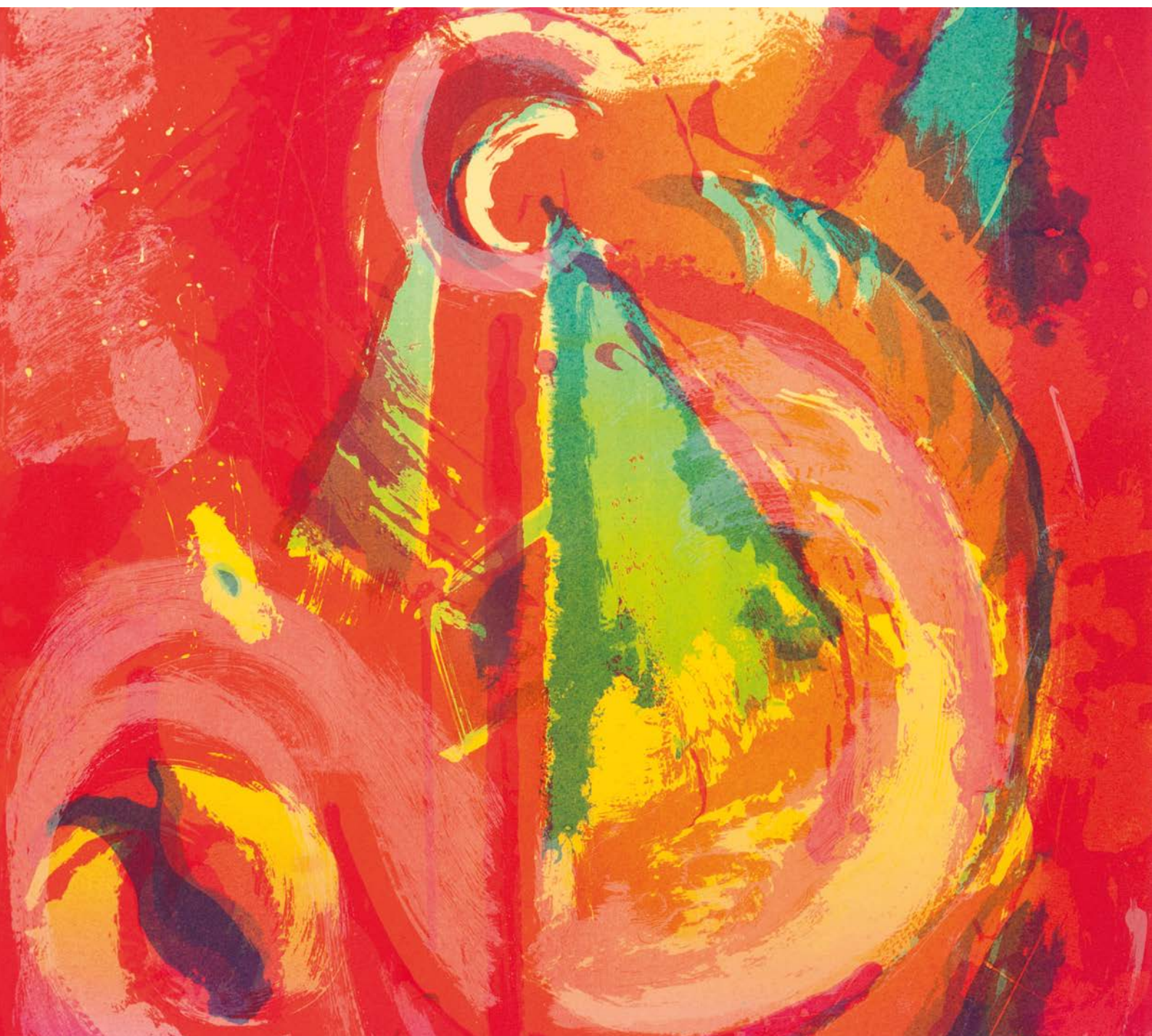


QUARTER ONE / 2017

INSIGHT



A QUARTERLY PUBLICATION FOR MEMBERS



DR FIONA GODLEE

Profile of the *BMJ* editor and campaigning medical journalist

DEMENTIA DENTISTRY

A new toolkit offers guidance on providing dental care to dementia patients

ON MAKING AN APP

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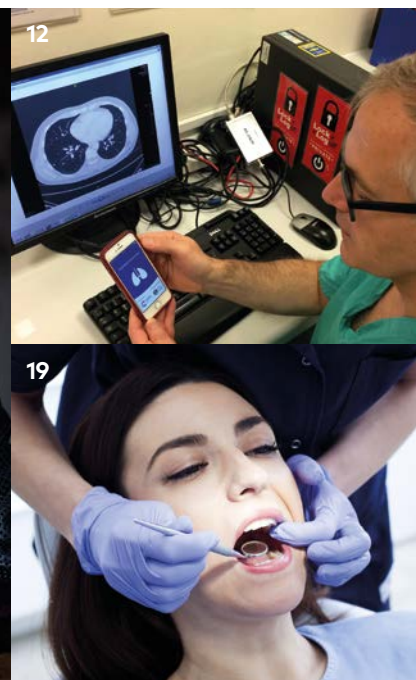
Nor any drop to drink, Gail Lemasurier

Screenprint, 1993

Gail studied fine art printmaking at Manchester Metropolitan University and graduated in 1990. She moved to Edinburgh and joined Edinburgh Printmakers, working on community arts projects. She is now an art psychotherapist and works full time in the NHS.

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

Photograph: Magda Rakita



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FROM THE EDITOR

YOU may be wondering what happened to *Summons*. Well after some long thought and discussion – informed by a recent readership survey – we have decided that now is the time to relaunch the magazine under a new name – *Insight*.

Summons has been the title of the MDDUS membership journal since 1989 when it was little more than a newsletter. It has undergone various revamps over the years under the same name – and for longstanding members has been a familiar and regular item in the letterbox. But the name has always been a source of debate, with some members finding it “quirky” and memorable, and others less than amused

receiving a regular “*Summons* in the post”.

“We have opted for a title that is more positive and aspirational – our aim to offer members helpful and interesting ‘insights’”

So we have opted for a title that is decidedly more positive and aspirational – our aim to offer members helpful and interesting “insights” into good practice and proactive risk management.

We have also taken this opportunity to make a few changes on the inside in response to reader feedback. Our case studies section has been expanded from two to four pages along with the range of case types – as stories are always more compelling

when considering risk. We have added a couple more semi-regular features – a Briefing page that picks apart a current regulatory or medico-legal issue in more detail and also a Dilemma page to alternate with occasional first person accounts of particular difficulties faced by members.

Design-wise, we have tried to make the pages a little less text heavy as the one thing all our members have in common is hefty workloads and often little time to wade through long articles. We hope you will appreciate this new-look magazine and we welcome any feedback or suggestions – as it is your *Insight*.

Dr Barry Parker

MDDUS News



MDDUS advice line there to be used

MDDUS is keen to dispel the myth that contacting the advice line impacts on individual subscription rates. Members are encouraged to seek advice from our team of experienced medico-legal and dento-legal advisers at the earliest opportunity – and are not penalised for doing so.

MDDUS chief executive Chris Kenny said: “As we have repeatedly made clear to the BMA and a number of LMCs who raise this issue, we can give a categorical assurance that the underwriting and pricing decisions of MDDUS are not affected by the number of times members contact the organisation for advice.

“Indeed, MDDUS positively encourages members to make use of the advice line available to them as a benefit of membership. We believe seeking our advice will assist the member in adopting safer clinical practice and we would never penalise them for contacting us for advice.”

Subscription renewal advice

MEMBERS receiving their annual renewal notice in 2017 should note that the subscription has been calculated on the basis of the NHS post, private earnings or sessions declared to us at the time of joining or last renewal (whichever came later). You should check this carefully and ensure that it remains appropriate for the year to come. If any change

is required then please inform us immediately so that a revised renewal notice can be issued.

We realise that it may be difficult to predict accurately the extent of your future work – we will allow you to make reasonable adjustments at any time during the year and up to one year following the end of each membership year. Please note that we may require proof of earnings or clinical activity, as set out in the *MDDUS Membership Agreement*.

MDDUS provides direct debit facilities for your convenience,

including the option to spread the subscription fee over 10 monthly payments at no extra cost (which the majority of members take advantage of). This also ensures continuity of renewal.

Membership is provided on an annual basis and should you decide not to renew, please contact our Membership Services Department on **0333 043 0000** at least seven days prior to your renewal date. Once payment is taken, annual membership is deemed to have commenced and cannot ordinarily be cancelled. Failure to maintain direct debit payments may result in this facility being withdrawn.

GPs working in minor surgery

MDDUS recognises that GPs may undertake a range of relatively minor invasive procedures, such as contraceptive implant or coil fitting, joint injections, acupuncture or minor surgery for skin lesions and "lumps and bumps". We will extend the benefits of GP membership to include work as described above where it accounts for less than 50 per cent of a member's clinical time and where it is provided to NHS patients.

Members must ensure that they work within the limits of their competence and training, and that the time spent undertaking such work is included within the sessions declared to MDDUS for the purposes of calculating their subscription.

Members undertaking more complex or specialist work, who are treating private patients or who are exceeding the 50 per cent limit set out above, should contact our Membership Services Department for a tailored quote.

Capping legal costs

MDDUS welcomes the announcement of a government consultation on capping excessive legal costs in clinical negligence claims.

Responding to the launch of a Department of Health consultation, *Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims*, MDDUS CEO Chris Kenny said: "We welcome this long-promised consultation on capping recoverable costs in clinical negligence cases. The proposals are thorough-going and capable of early implementation.

