

INSIGHT



PRIMARY

**Featuring: Keeping your spirits up /
Lessons from a pandemic /
Getting back to practice /
Ethics: Connected choices**

Helping hand

Escaping opioid addiction



Welcome

Dr Greg Dollman
Editor



CORONAVIRUS continues to loom large for primary care teams, but in this issue we bring you advice and features that not only address the pandemic, but look beyond at broader issues.

As lockdown measures gradually become less stringent, now is the time

for practices to start planning ahead for how to ease staff back into working life. Employment law adviser Liz Symon offers practical advice on **page 6**. The past few months have been enormously challenging and stressful. On **page 7**, MDDUS medical adviser Dr Roopinder Brar shares some personal insight and practical tips for managing your wellbeing. Dr Allan Gaw looks back to the 1918 Spanish flu outbreak and finds some cogent similarities to the current crisis. Read his fascinating article on **page 8**.

As we begin to consider a post-COVID world, there is a risk that misuse of prescribed opioid and analgesic painkillers will have increased during lockdown. On **page 10**, Graeme Dixon from change management firm Agencia shares insights from an innovative new approach to managing and reviewing prescribing.

In her ethics column on **page 13**, Professor Deborah Bowman considers the "fundamental connectedness" of clinicians, managers and lay members coming together to understand ethical dilemmas amidst COVID-19.

Our Call Log on **page 4** features common (and not so common) advice requests from GPs and practice managers, and our case study on **page 12** looks at a difficult case involving a failure to refer a patient complaining of abdominal pain.

Addenda on **page 14** features reviews of Monty Lyman's new book *The Remarkable Life of the Skin* and the award-winning, Obamas-produced documentary *Crip Camp*. Our Object Obscura is a 19th century "pricking instrument" and our vignette looks at the remarkable John W Thompson, the psychiatrist who defined medical war crimes.

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INSIGHT Briefing



GUIDANCE

Death certification guidance during COVID-19

DOCTORS should use their clinical judgement when deciding whether to include COVID-19 in a cause of death certificate.

A joint statement from the Care Quality Commission and the General Medical Council ([tinyurl.com/yd7shxgff](https://www.gov.uk/guidance/tinymce.com/yd7shxgff)) said clinicians should state what they believe to be the most likely cause of death based on their knowledge of the patient, the events surrounding the death and any available medical history or investigations.

Where no positive swab diagnosis is available, doctors should "apply clinical judgement" and state the cause of death "to the best of their knowledge and belief". The statement adds: "It is not required that the cause must be proven."

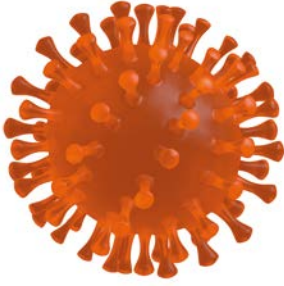
WELLBEING

Trauma helpline for NHS staff

A CONFIDENTIAL helpline has been launched to support NHS staff suffering bereavement or trauma.

Specialist counsellors and support workers will be on hand seven days a week, from 8am to 8pm, to speak to healthcare workers across the UK.

Call the helpline on 0300 303 4434. Further support and guidance are also available at [people.nhs.uk](https://www.nhs.uk/people-nhs/uk).



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REGULATORY

Concern over post-COVID complaints

A CROSS-PARTY group of MPs has joined forces to urge Government ministers to commission an independent advisory report into how patient complaints and claims against doctors will be dealt with fairly after COVID-19.

Dr Philippa Whitford, the SNP MP for Central Ayrshire, has led efforts — supported by MPs from five political parties — to support a call made by MDDUS for an independent expert committee to make recommendations on this issue.

She said now is the time for ministers to act to commission clear and independent recommendations on how to achieve a fair balance between protecting patients' rights and fully reflecting the pandemic conditions doctors were working in.

In an open letter to Matt Hancock, the Health and Social Care Secretary, and Justice Secretary Robert Buckland QC, Dr Whitford said independent guidance is needed on:

- The claims, complaints and regulatory issues likely to be raised by COVID-19.
- How these can be tackled fairly.
- What changes to normal processes may be necessary to minimise the stress and uncertainty on clinicians of investigations into decisions they made during COVID-19?

Dr Whitford, who is an MDDUS member, said: "It is important that the exceptional circumstances of dealing with the pandemic are not forgotten when using hindsight to judge medical decisions or actions."

MDDUS

Colin Slevin retires from MDDUS

MDDUS has announced the retirement of Colin Slevin after 32 years' service — most of that time in the position of Finance Director.

Colin joined MDDUS in 1988 as a young accountant, having worked for a few years with K M Stewart & Co Chartered Accountants after graduating with an MA Hons in modern and medieval history from the University of Glasgow. Five years later he took up the post of Finance Manager upon the retirement of Ian Stevenson CA.

In the year Colin joined MDDUS, the Union had around 16,000 members and an annual revenue of £7.5m. He has seen membership grow almost four-fold to over 55,000 with an annual revenue in 2018 of over £133m and net assets in excess of £554m. He has helped steer MDDUS through some turbulent periods, including the introduction of NHS indemnity for hospital doctors in the 1990s and the 2008 global financial crisis.

In his time managing MDDUS finances, Colin has worked with three CEOs/Secretaries and five Board Chairmen, latterly with CEO Chris Kenny during another challenging era for the organisation, with negotiations over state-backed indemnity for GPs in England and Wales.

In November 2019, Colin was appointed Special Executive Director to the Board, and James Parker took over as Finance Director. He will be sorely missed by all at MDDUS on his full retirement in June.

CEO Chris Kenny said: "Colin not only saw MDDUS through extensive changes but was also a key part of making those changes happen. We would quite simply not be in our current position without all his hard work, shrewd judgement and careful stewardship. He leaves with our thanks, best wishes and appreciation."

Yellow Card site for coronavirus

A DEDICATED Yellow Card reporting site has been launched for medicines and medical devices used in coronavirus treatment in England.

