Spring 2010

SUMMONS

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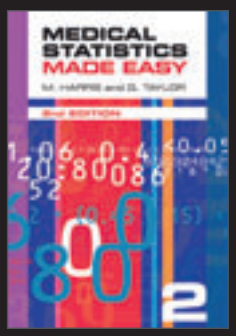

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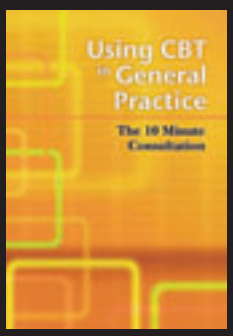

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IN BRIEF

I CAN CERTAINLY think of paintings I'd prefer not to see in hospital – anything by Francis Bacon or maybe visions of hell by Hieronymus Bosch. And I probably wouldn't have appreciated *The Scream* after recently waiting 8 hours in an outpatient ward for a registrar to decide whether to admit my wife. These prejudices apart, I think hospital walls are a brilliant place to hang art.

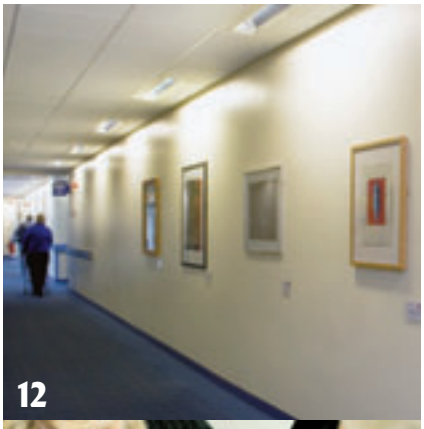
John Bellany, Alan Davie, Ian Hamilton Finlay, Wilhelmina Barns-Graham, Elizabeth Blackadder, Callum Innes, Mary Fedden – these are just a few of the artists whose works can be found in hospitals, hospices and other healthcare facilities throughout the UK thanks to two charities, Art in Healthcare (AiH) and Paintings in Hospitals (PiH). *Summons* is also much in debt to these organisations for supplying our cover images for the last seven years.

Stuart Davie, director of PiH, is apt in his description of artwork as "humanising the space" in hospitals. On page 12 of this issue, Adam Campbell celebrates the work of these two charities and the inspiration behind their establishment.

Sadly I must count myself among the "heavy metal generation" – subject of our feature article on page 18. Along with the rest of our failing organ systems we are about to further burden the healthcare system – and potentially the courts – with our teeth. But there is hope in preventive dental care.

Also in this issue we are pleased to have the views of Professor Gordon Moore (Q&A, p 10), who delivered a perceptive keynote address to the recent RCGP conference offering doctors a cautionary tale on the state of general practice (or family medicine) in the USA. His basic message to UK general practice: count your blessings but don't be complacent.

Jim Killgore, editor



REGULARS

Tiina Leppanen-Richie was born in Sotkamo, Finland in 1957 and studied at Edinburgh College of Art from 1978-82. She completed her postgraduate in 1983. She has exhibited widely in Scotland, Finland and England since graduating.

Leppanen-Richie's work is often concerned with an inner and spiritual journey. *Being of Light*, painted in 1989, depicts a solitary, stark tree with a wraith-like figure who contemplates it in attitudes of prayer.

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, Scottish Charity No: SC 036222. Photograph: Roslyn Gaunt

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New London office at One Pemberton Row

London expansion

MDDUS has moved its London office to larger premises where our three new experienced medico-legal advisers are now based.

This is a major development for MDDUS as our membership continues to grow across the UK. More than half our members now work outside Scotland and, for the first time, we have experienced advisers based outside our Glasgow headquarters.

Dr Anahita Kirkpatrick and Dr John Holden joined MDDUS on March 1 and will work alongside Mr Des Watson who joined the company in November. All three come to MDDUS with considerable experience as medico-legal advisers. The new advisers will join the MDDUS' existing London team of five lawyers and support staff.

The new premises are at One Pemberton Row, close to the capital's legal centre and a short walk from our previous base in Bell Yard. The recently refurbished offices are much larger and will also provide meeting space to accommodate the growing number of training programmes we run for members in England and Wales.

MDDUS chief executive Professor Gordon Dickson said: "MDDUS prides itself on its members being able to make immediate contact with us. Because the union's membership numbers and market share south of the border continue to grow year-on-year we are increasing the facilities we offer to members from our London base.

"Not only will the new, larger office house the new team of highly experienced medical advisers and our team of lawyers, it will be able to accommodate the growing number of training courses we run for our members in England and Wales."

Be clear on competency when providing 'fit notes'

New regulations replacing medical 'sick notes' with new 'fit notes' come into force UK-wide on April 6 subject to approval by Parliament.

The Statutory Sick Pay (Medical Evidence) (Amendment) Regulations 2010 introduces a new electronic Med 3 form (Statement of Fitness to Work) replacing the existing Med 3 and Med 5 forms and combining them into one. The Med 4 is no longer required.

