Casebook

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MPS

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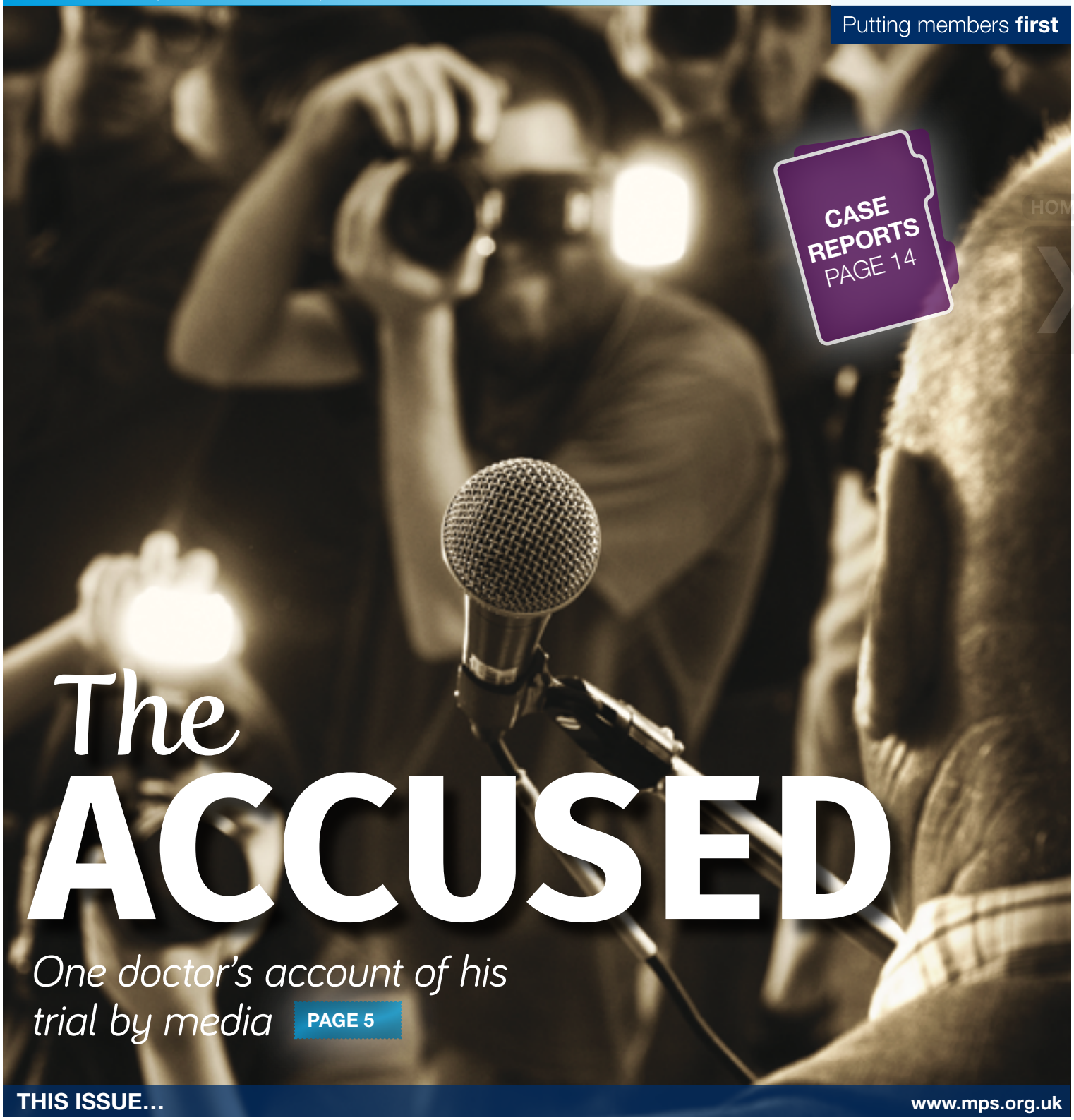

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Welcome

Dr Nick Clements – Editor-in-chief
MPS Head of Medical Services

Dr Nick Clements, MPS Head of Medical Services, has taken over as Casebook *Editor-in-chief from Dr Stephanie Bown, who left MPS in February 2014. Here, Dr Clements looks towards the task ahead.*

As this is my first column as the new Editor-in-chief of *Casebook*, I would like to say how much I am looking forward to life at the helm of a publication with a prestigious history of some 20-plus years.

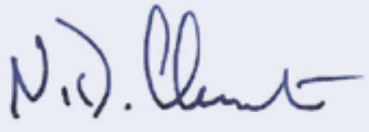
Of course, I must also pay tribute to my predecessor Dr Stephanie Bown, who left MPS in February to become Director of the National Clinical Assessment Service (NCAS). Dr Bown has been involved with *Casebook* since the May 2006 issue, and oversaw numerous successful design upgrades and a renewed focus on producing truly topical content for all of our six regional editions.

Dr Bown worked at MPS for 19 years, beginning as a medicolegal adviser and becoming head of the Medical Services department in London soon after; this after spending more than 12 years as a doctor in acute hospital medicine, then obstetrics and gynaecology before moving into general practice. Combining her editorial duties on *Casebook* and other MPS publications with high-profile external affairs work, Dr Bown also regularly appeared on radio – and once on morning TV – to protect and promote the interests of you, the MPS member.

So it is with slight trepidation but great relish that I step into Dr Bown's shoes, and build on her success with *Casebook*. My role as Head of Medical Services will continue, and I will try to use this experience to develop thought-provoking content that will be stimulating, informative and directly relevant to today's doctor, wherever in the world you practise.

The keen-eyed among you will have spotted my name in *Casebook* before, so I am not entirely new to the magazine – in addition to occasionally introducing each edition's collection of case reports, I have been on the editorial board for a number of years, helping to maintain the accuracy and educational value of each issue.

One thing will not change – and that is we continue to encourage your feedback, opinions and suggestions after each edition. Perhaps I will speak to some of you personally on our advice line…



Monday 12 May 2014

The ACCUSED

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Public exposure from complaints and claims can cause doctors to face a trial by media. In 2011, a UK GP was accused of sexually motivated conduct when he examined a patient's chest – he shares his experience with Sara Dawson

It seemed like a normal surgery day a couple of years ago. As I was signing scripts, my practice manager knocked on my door and brought in a brown envelope marked private and confidential. I opened it and read it – the contents were highly distressing. The letter contained details of allegations made by a female patient (Mrs B) that, two months previously, I had conducted a sexually motivated consultation.

I remember seeing Mrs B in early spring complaining of chest and stomach pain. Initially I offered her a chaperone, as it is practice policy; she declined, so I performed a thorough chest examination and referred her for surgery.

Her complaint was that during the chest examination I squeezed her breast, and behaved sexually while breathing heavily. She thought my front, back and side examination was inappropriate and not what she'd expected.

I was devastated to hear about the serious nature of the complaint, as it would have ramifications for me, as a doctor, and as a husband and a father, and as an upstanding member of society. My surgery staff were highly distressed and took it very seriously; I immediately contacted MPS.

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The ACCUSED

Investigation

We asked the patient to give consent so that we could send the complaint to be investigated thoroughly and in an unbiased way by the PCT (Primary Care Trust).[1] After a delay the records were shared and I gave my witness statement.

The local PCT determined that I should have a chaperone for every female consultation while the investigation was underway.

In spite of numerous attempts, Mrs B failed to engage with the PCT to give her version of events. The PCT felt they had no choice but to refer the case to the General Medical Council (GMC).

The GMC held an interim order panel meeting. Accompanied by an MPS solicitor, the panel listened to our case. They applied conditions to my registration that I was to have a chaperone for every intimate female examination, and to log each examination. The GMC's investigation took more than a year to complete and a hearing date was set, 18 months after the initial allegation.

The hearing

The first day of the hearing didn't go to plan. I arrived all geared up to defend my corner, but Mrs B did not turn up, so it was adjourned until the following day. When the hearing did commence Mrs B gave a witness statement, and there was a submission from my MPS-instructed barrister, then the panel went away to decide the next course of action. The next day the panel gave their decision that they found the allegation untrustworthy and uncorroborated, and the case was concluded.

Personal impact

The experience of having a patient make an unfounded allegation against you is devastating; I would not wish it on my worst enemy. The insecurity you feel day in and day out is worse than physical pain. There were days where I could not see any light at the end of the tunnel, like my head was under a guillotine. My mind was fractured; I kept thinking 'why me, why did this happen to me?'

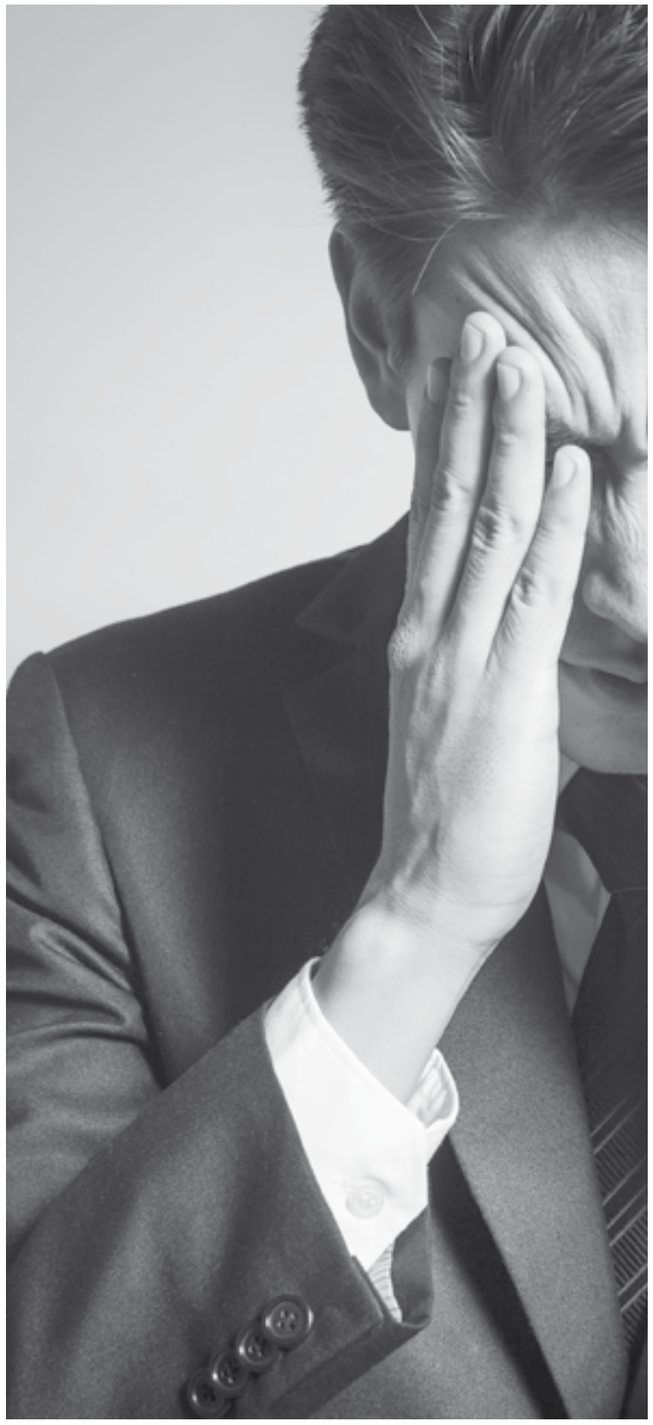
As a doctor this experience was earth-shattering: it's the worst thing to be accused of – an allegation of sexual motivation; how can you prove you were acting appropriately? It's their word against yours. If the GMC had found in Mrs B's favour, my license, my livelihood, my marriage, my social standing would have been demolished just like that.

