

TOP PRESCRIBING PITFALLS

An MDDUS analysis of claims reveals the most common prescription errors

MONITORING PERSONAL EMAILS

Can you legally access personal communications sent from practice computers?

WORK PLACEMENTS: CONSIDER THE RISKS

Is your practice set up to offer work shadowing to school pupils?

PEAK practice

WORKING JUST AN AMBLE AWAY
FROM BRITAIN'S HIGHEST MOUNTAIN



NOW ON FACEBOOK
ARE PRACTICES TAKING A RISK IN ENGAGING
WITH PATIENTS VIA SOCIAL MEDIA?





MOST patient complaints and many legal claims arise mainly out of communication failures – this is a well-established fact. So it is not surprising that as the use of social media has expanded so too have calls to our advice line in regard to digital communication, including networking sites such as Facebook and Twitter.

Members often want to discuss setting up and managing practice accounts or pages to help them engage more proactively with patients – sharing news about the service or advice or promoting local initiatives. There are certainly potential benefits but also risks. On [page 12](#) MDDUS senior risk adviser Liz Price considers some of the pitfalls to avoid.

Many practices feel an obligation to encourage young

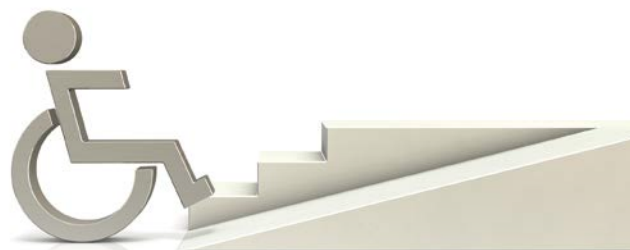
people into healthcare professions and regularly provide work placements offering valuable experience. On [page 7](#) practice adviser Jill Thomson offers advice on minimising the risks involved.

Our [page 6](#) employment law column looks at the legality of monitoring personal emails sent from work, and on [page 8](#) Liz Price reports on the results of an MDDUS claims analysis in regard to prescribing and considers common errors and how these can be avoided.

Our regular Call log on [page 4](#) covers a range of issues from patient access to “sensitive” data in their own medical file to dealing with suspected female genital mutilation (FGM). Our case study ([page 14](#)) deals with a prescribing error and is also about ensuring that staff are competent to handle delegated clinical tasks. Diary ([page 15](#)) is also back with some more gentle absurdities including the shy French physician who invented the stethoscope.

And on [page 10](#) Jim Killgore visits a dental practice in the Scottish Highland town of Fort William to chat not only about the challenges in providing quality dental care in a remote area but also how lifestyle can be a crucial factor in choosing the right job.

★ **Scott Obrzud**
Editor



New guidance on disability discrimination at work

ACAS have published new guidance to help employers and managers identify, tackle and prevent disability discrimination in the workplace.

Disability discrimination: key points for the workplace helps employers get to grips with what disability means, how it can happen and how to prevent and manage complaints.

Over the past year, the Acas helpline has dealt with around 12,000 calls on disability-related discrimination, while four out of 10 disabled people reported that misconceptions around their capacity to work were the biggest barriers to getting hired. In the new guidance Acas advises employers looking to prevent disability discrimination in recruitment to:

- give the details about a vacancy in an alternative format
- accept applications in alternative formats
- be careful when writing an advertisement for a job vacancy and stay clear of any wording that they are unsure about or think might be open to legal challenge
- avoid advertising solely in one kind of place or media
- be aware that a job application form could inadvertently be discriminatory
- only ask candidates to complete tests if they are relevant to the job, and where they are, make sure they can be accessed by people with a disability.

Access the guidance at <http://tinyurl.com/hwvx95f>

COVER PHOTOGRAPH: THE WRITE IMAGE; INSET: EVAN LORNE/SHUTTERSTOCK.COM



EDITORS:

Scott Obrzud
Helen Ormiston

ASSOCIATE EDITORS:

Jim Killgore
Joanne Curran

DESIGN:

Connect Communications
connectcommunications.co.uk

CONNECT



When you have finished with
this magazine please recycle it.

PRINT:

Printwell
www.printwell-ltd.co.uk

CORRESPONDENCE:

PM Editor
MDDUS
Mackintosh House
120 Blythswood Street
Glasgow G2 4EA

t: 0845 270 2034
e: PM@mddus.com
w: www.mddus.com

New national living wage

MILLIONS of workers across the country have become entitled to an increase in pay with the new national living wage coming into force from the beginning of April.

This new statutory minimum rate must be paid to workers aged 25 years and over, with the national minimum wage still applying for those aged 24 and under. The government aims for the rate to reach 60 per cent of median earnings by 2020, meaning an increase to around £9 per hour for those who qualify.

A new team of compliance officers in HMRC will investigate the most serious cases of employers not paying the national minimum wage and national living wage.

Currently, employers found to be paying under the national minimum wage rates face a fine equal to 100 per cent of the underpayment owed to each worker. This is being doubled to 200 per cent of the arrears owed if the debt is not settled within 14 days. The maximum penalty will be £20,000 per underpaid worker.

As of April 2016, the new rates are £7.20 for ages 25 years and over, £6.70 for ages 21-24, £5.30 for ages 18-20, and £3.87 for under-18s.

The apprenticeship rate is £3.30 and is payable to those who are aged 19 or under, or who are in the first 12 months of the apprenticeship.

Revalidation now required for nurses and midwives

REVALIDATION for all nurses and midwives in the UK has come into effect as of 1 April.

This means that all healthcare professionals on the Nursing and Midwifery Council (NMC) register must now demonstrate on a regular basis that they are "staying up to date in their professional practice and living the values of their professional Code by seeking feedback from patients and colleagues and engaging in a regular process of reflection, learning and improvement".

All 692,000 nurses and midwives on the NMC's register will go through the new process as their registration becomes due for renewal over the course of the next three years.

The new system is aimed at both improving patient safety and the quality of care that nurses and midwives provide to patients, and it fulfils a key recommendation from the Francis report into the failings at Mid Staffordshire Hospital NHS Foundation Trust.

Janet Davies, chief executive and general secretary, Royal College of Nursing, said:

"Improving patient care requires a clear and well implemented system to ensure all staff are up to date, and revalidation is an important step towards that. It's important that all staff who complete the process can get the time and supervision needed to make this vision a reality."

The NMC have launched a dedicated website providing a step-by-step guide to revalidation. Access at <http://revalidation.nmc.org.uk/>



Primary care in England nearing "saturation point"

CONSULTATION rates per patient by GPs and practice nurses in England increased by over 10 per cent between 2007 and 2014, suggesting that primary care as currently delivered could be reaching saturation point.

These are the conclusions of a major study conducted on behalf of the National Institute for Health

Research School for Primary Care Research and published recently in *The Lancet*.

Researchers undertook a retrospective analysis of over 100 million GP and nurse consultations at 398 English general practices between April 2007 and March 2014. They found that general practice workload increased by 16 per cent over the period, with patients seeing their GP 14 per cent more.

