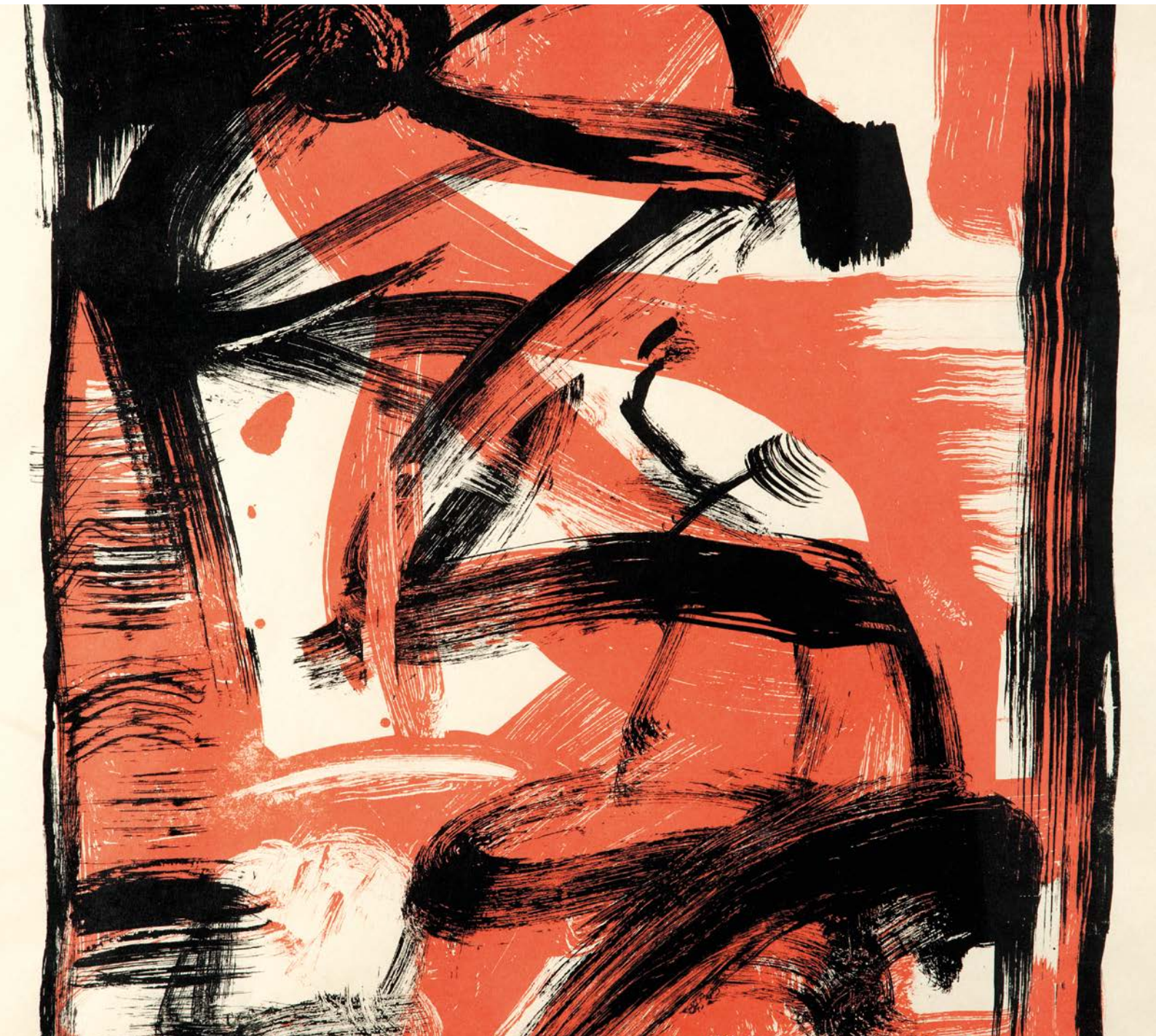


QUARTER THREE / 2018

INSIGHT



A QUARTERLY PUBLICATION FOR MEMBERS



WOUNDED HEALER

Dr Clare Gerada discusses the mental impact of patient complaints on doctors

A NASTY SURPRISE

The curious tale of the snail behind a landmark legal decision on 'duty of care'

TOOTH WEAR

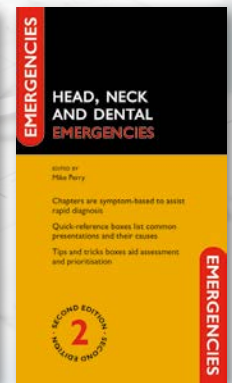
Prevention is preferable to treatment - but what are the clinical risks?

REALITY TV RISKS

What to consider when a media producer comes calling

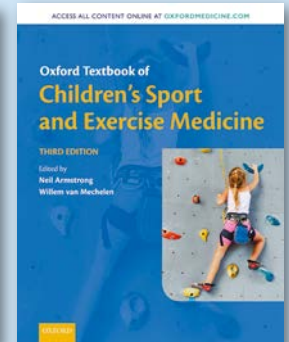
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Rush (detail), Corey Reid

Woodcut print, 2016

Corey Reid graduated from Duncan of Jordanstone College of Art and Design in 2015. He has been exploring the art of Japanese woodcuts, and his work adopts traditional techniques to create contemporary pieces.

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

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EDITOR

Dr Barry Parker

COMPLAINTS are an inevitable part of providing a public service, and in medicine and dentistry there are guidelines and defined processes to follow when they arise. Health professionals are expected to provide a calm, rational and reflective response, using a complaint as an opportunity to learn and develop. An important part of our role as a defence organisation is to help practitioners navigate these complaint processes and support them with the emotional turmoil that can accompany a complaint, including anxiety, frustration and despondency.

Sadly, in the case of more serious or protracted complaints, there can be a significant impact on the practitioner's health. On page 10, Dr Clare Gerada, GP and Medical Director of the

NHS Practitioner Health Programme, provides her perspective on this challenging and important issue.

Tooth wear is increasing in the UK – and there are myriad causes, from the effects of drinking too much fruit juice to bruxism to eating disorders such as bulimia. This can make identification and management particularly tricky,

with specialist care within and beyond dentistry sometimes necessary. On page 14, Professor Andrew Eder offers an expert view.

"Duty of care" is fundamental in establishing clinical negligence, and its origin in UK law can be traced to an obscure case involving a bottle of 'ginger beer' and a dead snail. Dr Allan Gaw relates the tale on page 12. Our Briefing column on page 8 looks at a promised digital revolution in primary care and the Risk topic opposite (p. 9) concerns clinicians engaging with media producers – be it TV, radio or online. Our Dilemma on page 20 looks at a scenario involving a police request to access practice CCTV footage in order to investigate a crime.

We are also pleased to welcome back Professor Deborah Bowman with her regular Ethics column on page 21. Here she looks at the curious "doubling" – or "simultaneous yearning for the contradictory" – that can occur when dealing with illness.

Dr Barry Parker

"Part of our role as a defence organisation is to help practitioners navigate these complaint processes"

MDDUS News

MDDUS reports significant growth

MDDUS has reported another year of growth, with significant increases in GP, hospital doctor and dental membership.

Figures from the *MDDUS Annual Report and Accounts 2017* reveal a year-on-year increase of 13.7 per cent in total membership. This upward trend has continued in 2018 with active membership at the end of June standing at over 47,000.

Overall GP membership rose by 13.9 per cent in 2017, with those practising outside Scotland making up 73 per cent of the total, reflecting our expertise across the UK. As of June this year, MDDUS now has just shy of 20,000 GP members in total. There was an increase of 11.9 per cent among hospital doctors.

Dental membership increased by 30 per cent in England, Wales and Northern Ireland in 2017. MDDUS now has more than 7,000 dental members and a fifth of the UK market share (two-thirds in Scotland).

MDDUS chief executive Chris Kenny said: "Increasing numbers of doctors and dentists are putting their trust in our professionalism, responsiveness and value. Our membership growth has shown no signs of letting up and we now offer our indemnity and non-claims services to more people than ever before and across a wider range of professions.

"With the twin uncertainties of the discount rate and state-backed indemnity casting big shadows over MDDUS in 2017, we have responded robustly in the interests of our members. We have invested a lot of time and energy speaking to politicians and officials at every level in Westminster and across all the devolved administrations to ensure that our members' interests are fully understood.

"We have also moved to adapt and develop the services we offer in response to market demand, but we remain focused on our core business of supporting, advising and defending our members."



MDDUS addresses "safe space" recommendations

MDDUS has welcomed an influential call for the Government to reconsider allowing NHS trusts and foundation trusts to conduct internal "safe space" investigations.

A government committee has published its findings on plans to establish the Health Service Safety Investigations Body and stated that while safe spaces where medical professionals can reflect on incidents were an essential part of investigations, allowing trusts and foundations to run their own was not a good idea. The Joint Committee on the Draft Health Service Safety Investigations Bill today said that internal safe space investigations were "misconceived". This was one of the main messages

that MDDUS had made in its written submission to the HSSI Bill.

Joint Head of Medical Division John Holden said: "We are pleased to see that the Joint Committee has agreed with our submission that whilst the public may have confidence in trusts carrying out their own 'safe space' investigations, such confidence is less likely to be shared by health professionals.

"Health professionals are unlikely to be reassured by the prospect of investigations being conducted by trusts in situations where resourcing or workload or other systemic issues within the control of the trust may be factors which have had a bearing on the patient safety issues under investigation.

"It is essential that the new body is seen to be completely independent of existing healthcare structures and organisations and we are pleased to see that being recognised by the Joint Committee."



Guidance on gross negligence manslaughter

A POLICY review has called for the establishment of a working group to set out a “clear explanatory statement” of the law on gross negligence manslaughter.

This is one of the key recommendations of the “rapid” review commissioned by former Secretary of State for Health and Social Care Jeremy Hunt and chaired by Professor Sir Norman Williams.