During the investigation I went to work as normal. Every day I had to face the stigma around me of what I had allegedly done.

Impact on the practice

It was particularly hard on the practice, having to have a chaperone from beginning to end. We were not just employing a GP, but two healthcare professionals at the same time. This had huge financial and logistical implications for the practice. Not being a big practice we don't have many nurses or staff, so it was difficult.

We had to consider the future of the business: if I were to be found guilty and forced to leave, how would the practice cope?



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Handling the media was not something I'd really considered. I'd definitely never thought about being on the front page of a national newspaper.

Media coverage

Handling the media was not something I'd really considered. I'd definitely never thought about being on the front page of a national newspaper. We were all worried about it: what would patients do? The stories were angled in a certain way that assumed I was guilty – it would have been nice to be captioned in a different way. I remember, during the hearing, getting messages from friends asking if I was ok, as they'd seen the coverage.

Even abroad, it was all over the internet. The pressure was huge and so upsetting. My name was exposed, I'd lost my anonymity – I was breakfast gossip. There was a sense of bias – why was I stripped of my anonymity when the person who made the allegations enjoyed full anonymity? The media coverage added salt to my wounds.

Support

Throughout the process I worked closely with the local medical committee, my MPS legal team, and the PCT. Without the understanding and professionalism of these people it would have been a much more difficult time. I drew strength from the fact that I knew I was professional and hadn't done anything wrong – I believed the truth would come out in the end.

I'm most proud of the way the practice dealt with the whole thing – we pulled together like a family. From the first day, I was honest about the allegation and discussed it with my staff, my patients, my family and my colleagues; from then on I informed them of all the developments. I could not have survived the experience if they hadn't supported me.

I always wanted to be a professional GP, dedicated to my practice and patients, and to be involved in the community as a doctor. Eighteen months have been wiped from my life and I will never get answers to why Mrs B did what she did, but I take some comfort in that justice has been done and I was vindicated – life goes on and I have learnt from it.

Names have been withheld to protect the confidentiality of those involved.

Legal opinion

By Dr Jo Galvin, MPS medicolegal adviser, who handled the case.

Unfortunately this case is not an isolated one. Mrs B came to the practice specifically asking for her chest to be examined thoroughly. During the examination she perceived that the actions of the GP in question, whom I shall refer to as Dr Z, were sexually motivated. Dr Z said that when he examined her, he explained what he was going to do and explained the depth and pattern of the breathing.

His situation was compounded when he locked the door to preserve her confidentiality, as the door had recently accidentally opened into the adjacent waiting room. Mrs B misconstrued this again to be sexually motivated.

Credibility

The credibility of Mrs B was undermined when she did not turn up for the first day of the hearing – she claimed that her father was in hospital. MPS requested full disclosure of the reasons for her absence. It came to light that she had sent the text message explaining her absence from her sister's house, and her father was not in fact in hospital.

Chaperones

Doctors are alive to the fact that they need to use a chaperone when performing intimate examinations, but they aren't always alive to the dangers of some examinations; for example, an accidental brush of the chest can get doctors into difficulty. An important point to make is that Mrs B's consultation was not an intimate examination – it was a chest examination – but Dr Z still offered Mrs B a chaperone.

MPS conducted an audit of Dr Z's previous consultations, and were able to prove that it was his consistent practice to offer a chaperone and document it. He'd documented contemporaneously in the notes that he had offered a chaperone to Mrs B and that she had declined – this helped his defence.

Good record-keeping

There were several important factors that further undermined Mrs B's version of events. During the consultation Dr Z also referred Mrs B to hospital to be treated for a different condition; Mrs B had no recollection of this or of visiting Dr Z a couple of weeks later about a different matter. It is unlikely that you would come back voluntarily and visit your GP again if you perceived him to have acted inappropriately.

This raised questions around Mrs B's recollection of the events. In contrast, Dr Z had documented everything contemporaneously. When there is a factual dispute, the credibility of a complainant is important. In this case there was a factual dispute and the weight of evidence was in Dr Z's favour.

His notes were further backed up by a GMC-obtained expert report about the correct standard of chest examinations; this proved that Dr Z's standard of chest examinations was appropriate.

Professional challenges

The situation presented professional challenges because Mrs B remained a patient at the practice. It is hard to justify removing a patient simply because they have made a complaint. Good practice management meant that Dr Z did not see Mrs B.

Advice

Dr Z was unlucky, but his contemporaneous note-keeping and good practice helped prove that he had not done anything wrong. He did everything he could to give himself the best protection.

Learning points

- Always use chaperones for examinations that are perceived to be intimate examinations
- Good record-keeping is essential
- Communicate effectively with your practice team
- Develop good working relationships with your staff and patients
- Expert evidence is helpful in disputes around standard practice.

For further information about chaperones and maintaining boundaries please visit the factsheets section of www.medicalprotection.org.

Ends

REFERENCES

1. Note for readers outside England: Primary Care Trusts were administrative bodies within the National Health Service (NHS), responsible for commissioning primary, community and secondary health services from providers, and for providing funding to GPs. They were abolished in 2013.

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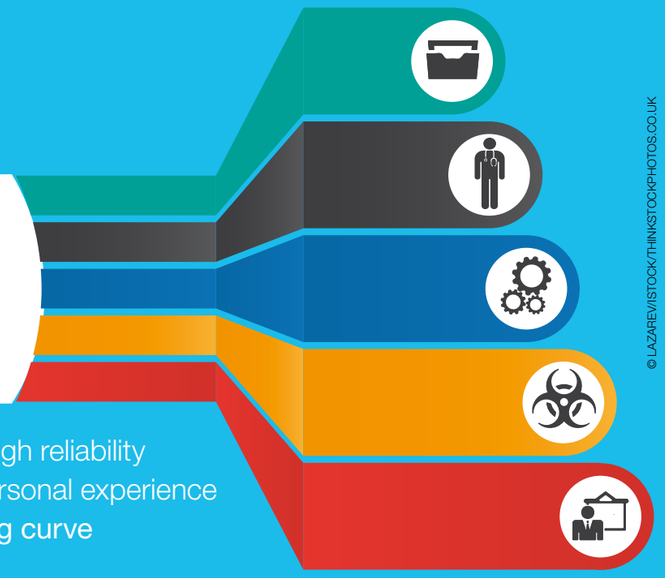

High reliability in healthcare: a personal failure

In his follow-up to last edition's article on high reliability organisations, **Dr Dan Cohen** revisits a personal experience that formed part of his own steep learning curve

With a steadily increasing focus on safety and risk aversion in the healthcare industry, much attention, appropriately, has focused on the stories that patients and family members have shared about their experiences. We have learned much, although in some instances, especially early on, we may have been reluctant to listen. Sadly, in my view, we have not always equally valued the stories that clinicians may tell about their own experiences, challenges, and even their personal needs and shortcomings.

As an example, I would like to 'fillet' myself and reveal a personal story that has affected me throughout my career. This is a story of multiple system and personal failures, fortunately embellished by transparency and honest disclosure long before these became everyday terms in our patient safety vernacular.

The incident

A, a ten-month-old girl, was admitted to an internationally prominent children's hospital at the weekend for evaluation of a kidney mass, likely a Wilms' Tumour, a highly curable childhood cancer. I was the paediatric oncology fellow (senior registrar) covering the service for the weekend. This institution's Wilms' Tumour protocol required the oncology fellow to administer Actinomycin-D intravenously as soon as the renal vein had been clamped at the time of surgical removal of the tumour. I wrote the orders correctly and legibly using our standard double-check process and then things became complicated…

In addition to covering the inpatient oncology service (about 25 beds in this large centre), I had additional weekend obligations for the outpatient clinic and a two-bed bone marrow transplant unit located in different, though adjacent, hospitals. Usually this multiple coverage obligation was not a problem, but on this particular weekend, two children with leukaemia were to receive outpatient L-asparaginase chemotherapy, and I had to be present in the clinic because of the substantial risk of allergic anaphylactic reactions. I could not be in clinic and the operating theatre at the same time. Recognising this dilemma, I arranged for the anaesthesiologist on A's case to administer the chemotherapy and briefed her thoroughly regarding the dosage, even providing a copy of the prescription. She and I had worked together for several years and I trusted her. She gladly offered to administer the medication.

Unfortunately, an emergent cardiac surgery case occurred on the same weekend and the anaesthesiologist, being 'pump-qualified', had to take responsibility for that case. She briefed a substitute anaesthesiologist and felt that the situation was well in hand. However, the pharmacist made a decimal point error and instead of preparing a dose of 97 micrograms of Actinomycin-D, he sent up a syringe containing 970 micrograms. The substitute anaesthesiologist did not recognise the error. This massive overdose was administered intraoperatively.

It was not until several hours later that the error was identified. While I was making evening rounds, I saw the syringe that had contained the Actinomycin-D, still attached to A's medical record (a standard procedure at that time), and the label revealed the dosage error. I was shocked! Although not immediately toxic, the effect on this child's bone marrow would be profound, beginning about a week after administration. I was reasonably certain that this child was going to die – and I was ultimately responsible!

I called my consultant immediately and, after calming me down, he said some things that really resonated. "Dan, we do not know that A is going to die. We can expect that she will encounter severe bone marrow suppression and gastrointestinal toxicity, but we do not know the outcome of that, and we need to be factual when we talk with the family."

The following morning we met with A's parents. My consultant wanted to take the lead in the conversation but I insisted that as A was my patient I wanted, and needed, to do the talking. I was the one who had originally met with the family and this was my responsibility, not his.

I carefully explained to the parents that A had received a higher than desired dose of medication and that we were very concerned about this. I apologised for this error and explained that we would investigate this further in order to ascertain how it had happened. I promised to correct any discrepancies in care identified in order to prevent this from ever happening again and then outlined the steps we would take to protect A.

I promised the parents that the comprehensive resources of our institution would be mobilised to support A. I did not tell them that I thought she would die because her death was not a certainty, and voicing my concerns would have served little purpose.

Our investigation revealed the following:

System problems

- The protocol for intraoperative chemotherapy was not evidence-based, ie, it was anecdotal and experimental, and there was no informed consent for this.
- A single oncologist was responsible for coverage in multiple hospital settings, which, although usually manageable, set the stage for conflicting obligations.
- A cultural barrier forestalled calling for backup unless there was a dire emergency.
- Not all anaesthesiologists were qualified for all procedures.
- There was no pharmacy double-check process for chemotherapy orders.

