

Summer 2010

# SUMMONS



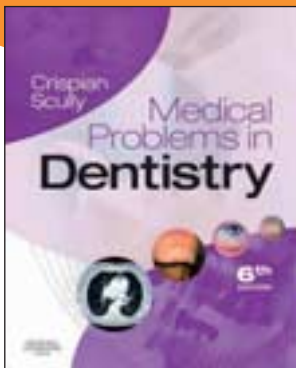
**JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND**



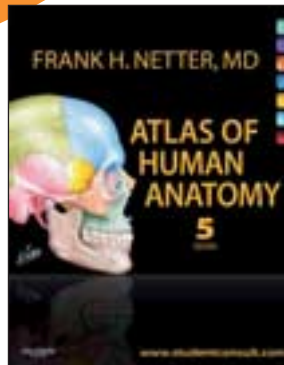
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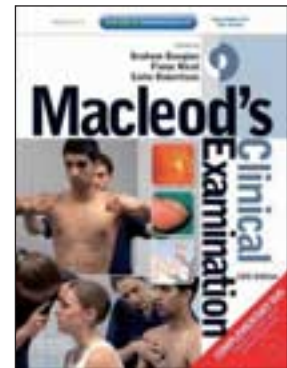
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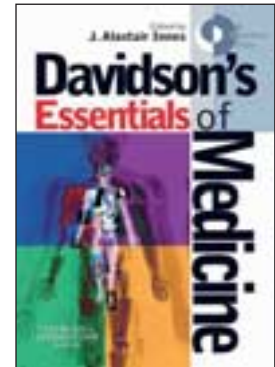
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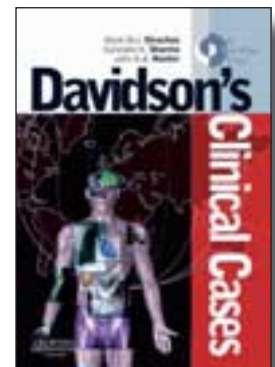
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## IN THIS ISSUE

IN MARCH of this year the BMJ Group held its second annual awards ceremony and handed out gongs in 10 categories recognising "individuals, organisations and initiatives that have demonstrated outstanding and measurable contributions to healthcare". MDDUS was headline sponsor of the event attended by over 700 of the great and good of the UK medical establishment at the Park Lane Hilton in London.

Among this year's recipients, *Summons* was particularly impressed with two organisations and both are featured in this issue. On page 10 we have an interview with Dr Stephen Hearn of the Emergency Medical Retrieval Service (EMRS) which was awarded the Secondary Care Team of the Year Award.

EMRS operates in the west of Scotland though will soon expand its coverage to all remote and rural areas of the country. Hearn's job combines the adrenaline-pumping field of emergency medicine with helicopter missions often in blizzards and gales to ensure seriously ill and injured patients arrive alive

at hospital. And to relax he does mountaineering and cross-country mountain biking...

On page 12 we herald the pioneering work of Pip Hardy and Tony Sumner who developed the Patient Voices programme, a series of some 400 "digital stories" illuminating the experiences of patients, doctors, nurses, managers, chief executives and carers across the spectrum of healthcare. Many are now available for free download as educational resources. The initiative took the Excellence in Healthcare Education Award. Congratulations to both.

Also this issue, David MacPherson of NHS Education Scotland offers valuable guidance on conducting dental audits (p. 18) and Professor Kevin Channer provides insight on clinical risk in diagnosing chest pain (p. 16). And on page 14 MDDUS medical adviser Des Watson concludes his two-part survival guide for members called to provide evidence at coroner's inquests.

Jim Killgore, editor



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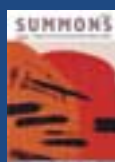
Audit is a necessary but challenging requirement for all dentists



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Wilhelmina Barns-Graham (1912-2004)  
Orange and Red on Pink

Born in St Andrews in 1912 and trained at Edinburgh College of Art from 1932-37, Barns-Graham became one of the most prominent members of the St Ives Society of Artists in Cornwall that included painter Ben Nicholson and sculptor Barbara Hepworth. This work demonstrated Barns-Graham's distinctive feel for composition, using radiant colour and pleasing simple forms to create an aesthetic harmonious effect.

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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## ➔ MDDUS appoints top 'special advisers'

MDDUS is pleased to announce that former GDC Chair, Mr Hew Mathewson, and former GMC Chair, Professor Sir Graeme Catto, have been appointed as honorary special advisers to the Union.

Both Mr Mathewson and Sir Graeme will provide guidance on specific regulatory issues and also on the future direction of MDDUS.



MDDUS special advisers Mr Hew Mathewson (above) and Sir Graeme Catto (below)

Professor Gordon Dickson, CEO of MDDUS said: "It is important that the Union keeps its finger firmly on the political and regulatory pulse as it continues to advise and support its medical and dental members throughout the United Kingdom. I am delighted therefore that two of our members, both recently retired from the two key regulatory bodies, have joined the Union as honorary special advisers. Sir Graeme Catto and Hew Mathewson bring a wealth of experience to the strategic roles they will play at the Union, which will I am sure be of significant benefit to our members".

Mr Mathewson was President of the General Dental Council from 2003 until the end of September 2009 and was the Council's first Chair until December 2009. In his role at MDDUS, Mr Mathewson will provide "strategic stimulus" to our dental and marketing teams as well as offering valuable insight into the workings of regulatory bodies, as he did in a recent briefing to professional staff in our Glasgow office. He will also assist the Union in fostering useful external/governmental relations.

Mr Mathewson said: "I am delighted to have been appointed special adviser to MDDUS. My role will not involve working on individual cases but rather helping the Union to consider the bigger picture of the ever-changing regulatory world. The existing dental advisers are all fully occupied looking after members and I think it is important for the development of the Union that we be aware of wider issues. I am particularly looking forward to joining forces with my opposite number from the GMC, Sir Graeme Catto, once more. We work well together."

Professor Sir Graeme Catto served in the role of President of the GMC for seven years and then Chair until 2009. Sir Graeme will also bring valuable insight into medical

regulatory issues and governmental matters with an eye to future developments that may affect MDDUS and its members.

Sir Graeme said: "At a time of change in clinical practice, rising patient and public expectations and financial stringency, the Union and its members need to be alert to future political and regulatory developments. As special adviser I look forward to working with Hew Mathewson in understanding that changing environment and helping the Union meet future challenges."

## ➔ Dental indemnity for cosmetic treatment

MDDUS now offers indemnity for dentists providing non-surgical cosmetic treatment, including Botox. This protection is offered without additional charge as part of a standard GDP subscription but subject to certain conditions. Members must be in the '7 sessions or more' membership category for GDPs and should have graduated before 2008. The member also must provide details of courses attended for the provision of this type of treatment, as well as plans for updating knowledge.

## ➔ McDonald joins as non-executive director

Consultant surgeon Mr Peter McDonald has joined the MDDUS Board as a non-executive director. A bowel surgeon at Northwick Park & St. Mark's Hospitals in Harrow, Peter is perhaps best known among doctors as a satirical medical journalist through his column in *Hospital Doctor*, a magazine for which he wrote for a quarter of a century. He has worked for the *BBC* and still writes under several noms de plume.

Mr McDonald said: "My interest in medico-legal matters is mainly motivated by a sense that society (i.e. patients, lawyers and politicians) fails to appreciate the uncertainty that doctors have to work with as they pursue their calling. I know through bitter experience that it is, indeed, a hard task to make a diagnosis and follow it up with a perfectly executed management strategy, and many complaints against clinicians must be defended against the ignorant philosophy that states if it was not perfect then sue".



He added: "I joined MDDUS in 2002 after reviewing the most excellent history of the Union (*A Century of Care*) for a journal and am now delighted to be serving as a non-executive director."

## IN BRIEF

### ● LEADERSHIP IN PRACTICE PROGRAMME

Practice managers are invited to sign-up for this MDDUS programme beginning in September and leading to the ILM Level 5 Award in Management. In five full-day workshops, participants will develop

an understanding of the management role with an emphasis on becoming an effective and innovative leader within the healthcare environment. For more details contact Ann Fitzpatrick at [afitzpatrick@mddus.com](mailto:afitzpatrick@mddus.com) or on 0845 270 2034.


### ● LEADING THROUGH UNCERTAINTY

For doctors and dentists in management roles, MDDUS offers a tailored programme also leading toward an ILM Level 5 Award in Management. Sign up for the first of five workshops starting in September

in both Glasgow and London. For more details contact Ann Fitzpatrick at [afitzpatrick@mddus.com](mailto:afitzpatrick@mddus.com) or on 0845 270 2034.

### ● SPORTSPROMOTE

will be running a course at Hampden Park on September 23 and 24. The course covers the assessment and



Evidence of protocols being used for patient assessment and the monitoring of treatment provided must also be supplied. Only procedures carried out in the immediate peri-oral area, nasal labial folds and elsewhere on the face are covered, with the neck explicitly excluded.

Only non-permanent injectable cosmetic procedures are included and the member must be registered with CHKS and under the IHAS Scheme, and possess the IHAS quality mark.

For more information call our Membership Department on **0845 270 2038**



### AiT learning day

Bookings can now be made for this year's popular and informative Associates in Training Day, run by the Royal College of General Practitioners in Scotland.

