Spring 2008

SUMMONS

MDDUS JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND

• Pharma reps • Business of dentistry • Slipped upper femoral epiphysis •

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HODDER ARNOLD

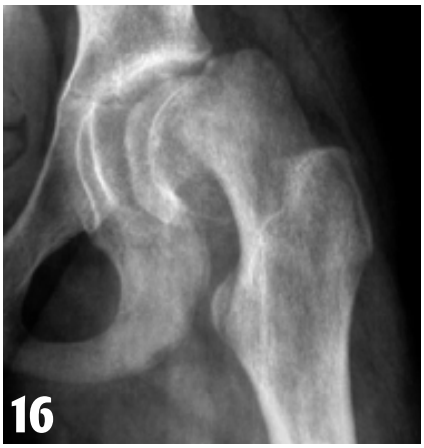
IN THIS ISSUE

EACH year the pharmaceutical industry spends some £850 million in marketing its products to GPs. This figure was cited in a recent House of Commons public accounts committee report on prescribing costs in primary care. The report also highlighted the results of a NAO survey of 1,000 GPs in which one in five said they felt that pharmaceutical company marketing had more influence on prescribing behaviour than did official NHS prescribing advisers. Certainly there is plenty at stake when you consider that in 2006 the NHS in England alone spent £8.2 billion on prescription drugs in primary care. But the survey result is perhaps even more surprising given the strict code of practice to which pharmaceutical companies must now comply in promoting their products.

In this issue of *Summons* the Director of the Prescription Medicines Code of Practice Authority (PMCPA), Heather Simmonds, offers some background and provides instances of how doctors and pharma reps most often fall foul of "the code". Gone are the days of sponsored golf matches followed by long leisurely lunches at the clubhouse. The emphasis in promotional activity must now be geared toward enhancing patient care.

Acting in the best interests of patients is also the starting point for new guidance recently published by the General Dental Council on management responsibilities of registrants when running a "dental business". On page 14, GDC President Hew Mathewson discusses some of the core principles inherent in the document which was prompted by changes in the amended Dentists Act, opening up "the business of dentistry". There's much for the dental professional to consider beyond simply balancing the priorities of quality patient care and profit/loss.

Jim Killgore, editor



REGULARS

Cover image: 'Magic Squares' by Clare Wardman. Clare was born and trained in Yorkshire and moved to Edinburgh in 1988. She now lives in Cornwall. Clare's abstract and highly textural works are a response to her surrounding environment. She is particularly interested in light and the movement of light. 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

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London legal – fully operational

OVER a year has passed since the MDDUS opened its Legal Services Department at its new London Office in Bell Yard, London. The office has enabled the Union to offer a more convenient service to members in England and Wales, and has been a great success in providing the members' legal needs in conjunction with the specialist barristers we have occasion to use.

I joined the Union after over 25 years in legal practice, specialising in health law in all its dimensions, and was very fortunate to have had the Union as a client. As such, joining the team, whose company I had enjoyed for many years, was not such a transition as it might seem and I am confident the Union will benefit from direct and unrestricted access to legal support.

I was very lucky to have been accompanied by Emma Parfitt, one of my partners at the Union's retained solicitors in England and Wales, and she has brought with her a detailed knowledge of dental law and dental negligence, which is a real asset to the Union's dental membership. Sara Miller and James Doake have also joined us as assistant solicitors, and the team is enjoying the task of sharpening the focus of the Union's legal services and making them more efficient and cost effective, as well as maintaining the standards that the membership expects.

In the first few months we were heavily engaged in reviewing the processes by which we work with members and the medical and dental advisers of the Union, and it has been refreshing to look at things that have been done in a certain way for many years to see if they can be improved or developed in the new situation.

One of the real benefits of working in-house within a company is the chance to achieve simplicity of process and to cut down on necessary formalities which sometimes go with working with external advisers. Understandably, there has to be a structure to the advice and to communications, but this can generate an unnecessary paper trail in many cases which, to the company man as I now regard myself, seems unnecessary and burdensome. Everyone can benefit from a more streamlined process – the lawyer who can be less concerned about external and formal communication; the adviser who receives fewer communications and can concentrate on broader issues and decision making and the membership, of course, who save money by efficiency of systems.

MDDUS appoints risk professional to Board

THE MDDUS Board of Directors has appointed an experienced risk management professional as its first lay non-executive director. Alan Fleming is a well known personality in the world of risk and insurance with a career that spans more than 30 years. He brings a wealth of practical experience to the work of the Board. After an extensive period of responsibility for the insurance of ICI, recent roles have included Head of Insurance and Risk Management at Railtrack Group PLC, Director of Global Risk Management at Diageo PLC and Director of Insurance of the Guernsey Financial Services Commission. Alan lives in Surrey, is a Freeman of the City of London and, when much younger, played international rugby for Scottish Schools.

Mr Fleming commented: "I am pleased to be asked to join the Board and hope that my experience will contribute to the ongoing success of MDDUS".

Ethics – a common agenda

TOMORROW'S doctors is one of those catchy phrases that took hold 15 years ago when the General Medical Council made it the title of their recommendations on undergraduate medical education. Updated in 2002, among its significant features is the requirement upon all medical schools to prepare students in medico-legal and ethical aspects of their future clinical practice.

The MDDUS has a direct stakeholder interest in this area of the curriculum, as do others, but is unique as an organisation by expressing it in the form of an innovative academic post in partnership with the five Scottish medical schools. Now that the Senior University Teacher appointment in medical ethics, law and risk is a year and a half into its course, how is this new initiative taking shape? The answer is in a growing programme of lectures and classes, from west to east, combined with key activity at a more strategic level.

All five medical schools in Scotland run their own ethics curricula, of course. Now, as a result of the Senior University Teacher role coming into place, the ethics theme leaders are beginning to work collaboratively under the common agenda of the Scottish Deans Medical Education Group, which sets out agreed learning outcomes in the five schools as summarised in The Scottish Doctor.

The encouraging response of the theme leaders to this new post led to their meeting up for the first time as a group, and a third gathering is currently being

IN BRIEF

NB: *DRUG SAFETY UPDATE*
GPs will be missing out on important pharmacovigilance updates if they are not registered for the MHRA's new electronic bulletin *Drug Safety Update*. This has replaced the previous print bulletin *Current Problems in Pharmacovigilance*. The MDDUS strongly advises GPs to register for regular email alerts and links to this monthly e-newsletter. To do so simply send an email to registration@mhradrugsafety.org.uk

INTERACTIVE 'GOOD MEDICAL PRACTICE' The GMC has launched an "interactive web zone" featuring a series of ethical dilemmas illustrating its core guidance. 'Good Medical Practice in Action' invites the user to be the doctor in a series of ethical case studies which highlight some important issues addressed in the GMC's guidance booklet.

A user clicks on one of four patients in a waiting room and watches and listens to his or her consultation with a doctor. Each patient consultation presents dilemmas, which explore issues such as conscientious objection, communication skills and reporting

The lawyers in the in-house department are not just managing claims for members. We will continue to use our expertise in regulatory representation, inquests, disciplinary matters and policy advice. Obviously, larger cases or those involving lengthy hearings are more suitable for management by the Union's preferred external solicitors, but the Union will be hoping to use its own team skills to look after members in whatever situation they may encounter that requires legal help.

If you, therefore, have the misfortune to need a lawyer for your medico-legal problems we shall look forward to welcoming you to the Union's London office in the heart of legal land in Fleet Street. We can promise you a warm and expert welcome, as well as resolute support and pragmatic advice. As the man said, however, "Here's to not seeing you".

Simon Dinnick is head of MDDUS Legal Services in England and Wales, and a former partner of RadcliffesLeBrasseur Solicitors

planned. To facilitate this interchange further, soon there will be the launch of an online resource allowing participants to share ideas and teaching resources, and also to develop new ones together as a dispersed community of practice in medical ethics education – all to the benefit of teachers across institutions, and for our doctors of tomorrow.

Dr Al Dowie, MDDUS Senior University Teacher in Medical Ethics, Law and Risk

'On hold' status

ARE you not working due to retirement, maternity, paternity leave or ill health? You can put your membership on hold. We have a status called Retired/Deferred Membership which is provided free of charge and covers you for 'good Samaritan' acts only. You can reactivate your membership at any time – fully or for periods of four weeks at a time. Phone our Membership Team for details (0845 270 2038).

Risk Alert: Co-proxamol withdrawal

IT'S now official as of 1 January – all marketing authorisations (MAs) for co-proxamol have been cancelled and no further stocks of the analgesic will be released into normal distribution. This follows a phased withdrawal of the drug to allow long-term users time to accommodate to suitable alternative medications.

A number of members have phoned the MDDUS asking for clarification on the continued use of co-proxamol by patients who find alternative pain relief ineffective. The MHRA has not banned the use of co-proxamol outright. Although no further stocks will be released into the market, it will remain legal to continue to supply co-proxamol distributed prior to 31 December 2007 up until the product expiry date on the label has passed.

The MHRA has further said: "We recognise that there is a small group of patients who are likely to find it very difficult to change from co-proxamol or where alternatives appear not to be effective or suitable. For these patients, following cancellation of the licences at the end of 2007, there is a provision for the supply of unlicensed co-proxamol, on the responsibility of the prescriber".

ACTION: In light of the medico-legal risks attendant with the MHRA decision the MDDUS is advising members to cease all prescribing of co-proxamol now or as soon as practical and consult with long-term users on alternative analgesics.

concerns about colleagues. Go to www.gmc-uk.org

FREE GIFT FOR 2007 GRADUATES MDDUS members who graduated in 2007 and who renew their membership now, for 2008/09, will receive a £10 voucher for Waterstone's. Call our Membership Team on 0845 270 2038.

NEW SIGN GUIDELINES ON CERVICAL CANCER New clinical guidelines on the management of cervical cancer have been issued by the Scottish Intercollegiate Guidelines Network (SIGN). These cover presentation, diagnosis, referral and treatment, and emphasise optimal management via multidisciplinary teams. Access the document at www.sign.ac.uk.