Personnel accountability issues

- The primary anaesthesiologist did not inform the oncology fellow regarding the emergent coverage changes.
- The pharmacist erred in preparation of the Actinomycin-D.
- The substitute anaesthesiologist administered an unfamiliar drug without self-identified need for verification of dose or knowledge of side effects.
- I did not call for qualified back-up!

So – what happened to this little girl? Although she encountered profound bone marrow failure and spent three weeks in isolation with much procedural pain and fear, she came through her experience wonderfully and was cured of her Wilms' Tumour.

Harm and hazards

Though the goals of healthcare professionals are coloured by altruism and compassion, a closer examination reveals that many of our processes for providing care are insufficient, even flawed; and patients continue to be harmed, sometimes fatally. Our hospitals, in particular, are highly complex and hazardous environments, not only for patients but also for staff. Dangers lurk and complacency is pernicious and harmful.

A quintessential characteristic of high-reliability organisations is reliance on the advice and knowledge of those on the frontlines of processes, those at the tip of the spear. In most industries we identify frontline staff as those working where "the rubber meets the road", and in healthcare this would mean the clinical staff who actually talk to patients and provide care.

However, in healthcare the calculus is even more complicated because the best and safest outcomes require intimate patient and family member engagement and collaboration. Therefore, in this expanded framework, patients and family members are components of the healthcare system, both on the frontline and as experts. Clinicians, patients and family members are frontline experts in their respective domains, and we need to listen to all of them.

Professor James Reason's 'Swiss cheese' metaphor for accident causation is a highly regarded model of how multiple aspects align in causality and how there are prevention barriers that usually, although not always, work to prevent harm.

The lessons

1. If the healthcare industry is to truly function as a highly reliable organisation, then the kinds of challenges and variances portrayed above must be anticipated beforehand so that appropriate failsafe mechanisms can be established to provide for all contingencies. This child deserved better from the system, from me, and from others. The Swiss cheese barriers hadn't worked.
2. Transparent and timely disclosure should be the gold standard for patient care. We are obligated to tell our patients the truth when things are good…and when things are bad.
3. Clinicians are often collateral or 'second victims' of patient safety incidents and principles of high-reliability require that hospitals provide necessary support within a just culture framework.

Doctors and nurses do not wake up in the morning intending to harm patients. We go to work each day with every intention of helping our patients. We expect the systems and processes in our workplace to support us in achieving that goal; in other words, we want to work in highly reliable, safe, collaborative and just organisations.

Dr Dan Cohen is International Medical Director for Datix Ltd (www.datix.co.uk), a patient safety and risk management company whose software application enables users to spot trends as incidents/adverse events occur and reduce future harm by prioritising risks and putting in place corrective actions. Dr Cohen can be reached at dcohen@datix.co.uk.

HOME

Medicine and manslaughter

Last year's custodial sentence for surgeon David Sellu, following a verdict of gross negligence manslaughter, raised concerns within the profession. Former *Casebook* Editor-in-chief Dr Stephanie Bown met with Professor Norman Williams, President of the Royal College of Surgeons, to discuss what the ruling means for healthcare professionals

Medical manslaughter cases fall into the area of involuntary manslaughter. In English law, involuntary manslaughter takes two forms – unlawful act manslaughter and gross negligence manslaughter.

It is the latter that gives rise to charges against healthcare practitioners.

Medical manslaughter – the background

The law, as it stands, was stated in the case of *Adomako (1995) 1 AC 171*. In this case the defendant, an anaesthetist, failed to notice for six minutes during an operation that the oxygen supply to the patient had become disconnected from the ventilator. As a result the patient suffered a cardiac arrest and died.

The House of Lords affirmed the conviction, and the elements of the offence were specified as:

- **The defendant owed the victim a duty of care**
- **The defendant breached that duty**
- **The breach caused (or significantly contributed to) the victim's death**
- **The breach was grossly negligent.**

The key point is that it is a matter for the jury to determine whether the breach was grossly negligent.

In summing up, Lord MacKay stated: "The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal…The essence of the matter…is whether having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgment to a criminal act of omission."

The law as it stands has been criticised on a number of counts, but particularly because the reach of the criminal law in this area is left to be determined by the jury.

When parliament enacted the Coroners and Justice Act 2009, no change was made to involuntary manslaughter; the reforms being confined to voluntary manslaughter. Observers at the time thought it unlikely any further reform of homicide would take place in the foreseeable future.

Doctors in the dock

In 2006, a paper[1] published in the *Journal of the Royal Society of Medicine* by Ferner and McDowell looked at the number of doctors charged with medical manslaughter between 1795 and 2005. The review found that 85 doctors had been charged with manslaughter in the UK since 1795, 38 of them since 1990. Of these 60 were acquitted, compared to 22 recorded convictions and three guilty pleas.

Other widely-reported cases include:

Dr Feda Mulhem (2003)

Wayne Jowett, 18, was in remission from acute lymphoblastic leukaemia, and had entered the maintenance phase of his treatment. In January 2001 he was inadvertently given vincristine intrathecally.

The sequence of events leading to this were complex and involved multiple errors and breaches of protocol by a number of staff. An analysis of the circumstances can be found online.[2]

Despite this, the registrar, Dr Mulhem, was charged and convicted of manslaughter in 2003. He was sentenced to eight months, and a further ten months on unrelated assault charges. As he had already served 11 months on remand, he was released from custody. The GMC subsequently suspended him for 12 months.

The law as it stands has been criticised on a number of counts, but particularly because the reach of the criminal law in this area is left to be determined by the jury. When parliament enacted the Coroners and Justice Act 2009, no change was made to involuntary manslaughter; the reforms being confined to voluntary manslaughter.

HOME

Mr Steven Walker (2004)

Mr Steven Walker was found guilty in 2004, after changing his plea to guilty, of the manslaughter of a female patient who suffered catastrophic blood loss during an operation to remove a liver tumour in 1995. He admitted he should have stopped the operation after finding the tumour was double the expected size and close to key blood vessels. Mr Walker received a 21-month suspended jail sentence and was erased from the medical register in 2005.

In November 2013 the case again hit the headlines when Mr Walker applied for restoration to the register.[3] Following adverse opinion, he withdrew his application.

Dr Michael Stevenson (2007)

A 54-year-old GP, Dr Stevenson admitted manslaughter after a patient died in 2005 when he injected six times the required dose of diamorphine for migraine. He made the same error on his next visit, but the second patient survived. He received a suspended sentence of 15 months in 2007. The GMC erased him from the register in September 2009.

Dr Bala Kovvali (2013)

Dr Kovvali diagnosed depression in a middle-aged patient who died shortly afterwards from diabetic ketoacidosis. He pleaded guilty to manslaughter and received a two-and-a-half year custodial sentence. An appeal against the length of sentence was unsuccessful, and he was subsequently erased from the medical register.

Mr David Sellu (2013)

This recent case resulted in a custodial sentence of two and a half years.

The case involved a patient admitted to a private unit for a knee replacement. Postoperatively the patient developed abdominal symptoms and Mr Sellu was asked to review the patient.

The patient subsequently died following a laparotomy, and it was alleged that there had been an inappropriate delay in the diagnosis and treatment of a perforated bowel.

The experts for the prosecution and the defence disagreed over whether Mr Sellu's actions were reasonable in the circumstances. The conclusion was that there was a lack of urgency in the investigation and treatment of the patient.

The custodial sentence imposed on Mr Sellu has caused surprise and consternation among the medical profession. As President of the Royal College of Surgeons, Professor Norman Williams has been uniquely placed to hear the concerns of Mr Sellu's wider surgical fraternity.

On the defensive

Although one can reasonably observe that the David Sellu case simply reflects the times in which we live – and more specifically the level of expectations patients have of us – the consequences mean that there is a real risk for doctors to practise defensive medicine. This is, of course, the pursuit of unnecessary investigations – the ordering of tests, treatments, etc, that help protect the doctor rather than to further the patient's diagnosis.

Dr David Studdert identified two types of defensive medicine:

- Assurance behaviour (positive defensive medicine) – providing services of no medical value with the aim of reducing adverse outcomes, or persuading the legal system that the standard of care was met, eg, ordering tests, referring patients, increased follow up, prescribing unnecessary drugs.
- Avoidance behaviour (negative defensive medicine) – reflects doctors' attempts to distance themselves from sources of legal risk, eg, forgoing invasive procedures, removing high-risk patients from lists.

Defensive medicine can make your practice more risky. Unnecessary treatment – particularly invasive procedures – could actually increase the risk of litigation. Some tests have their own inherent risks and doctors could potentially be criticised for ordering investigations that are not in patients' best interests (eg, if the risks associated with the procedures outweigh any potential benefit to the patient).

Professor Williams says: "I suppose patients have always expected very high standards but they also had a high level of trust in us and that trust has been eroded in recent years, with the problems with Mid Staffs. We have to understand that. Yes, we can bridle, it's unfair, but that's not the point here; I think we have to accept that. Therefore we have to be meticulous in exactly what we do and also we have to record everything very carefully."

Protecting yourself

Professor Williams sees the practical implications of the Sellu ruling as reiterations of long-established advice.

He says: "I think doctors have to ensure that they write everything down that relates to a consultation, such as management plans, etc. It's no good relying on verbal instructions, so you have to be very clear – and handwriting has to be legible.

"You have to be candid with patients and tell them what you are planning to do; informed consent should mean informed consent – you must discuss very clearly the possible pros and cons of any procedure you're about to embark on. You must make sure that the patient understands that and talks back to you to confirm they have been properly informed, and you need to judge the capacity of the patient to understand. It also goes without saying that you have to be compassionate and caring."

If things go wrong

Of course, adverse events are inevitable in medicine. Openness and effective communication in the aftermath is essential – not only is it the right thing to do, but it can be a pivotal factor in determining whether a patient makes a claim for compensation.

Professor Williams says: "First of all in any adverse event, we all have a professional duty of candour and if anything does go wrong you have to apologise, and it should be a sincere apology, not just to get you out of trouble. This should be accompanied by an explanation of what has gone wrong, and why, and how it has led to harm and what you are going to do about it. An apology doesn't mean you are liable."

Many doctors support the concept of open disclosure but have personal concerns that in responding to a patient, they may inadvertently expose themselves to further criticism or legal action – but it must be remembered that an apology is not an admission of liability. MPS has long supported a position of open communication and our advice to members is to be open when things go wrong.

This openness extends to reports to the coroner upon a patient's death. It is essential that your MDO looks at any such report before it goes anywhere else – in addition, MPS has a factsheet on the topic, available on our website: www.medicalprotection.org/uk/england-factsheets/reporting-deaths-to-the-coroner.

CONCLUSION

Looking back over many of the cases involving manslaughter convictions for doctors, some common themes emerge. They often contain serious errors by parties other than the accused; there are associated system errors – sometimes multiple; and the cases are sometimes complicated by associated factors, such as attempts to conceal or alter medical records.

