

QUARTER FOUR / 2019

INSIGHT



A QUARTERLY PUBLICATION FOR MEMBERS



THE ART OF MEDICINE

What can we learn from observations of medicine as depicted in art?

HUMANS LIKE US

Dental adviser Sarah Harford looks at human factors and clinical error

NO SNOWFLAKE

Trainee surgeon David Riding and the RCSEd call time on bullying with #LetsRemoveIt

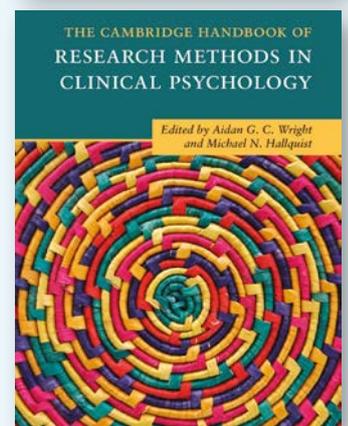
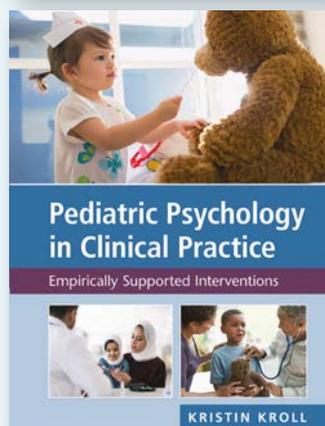
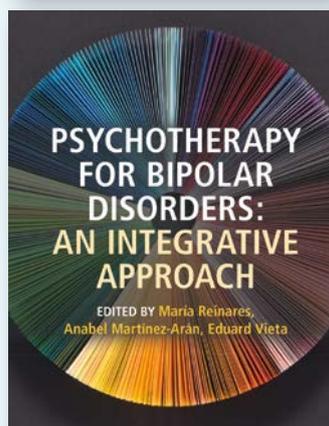
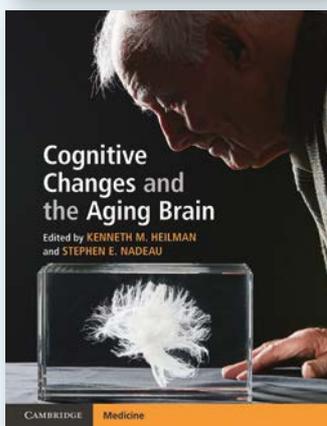
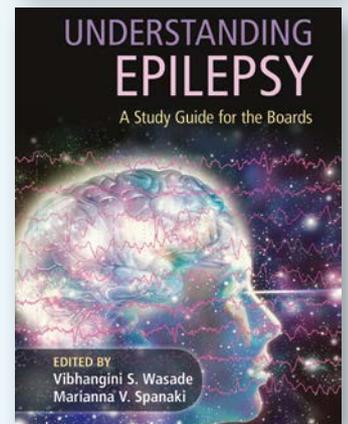
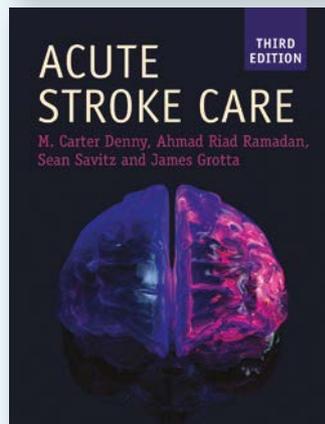
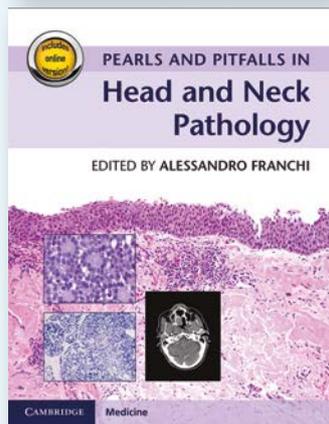
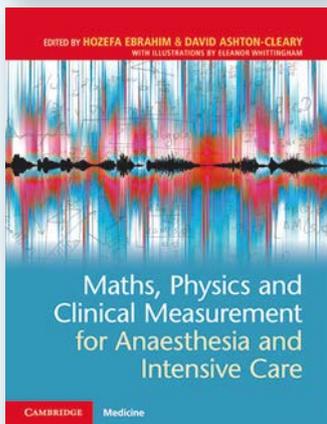
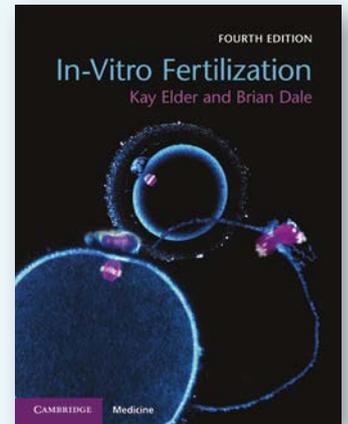
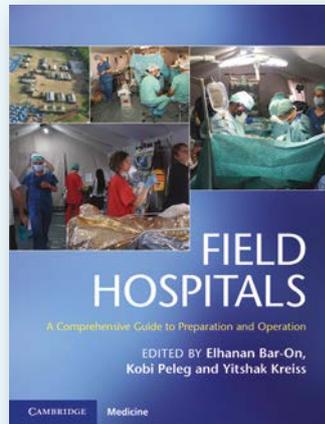
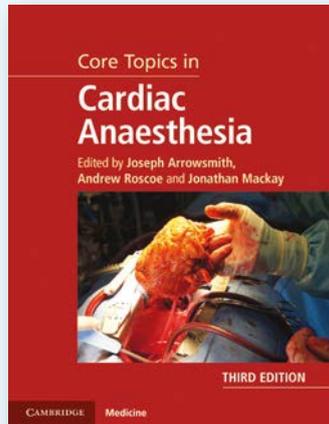
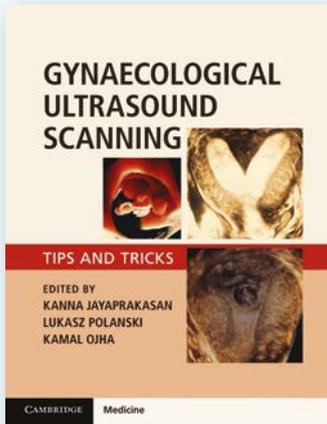
OPIOID PRESCRIBING

UK prescribers face increasing risk – how best to mitigate?



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INSIGHT



Editor

Dr Barry Parker

Managing editor

Jim Killgore

Associate editor

Joanne Curran

Editorial departments

Medical Dr Richard Brittain

Dental Mr Aubrey Craig

Legal James Doake

Design and production

Connect Communications

0131 561 0020

www.connectmedia.cc

Printing and distribution

L&S Litho

Correspondence

Insight Editor

MDDUS

Mackintosh House

120 Blythswood Street

Glasgow G2 4EA

jkillgore@mddus.com

Cover image

Hidden Gem I, Lorraine Balfour
Oil, 2018

Lorraine Balfour lives in Edinburgh and uses a variety of techniques in her work, including etching and collograph to evoke the natural scenes that she loves to capture. This painting won the Art in Healthcare purchase prize at the Royal Scottish Academy open exhibition in 2018.

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



Photograph: Tate Images



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EDITOR
Dr Barry Parker

THE recent report, *Caring for Doctors, Caring for Patients*, commissioned by the GMC, is a welcome and much needed attempt to address the hugely important issue of doctors' wellbeing. The underlying problems identified, including workload stress, lack of support and team dysfunction, will be sadly familiar to many doctors. Amongst the report recommendations, promoting compassionate leadership and tackling blame culture within the NHS are laudable aims.

In this issue, we include two articles which link with this theme. On page 12, David Riding talks about the RCS Edinburgh campaign to stop bullying, and on page 14 Sarah Harford, dental adviser, discusses a human factors approach to clinical error, taking account of the multiple background factors that may contribute to an incident, rather than viewing the clinician in isolation.

“Promoting compassionate leadership and tackling blame culture within the NHS are laudable aims”

Also in this issue, Allan Gaw takes a fascinating look at how art can enhance the teaching of medicine, offering “colour, subtlety and depth” on a human level (p. 10). Personal health budgets aim to give patients greater control in managing their care – but are they fair and effective? Joanne Curran investigates on page 8.

Our risk topic on page 9 deals with opioid prescribing, and our Dilemma (p. 20) involves a patient selling on prescription medicines. On page 21 Deborah Bowman discusses how practice makes perfect, even in ethics.

This will be my final edition of *Insight* as editor, but I look forward to the new developments in our publications outlined on this page. I would like to thank all of our contributors over the past five years, and pay special tribute to Jim Killgore and Joanne Curran who are responsible for all of the hard work and expertise that goes into producing each edition of *Insight*. It has been a pleasure and privilege to work with them.

Dr Barry Parker

MDDUS publications – a new approach

IN October of this year we launched the first edition of our new digital *Insight*, generated using the premium digital magazine platform, Foleon. This has significantly cut our per-issue production costs, yielding an 85 per cent saving to the membership. The move has also reduced our environmental impact in avoiding the printing and posting of over 55,000 hard copies.

This switch to digital was part of a larger initiative to reconsider our publication programme and how best to communicate with members going forward in 2020. Currently, MDDUS produces five magazines for various membership groups: *Insight*, *Practice Manager*, *FYI*, *GPST* and *SoundBite*.

We have now decided to broaden the scope of the content we produce for medical and dental members. Starting in March 2020 we will replace our current range of magazines with three branded quarterly *Insight* magazine titles:

- *INSIGHT Primary Care*
- *INSIGHT Secondary Care*
- *INSIGHT Dental*

These magazines will cover all the topic areas found in our existing titles and more – with targeted content appealing to a wider range of members. All the *Insight* titles will be generated using Foleon and sent out via an email link, but those existing members who opted for print will still receive a hardcopy in the post.

The new magazines will still feature important MDDUS news and articles with broad appeal across the membership – but also targeted content aimed at specific professions and healthcare roles, such as GPs, surgeons, specialist physicians, dentists, practice managers/staff, nurses, pharmacists, paramedics, trainees, students and others.