The average duration of consultations has also increased since 2007, rising five per cent from 8.45 minutes to 8.86 minutes.

The researchers conclude: "These results suggest that English primary care as currently delivered could be reaching saturation point."

Dr Maureen Baker, RCGP chair, said: "This important research confirms what the College has been saying for years. GPs and our teams are making more consultations than ever before, and our patients are living longer and with multiple, long-term conditions, meaning that our workload is growing in complexity as well as volume."

MDDUS reminds members to "say sorry"

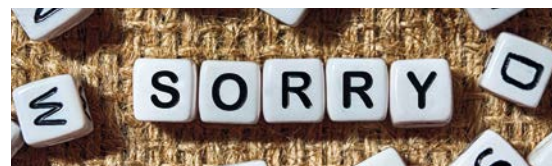
MDDUS has reiterated advice on the importance of apologising to patients when things go wrong.

This reminder comes following a Parliamentary and Health Service Ombudsman (PHSO) report on general practice complaint handling across England. The report is based on a survey of complaint handling in 137 cases involving general practices. In the analysis 36 per cent were rated "Needs improvement" and 10 per cent were "Inadequate".

In the category of "Appropriate apology given" nearly 20 per cent were rated inadequate.

MDDUS chief executive Chris Kenny said: "The Ombudsman's report is a timely reminder of both statutory obligations and good practice. GPs should find its combination of practical tips and illuminating case studies both relevant and helpful.

"In our experience, a sincere apology can prevent a patient complaint from escalating and we remind doctors that saying sorry is not an admission of guilt or liability in any potential litigation, nor is it a sign of weakness. In fact, at times it is the right thing to do and a genuine apology may be all that a patient wants."



Receiving a complaint from a patient is the single most common reason doctors seek advice from MDDUS and accounts for around a fifth of all contacts received.

MDDUS medical adviser Dr Greg Dollman added: "An open and honest approach is the best way to resolve complaints at the earliest possible stage. Doctors should avoid acting defensively and instead show empathy, responding objectively after consideration of the patient's point of view. Where doctors can identify any failings in their care of the patient, then a sincere expression of sorrow or regret should be offered as well as an explanation as to what went wrong.

"Often just listening and understanding a patient's concerns can defuse a situation. Even in a situation where the doctor does not believe a mistake has been made, it is still possible to adopt a conciliatory tone and express regret that the patient is dissatisfied."

Access *General practice complaint handling across England: a thematic review* at ombudsman.org.uk

New GP in your practice? Apply now

PLEASE note that Membership Services require a minimum of 28 days' notice for prospective members to apply for membership. To assess an application, MDDUS must request information from the GP's existing indemnifier. In our experience, responses can take as long as four weeks. We would therefore advise new GPs in your practice to submit MDDUS membership applications at least four weeks in advance - but the sooner the better.

It is important that GPs maintain alternative indemnity arrangements until MDDUS membership is confirmed.



These cases are based on actual advice calls made to MDDUS advisers and are published here to highlight common challenges within practice management. Details have been changed to maintain confidentiality

A PRIVATE LETTER

Q We have had a request from a patient for access to part of his medical record, specifically a recent letter from his psychiatrist. However, the psychiatrist expressly asked that the letter should not be shared with the patient as she was afraid it may upset him. Should we withhold it?

A The Data Protection Act entitles the patient to see a copy of his medical records, including any correspondence from other healthcare professionals such as psychiatrists. The main exception to this rule would be if disclosure would cause serious physical or mental harm to the patient (or another person). It may be useful to discuss the matter further with the psychiatrist, or with a colleague, to help you decide whether this exception applies here. You should also double check that none of the information requested relates to a third party who has not consented to disclosure and that there are no legal restrictions regarding disclosure (i.e. a court-ordered restriction or legal professional privilege applies).

WHO WRITES UP THE NOTES?

Q The principal dentist in our surgery has been pushing to make it practice policy for associates to have dental nurses write up clinical notes. One of our dentists is resistant to the idea and wants to record his own notes. What are the guidelines on this issue?

A GDC guidance clearly states that all dentists must "make and keep accurate and complete patient records, including a medical history, at the time you treat them". The ultimate responsibility for what is recorded in the records lies with the dentist providing care for that patient. In the

situation of your associate, he would be responsible for what is recorded and should check all notes and sign or initial them. In many practices, especially those using computerised databases, the nurse would record the findings of the consultation or treatment visits and the dentist would check and then initial them at the end. In essence there is no right or wrong answer as to who should make the recording. It is entirely a personal choice and if your associate prefers to do this then it would be reasonable to judge it is his decision and your principal should respect that decision.

PRISON CONFIDENTIALITY

Q A patient recently attended our practice for a blood test and the result revealed a low haemoglobin level. The patient is now currently in prison and our GP wants to request a follow-up test. Are we allowed to contact the prison to facilitate a follow-up or must we first have consent from the patient?

A It would probably be best first to contact the patient in prison to inform him that the prison doctor will be contacted in regard to the abnormal blood test – unless there are any objections. Failing this it would then be acceptable for the GP to contact the prison doctor directly. Healthcare staff at the prison will have a formal duty of care to the patient in which confidentiality will be maintained. The GMC states that: "Most patients understand and accept that information must be shared within the healthcare team in order to provide their care. You should make sure information is readily available to patients explaining that, unless they object, personal information about them will be shared within the healthcare team, including administrative and other staff who support the provision of their care."

ON THE REGISTER

Q We have a number of dental care professionals (DCPs) in the practice and it is assumed that they will take care of their own registration with the General Dental Council. I discovered recently that there has been a problem in the past with

one or two of the DCPs failing to pay their annual retention fee on time. I am a new manager and do not want to have to deal with this kind of disruption but I also do not want to cause offence.

A Practice managers are advised to ensure that all DCPs are registered with the GDC in order to avoid compromising patient care. Anyone who is not registered, or whose registration lapses for whatever reason, cannot carry out duties associated with their role. As you acknowledge, this could cause major disruption for the practice as appointments may have to be cancelled and temporary cover found. MDDUS often deal with cases where DCPs believe they have paid their ARF, only to discover the payment has failed. This can often be caused by a change in personal information, such as



home address or direct debit details. It would be wise to ensure that your DCPs have their registration in order (check on the GDC website) and that their payment details are correct and up-to-date. Re-registering is time consuming and not simply a matter of filling in a form.

FGM ALERT

Q Our practice is based in London and a 12-year-old patient attended this morning with her older sister complaining of stomach pains. She has recently returned from a trip to Kenya to visit family and she made reference to an "operation" she had over there. She seemed very withdrawn and unhappy but wouldn't give any more details when asked about the procedure. We are concerned she has undergone FGM. Is this something we should report to social services or the police?

