Summer 2008

SUMMONS

MDDUS JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND

• New consent guidance • Dental implant standards • Gray's Anatomy •

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IN THIS ISSUE

FIVE years ago I was working from home as a freelance editor – bobbing along in my little pedantic boat, landing the odd student text or colour atlas. Out of the depths rose an ancient leviathan of a book that swallowed me and about six other editors whole. I could bore you (and I mean truly bore you) with the tribulations of being a project editor on the 39th edition of *Gray's Anatomy* but alas so little space.

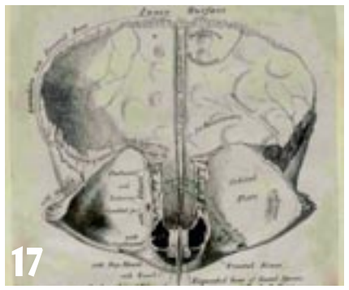
Suffice to say I'm certain that the rude health of this bruising book is down to its current editor's clear vision of how anatomy can be kept living and relevant to the pursuit of medicine. Professor Susan Standring took the helm at a time when *Gray's* needed inspiration and it was both challenging and daunting as an editor to work under her direction.

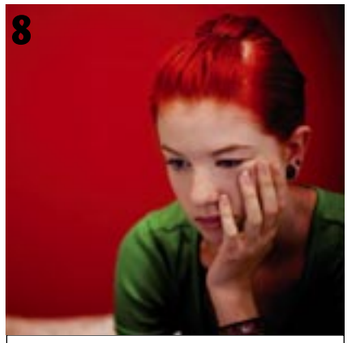
Now *Gray's* celebrates the 150th anniversary of its first publication with a new 40th edition. On page 17 Adam Campbell offers some fascinating insights into this most famous of medical textbooks.

Last month also marked publication of the GMC's revised guidance on consent. On page 9 of *Summons*, Jane O'Brien, head of standards and ethics at the GMC, discusses a new emphasis on shared decision making and the challenges posed by patients with impaired or fluctuating capacity.

More in the way of guidance is imminent for dentists in the wake of a recent GDC interim policy statement on standards in dental implantology. On page 14 we look into what is expected in revised standards soon to be published by the FGDP (UK) for GDPs seeking to demonstrate competence in implant dentistry – that evidence being potentially crucial should fitness to practise be called into question.

Jim Killgore, editor





REGULARS

Cover image: 'Journey II' by Elspeth Lamb. Elspeth trained at Glasgow School of Art in the 1970s and is recognised as one of Scotland's leading printmakers. For 21 years, she taught at Edinburgh College of Art, latterly as Head of the Printmaking Department. In 1999, she gave up all academic teaching commitments to pursue her artistic career and has since exhibited nationally and internationally. 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.
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New Scottish legal services division

THE MDDUS has created a new Legal and Claims Division in Scotland, recruiting four in-house lawyers to be based in our main office in Glasgow. The decision to open the new division came after a review of Scottish legal services being provided to the Union mainly by external firms. It was concluded that the time was right to create an in-house legal team to continue to provide the high level of service our Scottish members expect and to offer greater value for money. The decision also reflects the on-going success of our Legal Services Department in London.

David Holmes, formerly a partner with Shepherd and Wedderburn, has been appointed as Senior Legal Adviser (Scotland), reporting to the Head of Professional Services, Dr Jim Rodger. David will lead a team of three lawyers with broad experience in representing practitioners before The Scottish Courts and professional bodies. An experienced claims handler will also be joining the new legal division.

The London Legal Services Department – led by Simon Dinnick – will continue to be responsible for all legal services in England and Wales, and as head of legal services Simon will also continue to act as lead for the Union on policy, regulatory and governance issues.

David Holmes said: "I have greatly enjoyed working as an external adviser to MDDUS over many years. And I look forward to working with my new colleagues in the in-house team, focusing exclusively on the interests of the Union's members".

Change, unchanging

THERE is an old saying that a change is as good as a rest. I'm sure that sometimes we all might just like a rest from some of the change that seems to be constant at the moment. Whether it's the way healthcare is organised, the regulation of the professions, rules for revalidation, the appointments process or the training of those joining the professions, it seems that the landscape around us is constantly shifting.

We are not, of course, immune from change in the world of medical and dental defence and have had our own share of changing rules and regulations to cope with, and indeed one of our roles is to keep pace with change so that we are able to advise our members on its impact when this may be uncertain.

At the Union, we have also undergone a fair measure of change over the past few years. We have introduced new and improved systems internally for the handling of our members' business; we created an in-house legal department in London to deal with over half of all the legal work for members south of the border and have now done the same in Scotland by creating a new Scottish division of law and claims that will deal with almost all Scottish legal work. We also recently merged our dental and medical advisory departments to create a single professional services department and in this way strive to ensure consistent levels and standards of service across all membership categories, with advisers and other staff supporting each other. And this is not the end of the changes as we are in the middle of upgrading our computer systems, which we believe will have a direct and very positive impact on the service we deliver every day.

In the face of change some can be swept away by it, while others vainly try to hold out and argue against it at every turn. I think, however, that most of us realise that change is now a constant in our professional lives and simply get on with the job. That is certainly our approach at the Union.

We face change all the time both in the medical and dental defence work we undertake for our members and also in the corporate world in which we operate. We have made a promise to our members that we will be there to assist them when that assistance is needed, and so the responsibility we have is to anticipate change that might affect us or our members and to manage through it so that we will always be able to fulfil that promise. We do this by constantly reviewing what we do, how we do it and drawing up a strategic plan with clear targets that we want to achieve.

We are about to start that planning process for another year and will be taking time as a management team and a Board to look forward to the next five years and ask ourselves what the Union should be like then. Are there things we are currently doing we should stop; are there new things we currently don't do that we should consider doing; is there a change in the service we provide or how we provide it that would be beneficial; are there other categories of staff that might benefit from our service? These and other questions will help us structure our thinking and planning for the future of the Union.

As part of this process I am meeting members in many parts of the country to seek their views. The first meetings have just taken place in Newcastle and Leeds where I invited some members to join me for a discussion about the Union's future. These have proved to be very valuable sessions and, as it is impossible to meet every member, I wanted to give you all the opportunity through the pages of *Summons* to write to me with any ideas, comments or suggestions you have.

You can reach me by telephone on 0845 270 2034 or email at gdickson@mddus.com

Professor Gordon Dickson, CEO, MDDUS

IN BRIEF

DCP REGISTRATION – THE CLOCK'S TICKING
Dentists employing unregistered dental nurses and technicians after 31 July could be putting their own registration at risk. All DCPs are being urged to register now with the GDC to ensure they remain legally in practice. July 31 is also the deadline for experienced DCPs to register without need of a current recognised qualification. Go to www.gdc-uk.org for details.

JOIN A SIGN GUIDELINE GROUP
Over the coming year the Scottish Intercollegiate Guidelines Network (SIGN) will begin the process of updating a number of existing guidelines and will be setting up development groups. These groups will review the most recent evidence and make necessary changes to guidelines and recommendations. SIGN is looking for experts to help with the process. Go to the website (www.sign.ac.uk) for details.

ALERT ON PATIENT WEIGH SCALES
The NHS has issued a warning of potential medication errors due to patient weigh scales being incorrectly calibrated or of the wrong type. The Local Authorities Coordinators of Regulatory Services (LACORS) has recently audited a number of NHS organisations and identified areas where such weigh scales had the potential to lead to medication errors where dosages are calculated on the weight of the patient. The warning calls on hospitals, GP surgeries, nursing homes and other healthcare providers to ensure scales are of the right type (Class III) and are regularly maintained.

HELPLINE FOR DOCTORS
The Sick Doctors Trust provides a confidential service for doctors who think they may have an alcohol or drug problem. It is run by UK doctors for doctors and can offer information, advice and support. The Trust operates a 24-hour hotline and can be contacted on 0870 444 5163. For more information go to www.sick-doctors-trust.co.uk

Risk Alert: cremation certificates

THE Crown Prosecution Service (CPS) has published new legal guidance warning that breaching death and cremation certification rules will no longer be regarded as a matter for professional regulation, to be dealt with by the GMC, but as a potential criminal offence. A doctor who fails to fulfil obligations under the Cremation Act 1902 and associated rules could be jailed for up to two years.

In cases where a coroner has not ordered a post mortem, there is a three-step procedure before a cremation can take place:

- The doctor certifying a death completes form B having viewed the body.
- A confirmatory medical certificate, form C, is issued after a further examination by a second doctor, who must have been registered for at least five years, must not be a partner of or related to the first doctor, or related to the deceased.
- The medical referee then checks forms B and C before issuing form F, the authority to cremate.

A doctor who signs form C without viewing the deceased commits the offence of "wilfully making a false declaration, or representation, or signing or uttering any false certificate with a view to procuring the burning of any human remains".

Completing forms B and C without inspecting the body – which CCTV could confirm – is an offence under Section 8 of the Cremation Act 1902. Doctors who do not follow the correct procedures would also be breaching GMC guidelines on probity.

ACTION: Ensure that you follow rules for cremation certification.

Dr George Fernie, medico-legal adviser, MDDUS

Retired members and Good Samaritan acts

The recent decision by the GMC to end the exemption for registrants over 65 from paying the annual retention fee (see p. 6 of this issue) means that retired doctors face a choice – either pay the ARF or allow their GMC registration to lapse. A number of retired MDDUS members have phoned to ask what their medico-legal standing would be in undertaking Good Samaritan acts should they choose not to pay the ARF.

MDDUS policy is that members who permanently retire from practice and give up their GMC registration remain entitled to assistance and access to indemnity in respect of world-wide Good Samaritan acts – defined as "the provision of medical and dental services in emergency situations outside the scope of an individual's normal contractual obligations or clinical practice". Retired members also retain access to indemnity for any incidents occurring whilst in active membership. Please contact our Membership Department if you need any further clarity on this issue.

GMC to end age exemption from ARF

EXEMPTIONS from paying the annual retention fee (ARF) for GMC registrants over the age of 65 are to be ended having been judged contrary to laws prohibiting discrimination on the basis of age.