The annual event offers trainee GPs the chance to improve their knowledge and skills with an interesting mix of workshops and expert speakers. It will take place on Thursday, September 23, 2010 in Stirling Management Centre and is entitled 'Patient Safety – Every Little Helps'.

MDDUS are proud sponsors of the event and our chief medico-legal adviser Dr Jim Rodger will deliver one of the key presentations on patient safety and key medico-legal issues alongside fellow speaker Dr Neil Houston. In addition, GPs from across the UK will share their knowledge, experiences and expertise to give delegates a flavour of some of the challenges they will face in a career in general practice.

AiTs will have the chance to take part in three workshop sessions rotated throughout the day covering patient safety, clinical skills assessment (an insider's view) and career choices in general practice.

For further information contact [fmckenzie@rcgp-scotland.org.uk](mailto:fmckenzie@rcgp-scotland.org.uk) or call **0131 260 6800**

management of critically ill and injured athletes as well as the management of cardiac arrest. All faculty are consultants in their respective specialties including emergency medicine, cardiology, intensive care and maxillofacial surgery. Places are limited so

booking early is advised. Further information can be found at [www.sportpromote.co.uk](http://www.sportpromote.co.uk) or by contacting the course director Dr Jonny Gordon on [jonny.gordon@ggc.scot.nhs.uk](mailto:jonny.gordon@ggc.scot.nhs.uk)  
**COMPLAINTS HANDLING BOOKLET**

A revised edition of the MDDUS *Essential guide to complaint handling in primary care* can now be accessed by searching online on our Resource Library at [www.mddus.com](http://www.mddus.com). The short guide is intended to provide practical advice on dealing constructively with

patient complaints and in compliance with NHS and other regulations. Print copies are available by contacting Karen Walsh at [kwash@mddus.com](mailto:kwash@mddus.com)



## At last... MDDUS launches free employment law advice line



Practice managers within MDDUS group schemes or members who have employment responsibilities can now access a free helpline offering unlimited employment law and HR advice.

The new service is staffed by an experienced in-house team providing members with guidance on good HR practices and advice to those experiencing difficulties with employment matters. The service is intended to primarily operate during core hours but is available 24/7 for urgent enquires.

Members can enjoy prompt advice via telephone or email on pressing matters and assistance in drafting or amending employment-related policies and procedures – all compliant with latest legislation. As the advice service is unlimited, members can speak with the team regularly for follow-up on developing situations.

MDDUS Training and Consultancy Manager Liz Price said: "Our managers have been asking us for a specialist employment law service for a long time – so we were happy to listen. I think this service will be invaluable for our managers."

**The service will be available by calling 0845 270 2034 to speak directly with the team or by email at [employmentlaw@mddus.com](mailto:employmentlaw@mddus.com)**

In addition to the helpline, MDDUS is also offering to Practice Schemes – where all employing GP/GDP partners are members of the Union – the option of a Legal Support, Representation and Indemnity (LRI) package available for a small additional fee per head of employer. The LRI package provides access to assistance in matters that go beyond simple advice and guidance. It includes:

- Legal support and representation, including costs.
- Employment tribunal award protection: in cases where an employee is awarded financial compensation following representation of a practice by our legal partners the settlement will be met on the practice's behalf by MDDUS. This is a significant benefit as disability claimants have been awarded in excess of £200,000.

The annual subscription for this LRI package is based on the number of sessions that the employing GP/GDP partners within the Group Scheme undertake on average per week.

Note that the benefits of this service are subject to the membership terms as set out in our Memorandum and Articles of Association.

For advice and also further information about the service call our Employment Law Team now on **0845 270 2034** or email [employmentlaw@mddus.com](mailto:employmentlaw@mddus.com)



## DIY dentists beware

Dentists who do their own laboratory work must ensure they comply with new legislation following recent changes to the Medical Devices Directive 93/42/EC affecting the provision and manufacture of dental appliances.

MDDUS dental adviser Rachael Bell warns: "In these budget-conscious times some practitioners are making their own bleaching trays, doing small denture repairs or making orthodontic retainers for patients.

"However the rules have now changed and even in making simple appliances, dentists are covered by the same rules as dental labs."

Practitioners need to be aware that amendments to the directive are of relevance to all dentists and the General Dental Council are reminding dentists of their requirement to be familiar with and comply with all legislation affecting dental practice.

Dental practitioners who do their own lab work must register with the Medicines and Healthcare products Regulatory Agency (MHRA) and ensure that they comply with all requirements as a manufacturer - even if all they make are a few bleaching splints or do the occasional denture repair.

"The Department of Health has made it clear that any failures to comply with the directives are punishable as criminal offences," says Mrs Bell.

For further advice go [www.gdc-uk.org](http://www.gdc-uk.org)



## Greater protection for whistleblowers

NHS whistleblowers will be given greater protection from the government, it has been announced.

Health minister Andrew Lansley unveiled new plans to protect NHS staff who raise concerns. Measures include reinforcing rights and responsibilities for staff and employers in the NHS constitution, issuing new NHS guidance stating that employment contracts should cover whistleblowing, and supporting staff who speak up about concerns.

He revealed the plans as part of an announcement that a full public inquiry would be carried out into the failings at Mid-Staffordshire NHS Foundation Trust to examine events at the hospital where poor standards are said to have caused needless



patient deaths. Problems at Mid-Staffordshire were laid bare by the NHS regulator last March.

Mr Lansley said: "We know only too well what happened at Mid-Staffordshire, in all its harrowing detail, and the failings of the trust itself. This was a failure of the trust first and foremost, but it was also a national failure of the regulatory and supervisory system who should have secured the quality and safety of patient care." He said he wanted to strengthen the ability of staff to raise concerns.

The commitment to protect whistleblowers has been welcomed by the British Medical Association. They published the results of a survey of members in Scotland last month that revealed the majority of doctors questioned were too afraid to voice concerns.

## Revalidation delay 'welcome'

PLANS by government to delay the rollout of revalidation have been welcomed by doctors' and patients' groups.

The policy to regularly assess doctors' competence will now not come into force until at least 2012, health minister Andrew Lansley announced. He said he didn't have "sufficient confidence" that the current plans allowed enough time for the pilot projects to run, and said they should be continued for another year.

Mr Lansley (pictured right) said he also wanted to "be able to assure doctors, employers and commissioners" that the proposals are proportionate. But there are no signs the minister plans to scrap the scheme entirely, as he said "revalidation is something that the public expect their doctors to undertake".

The move has received the backing of the Royal College of General Practitioners, General Medical Council and the British Medical Association. BMA chairman Dr Hamish Meldrum said: "The BMA is pleased that the Department of Health in England has echoed the concerns of many doctors

that, for revalidation to work, it must be based on good evidence and ensure their confidence that what is being proposed is fair, proportionate and will support their professional desire to improve their practice.

"We, therefore, welcome the decision to extend the period of piloting for a further year and to make sure that the benefits are seen to be robust and achievable and the costs affordable, before a final decision is taken as to the timing and nature of any roll out of revalidation."



## IN BRIEF

### ● STEEP RISE IN GMC FTP PANELS

Nearly a third more fitness to practise panel hearings were conducted by the GMC in the year 2009 compared to 2008. A total of 270 fitness to practise panel hearings took place in 2009 compared with 204 in 2008. The

GMC attributes the steep rise to an increase in the number of enquiries made from the NHS, police and other public authorities, which have risen steadily since 2006. Erasures have increased even more with 68 doctors struck off the Medical Register at FTP hearings in 2009

compared to 42 in 2008.

### ● GDC BEGINS DIRECT DEBIT DRIVE

THE GDC is encouraging registrants to pay their annual retention fee by direct debit. Those who sign up to the payment method will be protected by an immediate money back guarantee in the event

of an error, receive advance notice if payment dates or amounts change and can cancel at any time. For more details visit [www.eGDC-uk.org](http://www.eGDC-uk.org)

● **END-OF-LIFE GUIDANCE** New GMC guidance calls for GPs to draw up advance care plans for dying patients. *Treatment and care towards*





### GP help to cut 'sickies'

GPs should be given better occupational health training to help cut the number of people taking sick days, UK employers have said.

The call follows the publication of a workplace health survey by the Confederation of British Industry and Pfizer. The survey showed employees took 180 million sick days last year – an average of 6.4 days each. Sickness levels were highest amongst public sector staff with an average of 8.3 days per year, which is 43 per cent higher than the private sector figure of 5.8 days. Overall, the absence rate is at its lowest since the survey was first carried out in 1987 and down slightly from an average 6.7 days per employee in the previously surveyed year of 2007.

Business leaders responded to the figures by calling on the government to do more. A total of 63 per cent of employers wanted better occupational health training for GPs with 56 per cent looking for improved working relationships between GPs and occupational health professionals. Companies also welcomed the introduction of "fit notes", which replaced sick notes in April, with 76 per cent of those surveyed saying fit notes would help people get back to work.

*the end of life: good practice in decision making* encourages "early, sensitive discussion and planning about how best to manage the patient's care" in order to avoid emotional distress or conflict between doctors and patients. Access at [www.gmc-uk.org](http://www.gmc-uk.org)

● **GUIDANCE ON ALCOHOL-RELATED HARM** New guidance documents to help reduce the health problems caused by alcohol misuse have been released by NICE. The two documents on alcohol-use disorders cover the care of adults and young people



with physical health problems related to alcohol use and also outline the most effective measures that can be taken to lower the risks of alcohol-related harm. Access at [www.nice.org.uk](http://www.nice.org.uk)

## OPINION



By Dr Ivor Felstein,  
Retired Consultant  
Geriatrician

### Howdy partner

Back in 2006, a GMC booklet introduced us all to *Good Medical Practice*. This was the profession's directional arrow, pointing to continued post-graduate medical education and periodic revalidation – all heralding (yet another) new era of doctoring.

