

QUARTER TWO / 2017

INSIGHT



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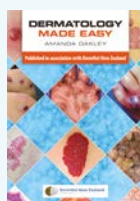
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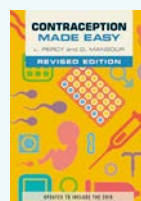
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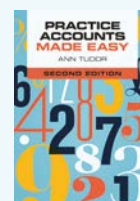
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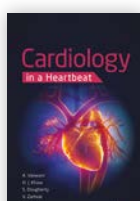
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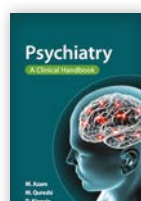
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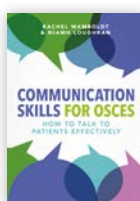
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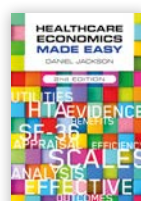
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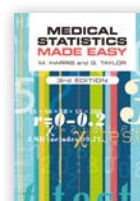
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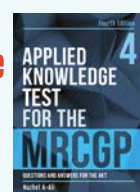
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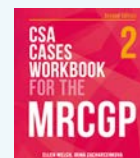
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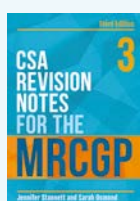
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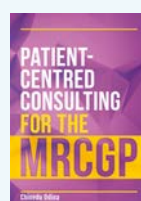
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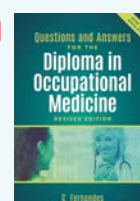
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Editor

Dr Barry Parker

Managing editor

Jim Killgore

Associate editor

Joanne Curran

Editorial departments

Medical Dr Richard Brittain

Dental Mr Aubrey Craig

Legal David Holmes

Design and production

Connect Communications

0131 561 0020

www.connectmedia.cc

Printing and distribution

L&S Litho

Correspondence

Insight Editor

MDDUS

Mackintosh House

120 Blythswood Street

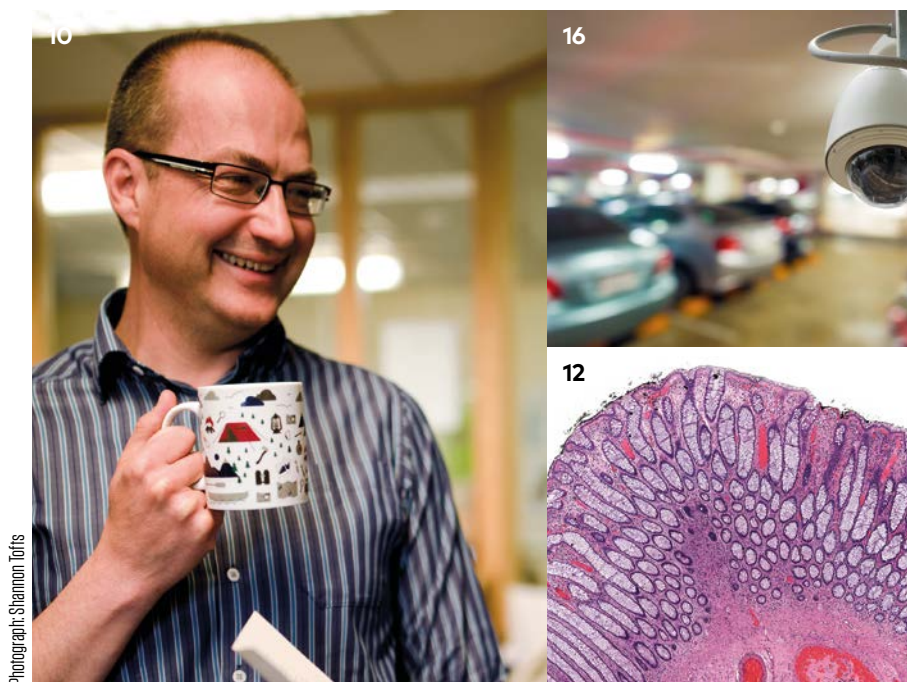
Glasgow G2 4EA

jkillgore@mddus.com

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Warm Summer Day, Caroline Wright
Oil on canvas, 1997.

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FROM THE EDITOR

WITH the recent terrible events in London and Manchester still foremost in our minds, I would like to express heartfelt condolences to everyone affected by these tragedies, and to pay tribute to the many health professionals and members of the public who showed such compassion and courage in helping the injured. We are very fortunate to have a health service staffed by doctors, nurses and paramedics capable of acting with professionalism and expertise in the face of such unimaginable circumstances.

We recently celebrated the innovation and high quality care provided by healthcare teams at the annual BMJ awards, sponsored by MDDUS. Congratulations to the inspirational

winners and indeed to all those who were shortlisted.

In this issue, Dr Peter Cawston talks to Jim Killgore about a Scottish initiative to integrate health and social care (page 10). Jim also discusses the current evidence relating to a 'weekend effect' in healthcare on page 8.

Liz Price offers advice on the medico-legal implications of documenting reflective practice on page 9, and on page 12, Allan Gaw explores the issue of ownership of human tissue as a source of data. Is it the same as other

health data?

Doug Hamilton highlights the distinction between the duty of candour and raising concerns about patient safety on page 14, and on page 21, Deborah Bowman focuses on the issue of motivation in medical ethics. And in our regular dilemma feature, Dr Gail Gilmartin offers advice on situations where patients on repeat medication are non-compliant with follow-up and monitoring arrangements (page 20).

Dr Barry Parker

MDDUS News



RCGP partnership provides savings for new GPs

MDDUS is proud to announce a new partnership with the RCGP that reduces the cost of indemnity and RCGP membership for newly qualified GPs in their first five years after qualification.

New GPs can apply for a tailored MDDUS indemnity package along with a contribution to RCGP membership fees. This will be available to new and current members of both organisations, with existing MDDUS members benefiting automatically at their next renewal date.

MDDUS Director of Development David Sturgeon said: "As principal sponsor of the RCGP annual conference, we are delighted to build on our already excellent relationship with the College.

"We are both focused on achieving high-quality care for patients and first-rate, high-value member services. Joining both bodies through this scheme provides a new lower-cost route for a new GP to get all the benefits of belonging to two innovative and complementary professional bodies."

Professor Helen Stokes-Lampard, Chair of the Royal College of GPs, said: "The first five years of independent practice are essential in shaping a GP's career, and it is important that our newest members are supported as much as possible so that they can concentrate on implementing their training and delivering good, safe patient care.

"Rising indemnity costs are a concern for all GPs, and in our manifesto in the run-up to the General Election in June, the College is calling for this to be addressed as a matter of urgency. I'm delighted that our newly qualified members can opt to benefit immediately from this discount scheme."

Find out more at www.mddus.com/join/rcgp-first-5-partnership

Mission statement and brand values

MDDUS has launched a new mission statement and set out its brand values after an extensive consultation involving staff, the Board and a membership survey and working group.

The mission statement and brand values represent the importance

we place on offering a professional, responsive membership that represents value for our members.

Our mission statement

We deliver indemnity and a professional, high-quality advice and support service to healthcare professionals throughout the UK. We manage our members' money soundly. Our members trust us to put their

interests first, knowing that we will always be there when they need us.

Our brand values

- Members come first - they are the focus of all we do.
- Experts in our field – over 110 years' experience of assisting healthcare professionals.
- Peace of mind – advice and support always available for the time in membership.
- Responsive and prompt – flexibility to deliver an efficient and personalised service whenever needed.
- Flexible support – free from the constraints of an insurance product.
- Cost effective – competitive subscriptions without compromising on quality.

CPD-accredited learning for MDDUS members

MDDUS members can log into our new website to access a wide range of risk resources, including CPD-accredited modules, video presentations, online courses and webinars.

Find out about key medico- and dento-legal risk areas such as consent, confidentiality and data protection by visiting the Training & CPD page at **mddus.com**.

There you can click the link at the top of the page to browse all training and CPD and search by keyword, or scroll down to check out our resources for medical and dental professionals.

Members can earn CPD points with our online courses accredited by the RCGP and the Royal College of Physicians. Other highlights include our popular GP practice-based drama series, *Bleak Practice*, with links to materials that will help you plan practice workshops within PLTs.

Members can also download practical risk checklists on topics such as duty of candour, clinical dental record keeping and results handling; watch video presentations on core risk topics; and access our CQC Toolbox to help prepare for inspections.

To log in, enter the email address you have registered with MDDUS along with your membership number. For help, email **risk@mddus.com**

Risk training day for GPs

Medico-legal actions against GPs are rising in frequency and as part of our internal governance, MDDUS conducts ongoing

analysis to understand the most common and serious medico-legal risks to which GPs are exposed. Over three quarters of negligence claims against GPs arise from missed or delayed diagnosis and failures in repeat prescribing.

MDDUS plans to share these insights with members in two single training days for GPs at our Glasgow and London offices. Delegates will learn more about why claims occur and explore ways in which known risk can be mitigated. The day will also cover recurrent and emerging pitfalls that can lead to GMC complaints, including the management of patient complaints, communication with patients, chaperone use and social media.

The training days are open to both MDDUS members and non-members. To book for Glasgow on 29 June or London on 18 July email **risk@mddus.com**. The cost is £85 (£95 for non-members) and a certificate detailing six hours of verifiable CPD will be provided to all delegates on the day.

A hospital doctor risk day in Glasgow has been set for 16 August with a London date to follow. Contact **risk@mddus.com** for more details.



MDDUS urges increase in FRC limit

MDDUS has urged the government to increase its proposed fixed recoverable costs (FRC) limit following the conclusion of a Department of Health consultation.

