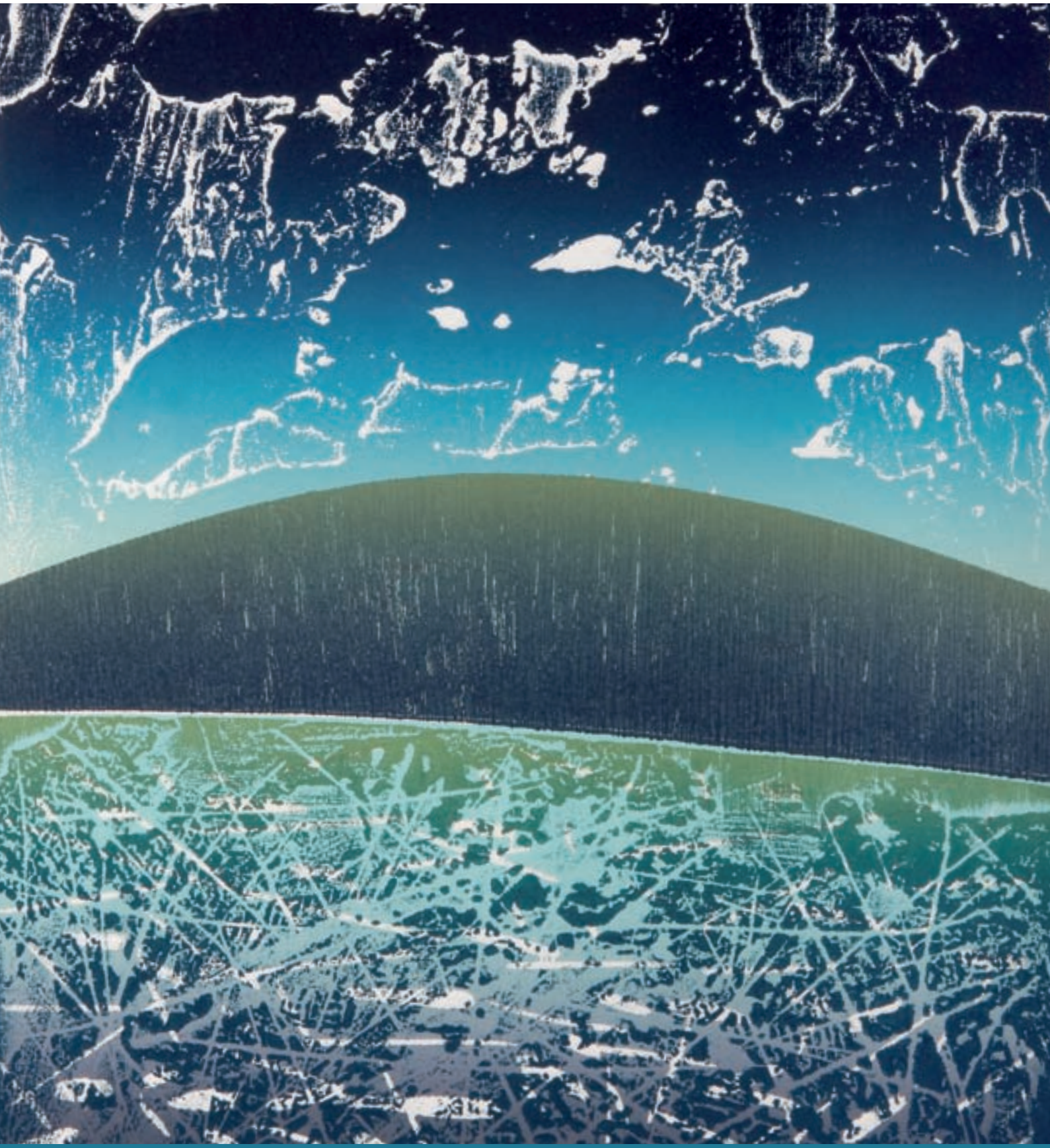
Autumn 2009

SUMMONS

MDDUS JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND



• Whistleblowing • Dental phobia • Charcot foot •

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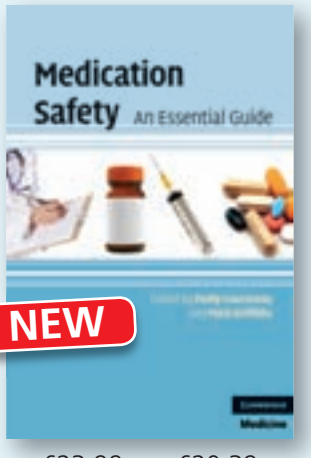

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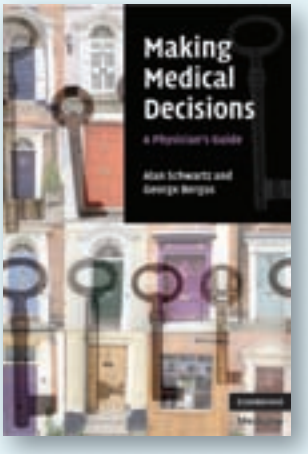

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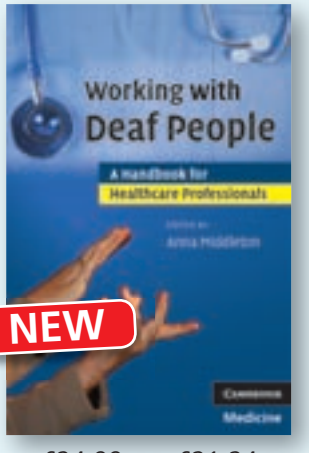

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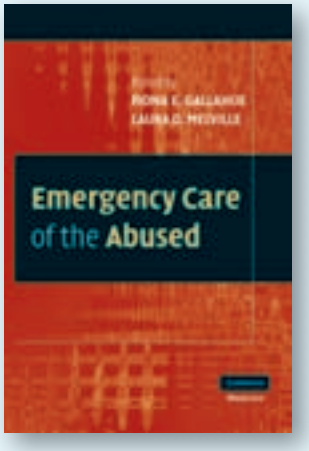

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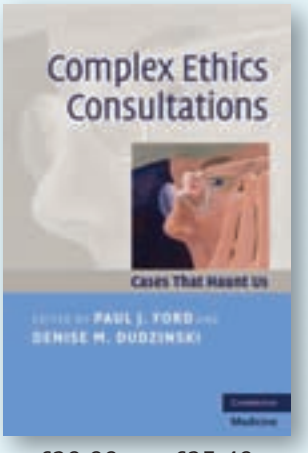

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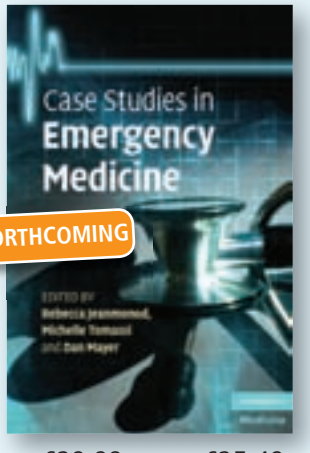

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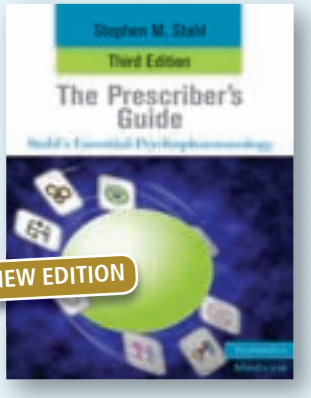

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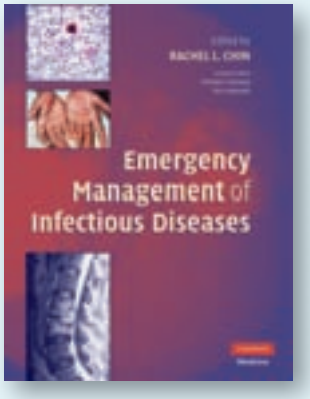

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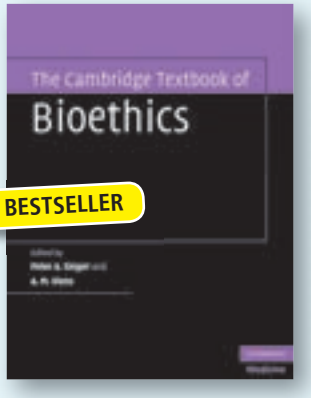

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IN THIS ISSUE

It's an all too popular assumption that doctors are a "clubbish set", always bound to cover each other's backs no matter what – public safety be damned. So it was heartening to have this countered in a recent BMA survey that reported some 70 per cent of hospital doctors had over the course of their careers voiced concerns relating to patient safety, malpractice or bullying. Not exactly a conspiracy of silence.

Less encouraging was the finding that 46 per cent were unaware of anything having been done in response to their expressed concerns and 15 per cent reporting that their trusts had indicated whistleblowing could be harmful to their career.

As set out in *Good Medical Practice*, it's a doctor's clear duty to report any worries in order to "protect patients from risk of harm posed by any doctors or other health care professionals' conduct, performance or health". No doubt this can occasionally put doctors in difficult positions. On page 14 of this issue Joanne Curran looks at this duty and the protection afforded whistleblowers.

It's common grist for comedy sketches – the fear (or perverse pleasure) of undergoing dental treatment. But for patients with a serious dental phobia it's no joke. Nor do dentists find dealing with anxious patients particularly funny, citing it among factors reported as being most stressful in their working environment. On page 18 of this issue, expert in dental sedation, Dr Nigel Robb, offers some useful insights on dealing with phobic patients.

And on page 12, Adam Campbell profiles the ongoing work of the Royal Medical Benevolent Fund, set up nearly 175 years ago "for the relief of medical men and their families under severe and urgent distress occasioned by sickness, accident and other calamity".

Jim Killgore, editor

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REGULARS

Cover image: Airs: Scoring the Earth by Michael Waight. Waight was born in Dorset and moved to Aberdeen to work with Peacock Visual Arts 15 years ago. He is now the printmaking coordinator for Peacock Visual. He teaches and collaborates as well as exhibits his own work in Scotland and internationally. Art in Healthcare (formerly Paintings in Hospitals Scotland) works with hospitals and healthcare communities across Scotland to encourage patients, visitors and staff to enjoy and engage with the visual arts. For more information visit www.artinhealthcare.org.uk,
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Unmarried fathers and parental responsibility

Married parents both have parental responsibility for their child's medical treatment, which includes access to records and the right to authorise disclosure of confidential information. This remains the case even if they subsequently separate or divorce.

But unmarried fathers also have parental responsibility when it comes to their children; the crucial difference is that they must "acquire" that responsibility. This can be done in one of several ways:

- by jointly registering the birth with the mother (effective from 15 April 2002 in NI, 1 December 2003 in England and Wales and 4 May 2006 Scotland)
- by a parental responsibility agreement with the mother
- by a Court Order determining parental responsibility.

It is important to bear this in mind when fathers approach the practice for access to a child's notes. In some circumstances the cases might be complicated if there are child protection matters, but where a father has parental responsibility he has the same rights and responsibilities as the mother.

In any circumstances of doubt or difficulty, we advise members to contact one of our medical advisers for specific guidance.

Gail Gilmartin, medical adviser, MDDUS

Mitigation evidence in FTP decisions

Four appeal cases from the GMC heard recently in the High Court in England have provided significant new guidance on the relevance of mitigation evidence in judging impairment in GMC fitness to practise (FTP) panels.

Since neither the Medical Act 1983 nor the GMC rules define 'misconduct' and 'impairment', panels must rely on judicial guidance in deciding on these issues in regard to a doctor's actions and fitness to practise. In the past, mitigation evidence was deemed only to be relevant for the determination of sanctions at Stage 3 of a hearing and could not affect a decision on impairment, which was heard at Stage 2.

The recent High Court judgements mean it is now possible at Stage 2 to take into account mitigation evidence showing that a doctor's misconduct was remediable, whether it had been remedied at the time of the hearing and whether it was unlikely to be repeated.

In one of the cases *(Azzam v GMC)*, the presiding judge stated:

"It seems to me that, in light of the authority cited, it must behove a FTP Panel to consider facts material to the practitioner's Fitness to Practise looking forward and for that purpose to take into account evidence as to his present skills or lack of them and any steps taken, since the conduct criticised, to remedy any defects in skill."

This development is particularly significant in cases which involve doctors who face charges following a single isolated clinical incident. Testimonials from colleagues and patients providing evidence of competence and skill will be highly significant at this stage and may result in the doctor being found to be unimpaired. However, when issues of public confidence are involved, as the recent case of *Yeong v GMC* has confirmed, such evidence will carry less weight.

