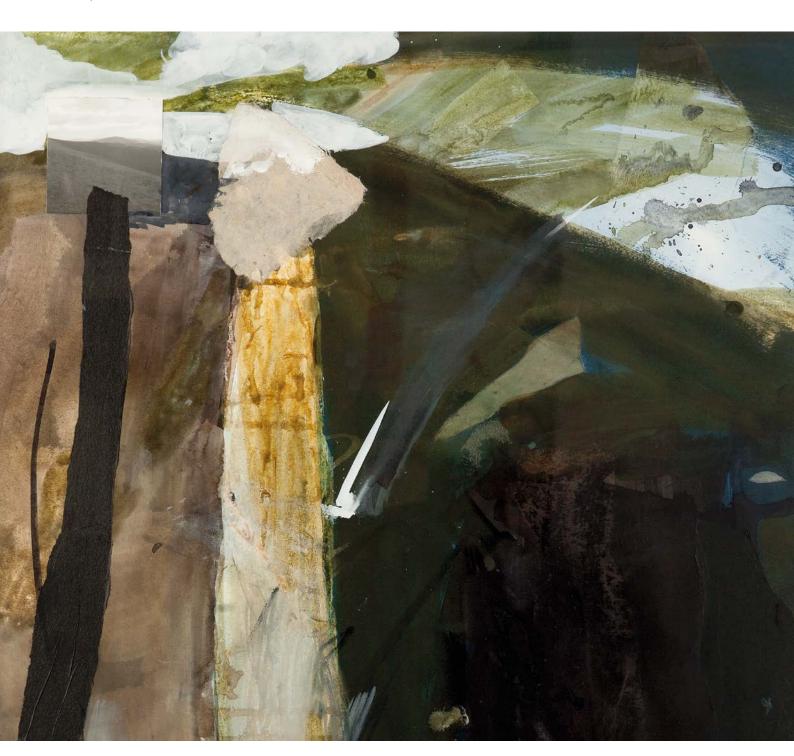
INSIGHT



A QUARTERLY PUBLICATION FOR MEMBERS



INDEMNITY UPDATE

What we do (and don't) know about the new state-backed indemnity scheme for GPs

VEXED QUESTION

New RCP exhibition celebrates 500 years of women in medicine

ON REFLECTION

What now for reflective practice in the aftermath of the Rawa-Garha case?

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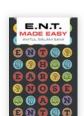
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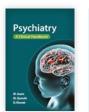
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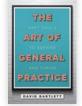


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Cover image

Winter Landscape, Marjorie Stark Mixed media and collage Marjorie Stark (1914-99) studied at Edinburgh College of Art between 1949-55, working in watercolour and also abstract collage. She was a member of the Society of Scottish Artists.

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



- MDDUS news
- News digest
- Briefing

General practice deserves better

Risk

Home but not alone

10 This vexed question

Adam Campbell highlights the background to an exhibition celebrating 500 years of women in medicine

12 Cut on the dotted line

Dr Selina Master looks at tonque splitting and other forms of oral "body modification" and the growing risk to public health

14 Reflective practice - what now?

Solicitor Joanna Bower considers the status of reflective practice following the legal case of Dr Hadiza Bawa-Garba

16 Case files

Gut pain, Healthy eating, Patient abroad, Honest assessment, Impacted wisdom tooth, An angry ending

20 Dilemma

Off label request

21 Ethics

Trials, hope and research ethics

22 Addenda

Book choice: This is going to hurt, Object Obscura: Detail from Trajan's frieze, Crossword and Vignette: Dame Anne Louise McIlroy, first female medical professor in the UK



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Dr Barry Parker

A GREAT deal has already been written about the prosecution and GMC investigation of Dr Hadiza Bawa-Garba, causing widespread concern within the medical profession. At the centre of the case is of course the tragic death of a young boy, but from a medico-legal perspective many questions have arisen in relation to gross negligence manslaughter, accountability, the GMC appeal against the Medical Practitioners Tribunal (MPT) decision, and the status of a doctor's personal reflective log.

In this issue (p. 12), solicitor Joanna Bower provides a useful summary of the current position relating to the disclosure of doctors' reflective records, dispelling some misconceptions and clarifying the legal position.

Until recently, dentists and doctors would

"At the centre of the case is of course the tragic death of a young boy, but from a medicolegal perspective many questions have arisen"

be very unlikely to see a patient with a bifid or split tongue, except perhaps for rare congenital anomalies. Now, however, this is regarded by a growing number of 'body modification' enthusiasts as a desirable effect, leading them to undergo extremely hazardous procedures and, in some cases, attempting their own surgery. Dr Selina Master of the Faculty of Dental Surgery highlights

potential complications on page 14.

The Royal College of Physicians is marking its 500-year anniversary and as part of the celebrations has launched a fascinating exhibition looking at five centuries of women in medicine (p. 10).

On page 8, MDDUS Chief Executive Chris Kenny offers an update on Government plans for state-backed indemnity for GPs in England and Wales, and on page 9 risk adviser Lindsey Falconer looks at the developing technology of remote medical monitoring and the inherent risks involved. Our regular Dilemma on page 20 concerns the prescribing of an unlicensed medication, and on page 21 Professor Deborah Bowman offers a personal perspective on what motivates patients to enrol in research trials.

Dr Barry Parker

News

Information hub on state-backed indemnity

THE English and Welsh governments have confirmed their intention to introduce a state-backed indemnity scheme (SBIS) by April 2019. Full details of the scheme have yet to be released (see p. 8 of this issue) but MDDUS will keep members updated.

To find out the latest on SBIS go to our information hub on the MDDUS website, which provides a range of information, articles and FAQs about the scheme and the work MDDUS is doing to ensure we influence the best outcome for clinicians and patients. Access the hub from the link on the **mddus.com** homepage.

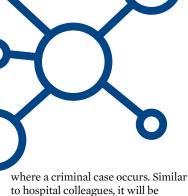
BMA advises MDO cover "essential"

GPs in England and Wales have been advised by the BMA that it will be "essential" to retain membership of a medical defence organisation (MDO) after the introduction of a statebacked indemnity scheme.

The government scheme for GPs in England and Wales is expected to launch in April 2019 and will cover clinical negligence claims for NHS services but will not cover private work or legal support in coroner's inquests, GMC hearings or other matters relating to professional regulation.

The BMA recently updated its Medical indemnity guidance for GPs with FAQs addressing a number of issues, including the need to retain membership of an MDO. The guidance states: "The scope of the state-backed scheme is to cover the cost of clinical negligence for NHS services. The MDOs will continue to play an important role in providing legal advice, representation for GMC

hearings and also for the rare occasion



where a criminal case occurs. Similar to hospital colleagues, it will be essential to maintain such medical indemnity."

MDDUS welcomes and strongly endorses the BMA advice. Director of Development David Sturgeon commented: "Doctors will continue to need comprehensive protection for all of their activity that falls outside the state-backed scheme – and from the consequences of the scheme if, as we fear, state-backed indemnity leads to claims settlements which take no account of damage to the professional standing and reputation of doctors.

"Only a strong MDO like MDDUS can offer that vital protection. There will be more details shortly. We will determine prices when we have more details of the Government's thinking."

Welcome clarity on reflective practice

MDDUS has welcomed publication of new GMC guidance to support doctors and medical students engaging in reflective practice.

The guidance - developed alongside the Academy of Medical Royal Colleges (AoMRC), the UK Conference of Postgraduate Medical Deans (COPMeD) and the Medical Schools Council (MSC) - emphasises the importance of reflection for personal development and learning to maintain and improve professional practice and patient safety.

Commenting on the new guidance,



Reception staff and duty of care

THE Supreme Court recently judged that non-medical staff members also have a duty of care to patients. Whilst the case in question took place in the A&E department of a hospital, MDDUS is flagging to its members working in general practice that there are important points that need to be borne in mind.

When GP partners delegate to non-medically qualified staff (including receptionists) the role of first point of contact for persons seeking

medical assistance, they must remember that they are also delegating the responsibility for providing accurate information as to its availability and that the information provided to patients must be complete and not misleading.

The case involved a 34-year-old man with a head injury presenting at A&E. He requested urgent attention but was informed by a receptionist that he would have to wait up to four to five hours to be seen by a clinician. The patient replied that he could not wait that long as he felt near to collapse. The receptionist was then reported to have said that if he did collapse then he would be treated as an emergency.

Neither of the two A&E receptionists on duty at the time recalled the conversation though each described their usual practice when a person with a head injury asked about waiting times. One said that they could expect to be seen by a triage nurse within 30 minutes of arrival and the other said that the triage nurse would be informed and that they would be seen as soon as possible.

The patient decided to go home but was later returned to hospital by ambulance and a CT scan identified a large extradural haematoma. Emergency surgery was undertaken but he unfortunately suffered permanent brain damage. Proceedings were brought against the NHS trust alleging a breach of duty by the reception staff concerning the information given about waiting times and a failure to assess for urgent triage.

The case was dismissed in the High Court and in the Court of Appeal on the grounds that neither the receptionist nor the trust owed any duty to advise about waiting times and also that there was no causal link between any breach of duty and the injury. The patient successfully appealed to the Supreme Court which ruled that the case fell squarely within an established category of duty of care in any casualty department – to take reasonable care not to provide misleading information which may foreseeably cause physical injury. The Court also found that this duty of care was owed to the patient by both medical and non-medical staff.