The new site, at coronavirus-yellowcard.mhra.gov.uk, will enable the MHRA to rapidly identify new and emerging side effects and medical device incidents in COVID-19 treatment. This includes side effects for medicines taken by patients to manage long-term or pre-existing conditions.

All suspected side effects associated with any medicine used in patients with confirmed or suspected COVID-19 should be reported to the dedicated platform.

Non-COVID-related side effects from medicines should continue to be noted on the standard Yellow Card website.

Clinicians in other parts of the UK are encouraged to report through the relevant agencies.

CALL LOG



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

Overseas prescription

Q One of our patients is currently abroad and doesn't expect to be home for two months. She has asked our GP for a short-term prescription for a stomach complaint. Are we allowed to issue this?

A It is important to understand the risks associated with responding to requests for prescriptions or medical advice from patients who are outside the UK. For patients requesting an acute prescription, you should be aware that, along with the risks associated with not being able to examine them in order to make a proper diagnosis, there are increased risks associated with treating patients in other countries. MDDUS is a UK-wide indemnity organisation and provides assistance to members for actions raised against them only within the UK and does not provide indemnity for medical treatment where the patient is located outside the UK. Members would be unlikely to be represented if action was taken against them in another country where harm had arisen as a result of their provision of medical advice. We would strongly advise members not to consult with a patient who is overseas. The patient should instead be encouraged to see a local medical practitioner.

Threatening patient

Q One of our patients had been behaving aggressively. He made abusive comments and threats to members of the practice team on several occasions and, when he repeated this behaviour despite receiving a warning letter from us, we decided to remove him from the practice list. Now he is threatening to come back and cause more trouble, which has alarmed our employees. How can we deal with this behaviour?

A If the patient has been threatening and aggressive in the surgery then your team would be within their rights to call the police. If appropriate, speak to the patient first and emphasise that he should stay away from the practice or you will be forced to involve the authorities. You have a duty of care to your staff and to other patients and such aggressive behaviour cannot continue. It may be advisable to review the practice policy on dealing with violence/health and

safety and to consult your CCG/health board's guidelines. Consider, for example, whether staff are trained in how to deal with aggressive patients. Are there staff members working alone late in the evening? Would your practice benefit from a door buzzer entry system? Do team members have access to panic alarms? There may be some simple preventive measures that can be put in place.

Text updates

Q We need to send out a message to all patients to keep them updated about changes to opening hours and the limited face-to-face services that are available during the pandemic. Are we allowed to do this or do patients need to opt in first?

A Service update messages – such as “the practice will be open for a health clinic next Monday” – would be allowed under the General Data Protection Regulation (GDPR). The intention is to inform patients about important service changes to prevent inconvenience and maintain the smooth operation of the service. Such texts are especially useful and important in the current COVID-19 pandemic. Specific patient consent is not required but the Information Commissioner's Office (ICO) advises that a descriptor of such types of communication should be included in your privacy notice. Do not be tempted to text patients without their consent to promote a service (whether for profit or

not). This constitutes direct marketing and would require explicit opt-in. Just because a patient has provided their mobile number does not mean the practice has open-ended consent to send messages.

Annual leave in lockdown

Q What are the rules on staff taking annual leave during the coronavirus outbreak?

A Rules relating to carry forward of annual leave have been extended in response to the coronavirus outbreak. The statutory four weeks provided for under the EU Working Time Directive can be carried forward and taken in the two leave years immediately following the year in respect of which it was due where it was “not reasonably practicable” to have taken it as a result of the effects of coronavirus. The latest government guidance now confirms that employees are able to take annual leave during a period of furlough. If an employee is on a period of annual leave, they should be paid their normal full-time pay for this time, with the practice able to claim back 80 per cent. You may wish employees to take any pre-booked annual leave to prevent large amounts of annual leave being taken in the latter part of the holiday year. Employers are also able to require employees to take a period of holiday by giving them double the difference in notice: so 10 days' notice is



required for a five-day holiday period. ACAS has issued some helpful guidance around annual leave which is available on their website: www.acas.org.

Online access to records

Q Our practice has an online service for patients to book appointments, order repeat prescriptions and access medical records. To apply, patients must fill out an application and present it at the surgery along with photographic ID. A mother recently filled in an application for her son, who is 14 years old, presenting his UK passport and a signed form. The email address supplied is the same as that of his mother. Is it appropriate to allow her access to her son's personal medical records, potentially without his consent?

A Given that the son is over the age of 14, he is likely to have capacity to decide who can access his medical records. The practice should assess the son to ensure he fully understands his right to set up his own login and password to the online system. If he is considered to have capacity, he should be asked to confirm whether he is happy for his mother to have access to his records. If he is considered not to have capacity, the practice may allow access to a parent with parental rights and responsibilities. The practice should carefully consider how best to communicate with the patient and his mother. Any communication or discussion should set out the importance of consent and confidentiality and the need to ensure that all patients, taking into consideration their age, are aware of their rights.

Crossing boundaries

Q I have been treating a patient who I feel has started making flirtatious comments. In our last consultation she suggested "meeting for coffee" and asked to connect on Facebook. I've tried to gently emphasise that our relationship is a professional one but the comments have continued. What should I do?

A This is a sensitive situation and your first port of call should be the General Medical Council's guidance *Maintaining a professional boundary between you and your patient*. It is clear that you must not use your professional position to pursue a sexual

or improper relationship with a patient or someone close to them. It may be worth having another discussion with the patient and politely, but firmly, explaining that your relationship must remain strictly professional. It would not be appropriate for you to meet for a coffee and it would not be advisable to connect via your personal social media accounts. If you feel unable to re-establish a professional boundary, then you may need to refer the patient to another GP. In extreme circumstances, you may need to follow the GMC's guidance in *Ending your professional relationship with a patient*.

Police enquiry

Q Our practice received a police request regarding a patient, Mr A, who was recently assaulted. The officer has asked for a statement outlining the injuries Mr A sustained and the subsequent treatment that was required. Am I allowed to disclose the information?