MDDUS BOOKLET ON RECORD KEEPING A new booklet providing guidance on good record keeping has been published by the MDDUS and is available to be downloaded from the Resource Library (members access only) at www.mddus.com. Browse from the 'MDDUS booklets' drop-down menu or search on *Essential guide to medical and dental records.*

Information sharing across Europe

CROSS-BORDER sharing of disciplinary information regarding health professionals is essential to ensure patient safety across Europe, says the General Medical Council.

At a time when 'health tourism' is being hotly debated, the GMC has called upon MEPs to recognise the importance of information sharing among European regulatory bodies. The GMC believes that the free movement of health professionals within the EU is an issue affecting all European patients. Each year around 60 per cent of new registrants with the GMC are doctors who have qualified outside of the UK.

In January the GMC signed up to the 'Portugal Agreement', which identifies shared principles of regulation and sets out how regulators can share information about the fitness to practise of European healthcare professionals. The agreement says that each regulator should develop publicly available web-based lists of registered professionals, with any disciplinary hearings and decisions made public.

For more information consult Healthcare Professionals Crossing Borders (www.hpcb.eu), a group of European regulators set up to maintain patient safety in Europe whilst supporting increasing professional mobility.

GDC seeks clarity on skill sets

JUST who is allowed to do what in dentistry? This is the subject of a new GDC consultation on draft guidance to clarify the scope of practice of each member of the dental team.

The draft guidance outlines the skills that dentists and dental care professionals should have at the point of qualification as well as suggesting additional skills that each group could go on to achieve during their career. It also addresses skills that should be 'reserved' to particular registrant groups.

In particular the consultation seeks views on which members of the dental team should be able to carry out tooth whitening, and whether treatments such as Botox, collagen fillers and bone harvesting should be recognised as part of dentistry.

Issues around the registration of dental technicians and dental nurses are also explored in the consultation document. Views are sought on questions such as the definition of 'in training' and who can do what in an emergency?

The consultation document is available at www.gdc-uk.org and the closing date for responses is 9 May 2008.

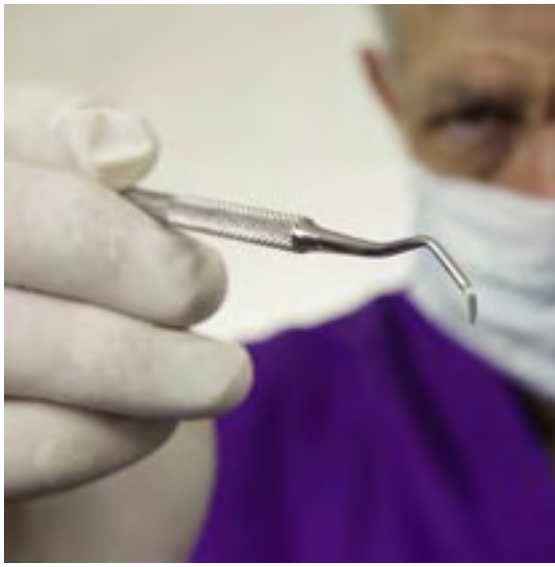
Help not censure

THE suicide of a promising young psychiatrist has prompted publication of a new Government report urging Trusts and other healthcare organisations to be more responsive to the special needs of doctors with mental health problems.

The report was authored by a working group chaired by Professor Louis Appleby in response to an enquiry into the death of an accomplished young psychiatrist, Daksha Emson. In 2000 Dr Emson killed herself and her three-month-old baby, having suffered a relapse of bipolar disorder after her child's birth. Her illness had been long-standing but well controlled and the inquiry into the tragedy highlighted inadequacies in the way that mental illness in doctors is managed.

Mental health and ill health in doctors **cites research suggesting that doctors have higher rates of mental disorder than the general population, with problems with alcohol, drugs and depression being particularly common. The report states that current pathways to care for sick doctors are largely ad hoc and dependent on informal arrangements, and at worst can be described as 'deficient and discriminatory'. The report calls on the medical Royal Colleges, medical schools, the GMC and the NHS to ensure accessible and appropriate services, and to better promote mental health and well-being in doctors.**

In response the Health Secretary Alan Johnson has announced that the Department of Health will fund pilot health and wellbeing schemes in selected NHS Trusts in which employees will get confidential feedback on their health, alongside personalised advice on healthy lifestyles. Employers will get anonymised data on the health status of their workforce that can be used to target actions to improve health and wellbeing.



IN BRIEF

NICE ON SMOKING CESSATION NICE has issued advice on the best way to encourage people to give up smoking. The guidance is aimed at all professionals who have a direct or indirect role in helping people to quit smoking, including PCTs and individual GPs. Among the recommendations is a warning not to offer varenicline or bupropion as treatment options to young people under 18 or to pregnant or breastfeeding women.

NEW FRAMEWORK FOR DwSIs IN CONSCIOUS SEDATION A competency framework for dentists undertaking training in conscious sedation of phobic patients has been published jointly by the Department of Health and The FGDP(UK). The framework is intended to provide PCTs with guidance to support the development of services where there is a local need. It will also help dentists with an interest in this area to identify learning needs and undertake further training. See www.fgdp.org.uk

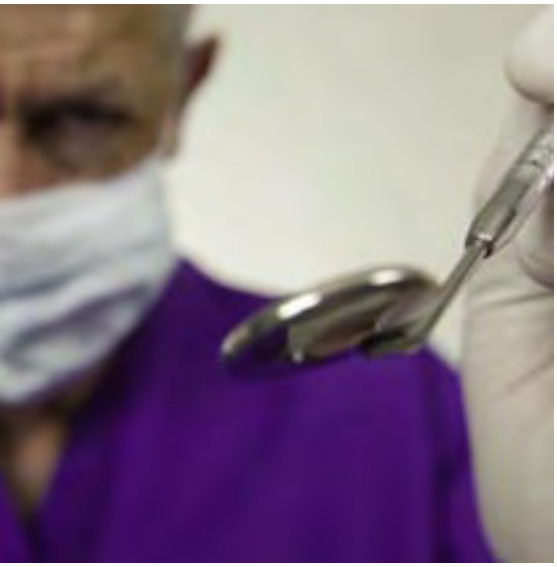
SEXUAL BOUNDARIES WITH PATIENTS A set of three documents on clear sexual

Violence goes unreported

ONE in three UK doctors has been the victim of a physical or verbal attack in the past year although most go unreported, according to research published by the BMA.

Around 600 doctors from across Great Britain responded to a BMA survey on their experiences of violence in the workplace in the past year. One in ten had been physically attacked, including being stabbed, kicked, punched, bitten and spat at. Of these, one in three received minor injuries and one in 20 was seriously injured. Junior doctors are the most likely to experience violence, followed by GPs. More than half (52 per cent) of doctors who suffered violence did not report the incident. This suggests both a degree of under-reporting and increasing acceptance of violence.

Dissatisfaction with the level of service, including frustration with waiting times and refusal to prescribe medication, was cited as the most frequent reason for workplace violence. This has doubled as a cause of violence since 2003, when the BMA last conducted the survey.



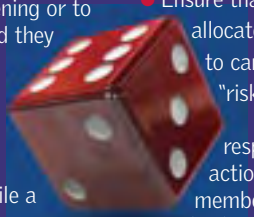
OPINION

by Ian Brennan
Risk Manager
MDDUS

Risk registers – what are they good for?

ABSOLUTELY nothing? Well I once chaired a conference on risk management in higher education where the keynote speaker, a prominent university vice chancellor, opined that the usefulness of the university risk register lay in the fact that it was handy for keeping the fire doors open in hot weather. He was speaking with his tongue firmly planted in his cheek (I think) but the scepticism was a useful counter point to the seriousness with which the rest of us took the whole business of compiling the risk register and allocating the relative rankings.

The basic idea behind the risk register is that you devise an inventory of the things that might go wrong and work out what you can do to stop them happening or to lessen the adverse effect should they happen anyway. You look at materiality – will it be cataclysmic or relatively harmless? You also look at likelihood – a weighting of one means that it is a certainty while a zero means that it will never happen. Naturally almost everything that you can imagine falls between these poles. Multiply materiality by likelihood and you get a figure which provides some measure of how much, relatively speaking, you should worry about each risk. More importantly you get some insight into the type of resources that you should allocate to preventative measures.



At MDDUS we would be delighted if all of our medical and dental practices and all of the organisations in which our members work went through the process of compiling their risk register but this is only the start. A successful risk register has to be a "living document". In short it has to lead to effective action designed either to prevent the risk from taking effect or to mitigate the consequences should the worst come to the worst. My sceptical colleague from academia was making the point that, in the world of higher education, risk registers were generally compiled due to an external regulatory requirement rather than an inner conviction that they could actually do some good. In those circumstances it's not a great surprise that, once compiled, the risk register was promptly forgotten.

So how do you ensure that your risk register is a living document rather than a wedge for the fire door? There is no single correct answer but carrying out some or all of the following should help to keep you on the right track.

- Build consensus: ensure that as many stakeholders as possible have the opportunity to contribute to the risk register.
- Ensure that actions are clearly allocated to the person best placed to carry them out and that each "risk owner" agrees to their part.
- Allocate overall responsibility for ensuring that actions are carried out to a named member of staff who carries out checks to certify that actions are being taken as agreed.
- Adopt a 'comply or explain' approach: there is no point in carrying out actions if circumstances change and the measure is no longer appropriate, but the "risk owner" should be prepared to explain any departure from the action specified.
- Keep your risk register up-to-date. As well as a formal process to update the risk register (at least annually) make it clear that everyone can contribute their view on risks and potential risks at any time.

In the same way that politics is far too important to be left solely to politicians, so risk management should not be left as the exclusive preserve of risk managers.

boundaries between healthcare professionals and patients has been published by the CHRE. The work was commissioned by the DoH in response to a series of inquiries into serious breaches of sexual boundaries by healthcare professionals. It was carried out in consultation with patient groups, professional bodies and health professions regulators, including the GMC. Access the three documents at www.chre.org.uk.