Source: PRESS SUMMARY/ Darnley (Appellant) v Croydon Health Services NHS Trust (Respondent) [2018] UKSC 50/ On appeal from [2017] EWCA Civ 151

Dr John Holden is joint head of medical division at MDDUS

MDDUS joint head of medical division Dr John Holden said: "We particularly welcome the document highlighting the importance of learning outcomes as the key aspect of reflective practice. Being able to learn through reflection is crucial to assisting doctors with education, training and development. We are reassured that the GMC will not use these reflective notes in order to investigate a fitness to practise concern.

"We would also like to remind members that they should contact MDDUS at the earliest opportunity if they are faced with any incident, claim or complaint. Reflection is not a substitute for reporting significant events or serious incidents. Doctors should also contact their medical defence organisation when a request for disclosure of confidential patient information is received."

Access *The reflective practitioner* at **tinyurl. com/y76q4g2e**

Tell us what you want...really

OUR MDDUS Training and CPD team are busy planning a packed programme of upcoming events, including our 2019 Practice Managers' Conference (date soon to be confirmed). Now is your chance to let us know what you would find useful in the way of conference sessions, stand-alone courses or webinars. Just contact <code>risk@mddus.com</code> with your topic ideas.

Members can also request a speaker or training event in their local area. Select a topic of your choice – from confidentiality and complaints handling to risks in general medical/dental practice. Local training courses can be delivered for a daily fee or for a per-delegate rate based on your preferences and available local arrangements.

WINTER INDEMNITY SCHEME

NHS England is again running an indemnity scheme to support GPs doing extra out-of-hours/ unscheduled care work and extended hours this winter. The scheme will run until 31 March 2019 and does not apply to pre-existing indemnity arrangements. Click the link on the mddus.com homepage for more details and to apply. Additional information on the scheme including FAQs can found on the NHS England website.

© GDC RENEWAL REMINDER

The deadline for dentists to renew their GDC registration is 31 December and those failing to do so will be removed from the register and not allowed to practise. The GDC is urging dentists to renew now to avoid the busy holiday period. The quickest and most efficient way of doing this is via eGDC (access at

www.egdc-uk.org). Contact the GDC with any questions by phoning 020 7167 6000 or by email at renewal@gdc-uk.org.

®BLEAK PRACTICE IS BACK

The eagerly-anticipated sixth episode of our flagship drama is now online at mddus.com. Join us for another eventful day in the Wellnot Surgery as staff wrestle with a variety of challenges and risks around consent, referral systems, delegation, working collaboratively with colleagues and breaches of confidentiality. Members can login to access the resource in Team Training in the Training & CPD section of mddus.com

Digest

NHS facing "year-round crisis"

EMERGENCY care services in England are suffering a "year-round crisis" with key indicators demonstrating that the summer of 2018 delivered worse levels of care to patients than five out of eight recent winters, according to BMA analysis.

Working with NHS data the BMA found that in the three summer months of 2018 (July to September), 125,215 patients were left waiting on a trolley for more than four hours after the decision to admit, a figure that was greater than every winter (defined as January to March) between 2011 and 2015.

The BMA also found that in comparing winter 2011 with winter 2018 (January to March) compliance with the four-hour waiting target to be seen, admitted or discharged from A&E reduced from 96.6 per cent to 85.0 per cent, and total trolley waits of longer than four hours saw a seven-fold increase. Total emergency admissions increased by 19 per cent.

Dr Chaand Nagpaul, BMA Council Chair, said: "These figures lay bare the long-term underfunding of emergency care services in England that have experienced years of declining budgets and staff shortages at a time when patient demand has rocketed."

Using Google Translate in consultations

USING Google Translate in medical consultations risks introducing communication errors that could lead to litigation.

A recent *BMJ* report from researchers at the London School of Hygiene and Tropical Medicine found that doctors were using Google Translate to overcome language barriers in patient consultations - partly driven by difficulties in using services provided by the NHS.

Responding to the findings, MDDUS medical adviser Dr Naeem Nazem commented: "We would recommend extreme caution in using, and relying on, computer translation in everyday clinical practice.

"In usual clinical practice, the risks of using computer translations, in the presence of validated alternatives, is likely to increase the risks to patient safety and leave doctors vulnerable to criticism and, potentially, regulatory action or litigation in the event of an adverse outcome."

Dr Nazem points out that Google Translate would fail to meet standards issued by NHS England on the requirements for, and use of, interpreters and translators in primary care. "It has not been validated for use in



Oral cancer on the rise with unawareness high

OVER 8,300 new cases of oral cancer are now diagnosed in UK adults each year, representing a 49 per cent increase over the last decade, according to a new report by the Oral Health Foundation.

The UK's first *State of Mouth Cancer Report* also highlights that less than half of UK adults can identify common potential warning signs, including long-lasting mouth ulcers (42 per cent), red or white patches (31 per cent) and unusual lumps (47 per cent). More than four in five (82 per cent) adults are unsure how to check for mouth cancer.

Chief Executive of the Oral Health Foundation, Dr Nigel Carter OBE, said: "We have published this report to highlight the need for greater awareness of mouth cancer. It is extremely concerning to see the lack of basic knowledge about the disease, especially as it continues to affect more people every year."

medical consultations, and the risk of error is significant."

He acknowledges that there may be situations (e.g. some emergencies) when online translation could be useful but adds that in such circumstances the treating clinician must be able to justify their actions.

Reduced antibiotic prescribing by dentists

DENTAL practices in England dispensed nearly a quarter fewer prescriptions for antibiotics in 2017 compared to 2013, according to figures published by the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR).

Antibiotic prescribing in primary care settings overall declined by 13.2 per cent over the period, with a 23.9 per cent drop in dental prescribing. Dental practice contributed to 8.2 per cent of antibiotic prescription items in primary care in 2017.

The need to preserve the potency of existing antibiotics was underlined recently in a report by MPs which estimated that antimicrobial resistance (AMR) could kill up to 10 million per year by 2050.

BDA President Susie Sanderson commented: "It is gratifying that statistics back up the fact that dentists are playing their part in reducing antibiotic prescribing. However, the existential threat from AMR is so great that none of us can rest on our laurels."

Cost of bullying put at £2.28 billion

BULLYING and harassment in the NHS in England costs the UK taxpayer an estimated £2.28 billion per year according to a new study.

Research published in the journal *Public Money and Management* (**tinyurl. com/ydgrg2a7**) calculated the likely costs by utilising a range of data sources related to sickness absence, employee turnover, diminished productivity, sickness "presenteeism" and employment relations.

Sickness absence as a result of bullying and harassment was found to cost the NHS £483.66m per year in lost wages, with an additional cost of £302.2m in paying overtime and agency staff. The largest estimated cost was £604m due to 'presenteeism', which puts a price on the loss in performance of staff who come into work unwell owing to stress or other problems.

These combined with other estimated costs for staff turnover, lost productivity and the impact of bullying on industrial relations,

compensation and litigation led to a total estimated figure of £2.28 billion. However, this excludes other costs which are difficult to predict, such as the impact on staff who witness bullying behaviour and reputational costs to the NHS as a "good employer".

BMA representative body chair Anthea Mowat, who is leading a campaign to end bullying and harassment, said the figures showed the NHS could not afford not to take action. "We already know that many doctors are counting the personal cost of bullying and harassment at work. It's not only harmful to staff, it's damaging to patient care, as countless inquiries have found."

Addressing violence against NHS staff

MORE than 15 per cent of NHS employees in England have experienced violence from patients, their relatives or the public in the last 12 months - the highest figure for five years - according to the most recent NHS

These figures are cited in an announcement by Secretary of State for Health and Social Care Matt Hancock of the "first ever" NHS violence reduction strategy.

The strategy involves the NHS working with the police and Crown Prosecution



Service to help victims give evidence and get prosecutions in the quickest and most efficient way. It will empower the Care Quality Commission (CQC) to scrutinise violence as part of its inspection regime and identify trusts that need further support. Staff will also be offered improved training to deal with violence, including circumstances involving patients with dementia or mental illness, and also prompt mental health support for NHS employees who have been victims of violence.

The new plans follow the Assaults on Emergency Workers (Offences) Act, which was recently brought into law and will see the maximum prison sentence for assaulting an emergency worker double from six months to a year.

Matt Hancock said: "We will not shy away from the issue - we want to empower staff and give them greater confidence to report violence, knowing that they will see meaningful action from trusts and a consistent prosecution approach from the judicial system.'

Consent suffers under pressure

HEAVY workloads among doctors are impacting the consent process and undermining the doctor-patient relationship, according to the GMC.

This warning comes as the regulator launches a consultation on draft updated consent guidance which aims to take account of feedback from the profession on the need for assistance in working more effectively with patients to make decisions about their care.

Professor Colin Melville, the GMC's Director of Education and a former consultant in intensive care medicine, said: "In the 10 years since we first published guidance on consent much has changed. Patients have more access to medical information outside the consulting room and rightfully expect to discuss options with their doctors before important decisions are made about their care. Health services and staff are more stretched and it is important that the guidance reflects the extra pressures doctors are facing."

Medical ethicist Professor Deborah Bowman is chairing an expert group advising the GMC on the consent guidance. She commented: "Consent and the ways in which people approach it will, inevitably, vary, but the constant remains the commitment on the part of professional and patient to collaborate.

"We want to hear from patients and doctors during the consultation to know about their experiences and priorities in seeking or providing consent."

The draft guidance is available on the GMC website and the consultation is open until 23 January 2019. A final version of the updated guidance will be published next year.

