

When things go wrong

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Case histories are based on actual medical negligence claims, however, certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

Despite the best intentions of medical practitioners, things do go wrong from time to time and a patient may experience an adverse outcome as a result of a medical practitioner's actions. This article discusses some of the issues that general practitioners should consider when things go wrong.



Case history

Mr Andrews, a 51 year old businessman, attended Dr Halliday for a check up. Mr Andrews was well but thought he should have a check up with a GP because one of his business colleagues had recently had a heart attack. Dr Halliday performed a physical examination. The examination was normal apart from a few solar keratoses on the patient's arms. Dr Halliday gave Mr Andrews a pathology form for a serum cholesterol and triglycerides. In view of the fact that Mr Andrews was now over 50 years of age, Dr Halliday also recommended that faecal occult blood testing (FOBT) be performed. After discussion, the patient agreed to undergo the tests. Dr Halliday asked him to make another appointment in two weeks to discuss the results of the tests and have the solar keratoses treated with liquid nitrogen.

The patient returned three weeks later. The results of the blood tests were normal, however, the FOBT results were not yet available. The patient said that he had dropped the FOBT kit into the pathology office a few days ago. Dr Halliday advised Mr Andrews that he would ring him when the results were available. He treated the patient's solar keratoses and advised him to return in two years for another check up or earlier if he had any problems.

Seven months later, Mr Andrews returned for review. He gave a several month history of intermittent abdominal pain and bloating. He had also had two episodes of bright PR bleeding on the day before the consultation. Abdominal and rectal examination did not reveal any abnormalities. Dr Halliday provided the patient with a referral to a local gastroenterologist with a view to having a colonoscopy to investigate the symptoms further. A few weeks later, Dr Halliday received a phone call from the gastroenterologist advising him that Mr Andrews had a biopsy proven cancer of the sigmoid colon. The gastroenterologist had referred the patient to a colorectal surgeon for excision of the tumour. The surgeon wrote to Dr Halliday confirming that the patient had undergone a successful abdominoperineal resection. Pathology confirmed a Dukes stage B cancer.

A few weeks after the surgery, Mr Andrews reattended Dr Halliday. The patient wanted to know why the FOBT performed seven months previously had failed to reveal the presence of the bowel cancer. Dr Halliday reviewed the medical records and, to his horror, discovered that the results of the FOBT were positive. For some reason the results appeared to have been filed before Dr Halliday's review.

Medicolegal issues

Dr Halliday immediately advised the patient that the results of the FOBT had, in fact, been positive for blood. He apologised to Mr Andrews as follows:

'I'm sorry but due to what appears to have been a problem with our filing system your test results had been filed before my review. You have my deepest sympathy for not being advised of the results earlier. I can assure you that I will be reviewing our practice systems with our staff to ensure that this type of problem with the filing of test results does not happen again. I'd be happy to sit down and discuss this with you further once I have had a chance to discuss this issue with my staff and your specialist, and again, I'm sorry'.

Mr Andrews appeared quite shocked and angry. He asked for a copy of the test results and his medical records. Dr Halliday provided him with a copy of his medical records and asked him to come back and discuss the matter in a few days time.

Dr Halliday organised a staff meeting where the issue of follow up and the filing of test results was discussed. The practice developed a stamp that was to be placed on all the test results received at the practice. This included a notation that the

results had been reviewed by the referring doctor and that the patient had been advised of the results and any follow up that was required. No results were to be filed until these steps had been completed. Dr Halliday also contacted his medical defence organisation and advised them of this potential incident.

Mr Andrews did return to discuss the matter with Dr Halliday. The patient wanted to know if the delay in diagnosing his bowel cancer had affected his prognosis. He also wanted to know what steps had been taken to prevent a similar event occurring with another patient. At the conclusion of the consultation, Mr Andrews confirmed that he would be seeing another GP in the practice in future.

Discussion

Despite the best efforts of GPs and their staff, errors related to a delay in diagnosis or incorrect treatment will occur from time to time. No human or system is error free.

A recent study exploring the attitudes of patients and doctors to the disclosure of medical errors and adverse outcomes revealed that both groups often had unmet needs following an error.¹ Patients wanted disclosure of all errors and sought information about what happened, why it happened, how the error's consequences might be mitigated, and how recurrences would be prevented. Doctors agreed that errors should be disclosed but were concerned about admitting legal liability. Patients also wanted emotional support from doctors following errors, including an apology. Doctors were also upset when errors occurred but were unsure where to seek emotional support.

Risk management strategies

When dealing with an adverse outcome, GPs should consider and respond where appropriate to the following issues. These points are not presented in order of priority as each set of circumstances will have different requirements.

Communicating with the patient

- Always discuss the problem with the patient and/or their family in a full and frank manner.
- You are encouraged to arrange a face-to-face meeting as soon as possible after an adverse outcome has occurred. This meeting should not be rushed.
- Spend time with the patient and offer support and concern for the situation the patient now faces. This can include a discussion about the uniqueness of the case and any extenuating circumstances involved in the treatment.
- Ensure your manner is one of empathy and compassion.
- The patient should be given time to ventilate their feelings about the outcome and anxieties regarding future treatment and care.
- Any discussion should use layman's language and care must be taken not to confuse the patient with technical terms.
- In all discussions avoid defensiveness and laying blame.
- Do not admit any negligence or liability.
- A factual account of the event is what the patient is seeking and is entitled to receive.
- When you offer support, follow up and additional treatment, this does not mean accepting legal liability.
- As the treating GP, you are required to arrange any appropriate referral for further treatment. Assistance should also be provided in arranging any allied health referral, such as physiotherapy, that may be warranted.
- As the treating GP it is your responsibility to ensure the patient is closely followed up. It is important that the patient does not feel abandoned when a referral is made.
- You should not agree, at this time, to pay for further treatment.

Handling the event

- An adverse incident is an emotionally charged event for all parties. The prime concern is to support the patient. Any investigation and review

of potential negligence can be undertaken when the crisis has subsided.

- There are appropriate avenues for redress if required. The immediate concern is to assist the patient and their family adjust to their changed circumstances.

Further actions to undertake

- Document the event in detail in a factual manner.
- Do not include additional comments with your personal interpretation of the possible reasons for this outcome. Date and sign the new notes.
- Advise your medical defence organisation of any adverse outcome that may lead to a claim as soon as possible and no later than one week after the incident.
- Access your medical defence organisation's 24 hour advice hotline for additional guidance on individual situations.

SUMMARY OF IMPORTANT POINTS

When an adverse event or error occurs, GPs should:

- Organise prompt and appropriate care for the patient and prevention of further harm.
- Always discuss the problem with the patient and/or their family in a full and frank manner. A factual account of the event is what the patient is seeking and is entitled to receive.
- An adverse incident is an emotionally charged event for all parties. The prime concern is to support the patient.
- Document the event in detail in a factual manner.
- Advise your medical defence organisation of any adverse outcome that may lead to a claim or complaint.

Reference

1. Gallagher T H, Waterman A D, Ebers A G, Fraser V J, Levison W. Patients' and physicians' attitudes regarding the disclosure of medical errors. JAMA 2003; 289:1001-1007.

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