WHAT DENTAL PATIENTS NEED TO KNOW Is it of benefit for patients to know the additional skills or qualifications of dental professionals on GDC registers? A consultation document seeking views on this question has been launched by the GDC. Issues of quality-assurance and ongoing competence are also addressed in the document. The consultation is available on www.gdc-uk.org and closes 9 May. The GDC agreed to abolish its current policy on recording additional qualifications in the register in December 2007.

More news and MDDUS events at www.mddus.com

Is that your face?

HAVING YOUR PHOTO taken as the party draws to an end and then seeing it displayed the next day attached to an email or, even more embarrassing, on someone's social networking web page is not so uncommon these days.

Making an idiot of yourself is bad enough when your colleagues or friends are the only witnesses. Having your indiscretions paraded in front of the world is a little more worrying. But just imagine a prospective employer admiring your 'cute' outfit or graphic evidence of your lecherous advances – before deciding whether or not to hire you?

There is evidence that employers are increasingly using the 'search' facility on sites such as Facebook, Bebo and MySpace to check out whether that respectable 'public' image that you are presenting to them is actually a wholly accurate picture of their prospective new admin assistant, practice manager or doctor.

Application forms, CVs, face-to-face interviews and references used to be the main methods for prospective employers to assess candidates. But now web browsers offer a new means of checking out applicants and, according to a recent survey by a recruitment consultancy, one in five employers are using information gleaned from social networking sites as an aid to selection.

So, whilst you might previously have been able to predict how prospective employers would check you out, widespread use of social networking sites has now moved the goalposts and you need to take appropriate steps to ensure that your social habits are not cramping your work prospects.

> You need to assume that your Facebook postings will be open to scrutiny by someone other than your 'best mate'

Of course, you may not have full control over the details being posted on the web. However, it is fairly obvious that voluntarily recording such indiscretions as:

- slagging off your current employer or disclosing confidential information about your job or boss
- expressing racist or sexist views
- admitting, on the website, that the information about your qualifications or experience, in the employer's possession, is inaccurate
- indulging in criminal activity (for example drug-taking or vandalism) are unlikely to endear you to that employer.

The fact is – you need to assume that your postings will be open to scrutiny by someone other than your 'best mate'.

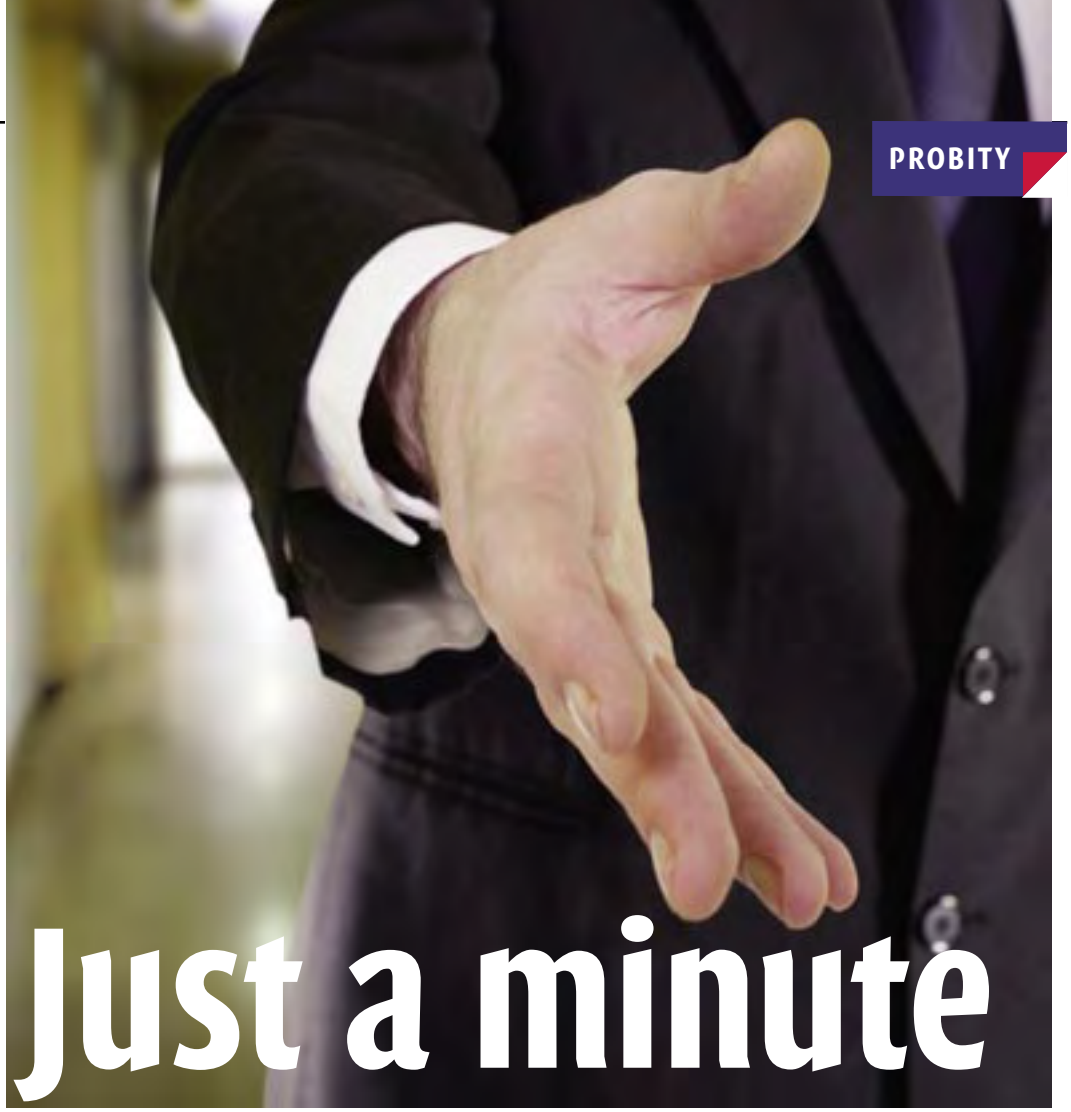
But employers who are rubbing their hands with glee at this new resource for sorting the sober wheat from the drunken chaff need to remember that they have legal liabilities too in this process.

For example, an employee or candidate who is gay or lesbian might reasonably wish this to remain confidential in a work context – even if they are out in their private life. If the information about the person's sexuality leads the employer to take a decision about their employment (either not to recruit or, possibly, to dismiss) based purely on their knowledge of this element of their private life, this may contravene the sexual orientation discrimination regulations. Similar legal restrictions might apply to using information about a person's religious or philosophical beliefs (as expressed in an online video, for example) as the basis for less favourable treatment by an employer.

The Information Commissioner's Code on the use of personal data in vetting employees or candidates suggests that, because of the danger of employers invading the privacy of the person concerned, candidates (or employees) should be told that web-checking is part of the process of assessing suitability. Even then, the nature of the post should determine whether the employer's snooping into the private lives of their employees or applicants is justified (and in compliance with the 'fair processing' principles in the Data Protection Act).

Ian Watson, Training Services Manager, Law At Work

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



Just a minute of your time...

Are you certain of what's now permitted when dealing with pharma reps? Heather Simmonds *of the PMCPA suggests you "know the Code"*

DO YOU feel that you make the most of opportunities to work with pharmaceutical companies for the benefit of your patients? Or do you feel that with increased scrutiny and regulatory controls it is now more trouble than it's worth?

Criticism of the pharmaceutical industry's relationships with health professionals has come from various sources in recent years, ranging from the media to the Health Select Committee enquiry into the influence of pharmaceutical companies. So it is understandable that doctors and other health professionals may be wary and unsure of what can be gained from working with industry.

However, with increasing pressure to meet targets, deliver a good service to patients and keep skills up-to-date it is important to look at a variety of ways to achieve your objectives. Pharmaceutical representatives can be a useful source of information on medicines and can support you in a number of other ways, including educational materials for patients. But unless you are aware of what is permitted, both you and the company could end up in hot water.

Rules of engagement

Two sets of rules govern these relationships – the Association of the British Pharmaceutical Industry's (ABPI) *Code of Practice for the Pharmaceutical Industry* and the General Medical Council's guidance, *Good Medical Practice*. Most pharmaceutical companies operating in the UK have agreed to comply with the ABPI Code and, of course, doctors must abide by the GMC's guidance. Both documents reflect UK law. The ABPI Code goes beyond the legal requirements.

The current version of *Good Medical Practice* prohibits doctors from asking for, or accepting, any inducement, gift or hospitality that affects, or could be seen to affect, their judgement. It also includes a number of requirements about conflicts of interest.

The ABPI Code has many requirements about the content of promotional material, including the need for all claims to be capable of substantiation whether made in writing or by representatives. It also places restrictions on the provision of samples, promotional aids, meetings, hospitality, subsistence, travel and ➤

REFERENCES

1. The ABPI Code of Practice and a guide to the Code for health professionals can be accessed at www.pmcpa.org.uk. Printed copies are available free of charge by calling 020 7747 8881.

2. *Good Medical Practice* can be downloaded at www.gmc-uk.org.

➤ accommodation. Detailed reports of all cases are published on the Prescription Medicines Code of Practice Authority's website (the PMCPA was established by the ABPI to administer the ABPI Code at arm's length from itself). Brief details of serious cases are advertised in the medical and pharmaceutical press.

As long as you are aware of what is and isn't permitted and are prepared to play your part in ensuring that these relationships remain professional, ethical and above reproach, working with pharmaceutical companies can benefit, and even improve, patient care. So how can you work together?

Meetings and hospitality

Pharmaceutical companies can sponsor meetings such as presentations in GP practices, but their sponsorship must be disclosed in all papers relating to the meeting and any published proceedings. Payment may not be made to doctors or other prescribers, either directly or indirectly, for rental for rooms to be used for meetings.

It must be the scientific or educational content that attracts delegates to a meeting. Lavish or deluxe venues must not be used and companies should avoid using venues renowned for their entertainment facilities. Meetings wholly or mainly of a social or sporting nature are unacceptable.