Look out for the first edition of *INSIGHT Primary Care* in March, followed by *INSIGHT Secondary Care* in April and *INSIGHT Dental* in May.



Members to be asked to approve arrangements for historic liabilities

MEMBERS will be aware that in April 2019 the Department of Health and Social Care (DHSC) introduced a Clinical Negligence Scheme for General Practice (CNSGP) which provides state-backed indemnity to GPs and other general practice staff in England in respect of NHS-funded work.

In September 2019, MDDUS entered into an agreement under which DHSC will take on responsibility for the historic liabilities of our members and former members who provided primary medical NHS services in England before 1 April 2019 during their membership of MDDUS. This means English GP members

will be indemnified by DHSC rather than MDDUS for those liabilities, and claims handling responsibilities will be transferred under the Existing Liabilities Scheme (ELS). Detailed information regarding claims handling will be published by DHSC in due course.

As part of the transfer of the responsibility for providing cover for historic liabilities, we intend to use a ‘Scheme of Arrangement’ (the Scheme), a formal process that is agreed by members and the Court. The Scheme documents will explain the key terms and what it means for MDDUS and its members and former members going forward. We think that a Scheme is the right approach as it will provide greater certainty to MDDUS and its members that the obligation to consider indemnity cover for liabilities in respect of English GPs’ historic NHS liabilities will lie with DHSC.

In the meantime, please check that



your postal and email addresses are up to date, so we can ensure you receive the letter/proxy form. If you have moved house in the last few months or have another email address that is preferential, please log in to our membership portal on mddus.com to update your details or email membership@mddus.com to allow us to update our records.

Private practice earnings

MDDUS subscription rates for doctors in private practice are calculated on an estimate of private earnings at the beginning of each subscription year. It is your responsibility to ensure that this remains sufficient to cover your private earnings and we urge you to review this for accuracy both during your subscription year and again before the following subscription year commences.

If at the end of the subscription year your estimate has proved to be too high or too low, you will have an opportunity to adjust it. May we remind you that it is your responsibility for checking the accuracy of your membership grade.

We would like to be clear that the private earnings figure you use should be your gross private earnings from the practice of medicine, however delivered. In the event that you have formed a company for accounting or other purposes, the relevant figure is the gross income to that company in relation to your practice of medicine. Gross earnings include, but are not limited to, fees, salaries, bonus payments and dividends before the deduction of any expenditure.

It is important that members make a fair and equitable contribution to the mutual fund and we reserve the right, as detailed in our Membership Agreement, to request evidence from members relating to private practice income, including a periodic audit of members. Falsifying or failing to provide full details may affect the benefits of membership or result in the withdrawal of any indemnity

or of the services provided by MDDUS.

We hope this is clear and fair to you as a member of a mutual organisation but if you have any questions please telephone Membership Services on 0333 043 0000.

New Finance Director appointed

MDDUS has appointed James Parker (pictured) to the role of Finance Director.

James will provide financial leadership as the mutual develops and expands targeted products and services for its medical and dental professional membership. James joins MDDUS from CS Healthcare, a health insurer based in London, where he was CEO.

MDDUS CEO Chris Kenny said: "I'm absolutely delighted to welcome James to the team at MDDUS. James brings with him a wealth of experience in the insurance and financial services sector. His arrival deepens our expertise and will play a key role in enabling us to build on our success and growth over the past few years. James will also steer us through a period of change as the demands on medical defence organisations evolve in today's market."

James added: "I am excited to join MDDUS at such an important stage of its development and growth. I'm looking forward to being able to continue to build on

MDDUS's robust financial position and reputation for excellent service as it evolves to meet the needs of its members in the next decade."

James is a Chartered Management Accountant and has over 30 years' experience working in financial services. Previously he was Managing Director of CIGNA's UK health insurance business in Greenock and before that held various finance roles with Prudential both in the UK and South East Asia.

He succeeds Colin Slevin, who remains as Special Executive Director but will retire from the company in 2020 after 32 years' service.



↓ MDDUS ADVICE ONLINE

Contact our Advisory Service at a time convenient to you by using our online advice form. Members can ask for advice on a particular medico- or dento-legal matter or notify us of a complaint or claim and request contact from one of our advisers. You can also attach relevant documents. To take advantage of this service, log in to the membership portal at mddus.com and click the **Get in touch** button and choose an option from the drop-down menu.

↓ PROFESSIONALISM COURSES

Learn about key issues around professionalism in medical and dental practice in two new MDDUS training courses to be held in our Glasgow office in January. Topics covered include accepting gifts, managing your online presence, personal relationships and much more. Professionalism – fulfilling your duties:

- Doctors: 21 January 2020
- Dentists: 29 January 2020. Go to Training & CPD > Events at mddus.com to book or email risk@mddus.com to find out more.

↓ BE A BETTER LEADER

Book now for a place on our popular MDDUS leadership training course for clinicians – *Leading through uncertainty*. The five-day programme (taking place one day per month) will challenge you as a leader and help you positively change the way you manage your team. Separate courses will be run in 2020 for doctors and dentists. Go to Training & CPD > Events at mddus.com or contact risk@mddus.com.

SNOMED CT reminder for dental practices

ALL electronic systems used in the provision of NHS services are expected to employ the terminology SNOMED CT as of 1 April 2020 – and this includes dental practices.

SNOMED CT is a structured clinical vocabulary used in electronic health records and is an international standard. The Health and Social Care Act 2012 mandates that systems involved in the care of individuals in dentistry in England must use SNOMED CT for patient record keeping, electronic communications and data capture.

This includes all practices that hold an NHS contract and any provider that does or may interact with the NHS for the provision of a course of treatment.

Dr Ian Bergin, Digital Project Manager for the Office of the Chief Dental Officer at NHS England has written to MDDUS to remind members: “It is incumbent on all providers to ensure that their PMS (practice management software) utilises SNOMED CT. I would strongly advise liaising with the BDA to ensure that all dental practices and practitioners have a PMS that is SNOMED CT compliant and, therefore, not in breach of the law as of April next year.”

New guidance on remote prescribing

NEW guidance on remote consulting and prescribing has been published by 13 healthcare organisations.

It sets out “high level principles” of good practice designed to safeguard patients who access medical and dental care online, via video link or by phone.

Aimed at those with prescribing responsibilities, the 10 principles have been agreed by the GMC, GDC and other organisations including royal colleges and faculties.

Among the key points, it states that healthcare professionals should:

- understand how to identify vulnerable patients and take appropriate steps to protect them
- carry out clinical assessments and medical record checks to ensure medication is safe and appropriate
- raise concerns when adequate patient safeguards aren’t in place.

The principles apply to all those involved in providing consultations and medication to patients remotely, including doctors, nurses, pharmacists, dentists and opticians.

The guidance has been welcomed by MDDUS. Joint Deputy Head of Medical Division Dr Susan Gibson-Smith commented:



Opposition to scrapping GP home visits

THE RCGP has expressed opposition to the scrapping of home visits in England after GPs voted to remove the duty from their standard contract at a recent LMC meeting in London.

Delegates at the BMA conference argued that GP practices are too overstretched to deliver the service, but Secretary of Health and Social Care Matt Hancock branded the position a “complete non-starter”. The RCGP also called home visits a “core part” of general practice and for some vulnerable patients the only means of seeing their GP.

Professor Martin Marshall, RCGP Chair, commented: “Of course, home visits should be used wisely as they can be time consuming and take GPs away from our surgeries where we could be seeing more patients. But it is vital that patients who need the skills and expertise of a GP are able to access them if they are unable to make arrangements to get to their local surgery.”

“It is reassuring to see healthcare regulators and organisations reinforce the need to mitigate against the risks associated with clinicians treating patients remotely when they have little or no access to their medical records.

“For example, contact with vulnerable patients requires a heightened level of awareness, as in our experience issues can arise if safeguarding clues are missed during remote consultations, or when arrangements for following up with the patient are not adequate.”

She added: “We are also reassured that the principles advise UK-based healthcare professionals on important considerations should they be asked to provide remote services to patients abroad, emphasising the potential indemnity and regulatory difficulties with this.”

GMC wellbeing report

MDDUS has welcomed publication of the GMC report *Caring for Doctors, Caring for Patients*.

The report highlights an urgent need to address the wellbeing of doctors faced with higher workloads and the impact on patient care. Recommendations include compassionate leadership models giving doctors more say over workplace culture, adopting minimum standards of food and rest facilities, and standardising rota designs taking account of workload and available staff.

Dr John Holden, Head of Medical Division at MDDUS, commented on the report: “This review by Professor Michael West and Dame Denise Coia is a welcome and timely intervention in the evolving discussion on factors which impact on the mental health and wellbeing of doctors and medical students in the UK.

“It has produced a set of recommendations that could, in our opinion, be the catalyst for transformative change in the workplace culture experienced by medical professionals.

“We embrace the GMC’s concern about the impact of current workloads on doctors’ wellbeing and mental health, and the potential knock-on effect this can have on patient safety.”

Early prevention best option in child tooth decay

A MAJOR three-year dental study of children has found no evidence to suggest that any one of three accepted treatment strategies was better than another in stopping pain and infection from ongoing decay in primary teeth.

Dentists involved in the study recruited over 1,140 UK children with visible tooth decay between the ages of three and seven. One of three treatment approaches was then chosen randomly: conventional fillings, sealing decay into teeth, and using prevention techniques alone, such as reducing sugar intake, twice-daily brushing, application of fluoride varnish and placing of fissure sealants on the first permanent molars. The children were then followed for up to three years.

No evidence was found to suggest that any one of the treatment strategies was better than another in terms of making a difference in children's ongoing experience of pain or infection, quality of life or dental anxiety between groups.

Professor Nicola Innes, Chair of Paediatric Dentistry at the University of Dundee and lead author on the paper published in the *Journal of Dental Research*, said: "Our study shows that each way of treating decay worked to a similar level but that children who get tooth decay at a young age have a high chance of experiencing toothache and abscesses regardless of the way the dentist manages the decay.

"What is absolutely clear from our trial is that the best way to manage tooth decay is not by drilling it out or sealing it in - it's by preventing it in the first place."