Lindsey McGregor, solicitor, MDDUS

Lifelong registration for dental patients

The recent change in the registration period for NHS dental patients in Scotland to four years – with a possible move to lifelong registration – could have serious implications for the standard of preventative care.

The change came into effect on 1 April after an agreement between the Scottish Government Health Directorates (SGHD) and the Scottish Dental Practice Committee (SDPC) arm of the British Dental Association. The changes mean that all patients currently registered with the NHS can go up to 48 months (four years) without a preventative check-up before being automatically removed from a practice list. Should continuous registration – which the SGHD supports – go ahead in 2010, there will no longer be automatic lapses in registration no matter how long it is since the patient has seen a dentist. It is interesting to note that there is provision for the fee the dentist receives for these patients to be reduced to 20% if the patient does not attend for 3 years.

Discussion is now needed to encourage patients to attend dentists regularly in order to promote preventive dental care. Continuous registration will mean that patients have no responsibility to attend for regular preventative check-ups. However, the dentist needs to be aware of the increased potential burden they might face. All these NHS registered patients are entitled to NHS care, which of course includes access to emergency dental

IN BRIEF

SURVIVAL GUIDE FOR NEW DOCTORS A survival guide for newly qualified doctors has been published on the *BMJ's* doc2doc website. *You Will Survive* includes hundreds of tips from qualified doctors on how to cope with issues like self-doubt, ward rounds and notes, on-call and nightshift as well as some cautionary tales. The nine-page guide offers words of advice on how to ask for help, de-stressing and which equipment to carry with you on rounds.

NICE GUIDANCE ON CHILD MALTREATMENT NICE has issued guidance to help healthcare professionals to identify children who may have been maltreated. The guidance provides a summary of alerting features that should prompt a healthcare professional to consider, suspect or exclude child maltreatment. Access *When to suspect child maltreatment* at www.nice.org.uk

RCGP CONFERENCE - NOT JUST FOR GPs! The Royal College of

treatment. The ethical responsibilities of dentists remain unchanged and dentists are advised to consider their ability to provide this care to all their registered patients.

Claire Renton, dental adviser, MDDUS

Legal representation at disciplinary hearings

A recent Court of Appeal hearing has – in effect – reintroduced the right to legal representation in disciplinary proceedings.

On 23 July the Court of Appeal handed down a judgement confirming that a junior doctor working for Milton Keynes Hospital NHS Foundation Trust was contractually entitled to be represented at a disciplinary hearing by a lawyer instructed by his medical defence organisation.

In the case, Dr Kunal Kulkarni had been suspended following a complaint by a female patient and was advised he would be subject to disciplinary proceedings. He was told that a legal representative could accompany him but would not be "acting in a legal capacity".

This was challenged by his MDO, first in the High Court who held that given the express terms of the Trust's policy, there was no discretion to allow legal representation. The High Court also held that this refusal was not in breach of Article 6 of the European Convention of Human Rights (a right to a fair trial).

But the Court of Appeal took a different view and, in allowing Dr Kulkarni's appeal, has effectively reintroduced the right to legal representation that doctors previously benefited from and was removed as part of the new contract introduced in 2005.

It had been argued by the Trust that the possibility of proceedings before the GMC rendered their disciplinary proceedings compliant with Article 6. In her observations in the Court of Appeal decision, Lady Justice Smith rejected this argument on the basis that the GMC was not a judicial body, did not hear appeals from disciplinary hearings and the proceedings at the GMC could not be instigated by the doctor.

Lindsey McGregor, solicitor, MDDUS

Backdating indemnity

YOU may be aware that many of the subscription rates for MDDUS members are based on projected gross private earnings, for hospital doctors, or projected number of sessions worked, for general medical and dental practitioners.

We would ask members to make a realistic estimate of their gross private earnings or sessions worked at the beginning of the subscription year. Realising that this can sometimes be difficult to forecast exactly, we allow members the facility to change their grade of membership during the subscription year and backdate indemnity, if required, to the beginning of the subscription year.

Any change of membership grade must be made before the next subscription year commences to ensure that you have appropriate indemnity for any claims of negligence or malpractice that may occur.

Vaccinations by HCAs

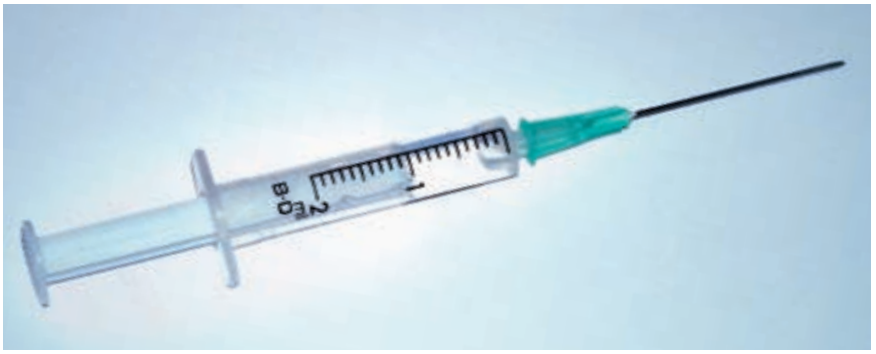
MDDUS has had a number of recent calls regarding potential liability for Heath Care Assistants administering flu vaccines – either for seasonal flu or the expected additional workload of H1N1 vaccines later this autumn.

It is important to remember that GPs – as employers – have vicarious liability for all their employees and for any duties that practice staff undertake. Doctors themselves must consider whether it is appropriate to allow the Health Care Assistants (HCAs) to undertake immunisations and also what training and supervision is required. Before deciding, it is important to consider GMC guidance on delegation and referral as contained in *Good Medical Practice*. This states that:

"When you delegate care or treatment you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved. You must always pass on enough information about the patient and the treatment they need."

Should there be any problem arising from the HCA providing immunisations, doctors may be required to justify their decision to allow that individual to immunise patients. To ensure this is possible, doctors should keep records of any relevant courses or in-house training undertaken by the HCA.

Mary Peddie, medical adviser, MDDUS



General Practitioners is encouraging participation from the whole primary care team at its Annual National Primary Care Conference 2009 on 5-7 November in Glasgow. The conference programme includes specific streams for both practice managers and practice nurses, including sessions on leadership, performance and finance management, commissioning, clinical updates, patient safety and much more. MDDUS is the principal sponsor of this year's conference and DPS practice managers can benefit from discounted rates. To register call Profile Productions on 020 8832 7311 and supply your MDDUS membership number when booking.

LOOK OUT FOR REVISED CONFIDENTIALITY GUIDANCE

The GMC is expected this month to release its new guidance on confidentiality. Among areas of expected revision or new guidelines are doctors' duties to report injuries incurred as the result of a suspected violent attack, patients' concerns around the security of electronic records and new guidance for doctors about responding to criticism from the press.

GPs missing 'red flags'

A SIGNIFICANT percentage of patients presenting to their GP with certain 'red flag' symptoms such as haemoptysis or rectal bleeding remain undiagnosed after three years, according to a recent *BMJ* study.

Researchers based at King's College London tracked 762,325 patients presenting to general practice with first episodes of haematuria, haemoptysis, dysphagia or rectal bleeding. A list of potentially important diagnoses (cancer and non-cancer) associated with each of the alarm symptoms was identified and these were compared with actual diagnoses recorded at 90 days and three years after the first recorded alarm symptom. In patients with haematuria, haemoptysis, dysphagia and rectal bleeding, around one in five had an associated diagnosis at 90 days.

However, after three years, over three quarters of patients presenting with rectal bleeding did not have a definite diagnosis, with comparable figures of about 67% for dysphagia, 64% for haematuria and 46% for haemoptysis.

The authors suggest that patients presenting with these symptoms merit timely investigation for both non-cancer diagnoses and potential cancer diagnoses, rather than a policy of watchful waiting.

"GPs in the NHS are seen as the gatekeepers and there is a bit of a feeling that they should restrict access," study leader Professor Roger Jones is quoted in OnMedica. "This is about investigating the right patients sooner - perhaps have a slightly lower threshold for it than before."

'Hands on' medical training

MEDICAL students in future will be given more 'hands on' experience in basic medical procedures before graduating. This is just one of the requirements detailed in new GMC guidance launched this week to ensure medical students have more opportunity to apply their medical knowledge and skills in hospitals and surgeries.

In the latest revised version of *Tomorrow's Doctors* the GMC will require medical schools and the NHS to work together to organise 'student assistantships' or hospital or GP placements undertaken shortly before a student enters foundation year 1. The guidance also includes a new list of specific clinical procedures, such as administering a local anaesthetic, which students must master with the help of life-like training mannequins and other advances in medical teaching technology, as well as providing opportunities for skills development using real patients with consent and under supervision.

GMC Council Member and Chair of the Undergraduate Board Jim McKillop said: "Basic medical knowledge and skills, while fundamentally important, are no good in isolation. The best doctors are continually updating their knowledge, they are prepared to ask for help and they can communicate complex, life changing decisions to patients who can often be vulnerable and scared."

Access *Tomorrow's Doctors* at http://tinyurl.com/mppzlx

Keep vigilant for dental neglect

ALL dental staff should have regular training in child protection in order to assess suspected dental neglect, according to a new policy document published by the British Society of Paediatric Dentistry.

Dental neglect is defined as a persistent failure to meet a child's basic oral health needs. Oral disease can have a significant impact on the health of a child and consequences can include severe pain, loss of sleep and even reductions in body weight and growth. Dental neglect may also suggest wider welfare issues in a child and be indicative of other forms of abuse. The policy document details the numerous factors that must be taken into account when assessing a child with suspected dental neglect and provides guidance on how the dental team should respond.

Dr Peter Sidebotham, associate professor of child health at the University of Warwick, who co-authored the policy, said: "There is evidence which indicates that abused children have higher levels of untreated dental disease than their non-abused peers. Many dentists have taken part in child protection training, but still find it difficult to put into practice what they have learned when they suspect abuse."

Access the document at www.bspd.co.uk/publication-27.pdf

Drug side-effects and readmissions

ONE in five emergency readmissions to hospital within a year of inpatient treatment are the result of often avoidable drug side-effects. These were the key findings from a study analysing 1000 patient admissions to a large Liverpool hospital. The results were presented last month at the British Pharmaceutical Conference in Manchester.

Complete data were available on 290 of

IN BRIEF

CHILD DEATH REVIEW PROCESS A document setting out the roles and responsibilities of GPs in the statutory review process after a child death has been published by the BMA. The publication sets out procedures including the role of the Child Death Overview Panel (CDOP) and also discusses important considerations for GPs dealing with bereaved families, including consent, confidentiality and statutory obligations. Access at http://tiny.cc/oHIYE

NICE APPROVES HAND ECZEMA TREATMENT Use of the drug alitretinoin as a treatment option for adults with severe chronic hand eczema has been approved by NICE – but with caution. The drug is recommended for patients assessed as having severe disease not responding to potent topical corticosteroids. The guidance also recommends treatment should be provided only by dermatologists or doctors with experience in managing severe chronic hand eczema and the use of systemic retinoids. Access guidance at www.nice.org.uk

DENTISTS CAN MANAGE CPD ONLINE Dental professionals

403 patients who were back in hospital within a year of their first admission. In 21% of these 290 patients, an adverse drug reaction contributed to re-admission.

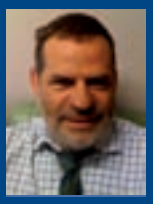
Overall, 91 suspected adverse reactions were identified and 22% of prescriptions for the medicines causing the side-effects were started during the patient's initial stay in hospital. A further 25% were started after the patient was discharged.

Aspirin prescribed to prevent strokes and heart attacks and diuretics commonly used to treat high blood pressure and heart failure were the medicines most commonly linked to adverse reactions leading to hospital readmission. Elderly patients were at greatest risk. Of the 91 adverse reactions, 57% were judged to be definitely or possibly avoidable.

Emma Davies, research pharmacist and study investigator, from the Royal Liverpool and Broadgreen University Hospitals NHS Trust, said:

"While medicines have lots of benefits, they can also have harmful side-effects resulting in re-admission to hospital. Managing this involves checking patients' medicines while they are in hospital and regularly reviewing prescriptions in primary care after patients are discharged."

OPINION



by Dr James Finlayson
Consultant Psychiatrist

Computerised records – for better or worse?