A Doctors in England and Wales now have a legal obligation to report to police cases of female genital mutilation (FGM) in girls under the age of 18. If a girl under the age of 18 discloses that she has undergone FGM, or has physical signs of having had FGM in the past, then this must be reported to the police. This should be done as soon as possible and certainly within a month of the initial disclosure or finding. Failure to do so is a breach of a doctor's statutory duty. According to the Serious Crime Act 2015, doctors who report FGM will not be held to have breached any duty of confidentiality or any other restriction on the disclosure of information. Any concerns should be carefully noted in the patient record, including any decision to report or not. Where a doctor suspects a girl

under 18 is at risk of FGM, then follow local safeguarding procedures and comply with GMC guidance on child protection. It may be useful to discuss the case in more detail with the local safeguarding lead and an MDDUS adviser.

SELLING-ON MEDICATIONS

Q Our practice has received an anonymous call claiming that a patient has been selling their prescription medications, including temazepam and co-codamol. One of the GPs had already suspected the patient of this activity. Should we inform the police of our suspicions?

A Prescription-only medicines (POMs) can only be sold or supplied at a registered pharmacy and under the supervision of a pharmacist in accordance with an appropriate practitioner's prescription. Sedatives and hypnotics are also subject to the Misuse of Drugs Act 1971 and classified as Class C drugs. It is not necessarily an offence to possess and use such medications without a prescription but it is illegal for a patient to sell or supply any Class C drug to another person. Given the allegations against the patient are "hearsay" it may be worthwhile investigating matters further by inviting the patient in to discuss the fact these concerns have been brought to the practice's attention – but only if you feel safe doing so. There is no legal obligation on the practice to disclose crime of this kind, but a decision should be taken on whether or not it is in the public interest to disclose such information to a relevant authority. GMC guidance on this matter advises that personal information may be disclosed in the public interest to protect individuals or society from risks of serious harm or serious crime. Where a decision to disclose has been taken, the patient should normally be informed unless this in itself would pose a risk to you or others or would undermine the purposes of the disclosure, e.g. by prejudicing the prevention or detection of serious crime. In this instance further discussion with an MDDUS adviser on the exact particulars of the case is required.

HYGIENIST PRESCRIPTION

Q The hygienist in our dental practice does not offer direct access to patients and therefore can only work under prescription from one of the dentists. Can you confirm from a legal perspective how long a prescription to a hygienist is valid for?

A Prescriptions in these circumstances will be made after a dental examination and as part of a full treatment plan. It can include single or multiple visits to the hygienist and should include specific items of treatment. The prescription should indicate a reasonable time frame for the care to be provided: for example, the dentist may wish for the patient to receive some hygiene phase

therapy, including sub-gingival scaling and polishing and oral hygiene instruction with a three-month review. Generally, the prescription lasts until the patient has completed the course of treatment. They cannot be left open-ended and it is unwise, for example, to prescribe three-monthly scalings without a plan for the next dental examination. As such, there is no formal limit on a prescription to a hygienist but it is unlikely that a treatment plan made more than six months ago would still be valid if the patient had not attended over this period.

SEEING MEDICAL RECORDS AFTER DEATH

Q The daughter of a deceased patient has requested to see a copy of her mother's medical records. What are her rights in this matter?

A The practice should have consent from the deceased patient's executor or personal representative prior to releasing any records. Should the daughter herself be the executor then this is straightforward but the practice should first obtain written confirmation of the identity of the executor (or a copy of the will or extract confirmation). There is also the possibility of disclosure if the daughter has a claim arising out of the death and the request is relevant. You might also consider asking the daughter to attend the surgery so that a GP or other member of practice staff can summarise/explain the medical records as they may be very clinical and possibly distressing to read.

FALSE NOTE

Q The employer of one of our patients has faxed over a copy of a fit note that was completed by one of our GPs. They suspect the patient has made changes to it, adding extra conditions to the diagnosis and extending the required time off work. They want us to confirm if the note has in fact been altered (which it has been), but we are concerned about confidentiality.

A A fit note is a formal, standardised statement issued by the Department for Work and Pensions that is completed electronically by GPs. As such, any unauthorised alteration is viewed as an act of fraud. It would be appropriate therefore for the practice to confirm the note is not now as it was completed, but to give no more detail than that. You may consider it appropriate to first contact the patient directly to explain you are aware of the alteration and that you intend to confirm this to their employer. It may also be worthwhile exploring the reasons behind the patient's decision to amend the note, in case any mental health or other issues are present. This further detail may impact on any decision you make regarding disclosing information to the employer, e.g. disclosure may cause significant harm to the patient's mental health.

Monitoring personal em@ils

A RECENT legal case in Romania – *Barbulescu v Romania* – has caused a bit of a stir, with headlines in the press declaring that employers can now snoop on employees' personal communications sent from company computers or smartphones. Is this really the case?

In a nutshell, no. This ruling does not allow employers to read all employee emails, although the *Barbulescu* case led to much debate on the subject and this article attempts to highlight some of the key issues. The decision was made at the European Court of Human Rights, who are not in a position to tell other countries what their laws should be, but it does consider whether there has been a breach of the European Convention on Human Rights.

In this case, the employee was asked by his employer to set up a Yahoo Messenger account for business purposes and client communication only. The company had a clear policy stating that their computers and telephones could not be used for personal purposes. It was brought to their attention that the employee was in fact using the app to communicate with friends and family, and after monitoring his account, the employee was found in breach of this policy. It is interesting to note that Mr Barbulescu was made aware that communications could be under surveillance.

The employee denied this, stating he had only used the email account for business purposes, but the company presented a 45-page transcript showing the usage, including messages to his fiancée and brother. He was then invited to a disciplinary hearing where he flatly denied any personal use of the account which the employer knew to be false. The outcome of the disciplinary hearing was that he was dismissed from his employment as a result of using the messenger service for personal use.

Are employers allowed to access personal communications sent from company computers or smartphones?

This prompted the employee to complain that his right to privacy had been violated and he attempted to claim unfair dismissal. However, his claim was dismissed with the court stating that the employer was entitled to monitor the use of work computers to ensure the account was being utilised solely for business purposes. The only way to do this was to check the employee's messages.

The employee took his claim to the European Court of Human Rights, contending his Article 8 right – that “everyone has the right to respect for his private and family life, his home and his correspondence” – had been violated. It was also noted by the courts that the emails had sensitive information contained within them relating to his health and sex life.

Despite finding the claim fell within the scope of Article 8, the court judged that the employer had acted reasonably and only relied on the 45-page transcript after the employee denied using the account for personal purposes. In this case, the employer's monitoring was not about the actual contents of the messages, but the fact that they existed and to such an extent.

The appeal failed and the court held that “it is not unreasonable for an employer to want to verify that the employees are completing their professional tasks during working hours”.

To conclude, this case does not give employers the right to be able to read all

private messages, and practices need to ensure they are still acting reasonably and fairly to employees. We would recommend that you ensure you have a clear policy that covers the practice's equipment (in terms of both computers and any work phones) and what staff are able to use and when. In any dispute regarding an employee dismissal a tribunal will want you to show evidence of the breach, but more importantly what rule they are alleged to have breached. If there is no evidence of a breach of a policy or contractual requirement then this will make the disciplinary decision more vulnerable to be challenged.

Nevertheless, this decision does illustrate that employees would be wise not to use work email accounts or equipment supplied by employers such as PCs, tablets, mobiles or laptops for personal purposes. Ultimately any equipment belongs to the employer.

