Autumn 2008

# SUMMONS

MDDUS JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND

• GMC warnings • Class of '48 • Pulmonary thromboembolism •

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# IN THIS ISSUE

IN THE 1960s American South where I grew up the term "socialised medicine" might easily have been heard in the same breath as "red peril". It conjured images of patients queuing dejectedly for grim cancer wards as might Soviet babushkas for hand-outs of bread. It was the product of a rather insular view – much changed now, of course!

Having spent the last 20 years in the UK and for most of that time lived with a chronic illness – to say my impressions of the National Health Service have altered would be an understatement. The fear and anxiety of being uninsured or uninsurable are ever-present in the USA and not just among those living below the poverty line. Sometimes it's easy to forget just what a bold and daring step post-war Britain took 60 years ago this past July – even more amazing when you consider how the NHS has continued to evolve to this day yet with the same basic guiding principles.

On page 14 we celebrate this year's anniversary from the perspective of three doctors who graduated from Edinburgh University Medical School on the same day the NHS was launched. They reflect differing views on the success and future direction of "free" healthcare in Britain.

Other essential reading in this issue includes a feature article highlighting the attendant risk in diagnosing and treating pulmonary thromboembolism (p. 12) and an investigation by Ian Sadler of the law firm RadcliffesLeBrasseur of the GMC policy and practice of issuing warnings to doctors under investigation in fitness to practise procedures (p. 17).

And on page 23 Iain MacLaren celebrates the life of another treasure of the British medical establishment – surgeon and educator Sir James Learmonth.

**Jim Killgore, editor**






## REGULARS




**Cover image:** 'Polar Man' by Susie Paterson. The piece was created in mixed media, utilising collage, spray paints, acrylics and silk screening as part of a series for exhibition in Jyvaskyla, Finland and depicts an abstracted face. Susie has now returned to college to study Graphic Design. 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: Roslyn Gaunt

**Editor:** Jim Killgore

**Editorial departments**
**MEDICAL** Dr Gail Gilmartin
**DENTAL** Mr Aubrey Craig
**LEGAL** Simon Dinnick
**RISK** Ian Brennan
**VIGNETTE** J Douglas Bell

Please address correspondence to:
*Summons* Editor
MDDUS
Mackintosh House
120 Blythswood Street
Glasgow G2 4EA
jkillgore@mddus.com

**Design and production:**
CMYK Design
0131 556 2220
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Email: • General: info@mddus.com • Membership services: membership@mddus.com • Marketing: marketing@mddus.com • Website: www.mddus.com

# Union seeks non-executive director

MDDUS is seeking a GP to serve as a non-executive director on its Board. The MDDUS Board is composed of two executive directors and 17 non-executive directors comprising GPs, hospital doctors, dentists and one lay person. It is a Board of governance and is responsible for the success of the Union. It is charged with determining strategy and policy, and monitoring the operation of the company. The Board operates through a number of committees.

Vacancies will be occurring due to forthcoming retirements of existing Board members. We are interested in hearing from practising GPs, hospital doctors and general dental practitioners who might be interested in being considered for a Board appointment. The Union is a national organisation and welcomes interest from throughout the United Kingdom. The Board is also keen to ensure that its composition reflects the increasing number of women working in medicine and dentistry.

The Board meets eight times a year and in addition each Board member serves on one Board committee. The committees often meet on the same day as the Board in order to reduce the travel and time commitment. Non-executive directors receive annual remuneration and necessarily incurred locum expenses, as well as reimbursement for all travel and other costs associated with Board membership.

This is an excellent opportunity for a practitioner who is keen to gain a broadened experience of business at Board level, in an area of some considerable importance to medical and dental professionals.

Interested applicants can forward a CV and covering letter to Professor Gordon Dickson, Chief Executive of MDDUS at Mackintosh House, 120 Blythswood Street, Glasgow G2 4EA, or email gdickson@mddus.com. Informal enquiries are also welcome and Prof Dickson can be reached on 0141 221 5858.

# Change in practice?

Have your professional responsibilities or duties changed recently? It is important to keep the MDDUS informed, as failure to do so may affect your indemnity status. Please contact us if you have taken up a new post or become involved in new procedures so that we can check that your grade of membership is still appropriate. You must also advise us if your contact details have changed or if you are unable to work for an extended period of time. The Membership Services Department: 0845 270 2038.

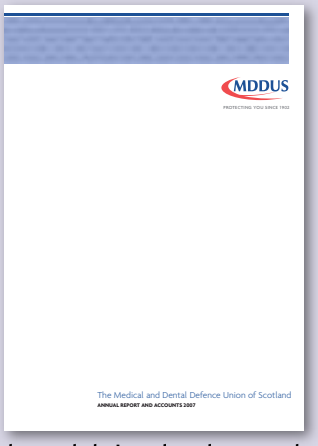
# Online info on revalidation

A new section on the GMC website has been launched to provide information and updates on developing proposals for

licensing and revalidation.

Plans are well underway for the regulatory reform with licences to practise due for introduction in the autumn of 2009. All doctors will be required by law to hold a licence in order to work as a registered medical practitioner. Revalidation will be introduced later requiring doctors to renew licences to practise every five years. Access the *Licensing and revalidation* webpage at www.gmc-uk.org

# 'Non-claims' cases on the increase




**THE YEAR 2007 saw a slight increase at MDDUS in the number and costs of 'non-claims' cases such as GMC or GDC matters, general complaints and inquests.**

**This is one of a number of trends highlighted in the Union's *Annual Report and Accounts 2007* which was published in September. MDDUS has seen its non-claims work growing now over a number of years. Casework involving negligence claims against both GPs and private doctors also showed a slight upturn but overall the long-term trend is still one of a gradual reduction in claim frequency with an increase in awards and legal costs.**

**Another noticeable trend in 2007 was a steady increase in the rate of use of our telephone advice line by members – possibly a reflection of increasing demands being placed on members and a growing awareness of risk.**

**"Whatever the reason," said Professor Gordon Dickson, CEO, "we are pleased that the telephone advice service is popular and do of course prefer members to seek advice when there is any uncertainty."**

**Active membership in MDDUS grew by over 4.25 per cent in 2007 with a 13 per cent increase in GP membership outside of Scotland. Overall 45 per cent of MDDUS total membership now work outside of Scotland. With this growth in membership – and despite the increasing costs in representing and indemnifying members in both claims and non-claims cases – the Union is in its strongest financial position for some time with total assets available to meet liabilities at just over £236 million.**

**Read the full report at www.mddus.com**

# IN BRIEF

**PORTER TAKES HELM AT EASTMAN** Congratulations to Professor Stephen Porter who was recently appointed Director of the UCL Eastman Dental Institute. Professor Porter is an eminent researcher, clinician and educator in the oral healthcare sciences and has been an occasional contributor to *Summons*. We wish him every success in this prestigious post.

**FALLON HONOURED WITH MBE** Congratulations also to GDP Kieran Fallon who was awarded an MBE "for services to the NHS and the community in Glasgow". He has practised in the Royston district of Glasgow – an inner-city area of high social need – for the last 25 years and is a member of the BDA's Scottish Dental Practice Committee as well as chairing the Greater Glasgow and Clyde Local Dental Committee. Asked if he thought the honour would change him he replied: "Well my practice team began teasing me by curtseying and bowing – but I've grown to enjoy it so I think I'll write it into their contracts!" Source: *Dentistry Scotland*.

**FERGUS HEWAT CUP** That the traditional friendly rivalry between

# Risk Alert: Secure patient data

Failure to adequately secure electronic medical records could present significant legal and professional risks for doctors.

This has been highlighted by two recent press stories. In June a personal laptop containing thousands of confidential patient records was stolen from the home of a Midlands GP. A Wolverhampton practice has written to all 11,000 of its patients to alert them and apologise. Last month the Health Service Journal reported on a survey in which two doctors interviewed 105 colleagues and found that 79 held memory sticks with confidential patient information but only five were password protected.

GMC ethical guidance warns that patient records must be effectively protected against disclosure at all times. In other words, GPs must take all reasonable steps to ensure patient records remain confidential, or face a potential GMC summons.

Additionally, the Data Protection Act 1998 (DPA) requires "appropriate technical and organisational measures" to prevent "unauthorised or unlawful processing of personal data". Under Section 55 of the DPA it is a criminal offence to intentionally or recklessly disclose personal data without appropriate consent, for instance of a GP practice.

The law could view taking patient information home on an unencrypted laptop, memory stick or other device, or leaving it in a car or office – all with the risk of theft – as 'reckless'. Breaching patient confidentiality could also lead to a patient claim for compensation. Protecting information by passwords may no longer be enough. If necessary, take professional advice on encryption. GPs are increasingly using laptops and PDAs (personal digital assistants) to record information during home visits. This is fine to achieve the GMC stipulation of keeping clear, accurate and legible records, but do store data securely. ACTION: Ensure adequate data security especially for electronic patient records held on laptops, PDAs and other mobile devices. If necessary take professional advice on data encryption.

**Dr George Fernie, medico-legal adviser, MDDUS**

# MDDUS GP registrar education grants

The MDDUS recognises that there is a wide range of educational opportunities available to support GP registrars and the practices that they work within. We also appreciate that there are financial constraints which determine the volume and range of educational opportunities that a registrar can expect to take advantage of as they develop within their new role.

To assist, the MDDUS is once again offering two education grants of £1,000 which will be awarded to successful applicants from GP practices where both the registrar (commencing training in August 2008) and the trainer are members of the MDDUS. The grant can be used for any form of educational training including attendance at courses, conferences and seminars, practice training and the purchase of equipment and textbooks.

Registrars interested in applying are required to submit a proposal that should include full details of how the grant would be used, the learning outcomes expected and a demonstration of how the practice will benefit. In addition, applicants must also include a statement outlining why this proposal is worth funding and how it relates to personal and professional development (no more than 500 words).

For further details on how to apply please visit our website at www.mddus.com or contact Caroline Gunn on 0845 270 2034 or email cgunn@mddus.com. The closing date is 31st January 2009.

