

Autumn 2010

# SUMMONS

**MDDUS** JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND



• Doctors in sport • Dental SEA • What place for homeopathy? •



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*cynical and otherwise*

FOURTH EDITION

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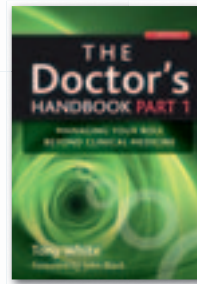
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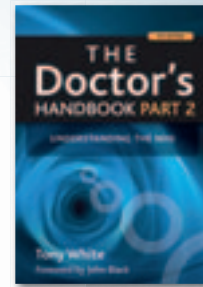
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*a practical guide*

**Edited by Roba Khundkar, Samantha De Silva and Rajat Chowdhury**, *respectively Specialty Registrar, Plastic and Reconstructive Surgery, Queen Elizabeth Hospital, Birmingham; Specialty Registrar, Ophthalmology, John Radcliffe Hospital, Oxford; Specialty Registrar, Radiology, Southampton General Hospital.*  
**Foreword by John Black and Tim Goodacre**, *respectively President, Royal College of Surgeons of England; Vice President, British Association of Plastic, Reconstructive and Aesthetic Surgeons, and Council Member, Medical Defence Union*

Outlines the consent process for common surgical procedures, including procedures from subspecialties such as cardiothoracic surgery neurosurgery, general surgery paediatric surgery, plastic and reconstructive surgery, trauma and orthopaedic surgery, otolaryngology and urology.

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## IN THIS ISSUE

I read recently on the web that front man of the band Kiss, Gene Simmons, has his tongue insured for \$1 million. On the same site it's claimed that Keith Richard's middle finger is covered for \$1.6 million while Heidi Klum's legs are insured for \$2.2 million – one of them for only \$1 million because it has a scar. Such policies may be mostly PR stunts but they do reflect a genuine risk.

Imagine an orthopaedic surgeon operating on the knee of Argentinean footballer Lionel Messi. Last year the player earned an estimated £29.6 million. It would take some deep pockets to bear the financial risk of a medical error ending such an athlete's career. It's for this reason MDDUS has adopted a policy of not providing indemnity to doctors currently employed full-time by clubs in the English Premiership, English Championship and the Scottish Premier League. The risk to the Union has been judged too great.

But such a policy does not mean that MDDUS is averse to doctors working with athletes and on page 14 our risk adviser Peter Johnson highlights two sports medicine courses that can help mitigate risk for pitch-side doctors.

Also in this issue we feature a Q&A (p. 10) with GMC chair Professor Sir Peter Rubin in which he discusses evolving plans for revalidation and other changes facing medical professionals in the UK. On page 12 Adrian O'Dowd looks at growing opposition to NHS funding for homeopathic remedies, and on page 18 David Macpherson of NES offers a primer on significant event analysis (SEA) as a means for dentists to comply with clinical audit requirements.

And this issue's clinical risk article takes us back to sports medicine with tips on managing head injuries.

Jim Killgore, editor



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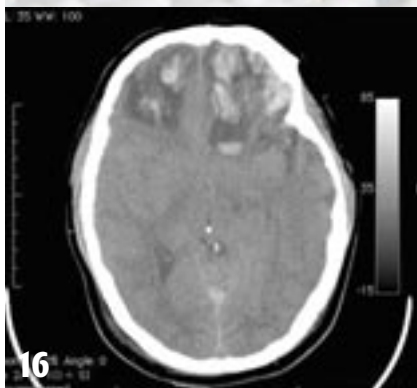
Head injuries –avoiding the pitfalls in diagnosis and management of head-injured patients

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Clinical audit is a requirement for all dentists but it need not be a box-ticking exercise



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Astley Clarke.



Cover image: Pool by George Devlin. Devlin studied at Glasgow School of Art from 1955 to 1960 where he won the premier awards and top national scholarships from the Royal Scottish Academy before studying extensively in Europe.

Last issue's cover was mistakenly attributed to George Devlin but was, in fact, Orange and Red on Pink by Wilhelmina Barns-Graham (1912-2004)

Art in Healthcare (formerly Paintings in Hospitals Scotland) works with hospitals and healthcare communities across Scotland to encourage patients, visitors and staff to enjoy and engage with the visual arts. For more information visit [www.artinhealthcare.org.uk](http://www.artinhealthcare.org.uk), Scottish Charity No: SC 036222. Photograph: Roslyn Gaunt

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**Donald joins MDDUS Board at London AGM**



Dental columnist Robert Donald joins the MDDUS board

Magazine columnist and dentist Robert Donald attended his first annual general meeting as an MDDUS board member in September.

Robert is a full-time general dental practitioner based in Nairn and has been an elected member of the BDA's Scottish Dental Practice Committee since 1994. He served as chairman of the Committee for a time and currently sits on its executive. He is also an elected member of the UK General Dental Practice Committee and has served as Secretary of Highland LDC since 1990. He is a former director of Highland Dental Plan and a former chairman of Independent Care Plans (UK).

Robert is currently a consultant editor and columnist for *Dentistry Scotland* and was a regular contributor to the *Scottish Dentist* magazine for several years.

Mr Donald said: "I am delighted to be involved with the MDDUS as a non-executive director as it expands its operations south of the border. Having been a member since qualification, I greatly appreciate the service that the union provides."

MDDUS held its one hundred and seventh AGM at its new London office at Pemberton Row, close to the capital's legal centre, which opened in February of this year.

The move away from the traditional AGM venue at our Glasgow headquarters reflects the latest membership figures for

MDDUS which reveal that for the first time in its history, the majority of the organisation's GP members and just under 50% of all members are now based outside Scotland.

**New equality laws come into force**

Tough new laws to combat discrimination have come into force from October 1 and will have an effect on employment practices.

The Equality Act 2010 aims to protect the rights of individuals and promote equality by updating and strengthening existing legislation. It is made up of a number of different provisions which will be introduced in stages to allow individuals and organisations time to prepare.

The vast majority of the act's provisions came into force on October 1 when the various pieces of discrimination legislation were brought together into one law. The act extends its provision to:

- Third party harassment
- Associative discrimination
- Perceptive discrimination
- Indirect discrimination

The changes mean employers face increased responsibilities to protect their employees from harassment on the basis of race, disability, religion, sexual orientation, gender or age. The government has described the laws as "a simple, modern and accessible framework of discrimination law" but practices may find them challenging to implement.

Under the new rules, employers will be responsible for protecting employees from harassment from a third party. This could be an individual who is not an employee such as a locum GP. Employers will also have to be aware of rules over discrimination by association where they must protect employees from being harassed or bullied about someone associated with them. This would mean an employer being held responsible if, for example, someone makes jokes about the age of an employee's partner.

Indirect discrimination also now covers disability and gender reassignment, while perceived discrimination extends to employees who are perceived as having a protected characteristic.

The Equality Act also aims to make it more



**Update your contact details**

Do we have an up-to-date email address and mobile telephone number for you? It's important that MDDUS is able to contact members if necessary – and possibly at short notice. So please email [membership@mddus.com](mailto:membership@mddus.com) with your name, membership number and mobile telephone number to allow us to update your contact details.



**IN BRIEF**

**• CORE DENTAL CPD**

The University of Glasgow is running a one-day conference designed to help dentists and DCPs meet GDC requirements for verifiable core CPD. The event is being held at the Leeds Marriott Hotel on 18 November and topics include

medical emergencies, radiography and radiation protection, legal and ethical issues, and handling complaints (presented by MDDUS head of dental division, Mr Aubrey Craig). For a conference leaflet and more information go to [www.tinyurls.co.uk/M12585](http://www.tinyurls.co.uk/M12585)

**• GPST MAGAZINE LAUNCHED**

MDDUS has launched a new publication aimed at GP specialist trainees. *GPST* is packed with practical articles and features aimed at doctors embarking on a career in general practice. Contact [gpst@mddus.com](mailto:gpst@mddus.com) to request a PDF or print copy.



difficult for disabled people to be screened out when applying for jobs by restricting the circumstances in which an employer can ask about disability or health issues.

For more information on the Equality Act log onto [www.tinyurl.com/2gyrk5n](http://www.tinyurl.com/2gyrk5n)

For further guidance on HR and employment law issues, contact the MDDUS Employment Law Team on 0845 270 2034. **Janice Sibbald, employment law adviser, MDDUS**



### ➔ Medico-legal report writing

MDDUS is looking for experienced general practitioners to prepare and write medico-legal reports for the purpose of assisting the organisation and its members. These can be for claims for damages, coroner's inquests, fatal accident inquiries or a variety of disciplinary or GMC matters. Many GPs will already be undertaking this kind of work and have some experience in this field. Reports are, of course, paid for and the fees reflect the current rates available for this work.

Experience in medico-legal work is not essential. However, we have basic requirements for experience in general practice of not less than eight years and possession of an MRCPG qualification.

If you are interested and want to know more please contact **Dr Jim Rodger**, Head of Medical Services, MDDUS, Mackintosh House, 120 Blythwood Street, Glasgow, G2 4EA (tel. 0845 270 2034); email at [jrodger@mddus.com](mailto:jrodger@mddus.com)

### ➔ Risk alert: delegate with care

Should new government plans for healthcare reform in England come to pass one thing is certain – the GPs affected will be doing a lot more delegating. How else will they find time to run the NHS?

Delegation has been an increasing area of controversy in primary care over the last ten years with the rise of the nurse practitioner and healthcare assistant. In medico-legal terms it is a common area of risk but not due to the overall quality of care offered by nurses and HCAs.