Access the FICTION trial findings at tinyurl.com/wtdcdqp

New guidance for expert witnesses

DOCTORS who plan to serve as expert witnesses should first undergo medico-legal training, according to new guidance from the Royal College of Surgeons of England.

This can help avoid common pitfalls such as inconsistencies in reports and the temptation to argue with legal counsel. Other common errors highlighted in the guidelines include taking on a case outside your experience or expertise, and inadvertent confidentiality breaches.

The College said serving as an expert witness can be fascinating and intellectually

stimulating but "expert witness testimony is faced with increased legal scrutiny in clinical negligence litigation".

The guidance provides practical advice on the nature and scope of the expert's role and addresses some of the main legal and ethical requirements for expert witnesses – providing advice on how to assess evidence, how to avoid common errors and how to navigate the different positions of the court, jury and solicitors.

Access the guidance at tinyurl.com/sk4r73t

Understaffing threatens patient safety

NINETY per cent of health leaders believe that understaffing is putting patient safety and care at risk, according to a new survey by the NHS Confederation.

More than four-fifths (83 per cent) also said the NHS Pension Scheme was having a detrimental impact on the workforce, with just under 70 per cent saying it is damaging patient care.

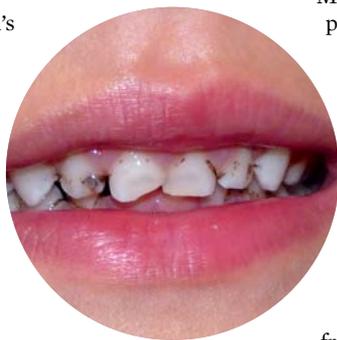
The views emerged in a survey of 131 health leaders in England, including chief executives, chairs and directors from NHS trusts, clinical commissioning groups and local integrated care systems.

More than three-quarters (76 per cent) of respondents said that supporting and growing the NHS workforce should be a critical priority, ranking it highest at a time when there are more than 100,000 vacancies among clinical and nursing staff.

The results come as the latest performance statistics for the NHS show that demand for services has continued to rise, with the NHS treating more people than ever before. However, key targets for hospital care and A&E have hit their worst levels since the standards were introduced in 2004.

More than half (58 per cent) of those surveyed believe this winter will be the worst on record for NHS waiting times and performance.

NHS Confederation chief executive Niall Dickson said: "Workforce gaps, the growing social care crisis and historic underinvestment are the biggest threats to improving care for patients and transforming services, and each of these issues needs attention, as do the pension rules which are discouraging some doctors from taking on extra work and encouraging others to take early retirement."



DRUG DRIVING CLAMPDOWN

NEW drug driving laws in Scotland will make it easier for police to stop and test anyone suspected of driving while impaired by drug use.

Officers can use mouth swabs to test for illegal drugs, including cannabis, heroin, ecstasy and cocaine, and also for limits on certain prescription drugs. Find out more at: www.legislation.gov.uk/ssi/2019/83/contents/made

DOCTORS TAKING PART IN PROTESTS

THE GMC recently addressed the issue of doctors taking part in political protest actions. Doctors are entitled to their own personal political opinions and nothing prevents them from "exercising their rights" to campaign on issues, but the GMC confirmed its legal duty to investigate complaints raised against doctors involved in protest (or via self-referral). Members facing legal issues should contact MDDUS.

SAFEGUARDING TOOLKIT

A NEW toolkit has been launched to support the safeguarding of children and young people who miss dental appointments. The new approach marks a move away from the "did not attend" pathway towards one that recognises children often have no control over whether they attend appointments. The "was not brought" pathway – WNB-CYP – was published in the *British Dental Journal* and is available for all dentists and their teams to use via the BDA website. Access at: www.bda.org/safeguarding

PATIENT PURCHASE POWER

Joanne Curran

Associate editor of MDDUS *Insight* magazine

IF THERE are two words that could sum up a key focus of UK healthcare strategy in recent years it would surely be “personalised care”.

Gone are the days of “one size fits all” medicine, with a decisive shift towards person-centred care and shared decision-making.

Giving patients more of a say in their treatment is widely supported, but the best means of achieving this goal are the subject of heated debate.

One such measure that has resurfaced in the headlines recently is personal health budgets (PHBs). Under the scheme, eligible patients are given an amount of money to spend – in a way that suits them – on services to support their health and wellbeing needs. A PHB is not new money, but rather enables people to use funding in different ways that work for them.

These were first launched in England in 2014 for adults receiving NHS-funded long-term health and personal care. Alongside personal budgets in social care, they form an important part of the government’s NHS Long Term Plan. Similar “personal budget” approaches exist in Scotland and Wales, but so far only apply to social care.

A recent update to the law in England means that, from 2 December 2019, those who use wheelchairs or need mental health support will have access to a PHB. This would more than double the number of people currently accessing budgets – from 70,000 to more than 170,000. The goal is to increase this figure to as many as 200,000 by 2023/24.

While PHBs have proved popular amongst certain patient groups, there remain serious questions for health leaders. How can they ensure that PHBs are an effective use of scarce NHS resources and don’t create inequalities or increase GP workloads?

There have been a number of media reports over the years of some PHBs being used to pay for the likes of holidays, computer game consoles and even theatre tickets. Cases have also been highlighted of funding being wasted in well-intended but ineffective ways, such as the patient who purchased a stairlift despite their condition deteriorating so rapidly that they would soon be physically unable to use it.

The Royal College of GPs published a position statement on PHBs in 2012 which recognised that PHBs are one of a number of tools that – under the right circumstances – have the potential to realise better outcomes for some patients.

The College expressed concern that PHBs could increase overall demand if patients who previously were not in receipt of NHS-funded services take up the offer of a personal budget. GPs, it says, could also see their workload increase as they are called upon to help patients plan or manage their budgets. Add to that, difficulties for GPs and commissioners in ensuring the quality of services provided through PHBs, as well as potential for the emergence of postcode lotteries between different areas.

It concludes: “While there is reasonably good evidence that PHBs are associated with increased patient satisfaction and empowerment, the evidence for a direct positive impact on health outcomes is currently sparse.”

The British Medical Association (BMA)



“The vast majority of people are far more scrupulous with their budget than stretched public services”

has taken a similar stance. Speaking to *Pulse* in April 2018, a spokesman said: “Whilst supportive of patients having more control over their care, the BMA is concerned that NHS funds... are being spent on non-traditional treatments and non-NHS services that may not be clinically effective, which the health service can ill afford.”

Despite these concerns, there are many first-hand accounts describing how patients have benefited from the scheme.

In a blog for the *BMJ* in August 2019, consultant paediatrician Helen Leonard described her hard-fought victory in securing a PHB for her disabled son as “transformative”. She describes the relief of moving from a care plan that involved a constantly changing rota of often unreliable, under-trained and unfamiliar agency staff to one in which she could choose a core team of familiar, capable carers.

She rejects the notion of frequent misspending, saying: “The vast majority of people are far more scrupulous with their budget than stretched public services who are remote from the day-to-day running where, for example, money can still be paid to agencies when carers have not turned up or money is spent on unsuitable equipment.”

“PHB spending is tightly audited. I have no doubt that there will be occasional misuse, but this does not mean the rest of us should be penalised or that the entire scheme is flawed.”

She concludes: “Until you have been on the receiving end of health and social care for long-term complex medical needs, it is hard to understand the rationale and importance of PHBs.”

Patient advocate and influential disability activist Lucy Watts takes a similarly strong line. In a recent speech she highlighted how a PHB “helps to future-proof my care so that, as I reach the end of my life, I have a care team around me who can manage my needs”.

With such strong support from patients and government, PHBs appear here to stay. But how to make them a success? Independent charity The Health Foundation sums this up by saying that personal budgets “need to offer adequate infrastructure, staff training and signposting, and support to service users”.

OPIOID PRESCRIBING RISKS

Dr Gail Gilmartin

Medical and risk adviser at MDDUS



Medicine has published: *Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain*. This offers specific guidance on best practice in the use of opioid medication for pain.

Appropriate practice in prescribing opioids should also be based on the GMC guidance: *Good practice in prescribing and managing medicines and devices*. Certain paragraphs are worth highlighting here. At paragraph 3 the GMC states:

"You are responsible for the prescriptions you sign and for your decisions and actions when you supply and administer medicines and devices or authorise or instruct others to do so. You must be prepared to explain and justify your decisions and actions when prescribing, administering and managing medicines."

And at paragraphs 53 and 58:

"Reviewing medicines will be particularly important where:

- a) patients may be at risk, for example, patients who are frail or have multiple illnesses
- b) medicines have potentially serious or common side effects
- c) the patient is prescribed a controlled or other medicine that is commonly abused or misused
- d) the BNF or other authoritative clinical guidance recommends blood tests or other monitoring at regular intervals."

"At each review, you should confirm that the patient is taking their medicines as directed, and check that the medicines are still needed, effective and tolerated. This may be particularly important following a hospital stay, or changes to medicines following a hospital or home visit. You should also consider whether requests for repeat prescriptions received earlier or later than expected may indicate poor adherence, leading to inadequate therapy or adverse effects."

Any doctor who prescribes opioids should look carefully at their practice to ensure that they are complying with current guidance and exercising appropriate clinical judgement.

ACTION

- Keep up-to-date with guidance.
- Check carefully to ensure the continued need for prescribing at current levels.
- Provide clear advice to your patients about the risks associated with opiate use.

OPIOID painkillers are highly effective and beneficial to millions of patients – but the risks of prescribing these drugs are well known. Used

regularly, opioids can cause dependence and (with overuse) addiction, possible overdose and death.

The Mayo clinic reports that after as little as five days use the likelihood of dependence increases sharply. The sheer magnitude of the current scale of prescribing has now attracted attention because of the rise in adverse events.

Recent headlines from the USA mirror the increased interest and focus on problems here. The US Center for Disease Control and Prevention estimated that opioids caused the deaths of approximately 47,000 Americans in 2017. Only a few weeks ago an Oklahoma state judge ordered the drug maker Johnson & Johnson to pay \$572m (£468m) for its part in the opioid addiction crisis.