Glasgow and Edinburgh can extend well into medical retirement was amply demonstrated in the annual golf match between Senior Fellows of the Royal Colleges at Glasgow Golf Club, 8th June. Following appropriate social preparation the match was played out in pleasant conditions resulting in a narrow victory for Glasgow thus regaining the Fergus Hewat Cup. Glasgow's victory was, in the post match conviviality, variously attributed to, depending on loyalties, superior skill and stamina, home advantage or a measure of luck. The universal agreement however was of an enjoyable day of golf and fellowship. **W B Mathewson**

**E-LEAFLETS AID IN RECOVERY FROM SURGERY** A series of online 'leaflets' have been developed to aid patients recovering from common surgical procedures such as coronary artery bypass graft, gall bladder removal or total knee replacement. The e-leaflets are being piloted by the Royal College of Surgeons of England and specialist surgical associations, and can be accessed on the RCSE website (www.rcseng.ac.uk).

# GDC expands tooth whitening duties

THE GDC has confirmed that dental hygienists and dental therapists can carry out tooth whitening on the prescription of a dentist if they have the necessary additional skills. This clarification from the GDC follows a public consultation on the scope of practice of the dental team earlier this year. The consultation sought views on which groups of professionals should be able to do what, including tooth whitening.

"This explanation should provide clarity to registrants who advised us that they wanted clearer guidance on which members of the dental team could carry out tooth whitening," said GDC President Hew Mathewson.

But he added that it does not alter the GDC's position that tooth whitening carried out by non-dental professionals is illegal. The GDC also decided that taking impressions and making bleaching trays to a dentist's prescription are within the scope of additional skills for dental nurses.

The GDC will soon publish new guidance on the scope of practice.

# Expert witness guidance

NEW guidance for doctors who act as expert witnesses has been launched by the GMC. The guidance comes at a time of increased reluctance among doctors to take the stand, especially in paediatrics and child health cases with the recent high-profile fitness-to-practise panels of Southall and Meadow. The GMC believes that it is important that any doctor who takes on the role of a medical expert can do so with confidence, knowing what is expected of them.

"When doctors act as expert witnesses, they take on a different role from that of a doctor providing treatment or advice to patients but remain bound by the principles of good practice laid down in the GMC's core guidance, *Good Medical Practice*," reads the GMC statement.

*Acting as an expert witness* expands on these principles and clarifies how they apply in the context of giving expert evidence in court or tribunal cases.

The guidance emphasises that medical expert witnesses must:

- recognise their overriding duty to the court and to the administration of justice
- give opinion and evidence within the limits of professional competence
- keep up to date in their specialist area of practice
- explain where there are a range of views on a particular question
- take appropriate action where they change their opinion.

Professor Sir Graeme Catto, GMC President said: "We hope that this new guidance will give confidence to those who take on this role, as well as providing clarification for doctors about the GMC's expectations of them when they are acting as an expert witness".

Access the new guidance at www.gmc-uk.org

# Drink and drugs "no excuse" for violence

**TOUGH revised guidelines governing the prosecution of violent offenders who target NHS staff make it clear that drink and drug abuse will not be seen as an excuse for such behaviour. The guidelines have been jointly issued by the Crown Prosecution Service (CPS) and the NHS Security Management Service (NHS SMS) and also extend to cover people who volunteer their time to the NHS.**

**The new agreement pushes a strong message that drink and drug abuse will no longer be considered a defence for violent behaviour and such factors may even make a stronger case against an individual. A new inclusion also prompts prosecutors to consider the potential harm to others if the assault leads to the withdrawal of medical services to people in need of attention, such as damage to an ambulance which puts it out of service.**

**Director of Public Prosecutions, Sir Ken Macdonald, QC said: "People who work hard to deliver patient care and services deserve the protection of the criminal law. NHS staff play a vital role in our society and without their skill, knowledge and dedication, lives would be lost. Where there is an assault against a member of NHS staff the perpetrator can expect to be prosecuted".**

## IN BRIEF

**NEW GUIDANCE ON STROKE** All patients suspected of having a stroke should be admitted as quickly as possible to an acute stroke unit, either from the community or transferred from A&E. This is the main recommendation from two new clinical guidelines launched this week, one from the Royal College of Physicians (RCP) and one from NICE. The guidance states that approximately 4,500 people could be prevented from being disabled through stroke if admitted to a stroke unit and thrombolysed. Access at www.NICE.org.uk and www.rcplondon.ac.uk

**RECORDS MANAGEMENT BEST PRACTICE** A new best practice guide to NHS records management has been issued by the Scottish Government eHealth Directorate. *Records Management: NHS Code of Practice* is based on current legal requirements and professional best practice. Among other useful information the document explains the requirement to select records for permanent preservation and sets out recommended minimum periods for retention. The code

# Keep vigilant for signs of abuse

DENTISTS and dental care professionals have a responsibility to raise concerns about potential abuse or neglect of children and vulnerable adults, says the GDC.

In a new statement on child protection the Council points out that dentists and DCPs are well positioned to observe and identify facial and other injuries such as bruising, burns, bite

marks and eye injuries that might suggest that a concern should be raised. All registrants should know who to contact for advice, e.g. a local health trust or board.

"It is the responsibility of all members of the dental team to know what to do if they are concerned about the possible abuse or neglect of children and vulnerable adults," says GDC President Hew Mathewson. "If you make a professional judgement and decide not to share your concern with the appropriate authority, you must be able to justify how you came to this decision."

Visit www.cpdt.org.uk (Child Protection and the Dental Team) which is a web-based resource developed specifically for the dental team.

## OPINION

**by Dr Gail Gilmartin**
**Medical Adviser, MDDUS**

## Reporting knife wounds

The GMC and Department of Health have issued interim guidance on the reporting of knife wounds. The guidance will go out for consultation but is likely to remain close to its current form. Not long ago we saw specific guidance about reporting gunshot wounds, now knife wounds are attracting particular attention, no doubt due to recent media coverage of knife crime among teenagers.

Until *Good Medical Practice* was published in 1995, advice on professional confidence was contained in *Professional Conduct and Discipline: Fitness to Practice* published in December 1993. This stated quite clearly that a doctor had a duty not to disclose to any third party information about a patient learned in a professional capacity directly from a patient or indirectly, though certain exceptions were noted.

Of relevance is the earlier guidance on disclosure without a patient's consent: "Doctors who are faced with the difficult decision whether to disclose information without a patient's consent must weigh carefully the arguments for and against disclosure".

Where public interest is a concern the old guidance stated "Rarely, cases may arise in which disclosure in the public interest may be justified, for example, a situation in which the failure to disclose appropriate information would expose the patient, or someone else, to a risk of death or serious harm."

Similar themes run through the latest interim guidance. However, of note is the statement: "Quick reporting at this stage may prevent further incidents or harm to others". Indeed the initial part of the interim guidance states "...the police should be told whenever a person arrives at hospital with a wound inflicted in a violent attack with a knife, blade or other sharp instrument". Accidental and self-inflicted injuries are excluded.

This emphasis is on promptly reporting such incidents to the police, though at this stage without providing identifying details. It would appear that the "difficult decision-making" of old is no longer a key factor. Therapeutic care must be paramount and this remains clear. However, it is difficult to see how the opening statement of the interim guidance sits with the later emphasis again on individual rather than public interest. That is that the patient should be asked whether they are willing to speak to the police and that "...you, the rest of the healthcare team and the police must abide by the patient's decision".

The guidance would appear to state – tell the police of the arrival of a patient with a knife wound without delay, this will result in a police attendance ("when the police arrive...") but then no further information, including name and address, should be disclosed without consent. The term "must" is used in relation to respecting the patient's decision which in the GMC's terms means there is an overriding duty or principle. It is difficult to know how such a limited disclosure can assist the police – but this would be a springboard to add pressure to busy medical staff to disclose more.

The guidance is 'interim' but doctors dealing with this type of patient must be aware of its terms. In cases of difficulty doctors are advised to liaise with the consultant in charge or the Trust's Caldicott guardian. In addition, it is relevant that as a defence organisation we too can offer advice in these situations.

Doctors are not the police but are expected to act responsibly as members of society. Appropriate guidance can balance the sometimes conflicting choices doctors have to make, with helpful explanation of the issues to consider. This writer believes that the interim guidance lacks such finesse and I would hope to see a little more of the GMC's reasoning, bearing in mind the day-to-day practicalities faced by doctors, patients and the police.

applies to all types of NHS records, including those held by GPs, in all media. Access at www.scotland.gov.uk

**SUSPECTED FAMILIAL HYPERCHOLESTEROLAEMIA**

Patients at risk of familial hypercholesterolaemia (FH) should be referred for diagnostic testing to determine if early treatment is necessary. This is a core recommendation in new NICE guidance aimed at reducing premature deaths in people who have inherited high cholesterol. FH is caused by an inherited genetic mutation and affects an estimated 1 in 500 people, making it as common as type 1 diabetes. The severely raised cholesterol levels characteristic of FH (if undetected) often result in serious coronary heart disease (CHD). The guidance advises that a family history of premature CHD should always be assessed in a person being considered for a diagnosis of FH. Access at www.nice.org.uk

**More news and MDDUS events at www.mddus.com**

# It's who you know

**WE HAVE ALL HEARD BANTER** at work and may or may not have been offended by it. The degree of offence felt often depends on the context of the comments and the history both of the person making them and of our relationship with them.

The law protects us from discriminatory comments and actions from colleagues and even (if they relate to sex) from customers and other third parties. We normally expect unlawful harassing behaviour to relate to some characteristic of our origins, gender, disability status, beliefs or age. But recent legal developments suggest that the sources of that protection will, in future, be increasingly extended beyond ourselves to our relations and the people we know and socialise with.

Sharon Carr worked for Walker Taxis in Newcastle as a clerk and had an Indian partner. Her employer, Mr Jubb, frequently made comments about her relationship in racist terms which grew even more pernicious when Ms Carr became pregnant. She was eventually dismissed and became angry and distressed – resulting in her needing medical help for depression.

