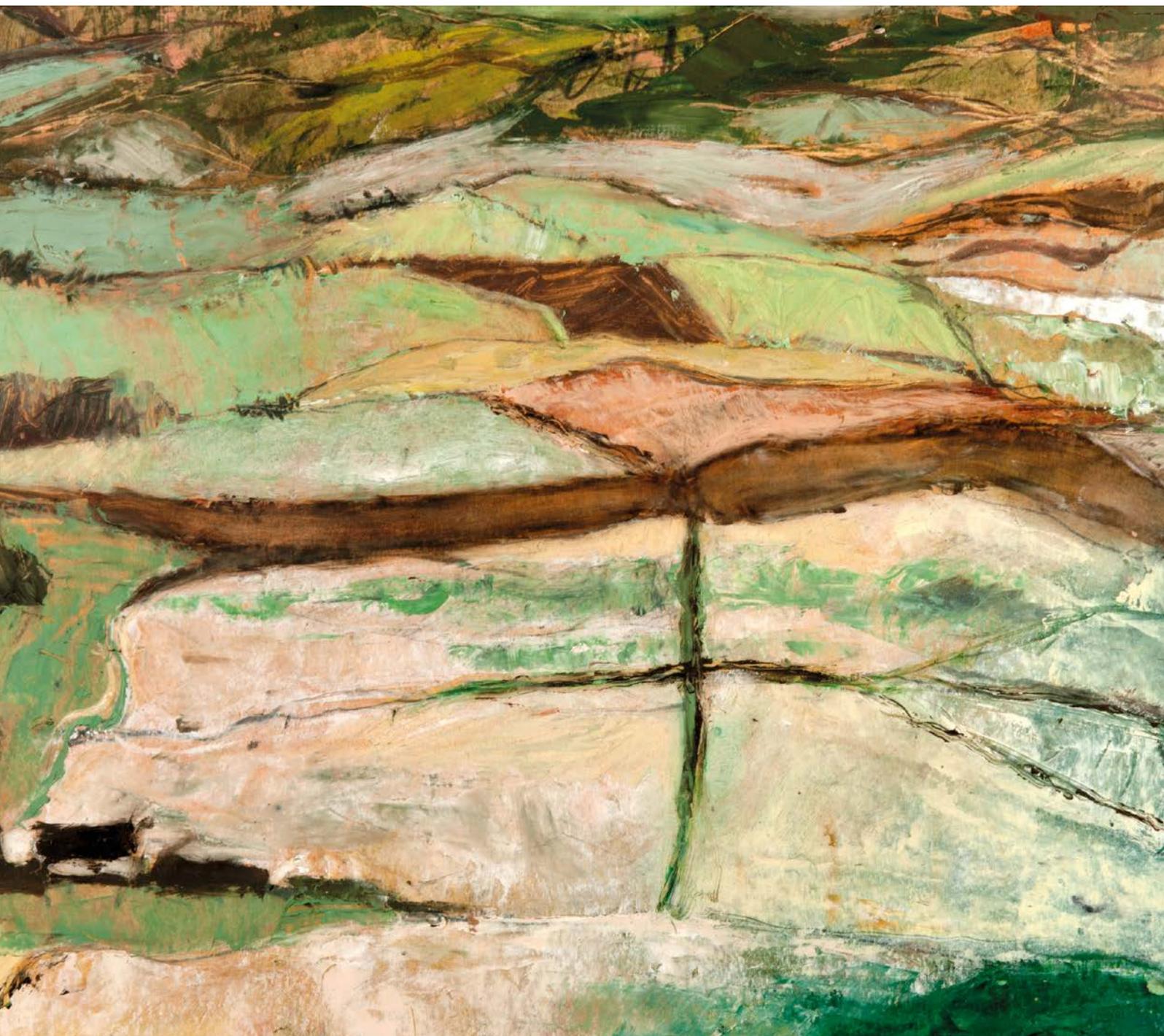


QUARTER TWO / 2018

# INSIGHT



A QUARTERLY PUBLICATION FOR MEMBERS



## HENRY MARSH

Profile of neurosurgeon and best-selling author of *Do No Harm and Admissions*

## RESEARCH READY

A personal perspective on the benefits of getting involved in primary care research

## WRONG TOOTH?

It happens more often than you think – how to reduce the risk of wrong-site extraction

## SPEAK UP

What can healthcare staff do when faced with a bad decision by someone senior?

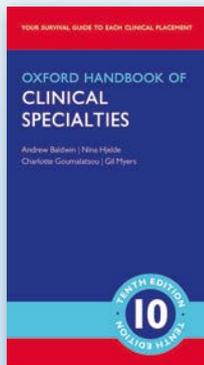
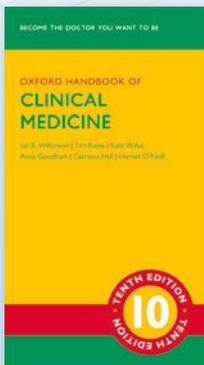
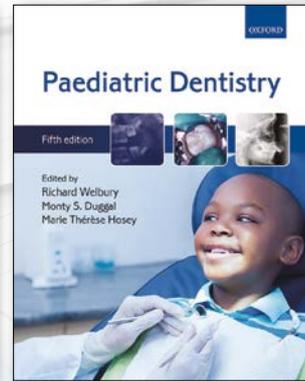
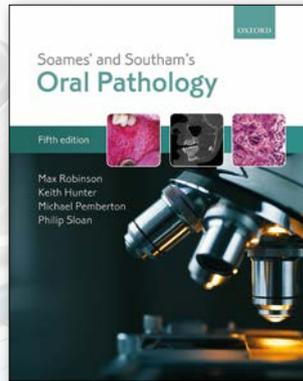
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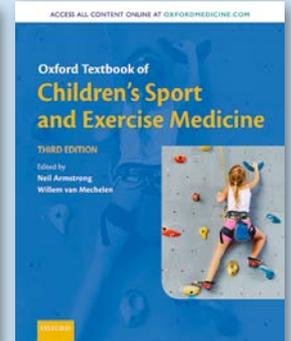
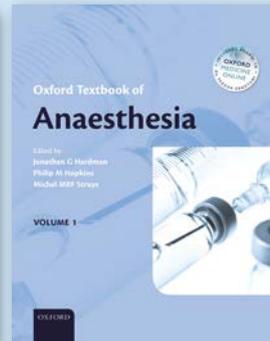
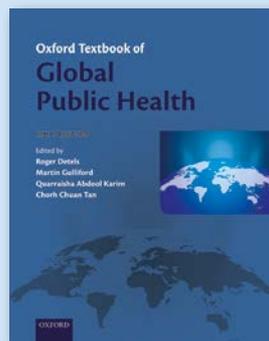


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# INSIGHT



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**Cover image**

Leslie from Lomond Hills, Tracy McAusland

Mixed media and collage oil painting, 1992

Born in 1970, McAusland studied drawing and painting at Edinburgh College of Art from 1988-92. She is inspired by travels around Scotland and Europe, and her style owes much to the Scottish Colourist group.

Art in Healthcare (formerly Paintings in Hospitals Scotland) works with hospitals and healthcare communities across Scotland to encourage patients, visitors and staff to enjoy and engage with the visual arts. For more information visit [www.artinhealthcare.org.uk](http://www.artinhealthcare.org.uk) Scottish Charity No SC 036222.



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Elsie Maud Inglis,

pioneering physician, suffragist and founder of the Scottish Women's Hospitals movement





EDITOR

## Dr Barry Parker

IN May of this year the National Institute for Health Research (NIHR) reported on a survey that found that only 14 per cent of people have ever taken part in a clinical trial – but 85 per cent said that they want to help the NHS find better treatments. Another NIHR report in 2017 found that out of the 7,840 general practices in England, 42 per cent are now active in research.

There is clearly a willingness among both patients and doctors to become more involved in the research behind new treatments being developed within the NHS and industry. On page 12 of this issue, GP David Shukla offers a personal account of how his practice was recruited to take part in clinical research – what was required and the benefits to both staff and patients, including the “altruism of giving

something back to the NHS”.

On page 10 we feature a fascinating profile by Adam Campbell of neurosurgeon Henry Marsh, author of bestselling memoir *Do No Harm*, with further musings from his new book *Admissions*.

Wrong-site surgery may seem unlikely

but these so-called ‘never events’ occur on a regular basis in surgical settings. Among dental never events, removing the wrong tooth is most common and on page 14 we report on efforts to reduce such mishaps through the promotion of local safety standards for invasive procedures (LocSSIPs).

On page 8 MDDUS CEO Chris Kenny provides an update on government plans for state-backed indemnity, and Alan Frame (p. 9) looks at how the concept of ‘authority gradients’ can be a crucial ‘human factor’ in patient safety.

Our Dilemma on page 20 deals with a doctor being pressured by a friend to prescribe a controlled drug while on holiday, and our Ethics column on page 21 looks at how ethical concerns can differ among professions and the need for both humility and “moral imagination” to understand the perspectives of colleagues and patients alike.

*Dr Barry Parker*

# MDDUS News

## MDDUS welcomes new dental advisers as membership grows

MDDUS has recruited two new experienced dental advisers in our London office as membership continues to grow throughout the UK.

Stephen Henderson and Susan Willatt joined the dental advisory team, bringing a combined 36 years’ worth of experience as dento-legal advisers.

Mr Henderson qualified in London in 1984 and obtained a master’s degree in medical law (LLM) in Cardiff in 2005. After working in hospital practice, he went into practice in Oxford where he still works as a visiting specialist in oral surgery. Prior to joining MDDUS, he worked for another indemnifier for 17 years. He was recently awarded an honorary fellowship by the Faculty of General Dental Practice.

Ms Willatt qualified in London in 1983 (BDS) and gained an MBA from Warwick University in 2000 and a master’s degree in medical law (LLM) in Cardiff in 2004. She worked in general practice (NHS and private) before taking up a clinical and management post in a large dental corporate. In 2000 Ms Willatt took up a part-time post in the community dental service and started working for another dental defence organisation. She soon became company secretary and then head of dental services.

Ms Willatt said: “I am excited to be part of a growing company and am really looking forward to providing support and advice for our members.”

Mr Henderson added: “I am delighted to join the dynamic team here at MDDUS and look forward to supporting our members when they need us most.”

These two new additions to the dental advisory team come as MDDUS has enjoyed yet another year of growth in dental membership. Overall, dental membership in England, Wales and Northern Ireland (including GPs and hospital dentists) increased by 30 per cent in 2017. MDDUS now has a fifth of the UK market share, while Scottish membership increased by 3.8 per cent to maintain two-thirds of the market share.