Recent figures in England and Wales have shown an increase in prescriptions for opioid painkillers of over 60 per cent in the last decade. In 2008, 14 million prescriptions were dispensed in the community alone, a figure which rose to 23 million in 2018. It is also reported that from 2008 to 2018, the number of codeine-related deaths in England and Wales more than doubled to

over 150. The National Records of Scotland showed that codeine-related deaths spiked at 43 in 2016, dropping to 27 in 2017. The Northern Ireland Statistics and Research Agency (NISRA) data shows that there were 16 codeine-related deaths in 2017.

In response to the growing problem, Secretary of State for Health and Social Care, Matt Hancock recently announced that all opioid medication will have to carry prominent addiction warnings.

At MDDUS we are frequently contacted for advice about difficult patients who exhibit drug-seeking behaviour. This can range from giving an inaccurate history in order to receive prescribed painkillers (or repeatedly reporting the loss of prescriptions) to clearly fraudulent actions such as altering prescriptions.

The continued prescribing of opioid medication also leads to complaints from both patients and their families. An adequate response to such complaints requires an explanation of why a prescription was continued and a clear rationale for doing so.

Inquests into deaths where a patient has received opiate medication will also look closely at prescribing and whether this may have contributed to the death. If the prescribing is criticised by the coroner in their conclusion, the doctor in question must then self-report to the GMC.

There is helpful guidance about good practice in prescribing in these circumstances. The Faculty of Pain

Dr Allan Gaw offers examples of how art can be used to enrich medical education

MEDICINE and Art have a common goal: to complete what nature cannot bring to a finish, to reach the ideal, to heal creation. This is done by paying attention. The physician attends to the patient; the artist attends nature... Art, like medicine, is not an arrival; it's a search. This is why, perhaps, we call medicine itself an art."

These are the words of Marie Therese Southgate, physician and former deputy editor of the *Journal of the American Medical Association* – an enlightened publication with such high regard for fine art that it reproduced paintings on its covers for almost 50 years.

I believe it is worth reflecting on these words and exploring the common ground between art and medicine – in particular the role of art in medical education. Below are three examples of paintings that can be used in different areas to enrich a formalised, and all too often conservative, medical curriculum.

MEDICAL HISTORY

I begin with an anatomy lesson (opposite bottom right) because this painting was the only one ever to feature in my own medical education – and I have never forgotten it. One afternoon almost 40 years ago, one of my lecturers went off-piste and surprised us by starting his lecture on orthopaedics with a slide of this painting. He talked us through the details and drew us in, which of course was his plan.

Here Rembrandt portrays the eminent anatomist Nicolaes Tulp demonstrating the dissection of the forearm muscles. Propped at the foot of the dissection table, perhaps to show his credentials, is his large anatomy textbook. Huddled around the cadaver are a group of rather ageing medical students... or are they? Despite the familiar group demeanour (the over-eager ones at the front, the one trying to crib from his notes and the one staring off into space at the back), these seven were in fact not medical students but Masters of the Surgeons' Guild of Amsterdam – the top Dutch surgeons of the day.

The dissection itself is also not all that it seems. Before the practice of preservation of cadavers, those organs that would deteriorate quickly had to be dissected first – the contents of the abdomen and head. A dissection would never begin with the arm, and as such this scene is staged and unrealistic.

This painting has obvious appeal to the pre-clinical anatomist, but it also raises more important issues on the use of fine art as documentation of historical fact. In many instances, what is portrayed is what it appears, but not always. We often wrongly ascribe an almost photographic quality to fine art representations of people, events and places connected with medicine. We should leave this example on a note of caution but remembering that even a misrepresented image may be of educational use.

IMAGES OF ILLNESS

Some artists clearly intend to represent illness, but sometimes it happens unintentionally, as was the case with Dante Gabriel Rossetti. *Monna Vanna* was a sumptuous portrait of his model Alexa Wilding, and Rossetti himself thought it one of his best (opposite bottom left).

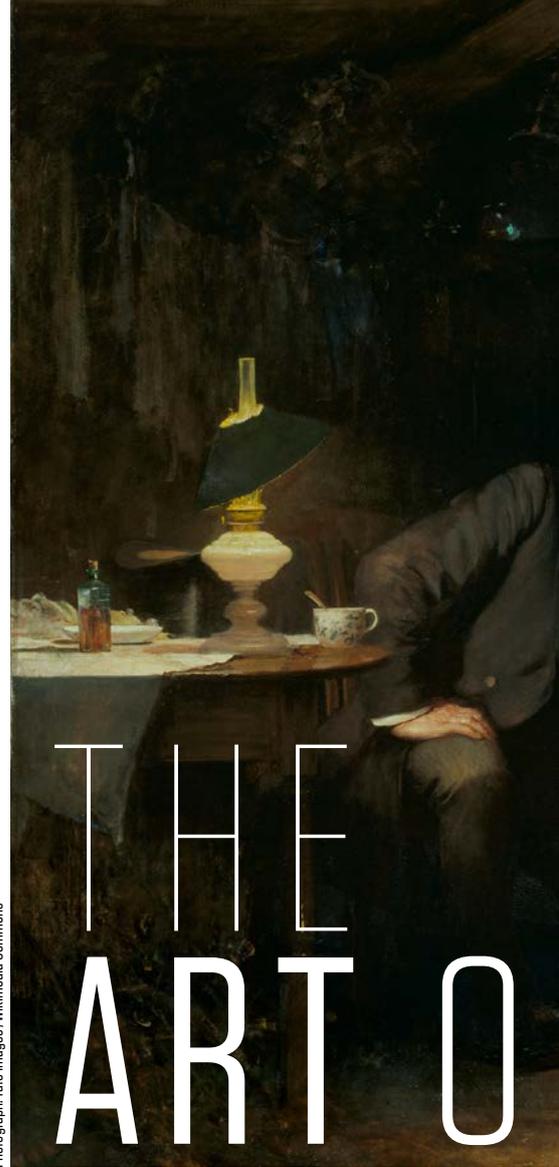
Alexa was a dazzling redhead, who like some of his other models was found by Rossetti on the London streets. She figures in several of his works and her features and colouring have become almost synonymous with the Pre-Raphaelite ideal of beauty. Beautiful though she was, look closely and you will see that she also had thyroid disease as evidenced from the goitre in her neck.

There are countless instances throughout the galleries of the world of clinical signs inadvertently captured by the observational powers of the artist, and identifying them can be both entertaining and educational.

IMAGES OF THE PHYSICIAN

Many formal portraits of famous physicians hang in hospitals and galleries around the world, but perhaps we can learn more by studying depictions of the doctor at work. *The Doctor* by Sir Luke Fildes (main image) has been described as “undoubtedly the best-known medical painting ever done”. On one level this is simply a sentimental scene of country life, which appealed to the rural nostalgia intrinsic to late Victorian Britain – so much so that an engraving of the painting published at the time was a best seller. However, it can be read more subtly.

Except for prevention, the Victorian physician had few of the tools of modern medicine – yet the central drama of medicine even in a staged scene, such as this, remains the same. It is played out, not in the expressions of the parents in the shadowy background (the helpless father



Photograph: Tate Images/Wikimedia Commons

THE ARTO

trying to comfort his distraught wife) but rather in the interaction between the two central figures: the physician and his patient. The relationship of the doctor to the child can best be summarised in a single word – attention.

In spite of great advances, what medicine is still all about is the patient, the physician and the quality of the relationship that exists between them. This painting has a lot to say about that relationship, and what it says, it says more eloquently than words.

LAST WORDS

Paintings can be used to illustrate the past, make a point or even start a discussion on what it means to be a physician. They can be a remarkable resource, not only providing useful educational tools, but can also offer the colour, subtlety and depth to topics otherwise so difficult to achieve.

We began with a quotation from Marie Therese Southgate and it is to her that I return for the last words.

“Medicine is itself an art. It is an art of doing, and if that is so, it must employ the finest tools available – not just the finest in science and technology, but the finest in the knowledge, skills, and character of the physician...And so I return to the question I asked at the beginning. What has medicine to do with art?”

“I answer: Everything.”

Allan Gaw is a writer and educator in Scotland



F MEDICINE

Clockwise from main picture: The Doctor, Luke Fildes (1891); Anatomy Lesson of Dr Nicolaes Tulp, Rembrandt van Rijn (1632); Monna Vanna, Dante Gabriel Rossetti (1866)



“A dissection would never begin with the arm, and as such this scene is staged and unrealistic”

CALLING TIME... ON BULLYING

Insight chats with ST6 surgeon David Riding about a high-profile RCS Edinburgh campaign to stop bullying in surgical training and beyond

FEW attitudinal surveys can match the roughly 95 per cent response rate of the GMC National Training Survey conducted each year among UK doctors. The 2017 survey highlighted an alarming statistic. Over five per cent of respondents reported being a victim or witness of bullying and harassment at work but did not want to report it. Among the specialties with the highest reported bullying were medicine, obstetrics/gynaecology and surgery.

The Royal College of Surgeons of Edinburgh (RCSEd) had posed that question in their own membership survey in 2015 and found that 34 per cent of respondents perceived that they had been bullied, with 37 per cent having witnessed bullying of a colleague. These and other observations prompted the college to launch a campaign in 2017 encouraging healthcare professionals to speak up and change the toxic culture in which such behaviour is tolerated.

David Riding is an ST6 in vascular surgery and, in his role as member and now chair of the Trainee Committee of the RCSEd, he has helped to develop and promote the *Let's Remove It* anti-bullying and undermining campaign. The project has seen significant success in highlighting the issue and educating the profession with its online resources and outreach activities.

How did you get involved in the *Let's Remove It* campaign?

I got elected to the Trainee Committee about four years ago and just as I started the then president of the college, Professor Michael Lavelle-Jones, instigated a survey of the members in which they were asked if they had ever experienced or observed bullying in their place of work. Over a third of people had, which was obviously incredibly high. We couldn't really ignore that data and so the College decided to do some investigatory work about what's behind the problem. How do people feel about it? What is the evidence base? What are the education and training aspects? And basically it opened a Pandora's Box of issues. None of it was surprising. Everyone who works in medicine and particularly surgery knows this kind of behaviour goes on. It's one of those things that's been brushed under the carpet.

