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# CASEBOOK

This issue...

**FROM THE CASE FILES**

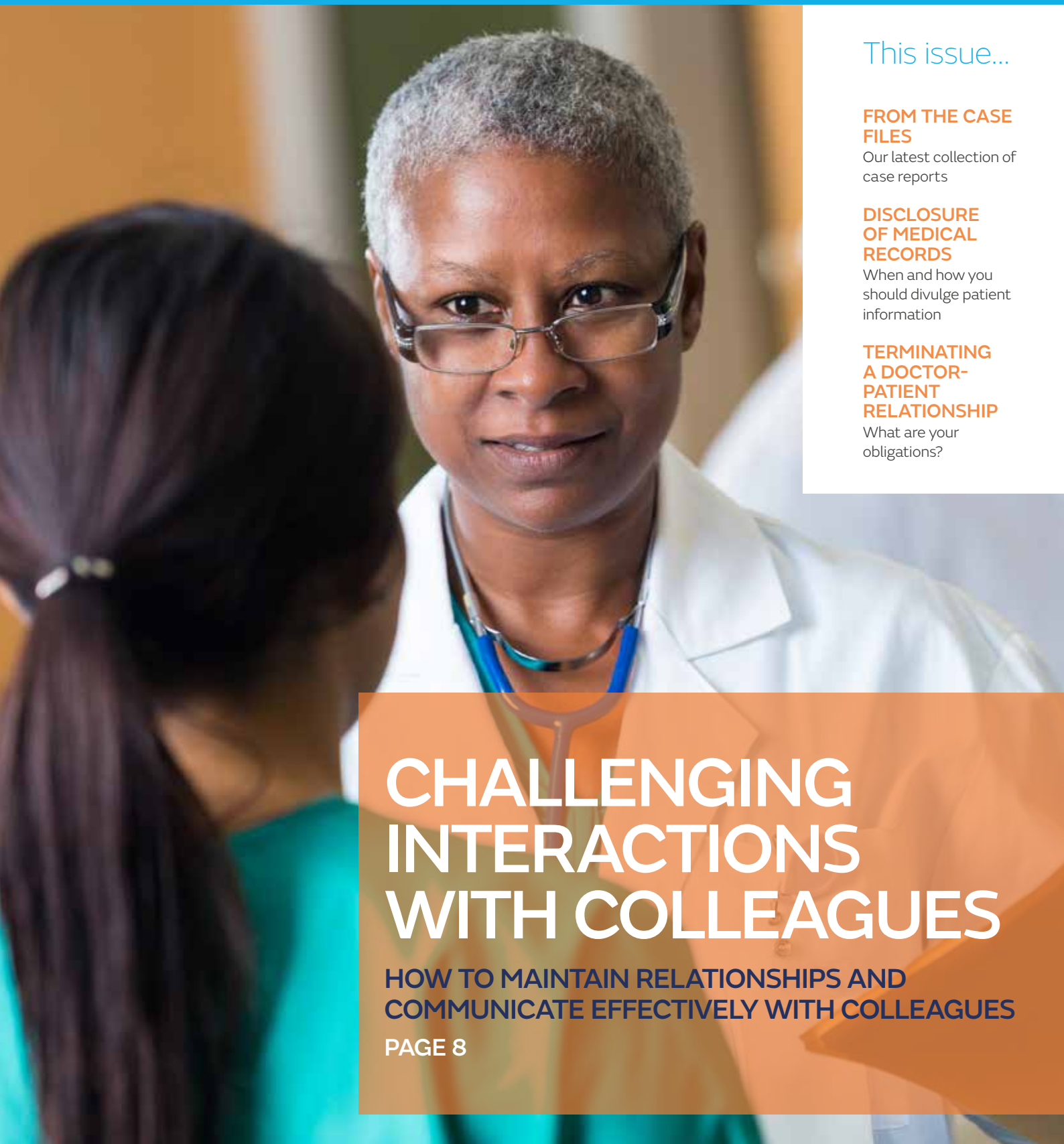
Our latest collection of case reports

**DISCLOSURE OF MEDICAL RECORDS**

When and how you should divulge patient information

**TERMINATING A DOCTOR-PATIENT RELATIONSHIP**

What are your obligations?



## CHALLENGING INTERACTIONS WITH COLLEAGUES

HOW TO MAINTAIN RELATIONSHIPS AND COMMUNICATE EFFECTIVELY WITH COLLEAGUES

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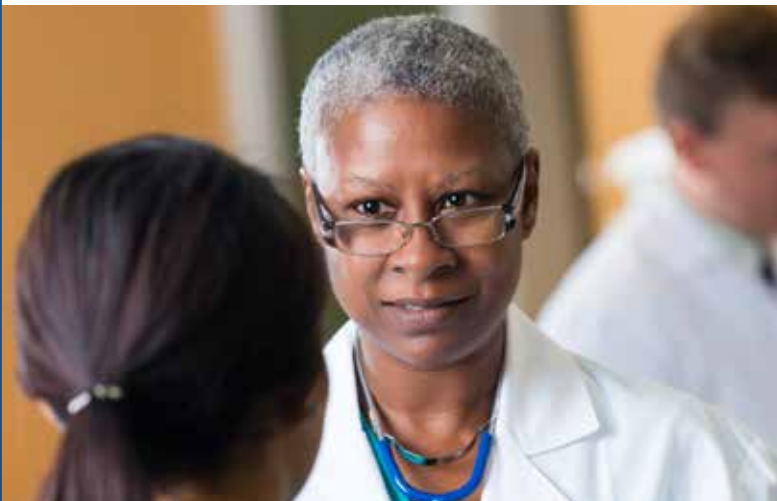
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# WELCOME

**Dr Marika Davies**  
EDITOR-IN-CHIEF



**I**n this edition of Casebook we have a particular focus on difficult interactions, whether that is with a patient or with a colleague. In our experience, poor communication between doctor and patient, or doctor and colleague, is the root cause of many of the complaints, claims and disciplinary actions we see.

