Winter 2009

# SUMMONS

MDDUS JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND

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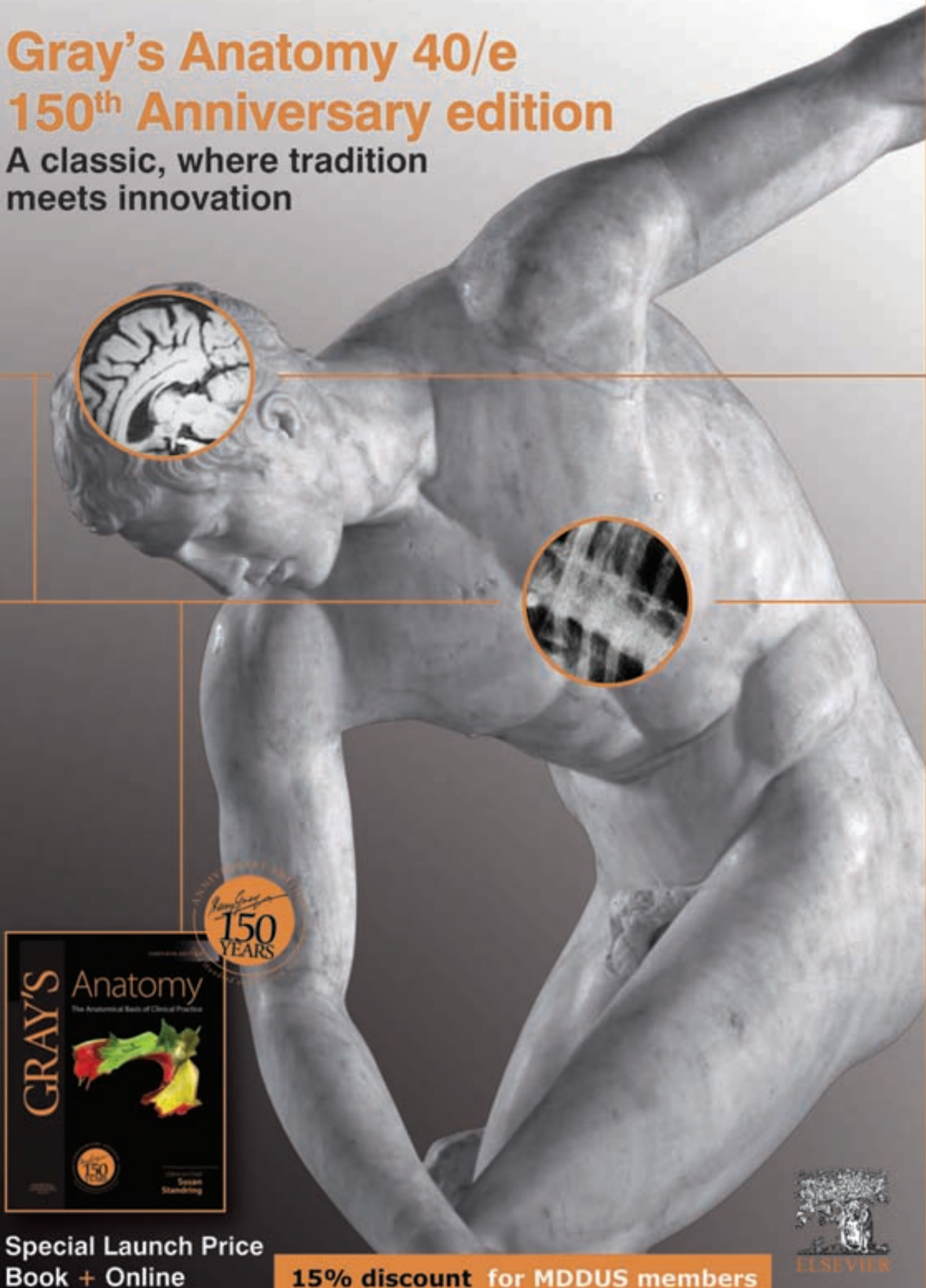


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# IN THIS ISSUE

INEVITABLE as this winter will bring the occasional blizzard to the Highlands of Scotland so too will newspapers bristle with outrage at walkers or climbers injured or benighted atop far-flung mountains in 'atrocious conditions'. Of course most mountain rescues can be avoided if people are well informed and prepared. But it's ironic that those most likely to defend the basic right of walkers and climbers to take to the hills in winter are the volunteers braving conditions to bring down the frozen and hurt.

On page 16 of this issue Adam Campbell profiles two such volunteers who also happen to be GPs. In offering up their free time, David Syme and Stephen Teale provide much needed emergency medical support to mountain rescue teams in Killin and Braemar. Says Dr Syme: "There is something quite nice about getting somebody who's cold and scared, and turning them into somebody who's had some pain relief, is wrapped up in a nice casualty bag and knows they're going to be okay".

A comforting sentiment – not that I ever personally hope to meet Dr Syme in such circumstances.

Also in this issue (p. 12), Lindsey McGregor, a solicitor and medico-legal expert, takes a look at new General Medical Council guidance to help expert witnesses avoid the pitfalls that landed Meadow and Southall before fitness to practise panels – and hopefully counter the increasing reluctance of doctors to offer opinions for fear of the potential repercussions.

And on page 9, Dr Jim Rodger provides a perspective on doctors who give too much of themselves to patients. 'Going that extra mile' can sometimes backfire and cause more trouble for doctors than they could ever imagine.

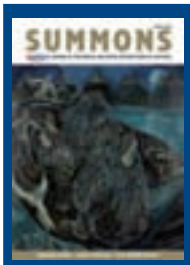
**Jim Killgore, editor**






## REGULARS






**Cover image:** 'Lapland' by an unknown artist. Mixed media. Art in Healthcare purchased this work in 1986 from the Collective Gallery Auction in Edinburgh. 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.
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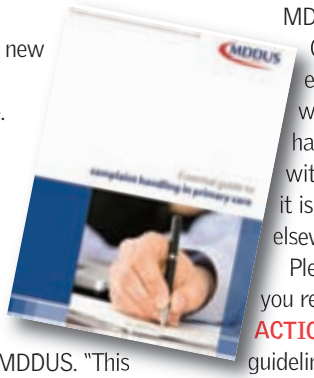
# Effective complaint handling




MDDUS has published a new booklet on complaint handling in primary care.

"It's a professional responsibility to listen, respond to and learn from comments and complaints from patients," says Dr Jim Rodger, head of professional services at MDDUS. "This guide is intended to give practices advice on dealing constructively and promptly with complaints, recognising their potential to improve the delivery of healthcare."

*Essential guide to complaint handling in primary care* was prepared with valuable input from the Scottish Public Services Ombudsman's office and features sections on practice-based complaints procedures and effective complaint handling. Contact marketing@mddus.com

# Risk alert: skin cancer surgery

GPs risk legal action if they fail to follow GMC guidance – as well as NICE guidelines – when they treat skin cancers. This warning follows concerns publicised by the British Association of Dermatologists that some family doctors are not following NICE guidance in performing such surgery.

Litigation may follow where an excision is incomplete, histology on the sample is not performed or the required standard of care is not provided. Complying with guidance should enable MDDUS effectively to support doctors who are asked to account for their actions in performing surgical procedures locally.

GMC guidance in *Good Medical Practice* advises doctors to "recognise and work within the limits of [their] competence". The GMC also advises: "You should be familiar with relevant guidelines and developments that affect your work".

MDDUS medico-legal adviser Dr George Fernie said: "GPs should ensure that they are working within their sphere of expertise, have robust systems and comply with all relevant guidance, whether it is from the GMC, NICE or elsewhere".

Please contact an MDDUS adviser if you require further advice or guidance.

ACTION: GPs must follow relevant guidelines when performing minor surgery for skin lesions

# Leading through uncertainty

MDDUS is offering an intensive 5-day course aimed at doctors in leadership positions. Based on a set of competencies evolved from the General Medical Council's (GMC) guidance on *Management for Doctors,* the course will provide training in:

- leadership and communication
- managing conflict
- problem-solving and decision-making
- project and change management
- delegation
- building a creative safety culture

# Valuable lessons from aviation

**AROUND one million inpatient adverse events occur each year in the UK and human performance is often cited as a significant contributing factor. In February 2009 MDDUS will team up with the specialist team resource management firm Terema to offer a *Masterclass in Patient Safety: Human Factors in Risk Management.* Drawing on well-established safety practices in the field of aviation the Masterclass will bring together a range of knowledge, skills and understanding to help healthcare professionals function more successfully within a team and reduce risk. The Masterclass will be held at MDDUS offices in central London and all members are eligible for a discount on fees. Go to www.mddus.com for more details.**

# IN BRIEF

***MDDUS eMONTHLY*** We have relaunched our monthly online update in a new format. *MDDUS eMonthly* is intended as a *Summons* supplement with relevant medico- and dento-legal news and features. The newsletter includes regular Risk Alerts – arising either from lessons learned in recent cases or changes in the law that might affect safe practice – and also the ever-popular Case of the Month with the usual important 'take-home' points. Any feedback, ideas, articles or other content of interest to MDDUS members would be very welcome. To subscribe email jkillgore@mddus.com

**GP REGISTRAR GRANT REMINDER** Applications are due 31 January for educational grants of £1000 for GP registrars. Both the GP registrar (commenced training in August 2008) and his or her trainer must be members of MDDUS. The grants can be used for any form of educational training including attendance at course conferences and seminars, practice training and the purchase

- clinical and non-clinical risk management
- emotional intelligence in leadership.

"I got a lot out of the course and, I have to say, gave a lot of myself to it!" commented one participant in last year's course. "It's given me an increased self-awareness of my own leadership behaviours and a better understanding of what I need to concentrate on to become a more effective leader within my own organisation."

The course is being offered both in our Glasgow and London offices. Contact lprice@mddus.com for details and a flyer.

