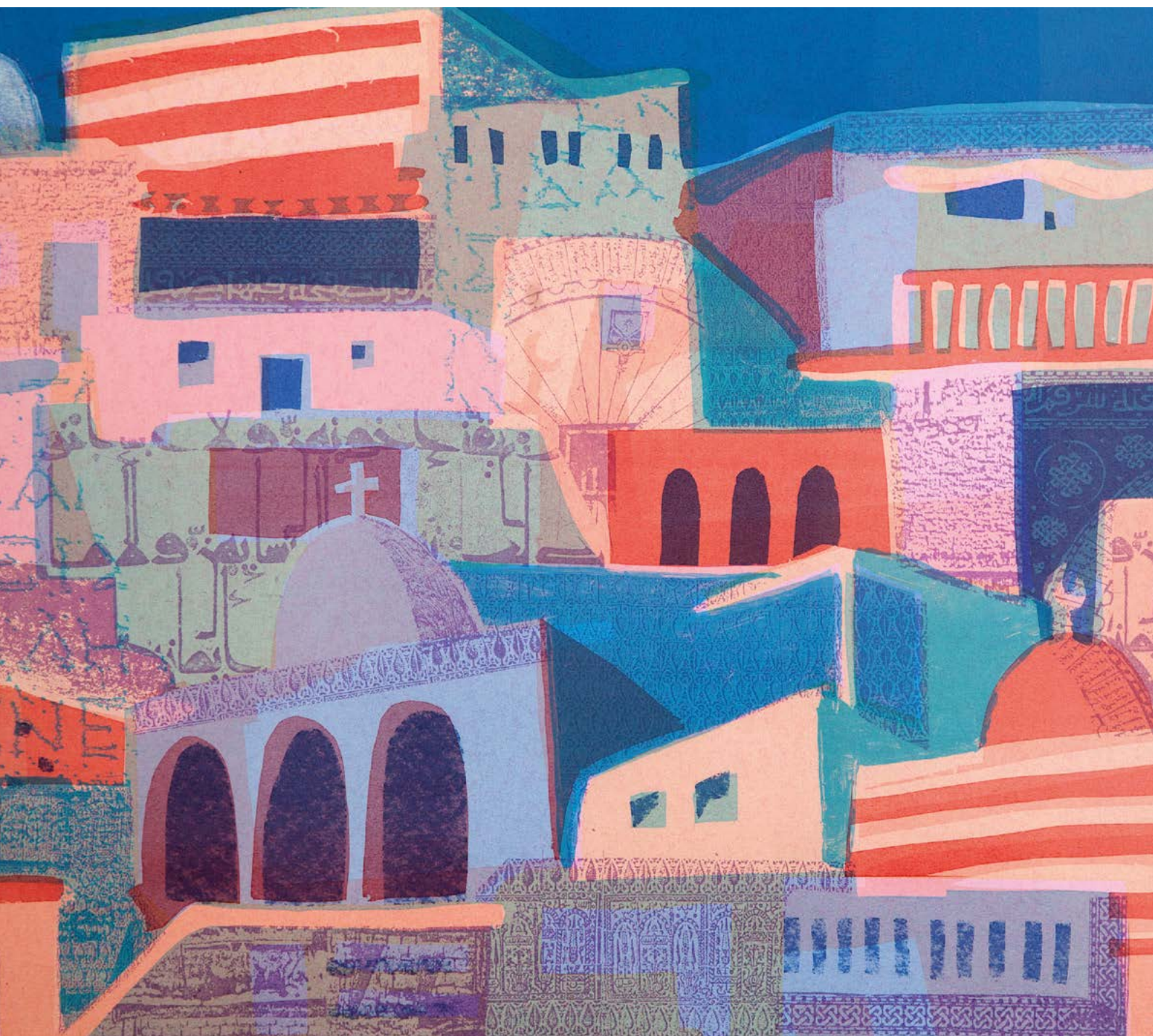


QUARTER ONE / 2018

INSIGHT



A QUARTERLY PUBLICATION FOR MEMBERS



WINTER YEAR ROUND

Q&A with Dr Tajek Hassan
of the Royal College of
Emergency Medicine

MY CHILD, MY CHOICE

Historical perspective on the
landmark legal case behind
"Gillick competence"

ENHANCE YOUR CPD

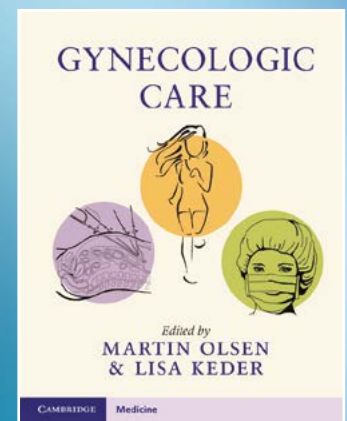
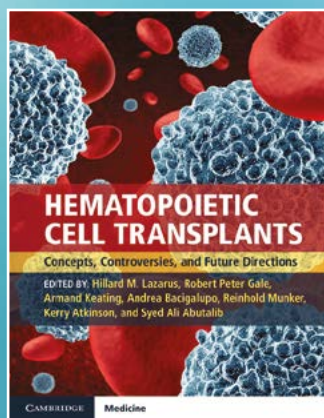
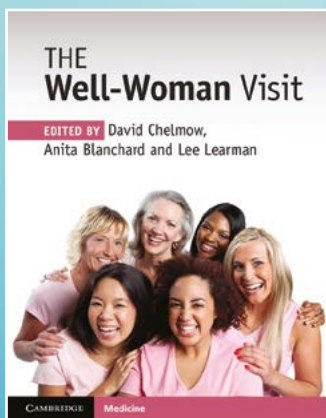
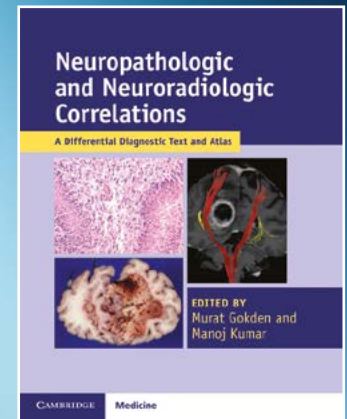
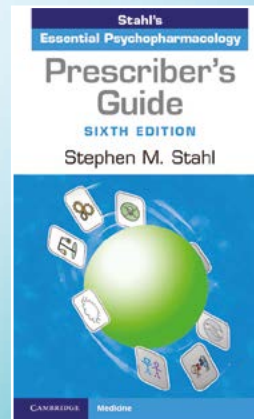
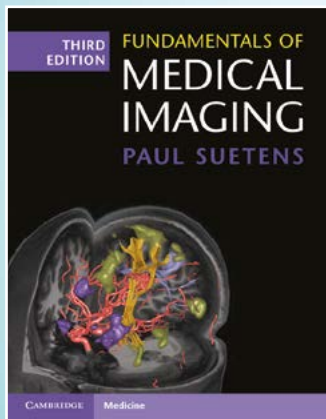
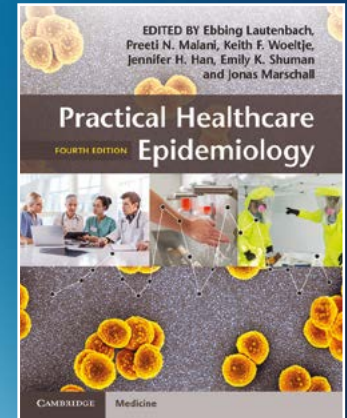
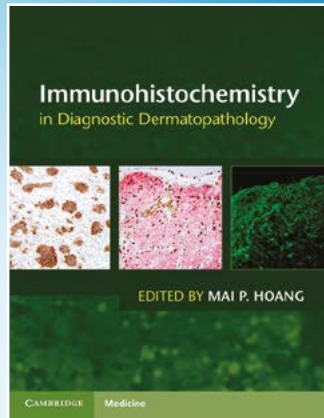
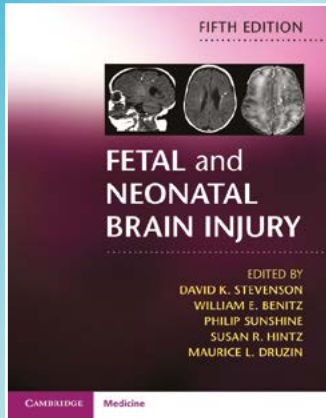
How can dentists maximise
benefit from the GDC's new
ECPD requirements?

UNDER PRESSURE

Ethical practice is never
more remarkable than when
delivered under pressure

CAMBRIDGE

Cambridge University Press Discount **20% OFF**



MDDUS Members can enjoy a **20% discount on all Cambridge University Press Medicine titles!**

For more information on titles go to www.cambridge.org/medicine and enter the code **MDDUS** at checkout.



CAMBRIDGE
UNIVERSITY PRESS

INSIGHT



Editor

Dr Barry Parker

Managing editor

Jim Killgore

Associate editor

Joanne Curran

Editorial departments

Medical Dr Richard Brittain

Dental Mr Aubrey Craig

Legal David Holmes

Design and production

Connect Communications

0131 561 0020

www.connectmedia.cc

Printing and distribution

L&S Litho

Correspondence

Insight Editor

MDDUS

Mackintosh House

120 Blythswood Street

Glasgow G2 4EA

jkillgore@mddus.com

Cover image

Maalula, Sheila Carnduff

Screenprint, 1996

Sheila Carnduff studied printmaking at Edinburgh College of Art. Her work is inspired by her extensive travels throughout Europe and especially the middle east. The subject matter in this work is based on a town near Damascus in Syria.

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
Scottish Charity No SC 036222.

Photograph: Press Association



4 Notice Board

6 News Digest

8 Briefing

Can we achieve a self-care revolution?

9 Risk

Antibiotics – damned if you do...

10 Winter all year round

Q&A with Dr Tajek Hassan, president of the Royal College of Emergency Medicine

12 My child, my choice

Allan Gaw recounts the famous Gillick case and events leading up to a landmark decision on medical consent in children

14 Getting the most from dental CPD

How can dentists maximise benefit from the GDC's new enhanced CPD requirements?

16 Case files

Sudden decline, Elderly visit, Notifiable disease, Failed extraction, Abusive patient, Lidocaine reaction

20 Dilemma

Burnout imminent

21 Ethics

Under pressure

22 Addenda

Book choice: *Admissions: a life in brain surgery*, Object Obscura: Napoleon's toothbrush, Crossword and Vignette: Henry Norman Bethune, physician, innovator and political activist





EDITOR

Dr Barry Parker

FIGURES released by NHS England in February of this year confirm a very challenging time for staff in A&E departments this winter, with only 77.1 per cent of emergency hospital patients being seen within four hours during January. There may be many factors involved, not least the seasonal surge in acute illness and a virulent flu outbreak. The strain on the NHS has been widespread and the hard work of frontline medical and nursing staff in primary and secondary care should be applauded.

We did not intend for “burnout” to be a special theme of this issue of *Insight* but several of the articles address the current “crisis” and the effect it is having on healthcare staff. In our Q&A on page 10, Dr Tajek Hassan – President of the Royal College of Emergency Medicine

– argues that deteriorating performance has created effectively “winter all year round”. He addresses the challenges in ensuring that the NHS is better prepared in future years.

