Spring 2009

SUMMONS

MDDUS JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND

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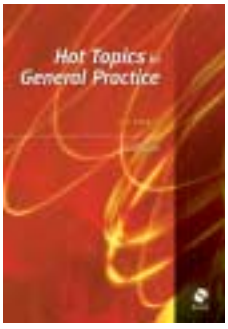

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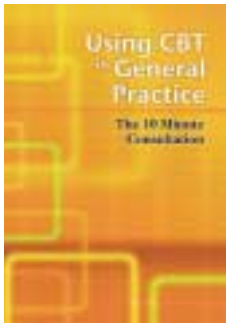

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IN THIS ISSUE

A FEW years ago it might have seemed that the humble mutual (a business owned by members and reliant on them for funds) was going the way of the dodo. Or so says Martin Waller, a city editor at *The Times*. Companies like Standard Life were leading a 'rush to market' seeking all those billions then floating about in available capital.

Other firms resisted demutualisation and some are now suggesting that this has protected them from the excesses that have led so many other businesses and banks into their – to be kind – "current difficulties". Mutuals are looking a much better bet these days.

Research commissioned by Royal Liver has shown 65 per cent of the public now mistrust the financial services industry as a whole and 73 per cent are concerned that such businesses would put shareholders' interests ahead of those of policyholders. Of course the big advantage with mutuals is that those interests are one in the same.

MDDUS is proud of its 100-year-plus status as a mutual. It has served the Union well in the past and does so even more today. On page 12 economic historian Professor Charles Munn makes the case for mutual status in general and at MDDUS in particular.

Also in this issue we take a closer look at Good Samaritan acts and associated risks (page 9), as well as ways in which doctors and dentists can improve communications skills to enhance the clinical consultation (page 16). And on page 18, MDDUS adviser Riaz Mohammed writes of a recent trip he made to see some "real medicine" at a hospital in Raxaul, India, where healthcare staff struggle to provide a basic medical service to patients living in grinding poverty.

Maybe we could all do with a bit more perspective.

Jim Killgore, editor

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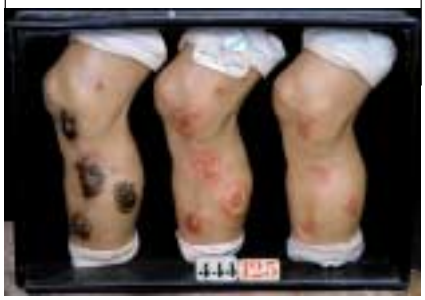
REGULARS



Cover image: 'In the Bosom of the Deep', etching, by Peter Standen who studied at the Edinburgh College of Art, and is a member of the Edinburgh Printmakers Workshop. 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, please visit www.artinhealthcare.org.uk. Scottish Charity No: SC 036222. Photograph: Roslyn Gaunt

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MDDUS appoints dental division head

MR AUBREY Craig has been appointed Head of Dental Division at MDDUS and will be responsible for the Union's dental advisory service. The move is in response to the continuing growth and development of the Union and is part of a reorganisation of the Professional Services Department at MDDUS.

Aubrey joined the MDDUS as a dental adviser in May 2006 and has long experience as a dento-legal expert. He qualified at the University of Dundee in 1987 (BDS) and gained an FDS from the RCPS Glasgow in 1991 and an MPhil in Medical Law from the University of Glasgow in 2001. Aubrey most recently worked as a partner in an NHS practice and is a former clinical teacher in restorative dentistry at Glasgow Dental Hospital and School.

"It's a great honour to be appointed Head of Dental Division at MDDUS," said Aubrey. "I'm confident that this further expansion of the dental advisory team will enhance the excellent service provided to our dental members."

MDDUS to sponsor BDA conference

MDDUS will be a major sponsor of this year's BDA Conference to be held on 4-6 June at the SECC in Glasgow.

Our main conference seminar will be held on Saturday 6 June in the Carron Room 2 at the SECC and will feature former international rugby player Gavin Hastings. MDDUS will also be the exclusive sponsor of the VDP Ball on Friday 5 June at The Arches in central Glasgow.

Visit the MDDUS stand (D30) where our dental advisers will be available to answer any questions. There will also be an exciting prize draw. Hope to see you there.

Team medics abroad

MDDUS members acting as team doctors to sports clubs on trips abroad are not eligible for indemnity in respect of any treatment undertaken out-with the UK.

IMAGE: EMPICS

The Union has confirmed its policy on the issue after a number of enquiries from members travelling with amateur football clubs and other athletic teams. We confirm that the cover provided to members would be limited to actions undertaken only within the jurisdiction of the UK.

The only exception to this would be a member acting in the capacity of a 'Good Samaritan' which is defined as: "the provision of medical and dental services in emergency situations outside the scope of an individual's normal contractual obligations or clinical practice".

Please contact the Membership Department at MDDUS if you need any clarification (tel: 0845 270 2038; email: membership@mddus.com).

Vacancy: Dento-Legal Adviser

MDDUS is looking to add to its team of professional advisers and invites applications for the position of Dento-Legal Adviser for up to 6 sessions weekly.

Candidates will be dental degree BDS or equivalent registerable qualified with significant experience of postgraduate dental practice, ideally with a relevant postgraduate qualification. This is an interesting and professionally satisfying role providing advice and support on claims, complaints and professional matters to dental members throughout the United Kingdom. Some experience of or education in dento-legal matters would be helpful, but full induction and ongoing professional training will be provided.

Founded in 1902, the MDDUS is an independent mutual organisation offering dento- and medico-legal advice and indemnity for doctors, dentists and other healthcare professionals throughout the UK. The post will be based in our Glasgow office. Informal enquiries to Mr Aubrey Craig, Head of Dental Division (acraig@mddus.com).

For an information pack please contact: Sheila Baumann, HR Assistant, MDDUS, 120 Blythswood Street, Glasgow G2 4EA (tel: 0845 270 2034). The closing date for applications is 14 April 2009.

Art and artist reunited

IN THE last issue of *Summons* we featured a painting on our cover from the collection at Art in Healthcare. It had been bought in auction by the charity and was without

IN BRIEF

HEALTH AND SAFETY COURSE
A course developed to introduce employees and managers to the requirements placed upon them by health and safety legislation is being offered by MDDUS at our Glasgow office on 27 April. 'Health & Safety Awareness' will provide guidance in the facilitation of risk, manual handling and COSHH assessments and the importance of accident/near miss reporting. The course is led by Thomas Elliot from MDDUS partners, Law At Work. To register interest or book, email education@mddus.com

EMPLOYMENT LAW UPDATE
MDDUS will be sponsoring a course for employers covering recent developments in legislation and case law, as well as highlighting forthcoming changes. Topics include updates on discrimination by association, sickness absence and redundancy selection, and future developments including the scrapping of working time opt outs. The session will be led by a lawyer from MDDUS partners, Law At Work, at our Glasgow

Professional football doctors

THE MDDUS is asking that any member employed in a medical capacity by a professional football team immediately contact our Membership Department.

In a recent policy decision the Union has decided to no longer provide indemnity to doctors employed by teams in the English Premiership, the Scottish Premier League, the English Championship (the second tier of English professional football) or the national associations of England, Scotland, Wales and Northern Ireland. The decision was based on the risk that legal action brought by a patient of a member providing medical care in such a capacity could result in high payouts due to loss of earnings both to the player and the club.

The problem was highlighted recently when Benjamin Collet, an 18-year-old footballer playing in the youth team at Manchester United, was awarded £4.3 million in compensation following an incident during a football match which ended his career. If such an award can be based on potential alone it is clear that an established player claiming medical negligence could be awarded a much higher amount.

The Union has decided that this presents an unacceptable risk to the membership. Doctors employed in such a capacity have been urged to ensure that their Club has made arrangements for the provision of adequate indemnity. Non-indemnity rates will be offered to those doctors affected by the new policy. Please contact the MDDUS membership department for details or clarification.

attribution. In January the widow of a GP and MDDUS member saw the cover and liked the image so much she saved a copy. Her daughter, Lesley Munro, takes up the story here:

"My mum had kept it to show to my son thinking he would like it (taking after his mother with the arty genes) and when she handed it to me in the kitchen I was shocked, and so was she, when I told her I had painted this."

Lesley had created the work 24 years ago not long after graduating from art college. The gallery originally holding the work had apparently auctioned it without her knowledge. Lesley is now a specialist art teacher but has recently begun to concentrate again on her own painting. Art in Healthcare have now amended their website and 'Lapland' again has an artist after all these years.

"My husband was astounded that I recognised it but you never forget something you've nurtured, no matter how long ago," said Lesley.

Online confidentiality

MDDUS has provided content for and sponsored a new medico-legal module on the BMJ Learning website. *Confidentiality: an up to date guide* is an interactive case history module which guides you through 'real life' scenarios involving confidentiality in the treatment of adults and children, the handling of data, when to disclose information and the management of information after a patient has died.

BMJ Learning is affiliated with the RCGP, and GPs completing learning modules can use these as evidence in their appraisals. Consultants and hospital doctors can also gain credits by completing learning modules.