It will allow doctors to record information to help inform discussion between individuals and their employers about whether there are any changes to the employee's work environment or job role which could help in achieving an earlier return to work. Specifically the new statement will include an option to allow a doctor to provide an assessment of an individual's fitness for work.

Doctors will be able to indicate with a tick in the box if a patient is 'fit for work', 'unfit

CEO Professor Gordon Dickson at BMJ Group Awards ceremony

BMJ Group Award winners

THE winners of the BMJ Group Awards – sponsored by MDDUS – have been revealed at a glittering ceremony in London.

The event at the Park Lane Hilton Hotel celebrated individuals, organisations and initiatives that have demonstrated outstanding contributions to healthcare. Winners were announced in 10 categories plus a special Lifetime Achievement Award.

MDDUS was headline sponsor of the awards and our chief executive Professor Gordon Dickson made a well-received welcome address to the large audience on the night.

We also sponsored the Secondary Care Team of the Year award which went to the Emergency Retrieval Service in the west of Scotland for their work in providing rapid access to expert medical treatment for seriously ill and injured patients in rural Scotland. The Lifetime Achievement Award went to Professor Marleen Temmerman, professor of obstetrics and gynaecology at the University Hospital in Belgium, for her commitment to improving women's reproductive and sexual health and rights, especially in Africa.

For full details of the winners visit www.groupawards.bmj.com

IN BRIEF

EMPLOYMENT LAW ADVICE
MDDUS are delighted to announce the launch of their Employment Advisory Service, coming this summer. It will feature for all members, including practice managers, a 24-hour a day advisory helpline staffed by MDDUS' own specialist HR advisors. There will also be the option to top up cover so that all partners have legal fee protection as well as employment tribunal award protection. This exciting new service is unique to MDDUS as we strive to offer our members the very best value and service. For more information on this, please see the back cover of this issue.

MDDUS IN *SCRUBBING UP*
MDDUS medico-legal adviser Dr Anthea Martin featured in the BBC's weekly online health column *Scrubbing Up*. She offered advice to doctors who may encounter internet-informed patients in their consultations. To read the full article visit tinyurl.com/ykwsz5l

PM CONFERENCE SUCCESS
The fifth Practice Managers' Conference run by MDDUS has been hailed a great success. The two-day

for work' or 'may be fit for some work now'. Opting to classify a patient as 'may be fit for some work now' will require a doctor to provide general details of the functional effect of the individual's condition and to suggest conditions in which the patient might return to work, including altered hours, amended duties or workplace adaptations.

The example given in the consultation document is where an individual has moderate lower back pain. A doctor may suggest that the patient will be unable to lift heavy objects.

Employers will not be bound to implement suggestions by a doctor for workplace changes that would facilitate a return to work; the provision of change will be at the discretion of the employer and with the agreement of the employee. Employers must, however, continue to meet their obligations under the Disability Discrimination Act.

We would advise and encourage GPs to bear in mind patient confidentiality and consent when completing the new forms and to have an open discussion with their patients so that agreement can be reached as to what to put on the form. The legislation allows that the medical condition may be specified less precisely where, in the doctor's opinion, disclosure of the precise condition would be prejudicial to the patient's well being, or the patient's position with their employer.

We would also advise that GPs exercise a degree of caution and do not give opinions beyond their clinical competency. GPs are not experts in occupational health medicine and we would caution against giving anything other than the most general recommendations.

If in doubt, seek advice from MDDUS.

Dr Susan Gibson-Smith, medico-legal adviser, MDDUS

PARTING WORDS FROM SHEILA

Sheila Baumann came to work for the MDDUS in 1977 and after nearly 33 years is now retiring. Much has changed at MDDUS over that time but much has also stayed the same. We asked Sheila for her perspective on both.

What was your first job at MDDUS?
I started here when I was 21 as a secretary. I worked mainly for Dr Patterson. Back then he was the only doctor employed by the union and dealt with the advisory services for both the doctors and the dentists, working in conjunction with a solicitor. Our offices were at 113 St Vincent Street though we later moved down the road to 105.

How large was the staff?
There were only nine staff [compared to the 80 plus now] – three of us doing secretarial work, an accountant who worked part-time, Dr Patterson and three people in the accounts department or what we now call membership. One lady who worked in conjunction with membership operated an addressograph machine making the certificates for members when they paid their subscription. Recently a medical adviser – Dr Peddie – brought in her old certificate to show us. I looked at it and saw my own initials.

How was business conducted? Obviously there were no computers.
No. We had ledgers. The people in membership wrote in the doctor's or dentist's name in a column on joining and gave them a membership number. Next to that were more columns for recording the subscriptions paid each year. We didn't take direct debits or payment by credit cards. Cheques would come in by post or members would just turn up at the offices and pay subscriptions over a counter.

What other jobs did you do at the Union?
When Dr Simpson became Chief Executive I was appointed as his secretary. I worked for him until he retired and then for Professor Dickson during his first year of office. I then moved over to work with our new HR contractor and later for our first permanent (and current) HR manager Paul Gray.