A The key issue here is consent. In order to disclose any information to police, you would need confirmation of appropriate consent from Mr A. Ask the detective if he has a signed medical consent form from Mr A. Alternatively, you could contact the patient and confirm whether he consents to disclosure of this medical information to the police. If you have consent, be sure to only speak to clinical records which you have access to. Avoid any discussion regarding, for example, the cause of the injuries or Mr A's state of mind, other than that noted in the records (for example, what the patient told the practice). It may also be advisable to avoid being drawn into discussions regarding the prognoses of any diagnoses, unless this is within your competence and is appropriate in your role as a treating clinician (rather than an independent expert).

Unsolicited image

Q Our practice is currently closed to most face-to-face consultations due to coronavirus. While checking the practice inbox, I noticed an email from an elderly patient who attached an image of a rash on



his leg that is causing him discomfort. The GP did not request this image (which is of poor quality) and now I am unsure what to do with it and how to abide by data protection laws.

A MDDUS has seen a sharp rise in queries of this nature. While digital photos can be helpful, particularly when patients cannot easily attend the surgery in person, they must be of sufficient quality and ideally provided following

discussion with a clinician. It would be best to contact the patient to arrange for a GP telephone consultation in the first instance to discuss his concerns. If the quality is such that it has no clinical use or relevance, you should also delete the photo (and inform the patient of this step). Had the image been of sufficient quality to be clinically relevant, it could have been saved to the patient's medical record (and then deleted from the relevant device), being sure to comply with General Medical Council guidance *Making and using visual and audio recordings of patients*. If, after telephone consultation, it is considered that a better quality photo would be of clinical use, this can be discussed with the patient and submitted via appropriate portals (in line with current practice, given the limited access to face-to-face consultations). If direct clinical examination is felt to be necessary, then the patient should be asked to attend the practice. It may also be worthwhile reviewing the practice's notices and policies regarding use of the practice email address.



GETTING BACK TO PRACTICE

Liz Symon

Employment law adviser at MDDUS

WHILST many employees have been furloughed or have been working from home during the COVID-19 pandemic, medical practices have been continuing to operate – albeit in different ways from normal.

As lockdown measures gradually become less stringent, now is the time for practices to start planning ahead for how to ease staff back into working life.

SAFE TO RETURN?

Some staff will still be unable to return to work if they have symptoms (seven days) or if anyone in their household has symptoms (14 days). These employees should receive statutory sick pay (SSP) from day one as a minimum but paying contractual sick pay should be considered.

Those who received shielding letters should follow the government guidance that applies in their area. The latest NHS guidance is that these employees should continue to receive full pay, even if they are unable to work from home.

Pregnant employees do not automatically need to stay away from the workplace but if there are health and safety concerns then other options, such as working from home, should be considered. If adequate changes can't be made to protect the employee, then they should remain at home on full pay.

CHILDCARE

As medical practice staff are deemed key workers, they should already have access to childcare places. This should be further alleviated as schools start to reopen. For those employees who say childcare is still a problem, speak to them to find out their concerns and to ascertain what measures can be put in place to allow them to return. This could include working from home or flexible working. If the employee still refuses to return to work, then they could consider taking annual leave or parental leave. Otherwise the leave will be unpaid.

ANXIETY

You may have some employees who do not fall into any of the above categories but are resistant and anxious about returning to work. Remain open minded and reasonable. Set up a meeting with the employee to discuss their concerns

and offer reassurances as to the safety measures the practice has put in place. Consider any further suggestions the employee may have. Other options may be again working from home, reduced hours or amended duties.

If the employee still refuses to come in, with no valid reason, this may lead to disciplinary action for unauthorised absence or possibly a capability dismissal but advice should be sought before taking any action. Employees with genuine health and safety concerns will have employment protection and they must not be subject to any action or detrimental treatment.

HOLIDAYS

During this time, normal employment rights apply and staff continue to accrue holidays. Most practices have been advised that many of the bank holidays are being cancelled and staff may be required to work. Any employee working on a bank holiday should be paid in accordance with their contractual right (so normal time or double time) and they will be required to receive a day back in lieu for working.

Many employees may be reluctant to use annual leave, but practices don't want a bottleneck of requests later in the year. Encourage staff to take holidays that are already booked. Or consider asking them to take, for example, a week's holiday by the end of July. Those who refuse can be required to give double the normal notice period, so 10 days' notice for five days' holiday.

But bear in mind that the purpose of a holiday is for the employee to enjoy rest and relaxation, which may not be so easy in the current situation. It would be

unreasonable to ask staff to take the bulk of their holiday entitlement during the lockdown period. The Government has also advised that staff will be able to carry over four weeks' annual leave over a two-year period if it is not practical for them to take the leave during the holiday year.

OFFICIAL GUIDANCE

The Government has provided guidance on the steps that workplaces should take for employees returning to work, which many medical practices may already be doing. These include:

- 1:** Working from home where possible. Staff who are unable to do this can travel to work
- 2:** Carry out a COVID-19 risk assessment to establish what safety measures need to be put in place
- 3:** Maintain two metre social distancing where possible – this may include re-designing workspaces, staggering start times, creating one way walk-throughs, opening more entrances and exits, or changing seating layouts in break rooms.
- 4:** Where employees are unable to be two metres apart, practices should look at erecting plexiglas barriers in shared spaces, creating shift patterns, fixing teams to minimise the number of people in contact with one another or ensuring colleagues are facing away from each other
- 5:** More frequent cleaning, paying attention to areas such as door handles and keyboards. Handwashing facilities or hand sanitisers should be available at entry and exit points.

Stay safe, and remember the MDDUS employment law team are here to help with any queries on advice@mddus.com



KEEPING YOUR SPIRITS UP

Dr Roopinder Brar
Medical adviser at MDDUS



DOCTORS are no strangers to hard work, stress and working in challenging environments. That being said, the impact of the coronavirus pandemic was something that none of us could have predicted or planned for.

COVID-19 has changed life for many of us. Some of us may have been deployed to another specialty or department, some may be consulting patients remotely, some may be treating critically unwell patients with coronavirus, some struggling with the lack of personal protective equipment (PPE) and some trying to deal with their colleagues falling prey to this virus.

