

QUARTER TWO / 2019

INSIGHT



A QUARTERLY PUBLICATION FOR MEMBERS



DAME CLARE MARX

Q&A with the first woman chair of the GMC in its 160-year history

DON'T GO IT ALONE

MDDUS advisers are here to assist members at the outset of professional difficulties

DO ME A FAVOUR

Dental procedures without fully informed consent do no one any favours

SOCRATIC SCRUM

What does ethical decision making have in common with rugby officiating?

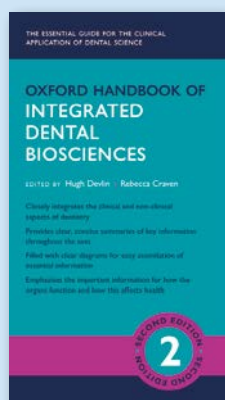
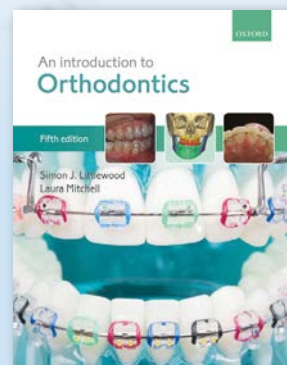
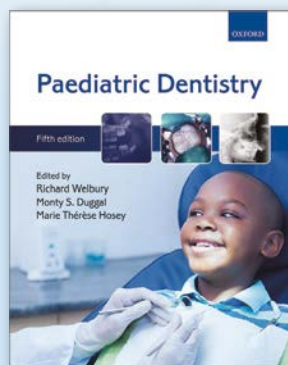
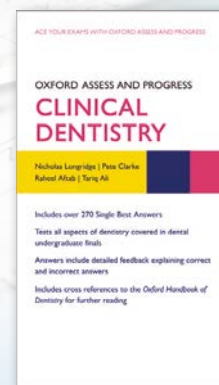
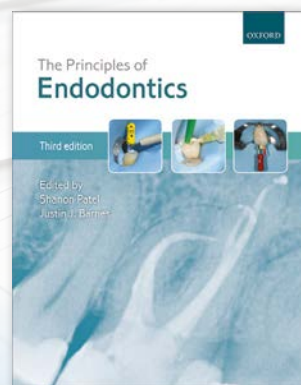
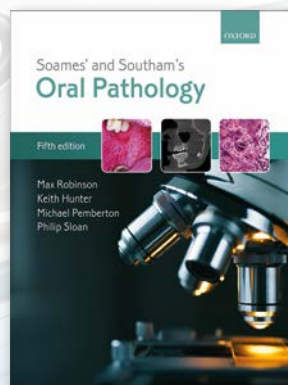
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Cover image

Waiting for the tide, Sarah Knox.
Mixed media and collage, 2014. Originally from North Norfolk, Sarah studied Fine Art and English Literature at Exeter University. Her work often involves shoreline or harbour scenes, using mixed media techniques including collagraph prints.

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.



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EDITOR

Dr Barry Parker

GMC investigations are extremely stressful for doctors, particularly where these are prolonged and result in MPTS fitness to practise hearings. However, we know from assisting doctors that the majority of cases are concluded in the early stages without any action on the doctor's registration.

The GMC has recently highlighted changes in approach in a number of areas, including increased support for doctors going through investigations and fewer investigations being opened for single clinical incidents. Many challenges remain, however, and in this issue (page 10) Dame Clare Marx, the recently appointed first woman chair of the GMC, responds to some of the most pressing concerns.

"The GMC has recently highlighted changes in approach in a number of areas, including fewer investigations being opened for single clinical incidents"

MDDUS advisers are here to assist members at the outset of professional difficulties, but not seeking assistance at an early stage can have far-reaching consequences, as our feature article on page 12 highlights.

On page 14, dental adviser Mike Williams looks at the particular risks associated with shared decision-making and consent in cases where the prognosis is not assuredly positive. He advises: "An explanation given in advance of a procedure tends to be viewed by patients as the mark of a clinician who

knows which direction trouble is likely to come from. The very same explanation given after the event is generally regarded as an excuse."

Joanne Curran peers into a digital future as envisaged by the NHS on page 8, and on page 9 Liz Price looks at some scenarios that can strain the boundaries of professional care. Our regular Dilemma (p. 20) concerns a covert recording of a GP consultation posted on Facebook – and on page 21 Deborah Bowman reveals how a passion for rugby can inform ethical decision making.

Dr Barry Parker

MDDUS

News

Changes to GP membership in England and Wales

FROM 1st April 2019, all GPs working in England and Wales will have access to indemnity for their GMS, PMS or APMS contractual duties provided by the Clinical Negligence Scheme for General Practice (CNSGP) for English GPs or the General Medical Practice Indemnity (GMPI) for Welsh GPs.

All MDDUS GP members working in England and Wales were sent a letter in mid-March regarding the changes to our GP grade of membership and detailing our new General Practice Protection (GPP) product. This new grade of membership will supplement the aforementioned state indemnity and will ensure continued access to the expert advice, support and representation currently enjoyed as MDDUS members.

All members affected by the state indemnity schemes have been transitioned onto the GPP product, and those due a pro-rata refund will now have received this. Most members will have seen from the pro-rata calculation that the cost of the MDDUS GPP product is significantly less than their previous grade of membership and members will continue to enjoy these lower rates when their annual renewal falls due.

Maintaining your MDDUS membership at renewal is vital to protect your professional interests in areas not covered by CNSGP and GMPI, as these schemes will not provide indemnity for any work that you undertake outside your NHS contract.

The BMA has highlighted the essential future role of medical defence organisations (MDOs). It advises: "The scope of the state-backed scheme is to cover the cost of clinical negligence for NHS services. The MDOs will continue to play an important role in providing legal advice, representation for GMC hearings and also for the rare occasion where a criminal case occurs. Similar to hospital colleagues, it will be essential to maintain such medical indemnity."

Our GPP product will provide you with access to expert advice and representation for the following:

- Complaints
- Ethical/professional advice

- GMC investigations
- Performer list/disciplinary investigation
- Coroner's inquests/fatal accident inquiries
- Criminal matters (related to medical practice).

Both CNSGP and GMPI have significant indemnity exclusions. The GPP product automatically includes indemnity for up to £10,000 annual earnings per GP, for non-NHS work on practice-registered patients, as set out below (the £10,000 limit applies whether or not the income is received personally or by the practice):

- Report writing (for NHS patients but non GMS/PMS work), e.g. for court purposes
- Occupational health reports
- Private certificates, e.g. fitness to attend court/sit exams etc
- Statutory notification forms, e.g. notifiable infectious diseases
- DVLA and sports medicals
- Adoption/fostering medicals
- Passport countersignatures
- Private prescriptions
- Life insurance reports and medicals
- Travel insurance – reports and claim form completion
- Event medicine – crowd doctor work at music, sports events, gala days, etc
- All cremation form completion
- All deprivation of liberty safeguards (DOLS) reports.

If earnings from this work exceed £10,000, we can of course offer a revised quotation based on personal circumstances.

For GP partners, the GPP product also provides indemnity for your share of liability arising from nurses, healthcare assistants and similar staff employed by you to perform the non-NHS work described above. Please ensure that you include your share of fees generated by such staff when you calculate your expected annual earnings. Again, we will be happy to provide a revised quotation for any GP whose earnings from this work will exceed £10,000 per annum.

We can also extend your membership to include access to indemnity for a range of medical work outside of your practice setting, including private GP work, occupational health, sports medicine, cosmetic medicine and work as a forensic medical examiner.

You should also note that standard inclusions within the pre-CNSGP/GMPI grade may now have been removed. It is important to verify that you have ongoing indemnity for additional work you perform, such

as medico-legal report writing and non-invasive cosmetic treatments, such as Botox and other non-permanent fillers. In addition, members should now declare all GP sessions worked to MDDUS in order for us to calculate the appropriate fee, including out of hours and sessions covered by other providers or schemes.

Membership Services is open Monday to Friday (8am-6pm) should you have any questions. Phone 0333 043 0000.

Stephen Kelly is head of Membership Services at MDDUS



Dental membership rises by a third

MDDUS dental membership in England, Wales and Northern Ireland rose by almost a third during 2018, as more dentists put their faith in our “gold standard” indemnity.

Total dental membership in England, Wales and Northern Ireland has doubled since 2015, while in England alone there was a 41.5 per cent increase in 2018 compared to the previous year. Market share in Scotland stands at approximately 70 per cent and is now above 20 per cent elsewhere in the UK and growing fast.

MDDUS Head of Dental Division Aubrey Craig believes the sustained growth is built on a firm commitment to quality and an indemnity model that provides comprehensive protection. He said: “MDDUS provides more than indemnity cover for claims in negligence. We believe what we offer is the gold standard, with personal service from a team of very experienced dental and legal advisers providing dentists with lifetime peace of mind that timely reassuring help is at hand should they find themselves in professional difficulty.

“Alternative commercial insurance products are becoming more widely available and it is increasingly difficult for dentists to access accurate information about the pros and cons of each product type... MDDUS is a mutual membership organisation. Unlike insurers, we’re not in it for the profit, we have no small print to hide behind.”

INSIGHT IS GOING DIGITAL

This magazine will be moving to a quality digital format – but with an option for existing members (joined before 1 May 2019) to receive a print hardcopy. The new digital *Insight* will be accessible in multiple formats, including desktop and laptop computers, mobile and tablet devices. Each new edition will be sent via an email link but will also be accessible from the Resources section of mddus.com. Go to the back cover of this issue for more details.