The Williams review was set up in light of the Bawa-Garba case to consider the wider patient safety impact resulting from concerns among healthcare professionals that medical errors could result in prosecution for gross negligence manslaughter, even if occurring in the context of broader system failings.

Of particular concern was the fear that healthcare professionals might be reticent if involved in an untoward event and thus reluctant to engage in reflective practice, which is considered vital to learning and improving patient care.

The review recommends that all relevant organisations should produce updated guidance on gross negligence manslaughter to promote a consistent understanding of where the threshold for prosecution lies.

Among further recommendations the review calls for the Professional Standards Authority (PSA) to retain its right to appeal fitness to practise panel decisions to the High Court on the grounds of insufficient public protection but that the duplicate power provided to the GMC to appeal decisions of the Medical Practitioners Tribunal Service (MPTS) should be removed. It believes this will “ensure a consistent approach to appeals across healthcare professions that are statutorily regulated”.

MDDUS has expressed broad support for the findings of the policy review. CEO Chris Kenny said: “We agree the need for high standards and current relevant clinical experience for expert witnesses and welcome the proposed clarification on not using reflective material for fitness to practise (FtP) investigations, unless, of course, the practitioner feels it is relevant. The proposals to ensure greater understanding of the law and more consistency in policy and coronal actions are also welcome.

“We welcome the decision to remove double jeopardy on appeals. Evidence shows that the PSA has used its powers more selectively and proportionately than

the GMC. We also support the opinion that conviction cases should not be decided without the opportunity for a fair hearing.

“Finally, doctors require legal support in FtP hearings as much as the GMC and MPTS need properly defended registrants to help guarantee just outcomes. The creation of state-backed indemnity for GPs may jeopardise this pursuit of justice. Therefore, as part of wider reform, the GMC should make clear that doctors need cover for non-claims matters as well as compensation for claims.”

Dr Brendan Sweeney retires as MDDUS Chairman

THE MDDUS AGM in September will see the retirement of the current Chairman of the Board – Dr Brendan Sweeney. “Benny” was first appointed as a non-executive director to the MDDUS Board in 1997 and took on the position of Chairman in 2012.

Benny (pictured below) spent 35 years as a GP partner in the same practice in south-west Glasgow before retiring from clinical medicine in 2010. He retains a lifelong interest in the training of GPs and also served as chairman of the Committee on Medical Ethics of the RCGP for seven years. In 2002 he was awarded an MBE for services to medical ethics.

He said: “I have many happy memories of my time at MDDUS and step down safe in the knowledge that my successor, Dr Jonathan Berry, brings a wealth of experience and very safe hands, ready to steer MDDUS through the opportunities and challenges of the next few years.”

MDDUS Chief Executive Chris Kenny commented: “Benny has been a pillar of both professional and personal support to me since I took up the role of Chief Executive in 2015, and I have always found him to be approachable, knowledgeable and affable. I wish him well for the future and thank him for his wise counsel and effective chairmanship of the Board through challenging and exciting times.”

Our next Chairman, Dr Jonathan Berry, first joined the MDDUS Board in 2007 and most recently served as Vice-Chairman and also Chairman of the Investment Committee. Jonathan is a retired GP partner and former Chairman of Trafford South PCG, among other leadership roles in primary care. He was recently appointed as a non-executive director to North West Boroughs Healthcare NHS Foundation Trust.



MANAGE YOUR MEMBERSHIP ONLINE

YOUR MDDUS online membership portal just got a whole lot better! Make credit and debit card payments, change direct debit details and update subscription levels using our improved full-service online membership interface which is available 24 hours a day. MDDUS members using the portal can also download and print membership certificates, copies of renewal notices and online CPD, and also update address and other details. Go to Log in at mddus.com to register.

GP RISK TRAINING DAY

JOIN us for an interactive risk training day focused on key areas such as complaints handling, patient communication, chaperones and social media. Time will also be spent examining key areas of risk in confidentiality and the General Data Protection Regulation (GDPR). London office: 23 October, 09:30 – 16:30. Glasgow office: Date: 27 November, 09:30 – 16:30. For more information or to book a place email risk@mddus.com

DISCOUNTED INDEMNITY FOR OCCUPATIONAL MEDICINE

MDDUS is pleased to announce a new partnership with the Society of Occupational Medicine (SOM) to provide cost effective indemnity membership benefits for doctors working in occupational medicine. Benefit from a five per cent discount on indemnity with membership of both organisations. Email ajkhan@mddus.com or call 078505 07780 to find out more about this offer.

NHS litigation costs continue to rise

THE cost of medical negligence claims to the NHS in England continues to rise despite a reduction in formal litigation as more claims are mediated.

NHS Resolution reports that the number of new clinical negligence claims in 2017/18 fell by 0.12 per cent (13 claims) but that the NHS paid out more than £1.63 billion in damages to claimants, an increase from £1.08 billion in 2016/17. Over £400 million of the increase was due to the change in the personal injury discount rate (PIDR) from 2.5 to minus 0.75 per cent.

Legal costs fell (by £31.8 million) for the first time in many years as NHS Resolution implemented the first year of its five-year strategy.

Helen Vernon, NHS Resolution chief executive, said: "The growing interest both from our NHS members and those who act for injured patients in working together to resolve claims for compensation without going to court has been very encouraging and we hope to build on this so that mediation is no longer seen as novel in healthcare.

"However, the cost of clinical negligence is at an all-time high. The total provisions for all of our indemnity schemes continue to rise from £65 billion last year to £77 billion as of 31 March 2018 which brings a renewed urgency to efforts across government to tackle the drivers of that cost."

Dental prevention pilot proves successful

A SCHEME for prevention-focused dental care piloted in 73 practices in England has led to "reduced or maintained levels" of tooth decay in 90 per cent of patients, according to a government evaluation.

The new system incentivises dentists to offer full oral health assessments and self-care plans on top of traditional treatments. In the first year of piloting the new approach, dentists also reported that 80 per cent of patients had reduced or maintained levels of gum disease and 97 per cent were satisfied with the dental care they received.

The Department of Health and Social Care has decided now to extend the pilot to a further 50 practices in England and it is hoped that, if proven successful, the scheme could be rolled out nationally from April 2020.

However, the BDA has called on ministers to be honest that their stated goals to maintain access and embed prevention in NHS dentistry cannot be achieved on a slashed NHS dental primary care budget. BDA Chair of General Dental Practice Henrik Overgaard-



England to implement opt-out organ donation

AN opt-out organ donation scheme is expected to come into effect in England in the spring of 2020.

The government has outlined plans to implement a new system of consent for organ and tissue donation in which everyone is considered an organ donor unless they have explicitly recorded a wish not to be, or are from one of three excluded groups. These include children under 18, individuals who lack the mental capacity to understand the changes and people who have not lived in England for at least 12 months before their death.

A 12-month transition period will allow time for discussion with friends and family about organ donation preferences. Patients will be able to opt out from the NHS Organ Donor Register either via the NHS Blood and Transplant website or by calling a helpline. The new NHS app expected to be launched at the end of this year will also allow patients to record their decision.

Jackie Doyle-Price, Parliamentary Under Secretary of State for Mental Health and Inequalities, said: "We believe that by making these changes, we can save as many as 700 more lives every year."

Nielsen said: "It's good to see wider testing of the prototypes, but when the one variable ministers won't change is funding cuts, we are unlikely to see progress."

Mixed review for NHS in global comparison

A GLOBAL comparison of healthcare systems has found that the NHS performs worse than average in the treatment of eight out of the 12 most common causes of death – but provides unusually good financial protection to the public from the consequences of ill health.

The independent report – *How good is the NHS?* – looked at three aspects of what constitutes a good healthcare system, comparing the UK to 18 similar developed countries, including France, Germany, Italy, Japan and the USA.

It found that the NHS performs worse than average in the treatment of eight out of the 12 most common causes of death, including deaths within 30 days of having a heart attack and within five years of being diagnosed with

breast cancer, rectal cancer, colon cancer, pancreatic cancer and lung cancer.

The NHS is also the third poorest performer in the overall rate at which people die when successful medical care could have saved their lives (known as 'amenable mortality'). It has a lower than average number of staff for all professional groups except midwives: one doctor for every 356 people compared to one for every 277 people on average across the comparator countries.

But the NHS does provide unusually good financial protection to the public from the consequences of ill health. For example, it has the lowest proportion of people who skipped medicine due to cost: 2.3 per cent in 2016 compared to an average of 7.2 per cent across the comparator countries.

Commenting on the report, Nigel Edwards, Chief Executive of the Nuffield Trust, said: "Discussion about the NHS is often marked by an unhelpful degree of exaggeration, from those that claim it is the envy of the world to those who say it is inferior to other systems.

"The reality is a much more mixed picture, but one thing is clear: we run a health system with very scarce resources in terms of staff

and equipment and achieve poor outcomes in some vital areas like cancer survival.”

Call for stricter rules on online drug sales

TOUGHER safeguards are needed to protect people buying medicines online, including a ban on the sale of drugs such as antibiotics and opiates, the General Pharmaceutical Council (GPhC) has warned.

The regulator said it is concerned that it can be “too easy” to purchase drugs on the internet that are not clinically appropriate. It has published a consultation paper calling for stricter guidance for UK-based online pharmacies. Among the proposals is a ban on online sales of medicines such as opiates, antibiotics, asthma inhalers and Botox without first contacting the patient’s GP.

A recent BBC *Panorama* investigation also highlighted the online sale of prescription-only medications to potentially vulnerable patients, and The Care Quality Commission (CQC) has advised patients to use only CQC-registered sites.

GPhC chief executive Duncan Rudkin said: “Medicines are not ordinary items of commerce, and must not be treated as such.”

Mandatory recovery period for trainees

JUNIOR doctors in Scotland are to be given a mandatory 46-hour recovery period after a run of night shifts before they can return to work.

