

QUARTER FOUR / 2017

INSIGHT



A QUARTERLY PUBLICATION FOR MEMBERS



AN EVENTFUL YEAR

Profile of RCGP Chair
Professor Helen Stokes-
Lampard

DIAGNOSIS UNKNOWN

How do you safely address
medically unexplained
symptoms (MUS)?

HOLISTIC DENTISTRY

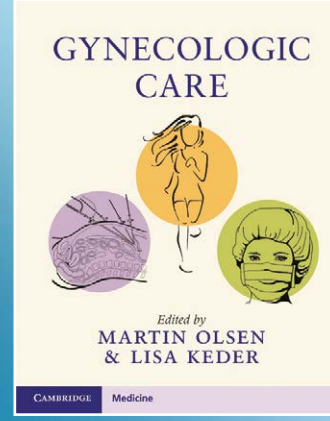
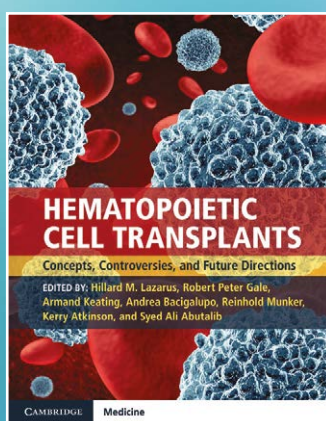
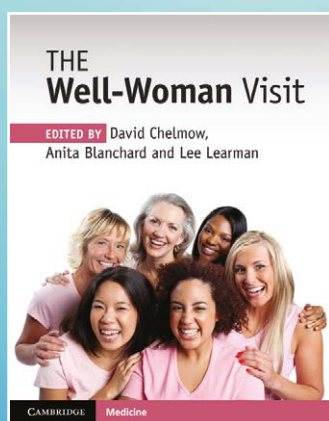
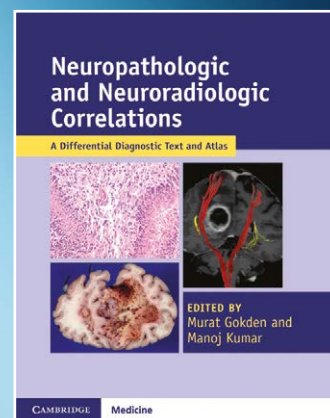
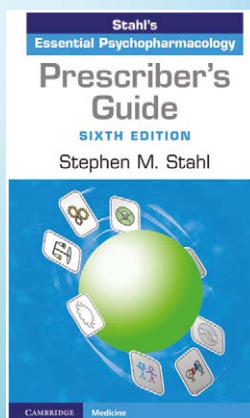
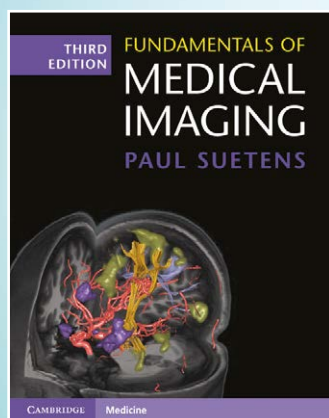
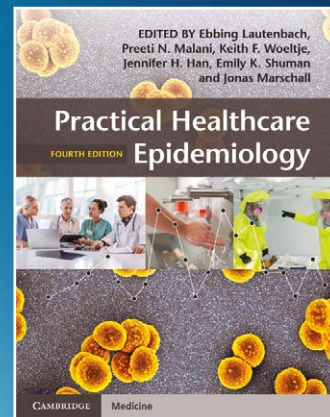
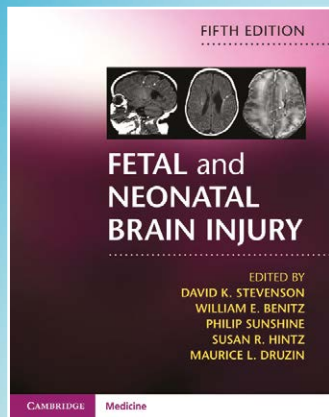
A look at the challenges and
opportunities of the shift
toward holistic healthcare

STATE INDEMNITY

CEO Chris Kenny offers an
MDDUS view on state-backed
indemnity plans in England

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Cover image

Lengthy Shadows Over Frosty Grass, Tom Davidson
Linocut, 1994

Having studied graphic design, Tom tried printmaking in the early 80s. His subject matter tends to focus on rivers and trees, and he loves exploring the interplay of light and shade.

Art in Healthcare (formerly Paintings in Hospitals Scotland) works with hospitals and healthcare communities across Scotland to encourage patients, visitors and staff to enjoy and engage with the visual arts. For more information visit www.artinhealthcare.org.uk
Scottish Charity No SC 036222.



4 MDDUS News

6 News Digest

8 Briefing

The state of indemnity

9 Risk

Altering patient notes

10 An eventful year

Professor Helen Stokes-Lampard talks to Adam Campbell about her first 11 months as Chair of the RCGP and what keeps her going

12 Diagnosis unforthcoming

How do you approach patients with medically unexplained symptoms? Professor Chris Burton offers some insights

14 Dentistry for the whole patient

Professor Nairn Wilson looks at the opportunities and challenges for

dentistry in the shift toward holistic healthcare

16 Case files

Loose fillings, Missed gallstones, Anonymous complaint, Non-compliant diabetic, Bad tattoo and Impacted wisdom tooth

20 Dilemma

Disputed consent in a minor

21 Ethics

Unexpected field work

22 Addenda

Book choice: *Your life in my hands: a junior doctor's story*, Object Obscura: Hypodermic syringe, Crossword and Vignette: Charles Stent, English surgeon who gave his name to the medical device





EDITOR

Dr Barry Parker

THE Government announcement in October of plans for a state-backed indemnity scheme for GPs in England has resulted in much media discussion and speculation, but to date the plans are conspicuously short on detail. MDDUS continues to lobby and engage with key influencers about the scheme to ensure that the views of members and patients alike are at the forefront of the decision-making process. Chief Executive Chris Kenny summarises our current position on page 8.

General practice currently faces many challenges, with a toxic combination of workload pressures and recruitment difficulties, and in our profile on page 10, Professor Helen Stokes-Lampard, current Chair of the RCGP, reveals how it feels to lead the organisation

through such turbulent times.

Also in this issue, Professor Chris Burton offers general advice on how to approach patients with medically unexplained symptoms (MUS). He believes that to do so safely requires a balance between firm reassurance and symptom

"The current plans for state-backed indemnity for GPs in England are conspicuously short on detail"

management while not closing down other diagnostic possibilities too quickly (page 12).

Professor Nairn Wilson looks at the opportunities and challenges for dentistry in the shift toward holistic healthcare on page 14. He is calling for strong transformational change to "put the mouth back into the body."

On page 9, Dr Gail Gilmartin urges clinicians to resist the temptation to alter patient records at a later date as this could lead to serious sanctions down the line, and also on page 20 she considers a common dilemma involving disputed consent between parents over the medical treatment of a child.

In her regular ethics column on page 21, Professor Deborah Bowman offers a personal perspective on patient autonomy and how it is "relational," predicated on interaction and exchange but also on trust – "the most precious form of connectedness".

Dr Barry Parker

MDDUS

News

MDDUS appoints members to new streamlined board

MDDUS is pleased to welcome two new non-executive directors to our Board – Dr Joanna Bayley and Professor Iain Cameron.

Dr Bayley (right) is a GP and chief executive of the Gloucester GP Consortium, which provides primary care to deprived communities, and of GDoc, the countywide GP provider in Gloucestershire. She is a clinical associate to the New Care Models programme of NHS England and an adviser to the Care Quality Commission.

Before becoming a GP, Dr Bayley trained in emergency medicine and intensive care. She was awarded an MA in medical law and ethics from the University of Manchester and has studied transformational change in healthcare at the John F. Kennedy School of Government at Harvard. She has a particular interest in clinical governance.

Iain Cameron (below) is professor of obstetrics and gynaecology and Dean of the Faculty of Medicine at the University of Southampton. After graduating in medicine at the University of Edinburgh in 1980, he underwent postgraduate clinical and research training in Edinburgh, Melbourne and Cambridge.

Professor Cameron held the regius chair of Obstetrics and Gynaecology at the University of Glasgow from 1993 and moved to Southampton in 1999. His main clinical and research interests are reproductive endocrinology and investigation of the impact of the maternal environment on early pregnancy.

He was chair of the Medical Schools Council from 2013-16 and was appointed as a non-executive director of University Hospital Southampton NHS Foundation Trust in 2011.

Our new additions to the Board come as seven members retire – namely Mr Ian Anderson, Professor Alastair Chambers, Dr Judith Chapman, Professor Hilary Critchley, Dr John Garner, Professor Gillian Needham and Dr Donald Pearson. A decision was made in 2016 to "streamline" the MDDUS Board, which now comprises 14 directors – 12 non-executive and two executive directors.

MDDUS chairman Dr Benny Sweeney said: "I would like to acknowledge the dedicated service of our seven retiring Board members. The professionalism, commitment, guidance and integrity that they have collectively contributed across a combined 142 years of service is nothing short of remarkable."



New GPs benefit from MDDUS and RCGP collaboration

NEWLY qualified GPs in their first five years after qualification are on course to make a combined saving of over £500,000 by the end of this year as a result of the partnership between MDDUS and the RCGP.

We have teamed up to offer a tailored indemnity package with a

contribution to RCGP membership fees for those newly qualified GPs who seek the benefits of both organisations. This unique offer is available to new and current members of both the RCGP and MDDUS, with existing members benefiting automatically at their next renewal date.

MDDUS Director of Development David Sturgeon said: "We are delighted that since its launch in April, more than 800 newly qualified First5 GPs have already taken advantage of a 75 per cent contribution to

RCGP membership fees, as well as a tailored indemnity product at a competitive price.

Find out more about the RCGP First5 partnership on the Join page at www.mddus.com

Winter indemnity scheme

NHS England is again running an indemnity scheme to support GPs doing extra out-of-hours (OOH) and unscheduled care work this winter.

The scheme has been developed in conjunction with UK medical defence organisations, including MDDUS, and runs until 2 April 2018. It is designed to meet the costs of indemnifying additional OOH/unscheduled care work this winter and does not apply to pre-existing indemnity arrangements.

The scheme will work differently this year with the additional cover allocated in blocks of 8, 16, 24 or 32 sessions. GP members interested in accessing the scheme should initially check with their local OOH/unscheduled care provider to determine what additional shift cover is required and then contact MDDUS to agree the appropriate package of extra indemnity. You will then be able to add these additional sessions to your current membership with payment being made directly to MDDUS by NHS England.