Hospitality can only be provided in association with scientific meetings, promotional meetings, scientific congresses and other such meetings. Subsistence must be strictly limited to the main purpose of the event and secondary to it. Hospitality cannot be offered to spouses or other such people unless they qualify as a delegate in their own right.

Under the Code, companies can also sponsor delegates' attendance at educational meetings as long as the requirements of the Code are met. Companies can only provide economy air travel when sponsoring delegates.

Gifts

No gift, benefit in kind or pecuniary advantage should be offered or given as an inducement to prescribe, supply, administer, recommend, buy or sell any medicine. Items must not be offered for personal benefit. Promotional aids must be inexpensive – the limit is £6, excluding VAT – and of a similar perceived value as well as being relevant to the recipient's profession.

Medical and educational goods and services

The provision of medical and educational goods and services which enhance patient care or benefit the NHS while maintaining patient care are permitted, provided they do not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine. Items must not bear a product name, but can bear a company name. The involvement of the pharmaceutical company must always be made clear. Therapy review programmes, which aim to ensure a patient receives optimal treatment following a clinical assessment, are permitted and can be a productive and mutually beneficial way to improve patient care by working with the pharmaceutical industry.

However, it is unacceptable for a company to assist with a switch programme where all patients on medicine A are simply switched to medicine B without any clinical assessment. Companies may promote a switch from one product to another, but must not assist in carrying it out.

Representatives

The Code applies to what representatives say as well as the materials they use. Representatives must maintain a high standard of ethical conduct and must be properly trained. All representatives have to pass an ABPI examination. Representatives must not use any inducement or subterfuge to gain an interview and no fee should be offered or paid for the grant of an interview.

Representatives can be a very useful source of information on medicines. If you are seeing a representative from a company that has products in a disease area that you are interested in, they should be able to provide information on the disease itself as well as medicines for treatment. Some companies may also have patient materials which you may find useful to distribute to patients when talking about their illness.

What to do if you have concerns

Complaints to the PMCPA are often made by doctors. Recent examples include complaints about the conduct of representatives, information or claims in advertisements and hospitality. Breaches of the Code were ruled in many of these cases. Full details are available on www.pmcpa.org.uk.

Companies ruled in breach of the Code are subject to a number of sanctions including publication of a detailed case report. Other possible sanctions include public reprimands, advertising in the medical and pharmaceutical press and possible suspension or expulsion from membership of the ABPI.

Complaints about the promotion of medicines, or the provision of information to the public should be sent to the Director of the Prescription Medicines Code of Practice Authority, 12 Whitehall, London SW1A 2DY (or by email to complaints@pmcpa.org.uk).

Further information on the Code and complaints procedure can be found at www.pmcpa.org.uk and advice on the Code can be obtained by calling 020 7747 8880.

■ ***Heather Simmonds is Director of the Prescription Medicines Code of Practice Authority and has worked on the Code for over 17 years. She is responsible for the day-to-day running of the organisation and chairs the Code of Practice Panel which rules on all complaints submitted to the Authority in the first instance.***

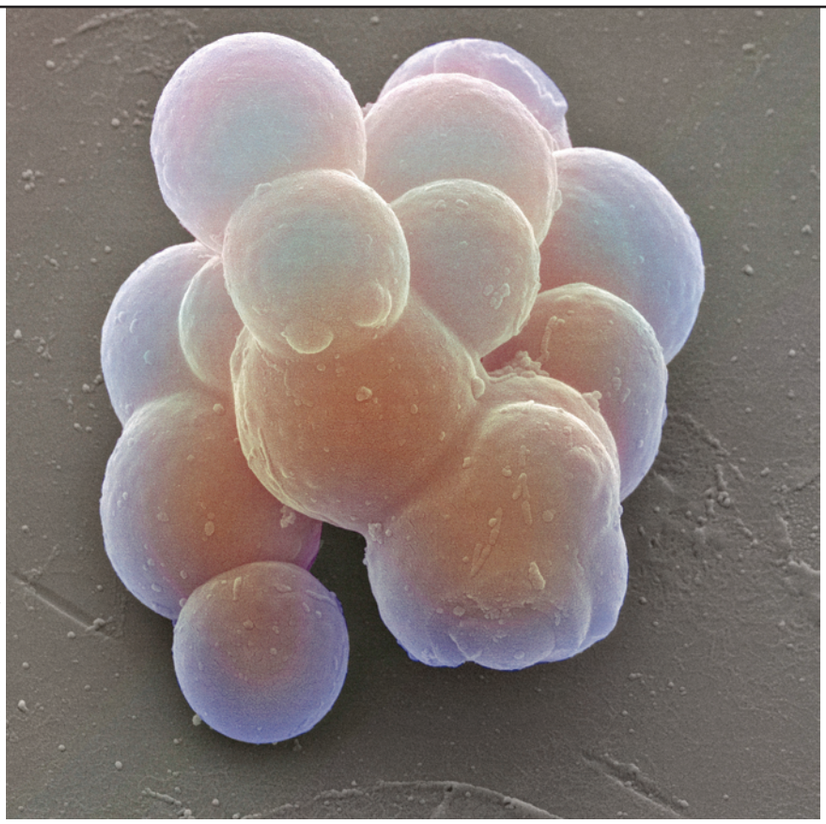
DOS AND DON'TS

DO

- Familiarise yourself with the ABPI Code and keep it in mind when meeting representatives and planning what support you would like.
- Be aware of what the GMC guidance says about accepting inducements, gifts and hospitality.
- Ask representatives for information about medicines and disease areas.

DON'T

- Have unrealistic expectations. There are restrictions on these relationships and being clear from the outset will help prevent misunderstandings.
- Accept support from a pharmaceutical company if you would not be comfortable to have the arrangements generally known.



PHOTOGRAPH: JUERGEN BERGER/SCIENCE PHOTO LIBRARY

Hope not hype

JUST THE MENTION of a name can be enough to make the heart either skip with delight or sink with despair. Think of Tortora, or Kumar and Clark, and the pulsing hearts of undergraduates old and new. But even in the most authoritative textbooks there comes a point where the scientific 'knowns' give way to 'unknowns' and the authors must insert a note: "the mechanisms of this process," they admit, "are not yet fully understood".

Stem cell scientists, too, are open about the 'known unknowns' of their field. This is perhaps most notable when they take the extra step of going outside the laboratory to communicate with members of the general public. The Scottish Stem Cell Network is one example of a research community that organises gatherings for experts and also schedules open meetings at the same events to bring together leading scientists and local people.

This is a good thing to do. Many people are intrigued by the new research being reported in the media. As patients, they may wish to know what therapeutic possibilities could become available to them – the realistic hope rather than the tendency for 'hype'. As citizens, they may be unsure about the use of human tissues in research. Some are satisfied that the blastocyst, as a very early division of cells and source of human embryonic stem cells, is entirely that: a ball of cells. Others consider its status to be ethically different for reasons to do with the nature of our species.

Regarding 'known unknowns', one of these is whether regenerative therapy could pass on abnormalities. Could regenerated tissue used in transplants become cancerous? Is there a risk of transmitting viruses or other pathogens from stem cell grafts? Even less discernible are the 'unknown unknowns' – the unintended and unanticipated consequences of this rapidly developing branch of biomedical science.

To help promote public understanding, the Research Councils UK partnership has produced an exhibition for display at events around the country entitled 'Stem cell science: hope not hype'. Bringing heads together among scientists and the public, the RCUK is eager to share information both about the science and the regulatory framework as laid down by Parliament on behalf of society.

In 2003 the UK Stem Cell Bank was set up to ensure all research is conducted using only the human cell lines that it supplies to teams working on projects meeting strict ethical and clinical criteria. This safeguards the source and consent requirements for depositing of cultures, together with the quality standards of stem cell lines that are reproducible, tested and stable.

Transplantation of stem cells has been saving lives for decades through bone marrow and umbilical cord blood therapies. Ten years have now passed since the landmark achievement of replacing the nucleus of a mammalian egg cell to propagate an embryo that became the sheep named Dolly. Then last year two separate teams succeeded in reprogramming skin cells from mice, demonstrating a more efficient method of deriving stem cells without requiring oocytes.

Today there is a growing public realisation that stem cells have capacity to regenerate all tissues of the body. Images of pulsing cardiomyocytes grown in the laboratory convey this possibility dramatically. In the future, tissues will be cultured from stem cells derived from patients so as to model disease processes. Drug toxicology is a particularly promising area in the testing of new compounds on standardised hepatocytes and other cells, thereby significantly improving clinical trials of pharmaceutical products.

'Images of pulsing cardiomyocytes grown in the laboratory convey dramatic possibilities'

Heartening stuff, and not least because of the efforts of stem cell scientists to communicate and inform. Engaging the head while avoiding the hype, this is a field that holds out hope for us indeed.

Dr Al Dowie, MDDUS Senior University Teacher in Medical Ethics, Law and Risk

Medical defence...

Today the bulk of medical malpractice coverage in the USA is provided by physician-owned and/or -operated insurance carriers – and it is the role of the Physician Insurers Association of America to protect their interests

THE era of the 1970s was tumultuous for physicians and medical professional liability insurance companies in the United States. During this period, both the number and cost of medical professional liability (medical malpractice) claims soared. The commercial companies that provided coverage for physicians responded by raising their premiums – sometimes doubling or even tripling them. Still, even at those rates, the medical professional liability insurance (MPLI) market was simply not attractive to commercial insurers, and many subsequently withdrew from it.

At the same time, numerous physicians, unable to afford coverage even when it was available, opted to limit the scope of their practice – or stopped practising entirely. In rural areas of the country, some physician specialties, such as obstetricians, became vanishing species. Then, in 1974, physicians in several states decided to take matters into their own hands. Largely through their state medical associations, these doctors began to create and fund their own MPLI companies. Most of the fledgling companies were set up as mutual or reciprocal insurers; the doctors themselves had a stake in the operations of the companies.