For the past five years I have been working as a psychiatrist in adult general psychiatry in Inverness. Previously I had worked for sixteen years as a GP in a very remote practice. Since returning to psychiatry I have developed an interest in medico-legal work and have provided quite a few reports, particularly in civil cases.

Psychiatric assessment is, to say the least, far from an exact science. In a legal dispute it is often hard to obtain an objective account of the effect of, say, an accident upon someone claiming psychiatric distress. Commonly the person who alleges psychiatric disability will claim that prior to the accident they were in perfect health and all the disability is due entirely to the injury suffered.

I find a corroborative account from relatives very helpful in clinical practice but of less use in medico-legal work. Most invaluable is the information recorded within the patient records, a copy of which I always insist on reading before preparing a report.

It is an extraordinary achievement that each person in Britain has a lifelong record of their interactions with their GP. Their childhood illnesses, the worries and anxieties of adolescence, the development of major health problems – all recorded within this record. I have found it moving to read the story of somebody's life in their general practitioner records. When I was in general practice and a patient registered it was always fascinating when their notes arrived and one could see how their lives had developed.

General practice records vary immensely in quality but generally they reveal the incredibly high degree of skill of general practitioners and the commitment to their patients' wellbeing. Doctors are obviously aware of the medico-legal importance of notes: how vital they can be in showing that we carefully assessed and treated a problem presented to us. Most doctors also know that if a patient interaction is not recorded then they will have little defence if something untoward happens.

Recent years have seen a dramatic change in the nature of medical records. They are now largely computerised. This has brought a huge increase in the amount of information held within medical records, with the increased importance of health surveillance.

Although the quantity of information contained within the computer records which I see has obviously increased it is my strong impression there is less clinically relevant information compared to the old handwritten notes. It may be that I am wrong; it could be that my prejudice is making me biased against computers. Many years ago in general practice I did argue against the introduction of computerised notes believing it would change the nature of the doctor-patient interaction. However, I did come to see their usefulness, and certainly in the dispensing practice in which I worked they became completely essential. Most of my friends in general practice tell me that their typing skills have developed to such an extent that they feel that they now record clinical interactions fully.

But it is still my strong impression from reading many GP notes that the quality of recorded clinical information has declined dramatically. One does see exceptions but it appears to me to be rare to find adequate clinically relevant information recorded that would prove the doctor had undertaken a proper history and examination in newly presented problems.

I would suggest that doctors do a small audit project looking at the information that was recorded in their clinical notes for a variety of patient-initiated encounters and see if the information recorded before and after computerisation is more or less extensive, relevant and useful. If they find that the quality of the information has been maintained or improved then they can regard this article as the demented ravings of an old Luddite but if my contention is proven in their particular practice then perhaps they should consider how best to ensure that their patient interactions are clearly and appropriately recorded.

registered with the GDC can now track and manage their continuing professional development returns online in a new section of the GDC website. Using www.eGDC-uk.org registrants can track and record CPD hours over their five-year cycle. The site shows how many hours they have to complete and re-calculates this when further hours are added. Find out more at www.gdc-uk.org

EVENTS MEDICINE A meeting on providing medical cover for competitors and spectators at major sporting events will be held on 2 March 2010 at the Durham County Cricket Club. Current government and BMA guidance will be outlined along with a discussion of the "The Great North Run's Coroners Inquest". The meeting is aimed at doctors, ambulance personnel and first aiders providing medical cover at large sporting events, as well as safety officers and managers of sporting stadia. For more information and application forms contact Mark.Foster@durhamccc.co.uk

More news and MDDUS events at www.mddus.com

Someone may be watching...

PRIVATE COMPUTER USE in the workplace has expanded beyond imagination from a few years ago and, although it may seem innocent enough, both employers and employees need to be worried about its impact.

Recent cases arising out of employers' scrutiny of employees' use of workplace computers for social networking, gambling, downloading pornography and harassment via email have highlighted that management monitoring of private use of work systems is alive and extensive.

Even offensive screensavers can get employees into trouble. William Hendry, a truck driver who had 18 years' service with Renfrewshire Council, was given his marching orders after a digital photo of Shona MacDougall, the council's director of environmental services, was doctored. The screensaver image of Ms MacDougall on a council computer was altered to give her a comedy goatee. But Mr Hendry's managers failed to see the funny side and, after carrying out an investigation, they summoned him to a disciplinary hearing where he was sacked. He is taking the case to an employment tribunal.

A Somerset man was sacked earlier this month by supermarket Tesco after posting a comment on his Facebook page about his bosses. The 22-year-old man was suspended before being dismissed for gross misconduct. His comment allegedly included a "highly offensive" swear word. His case came shortly after a female worker hit the headlines when she was given the sack by her boss after she left a message on her Facebook profile calling him "pervy".

Meanwhile, electrical retailer Dixons is investigating staff alleged to have insulted customers via an unofficial Facebook group, "DSGi Employees", which says it is for people who work or have worked for the company and has around 3000 members. Posts referred to customers as 'stupid' and described derogatory shopfloor conversations.

The social networking craze is increasingly being clamped down on by employers. Earlier this month, Portsmouth City Council blocked staff from using Facebook after it discovered that they had spent 572 hours - the equivalent of 71 working days - on the site in just four weeks. There have been widespread reports of recruiting employers searching social networking sites before offering jobs to candidates. The gap between the applicant's 'work' face and their 'social' face is sometimes alarming and there have been examples of employers changing their minds about hiring people after researching their web pages and finding boasts about drinking or taking drugs to excess and sexist or racist comments.

> 'Posts referred to customers as 'stupid' and described derogatory shopfloor conversations'

However, employers need to beware of using Big Brother techniques to vet or monitor employees' online habits. Legislation prohibits intrusive monitoring of emails, computer use or phone calls by employers, unless there are reasonable grounds for suspicion that a criminal or gross misconduct offence has been committed. What's more, it is possible that an unsuccessful candidate, who discovers that his sexuality or genuine (reasonable) beliefs have led to the withdrawal of a job offer, after digging online by the employer, may have a potential claim for discrimination against them.

Clearly, uninhibited private use of company systems cannot be tolerated by the management and a comprehensive and unequivocal computer use policy, communicated to all employees, is an essential starting point to ensure that no one can claim they don't know where the boundaries lie. Whether the online activity is illegal or not, employers can reasonably expect that, during working hours at least, their staff are not 'skiving off' electronically. Disciplinary action simply about the volume of online private activity (let alone the content) is a common outcome in such situations, in our experience.

From an employee point of view, 'photoshopping' pranks like Mr Hendry's won't always lead to the sack. But you can be sure there is a fair chance they will come to light and might prove less funny than you initially thought. Although you may enjoy a reasonable expectation of privacy at work, using this as cover for excessive or offensive use of emails, social networking comments or private phone calls will not protect you from the (rather predictable) consequences of your actions. Be careful out there.

Ian Watson, Law At Work

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Chances are...

TO BE HUMAN is to make judgements about risks and benefits on a regular basis. Shall I cross the road here? Should I accept the invitation to the party? Should I stay late at work and annoy my spouse – or go home on time and maybe annoy my boss? We are pretty good at all of this – using a series of automatic decision-making short-cuts known as heuristics (well described on Wikipedia).

But sometimes these short-cuts let us down. Making a decision about medical treatments can be such a time. A patient's instincts can lead to poor judgements and it is the job of a doctor, dentist or other clinical professional to communicate risks and benefits in an effective manner.

Until very recently, communicating risk was not taught at medical, dental or nursing schools and yet there is useful evidence from a number of fields that can assist us in this task.

There are situations in which clinicians already routinely attempt to counsel risks and benefits. An obvious one would be seeking formal consent (for surgery or other interventionist procedures). The prescription of some drugs (e.g. warfarin) also falls into this category. However, on reflection it can be seen that any action, or indeed non-action, by a clinician is attended by risks and benefits that must be communicated to patients. Deciding whether or not to undergo surgery, to take a medication, to agree to screening, or pursue a diagnosis are examples of judgements where it may be possible to find data to assist clinical decision-making.

Increasingly, patients approach us with information gleaned from the internet – some of which may be inaccurate. Again, we need to be skilled in being able to help educate such a patient.

Below are some common challenges clinicians face in communicating risks to patients:

Innumeracy. Even those of us with decent maths qualifications find it hard to get our head around risk data, whether presented as frequencies (e.g. percentages), odds etc. Many of our patients will not have formal maths qualifications and few people routinely use maths in their daily lives.

Getting good data. There can be a shortage of good data and even where there is relevant evidence it is often inaccessible. This means that the clinician in the front line may not be able to give a precise answer to the questions, "How likely is this to help me?" and "How big are the risks?"

Knowing how to represent data. Experiments (in applied psychology and other fields) have shown that the brain's wiring prevents instinctive understanding of standard formats for considering risk – the two commonest being frequencies (e.g. percentages) and odds (e.g. "1 in 28 chance").

So what are we to do? There is sufficient evidence to offer some guiding principles to clinicians:

- Pictures seem to be understood most easily. Numbers next. Words alone are in last place.
- Use natural frequencies. Express the data as a number in a larger number. For example: "Out of 100 people like you who take this drug, four would get one of these side-effects in one year".
- Frame positively as well as negatively. Following on the previous example: "This means that 96 people out of 100 would experience no side-effects in one year".
- Give absolute risks before relative risks. For example: "If 100 people had the condition, 10 would die without treatment. If 100 people have the operation, only 5 would die. In other words, this operation halves your risk of dying".
- Use graphs. For single or very simple conditions, a pictogram/crowd chart is preferred (1000 little men, or smiley faces, or similar). For presenting several facts at once (e.g. risks and benefits of HRT) then a bar chart is preferred.

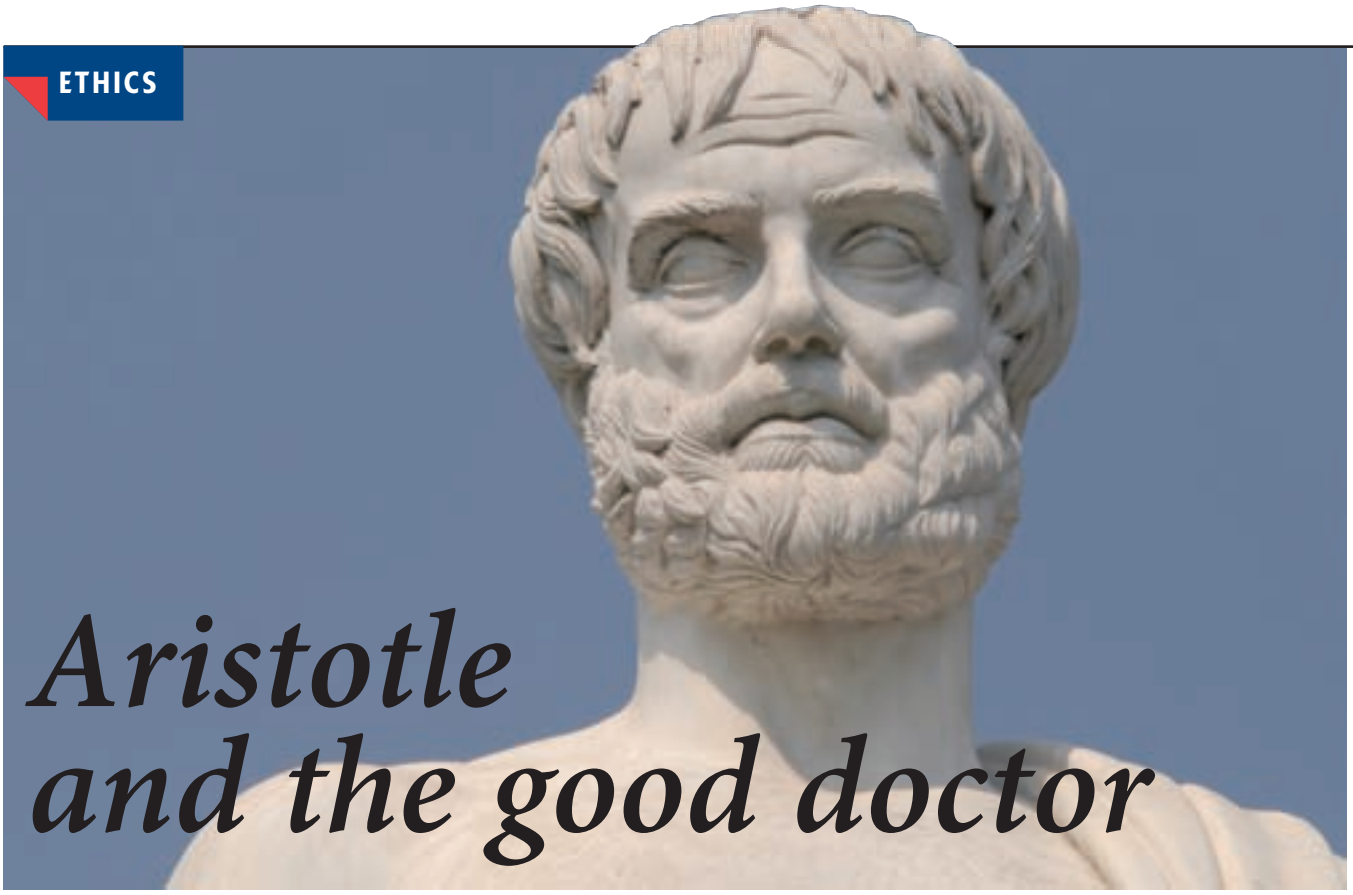
There is no magic bullet for communicating about risk. This is a difficult task even with well-educated patients and good data. The above principles are based on best current evidence and there is clearly scope for us to do a better job for our patients.