## Elective travel scholarships

**MEDICAL and dental students undertaking an elective abroad can apply for support to the British Medical and Dental Students Trust (BMDST). The BMDST is a charitable organisation offering travel scholarships to medical and dental students and is administered through the MDDUS.**
**Over the last 5 years some £200,000 has been awarded to projects including:**

- **Challenges of working in hospitals in the developing world**
- **Emergency medicine in Vancouver**
- **Comparing child-friendly environments of hospitals in the UK and Hong Kong**
- **Preconceptions of pain in the UK and Trinidad**

**On average, a third of students who apply for funding will receive an award of between £100 and £1,000. The deadline for applications is 31 January for elective periods from April to September, and 31 July for elective periods from October to March.**

**To apply go to the student site at www.mddus.com for details and to download an application form, or contact Sheila Baumann on sbaumann@mddus.com.**

## BMA loses its challenge on ARF

THE High Court has turned down a BMA application for a judicial review of the General Medical Council's (GMC) decision to abolish the exemption from the annual retention fee (ARF) for doctors aged over 65.

Retired MDDUS members can be reassured that it is Union policy that members who permanently retire from practice and give up their GMC registration remain entitled to assistance and access to indemnity in respect of world-wide Good Samaritan acts. Retired members also retain access to indemnity for any incidents occurring whilst in active membership. Please contact our Membership Department if you need any further clarity on this issue.

## MDDUS to host mock employment tribunal

A MOCK employment tribunal highlighting pitfalls in healthcare staff management is being hosted by the MDDUS at its 2009 Practice Manager Conference in February.

The tribunal will be staged by Law At Work – the preferred supplier of general employment law and health and safety services to MDDUS. Practice managers, GPs, GDPs and others responsible for staff management are invited to witness the court proceedings and have an opportunity to air their views on how the judgement should go before learning the decision of the tribunal and an explanation of the reasoning behind it. The programme will also include an additional session on how to avoid the employment pitfalls highlighted in the mock hearing.

The 2009 MDDUS Practice Manager Conference will be held on 5 February, 2009, at Hampden Park in Glasgow.

Delegate fees are £80.50 and £63.25 for additional members of the practice. To register your interest email marketing@mddus.com or call 0845 270 2034.

of equipment or textbooks. For details go online at www.mddus.com or email cgunn@mddus.com.

**GDC MOUSE MANAGEMENT** Dental professionals can now pay their GDC annual retention fee, update their contact details and check the details on their practising certificate before it is printed, all via the web, with the Council's new self-service website. To protect individuals' personal information, new e-GDC users will need to create an account. Go to www.gdc-arf.com

**BSC MED SCI AWARD** The 2007/2008 BSc Med Sci award for students at the University of Aberdeen, sponsored by MDDUS, was this year won by Ben Hall for his study entitled 'Does activated protein C save lives by affecting endothelial cell function?' Ben received a cheque for £500 and our congratulations.

# Reporting convictions to GMC

AN INCREASE in the range of offences settled by paying fixed penalty notices rather than being subject to formal charges has prompted the General Medical Council to issue amended guidance on reporting criminal offences and related matters.

GMC core guidance, *Good Medical Practice*, states that doctors: "...must inform the GMC without delay if, anywhere in the world, (they) have accepted a caution, been charged with or found guilty of a criminal offence, or if another professional body has made a finding against (their) registration as a result of fitness to practise procedures".

In its amended supplementary guidance, *Reporting criminal and regulatory proceedings within and outside the UK*, the GMC provides more detail about what doctors are required to disclose. Registrants must inform the GMC if, anywhere in the world, they:

- formally admit to committing a criminal offence
- are charged with or are found guilty of a criminal offence
- accept the option of paying a Penalty Notice for Disorder at the upper tier penalty level (in England and Wales) or a Fixed Penalty Notice under the Anti-Social Behaviour etc (Scotland) Act 2004
- receive a warning for the possession of cannabis
- are given an Anti-Social Behaviour Order
- have had their registration restricted, or have been found guilty of an offence by another medical or other professional regulatory body.

The duty to report the matters set out in the guidance does not change the circumstances in which the GMC will investigate a doctor's conduct, nor the threshold for taking action on registration. Access the revised guidance at www.gmc-org.com

# Smoking cessation therapy risk

THE smoking cessation drug varenicline continues to generate Yellow Card reports for suspected adverse reactions, according to the MHRA.

In the November issue of the *Drug Safety Update* the MHRA urged doctors to make patients and their family or care-givers aware of the possibility that trying to stop smoking might cause symptoms of depression and that those taking varenicline who develop suicidal thoughts or behaviour should stop their treatment and contact their doctor immediately.

"Varenicline should be discontinued immediately if agitation, depressed mood or changes in behaviour are observed that are of concern for the doctor, patient, family, or caregiver," states the MHRA advice.

Varenicline (Champix) is a non-nicotine aid to smoking cessation and was launched in the UK in December, 2006. It is a partial agonist at the nicotinic receptor and can help to relieve cravings and nicotine withdrawal symptoms. Up to the end of June 2008, approximately 450,000 people had used varenicline in the UK.

Patients with serious psychiatric illness did not participate in the premarketing studies of varenicline, and the safety and efficacy of the drug in such patients has not been established. The MHRA urges that care should be taken when prescribing varenicline to patients who have a history of psychiatric illness.

# Ensure implants competence

NEW revised training guidelines in implant dentistry published by the Faculty of General Dental Practice (UK) are the gold standard in ensuring competence in implantology, according to the GDC.

The guidelines make clear the minimum training the GDC would expect dentists to have successfully completed before undertaking implants. In a new policy statement the GDC has confirmed that it will refer to these guidelines when assessing complaints against dentists who have allegedly practised implant dentistry beyond their competence.

Inserting dental implants is considered a surgical procedure which should only be carried out by dentists with suitable training. This would normally involve a postgraduate training course in implant dentistry and an assessment of competence. Training can come from a variety of sources including university, Royal College or hospital-based programmes, as

## IN BRIEF

**PAIN CONTROL IN CANCER**
New guidelines on managing pain in adults with cancer have been issued by SIGN. The document focuses on pain secondary to cancer and includes pain assessment, management of psychological distress, pharmacological treatment with non-opioid and opioid drugs and also non-pharmacological treatments. Access at www.sign.ac.uk

**OBESITY DRUG WARNING**
Prescribers should not issue any prescriptions for the anti-obesity drug rimonabant, and should review the treatment of those who are currently taking this medicine, according to recommendations by the European Medicines Agency. The agency has called for the suspension of the marketing authorisation for Acomplia (rimonabant) because the benefits do not outweigh the risks of psychiatric reactions.

**DENTAL SCOPE OF PRACTICE**
A new document setting out the skills and abilities required of different members of the dental

well as from courses run by commercial groups or individuals.

Hew Mathewson, GDC President, said: "We have concerns that some dentists have been carrying out this very invasive procedure without having completed adequate training and an assessment. It's essential for patient safety that dentists have had sound postgraduate training before doing it".

Access the GDC 'Policy statement on implantology' and *Training standards in implant dentistry for general dental practitioners* at www.gdc-ord.uk

## Significant event audit

NEW guidance for general practice teams enabling them to learn from patient safety incidents and near misses has been launched by the National Patient Safety Agency (NPSA).

Significant Event Audit (SEA) was established in the mid 1990s as an effective quality assurance method in general practice with the aim of improving patients' experience, care and outcomes and to identify changes that might improve future care. Access *Significant Event Audit* at www.npsa.nhs.uk

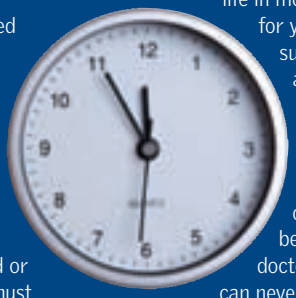
## OPINION

**by Dr Jim Rodger**
**Head of Professional Services**
**MDDUS**

### Status: on (always)

It's a great feeling to sit and pass your medical degree final examinations, and then to be ceremoniously awarded your degree and thereafter able to put Dr before your name. It impresses when it's on your cheque book, when booking restaurants – in a variety of social and personal networks. But then, after all, you have worked hard for the privilege of the title and should be proud to 'wear' it. Inevitably with the privilege comes the responsibility. You are and remain as long as you are on the Medical Register, a registered medical practitioner for 365 days a year, 24 hours a day.

A doctor who is registered cannot simply turn off that status at the end of a day's work or shift. We occupy a high status in the community and remain in the public eye and under public scrutiny at all times. This does not mean that doctors can have no relaxed or anonymous social life and must remain indoors, abstemious and not go to parties, outings or festivals. However, their behaviour at all social gatherings has an effect on the way that the public and patients view them and in turn view the wider profession.



The reason that patients do tell us their secrets and expect us to respect them is because of the ethical principles we must adhere to which are embodied in the Hippocratic Oath. These promises reinforce the trust that the public and the community places in doctors. To let that trust be undermined would prevent doctors being able to work with patients and act in their interests. That is why this is a fundamental principle of medical ethics that the General Medical Council guards carefully.

Failure to maintain high standards of conduct and personal behaviour by doctors brings the profession in general into disrepute and thus undermines the trust that the public bestows on doctors. This is the charge that the GMC will use in questions of conduct or behaviour, such as breaches of criminal law in general and in offences involving drug abuse and alcohol. We know that doctors, because of their work, can become more susceptible to drugs, which they are exposed to and have more ready access, and alcohol abuse which often begins in student days and continues into professional life. Such observations are not new.

What has emerged lately, possibly as a result of greater affluence and easier access, is a shift to the use of recreational drugs. While this may be a common feature of social life in modern affluent youth, it has risks for young affluent medics. The use of such drugs may be regarded as acceptable by friends and acquaintances in off-duty hours and in casual social encounters, such as parties or festivals. It is not so with the public at large or the GMC, who regard such behaviour as unacceptable for doctors. Use or abuse of illegal drugs can never be condoned and will cause the GMC to swiftly exercise their functions to sanction such doctors.

Charges involving possession or supply of illegal drugs are significantly increasing among young doctors. As a consequence, these doctors also face GMC charges and potentially hearings which can lead to restriction of or even end their registration status and thus prevent them following their chosen career. It is entirely possible that such charges might lead to erasure.

