

# INSIGHT



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GP practice offering specialist care to refugees and asylum seekers

## DUTY TO WARN?

Legal case tests whether a duty of care can outweigh the right to confidentiality

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Is mandatory NHS service a realistic solution to the shortage of doctors?

## POSTURE IS KEY

Prevention is better than cure when it comes to back and neck pain in dentists

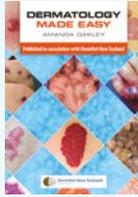
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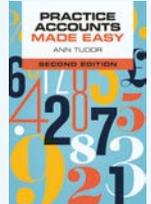
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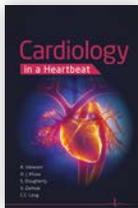
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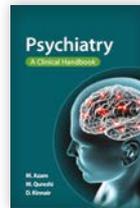
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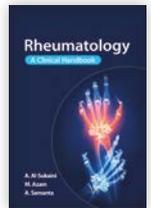
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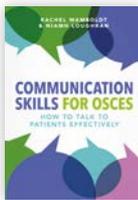
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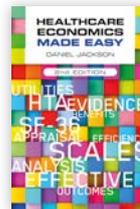
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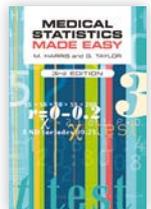
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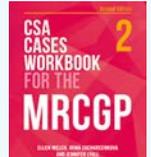
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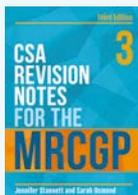
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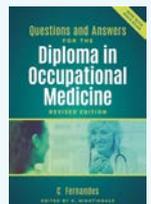
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# INSIGHT



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Wooden Anenorme, Stephen Cohn

Screenprint, 1970

Born in Frankfurt-am-Main in 1931, Cohn came to England in 1933 to settle. He served in the army before going on to study sculpture at Hammersmith School of Art. He died in 2012.

Art in Healthcare (formerly Paintings in Hospitals Scotland) works with hospitals and healthcare communities across Scotland to encourage patients, visitors and staff to enjoy and engage with the visual arts. For more information visit [www.artinhealthcare.org.uk](http://www.artinhealthcare.org.uk)  
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**EDITOR**  
**Dr Barry Parker**

THOSE who are displaced from their homes through war or conflict and seek refuge in the UK have particular health needs that may be difficult to meet under standard models of NHS care. Refugees may arrive in the UK in poor physical health, suffering infections such as TB or hepatitis, and with severe mental health issues such as PTSD and depression as a result of the traumas they have endured.

Problems accessing care may be compounded by lack of understanding of systems, language barriers and homelessness. It is therefore heartening to hear of the outstanding work undertaken by the Health Inclusion Clinic in

London. On page 10, Jim Killgore interviews two members of the team, which has been recognised with a BMJ award for its innovative work.

Also in this issue, Majid Hassan highlights an ongoing medico-legal case which addresses the duty to warn a third party about genetic risk, and conflict with a patient's right to confidentiality. We await the final outcome of this important

case with interest (page 12).

James Tang focuses on the common occupational hazard of back and neck pain in dentists, offering practical advice on page 14. Alan Frame examines the tricky issue of doctors receiving gifts from patients. Is it ever acceptable (page 9)?

On page 8, Joanne Curran discusses the controversial proposal to make NHS service mandatory for doctors trained in the UK. Would it be fair or workable? And in the wake of the tragic and high profile court case involving baby Charlie Gard, Deborah Bowman reflects on the virtue of "compassionate silence" on page 21.

Finally, Alan Frame tackles a dilemma related to the safeguarding of child protection records on page 20.

*Dr Barry Parker*

## MDDUS pressing for clarity on claims costs

MEMBERS will have seen reports about the impact of the change to the personal injury discount rate on indemnity subscriptions. Let me bring you up-to-date with developments.

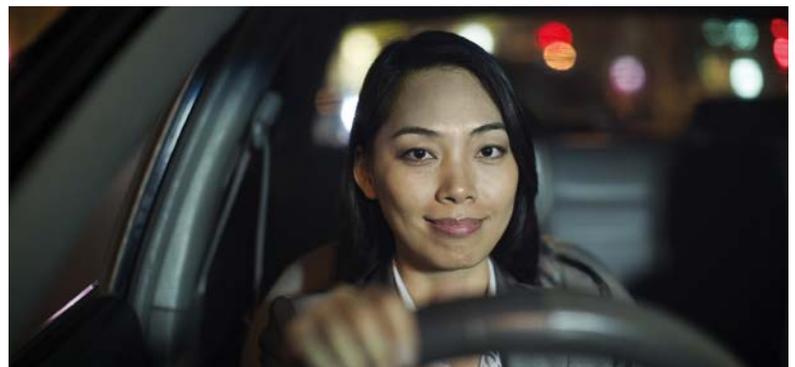
The UK Government lowered the personal injury discount rate from 2.5 per cent to minus 0.75 per cent in February. The Scottish Government followed suit in the following month. The effect is to increase the amount of damages paid to claimants in cases involving loss of future employment and long-term care costs, in some cases significantly. The Government recognised the problems caused to the NHS by earmarking an additional £5.9 billion in the March budget to meet the consequences and indicated that "appropriate funding" would be available to manage these consequences for GP indemnity. The Ministry of Justice also launched a consultation about finding a better system to set the rate in future.

Since then, MDDUS has been in the forefront of the debate to put some rationality into the system. We have made clear to both UK and Scottish ministers that we may well judicially review the decision unless the current consultation on a new system reaches a speedy and satisfactory outcome. We have underlined the need for a comprehensive set of legal reforms to limit the impact of claims inflation, whilst ensuring that legitimate claimants are properly and speedily recompensed. In the short-term, we have put proposals to Government for ensuring that subscriptions do not need to rise further because of the discount rate change, whilst ensuring that locum and salaried GPs' positions are also protected. We have also made clear how disappointed we are with the lack of ambition in Lord Justice Jackson's proposal on capping legal costs and the slow progress of the Government in tackling the issue.

We continue to talk to both Governments about these issues and the need to take a comprehensive approach which bolsters the model of profession-owned mutual discretionary indemnity. Neither anything in the market from commercial insurers nor crown indemnity matches this model, which ensures that doctors and dentists receive comprehensive, responsive 24/7 support covering the full range of medico-legal, regulatory, disciplinary, inquest and FAI-related matters, as well as a full claims service.

We will keep you up to date with developments.

**Chris Kenny is CEO of MDDUS**



## Working out of hours

MDDUS defines 'core' hours as being from 8am to 8pm, on normal weekdays (excluding bank holidays). Where any part of a session falls outside these hours, it will be categorised as 'extended hours' or 'out-of-hours' work, as set out below.

Extended hours work is that conducted outside core hours but where a GP has full access to the

patient's NHS GP clinical records and delivers predominantly non-urgent care to patients. It is allowable within our standard sessional rate. Pre-booked patient appointments on weekends and evenings are likely to fall into this category.

Out-of-hours care is defined by MDDUS as that provided between 8pm and 8am on normal weekdays, or any time at weekends or bank holidays, and which does not fall

into the definition of extended hours work (above). This includes the provision of urgent/emergency care to patients, as well as care delivered without access to patient records.

GP partners may include up to three out-of-hours sessions within the sessions declared to MDDUS for subscription calculation purposes. Alternative arrangements are in place for GP partners providing traditional 'on call' cover for patients on their own practice list. Please contact the membership services department to confirm if your subscription is adequate and appropriate.

Most locum/salaried GP subscription rates do not include any out-of-hours entitlement. It is important to ensure that MDDUS is aware of any OOH work that you undertake, and that this is appropriately reflected in your subscription on your renewal documentation.

## MDDUS risk training for RCGP faculties

GPs can learn how to reduce risk in their day-to-day practice at an interactive training day led by MDDUS in partnership with the RCGP. This case-based session – *Avoid harm and reduce your risk* – focuses on key areas such as complaints handling, patient communication, chaperones and social media.

RCGP faculties across the UK can apply to host these training sessions, providing a venue, catering and laptop/screen. The MDDUS risk education team will provide speakers and learning materials at no extra cost.

**Upcoming dates include:**  
**26th September 2017 – Gateshead**  
**7th November 2017 – Cardiff**

If you are interested in attending a training day, contact your faculty to find out if an event is coming to your area.

## MDDUS support for dental CPD

DENTISTS will soon be required to complete a personal development plan as part of the new enhanced continuing professional development scheme (ECPD) announced by the General Dental Council.

MDDUS Head of Dental Division Aubrey Craig welcomes the move as a "first step in

a long-term reform programme that aims to focus on the quality of CPD rather than quantity".

MDDUS is keen to help by offering members access to a wide range of online risk management resources, including CPD-verifiable modules, video presentations, learning tools and webinars. MDDUS senior risk adviser Liz Price said: "Our training and CPD team also provide face-to-face training to help members reduce risk and improve patient safety in their daily practice."

The new scheme comes into effect from January 2018 for dentists and August 2018 for dental care professionals. Arrangements will be made to transition those who are mid-cycle in the current scheme.

Go to the Training & CPD page at [mddus.com](http://mddus.com) for further details on applicable MDDUS resources.

## Enhanced cover for cosmetic procedures

MDDUS members working as general dental practitioners can now enjoy access to indemnity for earnings up to £15,000 gross income from the provision of certain minor cosmetic facial procedures.

This applies to members paying MDDUS a subscription in a "third year" GDP grade or higher. Above this earning level a supplement will apply.

The procedures must be performed personally by the member and include treatment with botulinum toxin and non-permanent dermal fillers in the treatment of facial wrinkles and/or lip enhancement. These procedures can only be carried out in the immediate peri-oral area, nasal labial folds and elsewhere on the face. The neck is explicitly excluded.

Members are no longer required to be registered with TYCT (Treatments You Can Trust) but to qualify you must be able to demonstrate at least two years post-graduation experience in dentistry and competence to provide the treatments performed, along with management of anaphylaxis and resuscitation. Premises must offer an appropriate clinical environment and be registered with the CQC or equivalent national body (if required by law), and afford immediate access to equipment and drugs necessary for the emergency treatment of anaphylaxis and for resuscitation.

See full details see [tinyurl.com/y9cs4fha](http://tinyurl.com/y9cs4fha) and contact the Membership Department at MDDUS if you require further information.



### ↓ MDDUS WINS GPST TENDER

MDDUS has been appointed the indemnity provider of choice for all GPSTs within Health Education England East Midlands, following a rigorous tendering exercise. In addition, MDDUS has also secured the contract to continue providing indemnity to the third year GPSTs at Pennine Acute Trust.