How have things changed for members in your time at MDDUS?
Society has changed – become much more litigious. That's certainly affected the service MDDUS provides. When I started work here the subscription was £35 for doctors and £16 pounds for dentists no matter what the specialty. Not a big chunk compared to today but over the years, as the number of claims and the costs have gone up, subscriptions have had to rise. It's been unavoidable.

MDDUS tends to hold on to employees long-term. Why do people stay?
Because it's a nice place to work. The people are nice; the premises are nice; the wages are good. It's just a nice package. And the company has moved on, it's progressed. Jobs don't stay the same.

Any negatives to the job?
Not really. Every job has parts you don't like – drudgery like filing. But nothing particular to MDDUS. Like I said – it's been a very nice place to work.

event – at the Fairmont, St Andrews on February 25 – attracted more than 200 delegates and feedback has been extremely positive. For more information on the event, see the next edition of our *Practice Manager* magazine in May.

MDDUS HEALTHCARE COURSES

Book now for a place on the five-day Healthcare Management Award course that takes place over three months, starting in September. It is ideal for any team leader looking to develop their skills. The Healthcare Management Certificate begins in August, covering topics like communication and staff recruitment. MDDUS' Receptionist Programme offers two-day courses in May for those in medical or dental practice. All three take place in Glasgow. For more information contact Ann Fitzpatrick on **0845 270 2034** or email afitzpatrick@mddus.com

BDA 'disappointed' at continuous registration

THE British Dental Association has said it is disappointed that continuous registration has been given the go-ahead in Scotland.

The group had campaigned strongly against the practice, saying it sends out the "wrong signals" to patients and will encourage dental neglect. Despite these concerns, the Scottish Government informed the BDA that it intended to press ahead with plans to introduce the regulatory changes from April 1.

Chair of the BDA's Scottish Dental Practice Committee Dr Robert Kinloch said: "Continuous registration encourages neglect of personal oral health, undermines modern preventive approaches to care and devalues the relationship between clinician and patient.

"It also removes the responsibility of patients to comply with recall intervals advised by their dentist. Scotland already faces unenviable rates of oral cancers. The fear among dentists is that more cases will now go undetected."

Once the changes come into force, Dr Kinloch has called on the Scottish Government to promote regular patient attendance and to allow dentists to decide whether the continuous registration of infrequent attenders would impact on the care of other patients.

Red flags for meningitis

LEG pain and cold hands and feet have emerged as leading 'red flag' symptoms in diagnosing children presenting with meningococcal disease in a new study.

Primary care researchers at the University of Oxford found that both signs are highly predictive of meningococcal disease in children and adolescents. The symptoms can help GPs distinguish children with meningitis from those with minor febrile illness. The results of the large UK general practice study will be presented at the Society for Academic Primary Care annual meeting later this month.

Children with leg pain were seven times more like to have meningococcal disease and children with cold hands and feet were twice as likely – compared to children with minor feverish illness, the study found. Researchers compared the symptoms of 924 children who presented to 15 practices in Oxfordshire and Somerset with feverish illnesses with the symptom frequencies recorded from 345 children with meningococcal disease.

Leg pain, cold hand or feet, confusion, photophobia and neck pain or stiffness were all rarely reported by the parents of children with minor febrile illness. All these symptoms were found to be "highly specific for meningococcal disease" but pallor and headache had little diagnostic value.

Dr Tanya Haj-Hassan, a researcher in childhood infections at the University of Oxford, said: "The early red flag features of leg pain and cold extremities, as well as classical features of photophobia and neck pain and stiffness, are all highly specific for meningococcal disease."

Source: *Pulse*

Consultation on revalidation

A MAJOR consultation on GMC plans for revalidation was launched in March and will run for three months.

Frontline doctors, patients and all those affected by revalidation will be asked 20 key questions in a bid to gather their views on the UK-wide scheme.

Under revalidation, the GMC plans to issue a doctor with a licence to practise on a five-yearly basis, with annual appraisals of their skills and knowledge. It will be phased in over five years from 2011 after extensive piloting, which is already underway.

The proposals are intended to create a flexible system that is relevant to doctors' day-to-day practice and builds on systems that already exist, or should exist, to support high quality care. The council have promised no "big-bang approach" to the introduction of revalidation and it will not involve a point-in-time assessment of a doctor's abilities. Instead, they say it will be based on a "continuing evaluation of their practice in the context of their everyday working environment."

The consultation will be formed around four main themes of how revalidation will work; what doctors and employers will need to do; how patients will be involved; and how and when revalidation will be introduced.

Chair of the GMC, Professor Peter Rubin, said: "We want to hear from doctors, employers and patients and I hope as many as possible go to the General Medical Council website and contribute to the consultation and share their experience and expertise to help shape how revalidation will work."