PATIENT SAFETY MASTERCLASS

Book a place now on our patient safety masterclass for PMs and GPs being offered in Glasgow on 29 August. The session will run from 10am to 4pm and focus on common medico-legal risks within GP practice, and ‘proactive’ and ‘reactive’ management strategies. The training days are open to both MDDUS members (£135) and non-members (£195) and provide five hours of verifiable CPD. Go to Training & CPD > Events at mddus.com to book.

DENTISTS LEADING THROUGH UNCERTAINTY

Join us for this five-day programme running one day per month between August and December 2019. You will be challenged as a leader to positively change the way you manage your team and create interdependent, effective relationships in the workplace. This programme has been approved by NES for 10 sessions of CPD. Go to Training & CPD > Events at mddus.com.

GMC to reduce number of full investigations

THE GMC has announced that it will reduce the number of full investigations into one-off mistakes by doctors – known as single clinical incidents – after a successful two-year pilot scheme.

More than 200 single clinical incident cases (one treatment to one patient) were closed during the pilot after additional information (such as medical records and input from independent experts, responsible officers and the doctors themselves) was considered at an early stage.

MDDUS welcomes the move, with medical adviser Dr Naeem Nazem commenting: “Being on the receiving end of a GMC complaint is extremely stressful and it is natural for doctors to fear the worst. While it is understandable to worry, in our experience very few GMC cases make it beyond the preliminary stages of investigation.

“MDDUS urges members who receive a letter of complaint from the GMC to contact us without delay for further guidance and support.

“Our team of medical advisers and lawyers have vast experience in assisting doctors through the process of being under investigation. Doctors are renowned for being resilient, but should not face the stresses of a GMC complaint on their own.”



“Disease mongering” burdens global healthcare

EXPANDING definitions of disease are leading to overdiagnosis and unnecessary treatment, and pose a threat to human health and the sustainability of health systems, according to a paper published in *BMJ Evidence-Based Medicine*.

The authors cite evidence suggesting that specialist guideline groups which regularly review disease definitions often decide to expand them by lowering thresholds to capture more people at lower risk of future illness and by creating pre-diseases. There can also be a tendency to over-medicalise common or mild life experiences, or to change diagnostic processes.

The authors contend this is leading to overdiagnosis and overtreatment, and that the specialist panels proposing these expansions are often conflicted and do not investigate potential harms.

Examples cited include the widely used definition of chronic kidney disease, which the researchers claim could apply to around half of all older people although many will never experience related symptoms, and a “new definition of hypertension which labels one in every two adults”.

The paper is calling for new ways to define disease in order to reduce overdiagnosis. Such processes would involve using “explicit guidance to assess potential benefits and harms when modifying disease definitions, with a focus on people-centred outcomes”. Decision panels should also be “primary-care led, multidisciplinary, with representation from civil society and independent from financial ties to industry”.

Access the paper at tinyurl.com/y3fjtdga

Record numbers get NHS cancer checks

THE number of people checked for signs of cancer exceeded two million for the first time last year, NHS England has revealed.

In 2018, a record 2.2 million checks were carried out in England following urgent referrals by GPs – an increase of almost 250,000 compared to 2017. The number of people receiving treatment for cancer also topped 300,000 for the first time last year, a rise of almost 13,000 on the year before.

New figures show cancer survival is at an all-time high, with 10,000 more patients surviving for at least 12 months after diagnosis, compared to five years earlier. But the NHS Long Term Plan aims to go even further and increase the proportion of cancers caught early from half to three-quarters, a move that would save as many as 55,000 more



Burnout or “moral injury”

A NEW BMA survey has found that eight out of 10 doctors are at substantial risk of burnout.

The survey of 4,300 doctors also found that more than a quarter had received previous, formal diagnoses of mental conditions, and four out of 10 said they were suffering from psychological or emotional distress which affected their work, training or study. Younger and junior doctors, medical students and those working longer hours are more likely to suffer from mental ill health.

Over 60 per cent of respondents with current or previous mental health diagnoses used alcohol, drugs and self-medications as a coping mechanism. Men and older doctors were most likely to engage in such behaviour.

Recently in a keynote speech to the Royal College of Physicians (RCP) annual conference, RCP president Professor Andrew Goddard questioned use of the term ‘burnout’. He commented: “What we call burnout, that sense of despair, hopelessness and loss of joy is not due to a failure of the individual. It is a failure of the environment they work in, the culture of the workplace, the workload imposed on this. Some, particularly in the States, have started to call this process ‘moral injury’ as it puts the onus back on the system.”

Professor Goddard says he is awaiting the new Workforce Implementation Plan from NHS England and NHS Improvement, but underlines how important it is for doctors to support each other.

lives each year.

NHS England’s national director for cancer, Cally Palmer, said: “Thanks to a greater awareness of symptoms, more people than ever before are coming forward to get checked for cancer.”

Only three per cent of under-ones attend dentist

RESEARCH from Birmingham University has found that only three per cent of under-ones in England attended the dentist and in some regions it was less than one per cent.

The British Dental Association (BDA) has said the figures are indicative of a failure of successive governments to offer a joined-up approach to the oral health of children in England.

BDA Chair Mick Armstrong said: “Baby teeth matter, and getting very young kids

attending requires joined-up action. Sadly ministers have offered little more than posters to pop up in dental practices.

“Preaching to the converted will not cut it. We need real engagement in schools and nurseries, and Scotland and Wales are already leading the way. Kids in England deserve better than a second-class service.”

Involve dentists in wider disease prevention

DENTISTS could play a much wider role in detecting health conditions such as diabetes and cardiovascular disease, says the Faculty of Dental Surgery.

The FDS has published a *Position Statement on oral health and general health* suggesting that dentistry could be better utilised in the diagnosis of certain wider health problems and also in providing preventative health

advice. Initiatives to diagnose diabetes and cardiovascular disease, as well as other conditions such as child obesity and eating disorders, should engage dentists and other oral health professionals, and the links between oral health and general health should be part of all healthcare training and continuing professional development.

Figures from NHS Digital indicate that over half (50.4 per cent) of adults in England were seen by an NHS dentist in the 24 months to 31 December 2018, suggesting that dentists and oral health professionals are well placed to play a broader role in supporting patients' general health.

RCGP offers vision for the future

EXTENDED GP consultations and continuity of care delivered via 'micro-teams' are key elements in a vision for the future of general practice.

The Royal College of General Practitioners has set out this vision in an extended report – *Fit for Future*. It states that by 2030, face-to-face GP consultations will be at least 15 minutes, or longer for patients with more complex needs. Research showed that the UK offers some of the shortest GP consultations amongst economically-advanced nations at 9.2 minutes.

Professor Helen Stokes-Lampard, chair of the RCGP, said: "It is abundantly clear that the standard 10-minute appointment is unfit for purpose. It's increasingly rare for a patient to present with just a single health condition, and we cannot deal with this adequately in 10 minutes."

The report also predicts that continuity of care will be delivered via 'micro-teams' with a named GP and other members of a multi-disciplinary team, including nurses, pharmacists, physiotherapists, occupational therapists, link workers, dieticians and health coaches. Vital health information will be available via personalised patient 'data dashboards', accessible by healthcare professionals across the NHS, drawing on data from the patient's genomic profile and wearable monitoring devices. A greater use of AI will include improved triage systems that assess the severity of a patient's health needs, enhance diagnosis, flag 'at risk' patients, and safely identify the most appropriate care pathway.

The report also predicts that GPs will no longer work in isolation – practices will operate in networks or clusters, allowing them to pool resources and people, but facilitating smaller practices to retain their independence and patient lists.

Professor Stokes-Lampard added: "Ours is an ambitious vision but it is not a pipe dream. Realising it will depend on having a sufficiently resourced service to keep people well and provide them with the care they need around the clock."

The full report can be found at bit.ly/2wedYEQ

RCS looks to guide surgical innovation

NEW guidance to avoid a "maverick" approach to surgical innovation has been published by the Royal College of Surgeons.

The RCS cites "exciting" developments, such as three-dimensional printing, artificial intelligence, robotics, nanotechnology and regenerative medicine, but identifies significant risks in allowing innovation to occur in the "absence of a clear guiding principle".

Mr Peter Lamont, who helped develop the new guidance and is a Royal College of Surgeons Council Member, said: "Surgery is set to be transformed for millions of patients by a new wave of technologies.... Historically though, the development of new surgical techniques have often taken place in the absence of the rigour associated with the development of new medicines or devices.

"It is absolutely vital that surgical innovation places both patient safety and the best interests of the patients at the core. The introduction of new technologies or techniques in surgery has no place for the maverick surgeon who proceeds without appropriate peer review or training."

The guidance sets out the clinical governance and oversight needed to introduce innovations. It also covers patient consent requirements, managing potential conflicts of interest, how new techniques should be translated into wider practice (with requisite training and mentors) and the need to measure long-term outcomes.

Access the guidance at tinyurl.com/yqy7wced



FALL IN POST-SURGICAL DEATHS

DEATHS following surgery have been reduced by more than a third in Scotland since the implementation of a safety checklist as part of the Scottish Patient Safety Programme. A study published in the *British Journal of Surgery* found a 36.6 per cent reduction in mortality since the World Health Organization (WHO) Surgical Safety Checklist was introduced in 2008. An analysis of 6.8 million operations performed between 2000 and 2014 saw rates fall to 0.46 deaths per 100 procedures.

NEW INVESTMENT IN REST FACILITIES

THE Department for Health and Social Care has announced it will invest £10m in improving doctors' rest facilities. Ninety-two trusts in England will receive £30,000 in 2019-20 to help improve facilities, with a further 122 trusts defined as having greater need and each receiving £60,833. Health Education England has welcomed the initiative to improve the working lives of NHS doctors and trainees.