Access is free for BMA members or if your employer has a group licence. For details on individual subscription rates go to http://learning.bmj.com/learning/main.html

Fernie to head medical division

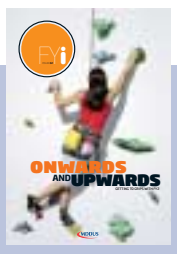
IN FURTHER restructuring of the MDDUS Professional Services Department, Dr George Fernie has been appointed Head of Medical Division. George has been with the Union for 12 years and is one of our most experienced advisers.

"I'm delighted to have the opportunity to take on this role at such an exciting time of growth for MDDUS," said George. "My aim is to maintain the high quality service to members with which we are associated".

Dr Jim Rodger, Head of Professional Services at MDDUS, welcomes the appointments of both Aubrey Craig (p. 4) and George Fernie in these important roles within the Union.

offices on 19 May from 09.00 to 11.00. Register interest or book at education@mddus.com

MEDPEDIA LAUNCHES Medpedia has launched the beta version of what it calls the world's largest collaborative online encyclopaedia of medicine. The project will involve a collaboration of physicians, medical schools, hospitals, health organisations and public health professionals. More than 110 organisations have so far pledged over 7,000 pages of content to the free site. Access at www.medpedia.com.



FYi ISSUE 02 The latest edition of our magazine for Foundation year doctors and final year medical students is out with feature articles on personal safety, paediatrics as a career choice, record keeping and hints on appearing in court as a medical witness. Check it out on the Foundation year page of our website at www.mddus.com

Who can do what?

THE GDC has now published its new guidance on the scope of dental practice, setting out "who can do what in the dental team".

The guidance lists requisite skills and abilities for dental nurses, orthodontic therapists, dental hygienists, dental therapists, dental technicians, dentists and clinical dental technicians (CDTs). It also describes additional skills that particular registrants might develop to increase their scope of practice.

"A professional's scope of practice is likely to change over the course of their career, as some registrants expand their scope by developing their skills and others will narrow their scope but become more specialised in a particular area," said Duncan Rudkin, GDC Chief Executive. "We will be keeping the lists under review to make sure that they remain relevant in the light of industry developments."

End of life guidance

THE GMC is consulting on revised guidance offering a wider consideration of the ethical principles governing good care at the end of life.

The GMC's current guidance on end-of-life issues, *Withholding and withdrawing life-prolonging treatments*, was published in 2002. In late 2007 it was agreed that this guidance should be reviewed to ensure that it was up-to-date, fit for purpose and consistent with the law and other GMC guidance.

The new draft guidance includes advice on when discussions about CPR are appropriate and how to approach these difficult conversations with patients, their families and carers. It also includes more detail on palliative care and how doctors should deal with requests and refusals for life-prolonging treatment.

A new section deals with care after death and organ donation, taking account of cultural and religious considerations and when it might be appropriate to discuss organ donation with patients or their families.

GMC Assistant Director of Standards and Fitness to Practise, Jane O'Brien said: "While the end of life consultation touches on many emotionally difficult subjects, this is not a debate about assisted suicide. Our guidance to doctors on this matter will always remain within the law".

GMC pandemic guidance

GUIDANCE on doctors' responsibilities in the event of flu pandemic has been published by the GMC.

Pandemic Influenza: Good Medical Practice – Responsibilities of doctors in a national pandemic follows on from GMC involvement in Department of Health emergency planning, and would apply should a UK Level 3 pandemic (involving a new virus outbreak in the UK following sustained human-to-human transmission) be announced by the Chief Medical Officer.

In the guidance certain elements have been removed from *Good Medical Practice* to reflect the practical challenges doctors would face in a pandemic. For example, the guidance recognises that doctors could be required to provide care for patients with influenza or other conditions which would not form part of their normal practice. The guidance also lifts requirements for participating in appraisal and performance review.

Jane O'Brien, Head of Standards and Ethics at the GMC, said: "The main principles of GMC guidance are still at the heart of this revised version of *Good Medical Practice*, and doctors must continue to ensure that the care of the patient is their first concern in the event of a pandemic. Core duties such as honesty, treating patients with respect and the provision of a good standard of practice and care remain unchanged".

The GMC will review any feedback after six months in order to consider any amendments. For more details go to www.gmc-uk.org

Surgical safety checklist

A PATIENT safety alert issued by the National Patient Safety Agency (NPSA) is requiring all healthcare organisations in England and Wales to implement a WHO safety checklist for every patient undergoing a surgical procedure.

The move follows 'dramatic results' from a year-long global pilot of the World Health Organization (WHO) *Surgical Safety Checklist* in nearly 8,000 surgical patients across eight countries. The pilot saw surgical deaths and complications reduced by a third. The NPSA alert is part of the WHO's second Global Patient Safety Challenge, 'Safe Surgery Saves Lives'.

The goal is to strengthen the commitment of clinical staff to address safety issues in the surgical setting including anaesthetic safety practices, ensuring correct site surgery, avoiding surgical site infections and improving

IN BRIEF

DOCTORS STILL TOP ON TRUST Doctors have been named the profession most trusted by the general public for the 25th year running. Nine out of ten adults believe doctors can be trusted to tell the truth according to the latest annual Ipsos MORI Veracity Index commissioned by the Royal College of Physicians. More than 2,000 adults were asked to say whether they generally trusted 16 different types of people to tell the truth.

NICE ON BREAST CANCER NICE has issued new guidelines on best practice for the diagnosis and treatment of both early and advanced breast cancer. Both guidelines aim to help clinicians provide coherent and consistent care for patients with breast cancer, providing a systematic framework to support patients with the disease and ensuring equal access to services across England and Wales.

NO COUGH MIXTURE UNDER AGE 6 The MHRA has advised GPs to discourage parents and carers from giving over-the-counter (OTC) cough and cold medicines to

communication within the team.

The final implementation date for the checklist is February 2010. Health Minister Lord Darzi, who chaired a WHO working group that played a key role in developing the checklist, said: "The beauty of the surgical safety checklist is its simplicity. By using the checklist for every operation we are improving team communication, saving lives and helping ensure the highest standard of care for our patients. The amazing results from the global pilot puts this beyond any doubt."

Improved complaints handling

FROM April 2009 there will be a single approach for dealing with complaints about NHS and adult social care services in England. Organisations will be encouraged to ask people what they think of their care, to sort out problems more effectively and to use the opportunities to learn.

To help complaints professionals make their organisations better at listening, responding and learning from people's experiences, the Department of Health has published a booklet designed to be accessible to all staff involved in receiving feedback and resolving concerns and complaints.

Access *Listening, Responding, Improving – A guide to better customer care* at the DoH website.

OPINION

by Mary Robertson
Solicitor
MDDUS

Regulating the regulators

The Council for Healthcare Regulatory Excellence (CHRE) has overseen the work of nine healthcare regulators including the General Medical Council and General Dental Council since 2004. CHRE can challenge fitness to practise decisions by healthcare regulators which it considers to be "unduly lenient" and has used this power in 38 cases so far.

The overall numbers are small and represent a tiny percentage of all regulatory cases. However, for the healthcare professionals involved, having already come through a lengthy regulatory process, a CHRE challenge has meant a further legal process and additional delay in bringing a case to a conclusion. Where the courts have upheld a CHRE challenge, practitioners have been subject to a more severe sanction or a re-run of the original hearing.

From April 2009 CHRE will be auditing not just final stage decisions by a formal regulatory panel but also decisions earlier in the regulatory process including decisions not to refer a case to a full panel.

In addition to challenging individual decisions, CHRE also has a wider and more strategic role in relation to healthcare regulation. This includes reviewing the performance and effectiveness of healthcare regulators more generally. CHRE works with regulators to improve the quality of healthcare regulation and has a role in encouraging greater consistency of practice and outcomes between health regulators. It is also involved in shaping future developments by advising ministers and by consulting with government.

As part of this over-arching role, CHRE undertakes an Annual Performance Review of all health regulators. The most recent review for 2007-2008 found that both the GMC and GDC were effective and well run regulators demonstrating good practice in a number of areas. The GMC's guidance on *Good Medical Practice*, for example, was described as a model of clarity and concision, and its Indicative Sanctions Guidance was praised as exemplary.

The GDC's standards and guidance documentation was also considered to be to be an area of strength. One concern, however, was the length of time taken to conclude GDC regulatory cases, the average time between receipt of a complaint and final hearing at that point being 20 months.

In the last year CHRE has for the first time published guidance on a specific type of professional misconduct. As several of the early regulatory decisions the CHRE challenged in court involved sexual misconduct of one sort or another, it is no surprise that the topic they chose to focus on was clear sexual boundaries between healthcare professionals and patients.

Three documents have been published by the CHRE on the topic, one aimed at healthcare regulators, a second providing guidance for fitness to practise panels and a third aimed at those with responsibility for educating and training healthcare professionals. The documents do not say much that is new but they do provide an in-depth review of the issues to be considered when regulators are issuing standards guidance on this topic or when panels are dealing with these inevitably serious cases. The reports usefully define what is meant by "sexualised behaviour" and make interesting reading for any health professional unfortunate enough to be involved in such a case and for those of us who defend them.

