily. Mr K's dentist had noticed a painless swelling on the right side of his neck during a routine check-up and asked him to see his GP. Mr K was seen by Dr A, one of the GPs at his surgery, who noted that Mr K was unsure how long the lump had been there, and referred him to the ENT outpatient department.

A letter came back to the practice confirming the presence of a lymph node in the anterior triangle of Mr K's neck, which was felt to be innocuous. The plan was for Mr K to be reviewed in six weeks' time and for further investigations to be pursued if the node was still present.

Mr K was busy at work and did not feel too concerned about the lump because it was not painful. He did not attend his follow-up appointment and a letter stating this was sent from the hospital to his GP.

Eight months later, Mr K began to get some discomfort in the neck swelling so decided to see his GP again. This time he was seen by Dr B at the surgery. Dr B noted his painful swelling and also a history of chronic tympanic membrane perforations. Dr B did not establish or document his previous referral to the ENT department regarding the same lump or the intended follow up. Dr B's brief examination notes detailed the tender, swollen lymph node but did not include an examination of the mouth, tongue or throat. Dr B prescribed ibuprofen to help with the discomfort and did not arrange any follow up.

Over a year later, Mr K was still troubled with pain and swelling in his neck. This was getting worse and affecting his mood and sleep so he went back to see Dr B. Dr B did not examine his neck but prescribed some antibiotics, antidepressants and sleeping tablets. He also advised a dental review.

Six months later, Mr K was still struggling with his symptoms and went again to see Dr B. This time Dr B made a referral to head and neck surgery. His referral letter stated "intermittent chronic right sided neck swelling in the pre-auricular and submandibular area". There was no mention of any previous referral in his letter. Dr B documented a differential diagnosis of a possible parotid lesion or salivary gland stone.

Mr K's neck lump subsequently proved to be malignant. As a result he had to have neck surgery and resection of a primary in his tonsil. He had a course of radiotherapy and since has not had recurrence of his disease. Unfortunately he was left with shoulder weakness and a dry mouth, which he found difficult to cope with.

Mr K was angry with Dr B and felt that he caused a delay in his diagnosis. He brought a claim of negligence against Dr B because he felt the delay had necessitated more radical surgery, leaving him with debilitating symptoms.

EXPERT OPINION

Medical Protection sought the advice of an expert GP (Dr F). Dr F felt that Dr B bore liability for the delayed diagnosis. He was critical of Dr B's history-taking and record-keeping. Dr F commented that Dr B had responsibility for establishing the history of his previous referral to the surgical assessment unit. Had Dr B known of that referral, then the duration and the continuing nature of the lymph node would have necessitated immediate re-referral back to that team. Dr F also criticised Dr B's inadequate examinations, stating that he should have documented an examination of the patient's neck, mouth, tongue and throat.

The opinion of a professor of otolaryngology (Professor Y) and head and neck surgery was also obtained. Professor Y commented that there was a significant delay between initial presentation and the final treatment. Professor Y thought that an earlier diagnosis may have allowed a less radical neck dissection and it may have been possible to spare the accessory nerve, which controls the muscles of the trapezius and sternocleidomastoid muscle. This would have resulted in less dysfunction to the shoulder and neck.

In addition, Professor Y considered that it may have been possible to spare radiotherapy if he had been treated earlier. The need for radiotherapy in this case was due to the size of the lymph node in the final specimen and the positive margins, which was evident following removal of the tonsil primary.

Due to expert opinion finding Dr B to be in breach of his duty, the claim was settled for a high amount.

Learning points

- Doctors should be familiar with the NICE guidelines (June 2015) for suspected cancer: recognition and referral. In the section on head and neck cancers, the guidelines state that patients should be considered for a suspected cancer pathway referral (for an appointment within two weeks) in people with a persistent and unexplained lump in the neck.
- In the UK the GMC's *Good Medical Practice* states that doctors must "adequately assess the patient's conditions" and "promptly provide or arrange suitable advice, investigation or treatment where necessary".
- GPs should review patients' previous records and ask about previous relevant history when consulting.

