

# Clinical Communiqué

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Next Edition: March 2019

## EDITORIAL

Welcome to the final edition of the Clinical Communiqué for 2018. We finish this year with a double edition, drawing attention to the important lessons covered through the year, and featuring three cases on the theme of doctor-patient communication. We wrap-up our extended edition with a special commentary by a renowned clinician and writer.

As in previous years, our 2018 editions have led our authors and readers through a diverse range of healthcare and patient safety topics. Our intention is to challenge each of us to stop and think about what we can do to ensure that such cases do not recur, and so need never be written about again. Over the past 12 months we looked at the rare but devastatingly fatal complications of gas embolism (Vol. 5, Iss. 1), the difficult clinical scenarios where missed diagnoses occurred in patients presenting to emergency departments (Vol 5, Iss. 2), and the confronting issue of healthcare practitioner suicide (Vol 5, Iss. 3).

The common threads weaving through each of these editions are the importance of building awareness, encouraging reflection, maintaining clinician well-being, and strengthening the systems within which we work. These factors all interact and contribute towards patient safety as demonstrated in the 'Polygon of Patient Safety' diagram (see page 2).

The diagram represents the four key goals that clinicians must develop to create real and sustained improvements to patient safety. *Building awareness* incorporates knowledge of cognitive bias, 'red flags' and commonly missed diagnoses, and lessons to be learned from cases. *Strengthening systems* includes learning from what goes wrong ('Safety 1') as well as from what makes high-performing systems work well ('Safety 2'), and then feeding that input back into systems for continuous improvement.

*Encouraging reflection* optimises the ability of individuals and systems to improve practice following adverse events, and truly identify the underlying causes, whether through knowledge distribution, or an improved ability to prevent, trap, and mitigate errors.

Finally, clinicians who are unable to look after themselves are more prone to errors, and are sometimes tragically a risk to their own lives. Maintaining well-being through fatigue management, breaking the stigma of mental health and providing support for those in distress, building resilience in individuals, and promoting wellness, is the pathway towards a well-slept, well-trained, and well-supported workforce. This will lead to a healthier environment for both staff and patients.

Whether we are at the beginning of our careers, or carry a wealth of lived experience and skill, we should aim to apply these concepts to our clinical practice. The imperative is promoting the well-being and safety of our patients and, notably, ourselves.

## EDITORIAL (Continued)

We go to work each day and strive to do our best and care for our patients. Most of the time, we succeed, however, sometimes we don't and the systems fail us and our patients. While we need to reflect on the contributing or underlying factors for system failure, we should also look at the times when things worked well. Patient safety is about looking forwards as well as back, always learning, so that we create the systems that will support our best efforts.

In this issue, we explore three paediatric cases, and the lessons learned from the sad, and unsurprising consequences of flawed doctor-patient communication. We welcome two new authors, Dr Raymun Ghumman and Dr Naomi Spotswood who bring their own expertise to the featured cases. Dr Ghumman is a Melbourne-based general practitioner who has taken a position as a clinical education mentor with the Australian Volunteers Program in Laos PDR. Her work focuses on improving the quality of medical education, including clinical communication skills and curriculum review. Dr Spotswood is a neonatologist practising in Tasmania who has interests in medical education, neonatal research, and improving health equity.

For those who want to read more on doctor-patient communication, I recommend the book *'What Patients Say, What Doctors Hear'*, by US medical practitioner and academic, Dr Danielle Ofri. In her book, Dr Ofri argues that, *"Of course, there's no shortage of barriers to doctors focusing on high-quality communication. There's crowded clinics, tight budgets, endless record-keeping and paperwork for a start. Even so, doctors can't afford to compromise their greatest tool — connecting with the ill and engaging patients in a meaningful way."*\* The cases we present in this edition demonstrate that two-way communication can also fail in the other direction. In other words, the gulf between what doctors say, and what patients hear.

There are many reasons why patients and their families may not fully appreciate the information given to them by their doctor. Denial, distractions, cognitive or language difficulties, are just a few of the legitimate obstacles to overcome. When we are sick, and in pain, causing us to be scared and worried, it is hard to comprehend even the most simple and direct instructions. So, when our well-intended clinical instructions are nuanced, vague, rushed, or conveyed in overly technical language, we are setting our patients up to miss the cues, and we have failed them. Medicine is imprecise but that is all the more reason why we need to be precise in how we communicate.