Those of us who had been in active medical practice during the mid-1990s had suffered variably from the inevitable loss of patient trust, reliance and good faith which had followed the crimes of Dr Harold Shipman. Few (if any) of us resented the notion of continuous appraisals and individual reviews, although the *Times* newspaper emphasised that the GMC was applying "the biggest reform of medical regulation for 150 years".

I recall two things that impressed me then. Firstly, that *Good Medical Practice* had been 'blessed' with a seal of approval from the 'plain English' Word Centre. I assumed this implied a minimum of medical jargon but not necessarily a mastery of prose, grammar and syntax. Neither did it praise the loss of Latinate words in the contemporary medical scene – contrasting with the post-1948 prescriptions of the early NHS era.

Secondly, the booklet was inset with a flier which boldly declared all this new doctoring would 'work in partnership with patients'. This inevitably reminded me of a welcoming opening phrase in many Hollywood Western films. In my mind, therefore, I could hear the hospital consultant, ready for his ward round, calling out "howdy partners" to all his bed-bound patients. The GP would do likewise, perhaps doffing a Stetson on entering the morning surgery.

Am I making a facetious suggestion? Not really, or no more so than the concept of a patient being a partner rather than a customer, client or consumer of doctors' services. I was not the only doctor puzzling the legal point. How did this Middle English word, partner, literally meaning 'joint inheritor', find its GMC way into a medical/health/sickness setting? I recall asking bluntly just which type of partner the General Medical Council wished us to consider. Would it be along the lines of today's informal civil partner relationships?

Perhaps it would require a written contract, jointly signed in legal argot, not dissolvable except by mutual agreement of doctor and patient (with yet another fee for the lucky solicitors). And in a given case, would a contract be limited to one illness, or cover several health problems or be limitless and so for all time? Perhaps it could be torn asunder (as they say in a marriage ceremony) by the patient visiting another doctor for a 'second opinion'? Or defaulted by the patient who follows internet advice rather than the considered opinion of his/her 'partner GP' or 'partner consultant'?

Now that I have retired since the 2006 booklet appeared, and therefore more often a patient than 'doctor', I cannot (hand on heart) say that any GP or consultant has ever offered me any of the possible partnerships noted above.

I am delighted to state that – as a patient – I have been treated as courteously and helpfully as ever, both in hospitals and in the practice surgery. Nor have I yet been slapped on the back with a loud 'howdy partner' in my ear.

However, it is still my view, that today's politicians would secretly be delighted if patients were 'doctor partners'. So that, for example, patients' complaints of faulty NHS services or lack of therapy or persistent waiting lists would invariably go to GPs and consultants rather than to administrators, councillors and MPs.

But for now – so long, partners!



## Happy holidays?

Ian Watson

**IT'S NATURAL** at this time of year for our thoughts to turn to sun-kissed beaches or lazy garden barbecues. But holidays from work have become a little more complicated, legally and practically speaking, in recent months for medical and dental practices and their staff.

For example, your practice may have a 'first come, first served' policy on who gets time off at a particular time of year. This may apply equally to all staff but those who have school age children or non-Christian employees may argue, reasonably, that their choices of time off are constrained or dictated by concerns other than those of non-parents or staff from a Christian background.

Having a policy on preference for holiday time off which takes account of the fact that some staff cannot book family holidays outwith the school holiday periods, or that being compelled to take holidays during a Christian festival is not the first choice of non-Christian staff, may be sensible for practices to consider.

Another recent holiday-related HR challenge has been the problem of staff stranded abroad by cancellations of flights due to volcanic ash or strikes by airline staff.

The technical legal position is that an employee has an obligation to turn up for work and, if they do not, they are not

entitled to be paid – unless their contract provides for paid leave in extreme unforeseen circumstances.

Naturally, a few well-publicised instances where some staff (for example, some teachers in Coventry) had been unable to return to work and allegedly had pay docked by their employer have resulted in bad publicity (and, presumably, poor employee relations) for the employers concerned.

It may be reasonable for staff to be asked to make an effort to return to work as soon as practicable. But if, following a reasonable investigation, it appears that they were excessively delayed beyond their control, it might be reasonable from a staff morale point of view to extend periods of

## "A written policy would go a long way to reassuring staff..."

paid leave, grant unpaid extra leave or allow a staff member to make up their 'lost time' over a period of some months.

And on another holiday-related topic which we have referred to in previous editions of *Summons*, the long-running legal saga over whether statutory holidays (flowing from the Working Time Regulations) accrue when the employee is off sick has reached a partial conclusion in the last few months with a few recent decisions of the European Court of Justice (ECJ).

Entitlement to the accrual of WTR holidays during long-term sick leave is now firmly established in law. This means that

(in a similar way to maternity leave) holiday accrues to the limit of the regulations when staff are off sick. The annual WTR holiday entitlement is to 28 days (or 5.6 weeks) holiday (pro rata for part timers). The employee is therefore entitled to take the accrued paid leave on their return after sick leave.

The courts have even said that long term-sick staff who have, for example, exhausted their sick pay might agree with their employer to take periods of 'holiday' whilst they are still off sick – in order to get holiday pay in the bank – at a time when this might be most welcome. This arrangement has the added benefit to the employer of discharging their obligation to give staff holidays in the current leave year.

In the light of all these developments Law At Work is recommending that practices develop a contractual holiday absence policy which defines how holidays can be requested and how any priorities in allocation of holidays will be exercised.

The policy could also require staff who become sick whilst on holiday to provide rather more substantial evidence of their incapacity than would be provided for in the normal sick leave scenario. Only on production of this evidence would sick pay be paid. Making clear the obligations on staff in these situations before they go off may allay fears of abuse of the system.

Similarly, given the possibility that staff may be delayed in their return by volcanic ash and/or airline staff strikes, it makes sense

to anticipate what will happen if, through no fault of their own, staff are stranded abroad and cannot get to work on time. A written policy which stipulates what rights, benefits and obligations staff have in these extreme situations would go a long way to reassuring staff who are delayed – whilst emphasising that taking advantage of an 'Act of God' and consciously choosing to avoid getting home on time will not be tolerated.

Have a great holiday – but mind how you go ! ■

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

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## GETTING TO KNOW YOU

Deborah Bowman

**I ASKED** my children what they thought I should choose as the subject for a new addition to my task list: this column. They were curious. Why was I asking the advice of those who have little interest in healthcare ethics and prefer to spend their time skateboarding and singing musical theatre songs? It was a legitimate question.

On reflection, the explanation was the significance of first impressions. The impression left by my debut mattered to me. Why do first impressions matter? I had found the subject for my first column.

Each initial encounter has an ethical dimension. Trust, sincerity, competence and commitment to service are inferred. Is this a doctor who can be relied upon? Does this dentist value shared decision-making? Will this consultant take the time to listen to patient concerns? Is this GP likely to make informed use of guidelines?

It is not just people who make a swift and often lasting impression. The state of the surgery, the clinic's administrative systems, the types of written information available and the tone of notices on the wall all contribute to the patient's perception of the environment. The new patient is making judgements from the moment he or she arrives. Those judgements are not insignificant. Indeed first impressions reflect the fundamentals of ethical practice.

Some readers by now will be protesting that first impressions are just that: impressions and perceptions. To infer that a clinician is trustworthy, competent and dedicated is not the same as it being indubitably proven. That may be so, but therapeutic relationships depend on fostering trust, confidence and rapport quickly. Without careful attention to those first impressions, patients will not confide in their doctors and dentists. First impressions are the gate to an effective therapeutic alliance.

When we think about a 'good' first impression and why it matters, we mirror different approaches to ethics. The person who believes that professionals should always present themselves in a particular way, irrespective of context or possible outcome, would make Immanuel Kant proud. A belief



in universal principles or even rules reflects a deontological approach. In contrast, those who cite the effects of making a positive first impression are grounded in the consequentialist approach. There will be others who believe in the importance of character and emotion in professional practice and would take their place on the virtue ethics team.

Whilst locating the routine business of first impressions in the philosophical language of moral theory might, for some readers, be a novel way to pass a coffee break, it probably doesn't matter why you believe that first impressions are important. The priority is simpler: it is to recognise and remember that first impressions are redolent with ethical meaning and opportunity.

Is it possible to describe what makes a 'good' first impression? Probably not definitively, although there may be consensus about core features and non-negotiable standards of behaviour at initial meetings. As someone who tends to line up in the virtue ethics queue, my vote goes to particular traits which will, when enacted, create an environment in which both

professional and patient can flourish. Those traits include authenticity, openness, humility, compassion, respect and kindness. Others will have their own lists which may reference rules or focus on outcomes rather than characteristics.

What are yours? At the risk of leaving an impression of bossiness, take a minute to think about the first impressions you have left and made this week. What worked? What puzzled you? What felt uncomfortable or even wrong? Your answers reveal your ethical priorities and go to the heart of what it means to be a doctor or a dentist.