IN BRIEF

CERVICAL CANCER GUIDANCE
New guidance has been published to help GPs identify possible cervical cancer in women under 25. A working group of the Advisory Committee on Cervical Screening has produced a pathway for GPs showing how they should respond to gynaecological symptoms. The guidance is on the Department of Health website at: tinyurl.com/ygsdy9p

ACCESS TO RECORDS
Updated guidance on dealing with access to health records requests has been published by the Department of Health. It sets out procedures on how to handle requests relating to living or deceased patients as well as parental requests to access children's records. Read the guidance in full on the DoH website at tinyurl.com/ycr6xrc

ALERTS IGNORED
Three-quarters of English trusts have failed to comply with at least one National Patient Safety Agency alert since 2004 according to the charity avma action against medical accidents

Dental decay in under-fives

URGENT action is needed to prevent dental decay in children from deprived areas, the British Dental Health Foundation has said.

Figures produced by the Audit Commission have highlighted an increasing gap in healthcare between children living in disadvantaged communities compared to the rest of the population. Over 150,000 more children have decayed, missing and filled teeth in deprived areas compared with the rest of the country, a gap which has increased dramatically over the last ten years.

It was determined that children living in these areas are 54 per cent more likely to live in workless households and face poorer health conditions than under-fives living in less deprived areas. One in five of these children have been judged to have poor dental health.

The BDHF said establishing good oral health in early years may be crucial in ensuring better health in later life, with reduced heart disease, stroke and diabetes. Dentists should encourage parents to bring young children for dental examination soon after the first teeth erupt and on a regular basis.

OPINION

by Dr Jim Rodger
Head of Professional Services, MDDUS

Care to the end

In England, Wales and Northern Ireland there have emerged new guidelines on the prosecution of people who assist others to commit suicide, and in Scotland Margo MacDonald MSP is promoting a Bill to make lawful in certain circumstances the assistance by doctors in suicide by patients.

The English rules are an attempt to ensure that relatives or carers are not prosecuted for assisting, even in remote ways, the individual's right to achieve their own death at the moment and in the manner they choose. They are yet to be examined in detail but I think they give some comfort to an individual as to the consequences of their act of suicide on those relatives, spouses, carers etc, left behind.

I fervently believe that a doctor's role is to secure health, prevent death where possible and to care for and comfort the person through all stages of an illness, including death. What concerns me, both in light of this belief and as a doctor, is that medical practitioners may be legally required to assist in a patient's suicide.

Doctors see many patients who suffer and struggle with impending death or a fatal prognosis and such care and compassion for patients in these circumstances is a part of the essence of medicine. Therefore, in principle and from deep within my heart, I struggle with the issue of assisting in a material way with a patient's wish to actively end their life.

I have heard all the arguments about autonomy and the right to choose when to die and about how different it is for a doctor – who could choose his own time and method of death – to refuse that to others and I do accept a degree of potential hypocrisy in this approach. I cannot accept that one reason to assist with suicide is to substitute for patients being given adequate relief from pain or suffering in a terminal illness. That is a failure of medicine to properly care for such patients and must be corrected.

I became concerned when I read of a patient in her 30s who secured her own suicide because she found it intolerable to live with her, non-terminal, illness of ME/chronic fatigue syndrome. Can any doctor see themselves actively assisting in such a suicide?

There is an argument, of some validity, that doctors display paternalistic approaches to patients by deciding to administer increasing doses of pain and suffering-reducing drugs in the final stages of an illness. While this may be true in theory, the practice, if professionally adopted, must always be in the patient's best interests and to relieve suffering and distress, often in the very late terminal phase. Perhaps we have to simply accept the accusation of paternalism.

While a law may protect a doctor from actively assisting a patient to secure their own death, it may only do so in the criminal law. It may not protect a doctor from a civil suit against them by relatives, for example. It will not protect a doctor from his obligations to the professional regulator, the General Medical Council. It also may not protect a doctor from complaints brought by relatives or carers in relation to a case where the doctor acted lawfully in assisting at a suicidal death.

Any such law must also allow, as the Abortion Act does, that a doctor be able to exempt themselves from the operation of the law on grounds of conscience or belief. While these grounds should not be used to obstruct a patient obtaining help, doctors cannot and should not be forced by law to act in a way that offends their own beliefs.

There are many good arguments surrounding a wish to choose the moment one's life must end but, in my opinion, this can not become part of the active role of a medical practitioner.

Action against Medical Accidents. Their report found more than 300 NHS trusts hadn't complied with at least one alert and that 2,124 separate incidences of patient safety alerts were not complied with by trusts. Eighty trusts had also not complied with 10 or more separate alerts. Alerts cover issues like safe use of injectable medicines and the risk of patients falling from beds.

HEALTH ISSUES IN DENTISTS

Dentists are amongst the sickest of all health professionals, according to the head of the NHS Practitioner Health Programme. PHP launched

last year in London to help clinicians with health problems including drug and alcohol addiction. During its first year, Clare Gerada said dentists were "a much sicker group" than other health professionals treated and often presented with complex or severe problems.

IT'S NOT IN MY CONTRACT!

Ian Watson

"Flexibility can work both ways in employment"

CONTRACTUAL RIGHTS have hit the headlines in recent weeks.

On the one hand, bankers have insisted that their generous bonuses must continue to be paid despite the recession (and public funds being put in to support their company) because they have a contract which entitles them to performance-related payments.