We are thrilled to round off our 2018 editions with the expert commentary written by Dr Ranjana Srivastava. Dr Srivastava is an oncologist, Fulbright scholar in ethics, award-winning writer and columnist for The Guardian. Her writings are also frequently published in the New England Journal of Medicine. She is a recent finalist for the Walkley Award for Excellence in Journalism and the recipient of the Medal of the Order of Australia for her contribution to the field of doctor-patient communication. Her thought-provoking and eloquent messages embody the theme of this edition - communication is the key.

In sharing her learnings with us, Dr Srivastava also imparts us with a clear sense of how powerful a message can be when communicated well.

\* Ofri D. *What Patients Say, What Doctors Hear*. Boston, Massachusetts; Beacon Publishing; 2018.

### The Polygon of Patient Safety



# CASE #1 MORE THAN A SORE THROAT

Case Number:  
24/2016 SA

Case Précis Author:  
Dr. Raymun Ghumman  
BA, BSc, GCertInt&CommDev,  
MBBS, DCH, FRACGP

## CLINICAL SUMMARY

BK was a previously well 10 year old girl with a past history of a tonsillectomy. One afternoon, BK became unwell and went to bed early. The following day she stayed in bed with a fever, vomiting, headache and a sore throat for which her mother gave her paracetamol. The next day, BK's mother took her to the local general practitioners' (GP) clinic where she was diagnosed with a viral infection. A script for antibiotics was also provided, which BK's mother was instructed to commence if she felt them necessary. The script was filled immediately.

Over the course of the day, BK did not eat or drink, and reported an unremitting sore throat. Her mother decided to take her to a major metropolitan hospital, some distance from their home. There she was assessed by a paediatric registrar, and reviewed by a paediatric emergency medicine consultant. A number of painful lesions were observed on the back of her throat. The lesions were swabbed and tested for respiratory viral PCR, general microbiology, and Bordetella PCR. Although BK was deemed well enough to go home, a period of observation in hospital was also offered. BK's mother chose to return home with her. At discharge, BK's mother was advised to return to the hospital or see their GP if BK became worse.

BK continued to experience throat pain and malaise. The day after the hospital visit, BK's mother took her to the local hospital where she was seen by a GP, Dr S, who noted her temperature was 38.8 degrees Celsius, pulse rate was 115 beats per minute (bpm), and oxygen saturations were 94% on room air. Dr S also noted multiple small ulcers at the back of her throat and diagnosed a viral infection, most likely glandular fever.

Dr S recommended a course of prednisolone (a corticosteroid) to relieve the sore throat, and requested that BK return for a review the next day.

The following day, Dr S deemed BK to be marginally better, her temperature was 37.6 degrees Celsius, pulse rate 95 bpm, and oxygen saturations 98% on room air. Dr S advised BK's mother to continue with the medications and fluids. BK's mother did not think that BK had improved though, as she was still listless and not interested in eating or drinking.

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*Dr H called BK's mother that afternoon saying that the blood results were unusual and that he would seek further advice from the laboratory, which he did in a discussion with Dr M, a chemical pathologist.*

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Five days after BK first became unwell, her mother remained concerned and arranged for BK to see her parent's GP, Dr H. BK required support to walk into the clinic for her appointment. Dr H noted that the throat swab results were negative, and diagnosed her with possible glandular fever for which urgent blood tests were taken. She was administered a dose of intramuscular ceftriaxone (an antibiotic) and sent home. Dr H called BK's mother that afternoon saying that the blood results were unusual and that he would seek further advice from the laboratory, which he did in a discussion with Dr M, a chemical pathologist.

The next morning Dr H called to check on BK's progress. BK's mother called him back after the initial conversation, reporting that BK had developed the urge to urinate but was unable to, and she seemed to be getting worse. Dr H told BK's mother to take her daughter to hospital immediately. On arriving at the hospital, BK collapsed outside the emergency department and had a seizure. A code blue was called. BK was admitted to the Paediatric Intensive Care Unit with multi-organ failure and was intubated, ventilated and dialysed. Despite maximal therapies she died in the early hours of the following morning, a week after she first became unwell.

## PATHOLOGY

An autopsy was performed and the cause of death given as multi-organ failure secondary to overwhelming herpes simplex virus (HSV) infection.

## INVESTIGATION

At inquest, the coroner heard from BK's mother and the doctors involved in BK's care. An expert opinion was provided by a microbiology and infectious disease specialist.