Any additional blocks of sessions can be applied for when your existing quota has been exhausted (subject to availability from NHS England).

Go to www.mddus.com/forms/winter for an online application to add additional OOH sessions funded by the scheme. More information on the scheme including FAQs can be found on the NHS England website at www.tinyurl.com/y7ghbqbf.

Doctors working with football clubs

MDDUS does not provide indemnity for doctors or dentists employed or contracted as a team doctor by football clubs in the English Premier

League, Championship or Scottish Premiership.

If a doctor is independently contracted by a **lower league professional football club** to provide his or her professional services to players, then professional indemnity will be provided at the appropriate subscription rate.

Members dealing with professional football players should note that their professional and contractual relationship is with the player alone, with contractual arrangements and subsequent invoicing being directed to the player, no matter whether the member is subsequently reimbursed by the club or its medical insurers.

MDDUS may extend cover to include indemnity for overseas events to the travelling party only and providing any claim is made in a UK court and under UK law. Any claim made outside UK jurisdiction or under non-UK law will not be indemnified by MDDUS.

Members who work with sports professionals are encouraged to obtain a recognised qualification related to such work.

MDDUS welcomes regulation reform

MDDUS has welcomed a new consultation on reform of the regulation of healthcare professionals.

Commenting on the Department of Health's *Promoting professionalism, reforming regulation*, MDDUS senior lawyer and practice development manager Joanna Jervis said: "We will be responding in detail to the consultation, focusing in particular on the difficulties which may be posed by a reduction in the number of healthcare regulators, as is proposed."

MDDUS agrees that the current regulation of healthcare professionals is outdated, slow and in need of reform. Legislative changes to the current framework are undoubtedly required but the key factors at the heart of any changes should be performance, fairness, transparency and patient safety.

Jervis added: "The focus must be on ensuring that the regulatory framework is fit for purpose and retains appropriate expertise in relation to each of the very different healthcare professions subject to regulation."

EARLY PRACTITIONER TRAINING DAY

New dental graduates can learn about common risks in practice at an MDDUS training day at our Glasgow office on 27 February 2017. Hot topics include the pitfalls of using social media and how to ensure informed patient consent. MDDUS early practitioner adviser Laura McCormick will also be available to speak with delegates. Email risk@mddus.com to book.

BMJ AWARDS ENTRY

Healthcare teams across the UK can submit entries for the BMJ Awards 2018 – with headline sponsorship from MDDUS. Now in their tenth year, the BMJ Awards expect more than 350 teams from across the UK vying to have their important work recognised. Find out more at thebmjawards.bmj.com

RISK BITES: MDDUS PODCASTS

Want to learn more about how to navigate a complaint, significant event review, negligence claim or GMC investigation? Tune in to the MDDUS *Risk Bites* podcast series. Each episode looks at how two different practices handle the case of a patient with breast cancer. Find them in the Resources section of www.mddus.com

UPDATE YOUR CONTACT NUMBERS

We have noticed that a few members are still contacting MDDUS on our old 0845 number and incurring a higher phone tariff. Please ensure you are now contacting MDDUS on 0333 043 4444, or 0333 043 0000 for membership enquiries.



“Bad apples” and other perpetrators

AN analysis of misconduct among health and care professionals undertaken by the Professional Standards Authority (PSA) has found that not all perpetrators are simply “bad apples”.

Researchers from Coventry University examined 6,714 fitness to practise determinations from the PSA database, covering doctors, nurses, social workers, paramedics and others. They identified three different types of perpetrator: the self-serving “bad apple”, the individual who is corrupted by the falling standards of their workplace (“bad barrels”), and the “depleted perpetrator” struggling to cope with the pressures of work and life.

Cluster analysis was used to identify how different kinds of misconduct group together for the different professions, and the researchers also looked in more detail at cases involving sexual boundary violations and dishonesty. The aim is to offer a more nuanced multi-dimensional perspective of wrongdoings and offer recommendations to aid regulators and employers to improve detection of perpetrators and ameliorate the occurrence of these behaviours.

PSA Chief Executive Harry Cayton said: “This research is the most ambitious project yet undertaken to use the information contained in the Authority’s database of fitness to practise determinations. In this report, Professor Searle [lead researcher] offers us a rich and fascinating discussion of the complex and subtle interplay between individual professionals, teams, workplaces, gender and culture.”

Access at www.tinyurl.com/ybr8jfe9

Dental services in England rate highly

A NEW report by the Care Quality Commission (CQC) has revealed that nearly nine out of 10 dental practices in England inspected by the regulator have complied with all five of its key standards.

Out of 1,131 practices inspected in 2016/17, 88 per cent were found to be safe, effective, caring, responsive and well-led, and 100 per cent met the tests for being ‘caring’ and ‘responsive’ to their patients’ needs and preferences. Community dental services fared particularly well, with 88 per cent achieving ratings of good or outstanding.

These findings emerged from the CQC’s annual *State of Care* report. The CQC has been collecting data on primary healthcare services since 2011 and inspects around 10 per cent of dental practices each year.



Longer GP opening hours does not reduce A&E visits

THERE is “no direct correlation” between longer GP opening hours and patient attendance at A&E, according to a new study.

Statistics show that in one area where three out of four practices provide extended hours commissioned by NHS England (known as DES), the A&E service is “red rated” for high attendances. In contrast, another area where practices do not provide any additional hours above the core contract has low A&E attendances.

The figures emerged in a report published by two Nottingham clinical commissioning groups (CCGs), Mansfield and Ashfield CCG, and Newark and Sherwood CCG. They evaluated the effects of extended GP access schemes on A&E attendances for practices in their areas between August 2016 and July 2017.

Their results suggested there was “no direct correlation” between GP opening hours and A&E attendance and that geography was a more significant factor in influencing patients’ decisions about which healthcare service to access.

The findings come as NHS England hopes to reduce A&E visits by encouraging more GP practices to provide extended hours.

The CCGs’ report recommends greater promotion of extended hours services and says these must be easily accessible for “hard to reach” groups.

Mick Armstrong, Chair of the BDA, said: “The latest CQC report represents another ringing endorsement for good practice in our profession, in spite of the huge challenges we face”.

Support for enhanced dental CPD

A SERIES of guidance documents and templates for dental professionals in support of enhanced continuing professional development (ECPD) has been published on the GDC website.

ECPD is being launched next year by the GDC as the “first step in a longer-term reform to move to a system based on quality of CPD activity rather than quantity”. It will include the introduction of a personal development plan (PDP) for each member of the dental team to support their CPD, with corresponding learning outcomes. The changes will take place in January 2018 for dentists and August 2018 for dental care professionals.

Among the new support materials being made available on the GDC website are ECPD guidance for professionals and CPD providers, and PDP and activity log templates with examples.

A new enhanced dental CPD guidance sheet from the MDDUS Risk Education team also offers a useful overview of the key points to consider. Go to Training & CPD at www.mddus.com (member login required).

Male dentists “over-represented” in FtP cases

AN analysis of GDC data has found that male dental professionals were more likely to have been involved in fitness to practise (FtP) cases than their female colleagues, as were older (over 30) registrants.

These are just two findings from the first in-depth analysis of fitness to practise data commissioned by the GDC and carried out in 2016 by Plymouth University Peninsula, Schools

of Medicine and Dentistry. It also found that dentists were significantly over-represented at all stages of the fitness to practise process compared to other registrant groups.

Dentists coming on to the register having qualified in an EEA country were more likely to be involved in a FtP case, but those coming onto the register by taking the Overseas Registration Exam were less likely to be involved compared to their UK-qualified counterparts.

The odds of having been involved in an FtP case were 22 per cent higher for dental professionals identifying as 'Asian' or 'Other' compared to those identifying as 'White', but the researchers are careful to note that there are significant gaps in this data as it was provided on a voluntary basis.

The GDC commented that the report reveals important insights into the types of FtP cases and the dental professionals involved but it is "just one source of information in a complex landscape, and is not, on its own, able to establish the factors that are causing these findings".

"We will be working closely with our partners to help us understand why we are seeing particular trends in the case data."

Access the analysis at www.gdc-uk.org/about/what-we-do/research

Antibiotic resistance common in UTIs

ONE in three urinary tract infection (UTI) samples showed resistance to the antibiotic trimethoprim in a recent analysis.

More than one million UTI samples were analysed in NHS laboratories across England in 2016 as part of the *English Surveillance Programme for Antimicrobial Utilisation and Resistance* (ESPAUR) report and antimicrobial resistance was found to be common.

Resistance to trimethoprim was found in 34 per cent of the samples analysed compared to 29.1 per cent in 2015. Trimethoprim was once the first choice treatment for UTIs before PHE recommended switching to the antibiotic nitrofurantoin. The ESPAUR report found that only 3 per cent of the UTI samples showed resistance to nitrofurantoin.

NICE recently launched a suite of new guidelines – *Management of Common Infections* (MoCI) – providing evidence-based advice on how common infections can be managed with the purpose of tackling antibiotic resistance. UTIs are one of the common infections the NICE MoCI committee has pledged to look into.

Professor Gillian Leng, deputy chief executive at NICE, said: "Making sure that we use these medicines properly, only when they are really needed, is vital. And our guidance is here to help healthcare professionals navigate these sometimes difficult decisions."

Early cancer diagnosis avoids chemotherapy

CANCER patients diagnosed at stage 1 are five times more likely to have surgical treatment and possibly avoid the need for chemotherapy than those diagnosed at stage 4, according to new figures.

Cancer Research UK and Public Health England (PHE) examined data from about half a million NHS patients with 22 different cancer types in England between 2013 and 2014 to determine how many patients received surgery, chemotherapy and radiotherapy, alone or in combination, as compared with their cancer stage.

The figures showed that 70 per cent of cancer patients diagnosed at stage 1 had



surgery to remove their tumour but this fell to 13 per cent of those diagnosed at stage 4. Chemotherapy was the treatment choice in 12 per cent of patients at stage 1 and this rose to 39 per cent of those diagnosed at stage 4.

Professor Mick Peake, a lead clinician in the study, based at Public Health England, said: "Doctors want to offer patients the best possible treatment. For some cancers, like leukaemia and lymphoma, that's chemotherapy. But in most cases the earlier cancer is diagnosed the more likely it is to be effectively treated by surgery, and that means chemotherapy isn't always necessary.