In sharp contrast to the bankers, low-paid civil servants are facing major reductions in their (albeit generous) redundancy pay – despite having a contractual entitlement to redundancy pay. The Government now proposes, because of the present financial climate, to cut it back.

This suggests that the way in which employment contracts are drafted is of considerable significance to both employers and employees. It is therefore of some concern that many employees have never had a written statement of their main terms and conditions of employment – even though they have a legal entitlement to such a document. Frankly, in the event of a dispute about employment, evidence of the contractual relationship can be of just as much assistance to the employer as to the employee.

Keeping the written contract up-to-date, as well as making it relevant to the developing employment relationship, is often lower down the list of the employer's priorities than business survival. But, arguably, business survival (and jobs) may depend on the employer ensuring that the employment relationship is properly described in the contract and that sufficient flexibility is built in to the contract to enable the best possible deployment of labour within the organisation.

Flexibility, of course, can work both ways in employment. An employee who habitually carries out tasks that are not in their contractual job description can find that, at some future point, their contract has been changed, through custom and practice, to encompass the new duties.

But the reverse can also be true. If an employer turns a blind eye to widespread departure from the precise terms of a contract to the employees' advantage – for example, finishing early every day - they can find that reverting to the original contract terms may be problematic. 'Custom and practice' is a double-edged sword.

There is no doubt, however, that an employment contract with no flexibility to it may result in unnecessary disputes between partners and staff. The challenge for partners and practice managers is to find the ideal combination of flexibility (for example in job role, hours or place of work) without relying on draconian contractual flexibility terms which may either create resentment amongst staff or be, in practice, difficult to implement without legal challenge from employees.

Staff who are properly consulted and whose individual concerns about contractual change are addressed may well be amenable, particularly in a difficult financial climate, to agreeing changes to their working arrangements which can be mutually advantageous - and which may be vital to reduce costs and save jobs.

Imposing contractual change without agreement (or consultation, at the very least) runs the risk of alienating staff and hardening attitudes to change generally. At worst, an employee faced with imposed changes by the employer may resign and claim constructive dismissal, on the grounds that the employer's actions amount to breach of contract. Even if the employee is unwilling to resign in these circumstances, there is still the risk that they will be deeply resentful of the imposed change and seek other employment as soon as they are able to find it.

Reviewing contracts regularly to ensure that they are a true record of the current working arrangements and using the opportunity to seek employees' agreement to flexibility or actual changes to contractual terms makes business sense for practices.

After all, we don't need to tell GPs and dentists about the resentment which imposed contractual variations create! What's more, industrial action by civil servants about imposed cuts in contractual benefits shows that negotiated change is preferable for both parties to the employment relationship.

Review now – or repent at leisure! ■

Ian Watson is training services manager at Law At Work

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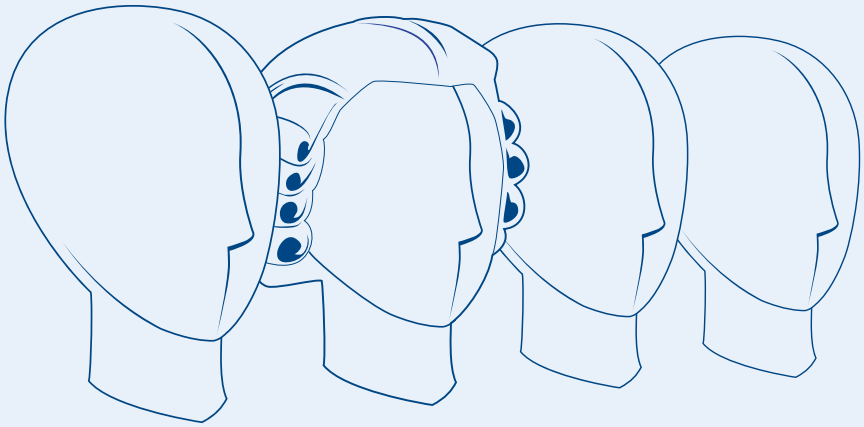
Law At Work is MDDUS preferred supplier of employment law and health and safety services. For more information and contact details please visit ***www.lawatwork.co.uk***



IS THERE A LAWYER IN THE HOUSE?

Charlotte Johns

DO DOCTORS or dentists have the right to legal representation at internal disciplinary hearings such as those conducted by trusts or health boards?

Historically, the right to be accompanied was limited to the statutory right to have a colleague or trade union representative present. But the courts have recently had to consider two cases in which employees have sought to assert a right to legal representation at such hearings.

In one of the cases *(R v The Governors of X School)* a teacher argued that an article of the European Convention on Human Rights (ECHR) established his right to legal representation at a disciplinary hearing where he was accused of having an inappropriate relationship with a pupil.

Article 6 of the ECHR sets out the right to a fair trial and states that everyone is entitled to a "fair and public hearing" in relation to the determination of civil rights or obligations or criminal charges. The right to a fair trial also includes the right to have legal representation and to cross-examine witnesses in the event of criminal proceedings.