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*The expert witness explained to the court that the transaminase levels in the liver function tests were markedly elevated (AST ~ 5300 U/L, ALT ~ 4000 U/L), and close to 200 times and 100 times the upper normal limit in a child respectively.*

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BK's mother stated that she had felt reassured by the doctors that she could take BK home, but would have stayed if they had communicated to her that she should. She explained that she did not return to the major hospital with BK because she did not feel that BK was getting worse, as per the instructions, but instead she was just not getting better. She believed that the local hospital would direct them back to the major hospital if needed, which would give them the authority to justify their return. Similarly, BK's mother described how although she did not agree with Dr S that BK was a little better on review, she wanted to believe it was true and therefore accepted the plan to return home and continue with the prescribed treatment.

Dr H and Dr M gave conflicting accounts at inquest as to the nature of the conversation between them about the blood test results. Dr M recalled indicating that BK needed intravenous fluids for rehydration. Dr H could not recall such words, and instead had been focussed on whether the results were consistent with glandular fever. The expert witness explained to the court that the transaminase levels in the liver function tests were markedly elevated (AST ~ 5300 U/L, ALT ~ 4000 U/L), and close to 200 times and 100 times the upper normal limit in a child respectively.

## CASE #1 MORE THAN A SORE THROAT (Continued)

The expert witness stated that regardless of the nature of the conversation, given the degree of abnormality on the blood tests, "...it was inconceivable that [BK] was not immediately referred..." Nevertheless, it was his opinion that even if BK had been referred to the major metropolitan hospital as soon as the results were known "...it would have been too late to avoid her death".

The expert witness suggested that had BK stayed in hospital initially and had blood tests taken at the time, it was possible that an evolving liver dysfunction may have been identified.

### CORONER'S FINDINGS

The coroner observed that there was a lack of continuity of care for BK over the course of her illness in the week preceding her death. The coroner considered whether the outcome would have changed had BK re-presented at the major metropolitan hospital instead of the local hospital. If this had occurred, it may have permitted a better comparison of the progression of her illness or at least precipitated a degree of caution given the re-presentation within 24 hours.

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*It is critical that patients and their carers understand in what circumstances they should seek review even if only for non-specific concern.*

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The coroner felt it pertinent to consider how best to encourage parents of sick children and their treating medical practitioners to make every effort to maintain continuity of care.

He recommended that the major metropolitan hospital undertake a campaign to educate parents about the importance of continuity of care. As such, parents should not hesitate to attend hospital for re-assessment for any concern.

## AUTHOR'S COMMENTS

This case highlights the importance of continuity of care, which is not widely appreciated in the community. It also demonstrates the significance of clear communication: between clinicians; clinicians and patients; and clinicians and the patients' carers.

Doctors in outpatient or ambulatory care settings must make an assessment based on one point of contact in time. As such, it is critical that patients and their carers understand in what circumstances they should seek review even if only for non-specific concern.

Ideally, re-assessment should be with the clinician who performed the initial assessment or at least at the same service so that disease progression and its complications may be appreciated, as well as to ensure prompt follow-up of results.

### KEYWORDS

Continuity of care, herpes simplex virus, sore throat, paediatric, parent, glandular fever, communication

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# CASE #2

## NOT JUST A ONE-WAY DIALOGUE

Case Number:  
2014/96 Qld

Case Précis Author:  
Dr Rachel Marr,  
MBBS (Hons.) FRACGP  
GP and Forensic Physician

### CLINICAL SUMMARY

Master HM was a 9 year old boy who had been treated for infrequent episodes of asthma over a number of years. HM was not prescribed asthma preventative medication as he had minimal symptoms between exacerbations.

One particular day, after developing chest tightness, shortness of breath and cough, his parents called an ambulance for HM. The ambulance officers administered salbutamol (an inhaled medication that opens airways) and transported him to the nearest major hospital where he was treated for several days with salbutamol, oxygen, prednisolone and hydrocortisone (steroids to reduce airway inflammation). During the admission, HM's father requested that his son be reviewed by a paediatric respiratory physician.

Three days after his admission, HM's asthma appeared to have improved and he was discharged home. He was not reviewed by a paediatric respiratory physician prior to discharge. That night, HM's cough and shortness of breath worsened. By the early morning, HM was struggling to breathe and was 'turning blue'. His parents called an ambulance and began CPR until the paramedic units arrived. HM was urgently transported to hospital where cardiopulmonary resuscitation continued, however, this was unsuccessful and he died.

### PATHOLOGY

An autopsy was performed which showed a small right-sided pneumothorax (collapse of the lung) and overlying subcutaneous emphysema (air under the skin, likely from the resuscitation attempts). There were no signs of pneumonia. The pathologist determined that the cause of death was asthma.

