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Casebook

YOUR LEADING MEDICOLEGAL JOURNAL

MPS

Putting members **first**

UNITED KINGDOM

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ON THE COVER

ALSO THIS ISSUE

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

Welcome

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

Wherever you are in the world, it is likely that you are working in an increasingly challenging environment. Financial constraints in your workplace and changes to how healthcare is delivered, and by whom, are complex issues affecting many of today's doctors.

Globally the population is living longer and presenting with multiple comorbidities that demand increasingly complex interventions. Patient expectations are growing – rightly patients expect high quality, safe care, delivered in a respectful, clearly communicated manner – but there has been a change in the doctor–patient relationship and this is something MPS has written about extensively. The patient is now a consumer and the health service has had to adapt accordingly.

These higher expectations mean that patients are more likely to complain about their care. This is something we have been seeing in numerous reports of growing numbers of complaints against doctors; there is no other evidence that the profession's standards are declining. I have personally heard concerns from our members that the gap between expectations and deliverables is widening, and that they are facing pressures to do more with less.

It is in times of great stress that your professional qualities come to the fore. Your sense of personal responsibility, pride in the care you deliver to patients, and your aspiration towards improvement are decisive attributes that can make all the difference when under pressure. In such moments your professionalism has never been more important.

CONFERENCE REPORT

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MPS Medical Director ***Dr Priya Singh*** shares her personal experiences of MPS's international conference

MPS was delighted to welcome more than 250 delegates to our International Conference 2012, Quality and Safety in Healthcare: Making a Difference.

Throughout the conference, delegates heard from leading international experts about the importance of listening to patient feedback to improve quality, the need to be transparent and professional when things go wrong, and the cost, both to the doctor–patient relationship and to the doctor's claims experience, in failing to do so.

I have been encouraged by the feedback from the conference so far – 100% of delegates who completed the post-conference evaluation form said that the programme of speakers met their expectations and they would recommend the conference to a colleague.

The real measure of the conference's success, however, will be the extent to which delegates take home the key learning points about improving quality and patient safety – and put them into practice.

Ninety per cent of delegates agreed that they were likely to change something in their practice as a result of attending the conference. One delegate said: "We need to challenge the culture of resistance to openness"; another: "I have a much more positive attitude towards aspects of appraisal because I see the evidence behind it now. I feel confirmed and remotivated in what I do."

I would be very interested to hear your thoughts on what we can do differently in our organisations to improve quality and safety in healthcare. If you have suggestions you would like to share, please do get in touch.

Making medicine safer

Healthcare in the 21st century has become highly effective, yet improvements in safety have lagged behind. **MPS's International Conference 2012 – Quality and Safety in Healthcare: Making a Difference** moved the focus from making medicine better to making it safer.

By Sarah Whitehouse

Part of making medicine safer is listening to a patient's experience. Patients are now very active consumers of healthcare, not just passive recipients. Described by conference speaker Dr Neil Bacon, founder of Doctors.net and iwantgreatcare.org, as "the smoke detector of patient safety", patient experience captures both excellence and the potential for improvement.

As well as patient experience, MPS's conference – held on 15-16 November 2012, at Church House Conference Centre, Westminster, London – addressed quality, safety culture, cost and professionalism. In partnership with the Canadian Medical Protective Association (CMPA) and MDA National, and key supporters CRICO and PIAA, MPS's conference welcomed more than 250 international delegates from around the world, including Argentina, Australia, Canada, the USA, the Caribbean and Bermuda, Uruguay, Norway and Ireland, as well as the UK.

Dr Gerald Hickson, Assistant Vice Chancellor for Health Affairs, Vanderbilt University Medical Centre, and Director of Centre for Patient and Professional Advocacy, delivered the first keynote address on delivering quality and trust. Quality, he said, is about making medicine kinder and safer. Each doctor has a duty to address faulty systems;

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rather than talk about each other when things go wrong, doctors need to talk to each other. Quality is also about promoting reliability – doctors need to know they will be supported by their organisation if they raise any concerns. Similarly, organisations need to tackle unreasonable variations in the performance of healthcare professionals that threaten safety and quality.

Quality, however, means different things to different people. The pursuit of quality in challenging circumstances has one main goal for Dr Devi Prasad Shetty, Chairman, Narayana Hrudayalaya Group of Hospitals – to dissociate affluence from healthcare. Quality is being able to reduce the costs associated with cardiac surgery, by putting a price tag on human life out of necessity. Delivering cardiac surgery for $800 involves streamlining processes, reducing costs, and involving families as primary care providers.

Typically, it takes a catalyst for new aims to be set, or behaviours to alter. If something goes wrong, writing a policy to improve patient safety is the default mechanism, said keynote speaker Dr Carol Haraden, Vice President at the Institute for Healthcare Improvement (IHI). Yet often, there is no well-developed execution strategy – and so excellent ideas and aims to improve patient safety are lost in documentation. Most healthcare organisations have at least 250 guidelines; yet typically, healthcare professionals only put five into practice. To achieve a culture of safety, we first need a culture of improvement.

The shift needs to come from the top. In every healthcare organisation, there needs to be a board level commitment in everything to do with quality, stressed Professor Martin Elliott, Professor of Paediatric Cardiothoracic Surgery at Great Ormond Street Hospital. Talking about teamwork, leadership and professionalism, he said that leaders need to help define the goals of their organisations, set and maintain standards, and act as role models. Force won't work: the best leaders never bully, but lead by example.

Forecasting medicolegal risk would allow medicolegal institutions (eg, liability insurers, medical boards, hospital risk management departments) to become more proactive in quality and safety improvement efforts, argued Professor David Studdert, Professor and ARC Laureate Fellow at the University of Melbourne. His study is using a unique national dataset on patient complaints against Australian doctors to develop new methods and tools for predicting a clinician's risk of a further complaint. Over a ten-year period, 18,900 complaints were received about 11,000 doctors in Australia. The research looked at practitioners' sex, age, practice location and specialty. For all practitioners, standards of clinical care and communication were the main issues. The more complaints a doctor received, the more they were at risk of further complaints. Prof Studdert explained how the PRONE score (PRobability Of New Events) predicts doctors' medicolegal risk, which could be used as a simple prediction tool for targeting interventions and reducing clinical negligence costs.

Tony Mason, former Chief Executive of MPS, explored the rise in negligence costs in a global context. For some doctors and hospitals, they have already proved to be unsustainable; in the UK, clinical negligence costs are the highest anywhere in the world, except the United States. The Panel Discussion provoked a lively debate about potential ways forward to address this unsustainable rise.

But the fallout from an adverse event is often not about the money, argued Dr Lucian Leape, Adjunct Professor of Health Policy at Harvard School of Public Health, in his keynote address on disclosure and apology. It is about communicating effectively when things go wrong. A serious preventable injury is devastating for the patient – they are doubly wounded. Not only do they suffer a physical wound (the adverse event), they also suffer an emotional wound, the betrayal and loss of trust in the healthcare professional. A serious preventable injury is a medical emergency. If a doctor does not act quickly, things become much worse. The necessary treatment is open, honest and full communication.

In this medical emergency, there is a second victim, the caregiver. Shame, guilt and fear can take over if the situation is ignored. Apologising or admitting something has gone wrong can be difficult, yet Dr Leape suggests it is essential for the caregiver to heal. Dr Stephanie Bown agreed, outlining MPS's belief in the necessity of a culture of openness. Legislation cannot work: it only serves to encourage fearful behaviour.

Mistakes do occur. Quality, however, is never an accident: it is always the result of high intentions, said Dr Jason Leitch, Clinical Director at The Quality Unit, Scottish Government, in his keynote address on safety and outcomes. Safer care can only be delivered by frontline professionals doing common things uncommonly well.

To achieve a culture of safety, we need a culture of improvement. John Tiernan, Director of MPS Educational Services, closed the two-day conference with a question: "Delegates from around the world have come to the conference and will leave with great ideas. What will you do with the information you have learnt?"

Visit the MPS website to read the event summary report which features links to videos, podcasts and speaker presentations.

Revalidation begins

The General Medical Council (GMC) has begun the process of revalidating all UK doctors.

Revalidation is the process whereby all licensed doctors will have to demonstrate to the GMC that they are up-to-date and fit to practise through regular checks, based on feedback they collect from their patients and colleagues.

The GMC, which has overarching responsibility for revalidating doctors, has set the standards for revalidation, and the medical royal colleges and faculties have defined the requirements for doctors practising in a particular specialty.

A fifth of licensed doctors are expected to be revalidated between April 2013 and the end of March 2014. The rest will be revalidated on a rolling five-year cycle; the majority by the end of March 2016, and all remaining licensed doctors by the end of March 2018. All responsible officers and other medical leaders should be revalidated by March this year.

Sir Richard Thompson, Royal College of Physicians president, said: "Regular participation in the revalidation process will support physicians to develop and maintain the highest standards of care for their patients, and to achieve excellence in their professional lives. It is vital that all doctors begin preparing for revalidation by collecting their supporting information for their yearly appraisal and making themselves familiar with the process."

The UK is the first country to introduce such a system covering all its doctors. Professor Sir Peter Rubin, Chair of the GMC, said: "This is an historic day for patients and for the medical profession. We are confident that the introduction of revalidation will make a major contribution to the quality of care that patients receive and will give them valuable assurance that the doctors who treat them are regularly assessed against our professional standards."

Further information:

- Access the RCP's revalidation resources – **www.rcplondon.ac.uk/cpd/revalidation**
- GMC, *Information for Doctors in Training* – **www.gmc-uk.org/Information_doctors_in_training.pdf_50256022.pdf**
- Academy of Royal Colleges, *The Impact of Revalidation on the Clinical and Non-Clinical Activity of Hospital Doctors* – **http://aomrc.org.uk**

NHSLA: new report on maternity claims

The NHS Litigation Authority (NHSLA) has published a report on clinical negligence claims in maternity services.

This report analyses the costs to the NHS of litigation in maternity services over a ten-year period between 2000 and 2010.

In that time, there were 5,087 maternity claims costing a total of £3.1 billion from a cohort of approximately 5.5 million births. This constitutes less than 1 in 1,000 births ending in litigation.

The most common causes of claims were for:

- Mistakes in the management of labour
- Mistakes in cardiotocograph (CTG) interpretation
- Babies suffering cerebral palsy.