The GMC frames the issue clearly in *Good Medical Practice*: Delegation involves asking a colleague to provide treatment or care on your behalf. Although you will not be accountable for the decisions and actions of those to whom you delegate, you will still be responsible for the overall management of the patient, and accountable for your decision to delegate. When you delegate care or treatment you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved. You must always pass on enough information about the patient and the treatment they need."

Each year MDDUS deals with many cases in which there has been a failure at the interface between GPs/GDPs and practice staff. A typical example would be a nurse asked to syringe a patient's ear. In one such case a practice nurse carried out the task under a GP's instruction but neither had ascertained that the patient had previous ear surgery, which is an absolute contraindication. Both were named in subsequent legal action although the nurse claimed she was just carrying out the task as ordered.

Here the case hinges on passing information but more often cases are to do with a failure to ensure that staff have appropriate training for carrying out a task such as taking blood. It is the responsibility of the GP to be satisfied that a delegated task is within a staff member's competence.

A similar regulatory principle holds for members of the dental team. The General Dental Council states in *Principles of Dental Team Working*:

"If you employ, manage or lead a team, you should make sure that all the members of your team understand their roles and responsibilities, including what decisions and actions have and have not been delegated to them..."

"Only carry out a task or a type of treatment if you are sure that you have been trained and are competent to do it.

"Only ask another member of the team to carry out a task or a type of treatment if you are confident that they have been trained and are competent to do it."

It is clear there is a shared responsibility to ensure that all medical or dental treatment is carried out only by appropriate and fully trained staff. But the ultimate responsibility for ensuring this is the case must rest with the employing GP or GDP and it is here that any major liability will certainly be borne. Remember also to keep good records of all staff training as proof of competence.

### ● WIN A HAND-PAINTED LES PAUL GUITAR

The charity Art in Healthcare (who supply our *Summons* covers) is raffling a hand-painted Gibson Les Paul guitar, donated by Gibson and the Hard Rock Café, Edinburgh. A winner will be drawn on 31 December

with all proceeds going to the charity. Tickets cost £1. For more information go to [www.artinhealthcare.org.uk](http://www.artinhealthcare.org.uk)

● **PRIMARY CARE LIVE**  
HR and employment law adviser at MDDUS, Janice Sibbald, will be one of the expert speakers at the

dedicated practice management stream at the Primary Care Live Conference being held in London's ExCeL on September 29-30 and then in Manchester Central on November 25-26. She will discuss the latest developments in employment law legislation

including the recent changes to the retirement process and new equality laws that come into force in October (see above). Admission is free to healthcare professionals. More details at [www.tinyurl.com/39tdtrw](http://www.tinyurl.com/39tdtrw)



## Doctors' beliefs influence end-of-life care

DOCTORS who have no strong religious beliefs are almost twice as likely to hasten the death of a very sick patient, according to new research. The report in the *Journal of Medical Ethics* found that doctors with a strong faith are less likely to discuss this type of treatment with a patient.

Almost 4,000 UK doctors from a range of specialties responded to a survey asking about their religious beliefs. Researchers then asked whether they supported the legalisation of assisted dying, whether they had ever provided continuous deep sedation until a patient's death, whether they had knowingly taken a decision that had hastened the end of a patient's life, and whether in taking that decision they had discussed it with the patient beforehand.

Irrespective of specialty, doctors who described themselves as "extremely" or



"very non-religious" were almost twice as likely to report having taken these kinds of decisions as those with a religious belief. The most religious doctors were significantly less likely to have discussed end-of-life care decisions with their patients.

Professor Clive Seale, professor of medical sociology at Queen Mary, University of London, said in the *BMJ*: "Religion plays quite a big part in influencing what GPs think and do when they are dealing with end-of-life care decisions... If I were a patient approaching the end of my life, I would want a discussion about religious views with my GP."

## Plans revealed for simpler revalidation

GPs UNDERGOING revalidation will be asked to submit fewer reports than previously thought, according to RCGP revalidation lead Professor Mike Pringle.

He said GPs will have to fill out one multi-source feedback (MSF) questionnaire and one patient survey every five years, rather than two of each as previously proposed. The move was reported in *GP* magazine where Professor Pringle said the policy decision had been made, and would be outlined in the next version of the college's revalidation guide, due to be released before Christmas.

Professor Pringle said the change was a "key area" that would make a significant difference to GPs in revalidation. He told *GP*: "The decision has largely come in response to the GPC, which has been helpful in looking at the guidance and at where it thinks the proposals can be streamlined. It is currently my intention that the next version of the revalidation guide will reduce the expectation of the MSF and patient surveys."

The changes were confirmed as the GMC claimed its latest revalidation plans had received "huge support" from both doctors and patients. GMC chief executive Niall Dickson said there was "strong backing" for many of the proposals including the move to a more streamlined process, but he admitted there were concerns about how revalidation will work in practice and when it will be introduced.

A full report on the revalidation consultation will be published on October 18 which will include a timetable for the introduction of the scheme across the UK.

## GDC consultation on dental education

A REVISED approach to dental training has been set out in a new GDC consultation document. *Learning Outcomes* is intended to replace both the undergraduate dental curriculum set out in *The First Five Years* and the DCP curricula *Developing the Dental Team*.

The GDC is seeking views on the document from various groups including dentists, dental and DCP students, those involved in dental training and education, professional associations and other regulatory bodies. The GDC said the content was guided by the priorities of the government White Paper *Trust, assurance and safety* which include:

- safety and quality of care for patients
- sustaining, improving and assuring professional standards
- no unnecessary burdens
- UK standards with country-specific flexibility.



The council has focused on four key areas: clinical, communication, professionalism and management and leadership. *Learning Outcomes* sets out the GDC's expectations for each different registrant group.

Education committee chairman Kevin O'Brien said: "The aim is to develop a rounded professional who, in addition to being a competent clinician or technician, will have the range of professional skills required to begin working as part of a dental team and be well prepared for independent practice."

For more information go to [www.gdc-uk.org](http://www.gdc-uk.org)

## IN BRIEF

● **MANDATORY CQC REGISTRATION** All dental practices in England should now begin the process of registering with the Care Quality Commission as more than 8,500 providers of dental services will be required to register by 1 April 2011. Providers applying as a

partnership or organisation will be required to have a registered manager. The CQC has issued guidance which is available on its website or in hard copy. For more information visit [www.cqc.org.uk/dental](http://www.cqc.org.uk/dental) or phone an adviser at the national contact centre (NCC) on 03000 616161.

● **MEDICAL MANAGEMENT FACULTY PROPOSED** Proposals for a new Faculty of Medical Leadership and Management are being developed by the RCGP and RCP on behalf of the Academy of Medical Royal Colleges and other stakeholders. The faculty is intended

to prepare doctors for leadership roles to enable them to "better deliver on their multiple commitments to the patient, to fellow professionals and to the organisations and systems within which healthcare is provided". See [www.tinyurl.com/393q52u](http://www.tinyurl.com/393q52u) for more details.

## OPINION



By Dr Gail Gilmartin,  
Senior Medical Adviser, MDDUS

## Blue book redux

Twenty years ago, not so long to many of us in practice today, the GMC published the 'blue book' containing its considered wisdom on good ethical practice for the medical profession. The booklet ran to 35 pages and covered, well, everything a doctor needed to know in relation to professional ethics, as well as information about the GMC's disciplinary processes.

Today we have in the order of 20 GMC booklets and a range of web materials, some very clever and interactive – but as I read the recent guidance on end-of-life decisions it struck me that not much has really changed.

In the very old days – pre-GMC – medical ethics existed in a variety of forms, some ancient indeed. The Hippocratic Oath, for example, involves the physician swearing to use his abilities to benefit the sick and do no harm, to remain free from intentional injustice, not to "use the knife" but to defer in this work to those who have the

necessary skill and to keep to himself all that he sees or hears in the course of treating a patient.

The Oath states further that there will be no "mischief" of a sexual nature with patients, that the physician will not administer a deadly drug to those who request such, nor would he give a woman an abortive remedy. Serious attention is also paid to allegiance with colleagues and teaching.

Much of this resonates in modern times. The blue book covers many of the same issues; for example, personal responsibility to act in the patient's interests, to maintain confidentiality, not to abuse professional privileges in personal dealings with patients, to refer to appropriate specialists and to desist from disparaging colleagues. Mention is also made of complying with abortion legislation.

None of this is surprising in a field which has been around in one guise or another for some 5,000 years (I am not including prehistoric remedies but the Ancient Egyptians had formalised medical practice). Basic ethical codes such as beneficence, non-maleficence, respect for autonomy and justice are common threads and one would expect these codes to have stood the test of time.

So in considering GMC guidance today what has changed?

There is certainly a lot of detailed explanation about the circumstances doctors face in their day-to-day practice and what would be the most appropriate action. There is often a range of next best options too. Today medicine comprises a huge variety of different specialities and

each has its own particular factors which may lead to difficult professional ethical decisions; for example, the neonatologist will have very different considerations compared to a sexual health physician. The new guidance reflects this broadened scope.

For years medical professionals have sought clarity from the GMC on making appropriate choices and avoiding potential disciplinary challenges – and the GMC has responded. We now have a lot of descriptive guidance. Some of it may not be terribly helpful, depending on the field in which you practice. But the core guidance remains in *Good Medical Practice*.

Doctors are still required to make the patient's care their priority, respect patients and not discriminate unfairly, maintain confidentiality and act with honesty and integrity. Please forgive this very brief summary but this piece does not allow too much detail – which I hope is not necessary to make the final point.

Keeping abreast of the most up-to-date detailed guidance from the GMC can prove challenging – especially if it appears that some of the guidance is not for you. However, it is essential that we are aware of the profession's stance on important issues.

