

QUARTER ONE / 2019

# INSIGHT



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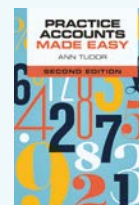
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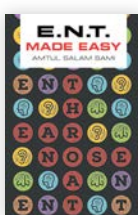
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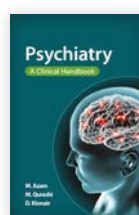
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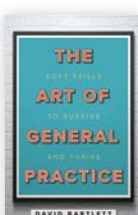
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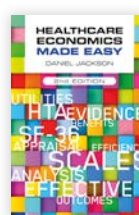
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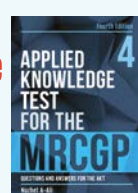
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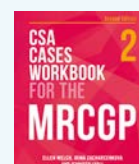
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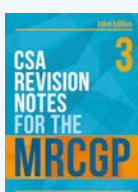
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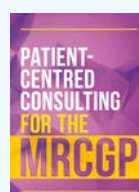
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# INSIGHT



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Constellation, Marjorie Stark

Acrylic and gouache

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](http://www.artinhealthcare.org.uk)  
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## EDITOR Dr Barry Parker

DETAILS of the new state-backed indemnity scheme for GPs in England have now been released as the Government launches a new five-year contract for general practice. A similar Future Liability Scheme (FLS) has also been announced for GPs in Wales.

Both schemes will commence on 1 April 2019 and in this issue of *Insight* we provide further details and also announce a new indemnity product for our GP members in England and Wales – General Practice Protection (GPP) – that provides protection for the many important exclusions not included in the CNSGP/FLS.

On page 9 of this issue, Chris Kenny provides an MDDUS perspective on the new schemes, and on pages 10 and 11 we go into the detail

of why it is so important for GPs to retain membership with MDDUS.

It's always inspiring to hear from doctors who manage to juggle two successful careers, and on page 12 Dr Gavin Francis, GP and author of *Adventures in Human Being* and *Shapeshifters*, discusses his "work-work" balance in these two roles. On page 14, Sarah Harford highlights the importance of maintaining professional boundaries in all dealings with patients, and in these times of polarised opinions Deborah Bowman provides her own insight into

the ethics of neutrality (p. 21).

Our regular selection of case studies on pages 16 to 19 includes a dispute over preventative care of enamel loss in a child, a clinical negligence claim alleging failure to diagnose Charcot foot in a diabetic, and a dental patient worried about mercury poisoning from his amalgam fillings. Our dilemma column (p. 20) deals with a GP in a rural area tempted to pursue a non-professional relationship with a current patient at the practice.

Dr Barry Parker

"It's always inspiring to hear from doctors who manage to juggle two successful careers, and author and GP, Dr Gavin Francis, discusses his "work-work" balance in these two roles"

# MDDUS News

## Resist requests to overprescribe during Brexit

GPs should avoid issuing longer repeat prescriptions in the run up to Brexit and should liaise closely with pharmacists if there are concerns over shortages of specific drugs.

If all GPs prescribed greater quantities then this would increase the risk of a shortage of medication. Whilst concerns may exist regarding specific patients, it is important to consider the wider issue of supply and whether, for some patients, a short-term clinically appropriate alternative drug may be indicated.

We would advise GPs not to alter their prescribing habits and not to be pressurised by patients into prescribing greater quantities of repeat medicines. However, GPs must also comply with their obligation to raise concerns in line with the GMC's guidance *Raising and acting on concerns* where they are worried that inadequate resources may put a patient at risk.

Each prescriber takes responsibility for the prescriptions they issue, so doctors must be prepared to explain and justify their decisions and actions when prescribing, administering and managing medicines. The GMC guidance *Prescribing and managing medicines and devices* states: "Whether you prescribe with repeats or on a one-off basis, you must make sure that suitable arrangements are in place for monitoring, follow-up and review, taking account of the patients' needs and any risks arising from the medicines".

If GPs continue to have particular concerns regarding specific patients/drugs, including short-term substitute drugs, then they should discuss these issues with the pharmacy lead of their local CCG/health board.

Dr John Holden is a medical adviser and joint head of medical division at MDDUS



## CNSGP falls short of integrated service

MDDUS Chief Executive Chris Kenny has responded to "enabling regulations" to implement the Government's plans for a new Clinical Negligence Scheme for General Practice in England (CNSGP). He commented: "We welcome the long overdue appearance of these regulations to enable the operation of the new Scheme. We are also working with NHS Resolution to help in the preparation of more user-friendly documentation for doctors."

"What the regulations show is how far the nationalised claims-only product falls short of the integrated service currently offered by MDOs."

He points out that, in particular, Regulation 6 is permissive, not mandatory: "the Secretary of State does not have to pay and could walk away from these commitments at any time". The Scheme therefore would not pass the regulatory tests which Government wants to impose on healthcare professionals in their consultation on regulation of indemnity.

Regulations 8 and 10 set out a range of exclusions and compliance rules on GPs which simply do not exist in MDDUS' current Articles of Association. They add risk to GPs rather than provide certainty.

He added: "In short, the Government must keep rules and exclusions to a minimum and set out a clear process and timescale for evaluating the new Scheme given its unproven nature."

Access the regulations at [tinyurl.com/yyvbgwou](http://tinyurl.com/yyvbgwou)

## Dentists leading through uncertainty

Well-led teams are best equipped to meet increasing demands and to manage risk. With this in mind, and GDC standards requiring dentists "to demonstrate effective management and leadership skills if they manage a team", we have adapted our popular and long-running leadership programme specifically for dentists with management responsibilities.

This five-day programme running one day per month between August



## Insight is going digital

DID you know that over 90 per cent of the cost of producing MDDUS *Insight* magazine is in paper and postage – and that membership growth over the last few years has pushed our print run to well over 55,000 copies? That's a lot of trees.

This has given us cause to think about how we can reduce our impact on both the environment and membership subscriptions. Many of our members now access much of their medical and general news content online. A recent *Insight* readership survey found that 87 per cent of respondents would support the move to a quality online magazine. So we have decided that now is the time to move to a digital format – but with an option

for members still to receive a print hardcopy of the magazine if preferred.

We are now developing a digital *Insight* that will be accessible in multiple formats, including desktop and laptop computers, mobile and tablet devices. Each new edition will be sent to you via an email link but will also be accessible from the Resources section of [mddus.com](http://mddus.com). The plan is to launch the new digital edition of *Insight* for the 2019 autumn Q3 issue in September.

In the meantime we will be sending members reminders of the change via email and our regular eMonthly newsletter, with an easy “opt in for print” if you prefer to keep receiving your hardcopy version of *Insight* in the post.



and December 2019 will challenge you as a leader and help you positively change the way you manage your team. It will furnish you with the tools to ensure that you tackle change positively and assist you in creating interdependent, effective relationships in the workplace – helping you to recognise the impact you have on your colleagues.

CPD accreditation has been applied for. Find out more at Training & CPD > Events at [mddus.com](http://mddus.com)

## MDDUS responds to GMC consent consultation

MDDUS has responded to the GMC consultation on its updated consent guidance: *Decision making and consent*.

MDDUS joint head of medical division Dr John Holden said: “We welcome the opportunity to comment on the revised GMC consent guidance, which focuses on the importance of communication, as well as doctors and patients making decisions about treatment and care together.

“We agree that it is not a set of rules but rather guidance, to aid and support professional judgements.

“As we have indicated in our response, the legal annex will form an essential part of the guidance and we believe that it is necessary to have one in draft form to accompany the draft guidance. Taking things in two bites runs the risk of delays and important points being missed, hence the need to tie them together again when the annex is available. We therefore look forward to receiving the legal annex in due course, as it will help our deliberations.

“Furthermore, we recognise that the GMC intervened in the case of Montgomery, and that in many respects the findings of the Supreme Court simply brought the law in line with professional guidance, as stated in the GMC’s existing 2008 consent guidance. However, the absence of a draft legal annex has prevented our ability to form a view of the weight that the GMC may ascribe to the nuances of cases that have been reported since Montgomery.

“We trust that when the GMC does produce a draft legal annex, then MDDUS and other stakeholders will be afforded the opportunity to review and revise comments on the draft consent guidance accordingly, before the overall consultation ends.”

## MANAGE YOUR MDDUS MEMBERSHIP ONLINE

Update your subscription, make debit card payments and change direct debit details using our improved full-service online membership interface which is available 24 hours a day. MDDUS members using the portal can also download and print membership certificates, copies of renewal notices and online CPD, and also update address and other personal details. Go to Log in at the [mddus.com](http://mddus.com) home page to register.

## MDDUS PM CONFERENCE 2019

Practice managers across the UK are invited to “save the date” for the next MDDUS Practice Managers’ Conference on 28 and 29 November 2019. The popular two-day event will be held once again at the Fairmont, St Andrews and will offer delegates a packed schedule of workshops and masterclasses, and a chance to network with fellow professionals. A programme for the conference is still being finalised. Email [risk@mddus.com](mailto:risk@mddus.com) to express your interest.

## RUN YOUR OWN DENTAL COMPLAINTS WORKSHOP

Improve your dental complaints handling skills with MDDUS’ new interactive workshop tool available exclusively to members. Designed to be used by GDPs and PM members, it contains everything you need to run your own self-directed workshops within protected learning time and explore a range of scenarios. Go to Training & CPD > Team training at [mddus.com](http://mddus.com)



## Staff struggle with volume of safety guidance

A REPORT looking at ‘never events’ in 18 hospital trusts in England found that NHS staff struggle to cope with large volumes of safety guidance, with little time and space to implement the guidance effectively.