On page 8, Joanne Curran asks whether greater patient “self care” might be one solution to rising demand

and dwindling resources within the NHS, and on page 9 Alan Frame examines the pressures faced by GPs to prescribe antibiotics when their patients have requested them.

Deborah Bowman (page 21) looks at the impact of work pressure from an ethical standpoint and her own personal experience of how ethical practice is never more remarkable than when it occurs under pressure. Our Dilemma on page 20 is about a GP on the verge of burnout but not wanting to let the side down.

Among the other content, Allan Gaw (page 12) provides some fascinating historical background to “Gillick competence” and medical consent in children, and Jessica Rothnie (page 14) offers advice on getting the most out of the new GDC ECPD requirements.

Dr Barry Parker

MDDUS

News

Dr Ian Simpson: An appreciation

WE ARE sad to report that former chief executive Dr Ian Simpson (pictured) passed away in December of 2017. Dr Simpson took up the post of secretary of MDDUS in 1987 in succession to Dr James Patterson. The title of chief executive was later added to the post. He retired in 2004 and during 17 years at the helm he guided MDDUS through major changes in the scope and volume of the business and implemented the staffing and infrastructure additions which this required.

Dr Simpson was an Aberdeen graduate and came with nine years’ experience and a wealth of knowledge as a medical adviser with the Medical Defence Union. When he arrived the membership was 15,910 and the annual indemnity and costs were modest by today’s standard at £1,778,752. The scene was, however, changing rapidly with rising levels of claims per member and costs per claim. The full member subscription was still a universal cost for all members irrespective of speciality and unrest was growing because of the inevitable steady rise to meet claims. This culminated in the introduction in 1990 of crown indemnity for hospital and community doctors and dentists. Transfer of assets from the Union to government required hard bargaining which was skilfully led by Dr Simpson. Differential subscriptions for different specialities were also introduced at this time, based on actuarial assessment of risk.

Despite the loss of hospital cases, the Union’s business burgeoned and the decision was taken to purchase Mackintosh House which opened as company headquarters in February 1994. Staff numbers were increased to cope with the increasing caseload and the establishment of an education department allowed us to reach out to members with a view to reducing the risk of costly incidents and, as a consequence, increasing patient safety. Improvements in the governance of finance, computerisation, human resources and communication with members all followed during the 1990s under Dr Simpson’s careful guidance.

On a personal note I had, as treasurer and later chairman, a close working relationship with Ian and found him unfailingly friendly and helpful. His last two years with the Union were overshadowed by the tragic loss of his daughter and by his own health problems but there is no doubt whatever of the debt we owe him for taking the Union forward in 17 years of major change.

Dr Alistair D Beattie



GDC proposals to reform dental regulation

THE GDC has published an analysis summarising responses to its discussion document: *Shifting the balance: a better, fairer system of dental reform*.

Commenting on the document, MDDUS chief executive Chris Kenny said: “We support the GDC’s ambitious proposals to build a new culture and encourage debate on reform. There is a great demand within the profession for accountability in terms of the GDC’s overall spending, particularly

with regards to the fitness to practise function.”

MDDUS head of dental division Aubrey Craig added: “The fitness to practise process should focus on the most serious allegations, where there is a risk of harm to the patient. This will help reduce the number of unjustified final hearings.

“We are particularly keen for steps to be taken to improve and streamline the early stages of the investigative process, prior to case examiner involvement. This would help ensure more efficient and fairer case handling for registrants.

“We are encouraged by the GDC’s aim of reforming dental regulation without the need for legislative

change. We believe it is important for the GDC to take forward as many proposals as possible without legislation, given the amount of legislative time which will inevitably be diverted to Brexit.

"It is equally important that the GDC takes the relevant stakeholders with them to develop momentum in implementation and to make sure that detailed processes and procedures match the scale of ambition."

Review of gross negligence manslaughter

MDDUS has welcomed the announcement by Jeremy Hunt that there will be an urgent review of gross negligence manslaughter in healthcare in light of the High Court case involving Dr Hadiza Bawa-Garba.

The review, led by Professor Sir Norman Williams, will report back by the end of April 2018 and intends to look at lessons to be learned by the GMC and other professional regulators, as well as how reflective practice, openness and transparency can be protected so that mistakes are not covered up but recognised as learning opportunities.

It is also intended that the review will provide much-needed clarity to doctors about where they stand with respect to criminal liability and professional misconduct.

MDDUS joint head of medical division Dr John Holden said: "We are pleased to note the priority this important issue is being given by the government and welcome the opportunity to participate in the forthcoming rapid review."

"It is vital that doctors experience an open and honest working environment and that they are able to learn from mistakes. We fully support any steps to encourage a learning culture that protects both patients and doctors."

Progress on fixed recoverable costs plans

THE Department of Health and Social Care has published a summary of the responses to its consultation on introducing fixed

recoverable costs in lower value clinical negligence claims.

MDDUS chief executive Chris Kenny commented: "We are relieved to finally see progress on this important project, given that the Department had committed to having a fixed recoverable costs (FRC) scheme in operation by October 2016.

"We are pleased to see that the Department remains committed to delivering a FRC scheme and that the proposed working group is intended to publish recommendations by autumn 2018. Timescales on this cannot be allowed to slip further and we hope for a speedy implementation by the Government thereafter.

"FRC in clinical negligence cases is vital to halt the runaway increase in claimant costs and to protect resources for the delivery of frontline NHS care. The Department's report fairly recognises the impact of excessive costs on claims in primary care and the savings that could be generated in primary care by the introduction of FRC.

"In order to have a real impact in terms of reducing the burden on the public purse, FRC is but one aspect of the necessary package of tort reform measures.

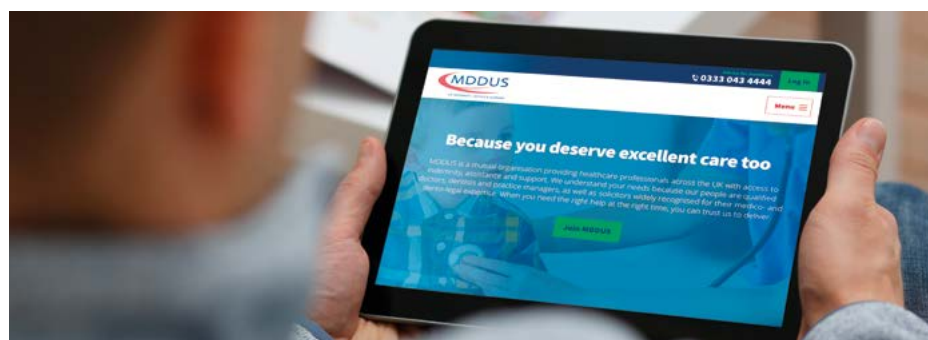
"Finally, we remain of the view that a cap of £250,000 is both necessary and proportionate. The report also shows that the arguments in favour of a cap in excess of £25,000 have been well made. We look forward to discussing these points in more detail as part of the working group."

Manage your MDDUS membership online

MEMBERS can now access a secure online portal allowing you to "manage your membership" – including the ability to download and print membership certificates, copies of renewal notices and online CPD, and also change your address and other personal details.

Over the coming months additional features will become available, enabling you to make changes to your subscription banding and payment details.

We encourage all members to register at the Log in prompt at www.mddus.com.



HOSPITAL DOCTOR RISK TRAINING

Join MDDUS at an interactive training day to explore common risks facing hospital doctors in areas such as consent, confidentiality and GMC compliance. Anonymised case studies will be used to highlight risks and explore how practice can be improved. London: 10 April 2018 and Glasgow: 15 August 2018. Contact risk@mddus.com.

GDPR FOR GP AND DENTAL PRACTICES

Check out a new topic area sited within our popular GP toolbox, with resources to help you prepare for introduction of the new General Data Protection Regulation (GDPR). These include a checklist, guidance sheets and helpful articles on data compliance. Go to the Training & CPD section at mddus.com. Member login required.

RISK BITES: MDDUS PODCASTS

Want to learn how good record keeping can help you navigate a complaint, significant event review, negligence claim or GMC investigation? Tune in to the MDDUS Risk Bites podcast series. Each episode looks at how two different practices handle the case of a patient with breast cancer. Find them in the Resources section of mddus.com.

LEADING THROUGH UNCERTAINTY

Calling on doctors with management responsibilities. Book now for this popular training course being held in Glasgow on 10-14 Sept and earn CPD points from the RCP. Contact risk@mddus.com to book a place.

NHS plagued with rota gaps and vacancies

OVER 70 per cent of hospital doctors reported rota gaps in their departments and a significant percentage believe that the delivery of care has worsened in several areas over the last year, according to figures published by the BMA.

The figures come from the BMA's latest quarterly online survey of 2,400 doctors from across all branches of practice. In the survey, 71 per cent of hospital-based respondents reported current rota gaps in their departments and 47 per cent of GP respondents reported vacancies in their practices.

The survey also revealed that 71 per cent of respondents felt that access to GP and primary care services has worsened, and 86 per cent thought that the NHS was less financially sustainable.

Commenting on the report, Dr Chaand Nagpaul, BMA council chair, said: "These figures highlight doctors' concerns about a decline in services and widespread staff shortages. As doctors, we want to be able to provide the best possible care for patients, but access and quality of care are being affected by staffing and financial pressures.

"The result is delays in patients being treated, and doctors juggling large numbers of patients to compensate for staff shortages. This isn't safe for patients and it isn't sustainable for doctors."

Mortality higher among women post heart attack

A STUDY conducted in Sweden has found that the mortality rate among women in the year after suffering a heart attack is three times higher than that of men.

Scientists from the University of Leeds and the Karolinska Institute analysed the outcomes of 180,368 patients who suffered a heart attack over a 10-year period to December 2013. The data was drawn from Sweden's online cardiac registry – SWEDEHEART – and the results published in the *Journal of the American Heart Association*.

The researchers found that women who had a heart attack resulting from a blockage in the coronary artery were 34 per cent less likely than men to receive corrective procedures, including bypass surgery and stents. Women were also 24 per cent less likely to be prescribed statins to help prevent a second heart



Pharmacist first for minor illnesses

A NEW health campaign in England is urging patients to first contact local pharmacists for clinical advice and treatment for minor health concerns.

The Stay Well Pharmacy campaign was launched by NHS England and aims to increase public trust in community pharmacy teams and encourage people to use pharmacies rather than visit GPs as the first port of call for minor illness. The campaign focuses on three key symptoms: sore throats, coughs/colds and tummy problems.

A survey conducted as part of the campaign found that only 16 per cent of adults get regular advice from pharmacists for minor health concerns and only 6 per cent of parents concerned about young children. This is despite 79 per cent of adults being aware that pharmacists are qualified to give advice on most common illnesses and are able to identify more serious symptoms needing further medical care by a GP or emergency department.

All pharmacies, GP and dental surgeries are to receive a campaign toolkit including posters, information cards and briefing sheets along with other resources.