"In general, the treatment of cancers at an early stage also reduces the risk of long-term side effects which can affect patients' quality of life."

Access the full study at www.tinyurl.com/yb2spv8u

DEMENTIA-FRIENDLY DENTISTRY

New guidelines have been published to help dentists provide better care for patients with dementia. *Dementia-friendly dentistry* from the Faculty of General Dental Practice UK (FGDP (UK)) advises dentists on how to adapt their management and clinical decision making for such patients. Free copies are being sent out to FGDP (UK) members and those joining by the end of 2017. Hard copies are available for £25 on their website.

ORGAN DONATION CONSULTATION

Plans for an organ donation opt-out system in England are to be put out to consultation by the government. It will outline ways to increase organ donation rates and propose assumed consent unless an individual opts out. There is a severe shortage of suitable organs, with around 6,500 people currently on transplant waiting lists. Full details of the consultation will be released soon.

DRAFT GUIDELINES ON LYME DISEASE

New guidelines from NICE advise that a patient presenting with a tick bite and a characteristic circular rash (erythema migrans) should be diagnosed and treated for Lyme disease with antibiotics. The draft guidance outlines when to diagnose without the need for tests and when to investigate further. It states that doctors should not diagnose Lyme disease simply if a person has been bitten by a tick but exhibits no other symptoms. The proposed guidance is expected by be published in April 2018.

THE STATE OF INDEMNITY

Chris Kenny

CEO MDDUS

THINK it is fair to say that the issue of GP indemnity has never been a hotter topic.

Since the last edition of *Insight*, the Secretary of State for Health, Jeremy Hunt, has announced the introduction of a state-backed indemnity scheme for GPs in England to be in place by April 2019. It is to be established and “administered” by NHS Resolution – but who will run it day-to-day and how is still up for grabs.

This has prompted a mixed response from the GP community, and one other medical defence organisation (MDO) has used it as a platform to launch a “claims-paid” product that we believe is a poor second best to our occurrence-based cover. The Department of Health has sounded an unprecedented note of caution about this type of product which “only covers claims which are reported and settled during the period of cover,” meaning GPs would have to pay for run-off cover separately.

MDDUS has been at the forefront of negotiations with the Department of Health and professional bodies throughout the UK to shape and influence what a state-backed scheme might look like. We are working round the clock to ensure that any deal is right for our members and their patients.

We have also set up a specific webpage (*State-backed indemnity - what you need to know*) to keep our members up-to-date with what is happening: just visit www.mddus.com and you will find a link on our homepage.

The rising cost of indemnity has been a major issue for GPs. MDDUS believes that the reasons for this are down to Government’s failure to take decisive action to reduce the increasing number and value of claims, and the addition of significant new costs by the misguided lowering of the discount rate to minus 0.75 per cent.

The initial idea of a state-backed scheme may sound attractive but we need to ensure any such scheme is future-proofed for inflation and doesn’t just bring members back to the position we are in now but with no MDO backing. That’s why we believe it’s so important that GPs have the ability to opt out and make their own choices about indemnity with no financial detriment.

As a not-for-profit mutual funded by our own members, with no shareholders to pay, we have been able to keep our costs as low

as we can, ensuring adequate indemnity for all our claims: historical, current and future.

It is vital that members know that a state-backed scheme will not cover them for non-NHS work, representation at inquests, GMC hearings and disciplinary investigations and will also not include advice and support – something highly prized by MDDUS members.

MDDUS is pushing the Government to spell out the details of what is involved and commit to tackling the real issues behind rising indemnity costs before GPs can make a choice on the scheme.

GPs need detailed and specific answers on a wide range of issues including the cost of the scheme and how it will be managed and still ensure they have a choice with fair competition. GPs have the right to expect such detailed assurances – and indeed, the scheme can’t operate without these in place.

The Government’s failure to reform the law of tort and cap the costs that lawyers are taking from the NHS and GPs has been the main driver in rising indemnity costs. That’s outside the control of MDOs, and a state-backed scheme does not address these issues. Health expenditure generally and GP remuneration in particular will continue to be squeezed because of this failure.

That’s why, on behalf of our members, MDDUS has sought detailed assurances on nine key principles (see our webpage). Among these is a commitment that claims must be handled in a way which protects patients and the professional reputation of doctors, as well as the financial interests of the state. GPs must be able to choose who provides the claims indemnity for them and their practices and organisations. That means a financially neutral choice with the same public support available to all GPs inside and outside any state-backed scheme.

If handled correctly and with all of our assurances in place, this may prove a welcome development for GPs in England. But an ill-defined scheme providing only short-term relief to a problem that is much wider and with many more issues at its core will not help anybody.

The recent announcement only affects GPs in England. MDDUS operates across the UK and is in discussion with the devolved administrations in Scotland, Northern Ireland and Wales about the direction they may wish to travel. The hazy and uncertain English model currently emerging looks a risky step into the unknown, taking no account of the very different circumstances of GPs elsewhere.



ALTERING PATIENT NOTES

Dr Gail Gilmartin

Medical and risk adviser at MDDUS

CLINICAL notes are an important record of the encounters between medical or dental staff and their patients. Their contemporaneous nature means they are relied upon in both a clinical and legal context; hence any attempt to alter them in a less than honest and straightforward way will result in sanctions for the practitioner involved.

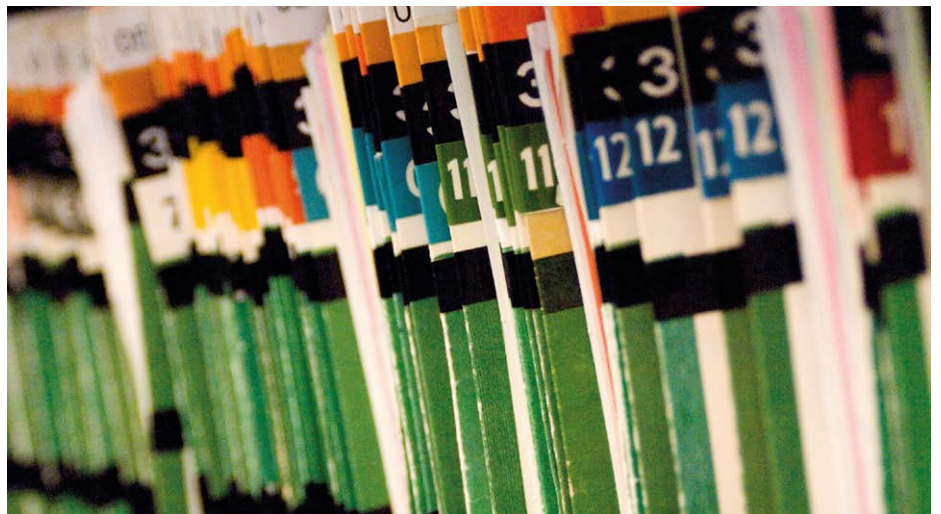
Notes offer a primary record of all care provided and assist in ensuring continuity and communication. They can be reviewed in any medico-legal process and, in addition, are of fundamental value for audit and planning to help with service provision and improvement.

Data Protection Act breaches attract a lot of attention because of the huge fines that can be imposed; however, inappropriate alteration of records can also result in serious consequences. There must be a legitimate reason to alter records in any way. Records changed to reflect more positively on the healthcare provider come with a risk of significant sanctions, including a finding of impaired fitness to practise by regulators. At the less serious end of the spectrum, doctors may face an official 'warning' if they have altered records inappropriately or failed to adequately identify retrospective entries.

In more serious cases healthcare professionals have faced criminal investigation with subsequent prosecution and imprisonment as a result of ensuing fraud cases.

Currently there is much interest in the new General Data Protection Regulation which will come into force on 25 May 2018. The greater ease of access which will be granted next year is likely to lead to many patients seeking to view their records and checking the accuracy of what is written. Also, the Regulation will keep and reinforce the need for accurate records.

In any medico- or dento-legal case the contents of the records will usually be central to the enquiry. In such circumstances it is natural for a practitioner to check what was written in the records. It might be tempting to add to them if on looking back it appears that the record was not sufficiently detailed. However, it is absolutely wrong to amend records in these



“Records changed to reflect more positively on the healthcare provider come with a risk of significant sanctions”

circumstances. If there is additional information about a case it can be provided in statements or reports but it should never be added to the original record in such a way as to suggest that it had always been there.

Is it ever reasonable to alter or add to medical or dental records?

The short answer is “yes”. The most obvious situation is where an entry has been made in error. Clearly this should be amended. The time of the alteration and a brief description of why and who has made the change should be noted.

If additions are necessary, for example because something has been forgotten, the change must be dated when it is made, stating what it relates to, why it has been added, and again the author should be clear. Retrospective entries must be identified.

Any amendment must be for a legitimate reason that can be explained in the notes, with clear timings and authorship also noted. In modern practice with electronic audit trails, all entries can easily be checked and any audit trail must match the entries in the record.

The GMC offers advice about record

keeping in many of its publications, and in *Good Medical Practice* it states: “Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.”

The GMC also advises: “You must be honest and trustworthy when writing reports, and when completing or signing forms, reports, and other documents. You must make sure that any documents you write or sign are not false or misleading.”

Similarly, the GDC in its *Standards for the Dental Team* states: “You must make and keep contemporaneous, complete and accurate patient records.”

ACTION

- Keep up-to-date with professional guidance about record keeping.
- If you must alter records ensure you have a clearly legitimate reason and can state this when making an amendment.
- Any amendment must be accurately dated and signed, showing that it was made retrospectively.



Professor Helen Stokes-Lampard talks to Adam Campbell about her first 11 months as Chair of the RCGP and what keeps her going

“IT HAS been quite a rollercoaster,” says Professor Helen Stokes-Lampard when I ask her about her 11 months as Chair of the Royal College of General Practitioners. The highs, she says, have been “amazing, remarkable, the best job in the world”, but the lows, about 20 per cent of the experience, have been “pretty grim”.

“It’s been fascinating how social media has kicked off in certain areas,” she says, by way of explanation. “Some pressure groups get very personal and nasty.”

Does she care to name any? She brushes this off with a hearty laugh. “Let’s not go there!”

The aggro is not wholly unexpected, says Stokes-Lampard – after all, she was RCGP Treasurer between 2012 and 2016 and worked closely with two previous Chairs, Clare Gerada and Maureen Baker – and she understands that most of it is directed at the role rather than at her personally.

She clearly likes metaphors and uses a particularly vertiginous one to make her point: “It’s like I’m constantly walking a tightrope in high heels.”