Not surprisingly, she took action against the company for unfair dismissal and racial harassment. Her discrimination action depended not on showing that the harassment was directed at her because of her own race, but because she was associated with someone else of a particular racial origin. Ms Carr was successful in her claims and was awarded £6,000 for injury to her feelings and £5,176 for the unfair dismissal. Her award was then increased by 20% because of the failure of the company to follow the statutory dismissal procedure. This is a perfect example of how 'discrimination by association' can be pursued in the courts.

'She was also accused of using her child to manipulate her working conditions'

Another case currently going through the courts illustrates the same point.

Sharon Coleman, a former legal secretary, is suing London-based Attridge Law for allegedly harassing her out of a job after she requested time off work to care for her severely disabled son.

Ms Coleman, 42, claims her former managers branded her "lazy" when she requested time off work to care for her disabled son, who has a rare respiratory disorder. She was also accused, she said, of using her child to manipulate her working conditions.

Her case, which was referred by the Employment Tribunal to the European Court of Justice (ECJ), rested on her being able to persuade the court that the UK's Disability Discrimination Act (DDA) should provide for discrimination by association and that this means that she, a non-disabled person, is able to bring proceedings against her employer for behaviour related to her son, not herself. Currently, the DDA only provides protection to those who pass a medically-based test to show that they are themselves disabled. Coleman's argument was that the EU Employment Equality Directive, which must be fully implemented into UK law, provides for 'association discrimination' and that this means that the DDA should reflect this form of discrimination.

The ECJ has upheld Coleman's argument and referred the case back to the Tribunal in the UK. According to the ECJ's decision, the Directive is intended to prohibit direct discrimination or harassment on grounds of disability, even where the person concerned is not disabled themselves. The Directive applies not only to disability but also to age, sexual orientation, religion and belief.

The implications of this case could now be far-reaching. Carers of disabled adults could now claim disability discrimination if their flexible working requests are dismissed in disparaging terms by their employer. If the 'association' discrimination principle also applies to age then consider this – suppose that Sharon Carr's partner had been considerably older than her and that Mr Jubb's remarks were equally insulting and offensive but related to the partner's age, not his race...

Law At Work will be happy to let you know the final outcome of the Coleman case in the Tribunal if you read our free monthly email employment law update newsletter, LAWmail. Just log on to our website (www.lawatwork.co.uk) and click on the link to subscribe.

**Ian Watson, Training Services Manager, Law At Work**

# A Pyrrhic victory

A dentist offers his account of defending unfair dismissal and sexual discrimination claims laid by an associate before an Employment Tribunal *

I HAVE been in dental practice for over 35 years and since 1975 have had responsibility for three practices, which I had started from 'scratch'. In 1995, we left the NHS (apart from the care of children and young adults whom we continued to accept under the NHS), offering private treatment under our own Care Plans to make dentistry affordable and predictable in respect of costs. This has been very successful.

In 2003, one of two dentists working at my East Gate Practice gave notice and we parted amicably. I advertised and found a replacement – Mrs W. She began work at East Gate which was also staffed by a half-time dentist, a part-time hygienist and full-time ancillary staff.

Mrs W had a small child and was only prepared to work a four-day week. She assured me she could look after all her patients and wanted to receive the full Care Plan amounts. I agreed to this as long as she could look after our patients properly.

All proceeded happily and in early 2005 she told me that she was pregnant. I congratulated her and said that I was pleased that she wanted to return after the birth of her baby. I told her that I would arrange for locum cover in her absence and, as practice owner, would supervise the arrangement.

Whilst she was on leave, every month, I sent Mrs W 100% of her NHS maternity payments, her normal payment in respect of NHS fees and, although not required by our contract, all Care Plan fees less the amount paid to the locum dentists covering for her. In fact, in the year spent on maternity leave, Mrs W received from me 90% of what I paid her in the previous year when she had worked for the full twelve months, less holiday and postgraduate course leave.

Over the period of her maternity leave, I began to receive phone calls and letters from Mrs W making various complaints about her earnings. Apparently, as made clear in her subsequent witness statement, she had expected to be financially better off when on maternity leave.

Immediately on her return to work, she requested a month off over the Christmas/New Year period which is a very busy time for us. In a meeting, she told me she could not arrange cover for her children so I agreed to the time off but advised her that, whilst I appreciated her situation, she had to be aware of her professional responsibilities to the patients and myself in future.

I continued to receive insulting letters from her accusing me of dishonesty and that I had begrudged her the maternity leave. In addition, I was receiving complaints from my staff of her unreasonable treatment of them and also some unprofessional behaviour to some of our patients.

I had never before experienced such problems with a dentist and I was tiring of the unrest and was personally feeling stressed and unhappy about the whole situation. Accordingly, after much thought and perusal of the contract, I wrote to her giving three months' notice that I was terminating our agreement.

## The claim

Mrs W worked her notice period and, some weeks after she had left my practice, I received notice that she was bringing complaints of unfair dismissal and sexual discrimination against me. The next few months were to be the most distressing in all my 35 years of dental practice. I retained the services of a lawyer who specialised in employment law. I then ➤

➤ had to spend many hours in correspondence (thank heaven for emails), informing him of the specifics of dental practice of which he had little knowledge.

In her submissions to the Employment Tribunal, in order to claim unfair dismissal, Mrs W asserted that she was an employee. Our response was that she had signed a contract agreeing to be self-employed and agreeing to pay her own tax and National Insurance contributions, although my lawyer did not think this was an adequate defence in itself. I obtained reports from my accountants and also from a firm of tax specialists who both confirmed that the circumstances in which she worked with me were consistent with a self-employed person. I also showed that as she had a list number from the NHS health board as an 'Associate', she was, ipso facto, self-employed since as an employee she would have been termed an 'Assistant' and not able to sign off her own GP17s.

In addition, I insisted that Mrs W show us copies of her HMRC Self Assessment Returns which we ultimately received. These showed that she had claimed to be self-employed and therefore derived substantial benefits to which she would not have been entitled to as an employee of the practice. Our suggestion that HMRC did not treat tax evasion lightly – nor did the GDC – resulted in, shortly after, her lawyers withdrawing this complaint of unfair dismissal. But there still was the claim of sex discrimination which, after much protracted correspondence, the other side admitted was restricted to three items: raised threshold, notice to terminate and termination.

She claimed that in raising the threshold above which her earnings increased from 40% to 50%, I had discriminated against her. The facts were that the agreement I had with all my Associates was that annually, notice being given, the threshold would be increased to reflect increased practice costs.

I produced records to show that the increase had been applied equitably to all my dentists and that her claim was totally unfounded.

## The Tribunal

When the Tribunal hearing commenced, I was concerned to be told by the Chairman that the papers had only then been given to him and could he and the other two members have a short recess to find out what the case was about. However, he proved to be a "no-nonsense", very fair-minded and totally impartial individual – a Yorkshireman, with an extensive legal career with much experience of hearing cases regarding compensation for accidents in the mining industry. The other two members, one with business experience and the other with trade union experience, listened carefully, took notes and only rarely asked questions but always in polite, courteous terms.

The hearing lasted for four days and I was cross-examined for one and a half days by the complainant's lawyer. This I found to be exhausting, especially since lawyers seem to rely on repeating the same question in the hope of hearing some inconsistency from you in your responses. My lawyer's repeated advice to answer the question put and nothing further was sound advice but sometimes difficult, especially if you feel that your integrity is being questioned.

'I was very relieved to have been vindicated but I had paid many thousands of pounds in legal fees'

In one session my practice manager was called to testify. She has worked with me since 1972, and gave concise and polite answers to questions from the claimant's lawyer, referring to her office diary which had been entered in evidence. She had to endure suggestions that she had altered her notes and was not telling the truth. But it was clear that her answers were all patently honest and when the lawyer was clearly out of her depth, the Chairman rebuked her and told her to "move on". I was very moved by the ordeal that she had to endure, without complaint, on my behalf.

The Chairman said that, in view of the complexities of this case, he would need some time to consider all the evidence before the Tribunal could give its findings. One month later my lawyer phoned to say that he had just received the result: a 42-page judgement and all the claims made against me had been thrown out. I was very relieved to have been vindicated but as I had paid many thousands of pounds in legal fees, it was a somewhat Pyrrhic victory. In Tribunal cases it is only in very rare cases that the successful side can claim costs; not to mention the months of stress and uncertainty.

## Key lessons

- ACAS can be very helpful in attempting a reconciliation of disputes but only if the other side agrees to the process (not so in my case).
- All contracts are fine until there is a dispute.
- Treating people fairly in most cases receives reciprocal treatment, but not always.
- Be very careful what you write and how you express yourself in drafting letters; keep copies of all correspondence and notes of telephone conversations.
- Retain a lawyer experienced in such matters.

**** Names and circumstances in this article have been changed to maintain anonymity***

# Real life, real questions

**SOME YEARS AGO** I had a heated argument with a member of the philosophy department in my university about whether ethics was or was not 'for' something. For him Ethics (with an upper case 'E') was an interesting field for academic study. For me ethics (with a lower case 'e') must be translatable into moral action: i.e. it has to work in real life!

Ethics, or moral philosophy, attempts to address such age-old questions as 'How do we know what is good?' 'How should I live?' 'How can we know which decision is right?' and 'What is justice?' in order to establish a basis for moral judgements. I find it helpful to compare the relationship between ethics and morals to that between DNA and cell proteins. Within the DNA (c.f. ethics) lies the fundamental information for the cell to function. The proteins (c.f. morals) produced by the cell interpret and follow that information by doing two things — they express both the nature and character of the cell and also perform its specific function.

In the same way that cells must work together within and among bodily structures and organs, ethics and morals are about individuals living and working in community – it is not just about 'me' and 'mine'. Thus each one of us is required to think ethically and act morally (i.e. we are all 'moral agents') in every aspect of our lives. This is not an optional extra!

Clinical practice, ethical analysis and moral action cannot be practised in isolation from one another. Ethics is a necessary part of good clinical medicine and dentistry. Indeed, you have been making ethical decisions every day since you qualified often without recognising it! How then do we go about making sound ethical judgements in the clinical context? Whatever method is used it must recognise the often complex realities of the clinical setting, identify the ethical conflicts, be consistent and free of contradiction within and among cases, and produce answers that are both comprehensive and clinically relevant.