Employers should take care when deciding if it is appropriate to monitor personal communications and aspects to consider are:

- Is there a clear business need for the monitoring?
- Is the level and intrusiveness of the monitoring proportionate to that business need?
- Have you made it clear to employees how and why monitoring might take place?

An employer does have significant obligations under data protection regulations to ensure that there is a clear requirement for the monitoring of personal data. This is a tricky area of the law and our employment law advisers can guide you through the process if you have any issues.

Janice Sibbald is an employment law adviser at MDDUS

Practices often receive requests for work placements from students or other healthcare professionals – but there are some key risks to consider



A SAFE EXPERIENCE

SUMMER is approaching and many practices can expect to receive a number of requests for work experience from would-be doctors and dentists, as well as other healthcare professionals.

MDDUS sees an increase in advice calls on this topic at this time of year from practices who are unsure how best to deal with such requests. For senior school pupils whose ambitions lie in the fields of medicine or dentistry, experience in a caring or service role, as well as direct observation of healthcare, are often a compulsory part of application processes. Similarly, other healthcare professionals may seek a placement to enhance their CV and assist with their career progression.

Before reaching a decision on any request for a work placement, practices should be aware of the various risk factors involved.

HEALTH AND SAFETY

It is important to note that anyone who is participating in work experience is regarded as a practice employee for the purposes of health and safety legislation. This means the level of employer's liability insurance will have to be checked and, if necessary, increased. It is also worth remembering that certain health and safety requirements – such as the need to record risk assessments in writing or have a qualified first-aider – become active above a threshold number of employees, so the addition of students or other clinicians to the workforce could have quite onerous practical implications.

You should also be aware that the law defines those under 18 years of age as “young people” and, as such, their employment must be preceded by a risk assessment which takes into account their lack of maturity, knowledge and ability to recognise danger. It is advisable to record the results of this assessment. Where prospective work-shadowers are aged under 16, the findings of your assessment must be put in writing and a copy given

to their parents or legal guardians. Many practices choose to impose a minimum age limit of 16 for patient observations, but this is up to the discretion of each practice.

All hazards, even the apparently mundane ones such as those posed by surface cleaning products, should be assessed with a view to eliminating or at least minimising the risks they pose. Clearly dental and medical surgeries are fraught with potential dangers unique to the clinical setting and will therefore demand careful attention. The Health and Safety Executive has a useful advice booklet called *The Right Start. Work experience for young people: Health and safety basics for employers* (<http://www.hse.gov.uk/pubns/indg364.pdf>).

REFERENCES

It may be worthwhile asking student applicants for a reference from their school to confirm that a career in the medical or dental field, or similar, is realistic, and that the school has no issues or concerns about their suitability for placement.

CONFIDENTIALITY

Before beginning their placement, it is extremely important that candidates are given clear, detailed guidance on confidentiality. This should include the fact that the patient's attendance in itself, or personal details such as address/clinical complaint, are entirely confidential. This should be reinforced by a confidentiality agreement, to be signed by the candidate, which makes it clear that the work placement will be terminated if the agreement is broken. Consider, for example, the security of clinical records and where/how they are stored. MDDUS is aware of one case where a work placement student who said he was going to use the toilet instead let himself into the unlocked room where patient notes were kept and was found a short time later looking through confidential files.

Where possible, it is advisable not to

accept work experience students who live in the local area to minimise the risk of them recognising a patient, or indeed being tempted to look for personal information relating to friends or relatives.

CONSENT

Express consent (either verbal or in writing where appropriate) must be sought from patients before they are treated or examined in the presence of someone on work placement. Patients should be told they can change their minds at any time, in which case the candidate should leave immediately and without protest. Practices could consider displaying an information poster in the waiting areas to allow patients to consider this.

HANDS OFF

If a practice decides to accept a request for work shadowing, it should be made clear that there will be no opportunity for “hands-on” experience. They should be aware they will be present in a purely observational capacity, and will be expected to conduct themselves in a proper manner. In a medical setting, students would not be expected to witness any examinations where a patient is required to undress.

It may be helpful to ensure that the student/healthcare professional has realistic expectations of what they will be able to do during their placement with the practice. Consider drawing up a timetable of suitable activities for them, including time with various members of the practice team. They must appreciate they are in a sensitive environment where they will have to work within limits and will not have access to everything that is going on. Afterwards, practices may find it helpful to seek feedback via an evaluation form to help inform any future placements.

Jill Thomson is a practice adviser at MDDUS

TOP 5

prescribing pitfalls

Liz Price highlights common prescribing pitfalls revealed from MDDUS analysis of GP negligence claims

PRESCRIBING errors constitute one of the top risk areas for general practice and every year account for around 13 per cent of all GP negligence claims reported to MDDUS.

In 2012, the GMC commissioned a study which found that one in 20 prescriptions had either a prescribing or monitoring error. Even more concerning, they found that one in 550 of all prescription items contained an error judged to be severe. Many errors are picked up before the patient is harmed, however when harm does occur, it can be serious and long-lasting.

At MDDUS, there is ongoing analysis of how claims of negligence arise as a result of failures in prescribing. Some claims arise due to a prescriber neglecting to stay up-to-date or through a lack of awareness of current, evidence-based practice. However, the remainder of causes can be grouped into the five categories discussed below. Risk levels in these categories can be reduced by good management of prescribing systems and ensuring adequate training and competence of the non-clinical staff who support these systems.

MEDICINE REVIEW

Here failures arise primarily as a result of the prescriber or practice team not fully utilising the patient record system effectively. This can mean that information "pushed out" when a patient requests a prescription is unhelpful and so ignored.

When a medicine is prescribed, the clinician is responsible for ensuring that appropriate reviews are undertaken. If review periods are not entered appropriately, short and long-term reviews of medicines are not triggered and therefore not actioned. This can lead to over-prescribing and continued prescribing in cases where a patient requires testing or review - both of which can result in significant patient harm and a potential claim for negligence. Reviewing medicines is particularly important where:

- the patient may be at increased risk, for example if they are frail or have more complex clinical conditions
- the medicine has potentially serious or common side-effects either on its own or when being used in conjunction with other drugs

- the patient is prescribed a controlled drug or other medicine that is commonly abused or misused
- the *BNF* or other authoritative clinical guidance recommends blood tests or other monitoring at regular intervals.

Action: It is important that appropriate review periods are added to the prescribing system and that subsequent alerts are actioned - or at least flagged for clinical review.

PRESCRIPTION ERROR

The second largest group of claims are caused by a prescribing error, such as with confusion over a drug name or dosage. The majority of these arise as a result of human errors in using computerised prescribing systems with drop-down lists to select drugs which may have similar names but very different properties. Recent examples include the prescribing of lofepramine hydrochloride (an anti-depressant) instead of loperamide hydrochloride (an anti-diarrhoeal), olanzapine (anti-psychotic) instead of omeprazole (a proton pump inhibitor) and fluoxetine (an anti-depressant) instead of flucloxacillin (an antibiotic).