TAKING THE BATON

The pressures facing GPs, says Stokes-Lampard, can be summarised under the heading “workload”. “I think just about everything else falls into workload, because it is going up inexorably. We have an ageing population, they have more chronic long-term conditions and the population is growing as a baseline, whereas the number of GPs is not growing.

“More work is being pushed into the community without the resource necessarily following it, which is putting stress and pressure on GPs at a time when we are more regulated than we’ve ever been. We’re having to tick a lot of boxes when what we want to do is deliver person-centred care. The stress is leading to burnout and to people haemorrhaging from the profession.”

She credits Clare Gerada for raising the alarm about the coming crisis in general practice long before it was clear to others, and Maureen Baker for launching the RCGP’s *Put Patients First: Back General Practice* campaign. This led, in England, to the *GP Forward View*, promising 5,000 more GPs, 5,000 more allied healthcare professionals and £2.4 billion extra per year for NHS general practice by 2021.

With the *GP Forward View* already on the table in



AN EVENT

England – and the College looking to secure comparable promises for Scotland, Wales and Northern Ireland – it was clear to Stokes-Lampard that her tenure should not be about starting something new but rather seizing the baton and taking it forward.

“I felt this was too important a time to destabilise what the College was doing for the sake of vanity,” she explains. “I genuinely felt that the right thing was to hold to account, not to mess things around and start again. And that seems to be working so far.”

Combined with the high-wire media act that comes with the territory – although she admits to quite enjoying “the adrenaline rush of a big media day” – this holding to account makes for a punishing schedule. Some weeks will see her travel from one end of the country to the other and back again. “The good bits, of course, are that I’m meeting GPs all over the place, but it’s physically very demanding.”

One regular port in the storm is the day a week she continues to work in the Lichfield practice where she has been a partner since 2002. It’s a job she loves, and working with patients “helps to keep you grounded”, she says. It also means that when it comes to discussing the pressures on GPs



“More work is being pushed into the community ... which is putting stress and pressure on GPs at a time when we are more regulated than we’ve ever been”

wanted to do more. I wanted to be teaching and doing research as well as the clinical stuff so I decided to move across to public health.”

But to do public health, she was told, she needed some experience as a GP. At that point she sought advice from Dr Steve Field, who, coincidentally, would go on to become RCGP Chair himself. “He encouraged me to apply for an academic GP job and within months of starting in my training practice I realised I’d come home.”

It was, she says, a Damascene conversion. “I realised that this was actually what I’d always wanted to do: the continuity of care, the wide-ranging nature of practice, the intellectual challenge and the opportunities to do research and teaching. It just ticked all the boxes for me.”

Looking at her subsequent career, what sticks out a mile is her inclination, and ability, to wear several hats at once. When she finished her GP training in Birmingham, for example, she became a part-time principal at the Lichfield practice, while also working as an academic at the University of Birmingham.

And as her academic career flourished – becoming, among other things, interim head of the Department of Primary Care, head of Academic Community-Based Medicine Teaching, and clinical director of the Primary Care Clinical Research and Trials Unit – there were always other hats too: a working party here, a personnel group there, at the RCGP locally and nationally, and as a mentor for Doctors in Difficulty.

When I bring it up, she points out that the “many hats” habit started long before this. “I have always wanted to improve my working environment and that of my colleagues,” she says. “When I was in my sixth form college I set up a branch of the NUS. When I was in medical school, I was President of the Student Union. When I was a trainee GP I got involved as a trainee rep with the College.”

But despite her many roles within the RCGP over the years, combined with her experience and success, she “never in a million years” thought it would lead to being Chair. “I’d always seen myself as a kind of backroom influencer, the sort of person who organises things quietly to make it run better, which is why I was Treasurer. It was only seeing it up close that I started to realise my own passion and that perhaps I did have the ability.”

Now, as she approaches her first anniversary in the role, I ask, with all the challenges faced by the profession in the coming years, what does the future hold?

“Times are really tough,” she replies. “But what I want – hope – is to restore pride to our profession and joy to the consultation. I want GPs to have the time to care for their patients so that general practice becomes, once again, the medical profession of choice where GPs can enjoy working for their entire careers.”

Adam Campbell is a freelance writer and regular contributor to MDDUS publications.

and practice teams due to workload, regulations and lack of investment, these are issues she understands intimately.

“I absolutely do,” she says. “Our practice is merging to survive. We’ve struggled to get partners and we’re not able to bid for new work or innovation because we are regarded as too small. When I speak about these things they are from the heart, because I am living it.”

COMING HOME

If one were plotting a route to become Chair of the RCGP, you would hardly set off from where Stokes-Lampard began. For starters, she never planned to go into medicine at all, not considering herself “bright enough”. But following a good set of exam results at her comprehensive in South Wales, her expectations rose. Medicine it was – but after qualifying at St George’s in London, she then opted, not for general practice, but for obstetrics and gynaecology.

It was only later, when her career progression had stalled somewhat, due to a surplus of obstetrics and gynaecology trainees, that she considered a change. “Truth be told I was getting a bit frustrated,” she says, “probably because I was a bit stuck at a certain training level. I

UL YEAR

DIAGNOSIS UNFORTHCOMING



How do you approach patients with medically unexplained symptoms?
Professor Chris Burton offers some insights

MEDICALLY unexplained symptoms (MUS) is an umbrella term commonly used to refer to physical symptoms in the absence of a diagnosed organic disease. It includes both individual symptoms (e.g. headache or abdominal pain) and syndromes (e.g. tension type headache or irritable bowel syndrome).

An estimated 20 to 30 per cent of consultations in primary care involve patients experiencing MUS with no clear diagnosis. Recent developments in neuroscience and physiology mean we are becoming increasingly able to explain these symptoms, and the term MUS should probably be abandoned: both because it's no longer accurate and patients dislike the term. However, it is still in use and these symptoms cause distress to patients, concern to doctors and occasionally lead to medico-legal consequences. For these reasons, it is important to think about what these symptoms are and how to manage them safely and effectively.

SYMPTOM MECHANISMS

Current thinking about symptoms takes a similar approach to the definition of pain: symptoms can be thought of as bodily sensations which indicate the presence or possibility of disease. Symptoms are sensed in the brain and all symptoms, whether explained or unexplained by disease, involve both peripheral and central processes.

In some symptoms, for instance an injured limb, it is simple to separate the peripheral and the central. We can see the injury which is triggering pain-sensing peripheral nerves and we know in turn that these nerves activate brain circuits which provide automatic protective responses (e.g. withdrawal) and a feeling of pain. For a patient with irritable bowel syndrome it is more difficult to separate the central and the peripheral. Visceral nerves may be triggered by modest changes in distension (perhaps in response to fermentation products of gut bacteria to certain foods) and in turn they activate brain circuits which also provide protective responses and feelings. But those circuits may, because of biology, past events or current concerns, be sensitised to produce a response which is more intense or more prolonged than expected from the size of the stimulus.

This model of peripheral triggers with central amplification can be applied to most symptoms. The key point is that medically “unexplained” symptoms involve disproportionate central processes relative to the peripheral triggers when compared to “explained”

diseases. This central processing approach is replacing older views that MUS represent the result of somatisation – the expression of mental distress as physical symptoms. While common mental disorders do have an increased prevalence in patients with MUS, the relationship between the two is complex and there is strong evidence that causes apply in both directions – symptoms can lead to distress and distress can amplify symptoms.

SAFETY IN DIAGNOSIS

There are good guidelines for common MUS syndromes which include clear diagnostic criteria. These guidelines and criteria are useful for setting practice protocols and are also a valuable resource for occasional use – to look up information about specific syndromes. Guidelines typically recommend appropriate screening tests to exclude other conditions. Carrying these out (and documenting their use) is a valuable way of ensuring safe practice in this area of inherent uncertainty.

In less specific symptoms it is important to look for (and document) both the absence of features of peripheral disease and the presence of features suggesting increased central processing. Positive indicators of heightened central processing include symptom features which are biologically implausible (e.g. non-anatomic pain distribution), signs of sensitisation such as the presence of allodynia or abdominal wall tenderness (Carnett's sign) and the occurrence of symptoms on examination despite signs of normal function (e.g. during a stepping test for dizziness). The level of distress is generally not a helpful measure in deciding whether a symptom is due to organic disease or not.

Clinicians often worry about missing organic disease due to gaps in their knowledge but there is evidence that mistakes are much more likely to be due to errors in thinking about clinical features (for instance closing down a differential diagnosis too early) than to gaps in knowledge or faulty examination technique.

Investigations have a mixed role in patients with suspected medically unexplained symptoms. Simple investigations (e.g. full blood count or C-reactive protein) represent an important safety net for patients with uncertain symptoms and, along with documentation of weight, represent an important part of safe management.

On the other hand investigations “to reassure the patient” have very little value. Negative tests may reassure doctors (sometimes falsely) but there is good evidence from a systematic review that diagnostic tests produce



very little sustained reassurance in patients. Patients may show relief about negative tests in the consulting room but that relief does not translate into longer-term assurance that ongoing symptoms are not concerning.

MANAGING MUS

Central to managing patients with MUS is some form of explanation. Patients expect explanations for their symptoms, regardless of whether they are due to organic disease or to central processing of sensations. Simply reassuring them that there is nothing wrong is generally not helpful, particularly when the patient has had repeated consultations and tests. Syndrome labels can be useful in this setting – where patients meet criteria for a syndrome such as fibromyalgia or IBS, there is no good reason not to discuss it. Some patients find more detailed explanations of dysfunctional bodily mechanisms very useful. These can commonly be found on patient-oriented websites such as for chronic pain or in books on the topic.

Patients given effective explanations for their symptoms may benefit from techniques to limit symptoms and reduce symptom-related distress or limitations. Treatments include self-management support, specialist psychological treatment and pharmacotherapy. Self-management support aims to teach symptom-control techniques, including progressive muscle relaxation as well as more advanced techniques such as sensory grounding.

Specialist psychological support may be appropriate for patients with multiple symptoms or high levels of disability. Cognitive behavioural therapy (CBT) is the most commonly used approach but other treatments can be effective in some situations. Pharmacotherapy is largely limited to pain management (avoiding strong opioids in fibromyalgia) and to treatment of comorbid depression or anxiety.