This is a key conclusion from research conducted by the Care Quality Commission (CQC) at the request of the Secretary of State for Health and Social Care, aiming to understand the barriers to delivering safe care and identify learning that can be applied to improve patient safety.

The CQC report, *Opening the door to change*, examines the issues that contribute to the occurrence of never events and wider patient safety incidents in NHS trusts in England.

It found that staff often try to implement guidance, but on top of demanding and busy roles which make it difficult to give such measures the required priority. The report also concluded that within the wider healthcare system, different bodies at national, regional and local level do not always work together in the most supportive way, with confusion over roles and where trusts and other organisations can find the most appropriate support.

Education and training for patient safety could also be significantly improved, with more appropriate training at undergraduate level and after staff have embarked on clinical careers.

Professor John Dean, clinical director for quality improvement and patient safety at the Royal College of Physicians, commented: “We must move from a place where we assume care is safe until something goes wrong, to working in a way as teams that minimises the chances of harm. This should build in safety to daily practice, and be open and supportive when error occurs.”

## GDC sets out revised principles for specialist listing

A CONSULTATION on the fundamental principles governing the GDC’s approach to specialist listing is now underway.

The GDC is seeking views on proposals to change the way it approaches three key areas:

- Revised purposes for specialist listing, setting out what the GDC expects listed specialties to fulfil, and the criteria by which the regulator will determine which disciplines of dentistry should be listed.
- Principles for the process of addition and removal of specialist lists.



## “Fake news” impacting vaccination rates

AROUND 50 per cent of parents with children under age five are exposed to negative messages on social media about the use of vaccines, according to research commissioned by the Royal Society for Public Health (RSPH).

The report, *Moving the needle*, reveals the extent to which social media propagates misinformation about vaccinations, with the perceived risks of side effects a key concern among those choosing not to vaccinate.

The UK maintains world-leading levels of vaccine coverage but the report reveals troubling findings about the extent to which

public concern over the side effects of vaccination continues to be a barrier to uptake. The authors conclude that “fake news” on social media may be influential in spreading these concerns.

The report found that UK attitudes to vaccines were largely positive, with 91 per cent of parents in agreement that vaccines are important for their children’s health. Trust in healthcare professionals remains high, with doctors and nurses being consistently valued as a source of information about vaccines.

The RSPH is calling for a multi-pronged approach to improving and maintaining uptake of vaccinations in the UK. This includes stepping-up efforts to limit “fake news” about vaccinations online, especially by social media platforms themselves. The RSPH believes vaccinations should also be offered in a more diverse range of locations, and reminder services should be improved.

Shirley Cramer CBE, chief executive, RSPH said: “With the rise of social media, we must guard against the spread of ‘fake news’ about vaccinations. We have found worrying levels of exposure to negative messages about vaccinations on social media, and the spread of misinformation – if it impacts uptake of vaccines – could severely damage the public’s health.”

- Processes for maintaining accreditation on specialist lists.

The consultation closes on 25 April 2019. To provide your views on the proposals go to [www.gdc-uk.org/about/what-we-do/consultations](http://www.gdc-uk.org/about/what-we-do/consultations)

## Updated audit tool for antimicrobial prescribing

AN updated version of a dental antimicrobial prescribing self-audit tool has been published by the Faculty of General Dental Practice (FGDP(UK)) and the British Dental Association to coincide with the launch of the government’s *5-Year Action Plan* and *20-Year Vision* for reducing antimicrobial resistance. Dentists issue around 5-7 per cent of NHS antibiotic prescriptions.

The *Antimicrobial Prescribing Self-Audit Tool* consists of a data collection sheet together with a comprehensive guide enabling clinical audits of prescribing and management of dental infections.

The tool has been endorsed by Public Health England and is designed to be used alongside the Faculty’s *Antimicrobial*

*Prescribing for General Dental Practitioners* guidance so that dentists can compare their practice against standards. The tool was originally launched in November 2016, and has now been updated to promote understanding that it facilitates, rather than performs, an audit.

Clinical audits have been shown to lead to a reduction in both the number of prescriptions and the number of inappropriate prescriptions, as well as dramatic improvements in the accuracy of the dose, frequency and duration of antibiotic prescriptions.

The Faculty also encourages GDCPs to take the *British Association of Oral Surgeons’ Antimicrobial Stewardship (AMS) e-Learning Modules*, which provide free verified CPD on application of the principles of antimicrobial stewardship to common clinical scenarios.

## Pledge to shake up GP IT

OUTDATED and frustrating IT systems in GP practices in England will be replaced with modern technology as part of widespread changes announced by the health and social care secretary.



The GP IT Futures framework promises to create an open, competitive market to encourage the best technology companies to invest in the NHS. All systems will be required to meet minimum standards to ensure they can “talk to each other” across boundaries.

The Department of Health and Social Care (DHSC) criticised the current market for being “dominated by two main providers”, saying this slows down innovation and “traps” GP practices in long-term contracts with systems that are “not suited to the digital age”.

The framework suggests moving patient data to cloud-based services which would allow secure, real-time access to clinicians and patients. It also wants every patient in England to have the option of accessing GP services digitally, with practices offering online or video consultations.

The plan is designed to free up staff time and reduce delays by allowing “seamless, digitised flows of information between GP practices, hospitals and social care settings”. Any digital providers who do not meet the new standards will not be used by the NHS, and the government will seek to end existing non-compliant contracts.

Health and social care secretary Matt Hancock said: “Too often the IT used by GPs in the NHS – like other NHS technology – is out of date. It frustrates staff and patients alike, and doesn’t work well with other NHS systems. This must change.”

The framework will be overseen by NHS Digital and builds on Mr Hancock’s recently published tech vision for the NHS.



## Higher death risk with missed GP appointments

PATIENTS with long-term health conditions who miss GP appointments are at greater risk of premature death, according to new research.

The likelihood of missing appointments increased with the number of long-term conditions, particularly among patients with mental health issues. These patients were found to be at significantly greater risk of all-cause mortality.

The study in *BMC Medicine* found patients with long-term mental health conditions who missed more than two appointments per year had a greater than eight-fold increase in risk of all-cause mortality compared with those who missed no appointments. These patients died prematurely, commonly from non-natural external factors such as suicide.

Researchers concluded that missed appointments represent a “significant risk marker” for all-cause mortality, particularly in mental health patients. They described existing primary healthcare appointment systems as “ineffective” and urged practices to develop further interventions to increase attendance by these patients.

RCGP Chair Professor Helen Stokes-Lampard echoed the report’s conclusions and said patients with long-term conditions need regular monitoring and treatment and advice tailored to their unique health needs.

She added: “People miss appointments for a range of reasons but this study highlights why it’s more important to show compassion to people who fail to attend, rather than punishing them – for some, life gets in the way and they forget, but others might not turn up precisely because of their health issue.”

### HOSPITAL DEATH CERTIFICATION E-TRAINING

Doctors in Scotland are being encouraged to complete two e-learning modules on death certification produced by NHS Education for Scotland (NES) in partnership with Healthcare Improvement Scotland. They are designed to support certifying doctors in completing Medical Certificates of Cause of Death (MCCDs). Access the modules at: [www.sad.scot.nhs.uk/atafter-death/death-certification](http://www.sad.scot.nhs.uk/atafter-death/death-certification)

### STAFF TRAINING KEY TO DIGITAL FUTURE

Healthcare staff should be trained in emerging technologies such as genomics, digital medicine and artificial intelligence to ensure the NHS is equipped for the challenges of the 21st century. That is one of the key messages of the *Topol Review* which looks at the role of technology in the future of NHS care. The report states that, within 20 years, 90 per cent of all jobs in the NHS will require some element of digital skills. Access the report at <https://topol.hee.nhs.uk/>

### ANTIBIOTIC PRESCRIBING FOR PNEUMONIA

NICE and Public Health England have published two draft guidelines on antimicrobial prescribing for pneumonia to optimise antibiotic use and reduce resistance. It advises that antibiotics should be given to people with pneumonia within four hours of establishing a diagnosis. Oral antibiotics should be given as first-line treatment unless the severity necessitates IV antibiotics. Read more at [tinyurl.com/yxdwgs9](http://tinyurl.com/yxdwgs9)

# AMBULANCE ON THE WAY

Dr Gail Gilmartin

Medical and risk adviser at MDDUS

**A** *PATIENT takes seriously ill in a GP surgery and an ambulance is urgently requested but is delayed for a prolonged period of time...*

This scenario recently featured in the medical press. Delays in ambulance calls to practice premises can be very disruptive and probably stem from a belief that, with the presence of medical staff and practice equipment, this is not too risky. It has also been reported that the ambulance service may sometimes downgrade such calls.

MDDUS has had a number of advice contacts regarding the best way to respond in this situation. Similar scenarios also typically involve patients seen at home. A GP determines that a patient requires urgent transportation to hospital and, after calling for an ambulance, the doctor is left waiting with the patient, despite pressing clinical commitments elsewhere. Should the GP stay with the patient until the ambulance arrives? If not, what is a reasonable timeframe?