In times like these, looking after your mental and physical health is paramount. Even if you can't get to the gym, go out with friends or fully relax, there are practical things you can do to look after yourself:

- 1: Talk to your family and friends.** It's important to stay connected with the people you care about.
- 2: Seek support from colleagues.** They may feel the same as you and speaking about your feelings and worries can be therapeutic for you all. Keep an eye out for each other. Ask how your colleagues are and, if someone is struggling, reach out and offer support.
- 3: Take regular breaks.** We are being overwhelmed by information and patients

“Be assured that you are not alone and there is always support available”

may have several concerns or questions about COVID-19 and the impact this is having on them. To avoid feeling stressed or burnt out, make sure you have regular breaks away from patients, your phone, your computer and all things COVID-19 related.

4: Don't keep things bottled up. If you are finding things tough, know that help is available. There is a confidential and free helpline run by Hospice UK for NHS workers suffering from trauma or bereavement on 0300 303 4434. Speaking to someone early on, can really help.

5: Exercise. There are plenty of ways you can get your daily exercise, even if you can't leave the house. Whether it's online yoga, a workout DVD or vigorous housework, even a small amount of exercise can really improve your mental health and wellbeing.

6: Sleep. It may be difficult, but try to schedule some wind-down time away from screens and work to give yourself the best

chance of a good night's sleep.

7: Eat and drink. Do your best to stay well-hydrated and eat regular healthy meals. Missing meals may affect your mood and increase stress levels.

8: Ditch the vices. Avoid using tobacco, alcohol and other drugs as a way of coping. If you are becoming reliant on any of these, it may be time to seek help.

9: Look after your physical health. Doctors need to be well and healthy in order to look after their patients. Take your medication, attend your routine appointments or telephone consultations and if you're struggling, know you can always seek advice from your own GP.

10: Be kind to yourself. It's OK not to have read all your emails, not to have done all the allocated schoolwork, not to be on top of the housework and to take some well-deserved time out to sit, relax, have a cuppa and reflect. Normal life will resume at some point, until then it's OK to focus on what you need to get you through each day.

I can assure you that I am taking my own advice. During these times, I have been much better at taking time out for myself. Giving myself time for me has helped me stay positive, focused and able to prioritise my daily tasks. I am baking more, watching TV (this is rare for me!) and call one person I know every day, just to say hello. The support I have received from my colleagues, family, friends and patients has been overwhelming. There have been good days and some not so good days, but I have always felt able to express my feelings and reach out for support.

The nation as a whole fully appreciates the work that doctors and other key workers are doing to keep the country going. Despite this support, it is normal to feel the pressures of working and living during this crisis. The impact of COVID-19 may last for some time after the pandemic ends, but be assured that you are not alone and there is always support available.

Seeking support is the only way we can ensure that our own health is not compromised by the work we do. We can only really care for our patients when we know how to care for ourselves.

For more advice on health and wellbeing — including short video interviews with our advisory team — visit the advice and support section of mddus.com at tinyurl.com/rgd2sxo

A WORLD awakens to a global pandemic, as cases of a new and poorly understood virus grow almost exponentially. There is confusion, mixed public health messages and a lack of international co-ordination and collaboration. Conspiracy theories about its origins start to circulate, and the headlines report that even the rich and famous are affected. Newspapers are full of complaints about the Government's slowness to take the disease and its impact seriously. Medical students are mobilised to assist in frontline hospital care. Social distancing measures are put in place and face masks become a normal sight on the streets. And the British prime minister contracts the virus.

However, this is not Boris Johnson, but David Lloyd-George and not 2020, but 1918. Evidence, if any were needed, that history does repeat itself and can offer lessons for those who choose to learn them.

UNKNOWN ENEMY

Today, in the midst of a new pandemic, we are inundated with graphs showing infection rates and death rates. On the nightly news there are coloured lines that soar and flatten, that compare and contrast, that dispute and justify. But, almost the same graphs, albeit hand-drawn, were produced in 1918-19. They tell the story of that other pandemic. They chart the weaknesses in their defences and record the successes and failures of different ploys used to "flatten the curve" a century ago.

The figures are stark. In 1918, as a world at war was at last seeing the possibility of an end to hostilities, a new enemy emerged — influenza. We still do not know where the new virus came from despite its common name of Spanish Flu, nor, despite decades of research, do we fully understand what made it so deadly. Over a two-year period, one third of the 1.5 billion global population were infected and somewhere between 50–100 million died—several times the number killed in the Great War. The death toll in the UK alone was almost a quarter of a million. One of the most striking things about that pandemic was the impact it had on apparently healthy young adults aged 20–30. Young men and women were often reported to be healthy at breakfast and dead by the evening.

HOLDING FIRM

Of course, the world in 1918 was very different to that of today. Despite a wealth of everyday experience, there was a much poorer understanding of infectious diseases. There were no antivirals, and even basic penicillin was still a decade away.



Photographs: Mary Evans Picture Library

LESSONS FROM

Dr Allan Gaw looks back to the 1918 Spanish flu outbreak and finds some cogent similarities to the current crisis

Intensive care in hospitals was unknown and the mainstay of management was general supportive therapy. Today, we have much more in our acute medicine arsenal, but from a public health perspective the responses to the 1918–19 pandemic are not so different from current measures.

Schools, shops and theatres were closed. Social gatherings were limited, quarantines were put in place and face masks became a common sight. However, the unevenness of how these containment policies were applied and how erratically they were followed provides a useful lesson. For example, in the United States, different cities adopted very different approaches to the pandemic, and, even those that put in place strenuous measures to limit the spread of the disease, did so on different timescales.

Those cities, such as Seattle, that reacted quickly and held firm to their policies, were the ones to fare best, with the lowest numbers of influenza deaths. Those that responded well initially but relaxed their lockdowns as soon as cases dropped, such as Denver, would see subsequent new waves of infection. And those, such as Philadelphia, that delayed in putting any meaningful measures in place, and thus allowed the infection to take hold, saw the worst death rates of all.