MEDICAL REGISTER HITS 300,000

The UK medical register reached a major milestone this year, welcoming its 300,000th doctor – up by a third from the year 2000. The GMC reports that 95,850 are on the specialist register and 70,154 are on the GP register. The number of female doctors has more than doubled over the past two decades, accounting now for 46 per cent of registered UK doctors.

FIRST STEPS TO A DIGITAL NHS

Joanne Curran

Associate editor of *Insight*

THE prognosis has been delivered and it is not good news for some old familiar friends. Fax machines and pagers across NHS England have been given only two more years to live, while pen and paper and outdated GP IT systems are on life support.

These are just some of the recent decisions made by health and social care secretary Matt Hancock whose report, *The future of healthcare: our vision for digital, data and technology in health and care*, sets out ambitious plans for a "fully digitised" NHS.

It envisions a future that is all but paperless, where patient data is cloud-based, GPs provide virtual consultations, and clinicians connect to high-speed internet. Pagers have been replaced by secure WhatsApp-style messaging and calling systems, and patients are kept informed via email rather than hard copy letters. Genomics, artificial intelligence (AI) and smartphone apps also have a starring role.

Mr Hancock's recent string of policy announcements have elicited a chorus of passionate responses on Twitter, often from those working within the NHS. While many welcome the investment, a common rallying cry is: "we need the basics fixed first".

This is illustrated by the health secretary's recent tweet announcing the introduction of high-speed fibre optic internet to NHS hospitals and GP practices in England and Wales. While this move was broadly welcomed, many responses raised a number of similar basic issues. These were summed up by one comment complaining that "our computers take 10 mins to boot up, the Wi-Fi doesn't work [in some areas of the hospital], and we have unusable medical records software." Others raised concerns over understaffing, bed shortages, mobile phone signal "dead spots" and delays in getting basic IT support/repairs.

Now the RCGP has joined the debate by launching its "tech manifesto" which sets out how it believes technology can best work for GPs and patients. The two-page infographic, echoing many concerns raised on Twitter and elsewhere, calls on the government to deal with the most pressing matters first before pushing ahead with more ambitious plans.

RCGP chair Professor Helen Stokes-



"NHSX is billed as a 'specialist bridge between the worlds of healthcare and technology'"

Lampard said a "robust and joined-up IT system across the NHS" must be a priority.

She said: "GPs want the latest, cutting-edge tech at our disposal but we need the basics to work first. That means everything from making sure that our computers don't crash while issuing a prescription, to making sure our systems talk to those in all hospitals so that we can improve the care and experience that our patients receive throughout the NHS."

"We want the NHS to be a world leader in technology, and we are ready for a new wave of exciting opportunities which have

the potential to revolutionise patient care, but a lot of work is needed before that can happen".

In a speech at the Spectator Health Summit in March, Mr Hancock acknowledged that realising his future vision will not be easy. He cited concerns from "naysayers" of understaffing and imperfect technology but called for NHS staff to embrace a "spirit of continuous improvement" and to "keep going, always aiming higher".

A large portion of his hopes are pinned on the success of the newly created NHSX, billed as a "specialist bridge between the worlds of healthcare and technology". He has tasked NHSX with creating a "culture of innovation and experimentation within the NHS" to help encourage the spread of "proven, safe, tested existing technology" across the system.

Former government director for cyber security Matthew Gould has been announced as the new NHSX CEO ahead of its planned launch in July 2019. Speaking at his appointment in April, Mr Gould said the organisation's single goal was to improve care by ensuring staff and patients have the technology they need.

He said: "I will know I have succeeded if in two years we have reduced the crazy amount of time that clinicians spend inputting and accessing patient information; if we have given patients the tools so they can access information and services directly from their phones; and if we have started to build a system in which patient information can be securely accessed from wherever it is needed, ensuring safer and better care as patients move around the system, and saving patients from having to tell every doctor and nurse their story over and over again."

For Matt Hancock to achieve his dream of making the NHS a world leader in tech innovation, there are considerable obstacles to overcome and the shadow of historical multi-million pound NHS IT failures loom large. But the health secretary – the first to have his own smartphone app – is nothing if not optimistic.

He hopes staff and patients will share his vision and follow his rallying cry: "Let's look forward now with confidence and optimism – as we have done before. Let's embrace the innovations... And let's shape a better future for all."

DETACHED BUT PERSONAL

Liz Price

Senior risk adviser at MDDUS

MDDUS advisers often hear from members concerned that the professional boundary with a patient has become blurred. It can be tricky to remain detached from patients, particularly in the early stages of your career. You may share a hobby in common or may have treated someone through a very traumatic illness or distressing period. You may also know a patient well as a member of a small local community.

These and other circumstances can be the starting point of a potentially “unprofessional” relationship and, without realising, you may find yourself in difficulty in regard to regulatory guidance or, at least, under pressure with additional workload or demands on your time with that patient.

Consider these examples:

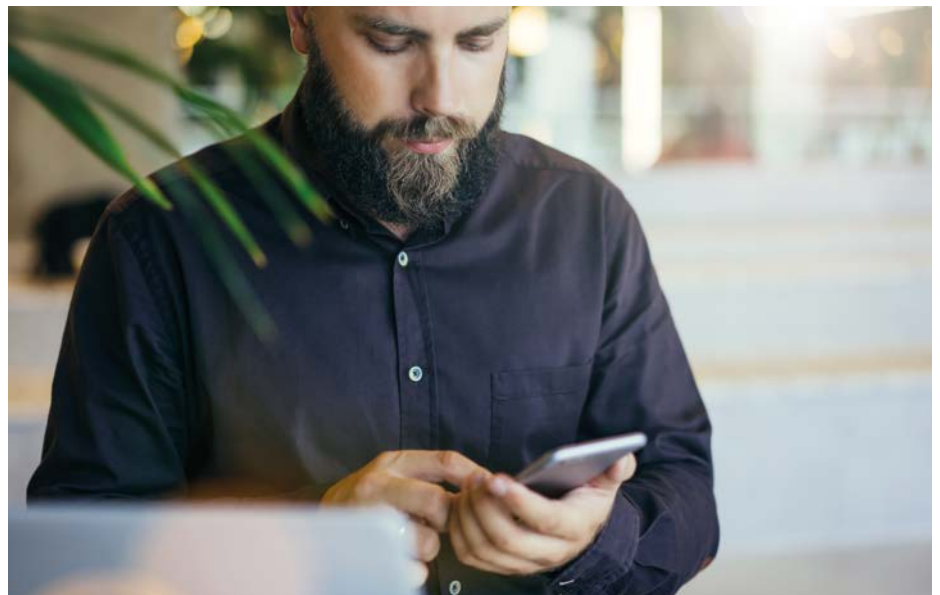
1. A GP accepts a small gift from a patient who is grateful to him for treating her elderly parent. He then finds that she starts to bring more gifts which, over time, start to increase in value. The GP doesn't want to offend the patient but feels that the nature of their relationship is changing and that by continuing to accept the gifts he is perhaps encouraging something unintended.

2. A GP colleague has disclosed that he has started seeing someone who is the mother of a registered patient. He has treated the patient previously and recognises that the relationship could be seen as inappropriate. To mitigate any problems that might arise, he suggests that in future he will ask that the patient consults with other doctors in the practice.

3. A trainee has shared his mobile phone number with a patient experiencing symptoms of depression, as at their last consultation she had become very distressed. The patient feels she cannot talk to her family and the GP didn't want her to leave without support. She is now calling frequently to talk to him and appears to be becoming dependent.

It can be difficult to identify the point at which a patient-doctor relationship starts to blur, particularly for GPs who often have longstanding relationships with patients, or other clinicians treating vulnerable patients with mental health issues.

GMC guidance *Maintaining a professional boundary between you and your patient*



states: “If a patient pursues a sexual or improper emotional relationship with you, you should treat them politely and considerately and try to re-establish a professional boundary. If trust has broken down and you find it necessary to end the professional relationship, you must follow the GMC guidance: *Ending your professional relationship with a patient*”.

GMC guidance also states that: “You must not pursue a sexual or improper emotional relationship with a current patient” and goes on to say that doctors “must not end a professional relationship with a patient solely to pursue a personal relationship with them”.

In Scenario 1 above, the GP should have considered whether accepting the gifts was in line with current guidance and, if not, he would most likely have politely declined at an earlier point in time. At this point, he could have explained his concerns to the patient. Whilst having this conversation might be embarrassing, it ensures that, whether or not such concerns are founded, there is now the opportunity to reinforce professional obligations to the patient and restate the boundaries of the relationship.

In Scenario 2, the doctor entering into a relationship with the family member of a patient is vulnerable to significant criticism and regulatory action. Even after a patient has left your care, you should think carefully before engaging in such a personal

relationship. GMC guidance advises doctors to consider the length of time since they treated the patient, how long the patient-clinician relationship lasted and the nature of the treatment and whether the patient or family member could be considered vulnerable (then or now).

Considering Scenario 3, there may be circumstances (although not advisable) where a doctor determines it is appropriate to disclose personal contact information to a patient – and patients may see this as good service. In this type of situation, it could possibly have been foreseen that the patient may become dependent. The doctor should seek advice from his trainer, who may decide to intervene – ensuring that the patient is aware of alternative mechanisms of accessing support and the boundaries of the doctor-patient relationship.

MDDUS has all too often seen these types of cases result in complaints against the doctor, particularly if a patient perceives that the doctor is withdrawing support, or if they feel embarrassed about their part in the situation.