MDDUS head of dental division Aubrey Craig believes the sustained growth is built on a firm commitment to quality and practitioners’ confidence in the indemnity model as the best way to protect patients and the profession.

He said: “We are delighted to welcome Stephen and Susan to our team. MDDUS continues to offer personalised, rapid and flexible service in dento-legal advisory work, support for members in legal proceedings and day-to-day handling of subscriptions and queries.”



## GDPR is here

IT would be hard to miss the news that the GDPR is now upon us as of 25 May. The European-wide General Data Protection Regulation is a comprehensive overhaul of existing data protection law, which hasn’t been updated since the Data Protection Act (DPA) came into being in 1998.

The Information Commissioner’s Office (ICO) has described it as the “biggest change to data protection law in a generation”. Everyone who

processes ‘personal data’ should be aware of the new law and of its likely impact.

MDDUS has produced helpful guidance for members which can be accessed in our ‘GP risk toolbox’ and ‘Dental risk toolbox’. These resources can be found in the Training & CPD section of [www.mddus.com](http://www.mddus.com) (login required).

The ICO has also produced comprehensive guidance on the new GDPR which can be accessed at [tinyurl.com/ya2gcd5d](http://tinyurl.com/ya2gcd5d).



## Five key messages to address discount rate reform

MDDUS has highlighted five key messages for the government to address as part of the process of setting the new discount rate to ensure fairness for all and ease wider pressures on the healthcare system.

This follows a House of Lords debate where proposals to reform how the discount rate is set were discussed as part of the second reading of the Civil Liability Bill.

MDDUS chief executive Chris Kenny said: “We have been at the forefront of the discount rate debate to put some rationality and hard evidence into the system and it is imperative that a new rate is set as soon as possible that is fair to claimants and defendants alike and gives the market greater certainty.”

MDDUS has highlighted the following five key messages for the government to address:

1. The current discount rate results in over-compensation.
2. The bill must be accelerated so that the new discount rate comes into force as soon as possible.
3. The first review should be conducted without the delay necessitated by input from an expert panel.
4. The review period should be five years rather than three.
5. The long title of the bill should be expanded to allow a more joined-up approach to tort reform.

Mr Kenny said: “We welcome the government’s offer to reflect on many of these points, but expect to see that reflection leading to firm proposals in later stages of the bill’s passage.

“We fully accept that there must be reasonable compensation for patients harmed through clinical negligence, but this needs to be balanced by society’s ability to pay. By setting the discount rate with reference to ‘low risk’ rather than ‘very low risk’ investments, this more accurately reflects evidence of the way in which claimants choose to invest their compensation payments.

“We urge the government to commit to having a revised rate in place as soon as possible. Justice officials have indicated that the bill is unlikely to be passed until April 2019. However, there is widespread

concern that this may slip further due to the pressures on parliamentary time caused by the Brexit process and associated legislation.”

## New dental risk toolbox

LEARN more about key risks in complaints handling, record keeping and the new General Data Protection Regulation (GDPR) with our MDDUS dental risk toolbox.

Members can login to access a wide range of tailor-made resources including practical checklists, guidance sheets, online courses, quizzes, instructive videos and advice articles. Test your knowledge on the GDPR, brush up on best practice in complaints handling and explore common pitfalls in record keeping.

Access all these resources and more in the Training & CPD section at [www.mddus.com](http://www.mddus.com) (login required).



## Wales opts for state-backed indemnity

THE Welsh government has decided to introduce a state-backed indemnity scheme for GPs in Wales from April 2019 – following in the footsteps of the recent decision by the Department of Health and Social Care (DHSC) in England.

MDDUS chief executive Chris Kenny responded: “We note the decision by the Welsh government and understand the rationale for it, given close links of primary care across the English and Welsh border.

“However, like DHSC, the Welsh government now need to urgently identify an operating model for the scheme and take cross-government action to reduce the drivers of unwarranted claims. Without that, it will simply shift rather than reduce cost to the NHS and potentially leave individual doctors worse protected.

“Any state-backed scheme will not cover GPs for non-NHS work, representation at inquests, GMC hearings and disciplinary investigations and will also not include advice and support – vital services which are highly prized by MDDUS members. We will continue to serve our members and meet their needs into the future.”

### UPDATED MDDUS PRIVACY NOTICE

MDDUS has updated the company privacy notice in compliance with requirements of the General Data Protection Regulation (GDPR). Members can view the updated notice at [www.mddus.com/mddus-policies/privacy-notice](http://www.mddus.com/mddus-policies/privacy-notice).

### HOSPITAL RISK TRAINING AT MDDUS

EXPLORE common risks facing hospital doctors at an MDDUS risk training day. The interactive sessions will cover consent, confidentiality, record keeping and GMC issues, using anonymised case studies. Venue: MDDUS Glasgow office. Date: 15 August from 09.30 to 16.30. Find out more or book at [risk@mddus.com](mailto:risk@mddus.com). A CPD certificate will be provided to delegates.

### MANAGE YOUR 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. Register at the login prompt at [www.mddus.com](http://www.mddus.com).

### GP RISK TRAINING DAY

LEARN more about how complaints and negligence claims occur in primary care in an interactive risk training day focused on key areas such as complaints handling, patient communication, chaperones and social media. Venue: MDDUS Glasgow office. Date: 30 August, 09:30 - 16:30. Find out more and book at [risk@mddus.com](mailto:risk@mddus.com)

## GMC recognises personal impact of complaints

AN independent review into the personal impact on doctors subject to fitness to practise procedures has led the GMC to make changes in the way it investigates complaints.

These include increased support being made available to doctors undergoing investigation and a commitment to obtain key information more quickly after receiving a complaint, to help determine whether an investigation is needed. The GMC says that this process, known as ‘provisional enquiries’, has already prevented around 400 cases from going to a full investigation.

The GMC will also now have the option to pause the process if a doctor under investigation is “very unwell” so that they can receive medical treatment.

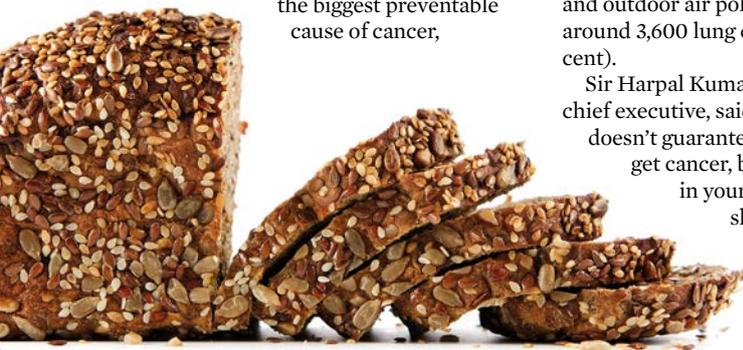
The independent review was commissioned by the GMC to look into cases where doctors had died from suicide while subject to investigation. Psychiatrist Louis Appleby was asked to advise on how to reduce the impact and stress of such investigations, and this involved working closely with policy teams, looking at each step of the investigation process from when a complaint is received to when the case closes or, in a minority of cases, gets referred to tribunal.

Professor Appleby commented: “Investigations can be punitive in effect, even if that is not the intention. Being able to see things from the point of view of the hardworking, perfectionist, sometimes distressed and probably remorseful doctor was key to reforming the process.”

## Many cancers preventable with lifestyle changes

OVER 37 per cent of cancers diagnosed each year in the UK could be prevented through lifestyle changes, according to new figures from Cancer Research UK.

The study published in the *British Journal of Cancer* cited figures from 2015 data that found smoking remains the biggest preventable cause of cancer,



## Dementia guidance for dentists

**NEW guidelines to help dentists provide better care for patients with dementia are now available free of charge online.**

***Dementia-friendly dentistry* from the Faculty of General Dental Practice UK (FGDP UK) advises dentists how to adapt their patient management and clinical decision making for patients with dementia. Written with input from organisations such as the Alzheimer’s Society, it covers the epidemiology and diagnosis of dementia, and its implications for dental professionals, including homes and domiciliary care.**

**It also includes information about local support, educational programmes and resources for patients, as well as more than 50 recommendations for practitioners.**

**First published in hard copy in October 2017, the guidance has now been added to the Faculty’s Standards Online portal. Access at [tinyurl.com/ycsoqr8g](http://tinyurl.com/ycsoqr8g).**

despite the continued decline in smoking rates. Tobacco smoke caused around 32,200 cases of cancer in men (17.7 per cent of all male cancer cases) and around 22,000 (12.4 per cent) in women.

Excess weight is the second largest preventable cause of cancer with around 22,800 (6.3 per cent) cases each year attributed to excess weight or obesity. The third most preventable cause is overexposure to UV radiation from the sun and sunbeds, which causes around 13,600 cases of melanoma a year (3.8 per cent of all cancer cases).

Other preventable causes of cancer include drinking alcohol and eating too little fibre (causing around 11,900 and around 11,700 cases respectively, which is 3.3 per cent each), and outdoor air pollution which is blamed for around 3,600 lung cancer cases a year (1 per cent).

Sir Harpal Kumar, Cancer Research UK’s chief executive, said: “Leading a healthy life doesn’t guarantee that a person won’t get cancer, but it can stack the odds in your favour. These figures show that we each can take positive steps to help reduce our individual risk of the disease.

“Prevention is the most cost-effective way

of beating cancer and the UK Government could do much more to help people by making a healthy choice the easy choice.”

## Decline in continuity of care

A STUDY of GP practices in England found an overall decline in continuity of care between 2012 and 2017.

Researchers in Leicester conducted an observational study in 6,243 primary care practices with more than one GP and calculated “patient-perceived relationship continuity” using two questions from the GP Patient Survey.

It found that relationship continuity declined by 27.5 per cent between 2012 and 2017 and at all socioeconomic deprivation levels.

Writing in the *British Journal of General Practice*, the researchers state: “Increased relationship continuity in primary care is associated with better health outcomes, greater patient satisfaction, and fewer hospital admissions. Greater socioeconomic deprivation is associated with lower levels of continuity, as well as poorer health outcomes.”

The study set out to examine whether deprivation scores predicted variations in the decline over time of patient-perceived



relationship continuity of care, after adjustment for practice organisational and population factors. It found that deprivation scores from 2012 did not predict variations but there was an overall decline.

Commenting on the study, Vice Chair of the Royal College of GPs, Professor Kamila Hawthorne said: “Continuity of care is at the heart of general practice and is highly valued by both patients and GPs alike – in fact, 80 per cent of UK family doctors say it is one of the most essential components of general practice.

“It’s disappointing but understandable to read that, according to this paper, continuity of care is reducing, but GPs across the country are striving to provide continuity, even if not in the traditional sense.”