No doubt the 'blue book' lives on in *Good Medical Practice* and practitioners should at least be familiar with that publication – it covers all the basics. And whilst most of us would find no surprises in there it is important to be reminded of the standards we hold as a profession. Any lack of awareness of these standards may well lead to significant difficulty.

### ➔ GDC acts on fitness to practise delays

A 40 PER CENT rise in the GDC's fitness to practise (FtP) case load has prompted the regulator to consult on a rule change that will allow the employment of 50 more panel members.

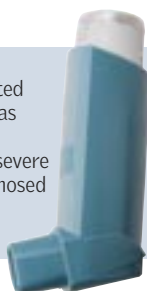
The rise in case load is being blamed for a backlog and delays in getting cases heard and the GDC is focusing resources in this area as a priority to speed up the process. FtP panel members sit on public hearings, which are the final stages of investigations into dental

professionals. Panel members can be asked to make difficult decisions about whether the GDC should step in to set out how and if a dental professional should carry on working.

Before the Council can increase FtP panel member numbers it must consult as this requires a change to the Council's Constitution of Committees Rules 2009. The consultation is available on the GDC's website at [www.gdc-uk.org](http://www.gdc-uk.org) and will run until 22 October 2010.

### ● TREATING SEVERE

**ASTHMA** Research reported last month in *The Lancet* has found that at least half of children with problematic severe asthma have been misdiagnosed or are using prescribed treatments incorrectly.



The authors conclude that a thorough multidisciplinary assessment should result in these children being successfully managed with standard treatment. Go to [www.tinyurl.com/2b9xqak](http://www.tinyurl.com/2b9xqak) for the full citation.

### ● ASPIRIN TO REDUCE HYPERTENSION RISKS IN PREGNANCY

Pregnant women at high risk of developing hypertensive disorders in pregnancy should be encouraged to take small doses of aspirin to help prevent complications, according to recent NICE guidelines.

The new guidance recommends that a low dose (75mg) of aspirin should be offered daily to women at high risk of developing hypertension in pregnancy, such as those with chronic kidney disease, autoimmune disease, diabetes or chronic hypertension. Go to [www.guidance.nice.org.uk/CG107](http://www.guidance.nice.org.uk/CG107)

## BE WARY OF JOB DRIFT

*Ian Watson*

**IT IS ARGUABLY** a manager's greatest wish that the staff he or she manage not only do a good job – but also take on extra responsibilities without bidding and for no extra pay. Yet there can be some unforeseen disadvantages to such willing horses.

Most job descriptions these days contain a clause stating that the employee will be expected to take on such reasonable extra duties as are allocated to them by their manager. If such flexibility is not built into the contract of employment there is a risk that employees may insist that any extra duties are not their responsibility and/or that they require extra recompense for undertaking them. In any case, there is an argument that, in the event of a dispute on the matter, such flexibility might be implied into contracts of employment, even if the requirement is not expressly stated in the documentation.

More common is the situation where the range of duties undertaken is not formally amended but the employee drifts into performing work that needs to be done and the manager simply allows them to do so, for convenience. In the majority of cases, this is unproblematic.

However, a downside of allowing this 'job drift' is that the best and most willing performers get the heaviest workloads – with the risk for them of burnout (or, at least, diminishing productivity). It also means that other staff who might require development (or, indeed, to be kept fully occupied) avoid these tasks.

Another risk, of course, is that staff who are taking on 'extra' duties (albeit with the acquiescence of their manager) may find that the new duties are more interesting, amenable or even taxing, than their original "mundane and boring" work. It is a natural progression from this to allowing the more mundane work to slip down their list of priorities and the manager then finds that mistakes or missed deadlines are creeping into the staff member's performance.

From the viewpoint of the staff member, there can be a risk that, having agreed to carry out extra work over and above their normal duties, it becomes over time an

implied part of their contract of employment. In other words, they are transformed from being willing volunteers into press-ganged workers. Naturally, this can play into the hands of an unscrupulous employer. Conversely, allowing a drift away from an employee's basic contractual duties to more interesting work can mean that a clever employee can argue, after an appropriate period of time has elapsed, that the new duties are now contractual and old duties have 'dropped off' their job description.

All of this suggests that allowing staff to carry out more stretching or important tasks can be a vital part of maintaining motivation and loyalty to the organisation – or meeting a short-term need in the workplace. However, as the list of disadvantages above suggest, it might be important for any such job drift to be done relatively formally and in a planned way rather than pragmatically or chaotically (or even by stealth).

The annual appraisal review process can give manager and staff member the opportunity to review the relevance of the formal job description. It is perfectly legitimate (indeed, essential) for such a

discussion – about exactly what the employee does day to day – to precede any assessment of how they have performed those duties in the past review period. If there is agreement at the appraisal meeting that the job description needs to be revisited and the new role formalised in an amendment to the contract of employment, then this can be a logical agreed action resulting from the annual appraisal. The contract will have been varied by agreement and will then be legally binding on both parties. Of course, this permanent change may have implications for grading of the job or, possibly, the salary of the job holder.

If it is agreed at the appraisal that the job drift was a mistake or only intended to be short term, or that these duties should more usefully be performed by someone else, the arrangement can be terminated without contractual implication for either party.

The message is – don't look a willing worker in the mouth, but ensure that you don't flog that horse to death! ■

*Ian Watson is training services manager at Law At Work*







## PRIVATE LIVES, PUBLIC DEBATE

Deborah Bowman

**IT'S THE TIME** of year when I am star-struck. I am a panelist on the programme *Inside the Ethics Committee*. As a passionate Radio 4 listener, spotting Jenni Murray in the loo, Evan Davis in the BBC canteen and sharing a studio with the *Woman's Hour* cooker cause me much excitement. Aside from glimpsing radio idols, participating in the series has been fulfilling and thought-provoking, prompting reflection on the relationship between ethics and the media.

Ethics is (despite what medical students sometimes feel) a sexy subject. People's lives become 'stories' daily. Ethical debates rage in the news, on discussion programmes, in broadsheet editorials and tabloid headlines. Ethical issues are a rich source for dramatic work: *Inside the Ethics Committee* has been accompanied by three plays.

Requests from journalists and producers are common in my working life yet I confess to ambivalence about ethics and its presentation in the media. Whilst I believe ethics should be public and inclusive, media work must be undertaken responsibly, authentically and honestly. When done properly, the media can provide a unique vehicle for ethical discussion.

Most ethical decisions neither are, nor should be, the preserve of ethicists. People make moral choices every day and not just in relation to healthcare. Clinicians and

patients share values and negotiate priorities routinely in surgeries, clinics and wards across the land. The perspectives of those who make and live with these daily choices are rarely well-captured. In situations where the media becomes involved, there can be distortion, distress and misunderstanding. Yet, I have learned from my work with Radio 4 in ways I never imagined when I originally agreed to participate six years ago.

The experience of hearing people's stories, really hearing them properly, is immeasurably valuable. Clinical practice and bioethics are problem-focused. From the earliest days, clinicians learn to sift information, seeking key points, looking for patterns and listening for alarm bells. A skill quickly acquired and required in clinical training is the ability to present, and respond to, a 'case'. We learn how to translate unstructured descriptions into histories, disparate subjectivity into objectively discernible signs and emotions into manageable agendas. We turn to consultation models and mnemonics to assist in navigating the messy and discomfiting worlds of patients.

Many clinicians do this well and have finely-honed communication skills and an abundance of empathy, but even the best will rarely have time to hear the multiple voices and perspectives that imbue moral decisions in healthcare. Both the words and the expression of words matter in ethics and medicine. Yet, we are adept at inferring, assuming and even imposing meaning: individual experience is quickly bundled up in concepts such as autonomy, rights, utilitarianism and best interests.

Consider Emily and Callum, whose experiences were discussed in the final episode of *Inside the Ethics Committee*. The subject was chronic pain, end-of-life decision-making and assisted dying. I have taught and written about the issues raised in the programme often. In preparation, I mentally listed relevant concepts that should inform the discussion including acts and omissions, the doctrine of double effect, the nature of the therapeutic relationship and the notion of futility.

However, when in the studio hearing Emily and Callum's stories, the perceptions and anxieties of the clinical team, the emotions and competing priorities, my textbook analysis seemed inadequate. Ethical concepts appeared a simplistic response to the palpable discomfort, uncertainty, hope, expectation and fear. A good decision was not one that neatly parceled the life and death of Emily into an ethico-legal framework. Her words were central, her story was unique, messy, changing, unclear and, at times, redolent with contradiction and regret. We were privileged to share it. The experiences of Emily, Callum and the clinical team involved were not just another vignette to illustrate core ethical concepts at the end of life.

In the programme, clinicians, patients and families come together as equals and all share a common task, namely reflecting on, explaining and describing their experiences in their own words. The vestiges of daily clinical practice are stripped away and what remains is the stuff of life (and death). It is an exercise in revealing that which is hidden, in sharing that which would otherwise not be known and in acknowledging diversity and disagreement.

Working with the media has led me to revisit what I take for granted, to attend to the emotion of ethical decision-making, to listen to every carefully-chosen word and to engage with multiple meanings. Whilst I am not keen on sound bites, I do believe that sound bites and, when we are used to being the expert dealing with that which appears routine, it is important to be reminded of its power. ■

*Deborah Bowman is a senior lecturer in medical ethics and law at St George's, University of London*

# Leading in a time of change



*Revalidation, the new government white paper on NHS reform, the PMETB merger – it's a crucial stage in the development of the General Medical Council. Here Professor Sir Peter Rubin reflects on the challenging role of GMC chair*

**P**ROFESSOR Sir Peter Rubin has had a hugely varied career in medicine. He has been involved in extensive research on the safe and effective use of drugs in pregnancy, written books on clinical pharmacology and helped establish the Nottingham Veterinary School, the first new vet school in the UK for over half a century.