Recognising early warning signs and seeking the views of partners/senior colleagues and MDDUS is advised. Approaching situations as soon as concerns are highlighted, with great care and sensitivity, can prevent a breakdown of the doctor-patient relationship and ensure that boundaries remain clear.

Dame Clare Marx – the first woman chair of the GMC in its 160-year history – discusses some of the many challenges facing the regulator and UK healthcare

A NEW 'NORMAL'

DAME Clare Marx was appointed chair of the General Medical Council in January of this year – the first woman to hold that position since the GMC was established 160 years ago.

She is the immediate past president of the Royal College of Surgeons of England and was also the first woman in the history of the College to hold that role. She worked as an orthopaedic surgeon at Ipswich Hospital NHS Trust for over 20 years before becoming associate medical director for appraisal and revalidation in 2013.

Dame Clare also chaired the Trauma and Orthopaedic Specialist Advisory Committee for the Royal College of Surgeons when the new trauma and orthopaedic surgery curriculum was written, and is a past president of the British Orthopaedic Association.

What are your first impressions as GMC chair five months in – both the strengths and challenges and how the public and profession regard the organisation?

I've been really struck by the organisation's commitment to change and delivering more proactive, preventative support as part of its regulatory function. I strongly believe that the best way to protect patients is to have well-trained doctors in supportive work environments.

Historically, the GMC comes right at the end of the story; a patient has come to harm and a doctor risks losing their career. We'd much prefer this cycle never started. Our mission now is to help prevent harm, by identifying concerns early, acting to remove risks and pushing for improvements where needed.

The GMC has teams working hard to improve the support they provide the profession in all four UK countries. A lot of our 'on-the-ground' work is not widely known, but I've found it eye-opening to see just how positive this sort of local contact can be. I would really encourage doctors to attend our locally-delivered sessions and let us know what else we could be doing.

Do you think the GMC has a duty of care to the doctors it investigates?

We know and see how distressing investigations can be and the stress they can cause. The current legislation that governs our processes means that we are obliged to investigate every complaint that comes to us. We are doing our utmost to work as flexibly as we can within these constraints to resolve complaints as quickly and with as little stress as possible for all concerned.

Mental health and wellbeing has been central to our recent programme of reforms, with the express intention to bring sensitivity and proportionality to our processes. Acknowledging the need for better support, we launched the Doctor Support Service, to provide confidential, emotional help to doctors during investigations, and we have seen the positive support that this service has been able to offer.

In cases where learning is evident and there is a low risk

of repeated harm we are working to reduce the number of unnecessary investigations. Overall, we have significantly reduced the number of full enquiries, by working to better understand issues at an early stage. Since 2014, as a result of our provisional enquiries programme, more than 950 unnecessary full investigations have been averted. A successful two-year pilot to consider 'single clinical incident' cases has further reduced investigations, enabling 202 of 309 cases to be closed.

Understanding the big picture of why referrals are made in the first place is essential. We're looking forward to seeing the results of independent research, which aims to uncover why certain groups of doctors are overrepresented. We hope this might result in more consistent processes across the board.

What key risks does Brexit pose for healthcare regulation in the UK?

European doctors have always made a significant contribution to our health services and we recently received some much-needed assurance about how they can continue to do so in the years to come. Our teams have worked closely with the Department of Health and Social Care to identify potential blocks and to suggest solutions which would ensure we could register European doctors in a fast and efficient way.

Last month, legal changes were secured to ensure relevant European qualifications would be recognised in the event of a 'no-deal' outcome – a welcome development amid the uncertainty. Whatever terms are agreed, it is essential that doctors from the EEA are not deterred from practising here.

How is the GMC balancing patient safety against a growing workforce crisis demanding increased recruitment of overseas healthcare professionals?

Safety will always be our top priority, and whatever measures we take to close the gaps cannot jeopardise the high standard of care patients expect and deserve in the UK. We welcome good, hardworking doctors from all over the world and we're confident in the checks we have in place to make sure they have the skills and knowledge required to work here. We're currently in the process of opening a new assessment centre – doubling our capacity – to test up to 11,000 doctors a year. But there must be a renewed focus on retaining the excellent doctors already working in the NHS, who must be the bedrock for building and growing a sustainable workforce. There must also be greater flexibility for doctors in training.

Do you think the NHS has a serious problem with bullying and sexual harassment among medical staff?

Recent reports are deeply troubling, and our frontline teams are hearing this particularly from doctors who work in high-risk, complex environments. The last thing they should have to suffer is the fear and worry these behaviours incite. Undermining can affect workers'

"Women have brought fresh perspective, skill and talent to evoke positive cultural change"





mental health and these kinds of distractions potentially pose a real threat to patient safety. A GMC survey of more than 1,000 doctors found that 40 per cent felt that colleagues had undermined respect and prevented effective collaboration.

The vast majority of doctors act with great kindness, respect and dignity. We want to empower them to challenge poor behaviour in others. We've just launched a new pilot training programme to give doctors the skills they need to stamp out bad behaviours. The evidence-based pilot will initially be delivered to at least 14 sites, led by our Regional Liaison Service. We've also joined other health leaders in forming the Anti-Bullying Alliance, to share ideas and raise awareness.

Does your appointment as the first woman Chair of the GMC feel like a shift in attitude within the profession?

Attitudes have changed in recent decades, and I'm heartened to be among a growing number of female leaders in medicine. Women have brought fresh perspective, skill and talent to evoke positive cultural change. However, we know many have not taken on more senior positions because they have not been encouraged, empowered and supported. I want women to know they can do these roles and help shape a better future for the medical profession. If we want to make sure women are having meaningful careers we must enable people to interface in every part of the system and make it 'normal' to see women in leadership roles.

You've been around the four nations of the UK. What is your sense of there still being a single UK NHS? Does the GMC need to operate differently in each nation?

While visiting the four countries I saw that all face similar issues but there are also unique challenges. It's important

we have a strong and effective presence in each to ensure local needs are understood. Having an on-the-ground team means we can shape our approach to align with local systems and work with administrations more directly – offering solutions as a four-country regulator.

Our employer liaison advisors are vital to this understanding but also provide a consistent approach as they work with responsible officers, medical directors and medical managers to assist the management of concerns at a local level. We're currently expanding our local offices and services, including ID checks and our free Welcome to UK Practice workshops for doctors new to the UK, in each of the four countries.

Has revalidation had a demonstrable effect on the quality of UK healthcare? What will the process look like in 10 years' time?

Revalidation does help to foster a culture of reflection and we're working to make sure it's a positive and meaningful experience for everyone. Doctors tell us they enjoy hearing from patients, so we want to make the feedback process easier by broadening the range of sources that can be used.

Revalidation is still in its early years, but the framework has been set and now doctors are in a governed system. It has increased appraisal rates, meaning more doctors are considering their practice, what's worked well and where things can be improved. We are working with partners to track the impact of revalidation against a range of measures through post-appraisal surveys and feedback from responsible officers.

In the years to come, revalidation will be a regular, routine part of every doctor's working life, and I hope will be part of noticeable improvements in the quality of care.

Interview by Jim Killgore, managing editor of Insight

MDDUS advisers are here to assist members at the outset of complaints, claims and all regulatory matters. Not seeking assistance at an early stage can have far-reaching consequences

DON'T

GETTING notice that you face a clinical negligence claim or investigation by the GMC/GDC can feel devastating. An understandable reaction might be to immediately fire back a letter either denying or defending your actions – or maybe just slip the correspondence into your desk and forget about it for now. MDDUS would urge members to do neither.

We have recently dealt with several cases where members have not sought our advice or assistance at a sufficiently early stage. These include responding to complex or serious complaints, requests for disclosure of records or other documents, and correspondence relating to GMC/GDC investigations.

MDDUS advisers are here to assist members at the outset of claims, complaints and all regulatory matters, as well as with general queries. The consequences of not seeking assistance at an early stage can be far reaching and sometimes devastating for the future conduct of a claim or complaint.

COMPLAINTS

It is not unusual for doctors, dentists and practice managers to deal with complaints from patients without assistance, especially where a matter seems straightforward. In our experience, the manner in which a complaint is dealt with can determine whether it escalates to the ombudsman, into a GMC/GDC matter or a legal claim. It is important to respond within agreed timescales and courteously and to seek advice from MDDUS if in any doubt.

Sometimes, as a complaint progresses, additional information may be sought. This may seem a straightforward request but could be a “fishing exercise” for further information. Requests to confirm the position of the treating clinician in response to a complaint may go beyond the facts and stray into commenting on issues other than those which need to be addressed. Such comments can be very difficult to retract at a later date and may be used in any subsequent claim or regulatory proceedings.

Members do not need to inform us of the receipt of every complaint but it is important to consider the nature of a complaint carefully before responding. If there is any concern over the management of a patient, the complaint should be notified to MDDUS so that we can provide input from the outset. In addition, we would also encourage members to notify us promptly if the complaint relates to any kind of professional conduct matter, as these may later involve your regulator.

CASE EXAMPLE: A female patient writes to complain about the conduct of a male GP during a home visit. In answer, the practice manager writes a defensive and inaccurate letter of response and takes steps to remove the patient from the list. The letter makes no attempt to address the concerns of the patient, who later refers the GP to the GMC, as she feels she is not being listened to. This case illustrates a complaint which escalated very quickly. Discussion with an experienced MDDUS adviser could have prevented an unwanted outcome. The GMC investigation was closed at an early stage after MDDUS made submissions on behalf of the GP.

DISCLOSURE REQUESTS

Practices frequently receive requests for information from solicitors, other healthcare providers and the police.