Any conviction of a registered medical practitioner is automatically reported to the GMC, and now there is a professional obligation to self-disclose all such matters. Doctors cannot shed their registered mantle when not on duty. Indeed they are never off-duty as far as the public are concerned – fair or not. Their status in the public eye demands standards of conduct which are incompatible with recreational drug usage.

team has been published by the GDC after consultation. *Scope of Practice* sets out the skills and abilities that a registrant in each area should have, but the GDC has stressed that it is "not a list of tasks that registrants can do". The document also describes supplementary skills that registrants might develop after registration and 'reserved duties' limited to certain registrants. Access at gdc-org.com

**DIAGNOSING DEATH**

New guidance intended to remove ambiguities in the way death is diagnosed and confirmed by doctors has been launched by The Academy of Medical Royal Colleges. The code of practice has taken four years to compile and takes account of the rapid advances in medical science since the last code was published in 1998. It is hoped that the new guidance will help put an end to anecdotal stories about patients recovering after a diagnosis of death has been made. Access at www.aomrc.org.uk

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

# Keeping the 'event' happy

**THE STORY OF** the woman who received a pregnancy congratulations card from her employer with her P45 inside may be just an apocryphal tale to illustrate how insensitively some bosses react when a 'happy event' is announced. But managers contemplating dismissal or less favourable treatment for pregnant employees should take note that, in many recent Employment Tribunal cases involving pregnancy, the employers have lost and ended up paying large sums in compensation.

Jane Anstey began working for Advantage Healthcare Group (AHG) as a recruitment consultant. A month before a review meeting of her three-month probationary period was scheduled she informed the company that she was pregnant. A week later Anstey was called to a meeting with her regional manager, who told her that her performance was unacceptable and that her employment would not be confirmed at the end of her probationary period. She was dismissed that day with one week's pay in lieu of notice.

She suspected that her dismissal was directly connected to her pregnancy and decided to raise an action for direct sex discrimination in the Employment Tribunal.

If a claimant is able to present the tribunal with facts from which they could conclude, in the absence of an adequate explanation, that the respondent has unlawfully discriminated against the claimant, the tribunal must uphold the complaint.

At the tribunal, AHG argued that Anstey's dismissal was not discriminatory, as she had not been retained because of a lack of necessary skills or experience to carry out the role, a lack of organisation and an inability to complete any tasks.

The tribunal disagreed. They said that Anstey had established sufficient facts from which an inference could be drawn that the treatment meted out to her had been on the grounds of pregnancy. The allegation that she was dismissed for capability or poor performance simply did not 'stack up' in the light of the history of the matter prior to the announcement of her pregnancy and AHG Ltd's hastily arranged meeting to dismiss her. Her claim therefore succeeded, together with a claim for automatically unfair dismissal.

An employer's initial reaction when informed of an employee's pregnancy often has an impact on the tribunal's decision as to whether to draw an inference of discrimination. For example, asking "how much is the pregnancy going to cost me?" or saying that the pregnancy "completely changed the position and there would always be a place for you after the baby is born but not before" may shift the burden onto the employer to demonstrate that there was no discrimination.

On the other hand, in another recent case, the tribunal felt that the HR manager's casual, unsarcastic remark – "What, again?" – on being told of the claimant's fourth pregnancy, was not sufficient to shift the burden of proof to the employer.

As we all know, pregnant women may have periods of ill-health which are related directly to the pregnancy. Employers who seek to use absence as a reason for dismissing a pregnant woman may have difficulties in avoiding an automatically unfair dismissal claim. Protection under this provision is very wide and certainly covers ante-natal care, miscarriages and pregnancy related illnesses.

Here's a case in point. Ms Hill began working for The Old Rectory Nursing Home as a care assistant in May. In February the following year, after eight episodes of sickness absence, she was given a final written warning that if her attendance did not improve she would be dismissed.

In early June she informed her employer that she was pregnant. During June and July, Hill was off work on four occasions with pregnancy-related sickness. She was dismissed on 14 August because of her level of sickness absence. The tribunal found her dismissal automatically unfair under the Employment Rights Act.

Employers in a similar position would do well to ignore pregnancy-related illnesses in assessing whether to dismiss an employee for excessive absence. Even then, it may often be difficult to assess whether a particular absence is pregnancy-related or not.

Only a small percentage of tribunal cases reach court. However, employers who do find themselves involved in litigation risk un-capped awards with six-figure compensation becoming increasingly common.

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

*Sometimes medics can do too much for their patients, says* Dr Jim Rodger *of the MDDUS*

# Going that extra mile

DOCTORS who display a warm, friendly and reassuring manner with their patients are more effective. There is no doubting the truth in this and research bears it out. Displaying appropriate empathy makes patients more open with symptoms and concerns and encourages them to become more engaged in their own treatment – all of which can lead to improved therapeutic outcomes.

But sometimes doctors can be too helpful. General practitioners, especially, develop close relationships with patients in both clinical and social terms. This is particularly so with patients who have serious or long-term illnesses. A natural increased level of compassion for people in difficult circumstances may blind the doctor to the risk of overly close involvement with matters that are not strictly clinical.

It is not a wish to eliminate any feelings of sympathy or empathy for patients since the job depends on that, but rather a word of caution about the 'step too far'. To use another cliché, 'going that extra mile' for patients often backfires and confusingly causes more trouble for the doctor than they could ever imagine. We have examples of doctors who have gone to extraordinary lengths to see a patient referred, even hand-delivering letters to homes after work or offering to take patients in their own cars to appointments, then find a letter of complaint, to their astonishment, two weeks later.

Some doctors will take great pains to ensure access to weird and wonderful medicines that patients have read about or seen on the internet. They make efforts to see patients prescribed banned medicines (e.g. Coproxamol) despite all the legal and ethical advice to the contrary. It is not uncommon for patients to ask general practitioners to refer them to all sorts of 'specialists', and one doctor recently spent many hours searching for details of a person to whom the patient wished referred. The doctor was trying to find out the qualifications and registration of this individual to ensure that he was genuine and safe to refer to. He was absolutely right to try and check this information but it proved to be a major distraction and a time-consuming project.

## Beyond healthcare

Some doctors will try to give help and advice to families in relation to such matters as powers of attorney, capacity or incapacity, or the validity of wills. This must always be avoided; financial and other such personal concerns need professional legal advice, not that of a doctor. To become too closely involved in such matters risks being embroiled in legal proceedings – an issue of particular sensitivity now considering the legacy of Dr Shipman. Doctors may wish to be as helpful as they can but risk being thrust into the centre of family disputes.

There have been times when doctors, because of their concern for patients or their surviving carers, have thought to intervene in insurance claims which might be prejudiced by possible non-disclosure. All such reports must be factually true and supplied to an insurance company irrespective of their effects on the family. To do otherwise risks censure from an insurance company or ABPI or the GMC.

Custody battles between parents are another source of trouble for doctors. One may be pressured to take sides in such matters or asked to intervene on one side or the other. Too close involvement with the perceived rights or wrongs of these situations is dangerous. Both the parents' and children's futures are at stake and this has little, if anything, to do with clinical concerns. Parents must be directed to the right place to resolve these matters – a lawyer. ➤

Finally, there have been examples of doctors who become embroiled in correspondence with a patient's employer and decisions about suitability or otherwise for work or in relation to work-related illness. Unless a doctor has some special expertise in occupational medicine they should tread very carefully in fitness or otherwise for work, except in so far as they can comment in general terms.

## Empathy and detachment

Such dilemmas touch at the core of what it means to be a doctor. A recent article in the journal *Social Theory and Health* reports on analysis based on qualitative interviews of 52 doctors working in the NHS. The researchers were interested in assessing how the respondents "feel" about being a doctor. In summarising their findings the authors wrote:

"The feelings they [doctors] articulate are riven with ambivalence. We suggest that this is generated by a contextual tension which presumes that the medical profession are required to reproduce medicine as an abstract system – an objective, trustworthy, reliable, effective, competent and fair mode of healing – and yet individual practitioners are also required to be caring emotionally intelligent, intuitive, and sensitive."[1]

This conclusion is hardly surprising. A healthy degree of emotional disengagement has been a tenent of medical professionalism since the days of Hippocrates. Today such "boundaries" are formalised in guidance from bodies such as the GMC. In 2006 the GMC released revised guidance on *Maintaining Boundaries* which warned that doctors must not use their professional position to establish or pursue improper emotional, including sexual, relationships with patients. The main issue for the GMC is one of trust.

"Trust is a critical component in the doctor-patient partnership: patients must be able to trust doctors with their lives and health. In most successful doctor-patient relationships a professional boundary exists between doctor and patient. If this boundary is breached, this can undermine the patient's trust in their doctor, as well as the public's trust in the medical profession."

"Doctors have gone to extraordinary lengths to see patients referred... offering to take patients in their own cars for appointments"

The guidance also comments on the potential "imbalance of power" in the doctor-patient relationship. Vulnerable patients can become over-reliant on doctors and it can be hard not to let this spill over into non-medical aspects of their lives.

This is not to suggest that overly helpful doctors are necessarily pursuing exploitative relationships with patients. It's just that when therapeutic boundaries are blurred it can become a matter of perception. A patient's overreliance can become dependence with a strong emotional component. Only so much can be covered in a seven minute (or even longer) consultation. This can lead to anger and hurt, and feelings of betrayal on the patient's part when expectations are not met.

Getting too far drawn into the life of a patient can also raise questions of competence. The GMC's *Good Medical Practice* states: "In providing care you must recognise and work within the limits of your competence". Advising a patient on how to deal with financial debt may be tempting but it's opening the door to criticism when things go wrong and the patient makes a complaint.

## Burnout

Doctors must also consider the effects on themselves of not maintaining a healthy emotional disengagement with patients. Burnout and compassion fatigue are real issues for general practitioners. Today much of the mental health treatment in the UK is provided in primary care. GPs are well suited to this role, having a holistic view of patients' physical, social and psychological backgrounds. But some patients come with a seemingly insolvable tangle of interrelated problems. Trying to "take on" such patients can be both exhausting and thankless and often the best a doctor can hope for is to manage problems and conditions as they arise.

Some doctors may feel an ethical duty to sacrifice their own health and feelings for the good of their patients. This comes wrapped up in the vocational "call" to become a doctor. It is ironic but not surprising that these "good" doctors are those most susceptible to burnout and compassion fatigue.