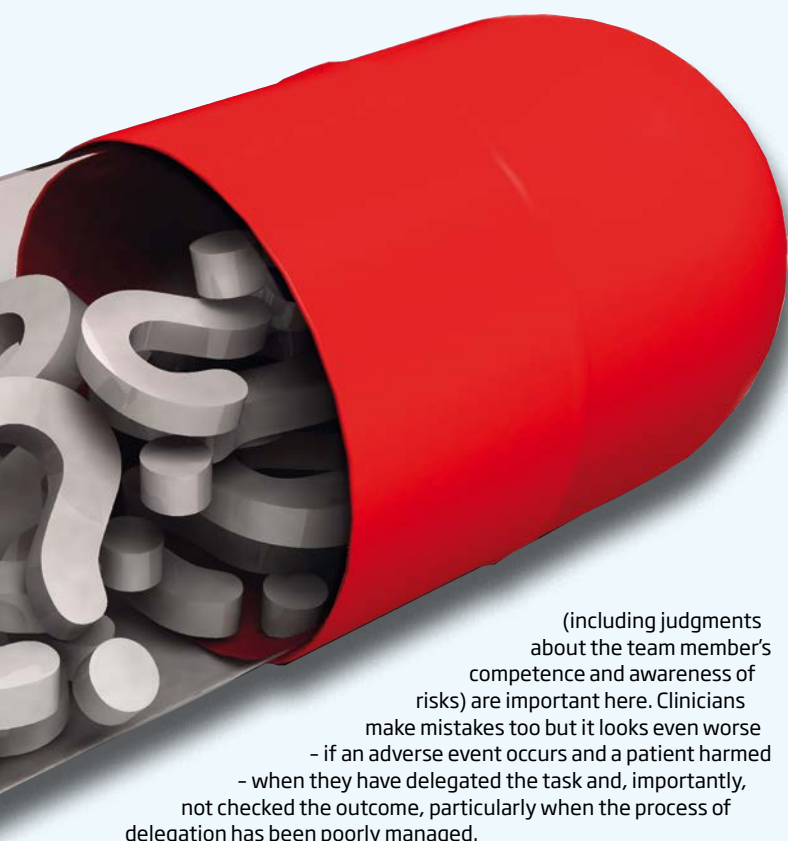
Action: Highlight the risks of such errors to prescribers and those delegated to prescribe on their behalf to ensure extra vigilance.

RECONCILIATION OF MEDICINES

The majority of these claims arise when responsibility for prescribing is transferred back to the practice after the patient has spent some time as an inpatient in hospital. It is thought that between 30 and 70 per cent of patients experience a medication error during this transition.

Even within your own practice there may be different systems in place. Many doctors recognise the complexities and risks associated with the task and so prefer to make changes themselves. Some will delegate the task to administrative staff and the delegation process





(including judgments about the team member's competence and awareness of risks) are important here. Clinicians make mistakes too but it looks even worse - if an adverse event occurs and a patient harmed - when they have delegated the task and, importantly, not checked the outcome, particularly when the process of delegation has been poorly managed.

Action: Review prescriber practices within your own team. If delegation occurs, ensure there is effective training in place which includes checks of competence. Make sure prescriber instructions to non-clinical staff are clear, and that there is a clinical review of the prescribing records before issuing repeats.

KNOWN ALLERGY

A common error here is when the allergy is recorded as free text in a prescribing system and not coded: for example adding "allergy to trimethoprim" as a free-text entry and not specifically coding "trimethoprim allergy". The consequences of a drug allergy can range from a mild rash to anaphylaxis and anything in between.

A recent case involving a known trimethoprim allergy caused the patient to experience a disturbing reaction with the letter of claim noting that the patient experienced: "severe bleeding of the skin on both sides of her face and neck and initially some difficulty with breathing. The patient also lost her eyesight for just over a week - which was terrifying as you might imagine."

Action: Ensure known allergies are coded appropriately to generate prescribing alerts. Ensure prescribers check verbally with the patient that they have no known allergies as a "safety net".

CONTRAINDICATIONS

Prescribing when medicines are contraindicated, either because the patient is on a medicine which could cause an adverse interaction or because the patient has a medical condition which could be worsened by the new medicine, is sometimes necessary but needs frequent monitoring.

Use of system coding of medical conditions to ensure accurate alerts are available is important. When a medicines alert arises, a

clinician should be the one to override this. It is important to record the risks of using a contraindicated drug in the patient's notes, be able to justify the reasons and demonstrate that risks versus benefits of doing so have been considered.

Commonly, risks occur when admin staff override an alert when they have been delegated the task of adding medicines, with the assumption that "the GP would've already been aware of, and considered, the interaction". Often, it is important that the patient is monitored more carefully and so the patient should be added to a robust call/recall system to ensure this does not get overlooked. If a patient defaults from review, staff should check the impact of this with the prescriber to ensure recall is escalated if necessary.

Actions: Clinical conditions should be coded appropriately so that relevant alerts are generated. These alerts should only be over-ridden where they have been clinically reviewed.

REVIEW THE FOUNDATIONS FOR SAFE PRACTICE

Consider your practice's relationship with local pharmacies. A good relationship with a pharmacist (for both the practice and the patient) can be very beneficial. Being approachable when it comes to prescription "queries" (rather than offering a brusque "what is it now?") can provide an additional safety net.

Undertake risk management of your practice systems - involve the whole team as this raises awareness and reduces the risks of individuals "doing things differently". MDDUS risk checklists can help. Ensure that when things do go wrong - or there is a near miss - the incident is reported and that you engage proactively in significant event analysis (SEA). This will assist in demonstrating reflection and learning from an incident where appropriate.

ENGAGING THE TEAM

Episode three of our MDDUS drama series, *Bleak Practice*, provides the opportunity to watch with your team as some of the most common prescribing errors unfold, whilst using the associated team discussion guide to consider the impact of your own practice's systems of working on levels of risk. Access the video module in the Risk Management eLearning centre at www.mddus.com.

Liz Price is a senior risk adviser at MDDUS

An active practice

Jim Killgore visits a dental surgery in the Scottish Highlands that recognises there is more to life than just work

NOT many workplaces offer the possibility of knocking off early on a summer afternoon to climb a mountain – and in particular Britain's highest.

The Fort William surgery of M&S Dental Care lies only a few miles from the trailhead of the famous "Tourist Route", climbing 1,352 metres up Ben Nevis. The day I visit the mountain is shrouded in cloud and most of the tourists are clad in waterproofs slick with heavy rain.

I have come to chat with practice manager Jillian Bruce and Director Gregor Muir about how they run this distinctly atypical dental practice – remote and rural yet still one of Scotland's largest.

M&S Dental Care operates out of a former NHS health centre with a large staff of 32 including 11 clinicians – and runs a branch surgery in the small Highland village of Glencoe. The practice has a list of around 10,500 NHS-registered patients in addition to private work. It covers a wide geographical area drawing patients from as far as Oban 44 miles south all the way to Inverness 65 miles north, and also from the inner Hebrides including Skye and the smaller islands – Eigg, Muck, Rum.