Solicitors are very adroit at requesting information on behalf of patients and then relying on it in subsequent proceedings. Any correspondence from solicitors relating to your medical practice should be brought to the attention of your indemnity provider without delay. What appears to be a straightforward inquiry such as a request for a particular record or document, for example a significant event analysis (SEA), could be a precursor to a claim.

Members should always bear in mind their professional duties of confidentiality when considering such requests for information. This is not to say that pertinent information should be withheld, but relevant guidance on patient consent should be considered at all times. Often requests may be accompanied by a court order with a time limit attached. Members should seek advice on how to respond to such requests promptly. It is important to remember that in the vast majority of situations, third-party information should be redacted (there will be limited occasions where it is permissible to retain this, i.e. if specified by the court order or if consent has been provided).

Members should not respond to such requests without first seeking advice if they are unsure of their obligations, and should pay particular attention to the dates that records are requested from. If MDDUS correspondence is included in a potential disclosure, it would be appropriate to seek input from our advisers as to whether it should be excluded.

'GO IT ALONE'



CASE EXAMPLE: A member is approached by a patient's solicitor requesting a precognition (preliminary examination of a witness). The member attempts to deal with this himself but seeks MDDUS advice when he is questioned about matters well beyond the actual treatment he had provided or his involvement in the case. MDDUS lawyers took over correspondence and drew the matter to a swift conclusion.

REGULATORY MATTERS

All regulatory matters should be brought to our attention without delay. For the avoidance of doubt, this includes all correspondence from the GMC or GDC where a concern has been raised about a member's fitness to practise.

Members should also familiarise themselves with their duties to self-report to their regulator if:

- they are charged or cautioned by the police in relation to a criminal offence, including notice of an intended prosecution
- they are criticised by a coroner or sheriff during an inquest or fatal accident inquiry
- a professional body has made a finding in regard to your fitness to practise (for example, a medical regulator in another country).

CASE EXAMPLE: A surgeon ignores a complaint from a patient who then reports him to the GMC. The surgeon also ignores correspondence from the GMC until the matter reaches the end of the investigation. He seeks MDDUS advice 10 days before the expiry of the deadline to respond to allegations. Due to the long delay, it is impossible to advise on remediation, insight and obtain supportive documentation. Case examiners therefore refer the case to a hearing, which could have been avoided if earlier advice was sought.

ACTION POINTS

- Avoid responding to legal requests without first seeking advice from your medical defence organisation (MDO) or indemnity provider.
- Resist engaging in correspondence with solicitors about complaints or claims without seeking advice.
- Do not enter into correspondence with your regulator without first notifying your MDO.
- Call MDDUS and seek advice promptly if in any doubt!

- Alan Frame is a risk adviser at MDDUS
- Lindsey McGregor is a solicitor at MDDUS
- Jane Scott is a solicitor at MDDUS

DO ME A FAVOUR...

Dental adviser Mike Williams examines a very particular pitfall in patient consent

COMMUNICATION and consent are key elements in contemporary clinical dental practice – and a failure to ensure a high standard in either or both can lead to a complaint or civil claim in negligence. The GDC in its *Standards for the Dental Team* (Principles 2 and 3) obliges us to communicate effectively with patients and to obtain valid consent.

The consent landscape has shifted over time in case law from *Bolam* (the view of the profession about what the patient should know) through *Sidaway* (the knowledgeable patient) to *Montgomery*, with the focus now on what the patient wants and expects to know about a treatment. Complaints tend to arise when expectation exceeds outcome. The safe and skilful clinician is able to identify both the relative merits of a particular treatment plan and the potential problems, and articulate these to patients in ways they can understand.

An explanation given in advance of a procedure tends to be viewed by patients as the mark of an experienced clinician who knows which direction trouble is likely to come from. The very same explanation given after the event is generally regarded as an excuse. In the latter situation, the patient is likely to think either that the procedure was straightforward and the clinician made a mess of it, or that the clinician cannot recognise a difficult problem when faced with one. Neither of these views is particularly helpful.

AVOIDING DISAPPOINTMENT

One particular type of case that we see here at MDDUS on a regular basis (albeit in small numbers) arises when a member (usually a dentist) decides for one reason or another to “do the patient a favour”.

We should not be surprised that our members want to do this. We work, after all, in a caring profession. We do not like disappointing patients, we do not like giving patients bad news, and we prefer to not take their teeth out unless we really have to. It is unsurprising then, when faced with difficult decisions and where we know that the treatment options will not be particularly attractive to the patient, we may try to help by delaying or avoiding unwelcome facts. This is not just a case of the ‘humble patch’, which can have merit in specific circumstances. This group of cases goes rather beyond the patch, with a number of common characteristics.

Firstly, the prognosis for the treatment (and usually the tooth) is often very limited or non-existent – or at least extremely difficult to carry out effectively and with any degree of predictability. But this is not made plain in any discussion with the patient, perhaps to spare them disappointment.

Secondly, the member tends to make a number of assumptions:

- The patient is bound to be grateful whatever the eventual outcome because, after all, you are “just doing them a favour”.
- It may be acceptable to cut the odd corner or accept a particular standard because you know that the prognosis is poor.
- Things may go wrong but the patient is bound to understand and be grateful that you tried anyway.
- A colleague may look at the case but it will be obvious that you were just trying to help in extremely difficult circumstances and it’s not your fault that things did not work out.

The trouble here is that the member is almost invariably wrong in making some or all of these assumptions. This is usually because no explanation has been offered to the patient as regards the limited basis on which the treatment was being carried out.

There are some further common features in this type of case:

- Almost always, at some point in describing the case, the member will



say: “I was only trying to do them a favour”.

- It is usually very difficult or impossible to justify or defend the member’s actions when viewed objectively.
- The member tends to be very upset or annoyed, or both, when the patient complains. They feel they have done nothing wrong, and after all were only “trying to do the patient a favour”.

Later when things go wrong and the case is reviewed, the member’s motives might well be recognised (though not invariably so). The tooth might be lost but it is generally agreed that the member’s treatment was not the direct cause, as that outcome was inevitable in any case. And yet that treatment will still be deemed to be negligent because the patient was not adequately informed and therefore not adequately consented. Such treatment will be considered futile and the patient deemed to have suffered unnecessarily.

PROGNOSIS: SUCCESS UNLIKELY

A recent example of one such case involved a patient with a failing bridge and periodontal disease. One of the bridge retainers had extensive secondary caries, although the patient had no symptoms. Our member knew that the carious retainer and the bridge were bound to be lost. However, he also knew this would represent a real problem for the patient, so in the hope of retaining the bridge for a little while



**“We do not like disappointing patients,
we do not like giving patients bad news,
and we prefer to not take their teeth out
unless we really have to”**

longer he tried to treat the carious lesion.

Unfortunately, the limited basis on which the treatment was provided was not made plain to the patient, who thought this was definitive treatment. The following day she re-attended with pain and eventually the bridge was removed and the tooth extracted.

A complaint followed. The patient's not unreasonable view was that she had not had any dental problems until our member's treatment and she had now lost a tooth and a bridge.

In response to the complaint, a full explanation of the clinical reality was given together with an apology for any lack of explanation prior to treatment. However, remaining dissatisfied, the patient took the

complaint to the ombudsman. The ombudsman took advice from a dental expert who agreed that the loss of the tooth was not a direct consequence of our member's treatment.

Nevertheless, taking everything into consideration, the ombudsman recommended that our member pay the patient a sum of money, provide a written apology and draw up an action plan to ensure there would be no recurrence of the situation, also to be sent to the patient.

IN CONCLUSION

Do me a favour....

In fact, do yourself a favour. If for some reason you feel the need to do the patient a favour of this type, make sure that he or she fully understands the basis on which treatment is being provided.

Please tell the patient exactly what is to be done and why, and what other more definitive and reliable (even if less palatable) treatment options might be available. Explain carefully how long the treatment is likely to last, and what may happen in the short and longer term so that when the treatment fails and the tooth is lost the patient will say:

“That's okay. You told me this would happen and I appreciate that by trying, you were just doing me a favour.”

Mr Mike Williams is a dental adviser at MDDUS

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.

CLAIM

SUSPICIOUS FRECKLE

BACKGROUND

A 48-year-old woman – Mrs K – attends the GP surgery with her young daughter, who is suffering with a persistent cough. The GP – Dr F – examines the child and offers reassurance that it is likely a viral infection and will clear in time with symptom control.

Just before leaving, Mrs K asks the GP if he would check a “freckle” in the scapular area of her own back as she is worried it has grown larger and changed in appearance in recent months. Dr F undertakes a quick examination and diagnoses a “wart-like lesion” – instructing Mrs K to book an appointment to have it removed by cryotherapy. Two weeks later Dr F treats the lesion with liquid nitrogen and Mrs K is advised to allow it to scab and fall off at home.

Two years later Mrs K attends the surgery concerned over a small lump under her right axilla. Dr F examines the lump which is diagnosed as a lipoma. The GP makes a non-urgent referral to the surgical unit at the local hospital and Mrs K is put on a waiting list – but three weeks later she returns to the surgery concerned that the lump is enlarging. A different GP examines the lump and suspects an enlarged lymph node. He expedites the referral to an urgent two-week cancer wait.

Mrs K is seen at the local hospital and the

lump is biopsied. This indicates the lesion is metastatic spread of a malignant melanoma – most likely the “wart-like lesion” removed by Dr F two years previous. Mrs K undergoes axillary lymph node dissection and removal of the nodal mass but she later develops further axillary and lung metastases and dies just over a year later.