The GMC announcement states that under provisions of the Employment Equality (Age) Regulations 2006 it is "unlawful for a qualifications body to discriminate on grounds of age in the terms on which it confers, renews or extends a qualification which is either required for, or facilitates engagement in, a particular trade or profession".

Under these terms qualification includes registration. The Council has agreed that no new exemptions from the ARF on the grounds of age will be granted after 30 June 2008 and that those who are currently exempt will be liable to pay the ARF after 31 October 2008 if they wish to remain on the register.

The GMC has written to doctors who are currently exempt or about to become so advising them of the change. The Council will write again in August 2008 to ask registrants whether they wish either to make arrangements to pay the ARF or relinquish registration. See page 5 of *Summons* for MDDUS policy.

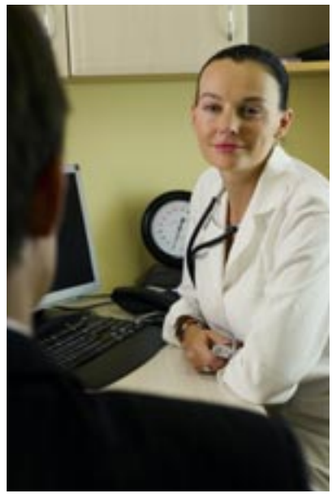
GMC introduces civil standard of proof

THE new civil standard of proof in GMC fitness to practise hearings has come into effect as of 31 May 2008.

Decisions on disputed facts in panel hearings will now by judged on the 'balance of probabilities' rather than the criminal standard of 'beyond reasonable doubt'. This has prompted fears that higher numbers of doctors will be suspended or erased under the new

"lower" standard of proof and also that the move will lead to inconsistent and unfair decisions.

But the GMC insists that the civil standard of proof is not a rigid criterion but flexible in application so that the "more serious the facts alleged the more cogent and compelling will be the evidence required". It has launched an FAQ page on its website (www.gdc-uk.org) offering a rationale behind the change and to answer concerns.



Lack of office space risks patient confidentiality

DECLINING office space for hospital doctors is hindering their ability to provide adequate patient care, according to research published by the BMA.

Half of junior doctors (54%) and a quarter of consultants (25%) who responded to a UK-wide BMA survey said the quantity of their office space had declined over the last year. Over half (56%) did not believe they had adequate resources to support their work. Over a third (36%) said that changes in either the quantity or quality of their office space had impacted on their ability to provide patient care, and around half (53%) said it had impacted on their working practices generally. Junior doctors were most likely to report problems.

Dr Jonathan Fielden, Chairman of the BMA's Consultants Committee, said:

"This is about quality of care and patient confidentiality. The plush, spacious, consultant's office is a figment of television imagination. Many consultants, junior doctors, and staff and associate specialist grade doctors have no office space at all. Those that do are struggling to cope in tiny spaces shared with colleagues.

"Doctors handle sensitive information and need space for private conversations with their patients and other staff. If they have to 'hot-desk', the confidentiality of their patients is put at risk."

New dental appliance standards

NEW draft standards from the General Dental Council aim to ensure accountability for the safety and quality of any dental appliance placed in a patient's mouth no matter where in the world it has been manufactured.

The GDC has launched a consultation document on the standards and is keen to hear from dentists, CDTs, dental technicians and other GDC registrants, as well as professional associations, patients and patient groups.

The draft standards spell out the

responsibilities registrants take on when commissioning work from a registered dental technician or CDT in the UK and the extra responsibilities if commissioning work from overseas. The draft standards also cover dental technicians who choose to subcontract to overseas laboratories. The UK-registered technician should be responsible to the GDC for the safety and quality of the appliance.

The Medicines and Healthcare Regulatory Agency (MHRA) is responsible for regulating dental appliances in the UK. All dental laboratories are required to be registered with the MHRA by law. Equivalent regulators exist in the European Union. The GDC draft standards supplement the requirements of the MHRA and are intended to ensure that there are no gaps in patient protection.

Access at www.gdc-uk.org. The deadline for response is 15 August 2008.

OPINION

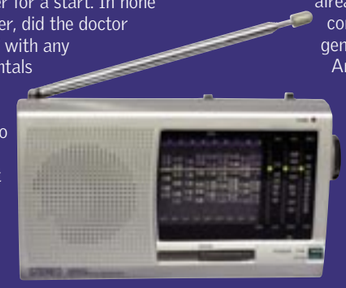
by Dr Ivan Felstein
Retired Geriatrician

Basically, it's obvious...

TRADITIONALLY doctors used the spoken word to confirm data, explain detail or delineate health problems. Today it's often less than clear what is the intention. I don't mean, for example, that it's overly euphemistic. To call leprosy, Hansen's disease, or tuberculosis, phthisis, is not too archaic. Older labels can give time to assess how to break the full news to patients and relatives. This is reasonable while impressing that a diagnosis and therapy are available.

So what is the problem? Listening to five questions put to a 'radio doctor' in a recent broadcast I heard the respondent reply to four of them: "Basically, you see..."

Well we know that radio is necessarily unseen to the listener for a start. In none of his replies, however, did the doctor follow his "basically" with any account of fundamentals or principles or foundations of the illness in question. No basics were evident. Rather he gave a list of possible causes and likely therapy.



His "basically" starter word was a time-wasting mechanism. Presumably it sounded more scientific than "um" or "ah" or "we-ll". However, four "Basically, you see..." starters in a row hardly impressed upon me his erudition.

But it's not just radio and TV medical pundits that employ less than precise wordage. Too many times we hear replies to medical questions that start with "Obviously..." and then continue with information which is not at all evident or undeniable or unmistakable. One might also point out that if a fact or conclusion is genuinely obvious, then listeners are already informed. No need for prodding.

I also hear medical lecturers and conference speakers who have adopted transatlantic habits. They don't say "in addition" but pointedly spell out the letters "P-S". They do so as if by mouthing these letters they are cleverly offering oral emphasis that writers use in a written postscript. Likewise, in quoting an example they spell out the letters "e.g." apparently feeling they are being somehow brilliantly concise. Worse still are those who think a spoken "i.e." gets the point home more succinctly than saying "that is".

You may say that medical acronyms and shorthand, like BP or TLC in case notes, have always been a favourite ploy for busy physicians. I contend that using mobile-phone-like teenager text only adds to the infelicity of language – wordage already overly contaminated by a general dumbing down.

And there are other indiscretions. We can thank trade unionists and administrators for the habit of devising longer forms of short words. Compared with the doctor's "hypoglycaemic coma" for "low blood sugar loss of consciousness", the popular phrase "at this moment in time" for the word "now" remains a real gem.

As for essentially slang phraseology, here are some oddities from so-called 'medical correspondents' in magazines and newspapers. I found "oh-no seconds" used to indicate panic attacks, "goat heaven" used to describe an addict's bliss after taking heroin, "cracker box" indicating a mental hospital and "left field" for the bizarre side-effects of a trial drug.

Basically, at this moment in time, obviously... can we have our genuine medical jargon back?

IN BRIEF

CHILD PROTECTION TOOLKIT
A toolkit designed to help GPs navigate the myriad of procedures for safeguarding children has been produced by the RCGP and the National Society for the Prevention of Cruelty to Children (NSPCC). *Safeguarding children and young people in general practice* consists of guidance notes and sample templates, procedures and a good practice code, as well as other guidance related to caring for children and young people in general practice. Access at www.rcgp.org.uk

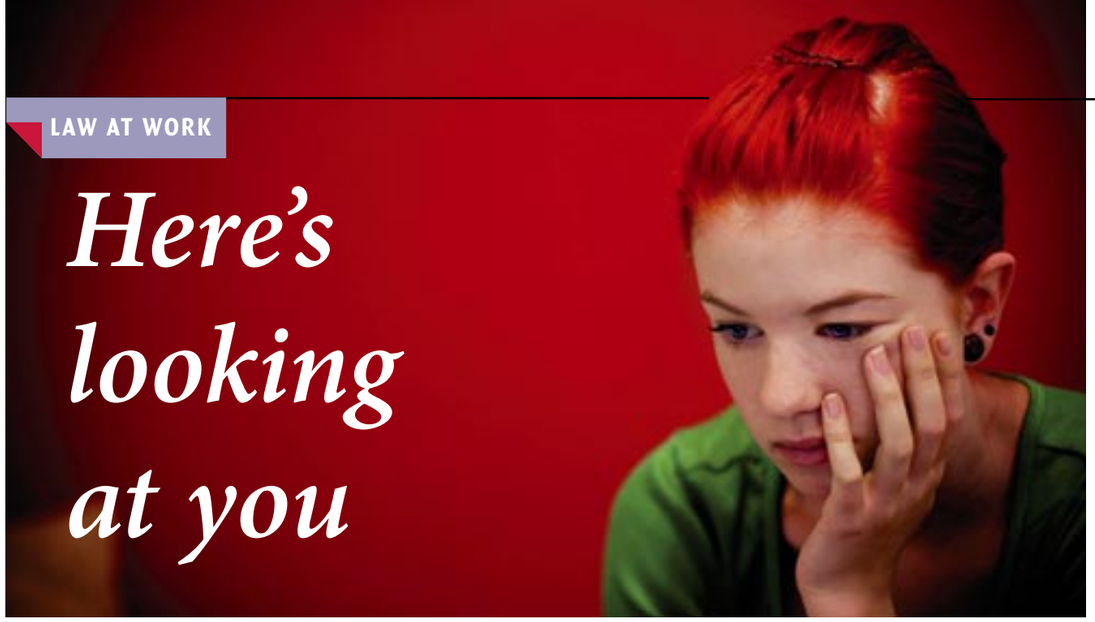
NEW ONLINE DENTAL FORUM
The BDA has launched an online initiative to identify priorities for research in primary care dentistry. The online discussion forum will allow dentists to voice their opinions on clinical issues and scenarios encountered in everyday practice. As well as providing GDPs with the best available evidence on topics, the forum will also identify research priorities in everyday practice. Access the forum at www.bda.org.