The consultation proposed a mandatory system of fixed recoverable costs for lower value clinical negligence claims in England and Wales applying to claims over £1,000 and up to £25,000, but MDDUS believes the limit is too low.

MDDUS CEO Chris Kenny said: "MDDUS has long believed that there should be a fair system for resolving clinical negligence claims. We welcome the government consulting on this issue and now hope for a rapid transition period as well as a swift and decisive introduction of reforms that ensure timely, proper and just compensation for those wrongly damaged."

"While we can understand the introduction of a limited scheme to ensure that the regime is robust and workable, we are disappointed the caps proposed only include claims of up to £25,000. We urge the government for a firm and swift commitment to increasing the upper limit to £250,000."

"We believe this is imperative in light of the current challenges facing the health service, not least the significant increase in the cost of claims that has already arisen from the recent change in the discount rate."



GOOD PRACTICE IN CONSENT

MDDUS members can learn how to get it right when obtaining consent with our new online module – accredited by the RCGP. *Good practice in consent for GPs* takes around 45 minutes to complete, with a CPD certificate on completion. Find out more on our Online courses page in Training & CPD at **www.mddus.com**



CONFERENCE ON MEDICAL LIABILITY

London will this year host the PIAA International Conference 2017 – *Change and Disruption: Strategies for managing the evolution of medical liability* on October 4-6 at the Grange St Paul's Hotel. The PIAA is an international trade association representing medical professional liability insurance companies, mutual indemnity organisations and other entities. Find out more and book now at **http://piaa2017.com/**



SIGN UP FOR MDDUS eMONTHLY

MDDUS members are invited to sign up for our monthly e-newsletter with helpful risk alerts, case studies, features and news updates. Just contact us via email (Subject: eMonthly) at **membership@mddus.com** giving your full name and/or membership number.



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 Training & CPD section (Webinars on drop-down menu) at **www.mddus.com** for more details.

Emergency cancer patients not seen by GP

A NEW study funded by Cancer Research UK has found that a third of cancer patients (34 per cent) diagnosed as an emergency in England had not consulted their GP beforehand.

The research published in the *British Journal of General Practice* used data from more than 4,600 cancer patients with 18 different types of cancer to determine how many times they had visited their GP before their disease was diagnosed in an emergency setting. Cancers diagnosed as emergencies are more likely to lead to poorer outcomes in patients, as these are usually at a late stage.

Among the cancer patients presenting as an emergency with no prior GP visits, most were men, the elderly and those from more deprived backgrounds. The researchers point to a range of practical, emotional and health barriers that can make these groups less likely to seek help promptly from their GP.

Dr Georgios Lyratzopoulos, one of the lead researchers based at University College London, said: "These findings tell us that some patients diagnosed as an emergency might not be acting on 'red flag' symptoms which could have prompted them to visit their GP. This highlights the need to explore all the reasons why cancers are diagnosed late, including what happens outside GP surgeries."

Call to improve dentistry for homeless

NEW research has shown that 15 per cent of homeless people have resorted to pulling out their own teeth.

The study by homelessness charity Groundswell asked 260 homeless people in London about dental care and found 70 per cent reported having lost teeth since they had been homeless. Just over a third (35 per cent) said they had teeth removed by a healthcare



professional, 17 per cent lost teeth following acts of violence, and seven per cent had no teeth at all.

The BDA's chair of England Community Dental Services Michael Cranfield said: "The failure to invest in community dentistry is hurting patients who can't always be cared for in traditional settings. This research should force government and health commissioners to reassess their priorities."

GMC guidance on DVLA disclosures

REVISED GMC guidance on confidentiality came into effect in April of this year and includes key ethical duties and obligations of doctors in relation to fitness to drive issues. The strengthened guidance clarifies the need for doctors to disclose information to the appropriate authorities in situations where a patient ignores advice to stop driving and is potentially putting others at risk.

MDDUS medical adviser Dr Barry Parker said: "We have encountered cases where patients disagree with the advice of their doctor and consider that they are still competent to drive, or they may seek to cope with the condition by offering to restrict driving in some way.

"No doctor wants to find themselves in the position of having to act against their patient's wishes and breach their confidentiality. After all, doctors are accustomed to acting as patient advocates and confidentiality lies

NHS cyber-attack: future planning

DOCTORS dealing with future ransomware attacks similar to the one recently affecting NHS IT systems are advised to apply common sense principles when treating patients without access to computerised or other medical records.

Doctors are advised to revert to time-honoured methods of noting a detailed history by making hand-written records, ensuring they are accurate, legible, contemporaneous, timed and dated. Once IT systems have been restored, the hand-written note should be recorded within the patient's electronic records, including the time and date of the original note, as well as when it is uploaded. We would also advise that the paper records be retained and scanned to the electronic record.

Given the absence of past medical history, doctors should take extra care to double check any relevant medical information with their patients and document these discussions. Doctors should prescribe for the minimum period necessary unless they are able to verify sufficiently the drug history. Other forms of communication such as telephone can be used to contact labs etc. if results are not available online.

Finally, doctors are reminded to act within the limits of their expertise and if in doubt, seek advice from a senior colleague or their medical defence organisation.

Dr John Holden is joint head of medical division at MDDUS



at the heart of the trusted doctor-patient relationship. However, confidentiality cannot be absolute and there are situations where a doctor may have to disclose confidential information in order to protect the public interest, even when consent has been refused by the patient.”

Access the new guidance at www.gmc-uk.org and contact MDDUS for any specific advice on fitness to drive issues.

Dental phobia linked to poor oral health

PEOPLE with dental phobia are more likely to have decayed or missing teeth, according to a new study. Those who fear dental treatment also reported a poorer oral-health-related quality of life than non-phobics.

The research conducted by King's College London (KCL), and published in the *British Dental Journal*, analysed data from almost 11,000 participants of the Adult Dental Health Survey (2009), of whom 1,357 were identified as phobic. Of these, the vast majority were women (1,023) compared to just 344 men. The results showed that dental phobic people were more likely to have caries compared to non-phobic respondents, and were likely to have one or more missing teeth. The report argued that this poorer oral health could be caused by phobics avoiding regular dental visits to address oral conditions that are preventable and chronic in nature.

Professor Tim Newton, of the KCL Dental Institute said: “The correlation between those with missing teeth and dental phobia could be the result of treatment decisions made when the individual with dental phobia finally seeks treatment. Both patient and practitioners may favour extraction of the tooth rather than booking a number of appointments to complete a restoration.”

KCL's Dr Ellie Heidari, lead author of the study, added: “Other research has shown that individuals with dental phobia express negative feelings such as sadness, tiredness, discouragement and general anxiety, less vitality and more exhaustion.”

New complaints procedure in Scotland

A NEW complaints handling procedure for the NHS in Scotland came into effect in April of this year.

The new NHS Scotland Model Complaints

Handling Procedure (CHP) is intended to be used by all NHS service providers, including GPs, dentists, opticians, pharmacists, as well as other contractors such as cleaning or catering providers. The CHP is designed as templates for NHS bodies and primary care service providers to adapt and adopt – and there is also an implementation guide available.

The revised two-stage procedure is intended to support a consistent person-centred approach to complaints handling across NHS Scotland, and bring it into line with other public service sectors. Stage 1 allows five days for early local resolution of a complaint. Should a complainant remain dissatisfied this can be escalated to a 20-working-day Stage 2, providing for a more “thorough and robust” investigation. Complex complaints where an early outcome is unlikely can be handled directly at Stage 2 of the procedure.

NHS Scotland says that the model CHP has been structured with as much flexibility as possible, while still providing standardisation across NHS service providers. Details on how to make a complaint should be widely publicised, simple and clear for all service users.

Access at tinyurl.com/ke3yrr3

Treat severe sepsis within one hour

PATIENTS showing symptoms of severe sepsis should be treated within one hour, according to a new draft quality standard from NICE.

The quality standard highlights areas from NICE's 2016 sepsis guideline and stresses that staff in any setting, from GPs to paramedics, should check patients for specific signs that will show if their symptoms are life-threatening.

This includes temperature and heart rate, and checking for rashes or skin discolouration.

NICE says that high-

risk sepsis patients should get antibiotics and IV fluid treatment within the hour. If it will take more than an hour to get someone to hospital, GPs or ambulance staff can also administer antibiotics.

Professor Gillian Leng, NICE deputy chief executive, said: “Severe symptoms can develop in sepsis very quickly. If high-risk patients are not identified and treated promptly, people can be left with debilitating problems. In the worst cases, they may die. This quality standard highlights priorities in the continued fight to improve sepsis care.”

The new quality standard is due for publication in August.



ALCOHOL ADMISSIONS HIGHEST EVER

ALCOHOL-RELATED hospital admissions in England have increased by 64 per cent over the last decade with 1.1 million admissions in 2015/16 – this despite data showing that the proportion of adults drinking is at its lowest level since 2005 (though 7.8 million people admit to binge drinking). The Royal College of Physicians and alcohol health experts are calling on government for more action to tackle the harm done by alcohol.

EXPANDED EMPLOYMENT OF IN-SURGERY PHARMACISTS

NHS England plans to introduce new, surgery-based clinical pharmacists to over 700 more practices in order to help free up GP time. NHS England has pledged over £100m of investment to support an extra 1,500 clinical pharmacists to work in general practice by 2020/21. This is in addition to over 490 clinical pharmacists already working across 650 practices as part of a pilot, launched in July 2015.