AF

ELBOW ARTHROSCOPY: RADIAL NERVE INJURY

SPECIALTY ORTHOPAEDICS
THEME RECORD-KEEPING/CONSENT

SUBSTANTIAL

Learning points

- With a CT scan showing extensive heterotopic ossification, the fact that there is no documentation of any discussion regarding risks of surgery, including possible nerve injury is unacceptable.
- Mr A's operation note was not of an acceptable standard, with only minimal procedural details of the debridement and no comment on the integrity of the capsule at the end of the procedure.

RMcN

Mr P, a right-handed project manager, developed a stiff right elbow following a previous injury, and had reached the limit of his progress with physiotherapy. X-rays showed degenerative changes and he was referred to an orthopaedic consultant, Mr A, who diagnosed osteoarthritis of his elbow. He advised Mr P that as he had significant anterior and posterior osteophytes he may need multiple arthroscopic debridements to achieve a good outcome.

After an arthroscopic anterior debridement, there was only minimal improvement and further surgery was planned. There were another two debridements, the third one being more than six months after the initial procedure, before Mr A was happy with the result.

Two months later Mr P returned with a reduced range of movement in his elbow. X-rays confirmed the presence of massive heterotopic ossification (new bone growth), which was confirmed on CT. Mr A planned a fourth arthroscopic debridement two months later. No discussion relating to the possible risks and complications of surgery was documented. The limited operation note for this complex arthroscopic debridement described significant bone removal and a full range of movement at the end of the procedure.

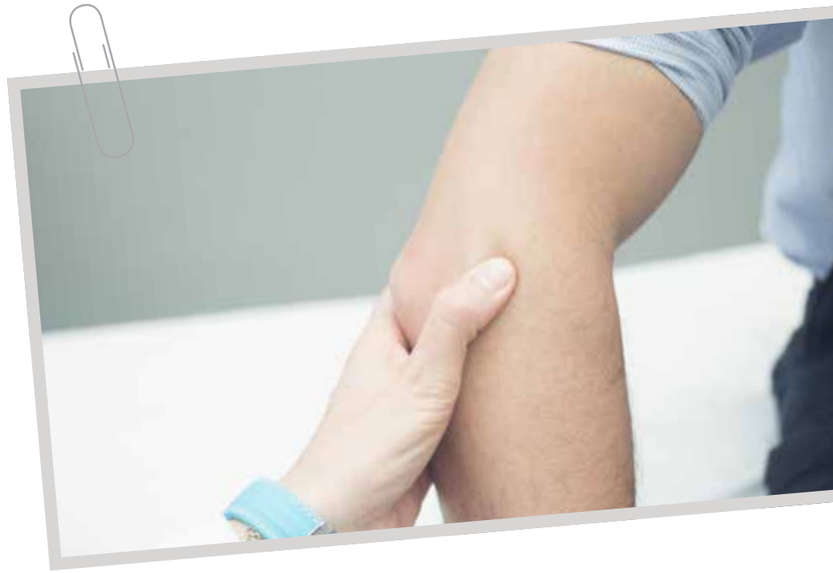
In clinic two days later Mr P was noted to have a radial nerve palsy, but Mr A felt that some nerve conduction was present and that this was a neuropraxic nerve injury, which should recover completely. He commented that the procedure had been lengthy at over an hour and ten minutes. Mr P returned ten days later as there was no change in his symptoms, but Mr A was reassured by the presence of a positive Tinel's test and felt the nerve palsy would recover. He planned for review in six weeks, which was three months post-surgery, but again there was little improvement. Mr A commented that the positive Tinel's could now be felt up to the fingertips. An appointment for three months later was made, but still there was no improvement.

Six months post-surgery, Mr A now requested nerve conduction studies, which were performed within days, and reported the presence of a severe radial nerve injury. Plans were then made for surgical exploration of the nerve with possible repair, grafting or neurolysis as necessary.

Mr P made a claim against Mr A, stating that his nerve injury had left him with a permanent disability including reduced grip and manual dexterity, plus an inability to extend his fingers. He believed that the surgery should have been an open procedure rather than arthroscopic, and that had his injury been diagnosed sooner, and not presumed to be a neuropraxia, then he would have had a better outcome.

On review of the case, an expert felt that as long as Mr A had the necessary experience it was not negligent to carry out the surgery arthroscopically. There is still a risk of radial nerve injury when carrying out this surgery with an open technique. However, Mr A was found to be negligent in causing the nerve injury, keeping poor documentation, and delaying arranging nerve conduction studies. The lack of any documented discussions about the risks of the surgery was also a factor in the outcome of the case.