These new structures, wherein physicians and insurance professionals focused together on the key elements of operating a medical professional liability insurance carrier (claims, risk management, underwriting and finance), provided important new benefits for the physicians they insured. The companies pledged to provide a vigorous defence for their insureds; commercial carriers were often willing to settle MPLI claims for economic reasons, even in the face of frivolous lawsuits. Also, as claims began to come in, the physicians who worked with these companies began to identify common themes in the causes of medical mishaps. The physician-owned companies used this information to develop new risk-abatement programmes for their policyholders.

A place to call their own

Domiciled in the individual states, these new "bedpan mutuals" (as commercial carriers sarcastically dubbed them) realised their need for a central forum, an organisation that would make possible an exchange of information and new solutions to common problems. From this realisation came the Physician Insurers Association of America (PIAA), established in 1977. At present, the PIAA has 56 domestic insurance company members in states throughout the USA, and 13 international companies (including the MDDUS) throughout the world.

The PIAA is the voice of medical liability insurers owned and/or operated by the entities they insure. As an industry association, the PIAA's member companies insure the majority of all doctors in the United States, as well as dentists, hospitals and other healthcare providers. In fact, the PIAA represents 775,000 healthcare providers around the world. In October 2008, the organisation will hold its fifth International Conference, where more than 250 delegates from across the globe will meet in Paris to discuss the globalisation of healthcare and liability risk.

Today's PIAA is comprised of insurer

American style

and non-insurer members – both groups providing services essential to the practice and advancement of medicine. Insurer members are mainly mutual and reciprocal companies owned by the doctors they underwrite, and physician-governed companies that have become publicly traded. Non-insurer members of the PIAA range from research and actuarial firms to information technology consultants and reinsurance companies and intermediaries.

The primary goal of the PIAA is to maintain a stable medical professional liability insurance market in which its member companies can provide affordable, accessible liability insurance to the healthcare professionals and facilities that keep the public healthy. In essence: the PIAA protects healthcare.

Advocacy, education and data sharing

The PIAA's activities address a wide variety of material developments that can affect the operations of its member companies. Under this direction come the PIAA's programmes for research, patient safety and advocacy for favourable reforms in laws and regulations, at federal- and state-level government. In addition, as a provider of continuing education for physicians, dentists, nurses and those in the field of accounting, the PIAA holds a variety of meetings each year focused on operational areas within a medical professional liability insurance carrier, as well as on patient safety and general medical liability issues. PIAA member companies have access to valuable research, continuing education programmes and networking resources to help them achieve their operational goals. The PIAA's services bolster its members' efforts to establish and improve risk management procedures, underwriting practices and advocacy plans.

Housed within the PIAA is its Data Sharing Project, begun in 1985, which now stores detailed data on more than 240,000 medical claims and suits submitted by its member companies. The sheer size of this database conveys statistical power revealing both major and minor factors that may be involved in medical mishaps. The outcome from analysis of the data is information that serves as the basis for patient safety and risk-abatement recommendations that help physicians advance the safe practice of medicine.

The PIAA's reputation for providing unbiased facts and serving as a consistent voice for the medical liability industry has made it a trusted source for medical malpractice claims data and insight on industry trends. Government agencies and officials, media outlets, medical liability insurers, medical schools, private healthcare organisations and other members of the healthcare community have benefited over the years from the PIAA's research and counsel.

The policyholder's perspective

After the hard times of the 1970s, physicians emerged with two paramount concerns about medical professional liability insurance: affordability and assurance of ongoing coverage, despite the ups and downs inherent in operating any insurance company. The PIAA and its member companies have responded, with constant attention and measured response, to the vagaries of the financial and insurance markets. Companies that are members of the PIAA and adhere to its "philosophy" create business plans, monitor claims, set underwriting standards and determine the best approach for allocating company assets. They do all this while operating at the lowest possible cost. In the majority of carriers within the PIAA structure, any money acquired in premiums that is not needed for operating the company or paying legal claims may be returned to the individual policyholder, as a dividend.

PIAA companies provide occurrence form and claims-made form coverage. But the trend is to claims-made coverage. Coverage against potential claims is only one element of the insurance provided to physicians by PIAA member companies, however. They typically offer a full suite of services, which may include education and risk management, risk assessment of individual practices, legislative advocacy and legal and consultative services, in the event a claim should arise.

Risk management services for physicians concentrate on areas of practice that frequently serve as the impetus for claims: medical records documentation, tracking of patients for recall or follow-up, diagnosis or treatment by telephone, prescription refills, laboratory results and referrals to other physicians.

When claims occur, despite all efforts at risk mitigation, policyholders immediately contact their insurer, which collaborates with them from the opening phase of discovery, right through to final settlement or verdict.

With all of the services that the PIAA (and its member companies) provide in place, physicians can focus on what is most important: providing quality healthcare.

For more information about the PIAA and its member companies go to www.piaa.us

■ ***Larry Smarr is president of the Physician Insurers Association of America***

GDC President Hew Mathewson *offers some essentials from a new guidance document on sound management principles in the 'business of dentistry'*

Mind your business

MANAGEMENT responsibility – two words that are increasingly familiar to thousands of dentists who run a practice or clinic.

Back in June of last year the General Dental Council launched a consultation on draft guidance concerning the responsibilities of registrants when acting in a business capacity. This was prompted by changes in the amended Dentists Act which came into force in July 2006 and opened up the 'business of dentistry' to dental care professionals as well as dentists. All members of the registered dental team can now receive payment for dental treatment, own practices and laboratories and employ other members of the dental team.

In light of these changes, the Council felt that it would be helpful to give guidance to registrants about their responsibilities in running a business. In February the GDC published the final document – but what is the guidance in essence?

Putting patients' interests first

Guidance on principles of management responsibility covers those who:

- own, or have responsibility for, dental practices or dental laboratories
- manage within dental healthcare organisations
- manage within educational establishments
- have responsibility for conducting clinical trials
- are directors of Dental Bodies Corporate (DBCs).

The document expands upon core GDC guidance, enshrined in *Standards for dental professionals*, which requires registrants always to act in the best interests of their patients, whether they manage people or resources. That means you have a professional responsibility as a manager, as well as a clinician, and must follow this guidance whether you yourself are managed by another person who may or may not be a GDC registrant. How does this work? Here are some suggestions, by no means exhaustive.

- *Put patients' interests before your own or those of any colleague, organisation or business.* If conflicts threaten your primary duty to prioritise patients' interests, raise your concerns formally with management colleagues, with external professional bodies, with MDDUS or with the GDC.

Here are two examples. First, by August, all dental nurses must be registered: if boards and trusts continue to rely on general nurses to replace registered dental nurses, for instance in maxillofacial units, then registrants should raise their concerns. Second, if directors of a DBC pressure a registrant to promote expensive or unnecessary treatments, then he or she must protest.

- *Make sure you work within your knowledge and competence as a director or manager.* Keep up to date with, and use, guidance on necessary knowledge, skills and attitudes. If you have an employer, they should support you in this. Individual registrants should read widely, and seek advice and support from MDDUS and their professional representative organisation.

Be aware of your legal responsibilities as a director, owner or manager and make sure that you fulfil them. In the same way that an HR director keeps up to date with changes in employment law, you must keep up with your legal responsibilities. Read widely and seek advice if necessary.

- *Understand and fulfil your legal and ethical responsibilities in relation to equality and diversity.* Responsibility for equality and diversity applies to how you treat everyone – employees and patients. It's not only a matter of employment law but also service provision, such as access to the building and services generally.

You cannot discriminate against HIV-positive patients; your cross-infection control should be effective. Think about physical access for disabled patients and your responsibilities under disabilities discrimination legislation.

When you take on a management role, you face

legal and ethical responsibilities on such issues as ionising radiation, disposing of hazardous waste, controlled drugs, etc. You must also be familiar with new laws on vetting potential employees and ensuring that they are not barred from "controlled activity" – essentially, access to your patients.

- *Justify the trust that your patients, the public, those you direct or manage, and other colleagues, have in you by always acting honestly and fairly.* This is essential as a director, owner or manager. No doubt you have told MDDUS how many clinical sessions you work and of every service you provide to ensure you pay appropriate indemnity fees. It means that if something goes wrong, your patients – and you – will be protected.
- *Make sure that you do not compromise the interests of patients by allowing financial or other targets to have a negative influence on the quality of care provided by those you direct or manage.* Financial and business pressures are very real, as I know myself. Beware of perverse incentives clouding your judgement about what's right for your patients. Guard against such distortions.
- *Ensure that if you delegate managerial responsibilities, the person you delegate to is competent to do what you are asking.* As with delegating clinical responsibility, you are still responsible and accountable for ensuring that employees know what they're doing. If you fail to check whether an employee is competent and something goes wrong, then having delegated carelessly, you are accountable.
- *Make sure that early warning systems are in place.* You should ensure that the organisation you work for has adequate early warnings of any concerns about the health, behaviour or professional performance of any staff you direct or manage, or of concerns about any aspect of the clinical or administrative environment, and that such concerns are addressed promptly and effectively.

Appraisals, health assessments, supervision, induction – such systems are all pretty standard stuff. Ensure that they are implemented. However, if you are dissatisfied with the clinical environment – the standard of premises or of equipment – and you are in a position to resolve the problem, then you must. Blaming senior managers isn't good enough.

- *Raise important concerns with colleagues.* If you have any concerns that an organisational decision or any activity within the organisation would put patients at risk, make sure that you raise that concern with your colleagues. This includes any decisions or actions that may compromise patient safety, or the wider public interest, such as dishonesty or incompetence. Do the right thing: raise the alarm.

'Encourage staff to raise any concerns they have about the activity of the organisation... create an environment which ensures that staff can raise concerns comfortably'

Promoting compliance

In addition to your own behaviour, the guidance also concerns the behaviour of others within your organisation. As a director, owner or manager within an organisation, you are in a position to influence the way in which the organisation works and the way in which the people within it work. You can also make sure that people you direct or manage are familiar with the GDC's *Standards for dental professionals* and its supporting guidance. For instance, as a registrant director of several practices within a DBC, it's your responsibility to ensure that unregistered practice managers respect patient confidentiality. And if you manage a small dental team, it's important to ensure that the unregistered receptionist takes patient confidentiality as seriously as registrants do.