WRITE DIRECTLY TO PATIENTS"

HOSPITAL doctors are being urged to avoid medical jargon and write outpatient clinic letters directly to patients rather than to GPs, and to use plain English. New guidance from the Academy of Medical Royal Colleges states that switching the focus in this way should mean less time spent interpreting correspondence for patients, leading to better compliance. It recommends using easier terminology (e.g. write 'kidney' instead of 'renal') and explaining the meaning of technical terms or acronyms. Access at tinyurl.com/

y8cucgxd

PENICILLIN ALLERGY

HEALTHCARE staff should double check reported allergies to penicillin, says NICE. Evidence suggests around 10 per cent of the UK population has a penicillin allergy documented in their clinical notes but only around five per cent have a "true" allergy. Those with a suspected allergy are more likely to be given broadspectrum antibiotics with increased risk of developing MRSA and C difficile infections. It can also contribute to antimicrobial resistance. Access the guidance at

tinyurl.com/y7xxddtt

HERBAL AND SUPPLEMENT USE

A STUDY of adults over age 65 found that 34 per cent were taking herbal medicinal products or dietary supplements concurrently with prescription medicines and 33 per cent were at risk of potential adverse drug interactions. Access the study at tinyurl.com/ y95esnue

BRIEFING

GENERAL PRACTICE DESERVES BETTER

Chris Kenny

Chief executive officer at MDDUS

T IS hard to believe that well over a year has passed since Government announced their intention to introduce a state-backed indemnity scheme (SBIS) for GPs in England (and later announced for GPs in Wales).

Unfortunately, since then, information

and details from Government about the scheme and what it means for GPs have been sadly lacking.

The reality is that now, only a handful of months away from its planned implementation, SBIS remains a great unknown and here at MDDUS we share the frustration of our members over this complete lack of detail and its impact on primary care services and staff.

We have been pressing Government to provide much more detail on the operating and funding plans for this new scheme for some time now, yet little has been forthcoming. There has been no consultation over the future plans. We believe it is a high-risk approach by Government that fails to protect GPs' professional reputation and removes choice. As independent contractors, GPs should have the option to choose an integrated indemnity and advice product as compared to the state-backed scheme.

We do not support the proposals and have made clear to Government that we do not think it is right for our members.

- First, we have grave doubts about the operating model for any state-run, as opposed to state-funded, scheme as no state body has the primary care skills to deliver it properly.
- Second, if there is a state-run scheme, we think that GPs should have a financially neutral choice to be able to remain with their MDO of choice and have an integrated service providing both claims and non-claims work.
- Third, there must be absolute transparency about how the scheme will be funded, as it appears that GP partners in particular may very well lose out.

GPs need detailed and specific answers on a wide range of issues, including the cost of the scheme and the impact on other parts of their remuneration. They have a right to expect unfettered choice, so that they can decide for themselves whether to stick with organisations with expertise in the full range of medico-legal problems in primary care, rather than be frogmarched



"We will continue to lobby Government to ensure that the views of members are at the forefront of the decision-making process"

into an untested claims-only monopoly state system.

We have started to make some of these arguments publicly.

Those who want absolute assurances that their personal professional interest, not the financial interest of Government, will be at the heart of the decision-making must be able to opt for that service.

The recent Government announcement confirming funding for the scheme would come from existing resources allocated for general practice does little to allay those fears. That means reductions and costcutting need to be made elsewhere in GP remuneration and primary care spending. The RCGP's recent letter to Matt Hancock, Secretary of State for Health and Social Care, raised similar concerns if funding for the scheme would come from existing resources allocated to general practice.

We have offered up a model for discussion that would have been far better for members and the NHS as a whole. We have also sought guarantees from Government that no GP principal will be financially disadvantaged by this new

scheme when compared to proposals MDDUS has put forward. To date, no assurances have been given. That's bad news for GP partners – and for patients in areas of greatest social need, as that's where any reduction or top-slicing from the global sum hits hardest.

One thing we do know for sure is that the scheme will not cover you for non-NHS work, representation at inquests, GMC hearings and disciplinary investigations. It will also not include advice and support – something highly prized by MDDUS members. The BMA recently backed the need for GPs to maintain membership of an MDO for that very reason, stating it "will be essential to maintain medical indemnity".

This is evidenced by the fact that over the past 12 months, MDDUS' team of expert medical advisers handled 6,561 calls and opened nearly 4,000 new case files from GP members relating to issues NOT included in the government scheme. We will still be there for you.

The MDO model is recognised as a gold standard. That's because it tackles GPs' problems comprehensively – claims, regulation, inquests, discipline. It puts preservation of the doctor's professional reputation and integrity at the centre of all decisions and doctors are involved in the key decisions on their claims. "No decision about me, without me" works for doctors as well as patients.

Writing MDOs out of a claims service is a false economy – and a threat to GPs' professional standing. That's why we expect the state-backed schemes in Wales and England to preserve these principles.

And what does this all mean for our GP members in Scotland and Northern Ireland? There's no reason for the other devolved nations to follow suit given the totally different market. The issues are very different and, in MDDUS' view, do not call for a similar response. Our subscription rates in Scotland are significantly less than those in England and, in fact, lower than they were in 2011.

We will continue to lobby Government to ensure that the views of members are at the forefront of the decision-making process. In the meantime, you can keep up with the latest news on state-backed indemnity on the MDDUS SBIS information hub at www.mddus.com/about-us/state-backed-indemnity.

HOME BUT NOT ALONE

Lindsey Falconer

Risk adviser at MDDUS

EMOTE monitoring is becoming more common as healthcare technology improves and more sophisticated devices become available. Along with remote consultations, remote monitoring is part of a rapidly changing area of technology known as telemedicine. Telemedicine can be defined as the delivery of healthcare services, such as assessments or consultations, over the telecommunications infrastructure. allowing providers to evaluate, diagnose and treat patients without the need for an in-person visit.

Remote monitoring allows patients to be monitored in their own homes through the use of mobile medical devices that collect data. It's much more than just recording blood sugar levels, blood pressure and other vital signs – advances in information technology combined with a growing demand from patients could trigger a revolution in remote health monitoring over the next few years.

A recent report from the M2M (machine to machine) technology market research firm Berg Insight has highlighted how quickly the use of remote health monitoring is expanding. It estimates that in 2016, 7.1 million patients were remotely connected to health monitoring devices. It expects this number to grow by over 40 per cent per annum over the foreseeable future – and greater integration of information technology in healthcare is a key strategy for all UK Governments.

Remote monitoring can be a useful way of improving care by giving patients greater involvement in managing their health and providing continuous tracking of their symptoms, so that interventions can be made before any problems become acute. Because the technology is becoming more user-friendly and unobtrusive to wear, patients can carry on with their normal activities. Increasingly, the software that tracks this information can be integrated into everyday devices, such as smartphones, tablets and now smartwatches, which should help to speed up adoption. However, this new technology does not come without some risks.

A standard for the assessment and approval of safe healthcare apps (as with MHRA approval of healthcare devices) is currently being established, but in the meantime it is important to conduct a comprehensive assessment before introducing new technology into practice. This should include carrying out a privacy impact assessment as required by the General Data Protection Regulation (GDPR). This is basically a risk assessment focusing on the potential impact of a data breach through the introduction and use of monitoring devices and software.

Clinicians will also have to set local standards for the use of remote monitoring by patients. These could be established through profiling different conditions. Patients will have to be aware that an alert might be triggered without them even knowing about it if the monitor is set up to send frequent readings across 24-hour periods.

Clinical staff should be trained in the proper response to alerts and the escalation strategy for each particular patient. Systems should be set up within the practice to ensure that monitoring alerts are dealt with in a timely manner. Without appropriate attention to monitoring alerts, a practice might miss an opportunity to deal with an emerging issue and prevent a serious problem.

'Alert fatigue' could also become a risk if system triggers are not set properly, leading to alerts being ignored – which can be very tempting if they are frequent and of a low level. Doctors should specify the alert trigger strategy for each patient so that they are aware of what is "normal" for that particular patient. It is also vitally important to agree how a doctor will contact the patient to discuss issues for

urgent follow-up. Additionally, the patient's family may need to be made aware of what is arranged so that if the practice has to contact, say, a wife or husband, there is no potential for a breach of confidentiality. All such issues should be discussed with the patient and recorded in the case notes.

To ensure continuity of care, monitoring information needs to be compatible with the clinical system so that information can be stored in the patient record and retrieved easily. Responses to all alerts should be documented with an audit process in place to ensure that monitoring procedures are adequate. Monitoring information should also be reviewed with the patient at regular clinic visits to reinforce adherence to care and treatment plans.

ACTION POINTS

- Carry out a privacy impact assessment before deciding whether to use a device.
- Train staff in proper responses to alerts and the escalation protocol.
- Specify and agree with each patient a "trigger strategy".
- Review monitoring information with the patients at regular clinic visits.
- Document all responses to alerts in the clinical record.

THIS VEXED Adam Campbell on the background to an exhibition celebrating 500 years of women in medicine

T'S hard to imagine a more unpleasant start to an anatomy exam. First, you have to walk the gauntlet of a baying mob – several hundred people throwing mud and refuse at you. Once at the exam hall, you find the front gate barred. Luckily, some supporters smuggle you in through a side door. But no sooner is the examination underway than the door swings open and a live sheep is shoved in, creating further chaos.

The so-called Surgeons' Hall Riot in 1870 was the culmination of months of harassment against the 'Edinburgh Seven', female medical students who had matriculated at Edinburgh University. Sophia Jex-Blake and her colleagues were already paying higher fees and arranging their own lectures, but had to put up with doors being slammed in their faces, regular jibes and other aggressive behaviour – and now this.