Four risk areas were identified for further review and analysis. These were antenatal ultrasound investigations, cardiotocograph interpretation in labour, perineal trauma and uterine rupture. In some of the categories, multi-factorial contributory factors were found.

The report was welcomed by the Royal Colleges of Obstetrics and Gynaecology (RCOG). It has called for:

- A clinical database to be set up, to run in parallel with that of the NHSLA, akin to the Centre for Maternal and Child Enquiries
- An audit of guideline implementation and an assessment of the role of failure of training and guideline use in claims
- Any analysis of litigation claims to be fed back to maternity services in a timely manner
- Urgent government action to improve staffing ratios, perhaps linking with the insurance and legal sectors for funding
- Increased investment in research and innovation.

For more information, visit **www.rcog.org.uk**.

NICE GUIDANCE WATCH

This is a selection of the guidance NICE is expected to publish over the next few months. Publication dates may be subject to change; visit **www.nice.org.uk**.

February

- Macular oedema (diabetic)
- Epilepsy
- Asthma
- Ultrasound-guided foam sclerotherapy for varicose veins
- IRE for the treatment of pancreatic cancer, primary lung cancer and metastases in the lung and renal cancer
- Electrochemotherapy for the treatment of skin cancers

March

- Hypertension
- Peripheral nerve field stimulation for chronic low back pain
- Selective internal radiation therapy for primary hepatocellular carcinoma
- Insertion of a subcutaneous implantable cardioverter defibrillator for prevention of sudden cardiac death
- Exposed customised titanium implants for orofacial reconstruction

April

- Conduct disorders in children and young people
- Asthma
- Vertebral fractures – vertebroplasty and kyphoplasty
- Ovarian cancer (metastatic)
- Management of venous thromboembolic diseases

May

- Social anxiety disorder
- Feverish illness in children
- Prostate artery embolisation for benign prostatic hyperplasia
- Hyperuricaemia (symptomatic gout) – pegloticase

OPINION

Failure to test for HIV infection: **A medicolegal question?**

We read with great interest the comprehensive and timely article on the topic of widening HIV testing by Gillespie and McCullough (*Casebook* 20(2)). Despite biomedical advances in treatment, HIV remains a highly significant clinical and public health issue in the UK. Efforts to maximise clinical and public health outcomes for HIV are undermined by undiagnosed HIV and late presentation: 24% of people living with HIV are unaware of their infection, and more than half of newly-diagnosed people have a CD4 count below 350cells/mm3 at first presentation. The benefits of diagnosing HIV earlier are manifold – for the individual and for the wider public health.

We believe that, in some specific instances, there are clear grounds where failure to offer an HIV test could be construed as negligence

As outlined in the article, great strides are being made in changing the HIV testing paradigm, supported by the publication of guidelines from specialist societies (such as the British HIV Association, the British Association of Sexual Health and HIV, and the National Institute for Health and Clinical Excellence). The guidelines follow three central themes: (1) to facilitate HIV testing in all healthcare settings for individuals belonging to recognised demographic risk groups (such as men who have sex with men) and their partners; (2) to promote the concept of routine testing for HIV in patients presenting for the care of "HIV indicator diseases" – a heterogeneous group of conditions thought to have an association with HIV infection through shared transmission route, or arising from the HIV-associated immune deficiency; and (3) to develop routine HIV testing programmes for whole populations in areas of high HIV prevalence (defined as a known HIV prevalence of >2/1000).

The utility of these approaches is now supported by a growing body of evidence, demonstrating routine HIV testing to be acceptable to the vast majority, feasible to deliver, and efficacious at diagnosing patients and transferring them to clinical care. As evidence amasses to support them, guidelines will evolve into benchmarks for expected practice. Thus, we would urge readers in all specialties to familiarise themselves with the guidance, and reflect upon how they might improve their own HIV testing practice. Late diagnosis of HIV is a preventable phenomenon – with negative implications for the individual, and for their partners. There is clear evidence that HIV-infected individuals access healthcare settings in the years preceding their diagnosis, often with HIV-associated morbidity. We believe that, in some specific instances, there are clear grounds where failure to offer an HIV test could be construed as negligence.

For the tort of negligence to apply, there must be: (1) a duty of care, (2) a breach in that duty of care, and (3) causation. Negligence turns on a breach of the duty of care, if harm (causation) thus results. The definition of duty of care, and thereafter a breach, may be difficult to prove. We are familiar with the "Bolam" principle – the respectable body of opinion that might define whether failure to test for HIV constituted a breach of duty – but how this applies to an area of flux and changing evidence, such as the HIV testing paradigm, remains a challenge.

In a multitude of look-back exercises undertaken by HIV services, examining opportunities for earlier diagnoses in individuals diagnosed with advanced HIV infection, there is often evidence that HIV testing ought to have been offered earlier on clinical grounds. In selected individual cases, a failure to offer an HIV test based on best available evidence, published guidelines and first principles could reasonably constitute a breach of duty. The natural history of HIV infection being well understood, and effective treatments being available, it is also very easy to conceive how delays in HIV diagnosis may result in harm to the individual. Thus, a case for negligence could fathomably be made.

Successful cases have been brought against medical practitioners in the US and Australia. In the UK, missed opportunities to test for HIV infection are being treated as clinical incidents, serious untoward incidents, and initiators of the incident review process in several trusts. The Health Protection Agency's Office for Sexual Health is currently working towards reporting all cases of late diagnosis of HIV infection in its South West division as serious untoward incidents, with a view to a national roll-out.

HIV testing is rightly high on the public health agenda. The accessibility of HIV testing, and late diagnoses of HIV infection, are prominent indicators in the DH Public Health Outcomes Framework 2013-2016. With prominence comes scrutiny.

Again, please review current guidance for HIV testing and see how it relates to your own practice. The HIV specialist societies in the UK are keen to facilitate the development of safe and efficacious testing strategies in all arms of healthcare, and have produced guidance documents to help you. Testing for HIV is safe, effective and acceptable. We hope that there need be no medicolegal precedent in the UK, but a late diagnosis of HIV is avoidable in many cases, and may have implications not just for the patient, but for you.

Dr Michael Rayment and Dr Ann Sullivan, Department of Sexual Health and HIV Medicine, Chelsea and Westminster NHS Foundation Trust (on behalf of the British Association for Sexual Health and HIV, and the British HIV Association)

Full references are available within the online version of this article.

Complaints culture

Complaints to the regulator against doctors have hit a record high, rising more sharply than for any other health professional. Is this down to poor practice or a changing complaints culture? ***Sara Williams*** investigates

Last year the GMC revealed that complaints around the conduct of doctors reached "record" levels, rising by 23% compared to the previous year, following a steady rise since 2007 (69%).[1] Information from medical regulators outside the UK identifies this as an international issue; in Denmark alone, complaints rose by 88% from 2007-2011.

What do the figures mean?

The three most prevalent types of complaint to the GMC were:

- concerns with investigations or treatment, such as the failure to diagnose or inappropriate prescribing
- problems with communication, such as not responding to people's concerns
- perceived lack of respect, such as being rude.

The figures indicate that certain factors, such as a doctor's gender, the organisational culture and the specialty in which they work, affect the likelihood of receiving a complaint. For example, men received more complaints than women, while psychiatrists, GPs and surgeons attracted the highest complaint rates proportionate to their representation on the register.

The findings need to be put into perspective as the majority of UK medical treatment is delivered to a very high standard in increasingly difficult times. The rise in complaints is symptomatic of the challenging environment that doctors are working in, rather than a decrease in performance.

GPs were one of the most complained about specialties, yet that same year the National Clinical Assessment Service (NCAS) reported a sharp drop in the number of GPs who were suspended amid professional concerns. This reversed an upward trend, as the figure almost halved compared to the previous year. So why are more patients complaining?

GPs were one of the specialties that experienced the biggest rise in complaints. Dr Clare Gerada, the chair of the Royal College of GPs, said that the rise was driven by an emerging complaints culture: "When you see such a rapid increase, such a sudden change, it's unlikely to be the fact that doctors have become less caring or less competent."

Complaints in surgery saw a similarly large rise. Claire Hopkins, a consultant ENT surgeon at Guy's and St Thomas' Hospital, says that complaints are rising alongside other factors. "In addition, we are constrained by the EWTD, resulting in less continuity of care, and changes in remuneration to hospitals, such that there is pressure to see more patients."

Dr Isabeau Walker, consultant anaesthetist at Great Ormond Street Children's Hospital, agrees that a rise in surgical complaints is down to the increasing complexity of medicine. "Our patients are getting sicker, our services are turning over more rapidly and we are handing over more patients. Healthcare is changing; we have higher expectations of our surgeons, and are increasingly asking them to perform trickier tasks. The perception is that anything is possible, so we expect our surgeons to be able to deliver anything."

The GMC's findings echo a recent report by the new health service ombudsman, Julie Mellor; the report identified a 50% rise in complaints from people who felt they had not received a clear or adequate explanation in response to their complaints.[2] Responding to the report, Katherine Murphy, chief executive of the Patients Association, called for a cultural change in how the NHS handles and responds to concerns from patients.

How to avoid complaints

Complaints are an opportunity to improve your practice and avoid potentially escalating issues. By better communicating with patients and managing their expectations, most complaints will disperse.

Effective communication

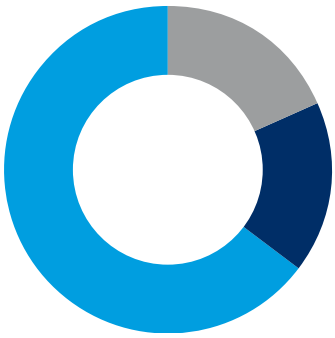
Most complaints are rooted in poor communication. Understandably patients experience difficulties in assessing the technical competency of a doctor, so will frequently judge the quality of clinical competence by their interactions with a particular doctor. Developing good communication skills will improve clinical effectiveness and reduce medicolegal risk. It is often said that body language speaks louder than words. A mismatch between verbal and non-verbal communication can lead to a strained encounter for both doctors and their patients. Being aware of your own body language is the first step in understanding how your body language is perceived.