It is clear that over the last five years, the CHRE has made significant progress in developing its strategic role in overseeing healthcare regulation. While its role in challenging unduly lenient decisions will impact on a very small number of healthcare professionals, any improvements it achieves in the overall quality of regulation can only be of benefit to healthcare professions as a whole.

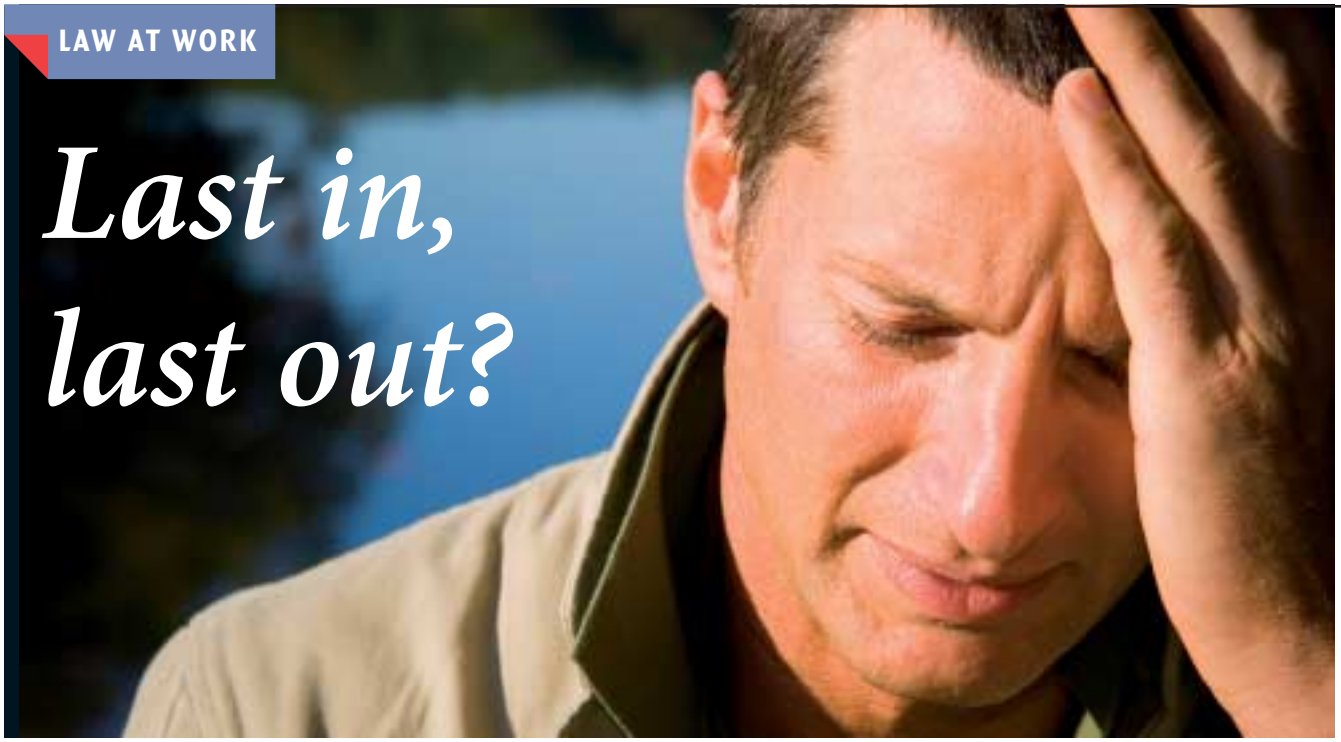
children under age 6. Evidence indicates that they are ineffective and can cause side effects, such as allergic reactions, effects on sleep or hallucinations.

HOSPITAL DRUG REACTIONS COMMON One in seven hospital patients experience adverse drug reactions according to research led by Liverpool University. Half of incidents were judged to be completely avoidable. The study followed more than 3,000 patients in 12 hospital wards over a six-month period and recorded complications ranging from constipation to serious internal bleeding.

LEGAL GUIDE TO RELIGION AND BELIEFS New guidance to assist NHS staff in complying with new legislation on religion or belief has been issued by the Department of Health. *Religion or belief – a practical guide for the NHS* reflects research that suggests attention to the religious and cultural needs of patients can contribute to wellbeing.

More news and MDDUS events at www.mddus.com

Last in, last out?



IN THESE CURRENT grim economic times, redundancy, as a weekly phenomenon, is once again on the news agenda. For some who have come recently into the labour market, this may seem a new threat. For others who remember the 1980s, the current headlines will seem eerily familiar. The fact that these older workers will apparently be more vulnerable to dismissal and will find it more difficult to find other employment adds a frisson to the memory.

A number of recent surveys indicate that redundancies are set to increase over the next few months. In this climate, medical and dental practices would be wise to familiarise themselves with the potential legal pitfalls that can arise when making staff redundant.

In the 1980s, the traditional criterion for deciding who should be selected for redundancy when an organisation was cutting back on staff was 'Last in, first out' (LIFO) – meaning that length of service was the yardstick used to select those with least service for dismissal and to protect the employment of those with most service.

However, times changed. Employers increasingly found that keeping long-serving staff at the expense of (usually younger) more recently recruited employees might put an organisation at a disadvantage when competing in a fast-changing world. So they began to introduce more sophisticated systems of selection for redundancy aimed at keeping a workforce that was, in the employers' view, best-equipped to adapt to new competitive market conditions. Selection criteria such as skill levels, experience of a variety of roles, disciplinary, performance and attendance records began to be used more often – aimed at choosing 'who should stay' rather than 'who should go'.

The legislation that apparently sounded the death-knell of LIFO was the Age Discrimination Regulations in 2006. Employers who now operate a selection method favouring older workers over younger workers run the risk of an indirect age discrimination claim from junior staff being made redundant. Clearly, a more 'subtle' approach to redundancy selection is now required. A recent court case decided that length of service could be used as a 'tie-breaker' only when other criteria have sifted the numbers down to a smaller group.

But age is not the only discrimination pitfall for organisations cutting back on staff. Those employers who use absence records as the basis for selection for redundancy need to ensure that such a policy does not discriminate against disabled workers. It may be that disabled employees who have had more sickness absence than able-bodied colleagues might reasonably argue that absences attributable to their disability should be excluded from any 'totting up' system for redundancy selection.

It is tempting to use 'performance in the job' as a selection criterion. However, many employers have come a cropper when using this criterion (and that old chestnut, 'attitude') as a selection tool when they have no proper objective historical record of comparative performance or behaviour – such as a robust and fairly-operated appraisal scheme. Relying on the opinion of the line manager or partner on the person's performance or attitude is a recipe for subjectivity and the appearance of prejudice and favouritism.

Remember: if a redundant employee suggests that their gender, race, age, disability, sexual orientation or religion was an explanation for their selection for dismissal, the burden of proof lies with the employer to prove otherwise in an Employment Tribunal. Those who have relied on subjective (rather than defensible, objective) selection criteria risk facing a successful discrimination (and, possibly, unfair dismissal) decision against them – with potentially unlimited compensation to follow.

A fair and objective selection process may not be victim-free. But at least the pain and cost for the individual and the practice should not drag on into the courts for months. Planning for such contingencies needs careful thought (and probably some expert advice) and may set some unnecessary alarm bells ringing amongst the staff, if poorly handled. But having a defensible, up-to-date and practically effective redundancy policy should be an urgent priority for medical and dental practices – even if redundancies are still only a theoretical possibility.

Ian Watson, Training Services Manager, Law At Work

LawAtWork

Law At Work is MDDUS preferred supplier of employment law and health and safety services. For more information and contact details please visit www.lawatwork.co.uk

Is there a doctor onboard?

Being a medical Good Samaritan is not without risk and it's best to be clear on what's expected, says Yueyue Fitzgerald

NO DOUBT most doctors would not hesitate in stepping forward in an unexpected emergency situation. This is borne out in a 2003 survey from Sheffield in which 91 per cent of medical practitioners said they would be willing to offer voluntary treatment in emergencies.[1] The main reason cited was a professional responsibility to assist anyone in need of emergency medical care, regardless of whether an existing patient or a complete stranger.

This attitude is consistent with GMC guidance to doctors as stated in *Good Medical Practice*: "In an emergency, wherever it arises, you must offer assistance, taking account of your own safety, your competence, and the availability of other options for care".

Doctors may not be overly concerned that a claim may be brought against them while acting voluntarily in an emergency situation – but there can be risks.

What is a Good Samaritan act?

Dr B walks into a local supermarket and notices someone having a seizure on the floor. The patient's wife explains that he is being treated for epilepsy. Dr B announces that he is a doctor and offers basic emergency treatment. He cushions the patient's head with a jacket and, when the convulsions stop, rolls the man into the recovery position. He checks airways and pulse and remains with the patient until he recovers.

This scenario can be regarded as a typical example of a Good Samaritan act. It occurs when an off-duty medical practitioner provides medical treatment in an emergency to someone who is not his existing patient. The treatment is administered in good faith, without asking nor having any intention to ask for fee or reward.

Most doctors will have at sometime been asked to act in a professional capacity outside of the working environment but involvement in serious emergencies is rare. In-flight incidents are perhaps the most familiar and dreaded scenarios. A recent *Lancet* review highlighted a growing number of such emergencies with the trend toward longer flights and an increasing number of older passengers with pre-existing medical conditions.[2] Data suggest that there are some 50 to 100 in-flight medical events daily on US air carriers.