The move will take effect by August 2019 and is the result of ongoing discussions between the BMA, Scottish Government and NHS boards. Fatigue has been linked to the deaths of a number of junior doctors in recent years. An inquest into the 2015

death of Suffolk doctor Ronak Patel found he had crashed his car after falling asleep at the wheel while driving home from a third consecutive nightshift.

Chair of BMA Scotland’s Junior Doctors Committee Dr Adam Collins said the recovery period would make a “tangible difference” to the working lives of trainees.

He said: “Evidence shows that moving from night shifts to day shifts is one of the biggest causes of exhaustion we face in our working patterns. Fatigue is a risk to junior doctors and a risk to our patients”.

Lower death rates with continuity of care

A NEW study looking at continuity of care has concluded that patients who see the same doctor over time have lower death rates.

Researchers analysed the results of 22 “high quality” studies with varying time frames from nine countries and found that – in 18 (82 per cent) – there were statistically significant reductions in mortality with increased continuity of care. The effect applied across different cultures and was true for family doctors as well as for specialists, including psychiatrists and surgeons.

The study published in *BMJ Open* was a collaboration between St Leonard’s Practice in Exeter and the University of Exeter Medical School. Professor Philip Evans commented: “Continuity of care happens when a patient and a doctor see each other repeatedly and get to know each other. This leads to better communication, patient satisfaction, adherence to medical advice and much lower use of hospital services.

“As medical technology and new treatments dominate the medical news, the human aspect of medical practice has been neglected. Our study shows it is potentially life-saving and should be prioritised.”



NEW DENTAL AMALGAM RESTRICTIONS

NEW regulations on the use of dental amalgam in treatment came into effect on 1 July. UK law now states that dental amalgam should not be used in the treatment of deciduous teeth in children under 15 years old and in pregnant or breastfeeding women. Access implementation advice and supporting tools at tinyurl.com/y7yhgx4u

HOMEOPATHY CHALLENGE REJECTED BY HIGH COURT

A LEGAL challenge by the British Homeopathic Association to overturn plans to no longer routinely fund homeopathy on the NHS has been rejected by the High Court. NHS chief Simon Stevens has welcomed the decision on measures adopted to curb prescriptions for medicines that can be bought over the counter or are of low value. Stevens said: “There is no robust evidence to support homeopathy which is at best a placebo and a misuse of scarce NHS funds”.

GMC REDUCES ARFs

REGISTERED doctors with an annual retention fee (ARF) date of 1 April or later will pay a reduced fee of £390 instead of £425 this year. Newly qualified doctors will receive a fixed-term discount, and those with an annual income less than £32,000 can also apply for a discount. Full details are available www.gmc-uk.org.



FAST FORWARD

Jim Killgore

Managing editor of MDDUS *Insight* magazine

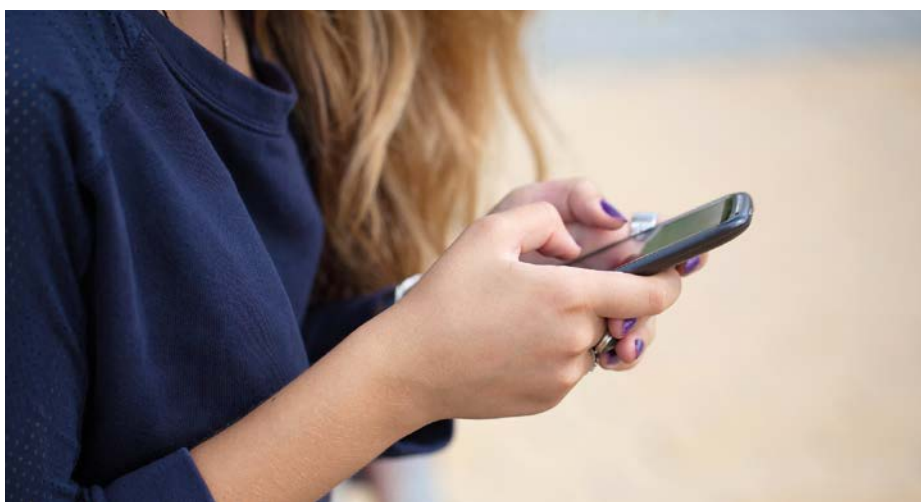
THE NHS does not have the best track record for delivering on large-scale digital projects – just consider the 2016 decision to finally abandon the care.data programme, having already cost the UK taxpayer in the region of £7.5 million. So it was no doubt with some trepidation that the Government recently announced the launch of a free NHS app allowing patients in England to access their GP record and book appointments, among other services.

Former Health and Social Care Secretary Jeremy Hunt said: "Technology has transformed everyday life when it comes to banking, travel and shopping. Health matters much more to all of us, and the prize of that same digital revolution in healthcare isn't just convenience but lives improved, extended and saved."

The Government has high hopes that technological development will help address a host of growing healthcare challenges, including ever-increasing patient demand in an era of funding and workforce shortages. This was made even clearer in the recent cabinet reshuffle which saw the appointment of Matt Hancock as the new Health and Social Care Secretary – a self-proclaimed tech evangelist who has promised investment of over £487m in developing "revolutionary" technologies in the NHS.

Mr Hancock said: "I came from a tech background before I went into politics, and I love using modern technology myself. Not only do I have my own app for communicating with my constituents here in West Suffolk, but as you may have heard I use an app for my GP."

So it was he stepped instantly into his first controversy – the app referred to being GP at Hand, developed by the digital healthcare firm Babylon. GP at Hand is provided through a London practice to registered patients but is also available to out-of-area patients who are required to move from their existing practice. The app, which is accessible via smartphone and other devices, incorporates a triage system based on digital algorithms, offering patients healthcare advice or the option to book a video consultation with a GP 24/7 – usually within two hours. Patients needing a face-to-face consultation have a choice of clinics in the London area.



The service restricts registrations from some patients with complex needs or those with some long-term conditions. This prompted the Royal College of General Practitioners to accuse Babylon of "cherry-picking" younger, healthier patients, leaving traditional GP services to deal with more complex cases and without sufficient resources.

RCGP Chair Professor Helen Stokes-Lampard, speaking at a King's Fund conference in London, called GP at Hand "disruptive innovation at its most disruptive at the moment" but also "phenomenal technology" that the NHS would do well to learn from.

"New technology needs to be expanded," she said. "We need equitable access to innovation technology across the NHS."

Babylon is certainly confident in the power of its AI technology, recently claiming it outperforms average candidates in MRCGP assessments. In tests using elements from both the AKT and CSA exams relating to diagnostics the AI system achieved a score of 81 per cent on its first attempt, according to Babylon's medical director Dr Mobasher Butt. The average pass mark for both exams was 72 per cent over a five-year period.

Another test involved 100 scenarios or 'vignettes' in which the AI system was tested against 12 experienced GPs with no connection to Babylon. The correct diagnosis rate for the doctors averaged 80 per cent, which Babylon's AI system equalled. Assessed

against conditions seen most often in primary care, diagnostic accuracy among the GPs ranged from 52 per cent to 99 per cent and Babylon's AI accuracy was 98 per cent.

RCGP vice chair Professor Martin Marshall commented on the findings: "The potential of technology to support doctors to deliver the best possible patient care is fantastic, but at the end of the day, computers are computers, and GPs are highly-trained medical professionals: the two can't be compared and the former may support but will never replace the latter."

"An app might be able to pass an automated clinical knowledge test but the answer to a clinical scenario isn't always cut and dried, there are many factors to take into account, a great deal of risk to manage, and the emotional impact a diagnosis might have on a patient to consider."

One point on which there appears to be a clear consensus is the need for digital health products to meet the same rigorous standards of evidence expected of traditional medical products. Recently the Government commissioned an independent technology review as part of an NHS workforce development strategy. It is being led by cardiologist and digital medicine researcher, Dr Eric Topol.

He recently told the *Health Service Journal* that in regard to digital innovation: "There should be no exceptionalism."

"The priority is getting the evidence base before going forward, putting in the resources to nail it. It's so important."

IS REALITY TV TOO RISKY?

Dr Gail Gilmartin

Medical and risk adviser at MDDUS

FEW would argue that electronic media – be it broadcast or online, via websites or apps – is not now an integral part of everyday life: some would say essential. It offers a seemingly unlimited

source of engaging material on a vast range of subjects from the serious and factual to the downright banal or sometimes offensive. Growth in this area has been enormous over the last few decades, reaching into every aspect of our lives, both personal and professional.

Popular medical websites and TV programmes have always proved gripping to the public and there doesn't appear to be any decline in appetite. MDDUS regularly receives calls from members seeking advice about engaging with media producers and these types of calls are on the rise.

Common scenarios which raise questions from members include:

- Requests to participate in online channels with real-time comments on popular TV programmes. Producers often are just looking for a personal view but in the context of being a medical/dental professional.
- Contributing to online blogs or publications which are not directly related to professional practice but which would state your professional qualifications (which are no doubt seen as a good selling point).
- Patients with complex histories who agree to be 'followed' for a documentary. They want the doctors involved in their care (both primary and secondary care) to speak to the producers about participating in the programme, including being filmed whilst consulting and later interviewed about the patient's condition.
- Requests from friends to add some clinical content to their blog about a particular medical condition.
- A TV company asking a dental practice if they would be agreeable to participating in a 'fly-on-the-wall' documentary.

Medical and dental professionals are not forbidden to take part in any of these activities but it is essential to remember that anything you do is judged against professional standards. For medical professionals, the relevant standards set out in *Good Medical Practice* must be

applied. Remember that the GMC places great emphasis on maintaining public confidence in the profession and takes seriously any doctor's activities which could bring the profession into disrepute.