The case was settled for a substantial sum.



POOR NOTES, FATAL CONSEQUENCES

SPECIALTY GENERAL PRACTICE/OBSTETRICS
THEME RECORD-KEEPING/INVESTIGATIONS

SUBSTANTIAL

Mrs Y, a 39-year-old chef, opted to see consultant obstetrician Mr B for private antenatal care. It was her first pregnancy and other than a BMI of 30 she had no pre-existing medical problems. She was reviewed regularly throughout her pregnancy and noted to have elevated blood pressure through the first trimester, between 126/83 – 157/90. Methyldopa was considered at 23 weeks but not initiated since a pre-eclampsia screen was negative, and close monitoring continued.

At 36 weeks Mrs Y presented to the emergency department complaining of a headache and feeling generally unwell. Her BP was 170/120 and she was admitted that afternoon and commenced on both methyldopa and nifedipine. Despite commencing this treatment, her hourly observations showed a persistently elevated blood pressure with proteinuria in spite of ongoing antihypertensive therapy. Mr B was contacted by the ward team and provided telephone advice to continue antihypertensives. The following morning the decision was made to deliver by caesarean section on a semi-urgent basis, and Mrs Y gave birth to a healthy son. She was discharged on oxprenolol to control her blood pressure.

A week following delivery Mrs Y continued to have elevated BP readings of 160/90. Mr B asked her to see her GP Dr A. Dr A arranged a routine home visit two days later and found Mrs Y had a headache and a raised BP of 180/90. He treated her with voltarol suppositories and a combination of bisoprolol and irbesartan.

Three days later Mrs Y was unchanged. Dr A visited her at home again. Her BP remained elevated at 160/90. He issued metaclopramide and meptazinol and wrote to consultant neurologist Dr D requesting a second opinion. He described her headaches as "vigorous" with some neck stiffness and photophobia, and queried a degree of meningeal irritation from a small bleed versus "functional overlay".

The following morning, with no relief of her symptoms, Mrs Y was admitted to hospital where a scan confirmed a cerebral haemorrhage. She died four days later.

EXPERT OPINION

Experts were critical of Mr B, commenting that it was unacceptable for him to fail to visit Mrs Y when called by the ward team regarding her symptoms. Mrs Y's persistently elevated BP warranted high dependency management with half hourly BP and hourly urine output measurements, which Mr B should have initiated.

Dr A was also criticised by the experts, particularly regarding his consultation notes, which were lacking in a clear description of the headache and its associated symptoms. The BP was recorded but there was no evidence of any further examination including fundoscopy. The experts felt on the basis of the letter Dr A wrote requesting a second opinion, the patient was displaying red flag symptoms and a reasonably competent GP would have made arrangements to admit Mrs Y as an emergency to exclude intracranial haemorrhage.

Expert neurosurgeon Mr G commented that causation was difficult to determine: it was possible that Mrs Y could have had the cerebral haemorrhage before, during or after delivery. He noted that the hypertension during pregnancy could have been responsible for the development and subsequent rupture of the intracranial aneurysm. Mr G commented that although based on the information available there was no evidence that the outcome would have been different, earlier admission to hospital would have been preferable.

The poor standard of note-keeping ultimately left too many unanswered questions over Mrs Y's treatment, which, along with a failure to manage the hypertension, meant the case had to be settled for a substantial sum.

Learning points

- It is easy to attribute any new symptoms a woman may develop during pregnancy to the pregnancy itself, but this should not distract from red flag symptoms, which require urgent assessment.
- As always, documentation is essential. Dr A later commented that the patient was understandably reluctant to be admitted, and that he did take a more thorough history than he documented; but years down the line if a complaint comes in, the notes are the only record you have to rely on.
- Mr B was criticised for not reviewing Mrs Y early enough when she was an inpatient. It is important to have back-up options in these situations, to ensure patients have access to appropriate care when you are not available.