Professor Helen Stokes-Lampard, Chair of the Royal College of GPs, commented: "GPs and our teams across the country are currently facing intense resource and workforce pressures, and patients can certainly help to ease this pressure by seeking advice from a pharmacist where appropriate, before making an appointment to see their GP.

"Pharmacists are highly-skilled medical professionals who play an important role in advising patients on a huge variety of minor illnesses and conditions...But of course, they are not GPs and in an emergency or situation where genuinely unsure, patients should always seek expert medical assistance."

attack, and 16 per cent less likely to be given aspirin to help prevent blood clots.

Professor Chris Gale, professor of cardiovascular medicine at the University of Leeds and a co-author of the study, said: "We need to work harder to shift the perception that heart attacks only affect a certain type of person."

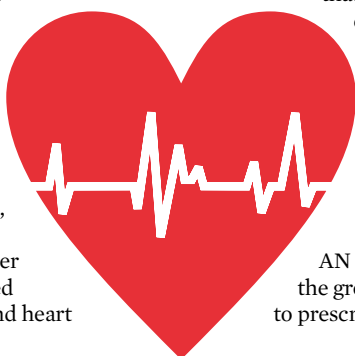
Prescription drug addiction review launched

AN independent review into the growing problem of addiction to prescription drugs has been

announced by the Government as statistics show that one patient in 11 was prescribed an addictive drug last year.

The review will be undertaken by Public Health England (PHE) and will address a number of issues, including why the prescribing of addictive medicines has increased 3 per cent over five years and how 8.9 per cent of patients were prescribed such drugs last year. It will also look at antidepressant prescriptions in England which have more than doubled in the past 10 years and a recent survey that found that 7.6 per cent of adults had taken a prescription-only painkiller not prescribed to them.

PHE will assess the scale of the problem, the harms caused by dependence and withdrawal, how they may be prevented and the best way to respond. The findings of the



review will be published in early 2019.

Public Health Minister, Steve Brine said: "We know this is a huge problem in other countries like the United States – and we must absolutely make sure it doesn't become one here.

"While we are world-leading in offering free treatment for addiction, we cannot be complacent – that's why I've asked PHE to conduct this review."

Ban on lawyers targeting the NHS

LAW firms and "claims management" companies who encourage patients to sue the NHS will no longer be provided office or advertising space in NHS hospitals in England.

NHS England says it has taken this action to protect patients, families, the NHS and taxpayers. It follows a consultation exercise and the new rules are being introduced through changes to the NHS Standard Contract.

Clinical negligence claims cost taxpayers around £1.7 billion in 2016/17, with legal costs accounting for 36 per cent of the total bill.

An NHS England spokesperson said: "Money spent defending speculative legal claims is money hospitals can't then spend on looking after patients. That's why legal firms who pursue the NHS should not advertise in or operate from our hospitals."

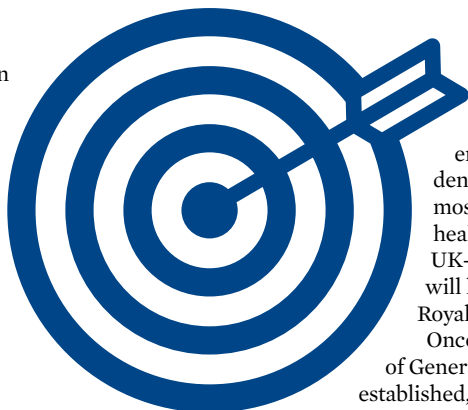
New dental college nearing reality

THE Faculty of General Dental Practice (UK) (FGDP(UK)) is taking forward plans to form a new College of General Dentistry and pursue a Royal Charter.

A transition board is working with the current FGDP(UK) board, the Royal College of Surgeons of England (RCS Eng) and the Faculty of Dental Surgery (FDS) of the RCS Eng with the goal of establishing the independent college within the next 12 months.

The new organisation aims to provide a collegiate home and new professional standing for general dental practitioners and all members of the general dental team. It will provide leadership and champion the further development of dentistry.

Support for the formation of the proposed College of General Dentistry has been most



encouraging with a growing groundswell of enthusiasm to bring dentistry into line with most other elements of healthcare by having a UK-wide College, which will hopefully justify Royal status.

Once the College of General Dentistry is established, it is hoped that it will develop a number of faculties

and various groups and bodies may wish to become affiliated. The British Dental Writers and Editors Forum has indicated that it wishes to be affiliated with the new College and discussions are taking place with other possible affiliates.

With many aspects of oral healthcare set to change and, with such change, the prospect of many new challenges, it is both timely and important for dentistry in the UK to have an autonomous, dedicated college. FGDP(UK) is encouraging members of the dental team wishing to play a part in creating history and contribute to the "beating heart" of the new college to join the Faculty now.

Nairn Wilson is chair of the transition board of the proposed College of General Dentistry

A&E pressures not down to GP access

DIFFICULTY in accessing a GP does not lead to increased use of hospital accident and emergency services, according to new research.

Factors such as multiple long-term conditions, smoking and being housebound were more significant in predicting A&E attendance. And the more frequently someone consults their GP, the more likely they are to visit A&E.

The findings emerged in a study by Queen Mary University of London which was published in the *British Journal of General Practice*. Researchers analysed primary care demographic, consultation, diagnostic and clinical data and linked it with A&E attendance statistics for more than 800,000 patients in London.

Increasing pressure on A&E resources is often linked to difficulties in accessing GP care. But the study concluded: "[T]he burden of multimorbidity is the strongest clinical predictor of ED attendance, which is independently associated with social deprivation. Low use of the GP surgery is associated with low attendance at ED. Unlike other studies, the authors found that adult patient experience of GP access, reported at practice level, did not predict use."

IMPROVED LUNG CANCER SURVIVAL

A new report has confirmed a further improvement in survival rates among lung cancer patients, with 37 per cent now living at least one year after diagnosis compared to a rate of 31 per cent in 2010. The National Lung Cancer Audit (NLCA) 2017 annual report found that more cancers are being diagnosed at an earlier stage, with one in eight at the earliest stage.

INCREASE IN FEMALE TRAINEES

The number of female doctors in training in the UK increased again last year, according to GMC statistics, although overall growth is slowing down. The proportion of female trainees rose by over six per cent in the past five years and women now make up 58 per cent of doctors in training. But there was a nine per cent overall reduction in the number of female trainees under 30 between 2012 and 2017. One possible explanation is female doctors taking career breaks and extending training.

WARNING ON DRUG-NAME CONFUSION

The MHRA is urging doctors to take particular care when prescribing or dispensing medicines that could be confused with others. It cites recent cases in which patients have received the wrong medicine due to confusion between similarly named or sounding brand or generic names. Examples include clobazam versus clonazepam and propranolol versus prednisolone. Clinicians are urged to report look-alike or sound-alike errors to the MHRA.

CAN WE ACHIEVE A SELF-CARE REVOLUTION?

Joanne Curran

Associate editor of *Insight*

EMPOWERING patients is viewed by many as a crucial step to delivering sustainable, personalised healthcare fit for the 21st century.

Much has been made of the need for “patient-centred care” which The Health Foundation describes as supporting people to “develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and healthcare.”

Out of this debate has developed a push for greater patient “self care”, which has been heralded by some as a solution to the NHS crisis of increasing demand and dwindling resources. Making patients less dependent on the medical profession could save billions, it is argued, while giving people more confidence and control over their own wellbeing.

This sounds like the perfect solution – but is self care achievable? The Self Care Forum, an online resource for doctors and patients, defines it as: “The actions that individuals take for themselves... to develop, protect, maintain and improve their health, wellbeing or wellness.” (Proponents are clear that patients are not expected to cope on their own without any help from a health professional.)

An estimated 80 per cent of all care in the UK is self care, with the majority of people content to manage minor ailments such as coughs and colds using over-the-counter medicines. Despite this, the Forum says there are still 57 million GP consultations a year for minor ailments at a total cost to the NHS of £2 billion. It cites research suggesting people often abandon self care earlier than they need to, largely due to a lack of confidence in understanding the normal progress of symptoms. They often see their GP for reassurance that nothing more serious is wrong and for a prescription to “cure” their illness, even though the same medicine may be available over the counter.

In a January 2018 column for *Pulse*, Dr Shaba Nabi argues that time-constrained doctors focus more on compliance with medication than compliance with lifestyle changes. She says: “It is far easier to sign an FP10 than to encourage a patient to adopt a biopsychosocial model for their pain... so our patients adopt the same preference for



drugs over anything else. By adopting a narrow medical model, we have created patient dependency.” She adds: “Self-care, if truly embraced by the Government and the medical profession, could save the NHS billions of pounds.”

There was support for her viewpoint from readers, with one locum GP commenting that “self care is vital for both patients and the salvation of the NHS”. But equally there was scepticism, with a GP partner adding that dreams of self care were “pie in the sky” because “the free all-you-can-eat NHS buffet torpedoes any valiant self-help campaign”.

So what can be done to increase levels of self care? Research published in the *BMJ* in September 2007 notes that, despite “enthusiastic promotion of self care, randomised controlled trials often show modest benefits.” Authors Anne Kennedy, Anne Rogers and Peter Bower argue that teaching patients self-care skills is unlikely to be sufficient for effective self care and that fundamental changes are needed in professional attitudes and the way healthcare is delivered.

Previous attempts to deliver self-care training have faltered, they say, because they do not take sufficient account of patient variability and the different ways in which people self care. They have also found that self care can “raise tensions

between patient autonomy and professional responsibility and the delivery of evidence-based care”.

They say two key changes in thinking are required: a whole systems perspective that engages patient, practitioner, and service organisation; and widening the evidence base to acknowledge recent research on the way in which patients and professionals respond to long-term conditions.

An article on the Self Care Forum’s website by Catherine Macadam encourages doctors to “adopt a coaching approach”, using one-to-one discussion to enhance patients’ knowledge and skills. This would in turn restore confidence, reduce dependency and free up more time to deal with serious and complex conditions.

Encouraging children to self-care and to live healthy lives is an important step, says GP and Self Care Forum co-chair Pete Smith. He believes early years education could improve health literacy and give youngsters “the grounding to prepare them for dealing with bigger issues in later life”.

Achieving a self-care revolution will require considerable time and investment from patients, professionals and government. As the Forum says: “Self care is not something to be added once everything else has been put in place. Indeed, the NHS must support people to self care at every appropriate contact.”

ANTIBIOTICS – DAMNED IF YOU DO...

Alan Frame

Risk adviser at MDDUS

CERTAIN things are sadly inevitable every winter, including the increase in patients presenting in GP surgeries with sore throats, earaches, sinusitis, colds and other flu-like illnesses – but also the upsurge in demand for antibiotics.

Over 80 per cent of NHS antibiotic prescriptions are issued in primary care, with acute respiratory infections and associated complications among the commonest justifications. NICE reported in 2015 that nine out of 10 doctors feel pressured to prescribe antibiotics, with 97 per cent of patients who ask for them being given scripts – although there has been improvement in recent years with NHS England reporting that antibiotic prescriptions fell by 7.3 per cent in 2015/16.