There is no 'magic' formula (beware those who suggest that there is) and each case is different from any other. Indeed, there is seldom an absolutely 'right' or 'wrong' decision. One is often trying to balance the greater good or the lesser evil. This does not mean that ethical decision-making is necessarily arbitrary (though it may be if the basis for decision making is flawed). Although some decisions must be reached quickly, the decision-making process should be no less rigorous. This involves defining and analysing the problems and their context, considering the underlying principles involved, then moving to recommending actions that best meet the whole clinical picture.

Some of the ethical issues we face can be dealt with relatively straightforwardly. Others are highly complex and may be intractable. Ready-made answers cannot be found in textbooks, because the situations in which problems arise and the stories of people involved are all different. The desired goals may also differ. For example, the prevention of disease and health promotion raise different issues and require alternative solutions to the relief of symptoms, pain and suffering or the cure of a disease. The establishment of clinical ethics committees by some NHS trusts has helped to deal with particularly difficult problems (e.g. end-of-life decisions) and develop guidelines for good practice in dealing with them.

'Ethics and morals are about individuals living and working in community'

In my opinion undoubtedly the best context in which to resolve ethical issues is in a clinical consultation involving an experienced clinician well versed in ethical principles. From my experience of clinical practice and teaching students and doctors over four decades we cannot rely solely on 'common sense' to achieve the objectives outlined above. That is why it is vital that learning about ethics should be at the heart of medical and dental education and life-long learning for doctors, dentists and, indeed, all healthcare professionals.

**Professor Gordon M Stirrat, Emeritus Professor of Obstetrics and Gynaecology and Senior Research Fellow in Ethics in Medicine, University of Bristol**

# Pulmonary thromboembolism

Thomas Martin *and* Adrian Brady *highlight an often missed but potentially catastrophic condition for both patient and clinician*

THERE are certain conditions that prompt urgent investigation as soon as they enter the differential diagnosis. Pulmonary thromboembolism (PTE) is amongst the most important, with an in-hospital mortality rate of 6-15% and a high proportion of early deaths. Yet PTE is often missed, and frequently poorly managed. If PTE is suspected in primary care then the patient should be rapidly sent to the nearest secondary care service for diagnosis and appropriate treatment.

The annual incidence of PTE is 60-70 cases/100 000 and increases with age. In half of these cases it is the primary complaint, the remainder occurring whilst the patient is in residential care for another reason. Overall, three-quarters of patients will have a recognised predisposing factor (see panel opposite).

IMAGE: DU CANE MEDICAL IMAGING/SCIENCE PHOTO LIBRARY

This article will focus on suspected PTE and only deal with deep venous thrombosis (DVT) where relevant, though they are part of the spectrum of venous thromboembolism (VTE). The European Society of Cardiology (ESC) is publishing its new PTE guidelines in September 2008. The Scottish Intercollegiate Guidelines Network (SIGN; www.sign.ac.uk) are to publish their updated guideline in 2009/10.

## Investigation

There are many ways in which a PTE may present, ranging from dyspnoea and/or pleuritic chest pain to haemodynamic collapse. History and examination are unreliable, particularly in excluding the diagnosis of PTE, and it is always wise to assess these patients in person rather than over the phone.

Defining individual risk is fundamental. A patient is high risk if they have clinical features of PTE, a major risk factor and absence of a reasonable alternative explanation. Tables to define individual risk, such as the Revised Geneva and Wells scores, are well established but should be used more often.

Suspected high-risk and non-high-risk PTE are two distinct situations with different diagnostic strategies. Indeed, the likelihood of death from non-massive PTE is small. But the chances of dying from massive PTE are substantial, and failure to diagnose or treat appropriately leaves the medical practitioner open to accusations of poor clinical care.

A negative plasma D-dimer result (<500 μg/l) coupled with low or intermediate clinical probability does not require further investigation, with a 3-month thromboembolic risk in patients left untreated below 1%. The crucial investigations in modern management are markers of myocardial injury, either troponin I or T, or brain natriuretic peptide (BNP). These markers of injury as well as concomitant assessment of markers of RV dysfunction, by echo, help to better sub-stratify patients with acute PE.

A chest X-ray is often taken, but is normal in PTE, unless there is other pathology present. In most centres, CT pulmonary angiography (CTPA) is the best test in patients with an elevated D-dimer level and the first-line test in patients with a high clinical probability.

Isotope scanning (the V/Q scan) is used for detection of segmental lung ventilation-perfusion mismatches and has been in use for many years. However, it only reliably diagnoses or excludes PTE in a minority of patients due to the high frequency of non-diagnostic or 'intermediate probability' scans. Crucially, V/Q scans are unavailable out of office

hours, when most patients present, and cannot be performed in the critically ill. If the suspicion of massive PTE is high, an urgent CTPA should be performed.

Compression ultrasonography (CUS) to identify thrombus in lower limb veins is a difficult technique and should be reserved for patients in whom a CT is contraindicated (irradiation, renal failure, allergy to iodine contrast dye).

## Acute treatment

All patients will require respiratory support in the form of supplemental oxygen with ventilation as a back-up. Immediate definitive treatment is determined by cardiovascular stability.

**Haemodynamically unstable.** This is an emergency situation and the clinical probability of PTE is usually high. Shocked patients need haemodynamic support with fluids or inotropes and specific treatment strategies which include thrombolysis, surgical embolectomy or catheter disruption. Simply administering subcutaneous heparin and hoping for the best is poor medicine and this practice must be abandoned.

Thrombolytic therapy rapidly resolves thromboembolic obstruction and exerts beneficial effects on haemodynamic parameters so should be administered to patients with high-risk PE, unless there are absolute contraindications to its use, such as active internal bleeding and recent spontaneous intracranial bleeding. Currently the best agent is recombinant tissue plasminogen activator (rtPA) but urokinase or streptokinase can be used if rtPA is unavailable. Like thrombolysis for acute MI, the risk of haemorrhagic stroke is low in younger patients but much higher among the elderly.

In patients with absolute contraindications to thrombolysis, or those in whom thrombolysis has failed to improve haemodynamic status, surgical embolectomy or percutaneous catheter embolectomy or thrombus fragmentation may be considered and can produce spectacular success.

Full dose, weight-adjusted intravenous heparin should be administered immediately upon diagnosis, while the decision for specific therapy is considered. Subcutaneous low molecular weight heparin (LMWH) is poorly absorbed from underperfused skin in shocked patients and should not be used.

**Haemodynamically stable.** This is the category with the greatest body of evidence and patients who are non-high risk usually have a favourable prognosis. Patients at intermediate risk (normotensive but with evidence of RV strain or damage) may have a risk-to-benefit ratio that favours thrombolysis, particularly without an elevated bleeding risk.

All patients should be anticoagulated with weight-adjusted LMWH using either enoxaparin 1mg/kg b.d. or tinzaparin 175 IU/kg o.d. while awaiting results of diagnostic work-up. LMWH should be given with care in patients with renal failure and their dose adjusted according to anti-Xa level.

Warfarin should be initiated as soon as possible and preferably on the same day as the initial anticoagulant. Parenteral anticoagulants should be stopped when the international normalised ratio (INR) lies between 2.0 and 3.0 for at least 2 consecutive days.

Finally the patient should be measured for compression stockings, which have been shown to reduce the cumulative incidence of post-thrombotic syndrome in patients with proximal deep vein thrombosis at 2 years after the index event.

## Long-term treatment

The aim of long-term anticoagulant treatment of patients with PTE is to prevent fatal and non-fatal recurrent VTE events. Warfarin is used in the vast majority of the patients, while LMWH may be an effective and safe alternative in cancer patients. For patients with PTE secondary to a transient (reversible) risk factor such as surgery, trauma, medical illness, oestrogen therapy or pregnancy, treatment with warfarin is recommended for 3 months.

For patients with unprovoked PTE, treatment with warfarin is recommended for at least 3 months. If at low bleeding risk and stable anticoagulation can be achieved then long-term oral anticoagulation may be considered. Patients diagnosed with a second episode of unprovoked PTE should have long-term treatment. Patients who receive long-term anticoagulant treatment should be reassessed at regular intervals regarding the risk-benefit ratio.

Permanent inferior vena cava filters may be used when there are absolute contraindications to anticoagulation and a high risk of VTE recurrence but have inherent risk so their routine use is not recommended.

## Medico-legal aspects

Individual cases make harrowing reading, particularly as the outcome that prompts compensation claims is often death. Pitfalls in diagnosis and treatment include:

- Having too low an index of suspicion for thromboembolic causes of chest pain/dyspnoea.
- Over-reliance on normal clinical findings on clinical examination – up to 50% of patients with convincing symptoms but no signs may have a DVT.
- Omitted thromboprophylaxis: extensive guidelines exist as to who should receive this and most hospitals will have an agreed protocol as part of an integrated care pathway in place to ensure best practice.

Making the diagnosis of PTE in most cases is relatively straightforward as long as it has been considered, and is greatly enhanced by knowledge of the major risk factors and clinical probability. Thrombolytic and/or anticoagulant treatment is commenced in secondary care; the risk–benefit ratio should always be considered, aided in the acute situation by the dichotomy based on haemodynamic stability. Ultimately, the diagnosis and treatment of PTE relies on a close relationship between both primary and secondary care.

■ ***Dr Thomas N Martin is a Specialist Registrar in the Department of Medical Cardiology, Glasgow Royal Infirmary***

■ ***Dr Adrian J Brady is Consultant Cardiologist in the Department of Medical Cardiology, Glasgow Royal Infirmary and is one of the authors of the new ESC Guideline on Pulmonary Embolism, published September 2008***

## RISK FACTORS

| MAJOR (RELATIVE RISK 5-12) | MINOR (RELATIVE RISK 2-4) |
|---|---|
| • Surgery | • Cardiovascular |
| • Obstetrics | • Oestrogens |
| • Lower limb problems | • Chronic illness |
| • Malignancy | • Travel |
| • Reduced mobility | |
| • Past history proven VTE | |

# Class of '48

Adam Campbell *talks to three doctors who grew up with the NHS from day one*

BACK in June, at a reunion held in Edinburgh, 46 retired doctors gathered to celebrate the 60th anniversary of their graduation from university. "We feel there's a rather special camaraderie that exists amongst us," says Dr Douglas Bell, who organised the get-together, the eighth since 1969. "It is probably because of the collective privations we experienced, with food and clothes rationing and the total disappearance of everyday things such as bananas!"