EW

LOST IN TRANSLATION

SPECIALTY GENERAL PRACTICE
THEME SUCCESSFUL DEFENCE

Mrs S, a 27-year-old Romanian woman who lived with her husband in the UK, became pregnant and presented to her local GP surgery to commence antenatal care. Mrs S did not speak English and usually brought a family member with her to interpret. Mrs S presented to the emergency department at six weeks with vomiting and since she had previously suffered with a hydatidiform mole, an early scan was carried out, which confirmed a viable pregnancy. Mrs S received IV hydration and was discharged with oral cyclizine to use if the vomiting persisted.

A month later, she was feeling better. The vomiting had resolved and she was no longer using the cyclizine. She visited her GP Dr A, who noted "had Down's scan, family member interpreter present, review at 16 weeks".

Mrs S visited Romania for a holiday to see her family. While she was there she presented to hospital complaining of possible kidney problems with a secondary concern over reduced foetal movements. Mrs S underwent a pelvic ultrasound scan, which appeared to have shown a growth on her right kidney. Mrs S also claimed she underwent a triple test at this point.

After returning to the UK, Mrs S attended her routine 16-week check with Dr A. The practice antenatal template was completed and Dr A ticked that the Down's screening test had been done. A month later, Mrs S was given the results of her Romanian triple test, which allegedly gave a risk of Down's Syndrome of 1 in 67. Her combined test in the UK gave a much lower risk of 1:835. Based on her age, Mrs S had a background risk of 1:800 – therefore a risk of 1:67 would represent a significantly increased risk.

At 20 weeks, Mrs S presented to Dr A – her husband was present to translate but communication still presented a difficulty. Dr A documented that Mrs S had undergone an ultrasound in Romania that possibly showed a right kidney cyst. No reference was made to screening for Down's Syndrome and Dr A asked the couple to return the following morning when a Romanian patient advocate would be present. There were no further entries made in the notes, but Dr A believed the advocate had spoken to him a few days later and confirmed Mrs S was concerned about the kidney cyst, which he advised could be explored further at her scheduled 20-week scan.

Mrs S reached term and gave birth to her son by emergency caesarean section due to fetal distress. The baby was born with Down's Syndrome and patent ductus arteriosis and developed septicaemia and pulmonary hypertension.

Mrs S made a claim against Dr A, stating that she had been given false reassurance regarding her test results, which had also failed to be documented adequately in her notes. It was alleged that had she been referred to an obstetrician for amniocentesis, then she would have chosen to undergo a termination of pregnancy.

EXPERT OPINION

Expert GP Dr C maintained that Dr A's standard of care did not fall below that expected of a GP. Dr C felt that Dr A was entitled to rely on the screening performed in the local secondary care setting, which indicated a low risk of Down's Syndrome with no need for further investigations. Dr A's account was that he was not told of the Romanian result, so was unable to take this into consideration. Dr C maintained that it would have been prudent to refer if this conflict had been made clear; however, even if this result had been available, given that it was carried out at 16 weeks – at a time when it would be less sensitive – it would have been reasonable for Dr A to have confidence in the local test carried out at the appropriate time.

Dr D, expert in feto-maternal medicine, stated that had Dr A been made aware of the test from Romania, it would have been a breach of duty to discount it. Assuming that Mrs S would have accepted the offer of amniocentesis, based on the timings, the diagnosis of Down's would have been made between 22 and 24 weeks gestation, at which point a late termination of pregnancy could have been contemplated.

The case went to trial. Dr A proved to be a credible witness and set out his evidence well, which helped in the claim being dismissed.

Learning points

- Consultations with patients who do not speak the same language present a significant challenge for all healthcare professionals. If you cannot understand what a patient is saying to you then the consultation is inadequate, and you are putting both yourself and the patient at risk. It is important to try to use an interpreter rather than a family member if possible, unless a patient presents acutely.
- Patients who undergo investigations overseas often return home for ongoing care and this presents a challenge to GPs, as the validity of tests performed may be questioned. If in doubt, referral to a specialist may be the best course of action.

EW

REPEATING THE RISK

SPECIALTY GENERAL PRACTICE
THEME PRESCRIBING

SUBSTANTIAL

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Mrs L, a teacher, was first prescribed the oral contraceptive pill microgynon by her GP, Dr G, when she was 17. Her blood pressure was taken and recorded as normal. At this time, no other mention was made in the records of her risk profile or family history. Later, Mrs L's medical records showed that she was changed to ovran and then ovranette, but there was no explanation why these changes were made. Mrs L was changed again to ovulen 50. The reasoning this time was due to "excessive bleeding on ovranette". At her review consultation, Mrs L's blood pressure was taken and recorded as normal.