On page 8 our director of education, Dr Mark Dinwoodie, takes a look at challenging interactions with colleagues. He provides practical tips, based on those in our Mastering Professional Interactions workshop, to help you through these difficult situations.

On page 10, we examine similar issues with patients and ask the question, when is it right to terminate the doctor-patient relationship? This is not something to be done lightly, and there is much to consider before taking the decision, not the least of which is the continued care of the patient. Ralitsa Sahatchieva breaks down the issue.

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

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

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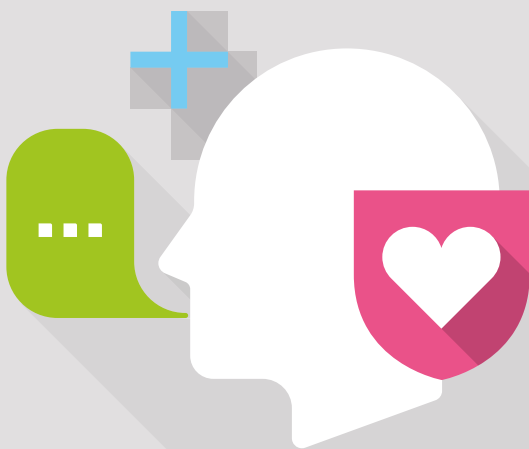
# NOTICEBOARD

## NEW ONLINE RESOURCES

**Y**ou can now access podcasts and videos on the Medical Protection website. These enable you to keep up-to-date with key medicolegal topics such as mental health developments and dealing with medical errors and patient safety. In addition, we have uploaded two new factsheets about confidentiality to our website, and you can also read a recent case report which addresses issues surrounding consent. To access these resources and past issues of *Casebook*, visit [medicalprotection.org](http://medicalprotection.org) and click on the Casebook & Resources link.

## WRITE FOR CASEBOOK

**M**edical Protection is your organisation and we want you to be part of it. We are currently seeking new contributors to submit well-crafted and informative feature articles for *Casebook*. If you would like to have your writing published, or if you have any ideas for content, please contact the *Casebook* Editor at [casebook@medicalprotection.org](mailto:casebook@medicalprotection.org)



## EMAIL COMMUNICATIONS

**Y**ou may have noticed that you are receiving more information from Medical Protection via email recently. This is because it can be a more cost effective and efficient way of sending certain communications. If you haven't received anything from Medical Protection by email, it could be that we don't have your email address, or that the one we do have is out of date or incorrect. If you think that you need to update the information that we hold for you, please send an email to [caribbeanandbermuda@medicalprotection.org](mailto:caribbeanandbermuda@medicalprotection.org) telling us your membership number and the email address you'd like us to contact you on, and we'll update our records.

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# DISCLOSURE OF MEDICAL RECORDS

*Confidentiality may seem a very straightforward principle, but knowing when to divulge patient information can be problematic says Medicolegal Adviser Dr Jonathan Bernstein*

**Y**our duty of confidentiality to your patients is fundamental to the trust that forms the basis for the doctor-patient relationship. There are all sorts of situations where it is difficult to know if patient information should be shared or not.

According to guidance, “medical information should not be disclosed to a third party without the consent of the patient,”<sup>1</sup> although implied consent would enable the sharing of relevant information between medical professionals involved in a patient’s care.<sup>2</sup> There are times where disclosure of information without patient consent is obligated by legislation<sup>3</sup> or by court order,<sup>4</sup> and other instances where you have discretion to disclose confidential details about your patient in the absence of consent. These situations are some of the most challenging to the security of the trust inherent in the relationship with patients.

## CASE STUDY 1

### A REQUEST FROM AN EMPLOYER

A patient visits your office with back pain. You sign them off as unfit for work for one week. A short time later, their employer writes to you to request information about the patient, who the employer says is frequently off sick. The patient seeks a copy of the letter sent by the employer. Subsequently, the employer again writes to you seeking clarification as to whether you signed the sick note in their possession. They provide a copy that suggests you have signed off the patient for four weeks.

### ADVICE

Information may only be shared with the employer if there is patient consent to do so. The note and its contents were given to the patient in the context of a confidential consultation, and it is ultimately up to the patient to determine whether to disclose it. Many doctors would argue that the patient’s deceit would entitle them to share relevant details with the employer in the absence of consent. However, unless the ‘crime’ is serious (see below), disclosure is unjustified. You may, however, wish to protect your reputation and

advise that you did not issue the sick note. This does not breach your duty to the patient.

## CASE STUDY 2

### SHARING INFORMATION WITH THE POLICE

During a busy morning surgery, a practice nurse returns to her empty treatment room to find that her handbag and house keys, which were hidden in a drawer, have gone missing. The theft is reported to the police. Later that day, her house is burgled, with the missing keys apparently used to gain entry. There is CCTV in the surgery and a camera which monitors the corridor outside the nurse’s room. The police request sight of the CCTV footage.

