The consequences of medical mistakes: the stakes are getting higher!

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In February 2010, consultant colorectal surgeon David Sellu was referred and subsequently operated upon a patient with a perforated bowel who later died. The surgeon was found guilty of manslaughter by gross negligence and sentenced to two and a half years in prison. Roger Kirby reviews the case in detail and outlines the lessons to be learned from the tragedy.

No doctor comes to work aiming to injure a patient. Unfortunately, mistakes can and do happen, and as a result a patient may be seriously harmed; he or she may even die as a consequence of a doctor’s action, or inaction. This is why we all need medical insurance and why we need to be aware of how to react and what can happen to us if we do inadvertently make a serious error.

When a patient is badly injured as a result of a medical error, a ‘serious untoward incident’ investigation is likely to be initiated; suspension, litigation, or action from the General Medical Council (GMC) leading to erasure from the medical register may follow. If the medical mistake is considered serious enough, the police may even become involved and rarely a criminal charge may result.

The following case study is adapted from a report in the Sunday Times Magazine.

CASE STUDY
Jim Hughes, a 67-year-old from Northern Ireland, had spent most of his life in Chiswick, West London, where he brought up six children and started a successful building firm. When he retired, he settled with his wife, Ann, back in Loughgall, Co Armagh. When knee trouble started to interfere with his golf 4 years ago, he was told he needed a knee replacement. On the advice of a GP friend, he chose to have it done at the Clementine Churchill private hospital in Harrow.
The knee replacement itself went well, but after 4 days Mr Hughes started complaining of unrelated abdominal pain. He found it difficult to make himself understood to the Bulgarian resident medical officer, who was responsible for monitoring patients once their consultants had gone home. Dr Georgiev was the only doctor after hours in the 141-bed hospital. In broken English, he explained in court that he had been on a 24-hour shift and was so busy he had prescribed painkillers for Hughes, but had failed to make medical notes. Nor had he informed Mr Hollingdale, the orthopaedic surgeon, about the problem.

In desperation, Hughes phoned his GP friend for help. She told him to ring Mr Hollingdale direct, who ordered an x-ray and asked Mr David Sellu, a 63-year-old general surgeon with a previously unblemished record, if he would take a look at his patient. Mr Sellu went to visit Jim Hughes when his outpatient clinic at the Clementine Churchill hospital finished, around 9pm on Thursday evening.

Perforated bowel suspected

The next 24 hours would have disastrous consequences for both men. The x-ray was inconclusive, so Mr Sellu, who suspected a perforated bowel, ordered a CT scan for the next morning, explaining later that he ‘really wanted the patient to have a peaceful night’.

David Sellu said that he asked Dr Georgiev to administer two varieties of antibiotic. Dr Georgiev denied being given that instruction. David Sellu said that he checked on Hughes as he arrived at the hospital at 9.30am on Friday morning, but no one saw him go into Hughes’ room, he did not write in Hughes’ notes, nor did he notice that his patient had not been given antibiotics.

Later that morning, Hughes had the CT scan. David Sellu was informed by the radiologist at lunchtime that there was free gas in Hughes’ abdomen, confirming a bowel perforation. On past experience, and believing Mr Hughes was on antibiotics, David Sellu calculated that surgery could wait until he had finished his afternoon list. Just before operating, he logged on to the hospital computer to refresh his memory on the CT scan results. The criminal charge arose from a dispute over when he had actually seen those results. Mr Sellu had told the coroner it was at lunchtime, understanding the question to mean: ‘When did he know the results?’ The coroner, aware that the computer record showed Sellu had not seen the scan until 9pm, suspected he was lying. Sellu was charged with perjury but later acquitted of that particular misdemeanour.

While Hughes was having his CT scan, Mr Sellu was performing a series of endoscopies on a pre-booked list of patients. Having decided Hughes needed surgery, Sellu tried, but failed, to find an anaesthetist who could assist. Unlike an NHS hospital, which always has a staffed emergency operating theatre at the ready, in private hospitals a consultant anaesthetist has to be found who is ready and willing to take on the case.

Mr Hughes’ daughter spoke to her father mid-afternoon. ‘I was concerned when I heard he needed another operation. I said I’d come straight away and he told me he was going to theatre soon, so I might miss him — that’s how quickly he expected it to happen.’ Meanwhile, Sellu had called half a dozen anaesthetists and was running out of options. He eventually managed to persuade a colleague who was already booked for an hour-long gynaecological operation to assist once that was finished, around 6pm, but the operation was more complex than expected. As a consequence, several hours’ further delay resulted.