When she was 26, Mrs L was seen by her GP for antenatal care, where it was recorded that she now smoked 15 cigarettes a day. Her blood pressure was recorded as normal. After her first child had been born, Mrs L was prescribed minulet, before she changed to the combined pill.

Three years later, Mrs L consulted her GP as she was under significant stress. Her records showed that she had increased her smoking to 25 cigarettes per day and did not exercise. Counselling was arranged, amitriptyline 50mg was prescribed and exercise was advised. In addition, a prescription microgynon was also issued.

For the next six years, Mrs L was given repeat prescriptions of the microgynon without any record of her blood pressure being taken or her risk factors being assessed. Mrs L was now 35, but the medical records from Dr G did not say whether she was still smoking, under a lot of stress, or whether or not she was still exercising.

Four months after her last repeat script, aged 35, Mrs L presented to the same practice with central chest pain and saw another GP, Dr F. She had been under a lot of stress for a few months. A full examination was largely normal, and a comprehensive history was taken, where it was noted that she was now smoking 30 cigarettes a day. For the first time, it was recorded that her father had had an MI aged 56. Tenderness in the costocondral area and the presence of anxiety led Dr F to prescribe paroxetine 20mgs daily and a sleeping tablet for two weeks. However, Dr F noted that Mrs L was advised to call the emergency services if the pain became worse.

Two years later, Mrs L fell to the floor with severe central chest pain and attended her GP surgery the next day. Mrs L had been getting palpitations once every two weeks that lasted two hours to two days over the previous two years. These were accompanied by sharp central chest pains. Mrs L was noted to be under less stress now and was smoking slightly less at 20 per day. She was advised about smoking. Mrs L was referred to the chest clinic, where she was diagnosed with non-cardiac chest pain.

Mrs L was seen on a number of occasions in the practice for a repeat prescription for microgynon and other matters, including further chest pain, collapse and migraine.

Aged 41, Mrs L collapsed and was admitted to the Emergency Department, where investigations found that she had had a stroke. She was unable to return to work due to paralysis affecting her left side.

Mrs L made a claim against Dr F. She alleged that he had been negligent in continuing to prescribe microgynon after she was 35 years old when she had three risk factors: a family history of heart attack, smoking and being over the age of 35.

EXPERT OPINION

Expert opinion found that a reasonably competent GP would have stopped prescribing microgynon from the age of 35 onwards and changed Mrs L to a progesterone-only pill (or at least have warned Mrs L of the increased risks in order that she could have considered the alternative options). Mrs L's notes show that the practice knew of Mrs L's family history and her smoking, but despite these risks continued to prescribe the pill.

The case was settled for a substantial sum.

Learning points

- Dr F should have considered all the risk factors involved in prescribing the contraceptive pill to Mrs L. He should also have revisited the prescription as the patient reached 35 and discussions about alternatives should have taken place. For more information on prescribing the combined pill see: Faculty of Sexual and Reproductive Healthcare Clinical Guidance, Combined Hormonal Contraception (August 2012) www.fsrh.org
- Remember to exercise clinical judgment when prescribing – be careful not to just accept a patient's request for a repeat prescription if it is not in their best interests.
- Consider what drugs are on your practice's repeat prescriptions – careful monitoring is important, as is having a robust repeat prescribing protocol.
- Clinical notes should show the reasoning behind your decisions, as well as the clinical facts. The records here did not indicate any further history had been taken.

PH

WE NEED TO TALK ABOUT DEATH

SPECIALTY VASCULAR SURGERY
THEME CONSENT/COMPETENCE

HIGH

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Mrs S was a 36-year-old patient diagnosed with a benign giant cell tumour of the sacrum. She was seen by Mr A, consultant in orthopaedic oncology, and listed for resection of the lesion. Prior to surgery Mrs S underwent preoperative tumour embolisation.