Dr F subsequently receives a claim for damages on behalf of Mrs K’s family alleging clinical negligence in her care. It is alleged that the GP failed to consider that the initial lesion might be cancerous and thus refer the patient for excisional biopsy. Dr F also neglected to adequately record the lesion, including shape, size and growth. The subsequent delay in diagnosis allowed the cancer to progress such that the prognosis was poor.

ANALYSIS/OUTCOME

MDDUS acting on behalf of Dr F instructs a GP expert to review the case, including the patient notes and letter of claim. She finds that the medical records are unacceptably brief, stating only that Mrs K presented with a “wart-like lesion” on her back which was later treated by cryotherapy. In the letter of claim it is alleged that Mrs K complained of a “freckle” that had become raised and enlarged, with oozing. The expert comments that this would not be the appearance of a viral wart and – given

the change in size, shape and colour and reported oozing – such a lesion as described would certainly have merited excisional biopsy.

She concludes that in the absence of a contemporaneous record regarding the appearance of the lesion and given the description in the letter of claim, Dr F’s actions would be difficult to defend.

A consultant dermatologist is also instructed to offer a view on causation (consequences of any breach of duty of care). It is his opinion that the scapular lesion was likely a misdiagnosed melanoma which may have regressed in response to cryotherapy, but over the subsequent two years spread to the lymph nodes and lung, resulting ultimately in the patient’s death.

MDDUS decides with agreement of the member to settle the case.

KEY POINTS

- Record a detailed description of skin lesions including size, colour, shape.
- Be suspicious of any description of change in an existing mole or freckle.
- Consider the need for excisional biopsy to rule out melanoma or other forms of skin cancer.

CLAIM

EYE TEST ERROR

BACKGROUND

MR W is a 48-year-old lorry driver and attends his GP, Dr B, for a medical test. He is required by the DVLA to undergo regular health checks in order to retain his HGV licence. As part of the consultation, Dr B carries out a visual acuity test, measured on the Snellen scale. She records a score of 6/9 in each eye (uncorrected) on Mr W's DVLA form and concludes the consultation with no further advice.

Five weeks later, the practice receives a letter from solicitors acting on behalf of Mr W stating that the visual acuity scores provided by Dr B did not meet the minimum standards set by the DVLA, causing his HGV licence to be revoked and leaving him unable to work. It explains that Mr W had his vision tested at a high street optician,

but this time while wearing glasses. The subsequent score did meet the DVLA standards and he successfully reapplied for his licence.

They accuse Dr B of not fully explaining the consequences of the patient's test scores and hold her responsible for his loss of income during the period his licence was revoked.

ANALYSIS/OUTCOME

Dr B contacts MDDUS for assistance and admits that she may not have carried out the test correctly. In discussion with a medical adviser, she explains that she conducted the test in a dark room and accepts she should have advised the patient to wear his glasses to ensure he met the minimum standard, as per DVLA guidance.

She also accepts that she should have explicitly advised the patient regarding his sub-standard test results before concluding the consultation.

In agreement with Dr B, MDDUS settles the case by paying a small sum of compensation for Mr W's lost earnings.

KEY POINTS

- Be mindful of the practical consequences of patient health test results.
- Ensure the consequences of results are fully explained, particularly in regard to potentially negative impacts.



GDC

REGISTERED WITH CONDITIONS

BACKGROUND

A practice contacts MDDUS seeking advice in regard to the employment of a dental associate. Having conducted interviews, the practice principal has identified a suitable candidate – Dr T – but he is currently "registered with conditions" by the GDC. The principal wants to know what obligations, if any, she has to inform patients or other members of staff about the nature of those conditions.

ANALYSIS/OUTCOME

A dental adviser replies to the query pointing out that the GDC conditions imposed on the registrant stipulate that they must inform a current or potential employer and provide a copy of those conditions.

Should the practice decide to employ that dentist and a patient were to ask about the conditions, it would be a matter of simply referring them to the GDC website to access the details, which will be in the public domain. The practice should supply the dentist's GDC registration number if requested (all advertising material about the practice must comply with GDC guidance including the availability of GDC registration numbers). Other staff are free to access details regarding the new associate on the GDC website, but any conditions should not be

considered a matter of concern unless they have a direct impact on day-to-day practice management (e.g. if there is a chaperoning condition).

Should the conditions involve a health concern, details will not be disclosed on the GDC website, as such matters are kept confidential. Patients and staff are only entitled access to information in the public domain and any private health matters should be kept confidential, as registrants have a legal right to a private life. A practice principal should be able to ask about a relevant health issue and be given an open and honest answer. However, that should be with the understanding that such information is kept confidential.

KEY POINTS

- Any "conditions" on dental registration are in the public domain and displayed on the GDC website.
- Details of health conditions are not subject to public disclosure.
- Patients are free to consult such conditions and the practice should display GDC registration numbers on the surgery website.

CLAIM

BROKEN ROOT



BACKGROUND

Mr P is 59 years old and attends his dental surgery complaining of extreme pain in UL6. A bitewing radiograph indicates a deeply carious tooth. Mr P is advised by the dentist – Dr U – that he could fill the tooth but the prognosis would be poor, with a significant chance of other treatment being required including root canal and a crown, or extraction. Mr P opts to have the tooth extracted.

Dr U undertakes the extraction under local anaesthetic but the buccal root fractures during the procedure. The dentist attempts to remove the fragment as it is visible and mobile but this is unsuccessful. An X-ray reveals an apical root fragment close to the floor of the right maxillary antrum. Dr U checks for an oro-antral communication but none is noted. Antibiotics and analgesia are prescribed and Dr U refers the patient to the local dental hospital. Mr P is also advised to avoid blowing his nose or sneezing if possible.

Two weeks later Mr P attends the dental hospital and complains of pain at the extraction site and a bad taste in his mouth. A consultant surgeon notes an "oro-antral communication" at the extraction site and the patient is placed onto a surgical waiting list.

Two months later Mr P attends for removal of the root fragment under general anaesthesia, which is undertaken using a Caldwell-Luc approach. Pus is noted by the surgeon and the root is located within the lining of the maxillary antrum. The operation is completed without complications.

KEY POINTS

- Ensure you always record discussions regarding consent and risks.
- Provide justification for treatment decisions backed up by appropriate clinical guidance.

Over a year later Dr U receives a letter of claim alleging clinical negligence in his treatment of Mr P. It is claimed that he failed to take a preoperative periapical radiograph prior to extraction of UL6. This would have demonstrated a "pneumatised" left maxillary sinus extending over the roots of the tooth, with a high risk of creating an "oro-antral communication" in a non-surgical extraction. Referral to an oral surgeon would have been indicated had imaging been undertaken prior to the procedure.

It is also alleged that Dr U failed to obtain informed consent from the patient in neglecting to warn him of the risks involved with the procedure – in particular that of the tooth fracturing and possibly displacing a root into the maxillary antrum.

The claim further states that this breach of duty of care led to the need for a surgical procedure and subsequent gum sensitivity and sinus/facial pain requiring ongoing medication. Mr P claims that had options been discussed he would have insisted on a referral for surgical extraction at the dental hospital, thus avoiding the subsequent complication.

ANALYSIS/OUTCOME

An expert GDP is instructed by MDDUS to assess the case and consider each of the allegations against Dr U.

In regard to the need for a preoperative radiograph he cites guidance from the Faculty of General Dental Practice (FGDP) UK stating that there is no conclusive evidence to support the need for routine radiography prior to extraction in adults – thus there would have been no indication for onward referral to an oral surgeon.

In regard to the failure to obtain informed consent the expert notes that the records state: "Extraction procedure explained, warned re risk of sinus perforation, pain, swelling, infection, etc. Patient understands, ok to go ahead". It appears that Mr P accepted the risks and opted to proceed with the extraction.

An opinion on causation (consequences of any breach in duty of care) is also commissioned from a consultant oral and maxillofacial surgeon. He cites ongoing sinus pain and gum sensitivity evidenced over many years in Mr P's medical and dental records and takes the view that these symptoms were not new or a result of the fractured UL6.

MDDUS lawyers draft a letter of response repudiating the allegations and the case is eventually dropped.

ASSAULT ALLEGATION

BACKGROUND

A specialist trainee in emergency medicine – Dr D – is working a Friday evening shift in a busy inner city hospital. A 15-year-old boy attends reception with his mother, having fallen in the street. He is bleeding from a cut above his eye and clearly inebriated, swearing at the charge nurse.

The patient is taken through to the treatment area but refuses to be examined and becomes aggressive. In an attempt to restrain the boy Dr D grabs him by the shoulders. His mother intervenes and the boy calms down such that he can be treated.

A week later Dr D is visited by police at his flat and cautioned and charged with common assault against the boy.

Dr D phones MDDUS and is advised to inform his employing trust and the GMC. A Rule 4 letter later arrives from the GMC stating that his case will be investigated to determine if further action might be necessary with regard to his fitness to practise.

ANALYSIS/OUTCOME

MDDUS works with Dr D in composing a response to the GMC letter, explaining the circumstances behind the assault charge. He describes how the patient became



increasingly loud and disruptive, such that other patients were becoming alarmed, and his only intention was to calm the boy down. Other witnesses, including nursing staff, support this version of events.

The GMC contacts the trust, which confirms that it has carried out a risk

assessment and ensured that Dr D is chaperoned while the charges are pending. The GMC investigator also contacts the doctor's responsible officer (RO) who states that having spoken with witnesses he believes Dr D has done nothing wrong. The RO also reports that Dr D has undertaken reflective practice involving how he should behave in future with such patients.

Dr D is given a date for a court appearance but is later informed by the prosecutor that no further action will be taken against him and the matter is closed. This is communicated to the GMC who later responds that its case examiners have considered the information provided and decided to conclude the case with no further action.