But the key thing was that the more we looked into it, the more we realised it's actually a patient safety issue as well as something that affects the mental health and wellbeing of our colleagues. That's when we decided we needed to have a proper campaign. Both to highlight the issue and to campaign against it, to educate people how to handle undermining and bullying within their departments.

Isn't it almost a cliché – the bullied and harassed surgical trainee?

Absolutely. I've been a doctor 13 years now and it's definitely improved in that time but you still find it – that sink or swim approach. There are so many clichés involved in this work. One of the things often said was that the best surgeons don't accept anything less than perfection and so if you don't offer perfection as a trainee then you're right to be called out for it – which is nonsense.

There is this image of surgeons as autocratic decision-makers who save lives on a daily basis and all this kind of rubbish. People accommodate to their egos. So you'd often hear it said: he's a great surgeon but one of the most unpleasant people I've met. And our argument is you can't be a great surgeon if you're treating your colleagues like this. It's about shifting the way people think about it.

Is there almost a kind of laziness in that attitude – not wanting to deal with people's feelings?

Exactly. The excuse is that, as long as the patient gets a good outcome, does it matter? But actually we know that patients get worse outcomes when they are treated in departments that have this kind of problem. So if you look at some of the big scandals in recent years like Mid-Staffs hospital or Morecombe Bay obstetric care, you realise that often underpinning poor clinical decision making is bullying and intimidation of people who don't feel like they can speak up about it. This has allowed it to continue for years and years.

Look at fitness-to-practise hearing reports on the GMC website. People are censured for making serious and repeated clinical errors but there is often a coexisting culture of bullying that suppresses whistleblowing. So it's a really complex situation.

It's incredibly difficult to speak up in such a hierarchical profession as medicine. You're a junior doctor who's got six months' experience – are you really going to take on the professor of surgery who's been there for 50 years? You just think: 'You know what, I'm going to keep my head down and get through the next two or three months and then I'll be rotating somewhere else'.

Have you experienced bullying in your training?

I definitely experienced it as a student. I didn't feel victimised as such; everyone was treated badly by certain consultants. The other thing is I'm a white guy who works in Manchester. All the data shows that if you're from an ethnic minority or female or from an LGBTTT background you are much more likely to experience this stuff and much less likely to continue your career in surgery. So



I'm not necessarily the person who would be the first to be bullied: purely because of my skin colour. There is definitely a racial undertone to a lot of this stuff and that's borne out by the evidence.

Do you ever hear the accusation that your generation complains too much?

Absolutely. We get a lot of that when we go around the UK presenting this material. That kind of lazy criticism: 'just another 30-something millennial complaining about working as a surgeon. We've all gone through it so why shouldn't you?' What we do is try to reframe it: 'Why should we have to put up with this? None of us enjoy it. None of us benefit from it. All it does is create a cycle of abuse where only certain people get through the system'. Yeah – I'm often called a snowflake though I usually respond that I grew up in Blackburn which is no place for snowflakes!

What are some of the effects of bullying?

I've seen very senior trainees in tears, clinically depressed, as a result of this kind of stuff. It's shattered their confidence. It makes them ill. And when they tell you what they've experienced, they worry because they think it sounds trivial. People throwing scalpels at you or screaming two inches from your face tends not to happen much anymore. It's a lot of the low level stuff which is

really insidious. I think now with email and social media it's easy to go behind people's backs and comment. None of it is clear and obvious. It's just a pattern of behaviour that over time wears people down.

Is it possible to be unaware that you are a bully?

The section on our website that received the most hits when we launched was the one entitled: *Are you a bully?* Most people don't set out to be a bully but they have to be sensitive to their behaviour and have to understand the impact it can have on others. Running through like a bull in a china shop with your Type A personality might not be to that trainee's benefit. People need to be able to understand that and change.

I think also it's a generational thing. I think with our generation – particularly as you get more women in the profession – this stuff will diminish naturally. But we just need to give it a bit of stimulus and make it clear what the red lines are. We are trained to be more self-reflective and self-analytical. In the past I don't think people have been as self-analytical about their behaviour – and that's changing.

Interview by Jim Killgore, managing editor of *Insight*

Find out more about the Let's Remove It campaign and access a range of helpful resources at tinyurl.com/tdn4ebo

Sarah Harford considers the role human factors can play in clinical error

HUMANS LIKE US

IT'S NO accident that the title of this article sounds like one of Ian McEwan's latest novels, *Machines Like Me*. I read the book recently and it set me thinking about human factors. Interestingly, it seems to imply that rather than trying to create robots which act like humans, we should pay closer attention to our own 'circuitry', along with the external factors which influence or affect why we do what we do.

No clinician goes to work with the intention of making a mistake – perhaps apart from the few who end up in criminal courts and even they may have been well-intentioned in their misguided actions. Human factors come into play in everything we do: our environment, the people around us, the systems in which we work and the design of equipment and technology we use. These aspects can help or hinder, sometimes leading to mistakes.

Human factors are now more widely recognised and are starting to be given greater weight by regulators. In a 2016 review, the Care Quality Commission recognised that skilled analysis was needed for serious incident investigations to “move the focus of investigation from the acts and omissions of staff, to identifying the underlying causes of the incident” and “use human factors principles to develop solutions that reduce the risk of the same incident happening again”.

Clinical human factors can be characterised as “enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities, and application of that knowledge in clinical settings” (Professor Ken Catchpole). These factors help us understand not only why things go wrong, but also why they go right.

MINIMISING RISK

Human factors analysis has been utilised for some time in the aviation industry to minimise risk and error, with the implementation of specific training, changes to protocol, standardised terminology and combined crew input during aircraft operations. Similarly, the World Health Organisation's (WHO) Surgical Safety Checklist has been introduced to medicine to minimise adverse incidents. An example of which is the implementation of ‘time out’ prior to operating to allow team members to confirm the patient's identity, procedure and known risks. Clinicians are only human and so systems or checklists, such as this, can help avoid important steps being missed when the pressure is on.

Consider the high-profile case of Dr Hadiza Bawa-Garba who was found guilty of manslaughter in her treatment of six-year-old Jack Adcock and later removed from the GMC register (though reinstated on appeal). Campaigners

argued on her behalf that the junior doctor was hampered by system and technical failures in the hospital. In response to its handling of the case, the GMC said it would consider the backdrop of such failings when reviewing conduct, and its case examiners, clinical experts and decision makers were to receive human factors training.

A 2018 white paper published by the Chartered Institute of Ergonomics and Human Factors explained that: “Human Factors uses measurements, observations, conversations and understanding about human physical and cognitive capabilities to make practical improvements to tools, software, furniture, workplaces and environments to initiate and support change for processes, techniques, interactions and communications”.

In general dental practice the opportunity for error is high. The Swiss cheese model of safety incidents demonstrates the impact of human factors. If we can increase the layers of defence (solid cheese) and reduce latent conditions, such as poor design, incomplete procedures and flawed decision-making (holes in cheese), we can reduce the frequency of active failures (patient safety incident).

Perhaps the most obvious patient safety incident in dentistry is wrong site extraction. During a busy day, time pressures, stress and fatigue can contribute to errors. Teamwork protocols, somewhat similar to the WHO surgical ‘time out’, can be implemented to check patient details and the tooth to be removed in order to prevent wrong site surgery. An example of this type of protocol is the Local Safety Standards for Invasive Procedures (LocSSIPs) for wrong site extraction in dentistry, which (using the toolkit) implements the principles of the National Safety Standards for Invasive Procedures.

AUTHORITY GRADIENTS

Another important area of research in human factors has been the part that ‘authority gradients’ can play in adverse incidents. The term was first defined in aviation where it was observed that pilots and crew may not communicate effectively in stressful situations and where there is a significant difference in experience, perceived expertise or authority.

An Institute of Medicine report, *To Err is Human*, first explored the concept in the practice of medicine, yet relatively little to date has been published regarding the potential role of authority gradients in clinical errors. In any organisation with different levels of professional stature and seniority, authority gradients can be intrusive – especially when senior staff have influence over job security and progression in those being supervised. This can make it extremely difficult to speak up and challenge the decisions of

SOURCES

- Care Quality Commission. Learning from serious incidents in NHS acute hospitals. 2016
- Chartered Institute of Ergonomics and Human Factors. Human Factors for Health & Social Care (White Paper). 2018
- Institute of Medicine. *To Err is Human: Building a Safer Health System*. 2000



people in positions of power or authority.

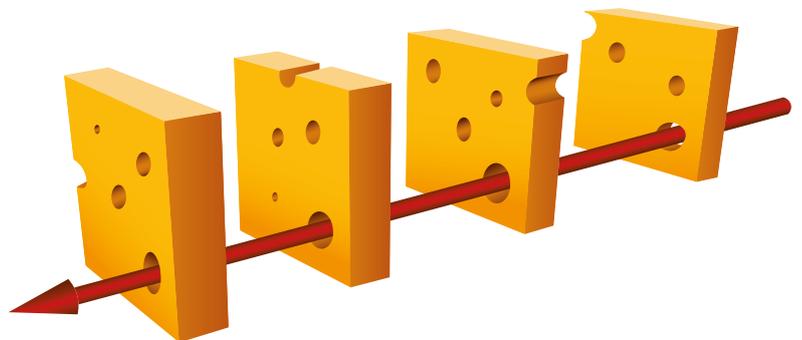
Some organisations recognise these risks and seek to maintain what is known as a ‘shallow authority gradient’, whereby everyone is actively encouraged to contribute opinions/suggestions so that an overall consensus emerges which is then acted upon. This can be a desirable approach for managing more routine,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

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

Dealing with authority gradients effectively requires situational awareness and flexibility within organisations in order to adjust to prevailing conditions and threats. Openness should be viewed as a positive attribute to minimise errors and poor decision-making – with all team members encouraged to speak up and challenge decisions without fear of recrimination.

IN CONCLUSION

Human factors analysis is concerned with the interplay between the clinician and the other elements of a system. Taking this system-based approach it is important to consider equipment, buildings, spaces, patients and team members. Human error may initially seem to be the cause



“If we can increase the layers of defence (solid cheese) and reduce latent conditions, such as flawed decision-making (holes in cheese), we can reduce the frequency of active failures (patient safety incident)”

of an incident but a human factors approach looks wider at root causes.