MDDUS' experience in this field mirrors the published data from the National Health Service Litigation Authority, both as to

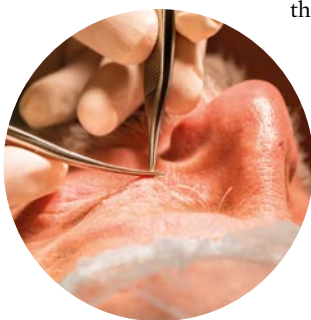
increasing claims frequency and the ratio of costs to damages.

"It is by no means unusual for costs to exceed damages by a very substantial degree, even if the claims are promptly settled with the minimum necessary investigation," Kenny added. "This is due to the very considerable front-loading of legal cost by claimant lawyers before a claim is even intimated to the practitioner.

"Money expended in compensating for clinical accidents should, as far as possible, find its way to the injured patient and not disproportionately to the lawyers supporting those patients' claims.

"The proposals will ensure far tighter management of costs at the level of the individual case, but it will have the right incentive effects in ensuring that strong cases are selected and prepared in the most cost-effective manner. That enhances, rather than subtracts from, access to justice.

"MDDUS will continue to work together with the Department of Health and NHS England to ensure early and successful change."



GDC reform

MDDUS believes patients and dentists will benefit if reform proposals from the General Dental Council are implemented swiftly, fairly and consistently.

Following the launch of the GDC's *Shifting the balance: a better, fairer system of dental regulation*, MDDUS chief executive Chris Kenny said: "The current dental complaints system is outdated and cumbersome. The often unjustified threat of regulatory action can destroy careers and reputations and lessen public confidence. That serves neither patient nor dentist.

"So we welcome the ambitious and radical plan from the GDC to shift the priority to upstream prevention from downstream punishment, to refocus fitness to practise work and to make the complaints process more transparent, consistent, fair and responsive.

"We look forward to continuing to work with the GDC to develop momentum in implementation and to make sure that detailed processes and procedures match the scale of ambition."

MDDUS Head of Dental Division Aubrey Craig added: "We support all steps that will make the complaints and regulatory processes less stressful for dentists and reduce the number of unjustified final hearings.

"Early local action is key to defuse complaints. In our experience, patient complaints that are dealt with quickly and efficiently between the patient and the practice are far more likely to be resolved."

NEW MDDUS TELEPHONE NUMBERS

Our new contact numbers make it easier for members to get in touch. Contact our main switchboard on **0333 043 4444** and our membership team on **0333 043 0000**. These are charged at the same rate as normal local or national landline ('01' or '02') numbers.

PRACTICE AND CORPORATE SCHEMES

Members with Practice or Corporate Scheme membership should note that it is their responsibility to ensure that membership is being adequately maintained by a scheme administrator, such as the practice manager. Failure to maintain adequate cover, for example failing to inform us of a return to work following maternity or paternity leave, cannot normally be rectified retrospectively.

BLEAK PRACTICE 4

The fourth episode in our popular video learning module *Bleak Practice* is now available. It follows on from the characters and events introduced in the first three modules – this time focusing on a new set of risks. A discussion guide is available and members can access the module in the Risk Management section at mddus.com. Verification for CPD available.

MDDUS WEBINARS

Check out our risk webinars which are delivered by in-house advisers and focus on areas of risk in everyday practice. Go to the Risk Management section at www.mddus.com for more details.

Mental health support for GPs

GPs in England suffering from stress, depression or addiction can now seek help from a new NHS GP Health Service offering specialist mental health support.

The new confidential service, backed with funding of up to £19.5 million over the next five years, operates on a self-referral basis but is not intended for emergency or crisis issues. It is staffed by professionals specialising in mental health support to doctors, who will be based in each of the 13 NHS England local team areas, available from 8am to 8pm Monday to Friday and 8am to 2pm Saturday.

It is being provided by The Hurley Clinic Partnership, who operate a similar service based in London, and can be accessed via phone 0300 0303 300, email gp.health@nhs.net or app.



More urgent dental care needed

DENTISTS could help ease pressures on accident and emergency departments if more in-hours urgent care slots were commissioned, according to the British Dental Association.

The BDA estimates that around 135,000 dental patients attend A&E per year at an annual cost of nearly £18 million. The majority of visits (95,000) are for toothache, costing the health service £12.5 million, while a further 600,000 patients a year seek treatment from GPs. Neither are best equipped to treat dental pain.

By commissioning more in-hours urgent care slots, the BDA argues this would help NHS 111 by giving a clear indication as to which dental practices have the availability and capacity to treat patients in need.

Chair of the BDA's General Dental Practice Committee, Henrik Overgaard-Nielsen, said: "We believe dentists could ease the burden [on NHS hospital and GP services] if more slots were commissioned for in-hours urgent care. This would ease the frustration for patients who cannot get the care they need from seeing their GP or going to the A&E."

Practices playing music "must buy a licence"

DOCTORS and dentists who play the radio or other forms of music in their practice must buy a licence or risk legal action.

A recent media report suggested dental



surgeries may be paying "unwarranted" fees to collection agencies PRS for Music and PPL to listen to music in waiting areas or consulting rooms. The article cited a decision made by the European Court of Justice in 2012 (*Società Consortile Fonografici v Marco Del Corso*) which found that broadcasting music within private dental practices in Italy did not require the purchase of a licence.

But a PRS for Music spokeswoman has confirmed that the ruling "concerns specific types of rights and remuneration which are not relevant in UK law or to PRS for Music".

She said: "The law in the UK clearly provides that the performance and playing in public of works, sound recordings, films or broadcasts, is an act restricted by copyright and exercisable only with the consent of the copyright owner. Therefore, PRS for Music has the right to license businesses who use PRS members' musical works in this way."

A PRS licence for a practice waiting room, she added, costs from £84.13 a year. Practices may also require a PPL licence. Find out more at www.prsformusic.com and www.ppluk.com

Revalidation needs greater clarity

A REVIEW of medical revalidation urges greater clarity in required supporting information, as well as re-doubled efforts to reduce workload and duplication for doctors also engaged with the CQC and other regulatory bodies.

The review into the operation and impact of revalidation throughout 2016 was carried out by Sir Keith Pearson, independent chair of the Revalidation Advisory Board. This involved gathering practical feedback from a wide range of individuals and organisations involved in the process, as well as analysing the findings of research into revalidation since its implementation.

Overall the report is positive. In his executive summary, Sir Keith states: "Revalidation is still a new process; it is important that we learn from the first cycle to make it more effective in the next. I do not believe major overhaul is needed."

Among key recommendations in the report he calls for updated guidance on the supporting information required in appraisal for revalidation to make clear what is mandatory (and why), what is sufficient, and where flexibility exists. He believes the system needs to be more robust for doctors who work outside mainstream clinical practice and those who move around the system, such as locums. Sir Keith also calls for the GMC to continue working with the CQC and NHS England to reduce workload and duplication for doctors, and to address similar issues

in Northern Ireland, Scotland and Wales.

Access the report *Taking revalidation forward* at <https://tinyurl.com/jcnq4dm>

New guidance on conflicts of interest

NEW guidelines to strengthen the management of potential conflicts of interest among NHS staff have been published by NHS England.

Guidance will permit staff to receive small tokens of gratitude from patients, for example a box of chocolates, but will require them to decline anything that could be seen to affect professional judgement. Gifts with a value over £50 will need to be declared.

It will also be standard practice for NHS commitments to take precedence over private practice, and for any member of staff – clinical or non-clinical – to declare outside employment and the details of where and when this takes place (although not earnings).

The guidance has emerged from a six-week consultation conducted by NHS England in September of last year inviting views on gifts, hospitality, outside employment and private practice, sponsorship and other interests. The resulting proposals were benchmarked against best practice in other industries.

The guidelines are expected to come into force on 1 June.

Clearer guidance on confidentiality

DOCTORS may be allowed to breach confidentiality without consent to protect a patient from a serious crime such as murder – even if no one else is at risk, according to updated guidance from the General Medical Council.

In “very exceptional circumstances”, disclosure without consent may be justified in the public interest even if a patient with capacity has refused and no one else is at risk. But the regulator says there must be clear evidence of an “imminent risk of serious harm” and advises clinicians to seek independent legal advice before acting.

This advice forms part of the GMC’s new “revised, expanded and reorganised” *Confidentiality* guidance which comes into



effect from 25 April 2017 and applies to all doctors practising in the UK. It will replace the current guidance which was published in 2009.

The new guidance also promises clarification on the importance of sharing information for direct care, recognising the multi-disciplinary and multi-agency context doctors work in and the circumstances in which doctors can rely on implied consent to share patient information for direct care. A new statement has also been included on the “significant role” that those close to a patient can play in their care, and “the importance of acknowledging that”.

Access the revised guidance at www.gmc-uk.org

GMC proposes single licensing assessment

ALL doctors wanting to join the medical register and practise in the UK may be required to pass a standardised Medical Licensing Assessment (MLA), under new proposals by the GMC.

The regulator has begun to consult on what it calls a “single route to the medical register for all doctors who wish to practise in the UK”.

Currently there is significant variation in arrangements for medical students across the UK and those wishing to join the register from outside the UK. International medical graduates (IMGs) have a number of means of entry, including the Professional and Linguistic Assessments Board (PLAB) test, but doctors from the EU can secure a UK licence to practise without any test of their competence.

Professor Terence Stephenson, Chair of the GMC, said: “Medical training in the UK is among the best in the world – our graduates do well here and when they work overseas. However, current arrangements do not allow us to assess whether UK graduates and overseas

graduates have attained the same threshold of competence when they are seeking the same licence to practise in the UK.”