KEY POINTS

- Be mindful that you will have to justify any actions you take in dealing with difficult and aggressive patients.
- Be aware of your legal rights/obligations and relevant guidance in regard to treating aggressive patients.
- Make a record of adverse incidents while events are fresh in your mind.

ADVICE

PRIVATE INTERPRETER

BACKGROUND

A dental hygienist, Ms H, emails MDDUS for advice regarding a 52-year-old patient, Mr Z, who speaks no English. He suffers poor oral health and has been referred to her for treatment on a private basis. Having looked at recent radiographs and carried out an initial examination, Ms H is of the opinion that Mr Z suffers from chronic periodontal disease affecting most of his teeth. The hygienist notes that, with reference to the dental records, Mr Z, in discussion with his dentist has declined to see a periodontist. Ms H has thus recommended four further appointments with her for quad root surface debridement under local anaesthetic. She has tried to communicate her treatment plan using Mr Z's wife as a translator, but her English is very limited and Ms H is concerned the

patient does not fully understand what is being proposed and the risks/costs involved. Ms H asks whether she should have refused to see the patient and how she should proceed, being aware of her ethical obligations regarding communication with patients (*Standards for the Dental Team* GDC 2013)

ANALYSIS/OUTCOME

An MDDUS adviser responds in writing and reassures Ms H that she behaved correctly by seeing the patient and by recognising his difficulties in understanding the proposed treatment. As the patient was referred on a private basis, Ms H is aware the NHS would not cover the cost of an interpreter. Therefore, the MDDUS adviser explains it would be acceptable to add this cost to the patient's treatment bill. Alternatively, Ms H

could offer to refer the patient back to his original dentist who could perform the treatment under the NHS, with the aid of an NHS-funded interpreter. The key is to ensure all of these options are clearly explained to Mr Z and discussions documented in his record.

KEY POINTS

- GDC guidance clearly states that clinicians should explore options to meet particular communication needs.
- Consider using a professional interpreter rather than a friend/relative.
- Explain/document all available options, including cost.

COVERT RECORDING MADE PUBLIC

Dr Naeem Nazem

Medical adviser at MDDUS

I AM a GP in a suburban practice and a patient recently attended our surgery for advice on an ongoing medical issue. She has in the past expressed dissatisfaction with accepted treatment options, having researched her condition on various websites and online forums. I have now discovered that she has covertly recorded our consultation and posted it on a public Facebook page without my consent. What can I do about this?

In an era of social media this is an increasing concern for many doctors, who must try to balance their duty of confidentiality with a patient's right of autonomy. Some doctors will feel personally aggrieved to discover a patient is covertly recording a consultation, and worse still to find that it has then been posted online.

Patients record consultations for a number of reasons. They may wish to aid their memory if there is likely to be a complex or lengthy discussion. They may wish to let their family members listen to help clarify matters or keep them informed. Or it may be that they are dissatisfied with the advice they are being given and want to promote their own view in a public forum.

So what can a doctor do about it? The answer lies in considering the type of harm, if any, you have suffered. GPs have privacy and data protection rights in relation to their personal information. However, a

consultation is focused on the patient's medical care and does not require a doctor to disclose any of their own personal data. In this scenario a patient has the right, under existing legislation, to post their information on social media should they wish.

The legal provisions which apply to recording consultations or other contacts include the Data Protection Act 2018 (DPA 2018), the General Data Protection Regulation (GDPR) and the Telecommunications Act 1984. A data subject, in this case the patient, is entitled to their personal information – including the information from a consultation. Once in the hands of the patient, it is at their discretion as to what they do with that data. They are not bound by the same ethical obligations as a doctor and so, if

“You might also consider inviting the patient to openly record future consultations in order to positively influence the situation”

they want to post their consultation on social media, there is no legal prohibition against it.

The Telecommunications Act 1984 requires businesses to inform individuals in advance if calls will be recorded but this does not apply to a patient. As such, there is no legal prohibition to a patient recording a consultation, even covertly.

In terms of regulatory guidance for doctors, the GMC does not provide specific guidance on patients recording consultations – their guidance is focused on a doctor's obligations if they want to make an audio or visual recording.

It is understandable why you may feel unhappy with a patient recording her consultation and posting it on Facebook. However, it is difficult to take any action against the patient for the manner in which she has handled her own information. You can exercise your own judgement as to whether it would be worth asking the patient to take down the recording but there is no obligation on her to do so.

A possible means to avoid this situation occurring in future is to focus on the relationship with each patient, so they feel able to raise any concerns they may have at the outset of a consultation. A patient who is engaged and reassured is less likely to feel the need to covertly record a consultation.

You might also consider inviting the patient to openly record future consultations in order to positively influence the situation. A gentle question around the perceived need to have a recording may help clarify matters for you and the patient. A request could be made that in the future they at least alert you to this activity but be aware that the patient does not have to comply with this – although demonstrating acceptance and lack of defensiveness may enable the patient to be more open and overt going forward. It is also worth noting that covert recordings are admissible as evidence when judged as relevant to a legal case.

Notwithstanding the above, if a patient states that they do want to record a consultation, you should allow them to do so, but perhaps request a copy of the recording to retain within the medical records. In the event that the consultation discusses third-party information, or might cause serious harm or concern for other reasons, then you should contact MDDUS for further support and assistance.



SOCRATIC SCRUM

Deborah Bowman

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

LOVE watching rugby. This surprises even me. I began watching when my son was selected for his school team (that surprised both of us). His playing career was short and, he'd admit, limited in its impact. He has long since abandoned me and is currently travelling around South America. I have carried on watching. Throughout chemotherapy, the Six Nations kept me going and my Irish RFC green hat was my favourite bald head covering. My enthusiasm is not matched by knowledge. I have patchy understanding of the rules and confess I am often puzzled by what follows from an incident. Nonetheless, I love it.

I am particularly interested in the referees. They have much to teach anyone interested in ethical decision-making. Referees tend to be calm – they model the behaviour that facilitates effective ethical practice. The emphasis on explicit reasoning is fascinating. The players and women spectating on their sofas may disagree with that explicit reasoning, but we understand the basis on which a decision is predicated. We know how to position our arguments because we have context for the decision. Alongside that explicit reasoning is a commitment to supporting players in meeting expectations.

It is common before a scrum, for example, for the referee to indicate what he expects and where teams need to concentrate their efforts to avoid infractions and penalties. The assumption is that people wish to do the right thing and the aim is to optimise the circumstances in which they are working rather than imposing sanctions *ex post facto* or worse, setting them up to fail. Naturally, the referee cannot allow teams or individuals to abrogate responsibility and most rugby fans will recall a courteous but firm Roman Poite in 2017 reminding Dylan Hartley and James Haskell that he was the match referee rather than their coach and referring the players back to England manager, Eddie Jones for guidance.

The standards to be applied are clearly articulated and transparent, yet the referee will, inevitably, have to use his or her (for an example of a splendid female referee, look no further than Sara Cox or, in rugby league, to Julia Lee) discretion. There is no dodging interpretation. An effective referee knows when to be flexible and how to



“Referees have one of the most important elements to facilitate their decision-making, namely time”

weigh context in applying the rules of the game. Sometimes, he or she will need to draw on character traits – to embody virtue ethics – and be courageous in taking decisions that are difficult or contested.

Referees have one of the most important elements to facilitate their decision-making, namely time. The clock is stopped whilst deliberations are ongoing and although there is clearly a limit to the amount of time that is allowable in a match, that act of pausing to consider the best choice matters both on and off the field. Wisdom is more likely to flourish when the clock is not looming large.

The referee is accountable for the ways in which he or she chooses to exercise their inherent judgement. It is not possible to duck that accountability or to pass the buck. Responsibility is embraced, if not perhaps welcomed, especially when a decision earns the opprobrium of rugby players, managers and supporters. When a referee makes an error, admission and an apology follows as demonstrated in the crucial Wales v Ireland match of the final Six Nations weekend, when Angus Gardner reversed his decision to award a penalty in Australian style with the words: “sorry guys, my bad”.

Of course, rugby referees do not work

alone. An effective referee is part of a team and has to work with the assistant referees, who will provide different perspectives, crucial information and informed advice. Additional evidence will be factored into the decision-making and becomes part of the referee's reasoning when making a call. Sometimes, as in clinical ethics, a referee will be open about having an intuition that something is right or not. He or she will admit that they are initially inclined to think x or y in a given situation.

Yet the referee knows that intuition alone may be seductively powerful but is not sufficient in effective decision-making. The interrogation and testing of that intuition by considering and reviewing the evidence is vital, just as in ethics the capacity to explore the full range of information and perspectives, including and perhaps especially those that are less immediately persuasive, matters. Thus it was in the final and compelling match of this year's Six Nations between England and Scotland when referee Paul Williams reviewed the TMO footage and reversed his decision to award a try.

Ethical analysis and practice reside in unlikely places; there is no substitute for a Socratic scrum on a Saturday whichever side one is supporting.

Addenda

BOOK CHOICE

Unnatural causes by Dr Richard Shepherd

Penguin, £8.99, 2019

Review by Greg Dollman, medical adviser, MDDUS

IN *Unnatural causes*, billed as the “best true life crime book of the year”, Dr Richard Shepherd writes that he became a forensic pathologist to be “a seeker of the truth”. This theme is evident throughout this fascinating book chronicling his years as a leading forensic pathologist. Within his memoir, Shepherd seeks to understand and manage “the awful collision between the silent, unfeeling dead and the immensity of feeling they generate in the living”.