"We are certainly the biggest practice in the Highlands and probably in the top 10 in Scotland," says Gregor.

WILD OUTDOORS

M&S Dental Care was established in 2001 when Gregor merged his smaller practice with another surgery in town run by dentist Kenneth Scoular. Gregor came to Fort William in 1998 having only just graduated from Glasgow University four years previous. He spotted an advert in the *BDJ* for a "small Highland practice" but already knew the area well, being a keen whitewater canoeist.

"I used to work in Milngavie and we did a lot of kayaking. On a Tuesday night in the summer we would jump in the car at half past four and drive up to Invergarry which is about 20 minutes north of here and go canoeing for two hours. That's what really dragged me up here."

A passion for outdoor pursuits unites many of the staff at M&S Dental – and Fort William is the ideal centre, on a narrow sea loch fringed with mountains. Here is some of the best hillwalking and mountaineering in Europe with Fort William being the northern terminus of the West Highland Way. The nearby Nevis Range offers skiing in winter and in the summer becomes a world class centre for mountain biking, each June hosting the UCI Mountain Bike World Cup.

TICKING OVER

Jillian Bruce's love of the area is perhaps less to do with extreme sports. One of her main passions is competing at dog shows with her five Tibetan Spaniels. She has lived in Fort William since age 13 and started working in a local practice at 17 as a dental nurse. In the intervening years she has also been employed by NHS Highland working in the



PHOTOGRAPHS: THE WRITE IMAGE

local community dental service but has worked with Gregor and M&S Dental from the start.

"We have gone from two dentists, two nurses and one receptionist. It's been quite a learning curve."

Managing such a large practice over two sites in a location remote from any major city is a particular challenge and Jillian works with a patient liaison officer who also acts as a part-time practice manager.

"My job is to make sure the clinicians only have to deal with the patients. I handle 90 per cent of their paperwork," says Jillian. "I do the buying and negotiate contracts. I look at all the dental companies and decide what's the best deal. They all know I'm not faithful to any of them, regardless. If I can get a better deal elsewhere, I will."

Gregor adds: "We are fortunate to be big enough to have Jillian to keep things ticking over. NHS forms are becoming increasingly onerous. There are more rejections if you don't dot the right 'i' and cross the right 't'. Jillian picks all this up and it means we run as efficiently as possible."

Jillian also undertakes property management as the practice owns the building, part of which is leased out to a veterinary surgery. M&S Dental is particularly proud of its spacious premises which six years ago was a derelict health board building.

Before moving they operated out of a small surgery on the High Street. Says Gregor: "It was a wee totem practice. There were only four chairs and we had to work shifts, back to back – eight to two and two to eight."

The new surgery has eight dental suites and a dedicated two-room decontamination unit with spacious waiting areas and even an extra consulting room used part-time by an optician and a sports remedial massage therapist.

AVOIDING REFERRALS

Economy of scale has allowed M&S Dental to bring advantages to its patients otherwise not possible in such a remote area. "One of the problems here is that the nearest referral centre is in Inverness," says Gregor. "So our philosophy is to try and do as much of the difficult treatment as we can in-house to save people having to make that 120-mile round trip."

The practice thus encourages its clinicians to pursue additional qualifications such as in oral surgery, orthodontics and implantology.

"OUR PHILOSOPHY IS TO TRY AND DO AS MUCH OF THE DIFFICULT TREATMENT AS WE CAN IN-HOUSE"



Clockwise from main picture: Gregor and Jillian outside the practice with kayak at the ready; Jillian with her prized Tibetan spaniels; Gregor at work; Ben Nevis, the UK's highest mountain is on the doorstep; Jillian chats with the receptionists



"Another problem is if something goes wrong here we are a long way from a hospital," says Gregor. "So we need to be able to follow-up on problems and manage any dental emergencies and general emergencies within a dental setting. This might include bleeding sockets, dental swelling, infections or trauma."

FINDING THE FIT

Recruiting the right staff is therefore crucial for M&S Dental. Not only are they keen on clinicians with an interest in developing their careers but also individuals who will fit in with the ethos of the practice and lifestyle of the area. Says Jillian: "For someone who likes arthouse cinema - a 120-mile round trip is a long way. And if you are into fashion and nightclubs... well it's more wellies and waterproofs here."

Dentist Ross Ellison first worked at the practice for a year as a VT in 2009. He then returned after working in a hospital at Dundee and in general practice in Aberdeen. "I had so many friends from dental school with horror stories about the practices that they worked in so I realised how well-run this practice is - everything operates smoothly and it's a nice environment. I always knew I wanted to come back eventually. So I kept in touch over the time I was away."

Ross has been encouraged to pursue an MSc in oral surgery and is

now working on his dissertation. "I am not an oral surgeon but I have more skills than a general dentist. We basically assess patients and see whether it would be appropriate for me to provide the treatment or whether to refer them. Usually I can do the treatment - but we try to minimise the risk of anything going wrong and refer if in doubt."

Again this means the practice can help patients who might otherwise have to travel to a more distant treatment centre. Ross' desire to return was also a lifestyle choice with his love of the outdoors. Most weekends he and his partner Nadia Madour - who also works as an associate dentist at the practice - can be found mountain biking or hillwalking.

"After being here for a year and going back to the city it was a no-brainer in coming back at some point," says Ross.

Jillian also does not regret living further from a city, apart from a few drawbacks such as a less wide choice of restaurants. "I miss a really good Italian."

But there are compensations, she says. "Coming back from Glasgow there is part of the road when in the dark or at dusk you can see right up the Loch to the twinkling lights and you think, I'm nearly home."

Jim Killgore is an associate editor of Practice Manager

Now on Facebook

Liz Price highlights some of the risks that practices face in engaging with patients on social media

JUST as online engagement has become ever more ubiquitous in society so too has MDDUS seen an increase in advice calls from both medical and dental practices regarding the use of social media to communicate with patients.

Often members want to talk through the potential risks associated with setting up and managing a practice Facebook page or Twitter feed to help them engage more proactively with patients – sharing news about the service or advice about common or seasonal illnesses or promoting local healthcare initiatives.

A significant number also contact us asking for advice on how to respond to breaches of confidentiality or to damaging public comments about the practice (or members of the practice team) on existing sites. In our experience it is much better to contact us at an early stage for advice on how to deal with these situations as they can escalate quickly, with practices sometimes threatening to remove patients from their list and then faced with increasing reputational damage.

Done in a considered way, though, there are real benefits to engaging with patients via social media. For example, there is evidence that communicating about the impact of DNAs via Facebook can reduce the number of lost appointments. Providing information about access to services or advice on how to deal with minor illnesses/seasonal conditions can reduce the number of calls to the practice. Many practices also use specialised subpages to increase the level of support provided to specific groups of patients, such as asthma sufferers or those needing to lose weight.

Problems mostly arise due to a lack of planning and care when setting up an online presence for the practice and below are some pitfalls to avoid.

HAVE A CLEAR PURPOSE

Be clear about the purpose of using social media for your practice.