### INVESTIGATION

A coronial inquest was held to look into the following issues:

- The appropriateness of discharge from hospital the day before HM's death.
- The adequacy of the information given to HM's parents about his diagnosis and management.
- The management of HM's father's request for a respiratory physician review during the admission.

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*Hospital records showed that HM was seen in an emergency department a year after his diagnosis for an exacerbation of asthma.*

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Evidence at the inquest was provided by:

- Medical records from HM's general practitioner (GP) and previous hospital presentations.
- The treating paediatric registrar and resident, and the paediatric specialist who took over HM's care towards the end of his admission.
- The nursing staff involved in HM's care during his admission.
- HM's parents.
- Two independent paediatric respiratory physicians for expert opinion.

The GP's medical records indicated that HM was first diagnosed and treated by his GP for asthma four years prior to his death. Hospital records showed that HM was seen in an emergency department a year after his diagnosis for an exacerbation of asthma. The documentation noted that HM had been diagnosed with asthma 12 months prior, though at inquest, his parents denied giving that history. It was also documented that while in hospital, HM's mother was given an asthma education book and observed to be administering salbutamol to her son with good technique. During that admission HM deteriorated, requiring intubation and admission to the Intensive Care Unit (ICU).

The medical records indicated that his severe exacerbation of asthma was due to a viral infection and that HM's mother was provided with an asthma action plan on discharge.

In the subsequent year, HM was reviewed by a respiratory physician and treated with an asthma preventer medication. His mother attended the appointments and was given updated asthma action plans. Specialist correspondence, sent to HM's parents, stated he had a history of a 'severe exacerbation of asthma requiring ICU admission.'

HM's parents gave evidence at the inquest that they were not aware HM was diagnosed as having asthma. His mother later stated she thought he had 'seasonal' asthma only.

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*The coroner heard from the independent paediatric respiratory physicians that sometimes parents are 'in denial' about the diagnosis of asthma in their children.*

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This was despite medical documentation from his previous attendances that showed: HM's parents had been told he had asthma; their receipt of multiple asthma action plans; they would administer salbutamol for symptoms of asthma; and that they had indicated a history of asthma on HM's school excursion forms. HM's mother conceded that she knew she was to follow the asthma action plans, which were kept in the kitchen with his salbutamol.

The coroner heard from the independent paediatric respiratory physicians that sometimes parents are 'in denial' about the diagnosis of asthma in their children, and that this is a risk factor for poor outcomes, including death, because treatment is not sought until the asthma is very severe.

Regarding his most recent and final hospital admission with exacerbation of symptoms, the paediatric registrar and resident who initially provided care gave evidence that they had had a conversation with HM's parents about his asthma. They told HM's father that the previous admission to ICU for asthma was a marker of how severe HM's asthma could get, and was the reason they were monitoring him in hospital for a longer period of time.

## CASE #2 NOT JUST A ONE- WAY DIALOGUE (Continued)

HM's father countered at the time that the ICU admission was the result of a viral infection, but this discrepancy was not discussed further.

The paediatric resident and registrar stated that they had demonstrated to HM's parents what the signs of increased work of breathing looked like, and had discussed with HM's father the signs to look out for that would indicate worsening asthma. They had also provided the parents with an asthma action plan the morning after HM was admitted. The paediatric specialist who reviewed HM on the morning of his discharge from hospital said she also discussed warning signs of increased asthma severity and increased work of breathing with HM's parents, which was corroborated at inquest by one of the nurses who said she had overheard the conversation. Both the paediatric specialist and the nurse stated HM's parents did not object to him being discharged from hospital.

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*During the inquest, HM's parents gave further evidence that was at odds with the hospital documentation and evidence provided by doctors and nurses involved in HM's care.*

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HM's father gave evidence that contradicted the hospital staff. He stated the doctor who reviewed HM the first morning was male (both the paediatric registrar and resident were female), that there was no conversation about signs of increased work of breathing or deterioration of asthma, and that no asthma action plan was left, though a receptionist did put some papers on the bed. HM's mother (who had not been present for the initial conversation) had seen the papers left by the paediatric doctors and identified them as an asthma action plan. HM's father stated he had disagreed with the plan for discharge and wanted HM to be reviewed by a respiratory physician. It was acknowledged by hospital staff that HM's parents had requested a respiratory physician review HM, though this was not documented and did not occur.