The GMC hopes to incorporate the new assessment into existing testing by medical schools – subject to approval – by 2022. A consultation at www.gmc-uk.org is open for feedback until 30 April 2017.



REGISTRATION DEADLINE FOR INDEPENDENT CLINICS

All independent dental clinics (totally private practices) in Scotland must be registered with Health Improvement Scotland (HIS) by 1 April 2017. Practitioners can register using an online service and more information is available from the Independent Healthcare Enquiry line at 0131 623 4342 or via email at www.hcis.clinicregulation@nhs.net.

Failure to register will result in the operating dentist being reported to the procurator fiscal service for prosecution.

IMPROVED LUNG CANCER SURVIVAL

A new report shows a seven per cent increase in lung cancer patients surviving for longer than one year compared with results from 2010.

The National Lung Cancer Audit Report 2016 reveals that one-year survival rose from 31 to 38 per cent in the five-year period from 2010 to 2015, and also that 60 per cent of lung cancer patients received anti-cancer treatment such as chemotherapy, radiotherapy or surgery, meeting a target set out in 2015.

NEW APP FOR GMC GUIDANCE

An app that allows healthcare professionals to conveniently access *Good medical practice* (GMP) guidance has been launched by the GMC.

My GMP can be uploaded for use in smartphones and tablets and is designed to allow a quick on-the-spot search for relevant guidance.

Find out more and download the app at www.gmc-uk.org

CAN WE REDUCE OVERTREATMENT?

Joanne Curran

Associate editor of *Insight*

THE more advances are made in medical tests, treatments and other interventions, the greater the pressure can be for clinicians to use them. Faced with a patient seeking relief from pain, suffering or anxiety, the question often follows: "Surely *something* can be done?" But the fact that *something* can be done is no guarantee of a positive outcome and in some cases the intervention may do more harm than good.

The Academy of Medical Royal Colleges (AoMRC) recently launched their *Choosing Wisely* campaign, part of a global movement to reduce "over-medicalisation".

At its heart is a call to both doctors and patients "to have a fully informed conversation about the risks and

benefits of treatments and procedures".

They highlighted a 2015 study in which 82 per cent of doctors said they had prescribed or carried out a treatment which they knew to be unnecessary. The vast majority cited patient pressure or patient expectation as the main reason.

As a first step, *Choosing Wisely* listed 40 treatments and procedures said to be of little or no benefit to patients. In terminal cancer cases, for example, they say: "chemotherapy may be used to relieve symptoms but can also be painful, cannot cure the disease and may well bring further distress in the final months of life."

Patients are also urged to ask five key questions when seeking treatment:

1. Do I really need this test, treatment or procedure?
2. What are the risks or downsides?
3. What are the possible side effects?
4. Are there simpler, safer options?
5. What will happen if I do nothing?

A 2015 *BMJ* article, 'Choosing Wisely in the UK: the AoMRC's initiative to reduce the harms of too much medicine', describes how under the campaign: "[D]octors and patients will be supported to acknowledge that a minor potential benefit may not outweigh potential harm, the minimal evidence base, and substantial financial expense and therefore that, sometimes, doing nothing might be the favourable option."

"A 2015 study found 82 per cent of doctors had offered treatment they knew to be unnecessary"

Academy Chair Professor Dame Sue Bailey says that improved patient outcomes rather than financial savings are the main motivation behind the campaign. "What's important is that both doctors and patients really question whether the particular treatment is necessary," she says. "Medicine or surgical interventions don't need to be the only solution offered by a doctor and more certainly doesn't always mean better."

So how will this translate into day-to-day clinical practice? The secret to success for *Choosing Wisely* appears to lie in wider

adoption of shared decision-making (SDM) in order to help manage patient expectations, coupled with a shift away from a so-called "more is better" culture.

NHS England describes SDM as "a process in which patients... can review all the treatment options available to them and participate actively with their healthcare professional in making that decision."

Writing for the *Guardian's* Healthcare Network, GP Dr Steven Laitner says SDM can lead to a better patient experience: "[It] can reduce treatment disagreements, lead to more realistic expectations, reduce clinically unwarranted treatments, and potentially reduce litigation. Importantly, patients are more likely to stick with a course of action or treatment when they have chosen it, rather than had it foisted upon them."

What's more, the Royal College of Surgeons (RCS) argue that, following the landmark 2015 Supreme Court judgement in *Montgomery v Lanarkshire Health Board*, there is now a legal imperative for doctors to adopt SDM in order to secure informed consent. An article in the January 2017 edition of their *Bulletin* magazine states the ruling "has confirmed that a patient's right to self-determination in treatment decisions triumphs over medical paternalism", and that "the principles of shared decision-making must become the norm."

There are concerns this approach may be unrealistic due to time pressures, but the RCS say "it need not be so". They point to

the range of available tools to support decision-making that "enable the doctor and patient to share information in an efficient and comprehensive way." In the feedback report for *Realistic Medicine*, the

2016 annual report from Scotland's chief medical officer Dr Catherine Calderwood, there are also calls for a change in culture "that permits doctors not to over treat – for example, treating an elderly patient in community and not hospital".

Looking to the future of healthcare, the key message seems to be less is more: less medicine and more patient involvement.

LINK:

- Choosing Wisely UK - www.choosingwisely.co.uk



FREE WILL IN CONSENT

Gail Gilmartin

Medical and risk adviser at MDDUS

MUCH has been written about the need to determine competence and what information a patient should have when providing valid consent to treat – but there is also a vital third element: ensuring free choice.

Respect for autonomy is a fundamental ethical principle underpinning medical ethics. We must respect the right of any person to make decisions affecting their own bodies and lives. This also means protecting them from adverse influences which interfere with their ability to make a free choice.

In *Consent: patients and doctors making decisions together*, the GMC states:

"Patients may be put under pressure by employers, insurers, relatives or others, to accept a particular investigation or treatment. You should be aware of this and of other situations in which patients may be vulnerable. Such situations may be, for example, if they are resident in a care home, subject to mental health legislation, detained by the police or immigration services, or in prison.

"You should do your best to make sure that such patients have considered the available options and reached their own decision. If they have a right to refuse treatment, you should make sure that they know this and are able to refuse if they want to."

Here the GMC highlights several situations where patients may be adversely influenced in their decision making. Many relatives and friends do influence patient choices – but this must not amount to substituting their decision for that of the patient.

For any treatment decision, the patient's choice depends on various factors, such as the impact on their day-to-day life, family responsibilities, employment, time of year and even personal foibles. As healthcare practitioners we need to be sensitive to these matters and be alert to any influence which crosses a line, even from a practitioner themselves.

Tensions often arise when a patient refuses treatment. A clinician can explore the reasons for making a decision which may not appear to be in a patient's own

best interests, but care must be taken not to inappropriately pressurise a patient to make a particular treatment choice. It is one thing to check the patient's beliefs and reasons for their choice but it is wrong to try to impose a choice upon them. Equally those close to a patient should not seek a decision of their preference as opposed to the patient's own.

In the landmark case of *Re T (Adult) 1992*¹, the judgement looked closely at these issues.

T was a 20-year-old pregnant patient who was injured in a car accident and ultimately needed to have blood transfusions after complications arising from a caesarean section. On admission to hospital she had indicated that she was an ex-Jehovah's Witness and information from the patient and those close to her demonstrated that her lifestyle departed from the teachings of that religion.

Although there had been no discussions with the patient about transfusion, after spending time with her mother, a practising Jehovah's Witness, T announced that she did not want to have blood transfusions. At that time it was not anticipated that she would require blood or blood products.

Later when she needed to have blood she continued in her refusal. Her father

took the matter to court and it eventually went to the Court of Appeal where it was found that T had been pressurised by her mother. This, along with the effect of drugs she had at the time, rendered her refusal invalid. The decision was that the transfusions could proceed.

In the Court of Appeal decision Lord Staughton wrote: "... every decision is made as a result of some influence: a patient's decision to consent to an operation will normally be influenced by the surgeon's advice as to what will happen if the operation does not take place. In order for an apparent consent or refusal of consent to be less than a true consent or refusal, there must be such a degree of external influence as to persuade the patient to depart from her own wishes, to an extent that the law regards it as undue. I can suggest no more precise test than that."

The ethical and legal position is clear that patients must be allowed to make their own decision on consent without undue influence. This can on occasion lead to concerns about valid consent. If such a case arises it is important to seek appropriate legal advice and if in any doubt contact MDDUS for guidance.

¹ *Re T (Adult) [1992] 4 All ER 649*

"It is one thing to check the patient's beliefs and reasons for their choice but it is wrong to try to impose a choice upon them"



THE ACC

Adam Campbell meets Dr Fiona Godlee – the forthright *BMJ* editor not afraid to take a stand

ASK FIONA GODLEE how she went from being a registrar in general medicine to editor of one of the longest-running and most influential medical journals in the world and she'll tell you it was all a bit of an accident.

To be fair, speaking to me down the line from Cambridge, where she did her graduate medicine and now lives, she's actually explaining how she came to work for the *BMJ* in the first place in 1990, after a year's placement turned into two years and then a full-time job. The placement – as editorial registrar – was set up as a “bridge” between the journal and young clinicians, who would bring a fresh injection of expertise and energy into the *BMJ* before heading back to the medical coal face. But for Godlee there was to be no return journey.

“It was very clear when I took the editorial registrar job that I wanted medicine as a career. It's not intended as a way out for doctors who are disillusioned. But it became very compelling, engaging, huge fun, very broad, wonderful people, all of that. I was drawn into it. So it happened by mistake really.”

Fifteen years later – having in the meantime led the development of *BMJ Clinical Evidence* and, in a three-year hiatus from the *BMJ*, established the open access publisher BioMed Central – her “accidental career move” paid its biggest dividend of all when she was named as successor to the legendary *BMJ* editor, Richard Smith. At 43, she was to be the first female editor in the journal's then 165-year history.