## New duty of candour provisions

NEW duty of candour provisions in Scotland came into effect on 1 April.

The provisions, as defined in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act, set out a range of things that must happen when there has been an unexpected event or incident resulting in death or harm during health or social care.

Principles of candour exist in many organisations and within professional codes of conduct but the Act introduces a statutory organisational duty of candour on health and social care services in Scotland.

Scottish government has produced guidance on the new provisions including factsheets and an e-learning module to support organisations with implementation. For more information go to [www.gov.scot/Publications/2018/03/1321](http://www.gov.scot/Publications/2018/03/1321).

## No exemption on DPO requirement

THERE will be no exemption for dental practices in the requirement for all UK primary care providers to have a dedicated data protection officer (DPO).

Government ministers rejected suggested amendments tabled by the Liberal Democrats following representations and lobbying by the BDA and other professional organisations when the Data Protection Bill was debated in Parliament on 9 May.

The new General Data Protection

Regulation (GDPR) did not require dental practices to have a DPO, but the UK Government put this duty on NHS primary care providers by including them in its definition of “public authorities”.

The suggested amendments would have exempted dentists and other high street primary care providers from what the BDA calls a “huge and needless burden”.

DPOs are now required to be in place and practices should take steps to comply in order to avoid potential penalties.

## Inequality gap in child tooth decay

NEW data in England has revealed an almost a 10-fold difference between some local authorities in the prevalence of child tooth decay.

The latest Child Oral Health Survey from Public Health England did find improvements in overall tooth decay levels but also wide regional inequalities, with 5.1 per cent of young children in Waverley in Surrey presenting with decay compared to 49.4 per cent in

Pendle in Lancashire. Five-year-olds in Pendle had on average 2.3 decayed, missing or filled teeth compared to just 0.1 for those in Waverley.

Dental advocates including the BDA have expressed concern that authorities in England have failed to follow the lead set by devolved governments to bring supervised brushing to schools and nurseries. They cite the Childsmile (Scotland) and Designed to Smile (Wales)

programmes which use targeted interventions and have had success in reducing NHS treatment costs.

The BDA points out that tooth decay is the number one reason for child hospital admissions in England. Each day 170 children and teenagers in England undergo tooth extractions under general anaesthesia in hospitals in England at a cost of £36 million per year. The number of operations has increased by 17 per cent since 2012.

The BDA advocates a coherent and appropriately funded strategy to bridge the inequalities gap and urges greater effort from both local and national government. Chair Mick Armstrong said: “It’s a tragedy that a child’s oral health is still determined by their postcode and their parents’ incomes. Sadly, while cavities are almost wholly preventable, official indifference means this inequality gap shows little sign of narrowing.”



### MHRA ALERT ON VALPROATE USE

VALPROATE medicines must no longer be used in women or girls of childbearing potential unless a Pregnancy Prevention Programme is in place, according to new guidance from the MHRA. Healthcare providers are urged to ensure all women and girls are fully informed of the risks with exposure to valproate, used primarily to treat epilepsy and bipolar disorder. For more information see the MHRA alert ([tinyurl.com/ycynqao3](http://tinyurl.com/ycynqao3)).

### UPDATED REVALIDATION GUIDANCE

THE GMC has updated its guidance on revalidation to address concerns raised in a detailed review. Research from UK Medical Revalidation Collaboration (UMbRELLA) has shown that for some doctors the requirements remain unclear, particularly in regard to collating information necessary for appraisals and revalidation. Access the updated guidance at [tinyurl.com/y7c7v9zf](http://tinyurl.com/y7c7v9zf).

### NEW MANDATORY DATA TOOLKIT

A NEW Data Security and Protection Toolkit has been launched by NHS Digital which all organisations in England with access to NHS patient data and systems must complete to help keep patient information safe. It replaces the previous Information Governance Toolkit and is an online self-assessment tool that enables health and social care organisations to measure and publish their performance against the National Data Guardian’s 10 data security standards and key elements of the GDPR.

# UPDATE ON STATE-BACKED INDEMNITY

Chris Kenny

Chief executive officer at MDDUS

**T**HE UK Government is pushing ahead with its plans to introduce state-backed indemnity in England by April 2019. Secretary of State for Health and Social Care Jeremy Hunt announced the plans at the RCGP Annual Conference in October last year.

Since then, government officials have met with a number of stakeholders, including medical defence organisations, to discuss the way ahead. In April 2018 the Welsh Assembly announced it too would introduce a state-backed indemnity scheme (SBIS) for all GPs by April 2019. No decisions have been reached yet by the devolved administrations in Northern Ireland and Scotland.

MDDUS had given a cautious welcome to the plans when they were made but has been pushing government hard since then to put some meat on the bones of the announcement. We recognise that concerns about the cost of indemnity were high on the agenda of GPs in England and Wales and that solutions needed to be found. However, as it stands, much of what is proposed remains unknown and information has been slow in coming out about what exactly is proposed, how it will be run and who will run it.

We do know that the government intends to launch a public consultation in the summer on whether regulated healthcare professionals should be permitted to hold only regulated non-discretionary products in respect of clinical negligence liabilities at some stage in the future.

MDDUS has been speaking to all levels of government to try to ensure that the form of SBIS chosen is best for GPs, best for patients and best for the taxpayer. There has to be a comprehensive end-to-end service – one that seeks to protect the reputation of the individual doctor as well as the balance sheet of the NHS. That's vital to protect patient confidence and relationships. The current model for hospital indemnity doesn't provide that and isn't therefore fit for translation to the primary care context.

We are also concerned that many GPs do not realise the significance of what is being proposed. SBIS will not cover non-claims work such as appearances in



**“We are concerned that many GPs do not realise the significance of what is being proposed”**

front of the GMC, professional conduct disciplinary hearings or coroner's inquests/fatal accident inquires, and the provision of medico-legal advice – all of which are included in indemnity with MDOs currently. When similar changes were made in the consultant market in the early 1990s, many consultants opted out of MDO membership – only to have a very rude awakening when they found themselves without support in front of the regulator or in local disciplinary proceedings.

Fundamentally, we feel that the governments in Westminster and Cardiff have failed to address the cost drivers of the increase in indemnity and have chosen instead to shift the cost onto the public

purse. Supposed savings to individual GPs may also not be as significant as is being made out in some quarters, especially as the new scheme progresses.

That's why MDDUS has been lobbying politicians across the UK on the risks associated with introducing state-backed indemnity without first addressing the drivers of the increasing costs affecting GPs. We have also been trying to establish just how the scheme will operate, how it will be funded and how government intends to enhance, rather than distort, the vibrant competition in the MDO market that has delivered value and quality improvements over the past decade.

We have been active in lobbying the House of Lords around the Civil Liability Bill, in relation particularly around the personal injury discount rate (PIDR) elements. In February 2017, we had the astonishingly bad decision to reduce the PIDR from 2.5 per cent to minus 0.75 per cent – a legally flawed decision which will have a legacy cost of hundreds of millions of pounds. As part of our lobbying on the Bill, we highlighted five key messages for the government to address as part of the process of setting the new discount rate to ensure fairness for all and ease wider pressures on the healthcare system (see p. 5 of this issue).

As well as individual lobbying, MDDUS was part of a coalition of organisations which called for urgent action to reduce the £1.7 billion clinical negligence bill in England. Along with the NHS Confederation, which represents organisations across the healthcare system, we called on parliamentarians to reform how the discount rate is set. Let us hope government pays as much attention as the broadcast and broadsheet media did to this important message.

The changing market forces at play have also led to MDDUS introducing a claims-made product for GPs in England, called MDDUS VALUE, as an alternative to our gold standard occurrence-based product. More details on this can be obtained from our Membership Services Team.

We will continue to speak on behalf of our members and ensure that they receive a full professional service, and we would hope to have more information by the next edition of *Insight* to pass on to you.

# SPEAK UP FOR PATIENT SAFETY

Alan Frame

Risk adviser at MDDUS

**C**ONSIDER the scenario: a 42-year-old man suffering with severe nausea and abdominal pain is 20 minutes late for a GP appointment. He explains the reason behind the delay to the receptionist (bad traffic) but the practice operates a strict policy whereby a patient more than 10 minutes late will be asked to re-book an appointment for the following day.

The receptionist is concerned and calls through to one of the senior partners but is told the policy is there for a reason. That evening the patient is taken from home by ambulance to A&E and admitted to ITU with a ruptured appendix.

The receptionist later laments not challenging the decision. "I just sit at the front desk and answer the phone. It's the doctor's call." This powerful statement sums up the often difficult position staff can find themselves in when faced with what seems to be a bad decision by someone senior.

Much has been researched and is known about the part which 'authority gradients' can play in errors, but how well is it really understood and applied in healthcare situations? The term was first defined in aviation where it was observed that pilots and co-pilots may not communicate effectively in stressful situations and where there is a significant difference in experience, perceived expertise or authority (Cosby et al, ACAD EMERG MED 2004).

The Institute of Medicine report *To err is human* first explored the concept in the practice of medicine, yet relatively little to date has been published regarding the potential role of authority gradients in medical errors, which may remain unrecognised in the undertaking of significant event analysis (SEA).

In any organisation with different levels of professional stature and seniority, authority gradients can be intrusive – especially when senior staff have influence over career progression in those being supervised. This can make it extremely difficult to speak up and challenge the decisions of people in positions of power or authority.

Some organisations recognise these risks and seek to maintain what is known as a 'shallow authority gradient,' whereby



everyone is actively encouraged to contribute opinions/suggestions and an overall consensus emerges which is then acted upon. This can be a desirable approach for managing more routine, non-critical decision processes where there is the luxury of time. The downside to a shallow authority gradient is that in times of stress or crisis, where leadership and decisiveness are required, critical decisions may not be taken promptly, with adverse consequences resulting from delay.

Conversely, other leaders and managers may opt for a 'steep authority gradient' where they are seen as the decision makers and expect instructions to be acted on without question or further discussion. This may be desirable in times of crisis but it does not serve to foster shared responsibility and decision-making, nor empowerment in staff to speak up and speak out to challenge transparently flawed decisions.

In reality, the recognition and use of authority gradients are specific to situational awareness, which requires those in positions of authority to demonstrate self-awareness and be prepared to adjust their preferred gradient approach to meet the prevailing conditions and threats.

One high-profile medical error case where authority gradients played a major role involved a junior hospital doctor administering intrathecal vincristine to a patient instead of the safe indicated intravenous route. Despite this being against the junior doctor's own judgement, he allowed himself to be pressurised by a

more senior colleague into doing so. After repeated questioning of his superior he eventually accepted the reassurances given and administered the drug, which subsequently led to the slow and agonising death of the patient.