But it was partly chance that led him to the GMC in 1998. Professor Rubin was dean of the faculty of medicine and health sciences at Nottingham when it was the University's turn to nominate a dean to the Council. Since then he has never looked back.

He remains professor of therapeutics at Nottingham and consultant physician at the Queen's Medical Centre and a non-

executive director of Nottingham Health Authority. In June 2010 he was awarded a knighthood for services to medicine in The Queen's Birthday Honours List.

#### **Why has the decision been made to extend the pilot period for revalidation?**

The Health Secretary, Andrew Lansley, recently extended the piloting phase for a further year in England so we can be absolutely confident that local systems of appraisal and clinical governance, on which revalidation will be based, are in place and working effectively. We need not only to ensure that revalidation adds value for both patients and doctors but is also practical and workable in the context of the pressured

and busy environments in which most doctors work. Revalidation will only be introduced once we are satisfied that the local systems necessary to support doctors in meeting the requirements of revalidation have been properly tested. We are determined to get it right and want a straightforward process which is genuinely helpful for doctors, patients and employers.

#### **Will revalidation stand solely on the quality of local appraisal systems?**

The annual appraisal will be the main way in which doctors will demonstrate that they are up to date and fit to practise in their chosen field. We know, however, that the quality of appraisal in different parts of the

UK is inconsistent at the moment and this needs to change. At least part of every doctor's annual appraisal should involve an evaluation of their performance against the professional standards set by the GMC. For most doctors, this annual evaluation of their practice through appraisal will be nothing new. In future, it will help them and their appraisers to link their performance to national standards and identify any areas for action and address any concerns long before they are required to revalidate.

#### **How would you respond to the worry that revalidation will eat up valuable clinical time with the administrative burden?**

We know it needs to be simple. Revalidation relies primarily on appraisal, which in turn is based on showing that we as doctors are up to date in our area of practice. Much of that is to do with continuing medical education, which we all do anyway.

Recording what you've done as you go along, for example in an e-portfolio as I do, will help enormously to minimise the time spent in preparing for appraisal. Multisource (360 degree) feedback should be done once or twice in a five-year cycle. With a bit of planning, it can again be pretty smooth – for example, I send MSF forms to new patients coming to my hypertension clinic and collate the replies periodically.

#### **How about the concern that revalidation may be used to settle old scores within a PCT or other health organisation?**

No one should face discrimination or unfair treatment in the workplace. All of the stakeholders involved in the introduction of revalidation, including the GMC, are fully committed to ensuring that revalidation is a fair and transparent process for all doctors.

In the responsible officer draft regulations, which have now been laid before Parliament, the Department of Health requires the PCT, or other 'designated bodies' to ensure there is no 'conflict of interest' or 'appearance of bias' between practitioners and the responsible officer appointed. The regulations also place a duty on organisations to appoint an additional responsible officer where there is a conflict of interest or an appearance of bias between a doctor and the first appointed responsible officer.

We have also developed a Good Medical Practice Framework for appraisal and assessment to be used in all appraisals for doctors, which should help to ensure further consistency in the process.

#### **What do you see as the main benefit in the merger of the PMETB (Postgraduate Medical Education and Training Board) with the GMC?**

For the first time ever, one UK organisation sets the standards for all stages of medical education and training, operates the register of doctors and ensures they are competent and fit to practise. The GMC can ensure that every stage of education and training successfully prepares the doctor for the next one and standards are continually improved. Our education strategy 2011-2013, which we are in the process of developing, will set out exactly how we will do this.

#### **How do you feel being the chair of the GMC at this crucial stage in its development?**

I feel hugely privileged to be doing this job at this time. Leading change is what I enjoy most and there's certainly a lot of change to lead right now! Medical colleagues often look askance when I say that I look forward to going to work at the GMC, but it's true.

"In the past, we (the GMC) have too often been reactive and inward looking, but we are now far more ready to take a stand on tricky issues..."

We deal with fascinating, varied and important issues and the breadth of our activities – spanning education, registration, standards and fitness to practise – ensures there's rarely a dull moment.

#### **What inspired you to go into medicine?**

I was the first member of my family to go to university, so there was no professional tradition to follow. I really enjoyed science at school and I liked people. Medicine seemed like a good idea and my teachers encouraged me to go for it. Most of the London medical schools turned me down without interview. St Mary's offered me a place (having ascertained what position I played at rugby!) but very kindly suggested I should go to Cambridge, which I did.

#### **How can the UK do more to encourage medical students from lower income backgrounds?**

I think raising the aspirations of young people well before they make career choices is key. Universities can play a part – and many medical schools have a variety of schemes to try and widen access. However, if people don't apply to medical school they won't get in. We've also got to accept that the financial landscape is very different to the one in which I chose medicine – I had a full student grant which in today's money was around £5500 per year and paid no fees. For many young people, the prospect of accumulating a large debt is going to be a major disincentive, but medical schools in the UK in general don't have the huge endowments enjoyed by the top institutions in, for example, the USA which can provide significant scholarships.

#### **What are the main differences between the GMC of today and the GMC when you started your career?**

I don't think the GMC crossed my mind when I started my career! I ended up on the GMC rather randomly in 1998, when it was Nottingham's turn to nominate a dean of a medical school to the huge Council of

104 people. I have to say that I entered a world that seemed pretty detached from the one in which I lived and worked. We've undergone enormous change in the last 10 years and continue to do so. In the past, we have too often been reactive and inward looking, but we are now far more ready to take a stand on tricky issues – for example language testing for graduates from elsewhere in the EU. I think we are now a much more outward-facing organisation, but I know we have a way to go to ensure that we communicate effectively and appropriately with those who pay for us.

■ *Interview by Jim Killgore, editor of MDDUS Summons*



# What place for homeopathy?

*Offering homeopathy “on the NHS” is a highly contentious issue among medical professionals today. Adrian O’Dowd looks at the current state of debate*

**H**OMEOPATHY sounds harmless. Its very nature is based on treatments that are highly diluted and non-toxic versions of an original substance.

But what is a benign and popular range of treatments for some people has recently provoked a perhaps surprisingly strong and angry reaction from parts of the medical profession.

Some doctors want an end to any NHS funding for such treatments and to stop pharmacists from labeling homeopathic products as ‘medicines’.

A storm erupted at this year’s BMA annual conference in June where during one of the longest and most animated debates, delegates voted overwhelmingly for an anti-homeopathy motion.

Prior to the debate, supporters of homeopathy gathered in front of the conference venue in Brighton with banners and placards to let doctors entering the building know their views and urge them not to vote for the motion.

Despite this, three quarters of the doctors there agreed that in the absence of valid scientific evidence of benefit, there should be no further commissioning of, nor funding for, homeopathic remedies or hospitals in the NHS.

Even more (82 per cent) voted in another part of the motion that no UK training post should include a placement in homeopathy, and 63 per cent agreed that pharmacists should remove homeopathic remedies from shelves if they are presented as ‘medicines’ and only sell them if clearly labelled as ‘placebos’.

Homeopaths were surprised at the degree of animosity voiced at the conference about the treatments and are now worried that the next generation of doctors is becoming more conservative and intransigent.

## Effective treatment or placebo?

Homeopathy – a system of healing which claims to help the natural tendency of the body to heal itself – was first proposed in 1796 by German doctor Samuel Hahnemann.

Some forms of complementary medicine including homeopathy have been integrated with the NHS ever since it started in 1948 and there are four NHS homeopathic hospitals in Bristol, Glasgow, Liverpool and London, which treat 55,000 patients a year collectively.

More than 400 GPs in the UK practise homeopathy, treating around 200,000 NHS patients per year this way. The NHS spends approximately £4 million a year on homeopathy for treatments and funding of the homeopathic hospitals – around 0.001 per cent of the £11 billion drugs budget.

Despite its firm footing in the NHS, homeopathy has prompted strong criticism for receiving NHS funding, initially emerging at the BMA’s junior doctors’ conference in May and then again at the full BMA annual conference in June.

One of the most notable and outspoken critics addressing the conference was Dr Tom Dolphin, vice chair of the BMA’s junior doctors’ committee.

Dr Dolphin says: “I don’t have a huge problem with the use of placebos as they clearly do have benefits for patients. The problem I have with homeopathy is that it is dressing up placebo with pseudo-science, which if you look at it, is farcical. My opinion of homeopathy is that it is nonsense and has no basis in clinical reality.

“Because of that, patients are being misled into thinking there’s more to it than there is. In over 100 clinical trials, it’s never been shown to be any better than placebo.”

He accepts that the £4million being spent by the NHS on homeopathy is not a huge amount from the NHS’s overall budget, but adds: “It is a waste of NHS resources and having it supported by the government gives it an undue legitimacy. I’d like to think in an era of austerity that things that have shown in many clinical trials to have no benefit would be stopped.”

Dr Mary McCarthy, a GP from Shropshire, who proposed the motion said at the conference: “Homeopathy can do harm – it can divert people from conventional medicine.

“We are not asking for homeopathy to be stopped. What we are asking is that it’s not funded by scarce NHS resources.”

## Why ban something that works?

However, other doctors at the conference spoke in favour of homeopathy, such as Dr John Garner, a GP from Edinburgh, who said: “Some patients find benefit and relief in homeopathic treatments be it placebo effect or not.



“We have a duty to support patients if something works for them. This [ban] would deprive patients who have found benefit from homeopathic remedies in their current treatments.”

Organisations like the British Homeopathic Association and the Faculty of Homeopathy, which represents doctors who practise homeopathy, were also not impressed with some of the comments made during the BMA debate.

Dr Graham Jagger, a GP and NHS primary care representative on the board of the Faculty, says: “To stop NHS funding for homeopathy is not going to save very much money at all.”