Their course was of five years' duration and some simple mental arithmetic will soon reveal that they embarked on their studies during wartime, completing their degree three years after the war's end. In many ways they were the lucky ones. Not only did they get a fine qualification, but as Dr Bell points out, those who failed "got a khaki suit for a present". And if you didn't go into the services you were likely to become a 'Bevin Boy', named after the wartime minister of labour, Ernest Bevin, whose scheme saw 48,000 18–25-year-olds conscripted into the mines between 1943 and 1948.

But there is another 'special camaraderie' that binds these medics. For on the very day they qualified, 5 July 1948, eager to embark on their chosen career, the medical landscape in Britain was transformed – the National Health Service was launched.

To be fair, the idea of government-run health services was nothing new in Scotland. The Highlands and Islands Medical Service, set up in 1913, was directly funded by the state and administered by the Scottish Office in Edinburgh. But in 1939, only around half of all Scots had a GP, and while hospital treatment was available at most voluntary hospitals, it was as charity and not a right. Hence the extension of services freely to everyone was revolutionary, and the booklet that went out to families outlined the promise of, among other things, a family doctor for everyone, medicines on prescription, dental services, free spectacles and free hospital treatment.

Within the first four months, half a million Scots had free spectacles, and in the first year, half a million got free dentures. The next 60 years coincided with a pharmaceutical and technological explosion, including the ready availability of infection-busting antibiotics, the contraceptive pill, kidney dialysis, ultrasound, chemotherapy, MRI scanners, in vitro fertilisation, keyhole surgery and organ transplants. Thanks to vaccines, polio and diphtheria are now almost unheard of, and the Abortion Act has made backstreet terminations a thing of the past.

There have been challenges, too, such as the advent of Aids and the emergence of the superbugs MRSA and *C. difficile*. Perhaps the biggest challenge of all, one which has dogged the service from the very beginning, is the question of how to fund this behemoth. Even in the very early years, the cost of the NHS turned out to be 40% higher than predictions. Charges were introduced for dentures and spectacles as early as 1951 – a move which would lead the Health Secretary who launched the service, Aneurin Bevan, to resign in disgust – and a year later the price of one shilling was attached to prescriptions.

Among those at the Edinburgh reunion were two doctors from Australia, two from the USA and four from Canada, reflecting the many graduates who went off to staff so many medical faculties overseas. But the rest of the alumni were the men and women on whom the new service would rely for its success, the young blood that would go on to perfuse the


WHAT TO DO NOW
1. Choose your doctor.
2. Get application forms from any Post Office, Public Library, or office of the Local Executive Council.
3. Fill one in for each member of the family.
4. Hand them in to the doctor.
ACT AT ONCE

**Above: graduation photograph of the Edinburgh University Medical School, Class of 1948. Douglas Bell: back row, 7th from the left; John Marks: 2nd back row, 9th from the left; Jake Davidson: back row, 14th from the right**



**John Marks, 2008; Radcliffe Publishing Ltd; £21.95**

arteries of the NHS for a full career.

In the following, three members of the Class of '48 – Douglas Bell, John Marks and Jake Davidson – offer a view of a life within the health colossus they grew up with and that grew up with them.

## Douglas Bell GP and medical inspector

Not everyone was in favour of Nye Bevan's NHS plan and Douglas Bell says he was one of the doubters. "Having been brought up as a Conservative, I had an instinctive dislike of what Aneurin Bevan was proposing," he explains, although he admits: "I was opposed to the service more because of him than because of what he was proposing."

Nevertheless he was involved in it very early and remembers well the excitement. "I did a locum in a mining community in Fife in August 1948. The queue outside my surgery was bigger than the queue outside the cinema up the street. The free consultations, albeit with someone who was qualified a month, were very attractive, quite apart from free prescriptions. And if one remonstrated with patients when calls were judged to be unnecessary, the answer would be, 'But you're paid for it, doctor.'"

After various jobs, including one as a ship's surgeon plying the waters between Britain and New Zealand ("I survived most of the passengers and they survived it too"), Bell went into general practice in Edinburgh in 1954. His training had been good, but he feels he may have been one of the lucky ones in what was an informal system. "I had a very good trainer who took his duties very seriously. But I think many other trainee assistants were cheap labour paid for by the state. Now with the RCGP and the standards they set, family doctors are going to continue to improve."

Starting work as a GP, with no access then to diagnostic services, Bell felt immediately frustrated. "We became in effect doctors who either wrote prescriptions or referred patients to hospital. We couldn't get even a chest X-ray or a blood test without going through the hospital."

With no support staff, he often worked seven days a week and is impressed with the current hours. "I really take my hat off to family doctors who have been able to cultivate contractual terms which allow them to contemplate having no consulting hours after half-five and none at the weekend."

It was the long hours – 20 home visits a day with five hours on two consulting sessions – that eventually drove Bell, "fed up with the NHS", to give up his GP practice. He went to work as a medical inspector in the early 1970s, a new career that took him up to retirement.

As to the future of the NHS, he declares himself optimistic. The service's great success, he says, is "its ability to cope with emergencies". On the minus side he names the administration costs of an "over-managed" system and league tables. "League tables of hospital efficiency and tables of mortality rate comparing one cardiac surgeon with another are grossly unfair because patients vary and there are so many other variables. Such league tables require careful and intelligent interpretation."

## John Marks GP and former BMA Chairman

John Marks was passionately in favour of the NHS from its inception, though for someone who would come to head the BMA, he admits his grasp of the detail was minimal. "We weren't worried about what was proposed, we were worried about getting qualified," he jokes.

But he does remember the initial demand among patients. "It was unbelievable. So many people had needed surgery and hadn't been able to think about it. People with huge hernias, women with enormous prolapses," he says. "Then there was the false demand, people asking for free wigs – for a while they got them then the government stopped it."

After a stint in the Royal Army Medical Corps, Marks returned to the UK and entered general practice in time to see prescription charges brought in. He remembers: "There was great anger about it. And about dental charges as well. The NHS was only four years old! We worked that last day until about midnight. People were coming in to save a shilling."

But it was medical politics that really exercised ➤

➤ Marks and he became increasingly involved, though continuing to practise as a GP. When the BMA opposed David Steel's Abortion Act he fought hard to overturn their view. "It incensed me. The attitude of the BMA hierarchy was that although it was legal it was unethical. Unbelievable! It was sheer prejudice. They thought the only people who would need an abortion were 'unmarried sluts'."

He won that battle and says that within three years there was a volte-face within the GP community. "They'd seen the benefit of it: women didn't die, they didn't become sterile and they didn't become infected."

The most high-profile political skirmish of all, however, was over the Tories' plans to introduce an internal market into the NHS in the late 1980s. Under his leadership the BMA wanted to see the scheme piloted first. "Ken Clarke [the then Health Secretary] said, 'You buggers would sabotage it.' He was obsessed with hatred of the BMA. He said we were the worst trade union he'd ever dealt with." Marks's formidable ad campaign against the plans included slogans like, "What do you call a man who ignores medical advice? Kenneth Clarke."

Despite winning the propaganda war, the reforms went ahead untested. It was the beginning of a black period, Marks believes, and he says the NHS's future is "miserable". He reserves his greatest criticism for the current Labour government, however. "Blair said, 'We'll get rid of the internal market.' And they did for about two years and then they brought it in. At a recent march, I said to my mates 'Aneuran Bevin is turning in his grave'. The Tories would never have got away with it."

## John Davidson radiologist

"I got the impression it was a good idea, because people had difficulty paying doctors' bills," says John ('Jake') Davidson, explaining his initial approval of the NHS scheme. But he also remembers a considerable amount of opposition to the setting up of the service, particularly among those who were established with large private practices. "I was in Edinburgh to begin with and there were several senior chiefs in the Royal Infirmary and elsewhere in Leith who were really quite against the NHS."

Following GP training in Edinburgh, Davidson worked as an assistant in Leith, but after what he describes as a "lousy offer" of a partnership, which included doing all the night calls, he was advised to try his hand in the expanding field of radiology. As he recalls, "A friend in the Union Bar said, 'Jake you'll do very well, most of the radiologists are dropouts. You're just barely above them.' "

It was, in fact, a very exciting time for radiologists.


IMAGE: SCIENCE AND SOCIETY PICTURE LIBRARY

Ultrasound was being developed in Glasgow and other technological advances were around the corner. Angiography, CT and later MRI scanners, nuclear medicine and interventional techniques and other ongoing developments kept things interesting for decades to come. "We were learning new techniques at the age of 60 to 65 when a lot of surgeons were bored to tears with what they were doing. It was just the way it worked out; I could never have envisaged it."

Having been appointed consultant in administrative charge at Glasgow's Western Infirmary in 1967, Davidson was to become familiar with the financial pressures on the NHS. There were fierce battles over money for equipment. "There was a lot of opposition to it, but the opposition came not just from the health board but also from other doctors. There was only a limited amount of money to go round and a CAT scanner costing a million pounds was a huge bite out of the general budget. But things began to change and people began to realise that radiology was a frontline specialty."

Davidson remains a firm believer in the NHS and is optimistic about the future. "When I was working and we were desperate for money, I thought the whole thing was a disaster, but I don't think that now. I am at the receiving end and I think it works very well, bearing in mind it's a huge organisation. I don't know the answer to that but as long as the government pays for it, they have to keep some control over the spending."

Of his time in the service, he is unequivocal. "Looking back on it all, I enjoyed it. People will be astonished to hear me say that."