### ADVICE

The temptation is to accede to the police request. After all, a crime was committed, and the CCTV may prove useful. However, the CCTV footage includes confidential patient information, such as the identities of all the other patients legitimately in the surgery. Without all of their individual express consent, disclosure would breach their confidentiality. In the absence of a “grave and serious crime”,<sup>5</sup> such as one that resulted in injury or death, you cannot justify disclosure of confidential information in the absence of that consent.

Your practice should have a CCTV policy in place and all patients and staff should be made aware of the policy.

## CASE STUDY 3

### PARENTAL RIGHTS AND CHILD PROTECTION

During a consultation, a mother of two young children accuses her husband of domestic violence. With your encouragement, she decides to seek police assistance. You seek advice from your colleagues, and in light of the potential risk of harm to the children, you report the situation to the social services. Subsequently, the father requests access to both the mother’s records and those of the children, seeking to understand your justification for reporting him to the police and social services.

## ADVICE

Obviously, disclosure of the mother's records without her consent is unjustifiable in this scenario. However, if the father has parental rights, he will retain a right of access to his children's records. You will need to determine whether disclosure is in the children's best interests, and may consult the mother to help determine if such interests exist. It is of course important to bear in mind that the mother has a vested interest in obstructing the father's request, and may not have been telling the truth about the domestic situation. Usually, the father will have a reasonable desire to need to understand his children's health issues.

In most countries, you would have justification for engaging the appropriate child protection services in a case such as this. Statistically, violent acts directed at the mother may unintentionally involve the children, or develop to include the children, putting them at high risk of harm. Such action could be reasonably defended if challenged by the father, although again, only if it does not involve a breach of the mother's confidentiality.

In the above case, the mother's records were subsequently disclosed in court as part of her evidence, and the father thereby became aware of their contents. Afterwards, he again approached you for copies of the mother's records, on the basis they had already effectively been disclosed to him. You were again advised that your duty of confidentiality to the mother precluded disclosure without her consent, even if the record had been disclosed in another domain.

## CASE STUDY 4

### AFTER A PATIENT'S DEATH

A famous patient died. His daughter applied to you seeking access to his medical records, so that she could better understand why he died. She later made a complaint against you. She is not the executor of his estate. Later still, attorneys seek copies of the notes as his children are in dispute over the will.

## ADVICE

Your duty of confidentiality to your patient extends beyond their death. However, it is not as protected as it would be in life, because clearly you cannot consult the patient. As a general rule, it would be considered acceptable to assist a close relative to understand the events leading

to the patient's death, even by sharing disclosure of the relevant part of the clinical record, although you may not wish to provide a copy without relevant consent from the next of kin or executor. There may be a need for appropriate caution, especially if the relative was known to have been previously estranged from the deceased.

Even if the relative is also the executor, their access to the records would still need to be justified and is not predicated on the fact that they have control over the estate.

If a relative of the deceased patient raises a concern regarding the patient's care, it is considered helpful – and may assist in preventing a subsequent claim – to attempt to provide a sympathetic and clear explanation of events, together with an appropriate apology, if necessary.

In the above scenario, even if you had previously disclosed details to help the daughter understand the events leading to her father's death, further disclosure, even of the same information, would be precluded if she made a complaint without the executor's consent. However, within the context of a legal dispute or claim on the estate, such consent may be inappropriate (if the identity of the executor is unclear because the will is disputed, for example). In these circumstances, attorneys can legitimately seek disclosure.

## IN SUMMARY

In all of the above scenarios, disclosure should only involve the minimum relevant information. Care must be taken not to disclose anything that may identify third parties (excluding clinicians involved in the patient's care) or cause the patient (if alive), or anyone else serious harm. Additionally, if the deceased had previously advised that they did not wish certain information disclosed after their death, then there should be no disclosure. However, there may be grounds for you to exercise some discretion in respect of sensitive data that, when alive, the deceased did not request remain confidential.

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

## REFERENCES

1. *Code of Professional Conduct for the Guidance of Registered Medical Practitioners*, Bahamas Medical Council (2013)
2. *Code of Standards of Professional Practice*, Cayman Islands Medical and Dental Council (2008)
3. *Code of Standards of Professional Practice*, Cayman Islands Medical and Dental Council (2008)
4. *Code of Ethics in the Practice of Medicine and Dentistry*, The Medical Council of the Virgin Islands (UK)
5. *Code of Standards of Professional Practice*, Cayman Islands Medical and Dental Council (2008)

## RELEVANT LEGISLATION AND GUIDANCE

Much of this issue is regulated by common law. Some countries have introduced legislation to cover additional elements:

### BAHAMAS

- Data Protection (Privacy of Information) Act 2003
- Code of Professional Conduct for the Guidance of Registered Medical Practitioners, Bahamas Medical Council, 2013

### BRITISH VIRGIN ISLANDS

- A Code of Ethics in the Practice of Medicine and Dentistry, The Medical Council of the Virgin Islands (UK)

### CAYMAN ISLANDS

- Freedom of Information Law 2007
- Code of Standards of Professional Practice, Cayman Islands Medical and Dental Council, 2008

### JAMAICA

- Access to Information Act 2002 (as amended)
- A Guide to Ethical Practice in Jamaica, The Medical Council of Jamaica, 2008

### ST LUCIA

- Data Protection Act 2011

### TRINIDAD AND TOBAGO

- Data Protection Act 2011
- Freedom of Information Act 1999

To read our factsheet on disclosure, visit [medicalprotection.org](https://www.medicalprotection.org) and click on the 'Casebook & Resources' link.