In this regard the GMC, in its guidance *Maintaining a professional boundary between you and your patient*, advises: "You must consider the potential risks involved in using social media and the impact that inappropriate use could have on your patients' trust in you and society's trust in the medical profession. Social media can blur the boundaries between a doctor's personal and professional lives and may change the nature of the relationship between a doctor and a patient. You must follow our guidance on the use of social media."

Similarly the GDC advises in *Standards for the Dental Team*: "You must ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession.

"You should not publish anything that could affect patients' and the public's confidence in you, or the dental profession, in any public media, unless this is done as part of raising a concern.

"Public media includes social networking sites, blogs and other social media. In particular, you must not make personal, inaccurate or derogatory comments about patients or colleagues."

Where patients are directly involved, their informed, documented consent is essential. If anonymised data is used or filming occurs in a medical setting, remember that inadvertent breaches of confidentiality can and do occur. We all remember the high-profile blunder when Jeremy Hunt was photographed standing in front of a board of named patients while visiting a maternity unit. MDDUS has this responsibility when filming our own drama series, *Bleak Practice*.

Also remember to check with your employers or contracting body to ensure that you comply with their requirements. The GMC provides specific guidance on *Making and using visual and audio recordings of patients*, which covers areas such as checking the agreement of your contracting or employing body, informed consent in line with the Ofcom Broadcasting Code and special considerations for vulnerable patients.

ACTION POINTS

- Think carefully before agreeing to take part in broadcast/social media.
- Check the details of any proposal carefully and ensure that the activity complies with guidance from your regulator.
- Ensure you also check with your employer before agreeing to participate.
- Seek advice from MDDUS if in doubt, particularly with regard to indemnity.

"It is essential to remember that anything you do is judged against professional standards"



In today's NHS, patients are encouraged to complain about the service they get from their doctor when they are dissatisfied and, not surprisingly, the number of complaints received by the NHS is reported to have increased by five per cent in the last year alone.¹ Patients seem to be more demanding than ever of their 'wants', which can often be in conflict with their 'needs', and the doctor has precious little time (or emotional energy) to explain why, for example, a referral for a gastroscopy is not the right investigation, or another MRI scan will not find the cause of their unexplained pain.

Whilst complaints might be difficult for patients to make, they can also be very hard for doctors to accept. Complaints therefore have two victims: the complainant and the doctor. The complainant in each case has a tried and tested framework which all parties (managers, clinicians, system) have to follow (in terms of time for response, who responds, what the response should contain and so on). The doctor about whom the complaint is received has no such framework. They are instead left to the vagaries of their employer or organisation, adding anxiety to an already anxious situation.

Sometimes the doctor is very much kept in the dark. A complaint can take months or even years to pass through the various processes, leaving the doctor caught in the middle of a confusing matrix of fear, uncertainty and anxiety. For more serious complaints, delays are inevitable – time is needed to prepare a response, gather information, seek expert views and so on. But the anxiety caused by the time taken for resolution adds to the emotional toll on the doctor.

'IT FEELS PERSONAL'

Many doctors (who, after all, are perfectionists) may feel a complaint to be personal, an attack on their core sense of self and on their vocational values. A doctor's response to a complaint is often similar to the stages of bereavement and it can be deeply painful, both physically and emotionally. Doctors have described receiving a complaint as similar to receiving a diagnosis of a terminal disease. Others have said that the complaint is felt with such force that they literally feel a heavy weight on their chest wall, or tightness in their throat.

Following shock there is a stage of denial ("this can't be happening to me"), often closely followed by anger, shame, fear and, in fact, a host of terrible and probably unfamiliar emotions. Most doctors experience a sense of isolation – erroneously feeling that they are the only ones who have ever had a complaint. After these stages, resolution hopefully follows, made easier if the complaint is handled professionally and where there is support by a medical defence organisation, family or colleagues.

For some, though, there is a prolonged grieving phase, especially so if the complaint is not addressed kindly, compassionately and in a timely manner, and if the complaint is escalated through regulatory or disciplinary processes, or as so often happens, both. Research by Bourne et al² has shown that a complaint increases the

chances of further defensive action, depression, anxiety, suicidal thoughts and sadly even suicide. They found that doctors who have had a complaint are 77 per cent more likely to suffer from moderate to severe depression than those who had never had a complaint.

In 2012, the GMC found that there were high rates of suicide among doctors going through their processes³, and whilst correlation does not mean causation, their findings must nevertheless be taken seriously. At the NHS Practitioner Health Service (PHP), a service I run for doctors and dentists with mental illness, we found that of those doctors who had died, the majority were involved with GMC issues. Amongst living PHP patients, the GMC is involved in around 10 per cent of cases, compared to 11 out of 21 (52 per cent) of patients who have died and nine out of 16 (56 per cent) of the patients who died from accidents, suicide or overdoses.

DO NOTHING...IMMEDIATELY

What should you do when a complaint lands on your desk? First and foremost, do nothing. Do not respond, do not fire off an email or write a letter to the patient, even if pressurised by your employer/trainer or colleague. Do not rant and rave (not publicly anyway). If you can, take the rest of the day off. If not, organise to meet someone you trust, soon. There are deadlines to meet, processes to follow but they can wait till tomorrow or next week.

Nothing need be done on the day of the complaint. Everything can wait until the first waves of shock have passed. Following on from this, speak to someone. A complaint (especially if potentially serious) will leave you shocked. Try not to be alone. A problem shared really is a problem halved, and at the very least will help add balance to the complaint as well as practical help in how to deal with it.

Talking allows for perspective. Complaints are common. Most complaints are handled informally and even those which are not have good outcomes. Whilst complaints hurt, they do get resolved (even if the resolution is not entirely to your satisfaction). At the earliest opportunity, contact your medical defence organisation (even if the complaint is trivial), talk to colleagues, your family, practice manager, support group, the practitioner health service, the BMA doctors' support service and/or local medical committee representative (if you are a GP). Do not suffer in silence.

Finally, try not to take the complaint personally. A complaint does not mean you are a bad doctor. It does not negate all the good work you have done in your life. It does not make you a bad person. Remember, each one of us at some point in our career has had at least one complaint, and some of us many more. This is more about the system we are working in rather than any personal failing on the individual.

Dr Clare Gerada is a GP and former Chair of the Royal College of General Practitioners. She is also medical director at the NHS Practitioner Health Programme

Dr Clare Gerada of the NHS Practitioner Health Programme highlights the sometimes devastating impact of patient complaints on the mental wellbeing of doctors

WOUNDED



“A complaint does not mean you are a bad doctor. It does not negate all the good work you have done in your life”

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2. Bourne T, et al. The impact of complaints procedures on the welfare, health and clinical practice of doctors. *BMJ Open* 2015 (tinyurl.com/yc571za2)

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INTERNATIONAL PRACTITIONER HEALTH SUMMIT



Photograph: Alamy

THE WOUNDED HEALER – The NHS Practitioner Health Programme will be holding a conference exploring the impact of complaints and other aspects of physician and practitioner health, with a particular focus on mental health. The International Practitioner Health Summit 2018: The Wounded Healer will be held on 4 and 5 of October 2018, at the Royal College of General Practitioners in London.

Sir Simon Wessely, President of The Royal Society of Medicine, will join Professor Clare Gerada (pictured) and speakers including NHS chief executive Simon Stevens, best-selling author and neurosurgeon Mr Henry Marsh, Dr Abigail Zuger of Icahn School of Medicine in New York, writer, comedian and former junior doctor, Adam Kay and others. Find out more and book a place at www.healthcareconferencesuk.co.uk/practitioner-health-summit

HEALER

Dr Allan Gaw explores the curious legal origin of "duty of care" in the context of clinical negligence

A NASTY

PAISLEY may be known for its patterns and its shawls, but this town to the west of Glasgow has another claim to fame, at least for those interested in the law. It was here, 90 years ago, that one of the most important legal decisions in history, and one that still has implications for clinical practice today, had its origins.

A COOL GINGER BEER

On the summer evening of 26 August 1928, Mrs May Donoghue, a shop assistant from the East End of Glasgow, took a tram ride to Paisley. There she met a friend at the Wellmeadow Café and they decided to quench their thirst. Her friend bought the refreshments and Mrs Donoghue was served a glass containing ice cream over which the waiter poured a portion of a bottle of ginger beer to make an iced drink, or float. After Mrs Donoghue drank some, her friend added more ginger beer from the dark glass bottle that had been left on the table. As she poured, Mrs Donoghue noticed something fall into the glass, which she recognised as a decomposing snail. Understandably, she immediately felt sick and became "shocked and ill".

Mrs Donoghue was clearly affected by the event and sought medical treatment three days later from her own doctor, and again three weeks later in mid-September at Glasgow Royal Infirmary.

LEGAL CASE

Because it was her friend who had purchased the ginger beer, Mrs Donoghue had no contractual relationship with the café owner. She would later learn that the only party she might sue would be the manufacturer of the drink, David Stevenson, whose name was clearly written on the dark glass bottle in large white lettering. Moreover, she would have to prove negligence on his part if she was to recover any damages, and that claim of negligence would require there to be a duty of care between her and Stevenson.

The law at the time supported the existence of a duty of care to people harmed by the negligent acts of others, but only in very limited circumstances. These would include instances where a contract existed between the parties, if the

manufacturer was acting fraudulently or if the product was inherently dangerous. In Mrs Donoghue's case, none of these applied, but she was determined to seek such damages and engaged the Glasgow solicitor Walter Leechman.

Interestingly, Leechman's firm had represented the unsuccessful pursuers in two recent similar "mouse in ginger beer" cases. It seems more than a coincidence that of all the lawyers Mrs Donoghue might have consulted, the one she chose had both the experience and the resolve to pursue such a case. Quite how she found him, or was directed to him, remains a mystery.