During the inquest, HM's parents gave further evidence that was at odds with the hospital documentation and evidence provided by doctors and nurses involved in HM's care. The coroner noted that HM's mother and father sometimes gave evidence that contradicted each other's statements.

The paediatric specialist stated that HM's parents did not dispute the diagnosis of asthma during the consultation prior to discharge. The specialist had not considered the possibility that HM's parents did not know he had asthma because: they had communicated to her that HM had asthma and; HM's mother was able to describe what was in the asthma action plan and the signs of deteriorating asthma. HM's mother denied this but said she knew what was in the asthma action plan although she had not discussed this with the doctor.

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*It was clear that HM's parents did not fully understand or appreciate their son's asthma diagnosis despite being given education materials and multiple asthma action plans.*

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The paediatric specialist confirmed that HM had not required any supplemental oxygen for over 24 hours before the decision that HM could go home. The independent paediatric respiratory physicians agreed that HM's care was in line with current standard practice and guidelines. They considered that his condition was sufficiently stable at the time of his discharge to be considered safe, providing that the parents knew the signs of deterioration and when to bring him back to hospital.

### CORONER'S FINDINGS

The coroner could not explain why HM's parents gave evidence that they were not aware of HM's diagnosis of asthma. There was sufficient evidence that they were aware of the diagnosis, had been told as much on numerous occasions, and that they knew it was not just a 'seasonal' illness. The coroner ultimately found that it was clinically appropriate to discharge HM from hospital that morning. The coroner also noted that although HM's parents were told about the warning signs of deterioration on the morning of discharge, there were missed opportunities to educate them about the nature of his condition.

It was clear that HM's parents did not fully understand or appreciate their son's asthma diagnosis despite being given education materials and multiple asthma action plans. A respiratory review in hospital may not have been clinically necessary but would have provided a good opportunity to further educate HM's parents about his asthma.

### AUTHOR'S COMMENTS

HM had experienced several episodes of exacerbation of asthma prior to his final admission. His GP, paediatric respiratory physician and hospital treating teams all had opportunities to teach HM's parents about his condition. Although it appears they did do this, as doctors we must keep in mind that *'message given is not always message received.'*

It is vital that we check that our patients and their families understand their condition, including the signs of deterioration that warrant prompt medical review. Providing medical resources without fully explaining the contents should not be considered adequate patient education. Asking patients and their families to recall and demonstrate their understanding of the information is a vital component of patient safety in hospital and the community. This should be followed by clear and contemporaneous documentation of the communication that take place.

### RESOURCES

Asthma Australia Education and Training. Available at: <https://www.asthmaaustralia.org.au/national/education-and-training>.

Royal Children's Hospital Kid's Health Info – Asthma. Available at: [https://www.rch.org.au/kidsinfo/fact\\_sheets/Asthma/](https://www.rch.org.au/kidsinfo/fact_sheets/Asthma/).

Henderson, J et al. Asthma control in General Practice, *Aus Fam Physician* 2013; 42: 740-743. Available at: <https://www.racgp.org.au/afp/2013/october/asthma-control/>.

Larson, A. et al. Impact of structured education and self management on rural asthma outcomes. *Aust Fam Physician* 2010; 39: 141-144. Available at: <https://www.racgp.org.au/download/documents/AFP/2010/March/201003larson.pdf>.

### KEYWORDS

Asthma, parent, patient education, paediatric, respiratory, communication

## CASE #3 RECOGNISING RED FLAGS

Case Number:  
COR 2014 4717 Vic

Case Précis Author:  
Dr Naomi Spotswood  
BMedSc, MBBS, MIPH, FRACP

### CLINICAL SUMMARY

Baby A was an 11-month old boy who had no significant medical problems. There were no antenatal concerns relevant to Baby A's health and he was immunised.

Baby A was seen by his General Practitioner (GP) on a Thursday for diarrhoea and a runny nose. Over the ensuing 48 hours he developed fever, breathing difficulties, and abdominal bloating. He was reviewed by two further GPs who each diagnosed a viral infection.

Early Saturday morning, Baby A's parents called an ambulance, and he was transported to the emergency department (ED) of an outer metropolitan hospital. Between two medical reviews he was noted to have increased respiratory effort, normal oxygen saturations, fever, and a distended but soft abdomen.

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*On Sunday afternoon, Baby A saw another GP who noted that he was a little better with symptomatic treatment, but had not had a bowel action for two days.*

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Nursing staff also noted that he was lethargic. A chest x-ray was performed, and interpreted as showing a 'viral picture'. Baby A was discharged home with advice to seek further review if he became more unwell. The chest x-ray was later formally reported as normal.