Dr Jagger feels the BMA debate reflects a shift in attitudes. He says: “We’ve been going through a change of junior doctors’ training that has unsettled the whole medical profession quite radically.”

**"We are not asking for homeopathy to be stopped. What we are asking is that it's not funded by scarce NHS resources." - Dr Mary McCarthy**

“The doctors are becoming a lot more conservative and more reactionary. It’s almost like a dark ages that we are going into. Doctors now have to look as if they’ve got their roots firmly on the ground and can’t look as if they are free thinkers or lateral thinkers.”

Dr Jagger says he has never been keen on placebos, but adds: “There is a placebo effect in everything. I don’t switch on my placebo hat just when I do prescribing for homeopathy.”

“Most of what I am doing might have some placebo effect; if I prescribe an aspirin, it will have a placebo effect as much as if I prescribed a homeopathic tablet. But I wouldn’t prescribe placebo as a treatment.”

Dr Jagger says he tends to recommend homeopathic treatment to patients instead of conventional medicine in about 10 per cent of cases. In situations where a patient chooses a homeopathic treatment rather than conventional medicine, he believes there does not need to be an ethical dilemma for doctors.

“There needn’t be a dilemma as long as we are treating something that we feel is going to respond and is not dangerous to do,” he says.

“If someone came in with malaria, for example, and said they’d rather have homeopathy, I’d say no. We know that there are conventional treatments that work very well and we

know there are homeopathic treatments that might not work at all. I would want to try the best for the patient.”

Asked why he thinks there is real antipathy to homeopathy in some parts of the medical profession, he says: “I think it’s because there isn’t a scientific basis to the theory of why it works. In 100 or 200 years time, we will discover why it works but at the moment we don’t know why.”

Dr Jagger believes more should be spent by the NHS on homeopathy and argues that the homeopathic hospitals have an important part to play.

“These hospitals do an enormous amount of good work that would be far more expensively addressed elsewhere. Homeopathy is a very useful adjunct to what we’ve got and we would be lost without it.”

## Political argument

Opposition to homeopathy also emerged earlier this year when MPs on the House of Commons’ Science and Technology Select Committee published a report of their inquiry into homeopathy<sup>1</sup> in February, calling for a ban on NHS funding. MPs on the committee urged the government to withdraw NHS funding for such treatments and for the medicines regulator to stop licensing homeopathic products. For doctors to prescribe a homeopathic treatment was damaging the integrity of the doctor-patient relationship, said the committee.

Despite this, in July, the Department of Health published its official response<sup>2</sup> to the report and rejected the MPs call, saying it supported NHS funding for homeopathy. The Department said the use of homeopathy on the NHS did not amount to a “risk to patient trust, choice or safety”.

Public health minister, Anne Milton said: “We believe in patients being able to make informed choices about their treatment, and in a clinician being able to prescribe the treatment they feel most appropriate in particular circumstances, which includes complementary or alternative treatments such as homeopathy.”

Homeopathy, it seems, has for now won the argument to stay.

■ **Adrian O’Dowd is a freelance medical journalist**

### WEB LINKS

1 <http://tinyurl.com/329mk2e>

2 <http://tinyurl.com/2vmv6pt>

# Doctors in sport

*MDDUS provides protection to many members who work regularly with athletes, says MDDUS risk manager Peter Johnson. Medical negligence claims in sport are rare but can we keep individual risk low?*

**I**N 2003, a relatively unknown Manchester United youth player named Benjamin Collett had his right leg broken in two places in a tackle by Gary Smith of Middlesbrough FC. The injury ended his career and later led to a suit for damages against Smith and his club.

In the court case Sir Alex Ferguson would testify that Collett had an “outstanding chance” of becoming a full-time professional. Lawyers for the young player would contend that in his prime Collette would have earned more than £13,000 a week and could have played until the age of 35 in either of the top two divisions in England. On the basis of Collet’s earning potential the court awarded him £4.3m in damages.

In this case the liability for the injury was borne by an opposing player and his club but consider an alternative scenario where the negligent actions of a doctor had ended the player’s career. Would a court have ruled any differently?

To some doctors, sports medicine is the ultimate career – exciting, rewarding and glamorous. But it is also a profession where there is a constant need to mitigate the risk of something going wrong, not only to protect athletes but also to avoid the potentially severe financial implications should an adverse incident end in court.

## The level of risk

Top football players in the English Premier league are believed to be earning over £100k per week and a few Scottish Premier League players may be earning over £30k per week. Transfer fees are regularly reported at well over £5m. The potential loss of earning is clearly very high and it is not just footballers that carry the risk.

One internet search ranked association football as sixth in



PHOTOGRAPH: LEE SMITH/ACTION IMAGES

the top ten highest paid worldwide sports. This would imply that doctors could be working with other sports professionals who are more highly paid than footballers, for example boxers and formula one racing drivers. However, the overall frequency and volume of medical treatment in these sports is likely to be much lower and UK association football remains the predominant sport in terms of medico-legal risk in both likelihood and impact.

There have been a few well-publicised cases. In 2008 lawyers for former footballer Brian Welsh negotiated a “substantial sum” after a negligence claim against a club doctor at Hibernian FC. Welsh was given a steroid injection by the doctor when he suffered pain during a game in 1998. He alleged that the injection into his left Achilles tendon caused injury that effectively ended his career in football. The case was settled without the doctor admitting liability.

Doctors working with top professional footballers face a clear risk of major medical negligence settlement costs. This is not something that MDDUS as an organisation can ignore and it is only sensible that we limit the exposure of our membership to very large claims. Our policy is that we do not indemnify doctors who are currently employed full-time by the English Premiership, English Championship and the Scottish Premier League (non-indemnity membership is still available).

## Reducing risk in sports medicine

Such a policy does not mean that MDDUS is averse to doctors working with other athletes. But we do encourage sports doctors to obtain appropriate training or a recognised qualification related to working with sports professionals and amateurs. A number of sports medicine courses are run either





**Main: Dr Jonny Gordon of SportPromote attends Celtic and Scotland's Shaun Maloney. Above right: Participants at SportPromote course**



REMO holds to the principle that course presenters should “only teach what they do” and all lecturers are specialists in their field. The course has been accredited with the Faculty of Sports and Exercise Medicine at the Royal College of Surgeons in Ireland and it is recognised for 11.5 CME points. It is currently under review for accreditation with the Faculty of Immediate Medical Care at The Royal College of Surgeons of Edinburgh.

## SportPromote

MDDUS in Scotland has formed an association with SportPromote. This course provider based at Hampden Park in Glasgow also focuses on the management of the acutely injured or unwell athlete and is run by emergency medicine consultant Dr Jonny Gordon. All SportPromote faculty are consultants in their respective specialties including emergency medicine, cardiology, intensive care and maxillofacial surgery. The structure is similar to the REMO course, each topic being covered by a lecture followed with a practical session useful for both doctors and physiotherapists.

Topics covered include basic as well as advanced life support with key skills including airway management and safe defibrillation using automated external defibrillators. Emphasis is also placed on the immediate assessment and management of cervical spine injuries including immobilisation and safe extrication of the athlete from the pitch. There are also sessions on trauma management including head and facial injuries and other medical emergencies such as diabetes and seizures. Wound management and medical kit requirements are also covered.

Assessment for the course involves MCQs and a practical examination, and the course manuals are tailored for both doctors and physiotherapists. Successful completion of the course earns 9 CPD points from the Royal College of Surgeons of Edinburgh, and SportPromote is also CORAS approved for general practitioners by NHS Education in Scotland.

MDDUS is keen to endorse the SportPromote course as we view such training as a valuable risk management tool in helping to reduce potential claims related to sports injuries. See below for contact information for both SportPromote and REMO.

### ■ Peter Johnson is risk manager at MDDUS

- SportPromote – further information can be found at [www.sportpromote.co.uk](http://www.sportpromote.co.uk) or by contacting Dr Jonny Gordon at the Victoria Infirmary ([jonny.gordon@ggc.scot.nhs.uk](mailto:jonny.gordon@ggc.scot.nhs.uk)).
- REMO – for further information go to [www.remosports.com](http://www.remosports.com) or email [enquiries@remosports.com](mailto:enquiries@remosports.com)

in association with the Football Association (FA) in England or the Scottish Football Association (SFA) in Scotland.

One such course provider is REMO (Resuscitation and Emergency Management Onfield) which is based in England. It was established in 2001 when the British Olympic Association and the United Kingdom Association of Doctors in Sport commissioned the development of an immediate medical care and resuscitation course tailored specifically for doctors and physiotherapists working in sport. The first REMO course was piloted in 2002 for doctors working in Olympic sport and was the first of its kind developed specifically for medical staff covering elite teams.

REMO provides training for medical practitioners covering over 25 different sports ranging from judo to football to rowing. The focus is on initial assessment and emergency management of an injured or unwell athlete. Topics covered during the two-day course include airway management, basic and advanced life support, automated external defibrillation, spinal immobilisation, orthopaedic emergencies and management of head injuries and maxillofacial trauma. Each session begins with a detailed introductory lecture before a practical session with time for instruction and feedback.

Over 500 people have completed the REMO course and it is now a compulsory qualification for UK specialist trainees in sports and exercise medicine. REMO also runs a course specifically for healthcare staff working in professional football. AREA (Advanced Resuscitation and Emergency Aid) was commissioned by the Football Association in 2008 and the course has now become a mandatory qualification for all medical staff required to run on to the pitch to attend injured players in the Premier League.



# Managing head injuries

Professor Paul Marks *offers advice on avoiding pitfalls in the diagnosis and management of head-injured patients*

**T**HIS article attempts to highlight some of the problems, both clinical and medico-legal, that may arise when managing head injuries. It is not possible in a review of this length to provide comprehensive guidance on all aspects of this complex topic. Interested readers are advised to consult standard texts and, in particular, the NICE guidelines for head injury management.