The aforementioned Institute of Medicine report on medical error acknowledged the importance of team-working and the need to improve communication between care givers. Openness should be viewed as a positive attribute to minimise medical errors and poor decision-making. The scope of potential approaches in the management of situational awareness is too vast to do justice to in this article, however one element which should be fostered is the active encouragement of all team members to speak up and challenge decisions without fear of recrimination. A simple but effective start in developing the required skills could be the agreement of key alert phrases that can be employed by any member of the team to communicate escalating threats.

This could commence with a lower level statement such as "I can see a potential problem here" progressing onto more active statements, such as "I'm worried", and in extreme situations, a direct challenge such as "something is wrong, you need to stop what you are doing / see this patient now!" Adopting this approach has been shown in the aviation environment to assist both the junior and senior officer in distinguishing between curiosity, concern and real threat, resulting in saved lives.

NEW



# ADMISSIONS

Adam Campbell chats with neurosurgeon and bestselling author Henry Marsh

**A**T ONE point in his bestselling memoir, *Do No Harm*, Henry Marsh compares surgery on an aneurysm to bomb disposal work. One false move when you're deep inside a patient's head and the result is likely to be fatal. He concedes the flaw in the analogy – after all, it's the patient's life that's at risk, not the surgeon's. But it captures well for the reader the high-stakes nature of a neurosurgeon's day-to-day work. The patient's life is literally in their hands.

Marsh was describing an operation at which he was, in fact, a mere spectator. He was an SHO with 18 months under his belt since qualification. This was the first neurosurgical operation he'd ever seen. As he watched, the surgeon picked his way stealthily into the patient's brain through a small opening in the side of her head, guided by an operating microscope, desperately trying not to disturb the aneurysm. Finally, he found it, clipped it and saved the woman's life.

"It was basically an epiphany," Marsh tells me, reminiscing about that day some four decades ago. "I knew immediately what I wanted to do." He went home and told his wife he was going to become a neurosurgeon. In the book he describes it as love at first sight.

Now 68, he's "retired" but remains as passionate about neurosurgery as ever. His work schedule says it all. "I do one day a week at St George's, flexibly, mainly teaching, occasionally operating, also doing occasional outpatient clinics. I spend about two or three months a year working abroad, mainly in Nepal, but also Ukraine and Albania. I'm now also starting to work a bit in Pakistan," he says.

He has also found time to write another memoir, *Admissions*, hot on the heels of the first, which was a runaway success. Both books are based on diaries he's kept throughout his working life – he was a consultant neurosurgeon at St George's from 1987 to 2015 – and both chart cases, thoughts and reflections of a lifetime in the operating theatre. They were never meant to see the light of day – "I'd have felt far too embarrassed", he says – but his current wife, a writer herself, persuaded him the contents were worthy of publication.

## TOO STRANGE TO UNDERSTAND

Marsh's writing is expert and alluring as he describes the secret world beneath the skull, the shining surface of the brain, its lobes, the mass of blood vessels, the Sylvian fissure, the structures that should be there and the growths that shouldn't. And you're there beside him as he navigates his way deep inside it, cutting, coagulating and sucking as he goes. The sense of vertigo is acute as he describes,

on the one hand, the physicality of what he's seeing but notes, on the other: "The idea that my sucker is moving through thought itself, through emotion and reason, that memories, dreams and reflections should consist of jelly, is simply too strange to understand. All I can see in front of me is matter."

There is also a searing honesty at work in these books, as you might expect from source material as personal as a diary. Yes, he writes of the successes he's had – or at least "of the profound sense one gets of having avoided disaster" – but he also writes about the deep despair caused by many terrible failures, which have left patients paralysed and utterly dependent for the rest of their lives – what he calls, unflinchingly, a "wrecked patient".

At one point he tells of a sense of intense relief when a patient who suffered a major stroke during an operation – rendering him unable to talk and unable to understand speech – later had a cardiac arrest and died, thereby avoiding a life of misery.

And he writes truthfully, too, about the very human aspects of the job. Of the thrill of a challenging operation, as well as its emotional flip side, the intense fear of making a mistake. Of the steeliness that's required, which makes that fear work for you instead of against you. "That's why I think most doctors don't want to become surgeons, and most surgeons don't want to become neurosurgeons, because the morbidity is so high," Marsh tells me with a wry chuckle.

"It does require a sort of iron in the soul and that's something you have to keep under control. And where you are on that spectrum between compassion and detachment depends on all sorts of factors – your personality, your age, your experience – and it varies over time."

He also talks about spats with colleagues and run-ins with hospital managers and this candour has won him plaudits the world over. "I think all of us are better off for being more honest and open," he says. "I've got lots of nice emails and letters from doctors saying how helpful they found my writing. Because they realised problems they'd tortured themselves over were not unique to them.

"Also, medically we learn the most from our mistakes, and success is in a sense bad for us. It makes us complacent and that distorts our judgment. The important thing about mistakes is admitting you've made one. In that sense, there's a strong onus on senior doctors to set an example of being honest."

## TREASURED MISTAKES

Marsh shines this light of honesty on his personal life too and describes the disaster that led to his first marriage. And long before that, at 21, there was the unrequited passion for an older woman that led him to run

away from Oxford University, where he was studying politics, philosophy and economics. He went off to a mining town in the north of England and there worked as a hospital porter and wrote "second-rate, self-obsessed poetry". A manic crisis followed and he had a brief spell in a psychiatric hospital, followed by weekly visits to a psychiatrist.

It's a period he describes in some detail in both his books, almost as if he treasures it. "I sort of do," he admits. "I'm embarrassed by it in some ways but it was very educational. We learn most from mistakes. We learn more from difficulty than from comfort and ease. I'm not a great fan of Nietzsche but, as he says, 'What does not kill me makes me stronger'."

It was an unhappy time – matched only by a year as a boarder at Westminster School when he was 13 – but the result was indeed life-changing because, having witnessed surgeons working up close, he began to get excited about the possibility of studying medicine.

After a year away, Oxford agreed to take him back and he finished his degree before being accepted at the Royal Free. It would be another few years before he witnessed that first aneurysm operation, the one that led him to opt for neurosurgery in the first place, but his future path was set.

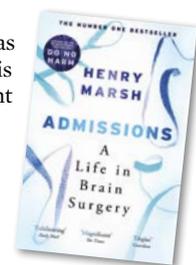
Now, at the other end of his career, with two well-received memoirs under his belt and a third one under contract, Marsh has added celebrated writer to his impressive CV. On the surgical front, he has cut the number of operations from a peak of around 500 a year to just 12. He recently operated on a petroclival meningioma and was happy with the outcome. "I think I've still got it," he says. "But I'll have to stop at some point and it's best to stop too early rather than too late. I have to step aside for the next generation."

In the meantime he's got plenty of experience to pass on to that generation and teaching is a big part of what he does. Having worked at both the bottom and the top of the medical world, there's one piece of advice he often gives. "I always say, working in a menial role in a hospital is valuable experience. It gives you much greater insight into what a hospital's really like for patients and other members of staff than if you just go straight from school to medical school and become a sort of vain, self-important doctor."

So does he feel those early experiences kept him grounded? "Well, I hope so."

He laughs suddenly. "You'd have to ask people who worked with me years ago whether I was grounded – or whether this shows a total lack of insight on my part!"

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



Has your practice ever considered getting involved in primary care research? GP David Shukla offers a personal perspective on the benefits

# RESEARCH READY

**I**N 2007 I joined a GP surgery in Dudley already established in teaching and training, and as a young partner I was keen to bring something new to the practice. We regularly received a newsletter from the local Clinical Research Network (CRN) hosted at the University of Birmingham, detailing research studies being run in primary care and recruiting GP practices to take part. The CRN is part of the National Institute for Health Research (NIHR), which is considered the 'research arm' of the NHS.

I contacted the CRN for further information and we were visited by two of their 'research facilitators' who explained what was involved and provided us with details of studies considered suitable for a practice with no research experience. We felt that getting involved in primary care research could benefit the practice by giving our patients the opportunity to partake in research relevant to them, which could potentially bring about benefits to their care.

We were encouraged to undertake training in Good Clinical Practice (GCP), which is the international ethical, scientific and practical standard to which all clinical research is conducted. Compliance with GCP provides public assurance that the rights, safety and wellbeing of research participants are protected, and is a requirement of the Research Governance Framework for Health and Social Care (2005) which covers all research in the NHS in England. The NIHR offers GCP training either as a face-to-face workshop, or as an online module.

## COUGH STUDY

The first study we joined was the 3C cough study which recruited patients presenting with an acute cough. The study involved asking a few questions about presenting symptoms, recording a detailed examination, and then undertaking a follow-up 'notes review' which was conducted by our practice nurse or healthcare assistant one month after initial attendance, detailing what had happened to the patient in the interim (e.g. recovered, admitted, referred, died or not returned).

Within a few weeks we were up and running with the study and the partners and GP registrars were recruiting patients into the trial. With an autumn start, the timing was perfect and our acute cough presentations generated practice income in the region of £30 per patient recruited. By the end of the recruitment period we had consented 117 patients, second highest in the West Midlands, and the study team reached their 30,000 recruit target overall.

The patients enjoyed being given a little extra time in consultations and asked more detailed questions, and the staff felt increasingly skilled in managing this particular clinical area.

So we took on other studies involving conditions including cancer, atrial fibrillation, chronic obstructive pulmonary disease (COPD), gout, heart disease, *Helicobacter pylori* infection and smoking cessation. Taking part in these studies meant that some of our patients were given access to novel treatments and received more intensive monitoring and review, as well as accessing additional support in managing their chronic conditions and generally enjoying the 'altruism' of giving something back to the NHS. As clinicians, we valued learning more about the conditions, gaining an understanding of how research is carried out and being able to add something different into our annual appraisal documentation. Income generated from our involvement was invested back into the practice, allowing for additional staff training and support.

The support that we received from our local CRN team was fantastic, and they would frequently pre-select us, knowing that we would recruit well into their studies. We subsequently completed the Royal College of General Practitioners' (RCGP) Research Ready accreditation, which is a framework to ensure practices run research in accordance with correct clinical and legal frameworks (including contacting indemnity providers to ensure this is in place, and notifying the Information Commissioner's Office).