On Sunday afternoon, Baby A saw another GP who noted that he was a little better with symptomatic treatment, but had not had a bowel action for two days. A suppository and ongoing symptomatic management were recommended.

That evening, Baby A became more lethargic and stopped drinking. As his mother prepared to take him for another review he began vomiting, had difficulty breathing, then had a seizure. An ambulance was called, and paramedics found him unresponsive with an un-recordable blood pressure. They commenced cardiopulmonary resuscitation however Baby A was not revivable and died shortly after.

### PATHOLOGY

An autopsy was conducted which revealed 'urosepsis and renal failure in a child with acute on chronic pyelonephritis secondary to hydronephrosis and posterior urethral valves'.\*

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*An expert opinion provided by an ED physician was that Baby A's clinical picture included 'red flags' which should have precluded discharge.*

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### INVESTIGATION

The coronial investigation noted that Baby A had been seen by multiple medical practitioners, never more than once, likely because his illness occurred over a weekend. There were no significant concerns identified in the management of Baby A at his GP reviews.

Opinions differed on the appropriateness of Baby A's clinical management in the ED and the decision to discharge. An expert opinion provided by an ED physician was that Baby A's clinical picture included 'red flags' which should have precluded discharge. These were his parents' concern with repeated presentations, a deteriorating state, and the combination of several clinical signs: fever, dehydration and respiratory distress. The expert's opinion was that hydration and perfusion could have been assessed more thoroughly, and also that investigations and empiric treatment for possible sepsis should have been initiated.

The coroner was provided with documentation from the ED's Mortality and Morbidity Committee, that Baby A had demonstrated some response to supportive therapy, and that undiagnosed posterior urethral valves are rare.

They also noted that his parents were advised to seek follow up if Baby A worsened, and overall deemed his discharge from ED an appropriate decision.

In light of the available evidence, the coroner was satisfied that no further investigation was required and the case did not proceed to inquest.

### CORONER'S FINDINGS

The coroner found that Baby A died due to urosepsis and renal failure. The coroner recommended that EDs mandate discharge summaries if it is foreseeable that the patient will need follow up. The ED involved implemented a system for this following this case. The coroner also recommended staff education on several important elements to assessing unwell children including:

- Available guidelines.
- Assessment of hydration status and blood pressure.
- Consideration of alternative diagnoses.
- Careful follow-up arrangements and communication of discharge information.
- Consultation with specialist paediatric services when families have presented multiple times for the same problem.

### AUTHOR'S COMMENTS

Identifying subtle signs that point away from common, self-limiting diagnoses such as viral infections can be difficult when assessing the unwell child. Online resources that delineate appropriate assessment steps are useful for these situations, as can be consultation with a specialist paediatric service. A red flag in Baby A's case was his family's repeated efforts to seek help. Significant parental concern is now a key element to many hospital-based paediatric early warning systems. Where these concerns are raised, a carefully-taken history which teases out the context behind a family's instinctive concern can be invaluable.

\* Posterior urethral valves are an abnormal membrane(s) present before birth which prevent urine from passing normally through the urethra. The urinary obstruction dilates the bladder, ureters and kidneys, and increases susceptibility to urinary tract infections. They are rare, occur only in boys, and are often identified in pregnancy due to dilation of the baby's developing urinary tract.

## RESOURCES

The Royal Children's Hospital Clinical Practice Guideline: Febrile Child. Available at: [https://www.rch.org.au/clinicalguide/guideline\\_index/Febrile\\_child/](https://www.rch.org.au/clinicalguide/guideline_index/Febrile_child/)

Monash Children's Hospital: Posterior Urethral Valves. Available at: <http://www.monashchildrenshospital.org/wp-content/uploads/2016/10/puv-posterior-urethral-valves.pdf>.

Taitz J. Building a culture of safety in paediatrics and child health. *Curr Treat Options Peds* 2015; 1:253-261.

## KEYWORDS

Urosepsis, paediatric, parent, posterior urethral valves, urinary tract infections, discharge summary, communication

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## FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to:

[cc@vifmcommuniques.org](mailto:cc@vifmcommuniques.org)

## EXPERT COMMENTARY DOCTOR-PATIENT COMMUNICATION: WHAT EVERY DOCTOR SHOULD KNOW

Dr Ranjana Srivastava, FRACP  
Oncologist & Fulbright Scholar,  
Monash Health  
Department of Oncology  
Dandenong Hospital, Victoria

In the process of building a house, my husband and I were shown a palette of colours for the cupboards in the kitchen and approved something that passed muster. Months later, walking through the nearly-completed house, I balked at the sight of the floor to ceiling bookshelves in the library, which had been ordered in the same pale Baltic shade rather than the rich oak I had envisioned. In fact, the library was the only part of the house that I was interested in and my heart sank at the achieved look.