## Scale of the problem

Head injury is the commonest cause of death amongst young adults in developed countries. Each year in the UK, approximately one million people will receive treatment for mild to severe head injuries in accident and emergency departments. Of these, 100,000 will be admitted for observation or specific treatment. In 5 per cent of those admitted to hospital, a neurosurgical opinion will be sought. Of those referrals, 1,500 individuals

will have sustained permanent brain damage or remain in a persistent vegetative state.

Head injury accounts for half of all deaths among adolescent males aged between 15 and 19 years, and if death occurs after a road traffic accident there is a 75 per cent chance it will be directly attributable to the head injury itself.

It is important to appreciate that patients who have sustained head injuries are often the subject of medico-legal action in one form or another. It is therefore vital that doctors who treat head-injured patients have a thorough understanding of the principles of management and the medico-legal consequences that might flow from the injury.

The NICE guidelines are essential reading for all those who may be called upon to treat head-injured patients. Here you can find guidance on:

- Initial assessment in the emergency department
- Criteria for imaging and its urgency for adults and children
- Investigation of cervical spine injuries
- Admission criteria
- When to involve a neurosurgeon
- Organisation of transfer of patients between referring hospital and neuroscience unit
- Advice about long-term problems and support services.

If you read nothing else, study the *Quick Reference Guide* on head injury which can be downloaded from the NICE website<sup>1</sup>.

## Surgical pathology

It is important for all clinicians who manage head-injured patients to have a basic understanding of the surgical pathology.

Head injury is traditionally divided into primary and secondary brain injury. Primary

brain injury occurs at the time of impact. It is divided into contusions and lacerations of the brain on the one hand and diffuse axonal or shearing injury on the other. Apart from preventative measures, such as wearing crash helmets, adhering to speed limits and so forth, there is nothing that can be done about such primary damage.

Secondary brain damage such as swelling, oedema, haematoma formation, epilepsy and infection are initiated by the primary damage and it is the goal of the clinician to avoid or minimise such damage, although this may not always prove possible.

Assessment of a head-injured patient requires a careful history and examination. Details of the mechanism of the injury are important and should be obtained from appropriate witnesses as well as the patient. For example, a blow to the head with a heavy spanner is more likely to result in a compound depressed fracture than an assault with fists.

The initial neurological examination is of vital importance not only because it enables the severity of the injury to be gauged but also because it provides a baseline of neurological function from which any improvement or deterioration can be measured.

The assessment should include the Glasgow Coma Scale (GCS), recording of vital signs and recording of the presence or absence of focal neurological deficit. It is vital that you have a clear and thorough understanding of the GCS and know how to derive the overall score from each of the three parameters that constitute it. Despite being in existence since 1974, our unit continues to receive referrals that quote a GCS of 1 or 2!

### Frequently asked questions

Head-injured patients and their relatives will invariably want to know the time frame during which recovery can take place. It is generally held that spontaneous improvement can take place for up to two years after a traumatic brain injury. Problems that persist thereafter can be regarded as being fixed, i.e. they should neither improve nor deteriorate.

Another common question which is important to address is the likelihood of developing post-traumatic epilepsy. Traditionally this is divided into early post-traumatic epilepsy, which arises up

to seven days after the injury, and late post-traumatic epilepsy, which arises at any time thereafter.

Risk factors for the development of late post-traumatic epilepsy include: early post-traumatic fits, structural brain damage, penetrating injuries and a period of post-traumatic amnesia greater than 24 hours.

The most widely cited paper on the risk and likelihood of developing post-traumatic epilepsy is by Annegers<sup>2</sup> and his group and this makes essential reading for anyone who is engaged in medico-legal reporting on head-injured patients.

### Medico-legal issues

Head injuries feature commonly among clinical negligence claims and some can result in high-value damage payouts or settlement costs. Among the most frequent reasons for negligence claims are:

- delay in diagnosis
- failure to appreciate the severity of the injury
- delay in transfer to a neurosurgical centre
- missed spinal injury
- incorrect attribution of loss of consciousness to alcohol or drugs.

Many categories of clinician are called upon to assess patients who have sustained head injuries. As in all areas of practice, accurate note keeping is essential and can provide a valuable safeguard and defence to subsequent complaints and litigation. Ensure that all entries in the clinical records are timed and dated.

A thorough understanding of the NICE guideline for managing head-injured patients and the maintenance of a high index of suspicion, especially in intoxicated patients with head injuries, will mitigate against inappropriate management and the tragedy of a death occurring when a surgically remediable condition is missed.

■ **Professor Paul Marks is a consultant neurosurgeon at Leeds General Infirmary and HM Deputy Coroner, West Yorkshire (Western District). He is also a visiting professor and associate at Leeds Metropolitan University Law School**

#### References

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- 2 Annegers JF et al. A population-based study of seizures after traumatic brain injuries. NEJM (1998);338;1:20-24



Above: This man fell 3 metres and sustained a head injury. He complained of neck pain persistently but this Jefferson fracture of C1 shown on this CT scan was missed on plain radiology of the cervical spine.

Opposite: This 33 year old was assaulted whilst intoxicated with alcohol. He was sent home from an A & E Department by taxi only to return 30 minutes later having had a fit whilst getting out of the vehicle! His CT scan shows extensive bilateral frontal contusions.

### Medico-legal issues to consider in head injury

- Treatment of victims of crime
- Criminal Injuries Compensation Authority (CICA) reports
- Negligence surrounding management
- Personal injury compensation claims
- DVLA forms

### Practice points

- All head injuries should be regarded as serious or potentially life-threatening.
- Head injuries are associated with a cervical spine injury until proven otherwise.
- The purpose of observation is to set a baseline from which improvement or deterioration can be assessed.
- Minor head injury may be a source of considerable morbidity.
- A head injury does not just affect the patient; the family and society may also be seriously affected.



# Making a SEA change

*Clinical audit is an unavoidable requirement for all dentists – but it need not be a box-ticking exercise, says David MacPherson of NES*

**M**any dentists view clinical audit as a necessary evil – “it’s done because we have to”. Indeed, the General Dental Service (GDS) terms of service require us to complete 15 hours of audit in every three-year cycle, though recent figures suggest that less than 50 per cent of dentists have done so.

Last year an NHS document distributed to all practices stated: “where a dentist did not undertake the required 15 hours of clinical audit activities under the 1996 regulations he/she will require to complete 5 hours of clinical audit activities before 31 July 2011”. No doubt many of us will be looking for 5 hours of clinical audit very soon.

My article in the last issue of *Summons* argued that a well-structured, meaningful clinical audit can greatly improve a practice but if you still find the prospect daunting then significant event analysis (SEA) may be your answer! Not only will GDS accept SEAs for the full 15-hour clinical audit requirement, it’s also a process that you can make an almost instant start on and one that will be directly relevant to your practice.

## What is an SEA?

A significant event can be described as “any event thought by anyone in the healthcare team to be significant in the care of patients or the conduct of the practice or organisation” (Pringle et al). Significant event analysis has been around for years in the military and aviation industry. Not only are accidents fully investigated but any near misses are also analysed for useful information to contribute to protocols towards improving passenger safety.

To this day there are approximately 30,000 near misses reported annually in the aviation industry. Similar figures also exist in medicine, and *Science Daily* reported in 2008 that medical errors cost the US \$8.8 billion and resulted in 238,337 potentially preventable deaths between 2004 to 2006. Lessons can be learned from these accidents, errors and near misses.

The *Oxford English Dictionary* defines *significant* as “extensive or important enough to merit attention.” This covers just about anything as long as one of your team members

considers it important enough to merit further study. *Analysis* is simply a systematic process to ascertain what can be learned about the event and what changes might be made to foster improvement.

We can basically analyse almost any kind of significant event. Let’s break them into four main groups:

1. **A near miss (incident)** – e.g. forgetting not to wear latex gloves in treating an allergic patient but no harm done as this is realised in time.
2. **An adverse event (accident)** – e.g. forgetting not to wear latex gloves and the patient has an allergic reaction.
3. **An error** – e.g. wrong patient records or records not written up correctly to indicate latex allergy, however no harm done.
4. **Good practice** – e.g. notes clearly indicate latex risk and robust protocol in place to ensure the patient is not exposed to latex; correct procedure carried out.

I’m sure you can already think of more examples from your day-to-day practice of all four of these. Such events can involve almost anything from lab work to staff training, from data protection to patient safety. Should you have lots of potential SEAs already, it is suggested that they be prioritised on the basis of consequences (actual or potential) for the quality and safety of patient care.

## Why analyse significant events?

In the case of a good event, that’s easy – we would all like to bottle the formula that makes our day run like clockwork and repeat it on a regular basis. When something goes wrong (or almost does) we want to make sure it doesn’t happen again. Without proper systematic analysis, it’s too easy for us to jump to conclusions – to blame a nurse or that lab!

But it may be that the problem lies much closer to home. Perhaps it is a training gap or even poor communication. A structure reduces speculation and conjecture and focuses

more on the factual evidence. Any resulting change in practice is likely to be more positive than just “we must try harder”.

Analysis helps us view incidents as important learning and quality improvement opportunities. It allows us to gain insight into what happened and take appropriate action. SEA is a highly flexible, non-threatening and team-based method of identifying training, managing risk and enhancing patient safety.