Legal liability

In general, Good Samaritan acts are unlikely to lead to litigation. Most doctors' endeavours to 'step up' in difficult circumstances will be appreciated. Current tort laws in the USA and Australia have excluded Good Samaritan and certain volunteer acts from liability, in order to encourage medical assistance at accidents or emergencies. Many countries, including a number of states in the USA, also have Good Samaritan legislation which provides people offering emergency first aid various levels of immunity from legal liability. No such legislation exists in the UK nor is there yet clear precedent in the law. ➤

➤ The common law has a long history of endorsing the 'No duty' rule, which means in English law there is no legal duty to act as a Good Samaritan by aiding a stranger in distress. In other words, a doctor who witnesses a road accident is not bound by law to stop and help. Even if he does volunteer, his "only duty is not to make the victim's condition worse".[3]

Some GPs have a contractual duty under the core General Medical Services contract to attend at emergencies within their practice area no matter whether it is to a patient or not. But the most clear-cut guidance can be found in professional ethical standards. In *Good Medical Practice* the GMC makes it clear that doctors are required to assist anyone in an emergency, except in situations posing real personal danger. Failure to act could prompt a charge of impaired fitness to practise.

Some general rules

In order to minimise potential legal risks, there are some general rules doctors should follow regarding Good Samaritan medical practice.

'Proper care' principle. Given special circumstances in some medical situations, such as lack of equipment, emergency training/experience and access to previous medical records, it is unreasonable to expect that medical Samaritans should fully exhibit the skills of an experienced accident and emergency specialist. The British Medical Association noted that volunteer doctors should recognise that just calling for help may be the most appropriate action in an emergency situation.[4] In most cases, stopping blood loss, administering pain relief or even simply arranging transfer of the casualty to a hospital as soon as possible would be sufficient to show proper care of the casualty and, thus, an adequate defence against unmeritorious claims.

Acting within the limits of experience and qualifications. Researchers writing in a 2002 BMJ article commented that "even if well trained in hospital trauma management, a doctor will not be able to perform well at the roadside without considerable extra training".[5] The GMC advises in *Good Medical Practice* that: "In providing care you must recognise and work within the limits of your competence". This would apply in providing emergency treatment but obviously it can become a 'judgement call'.

Make a record. Whether emergency treatment is provided or just help to make the patient comfortable it would be wise to make some notes at or near the time of the incident to account for your actions. This could help counter any potential claims in future. You should also give your details to those at the scene such as police or airline crew.

Seek clarification from your medical defence organisation. It is important that doctors are aware of the level of cover being provided by their MDO in regard to Good Samaritan medicine. MDDUS policy is to offer members assistance and access to indemnity in respect of world-wide Good Samaritan acts, which are defined as "the provision of medical and dental services in emergency situations outside the scope of an individual's normal contractual obligations or clinical practice". Instant access to your MDO is unlikely in most critical emergencies but MDDUS advisers can provide guidance should any questions arise after the event.

■ ***Yueyue Fitzgerald has a PhD in Law and is a research assistant at MDDUS***

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GMC AND GOOD SAMARITAN ACTS

IN AUTUMN 2009 the GMC will be introducing the licence to practise. No longer will GMC registration alone signify that a doctor has the legal authority to practise medicine in the UK, and licences will require periodic renewal by revalidation. Doctors will be allowed to remain on the register without a licence but this has raised questions about their standing in regard to Good Samaritan acts. The GMC has now confirmed that the lack of a licence will not prevent doctors from "providing assistance in emergencies".

There has also been recent concern over the decision by the GMC to end the exemption for registrants over 65 from paying the annual retention fee. Retired doctors now face the choice to either pay the ARF or allow their GMC registration to lapse. Many MDDUS members have wondered about their medico-legal status in undertaking Good Samaritan acts should they choose not to pay the ARF and, in effect, de-register. MDDUS has confirmed that retired members giving up GMC registration remain entitled to assistance and access to indemnity in respect of world-wide Good Samaritan acts.

Musings on the moral life

I GET INTO the back seat of a taxi at Boston's Logan Airport, hoping to catch a snooze during the drive. But the taxi driver wants to chat. In a soft Egyptian burr, he asks, "In town on business?" "Kind of," I reply, in an attempt to close down the conversation. Not taking my hint, he asks what I do for a living. I reply, "I teach medical ethics to student doctors."

Curious to observe his reaction, I watch his face in the taxi rear-view mirror. His eyebrow rises slightly and his reflection glances at me. A pause... and then, the inevitable, "What is this ... medical ethics?" I eye the driver, trying to gauge my audience. Boston is a funny old town. I once struck up a conversation with a shoe sales assistant, who turned out to be a Russian obstetrician earning some cash while studying for the US medical licensing exams. And a previous taxi driver had told me about his degree in economics from a Moroccan University.

"What is this ... medical ethics?" A difficult question to answer. The scope of medical ethics is broad, and there is no short explanation that does an adequate job of describing this discipline. I decide to keep my answer inadequate but simple. "Well", I reply, "learning about medical ethics helps doctors to know the right thing to do in a complicated situation."

He thinks about it, then says, "I think everybody always want to do the bad thing, the wrong thing – to lie, cheat, or steal – for their own gain. This is why we need so many rules and laws and religion – to keep us away from doing the bad thing and make us do the right thing." And then, he adds, "Doctors are no different in this." Nothing in the expression on his face tells me he is joking.

This is the age-old debate: where does one's moral compass come from? Does human nature really default to doing the immoral rather than the moral act? Is this why we need rules to keep us on the straight and narrow – to prevent us from slipping to 'the dark side'?

These issues are very relevant to medical education. For years, scholars have debated how moral and professional values can and should be shaped, or even 'instilled', during medical training. Students start medical school with their own mix of moral and personal values, already ingrained from their unique familial, cultural and religious upbringing. Medical training then imparts knowledge about the virtues and values expected of doctors by society, as laid out in professional codes of conduct. These are essentially the 'rules' that try to define what being a 'good' doctor entails, designed to keep us on the straight and narrow. Just as Aristotle's apprentices learned moral values through continual exposure to, and the habitual practice of, these values, medical students absorb the profession's culture and behaviours through exposure to medical practice.

And yes, it does appear that such rules are necessary. The spectre of doctor-murderer Harold Shipman warns us that doctors are not immune from immoral acts. Studies have shown convincingly that clinicians do exhibit unprofessional behaviour – rudeness, arrogance, dishonesty, self-interest, and disrespect towards both patients and colleagues – and, worse, that this is absorbed and copied by medical learners as part of the professional culture. And there have been recent international initiatives, such as the Medical Professionalism Project, in response to increasing concerns over self-interest and commercialism in medicine.

But are these examples related purely to flaws in the fundamental morality of doctors? The Chinese philosopher Mencius, in around 370 BC, argued that human beings were naturally compassionate, with an innate sense of right and wrong, and: "When they do evil, it is because adverse conditions have corrupted their nature". It is true that, in modern day medical practice, 'adverse conditions' exist; physician illness, isolation, depression, addiction and stress – as well as organisational pressures that intensify these factors – all potentially influence the behaviour of physicians. This can have serious consequences for patient safety and the quality of patient care.

Doctors are, quite rightly, held to the highest standards of morality by society. But it seems that the teaching of these ideal values must go hand in hand with the teaching of practical coping mechanisms for Mencius' 'adverse conditions'. Students need to develop insight and self-awareness, recognise that doctors are not infallible, and understand how to access sources of help and support. Fail-safe mechanisms for when the gasket is about to blow.

I ask the taxi-driver, "Do you really think that doctors are driven by self-interest more than by doing the right thing?" His face breaks into a grin, "No", he says, "but I made you think, yes?" And he switches on his radio, stifling any further talk with some loud and extremely dramatic Arabic music.

■ ***Dr Helen M Manson is a lecturer in medical ethics at Dundee University Medical School***

MDDUS takes pride in its status as a mutual organisation – particularly in the current economic climate. What's so special about mutuality? Economic historian Charles Munn *offers some context*

Mutual interest

MUTUAL organisations have a long history – much longer than other forms of business organisation. Since earliest times people have come together to pursue matters of mutual interest. Modern companies have their roots in the 18th century but mutual organisations can trace their history much further back in time.

Historically, mutuals were simple organisations formed by a group of people to pursue matters in which they had a common interest. Many of them were to be found in the shipping and financial services industries. The friendly societies may well have been the earliest examples but by the end of the 18th century they were followed by building societies and, in the early 19th century, by savings banks and the co-operative movement. As time went on various Acts of Parliament were passed either to give legal recognition to these organisations or to regulate their affairs and give some protection to the public.

The mutual form of organisation was also to be found in the insurance business. Many of the very early insurers were established to cover risks in the shipping industry. Some were formed to insure one ship for a single voyage and were thus impermanent, but others began to be organised on a more established footing to price and cover risks in shipping and other industries.

Similarly, many of the early life assurance companies were formed as mutual organisations. A few, like Scottish Amicable, were started out as public companies but later converted to mutual status.