### ↓ DENTAL RISK TRAINING DAY

Book a last-minute place on our dental risk training day to be held in Glasgow on 5 September. A range of experts will be on hand to deliver workshops on GDC fitness to practise procedures, complaint handling, safe use of social media and other topics. Email [risk@mddus.com](mailto:risk@mddus.com) for more details.

### ↓ CHAPERONES WEBINAR

Sign up for our risk webinar on the use of chaperones and common associated risks in general practice. Members can go to the Training & CPD section at [www.mddus.com](http://www.mddus.com) to book a place. Login required.

### ↓ 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 numbers are not linked to a specific geographical area but are charged at the same rate as normal local or national landline numbers.





## New quality standard on oral health in care homes

NICE has published a new quality standard on oral health for adults in care homes. It covers dental health and daily mouth care with and without nursing provision, and describes high-quality care and priority areas for improvement.

Over 425,000 people in the UK live in care homes and the new quality standard recommends that residents have their oral health needs assessed on admission and recorded in their personal care plans. Residents should also be supported to clean their teeth twice a day and/or their dentures daily.

Dr Paul Batchelor, fellow of the FGDP and a member of the committee which developed the new standard, commented: "The degree of oral health provision in care homes is highly variable, but these basic measures – assessing, recording and daily cleaning – could significantly improve the health and quality of life of residents, and should be applied universally."

Access the new quality standard at [www.nice.org.uk/guidance/QS151](http://www.nice.org.uk/guidance/QS151)

## Prescription purge urged

A FORMAL public consultation is being launched in England on new guidelines calling for 18 treatments – including homeopathy and herbal treatments – costing taxpayers £141 million a year to "generally not be prescribed".

This proposal is part of detailed plans published by NHS England to cut out prescriptions for what it calls ineffective, over-priced and low value treatments.

The consultation also covers a further 3,200 prescription items readily available and sold 'over the counter' in pharmacies, supermarkets, petrol stations, corner shops and other retailers, often at a significantly lower price than the cost to the NHS.

Initial action is proposed to limit prescribing of products for minor self-limiting conditions which currently cost taxpayers £50-100 million a year. The products include cough mixture and cold treatments, eye drops, laxatives and sun cream lotions.

Simon Stevens, NHS England's chief executive, described homeopathy as "at best a placebo and a misuse of scarce NHS funds".

He added: "The NHS is probably the world's most efficient health service, but like every country there is still waste and inefficiency... The public rightly expects that the NHS will use every pound wisely, and today we're taking practical action to free up funding to better spend on modern drugs and treatments."

## Action plan to improve revalidation

CLEARER guidance and greater support will be provided to doctors as part of a new action plan to improve the revalidation process, the General Medical Council has announced.

The regulator has set out how it will implement the recommendations made in Sir Keith Pearson's report, *Taking revalidation forward*, which was published earlier this year.

The plan includes commitments to provide clearer guidance for doctors and responsible officers on what is required from them for revalidation and to support and strengthen processes for doctors working in multiple settings, in particular across the NHS and private practice. More specific advice will be offered on how doctors should gather representative feedback from colleagues and patients.

The Department of Health in England will also lead a review of the Responsible Officer Regulations. The aim is to establish a connection to a designated body for certain groups of doctors that don't ordinarily have one, while making sure only organisations with robust governance arrangements are able to oversee a doctor's revalidation.

GMC chief executive Charlie Massey said: "We need the continued commitment from a wide range of organisations to make revalidation a better experience for doctors, especially at a time when they are under ever-increasing pressure."



## Survey reveals mistrust of medical evidence

A SURVEY conducted on behalf of the Academy of Medical Sciences (AMS) has found that when deciding whether to take or refuse medication, 65 per cent of the public trust the experiences of friends and family compared to only 37 per cent who trust evidence derived from medical research.

Clinical trials funded by the pharmaceutical industry are particularly mistrusted, with 82 per cent of GPs and 67 per cent British adults believing these are often biased to produce a positive outcome.

These findings are highlighted in a new AMS report on the use of scientific evidence to judge the potential benefits and harms of medicines. The report summarises data from surveys of 1,013 GPs and 2,041 British adults, and input from public and expert workshops.

The report states that poor quality evidence about medicines and the misrepresentation of evidence can lead to under or over-medication and thus prevent the full realisation of the health gains from medical innovation.

Among recommendations in the report are longer GP consultations to allow adequate time for shared decision-making about treatment options and lifestyle changes, particularly in the context of multimorbidity. It recognises the need for improved content and readability of patient information leaflets, offering a balanced appraisal of the benefits and harms of medicines.

The report also calls for NHS Choices to become the central repository of information on the benefits and harms of medicines – making direct reference to underlying evidence (and updates as new evidence emerges) and providing relevant, robust and evidence-based decision aids for use by patients and healthcare professionals.

## Inherited heart conditions commonly misdiagnosed

A SURVEY conducted by the British Heart Foundation has found that six in 10 patients living with inherited heart conditions were initially misdiagnosed, with symptoms attributed to other conditions like stress, anxiety and epilepsy.

Failure to make a diagnosis and start treatment puts such patients at increased risk of sudden cardiac death, but the BHF acknowledges the challenges involved. "A patient suffering from symptoms like difficulty breathing, palpitations, chest tightness and a racing heart rate could have an inherited heart condition, or they could have a completely unrelated problem."

Around 620,000 people in the UK could have the genes which cause serious inherited heart conditions and many will not have been diagnosed. In the survey, 17 per cent of respondents said that genetic testing helped with their diagnosis compared to 67 per cent who were eventually diagnosed through an ECG or echocardiogram.

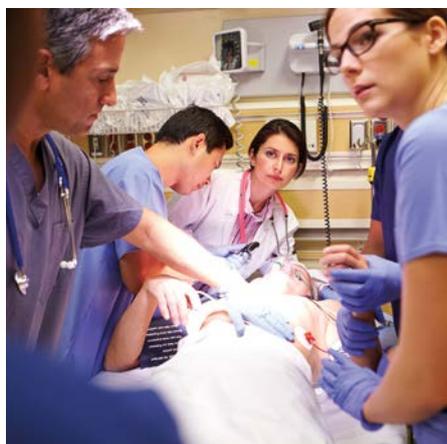
Dr Mike Knapton, Associate Medical Director at the British Heart Foundation, commented: "These results show that it can be extremely difficult to correctly diagnose people, meaning it's vital that we raise awareness about the symptoms and diagnostic tests for those most at risk of inherited heart conditions."

## Emergency sepsis care improving

AN audit of sepsis care has shown improvement in the proportion of patients receiving basic interventions within the first hour of arriving at emergency departments.

The report published by the Royal College of Emergency Medicine (RCEM) presents findings from an audit of 13,129 adults presenting to 196 emergency departments (EDs). It shows a steady improvement in the Sepsis Six, an initial resuscitation bundle designed to offer basic interventions within the first hour of arriving at an ED. Particular progress has been made in emergency antibiotic treatment, with 44 per cent of at-risk patients now receiving them within an hour of arrival. But the report also found that RCEM standards are not yet being met by all EDs.

Dr Taj Hassan, President of the Royal College of Emergency Medicine, said: "Sepsis continues to be a leading cause of death in



patients admitted to hospital as an emergency. It is vital therefore that staff in the Emergency Department are able to rapidly assess, recognise, risk stratify and treat such patients with proven evidence-based therapy.

"Studies have repeatedly shown the power of the Sepsis-Six resuscitation bundle in improving patient care if delivered in a timely fashion."

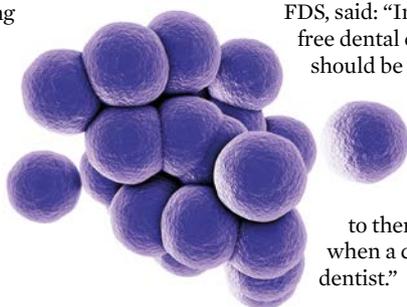
## Too few dental visits for toddlers

AROUND 80 per cent of one to two year olds in England did not visit an NHS dentist in the last year despite the fact that dental care for children is free, according to new figures collated by the Faculty of Dental Surgery (FDS) at the Royal College of Surgeons.

The figures also show that 60 per cent of children aged one to four did not have a dental check-up in the same period up to 31 March 2017. The Faculty believes that there is "widespread misunderstanding" among parents and some health professionals about when a baby should first visit the dentist. Children should have regular dental check-ups starting from when their first teeth appear at around six months of age, according to accepted guidance.

Over 9,200 tooth extractions were performed in 2015/16 on children aged one to four in hospitals in England. Many of these cases can be attributed to tooth decay which is largely preventable through good oral hygiene with regular check-ups.

Professor Nigel Hunt, dean of the FDS, said: "In a nation which offers free dental care for under-18s, there should be no excuse for these statistics. Yet we know from parents we speak to that there is widespread confusion, even in advice given to them by NHS staff, about when a child should first visit the dentist."



## HOLISTIC DENTISTRY CONFERENCE

The Faculty of General Dental Practice (UK) will be hosting a conference with the theme of *Holistic Dentistry – Putting the Mouth Back into the Body* on 3 November at the National Motorcycle Museum in Solihull, West Midlands. The FGDP(UK) celebrates its 25th anniversary this year and the conference aims to provide an insight into the complex inter-relationship between oral diseases and general patient health in all age groups. Find out more at <http://holisticdentistry.eventbrite.com>

## ANTIDEPRESSANT PRESCRIPTIONS IN ENGLAND RISE AGAIN

Antidepressants saw the greatest numeric rise in prescription items in England for the fourth successive year – increasing by 6 per cent in 2016 as reported in new statistics released by NHS Digital. The number of antidepressant items dispensed has more than doubled in the last decade. Drugs used in diabetes cost the most in 2016 (for the tenth year running) at £984.2 million and the most prescription items dispensed were to treat hypertension and heart failure

## CONSCIOUS SEDATION IN DENTAL PRACTICE

A new edition of *Conscious Sedation in Dentistry* has been published by The Scottish Dental Clinical Effectiveness Programme (SDCEP). The guidance has been subject to a thorough update using a NICE-accredited methodology and is formally endorsed by the dental faculties of the Royal Colleges.

# WOULD MANDATORY SERVICE HELP THE NHS?

Joanne Curran

Associate editor of *Insight*

**N**HS staff shortages are well documented with thousands of unfilled UK posts. Vacancy rates for doctors in England are estimated at seven per cent with some surveys suggesting GP vacancies could be as high as 12 per cent.

A problem so stubbornly difficult to resolve has inspired a drastic proposal from the Department of Health (DoH): mandatory NHS service.