This winter Public Health England launched a new campaign designed to discourage patients from pressuring their GP into prescribing antibiotics. A letter from the chief medical officer to all GPs in England cites the O'Neill independent *Review on Antimicrobial Resistance*, which recommended a "massive global public awareness campaign" to tackle low understanding and reduce inappropriate demands for antibiotics which is contributing to growing antimicrobial resistance.

Keep Antibiotics Working was launched on 23rd October 2017 and was seen across the country on billboards, TV, press, online and radio. The campaign is supported by a range of free resources including posters and leaflets which are available to help GPs reinforce this message and support conversations around self-care alternatives.

Initiatives such as the new campaign are no doubt very welcome in the fight to reduce current levels of antimicrobial prescribing but doctors are reminded that they have a responsibility to consider the wider body of evidence available to inform their clinical judgement and decision-making on a patient-by-patient basis. Good communication and recording of prescribing decisions in consultation notes provides excellent evidence of clinical judgement on whether a prescription or self-care measures would be more appropriate for the patient.

NICE is currently developing guidelines



"A survey of over 1,000 GPs across the UK found that 28 per cent had prescribed antibiotics several times a week even when uncertain of the medical necessity and 45 per cent did so knowing it would not help"

for managing common infections, including those which can be exacerbated during the winter months, and will look at the evidence on appropriate prescribing of antibiotics at a national policy level. It is hoped that the new guidelines will offer practical advice on whether a patient should receive antibiotics immediately, be issued with a delayed prescription or educated in how best to self-manage their symptoms.

Members are also reminded that NICE has recently published updated guidelines on the prescribing of antibiotics for sinusitis, and also provides clinical guidelines on antimicrobial stewardship.

Many doctors admit to prescribing antibiotics despite being reasonably sure an illness is viral in nature. A 2014 Longitude Prize survey of over 1,000 GPs across the UK found that 28 per cent had prescribed antibiotics several times a week even when uncertain of the medical necessity and 45 per cent did so knowing it would not help. There is an understandable worry for GPs that a refusal to prescribe an antibiotic will lead to dissatisfied patients and increased complaints – or worse a potential claim for clinical negligence.

Aside from these concerns, are there other factors which make it difficult for a doctor to say "no" to demands for an antibiotic, for example the patient's anticipated reaction – upset, angry or aggressive? Is it the possibility of future damage to the patient relationship? Or is it simply time pressures and a full waiting room increasing the onus on the doctor to finish the consultation? These are all legitimate issues but they have to be balanced against the now well-known and publicised risks to individuals and society of overprescribing antimicrobials.

Good record keeping of clinical decisions and the justification behind them are the best ways to refute any potential allegations or complaints.

ACTION

- Ensure you remain up-to-date and familiar with both current local and national antibiotic prescribing guidelines.
- Always communicate your decision to prescribe (or not) effectively to patients to avoid unnecessary complaints.
- Maintain careful records of your decisions to prescribe or decline antibiotics together with the reasons why.

DR Tajek Hassan has been a consultant in emergency medicine in Leeds since 1999. He was elected president of the Royal College of Emergency Medicine in 2016 and on taking up the role in September of that year, he was blunt about the current state of emergency medicine: “Performance is the worst in over a decade due to a host of complex reasons and reflects that the care we deliver to our patients is being compromised all too frequently... change is needed and the present situation is not sustainable.”

Dr Hassan previously served as vice president of the College and also has a range of academic interests including leadership development, acute decision support systems and neurological emergencies.

Theresa May has claimed that the NHS was better prepared this winter than ever. Is this at odds with your experience?

[Laughs] What an icebreaker. I think there is no doubt that a very significant amount of effort was put in to try and prepare ourselves for what we call ‘winter’. But if you look over a three to four year period, urgent and emergency care systems have been under increasing pressure and performance has steadily deteriorated so that effectively what we have created is winter all year round – a sort of chronic crisis mode. And when you add in other factors such as colder weather in the autumn-winter or norovirus or flu, that produces a spike in activity which a resilient system could cope with, but not one

What measures has the College proposed to deal with the crisis in the short term?

It’s very difficult to plan when you’re in the midst of a storm. The issue broadly falls into two sorts of cohorts. One is the system. We know that the medium-term solution is to invest more money in social care so that there are more community care beds and more community care packages for patients. Our DTOC [delayed transfers of care] rate in hospitals is way too high, on average around five per cent but actually in some systems it’s much higher. That is a big medium-term issue.

The other thing we have been campaigning on for quite a long time is ensuring there are enough acute beds in our systems. As I said, around 85 per cent is regarded as safe practice so it was disappointing to see NHS Improvement put an acceptable bed occupancy rate at 92 per cent, which is because that was all they thought might be achievable on a really good day. But that’s not sensible. The latest figures show we are at 95 per cent [early February] and that means a significant number of systems are effectively at 100 per cent – because it’s an average.

What that means in actual fact is that you don’t get flow within a system and you get very crowded emergency departments. Crowded emergency departments then lead to delays in assessment, delays in diagnosis, delays in basic interventions like pain relief and antibiotics and other therapeutic delays. That leads to increased harm in patients which then leads to increased litigation and even more money sucked out of the system. So at the moment we’re

The NHS has faced unprecedented pressures this winter. *Insight* asks the president of the Royal College of Emergency Medicine, Dr Tajek Hassan, what is needed to put the service on a more secure footing



WINTER ALL YEAR

that is chronically suffering.

So with due respect to the prime minister, it’s not just semantics, it’s important to be accurate. I think going into this winter period we were very clear that we were ill-prepared and it was highly predictable that what would happen, did happen.

Were the external pressures worse than in past winters?

The flu virus has been the worst in five or six years. We knew also that our bed occupancy rates were far too high going into the autumn-winter period. Safe bed occupancy rates should be at about 85 to 87 per cent. We previously estimated that we needed at least 5,000 extra beds if we were to get bed occupancy down to safe levels. There was also no winter funding until the budget, which was in November, and that was only £350 million – an inadequate figure – which was used to basically shore up balance sheets for Trusts that were really in dire trouble. The bottom line is that a lot of effort was made but the planning was not adequate to meet what was coming.

shooting ourselves in both feet by not investing wisely.

But your question is what could we do in the short term. In order to create a bed overcapacity or be at capacity there are two options. One – we can cancel elective care and that was done as an emergency measure. Over 50,000 operations were cancelled.

Has that eased the pressure?

I think it’s a transient Elastoplast on a creaking system – and of course it has consequences for those patients who have had delayed operations. Some of them will deteriorate and end up in the emergency department which will add to the pressure even more.

The other option which a number of systems are doing is this concept of full-capacity boarding, which basically says if the emergency department is very crowded, say with 40 or 50 patients ready for a bed, every ward should take an extra one or two patients on a trolley. So you end up spreading the risk around the hospital rather than focusing it all on the emergency department.



“Emergency medicine is a very strong specialty with a lot of passionate people”

Photograph: RCEM

ROUND

Has staffing been a serious issue?

Yes – that’s the other big bucket. There’s no doubt that the NHS is chronically understaffed. I can only speak for the clinical workforce in emergency departments and in the short term we are struggling badly. However, there is some light at the end of the tunnel. Last October, after nine months of negotiation, we launched probably the most comprehensive workforce strategy in College history – a comprehensive plan for growing the workforce, reducing attrition amongst trainees and retaining the older workforce. We hope over the next four to six months that we can begin to drive that forward. It is a four-year program but we really want to get it up and running in the next few months so that it begins to bear fruit by this coming autumn.

Is there currently an overreliance on locum and agency staff in emergency medicine?

Yes. We are spending around £2.9 billion on locum and agency staff in the NHS and about £464 million of that is being spent in the emergency department per year. So that

was a key driver and a lever behind the workforce strategy – to put something sensible in place and drive down that cost.

Are you worried about the effect of all this negative publicity on recruitment to the specialty?

I have been doing emergency medicine for a long time and in the last 30 years being a doctor, on numerous occasions people have said ‘oh, there is a massive crisis in emergency medicine, nobody will go into the specialty, it’ll be awful’. However, against the odds, we’ve continued to slowly grow as a specialty, though we are still a long way short of the staff numbers we need. But if you take the broad trend, emergency medicine is a very strong specialty with a lot of passionate people. We can only hope that it will continue to grow in the face of adverse conditions.

Such unprecedented stress on the NHS leads to the obvious worry of staff burnout. How do you personally de-stress?

Everybody is different but it’s a big issue for emergency medicine because we are always at the top of the list when it comes to burnout. Six years ago we developed a College strategy on burnout called *Creating successful, satisfying and sustainable careers in emergency medicine*. You can check it out on our website. It’s an area I’m very passionate about.

Personally I tend to have a glass half-full approach to life. I have a great family. My kids are ages 7 to 12 and they and my wife keep me on the straight and narrow.

Interview by Jim Killgore

MY CHILD, MY CHOICE

Allan Gaw recounts the famous Gillick case and events leading up to a landmark decision on medical consent in children

TO SAY that Mrs Gillick was angry is an understatement. She felt her rights as a parent had been undermined by a set of government guidelines issued to doctors, and she was furious. Her outrage was further fuelled by her belief that this guidance was tantamount to condoning and even encouraging underage sex.

Victoria Gillick, a mother of four daughters under 16 at the time, took legal action. What happened next would fundamentally change the way we view and assess the competence of children to make treatment decisions. Today, more than 30 years later, when we speak of consent in children and young people, we still talk of ‘Gillick competence’, but what is the story behind that phrase?

DWINDLING RIGHTS

In December 1980, the Department of Health and Social Security (DHSS) issued a circular giving guidance on family planning services for young people, which stated, or implied, that at least in certain cases which were described as ‘exceptional,’ a doctor could lawfully prescribe contraception for a girl under age 16 without her parents’ consent.

Gillick regarded this stance as illegal and in March 1981 she objected in the strongest terms to her local area health authority (AHA) — West Norfolk and Wisbech — and sought their assurance that her children would not be given advice or prescribed contraceptives without her knowledge or consent. She received no such assurance and in August 1982 she took both the AHA and the DHSS to court.

The case went initially to the High Court in 1984 where Mr Justice Woolf, who presided, turned down Gillick’s claim and dismissed the action.

He noted: “...whether or not a child is capable of giving the necessary consent will depend on the child’s maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent.”

However, Gillick appealed against the ruling and the

following year was successful in having this decision overturned. Against that decision, the DHSS appealed to the House of Lords in October 1985 and the case was examined by the Law Lords — Scarman, Fraser and Bridge. Gillick’s case was centred on her loss of parental rights and the legality of the DHSS’s position, and the judges reviewed these in turn.

The Law Lords examined the issue of ‘parental rights’ and concluded that these only really exist for the benefit of the child and effectively dwindle as the child grows in age and maturity. Lord Scarman stated that this “parental right yields to the child’s right” when she becomes sufficiently mature to make autonomous decisions.

The judges also firmly concluded that any doctor who exercised clinical judgement in offering contraceptive advice to a girl under 16 without her parent’s consent would not be guilty of an offence. With these rulings the decision of the Court of Appeal, which had overturned the original ruling, was itself quashed, and Gillick had finally lost.