SURGICAL HYPOTHERMIA
Up to 70% of "unwarmed" surgical patients may be hypothermic on admission to the recovery room according to statistics cited in new clinical guidance issued by NICE. Patients who develop perioperative hypothermia can experience a number of complications, including a greater chance of heart problems, higher rates of infection and increased blood loss, leading to longer hospital stays. *Perioperative hypothermia (inadvertent)* provides guidelines on preventing hypothermia in patients before, during and up to 24 hours after surgery. Access at www.nice.org.uk/CG065

SIGN ON MENINGOCOCCAL DISEASE
Guidance on the early diagnosis and management of invasive meningococcal disease (IMD) in children and young people is a key feature of new guidelines issued by the Scottish Intercollegiate Guidelines Network (SIGN). Access *Management of invasive meningococcal disease in children and young people* at www.sign.ac.uk

More news and MDDUS events at www.mddus.com

Here's looking at you



IT CANNOT HAVE escaped your notice that looks are becoming increasingly influential in recruitment and promotion decisions. Gradually, how you look is arguably becoming more important than what you can do in many organisations. It is said, after all, that you typically form an opinion about someone within seconds of seeing them.

Physical appearance is also being used as a (metaphorical) stick to beat colleagues with, as the recent case of Sarah Primmer illustrates. Primmer, who has red hair, worked for Mayflower Kebabs. She was treated to constant taunts about her "gingerness" by other staff and management alike and eventually resigned under this pressure. She claimed that a man would not have been treated to a similar onslaught of teasing.

In an excellent illustration of the new, recently-widened definition of harassment in the Sex Discrimination Act (SDA), she successfully argued that this sex-based (as opposed to 'sexual') harassment undermined her dignity at work and created an offensive and intimidating environment for her. Successful harassment claims under the SDA need no longer be based on sexual or suggestive conduct. As long as the victim is able to demonstrate that employees of the opposite sex would not be subject to the same humiliating treatment, then the employer will be liable for the behaviour of the harassers.

Interestingly, although Primmer's case can hardly be said to be a green light for a flood of harassment claims in the Employment Tribunal based on hair colour, it does illustrate a new avenue for those who are teased about their appearance to seek legal redress.

Comments about a colleague's appearance could constitute bullying if they are persistent and unwelcome. A recent House of Lords case (Majrowski v Guy's & St Thomas's NHS Trust) confirmed that the Protection from Harassment Act 1997 extends to workplace harassment – despite the fact that it was never conceived as employment legislation.

There is a serious general problem of harassment of disabled people – which is often based on their different looks. For example, the Disability Rights Commission has published revisions to its Code of Good Practice in Employment – one of which suggested that obesity, in some circumstances, might be regarded as a disability covered by the Disability Discrimination Act. This would have to be linked to a physical or mental impairment with a long-term adverse effect on the employee's ability to carry out normal daily activities. But 'morbid obesity' is already legally recognised as a 'disability' in the USA. Persistent teasing of employees about their weight could, therefore, be contrary to the Disability Discrimination Act and the practice would be liable for the harasser's actions.

Dress codes have got a number of employers into difficulties in the Tribunal. Whilst it may be reasonable for a practice to insist that, for example, smart business dress (or even a uniform) be worn where appearance is important in maintaining a corporate image to customers, it is important that insistence on dress standards does not become indirectly discriminatory. For example, a Job Centre worker was successful in arguing that the Department for Work and Pensions was applying their dress code (including the need to wear a tie) in a way that discriminated against men.

Provided the overall effect of the rules is the same for both sexes, dress codes will probably not be directly discriminatory, although they may indirectly discriminate against a particular racial or religious group. Some employees may not be able to comply with a dress code for these reasons, so it is important that employers are flexible about how such policies are applied in practice.

'She was treated to constant taunts about her "gingerness" by other staff and management alike'

In order to reduce the risk of claims arising out of management decisions based upon appearance or harassment by fellow employees on the basis of hurtful remarks about appearance, practices should make it clear that unfair treatment on these grounds will be contrary to the organisation's equal opportunities policy and partners and staff alike will be held accountable for their actions.

Ian Watson, Training Services Manager, Law At Work

Law At Work is preferred supplier to the MDDUS of general employment law and health and safety services for members. For more information on our services please visit www.lawatwork.co.uk or call us on 0141 271 5555

PHOTOGRAPHS: GMC

Decision time

WHEN you think of getting consent, what immediately springs to mind? For some it is all about finding time to get a patient's signature on a form as part of the bureaucracy before a procedure. For others, both doctors and patients, it is a legalistic process to prevent the prospect of a patient bringing charges of assault. But is that the start and end of it?

Doctors often talk about 'consenting' patients and, whilst this may be convenient shorthand, it misrepresents consent as something done by a doctor to a patient. Our revised guidance, *Consent: patients and doctors making decisions together*, came into force on 2 June 2008. It starts from the premise that consent is the culmination of a good decision-making process that involves wider discussions between doctors and patients. This will often involve other members of the healthcare team and the patient's relatives and carers.

A shift to patient-centred care

The new guidance reflects a shift in professional and public attitudes towards more patient-centred care, as well as containing practical advice on sharing information and discussing treatment options. It will have an impact on all patients, but in particular on those who may need extra support to make decisions about their care.

The updated guidance aims to provide a framework that can be used in a variety of circumstances in which patients make decisions about treatment. It includes new advice for doctors on:

- Partnerships with patients – listening and sharing information
- How to communicate the risks and possible side-effects of treatment to patients
- What to do when patients refuse information
- Changes in the law, including the new legal safeguards for patients who lack capacity to make their own decisions.

Jane O'Brien, *head of standards and ethics at the GMC, highlights new guidance on consent*

In developing the new guidance we engaged and consulted widely to find out the key issues doctors, patients, carers and others thought the guidance should address.

As part of the consultation process we ran a series of workshops across the UK in partnership with Theatreworks, part of the National Theatre, and charities for older people and people living with dementia. This included the Scottish Dementia Working Group. The workshops were an innovative way for us to gather views from those who have direct experience of the issues, but who would not usually respond to a formal consultation. They allowed us to explore, with an audience of doctors, people with dementia and their carers, some of the difficulties that arise when a patient's ability to make decisions is impaired or fluctuates because of a condition such as dementia.

The workshops incorporated a play which followed Will, who has early stage dementia, and his wife and carer, Helen, through a series of unsatisfactory encounters with doctors, both in primary and secondary care. The audience were asked to explore the issues and to take the place of the actors to show what they would do differently in order to get a better outcome. The information we received through this process helped to shape the principles of good practice in the guidance. ➤

Partnerships with patients

Good decision-making should be based on a partnership between doctors and patients and will often involve the wider healthcare team. The guidance stresses the importance of doctors listening to patients and respecting their decisions, and requires them to provide information that patients need to know in order to make a decision – and any further details that they ask for, directly or indirectly. The phrase we use is 'the information patients want or need in order to make a decision'.

Talking about risk

For the first time, we have included advice for doctors on how to approach discussions with patients about potential side-effects, complications and other risks of treatment. This also includes discussing the potential outcome of taking no action. Risks can vary in both severity and frequency, and in their impact on patients. The guidance asks doctors to consider the risk and its significance for the patient. Doctors should take into account a patient's diagnosis, prognosis, history and personal circumstances, and the guidance offers suggestions on how to tailor the discussion to the individual patient's situation.

It is important that information about risk is given to patients in a way that can be understood. Doctors should check that the patient understands the terms they use when describing the seriousness of a particular adverse outcome, or the likelihood of it occurring in a particular situation. They should also present risk in a balanced way, avoiding bias and explaining the benefits as well as the risks and burdens of treatment options.

Patients who refuse information

The new guidance also contains advice on what to do if patients do not want detailed information about a condition or proposed treatment, or ask the doctor or someone else to make the decision. While it stresses that doctors must respect patients' wishes and should not force information on them, it also outlines the minimum information that a patient is likely to need to give valid consent.

In particular, the guidance emphasises that doctors should try to find out why the patient does not want the information. Sensitive exploration of patients' views and concerns can often overcome their initial resistance to being given information about their condition or treatment options.

Where patients insist that they do not want to be told about their condition or treatment, doctors should explain why it is important that they are given information, at least, about what the treatment will involve and what it should achieve, the level of pain or other side-effects that are likely to arise, how they should prepare for the procedure and any serious risks. Without having this information, patients' consent may not be valid.

Images are from Theatreworks dramas used in consultation workshops

Changes in the law

Part Three of the guidance deals with decision-making when patients lack capacity or their capacity is impaired, taking account of the introduction of the Mental Capacity Act 2005 (England and Wales) and the more established Adults with Incapacity (Scotland) Act 2000.

The guidance in this section is consistent with the law across the UK, but it is still important that doctors keep up to date and comply with the laws and codes of practice that apply where they work. Doctors should consult their defence body or professional association, or seek independent legal advice, if they are unsure about how the law applies in a particular situation.

There have also been some significant developments in common law, relating to the importance of providing information about risks, and these changes have also been reflected in the guidance.