Patients with MUS vary greatly: from those with occasional relatively minor and self-limiting symptoms in one body system to others with severe disability due to multiple symptoms. A recent prognostic classification for use in generalist settings employs the notion of “multiple symptoms, multiple systems, multiple occasions” as a way of assessing the likelihood of sustained problems. In this scheme, the more systems (e.g. cardiopulmonary, GI, musculoskeletal) involved and the more occasions, the less likely it is that symptoms will resolve without specific action.

COMBINING SAFETY WITH EFFECTIVE TREATMENT

Doctors in any specialty can manage patients with MUS. Doing so effectively requires confidence in explaining symptoms in a way that patients find acceptable, supporting self-management and being able to handle emotional distress and mental health problems if they emerge. Doing so safely requires attention to clinical detail, judicious use of diagnostic tests and a balance between firm reassurance with symptom management and closing down other diagnostic possibilities too quickly. As the science which enables us to explain MUS becomes stronger, the art of maintaining this balance will remain.

“Investigations ‘to
reassure the patient’
have very little value”

DENTISTRY FOR THE

Professor Nairn Wilson looks at the opportunities and challenges for dentistry in the shift toward holistic healthcare

CARE for the patient, the whole patient and nothing but the patient” may well become the mantra to promote a shift to holistic healthcare. ‘Holistic’ is described in the *Oxford Medical Dictionary* as “an approach to patient care in which the physical, mental and social factors in the patient’s condition are taken into account, rather than just the diagnosed disease”.

Such use of the term ‘holistic’ has superseded the now outdated use, indicating complementary medicine, homeopathic and other alternative approaches to patient care. For clarity in contemporary literature, holistic may be qualified by the addition of ‘whole patient’ – ‘whole patient holistic care’.

In dentistry, as in most if not all other aspects of healthcare, conditions treated as having a simple cause and effect aetiology may recur or possibly even be aggravated through a failure to recognise and manage all aspects of the causation – in other words by “not getting to the bottom of the problem”.

Take, for example, a simple like-for-like replacement of a fractured restoration in a patient who has developed parafunctional occlusal activity. This activity might follow the acquisition of an occlusal interference, subsequent to a fracture, wear, or an extraction allowing passive eruption of an opposing tooth. Good long-term success in the replacement of the fractured restoration may only be achieved through initial management of the occlusal dysfunction. However, this may not guarantee success as the parafunctional activity, although triggered by an occlusal interference, could be found to have a more complex aetiology than is first apparent. Psychological stress would be top of the list of likely confounding aetiological factors. In this way, a holistic, whole patient approach is required to successfully manage an apparently simple, everyday problem in dentistry.

“TROUBLESOME” BLACK HOLE

Scaling-up such thinking to consider the management of a patient with, for example, a chronic non-communicable disease such as diabetes, it quickly becomes apparent that an inter-professional, coordinated team approach is indicated to manage and minimise the effects of the patient’s condition efficiently and effectively. The evidence base to support such thinking continues to grow¹.

Oral healthcare must be integral to such teamworking,

given the now widely recognised association between oral disease and general health and wellbeing, specifically periodontal disease. Realising this goal will be a two-way process – expansion of the nature and scope of oral healthcare (dentistry) and other healthcare professionals being trained not to forget the mouth, its importance, how to prevent and manage certain oral conditions, and when to refer to a dental team for management².

Dentists will become as much physicians as surgeons, and other healthcare professionals will come to better understand the mouth rather than tending to view it as that rarely to be ventured into and sometimes troublesome “black hole” in the lower third of the face. For example, in prescribing drugs, all healthcare providers should consider the effects that certain drugs and polypharmacy may have on salivary function and quality – xerostomia (apart from being very unpleasant) may greatly increase caries progression and be associated with candida infections and difficulties with dentures.

EXPANDING OPPORTUNITIES

With the integration of oral healthcare into general healthcare, there will be many different opportunities for dentistry, including involvement in screening, vaccination and other programmes. This will help prevent, diagnose and limit a range of conditions and diseases with life-changing

consequences and high cost burdens. In this way, dental teams will add significantly to their existing role of managing dental problems and helping patients achieve and maintain oral health.

To create time and opportunity for members of the dental team to acquire and maintain the necessary knowledge, skills and understanding to realise their potential in inter-professional, shared-care of patients of all ages, there will need to be a fresh approach to dental education and workforce planning. No longer will estimates of future numbers of students in different dental programmes be largely based on projections of changes in the pattern and incidence of dental caries and periodontal disease, not to forget tooth wear. New and attractive career pathways may emerge, helping to recruit and retain bright, high-potential people into dentistry, assuming suitable recognition of expanded roles and responsibilities.

“Given the scope of the challenge, there is little time to waste if the future needs and expectations of patients are to be met”



THE WHOLE PATIENT

To achieve this, dentistry must be transformed together with its existing image, which sadly, for many, still reflects bygone practices and historic approaches to pain control. Given the scope of the challenge, there is little time to waste if the future and rapidly changing needs and expectations of patients are to be met.

MOVING MATTERS FORWARD

Growing evidence suggests that the integration of oral healthcare into general healthcare creates opportunities for efficiency savings, allowing more people to be managed better within existing resources. In addition, patient satisfaction should be favourably impacted, and through enhanced inter-professional auditing and understanding, the process of identifying future research and development (R&D) priorities should be greatly facilitated.

What then is stopping the planning and introduction of the necessary programme of change? Is it a lack of leadership, inertia in dentistry (as presently practised and perceived) or the opportunities afforded by the integration of oral healthcare into general healthcare provision not being on the “radar screen” of healthcare planners? Alternatively, is it down to a lack of joined-up thinking amongst all relevant stakeholders? In all probability, all of these factors and others are culpable.

So, what is to be done to move matters forward? Do we need more publications aimed at stimulating debate?

Or, is it a matter of funding research to confirm the value of oral healthcare being integral to holistic general healthcare provision in the UK?

Personally, I believe that the key is strong, suitably empowered leadership which has the confidence and trust of those who will be influenced most by change – patients, dental millennials, funding agencies and those who will need to guide academic and postgraduate dentistry through the necessary transformational change. Is this a challenge for a College of Dentistry, which is now in the process of being formed, subsequent to the Faculty of General Dental Practice (UK) – FGDP(UK) – having announced its intention to become an independent body earlier this year.

The recent FGDP(UK)/Simplyhealth conference entitled *Holistic dentistry: putting the mouth back in the body* may be the first step in rising to the challenge. If forward thinking individuals and informed patients had their way, holistic, whole patient care, including oral healthcare provision, would be high on the agenda of promising developments in UK healthcare provision.

Professor Nairn Wilson is emeritus professor of dentistry, King's College London and, amongst other positions, chair of the Shadow Board for a College of Dentistry and a non-executive director on the MDDUS Board

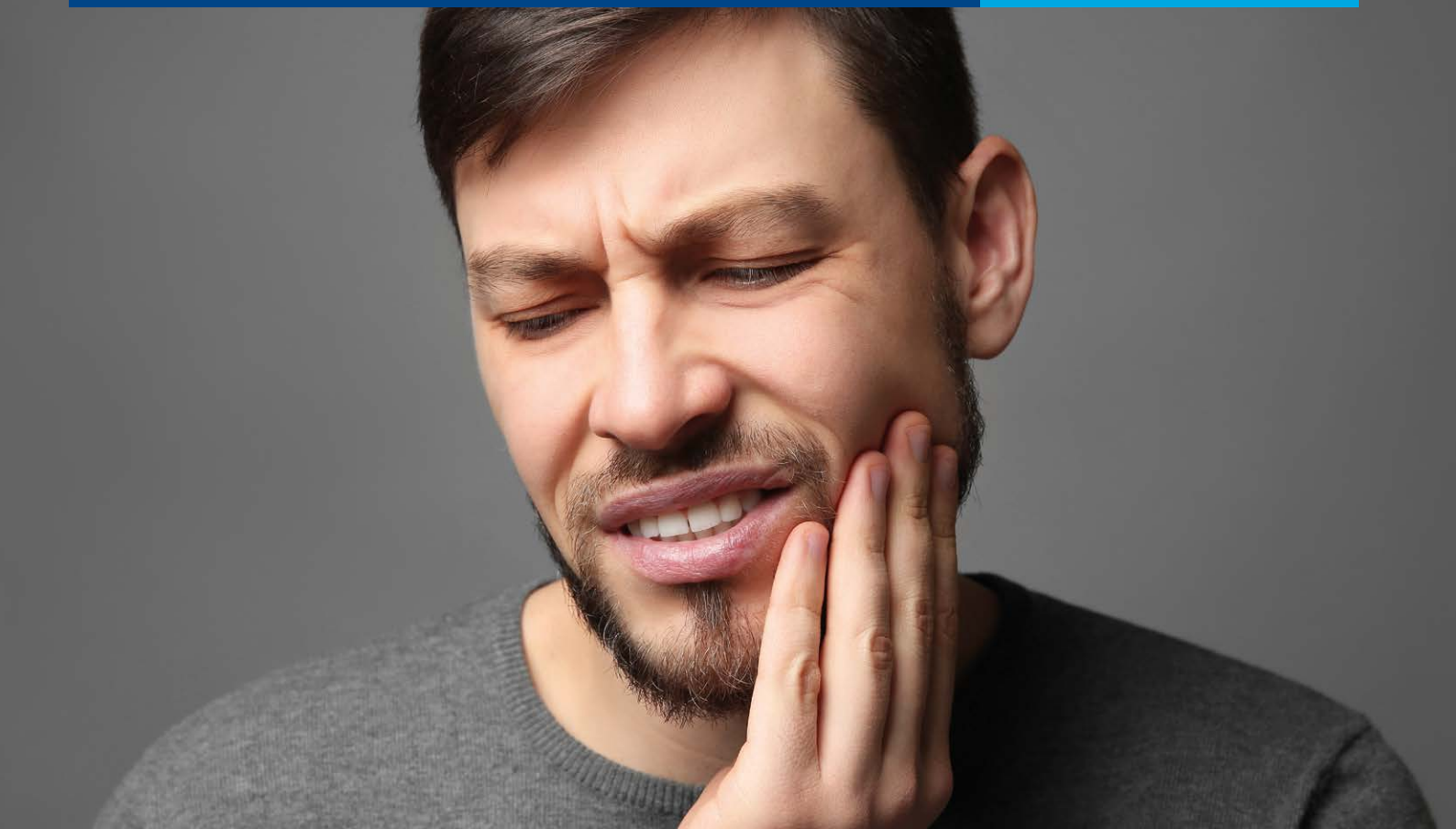
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CASE FILES



These case summaries are based on MDDUS files and are published here to highlight common pitfalls and encourage proactive risk management and best practice. Details have been changed to maintain confidentiality.