Most social media users cite “gaining useful information about the service” and “to receive information which might be relevant to their interests” when asked why they subscribe to services to receive notifications. Believe it or not, complaining and providing feedback are not usually listed.

So it is probably best to use social media as a positive way to communicate with patients – that is, to “push” information about services or advice that might be relevant to patients – rather than as a means to obtain feedback about your service.

You should consider whether you want patients to be able to clarify information in posts via comments or to add useful pointers or support for other patients to access. There are risks associated with allowing patient engagement on your page, however these can be mostly mitigated by ensuring your privacy settings are tightly controlled and having all posts viewed or moderated quickly so that any emerging problems can be avoided or resolved professionally.

Bear in mind that this means that you will need to have a group of administrators trained and ready to respond.

HAVE A SOCIAL MEDIA POLICY IN PLACE

Most practices will already have adopted a social media policy for staff which might include rules around what is acceptable use in and outside the workplace. It will probably include statements about the importance of protecting confidentiality in personal use of social media and not bringing the practice into disrepute.

There is also clear, professional guidance from the GMC, GDC and the Nursing and Midwifery Council on use of social media and so clinicians should be aware of their personal responsibilities – particularly in relation to confidentiality, maintaining professionalism and protecting patients.

“PROBLEMS MOSTLY ARISE DUE TO A LACK OF PLANNING AND CARE WHEN SETTING UP AN ONLINE PRESENCE FOR THE PRACTICE”

When considering whether to create a social media presence for the practice, or when reviewing your current online practices, it is important that similar rules and processes exist for page administrators. These should include:

- Clear guidance on what types of posts can be created or shared.
- Clear guidance on who can post or share posts to the practice pages.
- Any necessary authorisation from a GP, dentist or practice manager before an item is posted or shared.
- Agreeing what posts/pages are acceptable to share from a health advice point of view – e.g. sticking to a set of agreed NHS pages, such as NHS Choices or a reputable health news source.
- Ensuring regulatory guidance is complied with if you are engaged in advertising. Social media sites can be used to advertise your practice but all content should comply with good practice on advertising. For example, in *Good medical practice* the GMC states: “When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit

PHOTOGRAPH: YMCERMAN/SHUTTERSTOCK.COM



patients' vulnerability or lack of medical knowledge". The GDC has similar statements within their *Standards for the dental team*.

- Checking to ensure that posts are not discriminatory or offensive (while "funnies" may be very engaging some patients may find them offensive).
- Setting standards for the regularity of posts.
- Determining availability to provide responses and the standards for moderation of comments or posts (e.g. all comments/posts to be moderated within two hours).
- Providing guidance on how patient comments will be responded to and the types of posts or content that should be disallowed or raised with senior colleagues.

SET OUT RULES FOR FOLLOWERS

Facebook is the most popular vehicle for practices as it reportedly has twice the number of users than Twitter. No matter which platform you use, be clear in your 'About' description on the purpose of the pages. This might include a statement that the pages are designed to help patients stay up-to-date with what services are available at your practice, how to access these services and any relevant advice or seasonal health information.

Make it clear also what the pages are not designed to do. Remind patients that

the practice welcomes feedback about the service but that this is best raised via the most appropriate channel. Include a statement about the importance of patient confidentiality and provide contact details if patients wish to provide feedback or raise a complaint.

Patients should be advised to apply caution if they comment on the site, as anyone can see their comments. In particular, no comments should be made which involve the experiences of third parties, to avoid breaching confidentiality.

Information on availability (and responsiveness if this is appropriate) within practice opening hours is also important, along with a link to your practice website where more detailed information can be found.

MANAGING PATIENT COMMENTS AND FEEDBACK

Practices can choose to set their privacy settings to "no tagging" and "no comments". This means you lose some of the benefits of engagement but that the risks are dramatically reduced. If you so decide to allow patients to comment or post on your site, it is important to ensure that your administrators are set up (and have enough time) to access and deal with notifications of these.

Consider how you will deal with critical comments in advance and have a process/

script to respond to any negative posts. Consider your responsibility to other patients and as an employer.

Explain why in your 'About' section if you allow posts or comments only after moderation. Ensure posts are assessed quickly and, if not authorised, the person is provided with an explanation and offer an alternative mechanism of communication to offset any frustration. Ensuring that comments are allowed but moderated prevents conversations starting on any practice posts, which can sometimes become problematic.

RISK CHECKLIST: SOCIAL MEDIA ENGAGEMENT

- Consider the purpose carefully and get it right for your practice.
- Consider whether you have the capability and capacity to manage your online presence effectively.
- Consider whether and how you wish patients to be able to engage with the practice online.
- Take time to identify, consider and take steps to mitigate risks.
- Remember that social media posts should be simply another way to demonstrate the professionalism of the practice.

Liz Price is a senior risk adviser at MDDUS



Knowing the limits

Day one

Mr D is a 78-year-old retired plumber who had undergone mitral valve replacement surgery two years previously. He is taking warfarin and his last recorded INR three months ago was 3.5. He phones the GP surgery complaining of a "flare-up" of a chronic painful left elbow. One of the senior practice partners Dr T undertakes a telephone consultation with the patient in which he prescribes co-codamol 1-2 tablets four times daily.



Day five

Mr D phones the surgery for an appointment and Dr T delegates the consultation to nurse practitioner Ms G. The patient is still complaining of a painful elbow and Ms G notes the presence of a "gross haematoma" though Mr D cannot recall injuring the joint. Ms G informs the patient that she will arrange an X-ray to rule out a possible fracture. In the meantime she issues a prescription for co-codamol and diclofenac (50mg three times daily). Mr D is advised that the diclofenac may give him an upset stomach but there is no record in the notes of any other advice being offered.



Day six

Mr D's daughter stops in at the pharmacy to collect the prescription. The pharmacist raises concerns over the prescription (possible adverse drug interaction) and Mr D later phones the surgery. He is reassured by the practice nurse that it is okay to take the tablets but to stop taking them if he feels unwell.



Day 14

Mr D's daughter contacts the out-of-hours service on a Sunday stating that her father is feeling "seedy and light-headed". He has also developed black stools. The GP on-call notes that the patient is on warfarin and recommends that Mr D attend A&E. In hospital he is assessed and found to be tachycardic and with a low haemoglobin level of 7.3 g/l and an elevated INR reading of 20. Mr D is given treatment to correct the anticoagulation and also undergoes an endoscopy and colonoscopy both of which are normal. It is concluded that his gastrointestinal bleeding is probably due to diffuse oozing from the GI tract secondary to a combination of a high INR and diclofenac. The patient spends the next 10 days in hospital recovering from the GI bleed and makes a slow recovery over the next two months.

S EVEN months later the practice receives a letter from solicitors acting on behalf of Mr D claiming damages arising from the treatment provided by the surgery.

It is alleged that the practice breached its duty of care to Mr D in prescribing the diclofenac. A gross haematoma of the elbow had been noted and in these circumstances an urgent INR check should have been undertaken to ascertain if excessive anticoagulation was a factor. Prescribing the NSAID (nonsteroidal anti-inflammatory drug) is alleged to be entirely inappropriate. It is also claimed the practice was negligent in delegating the care of the patient to Ms G as the medical management of an elderly patient on warfarin was beyond the expertise of a practice nurse.