SUFFICIENT UNDERSTANDING

This case will be remembered, however, not for what it said about the legality of offering contraceptive advice to minors, but for its more general rulings on child consent. The case afforded the judges the opportunity to address the issue of competence in those under 16 more generally, and in so doing to create the concept of Gillick competence.

Lord Scarman ruled: “I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.”

Thus, Gillick competence allows a child under age 16 to consent to or refuse medical treatment, and it is up to a doctor to decide whether a child has the maturity and intelligence to fully understand the nature of the treatment, the options, the risks involved and the benefits. Importantly, no lower age limit was defined in the ruling for the potentially competent child.

The nature of that “sufficient understanding and intelligence” has of course been much debated and in the

Photographs: Press Association





“It is up to a doctor to decide whether a child has the maturity and intelligence to fully understand the nature of the treatment, the options, the risks involved and the benefits”

Victoria Gillick below and left with seven of her 10 children in 1983.

absence of any clear test is likely to be somewhat subjective. However, this competence is deemed also to be ‘situation dependent’ – that is, it applies only to the treatment in question. Thus, a child may be deemed Gillick competent to understand one treatment, but not another.

This House of Lords ruling that gives the competent child the right to decide about their medical treatment has also been adopted in various Commonwealth countries and is more formally encoded in the Age of Legal Capacity (Scotland) Act, 1991.

WHICH TERM TO USE?

There has been much confusion regarding the terminology used in this area. In the 1990s there was a commonly held belief that Mrs Gillick, who had lost the appeal, objected to her name being attached to the concept of adolescent competence. As such, an alternative term ‘Fraser competence’ was introduced and widely recommended. This referred to the guidelines proposed by Lord Fraser in the same 1985 House of Lords judgement that defined Gillick competence. Unlike Lord Scarman’s ruling, these guidelines were very specifically concerned with contraceptive advice and treatment but do not have any general application; thus, the term ‘Fraser competence’ should be avoided as it is not, and never has been, a synonym for Gillick competence.

But what of Mrs Gillick’s feelings on the matter? In 2006, the author of a *BMJ* editorial took the entirely reasonable step of writing to ask her if she objected. Mrs Gillick replied saying she “has never suggested to anyone, publicly or



SOURCES

- Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security [1984] Q.B. 581.
- Gillick v West Norfolk & Wisbech Area Health Authority [1985], UKHL.
- Wheeler R. *BMJ* 2006; 332: 807.
- Hayhoe B. *InnovAIT* 2008; 1: 764.
- www.nspcc.org.uk (Accessed Feb 8, 2018).

privately, that [she] disliked being associated with the term ‘Gillick competent.’” Thus, Gillick competence is not only the correct but also the respectful term to use.

CONCLUSION

When treating children and young people, clinicians have an overriding duty to act at all times in their best interests. The Gillick rulings have served to clarify what can and cannot be done in this area, but they have also brought into focus the importance of involving competent children in medical decisions that will affect them. Indeed, the NSPCC reminds us that all professionals working with children must “balance children’s rights and wishes with our responsibility to keep children safe from harm”.

And what of Victoria Gillick today? Now in her seventies, she remains active. A mother of 10, and now with more than 40 grandchildren, she has continued to work and campaign against under-age sex and abortion. In 2002, she won an apology and damages in a libel case against a teenage sexual health advice charity. She claimed they had alleged that her challenge against the legality of contraception guidelines was one of the reasons for a rise in teenage pregnancies during the 1980s. More recently, she has spoken out on matters of immigration and is supportive of her husband, a former UKIP County Councillor.

Allan Gaw is a writer and educator in Glasgow

ENHANCING YOUR DEN

A new system for CPD was rolled out to dentists in January and here GDC policy manager Jessica Rothnie answers – why the change?

IN THE many conversations we had with dental professionals in developing our new enhanced continuing professional development (ECPD) system, we heard a plea for CPD to achieve much more than it has in recent years. This included recognising the importance of professionals driving their own development and learning, and how this responsibility relates to being a professional. We listened to what registrants felt would be a good fit for their developmental needs and applied this to how we formulated ECPD.

The new system was rolled out for dentists on 1 January this year and comes into effect for dental care professionals (DCPs) on 1 August. The experience dentists gain with ECPD between now and then will be incredibly valuable for the wider dental team, so I would really encourage the whole team to work together in the lead-up to the wider launch in August to ensure everyone is ready to embrace the changes.

NOT JUST COUNTING HOURS

ECPD introduces the first steps towards a more meaningful approach to professional development – a system that encourages professionals to prioritise the quality and relevance of learning activity rather than simply the number of hours required. It is also a system that works to better support professionals in their development, which focusses on building or maintaining the skills and knowledge required for everyday working lives.

Central to the new system is the introduction of the personal development plan (PDP). It's designed to help professionals think about their current maintenance and development needs and the learning activities they will need to fulfil them. It also aims to provide a framework for professionals to reflect on their learning and how it applies to their work, whilst providing us – the regulator – with the assurance that CPD is being taken seriously and planned effectively by professionals.

We know that there are many professionals who already have a PDP in place, which is great because they'll be ahead of the game. For everyone else, we have developed a template as a guide. It's not compulsory to use the template, and for those with PDPs in place there's no need to start from scratch. The one thing they will need to do though is incorporate the development outcomes, which is a new requirement.

FOCUS ON OUTCOMES

Professionals have told us they wanted their learning and development to be linked more closely to our *Standards for the dental team* and this is what the development outcomes introduce to CPD. They are a way of encouraging professionals to think more widely across the full breadth of what the standards cover, rather than a heavy focus on CPD that may contribute to clinical skills, for example.

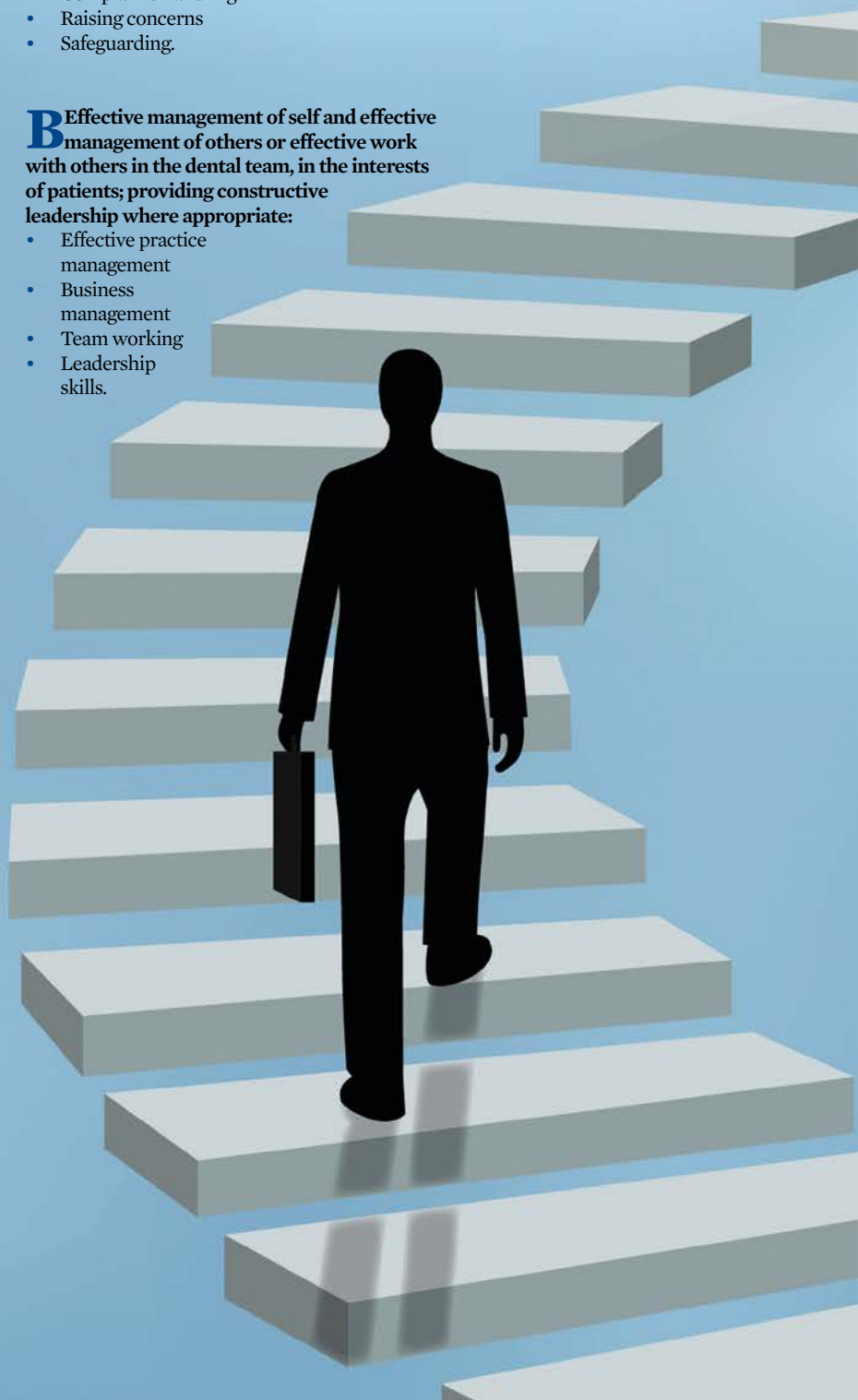
All ECPD activity must now link each planned and completed activity to at least one development outcome. Below are development outcomes A, B, C, and D and some examples of what kinds of CPD activity might be linked to each. It is strongly encouraged, but not compulsory, to complete CPD linked to each of the outcomes.

A Effective communication with patients, the dental team and others across dentistry, including when obtaining consent, dealing with complaints, and raising concerns when patients are at risk:

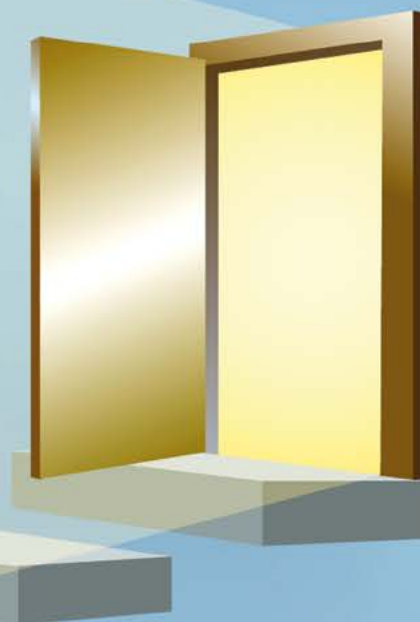
- Communication skills
- Consent
- Complaints handling
- Raising concerns
- Safeguarding.

B Effective management of self and effective management of others or effective work with others in the dental team, in the interests of patients; providing constructive leadership where appropriate:

- Effective practice management
- Business management
- Team working
- Leadership skills.



TAL CPD



C Maintenance and development of knowledge and skill within your field of practice:

- Clinical and technical areas of study
- Radiography
- Cross infection control
- Medical emergencies and CPR
- Emerging technologies and treatments
- CPD on quality assurance for MHRA
- CPD specific for your daily role(s).