She had not been gunning for the role, she says, but she was ready for it. “Richard had been my mentor. He's very generous and creative and I'd learnt a vast amount working with him. We were all very sad that he went. But then someone needed to do the job and I thought I could do it.”

MORE THAN ACADEMIC

Godlee was a new broom but she was not in the business of sweeping away the past. Her tenure, she says, has been a “natural evolution” of the direction of travel already in place. A key aspect of this has been to ensure the *BMJ*'s output is actually read – so that it can contribute to the debate. Readers' feedback is that they want things that are short and punchy. More “magazine-y”, as she puts it, “a pleasure read rather than a necessary work read”. But, she says, “they also want credibility and care and accuracy. So to try to do both of those things is really the challenge.”

This has meant professionalising the journalism, bringing in dedicated health writers and also using investigative techniques to shine a light into some of the darker crevices of the medical landscape. At the same time it has been crucial to maintain the academic standards of research which underpin the credibility of the *BMJ*'s output. It is this combination of academic strength and journalistic enterprise that gives the *BMJ* its unique position, she says.

This twin-pronged approach has seen the *BMJ* getting together with the likes of the BBC, the Centre for Evidence-Based Medicine and Channel 4 News to investigate issues, such as the lack of evidence behind many costly add-on treatments for IVF and the costs and (lack of) benefits involved in the switch from human insulin to analogues in the treatment of type 2 diabetes.

“Repeatedly it does seem to be that because the *BMJ* can be both of those things, it can be used as a sort of tool, if you

like, to put a knife into the oyster and try to winkle it open,” she says. “Over the 11 years I've been editor, it's become clear to me what the *BMJ* can do and what it can't do.”

AN INDEPENDENT VIEW

Falling firmly into the ‘can do’ column is the belief that the journal should take strong positions in the key health debates, and the *BMJ* under Godlee wears its campaigning heart on its sleeve, with a page on the website dedicated to its current campaigns. Whether it's NHS funding, overdiagnosis and waste of resources, corruption in healthcare, the decriminalisation of illicit drugs, transparency in clinical trial data or the health impacts of climate change, the *BMJ* has tackled them all – and firmly.

A major priority for the coming year is the idea of patient partnership, putting the patient's voice into research and education of doctors. The *BMJ* has already done a lot of work on this, including its regular ‘What your patient is thinking’ series. Godlee explains: “It's the idea that you need to take the patient's perspective into account, not just because it's the right thing to do but because it actually leads to better decisions.”

Of course, campaigns such as these are never one-sided affairs and there have been a few high-profile spats, including one with the editor of the *Lancet* over statins (the *BMJ* has been critical – unjustifiably so, says the *Lancet*). There was also a fundamental disagreement with her employer, the BMA, which owns the *BMJ*, over assisted dying.

IDENTAL EDITOR



"I initially argued the BMA should go to a neutral stance but I now think it ought to be a decision for society. If that was the case, I think society would probably vote for it." The BMA, on the other hand, is firmly against, though it has respected the journal's independence on this issue.

The decision to start talking about climate change as being a result of human activity and a risk to human health also provoked a considerable backlash. "A lot of it was, you're naive and stupid to think it's real – and even if it is real, what's this got to do with medicine? That seems extraordinary now but that was the initial response. I think it is a bit of a no-brainer now but it gets back to the question, what is the *BMJ*? What is a medical journal there for?"

These "skirmishes", as she calls them, are all part of the job, in other words. It is a question, she says, of "behaving well and reasonably" when putting your case. In this way the skirmishes are resolved and you move on.

FEW REGRETS

Another key challenge of the job, of course, is keeping your readership happy. On this score, with a global circulation of 122,000 for the print edition and 2.5 million hits every month on the website, her approach is clearly paying off.

There have been accolades from her peers, too, and in 2014 Godlee was named Editor of the Year at the Professional Publishers Association awards and the following year the *BMJ* was named Magazine of the Year.

So, despite all her success as a publisher, has she ever

"Readers of the *BMJ* want a pleasure read rather than a necessary work read...they also want credibility and care and accuracy"

wished she had gone back across that bridge into medical practice? She was, after all, breaking with a firm family tradition: her father was an oncologist and all three of her siblings are GPs. Further back, her medical pedigree includes a great-great uncle who was none other than Joseph Lister, pioneer of antiseptic surgery.

"I did feel quite nostalgic at one point, when my children were young. I was living up in Lincolnshire and commuting into London and I used to think, 'Gosh what would a local life be like? Could I retrain as a GP?' There's something magical about the interaction with patients and I also love the community of working in a hospital, the social scene – and moving into an editorial office is a rather smaller environment."

But no, she confesses, the regrets have been few. After all, she is positioned at the very centre of the worldwide medical debate. She puts it succinctly, as she remembers that first move: "Medicine had been a vocation for me – and the *BMJ*, well, I wasn't going into just any old publishing."

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

MAKING A MED

What goes into the development and testing of a medical app? Here Matt Wickenden describes how one innovative app was custom created for use by respiratory specialists

THE list of things that smartphones can do is constantly growing – and their role in assisting healthcare professionals on the ward and in practices is also expanding almost daily.

Apps in particular have the potential to offer quick and simple answers to some of the key questions doctors face every day. But they need to be reliable and effective.

Recently Cancer Research UK has been involved in developing an app for iPhone and iPads in partnership with the British Thoracic Society (BTS).

Our goal is to make it easy for health professionals to access comprehensive guidelines published in 2015 by the Society on how to manage patients with small tissue growths – called pulmonary nodules – that can appear on lung scans. These nodules can be harmless, but they can also be cancerous and need treatment.

The guidelines have been very popular with doctors and the teams they work with, offering information to help diagnose patients with lung cancer as quickly as possible – and without carrying out unnecessary tests on people who don't need them. But the different hospital staff who use the guidelines are almost always on the move. When we spoke to them it was clear they want the information they

need to move with them.

Our app is designed to make that possible.

WHAT ARE THE GUIDELINES FOR?

When a nodule is found on a scan, doctors must quickly decide if it needs further investigation. They have to balance this with avoiding unnecessary tests and worry for patients who may have harmless (benign) nodules.

The guidelines help doctors decide these next steps – whether to discharge the patient, bring them back for monitoring, or offer further tests that may lead to a lung cancer diagnosis followed by treatment.

The guidelines recommend using three different mathematical calculations to assess the risk that the nodule is cancerous and how quickly it's growing.

These have been turned into online calculators which are available on the BTS website (tinyurl.com/h6cpenn).

The guidelines and online calculators have been really popular. Since the start of 2016, the online calculators have been used over 18,700 times, helping doctors make vital decisions around the care of thousands of patients.

But there's a problem.

HOW CAN AN APP HELP?

As is often the case in medicine, the lung nodule guidelines contain a huge amount of information. The detail is vital but not something a doctor can quickly refer back to while they're in the clinic or in a multidisciplinary team meeting (MDT) planning how best to care for their patients.

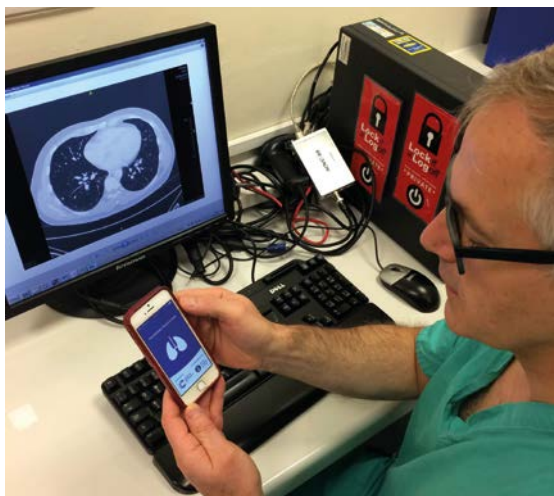
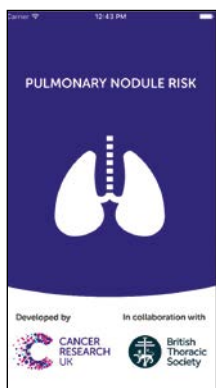
Also, while the calculators are available online, it's awkward for doctors and their teams to access them when they're on the wards or in MDTs. Simply using their phone isn't easy either because they often can't reliably get Wi-Fi or a mobile signal in hospitals.

Our app gets around both these problems. Summaries of the key information are already downloaded onto their phone, purpose built for handling the maths and available whenever clinicians need it.

DOCTORS HELPED DESIGN THE APP TOO

From the start we wanted to ensure that the design and functionality of the app did exactly what the doctors needed it to. First we collected feedback from 18 health professionals. We found that 11 were already using smartphone apps for their work at least several times a month, with three using them several times a day. The feedback also showed that 11 were very likely to use an app version of the guidelines and calculators.

We then worked with our in-house digital experts to develop a prototype app that we took to hospitals in Leeds



“From the start we wanted to ensure that the design and functionality of the app did exactly what the doctors needed it to”

ICAL APP



and London to get more feedback and understand how doctors might use it. We found that the doctors and their teams were always on the move around the hospital. This means they often won't have easy access to a computer when they need to make decisions about their patients.

We also found that there are a lot of different people who need to use the guidelines. And they all have slightly different needs. For example, the nurses supporting patients as they are having the scans and tests might use the app in a different way from the doctors interpreting what the scan results mean. So the easier we could make it for different people to access what was relevant to them, without having to spend lots of time referring back to the full guidelines, the better.

WHAT DIFFERENCE WILL IT MAKE?