Our participation also paid off in

our Care Quality Commission (CQC) practice inspection, where we were able to demonstrate how research benefited patients and contributed to continuous quality improvement (QI). For example, the FAST study (Febuxostat versus Allopurinol Streamline Trial) improved the management of our patients with gout by optimising urate-lowering therapy for them. Another study, the 'TargetCOPD2' trial, invited current and ex-smokers into the practice for lung function testing, resulting in a rise in recorded COPD prevalence with the associated benefits for patients previously not known to be suffering from the condition – the so-called 'missing millions'. We achieved an overall 'outstanding' rating from the CQC, with specific mention of our research activity in the report.

Several years on from that first study, we now participate in approximately five studies per year and have just taken on our first commercial research study, partnering with a major pharmaceutical company. The work required in a commercial study is more detailed and intensive and, again, the support we have received from the CRN has been invaluable.



“Income generated by our involvement was invested back into the practice...”

#### DATA HANDLING

Fortunately we have not experienced any difficulties with our research activity, but we have been careful to ensure that our clinical coding and records are kept up-to-date, and we screen every list of patients generated by the research ‘searches’ to ensure we don’t contact anyone recently bereaved or with a recent significant diagnosis, where it may be felt inappropriate to invite them at this particular time.

Many practices have also been concerned about the impact of the General Data Protection Regulation (GDPR) and how this may affect the way in which patients are invited into studies. Is individual patient consent now required to participate? The Health Research Authority (HRA) are due to issue further specific guidance on this, but it is hoped that very little will change in practice and patients can be recruited as before. Article 9 of the GDPR provides

exemptions for research carried out in the public health interest, or in helping the NHS carry out its statutory duty to ‘inform patients of research studies in which they may be eligible to participate’ (NHS Constitution 2015). Practices are encouraged to display posters, leaflets and notices on their website and new patient forms informing patients that the practice is ‘research active’ and where they can find out more information about what this means, and how to ‘opt out’ should they wish to (NHS Digital’s national data opt-out system came into effect 25 May).

I now work directly for the CRN as a Primary Care Research Lead and have clinical oversight of delivery of research studies taking place in Birmingham and the Black Country. About 45 per cent of our GP surgeries are ‘research active’, and with more GPs taking on portfolio roles and looking for other interests, research delivery can provide opportunities. The CRN is adapting

its support model for primary care, taking account of changes such as the formation of large super-partnerships, federations, vanguards and other ‘new care models’. Working at scale is likely to have benefits for research activity in primary care, hopefully giving more patients the opportunity to be involved in research studies.

Involvement with research benefits patients, doctors and other practice staff and is generally very easy to undertake with limited time resource and the support of a local CRN team. It’s also academically satisfying and provides relief from the demands of the day job – and, on the whole, patients are happy to take part.

Dr David Shukla is a GP Partner at Eve Hill Medical Practice in Dudley, Clinical Research Specialty Lead for Primary Care in the West Midlands and Clinical Research Fellow at the University of Birmingham’s Institute for Applied Health Research

**N**HS Improvement defines ‘never events’ as “serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers” – which is rather a mouthful.

Press reports of catastrophic errors such as removing a healthy kidney in place of a diseased one or amputating the wrong leg may seem to stretch credulity. And yet such things happen in the most up-to-date and “efficient” operating theatres. It has been estimated that one out of four orthopaedic surgeons in practice in the USA for more than 25 years will have performed at least one wrong-site surgery.

The concept of ‘never events’ was introduced in the NHS in England in April 2009, following a proposal by Lord Darzi in his report *High Quality Care for All*. Today all commissioners and providers of NHS care in England are required to report ‘never events’ for a list maintained by NHS Improvement. Statistics are collated and published regularly. In the year to March 2017, a total of 445 ‘never events’ were reported – and of these 42 per cent were classified as wrong-site surgery with the greatest number (46) being “wrong tooth/teeth removed”.

## SURGICAL CHECKLIST

The dental never event is a relatively new concept. Indeed, it was only in 2015 that wrong tooth extraction was first considered to be a never event as defined by NHS Improvement. Just how meaningful that 46 figure is could be debateable given this mainly includes reported incidents from secondary care. How many wrong tooth extractions go unreported in general dental practice is uncertain, but we can only assume the scale of such errors is of potentially greater magnitude.

Back in 2009 when the then National Patient Safety Agency first began compiling data on never events it was also in the process of implementing the World Health Organisation’s (WHO) Surgical Safety Checklist in every hospital in England and Wales. The checklist was devised by the WHO after a year-long global pilot of nearly 8,000 surgical patients across eight countries. The findings from this pilot study were compelling – adherence to the checklist resulted in a one-third reduction in surgical deaths and complications.

Later in 2015 NHS England introduced its own National Safety Standards for Invasive Procedures (NatSSIPs) which build on the existing WHO surgical checklist. NatSSIPs offer healthcare professionals general advice on how they can enhance best practice through a series of standardised

# WRONG-SITE EXTRACTION

It happens more often than you think – but some simple measures can help avoid this disastrous outcome



safety checks and education and training. The standards also support NHS providers to work with staff to develop and maintain their own, more detailed Local Safety Standards for Invasive Procedures or LocSSIPs.

Recently a working group of dental bodies including the Faculty of Dental Surgery and the Faculty of General Dental Practice produced a toolkit for developing LocSSIPs to avoid wrong-site extraction ([tinyurl.com/y9gxnbw8](https://www.tinyurl.com/y9gxnbw8)). The toolkit is aimed at all clinical dental teams involved in dental extractions and its developers acknowledge that wrong-site surgery in dentistry may not be on a par with the loss of a limb or major organ but it can still be devastating for both patient and clinician.

## TIME OUT

A significant number of errors in the operating theatre or surgery – including wrong-site surgery – result from a lack of communication both with the patient and among the clinical team. In addition there may be no established procedures and/or procedural compliance to avoid wrong-site extraction. The LocSSIPs are intended to provide safety critical steps to address these issues.

The process begins even before the patient arrives with first-stage consent undertaken prior to the appointment and confirmed on the day of the procedure. It calls for the treatment plan to be stipulated clearly using Palmer notation, with a written description of the teeth being extracted. A safety briefing with staff should also be undertaken, addressing specific issues including diagnosis and planned procedure, site and side, relevant comorbidities, need for antibiotic prophylaxis and equipment requirements.

Once the patient is in the chair, the dentist should recheck name, date of birth and address, and consent should be confirmed. They should also again check tooth notation and ensure it is clearly documented on the consent form, checklist, whiteboard or computer screen, which is clearly visible to the surgeon and team for verification during surgery.

A 'pause' or 'time out' is then advised before administering anaesthetic and starting the procedure. The time out should be conducted by a team member with all other tasks halted. This again is to confirm:

- correct patient
- correct treatment plan
- correct site.

Verbal counting of the dentition from midline is recommended to confirm surgical site using an instrument pointed at each tooth, with verification from an assistant (of side and countdown). Once the tooth has been extracted there should be a systematic check that nothing has been lost or retained during the procedure, such as bur heads, cotton wool or tooth fragments.

This protocol can be varied to reflect work carried out in general/specialist practice, including care provided under conscious sedation, but the fundamental principles remain the same.

Often surgical errors occur due to unanticipated interruptions during a procedure. The LocSSIPs advise that with any interruption, the surgeon should "repeat the 'three Rs': Reposition; Recheck; Reaffirm with your assistant".

A debriefing is encouraged post-procedure, including consideration of things that went well, any problems with equipment or other issues that occurred and areas for improvement. A record of this debrief should include an action log with any significant issues identified and recorded in the patient notes.

The British Association of Oral Surgeons (BAOS) provides guidance on its website in regard to the LocSIPPs process for wrong-site extraction. Here it advises that in mitigating such risks it is critical that dental teams develop checklists appropriate to their specific clinical environment and provide adequate training for staff in implementation and use. There should also be active audits of the processes involved to ensure that checklists are being used correctly and that teams can learn from mistakes – including investigation and root-cause analysis. Any "punitive" action should be avoided when incidents do occur to encourage openness.

## REPORTING

NHS organisations across the devolved UK nations are keen to ensure that lessons are learned from serious clinical errors. In England never events must be reported to both the Strategic Executive Information System (StEIS) and the National Reporting and Learning System (NRLS) – although currently a new patient safety incident management system is being developed. Find out more on the NHS Improvement website. Deliberate failure to report a never event is likely to constitute a serious failing and breach of Care Quality Commission (CQC) requirements.

Recently the Scottish Government launched a new duty of candour for all health, care and social work services setting out how organisations should respond when there has been an unexpected or unintended incident resulting in death or harm. This includes notifying the person affected and providing an apology and account of what happened. Organisations must also publish and submit an annual report on when the duty has been applied and what learning and improvements have been put in place in response.

Northern Ireland also has its own reporting requirements through the Regulation and Quality Improvement Authority ([www.rqia.org.uk](http://www.rqia.org.uk)).

Given the media coverage they often attract, instances of wrong-site surgery remain rare. One case reported in the *BMJ* concerned a healthy 23-year-old man who presented for cataract surgery. In pre-op he expressed some concern that the surgeon was clear which eye was to be operated on. Later after numerous routine site verifications the patient lifted his surgical cap and said: "Had I realised all these steps would be taken, I wouldn't have done this." Shaved into the short hair on the side of his scalp was a large arrow pointing to the correct eye – better safe than sorry!

Jim Killgore is managing editor of Insight magazine

## LINKS/SOURCES

- British Association of Oral Surgeons – Help and Advice for Professionals <http://www.baos.org.uk/for-professionals/>
- NHS Improvement – Never Events policy and framework <https://improvement.nhs.uk/resources/never-events-policy-and-framework/>
- Scottish Government health policy – Duty of Candour <http://www.gov.scot/Topics/Health/Policy/Duty-of-Candour>



# 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

# MOBILE IMPLANT

## BACKGROUND

In a regular check-up with his dentist, Mr G expresses dissatisfaction with his upper partial denture. He asks about the possibility of a fixed solution to his missing upper teeth and is referred to a dentist – Dr L – specialising in implant treatment.

Dr L examines the patient and undertakes a panoramic radiograph. A treatment plan is proposed to place three dental implants in the upper jaw, with a single implant-retained crown at UR5 and a three-unit bridge from implants at UL3 and UL5. The dentist notes the need for bone augmentation and also records that Mr G has a cross bite on his posterior teeth and an edge-to-edge occlusal relationship on his anterior teeth.

Three weeks later the procedure is undertaken, with the bony ridge surgically split and augmented to facilitate implant placement. A few months later Dr L records that the restoration has been completed as planned and Mr G is happy with the result.

Mr G attends his regular dentist – Mr J – for a check-up and hygienist appointment. He states that he is not entirely happy with the fit and appearance of the implant-retained bridge. The dentist notes inflammation buccally and deposits around the bridge, with significant inflammation and bleeding. He questions whether excess cement is present.