LOOSE FILLINGS

BACKGROUND

Mr B is a 31-year-old school teacher and contacts his dental surgery complaining of a loose temporary filling in LL4. His regular dentist Dr L is on holiday but the patient is booked in for a crown restoration of the tooth in three weeks' time. Another partner at the practice – Dr T – advises him to make an emergency appointment if the filling falls out.

Two days later this happens and the tooth is restored by Dr T with a resin-bonded composite. Mr B is informed again of the temporary nature of the filling and also the poor aesthetics due to the size of the cavity. A day later this filling comes loose and is lost. It is again replaced by a resin-bonded composite in an emergency appointment with Dr T.

Mr B attends his scheduled appointment with Dr L and the tooth is successfully treated with a crown. The patient is however extremely dissatisfied with the treatment provided by Dr T and sends a written complaint to the practice, as well as to the General Dental Council.

In his complaint to the GDC Mr B claims

that Dr T provided rushed and substandard treatment resulting in the loss of two fillings in the same tooth. He states that he was "in and out the dentist chair in less than five minutes" in both appointments and that Dr T displayed a poor attitude, as though he was being "inconvenienced" by the treatment failures.

ANALYSIS/OUTCOME

A letter is received by Dr T from a GDC caseworker asking for more details including the patient's dental records. MDDUS advises Dr T in compiling the relevant information and the GDC writes back saying the case has been referred to a case examiner who will determine whether the complaint amounts to potential impaired fitness to practise.

MDDUS assists Dr T in submitting a response to the allegations that he provided inadequate care on two occasions in the treatment of LL4 – including a poor standard of filling. The GDC has also noted inadequate record keeping in these consultations, including one which was not recorded at all.

The case examiner contacts Dr T two months later to inform him that the case will not be referred to a practice committee. The letter acknowledges that although it cannot comment on the standard of the fillings it recognises that composites are moisture sensitive and prone to falling out. It notes that the treatment plan was sound, as Mr B had not complained of pain, and crown treatment was planned within weeks.

The case examiner does observe that the patient notes are brief and lacking detail. A letter of advice is thus issued to Dr T in regard to the standard of his clinical records and this will form part of his fitness to practise history.

KEY POINTS

- Ensure adequate records of all patient encounters no matter how brief.
- Be conscious of how your attitude may be perceived by a patient.



🔍 COMPLAINT

MISSED GALLSTONES

BACKGROUND

A 16-year-old patient – Mr P – attends his GP surgery complaining of abdominal pain. He is seen by Dr H who examines the patient, diagnoses constipation and prescribes medication to relieve the symptoms. The next week he again presents with similar symptoms and Dr H prescribes a different laxative.

Over the following six weeks he attends the practice three more times and is examined by two different GPs who also diagnose constipation. On his third visit, Dr J refers him for specialist treatment. In the meantime, the patient attends on two more occasions and is given further medication to relieve his constipation.

Mr P attends hospital and is seen by Dr N who also suspects constipation. He administers sodium picosulfate and the patient is discharged the next day. His pain worsens over the following two weeks and

he is readmitted to hospital. An ultrasound shows multiple gallstones and he undergoes surgery two weeks later to remove his gallbladder. He is eventually discharged with pain relief, having lost a significant amount of weight.

The practice receives a letter of complaint from the patient's mother who demands to know why her son's gallstones were not diagnosed sooner.

ANALYSIS/OUTCOME

An MDDUS adviser helps in drafting a response to the complaint, having ensured consent from the patient to allow his mother access to all correspondence.

In the letter, the practice expresses regret that there was a delay in the diagnosis. It notes that the Mr P was referred to a specialist within weeks of first presenting with abdominal pain and the examination and treatment of the patient was carried

out in an appropriate and timely manner. The letter explains that gallstones are rare in such a young patient and his symptoms strongly indicated constipation, a diagnosis also suspected by the hospital. The practice offers a meeting to discuss the matter and the complaint ultimately progresses no further.

KEY POINTS

- Delays in diagnosing less common conditions do not always amount to negligence where doctors can evidence careful and thorough examination and treatment.
- A comprehensive and carefully written response, including an expression of regret, can lead to early resolution of complaints.



🔍 COMPLAINT

ANONYMOUS COMPLAINT

BACKGROUND

A dental practice receives an anonymous letter of complaint accusing one of their nurses of being rude and dismissive during a recent visit. There is a mobile number but no name or address is provided. The practice manager contacts MDDUS to ask whether they have a duty to respond to the complaint or, considering it is anonymous, would be within their rights to ignore it.

ANALYSIS/OUTCOME

An MDDUS adviser discusses the matter with the manager and advises her in the first instance to call the mobile number provided in the letter to try to identify the complaint's author. If that can be established, the next step would be to discuss the issue and confirm whether the person wishes to take the matter further or whether they can be suitably reassured

by telephone.

If they would like to escalate the complaint, the manager would then have to follow the practice complaints procedure – conducting an investigation into the allegations and issuing a formal response to the complainant within required timescales. The complainant should be given contact details for the Ombudsman if unsatisfied with the practice response.

KEY POINTS

- Do not be tempted to dismiss anonymous complaints – investigate them as fully as possible.
- Effective communication can help resolve most complaints at an early stage.

CLAIM

NON-COMPLIANT DIABETIC



BACKGROUND

Mr A is 53 years old and obese (BMI 34) and has type 2 diabetes. He attends his local surgery with a deep infected 'crack' in his right heel. His foot is swollen and he also feels generally unwell with nausea and vomiting. One of the GP partners – Dr T – examines the foot and prescribes oral antibiotics. The patient then sees the practice nurse for advice on dressing the wound.

Three days later Mr A returns to the practice and this time is seen by another GP – Dr F. He examines the foot and notes that it is "hot" and swollen. The patient's temperature is 36.5 and he still complains of nausea and vomiting. A diagnosis of cellulitis is made and Mr A is referred to A&E.

An emergency physician examines Mr A's foot and notes a "necrotic ulcer" on the right heel and a 6 cm blister mid-sole. Foot pulses are palpable. The entire foot is very swollen with multiple air pockets in the forefoot and adjacent to the calcaneum but there is no evidence of osteomyelitis. Mr A is admitted and commenced on intravenous antibiotics. Emergency surgery later reveals extensive tissue necrosis.

The infected foot proves unresponsive to antibiotic therapy and six days later Mr A undergoes a below-knee amputation. He makes a good recovery and is discharged from hospital two weeks later.

A letter is received by the practice from solicitors alleging clinical negligence in the

delayed referral of Mr A for emergency treatment of his infected foot – but also in failing to provide adequate long-term care which would have prevented the outcome.

ANALYSIS/OUTCOME

MDDUS lawyers review the allegations and instruct a primary care physician to provide an expert report on the case. In reviewing the notes it is revealed that Mr A was diagnosed with type 2 diabetes four years previous after attending the surgery with a non-healing foot ulcer. Notes from that consultation state that the patient was commenced on metformin tablets and given dietary advice. His BP was found to be 154/93.

Over the four-year period Mr A was invited to attend the practice numerous

times for routine diabetes care but did not respond. A number of letters were also received by the practice over that period from the local eye hospital service stating that Mr A had not replied to invitations for retinopathy screening. Mr A's only routine contact with the practice was for repeat prescriptions of the metformin tablets.

In that period Mr A attended the practice only once for a chest infection. His BP was found to be 173/108 and he was given an appointment for a week later to recheck his BP but did not attend.

It is alleged in the letter of claim that the practice failed to manage the various risk factors for peripheral vascular disease in the patient – namely excessive weight, high BP and poor blood glucose control. The primary care expert comments that this might seem principally due to Mr A's reluctance to engage with the practice for regular health checks and medical care. Checking the notes, however, the expert finds little or no evidence of any education provided to Mr A by the practice regarding the implications of diabetes or advice about lifestyle apart from diet.

The expert also questions why there is no record of antihypertensive therapy being considered, nor evidence of a frank opportunistic discussion with Mr A regarding his "non-engagement" when later attending for the chest infection.

In regard to the subsequent consultation over the infected foot, the primary care expert concludes that Dr T should have referred Mr A urgently for acute care with a local multidisciplinary foot service as per NICE guidelines. Dr T also recorded no assessment of systemic illness (temperature, heart rate, blood pressure), nor consideration of the patient's diabetes or vascular status (foot colour and pulses).

An expert view on the consequences of this breach of duty is commissioned from a consultant endocrinologist. He offers the opinion that if the patient had received and followed appropriate ongoing advice on blood glucose control and diabetic foot care the risk of infection would have been greatly reduced – but he acknowledges this would be much dependent on patient compliance.

In regard to the delayed referral for the foot infection it is viewed unlikely that immediate specialist in-patient treatment would have led to a different outcome.

MDDUS in consultation with the GPs involved agrees to settle the case out of court.

KEY POINTS

- Establish a standard policy and procedure for "escalating concerns" when dealing with repeated non-compliance in a patient.
- Record all advice provided to patients in regard to ongoing management of chronic conditions.
- Consult clinical guidelines regarding the management and referral of serious infection and potential sepsis.

BAD TATTOO

BACKGROUND

A 15 year-old-girl – Jemma – attends a consultation with Dr L. She is tearful and requesting a medical note to allow her to have a tattoo on her upper arm cosmetically altered.

Jemma had the tattoo done by an illegal artist and is upset by the appearance. She claims it has led to serious bullying at school and has left her depressed. She has approached a legitimate tattoo parlour but they are requesting a doctor's letter. Dr L offers to refer Jemma to a plastic surgery service for laser removal but she declines.