Medical ethics is often concerned with the grand, cutting edge moral dilemmas – euthanasia, cloning, abortion and gene therapy jostle for space in journals, on the news and at conferences. Yet, the most routine and unremarkable work of clinical practice is imbued with moral significance – nowhere more so than in the daily business of first impressions. ■

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



# Flying doctor

*The Emergency Medical Retrieval Service brings specialist critical care to Scotland's most remote regions. Dr Stephen Hearn discusses his work with this pioneering team*

IT'S SAFE to say that most emergency medicine consultants don't travel to work in a helicopter and wear flame retardant flight suits and safety helmets. But for Dr Stephen Hearn, this kind of equipment is standard issue. As part of the specialist team of doctors who make up the Emergency Medical Retrieval Service (EMRS), Hearn and his colleagues must safely transfer critically ill patients in remote and rural areas in the west of Scotland to the nearest appropriate medical facility.

The married father-of-three works at the Royal Alexandra Hospital in Paisley and is lead consultant for EMRS. He has been an active member of Arrochar mountain rescue team for 13 years and also trained with the London Helicopter Emergency Medical Service. He helped set up EMRS in 2004 and has spent the past six years developing the service alongside his highly trained team mates.

EMRS won the prestigious 2010 BMJ Group Award for Secondary Care Team of the Year (sponsored by MDDUS) in March

for its work in "transforming the care and transfer of seriously ill and injured patients in remote and rural Scotland". The service operates from Stranraer in the south to Stornoway in the north of Scotland, but it is hoped it will one day operate on a national level. The signs are good as the Scottish Government announced in March that a second team would be added to EMRS from October 2010. This will increase the number of part-time consultants working on the team from 16 to 22 and they will cover all of remote and rural Scotland.

## **How did your interest in emergency medical retrieval develop?**

As an emergency medicine trainee I became involved in mountain rescue medicine on a voluntary basis, organised medical cover for music festivals and acted as medical officer on a number of international expeditions. This gave me a taste for the challenges of providing emergency care to seriously injured or ill patients in difficult environments. I have always been interested in the management of serious problems

which require quick thinking, a broad range of clinical skills and experience and an ability to lead a multi-disciplinary team in challenging circumstances. Extrapolating this approach to the care of patients at the roadside, on the mountainside, in a remote hospital or in a helicopter with limited equipment, investigations and assistance is a very rewarding experience.

I first witnessed helicopter retrieval when working in Australia and realised that this was what rural healthcare in Scotland needed. I was lucky enough to finish my specialist training with the helicopter emergency medical service in London which offers the best pre-hospital trauma care training in the world.

## **What prompted the establishment of the EMRS pilot programme?**

A group of clinicians in hospitals in Glasgow and Paisley were becoming increasingly concerned about the poor state in which patients were arriving by aircraft from remote and rural facilities. Many had no chance of access to stabilisation procedures



for many hours prior to their arrival in the urban hospital and their outcomes were poorer than would have been the case if they lived in an urban environment. Some clinicians had started to undertake ad-hoc retrievals with no supporting governance structure which was very hazardous.

In 2004 a group of 10 consultants established a voluntary but well-governed retrieval service for Argyll and Bute. Its aims were to improve rural patient care, support our rural colleagues, develop retrieval experience and show that rural retrieval was feasible and effective. Three years later the Scottish Government provided finance for a fully funded West of Scotland pilot service. This pilot earned a very positive independent review.

#### **How is EMRS different from an air ambulance?**

It is different in terms of staffing and skills. A standard air ambulance is crewed by paramedics. Our retrieval team is made up of a consultant, a trainee and a paramedic. We carry a portable emergency department resuscitation room with us including a ventilator, invasive monitoring capability and a near patient testing device. This allows us to undertake a broad range of stabilisation and monitoring interventions including emergency anaesthesia, ventilation, arterial blood pressure measurement, central venous

press monitoring, chest drainage, drug infusions and cardiac pacing.

The capabilities in terms of assessment and management during an EMRS retrieval are therefore considerably more than that available during a standard air ambulance transfer. In addition the EMRS is actively involved in rural healthcare staff training and we provide expert advice over the phone regarding patient management and transport.

#### **What kinds of medical problems do you most commonly deal with?**

Two-thirds of our patients have medical emergencies such as respiratory failure, septic shock, cerebral haemorrhages, cardiac failure and severe overdoses. The remaining one-third have sustained major injuries.

#### **What factors do you think made the EMRS pilot a success?**

The success of the EMRS is down to the dedication and tenacity of the team. To man a 24/7 consultant rota voluntarily for three years demonstrated our commitment to providing a quality service. Our audit and research data proved that we improved

outcomes. We also developed a robust external communications policy to highlight our work to the public, health service managers and to politicians through news coverage, our website, newsletters and taking every opportunity to speak at conferences and meetings relating to rural healthcare.

In addition we had excellent support from a number of healthcare managers and rural clinicians and directors who could see the value of our service from the outset.

#### **What has been your most challenging case with EMRS?**

A few cases stand out. One was dealing with a multiply injured man from a paragliding incident on a hillside above Loch Lomond in a primary retrieval combining the mountain rescue team, the EMRS and two helicopters. Another was dealing with a lady with multi-organ failure on an island who deteriorated just as we were about to move her. At the same time it was getting dark and a storm was coming in. This meant that the ambulance

service helicopter had to leave us on the island. A few hours later when the patient was more stable we had to be transferred by search and rescue helicopter into a 50mph head wind and poor visibility.

#### **What's been your hairiest moment?**

On attempting to reach Skye one winter's night for a man with a serious head injury the search and rescue helicopter had to make an emergency landing on Mull due to smoke in the cockpit. The coastguard helicopter was dispatched to continue us on our journey but couldn't land on Skye for over an hour due to a blizzard. The team ended up staying with the patient all night as the weather was too bad to get off the island.

#### **What future do you see for the service?**

Increasingly people are beginning to acknowledge the evidence that patients with major trauma have better outcomes with a specialist doctor and paramedic providing roadside pre-hospital medical care followed by direct transfer to a centre capable of providing definitive care. We are very keen that our secondary rural retrieval

**"To man a 24/7 consultant rota voluntarily for three years demonstrated our commitment to providing a quality service."**

role expands to provide primary pre-hospital trauma care. Tasking the team appropriately for this role is however very challenging.

#### **How do you spend your free time?**

As well as time with my wife and three sons I enjoy a number of outdoor sports including mountaineering, road cycling sportive events and cross country mountain biking.

#### **Do you find it annoying when people go out in the hills unprepared?**

All mountain rescuers in Scotland are voluntary and unpaid. We enjoy training and undertake rescues no matter who or what is involved. Most incidents occur because people are unlucky and many incidents could happen to anyone. It is slightly frustrating however when we have to rescue people who have set out too late in the day, have inadequate equipment and who can't navigate to a basic level.

■ *Interview by Joanne Curran, associate editor at MDDUS*



# Speaking from the heart

*Much lip service has been paid to the notion of fostering patient-centred care – but one award-winning project is doing just that*

**I**N 2003, Pip Hardy and Tony Sumner, founding directors of educational consultancy Pilgrim Projects, were asked to produce some materials on clinical governance for the Royal College of Nursing. In the brief they were charged with being innovative and creative and also with making sure the patient's voice could be heard throughout the materials.

At around the same time they stumbled across what they felt was a powerful concept, digital storytelling, which involved the creation of a short personal story using video, audio, still images and music. It was a lightbulb moment: what better way, they thought, to 'hear the patient's voice' than to actually hear it?

As Tony explains: "We saw it as a methodology we could apply to the e-learning materials we were developing, to make them richer and more pertinent and get across the emotional point. So we had to persuade people that we could put patients talking about their experiences into the learning materials and it wouldn't make them less valid."

Having convinced the RCN to let them embed stories in this way, and delighted with the feedback they received, the pair decided to apply the concept more widely and set about persuading others in the healthcare sector of the validity of the method and the need to hear people's experiences directly rather than reflected through long reports filled with dry statistics.

"We were driven by our experience, and the experiences of people that we knew in healthcare, that healthcare wasn't always humane," says Pip. "It seemed that there was a real need to re-inject some humanity."

## Building 'social capital'

The result of this drive is the award-winning Patient Voices programme, a series of digital stories illuminating the experiences of people from all over the healthcare spectrum, including patients, doctors, nurses, managers, chief executives and carers. In the last six years some 400 stories have been created – through the likes of NHS Leeds, the NHS Heart Improvement Programme, the University of Nottingham and the Isle of Wight Stroke Club. Of these, more than 250 are available for free download from the Patient Voices website as an educational resource to stimulate discussion and reflection. It's what Pip and Tony, who describe themselves as social entrepreneurs, call the "building of social capital".



"Statistics tell you how the system experiences the individual, whereas the stories tell you how the individual experiences the system."

This means that, for example, Jimmy's Story, created in a workshop around patient safety for NHS Tayside and told by his sister Betty, is just a few mouse clicks away from anyone with internet access. In the story Betty recounts how, after her brother fell in hospital, he died three weeks later following a series of mishaps, lost notes and uninvestigated injury. Despite all her efforts at the time, she says she was ignored.

Then there's Monica Clarke's story, in which she describes the frustration she faced feeding her husband after he had a gastrostomy. Every time she had a problem to deal with, whether it was to do with the pump, the feeding tube, the attachment or a leak, she was told to contact a different person. In what is a call for some kind of central control, she asks: "How can we manage a simple thing like giving a feed when there are four or five different specialists all over the country?"