PRESCRIPTION HISTORY AID TO CANCER DIAGNOSIS

LOOKING for patterns in medication given to patients before they are identified with cancer could improve early diagnosis. Research to be funded by Cancer Research UK will analyse an anonymous dataset of nearly all NHS primary care prescription data – approximately 80 million medications being prescribed each month – alongside cancer statistics to identify trends that could help guide GP referrals.

AN ENDLESS WEEKEND EFFECT

Jim Killgore

Managing editor at *Insight*

IT'S official now – at least according to the *Daily Mail*. 'You ARE more likely to die if you are admitted to hospital on a Saturday or Sunday'. So stated a recent headline in the newspaper, with the subhead: "New report adds growing evidence to the NHS 'weekend effect'."

Surely the most telling feature in this headline is the rather strident "ARE" – clue to just how much the "evidence" here is still disputed.

The source of the *Daily Mail* article is an easy-to-miss report on the NHS Digital website entitled *Seven-day Services – England, October 2015 – September 2016, Experimental statistics*. The report summary starts off by citing the 2015 speech by Health Secretary Jeremy Hunt in which he outlined his commitment to "seven-day" NHS care and highlighted variation in outcomes associated with weekend hospitalisation.

This is the same speech in which he made the controversial claim that around 6,000 people lose their lives every year due to the lack of a proper seven-day service in hospitals and that patients are 15 per cent more likely to die if admitted on a Sunday compared to being admitted on a Wednesday.

The report then states that the "experimental statistics" compiled by NHS Digital are being published to provide a starting point for discussions on how the NHS can effectively measure both improvement and variation in care provision across the week.

It contends that among "key facts" consistently emerging from the data are that patients admitted at the weekend have an increased likelihood of mortality within 30 days of admission compared to those admitted midweek. It has also found that patients discharged on Friday, Saturday and Sunday are more likely to require emergency readmission within seven days of discharge compared to those discharged on a Wednesday.

The common assumption is that this is due to reduced availability of senior staff and diagnostic services in hospitals at weekends. But as Martin McKee, professor of European Public Health, wrote last year in a *BMJ* editorial "almost nothing is clear in this tangled tale". He makes the point

that evidence does exist to support a "weekend effect" but the real question is how do you tease out the causes and come up with an appropriate response.

McKee looked at two key studies used to support Jeremy Hunt's original claims on the weekend effect and commented: "The problem was that, while both did identify an increase in deaths among those admitted at weekends, neither attributed it to a shortage of medical staff. Both identified numerous possible explanations, including various data artefacts."

Just before the NHS Digital report was published this April another two studies appeared concerned in part with the weekend effect. Researchers at the University of Edinburgh published a study in the *British Journal of Surgery* looking at more than 50,000 emergency surgery cases in Scotland over a three-year period between 2005 and 2007. They tracked patient outcomes until 2012 and found that patients who were admitted over a weekend were more likely to be operated on sooner but there was no evidence to link day of the week to an increased risk of death for those undergoing emergency

"Evidence does exist to support a 'weekend effect' but the real question is how do you tease out the causes"



operations. Emergency patients are, in any case, eight times more likely to die than those who elect to have surgery, as they more commonly experience complications.

Another recent study from Bristol found that NHS patients admitted to hospital at the weekend with a hip fracture are at no greater risk of death compared to those admitted on weekdays. In fact, the risk of death during the hospital stay was lower at the weekend than in the week. It did find that a delay to surgery or undergoing surgery on a Sunday (when provision for operations in many hospitals is less) were associated with an increased risk of death at 30 days – as was being discharged from hospital on a Sunday or out of hours.

Both of these studies serve to illustrate that the picture is far from simple and caution is required when analysing and interpreting data.

Indeed the NHS Digital report itself concludes that there are "many possible explanations" for the weekend effect such as difference in the case-mix of patients, patient behaviour and provision of services both in and outside of the hospital (including social care) and that its analysis is "unable to determine the causes of the observed variation".

No doubt this is a debate that will run and run.

CAN REFLECTIVE PRACTICE BE “INCRIMINATING”?

Liz Price

Senior risk adviser at MDDUS

ALL healthcare professionals today are actively encouraged to engage in reflective practice – be it through submissions to an ePortfolio or through the analysis, reporting and sharing of lessons learned as part of a significant event review (SER). But recently MDDUS has noticed a rise in calls from members worried that taking part in these formal procedures might “incriminate” them should a complaint or claim arise.

The purpose of an SER or reflective statement is to reflect on performance where things may have gone wrong and also to focus on areas of good practice. For reflections to be effective it is important that they are completed openly and honestly. But what happens when a patient or a court asks for a copy?

A legal case reported in the media in April 2016 sparked particular concern. It involved a GP trainee who had consented to the release of reflective notes, only later to have them used as evidence against the trainee in court.

Such cases have the potential of stifling open and uninhibited reflection. For example, a doctor or dentist might be disinclined to participate properly in an SER out of fear it may be deemed disclosable – though to refuse might be unwise as it could result in regulatory scrutiny both in relation to supporting patient safety and quality improvement. Indeed, regulators considering fitness to practise decisions will usually ask for meaningful evidence of reflective practice.

Both the GMC and GDC set out expectations of openness and honesty and a requirement to engage in reflective practice in relation to revalidation and maintenance of registration. The GMC states that a doctor “must take part in systems of quality assurance and quality improvement to promote patient safety” (GMC *Good Medical Practice*). Doctors also “must cooperate with confidential and formal inquiries into the treatment of patients and complaints procedures”.

In England, the CQC expect to see meaningful SERs as evidence of learning from patient safety incidents under their key lines of enquiry (KLOE) S2: Are lessons learned and improvements made when



“To ensure the patient cannot be identified you should consider removal of their name, address, age, DOB and unusual features of the patient or circumstances”

things go wrong?

Recent guidance was published by the Academy of Royal Colleges (ARC) in relation to the April 2016 trainee case and as a result of concerns from colleges themselves about requests for access to

this type of submitted information. The ARC guidance stresses that these reports should be held/used/shared only as “educational tools and not a medical record”.

The Data Protection Act 1998 allows for access to records including personal identifiable information along with a description of the event. In order to reduce the risk of your analysis leading to unwarranted disclosure it is our advice that once the reflective or SER process has been completed the report itself should be stored anonymously.

In addition, to ensure that the patient cannot be identified you should consider removing their name, address, age, DOB and, if possible, any unusual features of the patient or the case. The names and titles of other healthcare professionals should also be removed.

Practices undertaking an SER as part of the investigation and sharing in response to a patient complaint should ensure that when storing completed SERs the individual is identified only by a random value (with an age bracket if necessary) which does not correspond to any other system that would identify the patient. This advice also applies to any reflective reports that you personally hold or submit for demonstration of CPD.

ACTION POINTS

- Anonymise reflective reports or SERs once completed so that the risk of breaching patient confidentiality can be minimised, if these are shared.
- Be aware that even when an SER has been anonymised there may still be the risk of a patient being identifiable when clinical/personal circumstances are rare or unusual.
- Be aware that even an anonymised SER produced as part of a learning/reflective process *may* be disclosable to a patient if they become aware of it and request access.
- Reflective statements requested as part of a confidential inquiry should avoid emotive language or judgemental statements about the patient – or yourself/other healthcare professionals.
- Seek advice from senior colleagues or MDDUS advisers in potentially serious cases.

A COLLEAGUE of Dr Peter Cawston has described him in the magazine *Pulse* as a bit like a professional horse rider: “They sit there and jump huge fences and yet you hardly know they are moving – no fuss.”

Certainly this soft-spoken GP has played a significant but understated role in seeing through an innovative policy shift in the way health inequalities are being addressed in Scottish primary care. Cawston is one of the founding members of GPs at the Deep End – a group of primary care doctors working in the 100 general practices that serve the poorest populations in Scotland.

His own practice – Garscadden Burn – is in the Drumchapel district of Glasgow, based in an ageing NHS health centre shared with five other practices. It’s a typical deep-end practice with 62 per cent of its 5,100 registered patients living in the 15 per cent data zones categorised as the most socio-economically deprived.

In these areas healthy life expectancy among men can be up to 18.8 years less than in more affluent areas and 17.1 years for women. Studies have also found that practices in deprived areas have 38 per cent more patients with complex health needs (five or more long-term health conditions) and twice as many with combined physical and mental health problems than in more affluent areas.

GPs at the Deep End was established in 2009 as both a network and advocacy group for practitioners dealing with health inequalities on a day-to-day basis. Says Cawston: “Away back when we started no one was really talking about the role of GPs in areas of deprivation. It was never really discussed. Inequality was seen as a public health issue, not a medical issue. So within general practice it was invisible.”

In 2013 the group published a “manifesto” on *What can NHS Scotland do to reduce and prevent health inequalities?* Cawston authored an annex to the report proposing the employment of “community link workers” within deep-end practices.

“A great many health problems are caused by social conditions,” he says. “GPs were being asked to address a lot of social conditions that we weren’t equipped to deal with in a very effective way. That’s where the idea of having a links practitioner as part of the practice came from.”

The role primarily involves “social prescribing” and improving links with local community resources and services. Links workers embedded within a practice can help patients with issues such as adult and child protection orders, bereavement, rent arrears or threatened eviction, dealing with police and social workers, as well as promoting healthy living, including organised walks, yoga and cookery classes. The scheme also gives GPs greater confidence to ask patients about underlying issues, such as debt or domestic violence, because they now feel able to offer an adequate response.

The proposal was picked up by Scottish Government and in April 2014 seven practices – including Garscadden Burn – began a pilot employing a “links worker”.