In the riot's aftermath, a supportive male medical student wrote to the *Scotsman* newspaper, castigating the perpetrators. In his letter he referred to the ongoing debate about women becoming doctors as "this vexed question". What he was referring to was not so much a glass ceiling as a steel door.

It's impossible to know how that correspondent would have reacted had he been told that 150 years later there would be near parity between the sexes in medicine, as there is today. But he would certainly have been astounded to find his words being used in the title of an exhibition at the Royal College of Physicians (RCP) celebrating 500 years of women in medicine – to coincide with the College's 500th anniversary. Not least because the RCP had done so much, in its first 400 years, to exclude women from the formal medical sphere.

"We felt Jex-Blake was an important pioneer in the whole story," explains Briony Hudson, the exhibition's curator. "And we thought 'this vexed question' was a really good theme to look at in the exhibition, raising debate."

PROBLEMATIC HISTORY

Jex-Blake and her female colleagues never did qualify at Edinburgh, prevented from doing so by the university. She eventually got her MD in Switzerland and then sat the Irish exams with the College of Physicians in Dublin before finally becoming registered in Britain.

Doing her part to settle "this vexed question", Jex-Blake set up the London School of Medicine for Women in 1874. It later joined the Royal Free Hospital. "We borrowed her portrait from the Royal Free Hospital and it's right at the beginning of the exhibition," says Hudson.

It's the second exhibition this year celebrating the RCP anniversary. The first was on the life and work of the ground-breaking anatomist William Harvey. It was decided, explains Hudson, to contrast this strong story about a well-known medical man with a more "multivocal" consideration of the part played by women over

the period. "The relationship between the College of Physicians and women has always been rather problematic. The museum team wanted to be very upfront about that and more analytical rather than just being celebratory," she says.

The result is indeed a very broad look at women in medicine over the 500-year period and beyond – and not just doctors, clearly, considering the time frame, but also apothecaries, herbalists, writers of recipes, midwives and more. One of the earliest artefacts in the exhibition is a page from the *Leominster Register of Deeds* in the 13th century, confirming the existence of two sisters, Solicita and Matilda, who described themselves as doctors.

From there, the exhibition traces the persistent, if sometimes fleeting, appearances of women in medicine right up to the present day. It shows how, despite the odds – starting with an Act of Parliament of 1511 preventing women, with a few exceptions, from practising medicine – they persisted and fought, defying the rules, using their connections, or simply bamboozling their way into medicine for centuries, before eventually winning the right to freely study, qualify and register as doctors.

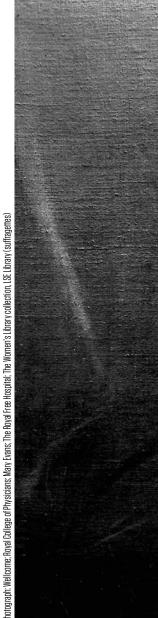
So there are women like Alice Leevers, who appeared before the officers of the RCP in 1586 accused of practising medicine. A repeat offender, Leevers had friends in high places and Queen Elizabeth's Lord Chamberlain wrote to the College requesting that she continue practising. Despite claiming that Leevers was "utterly ignorant" in medicine, the College complied.

Lady Elizabeth Grey and her sister Alethea Talbot were similarly well connected and in the 17th century they published books sharing their medicinal and chemical knowledge more widely. Between 1653 and 1726, Lady Grey's *A Choice Manuall* was republished no fewer than 22 times.

A woman who called herself Agnodice – taking her name from a female figure in Greek mythology who dressed as a man in order to become a doctor – boldly advertised her services as a "woman physician" in the 1680s. Margaret Anne Bulkley went one step further, practising as Dr James Barry and rising to become one of the most senior military medics of the 1800s – her secret only being uncovered after her death.

Hudson and the museum team combed the archives in search of letters, testimonies, portraits and other exhibitable material to tell this story. At Lambeth Palace, she uncovered Elizabeth Moore, one of 12 women licensed to practise medicine by the Archbishop of Canterbury (who, in addition to the RCP, had this power) between 1613 and 1696. According to testimonial letters in support of her 1690 application, she treated consumption, lameness, swooning fits, rickets, toothache and pleurisy. One witness said he had used "no other physician for 25 or 26 years ... & with good success".

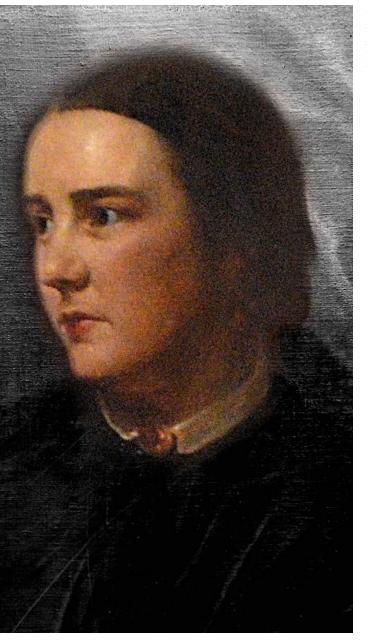












Clockwise from left: Sophia Jex-Blake was a pioneer; the London School of Medicine, which she founded in 1874; suffragettes marching in support of women studying medicine; Dr Elizabeth Blackwell.

ACCEPTANCE AT LAST

Reaching the late 18th and early 19th centuries, focus shifts from practising medicine to qualifying as doctors. Like Sophia Jex-Blake, Elizabeth Blackwell qualified abroad, in America – having first been rejected by 29 medical schools there. She later became the first British woman doctor to be officially registered, in 1859.

Women were finally able to earn a medical degree from a British university – the University of London – in 1882, although the battle to study on an equal footing to men would go on. Remarkably it was not until 1947 that all London medical schools were obliged to take women students.

In the meantime, women were finally allowed to become members of the RCP in 1909 and fellows in 1925. In 1934, Helen Mackay was the first woman to be elected FRCP; in 1943, Janet Vaughan became the first to be elected to the RCP Council; and in 1989, Margaret Turner-Warwick, a leading chest physician, was elected as the RCP's first woman president.

"This was not so much a glass ceiling as a steel door"

By 1972, 20 per cent of practising doctors in Britain were women. Today – 150 years after Sophia Jex-Blake was pelted with mud – that figure is nearer 50 per cent.

The exhibition offers a comprehensive picture of the last 500 years, and

to bring things fully up-to-date, the curators decided to ask today's women doctors to choose something to put on display to represent their careers. One chose an iPhone because "the only way you can manage to be a mother and a doctor is to have all of these different apps".

Coupled with the fact that, for the duration of the exhibition, the portraits of venerable male physicians in the RCP's Osler Room have been replaced by portraits of equally venerable women, it might well be an indication that "this vexed question" has finally been put to bed.

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

This vexed question: 500 years of women in medicine can be visited at the Royal College of Physicians Museum at St Andrews Place, London, until 18 January, Monday to Friday, 9am–5pm. Admission is free.

Dr Selina Master of the Faculty of Dental Surgery looks at tongue splitting and other forms of oral "body modification" and the growing risk to public health

CUT ON THE DUNE

ODY modification for cosmetic purposes has become increasingly popular over the last few years and as many as 10 per cent of the adult population have had some form of body piercing. It is particularly common in women between the ages of 16 and 24.

Tongue splitting is a form of body modification which creates a forked effect with the tongue, similar to a lizard or snake. Online sites recommend tongue splitting as a "disguisable and discreet body modification" which is "super-fast, simple and very reversible". One site suggested that it was simple to perform, and that all you have to do is "just cut on the dotted line".

Is tongue splitting legal in the UK? In March this year, the Court of Appeal found tongue splitting to be unlawful when performed by a body modification practitioner for cosmetic purposes – a ruling which applies to England and Wales.

However, the Faculty of Dental Surgery at the Royal College of Surgeons (FDS) and the British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) are concerned that the legal status of tongue splitting remains unclear in other parts of the UK and they highlight an urgent need for the law to be strengthened and enforced across the whole of the UK.

GBH BY CHOICE

The Court of Appeal's judgement on tongue splitting found that such procedures, when undertaken by a body modification practitioner for no medical purpose, constitute grievous bodily harm (GBH) even if someone has given consent. It is very important for patients to be aware that even if they agree to a tongue split with the associated risks, a body modification practitioner in England and Wales will still be breaking the law if they perform the procedure.

Initially, tongue splitting involved tying string around a tongue piercing and pulling it until the tongue split. However, this process was inevitably painful and lengthy. These days the most common procedure involves use of a scalpel to cut down the centre of the tongue – the sides are then separately stitched. Alternatively, a laser may be used to separate and cauterise the tongue.

The "High Priestess" method requires the tongue to be pierced before a scalpel is placed in the hole created by the piercing and used to slice the tongue. As a result, the tongue bleeds for about 15 minutes into a bag which is tied under the recipient's neck. Understandably, there is a paucity of data available on how and where these procedures are being performed.

Tongue splitting comes with some obvious clinical risks:

- **Haemorrhage.** There is a risk of significant blood loss if major veins or arteries are severed. The person carrying out the procedure may not be appropriately acquainted with the anatomy of the tongue.
- **Infection.** As with oral piercings, there is a danger of infection if the equipment used is not suitable or appropriate and, particularly, if it is not adequately sterilised.
- Nerve damage. Similarly, damage to nerves within the tongue is a



"Raising awareness of the risks of oral body modification, such as tongue splitting, is critical to helping our patients"

significant risk which may result in chronic pain, altered sensation or even permanent anaesthesia.