We hope the app gives health professionals all the information they need, where and when they need it. After extensive tests, a group of health professionals from across the country have been using the app in their hospitals over the last month. They've kindly given us their feedback, and early signs are positive.

"The app makes it much easier to plan nodule follow-up in clinics and MDTs as you don't have to wait for the website to load and it's much more phone-screen-friendly," said one user.

"Having the calculator immediately to hand saves me time spent finding a PC and getting through to the risk calculator online or trying to use mobile data to get there," said another.

We hope that many more doctors will now get similar benefits from the app and that it can help make sure the thousands of patients found to have pulmonary nodules each year get the best possible care.

WHAT HAPPENS NEXT?

Since launching in December 2016 the app has already been downloaded over 1,000 times. We're going to collect more feedback on the app to understand what features are most valuable to people and any areas we could improve it. Assuming the app continues to be successful, we'll be working with the British Thoracic Society to develop versions that will work across other mobile operating systems, such as Android and Windows.

We hope this app can help us to start to realise the potential for smartphones in supporting doctors and improving patient care. We'll be keen to learn any lessons that can help us develop more apps to support other areas of cancer patient care.

We also hope this app will prove a useful example of how apps can help improve patient care in general with quick and simple solutions.

Matt Wickenden is a cancer intelligence manager at Cancer Research UK

A version of this article originally appeared on the Cancer Research UK Science blog (access at www.cancerresearchuk.org)

DEMENTIA FRIENDLY DENTISTRY

Dental care for patients with dementia presents some obvious challenges – but also opportunities

BARELY a week goes by without another media story about the growing number of people living with dementia and the challenges we face as a society. Current predictions are that by 2025 there will be over one million people with the condition in the UK.

So what are the implications for the dental team? Whilst the increasing number of people with dementia can bring challenges, there is also an opportunity for the primary care dental team to make a real difference.

Good oral health enables people to enjoy a healthy and varied diet, to smile and interact socially – these are especially relevant for people living with dementia to support adequate nutrition and a good quality of life. Dental pain can be detrimental to all of these aspects, thus mouth care and effective oral disease prevention should be a high priority.

Even experienced special care dentists will agree that the provision of operative dental treatment in the later stages of dementia can be challenging. A thorough oral assessment as soon as possible after diagnosis and careful treatment planning and prevention can significantly reduce the chances of future dental problems and allow patients to make decisions for themselves.

Visiting the dental practice can be bewildering for people with dementia, even in the earlier stages. The appointment and reminder systems, busy waiting rooms, complicated forms and even shiny floors can all present difficulties.

TOOLKIT

Cheshire and Merseyside are exploring a partnership approach to dental care for this patient group. Each dental practice in the region could have as many as 120 patients with dementia seeking dental care by 2025. Community dental services and hospital-based special care dentistry services have clinicians with additional skills and expertise – but care pathways and shared care arrangements with general dental practitioners are also needed.

To this end a toolkit for the primary dental care team was recently developed and tested in Cheshire and Merseyside as part of a 'dementia friendly dentistry' programme. Subsequent phases of this programme will establish systems to direct those who are newly

diagnosed with dementia to local dental practices for early assessment and care planning, and to streamline the dental care pathways between general dental practice, community and hospital services.

DEMENTIA AND ORAL HEALTH

Following a dementia diagnosis, there are many issues to consider around the health and well-being of a patient and their future care – and oral health is an important component. In the early stages of dementia, oral care follows the same principles as for any patient. Preventive strategies should be tailored to the individual risk of oral disease, including caries, periodontal disease, oral cancer and toothwear. Current guidelines may be used to identify appropriate intervals for recall, radiographical examination and fluoride regimen.

Early treatment decisions should take into account the expected disease course and result in a dentition which can be maintained long term. As dementia progresses, risk of plaque-related disease increases and it may become more difficult to achieve a high standard of plaque control, particularly where a third party is relied upon for personal care. Advanced restorative dentistry, for example fixed bridgework and implant retained prosthesis, can present a particular challenge when dementia has progressed and oral hygiene may deteriorate.

A number of other factors may affect diet and nutrition and as a consequence increase the risk of dental caries. These include an increased reliance on convenience foods, changes to taste and appetite, increased snacking and subsequent increase in sugar consumption.

Dietary choices may be made by a patient's carers, or directed by medical needs. Nutritional supplements may be required in order to increase calorie intake, but these can also be high in sugar. Chewing may become more difficult, fluids may need to be thickened to prevent aspiration, and clearance of food from the mouth may be

“Special care dentists will agree that the provision of operative dental treatment in the later stages of dementia can be challenging”





delayed. These changes, together with a dry mouth due to xerogenic medicine, significantly increase caries risk.

PREVENTIVE DENTAL CARE

Access to dental care can become more problematic as memory deteriorates. Communication of pain can be less specific, and it may become necessary to consider other behavioural changes such as altered demeanour, sleep and eating patterns, alongside objective signs such as swelling or reaction to palpation of soft and hard tissues.

Anxiety and cognitive decline can mean reduced cooperation in dental treatment and it may become necessary to consider intravenous sedation or general anaesthesia in some cases. It is vital to carefully balance the risks of these procedures against the benefits of treatment. Medical comorbidities, such as chronic cardiorespiratory disease, may present increased risks such as aspiration pneumonia or post-operative delirium in the cognitively impaired patient.

Prevention of oral disease remains the foundation of care for people with dementia. The best time to discuss possible future problems associated with dementia is following diagnosis, whilst cognition and the ability to accept care are largely unchanged. Removal of non-functional, non-aesthetic, carious and heavily restored teeth may be advised, rather than providing treatment which is unlikely to be maintained in the longer term. The shortened dental arch approach may be considered, with the overall aim of providing a functional, easily maintained dentition with good long-term stability.

Regular preventive planning, including fluoride application, can be provided through a team approach using hygienists and therapists to deliver appropriate care – and this may be vital in establishing a continuing relationship with patients.

A patient living with dementia should be supported

to make their own treatment decisions for as long as possible, with information pitched at the right level and pace. Where capacity is shown to be lacking, any action taken must be in the patient's best interests, taking into account any advanced decisions, previous wishes and beliefs. Those close to the patient should be consulted and the least restrictive options chosen. Onward referral to a more experienced or specialist colleague may be necessary where assessment of capacity is unclear.

CARE PATHWAYS AND CLINICAL NETWORKS

Local structures will vary across the UK but the principle remains of using the right skill mix for patients matched to the complexity of their care. Supporting GDPs to provide care for people with dementia offers the benefit of establishing a familiar contact within the local community. Many dentists will have always provided long-term holistic care for patients with dementia and will continue to do so. These skills and experiences can be shared with healthcare colleagues.

A whole-team approach is recommended, as receptionists and dental nurses have a vital role to play in identifying ways to support patient care and could be the first to spot behaviour changes or difficulties which may indicate progression of dementia. Sometimes simple adjustments and greater general awareness of dementia can greatly benefit the patient/carer experience, and increase their ability to access dental care in the longer term.

Specialist services will always be required for those with complicated cognitive and medical issues, but these should be reserved for the most complex cases. Thorough early assessment, regular review and tailored evidence-based prevention can have a significant impact on maintenance of good oral health in the long term, and can be effectively provided by the primary care dental team.

Suzanne Burke is a specialty trainee in special care dentistry at Liverpool University Dental Hospital

Lesley Gough is a consultant in dental public health at Public Health England (North West Centre)

Andy Kwasnicki is a consultant in special care dentistry, Liverpool University Dental Hospital

Access the full Dementia Friendly Dentistry toolkit at tinyurl.com/h74krx

CASE FILES



These studies are summarised versions of actual cases from MDDUS files and are published in *Insight* to highlight common pitfalls and encourage proactive risk management and best practice. Details have been changed to maintain confidentiality.



CLAIM

DECADE OF NEGLECT

BACKGROUND

A 42-year-old woman – Mrs T – attends a dental surgery as a new patient and is examined by Mr P. The dentist notes that Mrs T is suffering from gross periodontal disease with numerous mobile teeth. The patient is referred to the periodontal department at the local dental hospital where she is examined and a report sent to Mr P.

The report indicates aggressive periodontitis in 15 teeth, with pockets greater than 6mm and generalised bone loss of 60 to 80 per cent. Almost all the teeth show varying degrees of mobility and the consultant recommends a treatment plan involving the extraction of seven teeth and the fitting of a partial upper denture. Mr P carries out the treatment over a series of appointments.

Questions then arise over Mrs T's previous dental treatment and it transpires she had been under the care of another dentist – Mr F – for the last 10 years. Mrs T first attended the dentist for treatment of caries in an upper molar and was referred to a hygienist for "perio pocketing" and poor oral hygiene. A pocket chart was taken and oral hygiene instruction provided to Mrs T but compliance was poor. Over the next few years Mrs T attended Mr F for routine scale and polish and examinations, in which over time her deteriorating periodontal condition was noted along with

attempts to encourage better oral hygiene, though with little success.

Bitewing radiographs were taken on two occasions over the period showing increased generalised bone loss. Mrs T suffered with bleeding gums and lost interdental papilla. Scaling and root planing were undertaken along with occasional antibiotic therapy and the patient was advised repeatedly of her poor periodontal condition and the importance of proper tooth brushing technique. Her husband eventually insisted that Mrs T consult Mr P for a second opinion.

A letter of claim is later received by Mr F alleging clinical negligence in his failure to diagnose periodontal disease over the 10-year period Mrs T was in his care. In particular he did not carry out BPE examinations and it is alleged he failed to act on radiographic evidence of the patient's deteriorating periodontal condition. It is also alleged that the dentist did not undertake systematic deep scaling and root planing, nor did he refer the patient for specialist treatment. Mrs T also claims that the dentist failed to inform her of the condition and the serious implications of her poor oral hygiene.