“We were very lucky as Peter was the lead. He’s pushed and pushed for this for years,” says Elaine Smith, the practice manager at Garscadden Burn. “A lot of patients we would see week in, week out – we now see less of because their problems have been sorted out by Margaret Ann [the links practitioner]. They only need to speak with



DOCTOR AT DEEP END

a doctor if they are genuinely ill.”

Says Cawston: “As a pilot practice we kind of felt we had to lead by example. But this has been a passion of mine ever since I became a GP, really, bringing together the social and medical models of health. General practice striding across the two.”

AN UNCONVENTIONAL APPROACH

This passion is perhaps not surprising considering Peter Cawston’s background. He was born in Peru where his parents were missionaries and he lived there until a young teenager, before moving to Scotland. After doing medicine at Glasgow University he took a job in the south of France for two years, working in HIV medicine and psychiatry.



Jim Killgore chats with Dr Peter Cawston – a GP at the coalface of health and social care integration in Scotland

He is fluent in both French and Spanish.

“I chose to work in North Marseille which is a very deprived area with lots of North African immigrants – profoundly affected by drug addiction and prostitution. So I was already pretty deeply ingrained in seeing the role of the GP as being social as well as medical, and about trying to bring social change through practicing scientific medicine in a community.”

Cawston returned to Scotland and began a two-year higher professional training fellowship, working two days a week practicing in Drumchapel and also undertaking a “participatory action research project” for his MSc in primary care. The topic was, not unsurprisingly, bringing about change in the health service by community

participation and engagement.

“The research only just scraped through,” says Cawston. “It was somewhat unconventional.”

Local volunteers created the questions and tested them before going to bingo halls and youth groups and other community settings to interview peers and conduct focus groups. The data was then analysed with Cawston acting as a facilitator.

“It was blood-stirring stuff,” he says. “One woman was learning how to read alongside the research. She was literally taking transcripts of interviews to her English teacher and learning to read the words of her peers.”

Cawston describes the process as an action-learning cycle – small cycles of change, taking a specific issue and trying to bring about change as quickly as possible to give people a sense that they actually could affect how things are done. The automatic doors in the health centre were a result of the process, as well as the introduction of adjustable examination couches for disabled people.

“What people also talked about was how doctors did not understand the bigger picture – and that has coloured my view ever since. Patients come in with a symptom but there is this whole back story that’s invisible – not present – and isn’t allowed into the consulting room. And that back story may be the key to why they are so distressed. In a sense the links worker programme is a direct consequence of listening to people talk about this bigger picture.”

Certainly it seems that Scottish Government is listening, with the integration of health and social care at a structural level now a legislated priority. It recently published an action plan involving the recruitment of 250 community links practitioners to work with GP surgeries across Scotland. Peter Cawston has been asked to advise on the implementation.

COALFACE ACADEMIC

Cawston describes himself as an academic practitioner but also a “coalface” GP. He worked for a number of years as a part-time clinical lecturer at Glasgow University but found it difficult to balance with his role as a partner at Garscadden Burn. “I tend to give a hundred per cent to whatever I do.”

GPs at the Deep End – with its strong alliance between academics and practitioners – has allowed Cawston a toe in both camps. Another aspect of the organisation that appeals is its active interest in influencing health policy. “That we can be heard at a national level if we join forces,” says Cawston. “It’s politics with a small p; perhaps advocacy is a better word.”

A central theme in the work of GPs at the Deep End has been the recognition – backed up by extensive research – that those patients most in need of adequate healthcare are often least likely to receive it and, conversely, those with least need tend to use health services more (and more effectively) – the so-called inverse care law.

Says Cawston: “If health services aren’t configured to take into account huge health inequalities then we actively contribute to them. It’s not a neutral situation. There is very solid evidence that the NHS, though free, isn’t impartial. It actively favours affluent populations.”

And this, he adds, is a challenge that must be faced by policy makers. “I think the line ‘at its best where it’s needed most’ encapsulates the whole argument.”

Dr Peter Cawston with practice manager Elaine Smith

Jim Killgore is managing editor of *Insight*

MOST legislation views the collection of human tissue and personal data as quite separate and distinct.

In the UK, we have different laws that govern these in the form of the Human Tissue Act 2004 (Human Tissue (Scotland) Act 2006) and the Data Protection Act 1998 (DPA), respectively. But, given that human tissue is a source of medical and genetic information, might we be creating a distinction that is not only unclear but also unhelpful in practice?

Within every nucleated human cell there are 23 pairs of DNA strands that if joined end to end would be approximately two metres long. Coiled around itself and then spooled, these molecules are packaged into chromosomes in a space a few millionths of a millimetre across. And what these ribbons of DNA contain is information – data just as personal as your national insurance number or the collective answers you may have given to a series of probing questions. Thus, human tissue, whether a biopsy sample of your breast or prostate or a blood spot or hair follicle, is a little memory stick packed full of around 700 MB of data written not in words or numbers but in the coded language of organic chemistry.

Why then do we view human tissue as something distinct from the personal data we collect in healthcare? Why do we need different legislation to govern its storage and use, and to protect against its abuse? What would happen if we viewed our blood samples as data collections, albeit written in a different format, but nonetheless readable and understood by appropriate means?

BODY SNATCHERS AND SPERM BANKS

The legal status of human tissue is at best uncertain. One professor of law recently noted that “the approach of the courts when considering proprietary... interests in human bodily material has been pragmatic and piecemeal”. Traditionally, most countries do not recognise any property value of the human body and, therefore, of human tissue. At common law, tissue is seen as a thing belonging to no one. What about body snatchers? – you may ask. Well, they were charged not with stealing the body (you cannot steal what is not owned) but with disturbing the grave and stealing the shroud.

However, our concept of tissue has had to evolve in light of advances in technology. Our previous approach was based on the notion that tissue was merely stuff. Tissue can now no longer be seen as a simple aggregate of cells but rather as a collection of information. If tissue is information, how should we deal with it in the law and how as healthcare professionals and researchers should we be expected to handle, transfer and potentially profit from it?

Much has been written about the ownership of tissue in recent years. In the last decade several high-profile court cases around the world have addressed this issue and brought into question our traditional views of tissue. In the UK, the most prominent of these was *Jonathan Yearworth and others v North Bristol NHS Trust* (2009). Several men about to undergo chemotherapy had semen samples frozen by the hospital to allow them to father children should their treatment render them infertile.

Can our tissue be owned or traded?
Allan Gaw considers an ethical and legal conundrum

IS HUMAN TISSUE DATA?

Unfortunately, these semen samples were destroyed due to laboratory equipment failure and the men sued for damages.

Initially these suits were unsuccessful as the Court did not view the semen as the men's property, but the Court of Appeal of England and Wales subsequently ruled that the appellants had, “for the purposes of a claim in negligence... ownership of the sperm which they had ejaculated”. In 2010 and 2011, two courts in Australia took a similar approach when deciding the ownership of stored semen samples of deceased men.

OWNERSHIP OR CONTROL

The *Yearworth* ruling was seen by many as a watershed, marking a new approach to the issue of human tissue ownership. Others, however, have argued that what was upheld by the Court of Appeal were not property rights, per se, but only limited rights of control.

Ownership is not a necessary prerequisite of control. There are things that no one owns (e.g. public domain data) and there are things that intrinsically cannot be owned (e.g. natural forces such as gravity or, traditionally, our bodies). But equally there are things which we control in whole or in part, that we do not own but in which we have interests.

Thus, the real question may not be one of ownership but one of control, and as we have seen these are not



necessarily the same things. If human tissue is to be used for research, for example, it is hard to imagine that the individual from whom the tissue was taken could be directly harmed by its use. However, it is easy to imagine how such an individual could be adversely affected by the misuse of the data derived from his or her tissue.

If we regard tissue as data in the first place, then the full force of data protection legislation applies and the unwarranted use, storage, sharing and exploitation of the tissue would be prevented. The principles of data protection are designed in fact to protect people by placing significant responsibilities on those who collect and store data, while conferring rights on those who are the subjects of the data. If it is all about preventing unwanted information trafficking, then control of that information is of paramount importance and data protection principles are, in practice, more about control than ownership.

However, it would also mean that tissue, when viewed as data, would become a commodity to be owned and traded, potentially for financial gain. Currently, tissue has value but no price; data has both. If tissue is data in a different format then it too is subject to a rethink. In some countries, such as Germany, they have formally ruled that tissue is not data, but in other countries they are not so sure and anyone working with human tissue samples should be aware of where these arguments are going and the impact future rulings might have on our practice.

HUMAN DIGNITY

But our legal approaches to this question have often turned on another dimension of human tissue – that of dignity. This is a complex concept, but dignity is the principle that perhaps best encapsulates what is important and unique about human tissue. In order to preserve the dignity of the human body there are inevitably certain things which we may wish to do with tissue that courts may decide are inappropriate.

It is not consistent with any meaningful concept of human dignity that the human body could be viewed as a commodity with a price, but information has always had a price and our data can be owned and therefore traded. It can also of course be stolen, but so can DNA. The Human Tissue Act created a new crime in the UK of DNA theft, whereby it is an offence to have “any bodily material intending that any human DNA in the material be analysed without qualifying consent”. If you can steal DNA, surely it must be owned by someone in the first place.

Perhaps, the best way to ensure that we preserve this dignity is to view human tissue as equivalent to sensitive personal data, wrapped in the bundle of legal protection that this definition confers. Direct application of these data protection principles in the collection and storage of human tissue samples would thus ensure both the protection of unwanted information flow and might uphold the special status of human tissue.

Dr Allan Gaw is a writer and educator in Glasgow

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BEING UPFRONT

Doug Hamilton draws a distinction between the duty of candour and raising concerns over patient safety in dental practice

EVERYONE makes mistakes. That's why keyboards have a delete button and (for readers of my vintage) why Tipp-Ex was invented – though please don't use it retrospectively to amend handwritten clinical records.