■ ***Dr Malcolm Thomas is a GP and founder of the training company EPI***

Contact afitzpatrick@mddus.com for details on the upcoming EPI course 'Communicating about risk with patients' being held in both Glasgow and London.

FURTHER READING

- http://en.wikipedia.org/wiki/Heuristic
- Gigerenzer G. Reckoning with risk. London: Penguin; 2005
- Communicating Risks. BMJ themed edition. 27 Sep 2003



Aristotle and the good doctor

MY TEACHING IS subsumed under what I call 'The Practice of Medicine', of which medical ethical issues are only a part. I believe that before discussing medical moral dilemmas it is more fundamental to ask the questions: what is good medicine? What is a good doctor? How is a good doctor–patient relationship established?

Nearly everyone would agree that the duties and core values of a good doctor as stated in the GMC handbooks are a comprehensive list of behaviours and attitudes which would stand the doctor in good stead. But as educators we must make them come alive for our students.

To do this I have chosen to use humanities resources, mainly in the form of short stories and plays, and sometimes in video format. My rationale for using this approach is best demonstrated in a brief play I use at the beginning of first year classes. Something which occurs at the end of the play is what I believe Aristotle tried to communicate in his ethics - we learn what the 'good' is by doing 'good things'.

During the brief play, ironically called *A Simple Procedure**, a relationally wise but educationally simple elderly female patient berates a relationally inept gastroenterology consultant for what she believes should be a simple task – to communicate effectively with a patient. In fact, when the consultant frustratingly informs her that he is trying to make use of methods he learned in a "communication skills" course, the patient derides him further by stating "you mean they have to teach you how to communicate? I thought your mother would have taught you that!" The consultant ultimately leaves the room with the patient shouting "Where are you going? I'm not finished with you yet!"

What happens next, I believe, is what Aristotle was effectively trying to tell us.

> 'We learn what the good is by doing good things...'

The doctor knocks on the door and starts all over again in a manner he could have simply accomplished in the first instance. He relates to the patient and not just her liver and all goes well. In a sense, he has learned from his experience, but he also acknowledges that understanding by 'doing' the good. In doing the good it is more likely to become part of his nature or even his character.

At this point in the teaching I return to the slide which lists the nine core values of a good doctor: competence, empathy, integrity, advocacy, etc. However, I emphasise the one which almost seems trite compared to most of the others – curiosity. And yet I think there is a very good reason it is on the list and, for me, fundamental. Without it, all the others (except for competence) are unlikely to become a part of the doctor's character. I think that is what the play is about. The consultant was not interested or curious about human nature, and in that sense it defeated his purpose or goal as a doctor.

This summer I decided to make a video of the play. I asked a consultant from our part-time staff who teaches communication skills if he would act the part of the consultant in the production. He read it and became quite enthused, saying 'I would love to do this, because I've had this experience', and implied that the experience had the same effect on him. I wonder if he's read Aristotle's *Ethics?* Perhaps not, but he saw the point. Moreover, he realised that it's necessary to observe, understand and interpret in the practice of medicine. Perhaps the best manner of achieving this for new students of medicine is through the humanities as they relate to medicine. Even the students who come to St Andrews to exclusively learn 'the scientific basis of medicine' often observe and understand this.

■ ***Dr Peter Nelson is Senior Teaching Fellow at the University of St Andrews Bute Medical School***

* Burns R. A simple procedure – a play in one act. In LaCombe M A, ed. On being a doctor. Philadelphia: American College of Physicians; 2000

Surgeon and Author
Dr Gabriel Weston

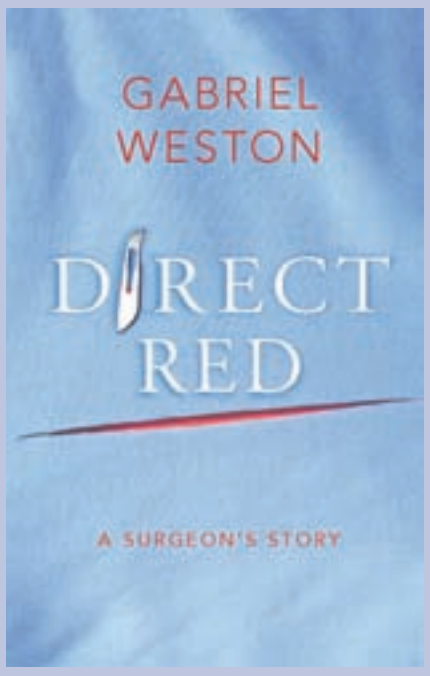
DR GABRIEL WESTON is a part-time ear, nose and throat surgeon in London and a mother-of-two. Her first book, *Direct Red: A Surgeon's Story,* was published earlier this year and has been nominated for the Guardian First Book Award 2009. Now 38, she became a member of the Royal College of Surgeons in 2003, just three years after qualifying as a doctor. She admits to being ultra-competitive and says she chose surgery because of "the drama, the machismo, the fear".

What inspired you to write such an honest book?
Before going to medical school as a mature student, I did an MA in English Literature at Edinburgh University. I have always been a big reader, although I never had ambitions to write. A literary agent friend of mine persuaded me to write a few surgical stories and she sent these to several London publishers. I was very surprised at how warmly they were received. In terms of the book's honesty, I couldn't see the point in writing it any other way. There are plenty of heroic doctor stories out there already. I wanted to write one about the uncertainties one feels as a surgeon.

How did your fellow doctors react to *Direct Red*?
I have been touched by how many doctors and nurses have contacted me to say that *Direct Red* reminded them of their own experiences and feelings. In particular, my colleagues in the ENT department at Frimley Park Hospital where I work have supported me enormously through the writing and publication of this book. I am sure there are plenty of doctors out there who may not feel as warmly towards me, but I haven't heard from any of them!

What is the most important lesson you have learned since your time as a junior?
Without any doubt, the most important lesson I have learned as a doctor is that it's always, always best to be honest. There is no shame in telling a patient you don't know the answer to a question they've asked, or that you don't know enough to make a diagnosis. And it's far better to tell your boss that you think you've done something wrong, rather than have him find out for himself. There have been no exceptions to this rule in my experience.

'There is no shame in telling a patient you don't know the answer'



How challenging is it to balance the demands of raising a family with those of a busy surgical career?
My view is not a popular one, but I think having a family and a career in surgery is really difficult. I know women who have managed to climb high in surgery by having very full-time help. And I see nothing wrong with this, but it wasn't for me. The way I manage is by having a surgical job now rather than a career. I'm a part-time staff grade with a tiny responsibility. I have given up my registrar number and the prospects that went with it so that I could spend more time at home. I'm happy with my choice, but it carried a big cost in terms of the kind of surgeon I have become.

How do you divide your time amongst medicine, writing and raising a family?
Tuesday is for writing. Wednesday and Thursday, I'm at the hospital. Friday through til Tuesday I'm with the kids. My husband helps a lot, and we have a four-days-a-week nanny.

Do you have any new writing or TV or film projects in the pipeline?
I have started writing my second book, a novel. I've also been taken on as one of the fiction reviewers for *The Telegraph* newspaper, and have recently sold the TV rights to *Direct Red.*

How different is it for a woman to progress in a surgical career compared to a man?
I don't think there's any difference, per se. The people who progress fastest in surgery are those who work hardest at it. I don't think there is any prejudice against a woman going to the top in surgery if she is as good as her male counterpart. The sticky bit is how women square this with family demands. Perhaps, one day, more men will be prepared to stay at home with their children and let their wives fly in their careers. But I have my doubts about whether female surgeons will want to marry these kinds of men!

Jonathan Cape 2009; £16.99

Doctor to doctor

Established nearly 175 years ago, the Royal Medical Benevolent Fund has certainly evolved but at heart it's still about doctors helping doctors, as Adam Campbell *discovers*

FOR one 30-year-old medic, it was rheumatoid arthritis. For another, recently qualified, it was bipolar affective disorder. For yet another, it was a car accident that left him in a coma for 10 days and with severe speech impairment. Each was a life-changing bolt from the blue that left its victim reeling and facing an uncertain future. But for all of these medical professionals, help was at hand.

The Royal Medical Benevolent Fund was set up "for the relief of medical men and their families under severe and urgent distress occasioned by sickness, accident and other calamity". In line with this remit, outlined nearly 175 years ago, it swung into action to provide practical aid in the aftermath of all three tragedies.

The result has been to offer each doctor the chance to put their lives on a more secure footing. In the case of the arthritic doctor, soon confined to a wheelchair, aid came in the form of a specially adapted vehicle, as well as financial support while he pursues further studies to help him get back into employment. The doctor with bipolar illness, unable to work, is receiving a weekly grant, travel costs and money advice, while the crash victim received money during the years of speech therapy and while he retrained, and has now secured employment in the sterile services unit at a local hospital.

Need not judgement

"Our role as a charity is to help those who are in need," says Michael Baber, chief executive of the Fund, echoing the broad approach of the Fund's original remit. "And my role is to make sure the Fund does what it was set up to do."

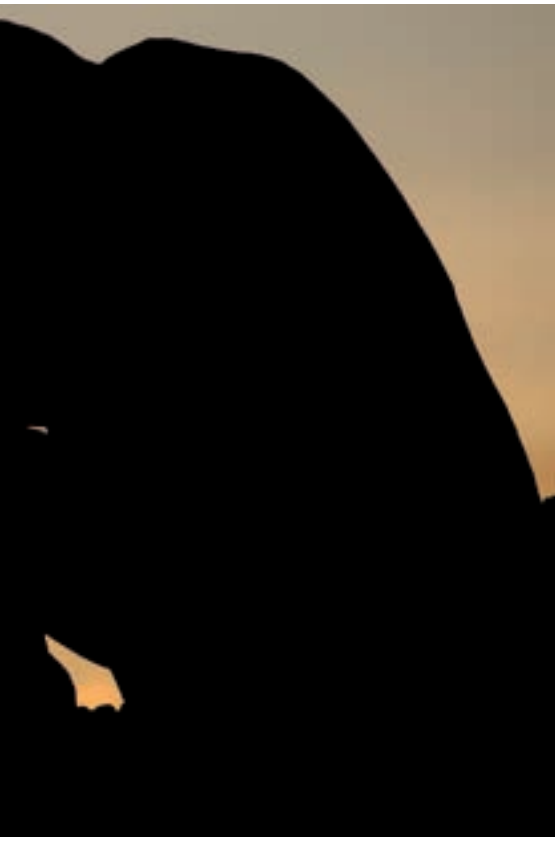
In the last year alone, the Fund has provided support to 524 people, 216 of whom were doctors and 308 their dependants. In monetary terms, grants to the tune of £713,000 were paid out, while £70,000 was offered in the form of secured loans.

The age range of those helped varies from the very young, in the case of dependants of doctors, to the very old, and all cases of need are considered, from the ill to the infirm, and the debt-laden to the addicted ("How they got into need is not for us to judge," says Michael). Once it is agreed that help will be offered, the type of aid is customised to the individual need.

"We're trying to get away from an idea of a set amount of money, like another form of state benefit," says Michael. "Our ultimate goal is to try and help people become financially independent again, that's our aspiration."

The help could be in the form of childcare to enable someone to commit time to retrain, or the Fund might pay professional fees, travel costs to attend interviews or perhaps pay for living expenses while a doctor works in an unpaid clinical attachment. "We'd rather spend more in the short term, help someone get back to work and then that frees resources to help new cases as they come through," says Michael.