All members of the dental team who have to register with us are individually responsible and accountable for their own actions and for the treatment or processes which they carry out. Make sure you don't compromise the ability of anyone you manage to comply with standards, for instance by cutting consultation times.

Encourage staff to raise any concerns they have about the activity of the organisation, including any risks that the health, behaviour or performance of colleagues may present to the safety of patients or the wider public. Create an environment which ensures staff can raise concerns comfortably.

If anything mentioned in this article comes as a surprise, ask MDDUS for advice. Meanwhile, we at the GDC will keep you informed of any regulatory changes in dentistry. You can sign up for email alerts at www.gdc-uk.org.

Guidance on principles of management responsibility is on the GDC website (www.gdc-uk.org), and in hard copy on request (call 0845 222 4141).

■ ***Mr Hew Mathewson is president of the General Dental Council***

A crippling

Slipped upper femoral epiphysis – a condition in which delayed diagnosis can result in lifelong disability and potential medicolegal difficulties

SLIPPED upper femoral epiphysis (SUFE) is a condition which occurs in 1-7 individuals per 100,000 and, as such, is likely to be encountered once or twice in any one general practitioner's career. A recent study has identified a 2.5 fold increase in the incidence of SUFE and has suggested a link with the growing problem of childhood obesity.

Unfortunately, in a proportion of cases, delay in diagnosis in primary care has a devastating effect on the outcome – a disabled adolescent being the end result. Despite many previous studies drawing attention to this problem, SUFE persists as a regular source of medicolegal claims, often in excess of £100,000.

SUFE occurs typically in the age group of 10-16, and boys are affected twice as commonly as girls. However, there has been an increase in children as young as 8 years presenting with SUFE, and when it occurs in this age group bilateral disease is more common. Whilst the classic body habitus is an obese "hypogonadic" child, it may also occur in tall thin individuals.

Certain conditions are associated with increased risk of SUFE in children:

- previous slip on the other side (30 per cent of slips are bilateral, half of which present simultaneously, the other half sequentially)
- hypothyroidism
- hypogonadism
- panhypopituitarism
- primary and secondary hyperparathyroidism
- growth hormone deficiency
- children on steroids
- children on chemotherapy and/or radiotherapy.

History and examination

The history is often misleading. Usually the onset of symptoms is insidious, with imprecise recall for timing. Frequently, symptoms follow sport and are attributed to muscular strain. Traditionally, three weeks has been the watershed between a slip being regarded as acute or chronic. This is somewhat artificial and is unhelpful in assessing outcome.

Most patients will have hip or groin pain, often referred to the knee. Isolated knee or distal thigh pain occurs in approximately 20 per cent of cases, with no suggestion of hip or groin pain, and it is these cases who are particularly at risk of misdiagnosis and subsequent delay to referral. The presence of a limp should be noted and whether it is painful. Pain on weight bearing is an important symptom.

It is often forgotten that SUFE is a condition that progresses and any increase in the severity of symptoms or signs is very important to recognise. In 10 per cent of cases, inability to weight bear with crutches may develop – this is the definition of an unstable slip in which rapid and severe displacement can occur spontaneously or precipitated by minimal trauma such as a stumble.

A careful examination is essential. Adolescent knee conditions such as Osgood–Schlatter's or chondromalacia patellae are common in this age group; however, knee pain in the presence of a normal knee examination should be regarded as SUFE until proven otherwise.

Hip examination has been reported as being abnormal in 90 per cent of cases of SUFE. Pain on passive hip movement is highly significant; however, SUFE can be "silent" and painless with deformity developing slowly over months. Such cases are identified by looking for asymmetry of limb rotation as demonstrated by:

- unilateral out-toeing on walking
- one foot pointing outwards when lying supine
- automatically moving into external rotation when

slip

the hip is flexed, or reduced internal hip rotation on prone examination.

Early diagnosis essential

With time, the angulation between the epiphysis and femoral neck increases. In most cases the patient is able to weight bear (a stable slip). Early diagnosis before the slip has progressed enables surgical stabilisation with a single percutaneous screw – an uncomplicated procedure with the expectation of a near to normal outcome.

With increasing displacement, the function of the hip is compromised to the extent that corrective osteotomy may become necessary to enable the patient to walk effectively. The outcome of such surgery is unpredictable and premature degenerative arthritis in the third or fourth decade not uncommon. Avascular necrosis develops in approximately 10 to 15 per cent of patients undergoing corrective osteotomy and may be associated with hip replacement or arthrodesis in the second or third decade. Avascular necrosis can occur in up to 50 per cent of cases if the slip becomes unstable. Instability occurs in 5-10 per cent of all cases of SUFE.

Medicolegal aspects

Individual cases make sad reading, with major impacts on patients' lives and, indeed, attitudes to life and work. The loss of earning potential in patients unable to pursue intended careers accounts for those cases which settle for over £100,000, whilst those involving pain and suffering, cosmetic problems and increased risk of osteoarthritis settle in the £10,000-£60,000 range. The legal costs associated with these cases tend to be high because of their complexity. Cases can also take 3-5 years to resolve, and this is another factor that young adults find difficult to come to terms with.

Common pitfalls leading to claims include:

- Failure to consider the diagnosis, particularly when knee pain is the presenting symptom.
- Failure to exam the hip and record the findings.
- Incorrectly being reassured by a previous "normal" X-ray report, and failing to appreciate that SUFE is a condition that evolves.
- Delay to referral often for administrative reasons despite considering the diagnosis.
- Lack of appreciation of the relevance of difficulty with weight bearing, the concept of instability and the urgency of referral.

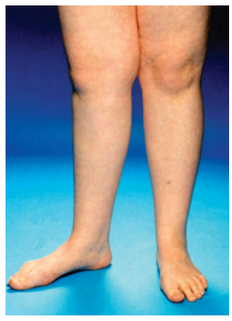
Minimising the risk

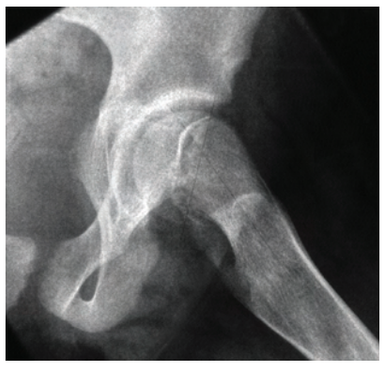
Hip, groin, distal thigh or knee pain in this age group should always be regarded as a potential SUFE. If the hip examination is normal it should be recorded, and review in the surgery is appropriate. Referral should be considered if symptoms persist without improvement beyond a week.

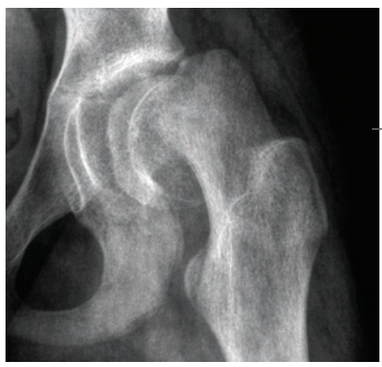
Deterioration in symptoms and/or the presence of abnormal hip examination are indications for early specialist review and should be discussed with the local orthopaedic service to agree timing of appointment.

A sudden increase in the severity of pain or difficulty in weight bearing should be regarded as an indication for immediate referral to hospital, avoiding movement of the affected hip and preventing attempts at weight bearing. Surgical treatment of such cases within 24 hours of onset of symptoms is associated with a lower rate of complications.

■ *Mr Jamie MacLean is Lead Consultant at Tayside Childrens Orthopaedic Service and also provides expert reports for the MDDUS*







Top: asymmetry – unilateral out-toeing in a patient with a stable slip of longstanding Above: X-rays of the same hip 8 days apart – the severe and rapid displacement associated with the development of instability

SUFE – KEY POINTS

- Incidence of SUFE is increasing
- 20 per cent present with knee or distal thigh pain
- 10 per cent are unstable and are at risk of major displacement with a simple stumble
- Avascular necrosis occurs in approximately 50 per cent of unstable slips
- Hip replacement or arthrodesis before the age of 30 is often required following severe avascular necrosis
- SUFE is a consistent source of significant medicolegal claims with high legal costs

Bodies of evidence

Adam Campbell *meets leading UK forensic anthropologist and Dundee University professor of anatomy, Sue Black*

PHOTOGRAPH: GETTY

ASK Sue Black which of her many contributions in the field of forensic anthropology she is most proud of, and there is not a moment's hesitation. It was 1999, in Kosovo, where she had been part of a British team of experts collecting evidence for the International War Crimes Tribunal. At one tragic site, a man had buried 11 members of his family, including eight children, who had been killed in a Serb rocket-propelled grenade attack on his tractor and trailer.

The man agreed they could exhume the collected remains but with one proviso. Speaking from her office at Dundee University, Professor Black explains: "He said, 'I'm happy for you to do that, providing you can give me back 11 body bags, because until I can bury each member of my family separately, God won't find them.'"

So she set about the grim task. "We excavated enough to fill two body bags. Then I sent everybody out of the mortuary for the day and I laid 12 plastic sheets out on the floor, because I knew there would be bits I couldn't identify. Then I slowly went through every single tiny fragment to see if I could identify undeniably who it belonged to. We gave him back 11 body bags and he was able to put each one in the ground and deal with his grief in that way. It was right place, right time to solve a grief that I can't even imagine."

Mental toughness

Dealing with unimaginable grief is an occupational hazard for the forensic anthropologist. Their remit is to establish the biological and personal identity of the deceased, such as sex, age, height, race and disease status, in cases where all the obvious signs have been eradicated and often there will have been foul play. Indeed, foul play is almost a given in the sorts of cases that pepper the 46-year-old's career, whether investigating war crimes in Kosovo, Sierra Leone and Grenada, working on a string of domestic murder cases, including that of Fred and Rosemary West, or helping with victim identification in Thailand after the 2004 tsunami and recently in war-torn Iraq.