As Mr Hughes was eventually taken down for surgery at 9.30pm on Friday night, a nurse reassured his daughter that ‘everything will be fine’, but in theatre there was alarm. Hughes could barely be stabilised for anaesthetic. At laparotomy his abdomen was full of pus. He died the following day of multi-organ failure resulting from sepsis.

The trial outcome

At the trial the prosecution’s case was that Mr Sellu had got it wrong at every stage. If he suspected a perforated bowel on the Thursday evening (a condition that carries a 40% mortality rate in a man of Hughes’ age), he should have ordered an immediate CT scan and acted on its results, either by transferring Hughes to an NHS hospital or operating straight away. He should have checked that Mr Hughes had received antibiotics, written notes, cancelled his pre-booked patients and insisted another surgeon operating at the hospital that day interrupt his list so Mr Hughes could undergo surgery expeditiously.

The judge said David Sellu’s attitude was ‘simply far too laid back’ for someone dealing with a patient with life-threatening peritonitis resulting from a perforated bowel.

While acknowledging that ‘even if you had acted more speedily, there was a chance that Mr Hughes would have died anyway’, the judge, Mr Justice Nicol, said David Sellu’s attitude was ‘simply far too laid back’ for someone dealing with a patient with life-threatening peritonitis resulting from a perforated bowel. Mr David Sellu was sentenced to two and a half years in prison.
DISCUSSION
David Sellu’s case has sparked considerable discussion and debate within the medical profession (www.bjui.org). Although his management of the patient was clearly inadequate and the delays unacceptable, many have found it hard to see what value to society is served by imprisoning a 67-year-old surgeon for two and a half years. A GMC enquiry, perhaps followed by a striking off the register, might be considered a more appropriate response to this case, rather than a police prosecution.

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If any good at all is to stem from this sorry tale, we should all take the opportunity to learn the lessons from it. Patients who become acutely ill either at home or in a private clinic that does not have its own intensive care unit should be transferred urgently to an NHS unit where such facilities are available. Clear concise notes need to be made in the patient’s records at each and every juncture. Other colleagues should be involved in cases where the patient is deteriorating or the diagnosis uncertain. When a tragedy as a result of a medical error has occurred, after all attempts to rectify the problem have been instituted, an open honest apology should be made to the family and relatives and every opportunity taken to learn from the mistake and thereby prevent a recurrence.

Improving patient protection

The GMC has launched a major consultation to improve patient protection and public confidence in doctors. Doctors who have harmed patients could face sanctions even if they can show they have subsequently improved their practice in serious cases. This is one of a number of far-reaching proposals to protect patients and uphold public confidence in the medical profession. Doctors will be expected to apologise to patients if they have caused them any harm, and in future failure to do so could affect the sanction they face. Under the proposals, doctors could face restrictions on their practice, suspension or even have their registration removed if, for example, it is shown that they knew or should have known they were causing harm to patients in serious cases. This could happen even if they had demonstrated that they subsequently had improved their practice.

Niall Dickson, Chief Executive of the GMC, said: ‘Doctors are among the most trusted professionals, and rightly so, and they deserve to be treated fairly. In the vast majority of cases, one-off clinical errors do not merit any action by the GMC. But if we are to maintain that trust, in the small number of serious cases where doctors fail to listen to concerns and take action sooner to protect patients, they should be held to account for their actions.

‘There have been occasions when we have been prevented from taking action in serious cases because the doctors have been able to show that they have subsequently improved their practice. We believe that doctors and patients want stronger action in these serious cases. It is also right that patients or their families are told what went wrong and if appropriate they should be given a full apology. We believe this should be taken into account when deciding what, if any, sanction needs to be imposed to protect future patients and uphold the reputation of the profession.’

Some readers may find the contents and implications of this article somewhat disconcerting, even alarming. However, if the climate of the response to medical error is becoming more stringent, we surely had better be aware of that, and try to adapt our practice accordingly. Adoption of a more cautious cross-checking approach is a good start; some may consider that defensive medicine. Unfortunately, medical mistakes will always occur, but after appropriate remedial action, a carefully considered, honest and apologetic response will hopefully avoid us being erased from the medical register, or worse, following the unfortunate Mr David Sellu for a prolonged spell at Her Majesty’s pleasure.

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REFERENCES