Be meticulous in your note-keeping, and always be honest and open about the facts. If an incident is followed by a criminal investigation, any account of the incident will be scrutinised and challenged – with any inconsistencies leaving a doctor extremely vulnerable. MPS members involved in the care of a patient who dies should consider making immediate contact with us, to ensure expert medicolegal advice is available as soon as possible. Most importantly, in any case where there serious concerns around the sequence of events, or an indication of a criminal investigation or inquiry, make sure you take professional medicolegal advice before taking any other steps.

What lies ahead

A change in the law on gross negligence manslaughter is highly unlikely in the current climate. The Law Commission has reviewed the law twice, with the most recent review not recommending any change. The Coroners and Justice Act 2009, which was the most recent review of the law, left the law on gross negligence manslaughter unchanged.

Changes to some other aspects of cases might gain more traction, such as pushing for a specific offence of medical manslaughter, with a more appropriate definition. How the law will evolve in relation to gross negligence manslaughter in the future is uncertain, but MPS will continue to monitor events – and the potential impact on the medical profession – closely.

Words: Gareth Gillespie

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It's your call

Members call the MPS advice line about a wide range of issues. Our useful infographic reveals what you have been calling us about, and how often. The figures are taken from calls made by MPS members around the world, between January and October 2013.

- **Adverse incident** 707
- **Advice** 4,128
- **Report writing** 1,378
- **Ethics** 448
- **Complaint** 3,067
- **Disclosure of records** 1,250
- **Disciplinary** 312
- **Confidentiality** 1,964
- **Medical or Dental Council matter** 998
- **Consent** 359
- **Claim** 1,522
- **Inquest (or Fatal Accident Inquiry in Scotland)** 758
- **Criminal investigation** 60

SPECIALTY GENERAL PRACTICE **THEME** RECORD-KEEPING/DIAGNOSIS **SUBSTANTIAL** £100,000+

Concealed sepsis

Mr D, 53, had suffered with osteoarthritis in his right knee since turning 50. This had been confirmed with arthroscopy. It rarely bothered him and he continued to work as a PE teacher. He had experienced a flare-up of knee pain at the start of the autumn term but this settled quickly with analgesia.

He contacted the GP out-of-hours service on the first weekend of the Christmas holidays, complaining of two days of bilateral knee pain, which was unrelieved by his usual codydramol. A home visit was arranged. He was seen by Dr C, who documented a normal right knee on examination, but limited movement in the left knee, with positive meniscal signs and no effusion. Dr C also noticed that Mr D had a painful swollen left little finger, which he had jammed in the door two weeks earlier. Since he was afebrile, Dr C attributed the symptoms to OA and advised Mr D should also arrange to get an x-ray of his finger to exclude a fracture. She provided him with naproxen analgesia.

The pain continued after the weekend and Mr D had been unable to leave the house to arrange the x-ray. He spoke to Dr V at his own surgery and an appointment was arranged for the next morning. The following day, Mr D was still unable to get to his car and called the surgery again, this time speaking to Dr A, who agreed to a home visit.

Dr A recorded an effusion and worsening right knee pain now radiating to the calf and hip. He also mentioned that Mr D now had swelling over the dorsum of his injured hand, and he also spotted two erythematous patches on the right elbow and left foot. Mr D had not reported feeling feverish and so vital signs were not recorded. Dr A prescribed a course of antibiotics to cover for possible infection in the right hand, and documented that the knee pain was likely to be a strain. She queried gout as a possible cause and recorded that she was uncertain what the satellite lesions represented. She advised Mr D contact the surgery again the next day.

The next day was Christmas Eve and Dr B was on duty for the day. He visited Mr D at home as requested by Dr A. By now he was feeling better, and the swelling in his hand had reduced, but he was feeling "spaced out" on the codeine analgesia he was now taking. Dr B asked the patient to get out of bed for a full examination, which he was able to do. Mr D's wife recalled the doctor taking her husband's blood pressure and advising he omit his antihypertensive medication. Dr B made no record of this examination. He later recalled that he examined the patient fully, including his temperature, and as he found nothing of concern he did not make a note of this. His advice was to complete the course of antibiotics and increase his fluid intake.

Mrs D recalled that her husband became worse towards the end of the day, with slurred speech and generalised weakness. He made an attempt to go to the toilet with the assistance of his son and it took him 40 minutes. Mrs D awoke the next morning to find her husband was dead.

The pathologist who carried out the postmortem concluded that Mr D had died from complications of septicaemia, but the focus of the infection remained uncertain. He noted splenomegaly but no lymphadenopathy. Experts agreed that the cause of death was perplexing but that the knee was the least likely site, with either the hand or an upper respiratory tract infection being the most likely causes. Crucially, expert opinion agreed that if intravenous antibiotics and volume replacement had been commenced on 23 or 24 December, then arguably the fatal episode of sepsis could have been avoided.

Expert opinion also found that neither Dr A nor Dr B had recorded anything like enough to suggest that their assessments were adequate. In Dr B's case, with no clinical details recorded and no plausible diagnosis, there would be no possible chance that a court would accept that his assessment was reasonable. Similarly, Dr A had not recorded enough to show that her assessment was reasonable on 23 December.

The case was settled for a substantial sum.

EW

Learning points

- Good note-keeping is essential. In this case, recording the vital signs and patient's mobility would have demonstrated that an adequate assessment had been carried out and made the actions of the doctors involved easier to defend.
- Clinical presentation can change quickly. Expert opinion was critical of a lack of a plausible diagnosis. It is not clear from the note-keeping how unwell Mr D was when assessed by Dr A. It may have been the case that Mr D appeared so well that Dr A felt it unnecessary to document normality. However, without adequate information or a clear diagnosis to prove that a reasonable assessment was carried out, it is difficult to defend her action given the symptoms of polyarthritis with patches of erythema suggestive of infection.
- Patients should be advised on the signs to look out for and when to seek further help if they continue to feel unwell.
- Identifying sepsis early can save lives. The diagnosis may not always be immediately obvious and a high index of suspicion is required to make the diagnosis and prevent fatalities. The surviving sepsis campaign, http://survivesepsis.org is an educational resource to train healthcare professionals in the recognition and immediate management of sepsis.

SPECIALTY GENERAL PRACTICE **THEME** SUCCESSFUL DEFENCE

Headaches and hypertension

Mr J was 43 and unemployed. He developed headaches and complained that sunshine hurt his eyes and he was bothered by noise. He made an appointment with his GP, Dr A, explaining that he had tried over-the-counter painkillers but that they did not help when he had one of his pounding headaches. Dr A documented Mr J had presented with headaches with some features of migraine and prescribed some tramadol.

Five years later, Mr J was struggling with headaches. He wondered if he needed new glasses so he visited his optician. His optical prescription had changed and he was given some new glasses, but when his headaches persisted he decided to see his GP again.

Dr A documented that he was suffering with headaches that were present in the morning and in the evening. He checked his blood pressure, which was 110/80. Mr J was also complaining of toothache and Dr A suggested that he saw a dentist, in case the headaches were related. Dr A considered other causes of his headache and noted that Mr J had also complained of neck pain. He suggested some exercises for cervicalgia.

Mr J visited his dentist who referred him to a consultant oral maxillofacial surgeon. He thought his headaches were coming from temporo-mandibular joint dysfunction, possibly secondary to a tender wisdom tooth. He had his wisdom tooth extracted under sedation. His blood pressure was not taken at this time. At his review, it was noted that his headaches had improved and could be managed with paracetamol alone. Mr J felt better and had been able to find a job in a supermarket.

The same year Mr J became concerned because he saw blood in his urine. He made an urgent appointment with his GP. Dr A documented that he had no dysuria or suprapubic pain. He noted that Mr J was very anxious about it and referred him to urology to investigate his painless haematuria. There was no mention of headaches at this consultation and his blood pressure was not taken.

A month later, Mr J fell whilst stacking shelves at work. He couldn't get up and noticed that his right side felt weak and his voice was slurred. An ambulance was called and took him to the Emergency Department, where a CT scan showed a large intra-parenchymal bleed with extension into the left ventricle and midline shift. He became agitated, irritable and started vomiting. His GCS dropped to 7 and he was admitted to ITU where he was intubated and ventilated. His blood pressure was found to be 260/140. His left pupil was found to be larger than the right and was unreactive.

Mr J had a left frontal craniotomy, releasing 230ml of haematoma blood. He remained ventilated for over a week because of issues with high blood pressure. Mr J was found to have left ventricular hypertrophy on ECG and impaired renal function. His hypertension persisted after he was extubated and he was found to have grade 2 hypertensive retinopathy.

A month later, Mr J was discharged home but had developed epilepsy and significant cognitive impairment. He needed neurorehabilitation, was unable to work, and required care.

At his nephrology follow-up, his blood pressure was 150/100 despite four antihypertensive drugs, but there was no evidence of LVH on echocardiogram.

Mr J made a claim against his GP. He felt that the diagnosis of hypertension had been missed and the delay in treatment had caused his brain haemorrhage. It was alleged that Dr A had failed to take his blood pressure despite persistent headaches and haematuria. He believed that Dr A had diagnosed somatisation headache without examining him.

Expert GP opinion had only one criticism of Dr A, in that he failed to examine the optic fundi when he presented with headaches in the morning. The opinion of a professor of cardiovascular medicine was also gained. He concluded that the intracerebral bleed was likely to be due to a small vascular abnormality rather than due to malignant or accelerated hypertension. He thought that he probably had only mild to moderate hypertension before his bleed because he had been found to have only grade 2 hypertensive retinopathy. There was no papilloedema, haemorrhages or exudates which accompany accelerated or malignant hypertension.

Expert opinion also felt that the very high blood pressure readings at the time of the stroke represented the usual physiological reaction to a cerebral bleed and did not represent the true ongoing level of hypertension. He discounted the relevance of headaches as a sign of hypertension in this case. He explained that hypertension usually only causes headache if it is malignant or accelerated, which he believed was not the case.

The case was successfully defended pre-trial and all costs were recovered.

EW

Learning points

- Tragic events don't always equate to negligence.
- MPS successfully defended the claim by gaining expert opinion from three doctors.
- It is useful to remind ourselves of the stages of hypertensive retinopathy and remember to examine the fundi in patients with hypertension.[1]

REFERENCES

1. www.gpnotebook.co.uk/simplepage.cfm?ID=-46858224&linkID=18777&cook=yes

SPECIALTY GENERAL PRACTICE **THEME** SUCCESSFUL DEFENCE

Nervous about neurosarcoidosis

Mrs W was a 44-year-old French teacher who was usually fit and well. She had two children and they enjoyed walking to the same school together in the mornings.

On one of these walks Mrs W was troubled by aching in her right buttock and some tingling in her right calf. She mentioned this to her GP, who noted that there had been no acute injury and that she was still managing to walk to school. He advised her to take paracetamol and ibuprofen and suggested some exercises.

A week later the pain was worse so Mrs W made an appointment to see Dr G, another GP. Dr G documented that she had acute backache with right-sided sciatica and paraesthesia in the right lateral leg. She noted that there were no bladder or bowel symptoms and documented that tone, power and reflexes were normal in both legs. Dr G's notes stated that she had discussed warning signs that would need review. She prescribed diclofenac and referred Mrs W to physiotherapy.