“Any resulting change in practice is likely to be more positive than just – we must try harder”

## Do it right

There are seven steps to a good SEA:

- Step 1** – Identify your significant event.
- Step 2** – Collect and collate as much information as possible relating to the event for all people involved.
- Step 3** – Convene a meeting with a non-threatening, no blame, egalitarian approach, focusing on the educational outcome.
- Step 4** – Undertake a structured analysis (see below).
- Step 5** – Monitor the progress of all actions/changes agreed upon as a result of the analysis.
- Step 6** – Write up the SEA.
- Step 7** – Seek educational feedback – peer review.

A good SEA will be relevant and can be a lifelong learning tool. The framework for the structural analysis is outlined in the following four questions:

- 1. What happened?** Describe what actually happened in detail and chronological order. Consider, for instance, how it happened, where it happened, who was involved and what the impact or potential impact was on the patient, the team, organisation and/or others.
- 2. Why did it happen?** Describe the main and underlying reasons – both positive and negative – that contributed to why the event happened. Consider, for instance, the professionalism of the team, the lack of a system or a failing in a system, lack of knowledge or the complexity and uncertainty associated with the event.
- 3. What has been learned?** Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education and training; the need to follow systems or procedures; the vital importance of team working or effective communication.
- 4. What has changed?** Outline the actions agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change, e.g. a letter of apology to a patient or a new protocol.

## A good defence

If you and your team follow the seven steps and answer the four questions of the structured analysis in as much detail as is possible and practical, then you can't go far wrong. Educational feedback adds further validity to your findings and, of course, peer review is high on the GDC's wish list for revalidation. Make sure your SEA is relevant, full of detail and legible (ideally typed).

From a medico-legal perspective, SEAs can be very valuable. They immediately demonstrate a proactive approach to an incident or a complaint and can show how you came about whatever improvements you have subsequently made.

When something has gone wrong, the production of a SEA will add to your defence by demonstrating reflection and empathy. You will be able to show how and why you have changed your protocols and reduced the risk of negative events reoccurring.

More information on SEAs can be found in section 13 of the NES Complete Audit Pack. Access at [www.tinyurl.com/29ke6p2](http://www.tinyurl.com/29ke6p2)

■ *David MacPherson is a Practice Development Plan (PDP) CPD tutor with NES*

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# 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



## DIAGNOSIS AND REFERRAL: CONFLICTING SCENARIOS

**BACKGROUND:** Mr P, 45 years old, attends his general practice complaining of epigastric pain after taking ibuprofen for cold sores. Dr A examines the patient and records "tender epigastrium but otherwise soft abdomen". There is no bowel or bladder disturbance. The GP advises the patient that the pain will likely settle with an antacid but to come back if there is no improvement.

Two days later Mr P returns to the practice worrying he might have appendicitis. This time he sees Dr B who records "moderate epigastric pain following ingestion of ibuprofen, also vomiting". On examination the patient has a tender upper abdomen but no guarding, with normal bowel sounds. Dr B makes a diagnosis of acute gastritis and prescribes omeprazole and metoclopramide. He advises Mr P again to return if there is no improvement.

Four days later Mr P returns to the practice. This time he is seen by Dr C who records pain now mainly in the right iliac fossa (RIF) with associated nausea, vomiting and diarrhoea. On examination the abdomen is tender over the RIF with rebound. Dr C refers the patient to A&E where CT confirms a diagnosis of acute appendicitis with appendicular abscess.

Mr P undergoes an exploratory laparotomy during which the necrotic appendix is debrided and the abdomen lavaged. A drain is inserted in the RIF prior to closure of the wound. After a prolonged hospital stay Mr P is discharged but later has to be readmitted with complications, adding to his pain and distress.

A few months later the surgery is notified of a claim of damages against Dr B for clinical negligence in failing to diagnosis and refer acute appendicitis.

**ANALYSIS/OUTCOME:** In the letter of claim Mr P presents a different version of the consultation with Dr B than that



PHOTOGRAPH: SIMON FRASER/SCIENCE PHOTO LIBRARY

recorded in the notes. He claims on returning to the surgery the pain in his abdomen was so agonising he could "barely walk" and also that it had moved from the epigastric area to "just below the right side of my stomach". Dr B disputes this account.

MDDUS commissions medico-legal reports from both an expert GP and a surgeon. The GP report finds that given the symptoms and signs recorded in Dr B's consultation with Mr P it would *not* have been reasonable to refer the patient to a surgeon at that stage. But this opinion discounts the patient's claim as to RIF pain and states in regard to the two conflicting accounts that it is "for the court to decide on issues of fact".

The expert opinion of the surgeon confirms that had Mr P been referred to the hospital with RIF pain after his consultation with Dr B it is unlikely the appendix would have perforated. The patient would have required no more than a simple procedure followed by a relatively rapid recovery.

Presented with these reports Mr P and his solicitors are still determined to press ahead with the claim but indicate a willingness to

settle. In the meantime Dr B grows increasingly stressed and worried over the case and is eventually signed off work. He is keen for a quick resolution.

MDDUS lawyers decide that on balance there is a risk in litigation that the court might give credence to the patient's account of the consultation with Dr B and award significant damages along with legal costs. It is judged best for the Union and the member to pursue a modest settlement without admission of liability.

### KEY POINTS

- Early stage appendicitis is difficult to diagnose and can present with pain anywhere in the abdominal cavity but often localising to the RIF.
- Be sure to record any relevant negative signs on examination if there is any suspicion – i.e. 'no RIF pain'.
- Decisions to settle or legally contest claims are often judgement calls based on litigation risk.
- Members' views are taken into account when deciding whether to settle a claim.





## TREATMENT: SIMPLE MISTAKES, BIG PROBLEM

**BACKGROUND:** Dentist Mr P is called before the Professional Conduct Committee of the General Dental Council to face charges about his treatment of three patients. Mr P is charged with failing to take adequate dental histories, failing to carry out and record basic periodontal examinations (BPE), failing to diagnose caries in one patient, failing to treat an abscess in a second patient and providing inappropriate treatment to a third.



**ANALYSIS/OUTCOME:** Mr P is advised by a team consisting of a solicitor, dental adviser and barrister. At the committee hearing he admits having not routinely undertaken a BPE at every examination but gives evidence that he has since changed his practice. The charge of failing to take dental histories is not upheld as Mr P, backed by his nurse, explains his normal practice, including full dental charting, and this is confirmed from practice records.

Among the specific cases, Mr P is criticised for not carrying out thorough checks on a patient, Miss T, who he had seen on six occasions and who had extensive caries. Mr P had placed a veneer but is charged with having missed caries on the mesial side of the tooth. He had no notes to support his claim that he had made thorough checks.

Mr P is also charged with failing to treat an abscess in a patient,

Mr G. The dentist claims that Mr G declined definitive treatment, but the dental records do not reflect the patient's refusal of root canal therapy.

Mr P is also criticised for using the "out-of-date" practice of leaving a tooth open to drain. He claims to have done so because the patient, Mrs K, had been too frightened to complete the original treatment after he had made a hole and widened the canal. No note was

made of her refusal or the advice given and the patient did not attend for further treatment, despite Mr P's efforts to contact her.

The GDC ultimately finds Mr P guilty of misconduct as the failures fall well below the standard expected of a competent GDP. But as the test for impaired fitness to practise is for current impairment, evidence presented by MDDUS on Mr P's behalf illustrates significant changes in his practice and the dentist is found to be currently unimpaired.

### KEY POINTS

- Record BPE codes at each routine examination. A visual examination, even if recorded, is insufficient.
- Consider completing a dental history proforma for each patient.
- Maintain full records including treatment provided and refusal of treatment along with the circumstances of refusal.



## CONFIDENTIALITY: TOO MUCH INFORMATION

**BACKGROUND:** A 56-year-old driver, Mrs A, is injured after being hit by a car in a road traffic accident. She makes numerous visits to her GP, Dr L, for treatment to back and neck injuries which cause her considerable pain and difficulty. Mrs A then lodges a compensation claim with the other motorist's insurance company. Dr L receives a court order asking for disclosure of Mrs A's medical records which detail the nature and extent of her injury and treatment following the crash.

Dr L responds to the order by sending the insurance company Mrs A's entire medical record. But a short time later, Mrs A writes to Dr L alleging he has breached doctor-patient confidentiality by disclosing the full medical record instead of only the section relating to the crash injuries.

Mrs A alleges that some information contained in her full medical file was used



against her by the insurance company who went on to raise a counter-claim. This meant she was forced to accept a poorer settlement and she demands compensation from Dr L.

**ANALYSIS/OUTCOME:** MDDUS, acting on behalf of Dr L, explains to Mrs A that the

wording of the court order was ambiguous and that Dr L was acting in what he thought was the best interests of his patient by disclosing the record. MDDUS also points out that, while this was an unfortunate situation, none of the information Dr L disclosed was inaccurate. Following discussions with Mrs A's solicitors, MDDUS agrees a small settlement without admission of liability on the part of Dr L.

### KEY POINTS

- Read carefully any official request for disclosure of personal patient information. Contact an MDDUS adviser if in doubt.
- Provide only the minimum information necessary when complying with a court order for disclosure of records.
- Document your reasons for making a disclosure.

## From the archives: an acid bath for scabies

In August of this year The National Archives completed a major project to catalogue and digitise a selection of Victorian workhouse records. *Living the Poor Life* is now available online and records correspondence between nineteenth century local and national poor law authorities – providing an “unrivalled source of raw history” on the life and experience of the nineteenth century poor.

One story found in the records is that of a young boy named Henry Cartwright. In 1839 his mother was committed to the Broomsgrove workhouse in Worcestershire along with Henry and his three siblings, as she was unable to support her family. A few months later Henry was taken to the nurses employed at the workhouse along with over a dozen other children, all suffering from the “itch”, a colloquial term for scabies.