In all such situations the main determinant will be the patient's condition. Are they stable and being adequately managed in their current environment? Is there a risk of rapid deterioration? These considerations require a complete assessment of the patient's condition as determined by a detailed history, examination and observations – all of which should be adequately documented. Are you reasonably confident of your working diagnosis? Can you make a safe judgement about being able to leave the patient, especially at home?

Always consider how you would justify your decision if anything went wrong. Remember that good notes will help if you have to account for a particular course of action. Your choices may have to be balanced against the risk to other patients if you are urgently required elsewhere, especially with another ill patient needing review. Is there someone who can wait with the patient? This might be a suitably capable family member, carer or other healthcare professional. Can you leave clear instructions with regard to what to do in the event of a deterioration and when to escalate to the ambulance service?

Should the patient's condition demand



an expedited ambulance request, having the clinical information described above will help to emphasise that need. Clear clinical detail is also essential in challenging the downgrading of an ambulance request.

Ultimately patient safety is the priority and you might have to be imaginative in finding the best response to a particular emergency situation. For example, is it appropriate to ask the patient themselves to call the ambulance so as to prevent delay? Again – always check that you can clearly explain your actions. Be careful to balance the pros and cons of prioritising one action over another. Being late for routine tasks is not usually sufficient justification for leaving a sick patient awaiting transport.

A practitioner may also find themselves in the unenviable position of having to provide supportive care to a patient waiting for an ambulance when there are limited resources to hand. Remember that you are very unlikely to be criticised for having done your utmost in the given circumstances to secure patient safety.

In terms of relevant guidance from the regulator, the GMC states:

- "Make the care of your patient your first concern. Take prompt action if you think that patient safety, dignity or comfort is being compromised..."
- "Work with colleagues in the ways that best serve patients' interests..."
- "You are personally accountable for your

professional practice and must always be prepared to justify your decisions...

- "You must contribute to the safe transfer of patients between healthcare providers..."

As mentioned at the outset, these situations appear to be occurring with greater frequency. It can therefore be helpful to discuss with colleagues the best approach. Talking through a theoretical "what if" scenario can help formulate a framework to enable a practitioner to react in a clinically appropriate way and within the limits of local resources.

Should a patient come to avoidable harm because of a delay or downgrading of an ambulance request, adequate records are key. Ensure that clinical notes are complete and include measured observations, such as temperature, pulse, BP and oxygen saturation. Keep a careful record of ambulance service contacts and the information exchanged. Remember to use clear unambiguous language when requesting an ambulance. After such an event it is important to carry out a significant event review and raise any concerns with the ambulance service.

## ACTION POINTS

- Consider a strategy for this type of event so that you have a plan of action.
- Remember to always put patient safety above everything else.
- Keep detailed notes (clinical and admin) regarding ambulance service contacts.



# GP INDEMNITY... WHERE WE ARE

Chris Kenny

Chief executive officer at MDDUS

**S**TATE-BACKED indemnity has a new name – at least in England – and that is the Clinical Negligence Scheme for General Practice or CNSGP. No one does acronyms better than the NHS.

The Government has now released details of the scheme as part of a new five-year contract for general practice across England. The CNSGP will start from 1 April 2019 and will be operated by NHS Resolution. All NHS GP service providers in England including out-of-hours provision will be eligible to become members of the scheme and will not have to pay a subscription for membership. NHS Shared Services Partnership – Legal and Risk Services will run a similar Future Liability Scheme (FLS) for general practice in Wales.

The Government has also confirmed that the scheme will be funded through a one-off permanent adjustment to the global sum but investment in the practice contract overall will still rise by 1.4 per cent in 2019/20, even after accounting for the indemnity change.

MDDUS welcomes this news as the only medical defence organisation (MDO) to have constantly lobbied for the need to protect the global sum from the cost of the scheme – ever since plans for state-backed indemnity were first announced in October 2017. This funding commitment now and in future years is good news, particularly as the costs of indemnity will certainly continue to rise in the absence of any meaningful tort reform. It is important that the Government offers assurance that in future no primary care monies will be diverted from frontline services to fund these increases – and not just for the lifetime of the current plan.

Recently the Secretary of State for Health and Social Care commented that changes in practice by trusts are a “necessary part of reducing the number and severity of claims”. We believe Mr Hancock is fooling himself if he thinks this will fully resolve the issue of increasing negligence claims and costs. Government should not pass the buck to hospital doctors, GPs and trusts. It should play its part through thorough meaningful tort reform and a much more radical approach



**“We see a real danger that NHS Resolution will face pressure to put the financial interests of the service ahead of the protection of the professional reputation of the GP”**

to capping costs. Such reform has already proved effective in other countries, such as Australia and the USA. We cannot understand why the UK won't follow suit and has instead taken the drastic and high-risk step of nationalising not just the cost, but the direct provision of clinical indemnity services in England and Wales.

We perhaps should not expect a Government which contracts with a ferry company with no ships to turn to expert organisations who know primary care inside out to run medical negligence claims – but we're convinced that choice, competition and direct reimbursement would have provided better outcomes and significantly reduced cost and risk than the model put in place.

But we are where we are. What's important now is that GPs in England receive more information about how the scheme will operate and particularly any workload impact on practices.

NHS Resolution has pledged to provide further details on the next steps that practices and professionals need to take to ensure that they are covered after 1 April 2019. It has also highlighted the need for practices and staff to take out “separate medical defence organisation cover for professional practice, additional advisory services, and private work”. The BMA, too, has advised that MDOs will continue to play an important role in providing legal advice, GMC representation and also representation in potential criminal cases associated with the practice of medicine.

MDDUS has long prided itself on a gold standard service providing medico-legal advice and support 24/7, and we will continue to do so for our members. MDO protection is still necessary (see pages 10-11 of this issue) and this can be evidenced by the fact that over the past 12 months our 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 estimate that almost two-thirds of cases handled by MDDUS in the past 12 months would not have been covered by the new scheme.

All this is not to say that we are without concern over the introduction of the CNSGP. Fragmenting the integrated service currently offered by MDOs remains a high risk and we see a real danger that NHS Resolution will face pressure to put the financial interests of the service ahead of the protection of the professional reputation of the GP. MDDUS has been the only MDO pressing publicly for the clearest possible commitments on this and our initial meetings with NHS Resolution to hear more about their operating model suggests that we may have been listened to. We will keep you posted.

MDDUS will still be there for you going forward – and we will never cease to put preservation of the doctor's professional reputation and integrity at the centre of all decisions.

“No decision about me, without me” works for doctors as well as patients.

**D**ETAILS of the new Clinical Negligence Scheme for General Practice (CNSGP) in England and the Future Liability Scheme (FLS) in Wales have now been released – and GPs may assume that these state-backed schemes will provide all they'll ever need in terms of professional advice and support. Some may give hardly a second thought to the idea of retaining their medical defence organisation (MDO) membership from 1st April 2019.

However, it may come as a shock to discover that there are a number of key exclusions to NHS cover, leaving some unsuspecting clinicians having to pay hefty legal bills out of their own pocket.

While it's true that GPs will be indemnified by the NHS for work done within an NHS contract, they will continue to need membership of MDDUS following the introduction of CNSGP/FLS, as there are a number of key areas where NHS cover will not provide assistance.

The schemes will *not* cover non-NHS work, representation at inquests, GMC hearings and disciplinary investigations. Such situations can seriously impact careers and could ultimately result in a GP being struck off.

The schemes will also not include advice and support – something highly prized by MDDUS members. It is crucial to have access to support and guidance from experienced medico-legal advisers. This is evidenced by the fact that over the past 12 months MDDUS' team of expert medical advisers handled more than 6,500 calls and opened nearly 4,000 new case files from GP members relating to issues NOT included in the government schemes. Also in the past 12 months, MDDUS assisted more than 200 GPs facing GMC investigations (see 'A case in point...') and advised 513 members who were called to appear at coroner's inquests. In addition, we helped almost 2,500 members deal with patient complaints – another key area that won't be covered by CNSGP/FLS.

As these figures show, there is a huge range of areas where GPs will not get support from the new schemes and

will need supplementary expert help. You can be sure that MDDUS will still be there for you.

### NEW MDDUS PRODUCT

We have developed a new product specifically designed for GPs practising under CNSGP/FLS that provides essential advice and assistance. MDDUS **General Practice Protection** (GPP) costs significantly less than our existing indemnity package and provides the following benefits:

- 24/7 medico-legal advice
- GMC representation
- Assistance with disciplinary matters
- Support with Ombudsman investigations
- Assistance with coroner's inquests
- Assistance with criminal matters (related to medical practice)
- Indemnity for private clinical work outside of your NHS contract\*
- Indemnity for writing insurance reports
- Indemnity for travel vaccination clinics
- Indemnity for worldwide Good Samaritan acts
- Assistance with patient complaints
- Advice on performers' list outcomes
- Assistance with HR and employment issues for practice staff
- A range of medico-legal publications, on and offline
- Discounted medico-legal training.

A letter is being sent from MDDUS to all GP members in England and Wales providing more details on MDDUS General Practice Protection (GPP), and you can also find out more by consulting relevant links on the home page of [mddus.com](http://mddus.com)

*\* Private work (non-practice-registered patients): we can extend your membership to include access to indemnity for a range of medical work outside of your practice setting. See details at [mddus.com](http://mddus.com)*

GPs in England and Wales may believe that state-backed indemnity will provide all the help and support they need in facing professional difficulties. But what about all the things it won't help with?