Three weeks later Mrs W saw Dr G again, complaining that the pain was so bad that she couldn't work. Dr G noted back pain with right-sided sciatica and paraesthesia but, again, found the power in her legs to be normal. Mrs W was getting indigestion with the diclofenac so Dr G prescribed codeine instead. She gave Mrs W a sick note and Mrs W said she would see a private physiotherapist in the meantime.

She managed to see a private physiotherapist a week later. The physiotherapist's notes commented on her right buttock and leg pain and numbness in the right foot without weakness. There were clear records of the absence of bladder or bowel symptoms.

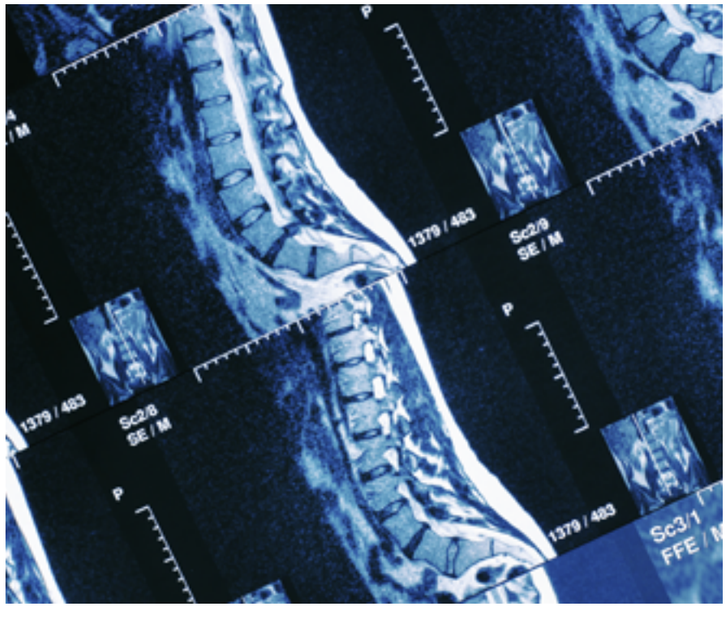
Mrs W was struggling to sleep with pain so made another appointment with Dr G. She documented that Mrs W was tearful but keeping active, doing jobs round the house. Dr G prescribed some senokot to help with "codeine related constipation" and a trial of amitriptyline.

Two days later Mrs W fell at home and rang the out-of-hours GP service. She told the triage nurse that her right leg felt numb and weak, and that she felt like she needed to pass urine but couldn't. An ambulance was called and records in the Emergency Department noted a five-week history of right-sided leg pain and paraesthesia with a one-day history of retention of urine and inability to pass stool. Examination revealed weakness and diminished sensation in Mrs W's right leg but normal findings on the left. There was reduced anal tone and sensation over the saddle area. She was catheterised and one litre of urine was drained. Shortly after, records stated that she had complained of numbness and weakness in her left leg and that power had been found to be reduced in her left leg. Ten minutes later Mrs W was found to have no power in both legs.

Mrs W was commenced on a three-day course of intravenous steroids, followed by a further two-day course. An MRI confirmed an extensive high signal throughout the thoracic cord, suggestive of either inflammation or infarction; a plasma exchange was begun. There was no change to Mrs W's condition and doctors noted her developing upper limb symptoms, a 6th nerve palsy and papilloedema. She was therefore treated on the basis that she had neurosarcoidosis, and Mrs W was recommenced on high dose steroids and started on intravenous cyclophosphamide.

Her condition stabilised and the 6th nerve palsy and papilloedema resolved. However, she was left with clumsy hands and paralysis of both lower limbs. Methotrexate was tried, but there was no substantial change to her clinical condition. She did report some improvement in the function of her hands.

Mrs W was left with flaccid paralysis in her lower limbs, rendering her unable to move either leg or stand. Her upper limbs were weak. She had a suprapubic catheter and was incontinent of her bowels. Mrs W



was devastated and made a claim against Dr G.

Mrs W alleged that she had told the GP of her difficulties in passing urine and opening her bowels several times prior to her admission. She claimed that her GP had failed to examine her adequately and had not referred her urgently. She believed that her disabilities would have been less severe if she had been diagnosed and treated earlier.

MPS's GP expert reviewed the notes from Dr G, the physiotherapist and the hospital. He felt that there were some vulnerabilities in Dr G's notes from the second and third consultations because they were rather brief, but considered her examination and management to be reasonable. He noted that Dr G prescribed senokot for constipation but thought it understandable for a patient taking codeine to be constipated.

He felt that constipation in itself was not sufficiently discriminatory to be a red flag necessitating urgent neurosurgical referral. He commented that the physiotherapy notes were clear and that the patient had been specifically asked about bladder or bowel symptoms and that there were none. The hospital notes stated that urinary symptoms only occurred on the day of admission. The records from all the clinicians involved point to Mrs W's bladder and significant bowel symptoms starting on the day she was admitted, and not before as Mrs W claimed.

MPS also sought the opinion of a professor in neurology. He concurred with the rare diagnosis of neurosarcoidosis. He felt that Mrs W's acute deterioration was a consequence of cord ischaemia and infarction resulting from inflammatory or granulomatous involvement of the arterial supply to the cord. This would explain the sub-acute illness with a rapid evolutionary phase to the point of severe neurological disability. It was his opinion that there is no proven effective treatment for neurosarcoidosis and that earlier treatment would not have altered the outcome. He noted that it is well recognised that cranial neuropathies, such as Mrs W's 6th nerve palsy, can resolve spontaneously without treatment, and the improvement in Mrs W's upper limbs was consistent with the variable natural history of neurosarcoidosis. The cord dysfunction that she had developed remained unchanged despite treatment.

MPS decided to defend the case to trial denying liability, supported by expert evidence. Mrs W discontinued proceedings two weeks before the trial, and MPS is now seeking recovery of all costs.

AF

Learning points

- Good note-keeping is important in patient care but also when defending a claim. Clinical records should include relevant clinical findings, negative findings and relevant negatives when excluding red flags, such as the absence of bladder or bowel symptoms.
- MPS carefully reviewed the records of the GP, the physiotherapists and the hospital doctors to see how the notes supported each other to aid the defence.
- It is useful to be reminded of the referral guidelines from primary care for lower back pain.[1] Repeated examination is needed to check that there is no progression of neurological deficit.
- This case highlights the value of revisiting your diagnosis and not making assumptions when a patient re-presents.

REFERENCES

1. www.gpnotebook.co.uk/simplepage.cfm?ID=-1227882441

SPECIALTY GENERAL PRACTICE **THEME** COMMUNICATION/DIAGNOSIS **SUBSTANTIAL** £100,000+

The Swiss cheese

Mrs X gave birth to J, a healthy baby boy. J was discharged, with a note in the records stating he was a "normal healthy infant"; a further note stated that, on examination, there was a bilateral red reflex.

At four weeks, the health visitor's notes showed that J's parents were concerned that J's left eye was smaller than the right, and the health visitor referred the baby to a community paediatrician. A couple of weeks later, the health visitor documented the left eye as being more open and the referral was cancelled.

J was then seen by the family's GP, Dr A, for a six-week check-up; his vision and hearing were recorded as being "satisfactory". At three months, Dr A referred J to the ophthalmology department after noticing a squint in his left eye; the left pupil was also smaller than the right pupil. Six weeks later – before the ophthalmology consultation took place – J was admitted to hospital as an emergency via Dr A, with coryza, vomiting and poor feeding. J was transferred to the paediatric department, but there was no record from this admission of any examination of J's eyes.

At six months, J's ophthalmology appointment took place. He saw a consultant ophthalmologist, Dr H, who noted that she could not detect any visual acuity in the left eye and that the eye was microphthalmic. She also noted a central cataract on the left side. J eventually became blind in his left eye.

His parents made a claim against Dr A and the hospital for the delay in the diagnosis of the congenital cataract.

Expert opinion

Expert GP opinion on breach of duty stated that Dr A had not been diligent when initially examining J's eyes at the time of the six-week check. By that time the health visitor had listed initial concerns about the size of the eyes, which should have prompted Dr A to be meticulous in his examination of the eyes; had the red reflex been absent, referral to a specialist should have occurred immediately. Prompt and appropriate referral would have led to a 20% chance of restoring J's visual acuity to a level adequate for driving.

Another expert report, provided by a consultant ophthalmologist, also stated this examination was inadequate, as an abnormal red reflex would almost certainly have been present; this would have allowed for appropriate surgical intervention of the cataract that was later diagnosed. This report also criticised the hospital paediatric department for failing to communicate the concerns in J's records about his eye size to the appropriate colleagues.

The case was settled for a substantial sum.

SH

Learning points

- Poor communication leads to poor treatment. Here there is poor communication at various stages, between GP and hospital and within the hospital itself.
- Congenital cataract has a finite time period in which surgical intervention is beneficial.
- J was not seen by a consultant ophthalmologist until he was six months old; this delay highlights failings at both ends. Dr A's referral letter did not make the urgency of the appointment clear but, also, the recognised association of microphthalmia with congenital cataract should have prompted the consultant reading the letter to offer an urgent outpatient appointment.

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SPECIALTY ANAESTHETICS **THEME** SUCCESSFUL DEFENCE

Wrong drug, no negligence

Mrs M was a 64-year-old care assistant in a retirement home. She visited her GP with a two-month history of blood in her stools, altered bowel habit, and intermittent lower abdominal discomfort. On examination the GP found haemorrhoids, and referred her to her local hospital to see Mr P, a gastrointestinal surgeon.

Mrs M was found to be overweight, with a BMI of 32, and was a smoker. Mr P performed routine blood tests, and booked Mrs M to undergo gastroscopy, proctoscopy, colonoscopy, biopsies, and injection of haemorrhoids, under general anaesthesia.

She was seen preoperatively by Dr D, consultant anaesthetist. Dr D noted Mrs M was on a number of medications, including metoprolol and quinapril for hypertension; simvastatin for raised lipids, and inhalers for a diagnosis of chronic obstructive airways disease. She was documented to be allergic to the antibiotic augmentin, which she had taken some years previously, and had caused a rash and wheeze. Mrs M reported that her brother had suffered a severe reaction to general anaesthesia, and had spent two days in intensive care following a hernia operation. However, she was unable to provide more details, and her brother had subsequently moved overseas. Mrs M had undergone two uneventful general anaesthetics at that hospital.

Dr D decided to proceed with general anaesthesia. The procedure was uneventful, but at one point, Dr D administered 1.2g of augmentin. In the recovery area, Mrs M was noted to have a widespread itchy rash and was complaining of wheeze. However, her pulse, blood pressure, saturations and conscious level remained normal. She was treated with antihistamines and hydrocortisone. As a precaution she was admitted to the hospital overnight, where the rash and wheeze resolved, and she was discharged the following day following a further set of blood tests.

During her stay, she was visited by Dr D, who documented that he had apologised to her for the accidental administration of augmentin. Dr D wrote a letter to the GP explaining what had happened, and gave Mrs M a copy. Mr P was also noted to have visited her, but did not document his visit or discussion.