A recent consultation suggested that newly trained doctors in England should work in the NHS for a minimum term of up to five years or more. Those who leave early to work for a different organisation or overseas could be ordered to repay the "recoverable elements" of funding invested in their education. The cost of training a doctor in England is estimated at £230,000 and the DoH is keen to ensure tax payers "obtain a return on this investment".

In return, the DoH plans to increase the number of annual medical school training places by up to 1,500 in a bid to make the NHS "self-sufficient". But would this be an effective solution to NHS workforce woes?

Health secretary Jeremy Hunt has compared his proposed scheme to the one offered by the Armed Forces which also requires a minimum service period. But unlike the DoH plans, there is a financial incentive. The Army Medical Services Professionally Qualified Officer bursary scheme offers UK medical students within three years of graduation £10,000 per year plus a £45,000 lump sum on completion of military training.

With no mention from the DoH of any financial input, new doctors would be obliged to carry out mandatory service after having paid (or incurred debt for) their own tuition fees and other costs.

Proponents of the DoH scheme believe this is only fair given the full cost of training a doctor. Health Education England chief executive Professor Ian Cumming said the proposals offer a "clear commitment to a sustainable future home-grown medical workforce". And one respondent to an October 2016 poll in *GP Online* said: "The NHS subsidises medical training and it is only right that some of that investment is returned."

But despite Professor Cumming's views,



**"Demotivated, burnt-out doctors who don't want to be in their jobs will not be good for patients"**

critics fear the threat of a financial penalty would deter potential doctors, particularly those from poorer backgrounds. In their consultation response, the British Pharmacological Society argue that medical students already graduate with some of the highest levels of debt of any undergraduate course, sometimes as much as £80,000. They said: "[W]e do not see how a further burden of debt is likely to encourage graduates to stay in medicine, given they will never be able to pay it in their lifetimes."

Their response also acknowledges concerns on widening participation, adding: "Health Education England recognise that one of the barriers to entry to medicine from those from disadvantaged backgrounds is a lack of financial support. We are concerned that any potential increase in the level of debt will exacerbate this issue, not improve it."

Stress and burnout affect a large number of medical professionals. While the promise of up to 1,500 extra training places annually would be a positive step in

addressing issues around understaffing, many believe mandatory service would only increase stress. British Medical Association chairman Dr Mark Porter warned: "Demotivated, burnt-out doctors who don't want to be in their jobs will not be good for patients." He called on the DoH to instead tackle the root causes of the NHS workforce crisis.

In their consultation response, the Royal College of Anaesthetists said: "Tying doctors to posts in the UK by instituting financial penalties risks a fall in standards and even higher levels of unhappiness amongst junior doctors", adding: "Students should be selected on their commitment to work in the NHS and posts should be of sufficient quality for doctors to want to stay in the UK."

Similarly, the Association of Surgeons in Training (ASiT) and the British Orthopaedic Trainees Association (BOTA) "firmly oppose" the proposal, stating that "mandating a period of NHS service will negatively impact patient care and surgical training." And, rather than increasing medical workforce recruitment and retention, they believe mandatory service (or "conscription" as they describe it) would be "detrimental to the motivation of dedicated, committed doctors, at a time when low morale is already well documented."

In addition to concerns over debt and morale, it is not clear whether mandatory service would be effective in preventing doctors from leaving the NHS. If five years of mandatory service begins at qualification, most doctors would stay for two years of foundation training regardless of future plans. Many would also likely undertake specialty training for at least three or more years, by which point the mandatory service period would have ended.

There is also the matter of enforcement and the extent to which the DoH is prepared to pursue and take action against those who refuse mandatory service and refuse to pay a penalty. Would they issue a default notice? Initiate court action? Or seek to deduct money from a doctor's salary to recover the debt?

ASiT and BOTA point out that most trainees who leave the NHS to work abroad return within three years anyway. They have urged the DoH to abandon mandatory service plans "for the good of patients, medical students and trainees."

# GIFT OR ABUSE OF TRUST?

Alan Frame

Risk adviser at MDDUS

IT'S a common dilemma for clinicians – when are “tokens of gratitude” more than just that and is it ever really okay to accept a gift from a patient?

NHS England recently published new guidelines which it claims will “strengthen the management of conflicts of interest and ensure that the NHS is a world leader for transparent and accountable healthcare”. These came into force on 1 June 2017.

The guidance permits staff to receive “small tokens of gratitude from patients”, such as a box of chocolates, but requires them to decline anything that could be seen to affect professional judgement. Gifts with a value over £50, accepted on behalf of organisations, will have to be declared.

The guidance does not apply to independent and private sector organisations, general practices, social enterprises, community pharmacies, community dental practices, optical providers or local authorities. However, these organisations are being “invited” to consider implementing the guidance as a means to effectively manage conflicts of interest and provide safeguards for their staff.

NHS organisations in England are required to maintain a register which lists potential conflicts of interest among all

staff and includes hospitality received and involvement in sponsored events and private business interests. Abuses of NHS standards of business conduct still occur, with a series of reports in the mainstream media in 2015 of health officials found to be on the payroll of certain drugs firms and others discovered to have been put up in luxury hotels. The industry’s own regulator concluded that “unacceptable” levels of hospitality had been accepted.

The critical point here is one of “transparency” which must prevail within a publicly funded health service, and a publicised register of interests will attempt to ensure national consistency.

In a recent call to the MDDUS advisory line, a GP asked for advice in regard to a watch received in the post, along with a note from a patient thanking him for providing excellent care. An enclosed receipt revealed the watch cost over £400. The practice partners were happy for the GP to keep the watch as the patient would probably be upset if it was returned but the GP wanted to check with us if it was okay.

In *Good Medical Practice*, the GMC states: “You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals”. It goes on to stipulate that

doctors must not ask for or accept any gifts or hospitality that may affect the way they treat patients. The guidance also states that doctors must not encourage patients to give, lend or bequeath money or gifts that will “directly or indirectly benefit you”.

It cautions in general that any doctor receiving a gift or bequest must always consider the potential damage this might cause to the patient’s trust in the doctor or the public’s trust in the profession. Doctors should therefore refuse gifts or bequests that could be perceived as an abuse of this trust.

However, the GMC advises that doctors may accept unsolicited gifts from patients or their relatives provided:

- this does not affect, or appear to affect, the way you prescribe for, advise, treat, refer, or commission services for patients
- you have not used your influence to pressurise or persuade patients or their relatives to offer you gifts.

The other matter to consider is registering the gift in line with Performers List regulations. Gifts with a value of over £100 should be entered on a practice gift register along with the name of the patient, doctor and approximate value. (The new NHS England guidance suggests lowering this figure to £50). Health authorities can request sight of such registers and the register itself must include information which identifies the name of the donor, nature of the gift and its estimated value.

It’s important to note that although these regulations only cover England, equivalent sets of regulations operate in the other UK countries.

Members should also be aware of the provisions of the Bribery Act 2010. The Act repeals all previous statutory and common law provisions in relation to bribery, instead replacing them with the crimes of bribery, being bribed, the bribery of foreign public officials, and the failure of a commercial organisation to prevent bribery on its behalf. This could be relevant, for example, if a doctor is suspected of receiving a gift or money as an inducement into providing a particular service or preferential treatment.

So the bottom line is to make sure that your organisation maintains a gift register, and consider the guidance and relevant law which applies to the country in which you are practising.

“Consider the potential damage to the patient’s trust in the doctor or the public’s trust in the profession”



# CARING FOR THE DISPL

Jim Killgore meets two GPs working in an award-winning specialist clinic in London offering primary care to refugees and asylum seekers



Photograph: Philippa George

**A**N estimated 65 million people across the world have been forced from their homelands in recent years due to war and other conflict – roughly equivalent to the entire UK population. This has created more than 22 million refugees worldwide, according to the British Red Cross. More than half of refugees (55 per cent) come from just three countries: Syria, Afghanistan and South Sudan.

A small number of these refugees make their way to Britain. Many of these displaced people will be suffering from a range of untreated conditions, including TB, hepatitis, HIV and other infectious diseases, not to mention the lasting psychological effects of war and violence either experienced or witnessed.

A typical example might be Ruth who is a 26-year-old Eritrean asylum seeker. Before fleeing her country she was a victim of rape and torture and has been “sofa surfing” for months among the Eritrean community in London. Ruth is pregnant and hepatitis B positive and suffering with PTSD (post-traumatic stress disorder) and severe depression.

GP Dr Shazia Munir is well acquainted with the difficulties faced by patients like Ruth in accessing proper healthcare. She is the clinical lead of a London-based specialist primary care service for destitute refugees and asylum seekers who have found it difficult registering with mainstream general practice. The Health Inclusion Clinic operates two days a week out of the Pavilion Medical Centre in Brixton and is part of the Health Inclusion Team at Guy’s and St Thomas’ NHS Foundation Trust.

In May of this year the clinic was awarded Primary Care Team of the Year at the annual BMJ Awards and I recently spoke to Dr Munir – who is currently on maternity leave – about the work of the clinic, and also to Dr Emma Preston, who is acting clinical lead.

## BARRIERS TO HEALTHCARE

Refugees and asylum seekers often face serious barriers in accessing primary care in the UK. Says Dr Munir: “A lot of it is

not knowing the system. They are in a new country and there is a general fear of authority, perhaps from experiences in their own countries. There is also the language barrier. But I think one of the biggest issues is receptionists in GP practices asking for documents that patients don’t actually need.”

NHS England operating principles state that anybody may register and consult with a GP free of charge. Patient identification and proof-of-address are not required. It is only for secondary care that a patient may be required to be “ordinarily resident” in the country or in possession of an exemption from NHS charges, such as those granted refugee status or asylum seekers.

Yet a survey carried out among patients attending the Health Inclusion Clinic found that 54 per cent had been turned away from GP practices. Another study by the charity Doctors of the World found that 94 per cent of refugees and asylum seekers reported difficulties in accessing healthcare.

“A lot of our patients are transient,” says Dr Munir. “They don’t have a home and they don’t have money. Maybe they’re sofa surfing or staying with a community member one day and another day somewhere else, on a mosque or church floor...They may worry that without a fixed address they won’t be able to register with a GP.”

The Health Inclusion Clinic was set up to address the specific problems faced by this patient group. The clinic attracts patients from numerous sources.

“Solicitors may refer to us because of previous experience with clients, and sometimes we get self-referrals from patients who have heard about us from friends in the community,” says Dr Emma Preston.