Demutualisation trend

In recent years it has been more common for mutuals to convert themselves into public companies and this has been especially prevalent among the building societies who have been enthusiastic about transforming themselves into banks. Savings banks have also followed the trend, firstly banding together (following publication of the Page Report in 1973) to form a single Trustee Savings Bank which then abandoned its mutual status and became a public company. Many of these organisations which gave up their mutual status have doubtless had time to reflect upon and regret their decisions to convert. This movement was particularly strong in the 1980s and early 1990s and was especially active in the UK, USA and Australia.

Perhaps the largest transition in recent years was that of Standard Life which, only a few years ago, put up a stout defence of its mutual status in face of opposition from a determined group of policy holders, only to change its mind a few years later and become a public company.

Its main argument for the change of mind was that its mutual status limited its ability to seek fresh capital from the money markets. This decision by Standard Life underlined one of the problems that mutuals face. If they want or need to expand, the option of going to the stock market for new money is not open to them. It might be possible to borrow money from other sources but for most mutuals the only way to raise money for expansion is to earn it. That is why having a healthy annual trading surplus and building up reserves is so important for

mutuals. A substantial reserve fund is doubly important during difficult economic times.

At the same time this is often the aspect of mutuals which is least well understood by their members. Bumbling along for years at no more than break-even will, almost certainly, lead to the demise of the organisation.

Plus points

There are many plus points for mutuals. It is often, but not always the case, that their governance is much simpler than that of public companies, although they may be subject to the same regulatory oversight which can make life more complicated. Many mutuals have charitable status which brings substantial tax advantages both at national and local levels.

Perhaps the main advantage of being a mutual organisation is that there are no shareholders and, if there are no shareholders, then there are no dividends to pay and the organisation gets to keep its entire trading surplus for re-investment. This may also have the consequence of allowing the organisation to charge lower prices for its services. Management time can be better concentrated on enhancing the service provided rather than on worrying about how to generate profits with which to pay dividends. That is not to say, however, that the annual general meeting will be any less troublesome than that of a public company. For the members of a mutual can be just as demanding and just as vociferous as the shareholders in a public company.

The other advantage of mutuals is that they are not under the same pressure as public companies to reduce costs. The result of this is that they are able to provide a better service to their members. It is an often recorded fact that staff in a mutual organisation will try harder to provide a better service because their customers are the de facto owners.

It is also the case that many mutuals were formed because there was either no need for large amounts of capital or because those who formed them had a particular need which was not provided for by public companies. Such was the situation in 1902 when the Medical and Dental Defence Union of Scotland was begun.

Medico-legal risk

In the closing years of the 19th century a number of high profile medical negligence cases began to appear in the courts, especially in England. Many were frivolous and regarded as 'vexatious' but there was a sufficient number of serious cases for the medical profession to understand that it had an insurable risk. The Medical Defence Union was duly established in London in 1885. Only medical doctors could obtain membership. Dentists were excluded. Differences between English and Scottish law led to a feeling that the interests of Scottish practitioners were not well served by a London-based organisation. An early effort to establish a similar organisation in Scotland was short lived and it was not until 1902 that the Medical and Dental Defence Union of Scotland was established on a mutual basis by a group of nine doctors and one dentist who were practising in Glasgow.

The judgement of the founders was strongly based and within a year there were almost 500 members from all over Scotland. The first annual report shows a balance of only £135 but, as most of the cases being handled required only advice, this was deemed sufficient for the needs of the organisation.

And so it proved. In the century and more since MDDUS was founded there have been enormous strides forward in medical and dental treatment. Society has also changed. Inter alia it has become more litigious. The need for MDDUS is greater than ever and it is a mark of the organisation's success that it has resisted pressures to convert into a public company and has maintained its mutual status.

■ ***Professor Charles W Munn, OBE, FCIBS, is a former chief executive of the Chartered Institute of Bankers in Scotland and an honorary professor in the universities of Dundee, Stirling, Glasgow and West of Scotland, where he gives lectures on business ethics. He is currently writing two histories of financial services companies***

Cervical spine trauma

Secondary injury is a major risk in spinal trauma. Mr Robin Johnston *provides some insight on a rare but serious emergency*

SPINAL injury is relatively uncommon. In Scotland there is a single National Spinal Injuries Unit which admits between 150 and 200 patients per year from a population of just over 5 million. The total comprises approximately 50 per cent patients who have sustained a cervical spine injury and 50 per cent who have sustained a thoraco-lumbar injury. This article will deal with cervical spine trauma primarily, although many of the issues and risks also apply to thoraco-lumbar spinal trauma.

The commonest causes of cervical spine injury are road traffic accidents, falls, sports/leisure related activities and assaults. Cervical spine trauma occurs with or without primary neurological injury. Spinal cord injury may be described as 'complete', with no retained motor or sensory function, or 'incomplete' with varying degrees of residual sensation and voluntary motor function.

The prognosis for recovery is substantially better in those patients who have an incomplete injury whereas only 2 per cent of patients who have a complete spinal cord injury will recover sufficiently to be able to walk again. Even patients with a severe incomplete injury who have retention of spinothalamic (pain and temperature) sensation have an approximate 70 per cent chance of being able to recover sufficiently to walk. Patients who have an incomplete cord injury are also likely to benefit most with an early diagnosis and appropriate management as failure will lead to what is in effect a secondary spinal cord injury.

The five main types of cervical spine injury are:

- vertebral fractures
- disco-ligamentous injuries
- penetrating injuries
- injury associated with pre-existing spinal pathology such as ankylosing spondylitis or rheumatoid disease
- distraction injuries.

This article will primarily focus on vertebral fractures and disco-ligamentous injuries which are the most frequent forms of cervical spine trauma.

Diagnosis and recognition

The diagnosis of cervical spine trauma is based on a relevant clinical history, a clinical examination and confirmation by radiological imaging. Of these the historical and radiological evidence are the most valuable, at least in terms of initial recognition and diagnosis. A detailed neurological examination is not necessary at this stage. A patient may present with a history of neurological symptoms, perhaps transiently involving all four limbs, or perhaps just involving one of the upper limbs. There may be no neurological signs at the time of initial assessment, but this historical evidence is salient and means that there has been a primary neurological injury, albeit transient, and that a secondary

IMAGE: SCIENCE PHOTO LIBRARY

neurological injury is therefore possible.

Simple, early and rapid cervical spine immobilisation is carried out with the primary purpose of keeping the 'spine in line' and preventing movement. At this time the local spinal injuries unit or the neurosurgical/orthopaedic department responsible for receiving patients with spinal trauma should be contacted. Advice will be provided by that specialist unit with regard to further management and in particular various measures such as the use of anti-DVT techniques, avoidance of volume loading to correct neurogenic hypotension, etc.

Cervical spine radiology

The most useful combination of radiological investigations is a good quality lateral X-ray of the cervical spine as the initial investigation supplemented by multi-slice CT scan with sagittal reconstruction. During this process the patient's cervical spine requires to be maintained 'spine in line' and treated as if there is a fracture or subluxation. Large numbers of very fine horizontal CT slices through the whole cervical spine are of little initial practical value and may even be confusing or distracting in terms of diagnosis. High quality sagittal reconstructions that demonstrate the right-sided facet joints through the centre, to the left side facets provide the most useful screening information.

The use of magnetic resonance imaging in the early diagnostic stages is of limited value. It may demonstrate abnormal high signal derived from the spinal cord itself and ligamentous or disc-related damage but this investigation can be carried out later in the specialist unit. There is also little place for cervical flexion/extension views in the early stages of diagnosis and management.

One recurring feature of patients whose cervical spine injury is not diagnosed for weeks or months is that the initial lateral cervical spine X-ray was reported to be normal. The initial injury may have been a fall or road traffic accident but re-assurance is taken from a radiological opinion which states that the lateral X-ray shows no abnormality. Persistent symptoms, however, demand repeat investigations. The patient complaining of ongoing neck pain may be treated in a cervical collar but if one week after injury the neck pain is still present, clinicians should not continue to take re-assurance that the initial X-ray showed no abnormality. A further X-ray will often reveal the covert fracture or subluxation.

Missed diagnosis

Following injury, a patient who has a painful neck and a transient history of paraesthesia in all four limbs presents with a straightforward diagnosis. Similarly, the patient who is quadriparetic at the time of first assessment would appear to present no special diagnostic difficulty. However, unlikely as it may seem, there are examples of such paralysed patients not being diagnosed or managed appropriately. The reasons behind missed diagnoses include the following:

- History and neurological symptoms are not given an appropriate level of credibility and/or cervical spine trauma is not considered (e.g. in an inebriated patient).
- Diagnosis of an anxiety/hysterical/manipulative psychological condition outwardly manifest by apparent limb paralysis (i.e. 'hysterical paralysis').
- Disbelief on the part of the clinicians, most often junior staff, and perhaps a 'mind set' which precludes objective assessment.
- Consideration of arcane neurological diagnoses in place of the more common diagnosis of spinal trauma.
- Inadequate or inappropriately interpreted radiology. General advice is a lateral X-ray of the cervical spine including all seven vertebrae if possible, supplemented with other imaging (CT) as necessary. Interpretation of lateral cervical spine X-rays, open mouth views of the odontoid process and sagittal reconstructions of computerised tomography is not easy and there is no substitute for obtaining a senior experienced opinion.
- Patient affected by alcohol, prescribed medication or illegal substances. The presence of a significant head injury will also preclude a useful history being obtained from the patient. Clinicians may have to rely on objective witness information as indication of the risk of a spinal injury. Screening X-rays/imaging are often the best source of objective information in such situations.
- Other injuries and pressure to 'clear' the cervical spine may distract from appropriate and thorough assessment of the spine and the need to re-assess if symptoms persist.