LESS IS NOT MORE  
WHEN IT COMES TO P





# ROTECTION

## A case in point ...

**THE following case study – based on a real MDDUS case file – illustrates how crucial membership of an MDO can be for GPs.**

Dr W arrives at the surgery to find a letter waiting from the General Medical Council. A complaint has been made to the regulator by the nephew of one of his patients – Mrs B – who recently died of cancer.

Allegations attached to the letter state that Mrs B had numerous medical conditions that were treated with high levels of pain medication. The nephew – Mr K – reports that his aunt abused her prescribed medication and suffered frequent falls due to overdoses, and on several occasions became an inpatient at the local hospital where staff told him that his aunt did not require this “cocktail” of pain killers and sleeping tablets. The GP is criticised for the management of her medication.

Mrs B was a difficult and demanding patient as acknowledged by all involved in her care – doctors, nurses and home help – but she did have a trusting relationship with Dr W who had been her GP for many years. Prior to her death she informed her family that she planned on leaving Dr W something in her will. It was assumed this would be a memento or a small sum but it turned out to be a substantial portion of her small estate.

In his statement Mr K suggests that the GP allowed himself to be manipulated by Mrs B in expectation of being favoured in her will. There were also charges that the doctor breached the patient's confidentiality in discussing her care via a series of text messages with Mr K.

The GMC letter states that the matter will be investigated and two case examiners will decide what happens next. Dr W contacts MDDUS in distress as this is the first GMC complaint made against him in over 30 years of practice. He speaks first with a medical adviser who reassures him that, handled appropriately, most complaints do not proceed past the investigatory stage. The adviser outlines standard GMC procedures in a letter and Dr W is invited into MDDUS offices to discuss the case with an in-house lawyer, highly experienced in dealing with GMC cases.

A GMC medical expert later assesses the complaint, patient notes and other associated documents and produces a report which is largely supportive of Dr W, apart from the alleged confidentiality breach. The MDDUS in-house lawyer carefully studies the report and drafts a detailed letter of response. The letter refutes all the allegations one by one and in particular establishes that Dr W had consent to discuss Mrs B's care with her nephew. It is submitted that Dr W has complied fully with GMC guidance and shown additional insight, undertaking relevant CPD in relation to confidentiality and carrying out an SEA leading to revised practice policies/procedures.

Six months after the initial complaint, Dr W receives a letter from the GMC stating that the investigation has been concluded with no further action. The GP writes to MDDUS:

*“I would like to express my thanks at the help I received during a recent complaint against me to the GMC by a patient's relative. At all times I was met by a professional but sympathetic and friendly attitude by your staff, especially Lindsey McGregor. I am pleased that the outcome was very much in my favour thanks in large part to the MDDUS' representations and advice.”*



# STRANGE

Adam Campbell meets celebrated writer and GP Gavin Francis

**I**N Gavin Francis' latest book, *Shapeshifters*, you'll come across a woman with a horn in the middle of her forehead, go on meandering, sometimes classical, journeys around subjects like sleep, prosthetics and werewolves, take a (vicarious) LSD trip and discover that in days gone by shepherds used their teeth to geld lambs. Speaking of which, did you know the Vatican didn't ban castration of boys for its choirs until the late 19th century?

You'll also discover an awful lot about the wondrous and vertiginous goings-on in the body as, unbidden and undirected, its systems and processes go about their daily business of keeping us fit and alive. And you'll meet a vast and various cast of characters, based on Gavin's experiences as a doctor, as he reflects on the fascinating and enduring nature of the medical encounter between physician and patient.

The book, says Gavin, who successfully combines an award-winning career as a writer with his work as a GP, is a hymn to change, be that the ongoing change wrought by Father Time, changes in our mental state, changes we make deliberately or crises we hope to overcome. More specifically, it's about the interaction between that change and medical professionals like himself.

"Why do we go to the doctor?" he says. "Because we want the doctor to facilitate, to invoke some new change. The book is a series of 24 examinations of these kinds of changes. Sometimes where there's some horrible change going on that you're trying to hold back, like dementia or cancer. Sometimes a change that's inevitable, like menopause or puberty, that you're trying to guide in some way."

As part of this examination, he enlists to his cause the work of painters, poets, writers and philosophers, a plethora of facts and figures, and myriad interactions with patients over his medical career to date. There are snatches of history and lessons in biology too. His is a learned, digressive style that weaves its way pleasingly around meditations on conception and birth, anorexia, bodybuilding, memory, laughter and death. All life is here.

## MEDICAL ARTS

So what lies behind this approach? "I'm trying to show that medicine is an area of the humanities as valid as any of the more traditional humanities," explains the 43-year-old. "What are the humanities, or what are the broad arts? They are different ways of understanding the human experience through paintings, through music, through literature and I'm trying to show that medicine can be used in a similar way to deepen our understanding of human experience, the human predicament."

It's a marriage of the artistic and the medical that reflects precisely Gavin's twin approach to his career. One that sees him working three days a week as a GP on the Southside of Edinburgh and the rest of the time as a writer – working on his books as well as articles for the likes of the *London Review of Books*, the *Guardian* and the *New York Review of Books*.

He finds that the two professions complement each other very well. "Practising medicine can be emotionally taxing and very intellectually challenging. It can also be very pressured in order to try and do the best by every patient. I find doing it full time, day after day, I become really very exhausted. Whereas when I do day about – medicine and then a day writing and thinking – I find the act of writing really pleasurable

# CHANGES

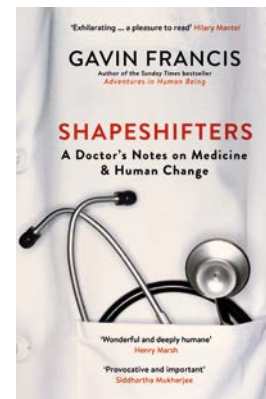


and restorative. Especially when you're writing about medicine, you use that time and that space to really reflect on your own practice.

"So, for me, they're really very complementary and I move through the week thinking that each one kind of self-corrects the other. The tendencies in me that enjoy and respond to one are self-corrected by the other, so the balance works out perfectly."

It's a work-work balance that is paying dividends in other ways too. This book, his fourth, has already been translated into 10 languages, while his previous book, *Adventures in Human Being*, a kind of literary journey around the human body, can be read in no fewer than 17. The latter also earned him the Saltire Non-Fiction Book of the Year in 2015





“After I qualified in medicine – I was about 23 or 24 – I just started travelling straight away”

Inset: Gavin Francis in his role as doctor in the Antarctic.  
Above: the new novel, *Shapeshifters*

as well as first prize in the Basis of Medicine category of the BMA's Medical Book Awards.

## WANDERLUST

His current literary focus is on medicine, but this wasn't always the case. In fact, his initial foray into writing was motivated by his love of being on the move. “After I qualified in medicine – I was about 23 or 24 – I just started travelling straight away.” Those early days in medicine were very much his “passport to travel” and he would do six-month stand-alone jobs, work non-stop, spend very little, and then go travelling for six months. “Because you were a professional, you were paid relatively well. And these stand-alone jobs still counted towards my training. It's harder now.”

His first book, *True North*, was about a trip he made through the northern reaches of Europe and the Arctic – from the Shetland Isles to the Faroes, Iceland, Greenland, Svalbard and then Lapland. It was written, ironically, while he was holed up in the Antarctic, where he spent 14 months as a doctor at Halley, Britain's most inaccessible research station. Originally trained in emergency medicine, and with a penchant for travel in sub-zero temperatures, he was ideally suited to the role. He later wrote about these Antarctic experiences in his second book, *Empire Antarctica*, which won the Scottish Book of the Year in the Scottish Mortgage Investment Trust Awards in 2013.

After Antarctica came an 18-month-long trip to New Zealand by motorbike with his wife, Esa Aldegheri (they co-wrote an essay about this trip, called ‘Freedom of Travel’, for the Edinburgh International Book Festival last year).

The move away from travel writing with *Adventures in Human Being* coincided with his return to Edinburgh to settle down as a GP and the subsequent arrival of their three children. But while medicine's gain

may have been travel writing's temporary loss, Gavin plans to rectify things in his next book.

“I have another travel book coming out next spring,” he says “although I can't say too much about it right now as it's still in evolution. I'm interested in the way that as a writer I can either write about the physical landscape around us, or the anatomical landscape that we carry with us, but the techniques and approaches to both these kinds of writing are essentially the same – they're both about reflecting on experiences in a way that brings together the history of a place, its philosophy and culture, with contemporary encounters I've had either out in the world in the case of travel writing, or in the clinic in the case of medical writing.”

The source of inspiration for this new book are journeys he's made both before and after settling down – having a young family has, of course, ‘grounded’ him somewhat. Does he miss the travelling? “Yes, a little bit but this is the phase of life I'm in – a kind of householder phase,” he says, chuckling.

Still, this latest book on the constancy of change is providing something of an outlet for his itchy feet, because with his continuing literary success, he gets regular invitations to attend book festivals in far-flung places. “My colleagues are very understanding – I was in Jerusalem and Siberia last year, and the year before that in the US and in Bhutan. So I still get to travel from time to time.”

Plus ça change.

Adam Campbell is a writer and editor in Edinburgh and regular contributor to MODUS publications

*Shapeshifters* is published by Profile Books.  
For more information on Gavin's books, visit [www.gavinfrancis.com](http://www.gavinfrancis.com)

**F**EW would argue that the way we interact, in all aspects of our life, is in a state of flux. The ever-rising use of social media means we rely less on face-to-face contact, interacting via digital platforms such as Twitter, Facebook, WhatsApp or Instagram. Behaviours that in the past might have been tolerated or even accepted as appropriate interaction are now being challenged.