“London is a particular draw because of the numerous multicultural communities,” adds Dr Munir. “We are also quite well known among charities working with this patient group, and we are part of the wider Health Inclusion Team at Guy’s and St Thomas’. They work in drop-in centres and soup kitchens and places like that. So if they pick up a homeless refugee they will signpost them to us.”



The clinic consists of three part-time GPs, two specialist nurses, two caseworkers and a health improvement specialist. Patients are provided extended 30-minute appointments, usually aided by telephone-based or face-to-face interpreters. The GPs also provide medico-legal reports and other supportive letters free of charge.

Patients attending the clinic get a comprehensive health check and screening with a full blood work-up. Says Dr Munir: “Thirty per cent of our patients are positive for latent TB. Not only do the patients come from higher-risk countries they also experience social deprivation which can lead to higher rates of TB. We also screen for blood-borne viruses and other infectious diseases, as well as vitamin D deficiency and diabetes.”

Mental health is also a serious issue in refugees and asylum seekers, with many suffering from PTSD. Research has shown that 72 per cent have a history of rape/torture, 61 per cent suffer significant mental health problems and 18 per cent have attempted suicide or experienced suicidal ideation. The clinic can help patients seek treatment to deal with these issues.

Patients will also see a case worker who can offer help with social issues, such as finding housing, liaising with solicitors, registering with a general practice, accessing free prescriptions and dental care, or signposting people to soup kitchens or where they can get food and clothing. “Our case workers are brilliant,” says Dr Munir. “One is

# AGED



Main picture: migrants coming ashore at Lesbos in Greece after a traumatic journey. Below: part of the team at the Health Inclusion Clinic with Dr Shazia Munir on the far right. Inset opposite: Dr Shazia Munir and Dr Emma Preston (right) at the BMJ Awards.

a refugee himself.”

But the ultimate aim is to transfer patients into mainstream general practice with a comprehensive health summary and a record of ongoing treatment needs.

## WAITING IN LIMBO

Among the perhaps less tangible benefits of the Health Inclusion Clinic is a particular understanding of the refugee experience. Dr Munir started working with vulnerable migrants after finishing her GP training in 2010. She spent time in a Ugandan refugee camp as part of a diploma course in tropical medicine and hygiene and on her return volunteered at a clinic for refugees and asylum seekers run by Doctors of the World, as well as writing medico-legal reports for the charity Freedom from Torture. Dr Preston also started as a volunteer and has taught primary care in Nepal.

“Often the asylum system can be long and protracted and people get stuck in it,” says Dr Munir. “It’s horrible for a lot of our patients – waiting in limbo for such a long time. They are not allowed to work and are only given a minimal amount of money to live on, so they can’t start rebuilding their lives. One of our patients works as a volunteer in one of the soup kitchens because he used to be a chef. He cooks every week. I can see that’s the thing he lives for – just to be able to cook for people and see them get joy from his cooking. On other days he’s really depressed.”

Sometimes the scale of need can seem



Photograph: Health Inclusion Clinic

overwhelming as the flood of displaced persons into Europe and the UK grows year on year. In the first quarter of 2017 the total number of asylum seekers including dependants receiving UK government support was 39,365, an increase of 10 per cent over the previous year.

Says Dr Preston: “We would love to be open more days, to expand and take more referrals as it is likely there are many more patients who could benefit from our

service. Unfortunately, within the NHS there are limitations in funding and space available to us, but we hope we can move forward with this in the future.”

Among those vulnerable migrants who are seen by the clinic there is almost universal gratitude – as expressed by one patient.

“You give me hope. You are the family I didn’t have for a while.”

Jim Killgore is managing editor of *Insight*

A recent case involving Huntington's disease poses difficult questions regarding duty of care and a patient's right to confidentiality

**D**OES a legal duty of care begin and end with a patient or can it extend to a third party such as a close family member? A case heard recently before the Court of Appeal has addressed this question – as well as the limits of patient confidentiality when in possible conflict with the best interests of others.

The ultimate outcome of *ABC v St George's Healthcare NHS Trust and Others* is still pending but the case could have some far-reaching implications, especially in the complex area of genetic risk.

### BACKGROUND TO THE CASE

In 2007 the father of the claimant in the case shot and killed his wife and was later convicted of manslaughter on grounds of diminished responsibility. He was sentenced to a hospital order under Section 37 of the Mental Health Act. In 2009 it was discovered that the patient was suffering from the neurodegenerative progressive condition, Huntington's disease. A child of a parent with the disease has a 50 per cent chance of developing the condition.

Staff working for the defendants discussed with the patient on a number of occasions the possibility of informing his three daughters of the diagnosis. Each time he expressly refused so as not to distress them and, in the case of the claimant who at the time was pregnant, he feared she may have an abortion. She gave birth in April 2010 and in August that year was accidentally informed about her father's diagnosis. Subsequent testing revealed she was also suffering from Huntington's disease.

The claimant pursued a wrongful birth claim against the Trust arguing that, despite her father's wishes and his right to confidentiality, she should have been informed of his diagnosis. Had this been done, she would have terminated the pregnancy rather than face the possibility of her child being dependent on a seriously ill parent, perhaps being orphaned and maybe inheriting the disease. In support of her case, the claimant referred to GMC guidance permitting disclosure where a patient's refusal to consent to disclosure would leave others exposed to a risk so serious that it outweighed the patient's and the public's interest in maintaining confidentiality.

The defendants applied to have the case struck out, arguing that under existing law they did not owe a legal duty of care to the claimant as she was not a patient. They accepted that the first two limbs of the three-part legal test for duty of care were established, namely that the injury the claimant suffered was foreseeable and that the relationship between her and the defendants was sufficiently proximate. However, the argument focused on the third limb – was it “fair, just and reasonable” to impose a duty of care on the defendants? On that point a number of policy reasons against imposing a duty were put forward.

In striking out the case, the High Court judge, Mr Justice Nicol, ruled that it was not fair, just and reasonable to find that the defendant had a duty of care to the

# DUTY TO



claimant, as there was no special relationship between the parties that could support this.

### COURT OF APPEAL JUDGEMENT

On appeal the decision was reversed and the claim reinstated. It was held that there was at least an arguable case that the existing law around who a clinician owes a duty of care to should be extended to include third parties. Key points from the judgement are:

**Potential for conflicting duties for clinicians.** The Court was of the view that this would not be made any worse – i.e. the threat of facing a claim by a patient if their information is released contrary to their express wishes versus the possibility of litigation from a third party. The professional guidance which the claimant referred to already raised the need for clinicians to consider conflicting interests and that in some circumstances the duty of confidentiality may have to be overridden on the basis of public interest to prevent harm.

**Floodgates argument.** The defendants argued that imposing a duty in such circumstances would lead to potential application to a wide variety of medical scenarios aside from those involving genetic conditions (e.g. a patient suffering from an STD, a contagious disease or a failed vasectomy). This was met with the response that “definite, reliable and critical medical information” is acquired by the clinician only in the field of clinical genetics, which often means that the third party should become a patient. These cases could be distinguished from other situations, thus limiting the occasions where the duty would apply.

**Patient autonomy.** One cannot overlook the strong trend



# WARN?

“The claimant pursued a wrongful birth claim against the Trust arguing that... she should have been informed of her father’s diagnosis”

in recent clinical negligence case authority to emphasise patient autonomy. It would arguably be irrational to emphasise the need to inform patients so that they may take their own decisions about treatment, yet at the same time depriving of any legal remedy identified individuals about whom a relevant doctor has specific information which should cause them to become patients.

**Undermining trust.** It was arguable as per the defendants’ case that a duty to disclose information to third parties could undermine trust and confidence in the medical profession, but the court questioned the degree to which such a loss of confidence might be affected by a common law duty of care to the third party.

In the end the Court of Appeal ruled that it was arguable that clinicians treating a patient with Huntington’s disease had a duty to disclose the diagnosis to the patient’s daughter despite the specific request of the patient not to do so. The court in following guidance from the GMC on confidentiality, as well as specific guidance on genetic testing from two Royal Colleges and the British Society for Human Genetics, allowed the claimant’s case to be reinstated for a trial to consider the existence of a duty of care to third parties.

## NO CHANGE AS YET

It is important to appreciate that the Court of Appeal is

stating no more than the fact that the claimant has an arguable case that a duty of care should be extended to a third party and therefore the case is to proceed to a trial. There is no change to the current public interest disclosure exercise which clinicians must perform if there are conflicting interests between parties.

The case can be seen as another example where, as with the *Montgomery* decision on consent, the law is catching up with medical guidance. The Court of Appeal specifically referred to existing professional guidance stating that “The Human Genetics Commission, the Nuffield Council on Bioethics and the GMC have all expressed the view that the rule of confidentiality is not absolute. In special circumstances it may be justified to breach confidence where the aversion of harm by the disclosure substantially outweighs the patient’s claim to confidentiality.”

It remains to be seen following the reinstated trial of this case if an actual legal duty is imposed, thereby potentially extending the scope of those who could argue that a doctor owes them a duty of care. There will be much debate about how far any such duty may erode the rights of the patient and the circumstances in which it may operate. Until then clinicians must continue to ensure:

- existing professional guidance is followed
- discussions are clearly documented
- professional advice is sought where necessary.

Majid Hassan is a partner in the clinical law team at Capsticks Solicitors

Dentist and personal trainer James Tang says prevention is better than cure when it comes to neck and back pain

# SIT UP AND

**A**N estimated 80 per cent of the population will experience back pain at some point in their lives and it is the largest single cause of disability in the UK, with lower back pain alone accounting for 11 per cent of total disability.

Figures from the Office for National Statistics suggest that almost 31 million days of work were lost in 2016 due to back, neck and muscle problems, costing the UK economy around £14bn a year.

Musculoskeletal pain is a significant occupational health hazard for dentists. A 2009 review of musculoskeletal disorders amongst dental professionals found that reported prevalence varied between 64 and 93 per cent, with the most commonly cited regions of pain being the back (36.3–60.1 per cent) and neck (19.8–85 per cent).

So chances are a fair number of dentists or other healthcare professionals reading this article will be suffering from back pain. But even if you are pain-free at the moment, prevention is always better than cure – and back pain is avoidable.

My interest in this subject began 15 years ago when I injured my back while lowering a piece of luggage. I am a practising dentist and was completely out of action for more than a week. Indeed, the pain was so severe that it took me more than 10 minutes to get out of bed the following morning. Thereafter, my back was so vulnerable that even minor tasks such as bending down to pick something up could trigger severe pain. It has never been bad enough for me to be off from work but can still restrict my movement and cause me discomfort as I sit and perform my job. It can be highly distracting and also affect my mood in dealing with patients.