Claire Hopkins says that the potential for miscommunication increases when treating a patient whose first language is not English, and translators are becoming a limited commodity. She explains: "The complaints that I have been aware of relate primarily to miscommunication, particularly when the consultation occurs through a translator, or perceived failings in continuity of care, rather than a question of clinical competence. They could often be avoided by offering to make a further appointment, perhaps with a friend, or with a member of nursing staff."

A mismatch between verbal and non-verbal communication can lead to a strained encounter for both doctors and their patients

KEY STATISTICS AROUND COMPLAINTS TO THE GMC

- In 2011, 8,781 complaints were made against doctors to the GMC; up from 7,153 in 2010
- This equates to 1 in 64 doctors on the register
- 17.5% (1,537) were limited to preliminary enquiries only, 26.5% (2,330) progressed to full investigations and the rest were discontinued.



Breakdown of complaints by origin

5,665 came from the public (64.5%)

1,481 came from public body workers, eg, police (16.85%)

1,635 'other', including doctors and the GMC (18.6%)

Managing patients' expectations

As the gap between patient expectations and what the NHS can deliver continues to widen, patients are likely to be left dissatisfied. As commissioning is implemented, doctors may find themselves with multiple responsibilities that raise the potential for conflicts. Doctors will not only be managing patients' expectations on a one-to-one basis, but also on a community level.

Claire Hopkins points out that a difficult situation arises when clinicians reach the limits of their ability to diagnose and treat common symptoms. "We have to be careful, be honest, reassure that we can find nothing to treat at present, but leave the door open for the patient to come back, or suggest someone who could offer a second opinion."

Although patients' expectations are sometimes unrealistic, eg, the doctor will have unlimited availability, will solve all the issues at once and all treatments will be 100% effective, these expectations can be addressed if they are identified early on.

Being open

Complaints can feel personal – many doctors describe how they feel angry, hurt and betrayed. The first step is to take some of the emotion out of the situation. Try not to react defensively by refusing to engage with the complaints process.

Complaints are stressful and time-consuming; often a prompt, well-balanced response to a complaint will be enough to defuse the situation. When it comes to complaints the best approach is do it once and do it well; complaints often do not get resolved because they are not investigated in a timely manner. The NHS Complaints Regulations require a complaint to be acknowledged within three working days and responded to within the agreed timescales.

Where there are differences of opinion between you and a patient, or a patient's relatives, there is much to be gained by acknowledging and empathising with their situation rather than becoming defensive. See them not as a critique of your clinical acumen, but as an opportunity to listen to a patient and improve your skills for the future. An apology goes a long way in defusing a situation, and is not an admission of liability.

The future

As patients' expectations grow, doctors will have to acquire new skills to manage them effectively, especially in the new commissioning environment; responding defensively will not deliver protection from complaints. A balance must be created where doctors are treated fairly and patients are assured of their safety.

VOXPOPS

"Many referrals to the GMC could be avoided early if we weren't so defensive and communicated more effectively. Complaints are mostly the result of poor communication; often we are too wrapped up in what we are doing to consider that and keep the communication channels open. People complain because they feel they have been ignored and feel a deep sense of frustration. We could avoid many issues by talking to a patient's family early on in the process."

Dr Isabeau Walker, consultant anaesthetist, Great Ormond Street Children's Hospital

"Expectations are rising, and if expectations can't be met, people are more likely to complain. GP practices are busier than they have ever been, and the pressures on time are immense; when practices are too busy there is a real risk that communication can deteriorate. It always helps if you can see the situation through the patient's eyes. That sounds trite, but explanation and communication can go a very long way."

Professor David Haslam CBE, National Professional Adviser, CQC

USEFUL LINKS

Communication skills workshops

The concerns around communication reflect MPS experience of the underlying reasons for dissatisfaction. MPS has created a series of communications skills workshops free to MPS members. For more information visit: www.medicalprotection.org/uk/education-and-events/courses-and-workshops.

Complaints advice

In the past 18 months MPS received more than 4,500 calls relating to complaints. MPS has a series of factsheets and booklets on our website.

REFERENCES

1. GMC, *The State of Medical Education and Practice in the UK* (2012)
2. Parliamentary and Health Service Ombudsman, *Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England 2011-12* (2012)

The worst of times

Medicolegal implications of the recession

Unemployment reduces wellbeing. Recession raises the demands on healthcare systems and makes it harder to pay for them. Doctors worldwide are having to adapt and change to cope with these additional pressures, says ***Sarah Whitehouse***

The impact of the recession on healthcare reads like a gloomy checklist of the multi-symptom patient: increased stress, depression and anxiety; an increase in alcohol consumption; an increase in stomach and digestive problems; and an increase in obesity. A study by the Insight Research Group of 300 UK GPs reported that 17% noted an increase in requests for terminations of pregnancy specifically because of financial concerns.[1] Skin complaints are even on the rise. Research by the British Skin Foundation suggests that nine out of ten dermatologists have noticed a marked rise in eczema, psoriasis and other skin conditions triggered by stress.[2] Most dispiritingly, international research suggests that for every 1% increase in the unemployment rate, there is a 0.78% increase in the rate of suicide.[3]

The impact on doctors

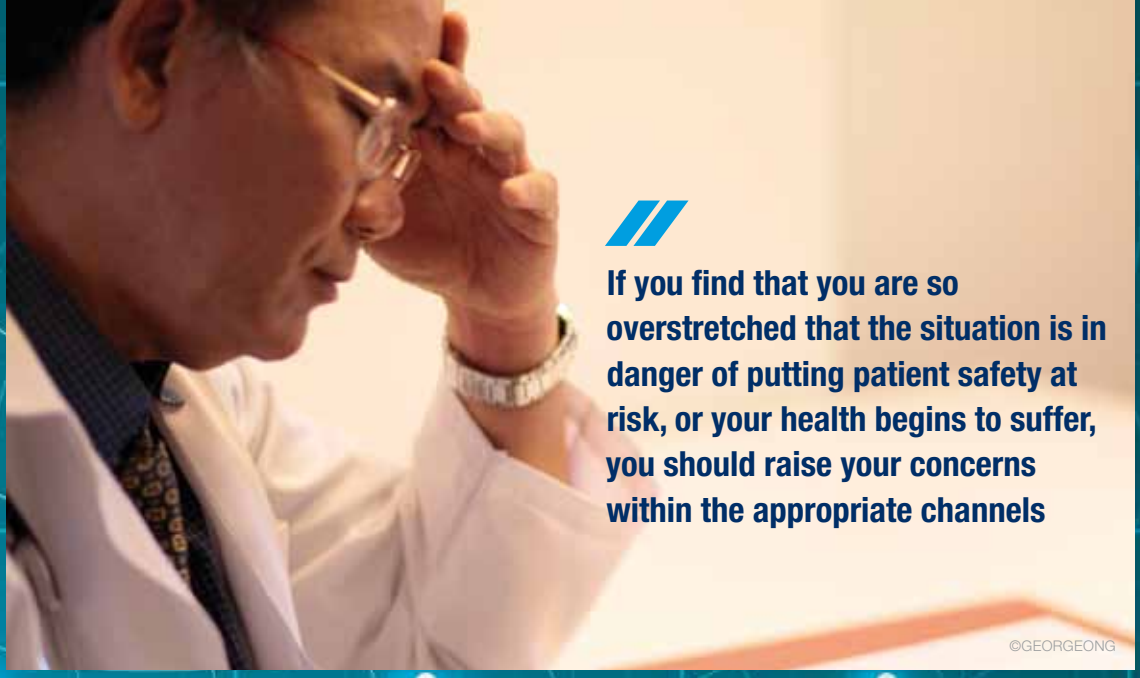
But what does all this mean for doctors? Primary healthcare, often the first point of contact, has been hard hit. The Insight Research Group also reported that 77% of UK GPs feel there has been an increase in new cases of mental health conditions in the last four years directly linked to the economic climate.[4]

Secondary care, too, has been affected. In the UK, almost 6,400 people were admitted to hospital with stress between the period January – May 2012, 47% up on 2007-8, when the economic crisis hit.[5] In the Caribbean, public healthcare systems are being stretched as the recession forces more patients to move away from private care. Dr Nancy Boodhoo, MPS Head of Operations, Caribbean and Bermuda, says that this is a particular issue for obstetric care because of spiralling costs.

Maintaining standards

One of the biggest challenges facing doctors is balancing an increase in patients' needs with maintaining high standards of care. Remember your professional obligation to take a thorough medical history and an examination if necessary – and document both. Record keeping standards can easily slip if a consultation over-runs, but it is important to stop and make notes before rushing to see the next patient.

Be aware too of "by the way" comments, where symptoms might be mentioned in passing as the patient is on their way out of the door. These symptoms can often be the real reason behind an appointment, so make sure you



If you find that you are so overstretched that the situation is in danger of putting patient safety at risk, or your health begins to suffer, you should raise your concerns within the appropriate channels

record them. If it is not urgent, or you do not have sufficient time to give the patient your full attention, you should ask them to come back.

If you find that you are so overstretched that the situation is in danger of putting patient safety at risk, or your health begins to suffer, you should raise your concerns within the appropriate channels, for example a senior colleague or your employer.

Act within your competence

MPS has received a number of calls from hospital doctors who feel uncomfortable at being asked to provide cover for an area they do not normally specialise in due to staff shortages. For example in psychiatry, adult psychiatrists are often asked to step in and cover children and adolescent psychiatric care.

Dr Ming-Keng Teoh, MPS Head of Medical Services (Asia) explains that some medical private practitioners seek to maintain their income (as patients turn to the public sector) by choosing to take on a wider range of treatments (eg, GPs undertaking cosmetic procedures), as well as patients (paediatricians seeing adult patients, obstetrics and gynaecology consultants examining patients with breast lumps). Doctors who choose to do this are practising in areas beyond their expertise and may fail to refer appropriately. You have a professional obligation to work within your competence – and should raise your concerns with a senior colleague or employer if you are asked to perform a procedure that you are unsure of.

Managing expectations

Speaking this year at an MPS conference for newly-qualified consultants, MPS Head of Medical Services Dr Nick Clements said: "There has to be a balance between the patient's interests, the need to control budgets and where the doctor's duty lies in these difficult circumstances. Often, the buck seems to stop with you, the doctor. If a patient cannot get the treatment they want, or the drugs they want, they will blame the doctor who is saying no. Doctors need to have the right communication skills to handle these situations carefully and manage patient expectations."