The dentist-patient professional relationship has also seen radical change in the UK over several decades, with a marked departure from medical paternalism to the autonomous patient. Throughout all of this change, we are obliged to navigate the complexities of human interaction whilst maintaining professional boundaries.

As dentists, we often see patients at their most vulnerable, in pain and nervous, facing necessary procedures. The treatment we provide is by nature invasive, probing into the intimate body space of a conscious patient who cannot see what we are doing. Good communication is key to gaining patient trust in such a precarious situation. It is important to give the profession credit in overcoming this challenge on a daily basis.

### JUSTIFIED TRUST

Professional boundaries can be defined as those “between what is acceptable and unacceptable for a professional to do, both at work and outside it, and also the boundaries of a professional’s practice”.<sup>1</sup> These boundaries exist to protect both the patient and the professional. Professionalism is a dynamic concept – given the variety of dentist-patient interactions – to which we must pay

It’s never been more difficult to judge when you may have “crossed the line” with a patient or colleague. Dental adviser Sarah Harford offers some insights

# BLURRING THE BOU

careful attention in order to manage the interface between our personal and professional selves. It can be difficult to absolutely define what is and what is not professional. In its guidance, *Standards for the dental team*, the GDC asks that you “ensure that your conduct, both at work and in your personal life, justifies patients’ trust in you and the public’s trust in the dental profession”.<sup>2</sup>

All health and social care professionals are expected to maintain professional boundaries. Research appearing in the *British Journal of Social Work* found that rather than relying on professional codes of practice, a clear majority of social workers relied on their own sense of what is appropriate or inappropriate, and made their judgements with no reference to any formal guidance<sup>1</sup>. Making such a judgement comes with an assumption that we can always determine for ourselves what is appropriate, even at potentially turbulent times in our life. It is of note that dentists involved in regulatory proceedings due to a breach in professional boundaries have often been facing difficulties in their personal life.

### PATIENT BOUNDARIES

The GDC states: “You must maintain appropriate boundaries in the relationships you have with patients. You must not take advantage of your position as a dental professional in your relationships with patients”.<sup>2</sup>

In some circumstances you might be the health

professional that a patient sees most often, especially if a regular attendee at the dental surgery. Patients may offload information about their personal lives during chair-side conversations and, whilst you would want them to feel relaxed and at ease, it is still important to maintain a professional distance. It is therefore wise not to share personal information about your own life.

You should not accept “friend requests” from patients on social media sites, and if you are concerned that a patient is making inappropriate advances, you should politely remind them that your relationship is strictly professional and document that discussion. In such circumstances you may need to suggest that the patient is treated by another colleague in future (unless in an emergency).

MDDUS has found that when boundaries become blurred and a patient is communicating with a dentist via text or social media there is always the risk that a “platonic” relationship can turn sour, especially if treatment problems are encountered. Any resulting complaint could soon escalate, with the dentist facing criticism for not maintaining professional boundaries.

Professionalism is, again, a dynamic concept and adaptation may be required in dentist-patient relationships, for example with cultural differences. On the European continent, kisses on the cheek when greeting might be commonplace but they would likely take UK patients by surprise. Equally some patients might not feel comfortable





# BOUNDARIES

shaking hands. Patients should therefore be treated as individuals and our interactions measured accordingly.

## AMONG COLLEAGUES

Successful dental practices depend on colleagues working closely together. We rely on each other when navigating our day list and looking after patients. “Getting on” is crucial to this working relationship and friendships often develop. However, it is still important to maintain a professional working relationship. An increasingly common cause for GDC investigations is a business or employment dispute which has turned particularly sour. One dentist or dental care professional complains about the other to the GDC and, frequently, both or multiple professionals end up being drawn into the investigation. In a similar way, an inappropriate relationship between colleagues can end up being aired at a regulatory hearing.

Some cases may involve a dentist providing treatment to a colleague; this is not precluded but should be approached with caution. In such situations, clinical judgment may become too subjective, which means we might not be treating a colleague as we would other patients. We still need to fully assess the patient, reach a diagnosis, give treatment options, gain valid consent, document everything in the clinical notes and provide treatment which is in their best interests. Knowing the patient in a professional context

means we may not be as rigorous in following usual routines and, in such cases, it may be sensible for the colleague to seek treatment elsewhere.

## SOCIAL MEDIA

Social media is now almost inescapable, infiltrating most of our lives. Personal information can enter the public domain and leave an indelible mark on a dentist’s professional reputation. GMC guidance on *Maintaining a professional boundary between you and your patient* states: “Social media can blur the boundaries between a doctor’s personal and professional lives and may change the relationship between a doctor and patient”.

GDC guidance similarly states that “when using social media, you must maintain appropriate boundaries in the relationships you have with patients and other members of the dental team”, and that social media has “blurred the boundaries between public and private life, and your online image can impact on your professional life”.<sup>3</sup>

A dentist should therefore always give very careful consideration to anything they choose to post on a public or private online forum. Social media might be disclosed during the course of a GDC hearing as evidence relating to an inappropriate interaction with either a patient or a colleague. Boundaries can also become blurred when personal telephone numbers or websites are used to communicate with patients. Patients should always be asked to communicate through practice portals.

The digital age has created a more fluid environment for social exchange in general. We must therefore pay careful attention in order to manage the boundaries between our personal and professional selves, and in doing so avoid blurring those boundaries.

Sarah Harford is a dental adviser at MODUS

## REFERENCES

- 1 Doel Mark, et al. 2010 Professional boundaries: crossing a line or entering the shadows? *British Journal of Social work* 40 (6): 1866-1889
- 2 General Dental Council 2013 Standards for the dental team
- 3 General Dental Council 2016 Guidance on using social media



# CASE FILES



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



GDC

## ENAMEL LOSS

### BACKGROUND

Mr N brings his 11-year-old daughter Lucy to the dental surgery for a regular six-month check-up with Dr K. She has been a patient at the practice for over two years. On examining the child the dentist notes a cavity in UL5. Mr N is concerned by this finding as Lucy had been previously diagnosed with enamel hypoplasia at age seven and the family is very regimented in ensuring she brushes properly twice a day and uses a fluoride mouthwash.

Dr K explains that there is nothing more that can be done in regard to Lucy's hypoplasia and that sometimes cavities are simply a matter of "bad luck". The dentist undertakes a restoration of UL5. Later that day Mr N phones the practice and asks to see another dentist. An appointment is made for two weeks' time.

Mr N also contacts the local dental hospital to request an appointment in regard to Lucy's enamel hypoplasia and is informed that this should be possible with a referral. Next morning he phones the practice asking for a referral but is later told this cannot be provided until Lucy sees her new dentist. Mr N asks why Dr K cannot make the referral and the receptionist explains that Dr K has refused as he is no longer Lucy's dentist. Two weeks later Lucy attends the surgery and another dentist makes the referral to hospital. Here a treatment plan is implemented involving regular fluoride varnish and Lucy is referred back to her practice.

A few months later Dr K receives notice from the GDC of a complaint from Mr N in regard to his daughter's dental treatment.

### ANALYSIS/OUTCOME

A GDC caseworker reviews the complaint and the patient notes and, after receipt of a clinical advice report, forwards the matter for consideration by case examiners. MDDUS assists Dr K in responding to the specific allegations. These are that the dentist failed to carry out sufficient diagnostic assessments and provide preventative treatment for the patient's enamel hypoplasia, including the application of fluoride varnish. It is also alleged that Dr K did not set up an appropriate recall period over the course of treatment and failed to refer Lucy as requested. There are also concerns over the paucity of his clinical records.

In his response Dr K disputes the allegation that he did not carry out adequate diagnostic assessments as he obviously identified the carious UL5, but he does acknowledge that his clinical notes make no mention of the previously diagnosed enamel hypoplasia. He also accepts that he neglected to undertake bitewing radiographs, which should have been taken at appropriate intervals, depending on caries risk.

In regard to preventative care Dr K states it is clear from the complaint that Lucy's enamel hypoplasia had been discussed and he contends that his

understanding at the time was that the principle benefits of fluoride application were to be derived before the age of nine. Having now undertaken CPD training in this area he acknowledges that this was wrong and he has changed his practice in such cases, ensuring three-month recall intervals and regular fluoride varnish.

Dr K defends his decision not to provide a referral stating that he believed it would be more appropriate for Lucy's new dentist to do so going forward. But he accepts that his record keeping has been less than adequate and states that he has since undertaken CPD in this area, with regular audit to improve this aspect of his clinical practice.

Two months later the GDC responds to say that the case examiners have concluded that there is no impairment in Dr K's fitness to practise, but that the standard of care provided was insufficient in diagnostic assessment, prevention/aftercare and record keeping. The case is closed with "formal advice" in these areas.

### KEY POINTS

- Ensure your practice is compliant with current clinical guidelines.
- Patients are within rights to seek a second opinion without prejudice.
- Comprehensive patient records are essential in verifying the facts of a case.