# CHALLENGING INTERACTIONS WITH COLLEAGUES

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

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

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

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

## IDENTIFYING RISKS

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

Changes in working patterns and the resultant increase in shift work and cross cover mean that a more doctors may be involved in a patient's care. As a result, abnormal investigation results may be missed, treatments may be monitored inadequately, or important comorbidities may not be taken into account, which all put the patient at risk of harm.

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

## PICK YOUR BATTLES

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

## CATCH AND STOP RISKY ASSUMPTIONS

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

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

## HANDOVER

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

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



## ACTIVELY MANAGE DISAGREEMENTS

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

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

## CASE REPORT

### WE DON'T TALK ANYMORE

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

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

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

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

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

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

## LEARNING POINTS

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

Medical Protection has a series of online learning modules on a range of topics including communication and interpersonal skills, to find out more visit [medicalprotection.org](http://medicalprotection.org) and click on the 'E-learning' link.



# TERMINATING A DOCTOR-PATIENT RELATIONSHIP

*A decision to end the relationship between you and your patient must be taken with caution and consideration, says Medicolegal Assistant Ralitsa Sahatchieva*

Once a doctor-patient relationship is established, it creates various obligations on the doctor relating to the duty of care that they provide. All healthcare practitioners should always regard a patient's well-being as their primary concern and ensure continuity of care. However, it is inevitable that some relationships will break down. In these instances you might need to know when it is appropriate to end the relationship, and what steps you need to take to ensure that no harm will be caused to the patient.

You are legally within your rights to refuse to treat a patient, except in an emergency. Below is a summary on how to terminate a doctor-patient relationship, while ensuring the patient's well-being and best interests are protected at all times.

## MAKING THE DECISION

A decision to terminate a doctor-patient relationship should be taken with great caution and due consideration.

It is imperative that you:

- reach this decision once all other means of resolving the problems have been explored and there is no other alternative
- can justify the decision to end the relationship, and that the decision was reached for the correct reasons, impartially and objectively
- ensure the termination is performed in an appropriate manner so that there is continuity in the care and treatment of the patient
- only decline to provide care if alternative care is made available to the patient, for example by referral to a public health facility or another practitioner.

It is also crucial that the patient is:

- given reasonable notice of when the termination of the relationship will become effective
- made aware of the process to avoid any expectations of continuing care.



## THE ACTIONS TO TAKE WHEN ENDING THE RELATIONSHIP

Should you reach the decision to terminate the relationship, you should take the following steps to ensure continuity of care and that the patient's well-being and best interests are protected:

- Inform the patient in writing of your concerns and that you are no longer able to treat them due to the irreparable breakdown of the relationship. The notification should indicate that you have taken this decision in the best interests of the patient and to ensure their long-term well-being. Remember to provide the patient with sufficient notice before the termination becomes effective.
- List your reasons for reaching this decision, and explain that you have explored alternative resolutions and exhausted all other measures of resolving the issue prior to reaching this decision.
- Indicate that you are going to assist the patient through the transition, including a referral to a new healthcare practitioner. Indicate that you will be happy to provide a referral letter containing all relevant clinical information if required.
- You should also inform the patient that they can collect a copy of their medical records, or alternatively a copy can be sent directly to the new practitioner, once that is established.
- Inform the patient that you will be happy to discuss this matter further.
- Ensure that you keep a copy of the letter and any further correspondence in the patient's medical records.
- Keep a detailed record of all your interactions with the patient.

## CASE STUDY 1

Mrs F saw Dr B with an infected ingrown toenail. However, at the end of the initial consultation, the patient became aggressive and violent. The patient continued to be hostile at the next consultation and was offensive towards Dr B and her staff. Dr B tried to investigate possible underlying causes for the patient's distress, for example fear or pain. She attempted to resolve the behavioural problems, but was unable to do so. Subsequently, she contacted Medical Protection for advice on whether she could terminate the doctor-patient relationship on this occasion.

### ADVICE

Dr B was advised that ending a doctor-patient relationship should only be used as a last resort. However, if a patient has been violent to any members of staff, or has been threatening to the point where there have been fears for personal safety, it may be reasonable to take steps to end the relationship. Dr B was advised to inform the patient of the reasons leading to the termination, and to document carefully the circumstances leading to her decision. She was advised she would need to make arrangements for the patient's ongoing care, and if transferring care to a colleague would be harmful to the patient, then she would have a responsibility to continue treating the patient until such time that the transfer of care would not cause harm.

## CASE STUDY 2

Dr A had been treating Mrs U for a couple of months, and she had recently started attending consultations with her husband. Dr A was not happy about this as the husband had a history of being verbally abusive towards his wife; however, the patient consented, and Dr A honoured her wishes. During the first consultation the patient's husband was offensive to Dr A, who had no choice but to ask him to leave the practice. Dr A felt very distressed and disheartened by this event and was concerned about continuing to treat the patient. He sought advice from Medical Protection on how to proceed.

## ADVICE

Dr A was advised that he would need to act in the best interests of his patient with regard to her care and treatment. The adviser suggested he ask to see the patient alone, and if this was not possible, explain to both the patient and her husband that abusive behaviour towards staff was unacceptable and would not be tolerated. Terminating the doctor-patient relationship should only be considered if all reasonable measures have been taken to resolve the situation, and if there was an irretrievable breakdown in the doctor-patient relationship. It should not be done because a patient (or their relative) complains or is critical or highly demanding, as this could result in a complaint from the patient or criticism by the regulator.

## CONCLUSION

Terminating a doctor-patient relationship can be challenging, however, if you choose to do this, ensure that:

- clear reasons are identified
- attempts have been made to address underlying causes with the patient concerned
- viable alternatives have been acknowledged, and either tried or rejected by the patient
- no overriding reason to continue has been identified for example, an emergency situation or a risk of interruption in necessary treatment.