IMAGE: NATIONAL MEDIA MUSEUM/SSPL

A respected local surgeon named Thomas S Fletcher who provided medical care to the workhouse instructed the nurse to dress the affected areas of skin with a “white ointment” but this caused pain, swelling and loose teeth so was discontinued. Treatment with brimstone and treacle also failed so Fletcher prescribed immersion in a caustic solution of “sulphuret of potassium” or potassium sulphate.

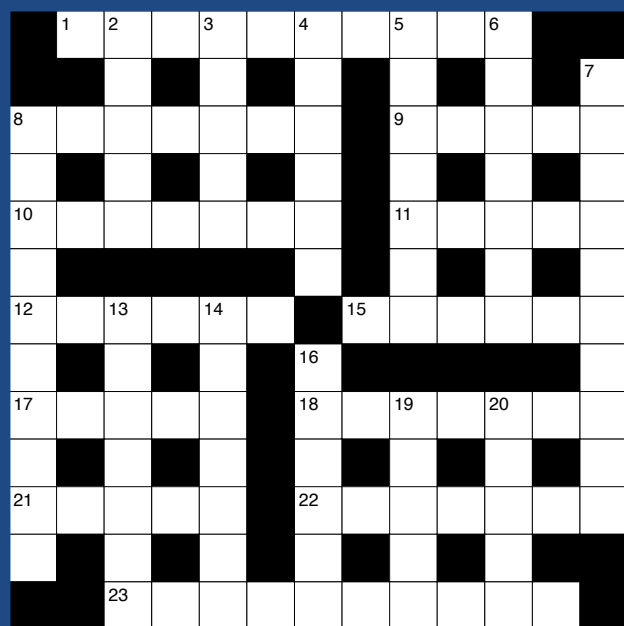
A nurse named Sarah Chambers was left to administer the treatment unsupervised. Most of the children were unaffected by the bath but Henry emerged badly scalded as though burnt. A few days later he died.

At the coroner’s inquest a number of doctors testified that use of potassium sulphate in a bath, ointment or lotion for the itch was not uncommon. It was the strength of solution used by Nurse Chambers that caused the boy’s death.

The jury of the coroner found that Fletcher’s failure to properly supervise the treatment was “injudicious and negligent”. The surgeon was “admonished in suitable terms” but avoided being sacked for his actions by the Broomsgrove Poor Law Union because of his “previous unblemished professional record, and kind attention to pauper patients”.

Search The National Archive for other stories from workhouse records at: [www.tinyurl.com/poorlife](http://www.tinyurl.com/poorlife)

### Crossword



**ACROSS**

- 1. Airways inflammation
- 8. Lumps on toes
- 9. Washbowl
- 10. Gums
- 11. Twin, like Dolly
- 12. Genus of mite
- 15. Intestines
- 17. Lent his name to regional ileitis
- 18. Exposure to silver dust
- 21. Adult-onset diabetes (abbr.)
- 22. Shoulder muscle
- 23. HIV combination therapy drug

**DOWN**

- 2. Quarrel (3-2)
- 3. Children’s hospice in Hampshire
- 4. Member of light cavalry
- 5. Primary cause of lung cancer
- 6. Phase of cardiac cycle
- 7. Comprehend
- 8. Prevents tuberculosis (3,7)
- 13. Dodged
- 14. Anonymous
- 16. Enrage
- 19. Paints gold
- 20. Buy back (2-3)

See answers online at [www.mddus.com](http://www.mddus.com). Go to the Notice Board page under News and Events.



PHOTOGRAPH: THE WELLCOME TRUST

### Object obscura: early dental marketing

This dental advertising card from the early 1900s shows how the basic appeal and marketing techniques of cosmetic dentistry have changed little over a century – although a drawing is perhaps less convincing than a glossy photograph. But why would The American Dental Co be offering treatment in Swindon? In a blog from the Wellcome Library where the card can be found, Lalita Kaplish writes: “A little historical research reveals that the high regard for American dentistry in the UK around this time goes back to the Great Exhibition of 1851 in London, when American dentists won top honours for their displays of artificial teeth, crowns and bridgework.”

## Vignette: physician, researcher and geneticist Sir Cyril Astley Clarke (1907 – 2000)

AN interest in butterflies formed the rather unlikely basis for one of the 20th century's most significant discoveries in preventive medicine.

Sir Cyril Astley Clarke's breakthrough is credited with saving hundreds of thousands of lives since it was first used around 1975 – and it all began with his interest in lepidoptery. The Leicester-born physician and geneticist built on his research into the inheritance of wing patterns in butterflies to eventually develop a method of preventing Rh Haemolytic disease of the newborn.

The life-saving method – which involves administering antibody injections during pregnancy – was developed by Sir Cyril and his team with a little help from his wife Frieda (known as Féo to her family). It was said to have been Féo's suggestion to inject Rh antibodies – the very things which cause Rh – that proved the key to successfully preventing the disease.

Numerous accolades followed this landmark achievement including a CBE in 1969, a knighthood in 1974 and the Albert Lasker Award for Clinical Medical Research in 1980. Latterly, he was awarded the Linnean Medal in 1981 by the Linnean Society of London and the Buchanan Medal in 1990 from the Royal Society "for his innovative studies on haemolytic disease of the newborn which culminated in new therapies leading to the elimination of this major foetal disease". He was also president of the Royal College of Physicians while in retirement from 1972 to 1977.

Sir Cyril was born in 1907 and educated at Oundle, Cambridge and Guy's Hospital where he qualified in 1932. After a number of staff appointments at Guy's he worked in medical insurance and sailed at the weekends at Itchenor, West Sussex where he first met Féo. They married in 1934 and had three sons. In a touching tribute at her funeral in 1998, he wrote a note on her coffin which read: "The prettiest girl in Sussex."

He served throughout the Second World

War as a medical specialist in the Royal Naval Volunteer Reserve, rising to the rank of Lieutenant Commander. After the war, he became a medical registrar in Birmingham and later a consultant at the David Lewis Northern Hospital in Liverpool. His life appeared set for NHS practice in Liverpool with private rooms in Rodney Street. But in the 1950s, his interests turned to genetics and he developed his lifelong passion for

worked together in the early 1950s on the evolution mimicry in swallowtail butterflies and also extended the work of HBD Kettlewell by studying the black and peppered moths on the Wirral peninsula.

Their genetic research naturally progressed into medicine and the first studies were on the influence of the ABO blood groups on the risk of developing peptic ulcers. They had noted the inheritance of butterfly coat colour and pattern was controlled by a group of linked genes called polygenes. This led to Clarke's interest in Rhesus blood groups in man, which have a similar method of inheritance.

The culmination of the work of Clarke and his team was the eventual discovery of the pioneering Rh disease prevention method which involved giving Rh-negative women inter-muscular injections of anti-RhD antibodies during pregnancy to prevent Rh disease in their newborn babies. The achievement was of great importance and typified Sir Cyril's flair and willingness to tackle problems that were sometimes outside his field of expertise.

In a tribute to Sir Cyril in the *BMJ* following his death, one of his sons described some of his many accolades: "He succeeded Lord Cohen of Birkenhead to the Liverpool medicine chair in 1965, transforming the department into one of the finest. Cyril became the first non-London Royal College president. He initiated its research unit and fundamental changes in the MRCP."

He told how his father had "boundless energy, charm, unusual intelligence, great impatience, and wit", adding: "He once told me he had failed to reach the House of Lords because he had infuriated a GP peer by indicating an association between deaths from meningococcal meningitis and Thursday afternoons, the GP's traditional half day. He added with a grin: 'Sic transit gloria mundi.' [So passes the glory of the world]".

lepidoptera. In 1958 he became reader in medicine at the University of Liverpool and in 1963 he established and directed the university's Nuffield Unit of Medical Genetics and two years later he was made professor of medicine. He held the latter two posts until his retirement in 1972.

Sir Cyril's research contributions were broad and he perfected a technique of hand mating butterflies which enabled him to produce rare hybrids. This remarkable feat attracted the attention of Philip Sheppard, a brilliant young lecturer in Oxford who moved to Liverpool as professor of genetics. The two men





# WANT TO READ MORE...?

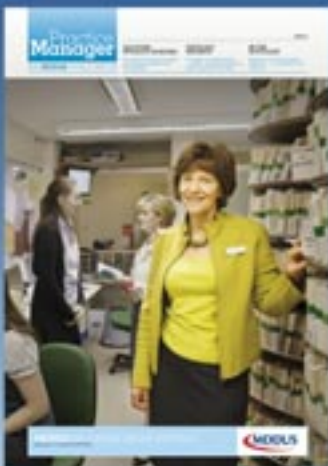


MDDUS publishes a number of membership magazines in addition to our main title, *Summons*.

We have recently expanded our range of publications by launching new titles aimed at practice managers, GP trainees, junior doctors and trainee dentists. These resources offer medico- and dento-legal advice on how to manage

risk in your day-to-day work, as well as general interest features and case studies.

We also produce the MDDUS *e-Monthly* email newsletter for all members plus the monthly *eFYi* for doctors in training.



**Practice Manager** – An informative resource for practice managers to help you run your medical or dental practice. It offers advice on how to handle challenging situations on the frontline of general practice as well as highlighting HR and health and safety issues.

**GPST** – This journal, launched in September 2010, aims to help trainee GPs face the daily challenges of general practice. Advice focuses on improving areas such as communication and consulting skills, while general features offer a perspective from working GPs.

**FYi** – This publication is for final year medical students and doctors in foundation years 1 and 2. Practical articles focus on a range of topics from breaking bad news to patient handovers, while other features highlight the varied work done by leading medics from various specialities.

**SoundBite** – Final year dental students and dentists in their first two years of post-graduate training will find this a valuable source of practical advice on how to improve professional skills. Launched in summer 2010, it also includes careers information and general interest features from around the dental world.

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