ANALYSIS/OUTCOME

MDDUS instructs an expert to report on the case and she is first critical of the lack of any recorded BPE screening in the

records, though there is reference to pocket charting by the hygienist. The record does reflect discussion of Mrs T's poor periodontal condition and the need for improved oral hygiene so it is unlikely that the patient was unaware of her condition. The expert is of the opinion that referral to a specialist was indicated, especially when the second radiograph confirmed the progressive nature of the patient's condition.

In regard to causation the expert states that it is not certain if earlier intervention would have prevented or at least delayed Mrs T's tooth loss but earlier referral to hospital for aggressive therapy might have made a difference.

MDDUS lawyers and advisers decide in agreement with Mr F to settle the case.

KEY POINTS

- Ensure that patients understand the serious nature of periodontal disease and the likely outcomes should treatment advice be ignored.
- Record BPE at each routine examination. A visual examination, even if recorded, is insufficient.
- Maintain full records including treatment provided and any lack of compliance.

GOOGLE GAFFE

BACKGROUND

Ms B is a principal in a practice offering general dental treatment along with minor cosmetic procedures. She receives a letter from the GDC requesting information in regard to an anonymous complaint concerning a Google Ad for the practice with the headline "Tooth Whitening Specialists".

In the letter it is first pointed out that a dentist is not allowed to use the term "specialist" unless qualified to appear on one of 13 GDC specialist lists – and second there is no specialist list for tooth whitening.

Ms B contacts an MDDUS adviser who helps her draft a reply. It emerges that Ms B had employed a web company to manage her online advertising campaign. The company removed the phrase "Tooth Whitening Specialists" when informed of the complaint and re-checked the "key words" agreed for the Google campaign. "Specialist" was not on the list of approved terms the practice asked to be used in the promotion of the business. The term had been inserted inadvertently via "dynamic keyword insertion" (DKI) when a user on Google typed in the phrase: "Tooth



Whitening Specialist". Use of DKI had not been explained or okayed by the practice and a letter setting out the error is provided by the company for evidence to the GDC.

ANALYSIS/OUTCOME

MDDUS replies on behalf of Ms B along with copy correspondence demonstrating her efforts to comply with relevant guidance in regard to digital marketing – including the letter from the web company. The letter also enquires why the GDC decided to take the matter forward for investigation when usual practice in such cases is in

the first instance to simply request changes to ensure compliance.

The GDC acknowledges receipt and explains that because Ms B had been subject in the past to a fitness to practise concern it was decided to look further into the present matter. A few weeks later Ms B receives another letter confirming the matter will not be taken forward and that the case file has been closed.

KEY POINTS

- Be careful not to use the title "specialist" unless you are registered on one of 13 GDC specialist lists.
- Use of terms such as "special interest in" or "experienced in" are permitted for non-specialist registrants.

TRANSGENDER RECORDS

BACKGROUND

A GP practice has been supporting a male patient transitioning to female over the past year. The patient is now demanding that personal details be changed in the medical record to reflect a new name and change of gender. The practice contacts MDDUS to ask if the patient should provide some kind of formal certificate or authorisation first?

ANALYSIS/OUTCOME

MDDUS advises that the patient should submit a signed request in writing. A Gender Recognition Certificate (GRC) or updated birth certificate is not required in order to have the record amended. The practice should then inform its CCG (Practitioner Services in Scotland) of the new name

and gender (with the patient's consent). If the patient wishes to be issued with a new NHS number then this can be taken care of by the CCG who will ensure the records are transferred to the new identity.

The practice is advised to explain that the patient may not be contacted for

current or future screening programmes associated with the sex at birth and explain the implications of this. Decisions about

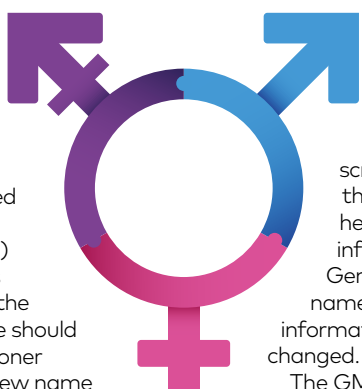
screening should be made in the same way as any other health decisions (ensuring informed consent is in place). Gender marker, pronouns and names on all the patient information held should also be changed.

The GMC has published

guidance on trans healthcare on their website, including the process for changing name, title or NHS number across the UK. Note that it is a criminal offence to share, without the patient's consent, information which reveals gender reassignment has occurred, where the patient has received a GRC. As such, provision of information on referrals etc. should be carefully reviewed.

KEY POINTS

- Transgender patients are not required to provide a certificate or authorisation before requesting changes related to gender status.
- A signed request from the patient is sufficient to make such changes.
- Consult GMC and other guidance on trans healthcare.



CLAIM

RECURRENT CANCER

BACKGROUND

Mr D is 72 years old and attends his GP surgery complaining of rectal bleeding. He had felt constipated about a week before and had taken a laxative which relieved the symptoms but in the past two days he has noticed more bleeding. There is no history of melaena or weight loss.

The GP – Dr F – notes in the patient records that two years ago Mr D had been treated for bladder cancer and later underwent a nephrectomy and partial cystectomy after the cancer had spread to his ureter and right kidney. In the months that followed the patient had regular routine cystoscopies and a CT urogram and these were normal. Eight months ago a cystoscopy revealed follicular cystitis but no tumour and the practice prescribed low-dose antibiotics. A further CT scan was to be carried out in three months but this was not recorded in the patient's primary care records.

Dr F undertakes an examination of Mr D and records that the abdomen is soft and non-tender with no masses. Digital rectal examination reveals an external pile and some light bleeding but no rectal masses. The GP advises the patient the bleeding is likely due to haemorrhoids and that he should continue to take laxatives as necessary and avoid straining. He asks the patient to make an appointment for review in 2-3 weeks but to return if the bleeding worsens.

Three weeks later Mr D is back at the surgery complaining of lower back pain radiating down his leg but he says that the

rectal bleeding, though still evident, has eased. He is worried that it might all be related to his cancer. Dr F exams him and finds good forward flexion and no para-spinal tenderness. He diagnoses mechanical pain and prescribes codeine with a laxative as necessary to avoid constipation. Mr D mentions he has not had a recent CT scan and the GP agrees to chase the hospital for an expedited scan and review.

A week later the patient is back in the surgery again with back pain. This time he is seen by another GP – Dr K – who makes a referral for an X-ray and orders bloods. Mr D is then called back two days later and informed that his haemoglobin is low (7.7). The patient confirms that he has noticed a dip in energy and also that he has dropped a few pounds in weight. He is also still finding blood in his stools. On examination Dr K notes that Mr D is pale but not acutely unwell and the possibility of an abdominal mass is noted.

A fast-track cancer referral is made and Mr D is seen by a general surgeon. A CT scan reveals an abdominal tumour which is diagnosed as a recurrence of the ureteric cancer. The patient deteriorates rapidly and dies two months later.

A letter of claim for damages is received at the practice from solicitors acting on behalf of Mr D's wife. It alleges clinical negligence on the part of Dr F in the delayed diagnosis of the cancer such that it became inoperable.

ANALYSIS/OUTCOME

Expert reports commissioned by MDDUS are critical of the GP in minor respects but with the overall opinion that no action on his part would have changed the outcome of the case. A primary care expert notes that Mr D first presented with symptoms that were suggestive of haemorrhoids. It was four weeks later when blood results indicated low haemoglobin (with weakness, weight loss and continued rectal bleeding) and the patient was given a fast-track referral. Bloods might have been taken earlier but again this would not have changed the outcome in this very aggressive cancer.

It is also alleged Dr F should have been aware of the missed CT scan, but there is no evidence in the records that the practice had been informed of ongoing hospital investigations.

A letter of response is sent to the claimant solicitors and the case is dropped.

KEY POINTS

- Even if evidence of a breach of duty of care is proven it is still necessary to establish causation.
- Sound medical records with clinical justification are essential to a strong defence.



ADVICE

OUT OF SCOPE

BACKGROUND

A dental hygienist – Ms B – is an associate member at MDDUS and contacts the dental advice line in regard to a prescription from a dentist to provide additional treatment out with her scope of practice. She has been asked to drill out composite covering implant screws in order to remove a superstructure of dentures and then carry out scaling of the restoration and the implants. She would then have to re-fit the appliance.

ANALYSIS/OUTCOME

A dental adviser responds to Ms B advising her that this procedure (beyond the scaling) would not be considered within the scope of practice of a dental hygienist. He warns her that the potential pitfalls in such a treatment plan are not insignificant and could lead to a claim of negligence and likely GDC proceedings.

KEY POINTS

- Do not give into pressure to act beyond your competence.
- To do so could lead to a negligence claim and GDC involvement.



COMPLAINT

HE SAID, SHE SAID

BACKGROUND

A letter of complaint is sent to a hospital ward by a patient – Mr K – in regard to a recent in-patient stay for assessment of a suspected neurological condition. In the letter he claims that an ST in the department – Dr D – had in an out-patient appointment stated on several occasions that he would receive an MRI scan, EMG (electromyography) and blood tests, with an appointment two weeks later to discuss the results and a referral for genetic counselling.

In the event the patient did not have the MRI and was still waiting months later for a follow-up discussion of his results (which were negative) and for the genetic counselling. The hospital contacts Dr D to ask for a response to the complaint.

ANALYSIS/OUTCOME

Dr D contacts MDDUS for advice in regard to her draft response. In the letter she states that, although considered, she did not offer an MRI and her notes from the various consultations confirm this. This was also supported by admission documents and a letter to the patient's GP.