HOSTILE REACTIONS

The politicians then also faced the same dilemmas that our policy makers do today. They had to balance public health concerns with the economic impact of a shutdown, and they had to deal with incomplete and often conflicting scientific



Overcrowded wards during the 1918 influenza pandemic. Right: public information poster of the time



FROM A PANDEMIC

advice along with growing public outcry over the consequences of their policies. A century ago, just as today, there were very vocal groups hostile to the strategies. Many flouted the preventive measures, with some calling them unnecessary and draconian and others expressing their outrage at the infringement of their personal liberties. Different administrations around the world followed different public health strategies with little, if any, co-ordinated effort and the global infection and death rates were equally variable.

Today, in a society with 24/7 news, we are acutely aware of how the complex story of a pandemic unfolds. New data informs as well as distorts the picture. Policies based on the latest information quickly become obsolete, and all the time we are expecting the best decisions to be made about our lives and our livelihoods.

UNTESTED TREATMENTS

In 1918-19, those having to deal with a disease they barely understood were eager to try any treatment that might work,

irrespective of evidence. Interestingly, one of the main contenders was the anti-malarial drug quinine. In 2020, in another startling parallel, one of the main treatments that has been advocated, with equally little evidence, is the anti-malarial drug, hydroxychloroquine. The notion of evidence-based practice was not strong in 1918 and perhaps the dash to use untested treatments might be understandable. However, in 2020 it is nothing short of unforgivable. In a matter of weeks, the collective global research project has turned all its energies and resources towards discovering effective and safe treatments and tests as well as a vaccine for COVID-19. But already concerns are being raised about the speed, quality and ethics of some studies. We must ensure that the immediacy of the challenge is not used to justify poor research practices.

There are clearly lessons to be learned from history, but as the philosopher George Santayana famously said: "Those who cannot remember the past, are condemned to repeat it." Our collective memories may be dimmed by the passing

years, but every line on those old graphs, despite their fading figures, represent men and women who lived and died during a pandemic a century ago. And their ghosts speak loudly and eloquently. Let us not give credence to the words of that other philosopher, Georg Wilhelm Friedrich Hegel who noted pessimistically that: "The only thing we learn from history is that we learn nothing from history."

Given the gravity of the situation we find ourselves in, perhaps it might do us well to try. History is an open book; the lessons are there if we choose to heed them.

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GETTING AHEAD OF ADDICTION

How can practices more effectively manage opioid prescribing amongst patients? Graeme Dixon from change management firm Agencia shares insights from an innovative new approach

AS WE begin to consider a new post-COVID world, there is a risk that misuse of prescribed opioid and analgesic painkillers, and indeed other potentially addictive prescribed medication, will have increased during lockdown.

We know these drugs are often misused to cope with stress, and we have just been through a period where 'business as usual', particularly in terms of appointments and regular reviews, has been severely disrupted. We also know that prescribing levels for these drugs tend to be higher in areas of greater deprivation and among communities likely to be most impacted economically by the coming recession. We could be facing a perfect storm of risk.

As director of innovation and service delivery at Agencia, I've worked closely with GP practices on a number of projects related to managing alcohol and drug misuse. We work in partnership with government to deliver new policies and to help providers and commissioners improve frontline services.

This is an opportune moment to share my experience in North Lincolnshire, designing and running ReWire, which worked with patients at high risk of opioid dependence.

BACKGROUND

Research identified opioid analgesic dependence (OAD) as a significant health risk to the population. Agencia worked with North Lincolnshire Council and a number of GP practices to identify the scale of the problem and develop workable and scalable solutions. From this pilot, the ReWire service evolved. It sought to address the issue through analysis of prescribing data, patient identification via the opioid risk assessment tool (ORAT), and provision of a service which combines a non-medical prescribing pharmacist and an experienced psychosocial worker to support individuals who wish to address their OAD.

THE REWIRE APPROACH

We ran ORAT (a validated diagnostic support tool) across a selection of practices which reflected the demographics of North Lincolnshire, and we filtered the results to include only under 55s and those identified as potentially most at risk. Of those engaged

in treatment, 44 per cent were female. The results were assessed consistently by an experienced pharmacist with clinical support from GPs. Patients identified as being potentially at risk were then invited by GPs to attend for a medication review, with immediate support available from an experienced psychosocial worker who could offer a six-session programme which covered interventions from brief advice through to full opioid substitution therapy (OST).

We focused on practical solutions, supported by lots of informal awareness-raising — leaflet drops and training the admin and reception teams on how to work with a group of patients who were nervous about being called in for a review and managing those anxieties sympathetically. The aim was to inform first, and then engage. Our engagement, treatment and session models recognised this patient group would not feel comfortable in a 'drug service'.

The results were surprising. A group of patients who were seen as potentially very resistant to change proved to be very open to new approaches to pain management and often expressed private concern about the amount of medication they were taking and its impact on their quality of life. Many changed their prescribing regimens, with 20 per cent of patients stopping repeat prescribing on receipt of a first letter. Even those who required OST usually swiftly became drug-free.

One case study provides an insight into the journey from over the counter (OTC) medication through prescribed medication, into full blown dependence:

Mr N, 43, is identified through ORAT. He works full-time and started using OTC painkillers for toothache before being prescribed codeine for a range of conditions. When invited to attend the review, he discloses that, in addition to his prescribed medication, he is using around 64 Nurofen Plus tablets per day (at a cost of £15). He engages in OST and psychosocial support and is now drug-free. Mr N had attended five outpatient appointments at gastroenterology clinics for stomach problems without disclosing his level of medication use. Post-treatment, those problems ceased.

LEARNING AND BEST PRACTICE

The reaction from patients to ReWire is generally very positive. There is real scope to make simple





changes which benefit patients and the GP practices. We focused on patients who had a number of risk indicators, including a previous history of addiction, increasing frequency of prescribing, and length of time on a medication. Earlier research carried out in South Gloucestershire indicated that there were 40 to 80 patients per thousand at risk of dependence and a recent Public Health England report indicated that up to one in four patients was prescribed potentially addictive medication. For patient engagement, a sympathetic and reassuring approach from all members of the team is an absolute pre-requisite.