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

**Recent photos are courtesy of Joan Rowlands**

# You've been warned

*Doctors faced with official GMC 'warnings' must carefully consider their options.* Ian Sadler *of RadcliffesLeBrasseur offers a frank assessment of a potential no-win situation*

AS PART of the major overhaul of its fitness to practise procedures in 2004 the General Medical Council introduced a new weapon to its armoury in the form of a warning to be placed on a doctor's registration record for a period of five years. Whatever the justifications for the introduction of this new power, and doubtless they were many and varied, surely one was pragmatism, given that the GMC is now able to impose a sanction upon a doctor's registration, in effect a disciplinary finding, without the necessity of going through a lengthy and costly adjudication process. All well and good for the regulatory body but what are the consequences and potential pitfalls for the practitioner being faced with a decision of this sort, and what have been the lessons learned so far from seeing how these new powers have been utilised?

The power to impose a warning appears at Rule 11 of the General Medical Council (Fitness to Practise) Rules 2004, although the explanation as to how the scheme works and the criteria for when a warning is deemed to be appropriate can only be found in the accompanying guidance (the most recent issued in June 2008). A doctor having been the recipient of a complaint which the GMC considers justifies investigation under its fitness to practise procedures may receive a letter stating that the case examiners have taken a preliminary view that it is the sort of case which might be dealt with by the imposition of a warning. The doctor is then invited to submit representations upon the matter before a final decision is made as to whether a warning is in fact to be imposed.

However, the process is not as straightforward as it may seem. At the same time as receiving such a letter the doctor is served with a statement of facts said to underpin the complaint. He or she will also be sent a précis of those facts and the proposed warning in draft form and these, if accepted, will be a matter of public record and will also appear on the GMC's website as a case concluded with a warning. The doctor is also informed that a warning can only be issued if the facts as set out in the statement are not challenged and he or she does not wish to take advantage of the right to have the whole thing looked at by an Investigation Committee at a public hearing further down the line.

## Little room to manoeuvre

Those of us involved in advising doctors and their defence organisations in respect of these matters have come to the realisation that there is little room for manoeuvre in the face of a proposal from the GMC that a complaint be dealt with by a warning: either accept it with all that that may mean in terms of a doctor's registration record and the potential damage to reputation and future employment prospects, or be ➤

➤ prepared to fight all the way to an Investigation Committee and, in theory at least, in front of a full Fitness to Practise Panel. Thus, the stakes can be extremely high and the doctor involved will want to give the matter very considerable thought, and doubtless take careful advice, before responding to the GMC's initial letter proposing a warning.

Warnings are deemed to be appropriate in those cases where a full hearing in front of a Fitness to Practise Panel is not considered to be justified. The decision maker must be satisfied that there is no realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree requiring action on his or her registration. A warning is likely to be considered appropriate where the offence or complaint is at the lower end of the spectrum of misconduct or concerns about performance; it is intended to mark the fact that the behaviour complained of is unacceptable and must not happen again. The test is whether the practitioner's behaviour or performance has fallen below standards to a degree warranting a formal response by the GMC, and in circumstances where there has been either a significant departure from the terms of *Good Medical Practice* or there is a significant cause for concern following a (formal) assessment of the doctor's performance. Bearing in mind that there is no definition of "significant" in the Medical Act or in the Fitness to Practise Rules – what sort of factors are taken into account in considering whether a warning is appropriate?

If the decision makers are satisfied that the doctor's fitness to practise is not impaired then they will look to see whether there has been a clear and specific breach of *Good Medical Practice* or other supplementary guidance. Further, a warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Consideration has to be given to the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. In theory at least, warnings can be implemented in response to any type of allegation with the exception of concerns exclusively in connection with a doctor's health.

Whilst it might be assumed that cases involving a conviction or caution would always proceed to the next stage of the Fitness to Practise procedures this is not necessarily so in criminal offences at the 'bottom end of the scale'. In such cases a warning may be deemed more appropriate. Each will be decided on its merits but the GMC's own guidance refers to potential warnings for one-off drink driving offences where there is no evidence of underlying health concerns, common assault offences outside the context of the doctor's professional practice, disorderly behaviour while drunk and criminal damage. The same principles are applied in relation to allegations of dishonesty which have not previously been the subject of criminal proceedings.

## Contested warnings

Figures obtained from the GMC at the beginning of Summer 2008 reveal that some 59 cases have been heard by the Investigation Committee so as to determine whether the imposition of a warning is deemed to be an appropriate sanction. These cases have gone to the Investigation Committee stage either because the decision makers of the Council have not been in agreement as to the right outcome or because the individual doctor disagrees with the facts alleged or argues that a warning is a disproportionate measure in all the circumstances of the case. It seems that in terms of outcome

## CASE STUDY

A doctor was applying for a job as a registrar with a local Trust. In filling out his application form he neglected to disclose two traffic offences: one for speeding and the other for driving without due care and attention. This was reported to the GMC.

GMC Case Examiners considered the matter and, while acknowledging there was no evidence of dishonesty, decided that the failure to declare the offences on a form represented a significant departure from the standards expected of a doctor. They judged that public confidence in the profession might be undermined if no action was taken and were minded to issue the following warning:

"You must adhere to Good Medical Practice which requires that you do your best to make sure that any documents you write or sign are not false or misleading and that you take reasonable steps to verify the information in the documents."

In written representations to the Case Examiners through his solicitors, the doctor indicated that he was not prepared to accept the warning. He admitted that he had not read the contents of the application form in detail and therefore did not appreciate that he had to provide details of the two driving offences. He acknowledged the mistake immediately when brought to his attention by the medical director at the Trust and offered an apology. He stressed that it was not his intention to mislead or gain an advantage over other applicants as the post did not include any driving duties. On a previous employment application to the Trust, the doctor did provide details (at the time) of one of the convictions – and the same Trust had decided to continue the doctor's employment despite referring the matter to the GMC. There was no (real) dispute as to the facts.

The case was referred to the Investigation Committee which accepted that the doctor was genuinely contrite and understood his failure. It "considered the issue of proportionality" when deciding whether it would be appropriate to issue a warning – weighing the interests of the public against those of the doctor. In the end it decided that on balance a warning was not appropriate and no further action would be taken.

Source: *GMC website*

'It is possible to seek to argue that a warning is too much of a Draconian sanction'

from those hearings there is an almost 50/50 split between a decision by the Committee that the warning as proposed should in fact be confirmed and a decision that the warning was not justified and that no further action should be taken against the practitioner.

Closer analysis of the statistics indicate, and this is unsurprising, that a very high proportion of those cases which end up being contested at an Investigation Committee hearing relate to probity issues and concern with clinical care. It looks as if the figures both in relation to outcome and types of matters being considered by the Committee have remained more or less static in the years since the power to impose a warning was introduced.

Given what we now know about how the GMC approaches cases where a warning is felt appropriate, what factors does a doctor need to bear in mind before deciding whether to accept the inevitability of the warning decision or taking their chances at an Investigation Committee hearing?

Firstly, it is important to be aware that there is a risk, albeit in the majority of cases a pretty small one, that if matters are contested the case could yet escalate and end up at a full Fitness to Practise Panel hearing at some time far in the future. The GMC's guidance makes it clear that this would only ever happen if there was new evidence, whether in documentary form or orally, given in front of the Committee that was not available to the original decision makers. This may be an important consideration where there is a clear dispute arising out of the facts of the case and would be particularly significant if the case raises issues as to honesty or integrity.

Matters before the Investigation Committee are in public, evidence is given on oath, and transcripts prepared as in full hearing cases. It has to be accepted, therefore, that what is said in one arena is bound potentially to have a very significant effect upon later proceedings. It should be noted at this point that for an allegation to go forward in any form, however serious, it must be capable of being proved to the necessary standard, and if it is not then the decision makers should not have considered the imposition of a warning at all irrespective of whether other criteria might be made out. Thus, if a doctor is facing a warning letter but feels that the evidence in support of the statement of facts is very weak then serious consideration should be given to putting in written representations and suggesting that the case against him or her simply cannot be proved. Sadly, in those other cases where the evidence may be more evenly balanced there would be a significant degree of risk in going down this path as the standard of proof at the GMC is somewhat lower than that which has been required in the past.

## Personal mitigation

Secondly, it should be borne in mind that, in theory at least, even in those cases where the doctor accepts the statement of facts alleged against him or her in its entirety, it is possible to seek to argue by means of written representations that a warning is too much of a Draconian sanction. The GMC's guidance recognises that the decision makers should apply the principle of proportionality, weighing the interests of the public with those of the practitioner. There is potential scope at this stage to seek to rely upon personal mitigation on behalf of the practitioner and relevant factors might include a previous good history, expressions of regret or apologies, any rehabilitative or corrective steps that had been taken together with relevant and appropriate references and testimonials. Again it is possible to seek to deploy such arguments and material at the initial decision-making stage but the reality is that they are only likely to be effective in front of the Investigation Committee. It must be remembered that the onus is on the practitioner to commit to a position at the outset of the procedure as to whether they ultimately want to contest the warning decision in front of the Committee at a public hearing.

The experience so far of the GMC's warnings regime is that doctors and their advisers need to feel that they are on solid ground if there is to be any prospect of persuading the decision makers to step back from a decision which has effectively already been taken if not quite set in stone. Further, all should be wary indeed of challenging before the Investigation Committee allegations that question the doctors' honesty or integrity as there must be a very real risk that a warning may be the least of their worries. It would seem that once again that doctors cannot win!

■ ***Ian Sadler is a solicitor and partner in the healthcare department of RadcliffesLeBrasseur***

# 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

PATIENT COMPLAINT

## Misunderstanding over dental payment

MRS P attended her dental practice for a series of treatment sessions over a period of months. Treatment began with Mr A who informed Mrs P that he would soon be leaving the practice. Further treatment was then carried out over two consultations by a different dentist, Mr B.

Upon receiving her bill at the reception desk following the second appointment with Mr B the patient enquired why she was being charged for the two consultations. Her understanding was that the treatment was for unresolved dental problems and was simply a continuation of the treatment begun with Mr A. Later it was confirmed that the treatment provided by Mr B was to a different tooth entirely and had nothing to do with the previous treatment provided by Mr A. But Mrs P claimed she was not aware of this at the time.