Mrs S was also reviewed by Mr B, consultant vascular surgeon, who planned to introduce an aortic balloon through the femoral artery prior to the tumour resection. If required, the aortic balloon could be inflated during the surgical resection in order to reduce blood loss. Mr B sought consent for aortic balloon occlusion and documented that the risks included "femoral artery injury, limb ischaemia and bleeding from rupture". Separate consent was obtained by the orthopaedic team.

Surgery was initially performed in the supine position to allow access to the femoral vessels. The right common femoral artery was cannulated and a 6Fr sheath inserted. This was exchanged for a 14Fr sheath under radiological control. A 40mm aortic balloon was introduced to the level of L3, its position being confirmed on fluoroscopy.

Mrs S was then turned to the prone position to allow tumour resection. The balloon position was re-imaged and found to be unchanged. Mr B left the operating theatre.

After two hours, Mr B was called back to the theatre to inflate the aortic balloon as haemostasis was required. The balloon was inflated by Mr B using an inflation device. Haemostasis was improved and the blood pressure stable. No further imaging was performed at this stage. The inflation device was exchanged for a syringe with a three-way tap to facilitate deflation of the balloon by the orthopaedic team. Mr B then left the operating theatre.

After 30 minutes, the aortic balloon was deflated by the orthopaedic team. After ten minutes it was noted that it was not possible to maintain Mrs S's blood pressure. After a further 20 minutes, the orthopaedic team re-inflated the aortic balloon in an effort to stabilise Mrs S in order to allow wound closure. There was a transient improvement in Mrs S's blood pressure and after 40 minutes the orthopaedic procedure was complete.

Mr B received a telephone call to inform him the operation was finishing and he should return in order to remove the sheath and aortic balloon. Prior to him arriving at the operating theatre, the patient suffered a cardiac arrest and CPR was commenced.

Mrs S had an unrecordable blood pressure and at laparotomy a large retro-peritoneal haematoma was discovered secondary to a 2.5cm tear in the anterior aorta. The aorta was surgically repaired but after release of the clamps, Mrs S suffered a further cardiac arrest and died.

Mrs S's family made a claim against Mr B. It was alleged that consent was inadequate as the risk of death was not specifically mentioned. It was also alleged that the aortic balloon used was inappropriate and that it was inappropriate to inflate the balloon without radiological guidance. In addition, it was alleged that delegation of the deflation of the balloon to the orthopaedic team was unacceptable.

EXPERT OPINION

Medical Protection sought an expert vascular surgery opinion from Professor T. Although the risk of vessel rupture and bleeding was discussed, he was critical of the failure to warn of the small risk of death from aortic balloon inflation.

Whilst acknowledging that re-inflating the aortic balloon without guidance may have been acceptable as a last-ditch effort to save the patient's life under extreme circumstances, the decision to initially inflate the balloon without radiological guidance and to delegate deflation to the orthopaedic team was also criticised.

The case was settled for a high sum.

Learning points

- Good communication and documentation are essential in the process of consent. Patients must be made aware of the risks of surgery and their implications.
- This should include common complications as well as any serious adverse outcomes, including rare complications, which may result in permanent disability or death.
- Patients need to be able to weigh up the benefits and risks of medical intervention so that they can make an informed decision as to whether they want to proceed.

JT

OVER TO YOU

We welcome all contributions to Over to you.
We reserve the right to edit submissions.
Please address correspondence to:
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Email: casebook@medicalprotection.org

Join the debate and leave your comments on medicalprotection.org

MISSED CRITICAL LIMB ISCHAEMIA

I don't understand why the out-of-hours GP faced with rest pain in a foot he thought had a circulation problem was not involved in the litigation. He missed the problem and failed to act properly by admitting straight away. I was left with the rather depressing notion after reading all the cases that we should not trust anyone.

It is interesting that the drive from the NHS is to be more streamlined and use records to improve continuity of care, and prevent patients having to repeat themselves at every point on their illness pathway – and yet the legal drive is to treat each appointment as an individual legal entity that will be judged in isolation.

Dr James A H Cave
Berkshire
UK

Response

Your assessment of the legal situation is quite right. Each professional involved in the care of a patient is responsible for their own actions, and can be held negligent for their actions or omissions. Every consultation will turn upon its own facts, and that will include what information the clinician has at hand, both from their own history and examination, and from any information in the records, or conveyed by others involved in the case.