Leechman issued a writ against Stevenson claiming damages of £500 plus costs and noting that "snails and the slimy trails of snails were frequently found" in the factory where his ginger beer was manufactured and bottled. Stevenson's counsel moved the Court of Session to dismiss the claim and were eventually successful. Leechman then began the process of appealing the decision to the House of Lords. However, Mrs Donoghue had no money. Not only had she to declare herself in writing as a pauper so she could be absolved of the need to post security to cover any costs if her appeal was unsuccessful, but her counsel had to proceed in representing her without any guarantee of payment.

NEIGHBOUR PRINCIPLE

On 10 December 1931, five Law Lords met to hear the first of two days' arguments in Mrs Donoghue's case. Some five months later they delivered their judgement and by a majority of three to two they agreed she did have a case. Mrs Donoghue, they ruled, was owed a duty of care by the manufacturer and bottler of the ginger beer and she could bring an action against him. This duty of care was founded on the "neighbour principle", eloquently expounded by one of the Law Lords, Lord Atkin. He summarised this principle in the ruling as follows:

"The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer's question, Who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law, is my neighbour? The answer seems to be—persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question."

The "lawyer's question" referred to was the one asked of Jesus in Luke's Gospel, and which prompted Christ to tell the parable of the Good Samaritan. Indeed, Lord Atkin's ruling was firmly based on his reading of Judeo-Christian scripture.

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"Today, there is... a bench and a memorial stone at the corner of Well Street and Lady Lane where the café once stood"

SURPRISE

DUTY OF CARE TODAY

The importance of this ruling lay in its implications for our understanding of negligence. Three criteria in law must be met for there to be medical negligence. First, a doctor must owe a duty of care to the patient in question. Second, there must be a breach of that duty of care. And third, the breach must result in harm to the patient. Thus, the concept of “duty of care” is central to our understanding of negligence, and it may be defined as an obligation we hold to take care to prevent harm being suffered by others. In defining to whom we owe this duty of care as our “neighbour”, Lord Atkin created a new basis for the law of negligence, and of course his wide definition of neighbour would certainly include any doctor’s patient.

Not long after the House of Lords had ruled that Mrs Donoghue would be entitled to recover damages if she could prove what she alleged regarding the snail, David Stevenson died. His executors agreed an out of court settlement of £200 (almost £10,000 today) and as such the case never went to trial. May Donoghue died in 1958, perhaps unaware of the global impact that summer evening trip to Paisley had had some 30 years earlier.

Today, in Paisley you will find a small park, a bench and a memorial stone at the corner of Well Street and Lady Lane where the café once stood. Most locals know little of its significance, but occasionally you will see a stranger standing reading the inscription on the stone. Often they will be lawyers, sometimes doctors, who have made the pilgrimage from England or North America or from even further afield, just so they can stand on the spot where duty of care and the concept of negligence began.

POSTSCRIPT

In everything that has been written about this case, including all of the original legal documents, the bottle in question is said to have contained “ginger beer”. What is perhaps not widely known is that the term “ginger” is a colloquialism in Glasgow for any fizzy drink. It is possible that in reality the bottle did not contain true “ginger beer” but some other form of flavoured, aerated water such as orangeade, referred to by Mrs Donoghue and her friend as “ginger”. Whether the bottle contained a snail at all is also a subject of controversy.

Some have argued that Mrs Donoghue’s claim was just a hoax to extort compensation. Whatever the truth of the contents of that bottle, it remains the reason for our understanding of negligence around the world.

Dr Allan Gaw is a writer and educator in Glasgow



Professor Andrew Eder considers some of the risks associated with the identification and management of tooth wear and how to handle them

MANAGING TOOTH WEAR

TOOTH wear – encompassing erosion, abrasion and attrition – is usually multifactorial and is increasing in the UK, especially in younger people. There are a myriad of causes, ranging from the much-publicised effects of smoothies, fruit juices and drinks to issues around which there is, perhaps, less awareness, such as stress (resulting in bruxism) and disorders like bulimia.

Just as in every area of oral health and dental care, prevention is preferable to treatment, especially since patients with severe tooth wear may require extensive restorative treatment – but more on that later. Signs and symptoms of tooth wear (images page opposite), which may or may not be what one would expect for a patient's specific age (i.e. chronological or pathological), include:

- teeth becoming rounded, smooth and shiny and losing surface characteristics
- incisal edges becoming short and appearing translucent
- cupping forming in the dentine
- cervical lesions which are shallow and rounded
- restorations standing proud of the surrounding tooth tissue (as they tend to be unaffected by erosion).

Patients are often shocked to be told they have a tooth wear problem. This revelation may be especially upsetting for those who have been regular attenders and never been made aware previously, and also for those who have embraced a 'healthy eating' regimen that inadvertently encourages the consumption of acidic – and therefore potentially tooth-damaging – foods and drinks. Some of the less well-known culprits include dried fruits, spinach and certain cheeses; all are favourites amongst the health conscious.

It is, therefore, very important that a diagnosis be handled sensitively, and especially so in cases where there is an underlying emotional issue, for example bulimia. Denial and shame are strong features of eating disorders, so emphasise to the patient that you and your team members are there to help. A staged approach, beginning with a non-judgmental and sympathetic discussion, is ideal.

As with any patient, it is important to share examination findings with them and explain how their signs and symptoms are linked. Aim to make the patient feel comfortable and not intimidated, assure them you have time to talk things through and gently ask questions aimed at encouraging the patient to identify the origin of their oral health problems. Advice rather than treatment features heavily during the initial stage of helping a patient suffering with bulimia.

KNOWING WHEN TO REFER

Of course, it is always important to treat the problem in front of you, but clinicians also need to know their limits. If you do discover that a condition beyond the usual scope of dental practice is contributing to tooth wear, it would be prudent to seek the patient's permission to liaise with their GP or medical specialist before taking further action. This does not just apply to patients with eating disorders – drug or alcohol addicts, for example, may need extra help too.

Even in general terms, referral to a specialist may be appropriate as tooth wear can be challenging to manage and/or restore. A dentist has a duty of care to refer patients for further advice if they have any concerns about their ability to carry out treatment to an appropriate standard. In addition, if a patient asks for a referral, for example for a second opinion, the dentist must fulfil that request.

When a referral is made, whether through the NHS or privately, it is important to have a process in place to track its progress, and to follow up if a response is not forthcoming from the specialist.

SHARED DECISION-MAKING

Modern dentistry requires any prevention and/or treatment decisions to be made in partnership with an informed patient. To help patients choose how to best move forward in terms of managing their tooth wear (and, indeed, any form of dental treatment), they need to be involved in a number of decision-making steps.

In order to secure valid consent, the dentist must communicate the following effectively (NB: this list is not comprehensive):

- the problem
- any treatment options and their material risks
- costs and the basis for treatment provision (NHS v private)
- benefits and limitations
- the evidence base.

These discussions should be confirmed by, at the very least, a written treatment plan/cost estimate. Dentists also need to understand each patient's expectations, values, preferences, understanding and any other personal circumstances that may be relevant. At the heart of this process remains patient safety and clinical suitability.

IT'S ALL IN THE NOTES

One fundamental tenet of managing risk in dentistry is keeping high-quality records. Accurate, contemporaneous,

REFERENCES

- 1 Clinical Examination and Record-Keeping: Good Practice Guidelines www.fgdp.org.uk; May 2016
- 2 Worn'ing: Tooth Wear Ahead. Slater L, Eder A. and Wilson, N Prim Dent J. 2016; 5(3): 38-42



“Monitor the rate of wear objectively by taking clinical photographs and study casts at regular intervals”



legible and up-to-date notes detailing the severity of any tooth wear, indices used, shared decision-making, actions taken and supplementary care are essential additions to the clinical records – always!

Dentists and patients may together choose to simply monitor the tooth wear, and this must be noted in case a claim of supervised neglect is made further down the line. In addition, in the event that a patient cannot or will not make a decision about their own care, it is important to add to the notes that an attempt at shared decision-making was attempted and efforts were made to engage the patient. The patient may request treatment which is justifiable but which differs from your recommendations. In these circumstances, it is particularly important to have a clear record of the discussions regarding the relative merits of each option.

This is a significant issue and to cover everything that is important is beyond the scope of this article, so I would recommend accessing the guidance issued by the Faculty of General Dental Practice relating to note taking¹.

In addition, it is critical to consider risk assessment² and to monitor the rate of wear objectively by taking clinical photographs and study casts at regular intervals, perhaps every two to three years for future reference.

It is also important to consider that, although the NHS contract requires the contract holder to keep records for up to two years after a course of treatment has been completed, the Consumer Protection Act 1998 allows claims regarding a “defective product” for up to 10 years. Therefore, both NHS and private records for adults should be kept for a minimum of 11 years following the last entry.

Always remember the adage: “If it’s not written down, it didn’t happen”. A dentist who does not have detailed records will be greatly disadvantaged in the event of an accusation that something has gone wrong.

EXCEEDING EXPECTATIONS

Even with the very best of intentions, mistakes do happen – nobody is perfect. In fact, NHS figures suggest



Clinical images courtesy of Professor Andrew Eder

that between 1 April 2016 and 31 March 2017, 13,493 complaints were made in England about NHS dentistry, nearly double that for 2015/16, possibly indicating a worrying trend. This may be partly because consumer expectations have risen in recent years, plus experience tells me that patients are more ready to question the care they receive than ever before.

As long as you have managed both your risk and that of your patient in terms of issues such as shared decision making, note taking and appropriate referral, you can rest assured you have provided the best possible approach to managing tooth wear and are in a position to demonstrate exactly that should the regulator come knocking.

Professor Andrew Eder is a specialist in restorative dentistry and prosthodontics and clinical director of the London Tooth Wear Centre, a specialist referral practice in central London. He is also emeritus professor at the UCL Eastman Dental Institute. For further information on the work of the London Tooth Wear Centre go to www.toothwear.co.uk

Top: palatal erosion and enamel loss in a 44 year old.

Above: tooth wear in an 80 year old.

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.