For an oncologist, it felt an ironic departure from usual life and death matters to contend with the shade of some bookshelves, but as a matter of principle, I called the architects.

'Don't you remember approving the joinery?', they asked.

'What's joinery?' I asked, equally puzzled.

'The woodwork in the house.'

'All of it?' 'But we only ever discussed the kitchen cupboards!'

'Because that colour would generally flow through the house.'

'But I don't recall you mentioning this.'

'We thought it was evident.'

This exchange left both parties frustrated.

The expert in this case, the architects, who built hundreds of houses, thought that a term like 'joinery' was self-explanatory. The customers, my husband and I, who had not built a house before, were flummoxed that the architects had failed to appreciate our novice status and had not distinguished between our passing interest in the kitchen and keen interest in the library.

Each side feeling a little irked but nonetheless, committed to the process we had started, we eventually arrived at a compromise that saw the shelves stained in the desired shade.

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*Our lives and those of our patients would be made easier if we wrote better clinical notes and challenged ourselves to identify the clinical question we are asking.*

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Alas, the cases discussed in this month's Clinical Communiqué did not reach any such happy ending. The coroners' reports of the deaths of the three children made for a sad, concerning, and at times, disturbing read. Each case had an issue of doctor-patient communication at heart. Here, I would like to distil the key messages that I believe are relevant to all clinicians.

### 1. You order a test, you follow it up

Anyone who has been a clinician for more than a few years can track the rise in the number of investigations we conduct on behalf of our patients, many of them arguably associated with marginal benefit and great cost. Indeed, the days of making a clinical diagnosis and confirming the diagnosis with relevant tests seem anachronistic, such is our dependence on investigations. In an era of multiple investigations for each patient, it is predictable that key findings will be misinterpreted, mishandled, or simply missed. Sometimes, this won't matter clinically, but I would argue it always matters psychologically.

I commonly meet cancer patients whose initial complaints prompted an investigation whose results were not followed up in a timely fashion. Weeks or sometimes, a few months, later a diagnosis of advanced cancer is confirmed. I take pains to reassure patients that making the diagnosis four weeks earlier would not have altered the overall outcome, but it would be presumptuous to argue that the knowledge would not have assuaged their uncertainty or set into motion a plan of action.

In an era of newer and increasingly sophisticated technology, doctors may order tests that they are not always confident in interpreting.

This is understandable, but it behoves every clinician to familiarize oneself with, and refresh one's understanding of, at least the most commonly used tests in one's practice.

For example, oncologists rely heavily on imaging; I have realized that to rely unquestioningly on radiology reports can do my patients a disservice because what the radiologist sees must always be combined with clinical acumen. Therefore, I periodically sit down with a radiologist to revise how to spot the adrenal glands or how to identify the segments of the liver.

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*It is particularly important to be attuned to patient preferences in a multicultural society, and while no one expects this knowledge to be innate, there is no excuse for not asking.*

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Meanwhile, the radiologist learns to appreciate the nuances of oncological management that lead to more considered evaluation. This process takes a few minutes, builds essential rapport between two providers, both of whom learn to deliver improved care.

The advice that non-clinical providers, such as pathologists and radiologists, provide us as clinicians, is only as good as the information we give them. Our lives and those of our patients would be made easier if we wrote better clinical notes and challenged ourselves to identify the clinical question we are asking. But ultimately, to emphasize, the person who orders the test must be the person responsible for the results. It's perfectly okay, even wise, to ask for help with interpretation, but the final responsibility rests with the prescriber. We should expect no less of ourselves and our trainees, and our patients deserve this level of attention.

### 2. Never underestimate a patient's concern

On a recent ward round, a frustrated patient admonished me, 'I don't understand why you don't treat my infection properly in the first place. If you did that, I wouldn't have to return every month for more antibiotics!' He had a mild chest infection and I was ready to send him home.

When the floor is busy with the sick, unwell and demanding, it can be tempting to eye some patients with a lesser degree of urgency, but there is a skill to appropriate clinical triaging versus ignoring a patient's concern.