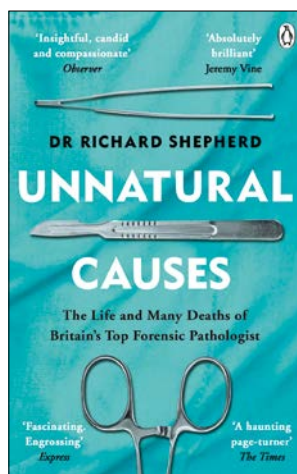
Shepherd describes how he would piece together the evidence, whatever the cause of the injury (be it premeditated, malicious or accidental), in order to understand how the person came about their death: he performed over 23,000 post mortems. The reader gets a glimpse into this world of comprehending how life became death, and how Shepherd would explain this

to “those left behind”. In his line of work it was impossible to separate life and death.

It is understandable then that Shepherd writes about seeking the truth with clinical detachment and a need to “suspend some aspects of [my] own humanity”. He describes events or accidents as people, who may pass by quickly or become an important part of his life. And he shares also his own personal stories of death and grief.

Unnatural causes provides an insight into the role of a forensic pathologist, and explains how practice has changed over the years as a result of medical advancement (including infection control), societal change (a rise in knife crime) and out of necessity (increasing body habitus in the modern age). Shepherd includes certain old wives’ tales (optography – “the eyes retained the final image they see”), the ‘big’ stories that will always be talking points (the Hungerford massacre, Princess Diana, 7/7), as well as his own personal interests (unexplained deaths in infants and the use of restraint by the police). And he conveys all these in easy-to-read and creative language (he describes a stroke as “a blob of redcurrant jelly in the brain”).

Shepherd explains that even when he was certain, and it was his job to be certain, he was bound to accept that “there are always other possibilities.” While death is final, closure does not always follow for the living and part of Shepherd’s work was to help them reach this.



OBJECT OBSCURA

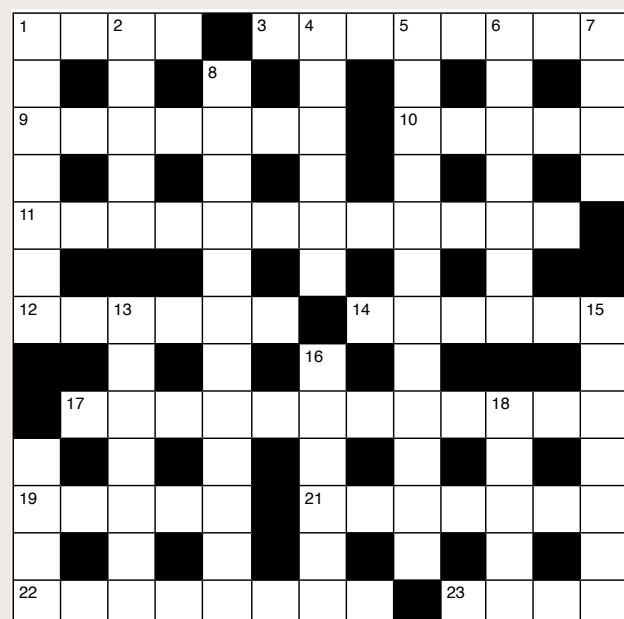
John Hunter life mask

This is a 19th century copy of a life mask of physiologist and surgeon John Hunter, aged 60. The original was made by Sir Joshua Reynolds in 1788. Hunter (1728-1793) has been called the ‘founder of scientific surgery’ and his writings revolutionised dentistry. He served as surgeon-extraordinary to George III and The Hunterian Society was founded in London in 1819 to honour his life and works.



Photograph: Science & Society

Crossword



ACROSS

- 1 Wise person (4)
- 3 Disgusted (8)
- 9 Formal advice (7)
- 10 Runner who sets speed (5)
- 11 100°C (7,5)
- 12 With all one's heart (6)
- 14 Major passages in the body (6)
- 17 Scottish Anglican (12)
- 20 Very slow tempo (5)
- 21 Have a rest (3,4)
- 22 Celebratory litter (8)
- 23 Places of exercise (4)

DOWN

- 1 Where the poorly recuperate (7)
- 2 Antoni ____, Catalan architect (5)
- 4 Mucus (6)
- 5 Pinched (12)
- 6 Of few words (7)
- 7 Mend embroidery (4)
- 8 Heart monitor display, for instance (12)
- 13 Over the counter analgesic (7)
- 15 In phonetics, voiced sounds (7)
- 16 WC (6)
- 18 Literary technique misunderstood by Alanis Morissette (5)
- 19 Alliance of countries (4)

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

VIGNETTE

JAMES McCUNE SMITH (1813-1865)

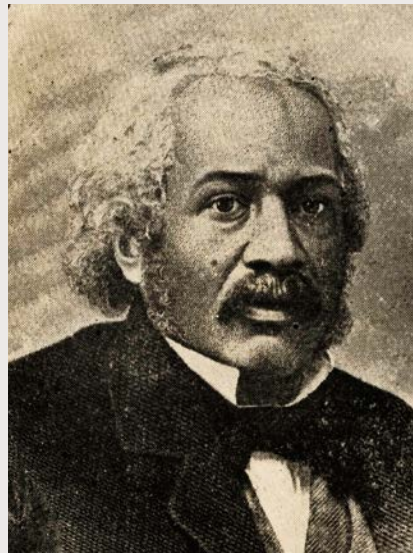
FIRST AFRICAN-AMERICAN TO OBTAIN A MEDICAL DEGREE

IN THE summer of 1832, a young man disembarked from the transatlantic ship *Caledonia* and as he stood on the Liverpool dockside, he declared: “I am free!” The 19 year-old was James McCune Smith, a student who had travelled alone across the world to receive an education denied him in his native America. He was articulate and gifted; he was also black and no medical school in the US would grant him entry.

After spending time in Liverpool, Smith continued his travels by steamer to Glasgow where he matriculated at the University. Arriving in Glasgow, he would have found a city of paradox. Glasgow had been at the centre of the New World slave trade, building its wealth on the cargoes of sugar, cotton and tobacco loaded onto the returning slave ships. While the UK may have offered him the liberty to study, he had arrived in a country that would not abolish slavery for another year. But, Glasgow was also an intellectual centre of the Scottish Enlightenment, which saw slavery as philosophically abhorrent. Indeed, this enlightened approach had prompted the French intellectual Voltaire, a generation before Smith arrived, to say: “We look to Scotland for all our ideas of civilisation”.

Glasgow at the time was a city already enjoying the benefits, and suffering from the woes, of the industrial revolution. In 1832 it had approximately the same population as Smith's native New York City, but there would have been considerably fewer black inhabitants and he would undoubtedly have been isolated. However, he was supported locally by the activists in the Glasgow Emancipation Society to whom his benefactors in New York had reached out, in order to facilitate his higher education.

At the University he studied in a class with 78 other young men and tackled a variety of subjects including Latin, Greek, logic, philosophy and astronomy, as well as the more traditional medicine, midwifery and surgery. He graduated with a BA in 1835, an MA the following year and, finally, he obtained his MD in 1837, graduating top



of his year.

After qualifying, he furthered his clinical experience in Paris before returning home to New York City, where it is said he was received by an enthusiastic crowd of some 16,000. He set up practice in Lower Manhattan and became resident physician at the “Colored Orphan Asylum”, but despite his obvious qualifications and experience, he was never accepted as a member of any New York medical associations or the American Medical Association.

As well as being a practising physician, Smith was also a prolific writer in both the medical and political spheres. In 1844 he became the first African-American to author a paper in a US medical journal and he would contribute important works to further the abolitionist movement. In the latter, he used his knowledge of statistics, acquired at university in Scotland, to systematically refute, argument by argument, the claims made by those who fought against emancipation. In medicine, he targeted homeopathy and phrenology, aiming to debunk the claims of their

exponents by careful analyses of the facts.

His position, as the first African-American with a medical degree, gave him considerable kudos, but it was his intellect and industry that allowed him to rise to a position of community leader and to move in the highest circles of the abolitionist movement. Indeed, the most prominent figure in the movement, Frederick Douglass, cited Smith as the single most important influence on his life. Furthermore, one commentator has noted that: “As the learned physician-scholar of the abolition movement, Smith was instrumental in making the overthrow of slavery credible and successful.”

Smith lived to hear of Lincoln's assassination but died in November 1865, one month before the ratification of the 13th Amendment that would formally end slavery in the US. He was buried quietly in an unmarked grave in Brooklyn by his family who did not wish to publicly acknowledge their African-American heritage. It would not be until 2010 that his descendants would rectify this.

Until recently, the only memorial in Glasgow to one of its most famous students was a café that bears his name near the original entrance to Old College in Duke Street. But what of the University of Glasgow itself? Glasgow has been at the forefront of academic institutions acknowledging their historical links with the slave trade and, as part of its programme of reparative justice, it announced in October 2018 that it would name its new £90m learning hub building in Smith's honour. An appropriate move, no doubt, but perhaps the fact that almost 200 years ago it saw fit to admit Smith when other universities turned him away because of the colour of his skin says even more.

Allan Gaw is a writer and educator based in Glasgow

Sources

- Morgan TM. *J Natl Med Assoc* 603-14; 95: 2003
- Matthews K. *Washington Post*, September 24, 2010
- BBC News, October 7, 2018

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To continue receiving your print *Insight* via post go now to www.tinyurl.com/y5l395wu

GO GREEN

Over 90 per cent of the cost of producing MDDUS *Insight* magazine is in paper and postage - and membership growth over the last few years has pushed our print run to well over 55,000 copies. That's a lot of trees.



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