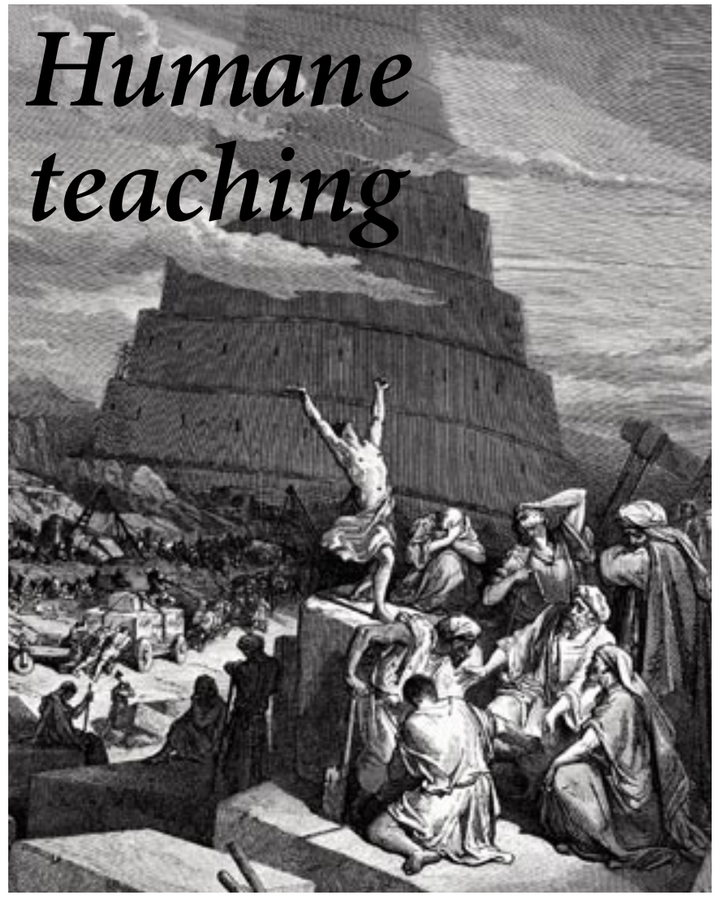
We hope that the new guidance will encourage doctors to work in partnership with patients to make decisions about treatment and care. Our guidance is not exhaustive, but sets out high-level principles of good practice. Doctors must use their judgement in applying the guidance to the situations they face in practice. The information provided to patients to allow effective decision-making should be proportionate to the patient's condition, the complexity of treatment, seriousness of risk, side-effects and complications.

No one size fits all, and doctors need to be responsive to the needs of patients. Doctors should adapt to ensure that patients are given every opportunity to make fully informed decisions.

Consent: patients and doctors making decisions together *can be downloaded from the GMC website at www.gmc-uk.org*

■ ***Jane O'Brien is head of standards and ethics at the General Medical Council***

Humane teaching



I RECENTLY ATTENDED a BMA Medical Ethics conference in London and was reinforced in my scepticism about the level of integration of medical ethics education in the UK curriculum. Many institutions still seem lost, frustrated and ill at ease with what is happening. Hence the reason for the conference.

Even when there was a workshop on the 'integration of medical ethics and the humanities', there was no one in the room who really had any experience of it or even any knowledge of what it meant. Perhaps that was why we were there.

Humanities resources are far better than the philosophical underpinnings of medical ethics which bore and confound students. Good writers of short stories and plays have the ability to get at the heart of the matter of what we call the practice of medicine. In addition, students, particularly those in a preclinical situation, often enjoy and are willing to think and talk about issues which they realise are genuine – even if they are fictional.

However, when I attempted to explain what this meant for me, there was very little interest in exploring or developing what I was saying.

I have been reflecting on this over the past weeks and during this time I received some emails from former students who have passed on to a partner institution for their clinical years. They are frustrated because of the lack of ethics teaching, dialogue or any kind of engagement with humanities, patient-physician relationship, etc. in the curriculum and the institution which they joined after departing St Andrews. I suspected that some of the people who attended the BMA conference must be in charge of their curriculum and realised that this is probably happening at other places as well, though this may be very presumptuous of me.

> 'Students are frustrated because of the lack of ethics teaching, or any kind of engagement with humanities'

At this point I have only been able to conclude that there are two main issues which are contributing to this 'Tower of Babel' education story.

Firstly, the vast array of backgrounds of the people who have been 'soldiered' into teaching medical ethics and anything related to it prevents them from having a meaningful discussion with each other. They are easily 'shouldered out' and pushed aside by basic science staff and clinical staff who have their terrain to protect and are much more homogeneous as a group. I mention this because I think students are not aware of the backgrounds and educational expertise of the people who teach them. Hence, behavioural scientists, philosophers and lawyers, not to mention the ethically ill-equipped doctor/clinician, are only part of the vast array of staff people who cannot agree on how to teach ethics.

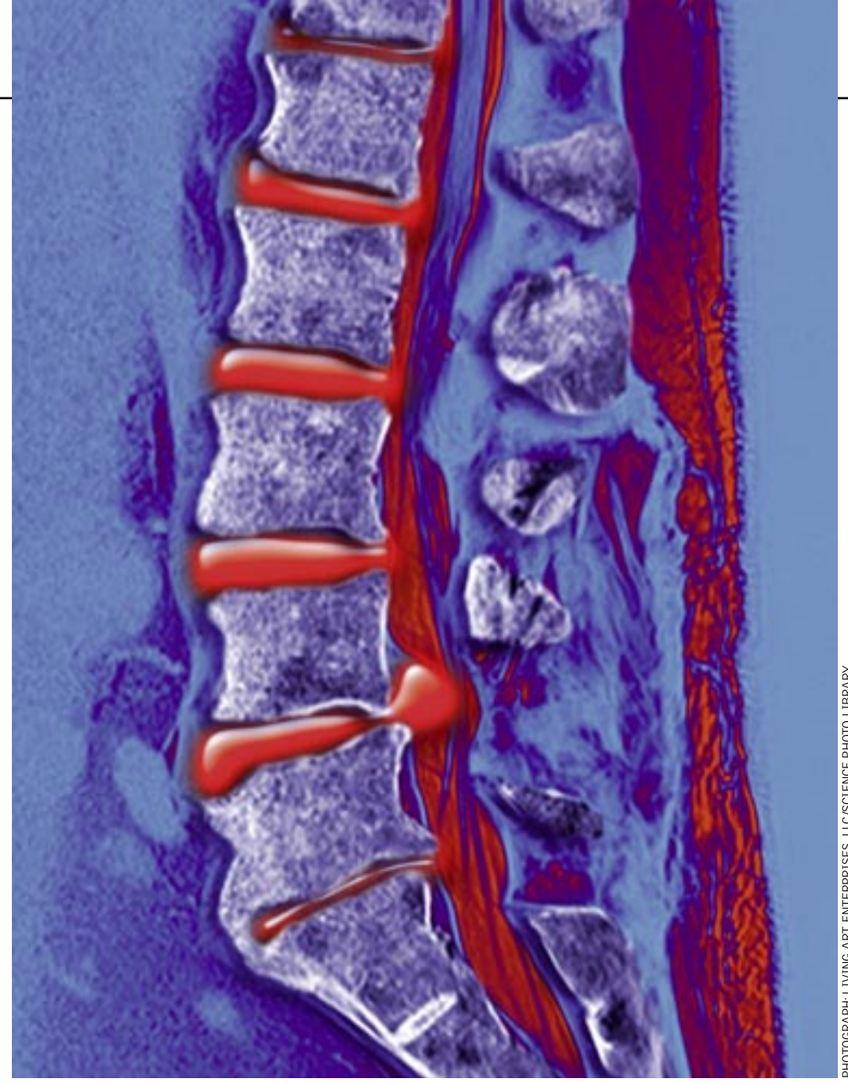
The second point is this. There are curricula that are integrated and those which are not. If you have a PBL curriculum (the extreme of integration?), there is no formal teaching prior to the PBL in order to establish how you think about, interpret and analyse ethical dilemmas (and you cannot learn it from a book on medical ethics) – so there is often little point in including ethical issues in the case studies. (A friend at Glasgow tells me that there is some formal teaching of medical ethics alongside the PBL portion of the curriculum.) In addition, some facilitators cannot be bothered with the airy-fairy, woolly stuff because doctors are people of integrity and compassion and advocacy and commitment and don't need to be taught about it in any case. (Incidentally, this is a good reason to use humanities resources – in order to demonstrate that often they are not any of the above.)

Anyway, because I don't know any better, I don't teach 'medical ethics' but The Practice of Medicine, which confounds everyone on staff – and they just leave me alone.

Peter Nelson
Deputy Director of Teaching
University of St Andrews

Cauda equina syndrome

Early diagnosis and treatment is critical to avoid irreversible nerve damage, writes consultant neurosurgeon, Robert Macfarlane



PHOTOGRAPH: LIVING ART ENTERPRISES, LLC/SCIENCE PHOTO LIBRARY

THE diagnosis and management of cauda equina syndrome (CES) can be fraught with potential difficulties. Back pain and sciatica are common conditions, but an average GP will probably diagnose only one or two cases of CES in their professional lifetime. A patient in pain from a disc prolapse may have difficulty passing urine purely for mechanical reasons, and the analgesics used in treatment almost invariably cause constipation. This situation is entirely different from CES where, instead of a lumbar disc protruding to one or other side of the spinal canal and compressing nerve roots to the lower limbs, it prolapses centrally. Here it impinges on the nerves subserving sensation to the saddle region, bladder, urethra and rectum, as well as the parasympathetic motor innervation to the bowel and bladder.

It is critical to diagnosis CES at an early stage because these nerves have characteristics which make them both vulnerable to injury and unlikely to recover from a severe insult. Firstly, they comprise small myelinated and unmyelinated nerves which are less resilient to compression than larger fibres. Secondly, because compression occurs proximal to the cell body, axons will not regenerate once Wallerian degeneration develops.

CES may be subdivided into two categories. At first there is impairment of bladder/saddle sensation and difficulty with micturition, but the patient remains continent (CESI – an incomplete lesion). The syndrome becomes complete when the bladder is no longer under voluntary control and the patient has painless urinary retention with dribbling overflow incontinence (CESR). At the outset the patient will be constipated through loss of the parasympathetic innervation to the descending colon, even although anal tone is lax. Faecal incontinence is generally a very late sign in CES and its absence should not be regarded as reassuring.

Although there remains controversy regarding management of CESR, many studies have concluded that, once this state is reached, the opportunity has been lost to reverse the situation by emergency decompression. In contrast, the outcome for CESI is usually favourable; therefore it is important to achieve decompression before the patient has progressed to CESR. Any perceived delay in diagnosis and treatment, or failure to warn the patient of the need to seek urgent attention should CES symptoms develop may lead to allegations of negligence.

Differentiating CESI

A detailed history is needed to differentiate between CESI and bladder disturbance secondary to pain and constipation. The patient in pain who is having difficulty with voiding purely for mechanical reasons is aware that the bladder is full, retains the desire to micturate, has normal sensation in the saddle region, and a tender bladder. Urethral sensation is preserved and the patient can differentiate flatus from faeces. In contrast, the patient developing CES will develop some or all of the following:

- altered saddle and/or urinary sensation
- perineal/rectal pain
- reduced awareness of bladder filling
- the need to strain to maintain urine flow.