Some patients see making a claim as a financial opportunity in these tough times. In Ireland, the average size of claims against doctors has increased by 37% between 2007 and 2011. Dr George Fernie, MPS Senior Medicolegal Adviser, says: "There has always been tension in Ireland with the public and private mix, but it's been magnified with the recession. We have seen a case where a doctor reasonably asked a patient on long-term prescription to come in for a review, but the patient felt that this was financially motivated and lodged a complaint." You should always explain your reasons for calling a patient in for a review, clearly explaining the health benefits and the need for follow-up.

Delaying a visit to the doctor

In some countries, the economic downturn means that patients are accessing healthcare less frequently. In Ireland, those without Medical Cards are increasingly putting off making an appointment, which can have an impact on early diagnosis and the treatment of long-term conditions. Requests for telephone consultations are on the rise, and with them the risks of potential missed diagnosis. Failure to diagnose is a common cause of a complaint or a claim, so it is important to have a low threshold to invite the patient in for a review.

Dr Brian Charles, Emergency Physician and MPS Consultant, based in Barbados, says: "A particularly worrying trend has been patients 'waiting to get better' before seeking medical care, particularly those with medical insurance who have to pay upfront and wait for reimbursement later. This has resulted in patients presenting to primary care physicians later in the course of their illness, with more complications."

Despite the impact of the recession being less marked in Hong Kong, Malaysia and Singapore, which generally have more private practices and less welfare spending, Dr Teoh says: "Recession has had an impact in the public sector, reducing the number of consultations,

Yet doctors must retain a degree of realism. They cannot be responsible for putting right the social and financial woes of all their patients, as well as their ill health

as patients are less likely to take time off work to seek healthcare. They cannot afford the time, rather than they cannot afford the cost of healthcare itself." A reduction in patient numbers has also led to many doctors in private practice resorting to longer opening hours, more practice promotion activities and more turf battles between doctors. The respective Medical Councils do not permit doctors to promote their practice or advertise or canvass for patients, and so doctors may find themselves in murky medicolegal waters if they do try to seek new patients in this way. They are advised to consult and seek legal advice if unsure.

Where does a doctor's duty lie?

The conflict between a doctor's duty to their patient, and the patient's ability to pay, can be all too real. An MPS GP, based in Ireland, describes a case where a patient with depression wanted to wait to pick up his anti-depressant prescription until he was paid. The GP was concerned – the patient had severe depression and was at risk if he did not take his medication. The GP spoke to the pharmacist and agreed to postpone the fees for a few days until the patient was able to pay.

Dr Charles says that in the Caribbean: "Private practitioners are frequently faced with the ill patient who cannot pay (or at least, cannot pay at the time of the encounter), and they too must be compassionate and not put that patient at harm by denying appropriate care. All must be done to ensure that these patients are stabilised and properly referred onwards for the complete care they need."

Yet doctors must retain a degree of realism. They cannot be responsible for putting right the social and financial woes of all their patients, as well as their ill health. To do otherwise may well result in burnout for the already overstretched doctor. In the UK, the GMC, in *Good Medical Practice*, states that good doctors "make the care of their patients their first concern", but "must make good use of the resources available".[6] Unfortunately, these are not finite.

Conclusion

One small positive can be gleaned from the UK GP research into the effects of the recession on healthcare: 38% of GPs believe that patients who smoke are giving up or cutting down to save money.[7]

However, the pressure cooker of reduced health and increased demand for healthcare continues to affect most doctors. Dr Clements sums up: "Do the best you can with the resources available. Make sure that any resource-related decisions are fair and based on clinical need and remember to be open and honest with patients about the constraints."

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On the case

Dr Rob Hendry, Deputy Medical Director, introduces this issue's round-up of case reports.

When treating patients who attend the surgery frequently, especially within a short space of time, it can be all too easy to be blinded by a familiar diagnosis based on pattern recognition, particularly if it is a commonplace, and seemingly innocuous, condition.

The safest approach when treating frequent attenders is to go back to basics: document a thorough history and be prepared to re-examine the patient if their symptoms change.

Back pain is one of the most common complaints seen in general practice. Doctors may easily discount it, but it is important to remember that a small proportion of such cases mean serious or life-threatening pathologies. In "Back with back pain" on page 16, Mrs S's recurrent urine infections and back pain were found to be co-existing with non-Hodgkins lymphoma. Despite a claim being made against Dr F for failing to refer Mrs S earlier, Dr F's good documentation of the history and each examination meant that this was discontinued. Experts found that there was a careful, well-documented assessment of Mrs S on every occasion, which showed that at no time was an emergency referral warranted.

In direct contrast, a claim against Dr W for a missed SAH in "Take me seriously" (page 14) had to be settled for a high sum. There was no evidence in the records that Dr W had taken any history or performed an examination. As a result, Mrs T's fatal SAH was missed. One consultation was recorded simply as "Migraine. Prescribed some painkillers." Despite Mrs T returning to the surgery several times with recurrent headaches, and later with pain shooting down the back of her neck, the potentially life-threatening causes of her recurrent headaches were not considered.

Similarly, in "Where the heart is" on page 21, Mr R's high blood pressure was attributed to anxiety before more sinister pathologies were excluded. His risk factors for cardiopulmonary disease should have been considered when taking the history, examining and arranging follow up tests.

The learning points from all these cases are that potentially serious pathologies should never be discounted before a proper assessment has been made and a detailed history taken. Comprehensive records should be made of both.

CASE REPORTS

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

Although case reports are based on real cases from the MPS caseload, they have been anonymised and amended. As a result, the narrative is not wholly factual. What is most important is the learning points that can be taken away from each report, rather than the clinical detail itself.

When read with this approach in mind, the case reports section provides an invaluable resource for medicolegal learning and risk management.

CASE REPORT INDEX

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

Take me seriously

Forty-year-old hairdresser and mother-of-three Mrs T had long-term problems with neck pains and migraines. She had seen her own GP Dr W, and many of the partners in the practice, several times over the years with the same complaint. Her symptoms had been largely attributed to muscular spasms due to her job.

One day, Mrs T attended Dr W's surgery with a headache she felt was much worse than usual. She had also experienced several episodes of vomiting that morning. Although the history of migraine was well-established, the symptoms she presented with "felt different to her usual migraine". She described pain shooting down the back of her neck, which had never happened before. Dr W documented the consultation with one line in the notes, stating: "Migraine. Prescribed some painkillers." There was no evidence in the records about any history taken or examination performed.

Over the next three weeks, Mrs T attended four more times with ongoing symptoms, seeing different partners each time. She asked for a private referral to a chiropractor as she thought she had "wry neck" and simple analgesia was providing no relief.

Frustrated with the ongoing headache, she even attended the Emergency Department once but no investigations were carried out, based on the chronicity of her symptoms and her long history of migraines.

Four weeks from the onset of this latest, severe headache, Mrs T had a seizure followed by a fatal cardiorespiratory arrest. The postmortem showed that she had suffered a subarachnoid haemorrhage.

Mrs T's family made claims against all the doctors involved in her care, including hospital doctors, and the case was settled for a high sum. **EW**

LEARNING POINTS

- Those who reattend frequently with the same complaint might be seriously ill. A safe approach is to go back to basics, by documenting a thorough history and examination of the problem.
- Listening to what the patients tell you remains one of the best medical tools. A patient with chronic migraine who describes her headache as different to previous ones deserves careful attention. Try not to allow a consultation to be prejudiced by what has happened before and do not let the patient's self-diagnosis prevent you from keeping an open mind as to the cause of their symptoms.
- SIGN have produced comprehensive guidelines: *Diagnosis and Management of Headache in Adults – A National Clinical Guideline* (2008) **www.sign.ac.uk/pdf/sign107.pdf**
- NICE have similar guidance: *Headaches: Diagnosis and management of headaches in young people and adults* **http://publications.nice.org.uk/headaches-cg150**
- Headache is a common symptom and missed SAH is a frequent source of litigation. *Casebook* has featured similar presentations of SAH in the past, which may be of interest:
  - MPS *Casebook*, Not just another headache, 17 (3) (2009)
  - MPS *Casebook*, Sudden first and worst, 16 (1) (2008)
  - MPS *Casebook*, Sudden, first and worst again, 16 (2) (2008)
- If aneurysmal SAH is treated urgently, complications can be reduced. Kowalski et al noted that misdiagnosis of SAH in patients who initially present in good condition is associated with an increased mortality and morbidity. They suggest a low threshold for CT scanning and highlight the importance of immediate aneurysm repair – stating that rebleeding occurs in 26%-73% of patients within days or weeks if left untreated. Kowalski R et al, Initial misdiagnosis and outcome after subarachnoid haemorrhage, *JAMA* 291(7):866-869 (2004) **http://jama.jamanetwork.com/article.aspx?articleid=198199**
- Remember the importance of lumbar puncture – CT scans may often come back negative.
- Ensure that you keep accurate records, as when a claim is made, evidence is collected from a number of different sources and records may be cross-referenced. For example, hospital records on admission may contain a history that is very relevant in a claim relating to a GP's earlier actions.

Missed breast cancer

Mrs B was a 35-year-old housewife with two children. She was well-known at her GP surgery since childhood and had needed support with a troubled past. She had suffered abuse as a child and domestic violence in her first marriage. She attended the surgery very frequently with anxiety issues and lots of minor ailments. She would have a list of things that she wanted to discuss each time she attended and consultations would frequently take a long time.

Some years ago, Mrs B had been referred to the breast clinic and was diagnosed with fibrocystic disease. Mrs B mentioned several times on her way out of the doctor's room of having sore and lumpy breasts. Several of the GPs she had seen had documented this as part of her lengthy consultations and she was examined several times. This, however, always seemed to be part of a "by-the-way" mention rather than a full and detailed examination. Mrs B felt anxious about her breasts and continued to report this when she saw her GP about other things.

Dr T knew Mrs B well and found her to be a challenging patient. He struggled to be able to separate her physical and psychological issues, which were often intertwined. Mrs B always seemed very emotional about her personal problems and Dr T knew he would always run late after he had seen her. He found her increasing breast discomfort was difficult to assess. Dr T had wanted to give fuller attention to Mrs B's breast symptoms and had asked her to return on another day for a new assessment, but she had failed to attend.