Approximately one week later, Mrs M developed a high fever and abdominal pain and was admitted to the hospital under Mr P. She was noted to be jaundiced and her other liver function tests were deranged. Investigations suggested a diagnosis of acute cholecystitis, and she was treated with antibiotics. The episode settled and she was sent home with an appointment for an elective laparoscopic cholecystectomy.

Mrs M brought a claim against Dr D and Mr P, alleging that the incorrect administration of augmentin had brought about her cholecystitis as part of an allergic reaction. Dr D, the anaesthetist, stated that he had given the antibiotic on the directions of the surgeon, Mr P. However, Mr P stated that he had left it up to Dr D to choose which antibiotic to give.

The experts concluded that there had been a clear lapse in standards, where it had been documented that Mrs M had received an antibiotic to which she was allergic. However, they complimented Dr D on his handling of the incident. They concluded that Mrs M's cholecystitis was unrelated to the accidental administration of augmentin. In the absence of demonstrable causation, Mrs M withdrew her claim.

The hospital subsequently changed several of its policies and procedures, including implementing a "time-out" check at the start of each endoscopy procedure.

AOD

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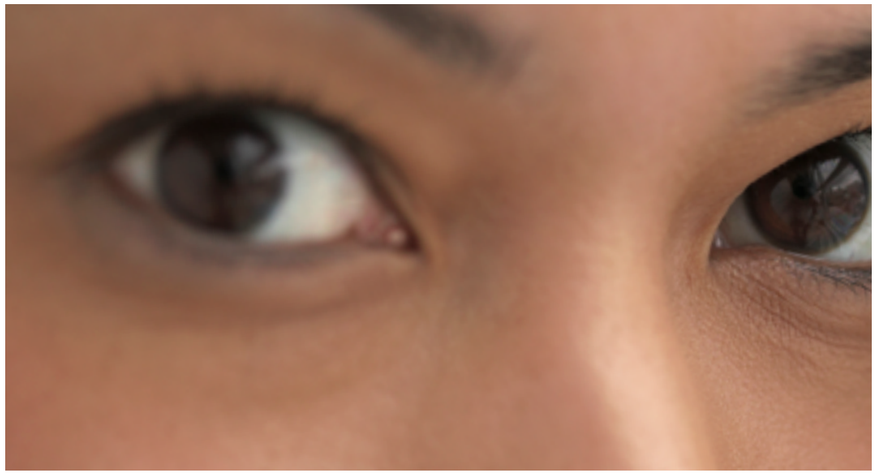
Learning points

- Adherence to simple protocols, such as the WHO Surgical Safety Checklist, can help prevent problems of this kind, where a known and documented allergy was overlooked. See www.who.int/patientsafety/safesurgery/ss_checklist/en/
- In choosing a TIVA technique for anaesthesia, Dr D was attempting to avoid a rare but dramatic problem, malignant hyperthermia: Mrs M might have been at risk given what happened to her brother. However, this may have distracted his attention from a much commoner problem, which is allergy to antibiotics. Take extra care when performing a technique that is unusual for you.
- Good documentation is the cornerstone of your defence. In this case Mr P didn't document anything that had been discussed or shared. If a junior doctor is making the notes, ensure you check their entries.
- Human error is inevitable in medicine, but doctors should always be open with patients and their families following an adverse event. An open and frank apology can often help to defuse anger. In this case, Dr D was praised for his handling of the incident afterwards.

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

No fundoscopy, no defence



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Miss Z, a 17-year-old sixth form student, visited Dr B at the end of the summer term of school after a stressful exam period. She was feeling generally unwell with a sore throat and some vomiting. Dr B reassured her that she was probably run-down following her exams, and she was likely to have picked up a virus. She had planned to go to America with her family over the summer, so he advised her to return to the surgery if her symptoms persisted when she came home.

A month later, Miss Z felt no better and returned to the surgery, this time seeing Dr Q. She complained of ongoing nausea, neck pain and headaches. She also noticed that her vision was 'blanking out' every few days. Dr Q documented a normal pulse and blood pressure and noted "normal cranials". Miss Z did not recall an eye examination taking place; however, Dr Q maintained that fundoscopy would have been part of his cranial nerve examination. He arranged some blood tests and a review with the results.

The bloods were all normal and Miss Z was not seen again for a further two months. She again consulted Dr Q, this time complaining of weight loss along with a persistent sickly feeling. She was also experiencing visual loss on a daily basis. No record was made in the notes. Further blood tests were arranged.

Over the next month, Miss Z consulted Dr Q twice, and on both occasions the weight loss was the focus of the consultations. Dr Q attributed the symptoms to stress as deadlines for coursework were looming. On their last meeting, Miss Z complained of vacant episodes where she described a complete loss of vision. This prompted Dr Q to make an urgent referral to the local neurology service, but there was no documentation that an eye examination was performed.

After five days of waiting for the neurology appointment, Miss Z was taken to an optometrist by her mother due to ongoing visual disturbance. The optician found severe optic neuritis in both eyes, complete loss of disc margins and tortuous blood vessels with dot haemorrhages. An urgent referral was made to ophthalmology. Dr Q received a phone call from the optician to expediate the referral during his busy on-call. He had several home visits and admissions so it was a day later when he managed to write the referral letter. He documented that Miss Z's vision had markedly worsened over the weekend, and after a period of the symptoms all subsiding she was now waking each day with headaches and nausea.

The next day (17 weeks after first presentation) Miss Z was seen by an ophthalmologist and an immediate hospital admission was arranged. An astrocytoma of the third ventricle was diagnosed and a shunt inserted that day to relieve the pressure. The tumour was subsequently excised. However, despite resolution of the papilloedema, her vision deteriorated further. She was left with perception of light in the left eye and movement vision in the right, and registered as severely sight impaired.

Expert opinion agreed that the delayed referral led to Miss Z's visual loss. If an appropriate referral had been initiated when the visual symptoms were first described, then it is likely that significant loss of vision would have been avoided. The case was settled for a high sum.

EW

Learning points

- As ever, clear documentation of a consultation is essential. Your standard of note-keeping says a lot about your practice. If you can demonstrate that your notes are generally of a high standard, it may assist you if you haven't mentioned something in the notes.
- If Dr Q had recorded the patient to have "no visual disturbance" and later "normal fundoscopy", that would have been more convincing than no mention of symptoms at all, when the patient clearly recalled reporting problems.
- Fundoscopy is an essential examination and can assist in the diagnosis of many diseases.[1] In this particular case, early fundoscopy could have prevented loss of vision. Experts commented that if Dr Q had carried out fundoscopy in his initial consult (as he said he did as part of a cranial nerve exam) then he failed to identify papilloedema, as it is likely to have been present at this time.
- If you do suggest a patient consults an optician to obtain a more thorough and immediate check-up, you should ensure that safety-netting is in place by arranging a follow-up consultation.
- Remember red flag symptoms,[2] especially in patients who may be presenting with vague non-specific symptoms. Ask the important questions, document what has been done and record any important negatives.

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2. SIGN, *Diagnosis and management of headaches in adults: Clinical Guideline 107* (2008) www.sign.ac.uk/pdf/sign107.pdf

SPECIALTY OBSTETRICS **THEME** RECORD-KEEPING **MODERATE** £10,000+

Record your reasoning

Mrs G was seen at 35 weeks gestation in an uncomplicated pregnancy. The consultant, Mr A, documented this consultation and the mode and timing of delivery was discussed. Mrs G was naturally anxious as she had had two miscarriages and Mr A counselled her regarding induction of labour around the due date. He discussed the increased risk of instrumental delivery and caesarean section as a result.

Mrs G saw Mr A again two weeks later. Delivery by induction was revisited and agreed upon. Mr A made arrangements with the labour ward and used the indication "reduced fluid around the baby", though he explained to Mrs G that this was to keep the midwife "happy". An ultrasound scan reassured Mrs G that all was well with the baby.

Mrs G was admitted for induction of labour at 37 weeks gestation. On examination by Mr A the cervix was found to be soft, posterior and partially effaced. Induction by 2mgs intravaginal Prostin gel was commenced at 09:30. An amniotomy was performed seven hours later and labour ensued within two hours. The first stage of labour was completed at 00:05 and pushing commenced 45 minutes later.

Progress was slow, Mrs G's temperature increased and the foetus developed a tachycardia. The midwife requested consultant review and Mr A assessed the patient. The baby's head was in an occiput posterior position but low in the pelvis. There was discussion with the parents about the possibility of ventouse extraction. Initially they were reluctant, having seen the effects of ventouse delivery on head shape and facial bruising before. However they consented and the procedure went ahead.

A Kiwi cup was used with positive pressure over two contractions to effect delivery. The perineum stretched well and episiotomy was not deemed necessary. A second degree tear was sustained with labial bruising and was repaired with vicryl under local anaesthesia due to pain.

Later, both the midwife and Mr A noted the perineum to be swollen. Mrs G questioned the possibility of prolapse but this was excluded by Mr A. Soon after,

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relations with Mr A deteriorated for unknown reasons and Mrs G refused to see him again.

She remained in hospital and saw other doctors and a physiotherapist. Each clinician acknowledged that she had ongoing pain, urinary and faecal incontinence, but none identified a problem with the repair. There was neuropraxia and infection but the anal sphincter was intact. Mrs G was discharged six days following delivery and was improving.

Mr B saw the patient 11 days post-discharge and noted constriction of the introitus that was thought to be self-limiting (the risk of requiring surgery being 25%). The following week there was no improvement: pain persisted locally, there was difficulty recognising feelings in the bladder and intercourse was impossible. Examination revealed a very tight asymmetrical introitus.

A second opinion gynaecologist, Mr F, recommended a Fenton's procedure, which was undertaken with ease and without complications ten weeks after delivery.

A claim was made against Mr A, alleging breach of duty for using oxytocin inappropriately, failing to rotate the head prior to delivery, using ventouse inappropriately, failing to perform an episiotomy, substandard repair of the perineum and failing to provide adequate postnatal care.

Expert opinion was supportive regarding breach of duty on all counts. Induction on psychological grounds was said to be reasonable, as was the use of oxytocin. Ventouse delivery without head rotation was cited as normal practice, as was allowing the perineum to stretch, avoiding the need for episiotomy. The expert stated that it would be unusual that a consultant of Mr A's standing would suture the labia together. The tissues were likely to have healed incorrectly rather than the repair having been performed in a substandard fashion. Induction of labour had had no bearing on the need for instrumental delivery.

Unfortunately, several key documents were missing from the notes and could not be traced. Despite the supportive expert opinion, in the absence of these key documents, we were advised it would be very difficult to defend the case. Accordingly it was settled for a moderate sum.