MDDUS commissions an expert report from a primary care specialist who examines the patient notes and accounts of the case from the GP and practice nurse. First in considering the action of Ms G the expert is critical of the patient's treatment in a number of respects. Mr D presented with a gross haematoma of the elbow and it was clear from the records that he was taking warfarin.

Standard practice would have required a review of this patient's current coagulation status. The last INR had been performed three months before and although within range it was inappropriate to assume the reading was still relevant. The expert further considers the decision to prescribe diclofenac as wholly inappropriate given that it is clearly established that NSAIDs can enhance the anticoagulant properties of warfarin leading to increased risk of haemorrhage and gastrointestinal bleeding.

Another key point addressed in the expert report are the practice systems in place to supervise and support the nurse practitioner and measures to ensure that staff work within their level of competence. It is acknowledged that nurse practitioners are usually highly experienced professionals able to examine, manage and prescribe for patients across a wide range of conditions but clear guidelines should exist for supervision in the management of complex and risky cases such as those involving anti-coagulant medication. The expert concludes that Dr T departed from standard practice in delegating and failing to supervise the care of the patient by Ms G.

In view of these factors it is agreed with the practice to settle the case out of court.

KEY POINTS

- Ensure practice staff work within their competence.
- Doctors delegating care must be satisfied that practice staff have the relevant knowledge, skills and experience and are adequately supervised.
- Foster an open and supportive practice environment in which staff feel comfortable asking for further guidance.

Diary



MORE random items of questionable relevance from the PM team...

➔ NEXT STOP...HEALTHY TOWN

Diary appreciates a good utopian vision as much as the next guy - especially when it comes from no less than Simon Stevens, chief executive of NHS England. Speaking recently at The King's Fund in London, Stevens announced plans to design 10 new "healthy towns" in England with clean living integrated into the "built environment from the start". He envisages the plan as "some kind of idealised version of Amsterdam" (presumably without the cannabis cafés) where planners will tackle the shortage of low-cost housing but also "design out the obesogenic environment for our kids, and design in support for independent living for older people and enable new ways of technology-enabled primary and community care right from the get-go". This means fast-food-free areas near schools, green spaces, dementia-friendly streets where the elderly navigate with ease and children walk or cycle safely to school "rather than just exercising their fingers on video games". Good luck with that.



➔ **JUST NOT SORRY** Struggling to get ahead in your career? It may be your choice of words in emails are to blame. Including phrases like "I'm just writing to say...", "I'm no expert but...", "does that make sense?", or apologising too much could be causing colleagues to lose respect for you and undermining your authority at work. According to the *Daily Mail*, the habit has prompted New York-based entrepreneur Tami Reiss and the tech team at Cyrus Innovations to create the web browser plug-in Just Not Sorry. It acts like a kind of spell-check in flagging up self-demeaning language to encourage you to eliminate it. Tami advises email writers to "be nice, be polite

and be direct. Be clear, honest and open - and that's true if you're asking someone to do something or if you're responding to a request for something." She says we should stop saying sorry but also be careful not to come across as too negative or aggressive. Diary is no expert but...

➔ **BABY COME BACK** Desperate times demand desperate measures. Diary recently noted that NHS Education for Scotland (NES) has responded to the ongoing recruitment crisis in primary care by announcing plans to send delegates to a medical conference in Perth to meet UK-trained GPs practising in Australia and coax them back to Scotland. Surely they must be sick of all that sunshine and easy living by now. NES says on its website: "With the development of a new GMC contract underway, more investment in general practice, access to the NHS pension scheme and a health service that is arguably one of the best in the world, there is much to commend working as a GP in Scotland right now. Why not come back to enjoy our four seasons of weather (sometimes in one day), our diversity of culture and proximity to the rest of the world. Scotland is more than ever a wonderful place to live and work." Dr Dean Marshall of the GPC executive team is less than convinced. "What we need to do is concentrate on keeping the ones we've got."

➔ **EAR NO MORE** Medical staff have one man's shyness to thank for the invention of that indispensable diagnostic tool - the stethoscope. In 1816, when confronted with an overweight female patient complaining of heart problems, the sober French physician René Laënnec felt the usual practice of pressing one's ear against the patient's chest was not appropriate. A keen flute player, the idea came to him to roll up a piece of paper into a tube and press it against her chest. In a research paper published

in 1819, he described how he was "not a little surprised and pleased to find that I could thereby perceive the action of the heart in a manner much more clear and distinct than I had ever been able to do by the immediate application of my ear." His early hollow wooden prototypes were eventually improved upon in the 1850s into a design very similar to that used today. The pioneering Laënnec, who died of tuberculosis aged just 45, was celebrated in a recent Google doodle on what would have been his 235th birthday.

➔ **WHY WOMEN SHOULD NOT BE DOCTORS** Last month on International Women's Day it was noted that females now comprise around 45 per cent of registered medical practitioners and 51 per cent of registered general practitioners in the UK - a far cry from the early Victorian period when the number of women doctors could be counted on one lace-gloved hand. Diary recently came across a blog by Claire Cock-Starkey who had trawled nineteenth century medical journals to compile a list of *Why Women Shouldn't be Doctors (According to Victorian medical men)*. Here are just a few of the highlights. From "Lady Doctors" in *Medical Press and Circular*, 23 February 1870: "Everyone knows that there is an abundance of cases of disease where a physician absolutely cures, not by his pathological knowledge, nor yet by his acquaintance with medicines [...] but [...] by the prestige of his mere presence; by being able to 'put his foot down'; in one word, by being a - man." And from "The Woman as a Physician" in *Medical Press and Circular*, 6 April 1892: "they [women] never know why they have failed until they have asked some man". Best of all is *The Lancet* correspondent who wrote to the journal in 1895 worried that the editor might "perhaps be tempted to sacrifice dignity to popularity and insert a weekly article on Fashions and perhaps also a column of Gossip, to please your numerous feminine readers".

CALL FOR DIARY ITEMS Do you have any tidbits, anecdotes or absurdities in a similar vein to the items above? Please write in or email them to **PM@mddus.com**

BE OUTSTANDING

Check out our new **CQC TOOLBOX** designed to help GPs and practice managers in England work through many of the areas of quality and safety identified as core by the Care Quality Commission.

A combination of new and existing MDDUS resources are now available for members, organised under each of the five key lines of enquiry (KLOEs) focussed on by the CQC in practice inspections. KLOEs assess whether a practice is: safe, effective, caring, responsive, and well-led.

A range of targeted resources are available including:

- video modules
- risk articles
- practical checklists
- advice and guidance sheets
- podcasts
- video interviews with experts

To access the toolbox go to the Risk Management section at **mddus.com**. For members-only content, log in with your surname and membership number.

Editable versions of all risk checklists are also available to MDDUS practices via **risk@mddus.com**



UK-wide support and indemnity