Risk reduction

- Do not entertain an initial diagnosis of hysterical or psychological paralysis.
- A history of transient neurological symptoms deserves a high level of credibility, particularly in the absence of objective neurological signs.
- The most useful diagnostic investigation is a good quality lateral cervical spine X-ray supplemented by multi-slice or spiral CT, particularly with sagittal reconstructions.
- Get a senior and/or an experienced opinion on the X-ray and imaging.
- Repeat the lateral X-ray if the patient continues to complain of neck pain a week later, especially in situations where the initial X-ray was considered normal.
- If uncertainty persists despite investigations, manage the patient for cervical spine injury and seek senior/experienced opinion.
- Specialist spinal injury services are available for discussion and advice.

■ ***Mr Robin Johnston is a spinal consultant neurosurgeon at the National Spinal Injuries Unit in Glasgow***

How is the clinical consultation like a game of tennis? A good coach can help, says GP and trainer Dr Malcolm Thomas

Skills development

COMMUNICATING effectively with patients is important. Everyone says so. The GMC has progressively refined their undergraduate curriculum to reflect it. The GDC now recognises this for dental students. Postgraduate training programmes increasingly teach and assess relevant communication skills.

Yet qualified GPs and hospital practitioners – whether medical or dental – have few training opportunities to further their abilities.

Maybe it doesn't matter. Maybe communication can't be taught. Or perhaps, if it is taught, it just leads to the 'Have a nice day' culture.

Why communication matters

The clinical consultation is an artificial business at the best of times. It's not a chat with a mate, or a business meeting, or a lecture (although at times it may contain elements of any of these).

So if it is an artificial situation, perhaps a bit of artifice would not go amiss.

Certainly research shows that specific aspects of the consultation are related to improved clinical outcomes and reduced medico-legal risk. We know the sorts of behaviours that help clinicians to discover clinically relevant information in the fastest way. We have clues to the ways in which patients can be put more at ease and reveal their deeper concerns. We know something about how to explain and give information to patients. And we have some good evidence to help us make individualised plans with patients, which improve the odds that they will stick to the plan we hatch.

To take a specific example, interpersonal skills are known to be important in drawing out clinically relevant information from patients. Deliberately asking for the full range of patient concerns at an early stage is related to finding out more information and missing less of what is crucial. In fact, Heritage and colleagues[1] reported the specific value of a single word in their study. They found that asking "Was there *some* other concern that you wanted to mention today?" was a more productive question than "Was there *any* other concern that you wanted to mention today?"

And which of us has not experienced the power of picking up on a look, a hesitation, a word. Something along the lines of:

Doctor: "You seem a little worried …"

Patient: "Well … What do you make of this?" [exposes suspicious skin lesion]

Explanation scenarios

To take another example, most doctors and dentists have a series of well-polished, standard little mini-lectures covering 95 per cent of all clinical encounters. In my experience as a coach, these 'explanation scenarios' typically contain a fair bit of information that the patient is not interested in – at the same time failing to reveal or answer the patient's main questions. Research backs this up.

So why not avoid this and sometimes save a little time by:

- asking the patient what they want to know
- finding out what the patient already does know
- organise our explanations to fill the gaps
- make a small number of well-organised points
- make use of pictures, models and lists.

CONSULTING SKILL MASTER CLASSES

MDDUS is particularly keen to help its members enhance their clinical effectiveness and bear down on their medico-legal risk – all in the context of time-pressed clinical consultations. For this reason, MDDUS has commissioned a number of half-day seminars from Effective Professional Interactions (EPI) – a training company founded and run by Dr Malcolm Thomas. The aim is to offer personalised training sessions; numbers are kept small to this end (no more than 20). Sessions mix GPs and secondary care practitioners in all branches of medicine and dentistry.

The seminars are in the form of consulting skill master classes, each with a particular focus. The titles are:

- Increase Your Effectiveness [and reduce your risk]
- Open Disclosure – When Things Go Wrong
- Communicating about Risk with Patients
- Enhance Your Telephone Consultations

Contact education@mddus.com for details of seminars being held in Glasgow and London in June 2009.

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These are all skills that can be taught, learned and improved – no matter what level the learner starts at. And we have some pretty good evidence of which teaching and learning methods produce the best outcomes in practice.

Talking tennis

It turns out that the best approach to improving communication skills focuses on behaviours, because these can be analysed and potentially changed. This behaviourist approach has injected life into teaching and training, especially for medical students and GP registrars. It finds its most comprehensive expression in the Calgary Cambridge framework.

The Calgary Cambridge authors brought together their combined experience of UK and North American research and teaching on the clinical consultation. In particular, they searched through the literature to find evidence about which skills doctors and dentists should use when communicating with their patients. A parallel search was conducted to discover the teaching and learning methods that have best been shown to help clinicians pick up new skills to use in daily practice with their patients.

This collaboration resulted in two books of which one – *Skills for Communicating with Patients*[2] – is the most comprehensive statement of the evidence and is required reading for all practising clinicians.

A fair analogy to the behaviourist approach can be made with the game of tennis. People vary in their natural ability to play tennis, but most able-bodied people would be able to play the game. No matter how innately talented you are, however, coaching and practice improve your tennis.

And here's the thing. An ordinary player, with good coaching and practice, will soon overtake a naturally gifted player who isn't coached. Furthermore, practising without coaching usually leads to a plateau in performance and the ingraining of bad habits. What does this mean for doctors and dentists?

The clinical consultation has some analogies with a tennis game. There are usually two players, and the play passes from one to the other in turns. The analogy only goes so far – after all there aren't many forehand ground strokes (or overhead slams, let's hope) in the typical consultation. But for a tennis player, it is ideal to have your own coach – to review your performance regularly and then design specific training and practice which addresses any concerns agreed between coach and 'player' (clinician). This is expensive in time and money and probably beyond what most clinicians will sign up to at the present time.

The next best thing for a tennis player or a clinician would be a series of master classes, where specific aspects would be taught to a small group with a trainer who could respond to individual learning needs. Such training is becoming more available for doctors and dentists (see box).

In summary the interpersonal behaviours needed by doctors and dentists to have safe, effective clinical consultations can be analysed, coached and learned. No matter how gifted you already are, you can improve your effectiveness and reduce your risk.

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

A humbling dedication

Wanting to see some "real medicine" in action MDDUS adviser Mr Riaz Mohammed *recently visited a hospital catering to the poor and destitute in Raxaul, North India*

FIVE years have elapsed since I escaped the rigors of consultant surgical practice to the relative calm waters of the work of a medico-legal adviser for MDDUS. The Memorandum and Articles of Association of the Union states: "The objects for which the Company is established are: to promote honourable and high standards of medical and dental practice".

With this object in mind I recently began to wonder what was happening in the world of frontline medicine. A visit to a "real hospital" to see proper medicine and dentistry being practised seemed like a good idea. But where to go?

After some discussion with a practising consultant surgeon and long-standing friend, I made the decision to visit the Duncan Hospital in Bihar, North India – one of the poorest places in the world. My friend had been there a number of times before and knew the setup well. The Duncan was built on the border with Nepal by a Scottish Christian missionary surgeon in 1930 with the object of delivering an honourable and high standard of medical care to the poor and needy.

Making preparations

The advice obtained from those on the ground was to fly into Delhi and from there to take the train to the city of Raxaul. Another option was to fly into Katmandu and take a taxi from there to the Duncan but local political activity appeared to make this option presently unsafe. A particular advantage of the Delhi route was that a visit to the famous Taj Mahal would be feasible. This settled the matter for all four members of the visiting party.

The opportunity to take some much needed medical equipment for the use of the staff at the hospital could not be overlooked. What happened thereafter was truly remarkable! Once word got out that the visit was planned, the number of 'ordinary' people who came forward with gifts of money, blankets, kids' clothing, etc was truly moving. Hospital staff offered so much surplus medical equipment that flight weight restrictions made it impossible to take everything. This, of course, necessitated having to make some very difficult decisions as to what would have to be left behind based on the priorities of need in Bihar.

I wondered how the staff of MDDUS would react to this visit. Would working in

Main: Riaz (right) with consultant surgeon, Mr Ian Hutchinson. Babies in obstetric ward (below) and the vision for a new hospital (right)

an environment where doctors constantly require assistance for claims, complaints, disciplinary hearings and GMC matters bring about cynicism to the extent that they wouldn't show much interest? I could not have been more wrong.

A coffee morning was organised with all kinds of truly magnificent home baking for sale. Most of the staff who were able to attend did so, with the result that a very handsome sum of money was raised for the hospital.