Dentistry unfortunately provides many working examples of things that can't be so easily fixed. After all, using rapidly rotating or sharp instruments within a confined, mobile environment is a bit of a high-wire act. Accidental pulp exposures, root perforations and needle-sticks injuries can happen in the blink of an eye and are often irreversible.

Most practitioners – once their heart-rate has slowed – will provide the patient with a full and empathetic explanation of what has happened. However, these conversations are never easy. Life being life, the incident occurs when time or the patient's forbearance is at a premium. There may also be a fear of litigation, conflict or censure and the temptation to just keep 'shut' may be keen whilst offering a silent prayer to the gods of teeth. After all, most of us have inherited historic dental catastrophes about which the patient is blissfully unaware. Maybe this case will be similarly blessed.

However, the harsh reality is that most errors come out in the wash. Usually the patient will return reporting symptoms, at which point the treating dentist has to come clean. Worse still, the problem may be drawn to the attention of the patient by another practitioner (more of which later).

Lack of forthrightness at the time of the incident has always tended to damage the relationship of trust, impede the resolution process and, if matters escalate, prejudice the practitioner's defence. However, there is now an increased likelihood that the issue of candour will be the subject of particular scrutiny.

A DUTY OF CANDOUR

Legislation has recently been enacted in England (incorporating specific reporting obligations) and will be introduced in Scotland which obligates health service providers, amongst others, to follow designated procedures following adverse outcomes above a certain severity. All clinicians in these jurisdictions should aim, where appropriate, to implement these procedures. Yet the applicability to the

practice of dentistry of the various adverse incidents described in the regulations may not be immediately apparent.

For example, removal of the wrong tooth is clearly a clinical error. However, should it be regarded as changing "the structure of the person's body"? Quite possibly – but the dental practitioner who has experienced this problem may still wonder whether the regulatory provisions have been triggered.

In practical terms, any such concerns are trumped by the duty of candour guidelines which were published by the GDC last year. To be clear, the GDC has always regarded transparency and forthrightness as professional obligations. However, registrants are now explicitly required to be open and honest with patients when something goes wrong with their treatment which causes, or has the potential to cause, harm or distress. Thus the bar for engaging with the duty of candour is set pretty low.

These rules mandate that the problem must be explained to the patient and an apology must be offered, together with

"Although not closing ranks with our fellow professionals, most of us would not deliberately seek to inflame the situation"

an appropriate remedy or support. Not surprisingly, these discussions must be properly documented. Failure to comply could result in free-standing candour allegations. The GDC's indicative sanctions guidance recommends that a conduct committee should regard deliberate failure to be candid as a serious matter.

COLLEAGUE CONCERNS

So registrants must tell their patients when something has gone wrong – but what is required when encountering an adverse outcome at the hands of a colleague? Clearly, the new dentist must not take the blame for another's error. The aim should be to offer nothing more than a professional and comprehensible account of the clinical findings. These discussions will ensure that

the patient is properly informed. They should also create a bright dividing line between past and future treatment so that the possibility of a practitioner being held liable for the negligence of a predecessor (commonly known as the "you touched it last" principle) is limited.


Patients will often press their new dentist to express a view as to whether the previous treatment was negligent. This is where the conversation can become particularly awkward. Although not closing ranks with our fellow professionals, most of us would not deliberately seek to inflame the situation. Yet there may be genuine concerns regarding the work carried out by the last practitioner. If so, it may be decided that the duty of candour obligates or justifies a critique of this colleague's professional standards. This approach is misguided (and is liable to fall foul of the GDC *Standards for the Dental Team* which prohibits the criticism of colleagues in front of patients).

The dentist who is alleged to be at fault should, with the assistance of his or her defence organisation, take ownership of any complaint or claim. The new dentist should aim to maintain a neutral position, reassured by the likelihood that if some failing in earlier treatment has caused harm, the patient will be offered a fair

solution.

Even so, the new dentist might believe that this case may be indicative of wider problems – other members of the public could be at risk of harm if the previous dentist continues to work unchecked. Few of us would relish the prospect of reporting a fellow professional. Yet it may be felt that further action is necessary. Guidance regarding this dilemma is provided in the section of the GDC's *Standards* which advises registrants about raising concerns.

Much of this text appears to mirror the relevant areas of employment law. However, there are clear messages which inform all registrants, including self-employed contractors. In the first instance, it may be wise for the concerned practitioner to seek advice from colleagues or a defence



organisation. If concerns persist then, ideally, this matter should be discussed with the underperforming dentist.

The truth is that very few of us welcome criticism, however constructive and well-intentioned. If barriers are met, the concerned dentist may wish to approach, for example, the NHS Board, area team or the CQC with an impartial and accurate account of the situation. Having done so, the matter can be left in the capable hands of the relevant agency.

However, there may be some circumstances in which it is deemed that these measures are insufficient and that referral to the GDC is required. This is a big step. Aside from taking advice, prospective informants should examine their own motives – the GDC has in the past been used as a sword and a shield. Consideration should also be given to the GDC's guidance in this regard.

Direct referral to the regulator may well be appropriate where there are serious risks to patient safety arising out of, for example, systemic cross-infection failures or drug abuse. However, lesser problems may well be manageable in a more discrete, proportionate (and, some might argue, efficient) manner, utilising the options set out above. In other words, GDC referral should be normally considered in extremis or where all else has failed.

TO CONCLUDE

Now more than ever, there is the possibility that a GDC investigation will consider whether registrants have discharged their duty of candour. It is also conceivable that, where a registrant's failings are serious or recurrent, other professionals may be asked why they did not protect patients by raising concerns at an earlier stage.

Although these concepts can have commonality, their pathways are distinct. Duty of candour is patient-facing: treating clinicians must be open and honest about adverse outcomes. Raising concerns involves different processes. If patients are deemed to be at risk, registrants must not turn a blind eye. However, concerns should be raised in good faith, at an appropriate level and should be voiced within a professional rather than a public setting.

Mr Doug Hamilton is a dental adviser at MDDUS

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

TELEPHONE TRIAGE

BACKGROUND

Mrs T – a 54-year-old smoker – phones NHS 111 in the morning complaining of left-sided chest pain and discomfort in both arms over the last 24 hours. She speaks to a nurse adviser who also records that the patient has been generally unwell over the last few days with a fever and cough.

The call is passed to a locum GP – Dr D – for triage and Mrs T relates that whenever she exerts herself she gets sharp chest pains and that lately at night she has awoken breathless and panicked. The GP asks if there is any history of heart disease in the family and Mrs T reports that her mother had angina and that her father died of a heart attack at age 60. Dr D records symptoms of cough with chest and arm pain but that, apart from being a smoker, the patient seems otherwise fit and healthy and is taking no medication – though he does note the family history of heart disease.

The doctor refers the patient to an out-of-hours clinic for review and that afternoon she is seen by another GP – Dr G – who records symptoms of cough, chest pain and fever. On examination the patient's chest is found to be clear apart from a slight non-focal respiratory wheeze. A diagnosis of upper respiratory tract infection is recorded and the GP prescribes amoxycillin.

Five days later Mrs T collapses at work and is found by ambulance crew to have

suffered a cardiac arrest. Attempts at resuscitation fail and she is pronounced dead on arrival at the local A&E. The diagnosis is myocardial infarction.

Dr D later receives a letter of claim from solicitors acting on behalf of the family of Mrs T, alleging negligence in not making an immediate referral to hospital in the telephone triage, given the "obvious" symptoms of acute ischaemic heart disease. It is also alleged that the history documented by Dr D and passed to the OOH centre omitted significant details from the call. The second GP – Dr G – is also claimed against separately.

ANALYSIS/OUTCOME

MDDUS instructs a primary care expert and consultant cardiologist to review the case on behalf of Dr D. In considering both a transcript of the call and the recorded

notes, the primary care expert forms the opinion that the GP failed to respond appropriately to the history provided by the patient. The symptoms reported in the call transcript should have prompted Dr D to undertake a more detailed enquiry into the nature and severity of the chest pain and breathlessness reported by Mrs T, including any significant accompanying symptoms. A more detailed history would have likely indicated the need for immediate emergency referral to hospital.

The patient was referred for a face-to-face consultation at the OOH centre but the primary care expert considers that the history documented by Dr D and passed to Dr G was not an accurate reflection of the telephone consultation and omitted significant details – including the breathlessness and panic – reported by the patient that might have led to more thorough investigations.

A consultant cardiologist also reviews the case in regard to causation and agrees that had Mrs T been referred to A&E by Dr D this, on the balance of probabilities, would have led to an ECG and blood tests revealing an ST elevation and raised serum troponin level. Immediate treatment could then have possibly prevented the fatal outcome.

A settlement is agreed by MDDUS acting on behalf of Dr D with a share paid by another medical defence organisation representing Dr G.

KEY POINTS

- Ensure that in any history of chest pain you enquire into the specific nature and severity of the pain and other related symptoms.
- Ensure that all details relevant to clinical decisions made in telephone triage are clearly recorded.

ROUGH TREATMENT



BACKGROUND

Mr G has been regularly attending appointments with his practice's dental hygienist, Mrs K, for several months. As a smoker, he is concerned about his general oral health and areas of brown staining in particular. During one scale and polish, Mr G experiences pain from the treatment and flinches, causing the scaler to cut slightly into his gum. Mrs K advises him to remain still to avoid any further slips. After the following appointment, Mr G again complains of painful treatment and is

concerned the hygienist has not attempted to remove the staining.