If you find yourself in this situation and need support, contact Dr Jonathan Bernstein, the Medical Protection lead for medical services in the Caribbean and Bermuda, on **+44 113 243 6436**.

## WHAT DO YOU THINK?

We want to hear from you. Send your comments to:

[casebook@medicalprotection.org](mailto:casebook@medicalprotection.org)



# CLINICAL GOVERNANCE AND PATIENT SAFETY



Dr Richenda Tisdale and Dr Brian Charles explore how members can more effectively manage their clinical risk

**I**t is not possible to eradicate all risk from healthcare provision, but Medical Protection is often asked how practitioners and healthcare providers can manage risk, and what to do when things do go wrong.

Risk management is a process with a number of equally important components:

**• Identifying what has gone or could go wrong during care**

This includes having a robust reporting system to ensure that data on clinical and non-clinical incidents is captured at the time, to facilitate analysis later. All incidents, including ‘near miss’ incidents, should be recorded in a standard format. Ensure that all staff are aware of the reporting system and that they have a duty to record and report any incidents they become aware of.

**• Understanding the factors which led to the incident**

Analysis of clinical incidents and near misses may take the form of a Root Cause Analysis to identify any individual error or system failings. Rather than looking to attribute blame, this exercise is to identify learning points.

**• Learning lessons from adverse incidents or near misses**

Where learning points are identified, it is helpful to keep clear records of who is responsible for undertaking any changes to systems, and to set an audit date by when these actions should be brought in.

**• Taking action to prevent recurrence**

Once any actions have been taken, it may be worth re-auditing to ensure that the new process is functioning and has achieved its aim of reducing risk in this area.

**• Devising robust systems to reduce risks**

Testing systems for issues can highlight any potential errors before they arise. Changes can then be made to introduce additional checks as necessary. For example, auditing the systems for prescribing and creating surgical checklists.

**Continuing Medical Education (CME)**

Clinical governance also includes continuing education for all staff, to ensure that they are working in accordance with best practice and are up-to-date with new guidelines or developments. In many regions, CME is now mandatory, and Medical Protection offers educational content online and conducts lectures throughout the region on a wide variety of topics. We are working to ensure that our educational courses are accredited in all territories.

**Improving Patient Safety**

Despite robust safety systems and checks, complications and errors will still occur. When they do, we are here to advise on how best to handle them. We work with our individual and corporate members across the region to help to improve patient safety.

Medical Protection corporate member Mount St John’s Medical Centre (MSJMC) in Antigua takes a proactive position on risk management and employs specialist staff to collect and analyse patient safety data. MSJMC benchmarks its performance against national quality and safety standards as part of a drive to ensure continuous improvement.

Cheryl Weaver, Clinical Risk Manager at MSJMC, is an experienced analyst and responsible for clinical incident reviews. She also designs policies to reduce adverse incidents, conducts regular clinical risk self assessments, and holds educational sessions with staff on risk management and the importance of adverse incident reporting.



Cheryl found Medical Protection advice helpful during a case in which communication with a patient’s family was difficult and resulted in a threat of legal action.

“There was disjointed and inadequate communication between the medical team and family members who threatened to sue for negligence and wrongful death,” she says.

“We approached Medical Protection for advice and a format was devised for a meeting with the family. I moderated the proceedings according to the plan, and the meeting was a success.”

Communication is key to resolving clinical incidents. Being able to demonstrate that a robust review has taken place if something has gone wrong can reassure a patient that this has been taken seriously and will not happen again. Some patients and relatives have felt that the only way to get information from a doctor is to bring a claim for negligence; being open, honest and transparent and demonstrating what steps have been taken to improve the service may go a long way to avoiding a complaint or claim.

Medical Protection has a series of online learning modules on a range of topics including communication and interpersonal skills, to find out more visit [medicalprotection.org](http://medicalprotection.org) and click on the ‘E-learning’ link.





# FROM THE CASE FILES

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



Join the discussion about this edition's case reports. Visit [medicalprotection.org](http://medicalprotection.org) and click on the 'Casebook and Resources' tab

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

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

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

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

Communication and process errors are other themes emerging from this edition's case reports. In Mr T's case an abnormal MSU result was marked as normal and filed in the records without action. Notwithstanding that Dr W had no record of having received the health screener's letter, the practice's failure to communicate the abnormal result to the patient or to flag it up in the records led to further actions which compounded

the problem and was indefensible. 'Turning a blind eye' is another example of how a failure to communicate an abnormal result to a patient can have devastating consequences. In this case Dr L, in his desire not to alarm the patient or to disclose sensitive information in a letter, failed to convey to Mrs R the urgency of his request such that she chose to ignore it. In such circumstances it is imperative that the request is followed up if the patient fails to attend within the anticipated timeframe.