Layers of defence to reduce errors will include education and training, practice policies, healthcare technology, co-ordinated teamwork, communication and check lists. Open dialogue when things do go wrong must be encouraged, with the emphasis being on continual learning and improvement of patient care.

Sarah Harford is a dental adviser at MDDUS

CASE FILES



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



COMPLAINT

EMPATHY LACKING

BACKGROUND

Ms W is 32 years old and presents at a busy ED with abdominal pain and heavy vaginal bleeding. The previous day an ultrasound had confirmed a miscarriage at nine weeks pregnancy and the patient had been administered medication (misoprostol) to speed up the process. This is Ms W's second miscarriage and she and her partner have been trying for a baby for over three years.

A specialist trainee – Dr J – attends the patient along with a nurse and, on examination of the cervix, finds blood clots along with the products of conception. These are removed and placed on a sanitary pad as there is no specimen pot on the trolley. A healthcare support worker is sent to find a specimen pot and in the interim period Ms W is left alone with her partner in the treatment bay. Three hours later she is discharged.

A week later the health board receives a letter of complaint from Ms W in regard to her experience in the ED. The letter states that she was left in the waiting area for

over an hour in severe pain before being taken to a treatment bay.

Dr J arrived looking "harassed" and offered only "perfunctory" condolences to Ms W on her "failed pregnancy". Ms W then describes how the doctor removed the "tissues" and left her baby on a sanitary pad in full view for over 10 minutes.

Ms W found the entire process "utterly dehumanising", with staff referring to her within earshot as the "gynae". No one seemed able or willing to acknowledge the trauma she was going through or her distress at the "callous treatment" of her fetus.

ANALYSIS/OUTCOME

Dr J consults an MDDUS adviser to assist in reviewing her response for the health board in reply to the complaint. Given the patient's very negative perception of her treatment the adviser suggests that Dr J focus on how she might have acted differently – in particular the suggested lack of empathy and how staff dealt with

and referred to the fetus and placenta ("tissues").

It is suggested that the doctor consider adding learning points and substantive actions taken to address these points, after discussion with her educational supervisor. These would include more effective patient communication before and during examination and treatment, including careful use of language and the need to be more empathetic and mindful, no matter how rushed or chaotic the circumstances.

KEY POINTS

- Avoid dehumanising shorthand references to patients in both written and verbal communication.
- Take care to ensure respectful tissue handling.
- Treat your patients as you would want your family treated.

NEFARIOUS ACTIVITY

BACKGROUND

A dental associate – Ms T – contacts the advisory service at MDDUS suspecting systematic breaches of NHS regulations at the dental practice where she works. These include duplicate claiming of NHS fees and shortened treatment times to allow UDA targets to be met. It is her opinion that her own conduct has been “by the book” and she has announced her intention to leave the practice. Ms T requests MDDUS advice to ensure she does not get caught up in any formal accusations of fraud.

ANALYSIS/OUTCOME

The MDDUS dental adviser responds by letter. He states that finding a new job would be a wise move. Given that Ms T’s conduct has been exemplary in terms of treatment delivery and claiming patterns there should be little risk of being caught up in any investigation undertaken by, for example, the BSA.

The adviser does suggest that, before departing the practice, Ms T should raise concerns regarding the apparent departures from the NHS regulations. Should there later be any accusation of turning a blind eye to these problems, Ms T would have an audit trail to demonstrate the apparent misclaiming was drawn to the particular attention of the practice owners. How these issues are then remediated would be a matter for the practice to address.



KEY POINTS

- Keep an adequate audit trail of your own practice to demonstrate compliance with NHS regulations.
- Report concerns over potential fraud to the practice owners and keep a record of your actions.

EMERGENCY TREATMENT

BACKGROUND

Mr V books an emergency appointment at the dental surgery on a Friday morning before a bank holiday. He is 10 minutes late for a 15-minute slot and complains of extreme sensitivity in an upper right molar. Mr V reports pain of short duration and made worse by cold and sweet things. Dr S does not find any teeth TTP, nor swelling or gum problems but does note a small crack in the tooth. He applies desensitising varnish to ease the discomfort and asks Mr V to make an appointment with his regular dentist.

That Monday Mr V attends A&E with extreme pain in the upper right jaw and is referred to the dental hospital. Following a clinical examination and taking of appropriate radiographs, a diagnosis of irreversible pulpitis is made. Treatment options are discussed and Mr V elects to have the tooth extracted. This is completed uneventfully.

A few days later the practice receives a letter of complaint from Mr V. He questions

why Dr S did not take a radiograph and diagnose pulpitis on the Friday, thus sparing him an “agonising weekend”. Treatment could have been offered then or at least a referral to the dental hospital.

ANALYSIS/OUTCOME

Dr S contacts MDDUS for advice. A dental adviser reviews the draft text of a response letter. First the dentist apologises for the inconvenience and distress the situation has caused and states that it is practice policy to investigate patient concerns and use that learning to improve services.

Dr S offers his view of the events based on the patient records. He points out that it was unfortunate that Mr V was 10 minutes late for a 15-minute appointment slot, leaving only five minutes for assessment and treatment. Nothing in the consultation suggested irreversible pulpitis and Dr S applied desensitising varnish for the discomfort until further treatment (if necessary) could be undertaken.

Dr S states that the complaint has given him cause to reflect on his clinical practice and how in future he will deal with similar dental emergencies. Mr V is invited to contact the practice if he wants to discuss the matter further – and is also provided contact details for the ombudsman if he is dissatisfied with this response.

Nothing further is heard from Mr V in regard to the matter and he remains a patient at the practice.

KEY POINTS

- Ensure patients are offered advice on how to deal with unresolved or worsening symptoms.
- A sincere apology or expression of regret will often prevent complaints escalating into a claim or GDC referral.

CLAIM

ALLERGY ALERT



BACKGROUND

A 26-year-old with severe asthma – Ms B – is going on holiday to Brazil in two weeks and attends the pharmacy at her GP practice to collect an emergency travel pack put together by the in-practice dispenser – Ms K. In addition to her regular medication Ms B is provided with an emergency supply of steroids (prednisolone) and a seven-day dose of amoxicillin.

Four days before her holiday Ms B speaks to the practice nurse in regard to the emergency pack. The nurse provides instructions on use but advises Ms B to attend a local clinic for any urgent health concerns.

Ms B enjoys her holiday without incident but five days after returning she phones the surgery from home feeling unwell. She

has a telephone consultation with a GP – Dr D – and reports having green catarrh and chest pain/tightness. She is also suffering with lower back pain/urinary frequency and thinks it might be a UTI. Dr D offers advice on adjusting her asthma medication and asks what medications she has to hand in her unused emergency pack. The GP suggests starting the prednisolone and amoxicillin and attending the practice for review after the weekend if no better.

Later that day Ms B is taken to hospital by her boyfriend with vomiting, sweating and tongue/lip swelling – and she later faints in the emergency room. The symptoms occurred almost immediately after taking the antibiotic. It transpires that Ms B has a known amoxicillin allergy and should have been provided clarithromycin in

the emergency pack. She is treated for anaphylaxis and spends the next three days in hospital.

A letter of claim is received by the practice alleging clinical negligence in the misprescribing of amoxicillin to Ms B. Solicitors acting for the patient claim that the practice failed to dispense the correct medication despite being aware of her amoxicillin allergy. It is also alleged that Dr D failed to provide competent medical advice in the telephone consultation and neglected to enquire about known allergies/contraindications before advising she take the antibiotic.

The resulting anaphylaxis led to hospital admission and a life-threatening medical condition with considerable discomfort and distress. Ms B reports recurring panic and low mood.

ANALYSIS/OUTCOME

A primary care expert is instructed to provide a report on the case and notes a clear failure by the dispenser (Ms K) to check the patient's allergy history and provide the correct antibiotic. This is an obvious systems failure that the practice has already addressed in a significant event analysis (SEA) – and one for which all the practice partners are vicariously liable.

The expert is sympathetic in regard to Dr D's actions, as the GP did not prescribe the antibiotic but only suggested the patient take what had already been provided by the practice. In such circumstances there would have been no call to check an allergy history. However, Ms B's decision to take the amoxicillin was based on the GP's advice to treat an undiagnosed UTI, which was a different reason for which the drug was originally prescribed.

MDDUS agrees to settle the case on behalf of and in agreement with the practice partners.

KEY POINTS

- Ensure allergy/contraindication alerts are working on practice systems and properly actioned.
- Prescribing staff should routinely check for allergies before prescribing an antibiotic.
- Give careful consideration to the need to examine a 'phone-in' patient before diagnosis and treatment.
- Conduct an SEA to ensure practice prescribing procedures are failsafe.

UPSELLING COMPLAINT

BACKGROUND

Mr K attends his dental surgery for a routine check-up and complains of sensitivity to hot and cold in the lower right jaw. Dr L examines the patient and undertakes a radiograph, noting a cavity in LR7. There is also discussion regarding the patient's obvious tooth wear caused by bruxism.

The dentist sets out the different treatment options available for LR7, including an NHS amalgam filling or a private composite filling, chargeable at £140. Dr L also recommends a bite guard to prevent further tooth loss due to bruxism. She explains that it can be provided on the NHS with a Band 3 fee of approximately £250 or on a private basis at a fee of £110. Another option would be to buy a bite guard at the chemist or online, but Dr L actively counsels against this. Mr K declines both options and leaves the practice without making a further appointment.

Two months later Dr L receives a letter from the GDC stating that she is the subject of a complaint by Mr K. It is alleged that the dentist failed to provide an adequate standard of care by offering misleading advice that amalgam was an unsuitable material for fillings. It is also alleged that Dr L did not provide the full range of options in relation to treating the patient's bruxism and misled Mr K in an attempt to "upsell" more expensive treatment.

Dr L is also accused of not providing a written treatment plan to the patient.

A GDC caseworker reviews the matter

and advises Dr L that, following receipt of a clinical advice report and formal assessment, the matter will be referred to case examiners for determination. The allegations also contain one of dishonesty.