## GOOD POSTURE

Musculoskeletal pain is most commonly caused by muscle imbalances (due to poor posture) and core dysfunction but without specific pathology (i.e. no herniation of discs or nerve compression). The majority of sufferers, like me, tend to have recurrent symptoms.

Muscles work in synchrony and rarely does a single muscle work without others contributing. In order to understand why prolonged static postures – such as sitting for long hours at a dental chair – can be detrimental, we need to understand that muscles adapt to the positions we put them in and can become adaptively shortened or lengthened. Although the body is efficient in coping with the stresses that we place upon it, these adaptations can lead to muscle imbalances, predisposing to back problems.

Good posture is key to the prevention of neck and back pain. The spine has four natural curves in the sagittal plane (Fig. 1) – cervical lordosis, thoracic kyphosis, lumbar lordosis and sacral kyphosis – and these curves are essential for shock absorption.

In the neutral position, the spine is mainly supported by the bony structures of the vertebrae resting on top of one another. When these curves become either exaggerated or flattened, the spine increasingly depends on muscles, ligaments and soft tissues to maintain its erect position – causing tension in these structures – leading to lower back strain and trigger points.

## BAD HABITS

So what are the particular postural habits of dentists and associated mechanisms that can lead to back and neck pain? Below are some of the most common.

**Prolonged sitting.** This is obviously common for most dentists, and related postural problems involve a process known as reciprocal inhibition. This is when muscles on one side of a joint relax to allow contraction on the other side of that joint. In sitting all day your hip flexor is in a constantly contracted state, whilst the gluteus maximus (agonist) will be neurologically switched off through the process of reciprocal inhibition. Movement occurs through the coordinated contraction of a number of muscles around a joint and if the prime mover (glutes) does not contract properly, then the brain will

look for alternative solutions to create the same movement, resulting in other helper muscles or synergists taking over the role of the prime mover (i.e. synergistic dominance). But synergists are not designed to be agonists and are less efficient. Over time, this can lead to dysfunctional movement patterns which can lead to lower back pain. It is therefore advisable to alternate work positions between sitting, standing and different sides of the patient. Switching positions allows certain muscles to relax while shifting the stress onto other muscles.

**Lower cross syndrome.** This is common in those with abdominal obesity, thus shifting the centre of gravity forward, or dentists who sit with a hyper-extended lumbar posture. This postural deviation is characterised by specific patterns of muscle weakness and tightness that cross between the dorsal and ventral sides of the body. These imbalances result in an anterior tilt of the pelvis, increased flexion of the hips and a compensatory lumbar hyperlordosis. Again, maintaining good posture and alternating work positions are key in prevention. Corrective exercises involve the activation of the deep core abdominal muscles, alongside the glutes (such as performing the “glute bridge”). The tight hip flexors need to be stretched.

**Upper cross syndrome.** Dentists at work tend to bend forward, protracting their shoulders for prolonged periods leading to a hyperkyphosis (curvature of the thoracic spine) and a forward head posture. Holding the head and neck in an unbalanced forward position means the spine increasingly depends on soft tissues to maintain an upright position. For example, the upper trapezius and erector spinae muscles must contract constantly to support the weight of the head in the forward posture and this can lead to predictable referral pain patterns, including tension neck syndrome characterised by headaches and chronic neck pain. The pectorals muscles will also be tight. Dentists can stretch the pectorals and strengthen the upper back with one simple exercise that can be easily done regularly at work (e.g. between seeing patients). Simply clasp your hands behind your back, retract your shoulders and squeeze your scapulae – hold this position for a few seconds before releasing (<https://tinyurl.com/yab777lg>).

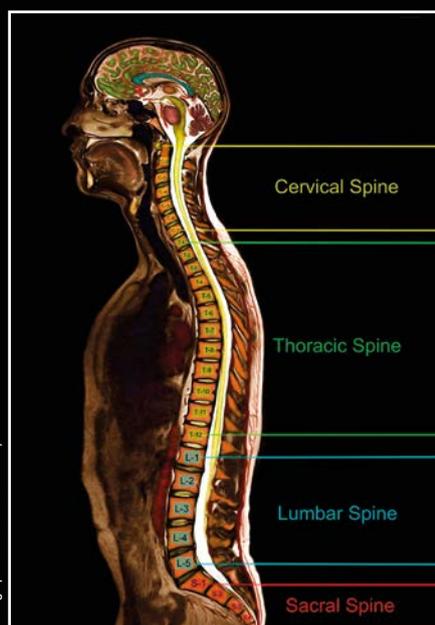


Fig. 1 Regions of the spine.

Photograph: Science Photo Library

# TAKE NOTICE

**Weakened deep neck flexors.** Dentists often suffer neck pain and this is commonly associated with weakness in deep neck flexors. There are exercises that can be used to strengthen these muscles including simple chin tucks. These can be done by moving the chin closer to your 'Adam's apple'. Stand against a wall so that when you retract your head, it just touches the wall. Hold this position while breathing normally for 10 seconds and repeat the process for 12-15 times. You can hold the position longer as you become stronger.

## CONCLUSION

This article obviously serves only as a primer to neck and back

pain and it must also be emphasised that corrective exercises alone are insufficient to deal with such problems. You must develop good postural habits by improving your general work ergonomics - and it is possible to train your body to recognise when you are adopting a poor posture. I would recommend all dentists to engage an appropriate professional to offer advice and guidance tailored to your particular work situation - and to seek medical attention for serious or prolonged back or neck pain.

James Tang is a general dental practitioner working in County Durham and also a personal trainer with a special interest in corrective exercise

# CASE FILES



These case summaries are based on MDDUS files and are published here to highlight common pitfalls and encourage proactive risk management and best practice. Details have been changed to maintain confidentiality.



## CLAIM

# MOLAR CONFUSION

## BACKGROUND

Dr T receives a letter from solicitors acting on behalf of a former dental patient – Mr F – alleging clinical negligence in the root canal treatment of an upper right molar (UR6). The letter states that during the procedure in May 2011 part of a fractured dental instrument was left in the tooth causing ongoing pain and suffering.

The patient subsequently attended another dentist who advised that removal of the fragment was not possible and extraction of the tooth was recommended with replacement by an implant. A treatment plan and cost estimate for the procedure is included with the letter of claim and a further amount demanded in recompense for suffering "endured for over three years".

## ANALYSIS/OUTCOME

The dentist contacts MDDUS and repudiates the claim. An examination of the records reveals that Mr F did indeed undergo root canal treatment in May 2011

but the procedure was not carried out by Dr T. That tooth was later extracted but again by a different dentist.

The patient did attend Dr T for treatment of a lower right molar (LR7) in June 2013. The dentist first placed a filling in the tooth but Mr F repeatedly complained of sensitivity over numerous visits. Treatment options were discussed before the patient opted for RCT of the tooth which was carried out in March 2014. In that procedure an instrument did fracture and become lodged in the tooth.

## KEY POINTS

- Comprehensive record keeping is essential for a sound legal defence.
- Dental mishaps may not in themselves be considered negligent.
- Acknowledge such mishaps immediately and offer the patient options for remedial treatment.

The patient was immediately informed of the incident and options discussed but the decision was made to "wait and see". A month later the patient re-attended the practice complaining of pain and further options were covered, including extraction of the tooth and replacement with an implant which the patient declined.

MDDUS responds with a letter suggesting that the solicitors review the records again, as their client's recollection is obviously incorrect. In regard to the root treatment of LR7, MDDUS contends there is no breach of duty of care on the part of Dr T as a fractured instrument is not in itself negligent. Mr F was advised of the incident at the time and options were discussed, including extraction and placement of an implant. The patient decided against this treatment option at the time.

The letter states that the claim will be robustly defended, and after further correspondence the case is subsequently dropped.

## ADVICE

# DISCLOSURE DEMANDED

### BACKGROUND

A medical practice has received a letter from solicitors acting on behalf of the Nursing and Midwifery Council (NMC). It is in regard to an NMC investigation into allegations of ill-treatment of a patient registered with the practice while in a local nursing home. The letter is requesting disclosure of confidential patient information and cites a statutory requirement. The practice contacts MDDUS for advice on its duty to disclose this information.

### ANALYSIS/OUTCOME

A medical adviser offers assistance to the practice manager both by phone and in a follow-up letter. He first draws attention to GMC guidance on *Confidentiality* which states: "Various bodies regulating healthcare providers and professionals have legal powers to require information to be disclosed, including personal information about patients."

The statute referred to in the solicitor's letter is the Nursing & Midwifery Order 2001; Section 25.1 which empowers an NMC Practice Committee to "require any person (other than the person concerned) who in his opinion is able to supply information or produce any document which appears relevant to the discharge of any such function, to supply such information or produce such a document."

MDDUS advises the practice that although this may seem unambiguous it does not necessarily mandate disclosure of confidential medical records. It is essential to take account of GMC guidance to ensure that disclosure is necessary for the purpose.

The practice manager is advised to respond to the solicitor acknowledging their letter and asking whether they have sought the patient's consent to the disclosure and, if not, to provide an explanation of why it would be unnecessary or inappropriate to obtain patient consent in this instance. The

NMC would also be at liberty to seek a court order to compel disclosure of the medical records and it would be appropriate to comply with any such order if received.

In the end the regulator provides evidence regarding the relevance of the requested information and it is disclosed with the patient's consent.

### KEY POINTS

- Disclosure of confidential data should normally be with the patient's consent.
- Disclosure without consent may be appropriate if the patient lacks capacity and it is in their best interests, or if specifically required by law.
- Disclosure may also be justified in the public interest.

## CLAIM

# MOLE TO MELANOMA

### BACKGROUND

A 42 year-old-patient – Mrs B – attends her GP surgery in regard to apparent conjunctivitis. In addition the patient mentions that she is worried about a mole just under her right breast. She reports that it has been there for a number of years but is worried about its appearance. Dr J examines the lesion and notes in the records *benign mole, smooth edge/no itch or bleeding*. He reassures the patient that the mole is "nothing to worry about" and referral is not necessary.

A year later Mrs B is back in the surgery for a stubborn chest infection. She again mentions the mole and expresses her concern that it might be skin cancer. She does not think the mole has changed since the last attendance, but is keen to have it removed. Dr J again records in the notes *benign mole* and reassures the patient that there is nothing to be concerned about but to return if she notices any change in size or appearance.

Around 18 months later Mrs B sees another GP in the practice – Dr L. The patient expresses concern that the mole

has recently increased in size and changed colour. The GP records: *Pigmented lesion under right breast – longstanding; recent increase in size. Variable pigment 0.6 cm.*

A two-week referral is made to a plastic surgeon with a suspected diagnosis of melanoma. The mole is excised and biopsy confirms melanoma. Mrs B undergoes a wider excision and further investigation shows no metastatic spread.