The receptionist asked that Mr B explain the charges. According to Mrs P the dentist came out into the reception area and, in an aggressive and bullying manner, accused Mrs P of unreasonableness and trying to resist payment for treatment provided in good faith. Mrs P claimed that other patients and staff were within hearing as the waiting room door was open.

Mrs P later wrote to the practice manager asking for a copy of the practice's complaint procedures as she intended making a formal complaint over Mr B's attitude. In reply the practice manager asked for further details of the complaint but did not enclose the requested procedure document.

In his reply to the complaint the practice manager stated that Mr B disputed Mrs P's version of events, saying that his manner had been straightforward and assertive but not aggressive. He also claimed that the door to the waiting room had been closed with music being played inside the room. The practice manager stated that Mr B regretted the incident had occurred but felt that the matter would be best concluded if both parties apologised for their "perceived behaviour".

The practice manager also made the statement: "When discussion arose about payment for this treatment it became clear that you were resistant to paying..." This further upset Mrs P who felt that she was only requesting a reasonable explanation for charges and not resisting payment. Feeling the matter significantly unresolved Mrs P complained to the Ombudsman.

**Analysis and outcome**

In looking into the complaint the Ombudsman's investigator could not verify Mrs P's account of the confrontation with Mr B nor was it felt that the use of the word 'resist' was inappropriate, as questioning a charge could be perceived in that way. However, the practice was criticised on a number of other counts. Passing on Mr B's desire that Mrs P apologise was felt to be inappropriate and almost certain to make matters worse. The failure to supply Mrs P with a copy of the practice complaints procedure after two requests was also criticised. The practice manager claimed to have enclosed a copy with the reply to the complaint but the Ombudsman's view was that this was too late in the process.

It was recommended that the practice acknowledge these failings in writing to the Ombudsman and ensure that procedures are tightened to ensure that similar incidents are not repeated.

**Key points**

- Patients have a right to question the treatment and service provided by healthcare professionals.
- Ensure that any patient making a complaint is supplied with a copy of the practice complaint procedure.
- Respond to patient complaints with tact and sensibility or you can expect more problems to come.

**This case is taken from a new MDDUS booklet – *Essential guide to complaint handling in primary care,* which is due to be published in November 2008. Access at www.mddus.com**

DIAGNOSIS

# To refer or not to...

IMAGE: CNRI/SCIENCE PHOTO LIBRARY

MRS M (age 54) presented to her GP practice with rectal bleeding and tenderness in the perianal region. Her medical records confirmed a past history of piles. She explained to the GP – Dr Y – that she had been using Anusol suppositories over-the-counter but with no real improvement.

Dr Y carried out a rectal examination and found a tender external skin tag and some slight swelling but no discrete anal masses. She thought the observations were consistent with a diagnosis of haemorrhoids. Mrs M later claimed that she had also advised Dr Y that she had been suffering from persistent diarrhoea but there was no record of this in the notes.

Dr Y prescribed a suppository for the symptomatic treatment of the haemorrhoids and also a laxative (Lactulose) to prevent further acute inflammation of the haemorrhoids. Dr Y later stated that she routinely discusses prescriptions with her patients and it would have been surprising if Mrs M had not objected to the use of a laxative if diarrhoea had been a problem.

Mrs M returned to the surgery two weeks later complaining that her piles were no better. She told Dr Y she wondered if it might be because of loose bowels. Dr Y recorded the bowel habit change in the records and again examined Mrs M. She found her abdomen diffusely tender but with no palpable masses. In the notes she recorded "no alarm symptoms"; this meant she would have routinely quizzed Mrs M for any signs of malignancy such as loss of appetite or weight.

Dr Y determined that the symptoms were consistent with irritable bowel syndrome and prescribed an antispasmodic. Mrs M rang the surgery a week later and reported her bowels were much better – opening now only once in the morning. She was happy to continue with the antispasmodic for another week. Dr Y asked her to attend the surgery in one to two weeks for a review but no appointment was made.

Mrs M did not return to the surgery again for another two months and at this time saw a different GP, again with bleeding and diarrhoea in addition to new onset upper quadrant abdominal pain. She was referred to hospital and diagnosed with severe ulcerative colitis. A subtotal colectomy and ileostomy were performed two weeks later.

**Analysis and outcome**

A claim of negligence was lodged on behalf of Mrs M by her solicitors against Dr Y alleging that the delay in diagnosis resulted in the patient suffering weeks of unnecessary pain and discomfort. However, it was not alleged that the delay would have had any impact on the eventual requirement for surgery or the prevention or cure of the ulcerative colitis.

Expert medical opinion in the case concluded that Dr Y's actions were in accordance with acceptable practice and that emergency referral to a gastroenterologist had not been indicated. Had Mrs M consulted again with Dr Y still complaining of rectal bleeding after finishing the course of the antispasmodic it would then have been reasonable to refer. But Dr Y could not be held responsible for the patient not re-attending as advised.

It was decided to settle the case for a modest sum without any admission of liability on Dr Y's behalf.

**Key points**

- Rectal bleeding is commonly from haemorrhoids but remember other causes.
- Deciding when to make a referral for rectal bleeding can be a difficult call but the index of suspicion should be high.
- Clear notes and full medical records are essential in defending claims of negligence.

TREATMENT

# Depot error

MRS B attended her GP for contraceptive advice. She had been on the pill but asked about trying a depot injection. Her GP discussed the options and issued a prescription for Depot-Provera and instructed Mrs B to return to the practice on the first day of her next period for the injection.

Three months later Mrs B attended the surgery for her second injection and on this occasion the GP discovered that at the previous visit Mrs B had been given Depo-Medrone (corticosteroid used commonly for treating inflammation) by mistake. Mrs B also reported at that visit that she had not had a period for two months. A pregnancy test the following day proved positive.

A solicitor's letter in regard to a compensation claim on behalf of Mrs B and her husband was received at the surgery.

**Analysis and outcome**

A healthy child was born at full term. A modest compensation claim was negotiated by MDDUS on behalf of the GP.

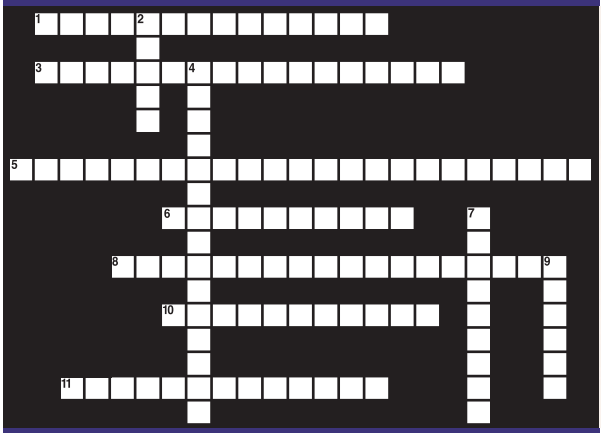
**Key points**

- Ensure proper checks on all prescriptions but especially long-acting depot.
- Healthy babies do not attract damages – only compensation for unexpected expenses.

# Medical Crossword: causes of cough

**Across**

**1** Severe disease with symptoms of a productive cough with thick, foul-smelling, green sputum (14)
**3** Cough associated with pleuritic pain and leg pain (9, 8)
**5** Disease associated with cough and heartburn symptoms (6-11, 6)
**6** Retrosternal pain 'like hot poker' with a barking, croup-like cough (10)
**8** Cause of bovine cough with unintentional weight loss (9, 9)
**10** Irritating, frequent cough with dysphagia, sore throat and rhinorrhoea (11)
**11** Severe coughing episodes in which the person turns red, tends to drool and may have a low-grade fever (8, 5)



**Down**

**2** Stridor and brassy cough which worsens at night, found mostly in children (5)
**4** Acute infective episodes of purulent cough, seen mostly in smokers (5, 10)
**7** Postnasal drip associated with a cough (9)
**9** Coughing with wheezing attacks occurring more frequently at night (6)

**See answers online at www.mddus.com. Go to the Notice Board page under News and Events.**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# From the archives: winning bedside manner

TIREDNESS can test any doctor's empathy but certainly not to the degree evidenced in a case heard before an Islington Coroner in 1911. It concerned a Dr Meagher who had been called out one afternoon to the home of a three-year-old boy suffering from whooping cough.

Witnesses testified that Dr Meagher arrived looking tired and dazed, as though he had been up all night. He examined the child who seemed to be "suffering from a laryngeal obstruction". Having done so he then sat on the edge of the child's bed and smoked a cigarette, pondering the diagnosis. When the Coroner asked him in court whether that was a good thing to do, Dr Meagher replied: "I don't know that it is a bad thing. It makes them cough".

Dr Meagher then reportedly spent the rest of the afternoon sitting in a chair by the fire smoking and playing with the family cat. At one point he tried to console the dying boy's mother by singing an Irish song – though he testified he hadn't been drunk. When the boy's father returned that evening he found his son dead and his wife hysterical. The doctor had reportedly said to her: "You are fretting over a dead piece of flesh".

The Coroner at the inquest instructed the jury that the "only question" to consider was whether Dr Meagher was guilty of gross negligence amounting to manslaughter. Having heard the evidence of a pathologist the jury returned a verdict of death by natural cause – asphyxia following laryngeal diphtheria. Dr Meagher was judged not responsible either by negligence or criminal intention.