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

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

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

## What's it worth?

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

- HIGH US\$2,000,000+
- SUBSTANTIAL US\$200,000+
- MODERATE US\$20,000+
- LOW US\$2,000+
- NEGLIGIBLE <US\$2,000

# A HIDDEN PROBLEM

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

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

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

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

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

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



## EXPERT OPINION

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

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

## Learning points

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

AF

## REFERENCES

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

# DIATHERMY DRAMA

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



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

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

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

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

**Learning Points**

- Flammable fluids employed for skin preparation must be used with caution.
- The UK Medicines and Healthcare products Regulatory Agency (MHRA) warns that "spirit-based skin preparation fluid should not be allowed to pool and should be dry or dried before electrosurgery commences".<sup>1</sup>
- The fire triangle is a simple model illustrating the three necessary ingredients for most fires to ignite: heat, fuel, and oxygen. In clinical situations such as the one described above, diathermy provides the heat and skin preparation fluids provide the fuel.<sup>2</sup>

AF

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



# TURNING A BLIND EYE

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

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

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

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

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

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

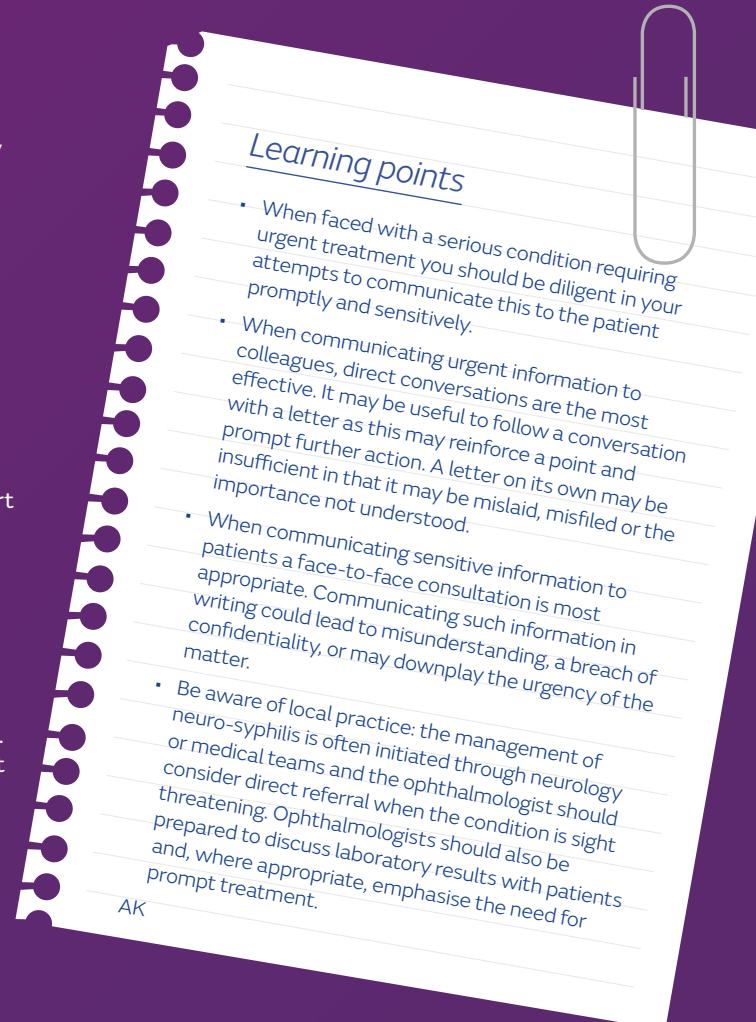
Mrs R was treated with penicillin and corticosteroids, which cleared the infection. Post-treatment visual acuity in the left eye was 6/5 but she had a severely reduced field of vision. In the right eye her visual acuity was light perception only. Although these changes had stabilised, Mrs R was assessed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

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

### EXPERT OPINION

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

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



### Learning points

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

AK



# TRIPPED UP

A child is unable to weight bear after a fall



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

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

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

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

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

Despite extensive surgery Master Y was left with a short-legged gait and by the age of 16 he was increasingly incapacitated by pain in his right hip. Surgeons considered that he would need a total hip replacement within 10 years, and that a revision procedure would almost certainly be required approximately 20 years after that.

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

## EXPERT OPINION

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

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

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

## Learning points

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

AF

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1. Peck D, Slipped Capital Upper Femoral Epiphysis: Diagnosis and Management, *Am Fam Physician* 82(3):258–62 (2010)

# TUNNEL VISION

A patient presents several times with a worrying vaginal discharge

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

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

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

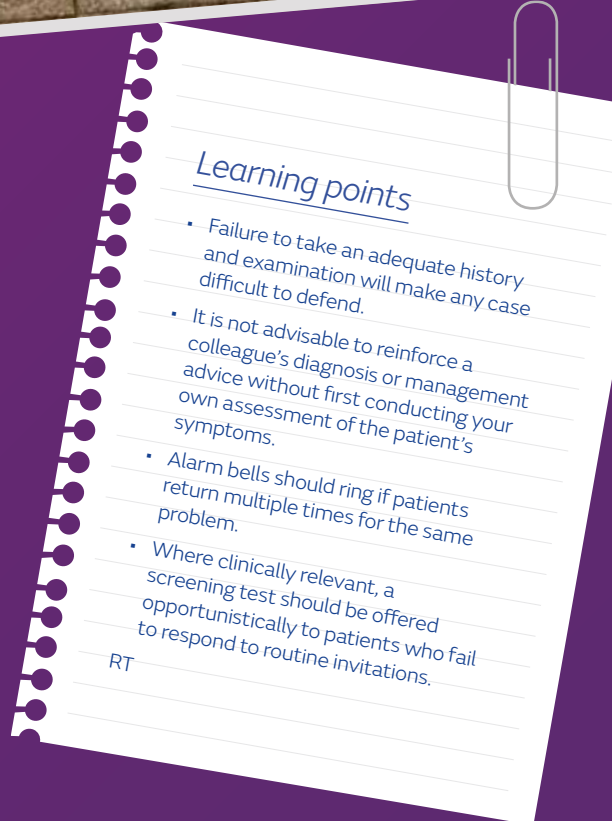
A week later, Mrs O re-attended the surgery where Dr B agreed to try empirical clotrimazole on the premise she may be suffering from thrush. Again, no examination or investigations were discussed, and there was no evidence of safety-netting advice documented in the records.