A claim of negligence is later brought against Dr J by solicitors representing the patient. It is alleged that at the first consultation no follow-up was arranged to monitor the mole after Mrs B had reported a change in appearance. It is also alleged that given the change in appearance the GP should have referred Mrs B for further investigation.

### ANALYSIS/OUTCOME

MDDUS instructs a primary care expert to assess the case. He is critical of Dr J in respect of his note keeping. The appearance of the lesion at the first consultation should have been documented in more detail, including the size, shape and

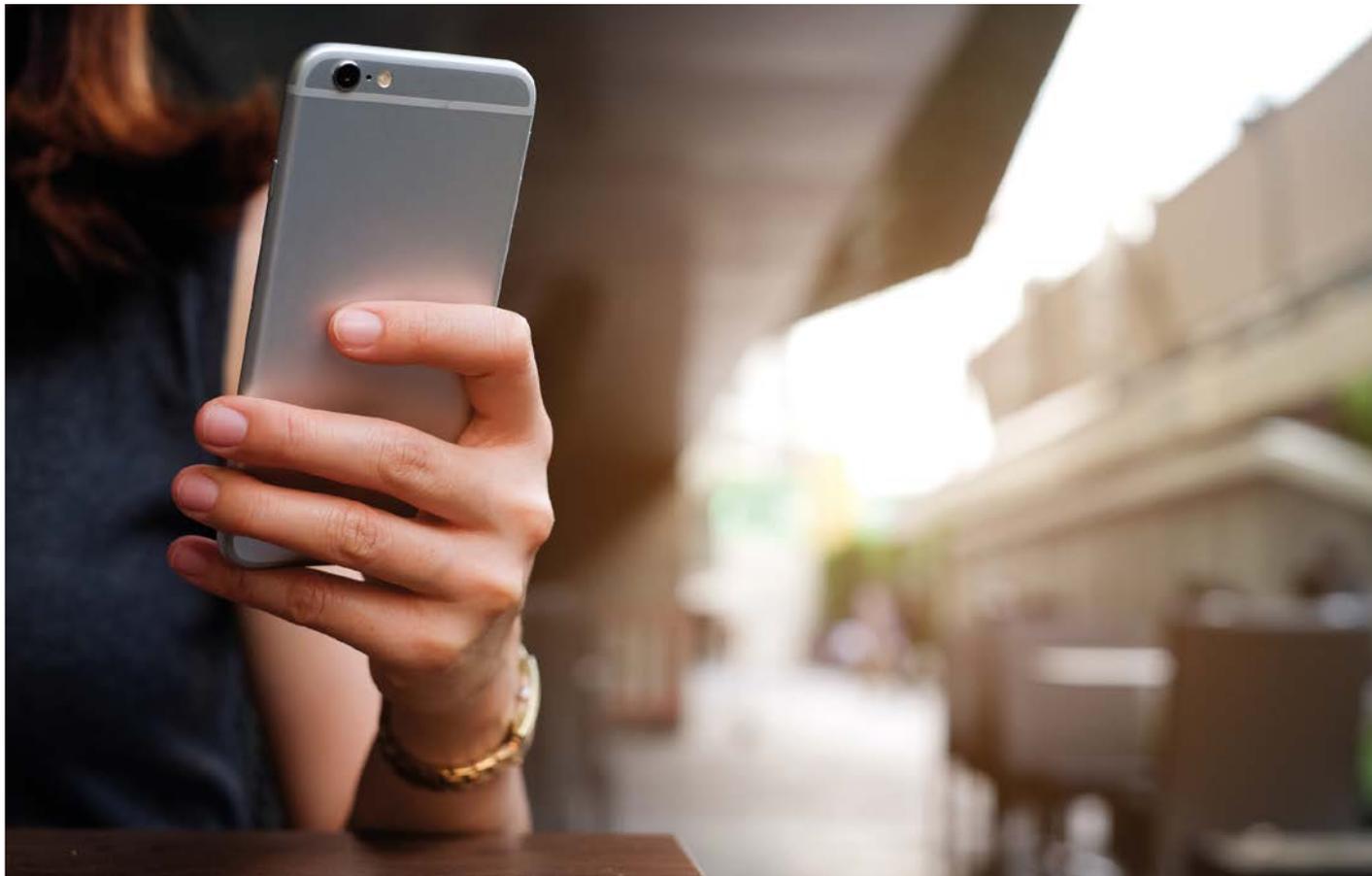
colour. This would have provided more evidence to support his conclusion that the mole appeared benign. Similarly the records in relation to the second consultation were very brief and lacked a sufficiently detailed description of the mole for comparison with the earlier consultation.

It is difficult, however, to comment on the point where the mole may have begun to show changes suggesting melanoma.

A letter of response is drafted denying liability and causation on the basis of Dr J's views that at both consultations the mole appeared benign with no change. The case is subsequently discontinued.

### KEY POINTS

- Good notes support a sound legal defence.
- Follow latest clinical guidelines in regard to suspect skin lesions.
- Proof of negligence requires evidence of both breach of duty and causation.



## INAPPROPRIATE TWEETS

### BACKGROUND

A specialist registrar in emergency medicine – Dr T – contacts MDDUS to report that she has had a letter from the GMC in regard to information it has received concerning inappropriate postings on her Twitter account.

A colleague at the hospital where Dr T works has sent the regulator a letter of complaint along with photocopied examples of some of her tweets. These have been posted under an anonymous Twitter handle and include various disparaging ‘jokes’ in regard to patients. Sometimes these reference characteristics such as weight or personal hygiene in connection with ethnicity or socioeconomic class. A brief bio identifies her on Twitter as an “A&E doc in the south of England”.

Dr T has also been reported to her hospital and has been contacted by the trust in regard to possible disciplinary action.

### ANALYSIS/OUTCOME

MDDUS offers initial advice in regard to the GMC matter and Dr T deletes the Twitter account. She insists that her posts were

simply humorous in intent, pointing out absurdities encountered working in the NHS. None of the patients referred to were based on particular individuals. Indeed, she finds it difficult to understand what all the fuss is about – but she is advised of the seriousness with which the GMC regards such matters as set out in its guidance document *Doctors’ use of social media*.

Dr T later responds to the GMC by letter acknowledging that she has not behaved in a manner consistent with the trust placed in her by patients or the public. She accepts that she has failed to follow GMC guidance

and understands that the high standards of behaviour expected of doctors apply not only in professional but private life as well.

She further acknowledges that notwithstanding her attempts to remain anonymous it is unacceptable for any member of the medical profession to be using social media in this manner.

Six months later she receives a letter from the GMC to say preliminary investigations into the matter have been completed and that allegations in regard to impaired fitness to practise have been considered by case examiners who have concluded that Dr T’s conduct merits a formal warning. It states that on numerous dates Dr T posted inappropriate and unprofessional messages on her Twitter account that contained content which could be interpreted as racist and offensive. Such conduct does not meet the standards required of a doctor and risks bringing the profession into disrepute.

Dr T responds to the GMC accepting the proposed warning which will be published on the GMC website for five years and then kept on record and disclosed to employers upon request.

### KEY POINTS

- GMC guidance states that any posting on social media from someone identified as a doctor should not be done so anonymously.
- Doctors use of social media must not risk compromising patients’ or the public’s trust in the profession.
- Consult GMC guidance on *Doctors’ use of social media*.

## ADVICE

# ENDING IMPLANT WORK

## BACKGROUND

A dental surgeon with expertise in implant placement has for the last few years been in a working arrangement at a colleague's practice in which he undertakes a limited number of procedures for a percentage split in fees after deductions for materials and laboratory costs. The dentist has now decided that he no longer wants to offer implant treatment as he feels the cases undertaken are too infrequent for him to maintain competence. A new surgeon with more experience has agreed to take on the implant work.

He contacts MDDUS for advice on who will have responsibility for the ongoing care of the implant cases he has undertaken and completed. The dentist also wants reassurance that he will be fully indemnified

for any problems arising in future from any of his completed cases.

## ANALYSIS/OUTCOME

An MDDUS dental adviser replies by letter

### KEY POINTS

- Ensure that you maintain ongoing competence for any procedures you undertake.
- Inform patients of future care arrangements if moving on from a practice.
- MDDUS offers occurrence-based cover for any treatment 'incident' arising while in membership.

saying that the case is little different from the situation when any dentist retires or leaves a practice. The member is advised to inform relevant patients of the change and ensure a system is in place to monitor the implant treatment and provide appropriate care should any problems arise.

He is advised that problems can sometimes arise when implants fail later after being restored by a different dentist, but in the end liability will be determined by expert opinion after examination of the clinical records and/or the patient. In terms of any complaint or claim, MDDUS liability is occurrence-based meaning the member will have access to indemnity for treatment carried out while in membership regardless of when the claim is made, even when he has ceased clinical work or retired.

## COMPLAINT

# INGESTED BUR

## BACKGROUND

A dental surgeon – Mr H – is polishing a restoration when a friction grip bur falls out of the handpiece. A dental nurse has been applying suction but is unsure if the bur was caught in the system.

Mr H asks the patient to sit up immediately and rinse but there is no sign of the bur so the dentist inserts another bur and finishes polishing. On completion of the treatment he advises the patient of the missing instrument and suggests that it was most likely caught in the suction system but that there is the possibility it might have been ingested or, much less likely, inhaled.

Mr H advises the patient that he will first check the suction system and filters and if the bur is not found it would be advisable to attend hospital for further assessment and perhaps a radiograph. A technician checks the system but no bur is found. The patient is advised to attend hospital along with a note of relevant information about the instrument (size, shape, photograph, etc). Nothing is found on X-ray and the patient is advised to return if he experiences chest symptoms.

An angry letter of complaint is hand-delivered by the patient the next day which includes a demand for compensation.

## ANALYSIS/OUTCOME

An MDDUS adviser assists Mr H in

composing a letter of response to the complaint. The dentist first expresses regret that the incident occurred and promises that the practice will conduct a significant event analysis to look at possible ways of preventing such a mishap in future – including contact with the manufacturer of the handpiece for an explanation of why the bur detached.

In addressing the demand for compensation Mr H states that, while sympathetic, he maintains that the incident was not due to any negligence on his part and thus compensation would not be appropriate. However, the practice offers to refund the cost of the treatment without any admission of liability.

No more is heard regarding the complaint and the patient remains registered with the practice.