Expectations placed on GPs can at times seem limitless. Only those able to manage these expectations and 'fight the good fight' but accept their limitations will avoid the common pitfalls of the profession.

■ ***Dr Jim Rodger is a medico-legal adviser and head of professional services at MDDUS***

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1. Nettleton S, Burrows R, Watt I. *How do you feel doctor?* An analysis of emotional aspects of routine professional medical work. Social Theory and Health 2008; 6:18-36

# Life & death, mince & tatties

**I HAVE TO** admit I was disappointed. I had spent many hours revamping the week-long palliative care attachment for our 4th-year medical students. I had developed, co-ordinated and indeed delivered several new sessions. The end-of-block feedback forms came in and the students, ungratefully I thought, ranked 'having a meal with the day unit patients' as the most enjoyable and most useful session – the only session I had had nothing to do with.

Thankfully, my fragile ego got a boost as I examined the feedback in more detail. The students also recommended the new 'quality of life' session. Here groups of three or four students meet patients in the inpatient palliative care unit on the first morning of the week. They are forbidden from taking a traditional medical history, instead they are asked to find out what factors are important to these patients in improving or diminishing their quality of life. These interviews last between 5 and 15 minutes. All the students then meet for a facilitated discussion.

They are invariably amazed that these patients, with their severe, advanced and advancing pathologies, rarely spontaneously mention health-related concerns, but rather discuss their families, the attitude of care given (whether they feel they are listened to and whether the caregiver has time), maintaining independence, financial problems or spiritual issues.

Both the sessions described above allow the students to see and interact with the person behind the illness. This is obviously a transformative experience for some of them: "lovely to be able to interact in a non-clinical way"; "getting to know a patient's experiences and connecting with them"; "made me think of issues I wasn't even aware of".

Unfortunately it is well recognised that medical students tend to become less patient-centred and less empathic as they progress through medical school. They are generally very poor at identifying patients' concerns. This is probably unsurprising as most student–patient interactions occur in the context of the structured medical history: history of presenting complaint, past medical history, drug history, family history, social history and the dreaded systematic enquiry. It is difficult to imagine a more effective way of inhibiting patient-centredness, whilst emphasising that only medical concerns are important, although the instruction "go and feel bed 12's abdomen, he has a great liver" probably does just that.

Equally bad are the health-related quality of life scales that we see used as primary or secondary outcome measures in clinical trials. Patients are bombarded with questions about symptomatology and deficits in function. Unremarkably, health-related quality of life correlates well with markers of disease severity. Thankfully for me, as the whole raison d'être of palliative care is the maintenance/improvement of quality of life in the face of life-limiting disease, individual quality of life (where the patient nominates the domains important to them) is not correlated with disease severity or functional ability. Indeed, individual quality of life can improve even as prognosis shortens.

I am lucky, I know, because I have time to spend with patients talking about hopes and fears, life and death. I don't have the pressure of being expected to make them better. Yet, as the students discover on their first morning with us, it only takes a few minutes to effectively establish what an individual patient's priorities are. This process ensures that patients feel listened to and validated. It can promote autonomy and inform an understanding of 'best interests' both for the physician and indeed the patient as they reconsider their life goals. Importantly, most patients don't want or expect you to deal with all the issues they raise.

Now nothing makes me happier than the gentle hubbub of voices and laughter, the tinkle of cutlery on plates and the smell of mince and tatties. I know I could never teach that lesson in a tutorial.

■ *Dr Gordon Linklater is a consultant in palliative care at NHS Grampian*

*Meadow, Southall – it's been open season on the expert witness, and recent guidance from the GMC has been long overdue, says* Lindsey McGregor

# Restoring authority

THE number of high-profile expert witnesses who have appeared before the GMC in recent years have given the media plenty of scope for vilifying experts, particularly paediatricians, who allegedly ply their trade for huge sums of money and ultimately mislead the courts and the public. The result of this has been wide reaching, particularly in the field of paediatrics where fewer experts, for fear of a complaint against them, have been willing to provide opinions. Ironically, this may mean that more children are at risk of abuse than before.

In an attempt to restore confidence and to provide the profession with sufficient guidance to ensure experts do not end up before the GMC, long-awaited guidance was issued by the GMC in the summer. To put this guidance into context it is useful to consider the catalyst for it, which would appear to be the tragic and well-publicised case of the late Sally Clark.

## Southall and the GMC

In November 1999, Sally Clark was convicted of the murder of her two sons. She was sentenced to life for smothering her 11-week-old son, Christopher, in December 1996 and shaking Harry to death in January 1998. She was freed in January 2003. During the appeal, it emerged that crucial medical evidence which may have shown that the babies died from natural causes was not seen by the defence team or the jury in the original trial. The Court of Appeal ruled that her conviction was 'unsafe'. It was revealed that the Home Office pathologist, Dr Alan Williams, who examined both her sons after their deaths, had failed to disclose vital information to other doctors involved in the case.

Although not involved in this case in any way, Professor David Southall, one of Britain's leading experts on Munchausen's syndrome by proxy, claimed the husband of cleared solicitor Sally Clark murdered their two babies. A Channel 4 *Dispatches* programme, broadcast in April 2000, featured an interview with Stephen Clark in which he described a nosebleed suffered by their first baby, Christopher, in a London hotel 10 days before he died in December 1996. Southall contacted the police after seeing the programme. He told them it was his view that it was Mr Clark rather than his wife who had killed the two children. He was of the view that Mr Clark had deliberately suffocated his son.

Southall filed a report stating his "near certainty" that Mr Clark, not his wife, had killed the babies and that his surviving son was unsafe in his care. He later said this was "beyond reasonable doubt". The courts appointed another paediatrician to review Southall's claims. The second paediatrician did not agree with Southall and the matter went no further.

Mr Clark lodged a complaint against the Professor with the GMC who subsequently found that Southall had abused his professional position. The Professional Conduct Committee held that the consultant had acted "irresponsibly, inappropriately and misleadingly" in stating that Mr Clark had deliberately suffocated his sons.

The GMC found that a theory had been stated as scientific fact and Southall had declared his report true when he was not in a position to know that. Southall admitted to the GMC that he made the allegations without seeing the case papers, medical records, post mortem results or speaking to the Clark family.

On 6 August 2004 Southall was found guilty of

Above: Sally and Stephen Clark

IMAGE: CHRIS YOUNG/PA PHOTOS

serious professional misconduct. The GMC told Southall that he must not engage in any aspect of child protection work either in or outside the NHS for three years. Therefore, he could continue to practise but he was not able to work in child protection.

The Council for the Regulation of Healthcare Professionals (CRHP) appealed the decision of the PCC, on the basis that the sanctions were too lenient. On 14 April 2005, the High Court imposed stricter conditions on Southall.

In September 2008, the GMC reviewed the conditions and Southall was allowed to return to child protection work. Whilst the Panel accepted that Southall was entitled to express his concerns and report his views, the language used was "inappropriate", "injudicious" and "too strong". Further, he was wrong to present his report in the format that he did. He was also wrong to use phrases such as "almost certain" and "beyond reasonable doubt". He should have made clear the information on which his report was based and should have indicated his lack of access to certain information.

## GMC provides clarity

Before Southall's review hearing in September 2008, the GMC guidance on *Acting as an Expert Witness* was published on 25 July 2008. Such guidance was called for in 2006 by the Chief Medical Officer in order to provide more specific guidance for expert witnesses as part of the *Bearing Good Witness* consultation. It was not until two years later, however, and with the threat of increased publicity from the impending lifting of restrictions on Southall that the guidance was finally produced.

The guidance makes clear that serious or persistent failure to follow it may put registration at risk. It has 19 paragraphs and commences with a review of the core guidance found in paragraphs 63-67 of *Good Medical Practice*, which is essential reading before embarking on any report and should be read in conjunction with *Acting as an Expert Witness*. The key elements are:

- You must be honest and trustworthy when writing reports and when completing or signing forms, reports and other documents.
- You must always be honest about your experience, qualifications and position, particularly when applying for posts.
- You must do your best to make sure that any documents you write or sign are not false or misleading. This means that you must take reasonable steps to verify the information in the documents, and that you must not deliberately leave out relevant information.
- If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so without unreasonable delay.
- If you are asked to give evidence or act as a witness in litigation or formal inquiries, you must be honest in all your spoken and written statements. You must make clear the limits of your knowledge or competence.

These core principals are developed and enhanced in the new guidance which commences with a clear statement on the paramount importance of probity.

The remainder of *Acting as an Expert Witness* expands upon the themes identified in *Good Medical Practice* and covers inadequate instructions, providing accurate expert advice and evidence-based reports, and changing views on a material matter. In particular the guidance calls for experts to:

- deal with matters and express opinions that fall within the limits of professional competence
- give balanced opinions and state the facts or assumptions on which these are based along with the range of opinion
- ensure that any written report or evidence given is accurate, complete and not misleading
- explain any limitations to your advice or opinion such as that given regarding an individual who has not been consulted with or examined.

It is to be hoped that the guidance will give clarity to those who act as experts and provide such a necessary service to the judicial system. It is clear that the GMC is keen to encourage the profession in general by introducing the guidance in conjunction with a statement on its website entitled 'Could you be an expert witness?'. This gives further advice to experts and is a helpful companion to the new guidance.

For those considering developing and expanding their career as an expert, there is now a plethora of guidance available which should be considered closely before embarking on this role. Equally, those who have provided reports in the past would be well advised to review their practice and ensure compliance. It can only be hoped that the revamped GMC guidance will have the effect of restoring confidence in experts and encouraging them to continue to provide the essential role they play in the judicial process.

■ ***Lindsey McGregor is an associate solicitor and medico-legal expert at Simpson & Marwick***

# Colorectal cancer

Mr Ian Finlay *discusses a common dilemma for practitioners – when to refer for rectal bleeding and other large bowel symptoms*

COLORECTAL cancer is important because it is the second most common cause of death from malignant disease in the UK. Approximately 35,000 new cases are diagnosed each year. Despite this, an individual general practitioner would expect to diagnose, at most, only 1-2 new cases of colorectal cancer per annum. This poses a clinical dilemma for practitioners because they see numerous patients with large bowel symptoms that are not due to cancer.