He submits a formal complaint to the practice who apologise and arrange for another hygienist to carry out future treatment. However, two weeks later the practice receive a letter from the GDC stating Mr G has complained about Mrs K's "unprofessional" behaviour, "aggressive" treatment and dismissive manner.

ANALYSIS/OUTCOME

The practice principal, Mr L, contacts

MDDUS. Both he and the practice manager have spoken with Mrs K about the complaint and about the manner in which she communicates with and treats patients. She denies being aggressive or dismissive towards Mr G. An adviser offers Mr L advice and helps him draft a full response to the GDC. The GDC later responds to say that the records show no evidence to support the allegations and the case will be closed with no further action.

KEY POINTS

- Ensure the entire practice team are trained to effectively communicate with patients, including those who express concerns about their treatment.
- Be sure to fully address all points of a patient complaint to avoid it escalating.
- Comprehensive dental notes can provide an effective defence during GDC investigations.

DATE OF KNOWLEDGE

BACKGROUND

Mr K attends his dental surgery complaining of swelling and discomfort around his upper left canine. A periapical X-ray is taken showing infection related to a post crown with possible perforation of the root. The patient is informed and opts to keep the tooth under review.

Two months later Mr K returns to the surgery still complaining of pain and swelling around UL3. He is administered an antibiotic and is referred for an apicectomy but the prognosis is not encouraging. The patient opts for extraction and bone augmentation in preparation for an implant.

Mr K asks for an explanation as to why the tooth failed and X-rays confirm a "perforated root with a post crown". It transpires that the post crown was placed over eight years ago by another dentist – Mr V. The patient had attended Mr V several times with ongoing concerns over UL3.

A letter of claim is sent to Mr V by solicitors acting on behalf of Mr K claiming

negligence in the root canal treatment (RCT) and post crown placement of UL3.

ANALYSIS/OUTCOME

MDDUS acts on behalf of Mr V who has since retired and is no longer an active member. An adviser reviews the patient records and instructs a dental expert. In notes taken at the time Mr V refers to the need for a radiograph of the upper left canine to be taken as a prelude to replacing a bonded crown but there is nothing to suggest this was done. There is also no reference to a post-treatment radiograph to check the alignment of the post following the patient's attendance with symptoms from UL3.

The dental expert concludes that Mr V was negligent in placing the post in UL3 as it caused a root perforation. The lack of evidence of a post-treatment radiograph in the records also casts doubts on the quality of patient care.

A claim of negligence arising so long after

treatment would normally be time-barred but in this case the "date of knowledge" determines the timescale. The tooth was asymptomatic over much of the period post-RCT with Mr K only seeking treatment within the last 18 months.

MDDUS in agreement with Mr V settles the case for a sum commensurate with the single implant treatment.

KEY POINTS

- Ensure complete patient records in RCT with pre and post radiographs.
- Inform patients immediately of any issues that might compromise treatment success.
- MDDUS provides occurrence-based indemnity meaning members are eligible for assistance for events occurring while in membership no matter when the claim is made.

Ψ COMPLAINT

NOROVIRUS DIFFERENTIAL

BACKGROUND

A locum GP – Dr R – is working at a practice after hours. A call comes in on his mobile from the mother of a 19-year-old patient – Joe – who is suffering with severe vomiting. The signal on the phone is poor and the GP has difficulty spelling the patient's surname in order to locate his file on the practice system.

There has been an outbreak of norovirus at Joe's college and his mother is very worried as he has not been able to keep down any fluids for the last 24 hours. Dr R agrees to visit the patient at home and finds him quite ill and distressed. His pulse rate is slightly elevated and blood pressure is 120/70. His abdomen is non-tender and there is no sign of peritonitis.

The GP diagnoses norovirus and is concerned that the patient does not become further dehydrated. An anti-emetic injection is administered and the mother is advised to contact the practice again if Joe's condition does not improve.

Later that night Joe loses consciousness and his mother phones an ambulance. Paramedics check his blood sugar which is 36 mmol/l. Joe is taken to hospital and diagnosed with diabetic ketoacidosis (DKA). He spends two days in the ITU and is released a few days later with a referral to a diabetic clinic.

A week later Joe's mother writes a letter of complaint to the practice in regard to Dr R's treatment of her son. She alleges that he was rude and impatient on the phone, claiming that he could find no record of her son in the files though he has been a patient at the practice since he was a child. She also accuses the GP of disregarding her concerns over the seriousness of her son's illness and putting his life at risk by misdiagnosing a serious condition.

ANALYSIS/OUTCOME

Dr R is upset and regretful at his failure to diagnose Joe's condition and the practice asks MDDUS for help in composing a response. First, the practice is urged to contact Joe for consent to allow his mother to deal with the matter, and then to offer a meeting to discuss the complaint if desired.

In the written response, Dr R first expresses his regret for what Joe has been through and that this has prompted the complaint. He is also sorry that the communication difficulty in the initial telephone contact had been perceived as rudeness by Joe's mother and that his manner seemed dismissive during the home visit. It was certainly not his intention. He explains that the symptoms and Joe's exposure to the outbreak at the college all



KEY POINTS

- A sincere expression of regret can do much to defuse an angry complaint.
- Recognise the potential for misunderstanding in non-face-to-face patient contact.
- Positive reflection on how risks can be prevented in future are often all that complainants want.

suggested norovirus. DKA would not have been an obvious diagnosis given the circumstances.

Dr R also states that he has reflected on his practice and manner of communication, and in future will be more mindful of the possibility of diabetes and consider a finger-prick glucose check in similar circumstances.

Nothing is heard back from the family and they remain registered with the practice.

ADVICE

CAR PARK CCTV

BACKGROUND

A patient – Mrs K – attending a busy city centre dental surgery asks to see the practice manager. The rear bumper and taillight on her car has been damaged in the car park and she wants to be allowed to view footage from the practice CCTV camera in order to identify the “culprit”. The practice manager contacts MDDUS to ask if Mrs K should be allowed to review the video footage.

ANALYSIS/OUTCOME

A dental adviser replies to the email referring to guidance from the Information Commissioner’s Office (ICO): *In the picture: A data protection code of practice for surveillance cameras and personal information*. The practice is advised that in this circumstance it would be inappropriate to disclose the images as well as any identifiable information such as patient registration plates to Mrs K without the individual consent of each person recorded. The images could be provided without consent as long as faces and other identifiable third party information are pixelated out – but this would also include the “culprit” who may be unwilling to allow disclosure of their identity.

Disclosure without consent would only be allowed in the event of a police investigation of a serious crime, such as a violent assault, or under a court order. The practice is advised to explain the situation to Mrs K along with their legal obligations.



KEY POINTS

- Practices are obliged under data protection laws to protect third-party information in most circumstances.
- Disclosure of patient information without consent is allowed only in cases of overriding public interest, such as in the prevention or detection of serious crime.
- Consult ICO guidance in regard to the use of CCTV cameras. The guidance also includes a helpful checklist to ensure compliance with data protection legislation.

ADVICE

UNWANTED CHEMISTRY

BACKGROUND

A specialist registrar working in cardiology receives an email from a patient that she had treated a year before. He had obviously searched for her address on Google and most likely found it among the contact details in a research paper. The patient is a young man who had been referred because of unusual ECG findings. Tests confirm nothing serious but the registrar recalls the patient had a history of depression and was still fearful that he was “going to die”.

In the email he says that he had detected some “chemistry” between them during an examination carried out by the registrar. He says that he has seen her once again

waiting at a bus stop but was too nervous to make an approach. In writing to her in this way he hoped to make contact again, perhaps just for a coffee. The registrar calls MDDUS for advice on how best to reply to the email given the history of depression – or if best not to reply at all.

ANALYSIS/OUTCOME

An adviser suggests that in this case a brief response should be adequate, setting out the professional obligation of doctors to maintain proper boundaries with patients – and informing the young man that any contact including further email communication would not be appropriate.

Given his history of depression it might also be helpful to suggest that should the patient have any further health concerns he should discuss these with his GP.

KEY POINTS

- Be clear with patients on your professional obligation to maintain appropriate boundaries.
- Try to be firm but polite in dealing with such approaches.
- Keep a record detailing all patient contact in these cases.

HOW DO I RESPOND TO A NON-COMPLIANT PATIENT WANTING A REPEAT PRESCRIPTION?

Dr Gail Gilmartin

Medical and risk adviser at MDDUS

HAVE a diabetic patient on insulin who has not attended for review for well over a year. When he last requested a repeat prescription for insulin he agreed to attend but then failed to turn up for an appointment. The practice has sent letters reminding him to attend but to no avail. He has now requested another prescription. How should I proceed?

Non-attendance for prescription review can be a tricky problem and, although this scenario involves insulin, the same issues can occur with many types of repeat prescriptions for essential treatment in conditions that need regular monitoring.

Doctors worry that prescribing for patients who refuse to engage adds to the potential harm that the patient faces. Sometimes doctors feel almost blackmailed into prescribing in an unsafe way where patients request their medication but fail to accept monitoring or follow-up.

All doctors are responsible for the prescriptions they sign and so must be prepared to justify their actions should something go wrong. The same applies if they decide not to prescribe.

What factors should be considered and what is the best way to proceed?

The GMC offers detailed guidance (*Good practice in prescribing and managing medicines and devices 2013*) about repeat prescribing and in particular states that as with any prescription you should "agree with the patient what medicines are appropriate and how their condition will be managed, including a date for review. You should make clear why regular reviews are important and explain to the patient what they should do if they suffer side effects or adverse reactions, or stop taking the medicines before the agreed review date (or a set number of repeats have been issued). You must make clear records of these discussions and your reasons for repeat prescribing."