In regard to a follow-up appointment to discuss results, Dr D was advised by the consultant neurologist that this was not necessary, and she regretted if this had not been clearly communicated to Mr K. Her notes also indicate that she informed the patient that genetic counselling would only be necessary if the test results were positive.

MDDUS reviews the complaint response which is forwarded to Mr K via the hospital. The patient replies to say he is satisfied

with the response but still feels there was a lack of communication – and the ST is encouraged to reflect on this.

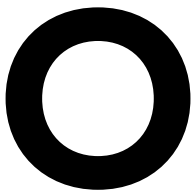
KEY POINTS

- Ensure patients are provided with clear, accurate information about proposed investigations/treatments, presented in a way they can understand.
- Ask patients to confirm their understanding of what is being proposed to ensure they know what to expect.
- Record what has been discussed with patients regarding treatment plans.

DO I ACCEPT A “FRIEND” REQUEST FROM A PATIENT?

Dr Barry Parker

Medical adviser and editor of *Insight*



NE of my regular patients has a keen interest in cycling – which I share. Sometimes we enjoy a quick chat about bikes after a consultation.

I am on Facebook and recently received a Friend request from the patient. Is it okay to accept?

Some healthcare professionals in this situation might feel that to refuse such a request would be rude. Certainly Facebook has now become an almost universal means of communication – with over 31 million users in the UK or nearly half of the population. How is sharing personal details via social media any different from doing so face-to-face in a practice setting?

Well, regulators have some very definite views on this matter. In 2013 the GMC published updated guidance on *Maintaining a boundary between you and your patient* which states: “You must consider the potential risks involved in using social media and the impact that inappropriate use could have on your patients’ trust in you and society’s trust in the medical profession. Social media can blur the boundaries between a doctor’s personal and professional lives and may change the nature of the relationship between a doctor and a patient.”

Just what is meant by professional boundaries can be widely interpreted but Facebook profiles can feature some highly personal information including photographs and details of friends and family, comments

and viewpoints both written and received from others. The BMA states in its social media guidance that although doctors often “choose to divulge personal information about themselves during face-to-face consultations with patients, they are able to control the extent and type of this self-disclosure. The accessibility of content on social media however raises the possibility that patients may have unrestricted access to their doctor’s personal information and this can cause problems within the doctor-patient relationship”.

Ask yourself would you feel as able to discuss treatment plans or difficult decisions with a patient who has seen photographs from your beach holiday or Christmas night out? Do you think it would impact the level of professional trust between you?

The two-way nature of the exchange can also create complications. The BMA states: “Difficult ethical issues can arise if, for example, doctors become party to information about their patients that is not disclosed as part of a clinical consultation.”

The GMC is clear that doctors should be careful not to invite unwanted attention from patients in the first place. There is always the risk that personal relationships may veer into entirely unintended directions. Your fitness to practise may still be questioned even if a relationship seems open and consensual with no obvious adverse consequences for the patient. Such a relationship need not be long-term or even sexual in nature to attract censure. In exchanging personal details with a patient

such as those commonly posted on sites like Facebook you may increase the likelihood of ethical difficulties.

There are steps you can take to minimise the chances of patients contacting you via social media. Take a good look at your privacy settings to make your profile as secure as possible, and try to keep a clear line between any professional and personal pages. Facebook allows users to block their profile from public searches which may help reduce contacts from patients. However, care should be taken in terms of anything you upload on your Facebook page, bearing in mind that social media sites cannot guarantee confidentiality whatever privacy settings are in place.

Should you be approached on Facebook in regard to a medical matter the advice from the GMC (*Doctors’ use of social media*) is clear cut: “If a patient contacts you about their care or other professional matters through your private profile, you should indicate that you cannot mix social and professional relationships and, where appropriate, direct them to your professional profile.”

But what about the scenario posed above? MDDUS would recommend that you decline the Friend request in this case and all such contacts from patients or former patients on Facebook. Should the matter be raised in a later consultation then politely explain the importance of maintaining a strictly professional relationship. Be sure to keep a clear record of your discussion with the patient so there will be no doubt how you resolved the situation.



“Would you feel as able to discuss treatment plans or difficult decisions with a patient who has seen photographs from your beach holiday?”

A VICE-LIKE GRIP ON VIRTUE

Deborah Bowman

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

THIS week I was in Warwick speaking at a conference on the theme of Professional Vices in Modern Medicine. It was an invitation that hooked me from the outset. The speakers were impressive and the subject was irresistible. Participating in the conference has led me to think explicitly about the relationship between virtues and vices, specifically when might virtues themselves become vices and are there 'vices' to which those working in healthcare are particularly susceptible?

however, wonder about two common features of healthcare practitioners and their work, which are offered here in the spirit of inquiry and curiosity.

First, I am fascinated by "ways of knowing" in medicine and healthcare, and the relative weight and attention afforded to different types of knowledge in making decisions. Whatever the speciality or clinical context, most consultations will involve multiple types of knowledge: the quantitative and the qualitative, the generalisable and the particular, and the expert and the experiential all coalesce in a

Secondly, I have been thinking about 'vocation' in clinicians. I have written before about the ambivalent and complex relationship between idealism and realism in healthcare, and the concept of vocation raises similar problems and questions. Might it be that the all-consuming dedication in which professional and personal identities are inextricably entwined is less positive than is often assumed? In professions where burnout, compassion fatigue, excessive stress, relationship breakdown and health problems are regrettably more prevalent than in most other occupational groups, might the demands and expectations created by a sense of vocation contribute, paradoxically, to vice-like emotions and behaviours in some?

Of course, not everyone has a sense of vocation and some progress through their

"Might the demands and expectations created by a sense of vocation contribute, paradoxically, to vice-like emotions and behaviours in some?"

Aristotle (forgive me, I know this is not necessarily the stuff of columns to thrill the busy clinical professional) argued that virtues and vices are inextricably linked. By identifying spheres of specific feelings or actions, he argued that those feelings or actions in excess or deficiency would be undesirable. It was in moderation – the golden mean – that virtue was found. For example, in the sphere of confidence, an excess would lead to rashness or impulsive risk-taking whilst a deficit would result in cowardice. Only in balance, could the virtue of courage thrive.

Aristotle's approach has found contemporary empirical expression in work carried out for the National Clinical Assessment Service, which found that practitioners in difficulty are often struggling with character traits that, were they in balance, would be considered desirable and virtues. So it is that the conscientious professional may, often as a result of external pressures, become obsessively perfectionist or unforgivingly critical of others.

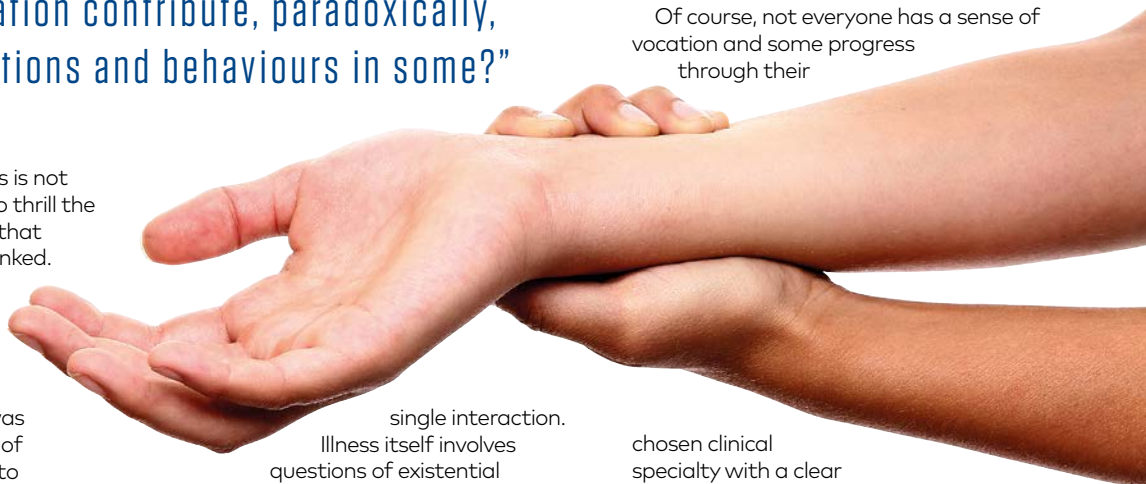
Are there particular vices to which healthcare professionals are inclined or susceptible? It seems like a risky exercise to generalise about a group or groups of people by professional affiliation alone. I do,

single interaction. Illness itself involves questions of existential knowledge in its impact on identity.

Attending to all these ways of knowledge is difficult and demanding. Yet not to do so is to risk what Havi Carel has described as "epistemic injustice", whereby an individual's testimony or experience is overlooked or disregarded. Moreover, even the evidence on which 'gold standard' clinical practice is predicated is problematic. The matter of who decides what to research (and to fund), how to design research, who participates in research and the ways in which findings are, or are not, disseminated determine the 'evidence' and, of course, the ways in which it is interpreted. Epistemological insight and interrogation of ways of knowing are integral to virtuous practice. The absence of the same may result in profession-specific vices.

chosen clinical specialty with a clear understanding that their work is simply a job. It may be a job that is valued and enjoyable, but it is not integral to an individual's sense of self or identity. Perhaps those are the people who have an inbuilt resilience born of their perspective, their boundaries and a balance between realism and idealism that enables them to adapt to the unpredictable course of a career in healthcare.

Vices are a difficult concept, implying as they do something character-based, individual and in some way blameworthy. Perhaps Aristotle was right to suggest that most vices derive from an excess or deficiency of virtue. What he was less able to help with was articulating how we recognise where we might be on the spectrum of virtues and vices. Perhaps even asking the question is a virtuous start.