Further, the numbers of these 'worried well' patients has increased rapidly as a consequence of several highly publicised large bowel cancer awareness campaigns. The difficulty, therefore, for the GP, is to select those patients with large bowel symptoms who should be sent for urgent investigation, having regard for the fact that if all patients are sent then the service will be overwhelmed. The danger of having a policy of selection, however, is that a patient with colorectal cancer will be missed inevitably resulting in litigation.

## Symptoms

In order to develop a strategy for referral it is important to have an understanding of the symptoms that may arise from colorectal cancer. These are site specific. Patients with rectal cancer classically present with tenesmus and/or rectal bleeding. Patients with sigmoid cancers have altered bowel habit (alternating constipation and diarrhoea) with a tendency to looser stools, while right-sided cancers produce no gastrointestinal symptoms and most commonly present as a palpable mass or anaemia. This is because the right colon is wide and the intestinal content is fluid.

The most diagnostically difficult symptom for the general practitioner is arguably that of rectal bleeding, because it is common and, in isolation, is rarely caused by bowel cancer. In a recent study of over 1000 patients sent to hospital with rectal bleeding alone, only 3% proved to have a cancer. The situation is complicated, however, by the converse fact that, of all patients with left-sided colorectal cancer, approximately two-thirds report rectal bleeding as a principal symptom.

Age is also important and potentially helpful in determining the degree of risk of a patient having colorectal cancer. Only 1% of all large bowel cancers occur under the age of 40; 4% of cases occur in the age range 40-50. After the age of 50, however, the risk rises rapidly.

Given these difficulties how then should the busy, beleaguered practitioner respond? The solution lies in distinguishing high-risk from low-risk patients.

## High-risk patients

The following patients are at high risk of colorectal cancer and should be referred for urgent investigation:

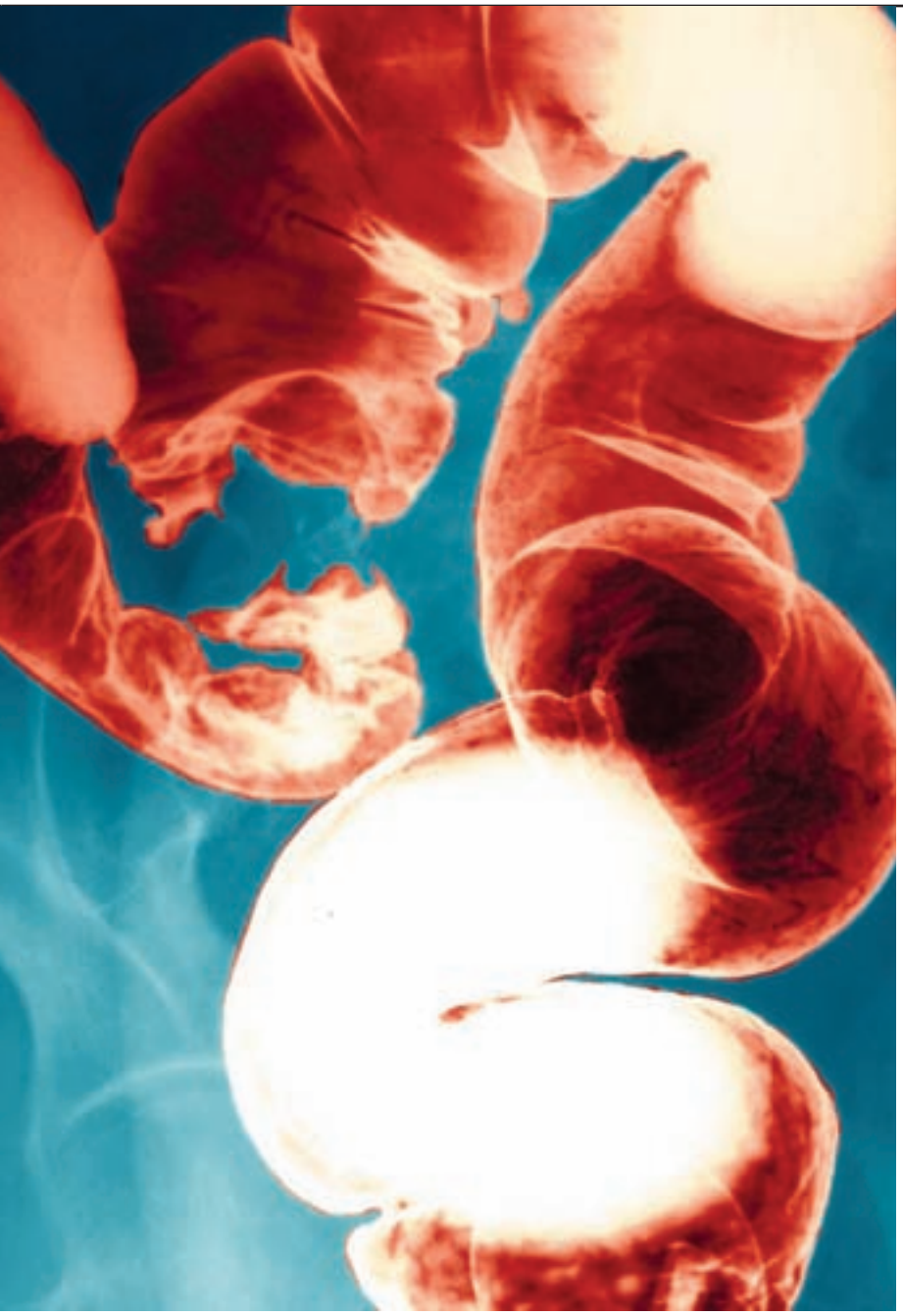
- Patients with anaemia or a palpable mass at any age.
- Patients over the age of 50 years with a change of bowel habit lasting 6 weeks (especially if it is to looser stools).
- Patients over the age of 50 with rectal bleeding (especially for dark blood). The danger of not investigating rectal bleeding in this age group, even if it appears to be from a benign ano-rectal cause, is that the patient may be falsely reassured and not re-present when symptoms persist or change in character.
- Patients of any age with symptoms and a strong family history of colorectal cancer. These patients tend to be anxious and are consequently difficult to reassure without investigation. Further, even young patients, dependent upon the nature of the family history, may be at high risk.

## Low-risk patients

Patients under the age of 50 years are at relatively low risk. It should be noted however that low risk does not mean NO RISK and it has been the authors' experience that the failure to diagnose a colorectal cancer in the young patient is likely to lead to litigation.

The recent guidance from the Bowel Cancer Advisory Group at the Scottish Executive is that it is acceptable to adopt a 'watch and see' policy for a period of 6 weeks in patients under the age of 40 who complain of a change of bowel habit since in

IMAGE: ZEPHYR/SCIENCE PHOTO LIBRARY



most cases the symptoms will be self-limiting. It is important, however, that arrangements are in place to review the patient, or that clearly documented instructions are given for the patient to return if the symptoms persist. An important exception to this policy applies to the patient with 'bloody diarrhoea' since this may indicate the presence of acute inflammatory bowel disease. These patients must be sent urgently since it has been shown that any delay in commencing treatment adversely affects disease progression.

Finally, there are a large number of patients under the age of 40 who complain of bright rectal bleeding at stool but have no change in bowel habit. These patients do not require urgent referral to a specialist but it is important that a definitive diagnosis is made in due course. This is likely to require that, as a minimum, a rectal examination and sigmoidoscopy are performed. Again a 'watch and see' policy for 6 weeks is acceptable although the practitioner may come under pressure from the patient to provide a definitive diagnosis or to provide treatment to stop the bleeding.

It should be noted that these are simply guidelines which may be of help to the busy practitioner. In the event, however, that the patient is unduly anxious or the practitioner has any concerns then it is better to "err by sending the patient for investigation" than to miss a cancer.

## Medico-legal aspects

The most common cause of litigation arises from the failure to refer a patient with high-risk large bowel symptoms and to provide inappropriate reassurance. This can cause the patient to ignore ongoing symptoms for months and in severe cases for over a year. In this circumstance, the pursuer/claimant invariably can obtain expert opinion to support a claim for breach of duty.

Another relatively common cause of a claim for breach of duty relates to the failure of the practitioner to perform a rectal examination in a patient who subsequently proves to have a rectal cancer. The evidence for this has recently become confused with reports questioning the value of rectal examination in general practice. The present situation may be summarised as follows. In the event that the practitioner has decided upon urgent referral to a specialist then rectal examination is unequivocally unnecessary. In the event that a 'watch and see' policy is adopted, however, then for the moment it is probably safer to persist with the use of rectal examination since the majority of expert witnesses appear to be of the 'old school'.

Despite a claimant successfully proving breach of duty it may be possible to defend a case on the basis of lack of causative consequences. This usually applies to the situation when disseminated disease has been identified and it can be argued that this would have been present even if the diagnosis had been made sooner and later referral would not have caused a deterioration in prognosis. The longer the time interval for the delay in diagnosis, however, then the less likely it is that such a defence will be successful. Further, improvements in treatment of disseminated disease, including hepatic resection, have also limited such a defence.

In conclusion, given that the NHS Service is embarking upon an ambitious screening programme for asymptomatic patients there is no reason to take risks with symptomatic patients. If in doubt – refer!

■ ***Mr Ian G Finlay is a consultant colorectal surgeon at Glasgow Royal Infirmary. He was the Founder and past Lead Clinician of the West of Scotland Clinical Managed Network for Colorectal Cancer and is a member of the Bowel Cancer Advisory Group at the Scottish Executive***

Adam Campbell *meets two Scottish GPs who face more than QOF targets in getting the job done*

# Mountain medicine

THE SCARIEST PART was when the helicopter was falling out of the sky and we didn't know where it was going to come down – because we were all underneath it in a line."

Dr David Syme is describing a fateful day back in 1987 when he and other members of the Killin Mountain Rescue Team set out on foot to help a climber who had fallen on the snow-covered peak of Ben More. They watched in horror as the rotor of a Wessex helicopter, which was attempting to drop off two further rescuers, hit a rock, causing the aircraft to crash and slide down the hillside towards them.