On abdominal palpation the bladder may be distended but not tender. Saddle sensation may be reduced to light touch and/or pinprick. In the early stages, anal tone will remain normal.

Unfortunately, the distinction between the two is not always clear. Some patients will complain of altered saddle sensation but an MRI will show no compression. Conversely, a person with CESR may remain continent by toileting regularly to avoid over-distension of the bladder, and micturate by straining or applying abdominal pressure. Although the presence of bilateral sciatica is well-known as a 'red flag' for CES, many cases will only ever have unilateral sciatica. Very occasionally, an L5/S1 central disc may compress the cauda equina without involving the laterally-placed nerve roots. CES can therefore occur without sciatica. Neither is report of an improvement in back pain/sciatica always reassuring. When the disc fragment migrates centrally, pressure may be relieved from the laterally-placed nerve roots. This results in relief of sciatica at the time that CES occurs. If doubt exists about the diagnosis, the only way in which this can be resolved is by emergency MRI.

Medicolegal aspects

In the context of general practice and accident & emergency, the areas most likely to cause difficulty are, firstly, failure to consider the diagnosis of CES. Secondly, patients may dispute the accuracy of their records, alleging that CES symptoms were present at an earlier date but were not recorded accurately or acted upon. Thirdly, patients may accept that they did not have symptoms of CES at the time of a particular consultation but allege that they should have been warned about the early symptoms and told to seek urgent medical attention should they occur. Fourthly, there may be a delay in seeking an emergency specialist opinion.

There are two particular additional hazards in hospital care. The first is in failing to arrange investigation of suspected CES with appropriate urgency, particularly in units that do not operate an out-of-hours MRI service. The second is the timing of surgery once the diagnosis has been established. The degree of urgency with which CESI should be investigated will depend upon the clinical circumstances. In nearly all cases MRI is required as an emergency because of the risk that they may progress to CESR with any delay. If it is not possible to arrange this out of hours then the patient should be transferred elsewhere. On rare occasions where a history of early CES has been obtained but symptoms have been static for some days, it may be acceptable to delay investigation overnight, provided the patient is warned to report any deterioration.

Whilst some clinicians have interpreted the outcome of a meta-analysis by Ahn et al (2000) as indicating that there is a 48-hour 'window' in which to treat CES, this notion is unsafe. In particular, it does not apply to CESI. Once the diagnosis has been made, CESI will usually be treated as a surgical emergency, regardless of the hour. However, this decision is not always straightforward. Surgery for a large central disc can be challenging and carries a risk of adding to the deficit if performed under less than ideal circumstances. It may be argued, therefore, that it is appropriate to delay decompression by a few hours if, by doing so, the risk will be lessened. As far as surgery for CESR is concerned, a recent meta-analysis suggests that there may still be merit from emergency decompression (Todd, 2005). However, much of the literature suggests that outcome is no better, and that decompression can be delayed until the first available elective list. In the interim, the patient should be catheterised.

Minimising the risk

A number of measures can be taken to minimise the risk of litigation, although they should not all be seen to represent a standard of care:

Think about the diagnosis of CES in every patient with back pain and sciatica. Make a written note if there is no evidence of this condition.

- Warn the patient to seek urgent attention if they develop CES symptoms. Document that they have been told.
- If CES is suspected, telephone the on-call orthopaedic or neurosurgery team. Do not be reassured if a junior doctor tells you to refer the patient as an urgent out-patient. If you are not satisfied with the response, seek a more senior opinion or tell the patient to attend A&E.
- Lack of an emergency MRI service is not a valid reason to delay investigation. If the degree of clinical urgency cannot be met, refer the patient elsewhere.
- CESI is usually treated as a surgical emergency, regardless of the time of day. If there are good clinical reasons to delay decompression, document why this is justified. If the delay is due to lack of surgical expertise, consider referring the patient elsewhere.

■ ***Mr Robert Macfarlane is a consultant neurosurgeon at Addenbrooke's Hospital, Cambridge, and also provides expert reports for MDDUS***

REFERENCES

Ahn UM, et al. Cauda equina syndrome secondary to lumbar disc herniation. A meta-analysis of surgical outcomes. Spine 2000; 25:1515-22

Todd NV. Cauda equina syndrome: the timing of surgery probably does influence outcome. British Journal of Neurosurgery 2005; 19:301-6

What's behind the new GDC interim statement on competency in implant dentistry? Jim Killgore *investigates*

Focus on standards

WITH fees in the UK routinely exceeding £2,000 per treatment it's no wonder dental implantology is the undisputed growth area of restorative dentistry.

In 2007 Merrill Lynch estimated the global dental implant market at £1.37 billion – a 20% increase over 2006. Long-term growth potential is huge as implant dentistry currently accounts for less than 10% of tooth replacements.

Done well, dental implants offer obvious advantages to patients over traditional bridges and removable dentures. Done poorly and the results can be far-reaching and costly for both patients and dentists – and consequently medical defence organisations.

Given this context the recent interim policy statement on implantology by the General Dental Council is hardly surprising. Released in April of this year the statement confirms that dentists practising implant dentistry without relevant additional training are putting their registration at risk.

So what is relevant additional training?

Dental practitioners are urged to refer to guidance published by the Faculty of General Dental Practice (UK) as the "authoritative source" of training standards for implant dentistry in the UK.

In the statement the GDC reiterates: "Dental professionals have an ethical responsibility to limit their scope of practice to what they are trained and competent to do. Any dental professional who carries out work for which they are not trained and competent puts their registration at risk".

The document cites GDC education guidance *The First Five Years* which states that dental students should "be familiar with dental implants as an option in replacing missing teeth". But it adds that a "UK-qualified general dental practitioner will not therefore be competent to practise implant dentistry without further training".

The GDC supports *Training Standards in Implant Dentistry for General Dental Practitioners* as the gold standard for such training in the UK.

Not a limitation on practice

These standards are the result of a working group convened in 2005 by the GDC and chaired by Michael Martin, then a senior lecturer at the University of Liverpool. The group's remit was to work independently of any organisation and consider what training standards would be necessary for a GDP practising implant dentistry and to publish these with a commitment to periodic review.

In his preface Mr Martin wrote: "Such standards could be used not only by practitioners but also by the GDC in the consideration of patient complaints against dental practitioners who, allegedly, practise implant dentistry beyond the limits of their competence".

But he stressed that the intention was "not to limit the practice of implant dentistry" which is seen as an important treatment option for patients. The working group recognised that training in implant dentistry could come from a variety of sources including courses offered by universities, Royal Colleges, hospitals and individuals or industry.

In considering the variety of different techniques and procedures involved in implant dentistry the group saw a distinct division between dentists qualified to place implants only and those doing so with major bone augmentation and/or modification of anatomical structures. Both require that a qualified individual has practised clinical assessment, treatment planning and the placement of implants in the presence of an experienced implant clinician, as part of a course in implant dentistry. But the placement of implants with bone augmentation or modification of anatomical structures demands a higher level of surgical experience with specific training in these techniques and some element of formal assessment.

It was also recognised that some GDPs may have gained expertise in implant dentistry by a variety of means and was recommended that practitioners keep a portfolio of their training, courses attended, any mentoring that they have had, and the implants they have placed.

The standards document states: "It would be expected that the outcome of their implant placement would have been audited. Such portfolios of activity could be used in any dispute as to whether they were competent in implant dentistry, including complaints before the GDC".

IMAGES: CHRIS KNAPTON/SCIENCE PHOTO LIBRARY; VOLKER STEGER/SCIENCE PHOTO LIBRARY

'The results of poor implants can be far-reaching and costly for both patients and dentists – and consequently medical defence organisations'

Just at the time of press for this issue of *Summons* the working group was due to issue an updated standards document. Expected revisions include additional detail on what represents complex implant treatment as compared to more simple cases.

"Whereas before it talked about placement of implants with or without major bone augmentation, the revised standards go into a little more detail of what would constitute more complex implant treatment," said Dr Anthony Bendkowski, president of the Association of Dental Implantology UK and the ADI representative on the working group.

The new document is also more inclusive in order to take account of new GDC requirements on the registration of DCPs. Said Dr Bendkowski: "It doesn't just talk about dentists – it talks about the team. So the implication is that technicians and nurses must have appropriate training and experience as well."

One criticism of the previous document and likely to be levelled at the revised standards is the lack of clarity as to how competencies in implant dentistry should be measured.

"It talks about training standards and what practitioners should be able to do," said Dr Bendkowski. "But it doesn't really establish the benchmark for measuring competencies and setting syllabuses. The view of the Chairman – and I support that view – is that we have been tasked to provide an overview rather than detailed course plans at this stage."

Scope of practice

Another possible factor in the timing of the GDC statement on implantology is the recently closed consultation on the *Scope of Practice* for members of the dental team. In initiating the consultation the GDC acknowledged that the current approach where dentists are expected to work within the bounds of "training and competence" is too open-ended and vague for both patients and professionals.

In response the GDC set up a working group which drew up lists of skills associated with each category of dental professional. In doing so they considered:

- skills which can be expected of a registrant on qualification
- additional skills which might be developed later in the registrant's career as part of their professional development
- skills which registrants in a particular group would not develop without becoming a different type of registrant.

Under the category of 'Dentists' the sole 'additional skill' listed is "providing dental implants".

Ensuring competence

So how does a dentist wishing to develop skills in implantology choose a path that ensures competency? Said Dr Bendkowski: "First it's important to differentiate between education and training. To be a good, competent, contemporary implant dentist you need both".

Education can be catered for by meetings, conferences and self-directed learning. GDPs can read books and keep up to date with articles in journals. But education is not enough.

"It's a bit like reading a book on flying," said Dr Bendkowski. "You can read a lot but it doesn't mean to say you can then jump in an aeroplane and fly it."