### KEY POINTS

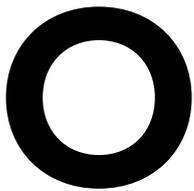
- Inform patients immediately if there has been any mishap during treatment.
- Advise patients to attend hospital in suspected swallowing of a dental instrument (with relevant details).
- Contact MDDUS for assistance in complaint handling, especially in cases with potential to escalate into a claim.



# SAFEGUARDING CONCERN

Alan Frame

Risk adviser at MDDUS



*UR practice has received a subject access request from a patient wanting a copy of the medical records of her 6-year-old daughter. Checking through the record*

*before sending it to the mother I noted an entry summarising the minutes of a recent multi-disciplinary child protection meeting held by the local social work service stating the girl may be at risk of sexual abuse from a named male relative within the family. There are also suspicions the mother may be complicit. The entry makes it clear that this information should not be disclosed to any member of the family at this stage. What information should be redacted to comply with data protection laws?*

The Data Protection Act 1998 would normally entitle a mother to access the medical records of her young child (who lacks capacity by reason of age) but in this case it is clear that a decision has been taken to withhold specified information from the mother due to ongoing safeguarding concerns.

This presents a risk as current advice from the GMC (*Protecting children and young people: the responsibilities of all doctors*) states that: "You should store information or records from other organisations, such as minutes from child protection conferences, with the child's or young person's medical record, or make sure that this information will be available to clinicians who may take over the care of the child or young person."

This guidance is intended to ensure that such information will be readily available to other healthcare professionals who will be providing care to that child, as well as appropriate safeguarding. But in this particular case a decision has been made to withhold specific information from family members, as disclosure could place the child at risk of harm.

The GMC guidance does, indeed, clarify that: "A parent may see their child's medical records if the child or young person gives their consent, or does not have the capacity to give consent, and it does not go against the child's best interests."

Confronting the risk of potential inappropriate or unlawful disclosure, as in this case, it is easy to understand why some doctors would make a decision to store all



such correspondence separately from the child's main medical record. However, the risk of important information being lost or misplaced outweighs other considerations in relation to the safeguarding of children.

The aggregate of guidance now makes it clear that case conference reports for any child now or formerly subject to a child protection plan must not be kept separate or isolated from handwritten or digital clinical records and these should also be transferred with the complete patient record if the child changes GPs. Further support for this approach can be found in other guidance such as that offered by the RCGP and NSPCC in their *Safeguarding Children and Young People: The RCGP/NSPCC Safeguarding Children Toolkit for General Practice*.

In particular it provides a *Specimen Child Safeguarding Policy for General Practice* with information in relation to all aspects of child protection. Guidance specific to record keeping can be found on pages 7 and 8. It states that case conference records must never be destroyed (e.g. by deleting electronic records or shredding hard copies) and advises that any welfare concerns should be passed on even if the child is not subject to a protection plan.

More specifically the guidance recommends:

- All reports should be scanned onto the relevant child's records.
- Reports should be vetted to remove any third party information, especially if external agencies request these medical records.
- Reports/correspondence should be seen and summarised by a GP.
- All contacts with any parties regarding any safeguarding children issues should be recorded on the patient's medical records and any necessary action taken immediately.

These steps are also relevant to the above dilemma – particularly the requirement to carefully scrutinise and vet the record for third party information and that such tasks should be undertaken by a GP familiar with the case and not delegated to administrative staff within the practice.

In summary, case conference reports for any child now or formerly subject to a child protection plan must not be kept separate or isolated from handwritten or digital clinical records – and these should be transferred with the complete patient record if the child changes GPs. But this means care and attention is needed when complying with subject access requests to ensure against unlawful or inappropriate disclosure.

# THE SOUND OF SILENCE

Deborah Bowman

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

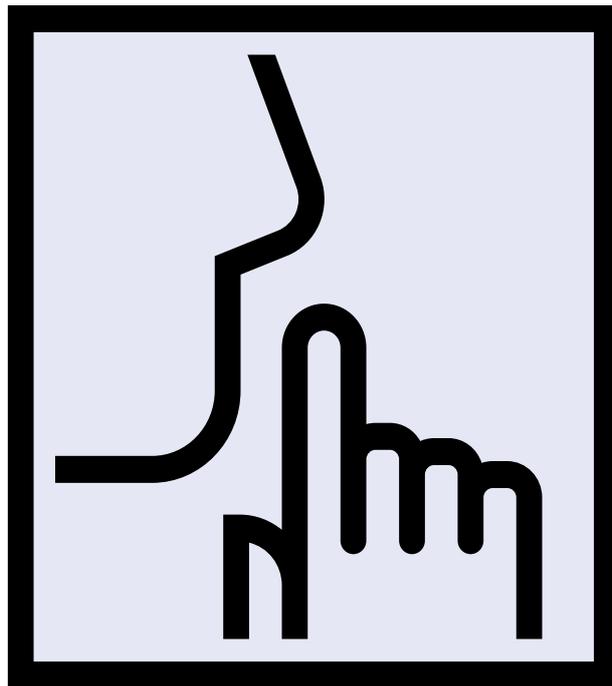
I HAVE always been interested in the ethical imperative to speak up and the influences that can make it more or less easy to raise one's voice. Many years ago, my choice of PhD subject was prompted by a passing conversation with a GP about the overwhelming challenges he had faced when he raised concerns about the clinical setting in which he was working.

I have worked with hundreds of students and junior doctors over the years who have shown courage and integrity in their willingness to question others; even when to do so has risked, or has actually had, an adverse personal impact. I have run forum theatre sessions at which people can 'rehearse' and practise speaking out, acknowledging the gap that so often exists between knowing the right thing to do and being able to do the right thing in practice. Yet, it has been staying silent that has preoccupied me recently.

For the last two months my phones have rung constantly and my email box has become unmanageable. Calls and messages have come in from across the world asking for comment, opinion and contributions on what was invariably described as "the Charlie Gard case". I have often taken part in programmes and written for the national press on medical ethics. However, on this occasion I was clear that, for me, this was not something about which I wanted to speak publicly. Initially, it was a simple, unshakeable intuition that to do so would not sit well with me. I hadn't articulated why, but I knew it to be my view.

As the days and weeks passed, I regularly saw and heard friends and colleagues speaking in the media with compassion and clarity about events at Great Ormond Street Hospital and in the High Court. Nonetheless, I remained sure that to remain silent was, for me, the better option. Quite simply, I believed that I did not, and could not, know what anyone in this most tragic of situations was experiencing. I imagined that everyone, staff and family members alike, were devastated and overwhelmed. The public nature of what was happening must only have exacerbated the emotional pressure for all involved.

Crucially though, I did not know what had taken place in the preceding months



“This was not a time for more words. It was a time for compassionate silence”

nor how those interactions had been perceived by the people directly involved. I did not know why or how these private sorrows had come to be considered by the court. As the judgments appeared from the different stages of the legal process, it was clear that many of the people commenting and reporting on what had taken place were doing so, inevitably perhaps, from a position of partial knowledge. Some who were passionate in their commentary appeared, surprisingly, not to have read the judgments at all.

I reflected on what value might be added by me commenting, even in the most general terms, on a situation where vulnerability, distress and despair were palpable. I concluded that there was nothing that I could add that would be anything other than superfluous and maybe even damaging. I was alarmed by the weight others afforded to my opinion: journalists, friends, taxi drivers and even my hairdresser all asked "what I really thought" about that morning's headlines. I politely refused to be drawn into those conversations, but the seemingly insatiable appetite for such discussion was

a sharp reminder of the power of perceived 'expertise' and the obligation we all have to use it wisely.

I am not critical of those colleagues and friends who responded to journalists more positively than I did. My silence is no more 'right' or 'ethical' than others' decisions to contribute to debates, news programmes, interviews and editorials. Whether to speak publicly or to remain quiet is a matter of judgement and a personal decision. And, of course, not all invitations are equal: some journalists, programmes and publications are more considered, careful and thoughtful than others. There are sound reasons why people have spoken publicly over the last few months, including the value in raising public awareness of the ethical dimensions of practice, clarifying and explaining clinico-ethical decision-making, exploring whether the current approach to disagreement in the clinical setting is effective and so on. Yet, for me, those and other potential gains were irrelevant in the face of tragedy and suffering. This was not a time for more words. It was a time for compassionate silence.

# Addenda

## BOOK CHOICE

### MEND THE LIVING By Maylis de Kerangal

TRANSLATED BY JESSICA MOORE

MacLehose Press: £14.99 paperback, 2016

Review by Dr Greg Dollman, MDDUS medical adviser

**T**RANSLATED from the French, *Mend the living* tells the story of a young man's heart – literally the beating organ in his chest. It is the latest award-winning novel from Maylis de Kerangal.

We meet Simon Limbeau's heart as its owner sleeps, "a muscle slowly recharging – a pulse of probably less than fifty beats per minute", only hours before Simon is declared brain dead in an automobile accident, "unconscious when the ambulances arrived, heart still beating". Later, as Simon's body is returned to his family we pick up the story of his heart which "contracts, a shudder, then moves with nearly imperceptible tremors, but if you come closer, you can see a faint beating, and bit by bit the organ begins to pump blood through the body, and it takes its place again, then the pulsations become regular, strangely

MAYLIS de KERANGAL  
MEND THE LIVING



rapid, soon forming a rhythm..." This is the first heartbeat of Claire Méjan's new heart.

This is a story of a heart transplant – but what makes this novel truly unique is de Kerangal's use of language.

It seems most appropriate, then, to use de Kerangal's own words, words that echo the rhythm of the human heart, to describe her novel. The sentences leap, swell, sicken, "waltz light as a feather" or "weigh heavy as a stone". Reading the novel is at times as beautifully simple as a rhythmic pulse, at others as frustratingly complex as electrophysiology. Pages pass without a full stop. The novel races, then slows, thumps then murmurs, always steadily progressing to an end.

The names in the novel have been chosen carefully. Birds, flight, tragedy and fixity are themes of this story of the heart and tragic loss. Simon's girlfriend is Juliette. The nurse who watches Simon's passage from life to death is Cordelia Owl. And Simon, himself, is a man in the shadows, a man in limbo.

De Kerangal calls her seemingly-endless sentences "language hold-up". In her translator's note, Jessica Moore elaborates on the author's "inventive use of rare words and concrete vocabularies... to approach the very tactile, grounded aspects of life in prose that astounds or makes strange, shimmering, beautiful".