UK legislation must be interpreted in a way that is compatible with the Convention. In addition the ECHR is directly applicable to public bodies. The High Court determined that although the proceedings in question were civil proceedings, the gravity of the case meant that the employee was entitled to legal representation in order to ensure that he was accorded a fair hearing.

In another case *(Kulkarni v Milton Keynes Hospital NHS Foundation Trust [2009])* a doctor was accused of inappropriately examining a patient. His contract stated that conduct issues were to be dealt with under the employer's disciplinary procedures, which were themselves to be consistent with the Maintaining High Professional Standards in the Modern NHS (MHPS) framework.

The Court of Appeal held that MHPS framework gave the doctor a contractual right to be represented at an internal hearing by a lawyer instructed by his defence organisation. This case turned on the wording of the contract, and the judges ruled that, if an employee is facing such a serious charge that they could be barred from practising, then Article 6 implies a right to legal representation.

Another relevant factor to be considered is the new ACAS code and guidance launched in April 2009. It replaces the statutory dispute procedures as the framework governing the way employers should manage disciplinary matters in the workplace. Natural justice is a concept to be found at the heart of the new employment regime and also most common law jurisdictions. It is based upon the premise in Roman law that certain basic legal principles are required by nature and should be applied universally. Natural justice incorporates the concept of procedural fairness and the right to a fair hearing.

The ACAS code places particular emphasis on the requirement for fairness, stating that employers should:

- deal with matters promptly
- act consistently
- investigate
- inform the employee of the basis of the problem
- allow the employee to state his case
- allow employees to be accompanied at formal hearings
- allow a right of appeal.

The right to be accompanied is not of itself seen as a pillar of natural justice but it has come to be accepted as one facet of a fair hearing and the ACAS code identifies this as one of the core principles of reasonable behaviour.

Just because employees may have a right to legal representation in certain circumstances should they exercise that right?

A lawyer can cross-examine witnesses and highlight procedural errors but unless the employer is going to allow a quasi-judicial hearing then this is not necessarily going to make a difference overall. Many of the perceived advantages of having a lawyer present at the hearing may be achieved by instructing a lawyer to advise from the wings.

The cases where lawyers are likely to be able to provide a real impact in attendance at internal hearings would, in the writer's view, be where there is no black and white in terms of the correct outcome. A senior QC once commented to his instructing solicitor that arguing his case was "like knitting with fine threads". The solicitor had to agree that the case for the defence was indeed a little thin on the ground but the QC went on to successfully defend that case drawing on all the persuasive powers for which he was renowned.

Although lawyers clearly have a part to play in the resolution of employment disputes it will not always be the case that legal representation at the internal disciplinary hearing is the most constructive use of this resource. Doctors or dentists would be well advised to think carefully, in conjunction with MDDUS, about whether bringing a lawyer to an internal hearing is the best course of action. ■

Charlotte Johns is a solicitor with Shepherd and Wedderburn LLP

Leading the way

Respected US primary care expert and key note speaker at this year's RCGP conference, Professor Gordon Moore *explains why he believes UK general practice continues to be a world leader – and why doctors must fight to ensure it stays that way*

IT WAS more than 20 years ago that Professor Gordon Moore first visited the UK to study general practice as a Fellow with the Kings Fund in England. The Harvard Medical School graduate came to these shores in 1988 when, he says, his "admiration and envy of GPs and the NHS" began. In the years since, Professor Moore has built a reputation as something of an international expert in primary care with a knowledge and insight into the field that would no doubt be the envy of many in UK general practice today.

The 72-year-old Bostonian, who qualified in 1963, shared some of this insight with doctors at the recent RCGP annual conference in Glasgow. His speech highlighting the lessons the US could learn from UK general practice was widely applauded and considered a number of timely issues, from the emergence of Darzi centres to the increasing corporatisation of our healthcare system.

The professor's first visit in 1988 was designed to build his knowledge of the UK healthcare system with a view to informing his work as director of teaching programmes at the Harvard Community Health Plan (HCHP). He followed it up with a second year-long visit with BUPA in 1995. Professor Moore practiced at the HCHP as a primary care internist (a GP for adults) for more than 30 years and helped create the Department of Ambulatory Care and Prevention – the country's first academic department fully based in a managed care organisation. He remains a professor in the department, which is now the Department of Population Medicine.

From 1997 to 2008, Professor Moore ran a national programme for the Robert Wood Johnson Foundation called Partnerships for Quality Education, whose purpose was to help doctors and nurses in training to become competent in systems thinking, quality and practice improvement. A father of two grown-up daughters, his work in Harvard currently focuses on a number of areas including educational strategies in healthcare, teaching about population health approaches, international health services and effectiveness of primary care.

What do you regard as the key strengths of UK general practice?

When people talk about general practice in Britain, it's really regarded as the jewel in the crown. There are a number of elements that I see as fundamental to its success. One would be its clear structure, the fact it is available everywhere and that the GP has the role of first access care and control over referrals into the acute sector. GPs in the UK also have a close relationship with their patients over many years, which is very important, as this continuity of care builds trust. GP training is very good in the UK and the general practice 'brand', or public image, is strong. Having one voice – in the form of the RCGP – is also crucial in conveying a single national message about general practice.