Further competence requires a sound foundation in general dentistry including good surgical and restorative skills with the final step being specific training in implant dentistry under the guidance of an experienced mentor. Said Dr Bendkowski: "This is probably the best way to achieve the necessary skills."

The Association of Dental Implantology offers further guidance on its website (www.adi.org.uk), including a selection of local or commercial courses as well as longer private and academic courses offering postgraduate qualifications and certificates.

Look out for the new edition of *Training Standards in Implant Dentistry for General Dental Practitioners* on the GDC website.

■ ***Jim Killgore is the editor of MDDUS Summons***

Crystal clear?

Hugh Harvie *provides some clarity on the NICE guidance covering the use of antibiotics in patients at risk of infective endocarditis*

Colour-enhanced SEM depicting *Staphylococcus aureus*

PHOTOGRAPH: SCIENCE SOURCE/SCIENCE PHOTO LIBRARY

FROM the number of telephone contacts and emails from dentists to the MDDUS it is clear that there is considerable confusion and uncertainty about the National Institute for Health and Clinical Excellence (NICE) guidelines on *Prophylaxis against infective endocarditis*. Perhaps it is the wording or the presentation that has led to this confusion among both dentists and patients.

The advice to regard "people with the following cardiac conditions as being at risk of developing infective endocarditis" tends to reinforce the previously accepted doctrine (at least in the minds of dentists) that certain groups of patients are at risk of developing endocarditis and antibiotics should be given!

The groups identified as 'at risk' include those with the following conditions:

- acquired valvular disease with stenosis or regurgitation
- valve replacement
- structural congenital heart disease including surgically corrected or palliated structural conditions, but excluding isolated atrial septal defect, fully repaired ventricular septal defects or fully repaired patent ductus arteriosus, and closure devices judged to be endothelialised
- hypertrophic cardiomyopathy
- previous infective endocarditis.

All of the above ring alarm bells for dentists who have been indoctrinated to prescribe antibiotics for such conditions! Having rung the alarm bells the guidance then goes on to give advice on "When to offer prophylaxis" under the sub-heading of "Do not offer antibiotic prophylaxis…" The situations where antibiotic prophylaxis is no longer considered necessary are then listed and the most significant to dentists is "to people undergoing dental procedures".

There it is…crystal clear…no antibiotic prophylaxis for dental procedures. Also, the guidance confirms that it is no longer necessary to offer chlorhexidine mouthwash as a prophylaxis.

Finally, the guidance offers advice on managing infection and emphasises the importance of the following:

- investigate and treat promptly any episodes of infection in people at risk of infective endocarditis to reduce the risk of endocarditis developing
- offer an antibiotic that covers organisms that cause infective endocarditis if a person at risk of infective endocarditis is receiving antimicrobial therapy because they are undergoing a gastrointestinal or genitourinary procedure at a site where there is a suspected infection.

So what does the dentist do?

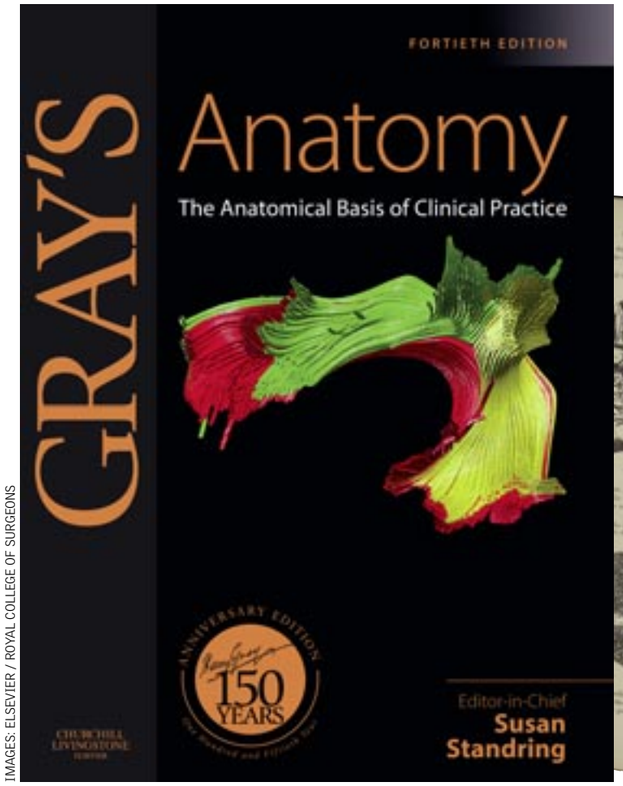
These guidelines make it clear that there is now no longer any requirement or recommendation to prescribe antibiotic prophylaxis for dental treatment. Dentists should adhere to the guidelines as follows:

- Carry out a thorough patient examination including an assessment of the medical history.
- Where the medical history indicates that the patient is in an 'At Risk' category then the patient should be advised on the NICE guidelines and informed that antibiotic prophylaxis is no longer considered necessary for dental procedures.
- If a patient is unhappy or concerned about the advice being given then the patient should be advised to discuss matters with the GP or consultant managing his or her care. If the GP or consultant confirms that antibiotics are required then the prescribing should be done by them. The dentist's role is to provide information on the treatment to be undertaken and to explain, if required, the NICE guidelines in relation to dental procedures.

The patient record should record all necessary clinical information and note the discussions/advice given to the patient.

The guidelines do remind dentists of the need to investigate and treat promptly any episodes of infection in people at risk of infective endocarditis to reduce that risk. In other words a dentist must effectively manage the presenting dental condition promptly and effectively.

■ ***Mr Hugh Harvie is a dento-legal adviser at the MDDUS***



IMAGES: ELSEVIER / ROYAL COLLEGE OF SURGEONS

A publishing phenomenon and medical icon marks 150 years with a new edition. Adam Campbell *turns the pages*

Gray matter

IT IS one of the most famous textbooks of all time. In 2005, a first edition sold for £4,920 at Christie's in London. This autumn, as its publisher prepares to unveil a 40th edition, it will have been in continuous print for 150 years. This anatomical reference book is of such renown it has even lent its title to an award-winning American drama – in the television age, brand approval ratings don't come any higher than that.

But do a little digging into the story of *Gray's Anatomy* – first published as *Anatomy, Descriptive and Surgical* – and there soon emerges an interesting paradox. For while the eponymous Dr Henry Gray was certainly at the centre of the production of the book's first edition, having written the words, at his side but unrewarded on its spine (and, from 1938, its modern title) was his colleague Dr Henry Vandyke Carter, who produced the illustrations that many suggest were the real root of the book's runaway success.

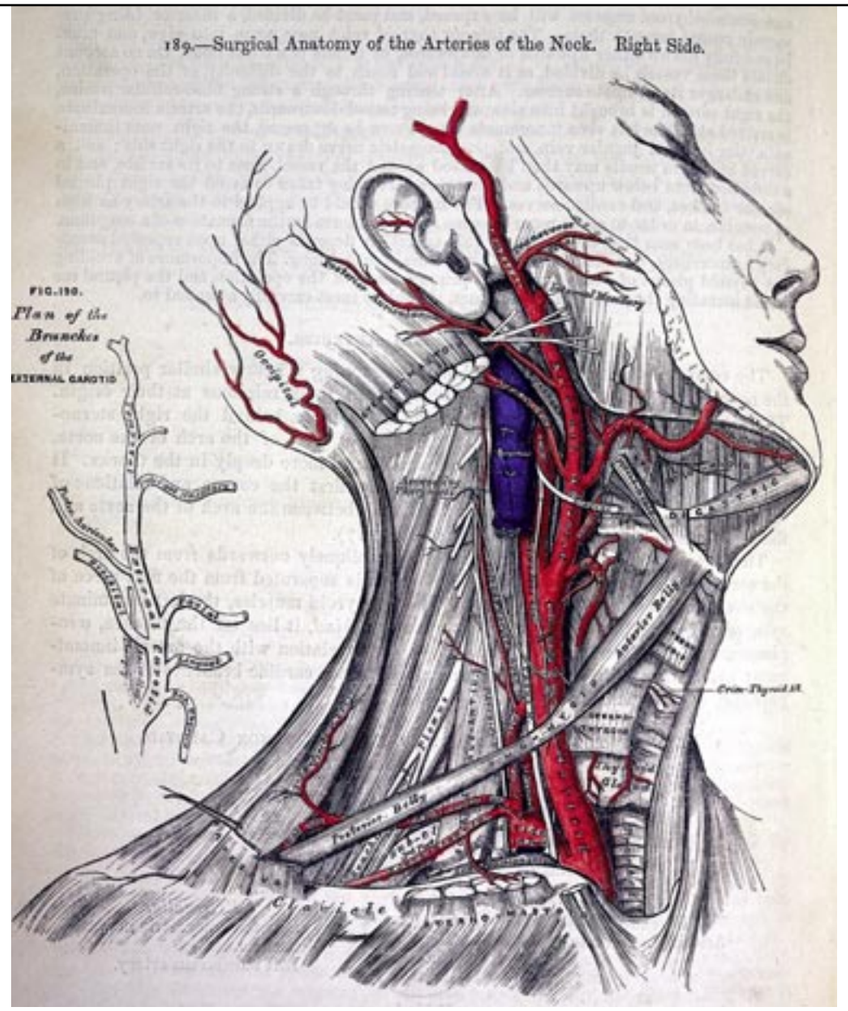
"I believe anybody who says the words 'Gray's Anatomy' should also know the name of Carter," says medical historian Ruth Richardson, who has just completed a book on the subject, *The Making of Mr Gray's Anatomy*. "It was the illustrations that sold the book."

The book's current editor-in-chief, Professor Susan Standring, agrees: "Why it's not Gray's and ➤

➤ Carter's I do not know. I think it's dreadful that it's not. Carter remains to be discovered. These days he would probably have been on the Today programme".

Whereas many of the leading student anatomy texts at the time were pocket-sized manuals, measuring around 6" x 4", with few illustrations occupying more than a third of the page, *Gray's* broke the mould, coming in at 9.5" x 6" and containing much larger and clearer engravings. Carter also moved away from the trend for 'proxy labelling' – using tiny numbers or letters on the illustrations with a remote legend – and unified both name and structure on the drawings themselves.