Of course, not everyone will make it back to work, and for beneficiaries who are elderly or seriously ill, the aim, he says, is to "make sure that their quality of life is as good as it



can be and they can live as independently as possible".

Time and money

Charity begins at home, the saying goes, and at the RMBF it really is the case that doctors are doing it for themselves. The bedrock of the Fund, the 240-strong army of volunteers, are either medical professionals or from medical families, as are most of the Fund's trustees, each of whom serves a six-year term.

The volunteers, who are located across the UK, take on a variety of duties, including fundraising, visiting current or potential beneficiaries at home, raising awareness of the charity and providing feedback on the medical climate in their region or speciality. "We have a small staff team who are not doctors," explains Michael, "and we need the doctors to move us in the right direction and keep us up-to-date. We need that medical input to do it properly."

Medical input also comes in the form of the all-important donations to the Fund, since it was decided back in the 1930s that appeals for money would only be made within the profession. Michael's tongue is only slightly in cheek when he describes the Fund as a kind of Robin Hood of the medical profession.

"We take from the… I won't say rich… but the vast majority of doctors are going to have successful careers, be relatively well paid and are not going to need help from the Fund," he says. "But equally some of their colleagues are going to fall by the wayside. So we go to those doctors who are successful and we say, 'Well done, now please help those of your colleagues who are in much sadder circumstances.' "

As such, all the cash that keeps the charity afloat comes, one way or another, from doctors themselves or their families, whether it be from direct donations in response to the annual appeal, through local medical committees or through the speciality associations. "Some people very kindly leave legacies and some of that we can put aside as investments and that generates a small amount of income," says Michael.

> 'The vast majority of doctors are going to have successful careers... but equally some of their colleagues are going to fall by the wayside.'

Keeping pace

Originally set up in Manchester in 1836 as a benevolent arm of the Provincial Medical and Surgical Association (which later became the BMA), throughout its long history the Fund has adapted its focus to take account of the prevailing needs. During the Great War, for example, an emergency fund was set up, and this was repeated in World War II, this time in league with the BMA. In the interim, in response to the Depression, money was raised and specifically aimed at widows and orphans of medical practitioners to enable them to be self-supporting.

Today there are new pressures to contend with and the Fund must adapt to keep pace. Recent initiatives include offering specialist debt advice, helping those with a right to state benefits to secure their full quota, and help for refugee doctors retraining to practise medicine in the UK.

In addition, the Fund has launched a series of websites, for both doctors and medical students, which aim to address problems before they occur. The **support4doctors.org** website offers a wide range of advice, from choosing a speciality and managing stress to coping with being a patient yourself and even eating properly.

The **money4medstudents.org** site, was set up in partnership with the Medical Schools Council, the BMA Medical Students Committee and the National Association of Student Money Advisors after carrying out a lot of research into medical students' perceptions of debt. "It's in tune with how medical students are thinking," says Michael, "otherwise you could do a website that is very worthy but is ignored."

And they are not planning to stop there. An initiative launched in July is looking at what the Fund's response should be to the increasing numbers of doctors with mental illness (along with the armed forces, the profession has the highest levels of work-related mental illness in the UK), the potential vulnerability of the rising number of sessional GPs, and the increasing financial hardship faced by medical students.

The Fund has always been forward-thinking – it was, as Michael points out, "the first true charity for a profession" – and staying relevant is crucial to its role. "Over the years the Fund has always responded to the changing need," he says. "So if now we help medical students, refugee doctors, doctors with addiction and mental health problems, that's because those are the needs now."

For more information visit **www.rmbf.org**

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

Whistleblowers take care

The law does afford protection for healthcare professionals raising concerns over patient safety but it's best to know the pitfalls in advance.
Joanne Curran *reports*

IN 2004, nurse Margaret Haywood brought a hidden camera into the hospital ward where she worked in order to secretly film the appalling conditions endured by the elderly patients cared for within.

The footage from the Royal Sussex Hospital in Brighton was broadcast in a BBC *Panorama* documentary exposing the unacceptable standards being tolerated there. Haywood claimed her motives were to serve her patients' best interests and that she was forced to take the extraordinary measures in the face of inaction from management.

But this extreme approach to whistleblowing ended Haywood's career of more than 20 years when she was struck off the nursing register by the Nursing and Midwifery Council in April. She was found guilty of misconduct at a hearing in London and heavily criticised by panel chair Linda Read for a "major breach of the code of conduct". While the panel admitted conditions at the Royal Sussex were "dreadful", they could not condone Haywood's breach of trust and confidentiality. It was unacceptable, they decided, for Haywood to film vulnerable patients, "knowing that it was unlikely they would be able to give any meaningful consent to that process, in circumstances where their dignity was most compromised".

Her case has angered many doctors who felt the severe punishment served on her could frighten other medics out of reporting concerns.

Where do you stand?

The case raises serious questions about exactly where medics stand when it comes to blowing the whistle. Are they obliged to report concerns and how should they do so? The law does afford certain protection for whistleblowers, but there are often concerns that speaking out could jeopardise a health professional's career.

The Public Interest Disclosure Act 1998 protects whistleblowers from victimisation or dismissal for exposing malpractice in the workplace. Each Trust is expected to have a whistleblowing policy in line with Department of Health guidance from 2003. Doctors should raise concerns by following the processes detailed in this policy and drastic measures, such as alerting the media, should only be taken as a last resort. Other whistleblowing guidance was issued to general practitioners by NHS Employers following the Shipman Inquiry and a code of practice was published last year by the British Standards Institute and Public Concern at Work.

New guidance on whistleblowing from the British Medical Association cites a clause in nationally agreed NHS contracts of employment which might provide further justification for some doctors to speak freely: "A practitioner shall be free, without prior consent of the employing authority, to publish books, articles, etc

and to deliver any lecture or speak, whether on matters arising out of his or her NHS service or not." But reliance on this clause is not free from doubt.

Duty to report

The General Medical Council defines it as a doctor's duty to report concerns in *Good Medical Practice (GMP)*. The guide states clearly: "You must protect patients from risk of harm posed by any doctors or other health care professionals' conduct, performance or health". The GMC is clear that patient safety always comes first. Doctors must put aside fears about the effect whistleblowing may have on their career and their relationships with colleagues. Doctors who ignore concerns risk being penalised, as *GMP* states one of the duties of a registered doctor is that they must "act without delay if you have good reason to believe that you or a colleague may be putting patients at risk".

Dr Gail Gilmartin, a medico-legal advisor at MDDUS, said doctors must always respect patient confidentiality when raising concerns. She said: "Whenever a doctor is considering whistleblowing they need to remind themselves about objectivity, evidence, issues of consent and confidentiality and using proper process. Most doctors are aware of various risks involved but we would urge members to seek our advice if they find they are contemplating such action."

It is key that any medical professional looking to raise concerns thinks carefully before acting. *GMP* dictates a need to have "good reason to think that patient safety is or may be seriously compromised". It can be hard to know when to act, but the BMA's new guidance* suggests medics ask themselves: "If you let the situation carry on, is it likely to result in harm to others?" If in doubt, they say you should "always err on the side of raising the concern with your manager/immediate superior as soon as you can". The GMC's guidance booklet *Management for Doctors* also states that any doctor with concerns should "declare the conflict, seek colleagues' advice and raise your concerns formally with senior management and external professional bodies as appropriate". The GMC has also launched a series of online tutorials on its website tackling ethical scenarios, including whistleblowing, to help guide doctors.

GMP and the BMA say would-be whistleblowers must keep a thorough record of their concerns and gather evidence of the alleged wrong-doing. Medics must give an "honest explanation" of their concerns, *GMP* advises, and if you are not sure what to do, it recommends discussing the concerns with a colleague, contacting your defence body, a professional organisation or the GMC for advice.

Lindsey McGregor, a solicitor with MDDUS, said doctors have a professional responsibility towards their colleagues as well as to their patients. She said: "Whistleblowing must be seen within the context of one's professional obligations. Speaking out on patient safety issues, systems or on a colleague's conduct will be a matter of individual conscience but at all times the GMC guidance on this issue must be at the forefront of your mind. It is important to have read the guidance before embarking on this path and you should be prepared to be able to justify your concerns to others at all times."

Frustration

A recent survey by the BMA, *Speaking Up for Patients*, found that hospital doctors in England and Wales are often frustrated in their attempts to raise concerns, with 74 per cent of the 565 who responded admitting to being concerned about issues like patient safety or bullying at some point in their career. Seven in ten doctors had raised a concern but nearly half of those felt nothing came of their complaint.

BMA chairman Jonathan Fielden called for a "culture change" in the NHS. He said: "No doctor, no nurse, no porter, anywhere in the NHS should be made to feel that speaking up for their patients is a bad career move". The BMA have pledged to support any whistleblower and urge them to have courage in the face of possible victimisation.

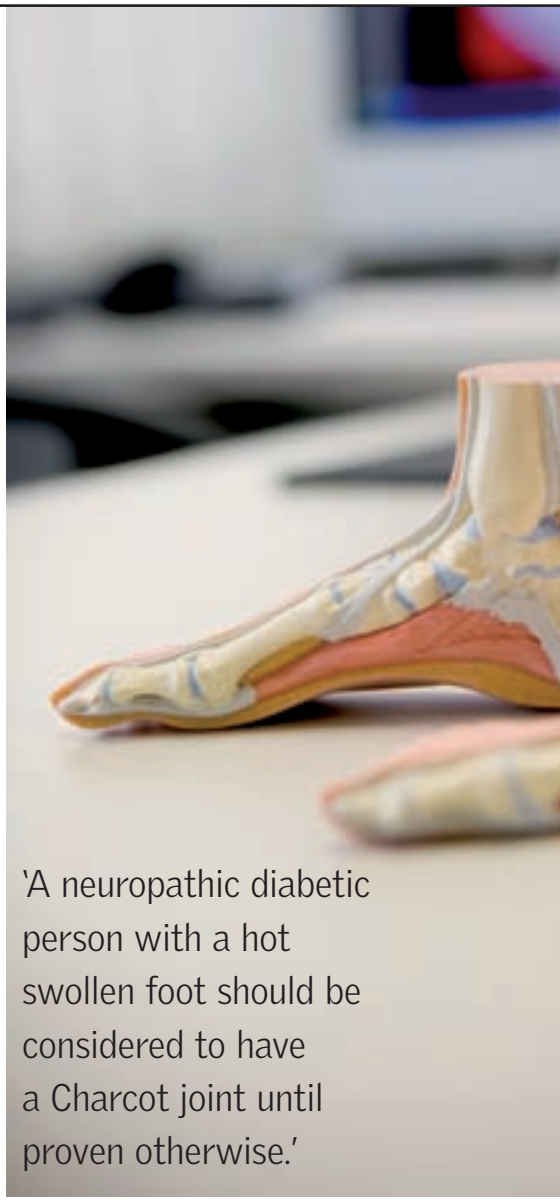
So, while politicians urge clinicians to report concerns, there still appear to be major hurdles to overcome before medics feel completely comfortable in doing so. Many doctors are fearful of being stigmatised by colleagues, intimidated or of destroying their careers. There remains a culture in some places that whistleblowing is considered "snitching" on colleagues and doctors shouldn't "let the side down". Certainly, *GMP* has a clear cautionary message for anyone looking to raise malicious concerns about a colleague. It demands you treat colleagues "fairly and with respect" and you must not "make malicious and unfounded criticisms" about them. Clearly any medic making false accusations risks serious punishment.

■ *Joanne Curran is associate editor of Summons*

*BMA guidance at: www.tinyurl.com/mekajm

Charcot foot

A GP might see one active case in a career but failure to diagnose Charcot foot can lead to significant deformity, says diabetologist Dr Matthew Young



'A neuropathic diabetic person with a hot swollen foot should be considered to have a Charcot joint until proven otherwise.'

CHARCOT neuroarthropathy is a relatively uncommon but serious complication of neuropathy. It was first recorded in a diabetes patient in 1936, and since then diabetes has grown to become the largest single cause of Charcot change in the developed world (leprosy in the undeveloped world). But it is firmly held by those who regularly treat patients with Charcot feet that such changes are frequently overlooked, particularly by general practitioners and emergency departments, with potentially devastating effects. Most general practitioners might only need to recognise one active Charcot foot in a working lifetime but failure to diagnose and treat a Charcot joint can lead to significant deformity, disability and amputation, with the potential for successful and expensive claims for negligence.