D Maintenance of skills, behaviours and attitudes which maintain patient confidence in you and the dental profession and put patients' interests first:

- Ethical and legal issues and developments
- Professional behaviours
- Equality and diversity training.

CHOOSING YOUR CPD

Whilst the GDC does not quality-assure CPD, it does place some requirements on CPD providers in order for courses to count as verifiable. One requirement is that evidence given to participants (i.e. the CPD certificate) must state that it has been subject to quality assurance and include the name of the person or body providing that quality assurance. In addition, the certificate should also feature the activity's aims, objectives, learning content and the intended development outcomes covered. We have not been prescriptive in exactly the form this should take but these criteria should act as a guide in helping to decide if a course will meet the development needs professionals are looking for. It will also provide evidence that the CPD meets the GDC's verifiable requirements.

While there is no approved list of training providers or courses, the ability of the CPD provider to demonstrate they are meeting the verifiable criteria can provide a good starting guide. Before booking a course though, professionals will need to have a good look at the course and use their professional judgement to decide if it will fulfil their development needs and will be counted as verifiable.

NEXT STEPS

ECPD represents significant progress on our journey towards creating a system that supports professional development in the best possible way, but it is

not the final destination. As we look towards the future, we are seeking approaches to CPD that offer the professions more opportunity to take responsibility for development, and to achieve this in a way that complements what they are already doing.

This might, for example, mean a greater focus on peer-to-peer development like mentoring, coaching and peer review activities. These new approaches will, however, only work if the opportunities on offer are seized. I encourage the whole profession to embrace these first steps and work with us in deciding how best to take these concepts forward.

I also encourage the whole team to work together to get the most from their CPD. In the meantime, there's lots of information, hints and tips on the GDC's website.

Jessica Rothnie is a policy manager at the General Dental Council and developed the enhanced CPD guidance documents for dental professionals

ECPD – KEY CHANGES

- Requirement for all dental professionals to have a personal development plan (PDP)
- Increase in the number of verifiable hours for most professional titles and the requirement to spread the hours more evenly across the five-year cycle
- Dental professionals no longer have to declare non-verifiable CPD to the GDC
- Requirement to make an annual statement of CPD hours completed, even if zero hours have been completed for that year
- Requirement to align CPD activity with specific development outcomes
- Professionals must plan CPD activity according to their individual "field(s) of practice"

TOP TIPS

- Your personal development plan is meant to help you plan your CPD – don't leave it until the last minute. Develop your PDP now and it will help you book the best CPD to match your personal development needs.
- Before selecting (and paying for) CPD, make sure it meets the requirements laid out by the GDC.
- The GDC has provided recommended topics to cover as part of its guidance but your main focus should be your field of practice – think about your daily work and use your professional judgement to decide whether the CPD fulfils your development needs.

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

SUDDEN DECLINE

BACKGROUND

Mr P is a 43-year-old father of two children – slightly overweight but otherwise in good health. Just after Christmas he complains to his wife that he feels “off” and must be coming down with something. Over the next few days he develops a sore throat with a cough and fever. His condition grows worse and Mrs P phones her local GP surgery.

A receptionist says a GP will phone back and later that afternoon Dr J rings and speaks with Mr P regarding his symptoms. The GP tells Mr P that he is likely suffering from an upper respiratory tract infection (URTI) and that it should clear up soon. He advises him to take paracetamol and come into the surgery if there is any concern.

Later that night Mrs P phones an out-of-hours service and reports that her husband is “burning up” and having trouble breathing. A locum Dr K attends the patient at home and notes some tightness in the chest, pharyngitis and mild wheezing. The patient is found to be “warm” but no vital signs are recorded. The diagnosis is viral URTI with a slight wheeze and Dr K advises Mr P to see his regular GP if the symptoms do not improve.

The next day Mr P's condition further deteriorates and his wife calls for an ambulance. He is breathless and panicky with a tight chest and tachycardia. A senior registrar in A&E examines the patient and takes his vitals. He notes decreased breath sounds on auscultation and a chest X-ray confirms parapneumonic pleural effusion.

Mr P is commenced on intravenous

antibiotics but his condition further deteriorates overnight. He is transferred to the intensive care unit and an echocardiogram reveals severely impaired left and right ventricular function. A few hours later Mr P suffers cardiac arrest and dies. A post mortem records the cause of death as multi-organ failure, sepsis and bilateral lower lobe pneumonia and pleurisy.

Solicitors acting on behalf of Mrs P issue letters of claim for clinical negligence against both GPs involved in her husband's care.

ANALYSIS/OUTCOME

It is alleged that Dr J breached his duty of care to Mr P by failing to make a home visit or urge the patient to attend the surgery for an examination – in which case the seriousness of his condition would have been recognised and appropriate antibiotic therapy prescribed, preventing his sudden deterioration. The locum Dr K is accused of failing to carry out an adequate examination. No vitals were recorded (BP, pulse, temperature, respiratory rate, capillary refill time). It is further alleged that

he failed to prescribe appropriate medication (antibiotics) and urgently refer.

MDDUS instructs a primary care expert to offer an opinion on the alleged breach of duty. She concludes that Dr J's management approach was reasonable given the reported symptoms and high seasonal prevalence of URTI. Dr K might be criticised for not recording vital signs but given that the patient looked well and at that point was suffering only from a sore throat and a mild wheeze – a reasonable body of general practitioners might have taken the same approach.

In regard to Dr K's failure to prescribe an antibiotic she does not find this unreasonable given the obvious symptoms of viral URTI and considering the general advice to doctors to be sparing in the use of antibiotics. A referral to hospital at this stage would not have been warranted nor would Mr P have likely been admitted.

Her overall view is that such a sudden progression to severe sepsis is rare and not something either GP could have predicted.

A respiratory physician is also instructed to comment on causation (consequences of the alleged breach). He concludes that had an antibiotic been administered on the first day Mr P spoke to his GP it is more likely than not the patient would have survived – but he agrees that such treatment would not have been indicated at this stage nor would referral to hospital.

A letter of response is drafted denying clinical negligence. MDDUS later receives notice the case has been discontinued.

KEY POINTS

- Be aware of the limitations in telephone or online consultations.
- Take and record vital signs as part of routine assessment.
- Ensure adequate safety netting in patients with acute illness.



🔗 COMPLAINT

ELDERLY VISIT

BACKGROUND

Mrs M is 92 years old and a widow living at home. She is frail with progressive heart failure but mentally competent. A carer arrives one morning to find Mrs M confused and in distress having wet the bed. She calls her son who lives nearby and he contacts the local GP surgery requesting a home visit.

Dr G attends late in the morning and examines the patient, noting that Mrs M has a slight temperature. The GP suspects a urinary tract infection and says he will arrange for an ambulance. In subsequent discussion he mentions the option of full-time care for Mrs M in a residential care home. She overhears his comment and becomes very upset. This has been a topic of discussion with her son and Mrs M is adamant about wanting to remain at home.

Dr G returns to his car and phones for an ambulance and just as he finishes writing up his notes the ambulance arrives. He has a quick word with the paramedics and then departs for another house call.

Two days later a letter arrives in the practice from the patient's son complaining of insensitive treatment in the care of his mother. He says it was not appropriate to raise the question of her ongoing care in those circumstances, when his mother was clearly distressed and suffering mild delirium in association with her UTI. He also states that Dr G left the house without informing them an ambulance was on the way.

ANALYSIS/OUTCOME

The practice manager contacts MDDUS on behalf of Dr G to ask for help in dealing with the complaint. First she is advised to ensure that Mr M has consent from his mother to deal with the issue. A simple mandate can be sent to Mrs M to sign and return stating clearly that aspects of her medical records may have to be disclosed in order to respond to her son's concerns.

Dr G then drafts a response and this is reviewed by the practice manager and an MDDUS medical adviser. In the letter he expresses his regret for the distress felt by Mrs M and acknowledges that he could have been more discreet in his discussion of her ongoing care. He also offers an apology for not returning to the house after phoning the ambulance.

Dr G offers to further discuss the complaint and also informs Mr M of his right to recourse to the ombudsman. Nothing more is heard from Mr M and his mother remains a patient at the practice.

KEY POINTS

- Competent patients should be involved in discussions about their care.
- Ensure patients/carers understand what follow-up is being arranged.

🔗 ADVICE

NOTIFIABLE DISEASE

BACKGROUND

A GP in London reviewing the results of a blood test for a patient – Mrs O – discovers that it has come back positive for hepatitis C. In attempting to contact her Dr A learns that Mrs O has travelled to Senegal in order to care for a sick relative and is not expected back anytime soon. The only contact number is a local landline which goes unanswered. Mrs O's ex-husband is also registered at the practice and Dr A phones MDDUS to enquire about the legality of contacting him in an attempt to ascertain the patient's whereabouts.

ANALYSIS/OUTCOME

An MDDUS adviser writes back to the GP advising that there are both statutory and

professional guidelines to follow in this circumstance. Medical practitioners have a statutory duty to report notifiable diseases, including hepatitis C. Doctors are obliged to disclose this information whether or not the patient consents, and Dr A is advised to notify Public Health England.

GMC guidance advises that patient confidentiality is an important duty but not absolute. Doctors must disclose information when required to by law or to satisfy a specific statutory requirement, such as the notification of a known case of infectious disease. Patients should be informed of this disclosure if practicable.

In this case, the concern is not just that the patient might object to disclosure but also that she is as yet unaware of the

diagnosis. The MDDUS adviser informs the GP that careful thought should be given to GMC guidance relating to public interest disclosure if he is considering contacting the husband. He advises that the responsibility to investigate further should now lie with Public Health England – including attempts to contact the patient.

KEY POINTS

- Medical practitioners have a statutory duty to report notifiable diseases, even without patient consent.
- Ensure disclosure (inadvertent or not) is within your area of responsibility.



FAILED EXTRACTION

BACKGROUND

Mr C phones his dental surgery for an emergency appointment complaining of severe toothache. Dr Y examines the patient and notes that UL6 is badly decayed and the canal appears to be partially sclerosed on X-ray.

He advises the patient of the options, including root canal treatment (RCT) or extraction. Two weeks later Mr C attends for RCT and is very nervous, asking Dr Y to stop at numerous points, but the treatment is completed without any major difficulties.

A month later Mr C returns to the surgery reporting that the UL6 had "cracked" when he was eating popcorn at the cinema. Dr Y examines the tooth which has catastrophically fractured. The only viable option is extraction.

Mr C is again very nervous and Dr Y reassures him that the area around the tooth will be well numbed and he has only to raise his hand to halt the procedure. The patient is clearly uncomfortable with injections and the dental nurse tries also to offer reassurance.

Dr Y leaves ample time for the anaesthetic to take effect and carries on with the extraction. Friable coronal tissue fractures off immediately and Mr C complains of "extreme pain". Dr Y attempts to reassure the patient and administers more anaesthetic. Just as soon as Dr Y starts again with the extraction Mr C becomes distressed and again halts the procedure.