COMPLAINT

HOCKEY TWIST

BACKGROUND

A 15-year-old girl – Liz – twists her knee playing field hockey at school. Her mother – Mrs K – is called and brings Liz to the local A&E. Here she is seen by a specialist registrar Dr J. The doctor examines Liz and notes pain and mild swelling. Liz displays a good range of movement and there is no obvious deformity or neurologic symptoms.

Dr J sends Liz for an X-ray which reveals no evidence of bony injury. She advises Liz and Mrs K that it is likely “just a sprain”. She provides Liz with a Tubigrip and advises rest and over-the-counter analgesia. Should there be no improvement in the next few days she advises that Liz attend her own GP for further investigation.

Later that night the pain grows worse and the next morning Liz cannot walk unaided. Mrs K makes an emergency appointment with her GP – Dr L. He examines Liz and diagnoses a probable torn meniscus and refers her to a private orthopaedic surgeon.

An appointment is arranged for the following day. The surgeon examines the knee and an MRI is arranged which confirms a medial meniscal tear. Liz is placed on crutches and prescribed physiotherapy in advance of ACL (anterior cruciate ligament) reconstruction and meniscus repair in three to four weeks when the swelling is reduced.

The surgeon expresses “surprise” that the diagnosis was missed in A&E and that there was no onward referral to an on-call orthopaedic specialist.

A week later the hospital receives a letter of complaint from Mrs K in regard to her daughter’s treatment in A&E. She is critical of the decision to send Liz home without a referral considering it might have further damaged her knee.

ANALYSIS/OUTCOME

Dr J is required by the hospital to make a statement in regard to her care of the patient and contacts an MDDUS adviser for guidance on the wording.

The adviser first reminds Dr J that when responding to a complaint made by a third party it is essential to obtain the subject patient’s consent prior to doing so. Liz at age 15 would be considered competent to provide such consent and Dr J is encouraged to confirm with the hospital complaints officer that this has been secured.

She is advised to open her statement with an acknowledgement of the family’s dissatisfaction and regret for the pain and inconvenience suffered. In setting out her recollection of the patient examination Dr J is reminded to highlight the source of any significant comments made, for example

from review of the contemporaneous medical records, recollections of events, discussions with colleagues and usual practice. It is also helpful to include both the positive and negative findings that led to the clinical diagnosis and management.

In particular the statement should include the justification behind Dr J’s conclusions from the examination and that a “wait-and-see” approach was appropriate. The records state that the patient managed to walk into A&E and a little more detail on this point could be helpful.

The MDDUS adviser then reviews the statement before it is returned to the complaints officer. Nothing more is heard from the complainants and the case is closed.

KEY POINTS

- A considered response with an expression of regret can often prevent a complaint escalating into a negligence claim.
- Patient notes should include clear justification behind clinical decisions.
- Ensure that appropriate “safety netting” is recorded in the notes.

PARENTAL NEGLECT

BACKGROUND

A dentist – Dr C – has been contacted by local police in regard to a four-year-old girl who has been taken into care and is now living with a foster family. Dr C had examined the child two weeks ago and found multiple grossly carious teeth and referred her to the dental hospital for extraction of the teeth under general anaesthetic.

The police are now considering charging the girl's parents with child abuse and have requested a statement from Dr C. He is concerned that providing this could breach patient confidentiality and he contacts MDDUS for advice.

ANALYSIS/OUTCOME

Ideally, the police would produce a warrant or consent from someone with parental authority (which may be shared between the mother and child services). If these documents are not forthcoming (perhaps any parental involvement would compromise the investigation or increase the risk of harm to the child), further information would be needed to allow the dentist to weigh-up the relative merits of making a non-consensual disclosure. In writing the report the dentist would be



advised to lay out the details as if presenting the case in an oral examination, commencing with the complaint and moving on to examination and then the diagnosis and treatment plan. Apart from being factually accurate, the report should be based on what is contained in the dental records as it is on this basis that the dentist may be questioned in court.

KEY POINTS

- Ensure disclosure is warranted before releasing details of a young child's dental care without parental consent.
- Always act in the child's best interests.



CLAIM

DELAYED VISIT

BACKGROUND

Mr G phones up his GP practice to request a home visit. He explains to the receptionist that he has been feeling unwell and short of breath for the past day and doesn't feel fit enough to attend the surgery in person.

The receptionist quickly explains that the doctors are very busy and that a home visit won't be possible until the next day to which Mr G reluctantly agrees.

The next morning the practice receives an angry phone call from Mrs G who informs them that her husband has died of a heart attack, before a GP was able to visit.

Three months later, a letter of claim is received by the practice from Mrs G against the practice partners. It is claimed that, had the receptionist consulted a doctor about Mr G's home visit request and explained his symptoms, they would have recommended an urgent home visit or to contact emergency services. This may have prevented the cardiac arrest or at the very least Mr G would have been in hospital where he would have received emergency care.

ANALYSIS/OUTCOME

Two of the practice's four partners are MDDUS members and they contact an adviser for guidance in how to proceed. The adviser explains that, as her employer, the

practice partners are vicariously liable for the actions/omissions of the receptionist. In addition, there was no practice policy in place at the time which specifically provided that any patient who was to be booked in for a home visit on a subsequent day should first be triaged by a GP.

Following consultation with a member of the in-house legal team, it is agreed that offering a settlement to Mrs G would be the best course of action. This settlement is shared with the defence organisation of the other two practice partners.

KEY POINTS

- Ensure robust practice policies are in place regarding the triaging of home visit requests.
- Receptionists who are not adequately supported by the clinical team may end up being drawn into giving advice to patients or even turning patients away who should have been seen by a doctor.
- Risk manage accessibility by taking time to ask your team which types of encounters are most difficult so that solutions and safety nets can be designed into the system.

DENTAL

TEETH OVERPREPARED

BACKGROUND

Mr F attends his dental surgery unhappy with the appearance of his upper front teeth which are misaligned and stained. He asks the dentist – Dr G – about having them crowned but is advised against this as the teeth appear healthy. An orthodontic referral is suggested but Mr F is not keen on protracted and expensive treatment.

He asks about veneers and Dr G explains that these will improve aesthetics but not realign the teeth. Mr F however requests a treatment plan and costs for placement of veneers at UR2, UR1 and UL1.

Two months later the teeth are prepared and temporaries are placed. Permanent veneers are cemented a week later. Flossed contacts and occlusion are checked and Mr F is happy with the appearance.

Mr F returns to the practice two weeks later complaining of sensitivity in the upper teeth and pain on biting. He also feels the veneers catching on the lower teeth. Dr G adjusts the bite and suggests a nightguard would help with possible teeth grinding.

The dentist arranges for follow-up in a week. At this appointment Mr F reports that the sensitivity has eased a little. Dr G advises waiting to see if the sensitivity will settle before considering other options such as root canal treatment.

One month later Mr F is back at the surgery complaining of increased sensitivity in UR1 and UL1 to heat/cold and percussion. The upper gum is also tender to touch. Appropriate radiographs show no pathology apically in the teeth. However, based on the clinical findings, a diagnosis of irreversible pulpitis is made and Dr G discusses possible root canal treatment (RCT) as the symptoms are not improving. An appointment is made but this is later cancelled and one month later the practice receives a letter of claim for damages, alleging clinical negligence against Dr G.

It transpires that Mr F has attended another dentist – Dr B – after debonding of the veneer at UR2. Dr B noted that a large amount of tooth tissue had been removed in the preparation of UR2 – more akin to crown provision. The dentist also diagnosed irreversible pulpitis in that tooth and in UR1 and UL1 and discussed treatment options. Subsequent debonding of the veneer at UR1 prior to RCT also revealed significant tissue loss.

ANALYSIS/OUTCOME

MDDUS in assisting Dr G commissions an expert report on the case from a primary



dental care practitioner. Examining radiographs and clinical photographs taken by Dr B, the expert notes significant loss of tooth tissue in UR2 suggesting over preparation – i.e. too much tooth substance removed so that dentine is exposed or removed. This has led to sensitivity which might have resolved once the veneer was fitted but only if the pulp had not been encroached upon.

KEY POINTS

- Remove minimal tooth tissue necessary in veneer/crown preparation.
- Ensure all contraindications have been considered and discussed with the patient and those discussions recorded in the notes.

The expert opines that the radiographic appearance of the tooth and the symptoms suffered by the patient all evidence the fact that Dr G over-prepared UR2 and so breached his duty of care to the patient. As a result the tooth will require root canal treatment with a reduced prognosis and further RCT in future.

A similar prognosis is likely for UR1 and UL1 with the reduced tooth tissue and the need for RCT – and the expert views this as a further breach of duty of care. However, he feels there can be no claim for a repeat cycle of veneers/crowns at UR1, UR2 and UL1 as this was always going to be necessary once the claimant agreed to have such restorative dentistry carried out.

MDDUS with the agreement of the member settles the claim out of court.

CHECK THE REGISTER

BACKGROUND

A dental nurse working for Dr P is signed-off by her GP for three weeks after having a minor operation. Temporary cover is arranged through an employment agency that the practice has used on numerous occasions over the last few years.

A replacement dental nurse – Ms T – starts work on the Monday providing routine chairside duties including preparing treatment materials and ensuring that proper equipment is available, as well as cleaning and sterilising used instruments. She carries out these tasks efficiently and with little need for instruction.

Dr P, in working with Ms T, learns that she studied part-time at college and recently completed her national diploma in dental nursing with hopes to further her career in some specialist aspect of oral care. Three weeks later the practice's regular dental nurse returns to work.

Six months later a letter from the GDC arrives at the practice concerning the employment of an unregistered nurse. It alleges that this action has put patients at unnecessary risk. The letter states that a GDC caseworker will be investigating whether this information could raise a question of Dr P's fitness to practise.