These short, poignant and highly affecting stories are, like all the others on the website, the result of workshops run by Tony and Pip and commissioned by healthcare providers and educators. A workshop might be based around patient safety,



Patient Voices participants. Above: BMJ Group Awards with Pip and Tony front right and middle

as in Jimmy's Story, a condition such as rheumatoid arthritis or a theme like patient involvement.

## The story is the agenda

As facilitators in the workshops, Pip and Tony adhere to a strict methodology which aims to let people come up with and tell their stories in the way they want, thereby achieving a direct line of communication between storyteller and audience with no over-arching agenda.

At the start of the workshop, says Pip: "We don't know what stories people are going to tell, and because we don't have an interview spine of questions, it really is a question of saying: 'What's the most important story you want to tell us around this issue?' Then our task is to help them make that the best, most powerful, effective and affective story it can possibly be."

Workshops vary in length, but usually last around three days. In groups of about six to eight – big enough to stop a dominant personality from taking it over, yet not so big for it to fracture into smaller groups – participants share their initial ideas for a story and use the group feedback, as well as the experience of Pip and Tony, to begin to home in on what it is they want to say.

Tony explains: "We are there in an editorial role and one of the things we always say when we're running the story circle is that the point is not to fix the NHS or to turn into a talking

shop about the way healthcare service should be better. The point is to fix that story so that it becomes the most effective way of conveying that experience."

Over the following days, participants prepare their own script ready for recording on to an audio track. They are then shown how to bring in their pictures and audio and how to assemble their stories themselves. "It's within the creative bounds of everyone, ranging from those with learning difficulties to tetraplegics. It's an accessible medium within which they can express their experiences," says Tony.

With the uploading of these stories on to their website, it means that instead of them being watched by friends and family and perhaps a few members of the sponsoring organisation and then disappearing into a filing cabinet or down the back of a sofa, they begin a journey of their own.

Searchable by title, description or keyword, or alternatively by the body that sponsored them, this tapestry of stories has found its way into a plethora of educational environments, including in-house education programmes, nursing education, interprofessional education and a large number of medical schools across the UK.

## 100 per cent personal

One of the things Tony and Pip have been fascinated by is the way the stories take on a life of their own in terms of their applicability. Jimmy's Story, for example, is used by one educator to underpin a whole series of lectures, starting with record-keeping and moving on to issues of corporate liability and the responsibility of directors on health boards.

"There are lots of interesting things that can be done with the story that go far beyond the original intention," says Pip.

It hasn't all been plain sailing, however, and some doubters have suggested that the stories are anecdotal and not statistically valid. To which Pip counters: "Well they are 100 per cent of one person's experience and that's a really valuable thing."

Tony adds: "The stories actually tell you what it's like to be that patient or that doctor. So the statistics tell you how the system experiences the individual, whereas the stories tell you how the individual experiences the system."

After a little over six years since starting the programme, Pip and Tony were delighted earlier this year when their work was acknowledged at the BMJ Group Awards (with MDDUS as headline sponsor), where they won the Excellence in Healthcare Education prize and were runners-up for Health Communicator of the Year. Recognition like this will, they hope, raise their profile further and allow them to continue what they both admit is a "mission" to spread the stories of individual healthcare stakeholders and thus oil the wheels of communication and understanding.

"We put all our time into it because it seems very important to us," says Pip. "And it's nice to be able to say after working for six years, in the face of some difficulties and resistance, that the *BMJ* has acknowledged that these stories are important."

■ Adam Campbell is a freelance journalist in Edinburgh and regular contributor to *Summons*

*Part two in a two-part series by medico-legal adviser Mr Des Watson on coroner's inquests and the obligations of healthcare professionals*

# Coroner's inquests



**T**HE first part of this article, in the last issue of *Summons*, discussed how to respond when asked by the coroner to draft a statement in regard to the sudden death of a patient. Sometimes this may also involve appearing in court to amplify or explain that statement. This can happen even when the facts in the statement are not disputed in any way. Sometimes the coroner will summon clinicians who seem only very peripherally involved in the events surrounding the death.

It is only natural that a clinician may be concerned that they will be criticised or faced with hostile questioning in an inquest. This is an area where support from MDDUS can be very important.

## Appearing in court

A member who is summoned before the coroner where there are no indicators of hostility or of criticism is unlikely to benefit from legal representation. If anything, a clinician who attends a non-contentious inquest "lawyered up" will only draw unwelcome attention. It can be helpful to have a supporter attend to sit in the public area. Trusts will often send a manager along to court to support their employed clinicians in this way. More information on the handling of inquests

where employing trusts are involved is provided towards the end of this article.

Clinicians should make sure they have the deceased's notes with them and should also have a look through their own statement before attending court. There is no expectation of a photographic memory and it is far better to refer to the notes if there is doubt about the clinician's recall of events. Having said that, it is embarrassing if there is a long leafing through notes looking for something that could have been anticipated and flagged with a post-it note.

The usual advice for witnesses unused to court appearances applies:

- **Turn up** – attend on time at the right place and be prepared for a long day.
- **Dress up** – you are a professional person so dress and behave as such.
- **Stand up** – less important these days: most inquest witnesses sit to give evidence.
- **Speak up** – the court needs to hear your evidence and the coroner needs to take notes so speak slowly and calmly.
- **Shut up** – once the initial nerves are past, there is often a



temptation to gabble the first thing that comes into one's head; just answer the question asked and then wait for the notes to be taken before listening to the next question.

Perhaps a useful sixth piece of advice is to "Listen up". Help the court by trying to answer the question asked. This is not a viva voce examination where something has to be said to fill awkward gaps. If the question is unclear then ask for it to be clarified. If you need to refresh your memory from the notes then say that you cannot remember and ask if you may check the notes.

After verifying identity, the coroner will ask the clinician to give evidence after an oath or an affirmation. The coroner then takes the witness through the statement either by asking for it to be read out or by question and answer. The coroner will then ask any questions he or she may have and will invite other interested parties to ask questions. This is the moment for the family to quiz the clinician and this has the potential to become heated and angry. The coroner will keep control in his or her own court and will intervene if the questioning is irrelevant or unduly hostile.

Once the clinicians have given evidence, they may well be released although it can be interesting to stay to hear the verdict.

## Coroners' verdicts

Traditionally verdicts were one or two words, such as "misadventure" or "natural causes". Increasingly, coroners are delivering narrative verdicts where they expand briefly on the main verdict. These short statements may point out where systems have gone wrong or could be improved to prevent similar deaths in the future. The coroner is not permitted to name any persons in these narrative verdicts but they can be uncomfortable for individual clinicians whose actions and responsibilities can be inferred from the verdict.

## The media

Most inquests are attended by a junior reporter or two and they are always on the lookout for a local interest story. Every clinician will be aware of whether or not their local rag likes a good "bash the Health Service" story. If there has been implied criticism of the clinician, the reporter may seek an interview as the parties leave the court. MDDUS can help with advice on how to deal with this if it happens. If a member is taken completely by surprise, it is unwise to say "no comment". A better reply is to say how sorry you are for the relatives and family and then to refer reporters to the coroner's verdict if they want any more information.

## Inquests with legal representation

Sometimes the indications are that there will be criticism of

an MDDUS member. In that case, legal representation is usually wise. MDDUS will arrange for the member to meet a legal team which can be a solicitor, a barrister or both. The meeting allows the lawyers to talk to the doctor or dentist, assess any concerns that may be raised by the clinician or from the notes, review any other evidence that the coroner may choose to disclose to the clinician (such as autopsy reports or statements of other witnesses) and brief the member on how the inquest is likely to unfold.

Lawyers cannot speak for the clinician who is a witness assisting the court and not a defendant. Besides anticipating difficult questions, they can intervene to remind the coroner

that the questioning is becoming irrelevant and, as properly interested persons, can ask questions of other witnesses that can deflect implied criticism of the MDDUS member.

There are times when the family appears with a solicitor who writes industriously but says not one word, leaving the legally represented clinicians wondering what all that was about. Inquests can be a very cheap and effective way for solicitors to find out details of a case before deciding

whether or not to bring a claim in negligence against a clinician or an organisation. The coroner may not point the finger of blame at individuals and only indirectly at trusts but the evidence presented, under oath, to the coroner can be used later to assess the prospects of a successful civil action.

## Trust inquests

Where the doctor or dentist is an employee of a trust (as opposed to a contractor with a trust), the coroner may summon a representative of the trust, such as the medical director, as well as the individual clinicians. In this case, the trust may well bring a legal team along. Provided there is no conflict of evidence between the clinicians and the trust, it is best if the clinicians attend under the umbrella of the trust, whether or not there are lawyers involved.

Problems can arise when a trust tries to protect its reputation by implying in evidence that individual clinicians are responsible for the death. If a trust instructs lawyers, their loyalty is to the trust and not to individual clinicians who happen to be employees of that trust. In this kind of case, the trust and its lawyers should advise the clinician that there may be a conflict and that separate legal representation will be a good idea. If a member is asked to give evidence at an inquest where his or her trust is appearing with legal assistance, early notice to the MDDUS adviser who is providing assistance is vital.