Mr J writes to Dr L requesting that he arrange to see the patient again to address these problems but a month later Mr G returns to the practice complaining now that the implant at UR5 feels “loose”. The

patient has also not heard back from Dr L. That afternoon Mr J phones Dr L and an appointment is arranged for the next day.

Dr L agrees both that UR5 is mobile and the upper left bridge needs redesigned to improve appearance and ease of home care. He plans to replace the UR5 implant and ease the bite on the upper right side to avoid heavy contact and allow implant integration.

This work is undertaken at no additional cost but over the next year Mr G has persisting problems with mobility in UR5 and fit in the upper left bridge with caries now in adjoining teeth. The patient loses confidence in Dr L and Mr J refers him to another implant dentist to carry out further remedial treatment.

Four months later Dr L receives a letter of claim from solicitors acting on behalf of Mr G. It alleges failure to properly assess the ridge profile and need for significant bone grafting to ensure implant success in both the upper right and left quadrants. Consideration should have been given to the potential for occlusal overload in the upper right quadrant given the patient's

unusual bilateral posterior crossbite and edge-to-edge relationship anteriorly. The claim also alleges failure to provide a well-fitted bridge in the upper-left quadrant, with excess cement and a lack of adaptation to soft tissues.

## ANALYSIS/OUTCOME

MDDUS acting on behalf of Dr L commissions an expert report from a restorative specialist with experience in placing implants. In regard to the assessment and treatment plan, the expert notes that Dr L did take a panoramic radiograph to assess alveolar bone height and, in combination with clinical examination, concluded that bone augmentation was necessary. In the surgical treatment the bony ridge was split and augmented without incident and postoperative radiographs were taken.

The expert further observes that although the initial bridge was not a good shape to make cleaning easy Dr L did provide a replacement, but he finds the initial excess cement and inadequate adaptation to soft tissues indefensible. In regard to the implant failure at UR5, the expert judges that the occlusal relationship was particularly critical to success, especially with the narrow ridge requiring splitting and augmentation. He concludes that it would be difficult to defend Dr L for not taking this factor adequately into account.

MDDUS in agreement with the member negotiates a settlement based primarily on the cost of further remedial treatment.

## KEY POINTS

- Ensure that all factors impacting treatment success are considered and communicated to the patient.
- Dental implant restorations often come with higher aesthetic demands and satisfying these in all patients can be difficult.

## COMPLAINT

# CALLING HALT

### BACKGROUND

A specialist registrar – Dr J – is to perform a flexible sigmoidoscopy on a 52-year-old male patient who has presented with a positive bowel screening test. Mr B is prepped for the procedure but is very nervous. Dr J explains what is involved and obtains consent.

The patient has not requested sedation and during the procedure he complains of extreme discomfort. Dr J reassures the patient but halts the procedure in the descending colon as Mr B is too uncomfortable to proceed. The segment of colon viewed is found to be “clear”.

Mr B later writes to the hospital complaining of “rough treatment” by Dr J. He also claims that the doctor carried on with the procedure despite his demand to stop. Dr J is contacted by the hospital complaints officer and asked to provide a statement in response to a number of specific questions.

### ANALYSIS/OUTCOME

MDDUS assists Dr J in responding to the questions. He is asked if the patient's informed consent was given to the procedure. In his answer Dr J makes reference to a signed consent form along with a patient information leaflet which he ran through with Mr B prior to the procedure. A review of the nursing notes



also documents that the patient did not request sedation for the agreed procedure.

Nursing documentation graded the

patient's comfort level from 0-1 (none to mild discomfort) but Dr J acknowledges that Mr B grew more vocal about his extreme discomfort and this was when he halted the procedure. However, at no time before that did Mr B call for him to stop. Dr J states that his usual practice if a patient asked him to 'stop' would be to pause and explain the clinical necessity of what he was doing and carry on only if the patient then verbally consented. In this he is again backed up by the nursing documentation.

The matter is resolved with no further action.

### KEY POINTS

- Medical consent is not a one-off decision but always ongoing and can be withdrawn at any time.
- Ensure all relevant treatment discussions with patients including consent are properly documented.

## ADVICE/GDC

# GDC WITNESS

### BACKGROUND

A dentist – Mr H – has been requested by the GDC to attend as a witness at fitness to practise proceedings involving another dentist. He has already provided a statement in regard to the case but GDC lawyers are insisting Mr H attend the hearing in person. It is expected to last five days. The GDC has offered to pay his expenses but not loss of earnings. The dentist asks MDDUS if he is allowed to refuse.

### ANALYSIS/OUTCOME

A dental adviser responds stating that it would be prudent to “engage with your

professional regulator on a voluntary basis” but that having to take five days off might be considered unreasonable. Mr H is advised to contact the GDC legal team and attempt to narrow the timeframe.

### KEY POINTS

- Witnesses can be compelled to attend GDC hearings but this power is rarely necessary.
- Engage with the regulator to narrow the potential timeframe for attendance.

Most individual witnesses in a GDC hearing are generally needed for less than a day. Five days is a relatively narrow timeframe for a hearing but if a witness is timetabled to attend on a certain day and things have moved quicker than expected the Practice Committee can simply adjourn or use the additional time to read other evidence.

Should a witness refuse to attend, the GDC does have the power to issue a formal witness summons. However, this is rarely used and registrants are best advised to engage pragmatically with the regulator to seek a narrower timeframe for attendance.

## CLAIM

## SUDDEN STROKE

## BACKGROUND

Mr S is a 48-year-old hospital porter and heavy smoker. He contacts an NHS helpline on a Sunday complaining of vomiting and severe dizziness on and off for the last two days, as well as pain and numbness in his right arm. A nurse adviser refers him to an out-of-hours GP clinic and he is seen by Dr T.

The GP confirms a history of vertigo and vomiting with no abdominal or chest pain but a slight headache. There is no mention in the notes of the arm complaint. Vitals are within range and the GP checks the fundi and pupil reactivity to light, which are also normal and she notes "no other neurological symptoms." The working diagnosis is labyrinthitis and she prescribes prochlorperazine for symptomatic relief.

Two days later Mr S attends his regular GP surgery complaining again of a sore right forearm and hand. He is seen by Dr A, who notes the OOH attendance and the working diagnosis of labyrinthitis. He records "hand pale/cool; some volar tenderness/redness but no clear sign of infection." The patient is sent home with advice to contact the practice if no improvement or if symptoms worsen.

Later that day Mr S collapses at home and is taken by ambulance to A&E with left-side weakness and severe headache. A CT angiogram shows extensive right MCA territory infarction with bilateral cerebellar ischaemia, and he also has an ischaemic right arm due to arterial embolus. Mr S is commenced on heparin but is not considered suitable for thrombolysis treatment. He suffers a prolonged recovery in hospital and is left handicapped and unable to return to work.

A claim for damages is pursued against both GPs alleging clinical negligence in failing to refer appropriately.

## ANALYSIS/OUTCOME

MDDUS acts for Dr A in the case. Expert reports are commissioned from a GP and a vascular surgeon. Considering notes from the initial consultation with Dr T the GP expert agrees that labyrinthitis was a reasonable working diagnosis but he questions why there is no comment in regard to the patient's arm, given the symptoms reported by the triage nurse. Assuming there was no gross abnormality present in the arm at this stage and no clear neurological problems, the expert concludes that failure to address this issue in the notes constitutes a legal vulnerability but no clear breach of duty.

Regarding the consultation with Dr A the GP expert observes that the notes focus



primarily on the arm complaint but no working diagnosis is noted – only the advice that Mr S should return if the symptoms do not improve. There is no indication in the notes of vascular examination, i.e. mention of the quality of the pulses in the left compared to the right arm, nor BP or capillary refill measured in both.

Given that Mr S showed no clear signs of serious illness in the consultation – no headache or sign of left weakness – the expert concludes there can be no breach of duty in the failure to manage this condition as a CVA (cardiovascular accident). But he does suggest a legal vulnerability if it cannot be established that Dr A at least considered the possibility of an acute vascular occlusion in the patient's arm.

However, the crucial factor in this case is causation (the consequences of any

potential failing) and this is addressed by the vascular surgeon in his expert opinion. Examining the practice and hospital notes he concludes that Mr S suffered cerebellar infarcts leading to the reported dizziness and a subclavian artery embolus leading to the right arm/hand symptoms. A middle cerebral artery embolus then caused the stroke suffered in the hours after the consultation by Dr A.

In addressing causation the expert opines that even if Dr A had diagnosed an arm embolus in the hours before Mr S suffered his stroke this would have made no material difference to the outcome. Hospital notes confirmed that on examining Mr S's hand the on-call vascular surgeon judged it was not "threatened" and decided not to operate. The neurologist who examined Mr S at the hospital considered thrombolysis but did not proceed with that treatment because of pre-existing contraindications. Mr S was given anticoagulation treatment with heparin as advised by the vascular surgeon at the hospital but this did not relieve his stroke symptoms. Earlier treatment with heparin would not have made any difference to the outcome.

MDDUS denies liability on behalf of Dr A on the grounds of causation and the action is subsequently dropped against both GPs.

## KEY POINTS

- Ensure you address the full range of presenting complaints in the notes – even if just a working diagnosis.
- Establishing liability in clinical negligence requires evidence of both breach of duty of care and causation.



## ADVICE

# FACEBOOK RANT

### BACKGROUND

A patient – Mr M – who has in the past verbally complained about the “rude attitude” of reception staff at his village GP surgery has now posted an extended ‘rant’ on Facebook. The practice disputes the version of the events described and is concerned by the public nature of the complaint on social media. It contacts MDDUS for advice on how to address the matter.

### ANALYSIS/OUTCOME

An MDDUS adviser suggests that the practice write to the patient in regard to the Facebook post and acknowledge his continued dissatisfaction and suggest that the practice would be happy to provide a formal written complaint response. It would be reasonable to request that Mr M remove the post and remind him that complaints are best dealt with via the formal practice complaints procedure (as set out on the surgery website). The letter could also include an offer to meet with Mr M to discuss his concerns.

The practice should also consider undertaking its own internal review of the complaint and the outcome could be reported back to the patient (if he wishes). Any response should include a reminder that Mr M is free to escalate the complaint for review to the ombudsman (provide

contact details) with no impact on his ongoing care at the practice.

Should Mr M refuse to remove his post the practice has the option to post a “response” on its own Facebook page highlighting that it has a formal complaints policy and inviting any person with a concern to contact the practice directly. This post must be “generic” – without divulging any specific patient or other information that might risk breaching confidentiality.