ANALYSIS/OUTCOME

Dr P contacts MDDUS and a dental adviser provides guidance on the process and assistance in gathering the necessary details required by the case worker. A subsequent letter from the GDC informs Dr P that the case will be further assessed by case examiners and she is invited to provide her "observations" on the allegations. Dr P requests assistance from MDDUS in preparing a response to the case examiners. This is actioned by a dental adviser with supporting documentation being disclosed.

In regard to the allegation that Dr P allowed an unregistered dental nurse to work at the practice – she admits it is her responsibility to ensure that nurses are employed in accordance with GDC requirements but she seeks to assure the case examiners that this was the result of a genuine error. It was her clear understanding that all the candidates –

including Ms T – supplied by the employment agency were fully qualified and registered with the GDC. She has now subsequently introduced a new system of validating the qualifications and registration status of all nurses and other DCPs working at her practice, whether on a temporary or permanent basis.

Dr P also acknowledges that GDC registration is essential to ensure patients are properly protected but she points out that there was never any question of Ms T's experience and apparent competence.

In responding the case examiners determine that the allegations do not merit consideration by a full practice committee, but the regulator does issue Dr P with a written warning that is also published on the GDC website. The dentist accepts that this is a fair result.

KEY POINTS

- Ensure the practice has a fool-proof system to ensure staff are adequately qualified and registered as required by law.
- Do not rely on guarantees from temporary employment agencies: carry out your own checks.



ADVICE

SOUL AND CONSCIENCE

BACKGROUND

Ms G has severe cerebral palsy with hearing loss and difficulty speaking and communicates mainly through her carer. She has some cognitive impairment but

there is no question of mental incapacity.

Ms G has been called to testify in a criminal court and wishes to be exempt on medical grounds. Her GP – Dr J – contacts MDDUS for advice in regard to a soul and conscience letter stating that the patient is medically unfit to appear as a witness. Is her condition sufficient grounds for an exemption?

long-term carer. It is presumably possible that, with the correct level of assistance, she may be able to provide evidence to the court. However, the court needs to understand the issues at hand.

As such, the adviser suggests that rather than setting out that the patient is 'medically unfit' to act as a witness, the GP should provide a factual account of her medical problems and why her ability to testify is difficult to assess. It would then be for the court to consider whether any steps are available to assist her in giving evidence. In this way it is a legal consideration for the court rather than a medical issue.

KEY POINTS

- Ensure that any judgement made on a patient's fitness to testify in court is strictly on medical grounds.
- A letter stating that a patient is not fit to attend should include detailed reasoning behind that judgement.

ANALYSIS/OUTCOME

An MDDUS adviser first consults with in-house legal colleagues and then responds to the query. It's clear that Ms G's ability to give evidence is difficult to assess as communication is mainly via her

CAUGHT ON CAMERA

Dr Barry Parker

Medical adviser at MDDUS and *Insight* editor

WORK as a practice manager and was contacted by a police officer this morning who requested that I show him our practice CCTV footage for the past week in order to investigate a crime that has been reported. He would like to attend the practice to do this. I don't know whether I am able to assist with this.

This is a relatively common scenario and MDDUS regularly receives calls from practices seeking advice on this topic. Practices will often have internal and external CCTV cameras for safety and security purposes, and any crime reported in or around the premises may prompt such a police request.

Although the practice may be keen to co-operate with police officers investigating such matters, this situation is more complicated than it first appears. CCTV footage which may identify individuals is considered personal data and must be handled under the provisions of the Data Protection Act 2018 in a similar way to written information. In 2014 the Information Commissioner's Office (ICO) produced a Code of Conduct specifically for camera surveillance information and this is helpful when considering the request. It predates implementation of the new GDPR (General Data Protection Regulation) and DPA 2018 but nonetheless contains useful guidance.

The Code states that care should be taken about how information is recorded and held, and that access should be restricted. Footage should also be deleted when no longer required. It also states that disclosure of surveillance information to a law enforcement agency can be appropriate when the purpose is to prevent and detect crime. Even when this is not the primary purpose of the surveillance, it would still be acceptable to disclose the information to police if failure to do so would be likely to prejudice the prevention and detection of crime.

However, the ICO emphasises that judgments about disclosure should be made by the organisation operating the system, and they have discretion to refuse any request for information unless there is an overriding legal obligation, such as a court order. Once information has been disclosed to police, they become the data controller for the copy they hold.



Such guidance would appear to allow disclosure to the police of the CCTV footage in the above scenario but the practice must be mindful of separate GMC guidance on *Confidentiality*. This highlights that disclosure of a patient's personal information is appropriate when they consent either implicitly in relation to their clinical care or audit, or explicitly for other purposes, or where the disclosure can be justified in the public interest.

The GMC makes additional comment on public interest disclosures: "If it is not practicable or appropriate to seek consent, and in exceptional cases where a patient has refused consent, disclosing personal information may be justified in the public interest if failure to do so may expose others to a risk of death or serious harm. The benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential.

"Such a situation might arise, for example, if a disclosure would be likely to be necessary for the prevention, detection or prosecution of serious crime, especially crimes against the person.

"If you consider that failure to disclose the information would leave individuals or society exposed to a risk so serious that it outweighs the patient's and the public interest in maintaining confidentiality, you should disclose relevant information promptly to an appropriate person or authority."

In the above scenario, the practice manager has insufficient information at present for the doctors to reach a decision on disclosure. She requires more information on the nature of the crime being investigated, and also whether the whole week's footage is necessary or whether a much more defined period would suffice. She should also establish whether it is footage from internal or external cameras that is requested.

Once she has sufficient information, the doctors must decide whether there is a public interest reason to disclose the footage, and what footage should be disclosed for the purposes. The practice must also consider whether consent for disclosure can reasonably be sought from the individual or individuals concerned, or whether this in itself may be impractical or prejudice the investigation.

If the practice declines to disclose the information, it should still be possible for the police officer to obtain a court order to compel disclosure of the data if there are sufficient grounds to do so. The practice would then be obliged to comply with any valid court order received.

REFERENCES

- ICO. In the picture: A data protection code of practice for surveillance cameras and personal information. October 2014
- GMC. Confidentiality: good practice in handling patient information. April 2017

DOUBLE VISION

Deborah Bowman

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

WHEN I was diagnosed with cancer a reader wrote to me. He said that he was looking forward to my

perspective on language, and specifically euphemism, in the context of serious illness. During my unexpected fieldwork, I have encountered numerous clinicians and had many conversations. Euphemism has been largely absent. I have been met with an honesty, clarity and responsiveness for which I am grateful.

I have reflected on those consultations and conversations and have been surprised by my capacity, maybe even my need, for doubling. By which I mean, the simultaneous yearning for the contradictory. I have craved both rationality and magical thinking, science and the ephemeral, stoicism and emotional expression, realism and hope. I am not alone. The neuropsychologist Paul Broks in his exquisite and moving book – *Darker the Night, the Brighter the Stars* – describes how, in the midst of his grief, myth, imagination and story are unexpectedly present and urgent. I have thought of Brok's words and experience as I salute single magpies whilst clutching the best available scientific evidence provided by the oncologists.

Since I walked into The Royal Marsden and at every consultation, I have wanted both to know and not to know, to understand and to deny, to reject and to accept, to question and to trust. Of course, sometimes, one preference has been stronger than the other. I cannot conceive of not wanting to know a diagnosis or of undergoing surgery without an appreciation of what is involved and why. Yet, more often than not, there has been a curious doubling, whereby competing and conflicting impulses co-exist.

It was, I am embarrassed to admit, a shock to experience the impact a standard consent form could have on a patient who had previously considered herself to be informed, rational and enquiring. When consent was being sought both for chemotherapy and for surgery, I was taken aback by the rising impulse to stop reading as I went through the possible side-effects and potentially serious and fatal complications. I noticed that when I



“The neuropsychologist Paul Broks describes how, in the midst of his grief, myth, imagination and story are unexpectedly present and urgent”

returned home, I hid my copy of these consent forms even as I knew it was absurd to do so.

At the beginning of my treatment, I asked to be copied into correspondence from the specialists to my GP. I am used to reading medical records and letters. Nonetheless, the effect of seeing my own experience captured in clinical terms with its brutal specificity, detached evaluation and the unavoidable facts laid bare, was disruptive and painful. I quickly learned to recognise the envelopes and to expect a lurch of my stomach. I would pick up the

letters from the doormat as if handling a grenade before bracing myself to read the contents. I emphasise that I wanted to receive these letters and I am grateful that copying in patients to correspondence has become common. I believe in openness and I am committed to sharing information. My response was borne of the doubling that had occurred.

I was both constant and altered. My academic understanding of, and commitment to, disclosure, choice and information remained, but illness rendered me simultaneously scared, vulnerable and overwhelmed by the impact of what I sought. I learned I could both crave and be undone by a consent process that was unquestionably exemplary. I understood that I both yearned for, and wanted to run from, the information that was being offered in a gentle and patient-centred way. That consistency and difference prompt an inevitable doubling and inherent contradiction whereby the patient may seek and avoid that which I have taught for years as being ‘best practice’ in clinical communication.

I have reflected on what it is to be a clinician in such a context. Perhaps professionals too are susceptible to doubling. Doctors may believe in the value of information sharing whilst wishing they did not have to impart painful news or life-changing knowledge. They may want always to be honest and realistic but also yearn to offer hope. A professional will draw on his or her scientific training and a rational evidence base whilst remembering the patients who surprised them. To be pulled in different directions, whether as a patient or as a doctor, by competing and opposing forces is perhaps not merely just common but inevitable. Yet, I do not recall it being discussed in clinical communication ‘training’ to which I have contributed. That seems like an omission.

To acknowledge the potential, maybe even the necessity, for these simultaneous and yet contradictory responses is to acknowledge the essential humanity of healthcare. It is to recognise that facts, knowledge, skills, experiences and emotions collide in the clinical consultation. It is to give permission to us all – doctor and patient alike – to meet and to interact in a context that is complex, uncertain, challenging, but ultimately, potentially transformative.