It is worth pointing out that we did see a history of significant drug-seeking behaviours in some patients, including changing practices and doctors when their prescriptions were challenged. Some actively sought locum appointments with the aim of avoiding awkward questions about their medication usage, and there were a number of patients who regularly 'lost' prescriptions. Having a process in place to identify and challenge these behaviours is essential, and failure to manage this effectively can have serious implications for the professionals involved.

An example is the case of Emma May, which was widely reported. Emma was a young mother of six, who died in June 2016 from Tramadol toxicity. An inquest was held, focusing on how Emma was able to receive so many prescriptions in the months leading to her death. The coroner was not only concerned regarding the continued prescribing, but also the practice's processes and guidance as to prescribing opioids to individuals suspected of misuse and the prescription of drugs to third parties, which she used

herself. The coroner issued a prevention of future death report to the practice and NHS England.

CONCLUSION

The situation around misuse of prescribed medication remains complex. There is evidence that prescribing practice is improving and more auditing of patients is taking place. However, the trend remains stubbornly high and, post-COVID 19, we see a real threat of a surge in misuse. In addition, Gabapentin and Pregabalin are emerging problems, with reports of misuse appearing in around 2010 from population-based studies, issues in secure settings and patients presenting to addiction services.

The aim of ReWire is to use data to intelligently target those most at risk, and to prevent individuals experiencing the worst of addiction. We've found it is possible to significantly reduce prescribing costs and improve patient outcomes. Beyond that, we've found it is possible to identify and intervene with individuals who may have continued on the slow path to addiction and also those who knew they had a problem but didn't know what to do. The level of appreciation from patients and their loved ones for having reached out to them was genuinely moving.

Graeme Dixon is director of service and innovation at Agencia, where he has run a number of services identifying and managing opioid addiction in partnership with GP practices

• Find out more about Agencia and ReWire at www.agencialtd.com. Follow them on Twitter @agencia_ltd, and @ReWirePKService

FAILURE TO REFER

DAY ONE

A 78-year-old retired teacher – Mr L – attends his GP surgery complaining of abdominal pain. He is seen by Dr W, who records a history of *generalised abdo pain, 3 weeks; appetite unchanged; normal daily bowel*. On examination she finds a soft abdomen with some tenderness but no guarding and no obvious masses or organomegaly. Bowel sounds are normal. A preliminary diagnosis of diverticular disease is recorded and a treatment plan is discussed with Mr L, involving blood tests and a referral for sigmoidoscopy and a barium enema. The blood tests are carried out (later results found to be “normal”) but Dr W is distracted by another difficult case and neglects to action the referral.



SIX MONTHS LATER

Mr L returns to the practice for a routine hypertension check with the practice nurse. He has attended the practice twice in the interim period for a chronic skin condition but without mention of any abdominal discomfort. The nurse records: *some tummy pain but pt says he has a gallstone and has put off operation. Advised to see dr with any ongoing weight loss or pains*. His blood pressure is within normal limits and Mr L is asked to book another check-up in six months.



TWO WEEKS LATER

An emergency appointment is made at the surgery by Mr L's wife. He is seen by a GPST who records: *Low colicky abdo pain intermittent over 4 wks; now more severe*. Mr L says he has been vomiting after eating although he is tolerating liquids well. He reports occasional problems with constipation and his last motion was a couple of days ago. The GPST examines Mr L and reports a soft but distended abdomen with mild tenderness over lower left quadrant. Anal tone is normal on rectal examination with a hard stool in the upper rectum. His diagnosis is constipation and a prescription for macrogol is issued. Mr L is told to return if there is no improvement or his symptoms worsen.



TWO DAYS LATER

Mr L attends A&E complaining of severe abdominal pain and vomiting. He is referred to the surgical department. A CT scan reveals a large bowel obstruction, and an emergency resection of the sigmoid colon is undertaken with a colostomy in the left lower quadrant. Mr L is assessed to have a Dukes C1 tumour with extra-mural invasion involving local lymph nodes. Further investigation reveals spread to the liver. Mr L develops a wound infection and sepsis, and three days later suffers a fatal cardiac arrest.

A LETTER of claim by solicitors representing the family is sent to Dr W alleging clinical negligence in her treatment of Mr L – in particular her failure to arrange a referral for investigation of his abdominal symptoms as noted in the treatment plan.

A review by a GP expert is commissioned by MDDUS. His view is that there was a breach of duty of care on the part of Dr W in not making the relevant referral as set out in the treatment plan. This is irrespective of the fact that Mr L presented with only generalised abdominal pain and no red flag symptoms, and in such circumstances a referral for further investigations would not have been required in terms of the NICE guideline for colon cancer at the date of the appointment.

A separate report on causation (consequences of any breach of duty) is commissioned from a consultant medical oncologist. She opines that, had Mr L been referred for a barium enema or sigmoidoscopy, the tumour would have been diagnosed and surgically removed within

two to three months. On the balance of probabilities this would have revealed a likely T3, N0, M0 or a T3, N1, M0 tumour. Mr L would not at this stage have presented with large bowel obstruction needing emergency surgery, and would have likely avoided the sepsis and subsequent cardiac arrest.

The expert also states that, with earlier detection, Mr L would, on the balance of probabilities, have avoided metastatic spread and enjoyed a significantly extended life expectancy. Even with metastatic spread, he would likely have survived for approximately 18 to 24 months with good quality of life.

In light of the risks associated with proceeding to litigation, MDDUS negotiates an out of court settlement in agreement with the member.

KEY POINTS

- Ensure follow-through on agreed treatment plans – or discuss proposed changes with patients in line with shared decision-making.
- Ensure practice procedures/systems are fail-safe in actioning referrals.

CONNECTED CHOICES

Deborah Bowman

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



I AM fortunate that when I sit down to write this column, I often have several ideas from which to choose. This time, I feel somewhat overwhelmed by those choices. In a time of COVID-19, there is no shortage of ethical questions.