ANALYSIS/OUTCOME

MDDUS provides assistance to Dr L and asks for her account of the treatment along with a copy of the patient records. In the GDC complaint Mr K states that in setting out the treatment options for LR7, Dr L tried to persuade him of the superiority of composite fillings over the cheaper amalgam, stating that it not only provided a better cosmetic result but was also "stronger and more durable". Having then opted for amalgam Mr K states he was not provided a written treatment plan before leaving the practice.

In regard to his bruxism, Mr K states that the dentist only discussed the option of an expensive NHS Band 3 bite guard before eventually suggesting that he could "buy a

cheap one off Amazon" and that it would be "better than nothing".

MDDUS assists Dr L in responding to the allegations – all of which she denies. In a letter the dentist states that she explained the restorative options for LR7 in a neutral manner and did not mislead the patient or induce him to agree to a more profitable option. Indeed, she routinely provides amalgam fillings to her patients, subject to informed consent.

In regard to the discussion of bite guards, Dr L states she informed Mr K of the option for an NHS Band 3 guard but also a less expensive but of equal quality guard provided on a private basis. Mr K declined both and it was only then that Dr L suggested that bite guards were also commercially available, but she offered no recommendation.

Dr L states that her routine practice is to provide a written treatment plan in compliance with her NHS contractual obligations and GDC standards. Normally, the receptionist asks the patient to sign the document at the front desk but Dr L acknowledges that sometimes the task is missed. No duplicates of Mr K's plan have been located which suggests it may not have been signed. In the end the patient did not return for treatment.

A few months later the GDC caseworker writes back to Dr L informing her that there is insufficient evidence to support the allegations and the case examiners have determined that no further action will be taken in the case.

KEY POINTS

- Ensure patients understand treatment options and costs, and in particular NHS vs private.
- Ensure these discussions are recorded in the patient notes.
- Patients should be provided with a written treatment plan detailing costs.

ADVICE

POLICE CONCERN

BACKGROUND

A practice receives a request from a solicitor for access to the medical records of a deceased patient – Ms H. The solicitor is acting on behalf of a close relative who is considering raising a claim of negligence. The patient's GP – Dr Y – is unsure how much of Ms H's sizeable notes should be disclosed. Specifically, there are several police concern reports attached to the file, mostly relating to her mental health, addiction issues and concerns over her living conditions. Dr Y asks an MDDUS adviser whether the police concern reports should be disclosed alongside the medical notes, or if these should be kept separate and not disclosed.

ANALYSIS/OUTCOME

The MDDUS adviser explains to Dr Y that the inclusion of police concern reports in a patient's medical record is something that could be justified if they are clinically relevant. The test as to whether the records

should be disclosed to a relative making a claim is are they relevant to that claim. The practice must also be satisfied that the patient had not, or would not have, objected to such disclosure.

If a decision is made to disclose them, the practice must comply with the GMC guidance on confidentiality and the Data Protection Act 2018, for example redacting information that could cause serious harm and identify third parties.

KEY POINTS

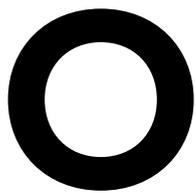
- Documents such as police concern reports should only form part of a patient's medical record if they are clinically relevant.
- Information not relevant to a claim, that identifies a third party or could cause serious harm should be redacted.



ALLEGED PRESCRIPTION FRAUD

Dr Myooran Nathan

Medical adviser at MDDUS



OUR PRACTICE has received an anonymous letter informing us that a patient has been selling his prescription medicine. What is our legal obligation in this matter? Should we report him to the police? Are we within our rights to remove him from the practice register?

When such vague information is received from an anonymous source it can be tempting to disregard it as hearsay and do nothing, perhaps assuming it to be vexatious in nature. Whilst this may be possible, it could be that the letter represents a genuine concern for others and a trust that medical professionals have the knowledge and integrity to react appropriately. Such trust underpins much of the GMC's ethical guidance.

However, a key principle of GMC guidance is to make the care of your patient your first concern. It may therefore be appropriate to invite the patient in to explore the issues raised in the letter, provided this does not risk harm to any individual. You may receive information from the patient that reassures you the allegations are not well-founded. Even if you are not reassured of this, you could discuss any potential risks to the patient's health of non-compliance with treatment arising as a consequence of selling medication.

From a legal point of view, under the Medicines Act 1968, prescription medication can only be sold or supplied at a registered pharmacy and under the supervision of a pharmacist, in accordance with an appropriate practitioner's prescription. If the medicines are controlled drugs, selling them is also an offence under the Misuse of Drugs Act 1971. However, neither law obliges anyone to report such an offence.

Whilst there is no obligation to disclose information about a crime when it is not required by law, it is recognised that doctors have a wider professional duty to protect

and promote the health of patients and the public, for example by protecting individuals or society from risks of major harm.

Ordinarily, consent should be sought from the patient to disclose information to allow these allegations to be investigated. Clearly it is not likely that such consent would be forthcoming in this situation but the issue of onwards disclosure should be broached (unless this would increase the risk of harm arising).

Disclosure of relevant information without consent in the public interest is appropriate in situations where it is "likely to be necessary for the prevention, detection or prosecution of serious crime, especially crimes against the person" (GMC guidance on *Confidentiality*).



In this particular circumstance, the crime may not meet the threshold to be considered "serious", which would usually refer to crimes such as murder, manslaughter, rape or child abuse. However, the serious harm threshold could be met, for example, were the patient a teacher and it was reported that he was selling controlled drugs to his students, which could be a child safeguarding issue. The specific details of the situation must therefore be taken into account.

If you intend to disclose without consent, you should inform the patient of this and what information you will be disclosing (again, unless this would worsen risk).

Were the allegations to have merit, you might consider whether the doctor-patient relationship has broken down (although the GMC considers such circumstances rare). Even if you feel there has been a breakdown in trust, removing the patient from the practice register (while tempting) should only be considered after repetition of unreasonable or inconsiderate behaviour, as set out in a warning letter.

You should try to do what you can to restore the professional relationship and explore alternatives to ending it. This may involve talking to the patient about the allegations and explaining why, if true, this is not appropriate either legally and ethically. Consider whether the patient is suffering financial difficulty or from a mental health problem such as stress/anxiety, which may provide some mitigation. Ask for a commitment to cease such activities.

Guidance on prescribing is also relevant here. You should reassure yourself that prescribing is appropriate, safe and serves the need of the patient. You could review the dose of the medicines and the ongoing need. If the patient has not been compliant, you could consider whether prescribing could be stopped or look at alternative medications less conducive to selling.

You may also consider taking steps to monitor and control any ongoing supply of medicines more carefully, for example by providing prescriptions of shorter duration. If the patient has been compliant but is receiving prescriptions too frequently (for example by making early requests or by claiming to have lost prescriptions), you may need to review practice systems to reduce the likelihood of repetition for both that individual and other patients.

With so many ethical and legal considerations involved, it is important to explore all the factors and use your judgment to balance the interests of the patient with those of the wider public. Remember that MDDUS is here to provide further advice and support.

HOW SHOULD A PERSON BE?

Deborah Bowman

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

THE assumption that anyone with ethics in her title is a 'good' person causes much amusement amongst those who know people with ethics in their titles. The field of ethics is no less susceptible to self-serving ambition, petty jealousy and unedifying behaviour.

The results of a US survey published earlier this year found that ethics professors were more likely to support higher ethical standards but, regrettably, no less likely to fall short of those standards in their own behaviour. There were some quirks that continue to fascinate me: ethics professors favoured a much higher level of charitable giving and were more supportive of vegetarianism than other philosophers. Those same ethicists though were more forgiving than their philosophical peers of not contacting one's mother at least twice a month.

Survey quirks aside, the question of knowing about a subject in theory and learning how to make sense of that knowledge in practice preoccupies me. For me, ethics is a practice and it should help people live and work well, especially in testing times. To be able to analyse a problem logically and to work through well-reasoned propositions is valuable. To be able to construct a coherent argument that convinces others is a skill. To locate moral intuitions in the philosophical literature and understand the relationship between the law, professional standards and morality provides a strong foundation on which to become an ethical practitioner. Yet, these abilities are necessary but not sufficient.

Like Aristotle, I believe that ethics takes practice and with that practice we improve our chances of embodying ethics. It is context-specific: some situations and people will facilitate ethical practice whilst others will inhibit it. How then can one learn the tricky business of being ethical in practice rather than merely having a sound knowledge of ethics?

Several years ago, I piloted an approach which was built on the recognition that we learn how to be, professionally and personally, by watching and talking to others. Perhaps this is particularly so in professional training where so much time is spent following and observing practitioners who are more senior and experienced. The



apprenticeship model is as influential in healthcare ethics as it is in diagnostic competence or clinical skills. Some people will be role models whilst others are, regrettably, cautionary tales. Nonetheless it is relationships which influence our approach and reveal the norms of a team, specialty or clinical unit.

I wanted to make the relational overt in thinking about ethical development. I gathered a small group of colleagues who were willing to train as ethical mentors and coaches. As we came together for that training, it was fascinating to explore where and how people had learned their ethics and 'how to be' as a practitioner. Few mentioned the formal teaching they had experienced. For the majority, it was someone specific who had inspired them. A smattering of individuals remembered those who had concerned or discomforted them as being equally important in developing an ethical identity.

Rather than rely on the serendipity of these interactions, we created a model to make explicit ethical development and practice within trusting relationships: building moral sensitivity, drawing out the emotions that imbue an ethical question or problem, being open about the challenges and tensions in 'practising ethically', reflecting on the interaction of individual with the system, and fostering a sense of ethical confidence to act. The tools and skills were drawn from the disciplines of

mentoring and coaching and there was an action learning set to support those serving as an ethical mentor and coach. The emphasis was on how to be, rather than how to talk about being ethical in clinical practice, recognising always the inherent fallibility of human beings and being honest about our limitations, ethical omissions and missteps.