- **Anaesthetic risks.** In instances where local anaesthetic is used as part of a tongue split, there is a risk that the person undergoing the procedure may suffer an adverse reaction.
- **Speaking and eating.** There are also potential long-term difficulties with eating and speaking, along with the fact that maintaining adequate oral health and hygiene could be more challenging after the tongue split.

ORAL PIERCINGS

In February, Wales became the first country within the UK to ban "intimate piercing" (including oral piercings) for those under 18 years of age. While some councils have put age restrictions in place locally, there is no national age limit in other parts of the UK.

Quantifying the actual proportion of body piercings that develop complications is not easy, as only a few people report having the procedure done. Despite this fact, complications do appear to be common and are reported in about a third of piercings, with one in seven requiring professional input. The patient tends to seek help from a pharmacist, the body piercer or from their GP. Although the majority of problems may be minor and resolve without intervention, approximately one per cent do lead to serious complications and a hospital admission.

Among the risks are:

- **Swelling:** this is the most common side effect following an oral piercing. An enlarged tongue can lead to serious breathing difficulties.
- **Infection:** there is a risk of introducing infection during the actual procedure and a piercing may also become a source of chronic infection.
- **Tooth wear/tooth fracture:** a ring or stud placed through a piercing has the potential to cause tooth wear over time and can also increase the risk of a fractured tooth.
- **Gingival recession:** a person with an oral or tongue piercing is three to four times more likely to experience gingival recession.
- **Oral lesions:** the presence of jewellery in the mouth can result in the development of oral lesions (known as tissue hyperplasia) around the piercing.
- **Inhalation/ingestion:** there is always the possibility of the jewellery becoming loose or dislodged, with the subsequent risk of inhalation or ingestion.

HELP FROM THE PROFESSION

Raising awareness of the risks of oral body modification, such as tongue splitting, is critical to helping our patients. Providing advice, being non-judgemental and respecting a patient's autonomy (within legal bounds) will hopefully encourage patients to attend for treatment of any possible complications. If the dental team and patient are fully aware of potential consequences and complications, a pro-active approach can be adopted with careful monitoring and regular reviews.

BAPRAS and the FDS have been unequivocal in advising against oral piercings, as well as tongue splits, as they can have a significant impact on oral health and lead to potentially serious adverse complications.

If your patient does choose to have an oral piercing, then we advise that they should have their oral health monitored regularly by their dentist. Patients should be made aware that body modification practitioners who offer tongue splitting services may now be doing so illegally. Members of the public should be warned never to contemplate carrying out these invasive procedures on themselves or anyone else.

It is important that all health professionals are cognisant of the potential complications following oral piercing and/or tongue splitting, together with appropriate management strategies and techniques.

Dr Selina Master MBE FDSRCS is the current Senior Vice Dean of the Faculty of Dental Surgery of the Royal College of Surgeons

• To access the recent FDS and BAPRAS Joint Statement on Oral Piercing and Tongue Splitting go to tinyurl.com/y7rcf5dc

REFLECTIVE PRACTICE

Solicitor Joanna Bower considers the status of reflective practice following the legal case of Dr Hadiza Bawa-Garba

HE death of Jack Adcock at Leicester Royal
Infirmary was a tragedy for all concerned: the
devastating loss of a son for the Adcock family
and a gruelling seven-year ordeal for one of
the doctors involved in his care, Dr Hadiza
Bawa-Garba. Criminal and regulatory decisions
made following Jack's death have had wide
implications for the medical community as a
whole, particularly around reflective practice.

On the incident date – 18 February 2011 – Dr Bawa-Garba was the most senior paediatric junior doctor on site at Leicester Royal Infirmary. She had just returned after 14 months of maternity leave. The lead consultant was off-site and the paediatric team were three doctors down. Patients were on six wards over four floors. The computer system was down, resulting in delays in obtaining test results.

Jack was referred to the Children's Assessment Unit by his GP. He had Down's syndrome and a hole in the heart. On admission he was unresponsive and limp with a history of diarrhoea and vomiting, shallow breathing and slight cyanosis of the lips. Jack was suffering from pneumonia and sepsis, but the diagnosis was never made. Later that day the sepsis caused heart failure, but there was a delay in resuscitation as Dr Bawa-Garba mistook him for another patient who had DNACPR in place. However, this had no impact on the outcome and Jack sadly died at 21:20.

The hospital's serious incident (SI) report made 23 recommendations and identified 79 actions to be taken but identified no single root cause.

CRIMINAL CHARGES

In November 2015, Dr Bawa-Garba and agency nurse Isabel Amaro were prosecuted for gross negligence manslaughter (GNM). The jury found that Dr Bawa-Garba had made a significant number of errors that were "truly, exceptionally bad". Both Dr Bawa-Garba and nurse Amaro were convicted and received two-year prison sentences, suspended for two years. The judge commented that:

"There was no evidence that either of you neglected Jack... You both had other patients to attend to. The problem was that neither of you gave Jack the priority which this very sick boy deserved and, in your case (Dr Bawa-Garba) you were falsely reassured by the apparent improvement in Jack's condition from the treatment which you did give him."

The judge also noted: "yours was a responsibility shared with others".

Dr Bawa-Garba was twice refused leave to appeal. In June 2017, the Medical Practitioners Tribunal (MPT) found that Dr Bawa-Garba's fitness to practise (FTP) was impaired and she was suspended for 12 months. The GMC appealed to the Divisional Court and in January 2018 the court substituted suspension with erasure. In August 2018, the erasure was overturned by the Court of Appeal who

referred the case back to the MPT for the suspension to be reviewed. Whilst they acknowledged that there are some cases where erasure is the only proper sanction, this was not one of them.

Following the criminal trial there was a media storm which heightened after the Divisional Court's decision. Doctors were concerned about the appropriate use of reflective materials in court proceedings and there were other concerns, including prosecution for GNM in a healthcare setting and the power of the GMC to appeal decisions. Subsequently, two reviews were commissioned: the government's Williams Review and the GMC's Hamilton (formerly Marx) Review.

REFLECTIVE GUIDANCE

It's a popular misconception that Dr Bawa-Garba's reflective journal was used at her criminal trial. Both her defence organisation and the Crown Prosecution Service confirmed that this was not the case, and neither the journal nor her appraisal are mentioned in the MPT decision. We now know that evidence was given during the criminal trial in support of Dr Bawa-Garba by her supervisor, Dr Cusack, which referred to her reflections.

In the midst of the Bawa-Garba proceedings, LMCs (local medical committees) lobbied the BMA to formally state that doctors should refrain from reflective practice. However, the GMC were quick to respond, issuing a formal statement warning doctors that they risk jeopardising revalidation unless they actively engage in reflective practice.

The Williams review has recommended that the GMC should not be able to request reflections in FTP cases. Currently, the GMC does have power to apply to court for an order for specific disclosure, although the GMC has now confirmed it will not compel disclosure of doctors' reflections. Unfortunately this does not extend to clinical negligence claims against doctors.

Guidance on reflective practice (*The reflective practitioner*) has been published by the GMC, the Academy of Medical Royal Colleges, the Conference of Postgraduate Medical Deans and the Medical Schools Council. Key points in the document include:

- Anonymisation of details this has to be more than simple removal of the patient's personal identifiers such as name, age or address. The GMC defers to the definition from the Information Commissioner's Office: data is anonymised if it does not itself identify any individual, and if it is unlikely to allow any individual to be identified through its combination with other data.
- · Focus on learning and future plans.
- Record factual details elsewhere (e.g. SI reports).
- Be open and honest, reflecting on both positives and negatives.
- The value of team reflection, which often leads to ideas to improve patient care.

WHAT NOW?



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DISCLOSURE

In which type of proceedings are reflections disclosable?

Civil proceedings. Reflections are disclosable if they are "relevant" and either support or adversely affect a party's case. Therefore, care needs to be taken when writing in a reflective journal. Anonymisation has to comply with the ICO's definition which means that reflecting on a specific incident is likely to be disclosable. A reflective piece would only be protected from disclosure if it is suitably generic and cannot be traced back to the patient or incident in question. The focus should be on learning rather than writing at length about the incident and what has gone wrong.

GMC proceedings. The GMC has confirmed that it does not request reflective notes. However, it can be helpful for doctors to submit them to show insight. The balance between being insightful yet minimising the risk of reflections being disclosed in any concurrent civil proceedings is a fine one. If advised by your medical defence organisation, apologise and accept errors early on notwithstanding any systems failings which can be used in mitigation. Write reflections early on and throughout the proceedings, e.g. after attending remedial training courses to reflect on learning points. In the wake of Dr Bawa-Garba's case, the GMC has confirmed that it will not require disclosure of doctors' reflective records as part of any fitness to practise proceedings, and the Hamilton review is looking at the possibility of introducing legal privilege for all reflective records so that doctors cannot be compelled to disclose them.

Criminal proceedings. Unlike civil proceedings there is no obligation for a doctor to disclose appraisals/ reflections in criminal proceedings, although the CPS could apply for disclosure of such documents. However, the CPS confirmed that reflective notes did not form part of the criminal case against Dr Bawa-Garba and, in the current climate, they may now be cautious in seeking disclosure of such documents in criminal proceedings against a doctor.