Initial discussions with patients on repeat medication should always include information about the importance of follow-up. At MDDUS we often have cases that arise where patients claim they were not fully advised of the importance of follow-up and review. Their non-compliance is blamed on the doctor for not providing sufficient information in a way the patient could understand. Discussions about review



form a central part of good care and need to be documented in the patient's notes should problems arise at a later date.

In all cases where there are significant health risks to the patient from non-compliance, it is the doctor's responsibility to pursue this. Communication with the patient should ensure they receive the message that review is necessary and why. This can be by personal letter or electronic means if email addresses and mobile numbers are known. Occasionally more urgent contact is needed.

Some members are concerned about possible breaches of confidentiality if messages are left. Care should be exercised, but if there is a significant risk of harm, the risk of breaching confidentiality must be balanced against the risk of harm to the patient if they are not contacted. Take care regarding how much information is left in case someone other than the patient might pick up a message. But again this needs to be balanced because if a message is too vague its importance may be ignored.

It is essential to act in a way you can justify based on the information you hold and the risk to the patient. If in any doubt

ring MDDUS and speak to one of our advisers. Often the simple act of talking things through can be very helpful.

Should you continue to prescribe in this case? You must consider the risks and benefits of the different courses of action. Is it less potentially harmful to prescribe as before or to adjust a dosage? You can also consider prescribing for a limited time to allow the patient to attend and be reviewed.

Should the risks of prescribing – or not prescribing – be unclear then discuss the case with your colleagues and any secondary care doctors involved so that you have a full picture of risks and benefits. It is essential to be adequately informed before making these decisions. Again, we always advise keeping a careful note of the information you have gathered and the way you have used this information to make a decision.

These types of dilemmas are quite common and require careful assessment. Preparing a patient for regular review at the time treatment starts can help to avoid these problems but should such a situation arise the practical steps outlined above can help.

ASKING WHY – MOTIVATION AND EXPLANATION IN ETHICS

Deborah Bowman

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

RECENTLY attended a presentation by a research team about doctors and consent. It was fascinating and thought-provoking, particularly the findings about how doctors perceived, understood and conceptualised consent in practice. I was struck by the ways in which the respondents talked about consent.

Recurrent references to bureaucracy, paperwork, rules, forms, "being sued" and systems were made. Articulation of dignity, relational ethics, autonomy, self-determination and choice were scarcely mentioned by these respondents.

There may, of course, be many reasons for these findings: methodological approach, sampling and selection, the context within which the research took place and any number of other variables which informed the project. That I was sitting in the audience as a professor of ethics interpreting what I was hearing, or maybe that which I thought I was hearing, adds a further layer to the analytic mille-feuille that characterises the interpretation of any research.

Nonetheless, the presentation lingered. Did it matter what motivated those doctors in how they sought consent in their practice? Were the rationales that they described for obtaining consent important provided that valid consent was obtained politely and efficiently? What difference does it make if consent is sought as a defence or because it is "required" by an employer, rather than with any consideration of values, virtues or principles? Was anything more at stake than an ethicist's professional pride as her hopes of hearing her own way of looking at the world reflected in the results diminished as the presentation progressed?

Several weeks of mulling have led me to conclude that motivation and explanation do matter when it comes to ethics. First, to focus on values, such as respect for equality and for others, or on virtues, such as trust, is to attend to the moral significance of the clinical encounter. It is to shift from the form or the paperwork to the interaction and the relationship. It acknowledges that there is something of value at stake that matters. It is not merely a transaction like any other: it is a complex meeting where need, vulnerability, expertise, power, emotion, information and choice collide.



"The 'why' of our behaviour reminds us what matters in a profession and a clinical encounter"

Considering the moral dimension of seeking consent is to show regard for the patient, the exchange and, importantly too, oneself as a professional. It is to accept the discretion that characterises most

professional roles and, therefore, to acknowledge the responsibilities and the challenges that inevitably accompany that discretion. To conceptualise the seeking of consent merely as a matter of routine or something that is imposed by a monolithic employer is to disregard the presence and potential influence of professional judgement, choice and individual approach.

To be actively engaged in the ethical considerations that underpin and inform consent as a concept is to allow for consideration of context. It is an approach that demands thought, reflection and discussion. There will be divergence. Doctors will disagree about the ethical value and purpose of consent. Patients will engage variably with the process. Choices and adjustments will be made in varying ways about how best to make information meaningful for an individual at a specific time or in relation to a particular decision.

That divergence and difference are necessary: the essence of an ethical rather than a bureaucratic approach which privileges the human and the personal over the generalised, unthinking routine. It is an approach that enables a professional to notice when the system within which he or she is working is compromising care and impeding ethical practice. It offers a language and framework for action to raise concerns and address systemic constraints with those who can effect change.

Motivation and explanation reflect engagement, awareness and commitment. The 'why' of our behaviour reminds us what matters in a profession and a clinical encounter, perhaps especially when we are under pressure. Attention to motivation alerts us when we are neglecting or privileging the wrong considerations or questions. Being able to articulate why we do what we do or act as we have done is to offer an explanation that prompts discussion and dialogue with others. It is the door to exchange and to rich learning. It demonstrates that we inevitably frame questions through our own lenses and it may give us pause.

So, as I sat in that audience and heard, with admittedly some disappointment, that consideration of and reference to the language of ethics were largely absent from the respondents' accounts of seeking consent, there was one important question I had to ask about my own reaction. Why?

Addenda

BOOK CHOICE

I contain multitudes

Bodley Head: £15.99 hardback, 2016

Review by Dr Greg Dollman, MDDUS medical adviser

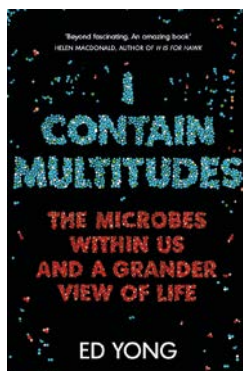
IF you're fascinated by faecal microbiota transplants, read on. If not, maybe you'd prefer to go wash your hands!

In *I contain multitudes*, Ed Yong delves into the infinitesimal detail of our everyday lives and discovers the microbes within us – ushering them in from the “neglected fringes” (“visible only through the illnesses they caused”) and onto centre stage, where he details their masterful performance from “cast as rogues, sooner to be eradicated than embraced” to saviours of humankind, and everything in between.

The average human swallows around a million microbes in every gram of food they eat. Fancy that! Every time we walk, talk, scratch, shuffle, or sneeze, we cast a personalised cloud of microbes into space. Yong writes about humans autographing the environment with around 37 million bacteria per hour. And your bacteria interact with mine, mine with yours, and with everyone and everything around us. This is the grander view of life that Yong explores.

Symbiosis can be defined as living together and sometimes with our greatest enemy. Yong returns to this concept throughout, comparing our interactions with the world at large to a human relationship, where good and bad, harmony and conflict are inevitable.

Yong has researched the science in its



microscopic creepy-crawly detail and presents his findings in a light-hearted and entertaining read. Do microbes affect our cravings? Do they affect our cognition as we age? What are the unintended consequences of antibiotic overprescription? How do microbes interact with everyday prescription

drugs? What is the link with diabetes, mental health and cancer? Yong explores these and many more subjects, drawing examples from across the natural world – from the depths of the oceans to jungles to desert landscapes and importantly hospitals, “where the flow of microbes can mean life or death”.

Yong celebrates “a new way of thinking about the microbial ecology of organisms”.

I contain multitudes explains that microbes are ubiquitous, they are vital (“they sculpt our organs, protect us, break down our food, calibrate our immune system” and the consequences are dire when the natural chain breaks) and they provide humans with the potential to live healthier and happier lives. The ecological opportunities when we are in a harmonious relationship are boundless.

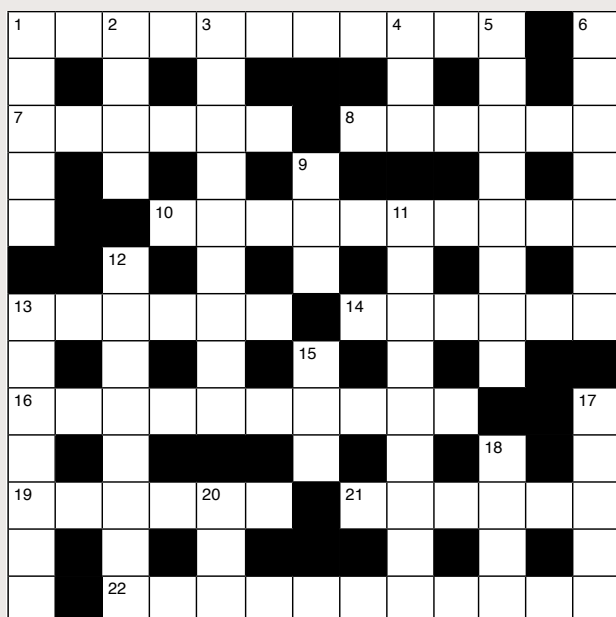
OBJECT OBSCURA

Chinese surgical set

THESE steel surgical instruments in a folding leather case date from 18th to 19th century China. Traditional Chinese treatments were diverse and included herbal remedies, acupuncture, massage and meditation, dietary and lifestyle advice, moxibustion and cupping, as well as some surgical procedures.