It was a rewarding project that quickly expanded, struggling to meet demand. I was memorably told by one participant that ethical awareness was often 'tiring and uncomfortable' rather than empowering. Another reminded me powerfully that single actors in unethical systems can feel isolated and lonely as a result of their commitment to ethical practice. Everyone brought themselves wholly and authentically to a shared endeavour.

It was, like human beings, a messy, complex, discomfiting and sometimes frustrating project - and I loved it. I loved it because it didn't dodge the difficult truths about ethical practice in demanding clinical environments. I loved it because of people's willingness to be vulnerable and open. I loved it because it made a difference to individuals in unexpected but significant ways. I loved it because it didn't assume that anyone, still less, a woman with ethics in her title knows how to be good in practice.

Perhaps I should have shared it with those who surveyed those ethics professors...

Addenda

BOOK CHOICE

Breaking & Mending By Joanna Cannon

Wellcome Collection, hardback, £12.99, 2019

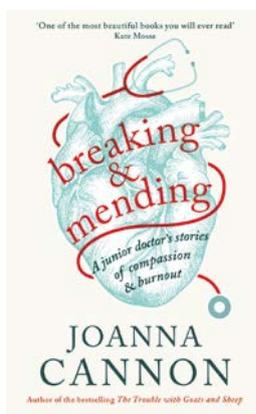
Review by Dr Greg Dollman, medical adviser, MDDUS

WHILE the style of Joanna Cannon's latest book makes for easy reading, its content is far from easy. *Breaking & Mending: A junior doctor's stories of compassion & burnout* explores the troubling reality of doctors putting aside their own wellbeing in the quest to help their patients.

More and more we hear and read about the culture of presenteeism, the burdens on NHS staff and burnout. Thankfully it is more accepted now that doctors too become ill and that our vocation should not equate with "sacrifice and the surrender of the self".

Breaking & Mending will remind you of the many highs and lows of being a junior doctor. Cannon tells of her grave doubts as a trainee about her choice of profession. She describes the difficulty of moving from one specialty to another, always trying to fit in, wanting to be the best but knowing this cannot always be the case. Happily she concludes that, having found her place in medicine (as a psychiatrist), she could not imagine doing anything else. She writes about the incredible privilege of being a doctor.

Cannon started her medical studies in her



thirties: the 'wild card' of her year. She describes her journey from optimistic student to depleted junior doctor, days away from leaving the profession. *Breaking & Mending* explores the concept of 'hope', what she calls "the most important ingredient" to mend a damaged life. Cannon explains

that it was only later in her medical training that she came to an understanding that "returning a life to someone very often has nothing to do with restoring a heartbeat" and that a life can be saved by a conversation or just listening.

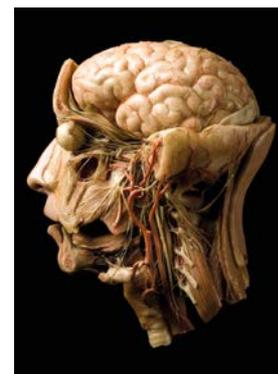
For Cannon, words are most important. She tells of being criticised by her colleagues for talking to patients "too much", and not being listened to when her physical and mental health declined into "a deep well of despair". She did not recognise this decline. "I'm fine. I'm absolutely fine," she would reply when asked. How true her observation that burnout is too often "quiet and unseen".

Towards the end of the book, Cannon writes "let's remember to check in with colleagues that they are okay - because this is what communities do". Perhaps we all need to ask our colleagues a second time: "truly, how are you?"

OBJECT OBSCURA

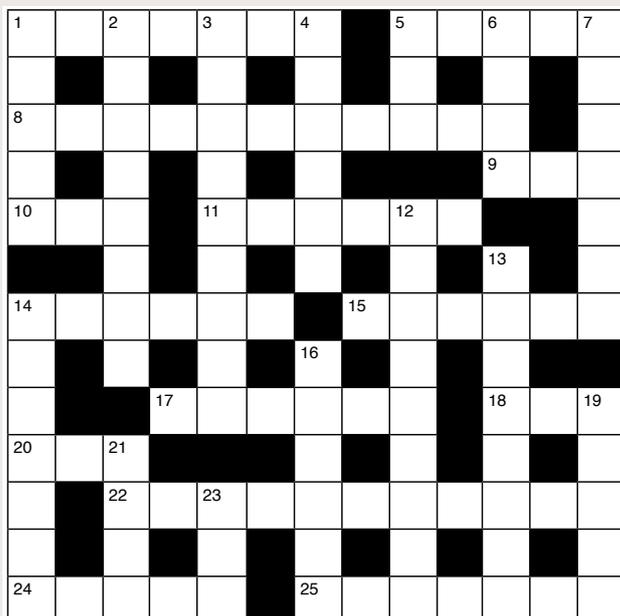
Anatomical model

THIS wax anatomical dissection model of the human head dates to the 19th century and is possibly German in origin. Such models were used for teaching medical students or as part of popular anatomy shows - especially at a time when few bodies were available for dissection.



Photograph: Science & Society

Crossword



ACROSS

- 1 Unauthorised absences from work (7)
- 5 Guy Garvey and Co. (5)
- 8 Pertaining to the appearance and position of teeth (11)
- 9 Virus that can lead to AIDS (3)
- 10 Animal hair (3)
- 11 Neck swelling caused by thyroid enlargement (6)
- 14 People who were once incarcerated (2-4)
- 15 Religious buildings (6)
- 17 Check for disease or infection (6)
- 18 Talking cure for depression (abbr.) (3)
- 20 Frozen water (3)
- 22 Harsh and discordant (11)
- 24 Sir Peter _____, founder of the Wildfowl and Wetlands Trust (5)
- 25 Those who find pleasure from others' pain (7)

DOWN

- 1 Satire (5)
- 2 A clouding of the eye's lens (8)
- 3 Compound not containing carbon (9)
- 4 Canadian Province, Nova ___ (6)
- 5 Consume (3)
- 6 Composer of noted fugues (4)
- 7 Textile makers (7)
- 12 Legendary outlaw (5,4)
- 13 International humanitarian charity (3,5)
- 14 Jealous (7)
- 16 Viral infection (6)
- 19 Elongated teeth in some mammals (5)
- 21 Sonic reflection (4)
- 23 Moggy (3)

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

VIGNETTE

FREDERICK AKBAR MAHOMED (1849-84)

KEY FIGURE IN UNDERSTANDING ESSENTIAL HYPERTENSION

HE WAS “always in a hurry and always had a book under one arm.” This was how one colleague remembered the man others described as tall, imposing, charming and of “oriental appearance”. He was Frederick Akbar Mahomed and his role in our developing understanding of hypertension has now been all but forgotten.

Mahomed was born in Brighton in 1849. His paternal grandfather had emigrated to England from India and married an Irish woman, and his mother was English. A precocious child with a fascination for mechanical toys, he began his medical studies aged 18 when he attended the Sussex County Hospital for two years. He then transferred to Guy’s in London where he excelled academically.

In 1871, he won the Pupils’ Physical Society Prize for his work on a device that he had been modifying and using to study the pulse. This was the sphygmograph. He did not invent the device used for clinically assessing the pulse wave, but he did modify it to make it portable, improved its sensitivity and made it quantitative. Using his sphygmograph, he studied the pulse in hundreds of patients with a variety of diseases and importantly made the connection between “high arterial tension” and functional renal damage. In one paper, Mahomed states: “The pulse ranks first amongst our guides; no surgeon can despise its counsel, no physician shut his ears to its appeal...”

In 1877, he gave the first description of apparently healthy individuals with raised blood pressure, thus identifying what would later become known as essential hypertension. His description of this condition is perhaps as valid today as it was when written 140 years ago:

“Let it be clearly understood, the existence of this abnormally high pressure does not necessarily mean disease, but only a tendency towards disease. It is a functional condition, not necessarily a



permanent one... These persons appear to pass on through life pretty much as others do... As age advances the enemy gains accessions of strength; perhaps the mode of life assists him – good living and alcoholic beverages make secure his position, or head work, mental anxiety, hurried meals, constant excitement, inappropriate or badly cooked food... tend to intensify the existing condition... Now under this greatly increased arterial pressure, hearts begin to hypertrophy and arteries to thicken...”

Thus, Mahomed was one of the first to attempt the clinical measurement of blood pressure and as one biographer puts it, he was “the first to correctly describe one of the most common medical scourges of humankind”.

He qualified as MRCS in 1872 and with the security of a position at Highgate Infirmary in North London, he married Nellie Chalk, with whom he had a son and a daughter. Tragically, only three years later, Nellie died of septicaemia shortly after childbirth. Mahomed later married Nellie’s sister Ada, but had to do so abroad as marriage to a dead wife’s sister was prohibited at the time in England. He and

Ada had a further three children. Tragedy struck again for the family in 1884. While working at the London Fever Hospital, Mahomed contracted typhoid fever and died of a haemorrhage three weeks later. He was only 35.

Interestingly, most of Mahomed’s observations and discoveries relating to hypertension were made while he was still a medical student or a newly qualified doctor, between the ages of 23 and 25. For his work, he was lauded briefly and loudly by his peers, but just as quickly the light of his celebrity faded and today his contributions are barely mentioned.

There were undoubtedly a number of interconnected reasons for this: his fertile research mind had quickly moved on to other problems, and his own enthusiasm for the implications of his work on the pulse led some to question whether he had over-interpreted his results and whether he simply saw hypertension everywhere. But, perhaps most of all, it was because he died a young man, leaving no coterie of acolytes behind to sing his praises.

Some have also questioned whether his Anglo-Indian appearance and his obviously foreign name might have contributed, but there is no good evidence that racial prejudice played any part. Indeed, his startling and apparently unhindered academic progress would suggest that he faced no such obstacles.

Shortly after his death, as with many of those who die prematurely, the plaudits flowed in from his professional colleagues. Many were keen to highlight how great a loss his death was to the profession. One contemporary concluded simply: “It is impossible to say what such a man might not have done.”

Dr Allan Gaw is a writer and educator in Scotland
Sources

- O’Rourke MF. Hypertension 1992; 19: 212-7.
- Cameron JS, Hicks J. Kidney Int 1996; 49: 1488-1506.
- Batty Shaw A. Guy’s Hospital Rep 1952; 101: 153-73.

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