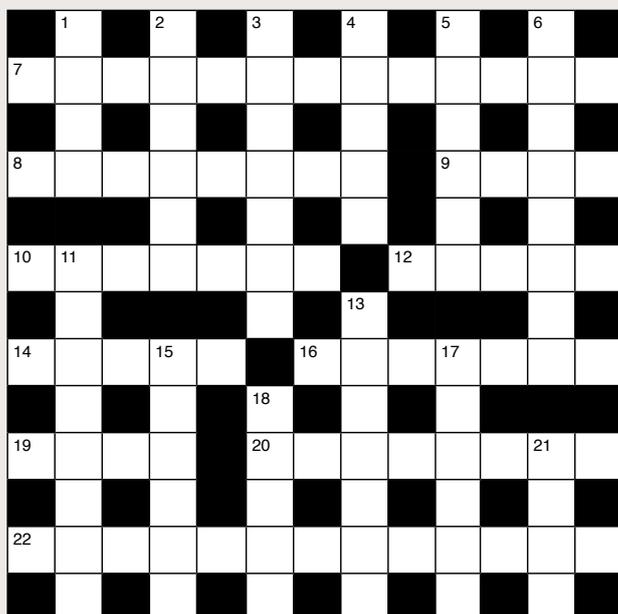
## OBJECT OBSCURA

### Medical lancet

THIS steel lancet in a bone sheath was made in India sometime in the 19th century.



Photograph: Science & Society



## Crossword

### ACROSS

- 7 Excessive curvature of the lumbar spine (13)
- 8 Undernourished (8)
- 9 Tide with least difference between low and high water (4)
- 10 Side by side (7)
- 12 Lips (5)
- 14 The sound of oars hitting water (5)
- 16 Extreme fatigue from over-work (7)
- 19 Legal prohibition served on offenders in the local community (acronym) (4)
- 20 Long pasta, slightly elliptical in section (8)

- 22 Excessive curvature of the upper spine (13)

### DOWN

- 1 Combustible heap (4)
- 2 Extent (6)
- 3 Subservient (7)
- 4 Deadly sin (5)
- 5 Transparent part of eye (6)
- 6 Italian dessert (8)
- 11 Central target of dart board (5,3)
- 13 Root vegetables (7)
- 15 Spray of water (6)
- 17 Impulse-conducting nerve cell (6)
- 18 Similar (5)
- 21 *The Killing, Wallander, The Bridge*: Nordic \_\_\_\_ (4)

See answers online at [www.mddus.com/about-us/notice-board](http://www.mddus.com/about-us/notice-board)

## VIGNETTE

# GERTRUDE HERZFELD (1890-1981)

## FIRST PRACTISING WOMAN SURGEON IN SCOTLAND

**I**N 2014, only around one in 10 consultant surgeons in the UK were women. However, a century earlier, when Gertrude Herzfeld qualified in medicine, there were none.

Herzfeld was born in late Victorian London, the daughter of Jewish Austrian emigrés, and enjoyed a comfortable middle class upbringing. She “longed to be a doctor” and studied at Edinburgh University in the years before the First World War. Throughout her studies there she excelled, and she graduated in the weeks before the outbreak of war in 1914. To be a newly qualified woman doctor at that time was challenging enough, as she had to navigate her way through a completely male-dominated profession. Having a German name was doubtless an added difficulty.

Nevertheless, she thrived and her career was a catalogue of firsts. She was the first woman house officer to Sir Harold Stiles at the Royal Hospital for Sick Children in Edinburgh. She was the first woman to be appointed honorary assistant surgeon at the same hospital, and in 1920 she became a fellow of the Royal College of Surgeons. She was the second woman to be admitted to the College but the first to “take her seat” or, in other words, to practise – and thus she became the first practising woman surgeon in Scotland.

She spent most of her career in her adopted home of Edinburgh, save for a spell during the First World War when she served as a surgeon at the RAMC Cambridge Hospital, Aldershot, and later as a surgical senior house officer at Bolton Infirmary. From 1920 until her retirement in 1955, she worked at the Bruntsfield, the Edinburgh Hospital for Women and Children. She was active in a variety of surgical fields, including gynaecology, plastics, orthopaedics and the management of burns and trauma, and she helped found the Edinburgh School of Chiropody and the Edinburgh Orthopaedic Clinic. However, she is widely regarded as the first woman paediatric surgeon.



Gertrude Herzfeld.  
Image courtesy of The Royal College of Surgeons of Edinburgh

One student described her as “a large woman in heart, mind, and build” and went on to recall how, “[n]one of her housemen could forget her great figure bending over a tiny neonate, opening and semi-constructing a blind cystic duct, easing a pyloric stenosis, or, later, apposing two raw edges of a minute cleft palate.”

The first modern treatment for infants with inguinal hernia was developed by her first chief, Harold Stiles, and Herzfeld was one of the few surgeons who carried it out. The procedure was a simple ligation of the hernia sac and could be performed quickly. Indeed, on one occasion, Herzfeld is said to have performed six of these operations in just 54 minutes.

This surgery was performed in outpatients, mainly because of bed shortages at the time, but it had significant benefits for the patient. The child would not need to interrupt breastfeeding,

and as a result these babies gained weight postoperatively rather than lost it. Outpatient surgery would become commonplace but Herzfeld and her colleagues were pioneering it half a century before it would become mainstream.

Throughout her career she was actively involved in medical education and was a lecturer in paediatric surgery at her alma mater. As a trainer, she advocated public praise and private criticism. One trainee said: “she never let us down in front of others, but quietly made it clear where we had erred – it was not a failure but part of learning”. Those who knew her respected her surgical skill, but they also praised her compassion, her wisdom and her warmth.

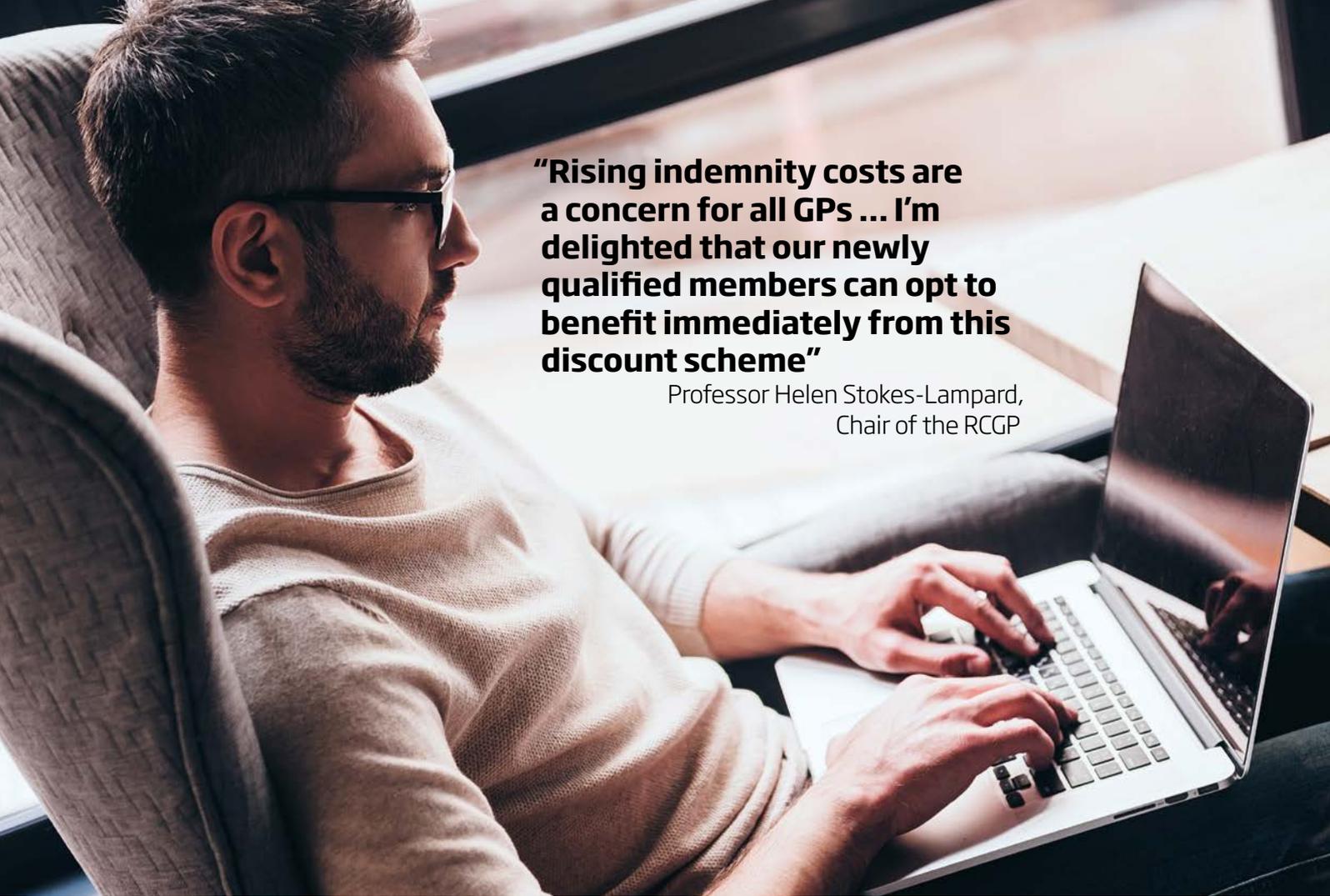
Herzfeld was called a trailblazer throughout her life, lighting a path for women in surgery. She had graduated from a medical school that had only started to admit women 22 years before and would not admit them on equal terms with men until two years after she left. She fought for positions and recognition and broke down barriers one by one by her determination, industry and talent. From 1948-50, she became the National President of the Medical Women’s Federation.

However, it has taken a long time for the path she forged to become well-trodden. Even today, more than three decades after her death, only around 30 per cent of surgical trainees are women. There is undoubtedly still much to do to promote gender equality in surgery, but without the early example of a woman such as Gertrude Herzfeld, we might not even be where we are today.

Dr Allan Gaw is a writer and educator in Glasgow

### SOURCES

- [Women in Surgery](#). Royal College of Surgeons, England
- [Obituary](#), BMJ, 6 June 1981
- [Alumni in History](#). University of Edinburgh
- [Biographical Dictionary of Scottish Women](#). EUP 2006.



**“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

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To find out more and take advantage of this offer go to **[www.mddus.com/join/rcgp-first-5-partnership](http://www.mddus.com/join/rcgp-first-5-partnership)**. The 75% contribution to your RCGP fees will be applied after your membership application is approved.

Existing MDDUS members who are RCGP First5 GPs will automatically benefit from the contribution at their next renewal date.

Contact Mairi Dixon on **0141 228 1267** or **[mdixon@mddus.com](mailto:mdixon@mddus.com)** for more information.