The practice could also consider taking further legal advice in regard to potential defamation. However, advice on this matter would be beyond the scope of expertise and support from MDDUS.

The GMC also provides extensive guidance to doctors with regard to good medical practice and the use of social media ([tinyurl.com/ydab9wxo](http://tinyurl.com/ydab9wxo)).

### KEY POINTS

- Ensure patients are aware of formal practice complaints procedures.
- Do not respond to complaints via social media if there is any risk of breaching patient confidentiality.

## COMPLAINT

# ACID BURN

### BACKGROUND

A young patient – Max – attends the dental surgery after school for treatment to fissure seal his permanent molars. Not long after leaving the surgery with his mother Max returns and reports to the receptionist that he feels a burning pain just under his lower lip. This is evidenced by a florid red mark.

Max’s mother asks to see the dentist – Dr W – who first suggests that it might be an allergic reaction to his latex gloves. This is discounted as Max has never experienced any such allergy before. Dr W then speculates it might possibly be due to the etching gel (orthophosphoric acid) used in the fissure sealant procedure.

Max leaves the surgery and attends A&E. Here the attending physician confirms that the lesion appears to be a chemical burn

rather than contact dermatitis. He speculates that the shape suggests the chemical agent may have rubbed off the dentist’s glove.

The next day the practice receives a letter of complaint from Max’s parents demanding an explanation of how the incident occurred and why Dr W tried to claim it was an allergic reaction.

### ANALYSIS/OUTCOME

An MDDUS adviser assists Dr W in drafting a letter of response. The dentist first expresses regret for the incident and acknowledges that the etching gel was the likely cause of the lesion. He promises to review his procedures in the use of fissure sealant and necessary first aid measures to ensure such incidents are in future dealt with immediately. The practice will also

undertake a significant event analysis to explore further how similar incidents can be prevented in future.

The parents acknowledge Dr W’s explanation and expression of regret. No further action is taken and Max remains a patient at the practice.

### KEY POINTS

- Ensure access to and familiarity with COSHH (Control of Substances Hazardous to Health) safety sheets for chemical products used in the practice.
- Conduct an SEA to ensure (and demonstrate) learning from adverse incidents.

# A FRIEND IN NEED?

Dr Gail Gilmartin

Medical and risk adviser at MDDUS

**'M an ST in dermatology and was recently on a walking holiday on the Isle of Skye. My friend is currently being treated for anxiety and low mood and arriving at the hostel she discovered that she had left her medication at home. She suggested rather than waste time going to a local GP I could write her a prescription. Was I right to refuse?**

It's not unusual for friends and family to turn to a doctor they know and seek advice or assistance for a variety of things medical. This can include asking for prescription-only medicines, which puts any doctor on the spot and can cause quite a dilemma. The reasons for such requests can include: not having enough time to see their GP before going on holiday, having run out of or forgotten medication or because they want something they know their own GP is reluctant to prescribe.

So, how best to approach this?

Whilst legally a doctor can prescribe for anyone – that is, the law allows it – the GMC advises caution and provides specific advice. Doctors must be aware that serious or repeated breaches of this guidance can lead to significant sanctions being imposed.

In some circumstances, prescribing for someone close to you may appear to be a fairly trivial matter; however this can cause difficulties in regard to patient safety. Risks arise where you do not have access to someone's full medical history and in particular their prescribing history. Can you reassure yourself that the prescription is appropriate to best serve the patient's needs? Will the patient's GP be made aware of the prescription you provide and the clinical reasons for doing so? Do you have any record of what was prescribed and why?

Remember you have a duty of care to the person for whom you prescribe and you are accountable legally and professionally. In particular there is significant risk if medicines of addiction or potential abuse are prescribed; in some cases there have been allegations of criminal behaviour on the part of the doctor involved.

The GMC is clear in its guidance, *Good practice in prescribing and managing medicines and devices*, that: "Wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship".

Sometimes it appears that the risks are

low and prescribing is appropriate and in the patient's best interests. For these situations the GMC advises:

*If you prescribe for yourself or someone close to you, you must:*

- a. make a clear record at the same time or as soon as possible afterwards. The record should include your relationship to the patient (where relevant) and the reason it was necessary for you to prescribe.*
- b. tell your own or the patient's general practitioner (and others treating you or the patient, where relevant) what medicines you have prescribed and any other information necessary for continuing care, unless (in the case of prescribing for somebody close to you) they object.*

However, it should always be remembered that your friends and family may not be entirely honest with you about all aspects of their medical history. They may have medical conditions or be taking other medication that they do not want to disclose. All these features add to the difficulty in prescribing to friends and family. They will have a confidential relationship with their own doctor, who is also more objective, and receive appropriate care.

A particular note of caution applies to prescribing controlled medications for

someone you know; this is fraught with difficulties. There might be the very rare occasion where this is necessary and the GMC offers specific advice:

*Controlled medicines present particular dangers, occasionally associated with drug misuse, addiction and misconduct. You must not prescribe a controlled medicine for yourself or someone close to you unless:*

- a. no other person with the legal right to prescribe is available to assess and prescribe without a delay which would put your, or the patient's, life or health at risk or cause unacceptable pain or distress, and*
- b. the treatment is immediately necessary to: (i) save a life; (ii) avoid serious deterioration in health; or (iii) alleviate otherwise uncontrollable pain or distress.*

It is clear that the guidance is intended to restrict doctors from prescribing for those close to them and a good rule of thumb is to always politely decline. In this way your friends will understand that this is not something you are amenable to and therefore should avoid asking.

On the rare occasion that you are asked to prescribe for a friend and, on balance, feel that the best option is to do so, remember the specific GMC guidance – by adhering to this you should avoid any critical censure.



# “EVEN NURSES ARE NOT COMPASSIONATE ANYMORE...”

Dr Andrew Papanikitas

Academic clinical lecturer at the University of Oxford

**E**VEN nurses are not compassionate anymore...,” the eminent plenary speaker informed the medical conference. He proceeded to describe an experience relayed to him by a current junior doctor.

“...She had a patient on the ward who was in pain, so she went up to the nurse who was administering the medications and asked for some painkillers. And the nurse said: ‘Wait until I’ve finished or ask someone else’ What do you make of that?”

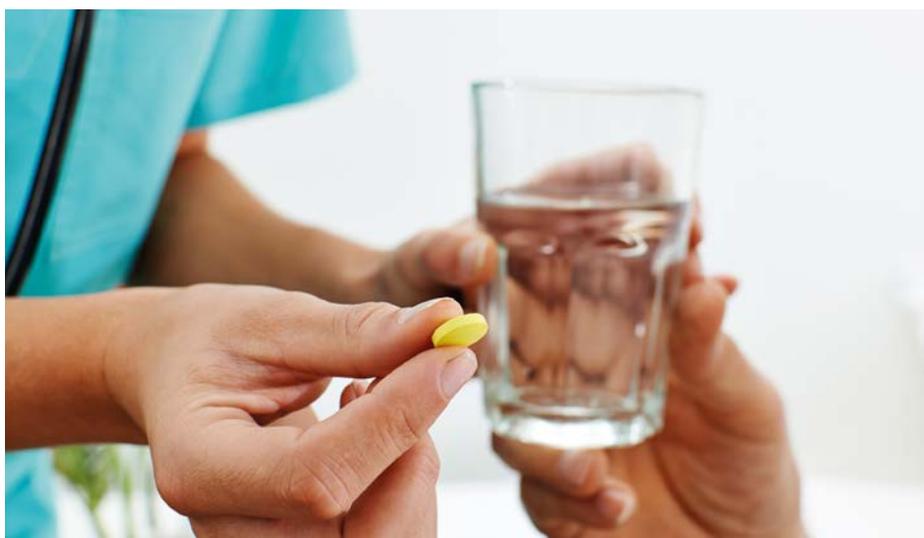
There was almost an audible sigh in the auditorium as the audience sadly shook its collective head at the thought that “even nurses” were no longer prepared to respond to a patient’s distress.

Some of the audience were shaking their heads for a different reason. They were seeing this story not as a failure of compassion on the part of the nurse, but a failure of moral imagination on the part of the storyteller. The nurse was the villain; the junior doctor – fresh from medical school, patient-centred and idealistic – was the hero. But what if life is more complicated than this?

Many of us have seen nurses forced to wear tabards over their uniforms as they dispense medications – these tabards usually say things like ‘Do not disturb me. I am administering medications’. Surely this is not mere formalised unfriendliness? And those of us who remember sessions on clinical governance and medical error will know the chances of a patient being given the wrong drug or dose are unacceptably high, especially if the person prescribing or administering is distracted or tired.

So the nurse in this tale may not have been lacking in compassion at all. Perhaps she was more motivated by the desire not to harm her patients. I have since used this story to illustrate the concept of inter-professional ethics to colleagues. Both the nurse and the doctor had worthy principles but different priorities and somehow there was a failure to see the other’s perspective.

In 2007, Phillip Clark and colleagues suggested in the *Journal of Interprofessional Care* that we might better ‘see’ that other perspective if we imagine that different professions, albeit engaged in the endeavour of good care, may have different or differently interpreted ethical principles, a different professional sociology,



and may be labouring under different conditions and processes. ‘Principles’ may include things like compassion – historically much more central to nursing (about care) than medicine (with its focus on diagnosis and scientific treatment). The ‘sociology’ and history (which Clark and colleagues call ‘structures’) might include the way that doctors often prescribe and nurses administer medications, or the way that obstetrics in the UK gravitates towards pathological pregnancy and midwifery towards physiological pregnancy.

The ‘processes’ refer to the factors that sway our everyday decisions. Whilst many professionals may come together as a notional team, they may be paid and penalised differently. For example, undergraduate students from different healthcare professions working on a joint interprofessional education project may have different marks allocated for their joint presentation and different incentives to participate. In the professional world, what may result in a disciplinary slap on the wrist for a junior doctor may mean worse sanctions for a trainee nurse or criminal charges for a pharmacist. Clark and colleagues wisely do not leave their explanation at the level of the individual – this way of thinking (principles, structures and processes) should also be applied at the level of the team and that of the organisation.

The story with which I began was told in

the wake of the Mid-Staffordshire scandal – widely declared as a corporate failure of compassion. Around the same time I came across another story told by Julie Wintrup in a paper on ethics education. Wintrup describes a scenario in which hospital nurses were too busy with their medical tasks to find time to help elderly patients drink an adequate amount of water. Doctors wrote up water to be given orally on the patients’ drug charts. Wintrup (no pun intended here) suggests that this is not an ethical solution. You might want to reflect on why this is the case.