■ *Mr Des Watson is a medico-legal adviser based in the London office of MDDUS*

# Chest pain – when is

*Most chest pain will not be due to MI – but prompt diagnosis is still vital as delay can sometimes lead to fatal consequences, says*

Professor Kevin Channer

**C**HEST pain is an extremely common symptom in secondary care but relatively uncommon in primary care, amounting to about 1-2 per cent of consultations.

The vast majority of patients with chest pain will not have symptoms caused by myocardial ischaemia. In one study of 35,075 GP consultations in Sweden, only 1.5 per cent were for chest pain and only 8 per cent of these were due to underlying ischaemic heart disease<sup>1</sup>. In a Swiss study of 24,620 GP consultations, 2.7 per cent were for chest pain, with coronary artery disease accounting for 12 per cent of these<sup>2</sup>. However, when chest pain is due to myocardial ischaemia there are potentially fatal consequences if action is not taken to reduce the risk for myocardial infarction.

## Important characteristics

Studies of large populations of patients with chest pain have identified those characteristics and symptoms which predict the presence of underlying coronary artery disease. Positive and negative predictors are shown in the table below.

Although considering the characteristics of the pain can help, so can the context in which this pain has occurred.

Consider these two case histories:

### Case history 1

A 66-year-old man and ex-miner experiences chest tightness on walking up hill to the paper shop every morning. He has smoked 20 cigarettes a day since age 14 years and is overweight (BMI 29), hypertensive and suffers from diabetes. The likelihood that this man has significant underlying coronary artery disease is very high. He has four important risk factors and a typical history.

### Case history 2

A 22-year-old female and non-smoker has an argument with her boyfriend, panics, feels breathless and develops tingling in the lips and fingers and then severe central chest tightness with pain in the left arm. The history of the pain is characteristic of angina, but she has no risk factors so is very unlikely to have underlying coronary artery disease. In fact the history strongly suggests

panic disorder and hyperventilation which can cause myocardial ischaemia because of coronary artery spasm.

Both patients have chest pain of cardiac origin, but the underlying cause of their symptoms and the mechanism behind their generation is different. The clinical implication of their symptoms, prognosis and management is very different.

Also apart from the characteristics of the pain and the circumstances around its occurrence, other factors have also been shown to have predictive value.

## Positive predictive factors

- Age (> 55 years in men and > 65 years in women)
- Gender (male)
- Presence of risk factors (more present greater risk)
- Previous history of coronary disease

## Risk factors

Coronary artery disease occurs progressively with age. However, in some individuals it starts earlier. There are a number of factors

### Typical

- Consistent relationship with exercise
- Squeezing, crushing, burning, tightness or heaviness
- Central, substernal or left-sided
- Relieved with rest
- Relieved with GTN
- Deep
- Radiation to neck and arms

### Atypical

- Pain lasting longer than 30 minutes
- Unprovoked pain at rest > with exercise
- Right-sided location in chest
- Stabbing
- Single spot
- Superficial
- Not radiating
- Inducible by local pressure
- Position, respiration or cough dependent



# it angina?

which have been shown to encourage the development of premature coronary disease. These risk factors include:

- Genetic factors – the tendency can run in families.
- Sex – men develop coronary artery disease earlier.
- Smoking (especially cigarettes) – there is a dose response also with the more cigarettes smoked the higher the risk.
- Hypertension.
- Diabetes mellitus.
- Hypercholesterolaemia.
- Obesity.
- Psychosocial factors – weak social links, low socio-economic status, north versus southeast

## Types of angina

When angina only occurs with exercise and it is reproduced by the same degree of exercise, this is called chronic stable angina. The pattern of angina may change with time over years, but can occur more abruptly over days. When the pattern changes so that it occurs more easily than previously, but still only on exercise it is called crescendo angina. When angina occurs at rest this means that the myocardium is ischaemic even in the absence of an increase in workload and implies critical myocardial perfusion. These latter two patterns of angina represent unstable angina. This is usually due to the development of a thrombus on the surface of an atheromatous plaque within the artery. Thrombus development is rapid and so symptom deterioration is sudden.

In patients with rest angina the pain lasts for less than 30 minutes and then is relieved. If the pain from myocardial ischaemia persists for longer than 30-45 minutes then cardiac muscle damage occurs – this constitutes a myocardial infarction.

These facts must also be taken into account when considering the presentation in primary care. Crescendo and unstable angina are pre-infarction syndromes and require

urgent action. The early mortality of chest pain in this situation is about 10 per cent. Admission is mandated for aggressive medical and, nowadays, interventional therapy (angiography and angioplasty).

If a patient presents late, say days after having rest pain, then it is possible to use simple diagnostic tests to determine whether the pain was of cardiac origin. If the pain was ischaemic in origin and lasted longer than 30 minutes then myocardial damage would have been caused which would result in an increase in blood troponin level. This is a very sensitive test and is nearly always raised in patients with unstable angina. It persists for about 2 weeks after an event. Similarly, if the pain lasted for hours then the only cardiac syndrome that could account for the pain is a myocardial infarction and this would usually cause a change on the resting 12-lead electrocardiograph which evolves over time after an infarction.

## Diagnosis essential

It is essential to make a diagnosis of coronary artery disease because the treatments available significantly reduce the risk of death or infarction. Avoiding or preventing infarction is also very important as myocardial damage reduces life expectancy; a damaged heart will not survive as long as a normal heart.

In patients with a typical history of angina and risk factors for the premature development of ischaemic heart disease, immediate treatment with risk-modifying drugs is indicated to minimise the risk of infarction or death, pending more definitive investigations or treatments. Thus, any patients in whom there is a suggestion that the presenting symptom is of cardiac origin should be given aspirin (75mg daily), a statin and a beta blocker.

The risk of developing an infarction is reduced by these treatments but the size of the risk reduction is important. The single most valuable risk reduction strategy is to

stop smoking. This reduces the chance of developing an infarction after presentation with unstable angina by about 30 per cent. Aspirin is also very important and reduces risk by about 40 per cent. By comparison, statins do not reduce risk immediately and there is a lag time of up to 12-18 months before risk is reduced by these drugs. Beta blockers reduce risk by about 10 per cent.

Early angiography and angioplasty reduce the chance of developing myocardial infarction (by about 20 per cent) but death is not significantly reduced by this strategy.

## Reducing medico-legal risk

Below are some important points to remember in reducing medico-legal risk in patients presenting with chest pain in primary care:

- Chest pain is uncommon in primary care.
- The history is the most valuable tool in the diagnosis of chest pain of cardiac origin.
- Simple tests like ECG and blood troponin are useful in the diagnosis of infarction.
- Unstable angina is a medical emergency and demands admission to hospital.
- Early confirmation of the diagnosis of angina is important as there is a 10 per cent mortality in the first year after diagnosis which then falls to an annual mortality of 3 per cent thereafter. Refer to a Rapid Access Chest Pain clinic.
- In patients suspected of having angina, advise stopping smoking and give aspirin, a statin and a beta blocker if not contra-indicated.

■ *Professor Kevin Channer is a consultant cardiologist at the Royal Hallamshire Hospital in Sheffield and Honorary Professor of Cardiovascular Medicine at Sheffield Hallam University*

1 Nilsson S et al Br J GP 2003; 53: 378-82

2 Verdon F et al Swiss Med Weekly 2008; 138: 340-47



# A job worth doing

*Audit is a necessary but challenging requirement for all dentists. David MacPherson offers some guidance*

**F**OR some dentists, the merest mention of 'audit' is enough to make them want to run and hide. Many will recall hours of useless data collection that only serves to establish that some obvious fact, that everyone knew anyway, was correct.

And don't mention statistics. This raises a raft of other questions. Is it probable or improbable? Is it even significant? Was the group size too small? We might wonder whether we are even collecting the correct data and if our questions are too open or too closed. We are often simply amateurs having a go in someone else's complex specialty.

So why do we attempt audit? Well primarily because we have to. The General Dental Services (GDS) terms of service require us to complete 15 hours of audit in every three year cycle – a situation that isn't likely to change. In fact there are pretty strong rumours that the monitoring of this could be about to change in Scotland and that NHS Education Scotland (NES) may have a role in recording dentists' audit histories.

I have recently seen the new, improved NES dental portal which will be launched in August. You will be able to print off your own NES CPD history and certificates and ultimately this may be where we will see, at a glance, our approved audit history. The e-Portfolio too is getting a facelift and here you can store, develop, share and submit audit reports. It is hoped in time this will store a data bank of audits which will become a useful resource itself. Remember that revalidation is coming and audit will be a significant part, so the easier it is for us to get our hands on our supporting evidence the better.

## Meaningful change

There are many benefits to getting involved in audit. We all do some form of audit in our practices, whether it is just taking test X-rays every day to comply with IRMER or changing something when a negative outcome presents itself.

But this informal approach runs the risk of missing that essential opportunity to make a meaningful change. We might decide to change labs because those crowns just don't fit as well as they used to, but that problem could be the fault of your impression material, the transportation or even your deteriorating eyesight.

Clinical audit is the systematic critical analysis of the quality of care provided to our patients. It is one of the only mechanisms we have of ensuring that we are doing a good job. We change our methods as we change our materials. We get older and

more experienced and adapt our techniques. We learn new skills and introduce them to our daily routine.

But how do we know if these all benefit our patients? An example of this was demonstrated to me recently at an implant course. I was surprised to learn that the long-term success of more recent modifications to an existing implant system was poorer – was this progress? It may have been easier for the practitioner to fit but surely the most important question had to be: "would it perform better than the previous version?"