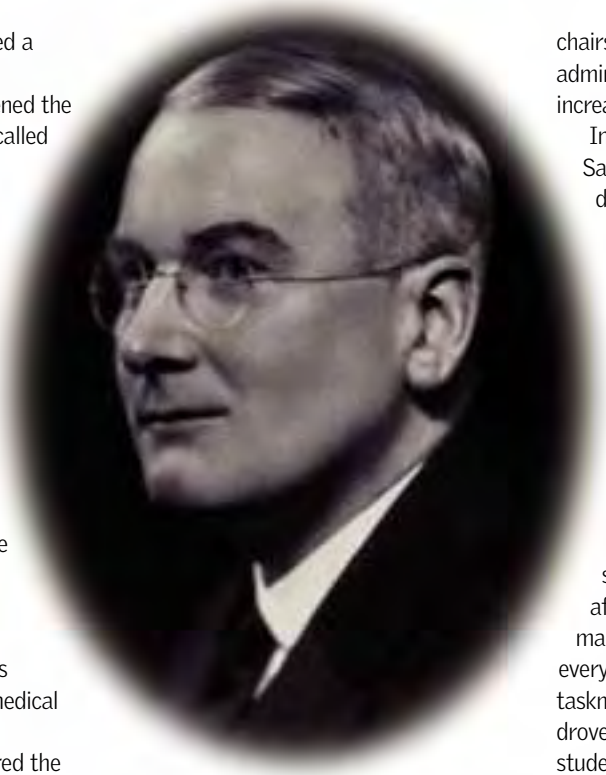
*Source: The Manchester Guardian, April 12, 1911*


# Object obscura: advertisement

**EXTRAVAGANT claims like those made in this 1913 promotional leaflet were not uncommon prior to the Dentist Act 1921. Even qualified dentists indulged in the practice. The Minute Book of the MDDUS Advisory and Financial Committee features the following entry dated 16 May, 1909: "The Secretary submitted a complaint by Mr M against Dr A, for exhibiting in his window a notice bearing the words 'Teeth extracted without pain'. The Secretary was instructed to write Dr A that this course was unethical and requesting him to withdraw the notice".**

IMAGE: WELCOME LIBRARY

# Vignette: exceptional surgeon and leader
# Sir James Learmonth (1895 – 1967)



IN 1949 HM King George VI suffered a serious flare up of thromboangiitis obliterans – a condition that threatened the viability of his leg. A specialist was called for and due to his reputation as a skilled surgeon in the field of peripheral vascular disease the job fell to James Learmonth. On 12th March, Learmonth carried out, in Buckingham Place and supported by his own anaesthetist and theatre staff, a lumbar sympathectomy which halted the progress of the ischaemia in the King's leg and produced symptomatic relief. In the immediate post-operative period, the royal patient conferred upon his surgeon, at the bedside, the Royal Victorian Order (KCVO).

This was but one of many honours conferred to this giant of Scottish medical history.

James Rognvald Learmonth entered the Medical Faculty of Glasgow University in 1913 but his studies were interrupted by the First World War in which he served as an officer in the King's Own Scottish Borderers. He survived some of the bloodiest battles on the Western Front but, in later life, seldom spoke of his war experiences. He was, however, always angered by ill-informed denigration of the British Army's WWI commanders and was vehement in defence of the military reputation of Field Marshal Haig.

When the war ended, he returned to Glasgow University and, in 1921, graduated MBChB with Honours and the Brunton Memorial Prize. After a number of junior posts, including that of assistant to the Regius Professor of Surgery, in 1924 with a Rockefeller Fellowship, he spent a year at the Mayo Clinic. Back in Glasgow, he obtained his Masters Degree (ChM) and the Fellowship of the Royal College of Surgeons of Edinburgh. At the invitation of Dr W J Mayo, he then returned to the Mayo Clinic as a member of its neurological division and over the next four years conducted research on the innervation of the bladder and on the physiology of micturition, for which he received international acclaim and a reputation as a top clinical scientist.

In 1932, he was appointed Regius Professor of Surgery in the University of Aberdeen. Seven years later, he was appointed to succeed Sir David Wilkie as Professor of Systematic Surgery in Edinburgh. The outbreak of WWII in 1939 meant that the plans for development of his new department had to be postponed but he did manage to establish a special unit for the treatment of peripheral nerve and vascular injuries at Gogarburn Hospital which became an important research centre. The activity of this Unit together with his teaching commitments and the clinical demands of his Royal Infirmary wards, constituted a heavy work load made more arduous by the absence on military service of several members of his departmental staff. In spite of many difficulties, he maintained an impressive research output which was recognised in 1945 when he was made a Commander of the Order of the British Empire (CBE).

In 1946, he was invited by Edinburgh University to fill the Regius Chair of Clinical Surgery in succession to Sir John Fraser and, as the then concurrent holder of two chairs, his academic, clinical and administrative responsibilities were vastly increased.

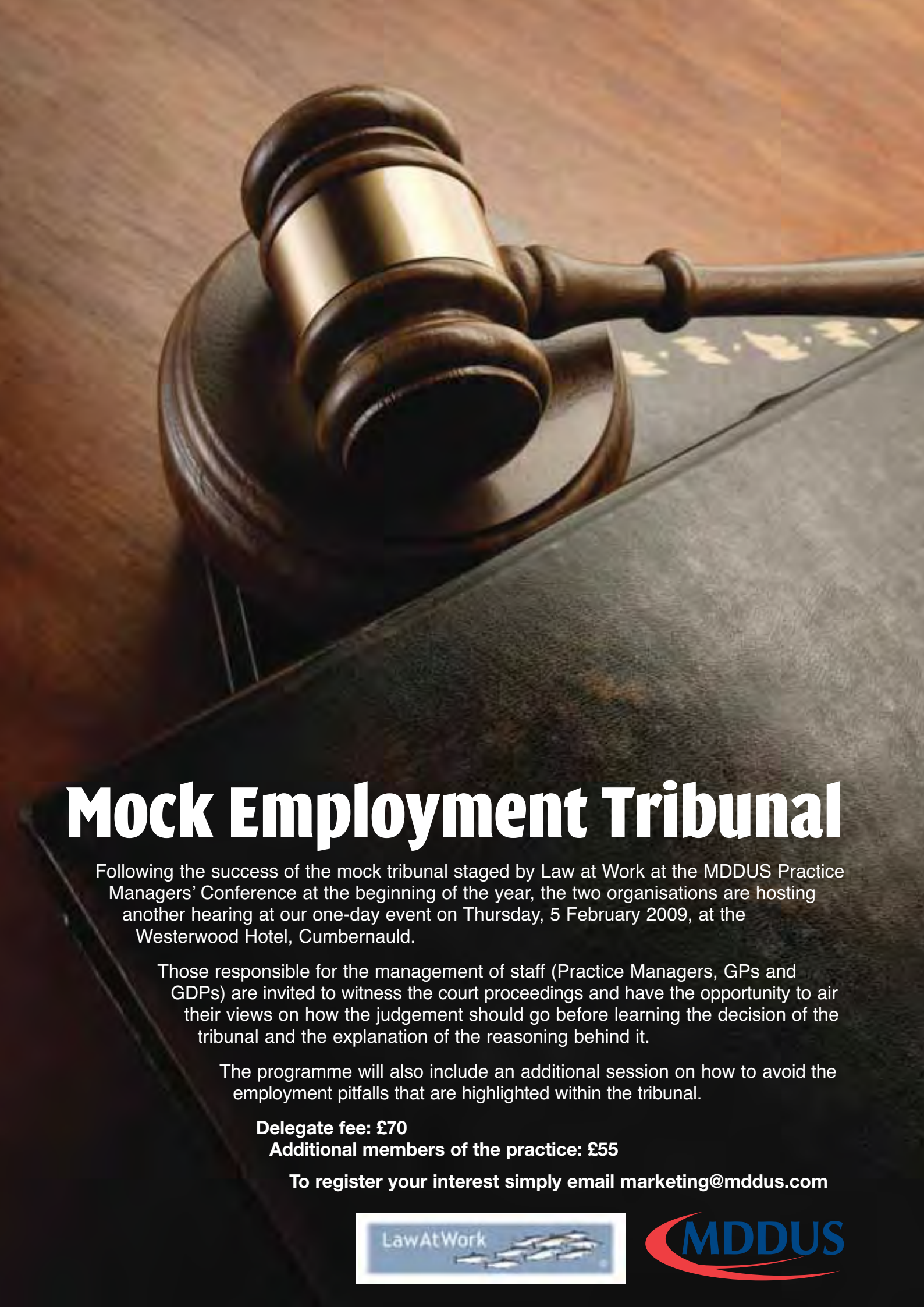
In 1948, he introduced the famous Saturday morning meetings for the discussion and evaluation of current surgical practices and the review of operative mortality. Soon all the surgical units in Edinburgh were participating in these meetings which were probably the earliest examples in the British Isles of systematic surgical audit.

James Learmonth's early retirement in 1956 surprised his friends and colleagues, most of whom did not appreciate that the strain of his heavy work load had affected his health. He set and maintained the highest standards in everything he did and, if he was a hard taskmaster, there was no-one whom he drove harder than himself. To most of his students and junior staff, he seemed a formidably stern authoritarian figure but, behind this severe façade, lay a deeply emotional, warm personality which was never more apparent than when he was dealing with patients. Even the author of this piece, when a hospital patient for six months, was regularly visited by his 'Chief'.

Sir James was a rapid dextrous operator and impressive diagnostician who never failed to inspire his patients with total confidence. He was an excellent clinical teacher and his formal lectures, which were models of clarity, always illuminated their subject matter for his audiences at all academic and professional levels. His writing had the same quality and all papers written by members of his University Department had to meet his exacting standards.

He was a great academic surgeon who inspired loyalty, affection and respect in all who worked with or for him. His concurrent tenure of two historic chairs of Surgery in Edinburgh University was a unique achievement which earned him an honoured place in Scottish medical history of which he was, in every way, most worthy.

**Iain F MacLaren FRCS**



# Mock Employment Tribunal

Following the success of the mock tribunal staged by Law at Work at the MDDUS Practice Managers' Conference at the beginning of the year, the two organisations are hosting another hearing at our one-day event on Thursday, 5 February 2009, at the Westerwood Hotel, Cumbernauld.

Those responsible for the management of staff (Practice Managers, GPs and GDPs) are invited to witness the court proceedings and have the opportunity to air their views on how the judgement should go before learning the decision of the tribunal and the explanation of the reasoning behind it.

The programme will also include an additional session on how to avoid the employment pitfalls that are highlighted within the tribunal.

**Delegate fee: £70**
**Additional members of the practice: £55**

**To register your interest simply email marketing@mddus.com**

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