Dr T's partners also saw Mrs B many times with multiple symptoms and issues. A breast examination had been documented several times by different GPs and always mentioned lumpy breast tissue. Fibrocystic breast disease was mentioned on each occasion. After 12 months she was eventually referred to breast clinic with her persistent symptoms. She was diagnosed with breast cancer. Unfortunately, her disease was quite advanced and she needed a mastectomy and chemotherapy.

Mrs B made a claim against the doctors at her surgery for the delayed diagnosis. The case was settled for a moderate sum.

AF

LEARNING POINTS

- Fibrocystic breast disease is a diagnosis of exclusion. If symptoms persist the diagnosis needs to be challenged on a regular basis. The initial diagnosis could have been wrong or it may have evolved into something else.
- Continuity of care is important, especially in reviewing the nature of a breast lump over time. This can be difficult in busy surgeries with many GPs but it is good practice to ensure that it is the same doctor each time in order to make the comparison objective. As more healthcare professionals are involved in a patient's care, comprehensive notes and good communication are important.
- NICE has published guidance on *Improving Outcomes in Breast Cancer* (28 August 2002). It has a useful section on managing breast lumps which GPs should be familiar with. The document makes several recommendations, some of which are outlined below:
  1. All patients with possible or suspected breast cancer should be referred to a breast clinic without delay.
  2. Urgent referral (within two weeks) should be arranged for:
     - Patients aged 30 or over with a discrete lump in the breast
     - Patients with breast signs or symptoms which are highly suggestive of cancer. These include ulceration, skin nodules, skin distortion, nipple eczema, recent nipple retraction or distortion (<3 months) or unilateral nipple discharge which stains clothes.
  3. Breast lumps in the following patients or of the following types should be referred but not necessarily urgently:
     - Discrete lump in a younger woman (<30 years)
     - Asymmetrical nodularity that persists at review after menstruation
     - Abscess
     - Persistently refilling or recurrent cyst.
     - **www.nice.org.uk/nicemedia/pdf/Improving_outcomes_breastcancer_manual.pdf**
- Beware of "by-the-way" mentions from patients on their way out of the surgery. Sometimes they hide serious pathology. If there is no time for a full assessment, arrange a new, later appointment.
- Challenging patients may require particular care. Patients with complex psychological, social and psychiatric needs can, and often do, have physical problems. There is an interesting article about challenging patients in *Casebook* (May 2009). It has some insightful case reports and tips on management.
- Patients that don't attend their appointments raise several issues. Where does the doctor's responsibility end? What should GPs do about it? It may be useful to have a practice meeting to discuss this and consider developing some practice guidelines about safety netting for "did not attend" patients.
- Breast cancer is the most common form of cancer-related clinical negligence claim against GPs – making up one in ten cancer claims (MPS press release, *One in ten cancer claims relate to breast cancer – MPS reminder for doctors to be vigilant*, 25 October 2012). **www.medicalprotection.org/UK/press-releases/One-in-ten-cancer-claims-relate-to-breast-cancer**

Back with back pain

Mrs S was a 35-year-old shopkeeper with an established history of recurrent UTIs, which had responded well to antibiotics. An ultrasound in the past had confirmed kidney stones.

She presented to her GP, Dr F, complaining of back pain for the past six weeks and tingling in her right leg, which was relieved by lying down. Dr F took a full history and examined her back, including a neurological examination. Dr F diagnosed Mrs S as having sciatica, exacerbated by lifting heavy boxes in the shop. Dr F prescribed regular analgesia and advised her about careful lifting and gentle exercises.

However, the pain continued to worsen. Dr F saw her again four weeks later and this time was concerned as Mrs S was having difficulty walking. She was referred for physiotherapy.

Whilst waiting for the physiotherapy appointment Dr F saw Mrs S again, this time with symptoms of a urinary tract infection including frequency and urge incontinence. Again a urine sample was sent to the lab and confirmed a urinary tract infection, which was treated successfully with antibiotics.

Mrs S's back pain and right leg sciatica continued to deteriorate to the extent that she could not sit and she returned to the surgery again. Dr F was concerned about the repeated urine infections in association with back pain and the recent onset of incontinence, and informed Mrs S that she felt an ultrasound scan of her urinary tract system would be prudent. A urology referral was made and a CT scan confirmed a renal stone and a retroperitoneal mass. Mrs S had further investigations for the mass and was eventually diagnosed with non-Hodgkins lymphoma.

Mrs S was very upset when she was diagnosed, as she felt the back pain had always been due to the mass, and she made a claim against Dr F for failing to refer her earlier.

Experts who looked into the case agreed that the management had been appropriate and Dr F had acted like any other reasonable GP would have at the time. The experts also found that although some of the examinations weren't examples of best practice, they were not below an unacceptable level. At no time was an urgent or emergency referral warranted.

The case was discontinued after a detailed letter of response was sent.

MR

LEARNING POINTS

- Back pain is one of the commonest complaints seen in general practice. Doctors may easily disregard back pain but it is important to keep in mind that a small proportion of them mean serious or life-threatening pathologies.
- Taking a good history and examining the patient regularly when they attend without a firm diagnosis with back pain is important, even if they come with a recurrent complaint. Re-examine if there is any change in symptoms. Good documentation of history and examination is safe practice. This helps other clinicians to understand the history of a complaint better. It can be the basis of a good defence if a case ever becomes a claim.
- When patients attend with different symptoms and illnesses at the same consultation, differential diagnosis can be more complex and therefore greater awareness is necessary.
- Keep up-to-date with guidelines on best practice for back pain. The NICE guidelines for low back pain can be downloaded here: **www.nice.org.uk/CG88quickrefguide**. This covers management of musculoskeletal back pain but not malignancy, infection, fracture and inflammatory conditions such as ankylosing spondylitis. Remember these alternative differential diagnoses when assessing a person with back pain.
- Failure to diagnose is not inevitably negligent. There was a careful, well-documented assessment of the patient on every occasion.

Ignoring the guidelines

Mrs H, a 23-year-old professional photographer in her first pregnancy, was pregnant with twins. The pregnancy progressed without any complication, until week 36 when she went into preterm labour. Mr L was the obstetrician on duty. As the first twin was a breech presentation, an emergency caesarean section was performed under spinal anaesthetic and both twins were delivered in good condition.

Soon after the procedure, whilst still in the recovery room, Mrs H began bleeding steadily vaginally and became hypotensive. She was resuscitated with intravenous fluids. Mr L administered oxytocin with little effect, followed by insertion of misoprostol per rectum. He did not follow hospital protocol for postpartum haemorrhage which advised the administration of ergometrine and carboprost if the bleeding continued despite the use of oxytocin. As the bleeding continued, Mr L decided to take Mrs H to theatre for an examination under general anaesthesia to identify the source of bleeding. In the meantime, resuscitation continued with blood products. During laparotomy, the uterus was found to be atonic, but there was no rupture or evidence of any retained products of conception.

Unfortunately, Mrs H's condition deteriorated and she began to develop disseminated intravascular coagulation. Mr L reported this to the patient's husband, informing him that "there were no options" other than removing the uterus. It was impossible to gain informed consent from the patient as a consequence of her clinical condition at that time. Mr L proceeded to perform a hysterectomy. Mrs H made a satisfactory recovery from her surgery, but made a claim against Mr L for his management.

Experts were critical of Mr L, as he had failed to follow the hospital guidelines on the management of postpartum haemorrhage and secondly by not considering alternative surgical options such as internal iliac artery ligation or ligation of the uterine and ovarian arteries. Furthermore, Mr L had not documented why he had not considered less radical intervention before resorting to a hysterectomy in such a young woman in her first pregnancy.

The case was settled for a moderate sum.

GM

LEARNING POINTS

- Postpartum haemorrhage remains a leading cause of maternal morbidity and mortality.
- As part of good clinical governance, obstetric departments will have guidelines on the management of massive haemorrhage.
- The management of massive obstetric haemorrhage should be included when practising emergency drills on the labour ward, as well as forming part of regular education for all staff that look after pregnant women. This would help ensure staff are familiar with local guidelines.
- The RCOG has published a guideline on the management of postpartum haemorrhage (*Green-top Guideline No. 52* **www.rcog.org.uk/files/rcog-corp/GT52PostpartumHaemorrhage0411.pdf**).
- It may be justifiable to deviate from local guidelines in an emergency, but it is very important to document any reasons for doing so.
- Women at high risk of postpartum haemorrhage should have a written management plan, including any prophylactic measures that need to be implemented. Multiple pregnancy is a risk factor for postpartum haemorrhage as a result of uterine atony.
- The decision to perform a postpartum hysterectomy can be a difficult one to make as it will have irreversible consequences. It is good practice to discuss the decision with an experienced consultant colleague.
- Women who have suffered a major obstetric complication should be offered the opportunity to discuss the events with a consultant obstetrician and senior midwife and be offered the necessary support.

No leg to stand on

Mr P, a 49-year-old taxi driver, had recently visited his local Emergency Department (ED) with chest pain. He ended up being transferred to the regional cardiac unit where, according to his brief discharge advice note, he had "emergency coronary bypass surgery (full discharge letter to follow)".

Three days later after getting home he developed aching discomfort in his right lower leg and reattended his local ED, taking the discharge note with him. He was seen by junior doctor Dr B. Dr B examined his lower leg and noted that the wound from his saphenous vein harvest site looked inflamed. He documented that there were no clinical signs of a deep venous thrombosis and discharged Mr P home with a course of oral flucloxacillin.

The following evening Mr P reattended the ED as he was still getting intermittent pain and was seen by Dr A, a more experienced junior doctor. After examining him Dr A obtained the notes from the previous day's visit and felt able to reassure Mr P that he simply had not given enough time for the antibiotics to work. Mr P specifically asked about the possibility of deep vein thrombosis, but Dr A advised him that her senior colleague had considered that on his previous visit and felt it was very unlikely. Dr A noted in a statement she wrote for the subsequent investigation that she did not bother her senior on the evening of Mr P's second visit as "he'd only just gone for a break". She discharged Mr P with some stronger painkillers.

During the next two days, Mr P rang his GP Dr X on two occasions. Dr X went through his symptoms on the phone and noted that the ED had "excluded a DVT" (he had not received any communication from the ED and had not yet received a full discharge summary from the tertiary unit). He reassured Mr P that he was happy with the assessment in the ED and that he should continue taking the antibiotics and the painkillers prescribed.