What are the main problems with general practice in the USA?

The biggest problem is that very few American graduates are choosing general practice as their field of career interest. So numbers are declining and waiting times have soared. Also, the structure is loose and fragmented, the system is very ill-defined and there is little continuity of care. Americans may see anyone they choose; there is no workforce planning, and there is no planning that assures that GPs practice where they are needed. Patients may self-refer to specialists and specialists are quite happy to

IMAGES: ANDY FORMAN

poach patients who would be better served by GPs. Also, US GP incomes lag dramatically behind those of hospital specialists because of the compensation scheme in place to support GPs.

What lessons could the USA learn from UK general practice?
A great deal of the success of the UK system is the pride of place of general practitioners in the system. They have a sense of personal self-worth, of contributing and of doing good. Also, there is no structural support for GPs in the US and little continuity of care; trust from patients has diminished. We won't be able to fix general practice in the US until we pay heed to the rules that our general practitioners would need to follow in order to give them authority, responsibility and accountability within the system.

What lessons could the UK learn from the USA?
The most important thing is that nothing is forever – your high regard from the public has to be constantly earned. You could easily miss important opportunities to make the system better or make mistakes which are driven by self-interest, ie: in out-of-hours cover. When I see things like out-of-hours provision, practices using more personnel who are not doctors, patients seeing their own doctors less, that has got to have an effect on continuity and trust. General practice should not make the same mistakes that have been made in the US that have led to a degradation in continuity of care.

"General practice should not make the same mistakes that have been made in the US..."

Do you see any worrying trends in UK general practice?
The erosion of continuity and trust is a major issue. The enlarging size of practice groups that cross-cover and the increasing number of Darzi polyclinics are two examples of how that can happen. The rise in GP-run referral centres can also lead to deskilling on the part of GPs and the loss of effectiveness at the triage interface. And what I call corporatisation is coming to the UK, whether in the form of international healthcare insurers buying the right to provide general practice in your community or the increasing use of salaried GPs. The net effect is to diminish the number and salutary effects of owner-operator GPs. I have found that salaried doctors without a long-term stake in the practice do not typically show the same drive for excellence, commitment and accountability to their patients as those who own their own practices.

Is free-market competition in medicine a good idea?
Yes. I've found that if salary is not dependent on performance then you start managing your time instead of your performance because the money is guaranteed. Market forces and some degree of pay for performance, some degree of competition in which patients are free to choose doctors who are providing better care, should be built-in. But unregulated market forces can also lead to bad outcomes. The more you pay according to specific indicator conditions the more you worry that the things you are not incentivising will degrade. Market forces can assist in delivering better value for money and service but they can go too far and there need to be checks and balances on the raw impact of market forces.

Should private firms be allowed to run primary care services?
Yes, I believe the existence of private primary care services, on an even playing field, can make things better. If someone can get a service free from their GP yet they choose to pay for a private service then, if I were the free service, I would be concerned I wasn't doing something right. It's a strength of the English healthcare system that you have a core service that's been improving over the last 10 or 15 years and also have a private opt-out. The presence of a free at the point of care public system which has to compete with patients who might choose to go outside puts pressure on that core public system to perform better and the public deserves that.

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

Humanising the space

Adam Campbell *looks at the work of two organisations bringing the healing power of art to hospitals throughout the UK*

WALK down one particularly busy corridor at the Edinburgh Royal Infirmary, just past orthopaedics on the way to casualty, and the routinely magnolia walls suddenly give way to a stunning display of colour and form. Here, completely unannounced, is a striking watercolour by John Bellany of the Madonna and child, with the Bass Rock looming large above them. Alongside is an abstract expressionist work by Alan Davie, *Energy is Delight*, and, further along, Ian Hamilton Finlay's 'concrete poetry' is given form in *AIEO Blue*. On the opposite wall, a series of abstracts by Wilhelmina Barns-Graham lights up the corridor further still.

It's a collection from some of the country's leading artists that would be at home in any major gallery. It is also, in the words of senior cardiac physiologist Linda Bernardin, who happens to be passing on the day I visit, "much more interesting than the usual notices and warnings". There's no doubt about that. More importantly, she says: "I think having nice artwork on the walls helps the patients – and the relatives."

Another passing healthcare worker, Janet Smalley, agrees. Plus, she adds: "We also need something nice and bright to put a spring in our step."

Paintings, drawings, sculpture

Views like these are grist to the mill of those people whose mission it is to get as much high-quality visual art as possible into hospitals, hospices and other healthcare facilities in the UK – charities like Art in Healthcare (AiH) in Scotland, which is responsible for the ERI display, and Paintings in Hospitals (PiH), their counterparts in England, Wales and Ireland. Art, they believe, has a powerful role to play in the health service, from providing a stimulating environment for patients, relatives and staff, to aiding certain kinds of therapy, and even helping to speed up recovery.