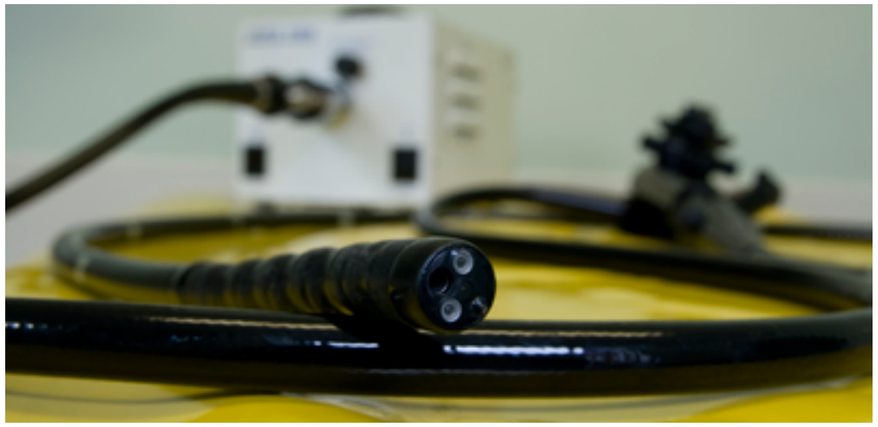
KE

Learning points

- Indications for induction of labour are set out in NICE guidelines as well as the RCOG green top guides. Psychological reasons and maternal choice are acceptable, but documentation regarding the counselling and consent process must be robust. The notes in this case were lost, which resulted in the case being indefensible.
- Good record-keeping is imperative throughout pregnancy, but especially so in the intrapartum phase.
- Delivery by ventouse is acceptable for most positions of the foetal head and is preferable to Kiellands forceps, which should not be used for rotational deliveries except in the most experienced hands.
- Postnatal care is as important as antenatal and intrapartum care and should not be dismissed. The care of Mrs G in the postnatal period seems to have been adequate but for reasons that are not clear she refused to see Mr A. When things go wrong it is important to be open, honest, conciliatory and empathic to the patient.

SPECIALTY GENERAL SURGERY **THEME** SUCCESSFUL DEFENCE

Complications of colonoscopy



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A 50-year-old accountant, Mrs A, developed altered bowel habit and rectal bleeding. She saw consultant colorectal surgeon Mr C, who found large prolapsing haemorrhoids and recommended a haemorrhoidectomy and colonoscopy. Mr C removed a 5mm polyp in the caecum with a snare and then went on to perform a haemorrhoidectomy. Both procedures were described as uneventful and Mrs A was stable throughout the anaesthetic.

A few hours later, after the operation, Mr C noted Mrs A was well and ready for discharge. She subsequently developed minor rectal bleeding and abdominal discomfort, and was kept in overnight. The following morning, her routine blood tests were normal and her observation chart had been unremarkable, but the abdominal pain persisted. A chest x-ray revealed bilateral sub-diaphragmatic free gas. Mr C prescribed broad-spectrum antibiotics, intravenous fluids and kept Mrs A 'nil by mouth'. An urgent CT scan confirmed an extensive pneumo-peritoneum but no signs of any fluid collection.

Mr C examined Mrs A and found a "completely soft abdomen with no peritonism and normal bowel sounds". He explained that the perforation had probably occurred at the polypectomy site, but appeared to have sealed as Mrs A was well and the CT scan had revealed no fluid collection. Mr C recommended conservative management with surgical intervention only in the event of septic complications. Over the next few days, Mrs A remained well, was apyrexial and had normal inflammatory markers. She commenced oral fluids and was discharged home with seven days of antibiotics.

Mr C reviewed her at the end of the week and noted "she continued to feel well, clinical examination was normal and the site of her haemorrhoidectomy was healing nicely". The pathology report of the polyp revealed a completely excised low grade tubulo-villous adenoma and Mr C explained the need for surveillance colonoscopy.

Two weeks later Mrs A contacted Mr C complaining of night sweats, abdominal pain and vomiting. He saw her immediately and arranged an ultrasound scan, which revealed a large pelvic abscess. Mr C organised her admission to another hospital for radiologically guided drainage of the abscess, but this proved unsuccessful. Her condition deteriorated and Mr B, the consultant surgeon on-call at this hospital, undertook an emergency laparotomy to drain the abscess and perform a defunctioning ileostomy.

Mrs A had a stormy postoperative recovery, initially requiring ITU support, and spent three weeks in hospital. Mr B subsequently reversed her ileostomy but Mrs A developed problems with an incisional hernia, requiring several attempts at repair. She also needed psychological support for post-traumatic stress disorder, resulting in prolonged absences from work.

Two years later, Mrs A brought negligence proceedings against Mr C. It was claimed that Mr C should have acted sooner by performing an x-ray and CT scan on the evening when Mrs A initially developed pain. It was also alleged that Mr C had selected inappropriate antibiotics and had discharged her too early, allowing the development of her abscess. It was suggested that these acts of negligence had delayed appropriate surgical treatment and directly led to all Mrs A's subsequent complications.

Expert opinion for MPS did not substantiate any of these claims. It was agreed that non-operative management for perforations after colonoscopy was an acceptable practice if the patient was stable, exhibited no signs of sepsis and the perforation appeared to have sealed.

The CT result, together with the carefully-documented clinical findings, nursing charts, and absence of a rise in the patient's inflammatory markers over several days, all supported this approach. Microbiology experts agreed that the antibiotics prescribed were appropriate and the length of administration sufficient. Mr C was also able to produce audit evidence of his colonoscopy practice, demonstrating a high volume (400 per annum) with a very low complication rate.

MPS defended the case and the claimant discontinued on the first day of trial, with full recovery of costs.

SD

Learning points

- Complications after procedures can occur and are not necessarily the result of negligence. Claims can be defended if clinicians are able to demonstrate that they acted appropriately in the detection and subsequent management of complications. Evidence of a high volume practice with a low complication rate (as in this case) can strengthen the defence.
- Claims often arise many years after the event. The careful documentation of events and discussions with the patient two years earlier enabled the facts of the case to be established, and a successful defence of the allegations.

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A catalogue of errors

›› As an orthopaedic surgeon, I was concerned about the number of cases related to orthopaedic surgeons in *Casebook* 22(1), January 2014. I was pleased to see, however, that many of these have been defended.

What surprised me was the case "A catalogue of errors". In that case, a lady underwent a knee replacement that appears to have been mis-positioned, which caused pain in the knee and the need for a revision procedure to be carried out at an early stage.

At that revision, carried out by a different surgeon, swabs were taken showing coagulase negative staphylococcus, but this was not thought to be significant. Subsequently, the patient developed an infected knee replacement and staphylococcus epidermis was grown (the same bacteria as coagulase negative staphylococcus).

This pattern of late clinical symptoms from infection is not at all unusual with this low virulence organism.

The importance of this, of course, is that the infection was clearly in the knee following the initial operation and would have become symptomatic in due course in any event. The patient would therefore have required a revision knee replacement for this infection, even if the original components had been perfectly placed.

I note that the first surgeon was sued and the claim was settled because of the poor technical skill exhibited in carrying out the original knee replacement, and your expert, Mr D, felt that this was a breach of duty which indeed it may well have been. However, the infection would not have been a breach of duty as it is a well-recognised risk following any knee replacement, and this would have required a two-stage revision in any event.

I note that the claim was settled for a substantial sum but it would seem that the main fault is misplacing the original component and then one revision procedure, rather than the eventual poor result with persistent pain, which is almost certainly due to the infection and consequence of scarring rather than anything to do with the original surgical procedure.

Professor Robert J Grimer, Consultant orthopaedic surgeon, Honorary professor, University of Birmingham, UK

Response

Thank-you for your observations on this case.

The expert in this case did carefully consider the issue of causation, and in particular the question of the infection that developed in the knee. His opinion was that the infection would not have developed if the patient had not required early revision surgery due to the sub-standard index operation. He was also of the opinion that had the initial procedure been carried out appropriately, the prosthesis would not have needed revision until it failed – in approximately 15 to 20 years.

The settlement in this case reflected these issues.

Anatomy of a claim

›› In *Casebook* 22(1), January 2014, the feature "Anatomy of a claim" tells a depressingly familiar story. Frequently and incorrectly termed "discitis", infections of the vertebral bodies are commonly missed clinically. The vascular anatomy in the juxta-discal area shows a pattern of end vessels throughout life – hence a vulnerability to infection. The disc is avascular and infection can only occur by direct innoculation, eg, during surgery or discography.

In cases of thoracic spinal infection and in my experience of more than 35 years as a spinal surgeon, careful clinical examination of the spine will invariably disclose clear evidence. Pain and tenderness on local pressure will always be associated with the back pain history. Chest pain or radicular pain may also be present. The ESR is invariably raised.

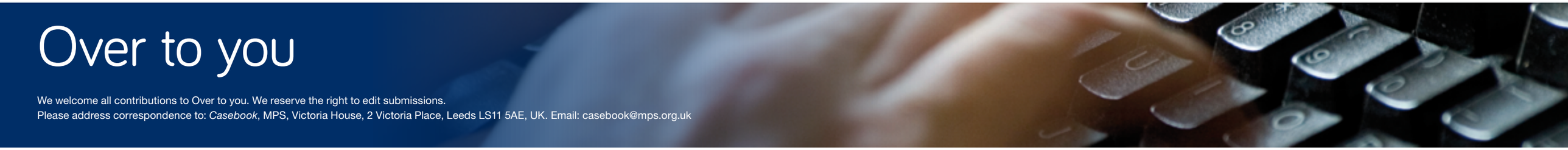
Given the typical history given by Mr P, Dr C's conclusion that the symptoms represented "muscular back pain" was made on the basis of symptoms that must have been present for more than ten days' duration, and this was Mr P's third consultation. Events showed this to be a serious misjudgment. Dr A's second consultation (Mr P's fourth) 25 days after his original assessment, with an increase in symptomatology and in the absence of a diagnosis, resulted in an entirely inappropriate referral for physiotherapy. This treatment is likely to have caused the onset of neurological symptoms six days later.

Mr P was noted to have a loss of sensation in his legs at the time of hospital admission. An MRI scan undertaken at another hospital disclosed an "infective discitis at T5-6". Two laminectomies were undertaken, following which Mr P was rendered paraplegic. Laminectomy has been recognised as contraindicated as a surgical procedure for infections of the thoracic vertebral bodies for over 100 years. The history indicates that the laminectomy directly resulted in the complete spinal cord injury in Mr P at T4 (at least one level higher than the bony pathology). If the indication for surgery existed, a closed biopsy followed by an anterior debridement via a thoracotomy or an approach via a costo-transversectomy should have been undertaken. A majority of cases can be managed by appropriate antibiotic treatment.

If Mr P's legal advisers had instructed experts who were familiar with the presentation and appropriate treatment of spinal infections, the outcome would have been very different. On the basis of the history, the claim that Drs A and C failed to suspect a spinal infection or arrange correct investigation that should have necessitated an urgent referral meant that Mr P's claim is self-evidently correct. This was a failure of duty of care. The subsequent surgical investigation and operative treatment was both inappropriate and negligent, and therein lay the liability and causation. This should have been recognised by Drs D, E and G, and Mr F, had they been familiar with the extensive surgical literature on the subject.[1]

With correct clinical management, Mr P's catastrophic outcome was avoidable. The case may represent a satisfactory outcome for MPS but it also represents a grossly unfair outcome for the patient/claimant.