"Once it had stopped," he continues, "we just did things because we needed to do them."

Among the things they needed to do was crawl in through the tail of the smouldering helicopter, pull the crew members out and attend to their injuries. Tragically, one of the men had been thrown from the chopper and was beyond help.

"We had spoken to the pilot and he had assured us that it wouldn't explode, because the fuel they use doesn't explode," says Dr Syme, in what seems to me a modest attempt to play down his courage on that occasion.

The following day, at first light, the team recovered the body of the climber whose fall had instigated the incident.

## No place for a broken leg

Most mountain rescues end differently. Not only do rescuers not end up having to rescue each other, but the vast majority of people are brought out alive. Recent figures from the Mountain Rescue Committee of Scotland (MRCOS), the umbrella body that oversees the country's 28 mountain rescue teams, reveal that out of 491 rescues last year, there were 20 deaths.

There is no doubt this figure would be a lot higher were it not for the volunteers who staff these teams. It is a fact that, for Dr Syme, a volunteer of some 25 years' standing, is hugely satisfying. "What I say to team members is this: if someone's got a broken leg and they're halfway up a Scottish mountain in winter, they're going to die [without assistance]. If we take them off and make them no worse, we've done a huge amount," he says.

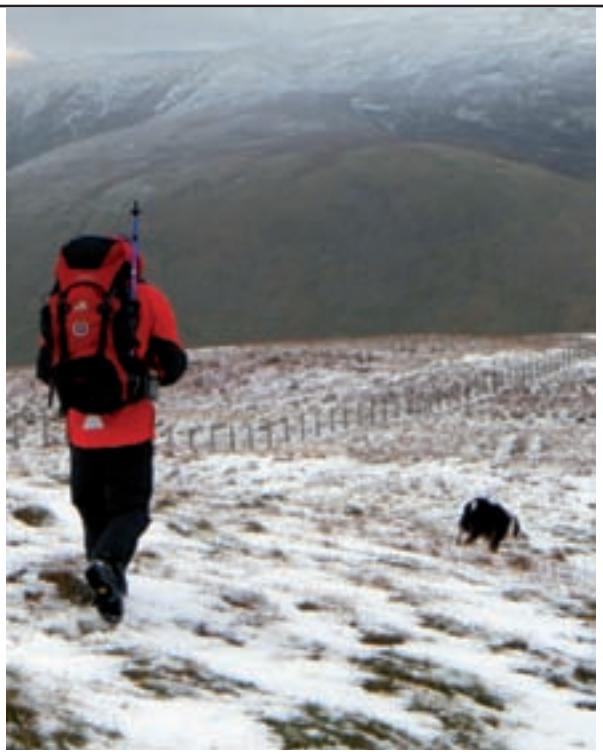
While there is no requirement for rescue teams to have a doctor involved – nearly all members are first-aiders, and many have a specific licence to administer opiates and prescribe from a limited formulary – most of them do.

Dr Syme's involvement began when he moved to Killin to work as a GP at the age of 29. Originally reluctant to join ("I'd done a bit of walking but I wasn't what you would call a mountaineer"), he soon found himself part of the team, hill-bound with stretcher and medicine bag, administering treatment in an environment somewhat different from the one he was used to.

What is in his 'medicine bag' – oxygen, Entonox, vacuum mattress, defibrillator and splints – is largely determined, he says, by the story of what's happened. The same is true for his mode of travel, which could be anything from a Land Rover journey to a long hike to a short helicopter ride, or a combination of all three.

Working on an exposed hillside presents obvious challenges. "In the casualty department, they would cut the clothing off you in a minute. We can't do that," he says. "So you tend to run your hands down the body, pressing. If you get a response you might unwrap that bit.

"Usually in a bad fall you're worried about head injuries and rib fractures. If there is the latter, they might have damaged the lungs underneath. There could be internal organ damage and bleeding. There may be leg fractures. Most often, you're just expecting to stabilise people. You can reduce fractures and




IMAGES: MOUNTAIN RESCUE COMMITTEE OF SCOTLAND

provide pain relief."

What began almost by chance for Dr Syme became a big part of his life, so much so that he was for 15 years the MRCOS's medical officer, overseeing the medical aspects of the service and playing a part in the exchange of information with rescue services abroad.

## Training of a different sort

His successor in that role, Dr Stephen Teale, who took over the baton two years ago, is similarly ensconced in the mountain rescue habit, though his decision to get involved was perhaps more predictable. A long-time climber, he has been volunteering for 18 years and is currently part of the Braemar Mountain Rescue Team.

"A team like Braemar is a climbing club," says Dr Teale, a GP who practises in Insch. "So there's always somebody you can go to the hills with."

With his climbing experience, Dr Teale is part of the technical, rope access, side of the team, as well as offering his medical expertise. When I speak to him, in November, the winter rescue season is well under way for the Braemar team. They have been training for the colder months – when they usually see 10 to 15 major rescues – throughout the autumn.

Keeping in tip-top shape is crucial for the kind of terrain they cover, which includes the likes of Lochnagar, a major winter-climbing area, and Creag an Dubh Loch, south of Ballater.

"A technical lower on some of the big cliffs is a high-risk activity," says Dr Teale. "Creag an Dubh Loch, our biggest, is 1,000 ft – and we've got 800ft ropes. They reach the ground just by the stretch in the rope," he says.

The height is only part of the adversity. On one rescue of a man with a broken ankle at the bottom of Creag an Dubh Loch, Dr Teale and his colleagues narrowly escaped an avalanche which would have swept them over a 30ft drop. The rucksacks they had put down minutes earlier, on their way in to see the patient, were not so lucky. "The cliffs are very slabby and smooth – the snow builds up on the face and it tends to slip off. There's absolutely no way of avoiding that sort of danger," he says.

And once he's got to a patient, the weather often intervenes further, hampering the assessment of a casualty. "It is such a hard environment to work in because you can't take your gloves off, it's always windy, and patients are always well wrapped up."

The kinds of injury seen by Dr Teale are in keeping with the locality. "Long-bone fractures and lower limb fractures are probably the commonest injuries. And for us as a winter team covering the Cairngorms, hypothermia is common. We also see a significant amount of trauma coming from Lochnagar and a lot of injuries that result in death."

## Downward trend in fatalities

Sadly, deaths continue to occur among the hill-going public, but a report published last year showed a distinct downward trend in fatal incidents over the last couple of decades.

One possible factor is highlighted by Dr Syme: "When I started, someone would hurt themselves and one of their pals would have to run down and raise the alarm. Now they can phone up and that makes for a quicker rescue," he says.

Another factor, suggests Dr Teale, is that nowadays people are better equipped when they visit remote landscapes. "They don't go out into the Scottish hills without doing a navigation course and other preparation."

Nevertheless accidents will continue to happen and no matter the advances that are made, there will always be weather in which helicopters cannot fly and terrain that can only be reached on foot or by rope. At times like this a patient stuck out in the middle of nowhere has to be thankful that volunteers like Drs Teale and Syme are prepared to give up their free time to come and help.

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

# Someone to watch o

*Chair-side chaperone is an under-acknowledged role for the dental nurse but one that just might be vital.* Caroline Holland *considers the case*

A CLOSER look at the role of the dental nurse may be timely following the recent introduction of mandatory registration for all dental care professionals. In particular, the chaperone function is frequently undervalued. Now that the dental nurse has, through General Dental Council (GDC) registration, a more official status in the practice, Hugh Harvie, a dento-legal adviser with MDDUS, believes the time is right for this important role to be more fully recognised.

"The dental nurse not only provides clinical assistance at the chair-side but also provides support and comfort to a patient," he says. "Many patients greatly value the dental nurse who often acts as a key interface with the dentist".

This article will examine the role of the chaperone and the GDC's position, and consider who can act as a chaperone in the absence of the dental nurse and what should happen in an 'out-of-hours' setting.

## Other person in the room

The Council for Healthcare Regulatory Excellence (CHRE) lays down guidelines for the regulatory bodies responsible for healthcare providers, including the GDC. It has produced a document called *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals*. As in many documents generic to the provision of healthcare, the ways in which dentistry differs from other professions are not acknowledged. This passage, however, may be applicable to dental practice:

"A chaperone does not need to be a healthcare professional but ideally they should understand the procedures involved in the examination. They should be sensitive to the patient's dignity and privacy, be prepared to support the patient if they show signs of discomfort or distress and be confident to raise concerns about a healthcare professional should suspected misconduct arise."

The value of a chaperone is certainly

# over me

clear in a dento-legal context, says Mary McCann, another dental adviser at MDDUS. "The dental nurse may prove a valuable witness if allegations arise about the professionalism or conduct of a dentist, or if a dispute arises over matters of fact in a complaint or claim of negligence."

While the CHRE guidance says the chaperone need not be a healthcare professional, in dentistry it is almost inevitable that in normal circumstances the chaperone will indeed be a healthcare worker such as a dental nurse. This is because the GDC's ethical guidance, *Principles of Dental Team Working*, recommends "when treating patients, make sure there is someone else, preferably a registered team member present in the room, who is trained to deal with medical emergencies".

This comes under the heading 'carrying out treatment' and is the sole reference to the dental nurse's chaperone role, albeit inexplicit. The GDC's emphasis appears to be in relation to a potential medical emergency. If, however, you are looking for a clear description of the chaperone from the GDC, you will be disappointed.

Hugh Harvie comments: "The GDC provides guidelines as opposed to being prescriptive. This guidance may appear to lack definition but this approach allows consideration to be given to individual circumstances".

One example might be an out-of-hours emergency appointment or domiciliary visit. It might not always be possible to have a dental nurse or trained person present and, in those circumstances, the dentist could request that the patient has a carer or friend accompanying them. Alternatively, the dentist could take a member of his or her family to the practice. Once again, the GDC is not prescriptive, stating in its guidance: "You are responsible for assessing the possible risk to the patient of continuing with treatment in the absence of a trained person".

While there may be an element of discretion, the GDC has demonstrated the value it places on the presence of a third person when treating patients. A dentist from the southeast of England was recently suspended for, among other things, working without a dental nurse, in contravention of GDC guidelines.