## ADVICE

# FIT TO WORK

## BACKGROUND

A practice manager contacts our advice line in regard to a patient with lower back pain who had previously been issued a Med 3 (fit note). The fit note will soon expire and Mr B – who has a desk job – is still in obvious pain and has asked for more time off. In discussing his condition with a GP, the patient confided that he does some volunteer work and is undertaking a part-time course at college. The GP expressed his reluctance to “tick the box” advising that Mr B is not fit for work, given the patient’s other activities. He asked about other possible options, such as a phased return to work or amended duties. Mr B has now phoned the practice manager again demanding the GP sign him off for another six weeks. The practice manager asks for advice on how to respond.

## ANALYSIS/OUTCOME

An MDDUS adviser responds pointing out that the Department of Work and Pensions

provides specific guidance on issuing fit notes. This states that GPs should provide simple fitness for work advice (not job specific) to a patient to help them return to work and it is then up to that patient and their employer to discuss this advice and consider possible solutions.

The Med 3 form offers the option to tick: “May be fit for work taking account of the following advice”, along with an open field to provide advice on the functional effects of a patient’s condition. This offers flexibility to the patient and their employer to discuss ways to accommodate the condition, which might include changing duties or reduced hours.

The adviser also directs the practice manager to GMC guidance which states that doctors must be “honest and trustworthy when writing reports, and completing or signing forms, reports and other documents” and must ensure that any such documents are not “false or misleading”. It also states that doctors

should use their own judgement when applying these principles in their everyday practice, and that they must be able to explain and justify any decision made or action taken.

The practice manager is advised that all such guidance would be relevant in explaining to Mr B the basis for any decision on fitness to work. In addition the GP should be available to discuss the basis of the decision, and it should be made clear that, if the patient remains dissatisfied, he is entitled to seek a second opinion.

## KEY POINTS

- Consult relevant guidance in discussing and issuing fit notes.
- Ensure you are able to justify any decision made or action taken in addressing a patient’s fitness to work and that this is recorded in the notes.



## ADVICE

# PRIVATE VS NHS

## BACKGROUND

A dentist emails the MDDUS advice line having read a comment on an online dental forum saying that a “mixed” practice should not offer private patients root canal treatment if also offered to NHS patients at an appropriate (lower) charge. She asks for clarification on this from a dento-legal standpoint.

## ANALYSIS/OUTCOME

A dental adviser responds that the important issue here is not whether the practice is mixed NHS/private but whether an individual patient is registered as an NHS or a private patient. An NHS patient will be entitled to the full range of available treatment on the NHS and that would include root canal treatment (RCT) at the appropriate charge. A private patient or one on a practice plan should expect to pay for treatment, including RCT, at an agreed private fee or via their monthly plan payments.

What is most important in a mixed practice is to make it clear to each

individual patient whether they are being seen on the NHS or privately. All patients must be given a treatment plan and written cost estimate which should indicate the basis on which treatment is being provided. There may be occasions where NHS patients opt for private treatment and this is entirely acceptable as long as the patient has not been coerced or misled to believe that the treatment is not available on the NHS – or would be provided more successfully on a private basis (“upselling”).

## KEY POINTS

- NHS patients have a right to consider private treatments but should be offered all available and clinically justifiable NHS options in a neutral and professional manner.
- Such discussions must be properly reflected in the records and relevant paperwork completed.

## CLAIM

## SORE FOOT



## BACKGROUND

Mrs H is 58 years old and has been a type 1 diabetic since childhood. Her control is moderate to poor and she is overweight. She attends her GP complaining of pain over the top of her right foot for a number of weeks with no history of trauma – but she has recently taken on a new job at a supermarket that involves spending more time on her feet. Paracetamol has helped to relieve the pain somewhat but it has “flared up” again in the last few days.

The GP – Dr L – finds no obvious swelling or deformity on examination and the tenderness seems to be localised to the tendons running over the dorsal surface of the foot. He concludes that Mrs H is most likely suffering from tendinitis. She is advised to use a topical NSAID gel with regular oral paracetamol and rest with supportive footwear. Dr L advises her to return in two weeks if the pain has not settled.

Two months later Mrs H attends a routine podiatry appointment and again complains of a sore foot. The podiatrist finds the arch of the foot (mid-tarsal joint) swollen and warm and notes crepitus on manipulation. She writes to the practice requesting a referral for an X-ray and blood tests to rule out the possibility of Charcot foot, in light of the patient's pre-existing diabetes. The letter is delayed in reaching the GP practice and the X-ray later reveals moderate to severe degenerative changes in the foot.

A month later Mrs H attends the practice diabetic nurse for a routine check and is given a copy of the X-ray to show the podiatrist at her next appointment in two weeks' time. Here Mrs H complains that her foot is very sore and she has had to take time off work. Again the foot arch is found to be warm and swollen with crepitus on manipulation. The podiatrist writes to the practice to ask that Mrs H be referred urgently to the diabetic foot clinic.

It takes another 10 days before that referral is sent and a further 10 days before Mrs H is seen at an outpatient clinic. Here a pedal temperature difference greater than 2°C is recorded alongside pain in an insensate foot, unilateral foot oedema and osseous deformity in the medial longitudinal arch. Diabetic Charcot arthropathy is diagnosed and an urgent CT scan is arranged. Mrs H is treated via an air cast boot and crutches.

A few months later Dr L receives a letter of claim alleging clinical negligence in failing

to diagnose and refer Mrs H for suspected Charcot foot. It states that as a result the patient has been left with a forefoot deformity with splaying of the second and third toes. She is now unable to walk long distances (requiring a crutch and orthotic footwear) and has been permanently registered disabled.

## ANALYSIS/OUTCOME

MDDUS commissions an independent GP expert to review the case. Notes from the first and only consultation undertaken by Dr L record tenderness localised to tendons running over the dorsal surface of the foot. Dr L observes no obvious swelling/deformity or redness/heat – nor any other signs indicative of Charcot arthropathy. The expert finds no specific reason why Mrs H should have been referred to the diabetic foot clinic at this stage and is not critical of the standard of care provided by Dr L.

The expert does believe that there is an issue with the 10-day delay by the practice in ensuring Mrs H was seen urgently by the diabetic foot clinic, as requested by the podiatrist. However, he recognises that this is not part of the allegations.

A letter of response is sent by MDDUS on behalf of Dr L denying breach of duty of care and causation (adverse consequences of that breach). Nothing more is heard from the claimant solicitors and the case is eventually closed.

## KEY POINTS

- Record full history/examination findings and justification for treatment decisions.
- Ensure practice systems adequately track urgent referrals and pick up “red flag” symptoms.



## COMPLAINT

# AMALGAM CONCERNS

## BACKGROUND

A 46-year-old businessman – Mr T – attends his dental surgery complaining of generalised mouth pain. His last appointment was over two years ago for a check-up and scale/polish and the records show no clinical issues at that time. Dr G undertakes a dental history and reviews Mr T's completed medical history questionnaire. Dr G notes Mr T smokes over 20 cigarettes per day and is a social drinker.

Mr T states that he recently heard on the radio that amalgam fillings had been banned in Europe due to mercury toxicity. He has numerous large "NHS fillings" in his back teeth and insists that these are poisoning his mouth and causing dental pain. He wants the fillings replaced.

Dr G carries out a detailed extra and intra-oral examination, noting calcified deposits and associated gum disease. A BPE is recorded with a score of 333/333 in each sextant. Appropriate radiographs demonstrate loss of supporting bone, particularly around the front teeth, but do not demonstrate the presence of dental decay. Peri-apical radiographs taken of two teeth (suspected sources of pain) do not reveal any apical disease. The dentist informs Mr T that he has periodontal disease and this is causing his mouth pain. He explains ongoing treatment will be required to prevent eventual tooth loss.

Mr T insists that – despite being a smoker – he has always looked after his teeth, brushing twice a day. He believes the pain is clearly associated with mercury "leeching into his gums".

Dr G explains that there is no evidence in the clinical literature of any connection between amalgam fillings and gum disease – and no European or UK guidance (that he



is aware of) calling for the removal of old amalgam fillings. The new legislation refers mainly to a general "phase down" in the use of dental amalgam aimed primarily at reducing the release of mercury in the environment. But Mr T is adamant that he wants the old fillings removed and the discussion becomes heated.

Dr G again advises regular appropriate periodontal treatment and asks the patient to make a follow-up appointment for next week but states that he is not prepared to electively remove his fillings. Two days later the practice receives a three-page complaint letter. It cites numerous articles on mercury poisoning found on the internet and accuses the dentist of disregarding Mr T's concerns and implying that he is ignorant. Dr G phones MDDUS to ask for assistance in dealing with the complaint.

## ANALYSIS/OUTCOME

Dr G formulates a response letter and this is reviewed by an MDDUS adviser. In the

letter he expresses his regret that Mr T is dissatisfied with the treatment advice and states that he in no way intended to be dismissive of the patient's concerns. He reminds Mr T that he is free to seek a second opinion on the matter – but restates that the removal of the existing fillings is contrary to his clinical judgment and will not be carried out in the surgery.

Mr T does not respond to the letter but remains a patient at the practice with ongoing treatment of his periodontal condition.

## KEY POINTS

- Ensure you engage patients in shared decision making with reasoned two-way discussion.
- Do not feel pressured to carry out treatment against your clinical judgement.

## ADVICE

# SEEKING CLOSURE

## BACKGROUND

A GP contacts MDDUS in regard to a request from a Mr F seeking access to the medical records of his deceased mother who was a patient at the practice. Mr F wants clarity over certain aspects of his mother's care leading up to her death.