The following night Mr P, unable to sleep because of the pain, reattended the ED. By now his leg was cold, pale and mottled. Further investigation identified an embolus occluding his femoral artery, which had arisen from the site of coronary angiography he had had performed via the right groin. Despite the best efforts of the vascular surgical team he went on to require an above knee amputation.

Mr P made a claim against all the doctors who had been involved in his care prior to his last ED attendance. The claim was settled for a substantial sum.

JJ

LEARNING POINTS

- Examine your patient properly and fully – had the entire leg been assessed the femoral arterial puncture site would have been seen and may have led to earlier diagnosis of arterial problems.
- Earlier and fuller discharge letters might have similarly alerted the doctors involved to the fact that coronary angiography had been carried out.
- Reattending patients can easily be perceived as a nuisance, but should instead prompt consideration of why they are reattending.
- Do not rely on a colleague's earlier diagnosis – they may have been wrong or things may have developed further, providing clues that they did not benefit from when they assessed the patient.
- You should always seek senior input, even if it is inconvenient.
- Beware of blinkered decision-making. Doctors often use heuristic pattern recognition to make rapid diagnoses, eg, one's intuition, but this can lead to errors if the wrong pattern is recognised and alternate diagnoses are not considered.[1] Keep an open mind. Do not be afraid to rethink your original diagnosis.[2]
- Pain out of keeping with the clinical findings or diagnosis should always prompt review – and merits more than telephone advice, especially when a patient has undergone major surgery.

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All in the timing

Mr C, a 40-year-old carpenter, attended his local Emergency Department (ED) with a severe headache, vomiting, blurred vision and photophobia. These symptoms responded to analgesics and antiemetics. History and examination suggested possible intracranial pathology. The CT scan performed showed no evidence of a subarachnoid haemorrhage but did show a large tumour in the pituitary fossa.

Recently appointed consultant neurosurgeon Mr Y was soon involved in Mr C's care. He requested immediate ophthalmology assessment and a visual field defect was excluded. Mr Y arranged a pituitary function test but proceeded before the result was available. Mr Y discussed the problem with Mr C and informed him that due to possible pituitary pressure on the optic nerves there was a high risk of blindness, and growth of the tumour might affect the function of the pituitary. Mr C agreed to immediate surgery.

Mr Y had very little experience of pituitary gland surgery. He chose a surgical approach that he felt familiar with, a left-sided fronto-temporal craniotomy, adopting a subfrontal and transsylvian approach to remove the tumour. The procedure was complicated as the tumour was very friable.

Postoperatively Mr C had a dense hemiparesis. A repeat CT scan revealed extensive capsular infarct on the left side of the brain and a lacuna infarct on the right. It took several months for Mr C to recover any independence and he was left with right-sided permanent neurological damage with hemiparesis. Subsequently he was also found to have raised prolactin levels and ACTH and gonadotropin deficiencies requiring hydrocortisone and testosterone. He made a claim against Mr Y.

Expert opinion was critical of Mr Y's management on various counts. Preoperatively Mr C had normal vision so he was not at immediate risk of blindness as a consequence of pressure on the optic nerve. However as the tumour enlarged he may have been at risk of pituitary infarction (apoplexy), further affecting the hormonal function of the pituitary gland. Cases such as this are usually managed jointly with an endocrinologist who will assess the function of the anterior and posterior pituitary, by appropriate biochemical tests, such as stimulatory hormonal testing, and for posterior pituitary, a prolactin level.

Medical management could delay surgical intervention if the optic nerves were not at risk and the tumour size did not suggest a risk of infarction. The experts were also critical of the surgical approach, which was not in line with usual practice. They agreed that there was no clinical indication for the urgency with which this procedure was undertaken; had an MDT assessment been undertaken he wouldn't have had surgery.

The case had to be settled for a high sum.

CS

LEARNING POINTS

- Patience and an awareness of one's own expertise and knowledge are vital to practise safe surgery. It is rarely appropriate to rush into a procedure, particularly if this means there is a risk of taking an incorrect or risky approach.
- A surgeon may need to take rapid and difficult decisions intraoperatively; however, preoperatively it is important to take appropriate time to review all investigation and treatment options to ensure the best outcome for the patient.
- In medical practice recognising one's limits (cognisance) and accepting that something may go beyond one's expertise and training is essential for good medical practice. This might be particularly hard for newly-appointed consultants eager to establish their clinical practice and expertise to their senior colleagues.
- It is important to gather all the facts available to define the clinical situation of the patient before deciding on any management plan. It is here that joint or team working may be appropriate and helpful. In retrospect, in this patient, there were a number of unanswered questions such as the precise nature of the lesion; whether more tests should have been carried out to define the situation; whether the surgery was needed at that time; and whether the patient was at risk of pituitary apoplexy.
- Working as a team provides an extra safety net to medical practice. In areas such as pituitary surgery, it is common practice nowadays to work in conjunction with the endocrinology team, who can give advice on the medical investigations to define the patient's problem and assist in postoperative hormone replacement as appropriate.

Short-sighted surgery

Ms W, a 45-year-old secretary, had poliomyelitis as a child, which left her with a leg length discrepancy, the right leg being several cm shorter than the left. Despite the obvious cosmetic appearance and impaired functional mobility, she had never thought of having any form of treatment. However, one day she watched a programme on TV about surgery to lengthen limbs, so she asked her GP to get her an appointment to see the surgeon involved in the programme, Mr A.

Mr A saw Ms W in clinic; soon after she had a date for her surgery. Mr A did not document any counselling of the potentially serious side-effects or the intensive physical therapy that would be required after the surgery. The possibility of subsequent surgery was not mentioned, nor the frequent development of contractures at a later stage, despite physiotherapy or bracing. Ms W was only seen once prior to the surgery and, although she was provided with an information leaflet, there was very little mention of the complications of the procedure. Although the aim of treatment was to improve limb function Ms W had very high expectations and thought that her leg would be 'normal' after the operation. All the people in the TV programme had had great results. Mr A did not explain that this was not always the case, nor was the risk that she may be worse off after surgery explored.

Mr A only made brief notes at the initial consultation, the operation and follow-up with no documentation about explanation of risks and complications. Unfortunately, the postoperative progress was not good and Ms W suffered incapacitating pain.

Over the course of a few months Ms W experienced progressive stiffening of the ankle and was subsequently left with an equinus contracture. During the next few years she also developed a valgus deformity of her proximal tibia with some procurvatum. Her mobility deteriorated. The cosmetic appearance of her leg, although longer, was no better and overall her clinical condition was worse than before the operation.

Eventually Ms W made a claim against Mr A. The experts involved thought it was difficult to decide how much of her subsequent problems were due to the surgery and poor quality of follow-up, or because of post-polio syndrome. However, due to lack of adequate medical notes, to demonstrate adequate warning of risks, the case could not be defended and was settled for a substantial sum.

RM

LEARNING POINTS

- Patients can often take away unrealistic expectations from what they see or read about in the media, and increasingly in social media. In these circumstances it is even more important to explore expectations about realistic outcomes, take proper consent and document appropriately. Remember good notes at all stages are the cornerstone of your defence.
- It is important that the patient fully appreciates all that is involved, not just in the surgery but in the follow-up. This can sometimes influence the final outcome as much as the operation itself.
- This case highlights the importance of a robust consent process when using innovative techniques.
- Limb lengthening surgery is highly specialised and complex. There are numerous recognised complications and these must be made clear to the patient.
- It can sometimes take more than one discussion before the patient is able to make a fully-informed decision to proceed with surgery.
- It is important to make timely decisions.
- MPS's workshop Mastering Shared Decision Making is available via the MPS website.

Where the heart is

Fifty-five-year-old Mr R had a history of hypertension for which he was taking an ACE inhibitor. He attended his GP, Dr S, with intermittent tightening of the chest and a sense of breathlessness. He did not have any symptoms of nausea or pins and needles. Mr R felt that he was suffering panic attacks, especially as he had recently been made redundant and was experiencing financial difficulties. On examination, Mr R's blood pressure was found to be high and Dr S attributed these symptoms to anxiety. However, he arranged an ECG and routine blood tests and asked Mr R to return to discuss the results.

When the results were available, Dr S considered the ECG for any abnormalities of rate, rhythm or appearance, and looked for changes suggestive of myocardial ischaemia or infarction. He felt that the ECG was essentially normal, aside from mild tachycardia, and did not see any gross abnormality requiring emergency admission.

Two days later, Mr R attended the surgery as an emergency, complaining of chest pain, shortness of breath and nausea over the weekend. Dr S saw him before surgery began in the morning and arranged for emergency admission to hospital. The ECG and blood test results were sent along with a handwritten referral letter. Upon admission to hospital, Mr R clinically deteriorated and CPR was given; however, Mr R died within an hour of admission.The postmortem found that Mr R had a large saddle embolus in the pulmonary artery causing complete obstruction of the lumen. The left popliteal vein showed residual deep venous thrombosis and that this was the likely source of the fatal embolism.

Mr R's widow made a claim against Dr S. Expert opinion criticised Dr S for his initial diagnosis of anxiety, his failure to consider that Mr R's symptoms were potentially life-threatening and for failing to note that the ECG showed right bundle branch block and right axis deviation compatible with pulmonary embolism. Mr R should have been referred to hospital when he initially presented with chest discomfort, where a cardiologist would have diagnosed him and Mr R would have survived.

The claim was settled for a moderate sum.

MR

LEARNING POINTS

- Mr R had a number of risk factors for cardiovascular disease, including his age, high blood pressure and other symptoms that could possibly relate to circulatory problems. In any patient with chest discomfort you need to rule out serious cardiopulmonary causes with a careful history, examination and ongoing referral if warranted.
- You should refer a patient for further assessment if an ECG is abnormal if they have risk factors for cardiovascular disease. Mr R should have been admitted to hospital to exclude an MI, even if Dr S was unsure of the diagnosis, because of his risk factors for cardiovascular disease.
- Be aware of non-cardiac causes of chest pain. In this case, the history, in combination with tachycardia, pointed towards pulmonary embolism. However, the doctor only excluded a cardiac cause without considering embolism.
- Anxiety symptoms can be very similar to symptoms of more sinister pathologies. When assessing someone with a history of or new presentation with anxiety symptoms, consider risk factors for cardiopulmonary disease when taking the history, examining and arranging follow-up tests.