In this case, the patient's previous history, not clear to the admitting doctor, warranted two things. A CT scan, which ruled out an underlying malignancy in a smoker, and a thorough explanation as to why smokers are prone to recurrent chest infections. Up to now, the patient had blamed the healthcare system for his repeated presentations. Being taken seriously was the first step towards assuming responsibility for his well-being.

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*Any number of public health messages encourage patients to speak up as the custodian of their own needs, but patients heed this advice only when there is an atmosphere of safety and trust.*

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Most people dislike coming to hospital and one can sympathize with their reasons, including noise, lack of privacy, and an array of ill-explained procedures. But nobody should ever avoid hospital due to the feeling of being a nuisance. How clinicians behave towards patients from the moment we encounter them has enormous bearing on how we empower them to share their concern, reveal their hunch, and feel safe in raising the alarm when something is really wrong.

Any number of public health messages encourage patients to speak up as the custodian of their own needs, but patients heed this advice only when there is an atmosphere of safety and trust. Therefore, it is incumbent upon every frontline clinician to find ways to express their openness to listen and to participate in genuinely shared decision-making. It is particularly important to be attuned to patient preferences in a multicultural society, and while no one expects this knowledge to be innate, there is no excuse for not asking.

### 3. We all succumb to cognitive bias

In times past, it was typical for a doctor, or a team of doctors, to follow a patient from admission to discharge, which meant that a clinician had time to get to know a patient and establish rapport. But now, with changing demographics and a host of modern healthcare pressures, this is a thing of the past. In the community, but especially in large hospitals, patients are relegated to seeing a virtual march-past of doctors – bewildering for patients and frustrating for doctors.

Lamentable as the discontinuity of care is, the problem is here to stay. Indeed, the problems of fragmentation of care and the still-hierarchical structure of medicine means that clinicians are less likely to question a diagnosis by thinking independently, which can spell disaster for patients.

On a busy day, with twenty or thirty patients to see and still more in the queue, it is tempting to follow a preconceived lead and ignore, or explain away, new and unfolding evidence. Patients are prescribed treatment or given advice based on what someone else thought at another point in time when the patient may have presented, reported or behaved differently. At one level, clinicians recognize the perils of our cognitive bias, but at another level, it is too easy to keep falling into this trap.

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*Self-care, kindness and forgiveness is something medicine is notoriously poor at, and to our own detriment.*

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The key is to be open to the possibility that even excellent clinicians can fall into bad habits and to encourage an atmosphere within the workplace where every provider, medical or otherwise, feels empowered to make constructive observations about patient care. It is particularly important to empower our residents and trainees to flex this muscle of independent thinking and highlight the difference this can make to a patient's welfare.

### 4. Even diligent doctors have disappointed patients

While it is true that the vast majority of behavioural infractions are perpetrated by a small minority of doctors, it is worth acknowledging that even kind, careful and diligent doctors have disappointed patients. We are all prone to errors and infractions.

In my role, I hold truth-telling to be a moral imperative. Many of my patients have a dire prognosis and I feel it is my duty to impart a sensitive but honest understanding of the facts that will guide some of their most important decisions. Patients and family members cannot make informed decisions without understanding the most relevant facts, including a guarded prognosis, but hearing the truth isn't easy. Some patients are genuinely grateful while others respond with disappointment or outright anger. It is easy to channel the resulting disillusionment into a vow to say less and save the angst, but on reflection, I think this would be a mistaken conclusion.

Clinicians have a sacrosanct duty to help patients navigate the complexities of illness. At all times, we must try our hardest and use inventive ways to help patients even when they are in denial, or demonstrate health illiteracy, or show straightforward disinterest.

However, when patient outcomes are less than ideal despite our attempts, we must have a way of letting ourselves down gently, caring for ourselves, and learning from our errors. Self-care, kindness and forgiveness is something medicine is notoriously poor at, and to our own detriment.

No matter what our field of expertise, it is impossible to read the three presented cases as impersonal reports. Far from it, they have prompted me to recall all the times that my actions could have resulted in unintentional harm had it not been for a stroke of luck, a lateral-thinking colleague, a diligent nurse, an observant student, or some other factor. It can be quite a process to recover from such jolts and to continue to care for patients with the highest standards.

Such recollections ought to humble us and fasten our resolve to reflect and to grow. It is only by growing our own capacity for compassion, empathy and self-care that we can become better providers. More than a hundred years ago, William Osler observed that in medicine, more is missed by not looking than not by not knowing. Looking attentively and communicating mindfully remain the key to better patient care.

Our patients deserve no less.

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