## Intimate examination

The GDC view that there should ideally be a third person present in the surgery when patients are being treated is one significant difference between dentistry and other healthcare professions. By contrast, the GMC only recommends that there is a third person present when any kind of intimate examination is undertaken.

While dentistry does not involve examinations of a comparable intimacy to those carried out in a medical setting, the dentist should recognise that certain patients may feel vulnerable. Some employers are unequivocal about the chaperone role of the dental nurse. For instance, an advertisement posted in December 2007 for a senior specialist dental nurse at Scunthorpe General Hospital specified all the duties it wanted performed including: chaperone patients, maintaining privacy, dignity and confidentiality.

Similarly, the Scottish Government's *National Standards for Dental Services* describes the role of the dental nurse in the following way: "A person who assists the dentist at the chair-side during dental treatment, acts as a chaperone, often has administrative duties and infection control responsibilities. They cannot provide dental treatment."

## Part of team working

Outside dentistry, the situation is less clear-cut. This is despite a document produced by the NHS Clinical Governance Support Team and designed to introduce procedures into medical settings. Published in 2005, *Guidance on the role and effective use of chaperones in primary and community settings* is a comprehensive document covering all aspects of chaperoning. But difficulties continue in properly defining the role of chaperone, as reflected in a healthcare briefing paper entitled *Chaperones: a help or a hindrance?* recently circulated by Arnish Goorbin of RadcliffeLeBrasseurs, a top law firm in the medical sector.

"The core problem facing the issue of chaperones is a lack of consistency," states Goorbin. In what situations is a chaperone necessary? "It may be that a female patient is uncomfortable with the touch of a male practitioner without the presence of another person in all circumstances."

Consistency is not so much a problem in dentistry as the presence of a dental nurse is inherent in the concept of 'four-handed dentistry'. A piece of GDC guidance which is highly pertinent is to be found in *Standards for Dental Professionals*: "Co-operate with other team members and colleagues and respect their role in caring for patients".

Hugh Harvie strongly believes that the dental nurse's role as chaperone should command respect. It is so important that, in the absence of a dental nurse, another member of the team should be ready to step in.

"The chaperone role has many aspects, including support and protection for both the patient and dentist and at times acting as a valuable communication interface," he said. "My view is that dentists, hygienists and therapists who have clinical contact with patients should always, where possible, have a member of staff present in the room with them."

■ ***Caroline Holland is a freelance writer on medical and dental matters***

# 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

GMC

## An honest admission

DR A was a 48-year-old GP working in a three-partner practice in a suburban area. One late morning just before the Christmas holidays he was involved in a minor traffic accident. The police smelled alcohol on his breath and Dr A was breathalysed. He was found to be well over the limit and was arrested for drink driving. Dr A contacted the MDDUS at this stage for advice.

In discussions with Dr A it was learned that three months previously his marriage had broken up and he had agreed to move out of the family home. Over the intervening period he stayed in various hotels and B&Bs, drinking heavily in the evenings and at weekends.

In the past Dr A had been a social drinker and at times had worried that he might be an alcoholic but his drinking had never seriously impacted on his work and health. Two years ago his younger brother died of a heart attack and Dr A suffered a period of depression in which his drinking had escalated. He attended a GP in another practice and was prescribed antidepressants. In time the condition eased and he managed to moderate his alcohol consumption.

But with the recent deterioration in his marriage his depression had returned along with the heavy drinking. In the weeks preceding the accident he was frequently late for work and distracted during office hours. A couple of patients had also complained about his off-hand manner and his partners had grown concerned.

**Analysis and outcome**

Dr A was advised to self-refer to the GMC before the traffic conviction was reported and to seek to defend his continued registration on health grounds. MDDUS arranged for medical reports to be prepared by Dr A's GP and a psychiatrist. In response the GMC instituted an investigation which involved, among other things, an independent medical examination. An Interim Orders Panel (IOP) was convened and the evidence considered. The IOP ruled it necessary in the public interest to impose conditions on Dr A's registration. Among these were complete abstinence from alcohol with blood testing to ensure compliance if necessary and continuing treatment for his addiction. Dr A would only be allowed to do work requiring GMC registration under the agreement of his doctors. The conditions were imposed for a period of 18 months. For the drink driving offence his licence was suspended for two years.

Dr A was relieved not to have had his registration suspended. He took a leave of absence from work and underwent psychiatric treatment while attending Alcoholics Anonymous. Six months later he returned to work with his practice on a part-time basis and another 12 months later the conditions on his registration were lifted.

**Key points**

- The prime aim of the GMC is to protect the public and not to punish doctors with health problems.
- Being open and honest about personal problems is always best in dealing with the GMC.
- Ensure that all convictions are promptly reported to the GMC.

## Missed follow-up

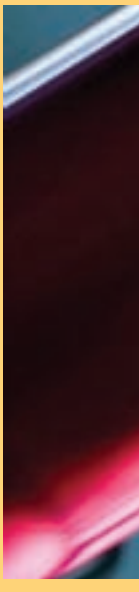
MRS B attended her local practice with a chronic headache and unexplained weight gain. Blood tests were arranged including thyroid function and her thyroxine level was found to be within normal limits but her TSH was slightly elevated. No follow-up action was taken on this result even when the patient presented again later in the year with a respiratory infection.

Mrs B attended the practice for various reasons over the next 6 years and in one consultation the GP noted that her weight had further increased and advised Mrs B to go on a diet. But on no occasion was there reference again to the elevated TSH level.

Six years after the initial consultation Mrs B again attended the practice complaining that she kept getting colds and "felt low". More blood tests were ordered by the attending GP including thyroid function, and her TSH was again found to be elevated. A note on the results form read – "mild hypothyroidism" – and an action stamp was applied to the form indicating the test should be repeated in 2 months. There was no record in the notes of the abnormal test result being communicated to Mrs B nor any follow-up.

Mrs B presented at the practice three years later with a bilateral goitre. Blood tests revealed a seriously elevated TSH level and the GP initiated treatment with thyroxine. The patient was referred to a surgical clinic. Later that year she underwent a total thyroidectomy to remove the goitre. The operation proved difficult and damage occurred to the recurrent laryngeal nerve, causing paralysis of the right vocal cord. Mrs B needed speech therapy to regain limited use of her voice and had to give up her job as a result of the complication.

Upon learning of the original abnormal thyroid function test and the lack of any follow-up or subsequent treatment Mrs B contacted her solicitors and a letter of claim was received by the practice. The claim alleged that the practice was negligent in failing to follow-up



# A reasonable expectation?

MRS Y, 48 years old, was referred by her GDP to Dr K, an experienced specialist in restorative dentistry. Mrs Y had previously had a full upper denture to replace teeth missing since her early twenties but had always wished to have a prosthesis that was not removable. To this end implants seemed a reasonable option.

Dr K carried out a full clinical examination and referred the patient for panoramic X-ray. After planning the case, he discussed the options with Mrs Y. Implants were placed in her upper jaw followed by full-arch temporary bridgework. The appearance and occlusion of the bridgework was assessed a month later and refined to serve as a template for the definitive bridgework.

In a subsequent visit Mrs Y expressed dissatisfaction with the final restorative work, complaining of poor function with cheek biting and speech problems which included air leakage around the bridgework and lisping. She was also unhappy with the appearance of the upper teeth, complaining they were "too short". Some slight adjustments were made and further review was organised, but Mrs Y phoned to cancel the appointment.

Another 8 months later Dr K was contacted by Mrs Y's GDP and another appointment was arranged. Again the patient expressed dissatisfaction with the bridgework – her main concern still being the speech problems. Dr K offered then to remove the fixed bridgework and apply a flanged overdenture prosthesis to overcome the problem of air escape. But Mrs Y was unwilling to accept this solution.

Two years later a letter of claim for damages arrived at the practice from Mrs Y's solicitors.

**Analysis and outcome**

An expert report obtained by Mrs Y's solicitors stated that the standard of care provided by Dr K was not satisfactory both in terms of functionality and aesthetics. A second expert opinion commissioned by MDDUS did acknowledge possible differences of opinion about the design of the bridgework but there was nothing that constituted negligence on the part Dr K. The expert noted that the position and the placement of implants could have been influenced by atrophy of the alveolar ridge – especially after so many years with removable dentures. He also observed that patient expectation can often be unreasonably high in implant therapy and it is important that the potential limitations are carefully explained.

In considering the patient records, X-rays and study models the expert judged that Dr K was not at fault in his treatment planning and execution of the dental work but that his records were lacking in detail. Detailed notes of patient consultations in which risks and patient expectations are discussed make such claims easier to defend.

It was decided that Dr K's case should be defended rather than settled but, in the end, Mrs Y decided to the abandon the claim. This was on the grounds both of further potential legal costs (which she would be required to pay if she lost the claim) and in consideration of the MDDUS contention that her claim had been filed beyond the period of limitation, thus making it unlikely that the court would allow the claim to proceed.

**Key points**

- Full and comprehensive notes are essential in defending claims of negligence no matter how experienced the clinician.
- A sympathetic approach to patient concerns can often prevent complaints escalating to claims.
- Limitations of treatment in comparison to patient expectations should be noted in the records, including that this has been discussed with the patient.

IMAGE: CHRIS KNAPTON/SCIENCE PHOTO LIBRARY



on the two abnormal tests and monitor Mrs B's TSH levels such that treatment could have been initiated at a reasonable stage.

**Analysis and outcome**

It was argued that had Mrs B been started on T4 replacement the goitre development might have been arrested and surgery, on that particular instance, would not have been necessary. Negligence was not alleged in the nerve damage during the surgical procedure – only that the operation should have been avoided.

The GPs involved admitted liability and the case was settled for a substantial amount. The practice has since conducted a full review of its records procedures in regard to laboratory results handling to ensure that such system failures are not repeated.

**Key points**

- Ensure robust systems for flagging abnormal results for review.
- Make sure that abnormal results are adequately followed-up and communicated to patients with a full explanation of significance.