The need for mental toughness is something she reinforces to her students at Dundee, where she is head of the Centre for Anatomy and Human Identification. "You have to counsel students that you can't afford to have the flashbacks or anything that interferes with separating your personal from your professional life," she says.

"You have to have a clinical detachment. If a doctor got involved in the emotions of every single

patient, they wouldn't be able to function. We're exactly the same."

Professor Black set up the UK's only undergraduate forensic anthropology course in Dundee in 2003, following a decade away from the academic coal face (prior to this she had been lecturing in anatomy at St Thomas's Hospital in London for six years after a PhD at Aberdeen). She spent much of this decade assisting police forces in the UK and working for the Foreign and Commonwealth Office on matters of criminal and war related incidents, such as her work in Kosovo, for which she was honoured with an OBE. She also found time to co-write *Developmental Juvenile Osteology*, one of the definitive textbooks on the bones of young children.

Her decision to return to academia full-time came about largely as a result of her experiences abroad. "What I found when I was taking other people's students out with me was that the fire wasn't there. And I couldn't cope with the fact that, in 20 years' time, when I fall off the perch, there might not be students there who want to do nothing else but get to the bottom of this. I met students who said, 'I want to be on television…'."

Quality at issue

Indeed, television and the steady stream of 'cold case' programmes like CSI had its part to play in the poor quality of students, she believes. "Prior to the 1990s almost anything that was forensic was related to medicine or dentistry. Then we got all these dreadful TV programmes, books and films and suddenly forensics became really sexy. And universities with a remit that 50 per cent of school leavers had to go into higher education had to produce courses the students would be attracted to. Forensics was the hook."

The problem, however, was that many of these postgraduate courses didn't even require a first degree that included anatomy, a lack that Black found absolutely perplexing. "How do you make a credible forensic anthropologist who's going to stand up in the courts of law and, through your evidence, commit somebody to a time of incarceration or, in Iraq, condemn somebody to a death sentence if you don't really understand the subject you're talking about? I cannot believe that comes from anywhere other than anatomy."

A friend, who is also a senior police officer, suggested that rather than complain about other people's students, she should "shut up and do something about it". The result is a four-year course of which she is immensely proud. The intake is 25 students per year and an average pass of 60 per cent is required to graduate from one year to the next.

The bar is set higher than many courses, but Professor Black is unapologetic about what some educationalists might describe as "elitism". "Frankly I don't care. We have to be elitist, because the stakes are too high," she says defiantly.

Another consequence of Black's work abroad is the Centre for International Forensic Assistance, of which she is a founder and director. This not-for-profit organisation holds a database of experts in the field of disaster victim identification. "Following Kosovo, we realised there were a number of people with a tremendous amount of expertise who, once an incident finished, disappeared into the ether. And when the next incident occurred you were scrabbling around trying to find where they lived, who they worked for – were they still alive?"

Now with this repository, she says, "If somebody needs five pathologists, we can find them; if somebody needs 13 forensic odontologists for the Asian tsunami, we can find them. It's about ensuring a currency of information."

It's a huge step forward in the administration surrounding the international community's response to mass-fatality incidents. And it is not Black's only contribution to this area.

Disaster planning

Last year Black and a team of academics from Dundee won a two-year contract to train the country's first national team in disaster victim identification, comprising 500 police officers from every force in Britain. The whole project moved ahead very swiftly and within three months the team completed the enormous task of putting together a 21-chapter textbook, which was then transferred to a virtual learning environment. The course also involves a week of face-to-face lectures and practical sessions, including work on a fictional ferry disaster in the Outer Hebrides, in which 'victims' are matched to their antemortem data.

"I have to admit it's exhausting. But it's something we believe in very strongly," says Black.

Her move back into campus life does not mean Black has adopted a hands-off approach to her subject. The day I speak to her, in fact, she is busy working on a murder case. "I'm able to predict the patterns of fracturing that I am seeing on the skull on my computer screen, to give me an indication of what this poor man went through before he died," she says. Although she has been pondering this case since October, Black says she won't give up "until we've got it right".

It's the kind of dogged determination that is key to the making of a good forensic anthropologist and it's what Black looks for in her students – although, she says, you can't teach that level of commitment. "Anatomy does that to people," she says. "You either hated it as a medical or dental student or you loved it – it's like Marmite, there's no middle ground. And I want students who, when I'm trying to close the door at five o'clock, say, 'Can I just have 10 more minutes?'"

■ *Adam Campbell is a freelance writer and editor living in Edinburgh*

Above: Sue Black Left: an Albanian woman lays flowers at the mortal remains of Kosovo Albanian civilians returned from an unmarked grave

PHOTOGRAPH: UNIVERSITY OF DUNDEE

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

DENTAL RECORDS

An unwelcome embellishment

A PATIENT attended a dental clinic for a tooth extraction. The GDP, Mr K, commenced what appeared to be a routine extraction of an Upper Right 7, but encountered difficulties when he discovered the tooth was fused to an unerupted Upper Right 8. He explained the position fully to the patient, completed the necessary surgical procedure and wrote up his records. Unfortunately, the patient developed post-extraction haemorrhage and attended the local accident and emergency unit. For whatever reason, the service was not ideal and the patient was transferred to a specialist oral surgery unit at a different hospital. Regrettably all this took time, in the middle of the night, and the patient felt that the initial responsibility lay with the GDP. This prompted her to send a complaint to the General Dental Council in regard to Mr K's standard of treatment.

Analysis and outcome

When the complaint arrived at the surgery Mr K took advice from the MDDUS and an appropriate response was sent to the GDC, including the records and radiographs. Mr K had computerised the records in his practice approximately one year earlier. Notes of the treatment on computer were fair but did not elaborate in detail. It turned out that Mr K was not an enthusiastic typist and, in situations like this, would supplement the computerised records with handwritten notes. These were also sent to the GDC.

In due course, a response was received from the GDC indicating they would be taking no further action in respect of the complaint by the patient. However, they wished to clarify the timing of the writing of the dental records. From examination of the actual card, the coding indicated that this card had been printed after the date of the record entry. Mr K was asked to comment. The dentist then sent us the original handwritten record, which he claimed had been made at the time of the operative procedure. He had prepared a new copy of this for submission to the GDC as he felt it would be more legible. Regrettably, in comparing his "transcript" with the "original" there was some embellishment.

On further review, the Investigating Committee at the GDC was highly critical of Mr K's actions. They felt that the additional information contained in the "transcript" was certainly not contemporaneous and a serious view was taken. It was recommended that the dentist should not run two separate record systems. Advice was also offered with regard to contemporaneous writing of records and fullness of notes.

It would certainly not be appropriate to discourage a dentist from writing full notes. If the task cannot be delegated, then the dentist should take the time to provide a full record.

Key points

- Take time to write full and comprehensive notes.
- Ensure notes are contemporaneous.
- Avoid having two separate record systems but ensure cross-referencing if unavoidable.

EXAMINATION

Infant injury

MRS T presented at a GP surgery with her 7-month-old baby who had a rash. The mother placed the baby lengthwise on the examination couch as the GP requested. Both mum and the GP then glanced away for just a few seconds. The infant rolled and fell from the couch to the floor, suffering a fractured skull.

Analysis and outcome

Fortunately the baby recovered well with no adverse sequelae and the patient did not pursue a claim. The practice undertook significant event analysis and suggested that in future babies of this age should be examined lying across the couch rather than lengthwise as usual. Should a similar incident occur, the baby will roll along the couch rather than fall off.

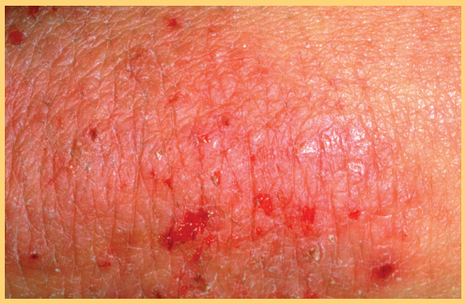
Key points

- Ensure infants in the examination room are monitored at all times.
- Never leave infants unattended on an examination couch.
- Undertake regular risk assessments for health and safety.

PHOTOGRAPH: LAUREN SHEAR/SCIENCE PHOTO LIBRARY

Dermovate overuse

A 42-YEAR-OLD male, Mr P, had suffered from eczema from a young age. His local GP surgery had always provided treatment for the condition. Some time prior to age 25 he was prescribed the corticosteroid ointment Dermovate. The exact date of the first prescription was uncertain as Mr P's records prior to that year had been misplaced. Over the next years he was issued numerous repeat prescriptions for the ointment which he applied mainly to the back of his knees, his elbows but also to his face.



In his early 30s Mr P began to notice redness and thread veins on his cheeks. His colleagues at work and friends also noticed and made comments on his appearance. Mr P attended his GP practice and rosacea was diagnosed. He was prescribed Oxytet and referred to a dermatologist. Mr P later opted for private laser therapy to treat the thread veins and was advised then by the laser therapist not to use Dermovate on his face.

A few years later he attended the GP practice and was seen by a locum. He enquired about a repeat prescription of Dermovate to treat his recurring eczema and explained that he had been using the ointment for years. The locum immediately advised him that long-term, repeated use of the corticosteroid was contraindicated. She prescribed another medication and removed Dermovate from his repeat prescription list.

Analysis and outcome

A claim was later received by the GP practice for negligence in the over prescription of Dermovate. It cited that in the BNF the medication falls under the heading of "very potent topical corticosteroids" and that it should only be prescribed for short-term treatment of severe resistant inflammatory skin. No evidence was present in Mr P's records that he had been advised on the proper use of the medication or the side-effects.

Mr P had been seen by numerous doctors in the practice over the years and it was a clear case of a "systems error" in which the repeat prescription was never adequately reviewed. The case was deemed indefensible and settled along with all legal costs.