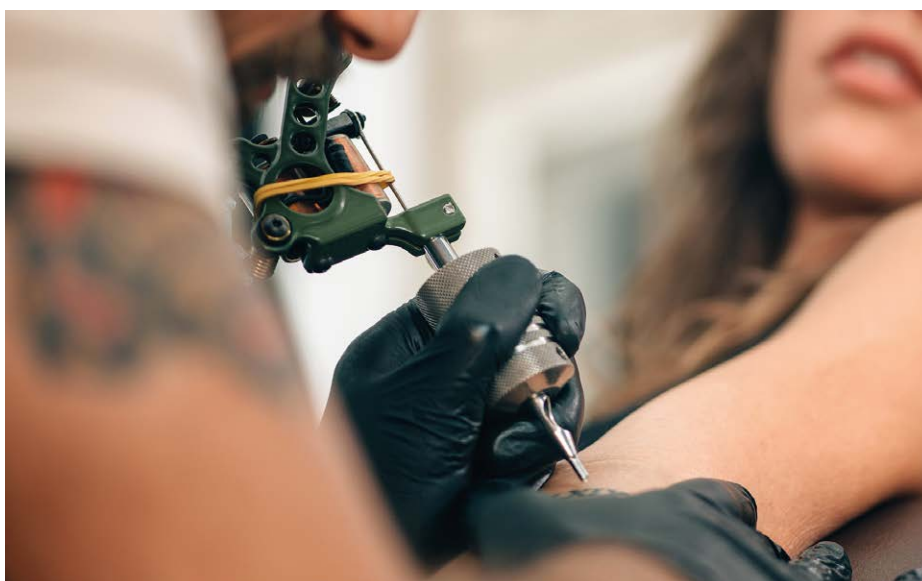
The GP contacts MDDUS for advice on the matter. He asks if, as a GP, his assessment along with a letter would be sufficient under current UK legislation.

ANALYSIS/OUTCOME

An MDDUS adviser looks further into the matter. She advises that under UK law it is an offence to tattoo a person under the

age of 18 except when the tattoo is performed for medical reasons by a duly qualified medical practitioner or by a person working under his or her direction. In this case a legitimate licensed tattooist has asked the patient to obtain a doctor's report confirming that there is a bona fide medical reason for this minor to have a tattoo cosmetically altered.

Dr L is advised that he must first consider whether Jemma has a legitimate medical reason to have her tattoo revised and secondly that he is satisfied for the licensed tattooist to work "under his direction". In the end Dr L supplies the medical note and the tattoo is revised. Jemma now feels less self-conscious.



KEY POINTS

- Keep notes of all discussions with patients justifying decisions made.
- Ensure you check current UK law in regard to cosmetic treatments.

IMPACTED WISDOM TOOTH

BACKGROUND

Mr K presents at his dental surgery with pain in the lower right jaw. Examination reveals a decayed and impacted wisdom tooth (LR8) and the patient is booked in for an extraction by one of the practice partners – Dr G.

A week later Mr K attends the surgery and is administered a local anaesthetic. Dr G attempts the extraction using forceps but the tooth is shattered and a periapical X-ray is taken to ascertain the position of the retained roots. The dentist explains to the patient what has happened and prescribes amoxicillin. Mr K is referred to another dental clinic where the roots are removed utilising sedation and a local anaesthetic.

Four months later a claim for damages is received by the practice citing clinical negligence in the treatment of Mr K's

impacted wisdom tooth. It is alleged that the dentist should have taken a pre-treatment X-ray of LR8 to ascertain the position and size of the roots in order to formulate a competent treatment plan. Failure to do so resulted in the failed extraction and the need for further surgery to remove the retained roots, along with consequent prolonged pain and swelling suffered by the patient.

ANALYSIS/OUTCOME

An expert report is commissioned from a dental surgeon who reviews the notes and associated radiographs. He states that examination of the post-extraction periapical X-ray clearly demonstrates angulation of the crown and roots which were mesially impacted. In his view a pre-treatment X-ray would have alerted Dr K that a simple forceps extraction was

unlikely to be successful. A pre-treatment plan would also have given the dentist pause to consider whether he was competent to extract an impacted wisdom tooth or if the case would have been better referred to an oral surgeon.

The expert concludes that in his view the pain and swelling suffered by Mr K until the roots of LR8 were removed were the result of negligent care on the part of Dr G.

MDDUS in agreement with the member offers to settle the case.

KEY POINTS

- Ensure pre-treatment radiographs taken to accepted guidance.
- Do not undertake procedures beyond your competence.

DISPUTED CONSENT IN A MINOR

Dr Gail Gilmartin

Medical and risk adviser at MDDUS

A *MOTHER recently rang our GP surgery to make an appointment for her six-year-old to seek referral to child and adolescent services because of abnormal behaviour. Mum and child are both registered with the practice. The next day we received a message from the child's father to say he objects to the referral and does not want it to go ahead. He is not registered and is unknown to the practice. What should we do?*

A conflict where parents disagree about the management of their child's healthcare arises quite frequently in practice. In the situation described here the child is also too young to be actively consulted about her views. Some disputes are related to administrative issues, such as the child's registered address, and these along with clinical matters require a careful and consistent approach to try to resolve them.

It is useful to start with basic considerations. First, try to establish who has parental responsibility and therefore legal rights in relation to the child. These are helpfully summarised in the GMC's *0-18 years: guidance for all doctors*. This states that mothers and married fathers both have parental responsibility, as do unmarried fathers of children as long as they are named on the child's birth certificate and the birth was registered after 15 April 2002 in Northern Ireland, 1 December 2003 in England and Wales and since 4 May 2006 in Scotland.

Unmarried fathers can acquire parental responsibility by way of a parental responsibility agreement with the child's mother, or by getting a parental responsibility order from the courts. Married step-parents and registered civil partners can also acquire parental responsibility in the same ways.

Parents who divorce do not lose parental responsibility, and when a child is taken into care the parents will usually share responsibility with the local authority. Parents do lose parental responsibility if a child is adopted, and it can also be restricted by court order. Adoptive parents, individuals appointed as a child's testamentary guardian, special guardians or those given a residence order will all have parental responsibility.



MDDUS advises healthcare professionals to get in touch if in any doubt about the legalities of parental responsibility.

In England, Wales and Northern Ireland these responsibilities continue up to the age of 18, and in Scotland up to the age of 16. If one parent has parental responsibility and the other does not, the consent of the parent with legal rights and responsibility is sufficient. However, it is often good practice to consider the other parent's wishes too.

In many disputes both parents have parental responsibility and so have equal rights and responsibilities towards their child. Therefore the key consideration must always be what is in the child's best interests.

Best interests are not always clear cut and due regard should be paid to cultural and religious beliefs, the views of those close to the child and other relevant professionals, e.g. school teachers and school nurses and the child's own views (if they are mature enough). Any action must not be discriminatory and where there are options for treatment the decision should err on the side of being the least restrictive for future choices.

In making any decision about the child's care therefore consider:

- What is the suspected condition?
- What are the options for investigation and treatment?

- Where will the care take place, e.g. GP or hospital?
- Does the patient or the parent have concerns or fears about the proposed plan?

Any fears expressed by the patient or parents should be addressed as far as possible. You must act in the child's best interests having considered the options and their impact on your patient and keep careful notes of discussions with all parties in the child's record.

Also, be open and honest about the care and the levels of communication that can be provided so that expectations are properly managed, e.g. how updates regarding the child's health can be provided.

Looking at the scenario above: if Mum alone has parental responsibility she can consent to the referral and this can be made if it is clinically indicated and in the child's best interests. Careful assessment and discussion with both parents is required and if both have parental responsibility the same principles apply. Consent from Mum alone would suffice if the action is in the child's best interests, but if it were not, it is reasonable to refuse to make the referral.

Remember that in difficult cases we are happy to advise on the issues arising in these situations.

UNEXPECTED FIELD WORK

Deborah Bowman

Professor of Bioethics, Clinical Ethics
and Medical Law at St George's, University of London

I OFTEN write about autonomy. I believe that individuals should be able to choose what happens to them in their care and that ethical practice attends to the differences amongst people.

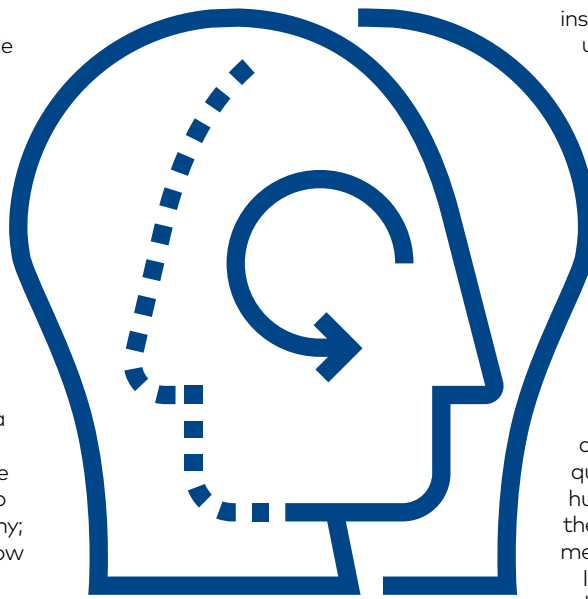
Nonetheless, autonomy isn't unproblematic. The notion of people as separate, rational and self-determining beings seems to overlook the connectedness and relationships that shape not only our own choices, but also inform what it is to be part of a flourishing community.

Autonomy depends on trust and understanding for it to be meaningful – a credible choice cannot be made without an appreciation of one's situation and the key variables at play. I have wondered too about the notion of prospective autonomy; the extent to which anyone can really know what it is he or she would want in unexperienced, hypothetical circumstances. Nonetheless, autonomy is, for me, central to clinical ethics.

I have been thinking a lot about autonomy recently as I have spent time with many clinicians and in hospitals doing some unexpected field work as a patient. It has been instructive and I have learned a great deal.

The experience of being ill changes us in ways that potentially both enhance and detract from our identity, sense of self and, perhaps, autonomy. I have been more reflective, enquiring and focused than ever before. A forensic wish to understand, to consider, to question and to analyse the information and possibilities presented to me has driven me. I am hypersensitive to the weight and meaning of words, gestures and facial expressions. I am also emotional: scared, overwhelmed, shocked and protective of those I love whom I long to shield from the impact of my diagnosis.

I have realised that to attend properly to autonomy is to attend to all the different 'ways of being and knowing' that co-exist in a clinical consultation. It is about much more than the provision of information and the facilitation of choice, although those are sound enactments of respecting autonomy. However, where autonomy is given real meaning, it is because a clinician accommodates and shifts between my forensic rationality, insatiable questions



“I have discovered that when illness strikes, the sharing of information in a paced, careful, caring and gentle way allows space for it to settle and to sift”

and emotional response. It is possible to make choices and difficult decisions with someone who recognises that what might be unexpressed – fear, shame, sadness, anger and doubt – is in the consultation room along with the apparently composed, professional woman talking calmly about surgical options and chemotherapy.