Addenda

BOOK CHOICE

Shapeshifters by Gavin Francis

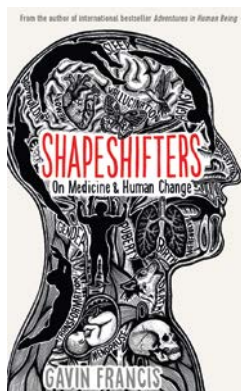
Profile Books, hardcover, £16.99, 2018

Review by Greg Dollman, medical adviser, MDDUS

WITH the recent trend of superhero blockbusters hitting the big screen every few months, Gavin Francis' new offering, *Shapeshifters: On Medicine & Human Change*, might be mistaken for the next series of adventures, telling the fantastic stories of humans capable of marvellous feats: individuals able to change their appearance, become giants, regenerate, create alternative realities, and also make sense of it all. But wait; this is not a fairy tale about superhumans, rather a story about you and me.

In his latest exploration of what it is to be human, doctor and writer Francis declares that "to be alive is to be in perpetual metamorphosis", and that his book "is a celebration of dynamism and transformation in human life".

Francis chronicles our growth as humans, from conception to death. He reminds us of the wonder of human development and the perpetual change that is part of our lives, through a mix of personal stories from the frontline of medicine, vignettes from medical history, along with references to the classics. Francis retells the thoughts and theories of Ovid, Descartes and Nietzsche (to name a few), which are neatly tied



into chapters setting out his memories of remarkable patients.

Lay readers will no doubt be fascinated by the broad range of patients and conditions that Francis has encountered. As doctors, we are able to add our own stories, which undoubtedly will cause us to marvel anew at the super

powers within us all (and also to appreciate the wonder of our profession).

Francis delves into the roles that humans take on, both healthy and unhealthy, and the transformations that can and do occur within our bodies and minds. He looks at humankind's attempt to make sense of these changes, including the ageing and healing processes, the effects of hormones, the mysteries of the mind, as well as the differences between 'male' and 'female' (and now, more and more, the fluidity between them). He acknowledges the significant part played by the medical profession in understanding this omnipresent change around us, which allows humankind both to explore the potential our bodies allow us and to address the limits they impose on us.

Shapeshifters is a fantastical story of the marvel of being human. It is confirmation of what doctors are privileged enough to experience first-hand on a daily basis.

OBJECT OBSCURA

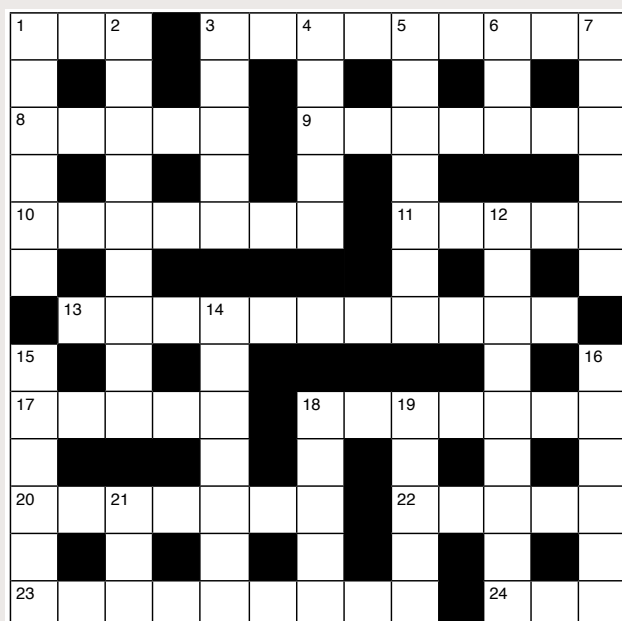
Phrenological heads

THESE heads were made in Ireland in 1831 by phrenologist William Bally to illustrate theories promoted by the Viennese physician Franz Joseph Gall (1758-1828). Gall proposed that the contours of the skull followed the brain's shape, with each region responsible for an aspect of personality or behaviour.



Photograph: Science & Society

Crossword



ACROSS

- 1 Official register of UK medical professionals (abbr.) (3)
- 3 Device used in neonatal intensive care (9)
- 8 English actor, famous for playing vicars, Derek ____ (5)
- 9 Enact (7)
- 10 Signs up (7)
- 11 Conspicuous (5)
- 13 Archer of Swiss legend (7,4)
- 17 Understand the joke (3,2)
- 18 Eating disorder (7)
- 20 Loss of tooth enamel from wear (7)
- 22 Japanese dish (5)
- 23 Heart-throb (9)
- 24 Informal name for guitar (3)

DOWN

- 1 Rhizome used as a spice (6)
- 2 Grievance handled by procedure (9)
- 3 Golf clubs (5)
- 4 As worn by superheroes (5)
- 5 Occupational stress (7)
- 6 One and another one (3)
- 7 Distant (6)
- 12 Convulsions in pregnant women with high BP (9)
- 14 Bipolar medicine (7)
- 15 Concurred (6)
- 16 Extreme scarcity of food (6)
- 18 Stringed instrument popular in US folk music (5)
- 19 Hungarian composer immortalised in rhyming slang (5)
- 21 6 Down divided by itself (3)

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

VIGNETTE

RICHARD ASHER (1912-1969)

MEDICAL INNOVATOR AND EDUCATOR

LIKE the boy in Hans Anderson's story of the *Emperor's New Clothes*, but with the eye of a physician, Richard Alan John Asher spoke up and revolutionised medical practice.

He was born in Brighton, the son of Louise and Reverend Felix Asher and educated at Lancing College. He learned to write elegantly, with wit and to the point, played music and acted. Activities he enjoyed for the rest of his life.

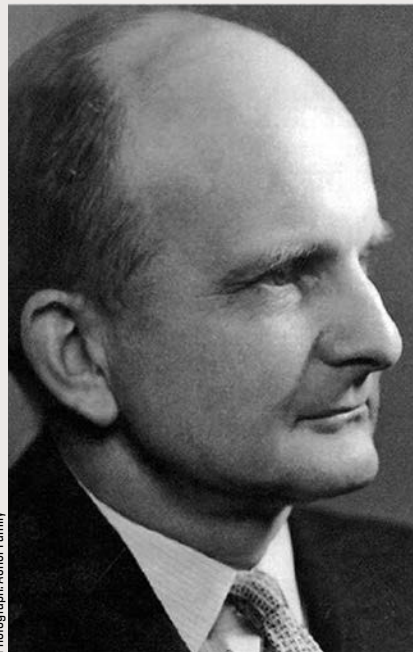
He studied medicine at The London Hospital and qualified in 1931. After a few years at the West Middlesex, and now with MRCP, he was appointed physician to the Central Middlesex in 1943, a hospital that was badly damaged by bombs in WW2.

In those days the mantra of doctors and nurses was 'keep diseased parts at rest', which meant bedrest for patients. Richard overturned that philosophy in an article published in *The Lancet* in 1947: 'The Danger of Going to Bed'. It changed attitudes and saved patients from long stays in bed that had damaging effects on the body.

The medical profession came in for more criticism when he gave a talk: 'The Seven Sins of Medicine'. These were: obscurity, cruelty, bad manners, over-specialisation, love of the rare, common stupidity and sloth. The talk was later published in *The Lancet* and widely quoted.

Another thing that caught Richard's observant eye was that some patients would go from doctor to doctor and take their fictional diseases to distant hospitals. When the deceit convinced a doctor, they were willing to suffer all sorts of treatment. Asher distinguished this from malingering and gave it the name Munchausen's syndrome.

He was not always happy about the assignation of names: for example, he thought Pel-Ebstein fever characteristic of Hodgkins disease did not need to be so called. More misleadingly subdural



Photograph: Asher Family

haematoma was known by a clumsy name 'pachymeningitis interna haemorrhagica' which inferred that it was an inflammatory condition and delayed the discovery that it follows head injury and is curable by operation.

Always a general physician, he was particularly interested in haematology, endocrinology and the organic causes of mental illness – all subjects that were in their infancy and he made notable contributions to them. He was invited to head the mental observation ward at the Central Middlesex, where, through observation, he identified the cause of mental illness in a group of patients. It was because of thyroid deficiency.

He wrote: "I consider there is only one infallible confirmatory test for myxoedema. Take a good photograph; then give thyroid for a month or more and take another photograph. The change

between the two photographs is clear confirmation of the diagnosis. In many cases where I have not been certain of the diagnosis the change recorded by photographs has been the only unequivocal proof of the answer."

He was able to instil in others his understanding of the practice of medicine at the teaching unit of the Central Middlesex (part of the Middlesex Hospital Medical School). Medical students taught by him included Jonathan Miller and Oliver Sachs.

In 1952 he was elected FRCP and in 1959 gave the Lettsomian lectures to the Medical Society of London (founded in 1773 by the Quaker physician Dr John Coakley Lettsome as a forum for discussion of difficult cases). Asher became President of the Clinical section of the Royal Society of Medicine in 1964, a sad year for him because he was replaced as head of the mental observation ward at the Central Middlesex. He resigned and this marked the end of his distinguished medical career. He had been lauded in America and in the United Kingdom.

He married a musician Margaret Eliot in 1943. They lived above his practice in Wimpole Street and there raised a family, Peter, Jane and Clare. At some time in his life he had a gastrectomy and had further surgery but this did not sap the vibrant energy he gave to his profession. Five years after retiring he committed suicide. The obituary in *The Lancet* called him a "superb diagnostician" and a "brilliant performer". He was also remembered as a generous and charming man.

In 1972 a book of many of his excellent lectures was published, called *Richard Asher talking sense*. The RSM and the Society of Authors award a prize in his memory for the best first edition of a textbook for undergraduates. Anthologies of his writings have also been published.

Julia Merrick is a freelance writer and editor

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