Key points

- Ensure that all repeat prescriptions are adequately reviewed.
- Record any and all discussions with patients regarding use and potential side-effects of medications.
- Be vigilant in the prescribing of steroid ointments.

PHOTOGRAPH: DR P MARAZZI/SCIENCE PHOTO LIBRARY

Weekly for daily

A 73-YEAR-OLD woman, Mrs B, attended a GP surgery to discuss medication for her rheumatoid arthritis. On agreement the GP, Dr K, started her on a course of methotrexate but in error he wrote out a prescription for 10 mgs, 2 daily, when the safe correct dosage was 10 mgs, 2 weekly.

Ten days later Mrs B was admitted to a cardiac unit seriously unwell with atrial fibrillation and flu-like symptoms. The hospital contacted Dr K when it became clear there had been an error. Dr K visited Mrs B in hospital and admitted his error and expressed sincere regret. In doing so he was following GMC guidance as set out in *Good Medical Practice*: "Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology". Mrs B seemed to accept his apology and it was hoped that this would be enough. But some time later a letter arrived from Mrs B's solicitors with a claim for compensation.

Analysis and outcome

As Dr K had also admitted liability in a letter to Mrs B there was no alternative but to settle. In the meantime it transpired that there had been an investigation into procedures at the pharmacy

which dispensed the methotrexate. It was acknowledged that the dispensing pharmacist should have noted the incorrect dosage. An agreement was struck with the pharmacy to share the moderate damages and legal costs.

Key points

- Double-check dosage when prescribing unfamiliar drugs.
- One should not rely on pharmacists to always pick up prescribing errors.
- Take advice on the form and content of an apology to a patient if you are unsure if this might imply liability.

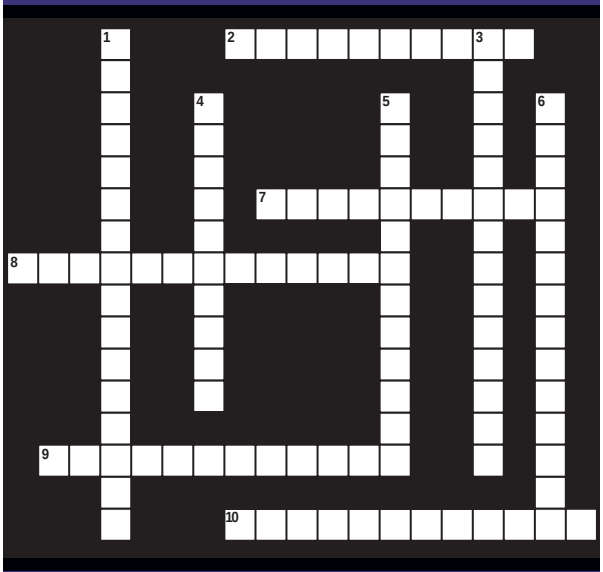
Medical Crossword: causes of anaemia

Across

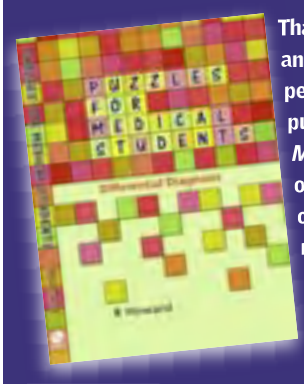
2 Type of anaemia in which mean corpuscular volume is between 76 and 96 fl (10)
7 Autosomal recessive cause of anaemia found more commonly in those of African origin (6, 4)
8 Inherited anaemia with symptoms of jaundice, splenomegaly and leg ulcers (13)
9 Term for reduced number of erythrocytes, leukocytes and platelets (12)
10 Term for varying shapes of blood cells (12)

Down

1 Anaemia associated with poor intake, e.g. in alcoholics (6, 10)
3 Anaemia related to chronic bleeding, e.g. from a peptic ulcer (4, 10)
4 A macrocytic anaemia found in autoimmune conditions due to B_{12} malabsorption (10)
5 Microcytic anaemia mainly affecting people of Mediterranean origin (12)
6 Enteropathic condition with megaloblastic anaemia (7, 7)



See answers online at http://www.mddus.co.uk/mddus/2739.html



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From the archives: child's play

A THICK skin has always been essential in general practice but every doctor has limits. On 20 June 1907 the MDDUS was contacted by a Dr Robertson of Musselburgh with an original copy of a printed school certificate of absence for a young girl being treated for bronchitis. Across the top was a note scrawled in red ink by Mr Gray, the headmaster of the local school. It read: "This certificate is either a deliberate falsehood or shows a wonderful incompetency in medical affairs. The girl was seen at play last night by at least thirty children."

The Advisory Committee of the MDDUS deemed the statement libellous and advised Dr Robertson that he had a "good call for action by demanding a withdrawal, apology, and possibly payment for damages". The doctor's solicitors wrote to Mr Gray's "Glasgow Agent" demanding a published apology as well as damages of five guineas. A no doubt surprised and regretful Mr Gray agreed and damages along with legal costs were paid.

A few months later the MDDUS was sent receipts from Dr Robertson for £2.12.6 donated to the Girls Training Home, Levenhall, and an equal amount to the Red House Home for Destitute Boys, Musselburgh. The Committee Secretary was instructed to ensure that the headmaster was informed of the destination of the money.

Object obscura: Archimedian dental drill

WHEN using a dental drill, a basic requirement is continuous rotation on demand. In the middle of the 19th century such technology was not available. At that time dental drills were simply rotated in the fingers. Bow drills could also be used but the rotation was not continuous. Another possibility was the Archimedian drill which had a spiral shaft, into which the bur was inserted, and a moveable collar with an attached lever. By working the lever backwards and forwards the collar caused alternate rotation of the shaft, first in one direction then in the other. This would have been inefficient and very difficult to control for fine work yet was considered "cutting edge" technology until the advent of the foot drill in 1871. Even as late as 1893 a catalogue of the dental firm C. Ash & Co was still listing the Archimedian drill: "Ebony handle with 3 burs and drills", priced 9 shillings.

Dr Paul Geissler, Dental Conservator, Royal College of Surgeons of Edinburgh

IMAGE: THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

Vignette: pioneering oral surgeon William Donald MacLennan (1921-2002)

ORAL surgery at the close of the Second World War was still a fledgling specialty. Dental surgeons in most UK units might be expected to remove teeth, replace dentures or perhaps advise on splints. It was to this field that a young Edinburgh surgeon returned from wartime naval service. Over the next 40 years William Donald MacLennan would contribute to the advance of oral surgery both in pioneering new techniques and in promoting education and professionalism, with the eventual establishment of the FRCS in Oral and Maxillofacial Surgery.

W D MacLennan was born in Edinburgh, his father a prominent dental practitioner in Newington. "Bill" was educated at George Watson's College and later obtained a place in the Dental and Medical School of the Royal College of Surgeons of Edinburgh, undertaking a combined diploma course in both medicine and dental surgery.

In the last stages of the Second World War he joined the Royal Navy and was posted to New York. Here he met his future wife, Milly, an accomplished young American equestrian of Olympic standard. They were married for nearly 50 years. He was later transferred to the west coast of America but, just before his arrival, Japan capitulated. Bill was awarded the "Pacific Medal", as he was technically in the war theatre, and often boasted that the Japanese surrendered on hearing that he was coming.

On returning to Edinburgh he was appointed to the Plastic, Oral and Burns Unit of Bangour General Hospital under Mr A B Wallace, later becoming the unit's consultant dental surgeon. In this capacity he taught students from the Edinburgh Dental School. Bill was a born teacher and produced an excellent series of lectures and residential clinical visits to the Bangour Unit, which were structured to emphasise clinical pathology and the general medical aspects of emergencies.

PHOTOGRAPH: THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

No student went through this course without lifelong memories, both clinical and social. Many had the opportunity to visit his large Victorian villa in Eskbank where they were well fed and "watered" and treated to musical performances by Bill on his electric organ. He was a pioneering exponent of stereophonic sound to the wonder of his student visitors. He was also a happy family man – a devoted father to his two daughters, Sandra and Barbara.

Bill's contribution to the advance of oral surgery was considerable. He pioneered mandibular osteotomies and developed the processing of surgical splints and cosmetic facial restorations in the dental laboratory. He published over 40 papers on a variety of subjects.

His influence at the Royal College of Surgeons was considerable. As Secretary to the Dental Council of the College, he negotiated the acquisition of the famous Menzies Campbell Historical Collection. His long experience in practice led him to believe that for the further evolution of oral surgery, practitioners should be encouraged to take an FRCS diploma in the specialty. The Royal College of Surgeons of Edinburgh had previously offered an FRCS in the specialty of Dental Surgery but with the advent of the FDS in 1948 the qualification was abandoned. Bill later became Convener of the Dental Council and was the first Dean when the Faculty was created. In this last office he proposed that an FRCS in Oral and Maxillofacial Surgery be introduced. The implementation of this task fell later to his successor, Dr Lawrence Finch, but Bill was acknowledged as the catalyst, a move which completely revolutionised the status and scope of the specialty.

In 1967, with the retirement of Dr David Middleton, who ran the autonomous Oral Surgery service at the Royal Infirmary of Edinburgh, Bill was invited to unify the regional services, including the RIE and Bangour. This he did and in 1978 he was appointed Professor to the Chair of Oral Surgery in Edinburgh University. He was also a founder member of the British Association of Oral Surgeons and was its president in 1966.

Bill was an addicted sportsman. He played rugby for the Royal Navy and later for Scotland in 1946 and 1947, earning caps against England and France, respectively. He played hockey with the students on "Field Days" and was an enthusiastic golfer. It was said that Hugh Watt, the professional at Gullane, whose advice Bill once sought, observed his swing and advised him to give up golf! A trivial matter like that would not deter Bill.

In many ways he was the "classic" surgical consultant, with his bowler hat, flower in the lapel, large car – Austin Princess or Rolls Royce – and his retinue of admiring staff. He had a very generous nature and although, like all humans, was capable of taking a dislike, Bill never at any time let that influence his duty to his specialty and his patients.

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