## ANALYSIS/OUTCOME

An MDDUS adviser responds by letter stating that there are both statutory regulations and professional guidance in regard to such a disclosure.

The Access to Health Records Act 1990 provides certain individuals the right to access the health records of a deceased person, including that patient's personal

representative (i.e. executor or administrator of the estate). The GP is advised to ascertain whether Mr F is either his mother's personal representative or can

provide consent from that person.

The GMC advises that doctors can also disclose certain details after death "when a partner, close relative or friend asks for information about the circumstances of an adult's death and you have no reason to believe that the patient would have objected to such a disclosure". This may be particularly important to help those close to a patient understand and come to terms with the death.

The adviser informs the GP that it is at the discretion of the practice how to proceed – bearing in mind what the patient's wishes would likely have been and her confidentiality (which still applies after death).

## KEY POINTS

- An executor/administrator will usually be able to access a deceased patient's medical records if there is no reason to believe the patient would have objected.
- Disclosure to close relatives would usually be appropriate (if the patient would not have objected).

# RURAL ROMANCE

Dr Gail Gilmartin

Medical and risk adviser at MDDUS

**HAVE** been working as a salaried GP in a rural medical practice for the last two years. Recently I became friendly with a local estate manager, having met casually in the village pub. This week he asked if I would like to join him for dinner in the city. He is a patient at the surgery, our practice being the only one for many miles around. Would it be ethical to pursue a personal relationship in these circumstances?

This type of dilemma is not unusual and can be particularly difficult when working in a rural environment, where everyone is likely to be a patient.

Doctors should be aware that there is a professional duty to maintain appropriate boundaries with patients but does this mean that you could never have a personal relationship? In order to address this dilemma it is essential to consider current GMC guidance.

*Maintaining a professional boundary between you and your patient* (GMC 2013) sets out, in some detail, what is expected of medical professionals. It is very clear that you "must not pursue a sexual or improper emotional relationship with a current patient", the term "must" indicating an "overriding duty or principle".

The guidance above also refers to a "current patient". Does this suggest that the GMC would take a different view about relationships with former patients? Yes, to a certain extent but important questions to consider are:

- How long ago did the professional relationship end?
- What was the nature of that relationship?
- Was/is the patient in any way vulnerable?
- Do you still have a professional relationship with others close to the person?

Having considered all of the above – would an easy answer to the dilemma be to end the patient relationship? Unfortunately, this is problematic for several reasons; not least in that you cannot expect a patient to deregister if there is no other practice in the local area. The GMC specifically states: "You must not end a professional relationship with a patient solely to pursue a personal relationship with them".

The GMC is clearly concerned about

possible abuse of your professional position, including a relationship that is, or could be seen to be, an abuse of trust. One of the GMC's overarching functions is to maintain public confidence in the profession. As such, the most appropriate approach would be to try to re-establish professional boundaries with this patient.

Certainly you must never pursue a non-professional relationship with a vulnerable patient, as this will always be seen as a significant abuse of trust. The GMC identifies "some patients who are likely to be more vulnerable than others because of their illness, disability or frailty, or because of their current circumstances (such as bereavement or redundancy)". Remember too that a patient may be vulnerable if they have a close family member who requires significant medical support.

Where there has been a serious departure from guidance on maintaining boundaries, a GMC investigation may result in suspension or erasure. This is particularly likely if a doctor has exhibited predatory behaviour. This means a clear

demonstration of motivation to pursue a sexual or inappropriate emotional relationship which may include misuse of social networking, using personal contact details obtained improperly from medical records or visiting a patient at home without a valid reason.

Back to the original dilemma: it is essential to carefully consider the relevant professional guidance. It appears that, at present, the relationship may be beginning to breach professional boundaries. The GMC advises: "If a patient pursues a sexual or improper emotional relationship with you, you should treat them politely and considerately and try to re-establish a professional boundary". It would be appropriate therefore to try to restore such boundaries and to discuss your concerns with a senior colleague in the practice and MDDUS.

If, at a future point, the doctor-patient relationship ends and a potential personal relationship might develop, it is important to keep in mind the GMC's guidance and to be able to demonstrate that the relationship is appropriate.





# NEGOTIATING NEUTRALITY

Deborah Bowman

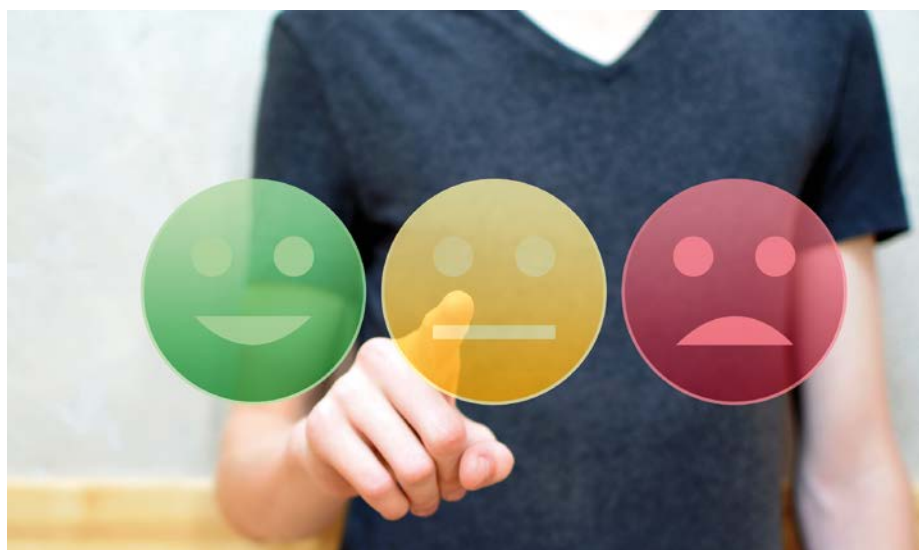
Professor of Bioethics, Clinical Ethics  
and Medical Law at St George's, University of London

**T**HESE are divided times. Polarised opinions and debate that sometimes generate more heat than light characterise public discourse at present. Neutrality is a rare phenomenon – and the notion of neutrality can attract suspicion and even opprobrium. Neutrality risks collusion, some argue. Others suggest that neutrality rarely supports the most vulnerable. It may be seen as the “easy way out”, dodging difficult questions and exposing a lack of moral courage.

In healthcare, divergent opinions and the role, or otherwise, of neutrality are live questions. The Royal College of Physicians has invited its members to vote in a poll on its position, which is currently neutral, on assisted dying. The tone and content of the discussions have, mostly, been considerate and inclusive. Nonetheless, it is clear that different people hold opinions that are hard to reconcile. Consensus looks, at the time of writing, likely to be impossible.

I have been working recently on difference amongst clinical teams, particularly in services where moral questions are particularly visible and personal. The question of the extent to which clinicians do and should bring their own views to responding to moral questions arising in specific cases has been a recurrent theme. Regulators distinguish between personal and professional perspectives, with the former generally not considered to have a place in clinical practice aside from situations where conscientious objection is legally permitted. Yet, in the messy, fallible business of being human, where emotions (conscious and unconscious) inevitably inform how we discern, conceptualise and react to situations, that line can be difficult to hold.

To suggest that anyone will be without opinion, preference, intuition, emotion and bias seems to deny, or at least misunderstand, the essence of human beings. We cannot avoid the personal, the subjective and the interpretative. What's more, clinical care is often better for it – compassion, empathy and kindness draw on our humanity. What is needed perhaps is an overt and considered reflection on, and engagement with, our own views, experiences, perceptions, preferences and



priorities. That is easy to write and immensely difficult to do, of course. To be honest about ourselves and to remain open to those who challenge, disagree and refute what we sincerely value can be painful, particularly if the encounter with difference is aggressive, hostile and personally critical.

Perhaps harder still is to admit to ourselves that we do hold personal views and have emotional responses that may, unwittingly, leak into our professional roles and affect relationships. I used to run a session with colleagues on taboos in medicine in which we explored themes such as patients who prompted fear, dislike or affinity. Even admitting that this was so was discomforting and unsettling for participants and for us as the facilitators.

Yet this sort of reflection and tussle with our humanity and difference allows us to negotiate neutrality – to evaluate for ourselves what the value and potential harms might be of our personal views, particularly when encountering those who disagree or working in situations where a patient or colleague is making a choice or apparently behaving in ways that are hard to understand. In my work, I consider it essential that clinical teams, patients, students and colleagues can be open about their own moral views and preferences. For me, that depends on them knowing that I will not judge their ethical perspectives. That is not to say I do not question what I

hear (which in many ways is the core of my work) but it is to try to prevent people second-guessing what opinions might prompt my agreement or disagreement and to encourage others to speak freely.

As a patient, I am grateful that my clinicians have never revealed, intentionally or otherwise, what they think of choices I have made during my care. That is not to say they have not been careful about giving me the information I needed to weigh options and understand the potential implications of the same, but I have been able to be open about my views on different interventions because I did not know theirs. I trust them as a result of the way in which they negotiate neutrality.

I am not neutral on moral questions and problems. However, I do negotiate neutrality professionally. That is my call and the right decision for me. It may not be so for others. We all have a different relationship with our personal and professional identities and views. The point is not to impose a single model or approach on others, but to encourage everyone to reflect on and interrogate how their opinions, experiences, emotions and preferences inform interactions with colleagues and patients. We are complex creatures whose relationship and negotiation with neutrality will vary and differ, just as our opinions do. That does not matter. To avoid recognising that we do so, however, does matter.