Natural history

Eighty per cent of the patients who develop Charcot neuroarthropathy have a known duration of diabetes of over 10 years. The long duration of diabetes prior to the initiation of the Charcot process reflects the degree of neuropathy that is invariably present in these patients. The risk factors for Charcot neuroarthropathy are listed in the box on page 17. The blood supply to the Charcot foot is always good. It is assumed that autonomic neuropathy plays a part in the increased vascularity of bone and this increases osteoclastic activity, resulting in the destruction, fragmentation and remodelling of bone.

The initiating event of Charcot neuroarthropathy is often a seemingly trivial injury, which may result in a minor periarticular fracture or in a major fracture despite the inability of the patient to recall the injury in many cases. The patient may notice a change in the shape of the foot and others describe the sensation, or the sound, of the bones crunching as they walk. Following this there is a rapid onset of swelling, an increase in temperature in the foot and often an ache or discomfort. It is these processes which, if left untreated, lead to the characteristic patterns of deformity in the Charcot foot, including the collapse of the longitudinal and transverse arches resulting in the rocker bottom foot seen in cuneiform metatarsal Charcot neuroarthropathy or collapsed and distorted ankle joints in rear foot Charcot.

The natural history of Charcot neuroarthropathy passes from this acute phase of development through a stage of coalescence, in which the bone fragments are reabsorbed, the oedema lessens and the foot cools, into the stage of reconstruction, in which the final repair and regenerative modelling of bone takes place to leave a stable, chronic Charcot foot. The time course of these events is variable but intervention must be made in the earliest phase to prevent subsequent deformity, disability, ulceration and amputation.

Diagnosis

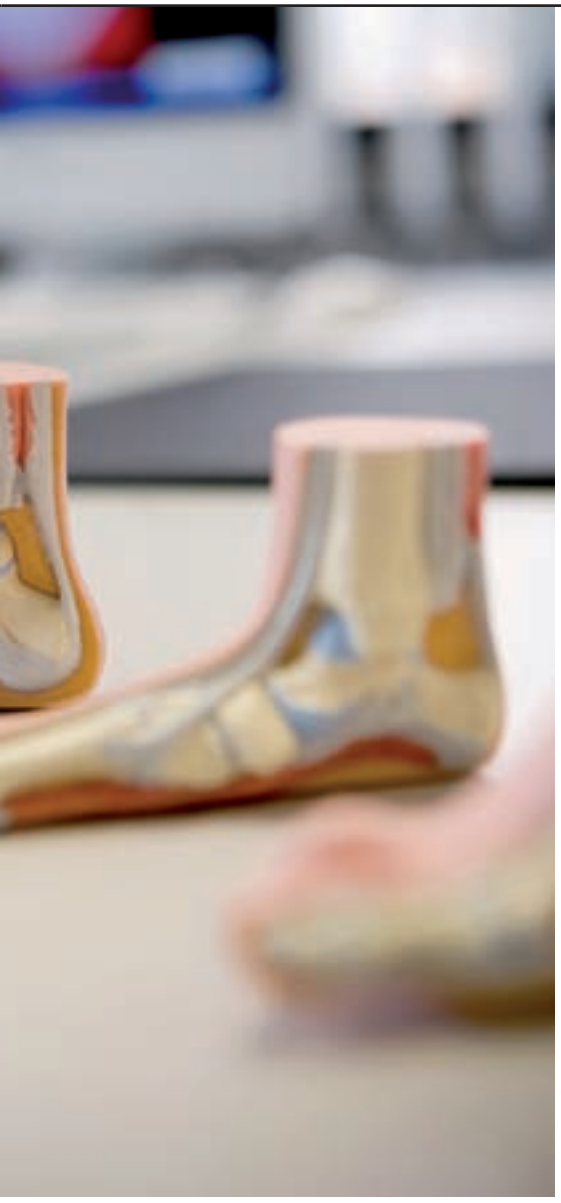
Charcot neuroarthropathy is frequently overlooked as the cause of a swollen, warm leg in a neuropathic patient with diabetes. If a history of injury, even a simple trip or toe-stubbing, is present then X-rays should be mandatory even if the other signs have not yet developed, and any fracture should be treated by casting. If the clinical signs of heat and swelling are present then normal X-rays should still be treated with caution. Precautionary casting or other immobilisation such as the air cast boot should be put in place until the X-ray is repeated or other investigations are performed. Isotope bone scans may help if the X-ray is normal.

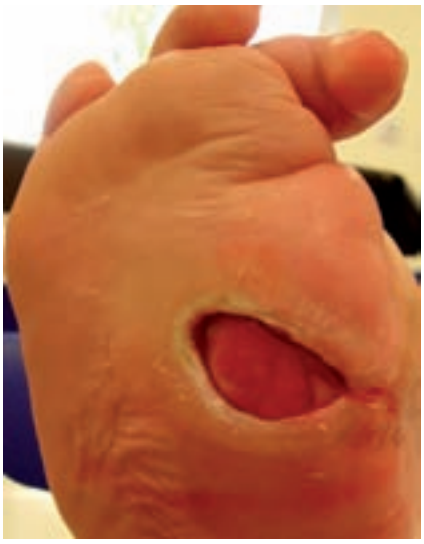
Again, if reported as being consistent with osteomyelitis, when there is no history of open ulceration prior to the development of the heat and swelling, Charcot is still more likely. Computerised tomography and MRI scanning are reported to be better at discriminating between Charcot change and osteomyelitis but still have limited immediate availability in many hospitals.

Investigation for deep venous thrombosis and osteomyelitis often delay the start of appropriate therapy. In a diabetic patient with significant neuropathy, and with these signs and symptoms, it is better to assume that there is Charcot neuroarthropathy and treat accordingly, even if there is no clear history of injury. This is particularly true of the Charcot process in the ankle joint.

Treatment

Once the diagnosis has been made then prompt and total immobilisation is the best way to reduce deformity. The duration of casting averages at least 18 weeks but the process can still restart after this period, requiring a return to cast. Patients, once





Deformity and ulceration due to rocker bottom foot

RISK FACTORS

The following are risk factors in the development of Charcot neuroarthropathy

- Duration of diabetes (usually greater than 10 years)
- Dense peripheral neuropathy
- Autonomic neuropathy
- Osteoporosis
- Other diabetes complications
- Transplant patients
- Young female patients with eating disorders (especially anorexia nervosa) leading to amenorrhoea

removed from cast, need careful monitoring to ensure that any recurrence is treated promptly. Skin temperature differences between the active and unaffected foot remain the best marker of Charcot activity and are the most frequently used tool for monitoring resolution of the Charcot process.

If the patient is not immobilised, and even sometimes when they are, then the Charcot process proceeds to a destructive phase. The fragmentation and weakening of bones causes tendon and ligament insertions to detach. This leads to collapse of the normal foot architecture. In the ankle it also leads to loss of talar or calcaneal height leading to leg shortening and ankle instability.

Attempts to internally or externally fixate the fragmented bone are more common in North American practice. Fixation surgery for Charcot feet often has only a modest success in the acute stages and there are very few case series of any size, and virtually none with adequate controls, to suggest that ankle surgery is any better. In many cases surgery during the active phase of Charcot destruction can actually accelerate the process. Late surgery to correct mid-foot deformity can be considered as long as the foot is stable and uninfected. Once the ankle has become deformed and the ankle is unstable, particularly if ulceration is present, then primary amputation may be the best way to provide the patient with a functioning limb for walking, as attempts at orthopaedic surgical repair are often only partially successful or fail.

Early diagnosis and treatment can limit deformity but there is no attempt to address the underlying pathophysiology. With growing evidence that weakened bones and increased osteoclastic activity underpin the initiation and destructive phase of Charcot neuroarthropathy, treatment with bisphosphonates has been piloted in Manchester in the United Kingdom. A further randomised study and trials of oral bisphosphonates showed similar results with reductions in temperature, pain and swelling but the use of these therapies remains controversial.

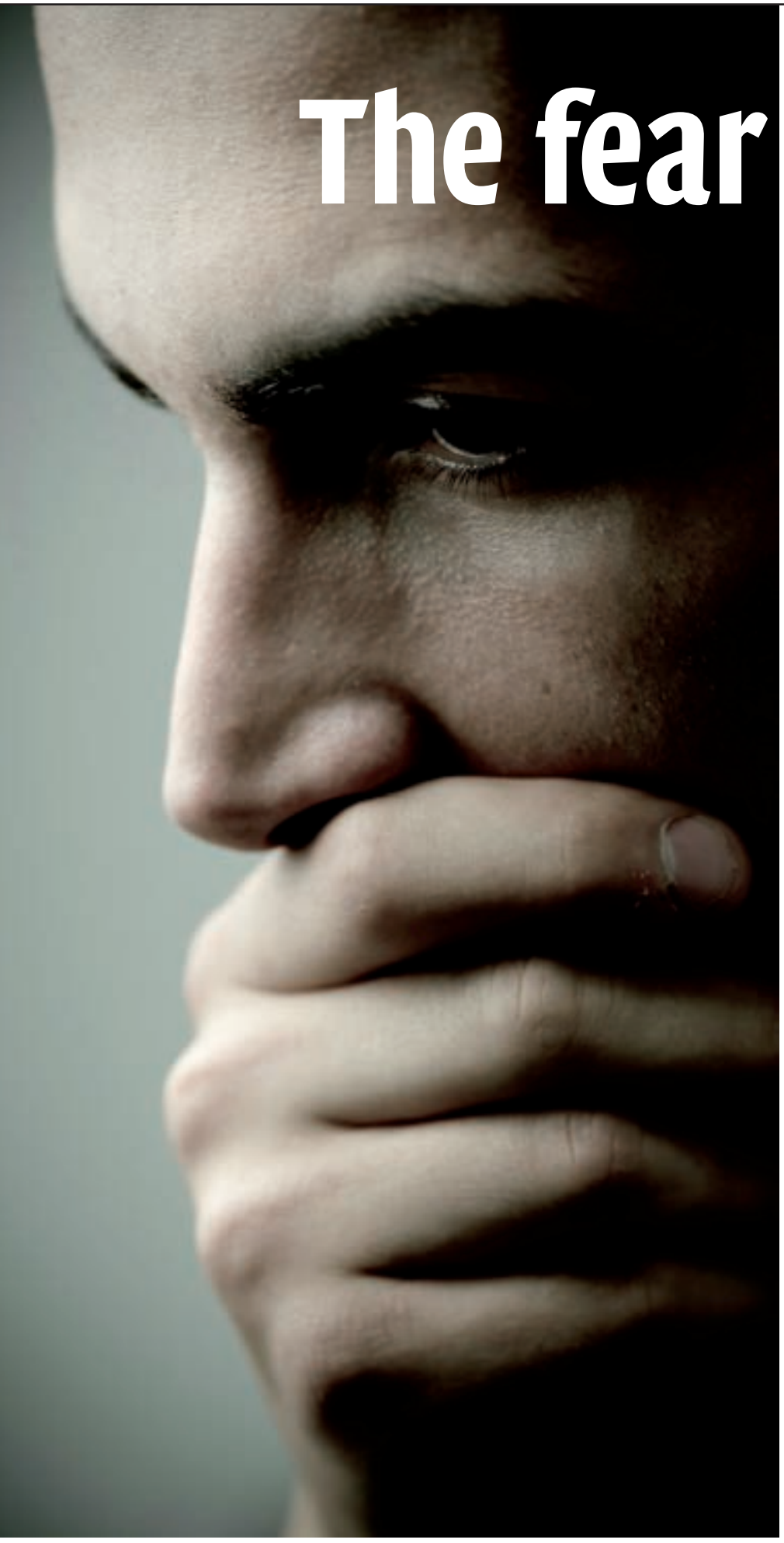
Medicolegal pitfalls

The main pitfall in managing Charcot neuroarthropathy is the failure to consider it as a diagnosis in a susceptible and symptomatic diabetes patient. Whilst this is still a relatively frequent occurrence for non-specialists, at least on first presentation, once a patient has had negative Doppler scans and/or courses of antibiotics for presumed cellulitis with no improvement, if no thought is given to alternative diagnoses then a claim is likely to be successful. The size of that claim is likely to be determined by the degree of deformity and subsequent ulceration, and significantly larger if an amputation is required which is so often the case for untreated Charcot feet and ankles.

Summary

Charcot neuroarthropathy in diabetic patients is more common than generally recognised. Prompt action is required to prevent deformity and this is dependent upon early recognition and treatment. A neuropathic diabetic person with a hot swollen foot should be considered to have a Charcot joint until proven otherwise. Casting will curtail the active phase of bone destruction and bisphosphonates may also help but are not proven to do so. If possible, surgical correction of any deformity should be delayed until the active phase is over and the foot is in a stable healed state. Occasionally, when the ankle complex has been destroyed, amputation will provide a more functional lower limb for walking than leaving the ankle in place.