Interprofessional ethics is an important facet of professional life in the 21st century. It is as relevant in hospital medicine as in primary healthcare. Moral imagination will sometimes allow us to see that different professions may have a perfectly valid reason for not agreeing, and a dose of humility may allow us to accept that sometimes another professional’s moral gaze sees something we do not.

#### Further reading

- Wiles K, Bahal N, Engward H, Papanikitas A, (2016) Ethics in the interface between multidisciplinary teams, *London Journal of Primary Care*, 8:6, 100-104
- Wintrup, J. (2015). The changing landscape of care: does ethics education have a new role to play in health practice. *BMC Medical Ethics* 16(22)

**Note: Professor Deborah Bowman will be back in the next issue of *Insight***

# Addenda

## BOOK CHOICE

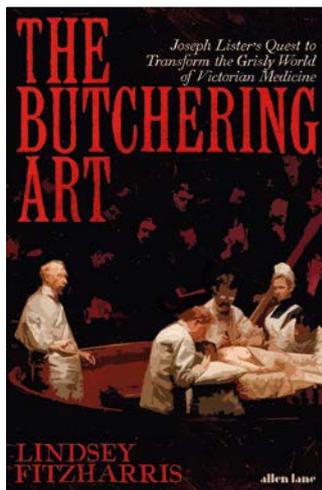
### THE BUTCHERING ART By Lindsey Fitzharris

Allen Lane, hardcover, £11.99, 2017

Review by Dr Greg Dollman, medical adviser, MDDUS

IN one of his regular letters to his father, Joseph Lister wrote: “thou canst hardly conceive what a high degree of enjoyment I am from day to day experiencing in this bloody and butchering department of the healing artist”. Lindsey Fitzharris’ *The Butchering Art* allows a glimpse into the personal and professional life of one of the most influential figures in modern medicine. And her description of “the bloody” and “the butchering” provided me with possibly the same high degree of enjoyment that Lister derived from his scientific art.

Fitzharris chronicles Lister’s journey from an ambivalent medical student (a Quaker, he had considered a life in the ministry) to his appointment as Queen Victoria’s personal surgeon (Lister once quipped: “I’m the only man who has ever stuck a knife into the Queen”) and the multiple honours that were bestowed on him in later years, including a knighthood and presidency of the Royal Society. In between, she describes Lister’s unwavering



pursuit (a different sort of ministry, really) of antiseptics, from London to Edinburgh (and around the world) and back again.

The subtitle of this history is *Joseph Lister’s Quest to Transform the Grisly World of Victorian Medicine*. And grisly it certainly was. The book describes the squalor of the hospitals (surgery may have been seen as lifesaving but hospitals were considered places of death, usually for the poor), brutal and rapid surgical procedures without anaesthesia (Fitzharris relays a possibly apocryphal tale of a surgeon who sliced off his assistant’s fingers during an leg amputation), and the putrid, sawdust covered places of surgery that really were ‘theatres’ (open to the public where matters of life and death were considered entertainment).

Apart from the story of medicine, *The Butchering Art* also provides a fascinating history of life in Victorian Britain, with vignettes about people (including Harvey Leach, “the shortest man in the world” who joined PT Barnum’s Circus), places (such as Crystal Palace and the Old Bailey) and processes (decorum and education).

While Fitzharris’ book is a delight to read, I was disappointed by the seeming overly optimistic portrayal of Lister. The book glosses over the depression and neurosis that appears to have affected this great man. The history only scratches the surface of this fascinating era of medicine, and it left me longing for more.

## OBJECT OBSCURA

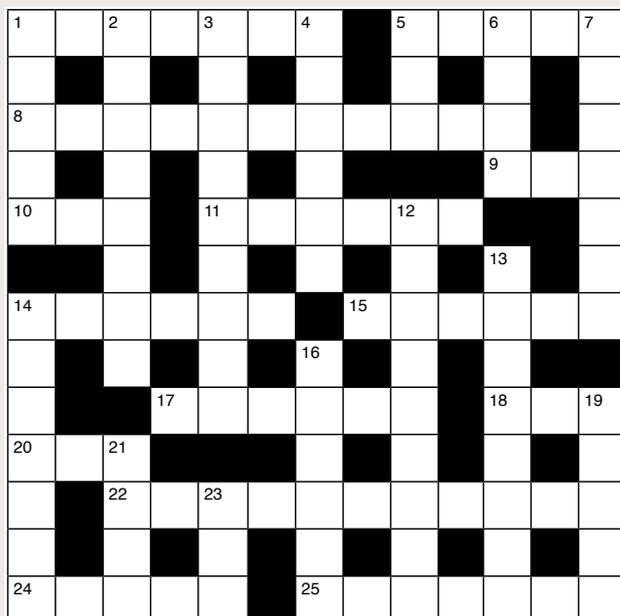
### Wooden prosthetic hand

THIS wooden prosthetic hand with rigid fingers and semi-opposed tenon thumb was made by Steeper nearly 100 years ago. The UK company which was established by Hugh Steeper in 1921 is still making prosthetic hands – though now with advanced ‘myoelectric’ technology.



Photograph: Science & Society

## Crossword



### ACROSS

- 1 Academic (7)
- 5 Spear (5)
- 8 Unable to distinguish between hues (6-5)
- 9 Organ of hearing (3)
- 10 Alkaline phosphatase (abbr.) (3)
- 11 This clue is 11 ... (6)
- 14 Economise (6)
- 15 A great number of (informal) (6)
- 17 A black sheep. Like Veruca Salt in the Wonka plant, perhaps? (3,3)
- 18 Grecian vessel (3)
- 20 Stuck in a ... (3)
- 22 In astrology, the archer (11)
- 24 Distinction (5)
- 25 Deal a hand incorrectly (7)

### DOWN

- 1 Bone at base of spine (5)
- 2 Where choppers land (8)
- 3 Cancer occurring in blood-forming tissue (9)
- 4,12 Scotland and Aston Villa winger (6, 9)
- 5 Hawaiian garland (3)
- 6 Part of plant stem from which leaves emerge (4)
- 7 Imperial ruler (female) (7)
- 13 Used to help prevent tooth decay (8)
- 14 Breastbone (7)
- 16 Wall dividing cavity into two, as in the nose (6)
- 19 Pertaining to the nose (5)
- 21 Person appointed to advise Government (4)
- 23 Gastrointestinal tract (3)

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

## VIGNETTE

# ELSIE MAUD INGLIS (1864-1917)

## PIONEERING PHYSICIAN, SUFFRAGIST AND FOUNDER OF THE SCOTTISH WOMEN'S HOSPITALS MOVEMENT

**A** CENTURY after her death, a memorial was unveiled to Dr Elsie Inglis in the Central Library of her native city, Edinburgh. The words on the plaque are simple, but they were Winston Churchill's who said of her: "She will shine forever in history". This pioneering Scottish doctor is lauded in other countries, but, like many before her, it has taken some time for her to be properly appreciated at home.

There were three overlapping strands to this remarkable doctor's work, each of which informed and influenced the other — her medical career, her support of women's suffrage and her work during the Great War. Any of these would have left a distinctive legacy; together they define her as a formidable force, more than deserving of Churchill's praise.

Inglis' father served with the East India Company and she was born in India while he was stationed there. Her parents were both enlightened and affluent. This afforded her the opportunity of a good private education, coupled with the encouragement to take her studies further. She began her medical education at Sophia Jex-Blake's Edinburgh School of Medicine for Women. This was a stifling environment and Inglis left three years later to join the new Medical College for Women, founded by her father and his friends, doubtless at her request. After qualifying in 1892, she further trained in Glasgow and moved to London to work at Elizabeth Garrett Anderson's New Hospital for Women and to Dublin to work at the Rotunda maternity hospital. She returned to Edinburgh in 1894 and founded a small maternity hospital on the Royal Mile called the Hospice. While running that hospital, she also held a consultant post in Edinburgh at the Bruntsfield Hospital for women.

Although she was active in the local women's suffrage movement in Edinburgh while she was a student, it was while working in London that she was exposed to the leading lights in the movement. From that point, the campaign for universal



Photograph: The Wellcome Collection

suffrage became a major driving force in her life. She deplored violence and took up public speaking on the movement's behalf, and on her return to Edinburgh she was a regular and powerful advocate of the cause. Her first-hand clinical experience of the effects of poverty and her commitment to everything she did allowed her to rise quickly through the ranks of the movement in Scotland.

With the outbreak of war in 1914, Inglis proposed the formation of mobile, all-female staffed medical units to serve on the front lines. Her idea was dismissed out of hand by the War Office. Undeterred, she gathered momentum and financial backing and was instrumental in establishing, through the suffrage movement, the Scottish Women's Hospitals for Foreign Service.

In December 1914, the first of these units was established — a 200-bed Auxiliary Hospital at the Abbaye Royaumont, north of Paris. In the following Spring, Inglis herself took the lead of a unit based in the Balkans. There, she worked particularly to improve hygiene and reduce the

devastating impact of various infectious diseases, including typhus. By the summer of 1915, the organisation was responsible for more than 1,000 beds with 250 staff, including 19 women doctors. However, a major offensive that year led to her unit in Serbia being attacked, and many of the staff including Inglis were taken prisoner. She was released after negotiations and repatriated. While in the UK, she turned her efforts to renewed fundraising and in 1916 returned to the front with a new team to work in Odessa, Russia. By the signing of the armistice in 1918, there would be 14 Scottish Women's Hospitals in France, Serbia, Russia, Salonica and Macedonia.

After only a year in Russia, Inglis was evacuated with her team. She died the day after arriving home from Russia on 26 November, most probably from the cancer she had been suffering for the past year. Her funeral was held in St Giles Cathedral and was reported to be an "occasion of an impressive public tribute". Her work, however, carried on. The Scottish Women's Hospitals continued its work into the 1920s, and in 1925 its surplus funds were used to found the Elsie Inglis Memorial Maternity Hospital in Edinburgh. This small institution was for six decades affectionately known as "Elsie's" but closed in 1988.

Today there are streets in Serbia named after Elsie Inglis, the British Embassy residence in Belgrade is named in her honour and she has been commemorated on stamps and banknotes. And now she has a plaque in a library in Edinburgh, where appropriately her name is joined by the 14 other women who died as a consequence of their work on the Scottish Women's Hospitals.

Dr Allan Gaw is a writer and educator in Glasgow

### Sources

- McLaren ES. *Elsie Inglis: the woman with the torch*. Macmillan Co, New York, 1920.
- National Archives <http://discovery.nationalarchives.gov.uk/>
- *Edinburgh Evening News*. November 7, 2017.

# Dental **risk** toolbox

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 Dentists and practice managers can review key risk areas within their practice using the new Dental risk toolbox.

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