A challenging combination

Mr Y was a 21-year-old unemployed man who lived with his mother. He was a heroin addict and in the last few months, he had started injecting into his groin. Each day he was spending about £40 on heroin and cocaine and had recently served a prison sentence for burglary to fund his habit.

Mr Y was well-known at the practice as he had attended since his childhood. The practice had supported him and his mother with some behavioural problems at school and with issues around domestic violence before his father had left home. His mother had schizophrenia and was also a regular attender at the practice.

Both Mr Y and his mother had been the subject of discussion as practice staff were finding them increasingly difficult to manage. Lately, they had both been regularly missing appointments and were rude to staff. Mr Y frequently requested appointments for minor ailments, such as aches, pains and colds, yet upon attending he asked for methadone or pethidine. His behaviour was rather manipulative and consultations were often challenging.

During one month, Mr Y attended several times complaining of back pain and feeling unwell with flu-like symptoms. Dr S and his partners saw him and documented their history and examination. It was recorded that he was suffering with severe back pain and feeling "hot and cold". His temperature had been recorded as 38.9 degrees. Notes also stated that he had symptoms of severe constipation and difficulty passing urine. A blood test had been arranged, which showed a significantly raised ESR and white cell count – the results were not acted upon.

Mr Y began to feel worse and was struggling to get out of bed due to the severity of his back pain. His mother attended the surgery on her son's behalf to ask for a home visit, but one of the receptionists refused the request and asked that the patient attend surgery. She mentioned later that Dr S had said previously that "he couldn't do any more for the family" and that she was trying to help.

The next day Mr Y felt very weak. He tried to get out of bed and collapsed. His mother called an ambulance and he was rushed to hospital. He was diagnosed with endocarditis and discitis. Despite intravenous antibiotics he died of overwhelming sepsis. His mother was devastated and made a claim against Dr S's surgery. The case could not be defended and was settled for a moderate amount.

AF

LEARNING POINTS

- Frequent attenders can and do have serious illnesses; doctors must not let an element of "crying wolf" blind their judgment. It is important to keep this awareness and objectivity when seeing patients.
- When investigations are requested it is important to have a system in place to ensure they are acted upon if necessary.
- Effective triage is an integral part of general practice and is better based on clinical need rather than catering to the most persuasive or demanding patients. An effective triage system could help direct patients to the most appropriate appointment at the most appropriate time, and identify patients who have an immediate medical need.
- The management of patients who are drug users raises issues that may need discussing within the practice to offer better care. For example, there should be an awareness of the guidelines to support patients with addiction including where and how to refer patients for support and/or detoxification, and offer "shared care" for the management of drug misuse.

USEFUL LINKS

- DH, *Drug Misuse and Dependence: UK Guidelines on Clinical Management*
  www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf
- *Substance Misuse in General Practice*
  www.smmgp.org.uk

Over to you...

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

Slipping through the cracks

We received a large amount of correspondence regarding last issue's case, "Slipping through the cracks". We have published the letter below as an example of the concerns raised, which were similar across all the letters we received. MPS's response is also below.

›› I have read and generally agreed with most of *Casebook*'s reports over the years; however, I really do not understand the outcome here. My husband (a GP) and I (an emergency physician) cannot fathom how the GPs are involved in this case. They tried their utmost to engage this patient by recalling him, starting an anti-hypertensive and making an outpatient appointment.

If a patient does not follow up any leads offered by a GP, denies any medication/health issues and uses multiple health services, it's very difficult to see how else he could have been helped.

We understand there are many more unknown details to this case but patients have to take some responsibility for their health too.

Drs Sally and Jonathan O'Keeffe, UK


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CASE REPORTS

GENERAL PRACTICE

Slipping through the cracks

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

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

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

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

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

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

MR

LEARNING POINTS

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

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Response

Many thanks for your recent correspondence about the case report, "Slipping through the cracks". We have, perhaps unsurprisingly, received many letters and emails from members working in different specialties and different countries, expressing similar views: Why was the case settled? What more could the GP have done? Where does the patient's responsibility lie?

On reviewing the claim, there are a number of differences between the facts of that case and the facts described in Casebook*, such that the material omissions (failure to adequately monitor or manage significant hypertension in presence of multiple cardiovascular risk factors) which led to expert criticism in the case, do not appear in the account given in* Casebook.

I offer my personal apology for this – we do change details of cases prior to publication so that anonymity of the parties is preserved, but on this occasion the changes severely compromised the credibility of the case and this was not picked up by our editorial process. Indeed, it is your MPS Editor-in-Chief who has 'slipped through the cracks' on this occasion. And we have some learning points to ensure that this does not happen again.

I am heartened to some extent that so many of you have taken the trouble to put us right, but am extremely sorry if the report caused unnecessary anxiety.

Dr Stephanie Bown, Editor-in-chief

A pain in the leg

›› I cannot disagree more strongly with your conclusion that Dr C had done everything she could and should have done. Clinical examination along with "Homan's sign" should be consigned to the clinical dustbin. How many more people will die from undiagnosed DVT causing a massive PE through a clear lack of understanding? You should be shouting the message loud and clear that a normal clinical examination has absolutely no predictive value in excluding a DVT whatsoever. It is useless!

Even a Wells score of 0, which it would have been in this lady, places her in the "Low risk" group. This is not the same as no risk.

What Dr C should have done is a d-dimer. Forget her fabulous documentation. There is no clinical finding that excludes a DVT. That you defended the claim successfully is a travesty. A life was lost. A positive result would have led to a Doppler USS, which may just have saved her life.

Dr S J Wallace, UK

Nasogastric tube errors – 1

›› The article relating to errors surrounding nasogastric tube placement (*Casebook* 20 (3)) raised several important issues pertinent to both junior doctors and also radiology performance and interpretation. The article mentions specifically the timing of tube placement and imaging – as far as possible this should be done in working hours when senior doctors and radiologists are available to assist with image evaluation.

Junior doctors will need training in chest radiograph interpretation, but often these radiographs are done in sick patients and image quality is poor, making assessment difficult even for more experienced doctors. Junior doctors must be able to appreciate when they need help and should ask for senior advice if there is any doubt; all decisions and consultations must be clearly documented in the patient record.

The article covers also in some detail how to approach a chest radiograph following tube placement – it does not mention some crucial points, namely that before any attempt at image interpretation is made the reviewing doctor must check that the film is of the correct patient done at the correct time and date. This is essential, especially on ITU for example, where a patient may have multiple chest radiographs in a day – errors are still made when the incorrect film is reviewed and cleared.

There is also the issue, alluded to in the article, of getting radiographs formally reported by a radiologist, ideally on the same day for inpatient work. This is a problem area in many trusts, with often long delays in getting inpatient films reported, or in some cases not reporting them

Primary postoperative care

›› There's a theme running through increasing numbers of the recent medical incidents reported in *Casebook* that does not entirely seem to have been picked up by your case report writers and I believe is worthy of discussion. This revolves around the increasing pressure on hospital doctors and medical teams to discharge patients as rapidly as possible back to primary care.

A case in point was in the article "A normal appendix" in the May 2012 issue, where a patient subsequently found to have a Meckel's diverticulum as the source of problems was discharged one day after appendicectomy in such apparent haste that neither the consultant nor the trainee saw him, and the article also makes clear that no follow-up appointment was offered. Subsequently the patient made numerous visits to his GP and to hospital Emergency Departments before the real reason for the problem was identified.

This pressure on hospital doctors to 'get rid' of their patients back to the community is encapsulated in a set of rules known as NTFUR (new to follow-up ratios) and is being applied ever more ruthlessly across the country. A figure for the average ideal number of times a patient should be seen by a certain specialty (and not by pathology) is devised without published evidence and imposed upon specialty departments. Often the ratio is well under one to two. Lead clinicians whose departments do not stick to the figures are called in by administrators (as I have found myself) and pressured to comply.

Clearly, because hospital care is seen (often wrongly) as expensive, the stimulus for this is cost-savings. However, it should fall to us as medical professionals to point out the very considerable dangers and indeed false economies. Firstly there is often no continuity of care because GPs understandably often feel unable or unwilling to deal with the nuances of postoperative care. Patients such as that in "A normal appendix" suffer needless delays and sometimes injury in reaching the real diagnosis.

Finally, over a longer period there's a massive loss of skill, experience and learning because surgery does not end at the door of the operating theatre or ward. It ends when the specialist discharges the patient from the follow-up clinic cured of his/her symptoms, and it's often during that follow-up that as a surgeon one realises one has missed something or perhaps done something less well than one might have. The changes now being forced away from us by NTFUR reduce the experience and excellence of doctors, nursing and clinical support staff. The problem applies equally in public and private practice where insurers are starting to apply the same pressures. Professional organisations and indeed our indemnity providers need to support doctors in dealing with this.

Mr Peter Mahaffey, UK


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CASE REPORTS

GENERAL SURGERY COMMUNICATION/CONSENT

A normal appendix

Mr A, a 35-year-old accountant, was admitted to hospital overnight as an emergency under the care of consultant general surgeon Ms Q. He described an acute onset of severe right iliac fossa pain. Clinical examination revealed lower abdominal tenderness with localised peritonism in the right iliac fossa. Routine blood tests revealed an elevated white cell count whilst urinalysis was negative. A provisional diagnosis of appendicitis was made and the patient was commenced on intravenous antibiotics, and kept nil by mouth pending review by Ms Q in the morning.

When Ms Q saw Mr A she was unconvinced by his physical signs and organised an ultrasound scan, which did not demonstrate any abnormality. The appendix was not visualised. Twenty-four hours later the patient's condition had not improved and Ms Q made a decision to perform an appendicectomy.

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

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

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

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

SD

LEARNING POINTS

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

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at all. Staffing/financial issues are the more common reasons quoted for reporting delays, but this area remains a medicolegal minefield and is currently the subject of a national audit on behalf of the Royal College of Radiologists.

Dr David Howlett, UK

Nasogastric tube errors – 2

›› We write in reference to the special feature article regarding nasogastric (NG) tube errors.