The result was spectacular. "The new book sent the anatomy world reeling. Other textbooks went that way later, but it took them about 10 years to come back," says Richardson. "*Gray's* set a standard that was very hard to match, even for itself."



Above: Henry Gray (centre left) among students and lecturers in the dissecting room at St George's Hospital, London
Above and right: illustrations by Henry Vandyke Carter from the first edition of *Gray's Anatomy*

An obscure genesis

No one is suggesting that Carter is turning in his grave at having missed out on primetime recognition in 21st-century America, nor indeed that Gray deliberately diddled him out of his just rewards. The truth is that very little is known about the genesis of *Gray's* – we don't even know whose idea the book was. The publisher, J W Parker, owned the copyright and may well have commissioned the book himself.

What is known is that in 1855, Gray, who was on the teaching staff at St George's Hospital Medical School in London, enlisted the help of Carter, whom he knew to be a gifted artist, to produce an accurate, affordable teaching aid. There followed 18 months of hard labour as the pair carried out the dissections that would form the basis of their opus and then produced its ground-breaking content. By the time of its publication in 1858, with a print run of 2,000 copies, Carter had pocketed his fee (a one-off payment) and set sail for India, for a new life in the medical service there.

Meanwhile Gray, who received a royalty of £150 per 1,000 copies, shepherded in a second, enlarged edition, before tragically succumbing to smallpox a year later, in 1861, at the tender age of 34. Carter was to live another 36 years, eventually dying in Scarborough, but he would play no more part in the book's history.

A century and a half and 39 editions from the first, the book's worldwide standing is as strong as ever. Over the period *Gray's Anatomy* has sold more than a million copies, and the 40th edition, weighing in at not much under a stone, has a whopping 1,700 pages, featuring 1,200 illustrations, and was put together by 10 section editors, 71 contributors and 62 reviewers from all the corners of the world. The book's publisher, Elsevier, considers *Gray's*, alongside *The Lancet*, as one of their most important brands. One of the main factors in its ongoing success over the years has been the commitment of its various editors to move with the times and to regularly update and amend the content.

> 'The new book sent the anatomy world reeling. Other textbooks eventually caught up, but it took them about 10 years'

The job of overseeing the most recent update has fallen to Susan Standring, Professor of Experimental Neurobiology at King's College London, who is editor-in-chief for the second time. "It's been fantastic," she says. "I have a team of incredibly committed section editors, and we've amassed a fantastic team of contributors." At the same time, she confesses: "It's been as tough this time as it was for the 39th edition. It's an enormous amount of work. It's not my day job but it's every night and every weekend."

Standring has, in fact, been associated with the title for over 40 years, having won it as her sixth-form prize in 1964 before going to medical school. She later did her PhD with Professor Peter Williams, who was an editor of *Gray's* from 1973 to 1995. "I suggested to Peter while I was a post-doc that it might be good if the book had a bibliography and so I started by creating that," she says. "I've been involved in every edition since then."

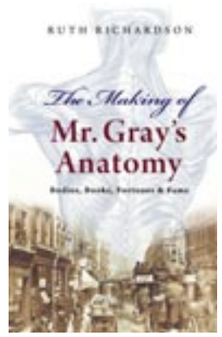
Root-and-branch overhauls

Her long period of association has meant Standring has been involved in two of the pivotal editions, involving the kind of periodic root-and-branch overhauls that have helped to keep the book at the top of its genre. Peter Williams and Roger Warwick's 1973 edition, the 35th, for which Standring created the title's first bibliography, saw more than half the text newly written, with new commissions for nearly a third of the illustrations. There were also plenty of other innovations, in both content and style, in what some have called the 'Pop Art edition', that set the pattern for the next 25 years.

The next key overhaul coincided with Standring's first stint as editor. As she explains: "The 38th edition had been out for quite some time when the book's commissioning editor came to see me and asked me what I thought of it. I'm afraid I was extremely honest. I said I thought it had lost its way – it hadn't really been revised and nobody really used it."

She also said that if it was up to her, the book would be arranged in regions rather than by system, as clinicians, particularly surgeons and radiologists, don't deal in systems. She continues: "He went off and consulted all around the world and came back and said, 'Everyone agrees with you – will you do it?' So I said yes, not realising quite what I was taking on".

Today, she says she would love to have both systematic and regional approaches, as there's a place for both of them, but "we just don't have enough space". Indeed, she admits, with the amount of information growing all the time – with more surgical detail than ever before – there has even been talk of having two volumes for the next edition.



As the story of this publishing phenomenon continues, one can't help wonder what Gray and Carter would have made of it all. Despite the early successes, it is almost impossible to believe that either of them could have had any inkling of what they had started.

None of *Gray's* text survives in the latest edition, nor any of Carter's illustrations. But with the latest edition making ever more imaginative use of up-to-the-minute imaging methods and the boldest of full-colour illustrations, the example set by that first edition in terms of its visual authority is surely part of the continuing success story.

And while Carter's contribution to the phenomenon has been somewhat overlooked, this July will see him finally begin to receive some official recognition, when a plaque is erected at his final residence in Scarborough. Ruth Richardson, for one, is delighted. "He hasn't got a plaque in London, but Gray has," she says. "Carter's never had the credit he deserves, but he's going to start having it now."

Gray's Anatomy *(Elsevier) will be published in September; Ruth Richardson's* The Making of Mr Gray's Anatomy *(Oxford University Press) will be published in October.*

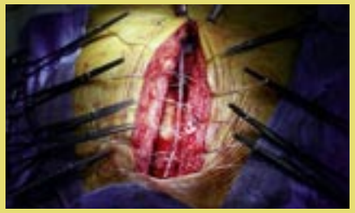
■ ***Adam Campbell is a freelance writer and regular contributor to Summons. He lives in Edinburgh.***

CASE studies

These studies are based on actual cases from MDDUS files and are published in *Summons* to highlight common pitfalls and encourage proactive risk management and best practice. Details have been changed to maintain confidentiality

TREATMENT

Tangled liability



A 52-year-old woman underwent a surgical procedure to close an atrial septal defect. Mr C, the cardiac surgeon, had consent from the patient to use minimal access key-hole surgery and a right sub-mammary cosmetic incision was planned. During cannulation to establish a cardiopulmonary bypass both the femoral artery and vein were damaged.

Mr C immediately called for the support of a vascular surgeon who attended promptly to repair the damage. In the meantime the cardiac surgery was completed using a conventional sternotomy. The patient had been informed of the potential for complications in the procedure and the possibility of having to resort to a sternotomy.

The patient was transferred to the ICU and overnight showed no complications from the cardiac procedure. But there was evidence of a lack of distal perfusion to the right leg – the foot was cold with an absence of pulse. Mr C was not made aware of the complication until the morning, at which time he was informed that the vascular surgeon was on his way in to assess the situation.

It was decided that a re-exploration was required but this was delayed due to a lack of theatre time. Mr C expressed his concern that the case be treated more urgently but the vascular surgeon did not operate until well after mid-day. Further vascular repair was necessary during the procedure together with fasciotomies of the calf to relieve a compartment syndrome.

Subsequent to the procedure the patient had a difficult post-operative recovery with infection in the fasciotomy wounds and neurologic damage from the ischaemia. Mobilisation was slow and painful with possible permanent impairment.

Analysis and outcome

A claim for damages was subsequently received from the patient's solicitors. Mr C was alleged to have breached duty of care in the injudicious use of or failure to properly carry out the cannulation procedure. He was also accused of failing to adequately monitor the patient's condition and expedite re-exploration once the leg complication had been established.

Medical experts provided opinion on the case and concluded that arterial or venous cannulation always carries a small complication rate and the damage in itself could not be considered negligent. It was also felt that Mr C acted correctly in immediately seeking the assistance of a vascular surgeon to repair the damage. In the matter of monitoring the patient's condition with regard to the ischaemic leg and the subsequent delay in emergency treatment – this was judged to be the responsibility of the vascular surgeon.

The case against Mr C was discontinued.

Key points

- Ensure that consent is informed by discussing potential complications and outcomes.
- Recognise damage to organs and vessels quickly.
- Seek prompt help in situations beyond your competence.
- Do not allow organisational and administrative factors to compromise duty of care.

TREATMENT

Accidental burn

Mrs P attended her dental practice complaining of a painful abscess in the lower right jaw and the cause was found to be a retained root from a previous molar extraction. The emergency was treated and an appointment was made to remove the root.

On the day a local anaesthetic was administered and a drill was used to remove bone. It proved a difficult operation and in the course of treatment the drill handpiece overheated causing an apparent burn to the corner of Mrs P's lip. She was unaware due to the anaesthetic and the dentist was wearing gloves.

Over the next few hours the lip swelled and grew painful as the anaesthetic wore off. Mrs P made an emergency appointment at her GP who confirmed a burn and prescribed an antibiotic to prevent infection. As the burn healed, scar tissue formed and the GP referred Mrs P to a plastic surgeon for assessment.

Analysis and outcome

A claim of negligence was received by the practice from Mrs P's solicitors. In the opinion of a retained dental expert the dentist had failed in his duty of care to Mrs P by not having protected the soft tissue from injury during the procedure.

The case was deemed indefensible and settled out of court.

Key points

- Ensure soft tissues are fully retracted.
- Ensure instruments likely to overheat are not in contact with soft tissue.

RECORDS

A needless expense

SOLICITORS acting on behalf of a patient contacted Mr L in regard to a potential claim of negligence in connection with repeated attendance at his dental surgery for a toothache. In the course of treatment an X-ray was taken and antibiotics dispensed but the patient's pain persisted and she re-attended the surgery numerous times. She claimed that as a result of this prolonged treatment she subsequently developed facial pain and persistent jaw problems.

The solicitor's letter asked for disclosure of the patient's notes and records in accordance with the Data Protection Act. The letter included a consent form signed by the patient and confirmation that a reasonable fee would be paid to the surgery for photocopying and postage costs.