Addenda

BOOK CHOICE

A is for Arsenic: The Poisons of Agatha Christie

By Kathryn Harkup

Bloomsbury; £9.99 paperback, 2016

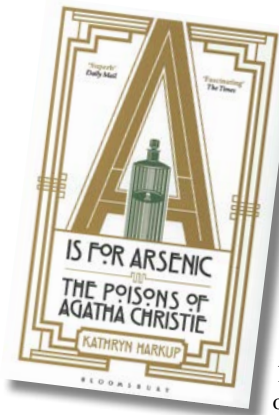
Review by Jim Killgore, managing editor

IN 1921 a review of a book published by a first-time novelist appeared in *The Pharmaceutical Journal*, which declared: "This novel has the rare merit of being correctly written". Not exactly fulsome praise but it was a cherished compliment for the writer – a young Agatha Christie.

The book was *The Mysterious Affair at Styles* and first introduced the famous fictional detective Hercule Poirot. It was Christie's curiously accurate account of how strychnine was used in a murder that earned the praise of the scientific journal, assuming that the author must have some pharmaceutical training or the help of an expert.

Indeed, Christie was something of an expert when it came to drugs and poisons, having trained as an apothecary's assistant when she volunteered as a hospital nurse during World War I. Her extensive chemical knowledge is the subject of a fascinating book by research chemist and science writer Kathryn Harkup, which was shortlisted in the 2016 BMA Medical Book Awards.

Agatha Christie used poison to kill her



characters more often than any other method and in each of the 14 chapters of *A is for Arsenic*, Harkup takes a different novel and investigates the poison(s) the murderer employed – considering the origin of the substance, its development and use throughout history, how it interacts with the body to kill (or cure) and how it is obtained, administered and detected. Harkup writes:

"Christie never used untraceable poisons; she carefully checked the symptoms of overdoses, and was as accurate as to the availability and detection of these compounds as she could be."

The book is a delight of fascinating facts and stories including real-life murder cases that inspired some of Christie's plots, such as that of Glasgow socialite Madeleine Smith, accused of putting arsenic in her lover's cocoa when he refused to break off their relationship and threatened to expose private letters. Smith was found 'not proven' in the murder trial but she lived out her life under suspicion. The book details succinctly how various poisons act to disrupt the body's basic biochemistry resulting in characteristic symptomatology and fatal decline. Arsenic for example is particularly efficacious, producing symptoms similar to those of food poisoning, cholera and dysentery. These and other such unsettling facts make for an intriguing read.

OBJECT OBSCURA

Laennec stethoscope

THIS is one of the original stethoscopes belonging to the French physician René Théophile Laennec, who devised the first stethoscope in 1816. It is made of brass and wood and consists of a single hollow tube. Laennec is regarded as the father of chest medicine and – sadly ironic – died of tuberculosis in 1826.



Photograph: Science & Society

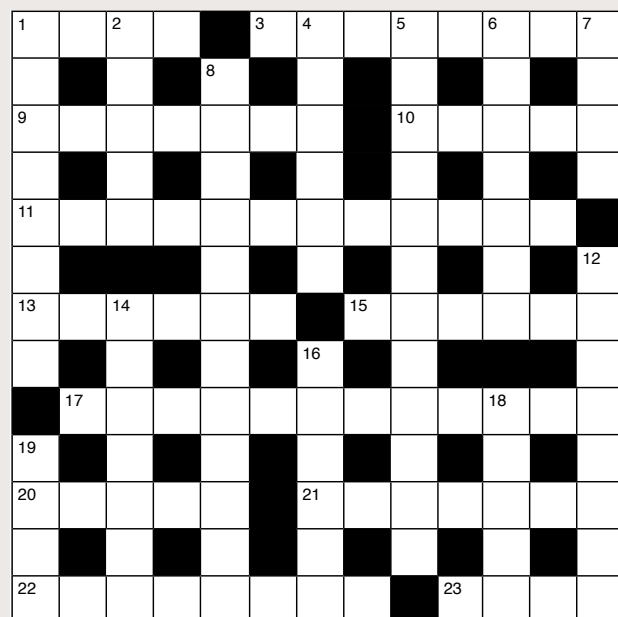
Crossword

ACROSS

- 1 Location (4)
- 3 Poirot creator, Agatha _____ (8)
- 9 Urinal tube (7)
- 10 Rounded swelling (5)
- 11 People to whom things are lodged in trust (12)
- 13 Pertaining to the "back passage" (6)
- 15 Elevated area of tissue or fluid inside or under the skin (6)
- 17 Impossible to control (12)
- 20 Oil from the frankincense family (5)
- 21 Most unwell (or best, in hip hop slang) (7)
- 22 Tardiness (8)
- 23 Ladies' fingers (4)

DOWN

- 1 Palliative care pioneer, Cicely Mary _____ (8)
- 2 Merger (3-2)
- 4 _____ (or ample) portion (6)
- 5 To become mutually connected (12)
- 6 Victorian 'mannequin challenge' (7)
- 7 Currency throughout most of Europe (4)
- 8 From Thessaloniki (12)
- 12 Senility (8)
- 14 Permission to receive medical treatment (6)
- 16 Bodily over-response to infection
- 18 Fracture (5)
- 19 Skin of fruit (4)



See answers at www.mddus.com/news/notice-board

VIGNETTE

Dame Cicely Saunders (1918-2005)

Innovator in palliative care

DAME Cicely Saunders transformed care of the dying – founding the first modern hospice – and was instrumental in establishing palliative care as an essential discipline in modern medicine.

Cicely grew up with two younger brothers in a country house to the north of London. Her father made his fortune as an estate agent and provided his family an upper class lifestyle. Cicely was intelligent, shy and pained by her mother's lack of affection.

At the girl's boarding school Roedean, she found music a comfort. After a failed attempt to enter the University of Oxford, a spell at a crammer gave her a place at the college that was the precursor to St Anne's to read PPE (philosophy, politics and economics). At age 20 she attended a retreat in Scotland and returned a fervent evangelist and from this time on Christianity became a source of strength.

The Second World War changed life for everyone. Cicely enrolled at the Nightingale Training School for Nurses at St Thomas' Hospital. There she made friends and became an admired, hard-working, efficient nurse. A back injury forced her to give up nursing but fortunately led to her learning other valuable skills. She returned to Oxford and in 1944 was awarded a degree and diploma in public and social administration. She qualified as a lady almoner and returned to St Thomas'.

At the end of 1947 she met a Polish émigré named David Tasma who was dying of cancer in Archway Hospital. He had no relatives in England, and although his grandfather was a Polish rabbi and he had a deep knowledge of rabbinic argument, Tasma was an agnostic. When Cicely visited him they immediately fell in love and spent long hours discussing how care of the dying might be transformed to a calm and pain-free experience. They



realised that a more home-like place to nurse and treat patients could best provide this. On his death Tasma bequeathed Cicely £500, probably all he had, and the encouragement: "Let me be a window in your home".

Cicely now had a purpose. First she volunteered to work in the evenings as a sister at St Luke's – a 'home for the dying'. She discovered that she had a gift for calmly listening to the patients, hearing their worries and offering only as much information as they really wanted. It was not customary at that time to tell patients they were dying. One of the most important changes that she made was to let the patient have morphine orally as they needed it to prevent pain. She advocated adjustment of the dose by nurses who knew their patients well and were more available than doctors. Tranquil, pain-free dying was achieved in most cases.

Cicely was advised that she needed to be medically qualified to have the authority to realise her ambition for a hospice and to raise the huge funds for lands and building. Never afraid of hard work she pressed for a place in medical school and qualified as a doctor in 1952. Her first of many papers was on the care of the dying, published in *St Thomas' Gazette*. She gained further experience at the Roman Catholic St Joseph's Hospice, Hackney.

Now in her thirties and single, she fell in love with another dying patient, again a Pole. His death filled her with a grief that was augmented by the death of a lady patient who was a good friend to her and then by the death of her father. Finally, she was rewarded by the lasting love of a Polish artist Marian Bohusz. They lived together and eventually married.

Cicely continued to raise funds for a hospice outside of the control of the relatively young NHS. She inspired others and gradually secured substantial funds from city companies, charitable trusts and the public. Lecture tours in America also raised funds and spread her philosophy on care of the dying – speaking of her patients' lives and deaths.

In 1967 St Christopher's Hospice was opened in Sydenham, south London and received its first patients. Important to the design was a garden and a church spacious enough to accommodate beds. Patients were accepted regardless of their religion but Christian prayers were said daily in the airy wards. Cicely was the medical director.

Recognition came from all quarters with honorary doctorates, MRCP, FRCP, and DBE and the Templeton Prize for Progress in Religion. Cicely continued to write and teach until her death from breast cancer in 2005 at St Christopher's – the hospice she was so instrumental in founding.

Julia Merrick is a freelance writer and editor

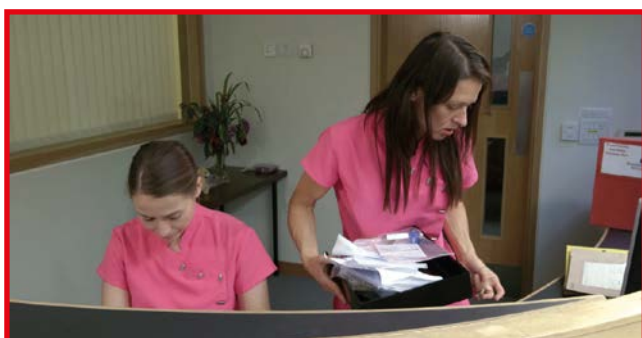
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