We are all bound by clinical governance – a key element in revalidation. Clinical governance is a system through which we are accountable for continuously improving the quality of service and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

In my role at NES, I have been trying to promote relevant audit through our course programme. In it, we highlight three ways in which we can analyse the quality of care provided to our patients:

- **Structural audit.** We can measure the resources we have, for example: Do we have enough time set aside for emergency patients? Do we have enough adequately trained staff?
- **Process audit.** We can measure the procedures used for diagnosis and treatment: Can we get useful information from our X-rays such as caries detection? How robust is our record keeping?
- **Outcome audit.** We can measure the actual outcome for the patient. Did the patient suffer pain after a procedure? What was the patient's satisfaction with their practice following a visit?

## Getting started

So how do we get started in audit? We could decide if we wanted it to be an individual audit, a practice/team audit or even join one of the larger facilitated audits that are run by regional audit committees in various regions.

We then decide on our topic. This should be relevant to what the biggest priority is to you. Consider if any change will affect a large number of staff or patients, if cost effectiveness can be improved, or if there is a potential to improve quality of care.



We must also consider if the audit will be easy to do. For this, consider if it will disrupt day-to-day practice running and if a commitment is necessary from team members. If we do not address these barriers at this stage it is less likely to succeed.

Next we have to consider what information on your audit topic already exists. Is there a recognised standard to compare against – for example SIGN guidelines, GDC guidance or BDA advice sheets? You may even have to search the internet or source some previous research or audits.

Then set aims and objectives which will relate to the reason why you chose to audit that particular subject in the first place and how this will be compared to your agreed criteria or

"Clinical audit is one of the only mechanisms we have of ensuring that we are doing a good job."

standard. Finally, choose your method – perhaps create a data collection sheet and collect your data. Remember, keep it simple, be specific and clearly define your area of focus. Once you have completed your first round of data collection, change can be implemented and a second round of data collection can see if

the change has been beneficial.

There is excellent advice on all of these stages and examples of completed audits on the NES website. Here you will also find help on sample size and suggested Clinical Audit Allowance hours. There is also information on the Department of Health website covering other parts of the UK.

## Clinical standards

Audit also has an important role in dento-legal matters. It is the only way to demonstrate monitoring of your clinical standards and building in continuous improvement. You should target weak areas of your practice (perhaps identified by a patient complaint) and investigate where you are at that point in time.

If faced with a complaint you may be able to demonstrate that your standard is in line with current best practice and the complaint is not representative of your practice. If you discover that changes require to be made then they can be implemented and you can then re-audit to demonstrate the improvement since the complaint.

If you still find clinical audit daunting then you may find Significant Event Analysis (SEA) an easier introduction. The GDS allow us to comply with our 15 hour/three year audit requirements entirely with SEAs. They often identify clinical audits. They allow us to make an instant start on an issue that is relevant to the practice.

There will be more information on SEAs in the autumn edition of *Summons*. To find out more about audit, visit [www.nes.scot.nhs.uk](http://www.nes.scot.nhs.uk) or [www.dh.gov.uk](http://www.dh.gov.uk)

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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

## RECORD KEEPING: RECORD INSULT



PHOTO: CHRIS KNAPTON/SCIENCE PHOTO LIBRARY

**BACKGROUND:** A young VT saw a 39-year-old patient the day after she had received a root canal treatment to her lower left premolar at another practice.

The patient didn't want to return to her previous dentist and complained of constant throbbing pain. The VT examined the patient and found the LL5 to be very tender to percussion.

There was no associated swelling but the patient said the left side of her lower lip was 'tingly'. The VT took a radiograph and noted the root filling material had perforated the apex and appeared to have entered the ID canal.

The VT called the oral surgery department at the dental hospital who advised removal of the tooth or an attempted removal of the attached extruded gutta percha and retrograde root filling.

Treatment options were discussed with the patient and the tooth and attached root filling material was successfully extracted. The next day the patient reported a great improvement in symptoms. The VT was surprised to receive a letter of complaint from the patient, claiming she had not been

provided with sufficient treatment options including immediate implant placement.

### ANALYSIS/OUTCOME

MDDUS discussed the complaint with the VT and his trainer. The contemporaneous notes taken by the VT clearly showed the patient had been given a full list of treatment options and had chosen extraction of the tooth. This case had cost implications of more than £5000 as the ideal replacement for any tooth lost through negligence is a dental implant. MDDUS drafted a letter responding to the complaint and stressed that the VT had acted entirely correctly. The patient accepted the explanation and raised a claim against her former dentist.

### KEY POINTS

- Always keep clear, contemporaneous dental records. These formed a crucial part of this VT's defence against accusations of negligence.
- Dental records in cases like this should confirm a thorough and comprehensive assessment has been carried out.

## ACCESS TO RECORDS: A FATHER'S RIGHT?

**BACKGROUND:** Mr B contacts a surgery in England where his child is a patient. He is not married to the child's mother, Miss C, and the couple are now separated. He wants Dr F to give him access to the boy's medical records so he can find out why his son has attended a number of recent appointments.

Miss C subsequently contacts Dr F to request that Mr B not be allowed access. She is concerned he will have access to sensitive information – including her address – which is noted within the records. Dr F is unsure of how to proceed.

**ANALYSIS/OUTCOME:** Doctors require the consent of children and young people with capacity before disclosing their records to anyone, even a parent. If the doctor deems a child lacks capacity – which applies in this case – then he should let those with legal parental responsibility access their child's medical records if it does not go against the child's best interests.

Dr F is informed by the MDDUS that Mr B has a right to access his child's records because he and the mother jointly registered the birth. The child's date of birth – in this case August 2005 – is also significant in determining parental rights to access the records.

Specific legislation for parental access to records varies among home countries and in relation to date of birth of the child. The MDDUS adviser also referred the GP to GMC guidance on access to medical records. Dr F was also advised that third-party information should be redacted from the notes before they are released to Mr B.

### KEY POINTS

- Be aware of variations in national guidelines governing parental access to children's records.
- Ensure sensitive third party information is redacted from records before disclosure.





## CONFIDENTIALITY: A SIMPLE DISCLOSURE



**BACKGROUND:** A GP is contacted by the headteacher of the village primary school who asks about one of her patients, an eight-year-old boy. The teacher wants the GP to confirm where the child lives and explains that he suspects the boy's parents are using a bogus address in order to get him into the school. The GP believes the family do not actually live in the school catchment area and wonders if there is any harm in confirming the headteacher's suspicions.

### ANALYSIS/OUTCOME

An MDDUS adviser tells the GP that even confirming whether or not the address held by the school was the same as the one held by the practice would violate patient confidentiality. The GP would need consent from the child's parents before releasing any information – even if she knew the headteacher's suspicions were well-founded. Only if the disclosure was made in the public interest, in accordance with GMC guidance on confidentiality, could a doctor consider disclosing without consent.

### KEY POINTS

- Always bear in mind patient confidentiality when dealing with requests for information from third parties and seek patient consent – no matter how innocuous the request may seem.
- Be aware of GMC guidance on disclosing confidential patient information.



## TREATMENT: FOREGONE OUTCOME?

**BACKGROUND:** Mrs J attended her GP – Dr L – with a mole on her back that her husband had noticed was changing in shape and colour.

Dr L diagnosed a pigmented papilloma and advised Mrs J to make an appointment to have it removed at the practice's minor surgery clinic. The patient spoke to the receptionist who informed her that there were no free slots in the next clinic and, as the practice did not operate a waiting list system, Mrs J would have to call the surgery every week to see when a slot would be available.

Mrs J phoned the clinic numerous times over the next two months but there were never any slots. In the meantime she noticed the lesion was changing more rapidly in colour and shape and starting to protrude. She told the receptionist of her concerns but these were not noted or passed on. Her husband eventually insisted she make another appointment with Dr L.

In the next consultation the GP noticed the changes and immediately referred Mrs J to a dermatology clinic where it was excised the same day. The histology report confirmed an invasive malignant melanoma. Fine needle aspiration of a lymph node in the left axilla determined that the cancer had spread.

Mrs J was admitted to hospital for block dissection of the lymph node as well as a re-excision of the scar where further melanoma deposits were found. Over the next months



there was rapid metastatic spread to the lungs, liver and bone. Mrs J died at home within 10 months of first seeing the GP.

Her husband instructed solicitors to bring a claim of medical negligence for misdiagnosis and failure to refer. It was alleged that had Mrs J been referred at the initial consultation there would have been no subsequent lymph node involvement and spread of the melanoma.

**ANALYSIS/OUTCOME:** MDDUS, acting on behalf of the GP, commissioned reports from both a GP expert and an oncologist. The GP expert was of the opinion that, given the location and changing nature of the lesion, Dr L should have made an immediate referral. He also was critical of the booking arrangements for the minor surgery clinic and the fact that Dr L was not alerted as to Mrs J's concerns over the developing lesion. Given these facts

the expert felt there was a breach of duty of care to the patient.

The oncologist agreed that the lesion should have been diagnosed earlier but was of the opinion that the delay would have made no difference to the overall outcome of

the disease in either cure or prolonged survival. It was an extremely aggressive melanoma.

The case was subsequently discontinued by the pursuer without explanation.