THE FUTURE

The Hamilton review will be published early next year offering greater insight. The GMC also recently announced that its investigators are to be given human factors training to "ensure that context and systems issues are always fully taken into account". This is welcome news, as is Sir Robert Francis QC's recent evidence to the Health and Social Care Committee. It has often been felt that doctors are left to stand alone when things go wrong but the former Chair of the Mid Staffs Inquiry has called for senior NHS managers to be held to account in the same way as their doctors and nurses when systems failures lead to medical error.

At the end of a long and difficult journey for Dr Bawa-Garba and the Adcock family, it seems that change is on the horizon.

Joanna Bower is a partner in the clinical law department at Capsticks Solicitors LLP

Dr Hadiza Bawa-Garba



생 CLAIM

GUT PAIN

BACKGROUND

A 46-year-old self-employed plumber – Mr H – attends the surgery complaining of recurrent indigestion and heartburn. He is moderately obese and has recently separated from his wife. The GP – Dr F – notes that the patient had seen another GP in the practice two months before in regard to stress and depression connected with the marriage break-up.

Dr F examines the patient and notes a minimally tender epigastrium (no upper quadrant pain) with a clear chest. A diagnosis of heartburn is made and Mr H is prescribed omeprazole and provided with dietary advice. The patient is advised to re-attend if the symptoms do not improve.

Four months later Mr H is back at the surgery and this time is seen by Dr K. He complains of recurrent epigastric pain and reports that the omeprazole supplemented with over-the-counter antacids have not helped. Mr H wonders if it might be gallstones as his sister had similar symptoms with her gallstones.

Dr K decides that, based on the history alone, it sounds like dyspepsia. He prescribes ranitidine and asks Mr H to return in four weeks for review.

Six weeks later Mr H returns to the practice and is seen by Dr F. He complains

again of epigastric pain and says it has grown worse. Neither the omeprazole nor the ranitidine have helped and he is still worried it might be gallstones. Dr F prescribes Peptac and arranges for an ultrasound investigation.

The ultrasound reveals a thin-walled gallbladder containing several calculi though a normal common bile duct.
A private referral to a general surgeon is made and Mr H undergoes a laparoscopic cholecystectomy. His recovery is uneventful and histology of the gallbladder confirms chronic cholecystitis.

A letter of claim is later received by the practice alleging clinical negligence against Dr K in the delayed diagnosis of the patient's gallstones. Mr H claims this led to unnecessary prolonged pain and missed work.

ANALYSIS/OUTCOME

MDDUS reviews all records associated with the case and instructs a GP expert. The letter of claim alleges that Mr H presented to Dr K with epigastric pain having been previously prescribed omeprazole without any benefit. The patient expressed worry that he might have gallstones but Dr K diagnosed dyspepsia without an examination to determine the nature of the

epigastric pain – leading to a failure to arrange a timely ultrasound investigation.

The GP expert agrees that the failure by Dr K to examine the patient constitutes a breach of duty of care. On the question of the findings had Dr K examined the patient, an expert general surgeon opines that it is likely that tenderness would have been elicited over the gallbladder in that consultation, leading to referral for an ultrasound scan. He concludes that causation (the consequences of the breach) is limited to two months of additional pain and missed work.

MDDUS considers the case represents a clear litigation risk and, with the agreement of the member, offers a small settlement with no admission of liability.

KEY POINTS

- Do not rely on notes from previous examinations in considering a diagnosis – re-examine the patient.
- Always carry out an adequate history/examination to determine the nature of reported pain.
- Record the justification behind key clinical decisions.

⊘ COMPLAINT

HEALTHY EATING

BACKGROUND

Eve W is eight years old and attends the dental surgery accompanied by her mother. She complains of a sore tooth and the dentist - Dr N - identifies two carious teeth and a loose filling in another deeply cavitated tooth. Checking the patient records he notes several other visits for the treatment of carious teeth in the past.

Dr N temporises the teeth with restorative material and asks reception to arrange a later appointment. He then asks Mrs W about Eve's daily diet in order to identify factors that might be causing the tooth decay. He tries to explain the importance of reducing the amount and frequency of sugary foods and that these should only be offered at mealtimes. He also tells her that fruit juice and/or smoothies should be limited to one portion in total per day and again only at mealtimes. Mrs W becomes tearful and the dentist is

unclear whether she has taken in all that has been said. An appointment is made for the next week.

Two days later the practice receives an angry letter from Mr W. He accuses Dr N of bullying his wife and suggesting that they are bad parents. He states that Eve eats lots of fruit as the advice

> from school is to provide your child at least five portions of fruit and vegetables a day.

ANALYSIS/ OUTCOME

The dentist contacts MDDUS for guidance in replying to the complaint. He drafts a response letter offering an apology for the distress caused by the consultation and the

misunderstanding as regards his intentions in discussing Eve's diet. The letter states that he in no way intended to cause offence or insinuate anything regarding parenting skills and was offering only general advice in

regard to diet as would be expected of any registered dental professional.

Dr N offers his full endorsement of the "five-a-day" campaign and states he only wished to suggest that juice should be incorporated with meals to reduce the frequency of consumption as fruits have natural sugars. He suggests that perhaps his language was unclear and apologises again if he seemed "blunt".

A face-to-face meeting is offered to discuss the matter further but Mr W does not respond and the family remains registered with the practice.

KEY POINTS

- Be conscious of language used in consultations be clear, comprehensible, neutral and non-
- Be aware that in responding to complaints a sincere expression of regret can often diffuse conflict.



₩ ADVICE

PATIENT ABROAD

BACKGROUND

A practice manager contacts the MDDUS advisory line with a query in regard to their video consultation service. A patient has telephoned seeking advice about a rash on her leg which she wants to show a GP using her smartphone. It transpires that the patient is on holiday in Spain.

The practice manager has phoned to ask whether it is appropriate for a GP from the surgery to advise the patient on her condition.

ANALYSIS/OUTCOME

The MDDUS adviser urges caution in handling this request for a number of reasons. Doctors are professionally obliged to make an appropriate assessment of patient symptoms, and with video consultations this is very much dependent on the quality of the system being used. A poor quality video connection could mean that images lack detail, and in any case it is essential to have the option to arrange a face-to-face consultation where appropriate. This is obviously not possible if the patient is abroad.

A second issue is one of legal jurisdiction. MDDUS generally recommends that doctors do not consult with patients abroad as this may be deemed to be outside the UK jurisdiction. This means that a patient may bring a claim in the local jurisdiction which MDDUS cannot likely indemnify. The GP may also be practising in contravention of local law in not being registered with the relevant regulatory body. Conceivably the GP could even be liable to criminal charges in that jurisdiction.

The practice is advised to urge the patient to seek treatment from a local doctor or hospital and attend the surgery on her return with any remaining concerns.

KEY POINTS

- Online/video consultation services should always allow the option of requesting the patient attend for a face-to-face examination.
- Video consultations abroad may be subject to legal/professional liability within that
- Legal indemnity will likely not apply when treating a patient abroad.

ADVICE

HONEST ASSESSMENT



BACKGROUND

Mrs P has recently registered with a new dental practice and attends for a check-up. In the chair she complains of slight mobility in a post-retained crown at UL2 though no pain. The dentist – Dr L – confirms movement in the crown but decides it's not loose enough to remove without endangering the root. She advises Mrs P to return if the tooth becomes a problem and takes a radiograph of the area to record the morphology of the roots.

Later, reviewing the radiograph, she notes root treatment in the tooth short of the radiographic apex, together with two posts in-situ, one not in the canal and deviating very close to what appears to be a perforation.

Dr L is unclear what to tell the patient regarding the tooth. She does not feel it is something she can keep from her but is

also concerned it will reflect badly on the patient's previous dentist. Saying nothing could make her complicit if an iatrogenic issue compromises the long-term viability of the tooth.

The dentist contacts MDDUS for advice and forwards copies of the radiograph.

KEY POINTS

- The GDC states healthcare professionals must be open and honest with patients when something goes wrong with their treatment or care.
- That duty overrides any personal and professional loyalties among colleagues.

ANALYSIS/OUTCOME

An MDDUS adviser checks the image and finds it difficult to determine if a perforation has occurred. There does appear to be intact tooth substance between the end of the post and the root margin but there is also thickening of the periodontal ligament in the region of what may be a suspected perforation.

He reminds Dr L of GDC guidance on the duty of candour which states that all practitioners must be honest and open with their patients. He suggests that the dentist meet with Mrs P to advise her of the radiographic findings and potential problem with the tooth. The patient could be encouraged to request a copy of her records from her former practice in order to chart the care provided. In any case, it is then up to the patient to decide if she wants to pursue a complaint.

IMPACTED WISDOM TOOTH

BACKGROUND

A 33-year-old man – Mr T – has been referred for outpatient surgery at a local dental hospital for removal of an impacted wisdom tooth (LR8). The patient is warned of possible complications including pain, swelling, infection and possible nerve injury affecting the lip and tongue. The patient is content to proceed and the procedure is undertaken without incident. A discharge letter is sent to the referring dentist – Dr C – for ongoing care.

Three weeks later Mr T attends the dental surgery complaining of pain in the lower right jaw with trismus and paraesthesia. Dr C examines the socket and reassures the patient that such symptoms are not uncommon following removal of a deeply impacted wisdom tooth. Sometimes it can take months for sensation to return and symptoms to ease. He advises analgesia for the pain.

Mr T is back in the surgery two weeks later complaining of "shells" (sequestra) coming from a painful socket and lip paraesthesia. Dr C again reassures Mr T that such symptoms are not uncommon and he prescribes a course of amoxicillin. No note of an examination is recorded.