The dentist at this stage judges that it would be best to discontinue the extraction given Mr C's significant distress. The root is still firmly in the socket and to further mobilise it without complete removal would risk more significant post-operative complications. Dr Y ensures that complete haemostasis has been achieved and offers Mr C post-operative advice, including appropriate analgesia. A referral to the local dental hospital is arranged.

A dental nurse attempts to follow-up on the patient's condition that next week but her calls are not returned. Three months later Dr Y is distressed to receive a letter from the GDC informing him of a potential fitness to practise investigation in regard to his treatment of Mr C.

ANALYSIS/OUTCOME

An MDDUS adviser reassures the dentist and asks that he forward the GDC letter, including Mr C's complaint. A detailed response is not required at this stage. The matter has been assigned to a GDC caseworker who will request a clinical



advice report and then review at formal assessment if it will be referred to case examiners.

In his complaint Mr C alleges not only "substandard" treatment but also "rough handling" and a dismissive attitude in regard to his clear anxiety. He further claims there was no follow-up after he left the surgery "bleeding and in agony" and that the next morning he had to go to A&E where he was given a prescription for stronger analgesia. A delay in the referral also meant that Mr C spent over two

weeks in pain before eventually having the remainder of the tooth extracted at the dental hospital under conscious sedation.

Two months later a letter arrives from the GDC stating that the information provided by Mr C does not amount to an allegation that Dr Y's fitness to practise is impaired. The clinical advice report states that the dentist took a pre-operative radiograph and advised Mr C of the treatment options following the fracture of UL6. He obtained consent before the extraction and stopped the procedure when the patient was experiencing pain and anxiety – making the appropriate decision to refer.

Communication issues were considered outside the scope of the investigation but the adviser noted that an unsympathetic manner does not necessarily warrant further referral.

The case is closed with no further action.

KEY POINTS

- Most cases do not progress beyond the initial triage or investigatory stage.
- Clear, comprehensive records are the best defence in such cases.

COMPLAINT

ABUSIVE PATIENT

BACKGROUND

Mr W appears at the dental surgery with a lost screw-retained post crown in UL5 that had been previously re-cemented. Dr T advises the patient that it will probably not last and a new post should be fitted prior to providing a new crown. An appointment is arranged but on later reviewing the X-ray the dentist has concern over the condition of the existing root filling and decides to schedule a shorter consultation to discuss treatment options.

Mr W attends the appointment and is annoyed that the treatment plan has changed. Dr T tries to explain his view on the necessity to carry out root treatment before refitting the post – but the discussion grows fraught. Mr W begins to shout, using aggressive and abusive language. Dr T manages to calm the situation and agrees to re-cement the old crown that afternoon. An appointment is made for the root treatment but the practice and Dr T are left



traumatised by the experience.

Dr T sends the patient a treatment plan and receives an angry letter of complaint, disputing the “extra” costs of the treatment made necessary by the dentist’s “indefensible clinical failure”. The dentist contacts an MDDUS dental adviser for advice on a draft letter of response.

ANALYSIS/OUTCOME

The dental adviser reviews the letter and makes a few suggestions, including the need to set out a clinical justification for reviewing treatment options rather than just re-cementing the old crown. The dentist is also advised to set out in the letter the practice policy toward aggressive and abusive behaviour and state how Mr W’s actions and language will not be tolerated in future.

Nothing more is heard on the matter and Mr W changes dental practice.

KEY POINTS

- Ensure you have a practice policy on dealing with abusive patients.
- Inform patients in advance of proposed changes to treatment plans.

CLAIM

LIDOCAINE REACTION

BACKGROUND

Mr U attends his dental surgery with a broken cusp at tooth LR6. Dr L examines the tooth and reassures the patient who seems particularly nervous in the chair. He advises that a new filling will be necessary and administers Lignospan (lidocaine) to block the nerve.

Following administration of a third injection Mr U reports feeling breathless and faint. He is placed in the recovery position on the floor and given oxygen and glucose gel. The patient asks about the anaesthetic and states that he has had previous reactions to lidocaine.

An ambulance is summoned and Mr U’s vitals are checked and found to be relatively normal at BP 175/80 and HR 68/min. The patient declines to go to hospital and leaves the practice under the care of his partner. Dr L later reviews the patient

notes and finds four separate written alerts stating that Mr U is “intolerant to lidocaine” and advising Citanest as the injectable anaesthetic of choice.

Mr U has the necessary dental treatment at a different dental surgery and a letter of claim is received by the practice alleging clinical negligence by Dr L in administering lidocaine despite a recorded intolerance. The letter states that Mr U is now suffering from dental phobia.

ANALYSIS/OUTCOME

MDDUS reviews the case papers along with a psychological assessment of the patient organised by his solicitors. Dr L admits that administering the lidocaine was an oversight on his part and a clear breach of duty of care. It is the consequences of this breach (causation) that are subject to dispute.

Mr U admits that he recovered quickly from the adverse reaction with no lasting physical effects. However, he has since been diagnosed with dental phobia. Cognitive behaviour therapy has been advised with graded exposure over 10-12 sessions.

Given the obvious error in not carefully checking the patient records and also considering causation, MDDUS settles the case in agreement with the member.

KEY POINTS

- Ensure strict protocols for highlighting potential adverse drug reactions.
- Double check with patients for “any allergies or bad reactions”.

BURNOUT IMMINENT

Dr Gail Gailmartin

Medical and risk adviser at MDDUS



AM a GP working increasingly long hours at the surgery and still falling behind. The stress is affecting my home life and I'm finding it hard to sleep. I worry that one of these days I'll miss something important. Everyone in our practice is struggling and I don't want to add to the overall pressure by requesting time off. What should I do?

We are all aware of the increasing pressures on GPs at the present time. Whilst most cope with the added pressure, many find themselves struggling against a tide of expanding workload and overstretched resources. Working extended hours and cancelling holidays might appear to help but can impact badly on work-life balance and more seriously on a doctor's health.

MDDUS takes many calls from GPs facing the situation described above. How should the problem be addressed?

It is essential to remember that patient safety must be the first priority – but in order to work safely and effectively doctors must also look after their own health and wellbeing. The doctor above is sufficiently concerned that he is troubled about the safety of his practice. He should therefore consider what steps to take in order to address the situation.

Initially the GP should consider if work practices can be improved. It is important to meet and discuss the problems with colleagues, i.e. partners, practice nurses, the practice manager and other staff. Colleagues should speak to each other about their difficulties. Meeting in this way should be with a view to consider if changes and improvements to work practices can be achieved: for example, changing consultation times, changing how the practice triages calls and how work is allocated to different healthcare providers (e.g. GP or nurse practitioner). If this is not possible the practice could consider investing in additional staff on a temporary basis to ease the immediate demand.

If meeting in this way is not practical the doctor should at least try to raise his issues with a close colleague. This type of direct communication can be very helpful in trying to identify and address the problems.

Every doctor must consider the risks posed by their own health. If in doubt you should see your GP for appropriate guidance. The General Medical Council (GMC) makes it very clear in *Good medical practice* that doctors have a responsibility to make sure they are fit (in the health sense of the word) to practise.

The guidance states: "If you know or

suspect that you have a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, **you must** consult a suitably qualified colleague. **You must** follow their advice about any changes to your practice they consider necessary. **You must** not rely on your own assessment of the risk to patients."

I have added emphasis to the expression "you must" which is used by the GMC to denote "an overriding duty or principle". The GMC further advises that: "You should be registered with a general practitioner outside your family".

The doctor in this scenario should take time to consult with his GP, or failing that, an appropriate specialist or occupational health physician. The advice offered must be followed. This may mean time off work, but a doctor given support and time to recover should be able to return once they are well. A doctor who is well is likely to perform better and in particular they should be safe.

As doctors we all have a responsibility to take steps if patient safety is compromised and that includes situations where there are adverse effects from a colleague who is struggling to cope. They should be encouraged to seek help but if they fail to do so the GMC is clear that it expects intervention.

Good medical practice states: "You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised... If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken."

The guidance is clear and whilst there are downsides to a colleague taking time off, if this proves too great a burden for the practice the local health board or NHS England should be consulted and asked for assistance. They should be informed of the problems experienced and the specific risk to patients.

In all such difficult or complex cases we encourage members to contact MDDUS for advice.

UNDER PRESSURE

Deborah Bowman

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

NHS STAFF are adept at managing pressure. They train for it. Most accept it as part of their role. Some may even thrive on it. Yet recent months have seen the discourse shift in relation to pressure. The news has been dominated by stories of 'crisis' and 'chaos'. Individual clinicians have written, often moving, accounts describing the impact of juggling increasing demand in an overburdened system. Politicians have opined on, and disagreed about, the extent of and solutions to pressure. Both doctors and patients have shared, sometimes painful, experiences of how pressure influences the care they provide and receive.

Throughout this period in which pressure has been a recurrent theme, I have been a patient. I have attended overbooked clinics, a visibly stretched chemotherapy day unit and waited for scans in packed imaging departments. I have had early appointments and those scheduled for the evening. I am never alone. The patients, their families and, of course, the clinicians caring for them fill every available chair, cubicle and consulting room. In my not-very-scientific experience, healthcare is indeed under pressure.

What impact or influence does such pressure have on ethical practice? An influential teacher used to describe ethics as "what you do when no one is watching". Whilst that continues to resonate with me, it does seem that pressure throws ethical choices and practice into sharp relief too.

There are, of course, specific ethical challenges that arise from rising pressure. How to attend to dignity and privacy when there is, quite simply, nowhere to put a patient? Resources are always finite, but pressure distils the hard choices between competing needs and interests to a concentrated dilemma that may be impossible to resolve. Moral distress – the phenomenon whereby a professional is discomforted by being unable to provide care that meets the ethical standards to which he or she holds himself – is more likely and, when it occurs, felt more acutely. For those in training, and those training others, pressure may compromise the education and supervision that can be provided in a stretched system. Pressure may make errors more likely and create



*"It does seem that
pressure throws ethical
choices and practice into
sharp relief"*

conditions that are unsafe.

The ethical tensions that arise in times of pressure are testing. For some, the circumstances prompt moral questions that extend beyond the usual dyadic relationship. To what extent does a professional have a duty to 'name' the problem and to speak up when the environment in which they are working is under extreme pressure? If an individual decides that he or she should challenge the circumstances in which clinical care is provided, to whom should that challenge be addressed? What might the consequences – intended and otherwise – be both for colleagues and for patients?

What ethical response might a clinician bring to bear when he or she believes care can no longer be provided safely?

Beyond these testing 'headline' ethical challenges lie a raft of choices that are equally challenging but perhaps attract less attention. These are the daily interactions that continue with care, commitment and kindness. They are clinical consultations as manifestations of virtue and values. This is ethical practice that is never more remarkable than when it occurs under pressure.

I experienced such ethical practice with the phlebotomist who, having rung a managerial colleague, was advised that she would have to manage the clinic alone because there were no more staff available. She turned back to me after the call and responded to my irrational anxiety about needles with gentle compassion, humour and patience. She knew that there were currently 35 people waiting, all of whom needed blood tests to inform their treatment for cancer, yet she made time to respond to me as an individual.

I experienced such ethical practice when the receptionist in the overbooked clinic offered to come and find me in the canteen when space became available in the waiting room and spent spare moments checking patients were coping with the delay.