The guidance that you quote from the NPSA is very difficult to implement in practice in many clinical circumstances. There are unintended consequences that expose patients to risks from repeated doses of radiation with multiple x-rays and failure of delivery of nutrition or medication for long periods; as well as increasing healthcare costs. The evidence quoted in the NPSA guidance is weak and focuses on small numbers of serious adverse events, while ignoring very large denominator numbers of tens of thousands of patients who receive NG feed to put numbers into perspective.

While we were pleased to see an article highlighting this important and preventable cause of morbidity and mortality in healthcare, there was a vital omission in the discussion: the implications of acid suppressing drugs for confirmation of NG tube position. Many critical incidents occurring with misplaced NG feeding tubes occur in ventilated critically ill patients. This group of patients frequently receive prophylaxis against stress ulceration with either an H2 antagonist or proton pump inhibitor, in line with national and international standards of care for ventilated patients.

The administration of these drugs frequently results in gastric aspirate that is above pH 5.5, necessitating a chest x-ray as proof of correct NG placement. The bullet point relating to repeat checks states that NG tubes "can be dislodged so they should be checked every time they are used, by aspirating and confirming a low pH, and only x-raying if this is not the case" – this needs further clarification. In a group with increased gastric pH this would mean a chest x-ray every time an NG drug is administered – possibly multiple times over the course of a day. We would suggest that

for ventilated critically ill patients the wording should be changed from "every time they are used" to "if there is any suspicion of displacement". This can be aided by ensuring that the cm marker at the nostril following insertion is clearly documented and checked every time the NG tube is used.

The guidance also has implications that extend far beyond critical care. There are many patients in community hospitals and rehabilitation units receiving NG feeding, who will be receiving concurrent acid suppressing drugs. There are large numbers of confused patients who repeatedly pull out NG feeding tubes and multiple x-rays on a daily basis and who are impossible to sustain. In many of these units there may not be direct access to x-ray facilities available. The guidance makes the maintenance of regular adequate enteral nutrition and medication administration impossible for large groups of patients, and should be revised. The major difficulty with that is that the NPSA was abolished last year and there is no mechanism for revision.

Dr Neil Young and Dr Brian Cook, UK

Skipping over the details

›› "Skipping over the details" (*Casebook* Vol 20(3), p14) raises an interesting point. It was a year from the first consultation to the next. At first sight this seems surprising; why ever did the patient not come back sooner; is the doctor really so responsible for the late presentation? After all, doctors can only ever offer reassurance that is relevant at the moment in time it is given, not that there will not be a problem later. GPs are well aware of how presentations may change over time; that a significant diagnosis may not be obvious at first presentation. Indeed the observation of illness over time is an essential part of our trainee GPs' learning experience.

Patients on the other hand seem to treat the reassurance as not anchored in time as it were, and treat it as if it could be considered as ongoing: "The doctor told me it was alright six months ago, so it's ok now…" It seems that the lay belief is that all problems are obvious from first presentation. Perhaps patients also underestimate the time it was since they last consulted about the problem and thus falsely believe that the reassurance is more recent than it actually was. From our point of view it all seems so unfair.

While this might raise the possibility that patients could consult too soon and be given false reassurance before the problem becomes clearer, the issue for us is to communicate the need to reattend if the problem gets worse, or other symptoms develop. So: are we approachable? Can we somehow give permission in advance to come back as well as showing a personal interest? A phrase offered to our trainees to adapt is something along the lines of: "If this thing misbehaves itself in any way I want to know about it…" Trainee GPs would be asked to record a contingency plan (in this case an ultrasound scan) to give some idea of what is expected. Another possible technique is to inject some deliberate uncertainty such as "I think that's OK, but you must let me know if…"

Dr Paul Vincent, UK

The internet: target practice?

This letter refers to an article that was in our UK edition only. To read it, visit: *www.medicalprotection.org/uk/casebook-september-2012/getting-the-best-out-of-online-reviews.*

›› The suggestions in the article "Getting the best out of online reviews" by Neil Bacon surprised me since they are the exact opposite of what I'd advise. I'm not aware of "powerful benefits" of online reviews. What is possible is that anyone may write anything they like about a doctor. There is no peer editing, there is no restriction, the writer cannot be identified (they might not be who they say they are) and there is no sanction against a derogatory or even malicious review.

Dr Bacon says that reviews are the norm in other service sectors. There have been documented cases of damaging reviews written by rivals of commercial organisations, the writer never having partaken of the service on which they are commenting. The motive is plain: to put a competitor out of business. Tracking these people down requires cyber detective work and there is no guarantee of success. The derogatory information might even be passed through a server in another country so it becomes difficult to invoke UK law – which itself offers scant protection anyway.

Hoping that a site is "secure, robust and has proven systems to prevent abuse" is no more than wishful thinking. Nothing on the internet is that secure. How does a doctor "ensure" that a site is secure, anyway? How many of us would understand the security measures in place, let alone be allowed to know their exact nature and function?

Information on one website quickly spreads and copies appear on others. Look at how social networks have become the new playground for school bullies. It just takes one disgruntled patient to ruin your reputation through the web – and you can't stop it. The greatest difficulty is removing adverse comments. There is no enforcement to make sure this happens. Many websites have no direct means of contacting their operators, there's no compulsion to reply to any email you might send them. Finally, what if you disagree with something an identifiable patient says about you? Any reply would be breach of confidence; it's the same problem as when trying to handle adverse newspaper publicity.

There are various branches of engineering – civil, mechanical, electronic, etc. The new discipline of socially-appropriate engineering is now becoming recognised. Of any technical achievement, it asks not can we do it, but should we do it? Yes, you can hand out cards to encourage patients (or anyone) to publish comments about you on the internet. Should you do it? Of course not. You can stick your head over the parapet if you want, but when they start to shoot, you can't stop them.

Dr Godfrey Manning, UK

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

Reviews

★★★★☆

The Creative Destruction of Medicine by Eric Topol

Reviewed by Dr Muiris Houston, medical journalist and health analyst

Not that long ago a discussion about "digital medicine" could only be construed as a reference to rectal examination. Such has been the pace of technological change and of the digital revolution, that an updated form of digital medicine is now unquestioningly seen as part of modern medicine's cutting edge.

In his book, *The Creative Destruction of Medicine: How the Digital Revolution will Create Better Health Care*, Eric Topol, chief academic officer for Scripps Health, a non-profit healthcare system based in San Diego, argues that the digital revolution can democratise medical systems in a groundbreaking way. The creative destruction in the book's title comes from Austrian economist Joseph Schumpter, who popularised the term "creative destruction" to denote transformation that accompanies radical innovation.

Topol boldly predicts the end of 'one-size-fits-all' medicine; instead patients can look forward to personalised and customised solutions for their health problems. It is almost Nirvana-like: as we collect ever more complex medical data about ourselves we can look forward to more personalised care at the point of delivery.

Informed consumers will be in the driving seat, controlling their own healthcare based on genomic information and real-time data obtained wirelessly through nanosensors.

Social networking will play a major role as ever-widening online health communities provide us with peers whom we never meet but who become crucial guides as we come to terms with our illness.

Topol really is convincing on the technological aspects of this coming revolution. But readers may have greater difficulty envisaging the consultation of the future. What will happen in the valuable crucible of the doctor – patient interaction?

In the years ahead Topol says he expects up to 70% of office/surgery visits will become redundant, "replaced by remote monitoring, digital health records and virtual house calls". But there is no convincing narrative to back this up, leading this reviewer wanting a follow-up volume in order to be entirely convinced that Topol's transformation can work in the trenches of frontline medicine.

★★★★★

Thinking Fast, and Slow, by Daniel Kahneman

Reviewed by Dr Mareeni Raymond, GP in London

Daniel Kahneman's book was recommended to me at my GP study group, my colleague telling me it was a must-read for any doctor. The book has been a bestseller since it was published in 2011 and having just read it I can see why; I couldn't put it down.

Kahneman is an Israeli American psychologist who has published some of the most well known and important papers on the subject of behavioural psychology. This book covers some of his and his colleagues' most notable ideas, experiments and theories about decision-making, behaviour and judgment.

Although his book may at first glance appear to be aimed at business people and economists it gradually becomes obvious that absolutely anyone could relate to the book's principal ideas, and could benefit from an understanding of the psychological theories described. As doctors we need to make quick decisions about patients as well as the interpretation of clinical information and statistics. We expect our decisions to be based on experience, intuition and knowledge. However the conclusions each person draws are different and this book clearly describes the possible reasons why.

Our brains are tainted by presumptions and are subconsciously influenced by what we are exposed to in our daily lives. This is partly about cognitive bias, which Kahneman describes in the first part of this book. If you are a person who questions what is happening around you, and is interested in understanding your own thought processes with a view to improving judgment, you will be enlightened. Take for example the effect of cognitive bias: it can lead to mistakes, inaccurate judgments, irrational behaviour and illogical conclusions. Perhaps we know that we are influenced by what is around us – that isn't a new idea – but what is so powerful about this book is that it points out totally unexpected and unpredictable influences on our state of mind. When a patient walks into a room there are hundreds of reasons why you may come to a conclusion – by understanding those reasons perhaps you can check yourself – that is, think slow, rather than fast, and make better judgments.

The reader may be put off by the potential of complex 'science bits' and long words – this is not something to be worried about. It is a bestseller because it is accessible, written in an informal way, each chapter peppered with example questions, scenarios, and details of experiments that clarify the arguments made for each of the theories.

Today our minds are heavily bombarded by mass media and marketing, and Kahneman's book also helps us unravel the decisions we make outside the workplace. After reading the book perhaps having an understanding of these shortcomings will make us question our decision-making, our behavioural responses and our confidence in judgments, but hopefully in a positive way.

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www.dentalprotection.org

General enquiries (UK)

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

MPS EDUCATION AND RISK MANAGEMENT

MPS Education and Risk Management is a dedicated division providing risk management education, training and consultancy.

T 0113 241 0696
F 0113 241 0710
E education@mps.org.uk

Please direct all comments, questions or suggestions about MPS service, policy and operations to:

Chief Executive
Medical Protection Society
33 Cavendish Square
London W1G 0PS
United Kingdom

chief.executive@mps.org.uk

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

UK medicolegal advice

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

UK membership enquiries

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

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

UK student membership enquiries

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

UK GP Practice Package enquiries

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