■ *Dr Matthew Young is a consultant diabetologist at the Edinburgh Royal Infirmary*



The fear factor

Expert in dental sedation, Dr Nigel Robb, *offers some useful insights on the phobic patient*

A FEAR OF going to the dentist is generally regarded as a trivial problem and patients who can't cope with treatment often think they are being silly or stupid. But such fear can have serious implications.

Studies show that a significant percentage of the UK population remain anxious about treatment despite advances in the delivery of dental care – and some of these patients display a genuine phobia of the dental chair. A phobia is defined as an "irrational and uncontrollable fear… related to a specific object or situation… that is persistent… and has a direct effect on the patient's lifestyle".

Avoiding dental treatment out of fear can have a clear impact on general health. There has been considerable debate regarding the relationship between gum disease and ischaemic heart disease. Avoidance of dental care can also mean patients are not regularly screened for diseases including oral carcinoma. A more extreme example is the recent well-publicised case of an eight-year-old girl in Cornwall who starved herself to death because she was afraid of dental treatment. Such stories are rare but not unheard of.

Dental phobic patients

There is no stereotypical anxious or phobic dental patient. Some practitioners report seeing more phobic women than men, but it's thought female patients are more likely to present for treatment and admit their anxiety. I have provided sedation for patients from all backgrounds, including medical consultants from varying specialties (including an anaesthetist), lawyers and accountants.

Patients who are anxious regarding dental treatment can show a number of signs. The most obvious include shaking, sweating (having cold clammy hands), looking very pale, having dilated pupils or gripping the armrests of the chair.

Other less obvious signs are:

- *Fainting at the time of injection*. Often patients will blame the contents of the injection rather than admit they are frightened.
- *Aggression*. Fear is marked by an excessive secretion of epinephrine which is part of the fight or flight response. It is quite common for frightened patients to become aggressive, particularly when they don't get what they want.
- *Repeated missed appointments*. The "regular irregular attenders" visit the dentist when in pain but don't complete courses of treatment. They attend every few years when the next problem can't be ignored.
- *Over-eager responses*. Some anxious patients will try to shorten the time they are in the dental environment by attempting to answer questions rapidly or by giving the response that they feel that the dentist wants.
- *Conversation in the waiting room*. Discussions about how quick or painful the dental treatment may be are signs of anxiety.

Treating anxious patients

The most common complaint GDPs have about treating anxious patients is the wasted surgery time and lost income caused by failed appointments. Other common problems include:

- *Failure to understand the explanations that are given to them*. Stressed patients often don't assimilate information as clearly and this may lead to claims that treatment consent was not informed.
- *Breakdown of the patient–dentist relationship*. This can be a particular problem when the patient's anxiety manifests as aggression. A judgement needs to be made as to whether the patient is genuinely aggressive or just frightened.
- *Prolonged treatment times*. Anxious patients are more likely to take a break, sit up and spit out, or otherwise interrupt treatment. This can irritate the dental team.

The most important thing with anxious patients is to recognise the anxiety. Over 50 per cent of patients cite fear as the major barrier to receiving dental care. In the USA, recent publicity associated with Root Canal Awareness Week suggested over half the population avoid attending due to fear while some degree of fear affects up to 80 per cent. We should, therefore, expect to encounter such patients on a daily basis.

Fear of the unknown is a basic human trait. A good explanation in advance of the treatment will often help reassure patients with mild to moderate anxiety. Tell–show–do is the model approach. Patients should also be given a stop signal, so that they can request a break. This allows a feeling of control, but be sure to act upon such a signal. Many anxious patients describe situations with a dentist where "he said he would stop, but he didn't".

Anxiety management

There are two basic approaches to anxiety management in seriously phobic patients. The first allows the patient to have their dental treatment carried out in a stress-free manner, but does not address the underlying problem. The second "treats" the anxiety.

Conscious sedation techniques are the cornerstone of the first strategy. This temporarily relieves the patient's anxiety and allows the dental procedures to be carried out with reduced stress levels for both patient and dental team. The other major advantage is that once the patient knows there is a way of having treatment carried out without stress they are more likely to attend for check-ups. Sedation may encourage patients to attend more regularly and complete treatment.

The second approach employs psychological treatments, usually involving behavioural therapies or cognitive behavioural therapy (CBT).

The behavioural approach takes the patient through a structured, graded exposure to an event or experience. The process starts with the least stressful part of the process and culminates in the most stressful. The patient is given relaxation techniques to use and repeats each stage until they can go through it stress-free.

Cognitive behavioural therapy is the term for a number of therapies that are designed to help solve problems in people's lives. CBT works on the premise that your problems are often created by you. It is not the situation itself that is making you unhappy, but how you think about it and how you react to it. Patients are taught to re-evaluate the way they think about a problem.

One example would be a man going through a divorce who feels that he has failed as a husband, which makes him depressed. The depression makes him tired and lack energy. This leads to him spending all his time at home and avoiding family and friends. The CBT approach would tackle this by firstly dealing with the thoughts: in this case that divorce is common. The break-up usually relates to faults on both sides. It is time to move on, learning from the mistakes. As this is addressed it will help the emotional and physical symptoms. The last step is to integrate this into a change of behaviour.

In common with conscious sedation, these techniques would require postgraduate training for a dental professional. But there is no reason why dentists can't be effective at providing such treatments, given appropriate training and experience.

Hypnosis can also be used as a vehicle for psychotherapy, and its main benefit is to increase the efficacy. Particularly in combination with the behavioural approach, hypnosis can make it possible to move through graded exposures more rapidly. The technique can also be used to help with immediate treatment, producing a state of non-pharmacological sedation.

Mutual stress

Dealing with anxious patients is among the factors dentists report as being most stressful in their working environment.

When both dentist and patient are stressed, there are high levels of adrenaline circulating. Both experience the fight-or-flight reaction. The dentist will not have the flight option, and thus it is important for him to be aware of, and avoid, potential confrontation.

Dentists should only manage situations they are trained and competent to deal with. If a patient's anxiety is beyond the scope of a dentist's management techniques, they should refer to an appropriate colleague.

■ ***Dr Nigel Robb is a senior lecturer in sedation in relation to dentistry at Glasgow Dental Hospital and School and an Honorary Consultant in Restorative Dentistry***

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

RECORDS

Poor records, poor defence

A dentist carried out a deep restoration in an upper left premolar tooth. The patient returned with symptoms which did not settle and eventually, with full explanation being offered, root treatment was carried out. Almost immediately afterwards, a cusp fractured from the tooth and the dentist recommended that the only appropriate restorative option was provision of a post crown. The patient did not wish to pay for this treatment as she felt the loss of the cusp had been caused by the dental treatment rather than the gross amount of decay which had previously been in the tooth.

The patient wrote a letter of complaint and the dentist responded, indicating he did not feel the loss of the cusp was his fault and that the patient would be required to pay for a crown if she chose this form of treatment. The patient did not accept this response and raised a complaint with the Ombudsman's office.

In order to investigate matters the Ombudsman examined the patient's records and was critical of the dentist's record keeping. There were no radiographs showing diagnostic working lengths. Some figures were written in the margin of the records, but no indication of what they meant. There was no post-operative radiograph.

When the dentist was asked to explain the record entry, he said that he routinely used an electronic apex locator and the figures in the margin related to the lengths of each canal. The patient had been quite irate about the tooth fracturing and the ensuing discussion with the patient lasted some time, such that the dentist was "running very late". He therefore did not take a post-operative radiograph and the patient had since failed to return to the practice.

When all this information was relayed to the Ombudsman's adviser, he remained critical of the record keeping, although he was supportive in the diagnosis and treatment proposals of the dentist. In conversation with the dentist, MDDUS pointed out that a reasonable standard of record keeping in relation to root treatments would include appropriate recording of working lengths, stating whether or not an electronic apex locator was used, and, of particular importance, taking a post-operative radiograph.

Analysis and outcome

On analysing the records more carefully, MDDUS judged that it was highly likely in this case that an expert – instructed by a solicitor acting on behalf of the patient – would be critical of the record keeping with the implication that the standard of treatment was possibly inadequate. In the absence of good information on the dental records, MDDUS would not be in a position to offer a strong defence of the dentist.

Key points

- Ensure that full and complete contemporaneous records are written.
- Records should be both legible and understandable.
- Irrespective of who writes the record it should be checked by the clinician after each patient contact.

GMC

Responsible supervision

MDDUS received a call from Dr B who was a partner in a large city practice. One of the other partners, Dr K, had been diagnosed with a mental disorder and as a result his GMC registration had been subject to 'undertakings'. He was undergoing treatment and had been signed-off for six months.

As part of the undertakings the GMC stated that if Dr K returned to work, he required supervision by a "senior partner" in the practice. Dr B had a number of concerns.

In the past when Dr K had been working under supervision in the practice there had been several adverse incidents which occurred related to his condition. Dr B was concerned about the possibility Dr K in future might suffer a relapse and the practice would not be able to provide supervision at a level which would make the risk acceptable. He was also unclear as to the level and exact definition of 'supervision' as set out in the GMC undertakings.

Dr K was not a member of MDDUS and Dr B was concerned that he had indemnity for liability that might arise in the supervision of Dr K's work.

Analysis and outcome

The MDDUS adviser reassured Dr B that he was fully indemnified for any supervision of Dr K's work. But Dr B was encouraged to seek clarification from the GMC in regard to the precise nature of the supervision set out in the 'undertakings'.

Key points

- Ensure you fully understand the terms of any responsibilities you accept from the GMC.
- Check with MDDUS if in doubt of the extent of indemnity cover.

PREVENTATIVE DENTISTRY

Dental neglect – but whose?

Mr M had worked for the same dental practice for 35 years and was looking forward to his retirement. One morning a letter of claim arrived at the surgery from solicitors representing a patient Mr M had treated for over 20 years from the age of four.

Mr M remembered D well as he attended over 70 times in the period that he was a patient at the surgery. His notes constituted a long list of caries and fillings with occasional antibiotics and, in the later teen years, numerous root canal treatments and crowns. In the claim it was alleged that many of the fillings and treatments were incomplete and required to be re-filled and crowned.

The patient also alleged that he had never been given any advice on diet or oral hygiene. Nor was he ever referred to the dental hospital where he might have been offered preventative treatment such as fluoride washes and sealants. Such measures might have prevented the extensive dental decay suffered by D and the remedial treatment that he now required at a cost estimated in excess of £8,000.

Analysis and outcome

Two dental experts were consulted by MDDUS on the case and both acknowledged the need for extensive remedial treatment. In answer to criticisms of his practice Mr M stated that he had persistently advised D and his family on the importance of sound dental care including regular brushing and diet (avoidance of sweets, etc) but suspected this was mostly ignored. Sadly there were no clinical notes in the records of this advice being given nor evidence of BPE charting.

The patient records were also incomplete in regard to radiographs – with missing pre- and post-operative films from numerous treatment sessions.

The experts acknowledged that there was clearly an element of contributory negligence on D's part for his poor dental health but that Mr M did share some liability.

MDDUS had no option but to settle the case although this was at a nominal sum in view of the patient's contributory negligence.

Key points

- Ensure patient records are complete including all radiographs, charts and notes of all treatment and advice provided.
- Ensure that you assess and record patient compliance regarding any preventative dental advice.

TREATMENT

Steroids and a bad hip

Mr P had been attending his GP surgery for over 15 years, suffering from periodic bouts of asthma for which he was treated with prednisolone tablets and a steroid inhaler. He was a heavy smoker and had a history of asbestos exposure.

In that period Mr P also struggled with alcohol abuse and suffered episodes of gout, possibly brought on by drug treatment for hypertension. In 2007 the patient began to suffer from low back pain and was referred by his GP to an orthopaedic clinic. He was diagnosed as having avascular necrosis of the hip. Replacement surgery of the hip was carried out and, although successful, Mr P continued to complain of groin pain and lack of mobility.

Later that year the GP received a solicitor's letter claiming negligence in the long-term prescription of steroids which Mr P alleged led to the avascular necrosis in his hip.

Analysis and outcome

MDDUS instructed a medical expert to review the case notes and the patient's records. He noted that there was a recognised correlation between avascular necrosis and the use of systemic steroids – but also that gout and excess alcohol consumption can also be factors. The expert found that Mr P had only been prescribed systemic steroids intermittently and judged that the short overall time span of treatment was unlikely to have been responsible for onset of avascular necrosis.