I experienced such ethical practice when the healthcare assistant on the chemotherapy unit made the time to re-take my blood pressure because we now know that I have Marsden-induced hypertension and it takes several attempts to obtain a non-scary reading.

I experienced such ethical practice when the oncologist answered my questions and responded to my concerns with generosity, attention and openness betraying no sense of urgency even though we both knew that his clinic was running almost two hours late.

I experienced such ethical practice when the car park attendant charged me less than the amount due because I had been delayed on the medical day unit.

I could go on. There have been so many of these ethical moments in which a stressed and stretched member of staff prioritised compassion, kindness, respect, dignity and commitment to care over pressure. These everyday ethical choices are transformative and never go unnoticed, even in moments of pressure.

Addenda

BOOK CHOICE

ADMISSIONS: A LIFE IN BRAIN SURGERY

By Henry Marsh

St Martin's Press, £16.99, hardcover, 2017

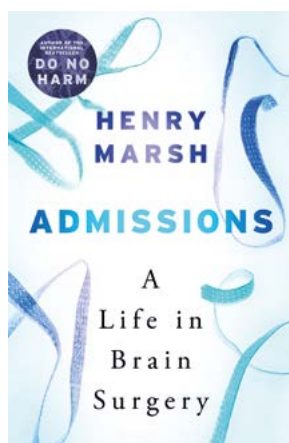
Review by Dr Greg Dollman, medical adviser, MDDUS

THE bestselling author of *Do no harm* returns. Three years on, Henry Marsh has now retired as an NHS surgeon and, in between operating in Nepal and Ukraine and single-handedly renovating a tumbledown lockkeeper's cottage, he shares more insights into his life as a

brain surgeon.

Marsh is again brutally honest about his personal life, the difficult clinical decisions doctors must make every day, the outcomes of his interventions as a surgeon and the daily struggles of working in the NHS.

After battling with mental health problems while a student at Oxford (he abandoned his initial degree), Marsh took up the role of a hospital porter. It was in the theatre that Marsh found a "sense of purpose and meaning". He fills the pages of *Admissions* with the highs ("wonderful triumphs") and lows ("the triumphs wouldn't be triumphant if there weren't



disasters") of his life as a surgeon.

Marsh tells us that his career in the NHS ended "ignominiously", first after a decision to resign "in a fit of anger" in the summer of 2014, then followed by an altercation with a member of staff over what Marsh describes as unnecessary 'tick-box' exercises overcomplicating clinical care in the modern NHS. He shares his thoughts on the "sad decline of medicine", and rues the seemingly inevitable collapse of the NHS.

Ever insightful, Marsh reflects on the frustration, anxiety, humiliation, anger, elation and privilege he has experienced as a neurosurgeon. He shares stories of life and death, both in his personal and professional life. He considers the issues affecting the practice of medicine in the modern world (in both developed and developing countries), from the inherent tension between caring for patients and making money, to treatment at the end of life, with

Marsh sharing his thoughts on euthanasia.

The cottage by the canal will be Marsh's woodworking workshop (this, he says, will help him cope with retirement). There he will swap patients for timber, paying as much detail to the grain of wood and type of join as he did to the sulci and gyri of the brain.

A few have questioned the need for a further memoir from Marsh. The reactions from across the world, however, have silenced the critics. Marsh describes neurosurgery as the "all-consuming love of [his] life", and his writing reflects this. It is a joy to read.

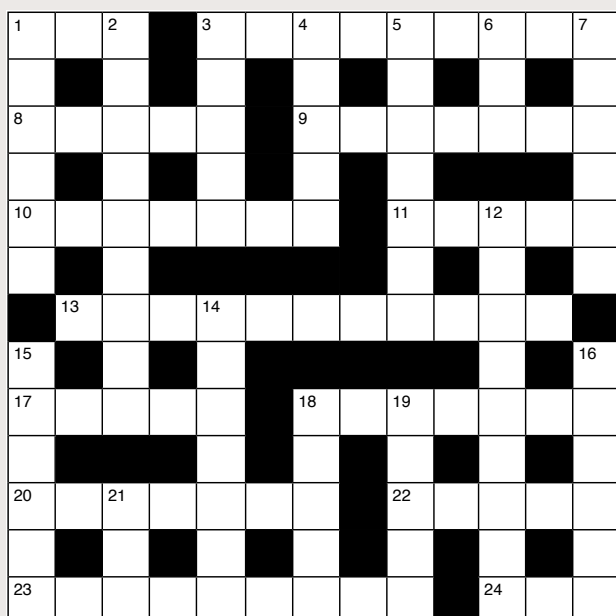
OBJECT OBSCURA

Napoleon's toothbrush

THIS toothbrush with silver gilt handle was made for Emperor Napoleon Bonaparte and dates from around 1795. The bristle toothbrush is thought to have been invented by the Chinese in the 15th century. Use of toothbrushes began to be promoted by French dentists in the late 17th century.



Photograph: Science & Society



Crossword

ACROSS

- 1 Gateway to mouth (3)
- 3 Tarsus (5,4)
- 8 Inexpensive (5)
- 9 Compared (7)
- 10 Arm muscles (7)
- 11 Assignments (5)
- 13 Part of kidney where ultrafiltration occurs (5,6)
- 17 Loft (5)
- 18 Oath (7)
- 20 Fruits paired with cream (6)
- 22 Odour (5)
- 23 Scapulae(9)
- 24 Total (3)

DOWN

- 1 Find (6)
- 2 Trump (9)
- 3 Gala fruit (5)
- 4 Fortified towers (5)
- 5 Central line of latitude (7)
- 6 In the open (3)
- 7 Of the greatest age (6)
- 12 Samples (9)
- 14 Intoxicating component of beer (7)
- 15 Group of bones in wrist and hand (6)
- 16 Wall between nostrils (6)
- 18 Glue (5)
- 19 Fertile place in desert (5)
- 21 Back in time from the present (3)

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

VIGNETTE

HENRY NORMAN BETHUNE (1890-1939)

PHYSICIAN, INNOVATOR AND POLITICAL ACTIVIST

HENRY Bethune had a raging hunger to make his mark in the world by helping others and this he did in a life dedicated to medicine and surgery. Seeing hardship among poor patients in depression-era Canada he became a communist and remained committed to that cause until his death in China.

Bethune was born in Gravenhurst, Ontario, son of a Presbyterian minister. He studied at Owen Sound Collegiate and Vocational Institute as a youth and in 1912 enrolled in the medical school of the University of Toronto, which his grandfather Norman Bethune had also attended. Bethune had to raise funds for his medical education and took jobs including teaching in remote lumber camps. The life of these illiterate, poor men made a profound impression on him.

At the outbreak of WWI Bethune served with the Canadian Army in France as a stretcher bearer and was hospitalised in England with shrapnel injuries. He returned to Canada to become MD in 1916 and served briefly in the Royal Navy. He treated patients during an influenza epidemic and was himself ill. In post-war England he was able to obtain a surgical post at Great Ormond Street Children's Hospital. An FRCS from Edinburgh completed his formal training.

A few years of marriage to a beautiful Scottish woman, Frances Perry, and luxurious travel in Europe ended in divorce. Bethune had now set up practice in Detroit but in 1926 a diagnosis of tuberculosis threatened his career and his life. He sought care in the Trudeau Sanatorium, New York. There he insisted on having the then new treatment of pneumothorax; a decision that saved his life. It also sparked his interest in thoracic surgery.

Working at the Royal Victoria Hospital, Montreal, where Dr Edward William Archibald practised, and at McGill Medical School, Bethune became a skilled surgeon. Bethune rib shears are among the tools



Henry Norman Bethune
Photograph: University of Toronto Archives

he invented or modified. He was also a somewhat tempestuous surgeon who would throw instruments on the floor in anger or frustration, and often this anger was fuelled by alcohol. He and Frances remarried but this lasted less than four years.

Bethune had a creative side and he studied art, painted a little and with two modernist artists, Fritz Brandtner and Marion Scott, started a Children's Art Centre. Ever mindful of others' needs he was moved to give free medical care to the poor in the economic depression in the 1930s and appealed to the Canadian Government to reform healthcare. He visited the Soviet Union to find out about their system and on his return joined the Communist Party of Canada.

It was from 1936 that Bethune's life took a turn which would bring him lasting fame. That year he set up a base in Madrid for a mobile blood transfusion service for

soldiers wounded in the Spanish Civil War. It was not the first such service but it covered a larger part of Spain than the Barcelona-based service. However, he was unable to handle personal accusations and conflicts within the organisation and with the Loyalist government. He returned to Canada for a fundraising lecture tour for the anti-fascist cause, never to return to Spain.

In 1938 Bethune resolved to support the communist cause in China with his surgical skills. He travelled to Shanxi province in China with a medical unit where the population was suffering in the Second Sino-Japanese war. Bethune was stationed with the Eighth Route Army. He had a short meeting with Mao Zedong and proposed running a mobile surgical unit. He also reformed and set up new medical services in the region, not only for the soldiers but for the general population. He taught battlefield surgery and wider skills to doctors, nurses and orderlies. There were endless difficulties, shortages of supplies, hazardous mountain treks, but from his mobile units he was able to treat wounded soldiers near the front and consequently had good results.

In the summer of 1939 Bethune was appointed medical advisor to the Shanxi-Chahar-Hebei Border Region Military District. He worked long hours in desperate conditions, fuelled by idealism and alcohol. Irascible with colleagues, he was most tender with patients and loved by them and their relatives. He was planning a return to North America to fundraise but a finger cut during surgery led to septicaemia and his untimely death on 12 November 1939.

The Norman Bethune Medal is a medical honour awarded in China where he is revered – so much so that coachloads of pilgrims come to visit the little house at Gravenhurst where he spent the first few years of his life.

Julia Merrick is a freelance writer and regular contributor to *Insight*

FACE to FACE

The Training & CPD team at MDDUS offer members and non-members a range of face-to-face learning programmes, courses and workshops throughout the year – in addition to our extensive online learning resources.

Check out some of our upcoming events in 2018

- Hospital doctors risk training day • London • 10 April
- GDPR training day • Glasgow • 20 April
- GDPR training day • London • 03 May
- Practice managers risk training day • Glasgow • 05 June
- Practice managers risk training day • London • 05 July
- Hospital doctors risk training day • Glasgow • 15 August
- GP risk training day • Glasgow • 30 August
- Complaints handling workshop • London • 04 September
- Leading through uncertainty • Glasgow • 10-14 September
- Complaints handling workshop • Glasgow • 18 September
- Terema – human factors masterclass • London • 08-09 November
- GP risk training day • London • 27 November

REQUEST A TRAINING EVENT

MDDUS can also bring workshops to your local area. Members can submit requests to host a training event on a topic of your choice – from complaints handling to risks in general medical/dental or hospital practice. We can also arrange and deliver webinar or video conferencing sessions. To find out more, email risk@mddus.com



UK INDEMNITY, ADVICE & SUPPORT

To find out more visit the Events page in the Training & CPD section of **www.mddus.com**.
To express interest or book a place contact **risk@mddus.com**.