# Addenda

## BOOK CHOICE

### Blueprint by Robert Plomin

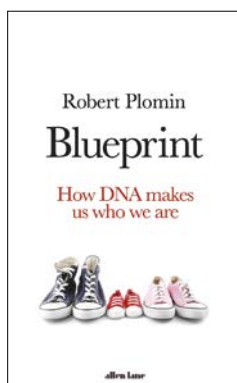
Allen Lane, £20, 2018

Review by Greg Dollman, medical adviser, MDDUS

THE psychologist Robert Plomin argues in his comprehensive new book *Blueprint* that “genetics is the most important factor shaping who we are”. A keen advocate of ‘nature’ being the design of our individuality, Plomin writes that he does not intend to discard the influence of ‘nurture’, but holds that this is “mostly random”. His work argues that the findings of decades of DNA research will shape the way we predict mental illness, and also influence how we parent and teach.

Plomin summarises: “Inherited DNA differences are the major systematic cause of who we are. DNA differences account for half of the variance of psychological traits. The rest of the variance is environmental, but that portion of the variance is mostly random, which means we can’t predict it or do much about it.”

Plomin clearly wants to start a discussion. He considers heritability (“the one per cent of DNA that differs between us and contributes to our differences in behaviour”) to understand the reason why we are different psychologically, even when environments are shared. He states that while our circumstances will direct outcomes, the genetic differences in personality increase



this happening. So our genetic makeup will determine our response to external events. That is, he argues that genetic research into ‘nurture’ “suggests that environment is imposed on us more actively than passively”.

‘What about the impact of death, illness or divorce?’, I hear you exclaim.

Plomin argues that, genetics aside, any significant environmental factors boil down to chance. They involve random experiences over which we hold little control. As such, Plomin concludes that long-term effects are insignificant, and we inevitably “bounce back to [our] genetic trajectory”.

He writes “life experiences matter, but they don’t make a difference”. He believes even societal factors have little impact on personality. Such assertions are sure to spark debate.

Plomin also explores the impact of this theory on individuals, society and psychology. He looks, for example, at predictor scores for mental illness, including schizophrenia and Alzheimer’s dementia, considering how we may use the findings to improve future detection and management. He does acknowledge the dilemma in identifying genetic risk when we are (currently) unable to do anything about it.

This book is accessible and thought-provoking.

## OBJECT OBSCURA

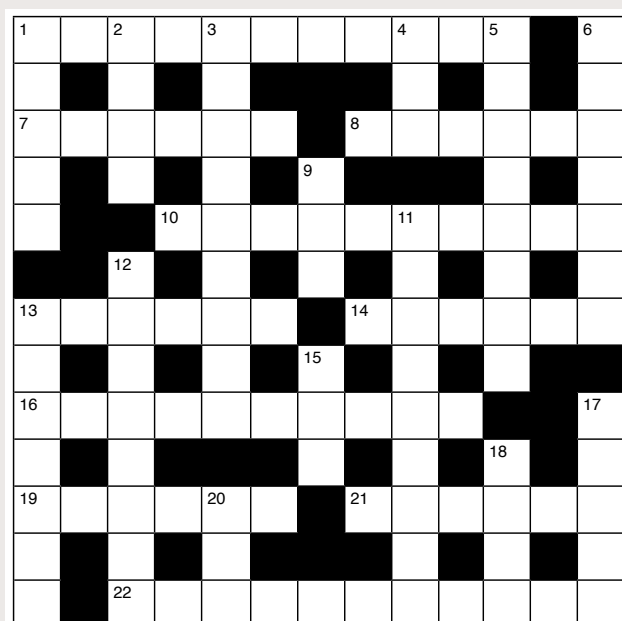
### ‘Livingstone’ medicine chest

This medicine chest covered in cow hide was taken by Swedish-American explorer Algot Lane on a 1911 expedition to the Amazon jungle in Brazil. It contains copious amounts of quinine to help prevent and treat malaria and was marketed under the name of the missionary and explorer Dr David Livingstone (1813-1873).



Photograph: Wellcome

## Crossword



### ACROSS

- 1 Type of lipid, harmful in high levels (11)
- 7 Precursors to punchlines (6)
- 8 Involuntary response to stimulus (6)
- 10 Instrument with bellows (10)
- 13 Ignorant (6)
- 14 Skilful (6)
- 16 Large measuring spoon (10)
- 19 Urge (6)
- 21 Align relative to specified position (6)
- 22 Device for measuring temperature (11)

### DOWN

- 1 Amounts to be paid (5)
- 2 Solemn promise (4)
- 3 Volatile (9)
- 4 Grain and Sussex town (3)
- 5 Kojak’s preferred confectionery (8)
- 6 Instrument for determining angular distance between objects (7)
- 9 Frozen water (3)
- 11 Old-fashioned furniture-style music system (9)
- 12 Gas turbine with a propelling nozzle (8)
- 13 Nah nah na nah na (2,5)
- 15 Group of viruses affecting skin/moist membranes (abbr.) (3)
- 17 Engine (5)
- 18 Camping shelter (4)
- 20 Anger (3)

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



## VIGNETTE

# WILFRED F GAISFORD (1902–1988)

## PAEDIATRICS INNOVATOR

**P**ROFESSOR Wilfred Gaisford once wrote:  
*“Wherever sick children are nursed there must be someone responsible who is primarily concerned with the care of the child as a whole, for the whole is greater than the part”.*

Holistic care to him was nothing new and such thinking was typical of this innovative and forward-minded paediatric clinician.

Gaisford was born in Somerset in 1902 and attended Bristol Grammar. He excelled at rugby and continued to play for many years for different teams, including Harlequins and the British Lions, touring South Africa in 1924. His father was in the Royal Navy in WW1 but Wilfred's application to join in WW2 was rejected. Instead he made sailing a much loved sport and chose medicine as a vocation..

Gaisford qualified at St Bartholomew's Hospital. There he became interested in paediatrics and gained experience in East London Children's Hospital and the Children's Hospital in St Louis in the United States, and then as Deputy Medical Superintendent at Alder Hey and honorary physician at the Royal Liverpool Babies Hospital.

Gaisford moved to Warwickshire in 1934, first to Dudley Road Hospital, Birmingham as physician and paediatrician where his research interests were encouraged by paediatric doyen Sir Leonard Parsons. Seven years later he was selected for the new post of consultant paediatrician and physician to Warwickshire County Council. There he also directed resuscitation units as part of the war effort and among his patients were Czechs whose forces were stationed in the area. His friendship and support for these refugees was recognised in 1945 by the Czech government, who awarded him the military Medal of Merit.

In 1947 Gaisford was invited to establish the first chair of Child Health in Manchester. He created a professorial paediatric unit at the Royal Manchester Children's Hospital and a neonatal unit at St Mary's Hospital, Whitworth Park.

Photograph copyright of the University of Manchester



It is interesting to look back on the post-war years in medicine and the spectrum of disease that faced Gaisford. Before penicillin was available other agents were sought. One was sulphapyridine made by Baker (M & B). He and Mary Evans, assistant medical officer, had performed a clinical trial of this at Dudley Road Hospital. Antibiotics cured numerous infections but not viral ones. An outbreak of acute laryngo-tracheo-bronchitis had to be managed by tracheostomy, not common since the days of diphtheria infections. Later the adverse reactions to drugs, notoriously thalidomide, presented new problems. He recognised that prevention of tubercular disease could be achieved with BCG and immunised neonates. Some problems were solved quite simply: Pink's disease was caused by poisoning from mercury in teething products.

He encouraged research into problems of immaturity of neonates, such as hyperbilirubinaemia. Gastrointestinal disorders were not well understood for many years. However, he recognised that some disorders were avoided when babies

were breast fed, so always encouraged this against a growing trend of bottle feeding.

Gaisford recognised a growing need for surgeons with paediatric knowledge, so posts for specialist paediatric surgeons and neurosurgeons were established. There was also a need for specialist oncologists. Gaisford started a Children's Tumour Registry which became a knowledge base for improved treatment. He was an inspiring teacher who raised the status of paediatrics. Thanks to him an examination on paediatrics alone was included in the final MB.

The part family played in the recovery of a sick child was recognised by Gaisford and he made sure that visiting hours were not unnecessarily restrictive. His policy was also to have children treated in wards dedicated to their needs, not placed among sick adults, and to foster a holistic approach to paediatric care. Gaisford insisted on warm hands for patient examination and carried a hot water bottle on his own ward rounds for that purpose. Never more than two attempts at venepuncture were permitted.

In 1935 he met and later married Mary Guppy and they had four children. Holidays were by the sea in North Wales. Later at their home in Bowden, Cheshire, they entertained generously. Gaisford suffered increasingly from osteoarthritis and retired in 1967 to live in Cornwall.

Commenting on his profession he said:

*“There are enough problems to be solved to ensure a lifetime of enthralling work in the field of paediatrics for all those who, by their love of children, feel drawn to work for their betterment. And love of children calls for patience, gentleness, kindness and humility.”*

Julia Merrick is a freelance writer and editor

### Sources

- Progress in Paediatrics 1914–64, the Catherine Chisholm Memorial Lecture, April 13, 1963, published in Jnl. Women's Federation 48 No 1 Jan 1966
- Smellie JM. Munk's Roll: Volume VIII: Wilfrid Fletcher Gaisford.

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