He found the GP had followed BTS guidelines on the use of oral steroids in acute exacerbations of asthma and was only critical of the case management in the lack of notes on patient compliance in the use of inhaled steroids. A record of poor compliance would have helped to better justify the use of oral steroids.

The expert also stated there was no significant body of opinion that advocated warning patients about the potential for avascular necrosis in either the short or long-term use of oral steroids.

MDDUS made the decision to argue the case and after a few months received notification that the claim had been abandoned.

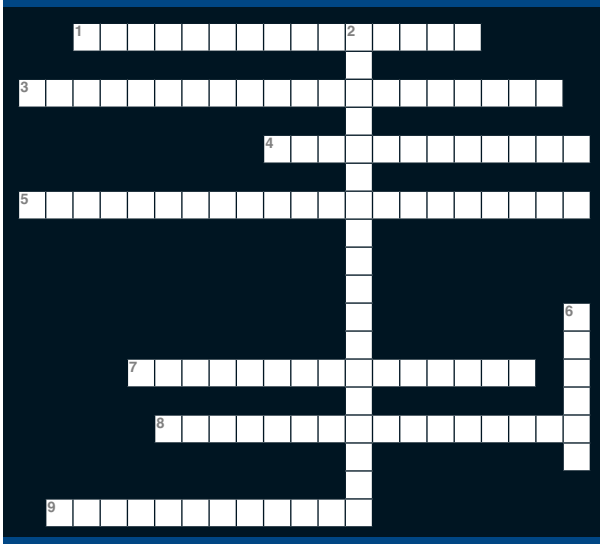
Key points

- Follow BTS guidelines in the treatment of asthma.
- Ensure you check and record compliance in inhaled steroid treatment.
- Be aware of bone damage in long-term steroid use.

Medical Crossword: causes of chest pain

Across

1 Localised, tender, anterior chest pain precipitated on movement of the trunk and can be preceded by an upper respiratory tract infection (15)
3 Crushing, severe, long-lasting pain at rest, may radiate to jaw or arms. May be associated with nausea and vomiting, and sweating (10, 10)
4 Sharp, well-localised chest pain aggravated by inspiration, coughing and movement, along with proliferant dyspnoea (12)
5 Non-cardiac chest pain with limited back movement (10, 11)
7 Localised pain and tenderness, unaffected by respiration and associated with vesicular rash (9, 6)
8 Severe, tearing chest pain radiating to the back (6, 10)
9 Sharp pain exaggerated by movement, respiration and change in posture especially from standing to sitting upright (12)



Down

2 Pain occurring at night, when bending or lying down, which may radiated to the neck and occur in conjunction with heartburn (6, 12)
6 Acute, crushing chest pain brought on by physical exertion and relieved by rest, which may radiate to the jaw or arms (6)

See answers online at www.mddus.com. Go to the Notice Board page under News and Events.

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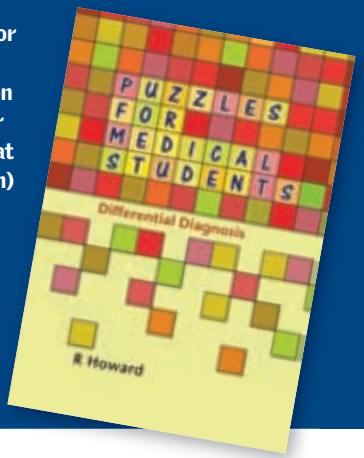


From the archives: action beyond the grave

One case from the MDDUS records of 1926 well demonstrates how court actions do not cease with the death of a defendant. The case concerned alleged negligence and had been raised by Duncan Carmichael, a dairyman married with five children, against Dr Alexander Miller, the Medical Superintendent of Belford Hospital in Fort William.

Mr Carmichael's son, Duncan, was certified as suffering from scarlet fever and on the instructions of Dr Miller and, it was claimed, without his father's consent, the boy was removed to Belford Hospital. He remained in hospital for over eight weeks. On his return home it was noted that he had a severe discharge from his ear.

Shortly afterwards, his brother John and sister Sarah were admitted to hospital suffering from diphtheria, from which the girl died one week later. Two weeks later, another son, Dougall was sent to hospital with diphtheria. A swab from the discharge in Duncan's ear demonstrated the presence of diphtheria bacilli and it was claimed that Duncan contracted diphtheria while in hospital and had subsequently infected the other children.

Dr Miller's defence team argued that the bacilli from Duncan's ear were non-virulent and that Sarah's death was due to delay in seeking treatment for her condition. Dr Miller died in January 1928 but the case continued against his Executors. The case was concluded on 23 December the following year with the Lord Ordinary, Lord Fleming, finding in favour of Dr Miller and awarding expenses to his estate.

Reproduced from: D Muir, D J Bell. A century of care – a history of the Medical and Dental Defence Union of Scotland. *Glasgow: MDDUS; 2002*

Object obscura: dental hypodermic syringe

This dental hypodermic needle (1885-1900) used for administering local anaesthetics was manufactured by Parke Davis & Co. Cocaine was the first local anaesthetic, demonstrated in 1884 Vienna in eye drops used to anaesthetise the cornea and conjunctiva. A year later a surgeon in New York, Dr William Stewart Halsted, began experimenting with injected cocaine in sensory nerve trunks to produce regional anaesthesia in the face, jaw and limbs. This discovery transformed the practice of dental surgery and earned him a gold medal from the American Dental Association in 1922. But it also led to Halsted and a number of his associates developing serious cocaine addictions.

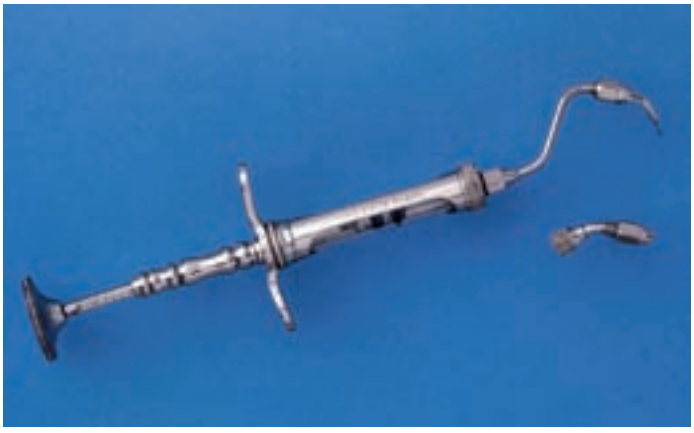
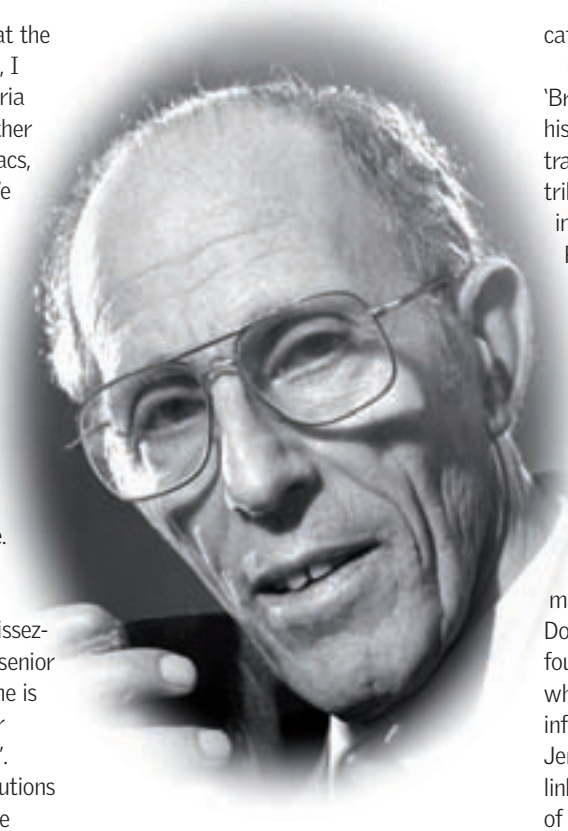


IMAGE: SCIENCE MUSEUM/SSPL

Vignette: giant of geriatric medicine

Professor Bernard Isaacs (1924 – 1995)

IN THE EARLY 1950S, as a student at the University of Glasgow medical school, I attended a series of lectures on materia medica. I recall waiting along with other students for our new lecturer, Dr Isaacs, not knowing quite what to expect. We were told he came from the famed department of Regius Professor Stanley Alstead. Dr Isaacs arrived smiling, business-like, and proceeded to galvanise and mesmerise us with his erudition, humour and insight. It was like watching GB Shaw, Chic Murray and 'Brains Trust' Professor CEM Joad somehow speaking in unison. That lecture has stayed with me for over half a century of practice.



Bernard Isaacs made his mark as one of the great innovators of British geriatric medicine. Not for him the laissez-faire notion that therapy for the sick senior may not prove worthwhile "because he is too old" or "the sickness is chronic" or "because it has not been tried before". Practising at Foresthall and like institutions of the day, he recognised that multiple illness of the senior years needed a broader perspective in socio-economic and medical terms.

A native Glaswegian, Isaacs attended Kilmarnock Academy and his prowess all the way to Dux of that notable institution was a fitting background to his career in medicine. He earned his MB ChB in 1947 at the University of Glasgow and an MD in 1957. In subsequent years he worked as assistant and then consultant physician at Foresthall Hospital before moving to Glasgow Royal Infirmary as Consulting Physician in Geriatric Medicine in 1964.

In 1975, Isaacs was appointed to the new Charles Heywood Chair in Geriatric Medicine at Birmingham University. Here was an ideal setting, from the mid-1970s onwards, to develop his progressive and original views on teaching and research in geriatric medicine, not to mention launching a gerontology certificate at the university.

Those of us who met up personally with Isaacs, through the 1960s to 80s in Glasgow, Birmingham or London, were enthused by his sharpness, drive and originality. When I was awaiting publication of my own book on hospital geriatric medicine in the late 1960s, I met up with Isaacs who also had a book coming out. My work was called, matter-of-factly, *Later Life*. As always, Isaacs came up trumps. His catchy title was *Survival of the Unfittest* – a searing analytical account of the socio-medical tribulations suffered by Glasgow's east-end elderly leading to referral to geriatric wards.

From this and other studies, Isaacs famously coined the expression the "geriatric giants" or the four I's: impairment of intellect (cerebral dysfunction), incontinence, immobility and instability (falls). The term 'giant' is seen to refer both to statistical frequency and to the huge personal burden of sufferers, escalating the need for socio-medical intervention.

A compassionate, clear-thinking academic, Isaacs was practical and logical. Long before role-playing and role-reversal techniques became part of health profession training, he adapted these formats to teach and to research. He believed that only by self-simulating serious affliction illness, for at least 24 hours, can anyone begin to appreciate the catastrophic effect on any individual.

Notwithstanding his successful years in 'Brummy-land', Isaacs expressed pride in his Scottish education and Scottish medical training. He was, like the author of this tribute, influenced towards elderly medicine in Glasgow by the charismatic geriatrician, Professor Sir William Ferguson Anderson.

Isaacs' humour could be literary, ironic or 'Glasgow dry'. Kindly attending one of this writer's medical talks in late 1970s Birmingham on the topic 'ageing and sexual dysfunction', Professor Isaacs afterwards asked me with a gentle grin: "are you the only geriatrician in England making a living at this?"

The aphorism 'behind every successful man....' was affirmed by happy marriage to Dorothy Berman of Glasgow and they had four sons. Isaacs relished his religious faith wherever he lived and this no doubt influenced his post-retirement move to Jerusalem in 1992. Here for a time he was linked with the former Brookdale Institute of Gerontology.

As a pioneering Professor at Birmingham, Isaacs looked not just within the establishment for positive solutions to the problems of the elderly infirm but he also encouraged a hands-on/feet-on approach to products used daily by and for old people, seeking their opinions directly and arranging to pass on consumer views appropriately: effectively an applied gerontology centre.

Even when officially retired in Israel, he still pondered furniture for the infirm, for example how to rise comfortably from a chair.

His last major publication in 1992, *Challenge of Geriatric Medicine*, impressed readers by its breadth and erudition. It readily confirmed that his 1989 CBE had been a well-justified honour. The volume remains a fitting reminder of a super-star of geriatric medicine, who, sadly for him, his family and world-wide admirers, was not to be blessed with very old age.

Bernard Isaacs is recalled not just for his giant four I's. We also miss deeply his personal three W's – wit, warmth and wisdom.

Dr Ivor Felstein

PHOTO: DES GERSHON/GANADEN PICTURE LIBRARY

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