Grinding poverty

The trip to the Duncan was not an easy one. The flight via Amsterdam took off at 0555 and we finally landed in Delhi at 2330 local time. By the time we got to the hotel it was well into the small hours of the morning. This was followed by a 25-hour journey by train to Raxaul, leaving Delhi the following afternoon.

Bihar was a fascinating mixture – a beautiful landscape but one of contrasting sights and smells, flies crawling over raw meat for sale, people urinating and defecating in road-side fields, uncontrollable traffic chaos, child labour, animal cruelty, and all against a background of grinding life-long poverty unlike anything I have seen before.

The hospital compound turned out to be a 'haven of rest' in the midst of this chaos. The staff – from the cleaners to nursing to medical personnel – were kind, friendly, hospitable and dedicated to the task of caring for the destitute, the poor, the blind, the sick and the helpless newborns and their mothers. They had insufficient equipment to do the job fully. Yet the respect and dignity with which they treated suffering humanity was breathtaking to observe. Many of the medical, nursing and dental staff had made considerable sacrifices to work in the Duncan when they could easily have enjoyed the luxury of practising elsewhere in some of the thriving cities of India. It was truly humbling to see such vocational dedication!

What was even more interesting was their vision for a new hospital as the old buildings are getting to the stage where they are becoming unsafe. They have begun construction on a new mother and child hospital (MCH) unit which is near completion. However, the building has come to a sudden and unexpected halt due to lack of finance because of the economic downturn. The world is truly a small place! Still they wait and expect God to work a miracle and believe that money will be donated to complete the task.

Not that the Duncan is without critics; I suppose human nature is the same the world over. Some patients, admittedly very much in the minority, choose to complain about the treatment they receive, often at no cost to themselves. Still, despite the setbacks, the staff, mostly indigenous Indians but supplemented by volunteers from the West, carry on doggedly delivering the best possible care under very trying circumstances.

Back home

The visit was all too short and after a trying return journey, we landed safely back home in the UK. However, the Duncan will always have a warm place in all our hearts. We received a great deal more than the little we were privileged to give!

Some people thought that it would be very mundane for me to return to the day job after my visit to Bihar. And in some ways this is, of course, inevitable. However, I reminded myself that it was the mundane job that funded the visit and you can't give what you don't have!

Oh well back to business as usual – now what was that doctor's heart-sink patient complaining about this time…

■ ***Mr Riaz Mohammed is a medical adviser at MDDUS***

Duncan Hospital is part of the Emmanuel Healthcare charity – www.emms.org

CASE studies

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

TREATMENT

Difficult tooth extraction

A 42-year-old patient attended his dental surgery complaining of a broken molar tooth. On examination his dentist found that UR6 was badly fractured. The dentist, Mr B, took an X-ray and recorded gross caries in the tooth with a "very poor prognosis for restoration".

Mr B suggested extraction of the tooth. Further detailed assessment of the radiograph revealed that the proximity of the UR6 roots with the maxillary sinus was not out-with the norm and anatomy did not suggest a low-lying sinus. The dentist warned the patient that the procedure might not be straightforward due the state and position of the tooth. He explained that it might be necessary to divide the molar and remove the roots separately. The patient agreed to the extraction.

A week later the patient returned and Mr B again repeated his warning of potential difficulties. A forceps removal was attempted but it was soon apparent the tooth would be resistant to normal extraction. Mr B then informed the patient that the tooth would need to be divided and again confirmed it would be a more difficult procedure and likely to result in additional pain and bruising.

Mr B managed to divide the tooth and removed the disto-buccal and palatal roots but the mesio-buccal pushed up into the antrum creating an oro-antral fistula. Mr B informed the patient of the complication and explained his proposed remedy and the need for referral to an oral surgeon. The dentist then performed a buccal advancement flap procedure to close the socket.

Mr B provided advice to the patient about follow-up and prescribed an antral regimen of antibiotics and nasal decongestants. The patient was referred to the oral surgery department at a local hospital. The flap healed well and Mr B later removed the sutures. Six months later the patient underwent surgery under a general anaesthetic to remove the retained root.

A letter of claim from solicitors acting for the patient was received at the dental surgery two months later.

Analysis and outcome

The claim alleged negligence for failure to use reasonable care and skill in the pre-operative assessment and planning of the extraction by not taking due account of the proximity of the maxillary sinus. It was also alleged that Mr B had not obtained fully informed consent by warning of the risks of complication. The claim also suggested that a lack of skill contributed to the poor result.

MDDUS supported Mr B and solicited expert dental opinion on the case which was supportive of the dentist's actions. Radiographs taken did not indicate any abnormal risk with the procedure. In regard to consent, Mr B did warn the patient of the potential difficulty in removing the tooth in one piece. In the opinion of the dental expert there was no obligation upon Mr B to warn of the elevated risk of an oro-antral fistula. The dentist's skill in carrying out the procedure and his remedial actions were also judged reasonable and appropriate.

However, it was felt that if the case went to court there was a risk that a judge might side with the patient in regard to the matter of informed consent – i.e. what the patient understood of the potential complications. The MDDUS judged that this risk and the cost of defending the case outweighed that of settlement and therefore it was agreed to settle the case without admission of liability.

Key points

- Unexpected complications in otherwise routine procedures can happen to any dentist.
- Ensure adequate discussion regarding potential complications.
- Record such discussions in the notes.

PROCEDURE

Bad blood

MRS T attended her GP surgery to have blood taken. A practice nurse undertook the procedure and the following day Mrs T suffered severe bruising and was unable to move her arm.

Three weeks later and after several visits to the practice the bruising and swelling finally eased. But Mrs T found the experience so traumatic she is now paranoid about having more blood tests.

She contacted her solicitor who sent a letter of claim to the surgery.

Outcome and analysis

It was alleged that the nurse had used undue force in obtaining the blood, resulting in a tear to the blood vessel. The nurse admitted the error and the practice agreed that it would be best to settle.

Key points

- Employing GPs are vicariously liable for their staff's actions.
- Ensure that staff are well trained and supervised.

TREATMENT

Holiday toothache

MRS V had booked an expensive family holiday in Thailand. Two weeks before departure a filling in a lower right molar fell out. She phoned her dental surgery and requested an emergency appointment.

The dentist examined the tooth and found a deep cavity but no exposed pulp. Mrs V said she was not in pain and felt only a little sensitivity to cold. In the limited appointment time available the dentist decided to place a temporary filling without anaesthetic. He requested that Mrs V then make an appointment for further treatment on her return from holiday.

A week later Mrs V contacted the surgery again to say part of the temporary filling had fractured. Another emergency appointment was arranged and this time the dentist applied a further temporary filling. Again the patient was advised that full treatment would be necessary at a later date.

On the flight out to Thailand Mrs V began to experience pain in the tooth. A few days later the toothache became unbearable and she had to seek local treatment. An X-ray was taken and antibiotics and painkillers were prescribed. Her holiday insurance only covered part of this treatment.

Mrs V returned to the surgery after the holiday. Her face was swollen and X-rays confirmed an apical abscess. She was angry and demanded that the dentist pay the balance of costs for her treatment in Thailand. The dentist declined on the basis that he had acted correctly on the information provided by the patient, and it could now be seen that the symptoms could have flared up at any time. A further appointment was arranged to initiate root canal treatment to the tooth. The patient missed that appointment and a letter of claim alleging negligence was received at the surgery from a solicitor acting on Mrs V's behalf.

Outcome and analysis

MDDUS requested the patient notes regarding Mrs V and it was discovered that there was no record of any discussions with the patient regarding her symptoms. Had she reported pain or other symptoms, further tests including an X-ray would have been indicated and an abscess would have been diagnosed. The dentists would then have been able to discuss options with Mrs V regarding both the urgent need for treatment and her holiday plans.

The lack of any notes in the patient records regarding the discussion of symptoms meant that any legal defence would rely on the dentist's memory. MDDUS judged that arguing the case would be risky and could involve significant legal costs. It was decided with the member's agreement to settle the case for a modest sum with no admission of liability.

Key points

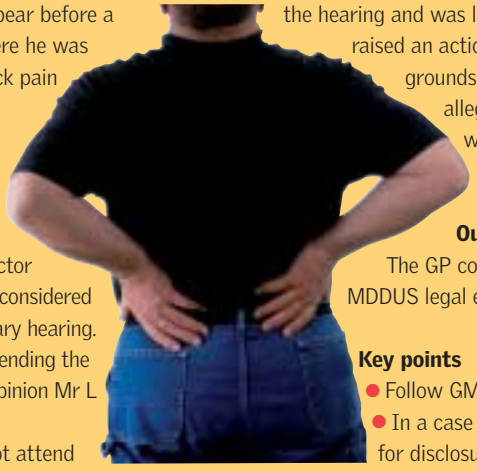
- Ensure adequate information including discussion of symptoms and treatment options are recorded on patient records.
- Emergency appointments require a high index of suspicion.

CONFIDENTIALITY

A painful disclosure

MR L, a civil servant, was summoned to appear before a disciplinary hearing at the local council where he was employed. He suffered from chronic low back pain and his GP had recently provided a medical certificate stating his unfitness to work.