Whether any individual has been negligent will depend on whether they have breached their duty of care, and whether the alleged injury was caused by or materially contributed to, by the breach of duty (causation).

The claimant and his or her legal advisers will determine which individuals to claim against, based on their understanding of the facts and the opinion of their experts. Of course in the case of an NHS hospital, the claim will be against the organisation itself (which is responsible for the actions of all its staff), but for GPs or those in private practice the claim is usually aimed at individual clinicians.

It is sometimes the case that the defendant or defendants in a case will wish to bring additional parties into the case (again usually based on expert opinion), but would need good grounds for doing so.

In this case neither the claimant nor the defendant sought to involve the out-of-hours service, based on the above principles. I hope this helps clarify the issues you raise about this case.

A PROBLEM WITH POLYPS
LETTER 1

Thank you for another stimulating and informative *Casebook*.

In the case "A problem with polyps", you quote your GP expert as saying: "A digital rectal examination would have revealed the polyps and thus [prompted] a more timely referral." Really? This suggests that your GP expert's opinion is that rectal polyps are all detectable on DRE, which is hardly the case.

It seems to me that the crucial error in this case was failing to refer in the knowledge that another doctor had seen two rectal polyps and had recommended further investigation (even if this information came by an unconventional route). A normal DRE, while contributing to a comprehensive assessment, would not influence that decision. It is difficult to see what Dr A could have learned from history or examination that would have trumped the clear recommendation from the overseas clinic. An element of irritation, perhaps understandable, at Mr S's deviation from standard procedure could have clouded Dr A's judgement.

In most of your GP cases, I can identify with the doctors involved, to the extent that I can envisage circumstances where I might have acted as the involved doctor did, and this is the great value of *Casebook;* this was not such a case.

Dr Aidan Finnegan
Waterford
Ireland

Response

Thank you for contacting us with your comments on this case.

Upon looking more closely at this case, the view of the expert GP was not that all polyps are detectable on DRE – they are not – but that, on the facts of this particular case, a DRE would have detected them. This view was echoed by the comments of our other expert, a professor of colorectal surgery.

On reflection, we could perhaps have made this clearer in the narrative. Thank you once again for drawing my attention to this point.

A PROBLEM WITH POLYPS
LETTER 2

I always enjoy reading *Casebook* and have often thought "there but for the grace of God..."

However, reading the report "A problem with polyps", I do find it extraordinary that MPS took this case to court. In the first paragraph a colonoscopy was properly recommended. Not arranging this is, to my mind, completely irresponsible, and the professor's comment about repeating the rectal examination just ignores the previous proctoscopic findings. The patient's lawyers must have enjoyed the case at great legal expense to MPS.

A B Richards
Tadley
UK

Response

I regret to say that this is an error on our part, and that this case did not in fact go to court. It was settled without matters going this far – as you correctly point out, there was no doubt that an error had been made by Dr A.

I am not entirely sure how our mistake slipped through but we will correct our online version.

Thank-you for getting in touch and drawing our attention to it.

TOO MUCH OXYGEN

I read with interest your case report of an extremely preterm baby with high oxygen saturations, who was not screened for retinopathy of prematurity (ROP) and who subsequently developed severe ROP, causing blindness.

However, the learning point that safe levels of oxygen saturation in low birth weight infants are between 86-92% is incorrect. In two large, multi-centre trials a targeted oxygen saturation level of 85-89% increased infant mortality compared with an oxygen saturation target level of 91-95%. [1,2]

While the incidence of ROP was lower with lower oxygen saturation target levels, this does not outweigh the increased risk of babies dying. It is recommended that extremely preterm babies should have target oxygen saturations levels between 91-95%. [3]

Dr Jane Alsweiler
Neonatal paediatrician
Auckland
New Zealand

Response

Thank-you for your email. We have discussed your comments with the author of the case report in question.

He has confirmed that the oxygen range quoted was from guidelines issued in 2010 and that a more recent meta analysis has found that the lower range of oxygen saturations are associated with higher mortality at a later stage.

We are happy to correct this point and would like to thank you for your helpful comments.