Another three weeks later Mr T is still in pain and while eating dinner hears a "crack" in his jaw. He attends the dental surgery the next morning and demands a referral. Dr C contacts the dental hospital by phone and requests that Mr T be seen in regard to

a non-healing extraction socket with associated swelling and obvious infection.

Mr T attends the hospital and a radiograph reveals a fracture of the right angle of the mandible. He is commenced on IV antibiotics and two days later undergoes surgery to reduce the fracture and internally fix with titanium plates. Five days later he is discharged but infection later recurs and further surgery is necessary.

A letter of claim is received by the practice alleging clinical negligence against Dr C in failing to refer Mr T for an unresolved infection associated with an iatrogenic fracture during the extraction of LR8. A separate claim is being pursued against the hospital trust.

ANALYSIS/OUTCOME

MDDUS instructs a GDP expert who notes that in the first consultation post-extraction Mr T complained of pain with trismus and paraesthesia, and that such symptoms are common following surgical extraction of an impacted wisdom tooth. He states it would be unusual to initially suspect a mandibular fracture at this stage with no other apparent clinical signs.

In regard to the second consultation the expert again finds nothing inconsistent with expected side effects – but he is critical of the dentist's record keeping. An antibiotic was prescribed but the notes provide no rationale for this or record of an examination/clinical findings.

Referral at the third consultation after the reported "crack" was "entirely appropriate", states the expert, and nothing from the available (albeit poor) clinical records suggests that Dr C failed to diagnose a fracture and treat the patient in an appropriate clinical manner.

An expert report is also commissioned from a consultant oral and maxillofacial surgeon. On considering the full patient records and radiographic evidence she contends the fracture was pathological rather than iatrogenic - the result of a post-operative low-grade infection which had been present from almost immediately after surgery, as evidenced by the ongoing pain, failure to heal and the presence of sequestra, and likely occurring when Mr T felt the "crack". In regard to causation, she considers that had the infection been treated sooner, the fracture would, on the balance of probabilities, not have occurred; but that, nevertheless, Mr T would have still required surgical intervention.

Given the vulnerabilities in the case, primarily arising from the poor record keeping, MDDUS agrees to settle with agreement of the member.

KEY POINTS

 Make adequate notes justifying clinical decisions and detailing examinations and findings.

₩ ADVICE

AN ANGRY ENDING

BACKGROUND

Mr B contacts his family medical practice asking to make an appointment for his wife that Friday, as her employer does not allow staff to make personal calls. He is told by the receptionist that the practice offer only "book-on-the -day" appointments and that Mrs B should phone back at 8.30am on Friday. Mr B explains that his wife will already be at work by then and asks why he can't simply arrange an appointment.

The conversation becomes heated and the receptionist passes the call to the PM who offers an appointment on the Monday. Mr B shouts that this is too late and the PM eventually terminates the call due to his aggressive tone.

The next day the practice receives a letter from Mrs B complaining about her difficulty in booking an appointment and also about "unhelpful practice staff". One of the GPs – Dr T – responds by calling Mrs B and offering to see her Friday afternoon.

Later the PM phones Mr B who apologises for losing his temper but Dr T is not satisfied and decides to remove him from the practice patient list. She informs him of her decision by letter, stating that his behaviour was unacceptable and that he should look for another practice. She adds that his request for an appointment was not in line with policy, details of which could be found on the practice noticeboard.

The next day Dr T receives a formal letter of complaint from Mr B. He objects to being abruptly removed from the practice list and asks to be reinstated. His understanding was that practice policy allowed patients to book up to two days in advance and he was unaware of any posters stating otherwise. While he

KEY POINTS

- Ensure your booking system is flexible and does not disadvantage some patients
- Practice policies should be advertised in multiple formats.
- Patients should not routinely be removed from the practice list without prior formal warning.

apologises for losing his temper, he accuses the practice staff of being obstructive and condescending and asks for a review of practice policy to make appointments easier to access.

ANALYSIS/OUTCOME

Dr T contacts an MDDUS adviser for guidance on how to respond. She is advised to address each individual point raised and, where appropriate, offer an apology and an explanation of the circumstances that led to the complaints.

In regard to the decision to deregister Mr B, the adviser warns that the matter could be referred to the ombudsman or the GMC, and Dr T must be prepared to fully justify her decision. She is advised to review guidance from both the GMC and RCGP on ending your professional relationship with a patient. The GMC states that before ending a relationship, the doctor should warn the patient and do what they can to restore it. Dr T accepts she has not given Mr B due warning. She agrees to reinstate him to the practice list and offers to meet to discuss his complaints.

DILEMMA

OFF LABEL REQUEST

Dr Barry Parker

Medical adviser at MDDUS and Insight editor

WORK as a GP and a patient of mine sufferina from a chronic severe neurological condition has asked me to prescribe a drug to help with fatigue and muscle spasm. I am not familiar with the drug but on checking the BNF I see that it is available as a prescription-only medicine but not licensed for use in the patient's condition. The patient has shown me a research paper from America that he has obtained from the internet on the use of the drug for his condition, but it refers to one small study only. He discussed the drug with his consultant but she would not agree to prescribe this. He has a doctor friend who has advised him that it could help him. I am keen to help, but not sure if I should prescribe.

This can be a difficult situation to manage. All doctors want to help their patients as much as possible and in this case the patient has a distressing neurological condition where treatments are limited. but the doctor is unfamiliar with the medicine in question and wants to proceed safely.

There is detailed guidance provided by the GMC on prescribing unlicensed medications which is helpful in this scenario. The GMC defines unlicensed medicines as those that are used outside the terms of their UK licence (off label) or have no licence for use in the UK. The guidance highlights that you should usually prescribe licensed medicines in accordance with the terms of their licence. However, you may prescribe a medicine that is unlicensed when, on the basis of an assessment of the individual patient, you decide for medical reasons that it is required to meet the needs of that patient. Unlicensed medicines are commonly prescribed in some areas of medicine such as paediatrics, psychiatry and palliative care, but can be used in other areas in certain circumstances.

Such medications may be necessary where there is no other suitable licensed drug that will meet the patient's need, or where there is a licensed medicine but it is unavailable, for example because of a temporary shortage. They may also be prescribed as part of a properly approved research project.

It is important to remember to follow GMC guidance when prescribing an unlicensed medicine. It states you *must*: a. be satisfied that there is sufficient evidence or experience of using the medicine to



demonstrate its safety and efficacy b. take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring, and any follow-up treatment, or ensure that arrangements are made for another suitable doctor to do so c. make a clear, accurate and legible record of all medicines prescribed and, where you are not following common practice, your reasons for prescribing an unlicensed medicine.

In addition, patients (or their parents or carers) must be given sufficient information about the medicine to allow them to make an informed decision. Where a doctor decides to prescribe an unlicensed medicine when this is not routine, or if there is a suitably licensed alternative, an explanation of the reasons for doing so must be given and recorded in the patient notes.

In the above scenario, it is the patient who has requested the medication, but the doctor is unfamiliar with its use. Doctors should only prescribe medicines when they are satisfied that the drugs or treatment serve the patient's needs. Doctors also have a duty to work within their own

sphere of knowledge and competence. If the doctor is considering prescribing the medication, he should investigate the risks and benefits in detail, including discussion with the consultant to establish why he has declined to prescribe.

Under GMC guidance, the doctor will be taking full responsibility for treatment and follow up, and so would require to have sufficient knowledge of the medication to be confident that it was appropriate and safe. He would also have to be able to present sufficient evidence to justify his prescribing decision if called upon to do so for any reason.

The desire to agree to the patient's request to help treat his condition is understandable but if there is any doubt in the doctor's mind about the appropriateness of the prescription, he should decline. It is of course open to him to encourage the patient to seek a second opinion on the matter.

• For further guidance consult the GMC's Prescribing and managing medicines and devices and Good Medical Practice.

ETHICS

TRIALS, HOPE AND RESEARCH ETHICS

Deborah Bowman

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

URING my chemotherapy, my oncologist explained that he would be including a note about potential trials for which I might be eligible once I had completed active

treatment. Knowing me well, he emphasised that this was included as an aide memoire for the team and research nurse, not a proposal that I should spend hours researching myself (there is little as frustrating for a clinician as a professor of ethics with PubMed access and an anxious disposition).

In the summer, before radiotherapy, I discussed the trial again but this time in more specific terms. I was introduced to the research nurse who, along with my oncologist, described the trial for which I might be suitable. They were, as ever, exemplary in their practice. The pace, sensitivity, responsiveness and clarity with which they discussed the trial, its aims and methodology demonstrated not only skills, but the characteristic ethical commitment and patient-focus that imbues their practice.

I went home from that initial discussion about the specific trial carrying a large amount of paper: patient leaflets, background information, the trial protocol and a weighty consent form. I read them all diligently, but was discomforted by my reaction to what I read. I had expected, on digesting the information and reflecting on the consultation, to be focused on the uncertainty inherent in equipoise, the risks of volunteering for research, the burden of continuing to visit the hospital regularly and the potential to contribute to scientific and clinical knowledge. Yet it was a deep-seated urge to "try anything possible" to prevent recurrence and/or secondary disease that dominated and shaped how I interacted with the information I had received.

I took myself in hand and asked expert colleagues and friends to review the data that had been published from earlier trials of the drug. They generously gave their time and shared their dispassionate analyses and informed thoughts with me. I deliberately read the materials several times, making myself focus on the information about risks as well as potential benefits. I spoke to trusted confidants about the trial and encouraged them to



"It was a deep-seated urge to 'try anything possible' to prevent recurrence that shaped how I interacted with the information I had received"

challenge my impulse to sign up. I reminded myself that I could be randomised to the control arm of the trial. These were important disciplines, yet I remained determined to participate in the trial in a way that surprised me.