A senior civil servant at the council telephoned the GP just before the hearing. He stated that he did not want any specific medical information but then asked if the doctor could confirm whether or not Mr L could be considered sufficiently fit enough to attend the disciplinary hearing. Mr L had never seemed to have difficulty attending the surgery before so the GP stated that in his opinion Mr L was fit to attend a hearing.



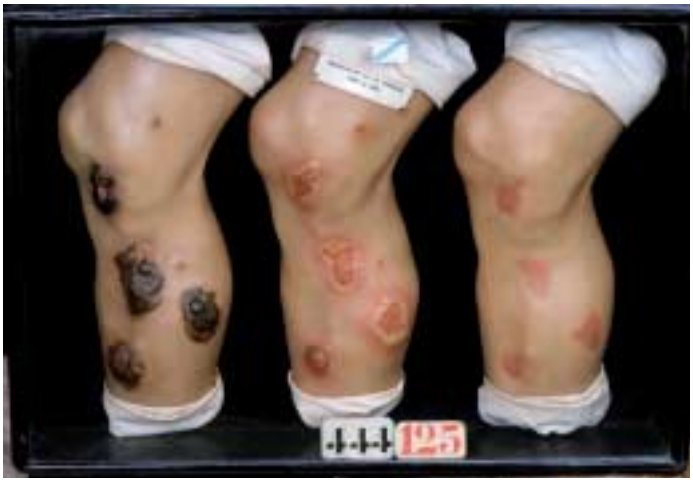
Citing the medical certificate Mr L did not attend the hearing and was later dismissed. He contacted a solicitor and raised an action against the GP and the Health Board on the grounds of negligence and breach of confidentiality. He alleged that the GP had made the disclosure without his consent and was thus responsible for his dismissal.

Outcome and analysis

The GP could not counter Mr L's version of events and MDDUS legal experts deemed the case indefensible.

Key points

- Follow GMC guidance on confidentiality.
- In a case like this ensure that patients provide consent for disclosure of medical information.



Object obscura: syphilis treatment models

THESE wax legs from 1910 were used to demonstrate treatment and recovery from syphilis. They can be found at the Science Museum in London and also in an innovative new online exhibition – *Brought to Life: Exploring the History of Medicine*. The site has been developed for GCSE history students and undergraduates but features content that would interest any medical history buff. The first phase of the project will include 2,500 objects covering centuries of medical history from around the world. Access the exhibition at www.sciencemuseum.org.uk/broughttolife

From the archives: a lost root

ENSURING that MDDUS subscriptions and details of practice are up to date has been important for members from the earliest days of the Union, as evidenced in this extract from the Minute Book of the MDDUS Advisory and Financial Committee, dated 16 March 1906.

"Application on behalf of Mr S of Dundee for defence in a threatened action in the Court of Session

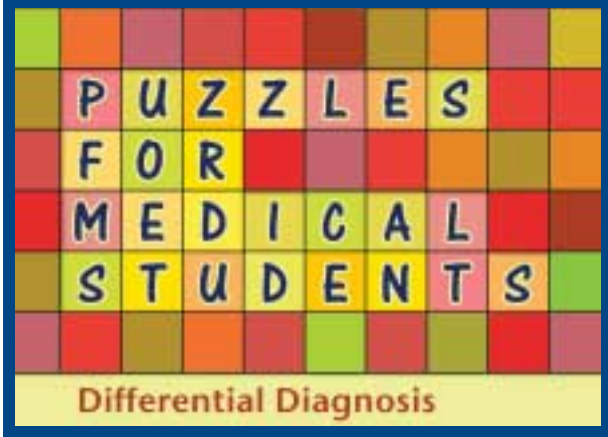
The case is as follows: on 17 January 1906, Mr S removed three back teeth from a girl named Cochrane. She alleged that whilst removing one or other of the teeth he allowed a large portion of the root of one to slip down the windpipe with the result that it lodged in the lung causing serious injury. Mr S says that the girl was particularly restive: that he got out one root and wished to deal with the remainder but the patient would not allow him. The patient received every care and skilful treatment and that whether the tooth was in the throat or not he has no evidence and does not think that there is any responsibility resting upon him.

The Treasurer stated that Mr S had been in arrears with his subscription from December 1903 till 6 February 1905 when he paid 20s (10s for last year and 10s for current year). The matter happened on 19 January 1906 and the girl's father called on Mr S on 24 January with the root of a tooth and stated that his daughter had coughed it up.

In these circumstances the Committee came to the conclusion that as Mr S had paid up the subscriptions after his getting into trouble in connection with this case, it accordingly resolved to advise the Council to refuse defence. The Secretary was instructed to write to Mr S's solicitors accordingly."

Medical Wordsearch: causes of sinus tachycardia

Find 10 causes of sinus tachycardia in the grid. Words can go horizontally, vertically and diagonally in all eight directions. See answers online at www.mddus.com. Go to the Notice Board page under News and Events.



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Vignette: pioneering liver specialist Dame Sheila Sherlock (1918-2001)

IN 1936 a clever and accomplished 17-year-old from Folkestone County School for Girls in Kent received a late acceptance to study medicine at the University of Edinburgh. She had applied and been interviewed for admission to several other UK medical schools but had been rejected by all. In that era young women still met with discouragement when aspiring to become doctors.

Had Edinburgh not accepted Sheila Sherlock the medical world might have been deprived of a brilliant and innovative research clinician. She went on to become one of the leading figures in the field of liver disease and was known throughout the medical world.

Sheila Patricia Violet Sherlock was born in Dublin in 1918, her father a Captain in the Green Jackets on a peace-keeping assignment. The family soon moved back to London but much of her childhood was spent in Kent.

At Edinburgh she studied under such notables as Sir Stanley Davidson and Professor of Surgery, James Learmonth, who became her mentor (referred to as 'Poppa'). Her degree was in part funded by a part-time job as science tutor at a "cramming" school for students taking entrance exams. Sheila graduated top of her year in 1941 and was awarded the Ettles Scholarship. This should have led to a job as house officer at Edinburgh but she was passed over – ostensibly because there were no live-in quarters for women.

Learmonth appointed her Assistant Lecturer in Surgery and Sheila began her long career in clinical research, publishing her first paper in 1942. An opportunity arose for a post in the medical unit at the Hammersmith Hospital in London. Learmonth wrote a letter of reference saying: "...if you get Sheila Sherlock as your House Physician you'll be darned lucky".

At the Hammersmith, working amidst the blitz, Sheila took an early interest in diseases of the liver. Jaundice was a major problem among the troops and under John McMicheal she learned the technique of aspiration biopsy of the liver to study the pathology of acute hepatitis. This work formed the basis of her MD thesis in 1945 for which she won a Gold Medal.

IMAGE: GODFREY ARGENT/ © NATIONAL PORTRAIT GALLERY, LONDON

In 1947 Sheila was awarded a Rockefeller Travelling Fellowship to Yale. In the USA she established contact with the leading lights of hepatobiliary medicine, including the renowned Hans Popper. In 1948 she returned to the UK as a lecturer in medicine and consultant physician at the Hammersmith – only 30 years old and a pioneer in the study of liver disease.

Here she continued her research doing ground-breaking work on hepatic encephalopathy, portal hypertension and ascites. Over 11 years at the Hammersmith she produced 90 papers and the first edition of her seminal textbook: *Diseases of the Liver and Biliary System*. In 1951 she became the youngest woman to be elected a Fellow of the Royal College of Physicians. That year she also married Dr Geraint James – later to become a specialist in sarcoidosis and other granulomatous disorders.

In 1959 Sheila was appointed to the Chair of the Department of Medicine at the Royal Free – the first woman ever to be appointed a professor of medicine in the UK. Here she was joined by talented colleagues from the Hammersmith including Barbara Billing and Roger Williams. The medical unit offices and laboratories were set up in rooftop wooden huts at the Free, reached by climbing up steep external staircases and "ladders" which were used by staff, patients and visitors alike. The Unit became a centre of excellence for research in liver disease, attracting registrars, house officers and fellows from across the world.

In 1974 the unit moved to Hampstead, occupying the 10th floor of the new hospital. It would be impossible to detail all the research over the next 10 years but, as an example, in 1978 more than 26 papers were produced from the unit, including articles on hepatitis B, primary liver cell cancer and primary biliary cirrhosis.

Sheila was at the centre of all this activity. She demanded excellence from her staff, be it in presenting cases or producing academic papers. Dr James Dooley of the UCL Institute of Hepatology writes: "She was a tough taskmaster but fair. She expected the highest clinical and academic standards in those who worked with her, and led by example". She was also sensitive to the collaborative nature of medical research. Many remember her habit of introducing colleagues at meetings as 'Brown is working with me' rather than 'for me' and never 'under me'.

Sheila relinquished her Chair in 1983 at the age of 65 but still attended an office at the hospital until age 82, presenting cases at regular Wednesday meetings. She continued editing her book, the 11th edition being published only weeks before her death in December 2001. That same month she and her husband Geraint celebrated 50 years of marriage along with their two daughters and two grandchildren.

"Generations of hepatobiliary academics and clinicians and patients remember her fondly and with gratitude," writes James Dooley. "A remarkable life."

Source: Dame Sheila Sherlock (1918-2001) Life and Work *by James S Dooley. Falk Foundation; 2003*

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