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REVIEWS

ESTABLISHING, MANAGING AND PROTECTING YOUR ONLINE REPUTATION – A SOCIAL MEDIA GUIDE FOR PHYSICIANS AND MEDICAL PRACTICES ★★★★

by Kevin Pho and Susan Gay

Dr Aidan O'Donnell, consultant anaesthetist, New Zealand

How social media savvy are you? If you are a medical student, the chances are that you are online more or less permanently. If, like me, you are a practising doctor who qualified in the last century (read 'dinosaur'), you might be a bit less comfortable. I've been using computers since you could measure the pixels with a ruler, and I carry my smartphone as if it were grafted onto my hand, but even I admit I am feeling a little left behind by the social media tsunami that has arisen around us. Social media is becoming increasingly popular among doctors and patients alike.

Where clear ethical and behavioural boundaries are well-established in traditional face-to-face relationships, the online community has developed so rapidly that the medical profession is finding itself in uncharted waters. How do you respond when a patient wants to "friend" you on Facebook? Or when someone harshly criticises your doctoring on a public forum?

My organisation has released guidelines about how to behave online, but they are a series of don'ts. Don't publish pictures of yourself drunkenly incapacitated on your Facebook page, where employers and patients can see them.

Into this environment come Kevin Pho and Susan Gay, with their book, *Establishing, Managing and Protecting your Online Reputation.* Pho is himself a doctor, writing for doctors, which gives him immediate authority. His blog, www.kevinmd.com , is well-known and successful.

The central theme of the book is that doctors' online reputation is just as important as their real-life one. Whether we like it or not, our basic information is already out there, but we usually don't take any ownership of it. Done properly, we can establish and cultivate an online reputation, which can be professionally and personally rewarding. In short, we can use social media to our professional advantage. To quote: "First, do no harm; second, get an online profile." Rather than don'ts, this book is full of dos.

The book is informal and readable, and covers the absolute basics well: techno-novices need have no fear. My main criticism is the book's overwhelmingly American perspective. Patterns of work and ethos of practice are very different where I work, and I don't need to build myself – or my practice – as a brand, or attract my paying customers. Social media is here to stay, and need not be a threat. We can ignore it, or use it to our advantage, and this book goes a long way toward telling us how.

I'LL SEE MYSELF OUT, THANK YOU: THIRTY PERSONAL VIEWS IN SUPPORT OF ASSISTED SUICIDE ★★★

Edited by Colin Brewer and Michael Irwin

Reviewed by Dr Ellen Welch – GP, London

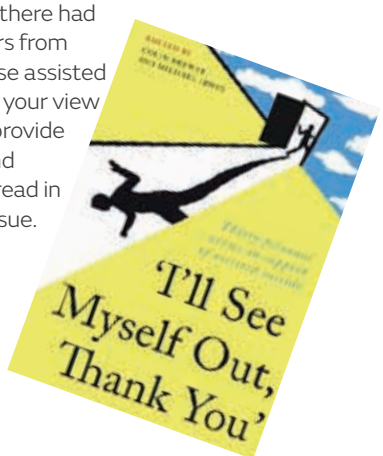
Following the recent rejection of the Assisted Dying Bill in the UK House of Commons by an overwhelming majority of 330 against to 118 in favour, this collection of essays in support of the issue provides the reader with some of the key arguments in the debate for the legalisation of what the authors term medically assisted rational suicide (MARS).

The book has been compiled by former psychiatrist Colin Brewer and former medical director of the United Nations Michael Irwin, with essays contributed by doctors, priests, politicians, philosophers and, most poignantly, from people suffering with terminal illness.

The writers discuss the facts and the law surrounding the subject in both the UK and overseas, with both ethical and religious perspective offered. Dignitas writes a chapter on their experiences in Switzerland over the last 16 years of their existence. And a chapter is dedicated to palliative care – both its promises and its limitations.

Perhaps the most thought-provoking stories come from people who have been faced with the reality of a painful, undignified death. They tell of their struggle, their pain, the frustration that they feel in a life they no longer want to live, but are unable to end. Several quotes are given from the 2014 House of Lords debate which sum up some of the main arguments.

A major limitation of this book is that it only presents one side of the argument on the debate and it would certainly provide more of a balanced read if there had been contributors from those who oppose assisted dying. Whatever your view may be, it does provide an interesting and comprehensive read in support of the issue.



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