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

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

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

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



## Learning points

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

RT

## EXPERT OPINION

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

# AN UNLUCKY TUMMY TUCK

A patient is unhappy with the outcome of cosmetic surgery



© Chris Ryan/gettyimages

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

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

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

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

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

## EXPERT OPINION

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

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

## Learning points

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

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

PM



# A RISK OF HARM

A psychiatric patient is placed under close observation



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

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

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

Miss A made a good recovery from this incident and subsequently brought a claim against Dr W and the hospital. She alleged Dr W had failed to prescribe adequate doses of medication to ensure the optimal level of improvement in her mental health symptoms, failed to adequately assess the level of risk she posed, and failed to ensure constant specialist nursing care was provided to supervise her adequately during her hospital stay. She also alleged the hospital had failed to ensure she did not have access

to a cigarette lighter. Miss A claimed that she would not have suffered the severe burns and subsequent post-traumatic stress disorder if not for these failings.

## EXPERT OPINION

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

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

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

## Learning points

- Mental health units should have clear policies regarding observation levels and all staff should be aware of these. The observation level deemed appropriate for each patient should be clearly discussed with ward staff and documented within the notes, both on admission and whenever changes are made. The justification for any changes in the level of observation should be clearly documented.
- Robust risk assessment is always important. Risk assessment tools are available, and you should be familiar with any relevant local policies regarding these. Decisions made about the risk posed by a patient to themselves or others should be clearly documented and communicated.

- Mental health units should also have policies surrounding the requirement to check patient's belongings when they are admitted and for removing any items that may pose a risk, including lighters and any sharp implements.
- If a lack of resources results in patient safety concerns, these should be raised by the clinician involved.

CNR



# PAEDIATRIC BRAIN INJURY

Surgery for an arachnoid cyst is complicated by an intracranial bleed



© minor/Gettyimages

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

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

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

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

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

The parents pursued a claim alleging:

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

## EXPERT OPINION

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

The expert was not critical of the decision to transfer BC to a paediatric ward (on the basis that she did not require ventilation and that the monitoring facilities on the ward were appropriate) but was concerned about the lack of written and verbal instructions (particularly directed towards the nursing staff) relating to the post-operative care and

neurological observations. In addition, the expert was of the opinion Dr S should have reviewed BC on the ward given that he had performed a surgical procedure on her that had been complicated by bleeding.

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

## Learning points

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

RS

# BACK TO FRONT

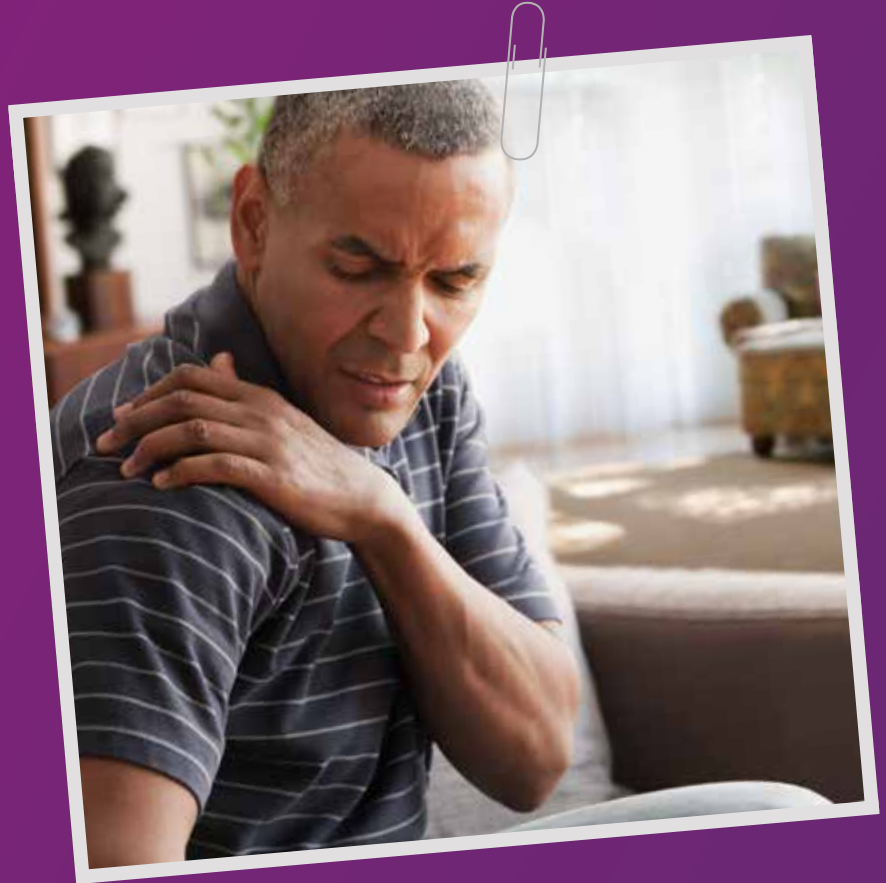
An unusual presentation masks a significant underlying diagnosis

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

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

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

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



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

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

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

Six months later, Mr W was struggling to work at all. He rang his GP surgery and was given an appointment with a locum GP, Dr R. Her notes detailed a several year history of chest

and back pain on lifting and exercise that had worsened recently. Pain was recorded as occurring every day and being “tight” in character. It was also noted that he was diabetic, smoked heavily and that his mother had died of a myocardial infarction at the age of 58. Dr R referred him to the rapid access chest pain clinic.