Photograph: Science & Society



Crossword

ACROSS

- 1 Focused on one's own misery (4-7)
- 7 Astounded (6)
- 8 Area (6)
- 10 Thoughtful (10)
- 13 Each of two or more compounds with the same formula but different properties (6)
- 14 Dialect (6)
- 16 Term of endearment (10)
- 19 Act without inhibition (3, 3)
- 21 Material used to provide bulk (6)
- 22 Optical device worn directly on the eye (7,4)

DOWN

- 1 Begin (5)
- 2 Principal (4)

- 3 Action that sets an example (9)
- 4 Frozen water (3)
- 5 American football (8)
- 6 Crazy (colloq.) (7)
- 9 Unwell (3)
- 11 Conveys skiers uphill (9)
- 12 Pertaining to the household (8)
- 13 Hormone produced in the pancreas (7)
- 15 Reflect on adverse incident to improve future care (abbr.) (9)
- 17 Conditions (5)
- 18 Used to focus Care Quality Commission inspections (abbr.) (4)
- 20 Atom or molecule with electron count unequal to its neutron count (3)

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

VIGNETTE

SIR ARCHIBALD EDWARD GARROD (1857-1936)

DISCOVERER OF INBORN ERRORS OF METABOLISM

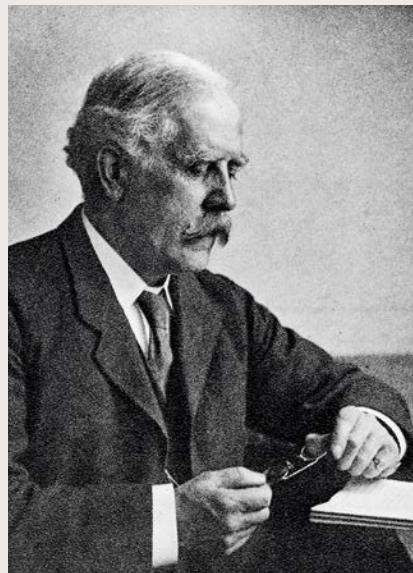
TOO learned to be confident.” This was how one colleague remembered the physician-scientist Archibald Garrod, who was responsible for laying some of the most important groundwork for the revolution in molecular pathology that would transform medicine in the 20th century.

Having been born into an eminent medical family in 1857, it would have been surprising if Garrod had not found acclaim in his profession. But rather than clinical practice, it was the science underpinning medicine and our understanding of disease that consumed him for most of his life.

Some said Garrod preferred his test tubes to his patients and that his bedside manner was geared towards the study of his patients’ urine rather than their ailments. Others, however, remark on a “deep sense of the dignity and importance” he had for his profession. Certainly from the beginning he was marked out as an exceptional clinician destined to rise through the ranks of the London medical establishment. Doubtless it was his industry and his meticulous care and attention to detail that made him both an accomplished doctor and a successful scientist.

His father, Sir Alfred Baring Garrod, had been responsible for finding the link between uric acid and gout, and perhaps Garrod inherited his fascination with the chemical basis of disease. Initially, like his father, Garrod also studied diseases of the joints. Soon, however, he turned his attentions to other conditions.

Without access to the sophisticated laboratory investigations that we today take for granted, Garrod had to find a way to study the complex metabolic processes that control normal function and often determine disease. Garrod’s strategy was to study readily accessible metabolic products that he could easily visualise: urinary pigments. This approach apparently began in 1892 with his discovery of an unusually coloured urine in a patient with



Sir Archibald Garrod. Photograph: Wellcome Images

a neurological disorder. Over the next five years, he completed a body of largely descriptive work on a series of other pigments, but in 1897 it was his study of the condition alkaptonuria that would take his understanding to a new level.

We now know that this is a rare inherited metabolic disease due to a deficiency of a functioning enzyme controlling the breakdown of the amino acids phenylalanine and tyrosine. This roadblock in their metabolism leads to a build-up of the immediate precursor, homogentisic acid. Although normally virtually absent from the body, in alkaptonuria this intermediary accumulates in the blood, connective tissues and of course the urine where it is easily detected when it reacts with oxygen in the air, turning the urine black.

In the 1890s this condition was thought to be the result of infection, but Garrod’s careful study of a number of cases led him to think it may be “a familial affair”. In 1899 he published his findings highlighting his hypothesis that it would be commoner

in first cousin marriages. An advocate of Mendel’s work, William Bateson suggested that this pattern of inheritance would be consistent with a recessive trait, and Garrod concurred. This important link between defects in the biochemical pathways that control metabolism on the one hand and faults in our genes on the other laid the foundation for all future developments in molecular genetics.

A few years later he demonstrated that two other conditions, cystinuria and albinism, were also the result of recessive metabolic defects. In 1908 he delivered the prestigious Croonian Lectures of the Royal College of Physicians which he entitled, ‘Inborn Errors of Metabolism,’ thus coining a term that we still use today.

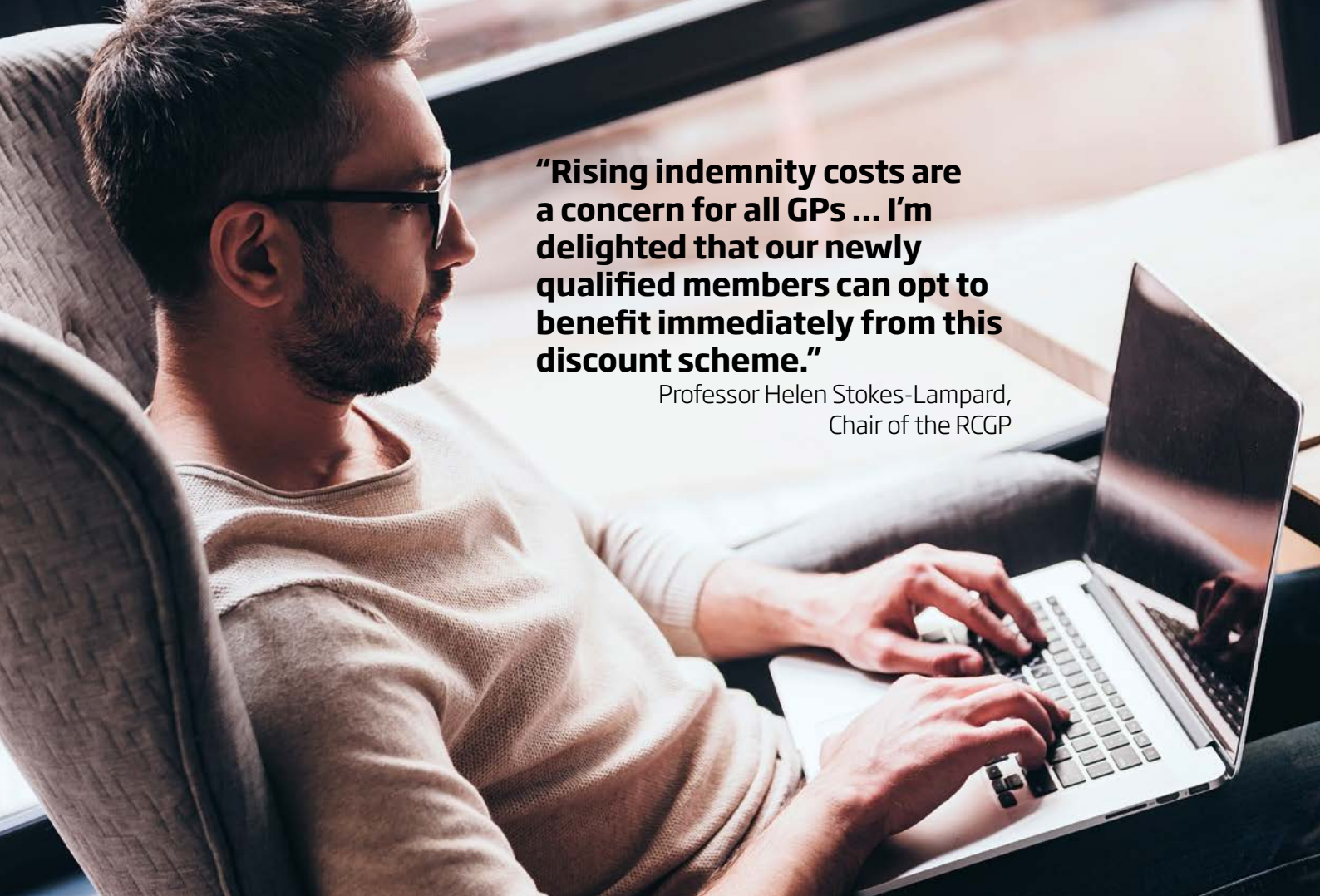
Garrod was elected Fellow of the Royal Society in 1910, knighted in 1918 and was nominated Regius Professor of Medicine at the University of Oxford in 1920. But it was not all honours. The First World War claimed all three of Garrod’s sons — two in action and one from influenza shortly after the armistice. His only surviving child, his daughter Dorothy, would go on to become an eminent archaeologist and indeed would become the first woman to hold an Oxbridge chair.

That same colleague who questioned Garrod’s confidence also said of him that although he was “universally respected and liked”, he was also “too gentle and honest to demand attention”. Nevertheless, more than a century after he coined the phrase, ‘Inborn Errors of Metabolism,’ it is clear that while Garrod the man may not have demanded attention, his work and its legacy does.

Dr Allan Gaw is a writer and educator in Glasgow

SOURCES

- Obituary Notices of Fellows of the Royal Society, 1936
- Historic Hospitals Admission Records Project, 2010
- DNA Learning Center, 2011



"Rising indemnity costs are a concern for all GPs ... I'm delighted that our newly qualified members can opt to benefit immediately from this discount scheme."

Professor Helen Stokes-Lampard,
Chair of the RCGP

RCGP FIRST5 PARTNERSHIP

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Contact Mairi Dixon on **0141 228 1267** or **mdixon@mddus.com** for more information.