### KEY POINTS

- Have a high degree of suspicion with any skin lesion said to be undergoing recent change in shape or colour – if in doubt, refer.
- Ensure that practice systems do not lead to significant ongoing delays in treatment.
- Instruct staff to report any significant patient concerns to the relevant GP
- It is important to consider in each case whether or not any fault by a practitioner led to any altered outcome. In this case, sadly, the patient's outcome was pre-determined by the aggressive nature of the disease.

## From the archives: an early lunacy case

MDDUS meeting minutes from the early 1900s refer to a number of lunacy cases. One particularly troublesome one was that of *Purves v Gilchrist and Carswell*. Doctor Marion Gilchrist was the first woman to obtain a medical degree from a Scottish university at Glasgow in 1894. In 1904 a Mr Purves alleged that she and Dr Carswell conspired with his wife to arrange his committal to a mental hospital with no prior examination to determine his mental state.

The MDDUS agreed to defend the two doctors despite both only having joined the Union when the action was threatened. The arrangement broke with precedent as the council had always determined only to defend those who were current members.

Both doctors agreed to refund any charges for costs and the case was deemed important enough for the MDDUS to be involved.

In January 1904, the patient had been released from the mental hospital following a successful appeal to the courts. The Sheriff stated that one of the certifying practitioners, who happened to be the GP of the patient's wife, had failed to consult the patient's own GP prior to taking certification action. The certifying practitioner claimed he had not been aware that the patient had his own GP.

The Proof was set for 7 November 1905 in the Court of Session. Many doctors and other witnesses were cited for the defence, including Sir Henry Littlejohn, eminent in medical jurisprudence at the time. After a month, the Edinburgh agent was already seeking legal fees of £300 but the MDDUS could only send £275 – an illustration of

the Union's precarious financial basis in those early years. Judgement was eventually given in favour of the defendants, both of whom wrote to the MDDUS expressing their gratitude. Legal costs totalled £949 18s 1d – part of which was raised by public subscription, leaving the balance to be paid by the doctors equally as agreed.

The case did have one early benefit. In 1908, the MDDUS issued all members with certificates to be signed by the relatives of those they were seeking to have committed, prior to completion of a certifying procedure. This would effectively indemnify certifying practitioners against similar actions in the future. This device was only adopted after failure to persuade the authorities responsible for the management of lunacy cases, to make appropriate arrangements to protect doctors in such cases.

## Medical Wordsearch: causes of breast lumps

N E L E C O T C A L A G L P F S L T  
W H T L B X D K Q G J N P J X I Z F  
P B J J G X D M P M R K X L V T T Z  
D U C T P A P I L L O M A A C I S A  
F J S N C A R C I N O M A M R T Y M  
H I N A B G K X B Y L Y A O L S C O  
F Z B G R K J B T Z L I B N N A S T  
A R J R N C G J K Z S L F E R M U R  
T B D N O P O M M A W B T D M L O A  
N G G A L A D M T F R S H A X A E M  
E L Y K M H D C A K Y Z H O R T C A  
C H M L N O E E L C A F T R M C A H  
R R D T T T P K N B L R G B K U B R  
O T M R C H V I S O M J T I Q D E N  
S T F U V J W C L B S K D F K I S M  
I L D H N N E F D J L I C N K R N K  
S T W Z T S N G J Y F G S R G E M L  
T R G L S M X R Q D G K L C F P Y H



Find 14 causes of breast cancer in the grid. Words can go horizontally, vertically and diagonally in all eight directions.

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

Thanks to Scion Publishing Ltd and Ranjita Howard for permission to reproduce this puzzle from *Puzzles for Medical Students* (order online and enjoy 20% discount for MDDUS members; look for Scion logo and follow instruction on 'Discounts for Members' page at [www.mddus.com](http://www.mddus.com))

From *A Century of Care – A history of the Medical and Dental Defence Union of Scotland*, edited by Norman Muir and Douglas Bell



PHOTOGRAPH: SCIENCE & SOCIETY PICTURE LIBRARY

## Object obscura: trepanned Bronze Age skull

This skull was excavated from Jericho in Palestine and dates from 2200-2000 BC.

Trepanning in ancient times may have been intended to release evil spirits believed to cause mental problems or illnesses, such as migraine or epilepsy. Holes were roughly circular if drilled or more square if knife-cut. This individual survived the process as evidenced by signs of bone healing.

# Vignette: pioneer for women in dentistry

## Lilian Lindsay (1871-1960)

THE odds were stacked against Lilian Lindsay achieving her ambition of becoming Britain's first qualified female dentist.

She was born Lilian Murray on July 24, 1871 in Holloway, north London, where she lived with her four brothers and six sisters. It was a time when male dentists were largely against women joining the profession, and while the 1871 census shows there were 116 women dentists, none held a Licence in Dental Surgery (LDS).

But breaking down barriers was something at which Lilian would eventually become quite expert, as she went on to realise her dream and become one of UK dentistry's leading lights. Her pioneering spirit inspired her to learn four languages and become a celebrated dental historian and respected, award-winning scholar. She was also the first female president of the British Dental Association.

Lilian knew from an early age the career she wanted to follow. She went to Camden School for Girls, founded by Frances Mary Buss, then won a two-year scholarship to the more expensive North London Collegiate School. Lilian clashed with the formidable Miss Buss who was determined her pupil should teach deaf and dumb people. Lilian disagreed and an annoyed Buss ensured she did not get the promised scholarship, so Lilian left the school.

She took up a three-year dental apprenticeship but wanted more and registered as a dental student. She applied to the National Dental Hospital in Great Portland Street, London, but the dean, Henry Weiss, refused to let her in the door for fear of distracting the male students. Lilian had to remain on the street while he leaned out of the window to interview her before refusing admission as a student.

Weiss tried to offer Lilian some guidance and advised against applying to the Dental Hospital of London as the English surgical college did not allow women to enter its examinations. Knowing that entry to the professions for women was more advanced in Scotland than in England he suggested she contact the Edinburgh Dental Hospital and School. To her delight Lilian was

accepted by the dean, W Bowman MacLeod, although some staff were unhappy about accepting a woman into the profession. Sir Henry Littlejohn said: "I am afraid, Madam, you are taking the bread out of some poor fellow's mouth."

She was the only female student at the time but Lilian excelled, earning the Wilson medal for dental surgery and pathology and the medal for materia medica and therapeutics in 1894. In 1895 Lilian became the first qualified British woman dentist, gaining the LDS with honours from the Royal College of Surgeons of Edinburgh.



Prejudice against allowing women into dentistry persisted for another 13 years. The English college twice voted against proposals allowing women to sit its LDS examinations and the ban was finally lifted in 1908. Four years later, Lily Fanny Pain became the first female to gain the college's LDS.

Lilian met her future husband, Robert, a fellow student, on her first day at the Edinburgh school but financial commitments forced Lilian to return to London to practise after she qualified. After clearing her debts a full 10 years later, they married in 1905 and practised together at 2 Brandon Street, Edinburgh.

Robert became secretary of the BDA in 1920 and the couple retired from practice and moved to a flat above its headquarters in London's Russell Square. The association started a small library and Lilian became honorary librarian. In addition to books she collected dental ephemera which became the basis for the museum collection. Lilian recognised their potential contribution for recording dental history and shaping the future profession.

To pursue her interests in history and contemporary literature she taught herself French, German, Latin and some Anglo-Saxon old English. They enabled her to maintain contact with colleagues in many parts of the world and she collected articles and extracts of interest from magazines and newspapers.

After Robert died she became sub-editor of the British Dental Journal in 1931. Her research led to many papers and lectures, the first to the Odonto-Chirurgical Society of Scotland in 1912. It was a further 12 years before her next paper but between 1925 and 1959 she published 57 papers plus many translations, letters, notes and annotations for the *BDJ*, at least 10 of major historical importance. All exhibit her scholarly approach and knowledge.

Lilian received awards and honours too numerous to report in full. In 1946, in Edinburgh, she became the first female president of the BDA, received the degree of Doctor of Laws (honoris causa) from its university and an honorary HDD from its Royal College of Surgeons. There followed a CBE and in 1959 the Edinburgh college awarded Lilian an honorary FDS.

The English surgical college also honoured her with the John Tomes Prize in 1945 and the Colyer Gold Medal in 1959. At the Royal Society of Medicine she was CE Wallis lecturer (1933), president of the odontological section (1945) and president of the history of medicine section (1950). In 1938 Lilian also became president of the British Society for the Study of Orthodontics.

Lilian Lindsay died on January 31, 1960, at age 88. Truly a remarkable woman.

Professor Stanley Gelbier



# At last

From 1st June 2010, employing MDDUS members and Practice Managers within group schemes, will have access to our own HR specialists and Employment Law partners.



**FREE &  
Unlimited**

access to our HR and  
employment law  
advisory service

The MDDUS is the only UK defence organisation to provide a free and unlimited helpline operated by in-house HR and Employment Law Advisers. This team will provide a personalised service where supportive relationships can be formed.

For an additional subscription, practices\* can also benefit from access to:

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- Employment tribunal award protection

For further information contact: Employment Law Team  
on 0845 270 2034 or email [employmentlaw@mddus.com](mailto:employmentlaw@mddus.com)



\*These additional benefits are exclusively available to our Practice Schemes where 100% of partners are MDDUS members. The additional subscription will be a maximum of £75 per annum, per partner.