I have thought a lot about that determination and impulse to participate and the implications for research ethics. Although I have often framed discussion of research ethics with reference to vulnerability, I had underestimated, indeed been ignorant of, the urge to pursue hope in the face of serious illness. Irrespective of

training, professional background and efforts to be rational, there was for me an overriding wish to "do everything possible" to maximise my chances of preventing further disease. Much as I deliberately slowed myself down and challenged that impulse, it dominated.

I found easy narratives to support my decision ex post facto. I told myself that altruism and the prospect of contributing to knowledge resonated with my values. The results from earlier trials of the drug had shown promise and impartial colleagues agreed (although noted the different population). I would continue to be a regular visitor to the hospital which would allow for surveillance. All of those narratives are true, but they were not the driving force for my decision which was an irrational, almost primitive, search for hope and control

How then might researchers approach potential participants about enrolling in trials and studies? Perhaps the first step is, alongside the emphasis on time, space and information, to acknowledge the complex drivers and influences that shape an individual's thinking about trials. I do not presume to generalise from my experience - I have met many patients in my professional life who appeared to take a more interrogative and rational approach to enrolling in research along, of course, with those who decide it is not something in which they wish to participate. However, I do suggest that the individualism of anyone who is approached as eligible for a trial or research study cannot be captured in leaflets, forms, protocols and papers. Whilst research is often concerned with populations, cohorts and groups, the recruitment of those units is predicated on an ethical awareness of, and response to, the individual and the specific. And those individual and specific dimensions of choice and decision-making may be unarticulated, surprising, contradictory, confusing, changing and hidden.

What might be needed is both someone who knows the individual and someone who is independent of the person, and a recruitment process that is both consistent and adaptive, that is attentive to signals and cues and that acknowledges that the prospect of a trial may represent much more to the participant than can ever be expressed or understood.

Addenda

BOOK CHOICE

This is going to hurt by Adam Kay

Picador, paperback, £3.99, 2018 Review by Greg Dollman, medical adviser, MDDUS

ADAM Kay's bestseller, now in paperback, has perhaps done more than any investigative reporter or reality TV show to highlight what it is really like to be a junior doctor. Hilariously funny throughout, *This is going to hurt* closes with a very solemn message to society: "Remember [healthcare professionals] do an absolutely impossible job, to the very best of their abilities. Your time in hospital may well hurt them a lot more than it hurts you."

The book is a collection of amusing stories from Kay's "secret diaries" whilst a junior doctor. Think Adrian Mole in a lab coat (and after the infection control lead nurse visited, bare below the elbow). These include the obligatory "lost in translation" funnies (including medical students trying to make sense of a new vocabulary), the literary gems produced by outsourced dictation services, the inevitable "unexpected objects stuck in orifices", the banter between colleagues, and of course the abundant humour patients bring, wittingly or often more so unwittingly, with them to hospital. And Kay was a trainee in obstetrics and gynaecology, so expect plenty of body fluids gags.

And yet, Kay tells us that he "hung up his



stethoscope" when "one terrible day, it all became too much for me". This is a very personal story of how the vocation took its toll.

I would think that all doctors can relate to the hurt that Kay describes in his book. There's the seemingly endless hours of overtime, the many missed or cancelled

personal activities, the numerous changes of clothes covered in someone else's body fluids (for me, it always seemed to happen when wearing a new pair of trousers), the constant move to new departments or hospitals, the anxious wait after a needle stick injury, the endless suffering of patients. And yet, doctors return day after day, to continue their extraordinarily valuable (if not always valued) efforts.

I, like Kay, no longer work as a clinician, yet I share his immense "respect for those who work on the front line of the NHS". I also agree with his recommendation that doctors talk about "the sad stuff, the bad stuff" they encounter during their work. This is a wonderful book. It makes you laugh, it makes you cry, it makes you angry, it makes you think. And most powerfully, it reminds society (and politicians) of the sacrifices that doctors make.

OBJECT OBSCURA

Detail from Trajan's frieze

THIS detail from a fibre glass copy of a Roman frieze dating from around 110 AD, depicts first aid being given to a Roman soldier during the Emperor Trajan's successful campaign against the Dacians in central Europe. Roman medicine was based on the Greek tradition and wounds were generally treated with herbal medicine and surgery.



Crossword

1 2 3 4 5 6 7 8 9 10 11 11 12 14 15 16 17 19 20 21 22 21

ACROSS

- **1** Male sibling by marriage (11)
- 7 Don Corleone's child? (6)
- **8** Descend vertical surface with rope (6)
- **10** Theatrical promoter (10)
- 13 Drink sabotaged by sugar tax (3-3)
- **14** Not coastal (6)
- **16** Act in a rude and hurtful manner (10)
- 19 Sufficient (6)
- 21 Where we find tomorrow, the _____(6)
- **22** Someone who sells goods or services (11)

NWO

- 1 Greek letter, used to represent "sum" (5)
- 2 Small whirlpool (4)
- **3** URLs saved for future reference (9)
- 4 Central part of a wheel (3)
- **5** Dark loaf, popular in Germany (3.5)
- **6** English New Town with NHS Trust in "special measures" (7)
- **9** Rugby goal (3)
- 11 Word of the year, pertaining to plastic waste (6-3)
- **12** Gigantic (8)
- **13** Visually descriptive language (7)
- **15** Fertility treatment (abbr.) (3)
- 17 Pacific, Atlantic, Billy or Frank (5)
- **18** Swear (Americanism) (4)
- 20 Jelly-like substance (3)

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

VIGNETTE

DAME LOUISE McILROY (1874-1968)

FIRST FEMALE MEDICAL PROFESSOR IN THE UK

T THE end of her long life, Louise McIlroy may have reflected on the battles she had fought. From a provincial start she would rise to the very top of her profession and would break down every barrier placed in her path. She would work in hospital tents on the front lines of one war and in the black-outs on the home front of another. She would accumulate military, academic and professional honours and praise along the way. But all of this might have been secondary to the battles she fought in operating theatres and on labour suites for the benefit of her patients.

Louise McIlroy was one of four sisters born in Ballycastle, County Antrim. Two would follow distinguished medical careers, while two would study the arts. Their father was a GP and sufficiently enlightened to encourage all his daughters to pursue a higher education. Louise McIlroy matriculated at Glasgow University and was amongst the first women to graduate in medicine. In 1900, she became the first woman ever to be awarded an MD by the University.

After appointments in Dublin, Berlin and Vienna, she returned to Glasgow to take up a number of clinical posts, culminating in her appointment as the first female gynaecologist at Glasgow's Victoria Infirmary from 1906-10. In those early years of the twentieth century, medicine was indisputably a male domain (see p. 10 of this issue), yet her competence and her resolve ensured her steady advance.

On the outbreak of war, she was further frustrated by the professional sexism of the day and wrote: "It had been ordained that women could not fight, and therefore they were of no use in war time." However, she and other like-minded physicians would not be thwarted and money was raised to create the Scottish Women's Hospitals for Foreign Service, which would ultimately consist of 14 units across Europe. She served in France in 1915 and in one letter



home said: "We are hoping to [teach] the French the enormous advantages of open air and sunlight for septic wounds ... Our results have been simply extraordinary ... no antiseptics at all."

Later, she would continue her work in Serbia and Greece, and a contemporary wrote of her: "[She] is one of a little band of notable women chief medical officers who made the name of the Scottish Women's Hospitals synonymous with surgical brilliance and administrative efficiency on three fronts during the war." She was awarded the Croix de Guerre in 1916 and four years later received an OBE for her war service.

After the war she continued her medical work with the army in Turkey before returning to London, where in 1921 she became the first woman appointed to a medical chair in the UK as the Professor of Obstetrics and Gynaecology at the London School of Medicine for Women. The press

were keen to highlight the achievement: "She has arrived at last – the first woman to secure an appointment open to both sexes". There was also marvel at her salary: "£2,000 is the largest ever paid to a woman for University work". She would spend 15 years in London during which time she was made a Dame in 1929 and in the same year became one of the founding Fellows of the Royal College of Obstetricians and Gynaecologists.

Throughout her career she wrote extensively on her specialist interests, the toxaemias of pregnancy and the relief of pain in childbirth. Indeed, she was one of the first to insist that analgesia and anaesthesia be offered to every woman in labour. Her clinical teaching was noted to be as excellent as her criticism of those who displeased her was harsh.

She retired early in the hope of having "a few years of freedom" but the Second World War brought that aspiration to an abrupt end, and she immediately offered her services again. Throughout the war she organised emergency maternity services in Buckinghamshire, working tirelessly often through the black-outs with minimal equipment and support.

She finally found her years of freedom, spent on the Ayrshire coast with her sister, and she died in Glasgow at the age of 93. Hers was a long life, spanning world wars and innumerable lesser, but no less challenging, conflicts in her professional life, as she fought for not just personal recognition but for that of all women in medicine. She will be remembered as the first woman to reach many medical milestones, but perhaps her real legacy is as a clinician who fought for the well-being of the women in her care.

Dr Allan Gaw is a writer and educator from Glasgow

Sources

- · Cross M. First World War Glasgow, 2013.
- Royal College of Physicians London Munk's Roll.
- Obituary, Lancet, 24 Feb 1968, 429-30



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