## From the archives:
# The celestial bed

IN 18th century Britain there was sometimes little to distinguish established medical men from the quacks and mountebanks that roamed the country. James Graham was born in Edinburgh, the son of a poor saddler, and apprenticed as an apothecary but never finished his training. In later travels as an itinerant healer and lecturer he picked up some unorthodox methods. On a visit to America he developed an interest in the recent experiments of Benjamin Franklin into the principles of electricity and magnetism. Here he conceived the idea that "electricity invigorates the whole body and remedies all physical defects".

Upon his return to Britain, Graham developed various devices employing electricity to treat ailments. Sir Walter Scott was one of his patients, having mild electrical charges applied in an attempt to treat weakness in his leg resulting from polio suffered as a child.

Graham's success allowed him funds to open in 1780 a grand "Temple of Health" on the banks of the River Thames in London. It featured an electrified bed in which childless couples could boost sexual


IMAGE: GETTY IMAGES

enjoyment and fertility. One session in his "celestial bed" cost up to £100 – by no means an insubstantial fee at the time. A later version of the bed was 12 feet long – resting magnificently on 40 glass pillars and surrounded by mirrors. The mattress was stuffed with hair "from the tails of English stallions".

Graham was a masterful self-promoter and has been called the first sex therapist. He even provided advice to the childless Georgiana, Duchess of Devonshire (recently portrayed by Keira Knightley in the film *The Duchess*). But his fortunes in London eventually declined along with the shifting moral climate of the time. He ended his days in Edinburgh, eking out a living as a healer offering advice on hygiene and healthy living. He died suddenly of a brain haemorrhage at the age of 49.

*For more read* Doctor of Love: James Graham and his Celestial Bed *by Lydia Syson, Alma Books; 2008.*

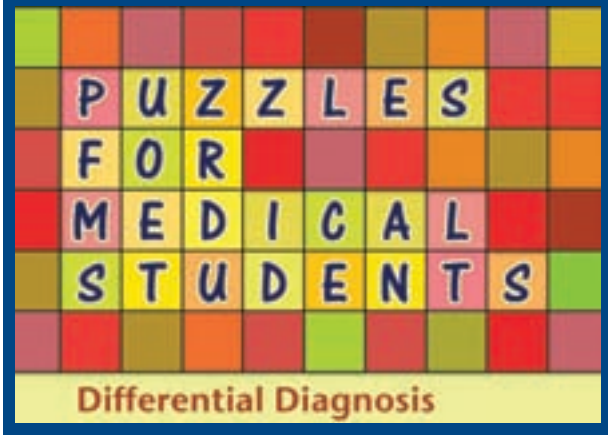
## Object obscura:
# Bakelite face phantom

IMAGES: SCIENCE AND SOCIETY PICTURE LIBRARY

**THIS Austrian surgical simulator was used for practising eye operations and was made by Leiter of Vienna in the early 20th century.**

## Medical Wordsearch: causes of hypoglycaemia

**Find 16 causes of hypoglycaemia 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: the engineering surgeon Norman Dott (1897-1973)

THE factors which determine success in any one surgical career can be difficult to analyse. A compassionate concern for patients and a meticulous attention to detail are two which most would regard as essential. Norman Dott had both of these in abundance: his compassion for patients sharpened by his own experiences, and his attention to detail the result of his training in and aptitude for engineering.

Norman McOmish Dott was born in Colinton on the southern outskirts of Edinburgh. His forbears were Huguenots, originally called D'Ott, who had settled in Fife and his grandfather, Aitken Dott, had founded the Firm of Art Dealers, Aitken Dott and Son (now trading as The Scottish Gallery) in Edinburgh.

His father, Peter Dott, developed the firm and in his early days was a supporter of the Scottish colourists, particularly SJ Peploe and William McTaggart.

After schooling at George Heriot's School, Dott became an engineering apprentice. Riding his motor cycle home one day he was involved in a collision which resulted in multiple fractures of the left leg. In The Royal Infirmary he came under the care of Henry Wade who decided not to amputate the leg. The incident left him with a permanent limp but inspired him to pursue a career in surgery.

The following year he enrolled as a medical student in Edinburgh, graduating in 1919 and becoming a resident in The Royal Infirmary. After obtaining the Fellowship of The Royal College of Surgeons of Edinburgh, he worked as a lecturer in physiology under Professor Sharpey-Schafer who had marked him out as an outstanding student. Here his researches included the effects of pituitary ablation, work which led to the award of a Rockefeller Fellowship with Harvey Cushing, in Boston. If Godlee (Joseph Lister's nephew and biographer), Macewen and Horsley were the pioneers, it was Cushing who refined and made safe modern neurosurgery. Working with Cushing inspired the young Dott – both were perfectionists, original thinkers and tireless workers.

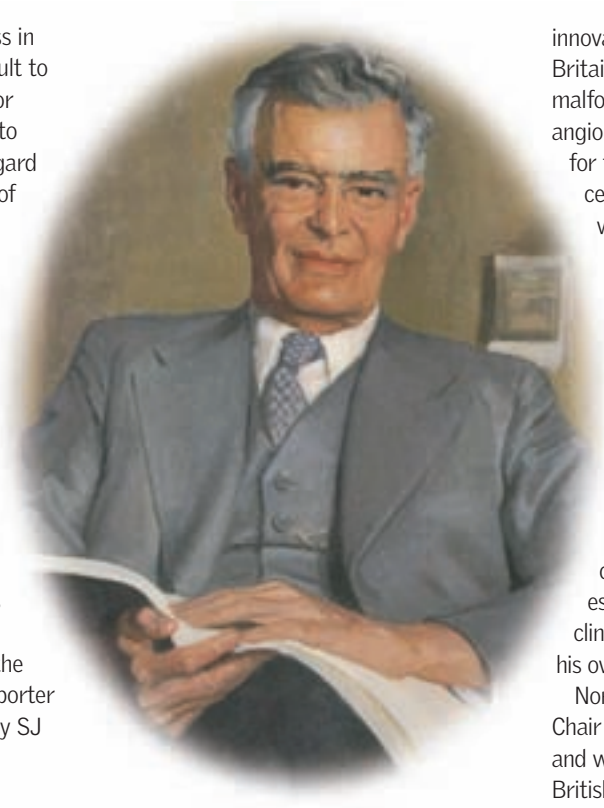

IMAGE: THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

Returning to Edinburgh in 1924, Dott embarked on a career in surgical neurology. The facilities did not exist for this fledgling specialty and he was required to improvise. His initial appointment was to the children's hospital, where he established the equipment, but adult neurosurgery was performed in nursing homes to which he took his equipment by car or taxi.

In those early days his repertoire encompassed much of paediatric surgery and he would later commend this as valuable training for any branch of surgery. His observations on the malrotation of the intestines in the neonate, published in 1924, and illustrated with his own drawings, helped both the understanding and management of this condition and the paper remains a classic to this day. It was Sir David Wilkie, Professor of Surgery, who offered him adult beds in The Royal Infirmary which led to the establishment of the Neurosurgical Unit in Ward 20.

As a result of his drive, the Department of Surgical Neurology at the Western General Hospital was established and he was largely responsible for the design. His pioneering spirit resulted in some notable innovations. He was the first person in Britain to demonstrate an arterio-venous malformation in the brain using angiography. He pioneered the operation for treating aneurysm of the middle cerebral artery by wrapping the lesion with muscle.

Throughout his life he retained his engineer's love of design and invention. His clamps for intestinal anastomosis remained in use in Edinburgh until the end of the 20th century. He designed retractors, traction callipers and operating tables, all with an engineer's precision and care for detail. Well into retirement he responded to the challenge of a colostomy by establishing Edinburgh's first stoma clinic, inevitably designing and producing his own stoma appliances and devices.

Norman Dott was the first holder of the Chair of Neurological Surgery in Edinburgh and was instrumental in establishing The British Society of Neurological Surgeons. He became President of that Society and Vice President of The Royal College of Surgeons of Edinburgh and was gazetted CBE. But of the many honours which came his way, that which he said gave him greatest pleasure was being made a Freeman of his native City of Edinburgh in 1962.

His philosophy of "do what is best for the patient" endeared him to the lay public to a greater extent than that enjoyed by most surgeons. Perhaps this was the result of his lifelong experiences as a patient – saved from an amputation by Sir Henry Wade, having a chronically painful hip fused by Sir Harry Platt, leg shortening by Sir Walter Mercer, a cordotomy for chronic pain by his friend Sir Geoffrey Jefferson and a colostomy by Tom McNair. Experiences of life as a patient undoubtedly contributed to his greatness as a surgeon.

**Iain Macintyre**

*Grateful acknowledgement is made to Iain Macintyre FRCSEd and Iain Maclaren FRCSEd, and the Royal College of Surgeons of Edinburgh for permission to publish this article adapted from the book* Surgeons' Lives *published by the RCSEd in 2005.*

# Leading through uncertainty – a course for doctors

MDDUS is offering an intensive 5-day course aimed at doctors in leadership positions. Based on competencies evolved from the General Medical Council's (GMC) *Management for Doctors*, the development programme includes:

- communication and managing conflict
- problem solving and decision making
- project and change management
- building a creative safety culture
- clinical and non-clinical risk management
- emotional intelligence in leadership.

Leading through Uncertainty is designed to challenge participants as leaders and help positively change the way teams are managed.

**DATES**

- MDDUS Glasgow office: 26 February, 12 March, 30 April, 14 May, 4 June 2009
- MDDUS London office: 17 February, 17 March, 28 April, 26 May, 30 June 2009

**COST**: members £695 + VAT; non-members £795 + VAT

Contact: Liz Price, Training, Consultancy and Business Services Manager; Telephone: 0845 270 2034; Email: education@mddus.com

# Mock employment tribunal

Practice managers, GPs and GDPs responsible for the management of staff are invited to attend a mock employment tribunal to be held at the MDDUS Practice Managers' Conference on Thursday, 5 February 2009.

Witness the court proceedings and air your views on how the judgement should go before learning the decision of the tribunal and the reasoning behind it. The programme will also include an additional session on how to avoid the employment pitfalls highlighted in the tribunal.

Hosted by MDDUS and Law At Work
Delegate fee: £80.50
Additional members of the practice: £63.25
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