Reflection based of Rolfe et al (Example 2)

What? – (a description of the event)
What happened? What did I do? What did others do? What did I feel? What was I trying to achieve? What were the results? What was good or bad about the experience?

I (and others) missed a diagnosis of a very rare condition with an unusual presentation over a period of several months, which resulted in a partial loss of sight for a young patient. I treated the gastroenteritis that the patient consulted me with as an intercurrent illness and recognised from the long previous history given that there was also 'something else going on'. I decided blood tests were needed but not to do them while the patient was acutely ill. I advised the patient and family member with them that bloods were needed and that they should come back for them. Unfortunately, this did not happen, and the patient only re-presented six weeks later. Bloods were done then and revealed extremely high inflammatory markers. Eventually the patient was admitted. The diagnosis was made after some time in hospital by which time some sight had been lost. The result was a complaint against several clinicians including me. The quality of my record keeping, and recorded safety netting allowed my defence organisation to feel that my actions could be defended. My sincere apology and explanation led to the complaint being dropped.

So, what? – (An analysis of the event)
So, what is the importance of this? So, what more do I need to know about this? So, what have I learned about this? So, what does this imply for me?

This is important because an adverse outcome for the patient might have been avoided by earlier investigation. I still think that acute gastroenteritis would have affected the blood tests I recommended and that it would have been confusing to do them at the time of my consultation. I felt very sorry when I saw the discharge letter with the diagnosis and outcome for the patient, so I was not surprised by the time the complaint arrived. I had wanted to be helpful and I had missed an opportunity to change a negative outcome. I also felt frustrated because I felt I had done my best at the time and I did not initially see what I could have done differently. This has reinforced the importance of good record keeping and safety netting.

Now what? (Proposes a way forwards following the event)
Now what could I do? Now what should I do? Now what would be the best thing to do? Now what will I do differently next time?

This is one condition that I hope I will never miss again having read up on it. I still feel dreadful that this patient has had such a life-changing outcome, but I have accepted that illnesses are like that – sometimes we do our best and it is still not good enough to save someone. In another era this patient would have died. The most important learning for me is to provide written information to my patients, even when a family member is there, especially if I want some further action to be taken. I am now in the habit of printing off a recommendation to have a blood test if I want one, so the patient has a concrete reminder to take away, and I use more information sheets.