I had my first inkling of what might be to come in February when I was invited to a meeting to consider the ethical implications of pandemic. It was a fascinating multidisciplinary conversation with a diversity of perspectives, expertise and experiences. It was also a strange meeting with an otherworldly atmosphere. As we talked, London continued its routines seemingly unchanged by the possibility of a pandemic.

When, four weeks later, the country found itself moving into that other world of lockdown and loss, ethics took its place front and centre in a way I have not seen before. Journalists approached me frequently for comment. I have written before about how I decide whether to talk to the media and will not revisit those thoughts here. Suffice to say, I was not convinced my contribution would add much to public discourse in this time of crisis.

More significantly, large numbers of NHS organisations and clinical friends and colleagues contacted me to ask for support, or simply to talk through the ethical dimensions of their changed and changing work. These calls, in the early stages, were heightened conversations. People

were anxious and felt the burden of the knowledge they were beginning to have about what this virus could do. They were distressed by the dissonance between what was being said about the safety of their working conditions and their experiences in clinical settings. They sensed that there was an inherently moral character to many of the choices and decisions that they were making. They were individuals caught within a complex system imbued with expectation and uncertainty. It was clinical ethics on steroids: familiar tensions reframed in a context of urgency, pressure and uncertainty that was unknown and perhaps unknowable.

Following these calls, came the emails. There was a recommendation that all NHS Trusts should have ethics committees to consult as they made decisions relating to COVID-19. I was, like many colleagues with ethics in their title, approached several times a day by whomever in the organisation had been charged with setting up 'the ethics committee'. I worried about these people who had no time and seemingly little support to create a functional group from out of nowhere with a brief that would be demanding both intellectually and emotionally. The way ethics was defined in these emails sometimes discomfited me too: as an organisational salve for moral distress that was complex, deep and likely to endure long after any nascent ethics group had disbanded.

I agreed to chair a couple of ethics groups and to act as support for two clinical teams in different settings. That work has always been challenging and sometimes distressing. However, it has also been a source of hope because of the fundamental connectedness it has revealed. That connectedness resides in the willingness of clinicians, managerial staff and lay members to come together, to listen and to strive to understand each other's perspectives and experiences. If that sounds 'cosy', I have done these groups a disservice. These are searching conversations. Assumptions are noted and intuitions interrogated. Difference is the currency of the discussion with conflicting and contrasting ethical preferences. Yet, each person also shares an ethical disposition which prioritises respect for others, curiosity, commitment to the task and openness to divergent views.

The questions, dilemmas and problems that each group or team brings and considers vary enormously. The much-anticipated ethical questions about resource allocation and impossible choices about who has access to care in an overstretched system have not, in my work, been raised. Rather the questions have included considering the ethical implications of excluding visitors, the imperatives of providing good end-of-life care, indeed of articulating what care means and how to support clinicians experiencing moral distress.

The approach, composition and format of the different committees and groups are distinct. Each one has its own preferences, rhythm and style. However, there is a connection and a commonality in the values that underpin the work, irrespective of the organisation it serves and the type of healthcare setting in which it is located. That connection and commonality reflects and engenders hope. It demonstrates that we will find ways to connect with others, especially through difficult times. It reminds me that whatever the specific question, case or dilemma, the commonality of purpose remains - namely to care and to care well for others. It is grounded in hope that this time will pass, and we will have learned together. It is an acknowledgement that our relationships are as powerful and important as the search for a vaccine.

Addenda

OBJECT OBSCURA

Pricking instrument

CHRONIC, painful afflictions such as rheumatism, sciatica and neuralgia were treated using a percusso-punctator. It consisted of an ebony sheath containing a spring mechanism with needles in the base that were pushed into the skin. It caused irritation to the skin in the belief it would ease a deeper complaint. The treatment gained credence with the medical profession during the late 1800s when the instrument evolved to use a small electric current that stimulated the skin.

PHOTOGRAPH: SCIENCE MUSEUM



BOOK CHOICE

The Remarkable Life of the Skin: An intimate journey across our surface

Transworld, hardback, £25.00 2019
Review by Dr Greg Dollman, *Insight* editor

I FELT a sense of irony while reading *The Remarkable Life of the Skin* during the COVID-19 lockdown. Dr Lyman provides a fascinating account of our body lining, describing his book as “an intimate journey across our surface”. He writes about how we exchange microbes when shaking hands and playing contact sports or even sharing a crowded train carriage; the significance of human touch (which “is necessary for good physical and emotional health”); and the importance of those around us as we try to comprehend “our journey from sensing to feeling” (consider, for example, our inability to self-tickle).

Lyman’s book describes the clear link between our physical being and our mental wellbeing, which is an important message in this unusual time.

His writing made me wonder how our skin surfaces may have changed in the months of social distancing and self-isolation.

A good starting point when pondering any question about this often overlooked organ is to refresh our knowledge of the anatomy and physiology of the skin, in a chapter entitled ‘The Swiss Army Organ’. Lyman reminds us about the slickness,

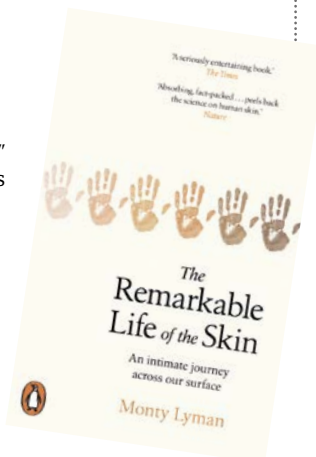
compactness and utility of our covering.

And the inevitable question arises: where does the skin end and the body begin? Well, that seems to be up for debate.

The wonder and beauty of the skin is deeper than the epidermis and dermis we learnt about in histology lectures. Lyman details, for example, kangaroo care. Skin-to-skin touching (like hugging) stimulates our nervous system and produces ‘feel-good’ hormones that reduce stress, improve wellbeing and boost our immune system.

Lyman explores the connection between our outside layer and the outside world, explaining how sunshine and light can be both good and bad for us, and how our “skin safari” commensals keep us well and can make us sick.