Time matters to facilitating autonomous choices. From the purely practical matter of how much can be shared in a single meeting to a more abstract but powerful influence on the extent to which information can be borne at a specific point. I am someone who believed I needed to know everything: all of it, at once. Leaving aside the impossibility of such an

insatiable appetite for knowledge and an unrealistic wish for certainty, I have discovered that when illness strikes, the sharing of information in a paced, careful, caring and gentle way allows space for it to settle and to sift. Had I been allowed, I would have made significant and irrevocable choices on the day my diagnosis was confirmed. Uncertainty – my oldest foe – was to be vanquished by knowing as much as possible and simply 'doing something'. Yet, my wise, experienced and caring clinical team instead slowed me down, sharing what I need to know at that point and answering my questions, but also cautioning against hurrying and gently letting me adapt to the new normal whilst walking alongside me without judgement.

I will never again underestimate the value of written information and supportive resources. However much the patient may consider herself intelligent and informed and irrespective of the exemplary communication skills of the clinician, there is simply nothing that compares to having materials that can be explored at home and at a time that works for the individual. Being in touch with others who have navigated this testing terrain before you is a uniquely therapeutic contribution when learning to make choices in circumstances no one would choose. I confess that initially I took the booklets and details of support organisations with reluctance. Yet, they have been invaluable.

Fundamentally, autonomy is relational. It is not solely intellectual. It is predicated on interaction and exchange. It does not and cannot exist without the kindness, patience, sensitivity, wisdom, honesty, commitment and expertise of professional staff. To be able to be vulnerable enough to express fears, to be confident enough to convey personal priorities, to be respected enough to have questions answered truthfully and to be informed enough to make meaningful choices depends on trust. That is trust in other human beings. It is the most precious form of connectedness and I am grateful for it every day as I begin treatment for breast cancer. Thank you to everyone at The Marsden who gives meaning to my autonomy.

Addenda

BOOK CHOICE

YOUR LIFE IN MY HANDS: A JUNIOR DOCTOR'S STORY By Rachel Clarke

Metro Publishing: £8.99 paperback, 2017

Review by Dr Greg Dollman, MDDUS medical adviser

RACHEL Clarke, an experienced journalist before retraining as a doctor, knows her way around words. In her memoir, *Your life in my hands*, she recognises she met her match in Jeremy Hunt. "On 16 July 2015, the Health Secretary went to war.

For a former PR man turned politician, Jeremy Hunt's weapon of choice would always be words – deployed, on this occasion, with explosive aplomb."

This is a story of the NHS at a time of perhaps the greatest unease it has known, as told by a junior doctor. Clarke joined the campaign against the government over the junior doctors' contract, and tells of the struggle to save not only the patients she trained to heal but also the system that she loves.

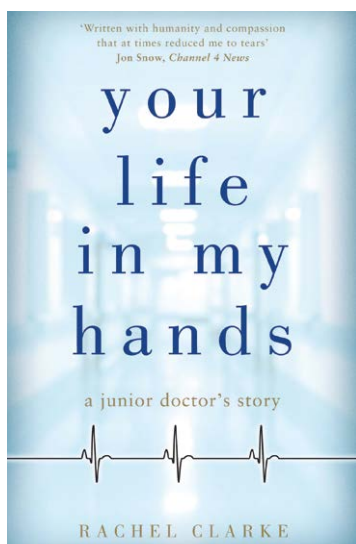
Clarke was born into a family of doctors. She recalls the ceremony of accompanying her GP father to the cottage

hospital each Christmas Day where she would visit each patient in turn. Although choosing arts over science as a teenager, her pull to medicine was too strong and at age 29 she entered medical school. She writes poignantly how her grandfather died in an NHS institution where the care fell below the standard expected, and she concludes her story with a stark warning: "Another Mid Staffs is not looming: it is already here. Yet the government is choosing to turn a blind eye".

Clarke tells her own version of the "weekend effect" that Hunt preached, recalling the highs and the lows of countless night shifts and weekends spent racing between fluorescent-bright wards and dimly-lit side rooms where patients of all ages were rallying or dying. While

Clarke celebrates the marvels of medicine and shares the joy and pride she felt in caring for patients and being part of a system that provides care to those who need it without charge, she does not shy away from the reality of being part of the "backbone of the NHS".

This is the story of the first full walk out of junior doctors in the history of the NHS, reported from the picket line by a junior doctor. It tells of the very real dangers to the NHS, its staff and its patients. Clarke believes that the system is "falling apart", but she, like the other 1.4 million employees, battles on, committed to the success of the NHS.



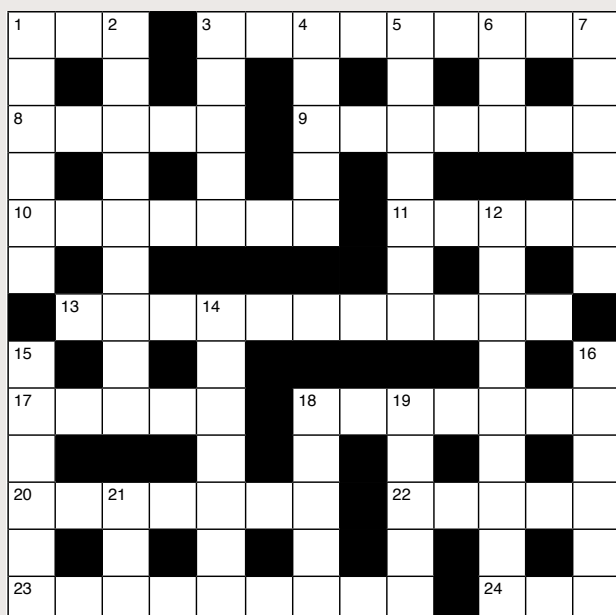
OBJECT OBSCURA

Syringe

This hypodermic syringe with a spare needle and metal case dates from the late 19th century. Francis Rynd, an Irish physician, invented the first hollow needle in 1844 and Charles Pravaz, a French doctor, developed the first practical metal syringe in 1853.



Photograph: Science & Society



Crossword

ACROSS

- 1 Epoch (3)
- 3 Angler (9)
- 8 Point of interest (5)
- 9 Congenital absence of an organ (7)
- 10 Coagulated milk products (7)
- 11 Eliminate (5)
- 13 Infection spread by ticks (4, 7)
- 17 Injection of fluid into lower bowel (5)
- 18 Person receiving treatment (7)
- 20 First letter of name (7)
- 22 Relating to birth (5)
- 23 Having indigestion (9)
- 24 Law relating to use of personal information (abbr.) (3)

DOWN

- 1 Bring about (6)
- 2 Very typical example (9)
- 3 Hands poised for fighting (5)
- 4 Chairs (5)
- 5 Astronomical event, one body obscures another (7)
- 6 Unknown conditions (abbr.) (3)
- 7 Closer (6)
- 12 Admired (9)
- 14 Scrutinise (7)
- 15 Timeframe (6)
- 16 Lager lady? (6)
- 18 Test programme (5)
- 19 Scrub top (5)
- 21 Common digestive ailment (abbr.) (3)

See answers online at www.mddus.com/about-us/notice-board

VIGNETTE

CHARLES STENT (1807-1885)

ENGLISH DENTAL SURGEON WHO GAVE HIS NAME TO THE MEDICAL DEVICE

THEY are a small select group. Those individuals whose surnames have been transformed over the years into nouns and even verbs have certainly achieved immortality of a sort. But sometimes when we use eponyms we do not even recognise that they were once names. The French physician and inventor Joseph-Ignace Guillotin is a member of the group, as is the American industrialist William H Hoover. And so also is a largely forgotten English dentist, Charles Thomas Stent.

Stent was born in Brighton and practised dentistry in Victorian London. His principal contribution to his field came in 1856 when he successfully modified the material used to make dental impressions. Earlier in the nineteenth century the main impression materials had been beeswax and plaster of Paris. Because these were far from perfect, the English dentist Edwin Truman had introduced the use of gutta percha in 1847.

This natural material derived from rubber trees was an improvement over its predecessors but was still found wanting. It had a tendency to distort after removal from the patient's mouth and would shrink on cooling. To stabilise the gutta percha and improve its plasticity, Stent decided to add stearine derived from animal fat. He also added talc as an inert filler and red colouring. When the new, improved material was introduced it was an instant success and indeed Stent was lauded by his profession.

Both Stent's sons followed him into the dental profession and together they founded a company, CR and A Stent that would manufacture the increasingly successful Stent's Compound for the next four decades. In 1901, when the second of his sons died, the dental supply company Claudius Ash and Sons of London purchased the rights and continued its manufacture under the Stent name.

But how did the name of a dental



impression material find its way into the wider world of surgical devices? The story is convoluted and not without controversy. Stent's compound was certainly widely known in dental circles throughout the latter half of the nineteenth century, but the story really begins with its use by a Dutch plastic surgeon in the First World War. That surgeon, J F Esser, was trying to find novel ways of repairing serious facial wounds in soldiers from the trenches. He described in 1917 how he used "the mould of denticle mass (Stent's) in fixation of skin grafts in oral surgical repair of war wounds."

Later in the same article, he referred to the material he used as "stent's mould". This pioneering work was cited in a 1920 book on the *Plastic Surgery of the Face*, in which the author noted: "The dental composition for this purpose is that put forward by Stent and a mould composed of it is known as a 'Stent'." Thus, Charles Stent's surname became a noun for the first time.

Throughout the subsequent decades of the twentieth century, surgeons trained in the UK and US would have

been well aware of such material being used in oral and plastic surgery. As there is often significant crossover from one sub-speciality to another, the concept of the "Stent" would find its way into diverse fields. In the reconstruction of the common bile duct, polyethylene tubes would be used to maintain the structure's patency, and in 1954 this was referred to as "a stent for the anastomosis". In urology, where there is also an obvious need to hold tubes open, the word stent was first used in 1972.

However, today the most common use of the word stent is in cardiology. The first use of the word "stent" in that field was not until 1966, where it was used in the context of heart valve surgery. While its author was fully aware of the use of the word by plastic and oral surgeons, he later claimed that he thought it was "an all-purpose term for any kind of nonbiological support used to give shape or form to biological tissue." The notion of an endoarterial tube graft as we know it today is attributed to researchers in the 1960s and the first coronary stent was implanted in Toulouse in 1986.

Today, the word stent has entered common usage and as one cardiac surgeon noted: "The greatest accolade that can be given to any inventor is to have the initial capital letter dropped from his name, for that is recognition that the word is now in the general language." Charles Stent, the Victorian London dentist, has certainly achieved immortality, but his part in the development of the modern stent has often been overlooked.

Dr Allan Gaw is a writer and educator in Glasgow

SOURCES

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