Alistair G Thompson, Consultant Orthopaedic Spinal Surgeon, Birmingham, UK



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REFERENCES

1. Bridwell KH and De Walt RL (eds), Textbook of Spinal Surgery (2nd Edition), Philadelphia: Lippincott-Raven (1997)

Response

Thank you for your comments on this article.

In this case it is important to note that in this case the claimant did not bring any allegations in respect of the surgical treatment provided. The allegations were in respect of Drs A, B and C who saw Mr P at the GP surgery. In accordance with the general principles of medical negligence, the standard on which the three doctors are judged is that of the reasonable general practitioners.

On the doctors' account of the case the GP expert evidence was supportive. Although there was a potential conflict of factual evidence (ie, what actually happened in the consultations), at trial it was clear that Mr P had no real recollection of what he had told the GPs about his symptoms during the various consultations.

Whilst an assessment at the beginning of the process by a specialist might potentially have resulted in an earlier diagnosis (depending on what symptoms were actually present), the standard to be applied is that of the reasonable GP, and our expert was clear that doctors A, B and C had reached that standard.

Consent templates?

›› The question of adequate consent and the preoperative discussion of possible risks and complications frequently appear in *Casebook*. Are there any templates of consent forms available for gynaecological procedures (especially laparoscopic procedures)? Is it not something that MPS should be involved in creating or developing?

Dr AA Carolissen, Gynaecologist, South Africa

Response

Thank you for your observations and comments.

MPS does not produce specific templates or forms for use in the consent process. Consent is a process that will vary depending on the circumstances. Although there are some specific exceptions in relation to certain procedures, interventions and circumstances (eg, sterilisation and termination of pregnancy, which require the completion of statutory forms), the actual format of the consent is less important than the accurate documentation of the process.

MPS has produced a comprehensive guide – Consent to Medical Treatment in South Africa – *which is available on our website.*

Controlled drugs

›› (This letter refers to an article in the New Zealand edition of *Casebook* – non-NZ members can read it here: www.medicalprotection.org/newzealand/casebook-january-2014/controlled-drugs-what-you-need-to-know)

Thank-you for another informative issue of *Casebook*.

I am responding to Helen Moriarty's article on controlled drug prescribing ("Controlled drugs – what you need to know", *Casebook* 22(1)) in New Zealand.

The article is clear and helpful, and the message that prescribing to any dependant person must be by a gazetted practitioner (and sometimes location) or under the specific written authority of such a practitioner, is clear.

However, the article does not address the question of colleague or locum prescribing, and I have wondered about this in the past.

Specifically, if the duly gazetted authorised practitioner is away/unavailable (not just fully booked that day), does a colleague from the practice, or a locum, have the legal right to prescribe for dependant patients?

It is a widespread convention that locums (if not colleagues) are authorised to do all that the doctor they are replacing would normally manage, including prescribing to this category of patient.

I shall be grateful for Dr Moriarty's further advice.

Dr Crispin Langston, Waimate, New Zealand

Response

Restriction Notices always specify "Doctor (name) or Locum" for this specific reason. You should find that this is the standard wording on Restriction Notices held in the practices that you work in.

How reliable is healthcare?

›› I'd just like to compliment the excellent article "How Reliable is Healthcare?" by Dr Dan Cohen in the current (January 2014) issue of *Casebook*. As both an airline captain and former surgeon, I have a view from both sides of the debate. I'd like to agree with his views on complacency leading to errors but must disagree on two points.

While I agree that patients are infinitely more complex than aeroplanes, the important point is that aeroplanes (patients) generally don't cause accidents – it's caused by human error due to the operator (healthcare professional or pilot). Therefore this is where we need to focus our energies, namely in human factors training for staff to help recognise and deal with error.

Also, as in healthcare, we consider our passengers (patients) an integral part of our safety awareness system. Any issue brought to the attention of our cabin crew, such as unusual smells, sounds, ice on the wings or leaks from engines (both of which are much more easily seen by our passengers due to their better view of that area of the aeroplane), are brought immediately to the attention of the captain as part of our crew resource management information gathering system, ie, communication, leadership, situational awareness, leading to decision-making. We regard passengers as much more than passive consumers of our service.

Captain Niall Downey FRCSI, Managing Director, Frameworkhealth, Ireland

Response

Capt Downey makes some excellent points and his thoughts are aligned with mine. It is certainly true that aeroplane safety relies to some extent on passengers alerting crew to potential problems, and in adopting a healthcare outcomes paradigm, similarly relying on patients for their expertise is crucial. A difference is that the passengers on an aeroplane, except perhaps in the case of a mid-air emergency, do not rely on the crew to instruct them how to be successful passengers (after the initial safety instructions prior to takeoff), whereas achieving healthcare outcomes uniquely requires clinicians and patients to work very hard together across all aspects of care planning to achieve successful care implementation.

One of the reasons that 20-25% of elderly patients discharged from hospital with a diagnosis of congestive heart failure are readmitted within 30 days is because patients are not viewed as components of the healthcare system in a high-reliability model. Many clinicians have no real window on the challenges that patients face once discharged and back in their homes. Every preventable readmission is a failure of our system and a cause of physical, psychological and financial harm; the antithesis of a high-reliability system.

Clinicians and patients are both encumbered with many human factors liabilities and training or interventions for both are likely to serve good purpose. The processes of diagnosis, therapeutics and of care plan implementation present numerous human factors challenges. If the goal is preventing readmission then planning for that should begin at the time of admission with defining, and then modulating, the human factors that confound success.

DL Cohen, MD, FRCPCH, FAAP, International Medical Director, Datix (UK) Ltd. and Datix (USA) Inc. Dcohen@datix.co.uk

Cutting corners

›› As an anaesthetist, I was interested to read the case report "Cutting corners", describing the severe brain damage that befell a four-year-old boy following an anaesthetic mishap (*Casebook* 22 (1)).

The anaesthetist, Dr B, was criticised on several aspects of his care, including failing to warn the child's parents of "the risks of anaesthesia". I should like to know what MPS recommends in this regard, given that in the case quoted, the child was fit and well, with no medical problems or allergies, and was appropriately fasted.

He obviously required a general anaesthetic, and in the overwhelming majority of such cases, one would expect this to be uneventful. What should Dr B have told the parents, without alarming them unnecessarily?

Dr Ian R Fletcher, Consultant anaesthetist, Newcastle upon Tyne, UK

Response

We have had several letters in relation to the issue of consent to anaesthesia in this case, and specifically the issue of warning of the risks associated with anaesthesia.

It is fair to say that the medicolegal landscape does change with time, and can be dependent on the jurisdiction. The general trend, however, is towards a full disclosure of risk, and a process of joint decision-making with the patient (or in this case, the parents).

In respect of rare but serious complications such as awareness, nerve injury, disability and death, the AAGBI (Association of Anaesthetists of Great Britain and Ireland) recommend in their guidance Consent for Anaesthesia Revised Edition *2006 (para 5.3.8), that written information should be provided, and the anaesthetist should be prepared to discuss the risks.*

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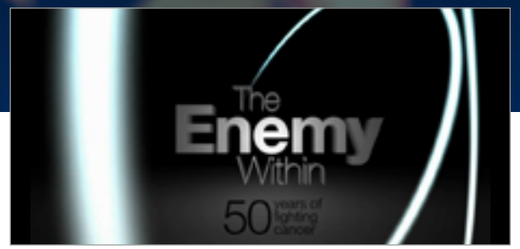
Reviews

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

★★★



FILM: The Enemy Within (50 Years of Fighting Cancer)

Dependable Productions
By Dr Omar Mukhtar, 'Darzi' Fellow, Health Education South London, UK

The Enemy Within is an hour-long film presented by Vivienne Parry – it tells the story of the human fight against cancer over the last 50 years.

Contributors include the great and the good of cancer research – Professors Robert Weinberg and Umberto Veronesi, Lord Ara Darzi, Professor David Nathan, Professor Brian Druker and many more. Equally, there are contributions from a number of patients, including Karen Lord, a survivor of childhood leukaemia, Julian Tutty, one of many patients who benefited from the development of Gleevec, and Bobbie Ariaudo, who eventually succumbed to pancreatic cancer.

In chronicling the fight against cancer, it describes any number of important events – be that the debate surrounding combination versus sequential, single agent chemotherapy, the provision of palliative care or the realisation that a conservative surgical approach, as opposed to radical mastectomy, might be equally beneficial and less disfiguring for patients with breast cancer.

It also focuses on achievements further afield that have helped improve survival rates for many cancers – the vast technological advances that have led to the development of CT, MR and PET imaging, the sequencing of the human genome and the realisation that environmental exposures (smoking, alcohol, obesity and sunbeds) are significant causative factors that need to be addressed. In doing so, it tells a calm and sober story of human endeavour.

Whilst the film also acknowledges the role of survivors, politics and 'people power', you sense that the nod to these groups is simply that – a nod. The power of the human story, the story of those who have succumbed to cancer and those who have survived, feels sanitised – devoid of the emotion that might invigorate this short film. Moreover, you can't help but feel that it glosses over many of the challenges that remain – the failure to diagnose and treat virulent cancers, especially pancreatic and thoracic disease, the inadequacy of treatment in the non-industrialised world, and the considerable costs arising from non-adherence.

This is a non-commercial, editorially independent piece, supported by Cancer Research UK and funded by an educational grant from Roche. The film-makers set out to educate and inform those who are affected by cancer. Whether they have achieved that is questionable, as the focus and language is largely directed towards the medical fraternity. However, in a little over an hour, this film provides a high level overview of what has been achieved in 50 years, which will be enjoyed by many a clinician.

★★★★★

The Checklist Manifesto: How to Get Things Right

Review by Dr Amir Forouzanfar, surgical specialist registrar, Doncaster, United Kingdom

Atul Gawande has written an insightful, in-depth and stimulating book about the challenges of modern medicine. His honest reportage of challenging medical scenarios including personal mistakes, combined with stories from other professions, certainly convinced me that surgical checklists are a good thing.

I work as a specialist registrar and we now routinely undertake the WHO operating checklist. I've noticed an increase in its uptake and implementation, which can only be a good thing. I see errors picked up on a weekly basis simply by having an easy-to-follow checklist for the whole team to follow.

Gawande distinguishes between errors of ignorance and efforts of ineptitude – the most common and relevant in today's medical world being the latter. He explains that the high pressured and intense environment that is prevalent in the medical world means mistakes are inevitable.

He borrowed a concept from the aviation industry: the checklist, similar to the checklists used by pilots before take-off, and applied it to medicine. He then argues that implementing checklists that walk surgeons through procedures actively prevents mistakes. Good checklists and clear communication amongst the team can significantly reduce errors.

For those among the medical profession who are sceptical about using checklists, or are interested in how the WHO operative checklist came about, I suggest you read this book, as it is powerful enough to make you rethink your ideas.

I've found myself using examples of Gawande's book to inform my operating staff of the origins of the checklist, while stressing its importance to us all.

Surgeon or paediatrician, GP or psychiatrist – I encourage every doctor to read this well-crafted and fascinating book – it will change the way you think.

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How to contact us

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33 Cavendish Square
London, W1G 0PS
United Kingdom

www.mps.org.uk
www.dentalprotection.org

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

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