Mr L ignored this request and a subsequent letter from the solicitor a month later informing him that under the Data Protection Act an acknowledgment of a request was required within 21 days with disclosure within 40 days. Two further letters were ignored at which point the solicitor instituted Court proceedings to force disclosure.

Copies of the records were eventually forwarded to the patient's solicitors and Mr L was made aware that he would be liable for legal costs (just over £400) involved in the forced disclosure. Only after repeated letters from MDDUS over a period of approximately three months did Mr L eventually send a cheque made payable to the patient's solicitors.

Analysis and outcome

The patient's solicitors made further preliminary investigations after finally receiving the records and a decision was made not to pursue the case. Despite repeated requests, Mr L has yet to present MDDUS with a detailed report on his treatment of the patient.

Key points

- Ensure that you respond promptly to communications from solicitors requesting copies of dental records.
- Be aware that you will be responsible for any legal costs in relation to forced disclosure.
- Be aware of general DPA requirements.

TREATMENT

Limits of competence

Mrs P attended a local GP with her four-year-old son, Ross, who was suffering from a painfully inflamed glans penis. The GP diagnosed balanitis and prescribed antibiotics. Although it was the first time Ross had presented with the condition the GP decided to refer the boy to a consultant to consider circumcision.

Mr Y, the consultant, had no obvious specialist experience in circumcision but decided the procedure was warranted and arranged for Ross to be admitted at an early opportunity. Mr Y performed the circumcision and Ross suffered substantial pain on recovery and had to be treated with antibiotics for post-operative infection. Later Mrs P became very dissatisfied with the result upon healing and claimed that Ross now suffered teasing from his friends.

Analysis and outcome

Mrs P contacted her solicitors and Mr Y received a letter of claim alleging negligence. It was stated that he was at fault for first accepting the referral from the GP without having the necessary expertise and for opting for circumcision without sufficient cause. Ross had suffered only one episode of balanitis and other more conservative options should have been considered.

Mr Y was also found at fault in the conduct of the procedure. A medical expert hired by Mrs P's solicitors reported that although the circumcision was generally well healed, the suturing had been performed "clumsily" resulting in an untidy appearance and an increased risk of meatal stenosis, painful erections and phimosis. The case was settled out of court.

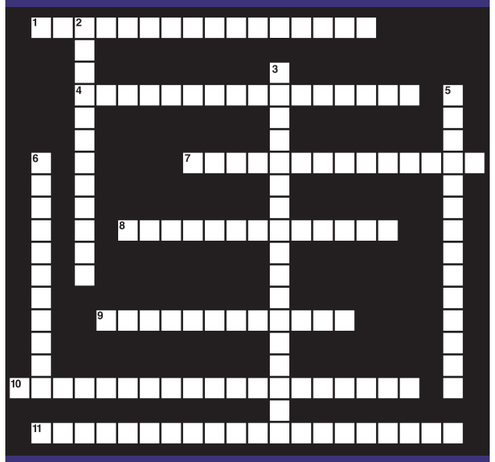
Key points

- Ensure that surgery is warranted by evidence of current accepted practice.
- "Recognise and work within the limits of your competence." (GMC *Good Medical Practice*)
- Ensure that the patient or patient's representative provides fully informed consent.
- Discuss all potential complications prior to surgery.

Medical Crossword: causes of lower GI bleeding

Across

1 More likely in over 50 year olds, sudden onset of abdominal pain with bright red rectal bleeding (9, 7)
4 Progressive disease which presents as altered bowel habit and rectal bleeding (10, 6)
7 Symptoms of severe colicky pain in left iliac fossa, nausea, flatulence, pyrexia is more prevalent in those over 50 years of age (14)
8 Inflammatory disease affecting whole gastrointestinal tract with features of diarrhoea and abdominal pain along with extra-abdominal complications, e.g. uveitis, sacroiliitis, erythema nodosum (6, 7)
9 Painless passing of bright red blood mostly whilst defecating (12)
10 Congenital abnormality associated with blood per rectum (7, 12)
11 Multiple benign polyps in large and small intestine which can produce small amounts of blood, mainly found in young people (5, 7, 8)



Down

2 Progressive disease with clinical features consisting of palpable mass in right iliac fossa and iron-deficiency anaemia (as a result of GI bleed) (6, 6)
3 Inflammatory disease affecting large intestine with frequent episodes of bloody diarrhoea, accompanied by symptoms of fever, anorexia, abdominal pain and weight loss (10, 7)
5 More prevalent in the elderly, the only presenting features are directly related to lower gastrointestinal bleed which include anaemia, and dark or bright red rectal bleeding (14)
6 Condition related to painful defecation with bright red blood on outside of stools (4, 7)

See answers online at http://www.mddus.co.uk/mddus/3087.html

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From the archives: cocaine

PRIOR to the Dentists Act 1921 just about anyone could practise dentistry freely and without the inconvenience of formal qualifications. On 21 May 1913 a Mrs Elijah Stanway of Congleton, Cheshire, underwent an operation in the front room of her house to have teeth extracted in order to replace them with a set of false ones provided by Mr Ernest Edwards, an unqualified dentist. Before the operation Edwards injected a quantity of cocaine into Mrs Stanway's gums. Relatives reported hearing her call out soon after: "Do come: my hands and feet have gone funny." She was carried out to the yard where she died a few minutes later.

A coroner's inquest was held and the doctor who carried out the post mortem testified that he believed an excess of cocaine had been administered to Mrs Stanway as "the symptoms I found at death were more than those of ordinary syncope". He also added that the action of cocaine was "very irregular" and there were other agents on the market "considerably safer". But in the end the coroner ruled there was insufficient evidence to put Mr Edwards on trail for manslaughter.

After deliberating for twenty minutes the jury returned a verdict of death due to misadventure but added a recommendation that the law should be amended to prohibit the use of anaesthetics except by fully qualified practitioners. The coroner said he would communicate this recommendation to the Home Office.

Enough such cases prompted the Government to change the law such that only dentists with recognised dental qualifications or those in continuous practice a predetermined number of years would be entitled to have their names on the Dentists Register.

Source: The Guardian Newspaper, 9 June, 1913

IMAGE: SCIENCE MUSEUM/SCIENCE AND SOCIETY

Object obscura: Portable anaesthetic kit

THIS portable anaesthetic kit dates from World War I (1914-1918) and consists of a chloroform bottle, a dropping bottle with graduated scale and Schimmelbusch mask. Chloroform was administered from the dropping bottle onto the cotton material of the mask. It would then evaporate and the patient would breathe in the gas. It was made in Germany and would have been used when treating battlefield injuries.

Vignette: eminent physician to lifeboat man

Professor Leslie J Davis

IN 1961 a new volunteer signed on with the Royal National Lifeboat Institution at Yarmouth Harbour on the Isle of Wight to help crew the local lifeboat – the *Earl and Countess of Howe*. He was a seasoned yachtsman but otherwise not a typical recruit, being the former Muirhead Chair of Medicine at Glasgow Royal Infirmary.

Professor Leslie J Davis loved the sea and records show that in the years 1961-64 the *Howe* and the reserve lifeboat, the *Elizabeth Elson*, took part in 28 missions, rescued 55 persons and 15 small craft – not exactly a quiet retirement. But it was typical of LJ who was an exceptional man in many ways.

Born at the turn of the century LJ saw active service at sea in the 1914-18 War in which he served as a wireless operator. At the end of the war, he studied medicine at Edinburgh after which he took up posts in East Africa for some years before moving to Hong Kong. His duties were mainly in laboratory medicine.

When the Second World War became imminent, he returned to Edinburgh to work with Sir Stanley Davidson. He was appointed to the Muirhead Chair of Medicine at Glasgow in 1945. At the time of his appointment, perhaps surprisingly, he was not widely experienced in clinical medicine. His students were soon to realise this. He often wore a bow tie and his quote in their yearbook was 'a test tube with a bow tie'. The bow tie was not seen again by his students. He was highly intelligent, a shrewd judge of men and picker of staff.

LJ anticipated that medical specialisation was inevitable and under his guidance the use of isotopes in medicine (Edward McGirr), haematology and coagulation disorders (Stuart Douglas), nephrology (Arthur Kennedy) and rheumatic disease (Watson Buchanan) all flourished. The Department was able to select the pick of new graduates for house posts, registrars and junior academic staff, several of whom were to retain links with the Department for years. A healthy rivalry developed with the sister academic units at the Western Infirmary.

PHOTOGRAPH (LOWER RIGHT): RNLI

Leslie Davis had rather a brusque manner – not without reason was he known in Hong Kong as Tiger Davis! He was to mellow as his department flourished. He addressed all his staff by surname – it was only in his retirement that he used my first name. His wife, Marjorie, in contrast, was charming. They had no children and I recollect at a Sunday morning visit with my wife and infant daughter, in her carrycot, he said: "Well, Kennedy, what's her vocabulary?" Marjorie protested "Leslie, I remember your mother telling me that you didn't utter a word until you were two". "Humph" was the response. Although childless himself, it was later learned that he was supportive of a nephew in England who lost his father in World War I.

Both Davis and his wife enjoyed sailing on the west coast of Scotland. Their yacht (named *Le Mar* from their own names) was built to specification at Clynder on the Gairloch. Unmarried registrars were enlisted to assist when he was involved in racing. Stuart Douglas (later appointed to the Chair in Aberdeen) was on one occasion swept overboard in rough seas in a round-Arran race. Fortunately, he was attached to a line and was hauled back on board. Stuart said later that he envisaged LJ considering his options – "pause to let me get back on board and lose the race or...?" He did win the race but on a later occasion!

LJ was a Fellow of the three Royal Colleges of Physicians in the United Kingdom, of the Royal Society of Edinburgh and a member of the Association of Physicians of Great Britain and Ireland. He served as external examiner in Edinburgh and in Hong Kong. It is surprising and disappointing, in view of his sterling contributions to medicine in Glasgow, that he did not receive a national award although three of his academic staff did become CBE.

He retired when he reached the age of 60 and moved to Yarmouth where he continued sailing. In addition to being on the crew, he was also a committee member of the Yarmouth Lifeboat from 1962 until his death.

AC Kennedy

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