Our skin makes us who we are, and influences how the world interacts with us.



FILM CHOICE

Crip Camp: A Disability Revolution

Directed by Nicole Newnham and James Lebrecht, Netflix, 2020.
Executive producers, Barack Obama and Michelle Obama.

IT’S 1971 and in upstate New York, a disability revolution is beginning. At Camp Jened, teens with disabilities enjoy a safe space offering fun, freedom and acceptance. Through vintage footage and interviews with surviving participants, we watch the young people play and smoke and speak freely on key issues away from the constraints of over-protective parents. Nothing is the same after that summer, as Lebrecht and his fellow campers turn campaigners and lead a civil rights movement that achieved major systemic change. It culminates with their participation in 1977’s 504 Sit-in protest, which led to major amendments to the 1973 Rehabilitation Act. It’s a story that is surprisingly unfamiliar but, with superstar backing from the Obamas, this inspiring documentary beautifully tells a tale that everyone should hear.

VIGNETTE

John W Thompson (1906-1965)

Psychiatrist who defined medical war crimes

DESCRIBED as quiet and reserved with a powerful handshake, John W. Thompson's voice was deep but his accent difficult to place. Indeed, if asked where he was from, he might have struggled to reply. Born in Mexico, his father was American and his mother was Mexican/Scottish. He was raised in California by Scottish relatives and, after attending an American college, went to medical school in Edinburgh. He worked as a psychiatrist in Scotland and the US, and when war broke out he moved to Canada, where he was commissioned in the Royal Canadian Air Force.

Early in 1944, he became medical liaison officer of the Joint Services Medical Intelligence Organisation. The following April he joined the forces liberating the concentration camp at Bergen-Belsen, Germany. What he witnessed there would change him forever. Of the 53,000 inmates, 13,000 would die of starvation and diseases such as typhus in the weeks after liberation.

He spent months working with the survivors in unimaginable conditions, and managed through forged documents to have older women inmates transferred to care in France. In September 1945, Thompson was assigned to investigate German wartime aviation research with a British army intelligence group. For three months, he and his team interviewed researchers and examined thousands of documents. What quickly became apparent was the underlying abuse and inhumanity of the research that had involved human participants. Thompson categorised these as "medical war crimes". By December 1945 Thompson presented his startling conclusion to the British War Crimes Executive at Nuremberg that most German doctors at the highest

levels were involved in unethical research.

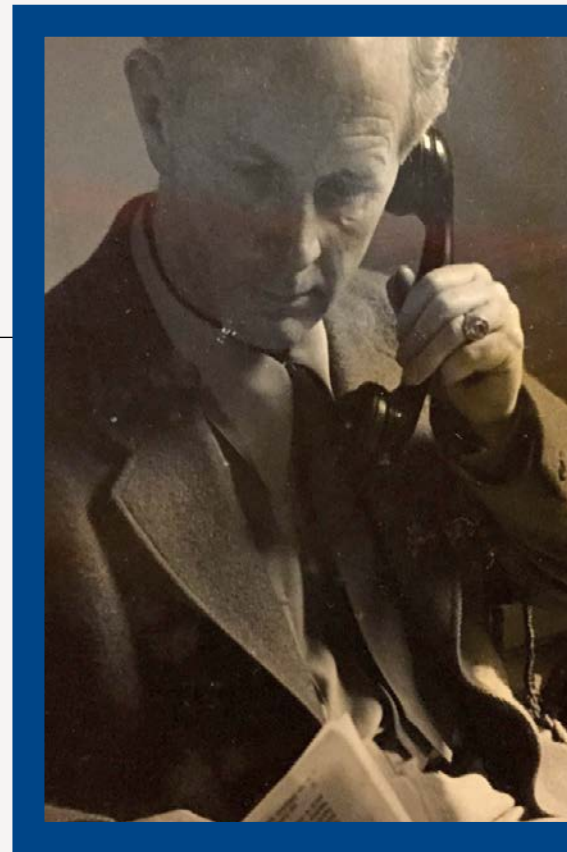
He worked tirelessly to bring those responsible to account. To this end he liaised closely with Colonel David Marcus, the American chief of the War Crimes Branch in the US military whom he convinced to go forward with what would become known as the Doctors' Trial in Nuremberg.

In 1946, before the trial, Thompson convened a conference in Paris on "medical war crimes, the importance of informed consent, and ways to protect human research subjects." At that conference it is thought the groundwork was laid for what would later become the Nuremberg Code. During the trial itself, Thompson attended as an observer and consulted throughout with the two expert medical witnesses

His religion brought him solace but never contentment

Andrew Ivy and Leo Alexander. Ivy and Alexander are generally credited with the creation of the Code, but Thompson likely also played a pivotal role.

As a devout Roman Catholic convert, Thompson lived a life of devotion and observance. He spent time in the 1950s living in a religious community near Paris called Eau Vive that he helped to develop. He also returned to work as a psychiatrist in New York in 1959. There he devoted much of his time working with patients who were deemed incommunicative, spending hours sitting with them on the floor in non-verbal communication. Thompson viewed the whole of New York City as a "vast asylum" where, "The Bowery is the open ward and



Bellevue the closed."

He also served with UNESCO in Germany and as a result of his various roles his address book read like an international Who's Who with names such as German chancellor Willy Brandt, the poets TS Eliot and WH Auden, the educationalist Maria Montessori and even a Pope, John XXIII. He was well connected and continued to use his influence to effect change.

His religion brought him solace but never contentment. As he grew older he said he looked forward to death as, "immersion in the sea, absorbed by the infinity of being." In 1965, while snorkelling in the Caribbean, he swam away from his friend and was later found dead in the water. Whether it was an accident, suicide or something in between we will never know. What we do know is that Thompson was a man of conviction and compassion, a gifted physician thrust into the depths of atrocity. And we also know that his contributions have all but been forgotten, yet his biographer writes that "he must be counted among the saints of his century and of medicine, a person who could confront horrors that others ignored and devote his life to rectifying them."

Allan Gaw is a writer and educator from Scotland

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