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

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



## EXPERT OPINION

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

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

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

## Learning points

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

AF

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# A MISSED OPPORTUNITY?

A patient suffers complications following spinal surgery

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

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

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

## EXPERT OPINION

An orthopaedic expert instructed by Medical Protection made no criticism of the conduct of the surgery, but was very critical of the poor quality of Dr D’s clinical records. Although Dr D was adamant that the risks of surgery and alternative treatment options

were discussed with Mrs W, he made no note of this in the patient’s records nor did he make reference to any such discussions in his letter to the GP. Furthermore, despite Dr D’s assertions that he reviewed Mrs W every day post-operatively prior to her discharge, he made no entries in the records to this effect, stating that he had relied on the nurses to do so. The nursing records did not corroborate this.

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

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

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



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Learning points

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

JP

## DIAGNOSING PNEUMONIA OUT OF HOURS – CORRECTION

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

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

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

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

Dr Brian Murray

### Response



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

## FAILURE TO DIAGNOSE PRE-ECLAMPSIA

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

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

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

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

Dr Douglas Salmon

## A FAMILY MATTER

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

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

Dr M Shah

## PROBLEMATIC ANAESTHETIC

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

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

Dr Mohammed Akuji

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2. Folstein, MF, Folstein SE and McHugh PR, "Mini-mental State". A Practical Method for Grading the Cognitive State of Patients for the Clinician. *J Psychiatr Res* 12(3): 189-98 (1975)

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# REVIEWS

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



## OMNIFOCUS (IOS, MAC) OMNI GROUP

[omnigroup.com/omnifocus](http://omnigroup.com/omnifocus)

Review by: Dr Jennifer Munroe-Birt

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

For doctors, the app is useful to arrange and categorise the abundance of tasks at hand (projects, meetings, CV, CPD). You can easily categorise individual tasks into bigger projects (holiday, that audit you've been meaning to finish

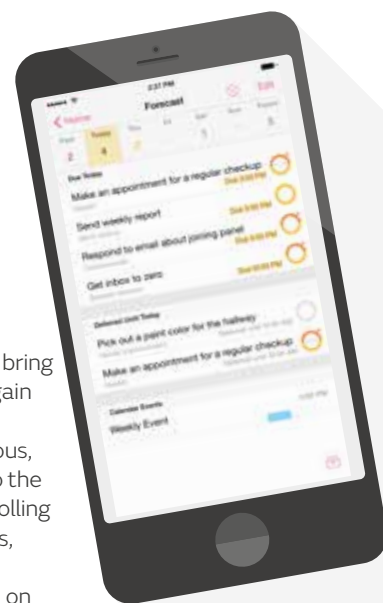
all year) and assign deadlines to each task. Being able to break each 'project' into smaller, more manageable chunks will appeal to anyone who has sat down to start a big piece of work and found themselves still on Facebook half an hour later because they are too daunted to take the first step.

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

One of my favourite features is the ability to defer certain tasks once they are out of your control

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

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



## RISE

By Sian Williams

Review by: Rosie Wilson

Rise describes itself as a "psychological first aid kit" and it's easy to see how – to a certain reader – it could serve as just that. The autobiographical book follows BBC newsreader Sian Williams' journey through the treatment of, and recovery from, breast cancer.

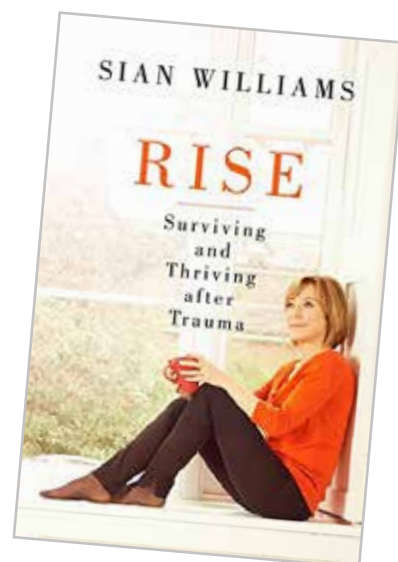
From a doctor's perspective, it is interesting to see the patient's perception of her medical journey. The book includes a lot of medical jargon, records of what was told to Williams, followed immediately by her confessions of feeling confused and overwhelmed. It can be easy to forget how alien all the information about a disease or condition is to a patient when you've been immersed in it for years.

Treat Rise almost as a manual, then; Williams talks in detail about the doctors she liked – and the ones she didn't – and the differences in their treatment of her. Compassionate, matter-of-fact and not at all pandering, Williams' accolades for her favourite doctors reflect the sort of praise we might want to hear about ourselves professionally.

From a general human perspective though, the reader is struck by the emotion and candour of the book. Williams focuses not just on herself but on those around her: her mother, who died of cancer just a few years before she was diagnosed herself; her brother-in-law, who she perceives to have "worse cancer" than she does; and the

interactions she has with her young children as they struggle to understand the situation. After all, medical professional or not, all of us have experienced – or will experience – cancer on a personal level at some point in our lifetimes, and it's the relatability that makes the book so hard to put down.

Thanks to her background as a journalist, Williams understands the balance between facts and feeling. The book is an insight into the typical everyday thoughts of a patient going through long-term treatment – not just for cancer, but for anything that has an impact on day-to-day living.





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