Stuart Davie, the director of PiH, cites a 2002 study carried out at London's Chelsea and Westminster Hospital on the effects of visual arts in healthcare. "There was a reduction in the length of stay in hospital by up to one day and in the use of some medications, such as painkillers," he says. "They also noted that staff morale – and this wasn't something they were looking to measure – was improved."

It is but a single study and drawing strict scientific conclusions is always going to be controversial in an area like this, but nevertheless Chelsea and Westminster have acted on their

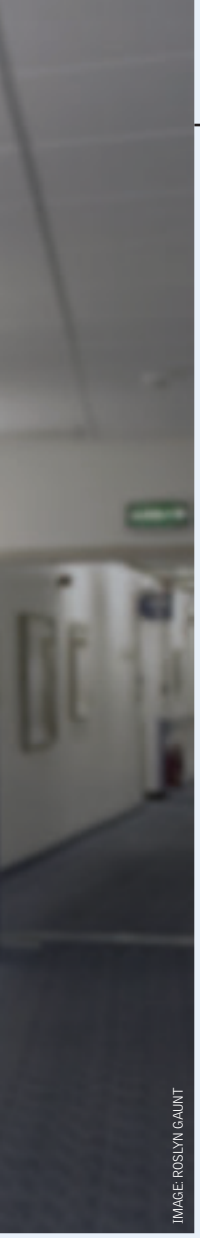


IMAGE: ROSLYN GAUNT

findings. "All of the main corridors are jam-packed full of interesting pieces of artwork," says Davie.

And the London hospital is far from alone in what Davie calls "humanising the space". Pieces from PiH's nearly 5,000-strong collection of photographs, paintings, drawings and sculpture – built up since the organisation's inception in 1959 and including such luminaries as Op Art proponent Bridget Riley, Mary Fedden and Young British Artist Ian Davenport – have found their way into more than 250 healthcare sites. In Scotland, work from AiH's collection of 1,200 pieces is to be seen in around 40 locations.

Both schemes operate in a similar way (in fact, AiH was formed in 2005 from what was then the Scottish branch of PiH, itself formed in 1991). Healthcare bodies rent each artwork for two years for a small amount – £35 per year from AiH, £40 from PiH – that is unrelated to artist or size and includes insurance. Users are encouraged to choose their own works, through the formation of an arts committee of clinicians, patient representatives, and administrative and auxiliary staff.

It is a crucial part of the process, says Trevor Jones, AiH's assistant director. "It's important that the people who will be seeing the pictures have a say in which ones are chosen," he says. "It makes more sense, as they're going to be living with them – rather than me just showing up with a couple of pictures and putting them on the wall."

Pictures are selected online or, in certain cases, visits to the storage facility can be organised. In the case of Lynebank Hospital in Dunfermline, for example, a long-stay hospital for people with learning disabilities, Jones says: "They came down and brought about six of the residents. Along with a couple of staff, they chose the pictures directly from our picture store."

Works by the likes of Elizabeth Blackadder, Turner Prize nominee Callum Innes and Mary Fedden – whose still-lifes are more usually seen in the Tate Gallery and the Queen's Collection – don't come cheap, and most of the pieces in these vast collections have been donated, bequeathed or lent by artists and owners, though some are commissioned specifically, usually using grants from arts councils or trust funds.

Art as therapy

Sometimes artists see works in hospitals from AiH and PiH and decide to get involved, and sometimes, says Jones, their involvement comes about because of what isn't on the walls. Two years ago, for example, artist Miriam Vickers underwent treatment at the Princess Alexandra Eye Pavilion in Edinburgh. "She was spending a lot of time at the Pavilion," says Jones, "and she thought, 'This place really needs some art!'" Vickers contacted AiH and, as a result, six of her landscapes now have pride of place at the hospital.

Usually, the impetus for hanging artworks comes from the other side of the medical equation. When Dr Conor Maguire, consultant physician in care of the elderly at the Royal Victoria in Edinburgh, first came across AiH paintings at the hospital, he felt immediately this was an organisation from which his patients could benefit. He is now a contract holder with AiH and has increased the number of paintings at the facility. But for financial constraints, he says: "I would fill up every wall in the hospital."

> "It's important that the people who will be seeing the pictures have a say in which ones are chosen"

Before taking up his current post, Dr Maguire had done some research into art in dementia in Bristol. "I noticed the way patients with dementia would interpret art differently from those who didn't have dementia," he says. "One patient was an artist and he started changing all his pictures when he became more demented, using more vivid colours."

He now finds that, along with pets and music, artwork – often colourful abstracts – can help to get through to patients who might otherwise sit curled up in a chair not talking to anyone. They provide a fresh and neutral source to approach patients about, so they don't end up talking about the hospital food or the temperature of the wards.

There are other benefits too, he says. Some of the occupational therapists use paintings in reminiscence therapy, while stroke patients might be encouraged to copy the paintings or, for those with speech problems, to talk about them. Dr Maguire has even managed to build a painting into the exercise regime of one of his Parkinson's patients.

"I said to him: 'There's a lovely painting near my office.' And he now walks to that painting as part of his mobility exercise. To me that's fantastic."

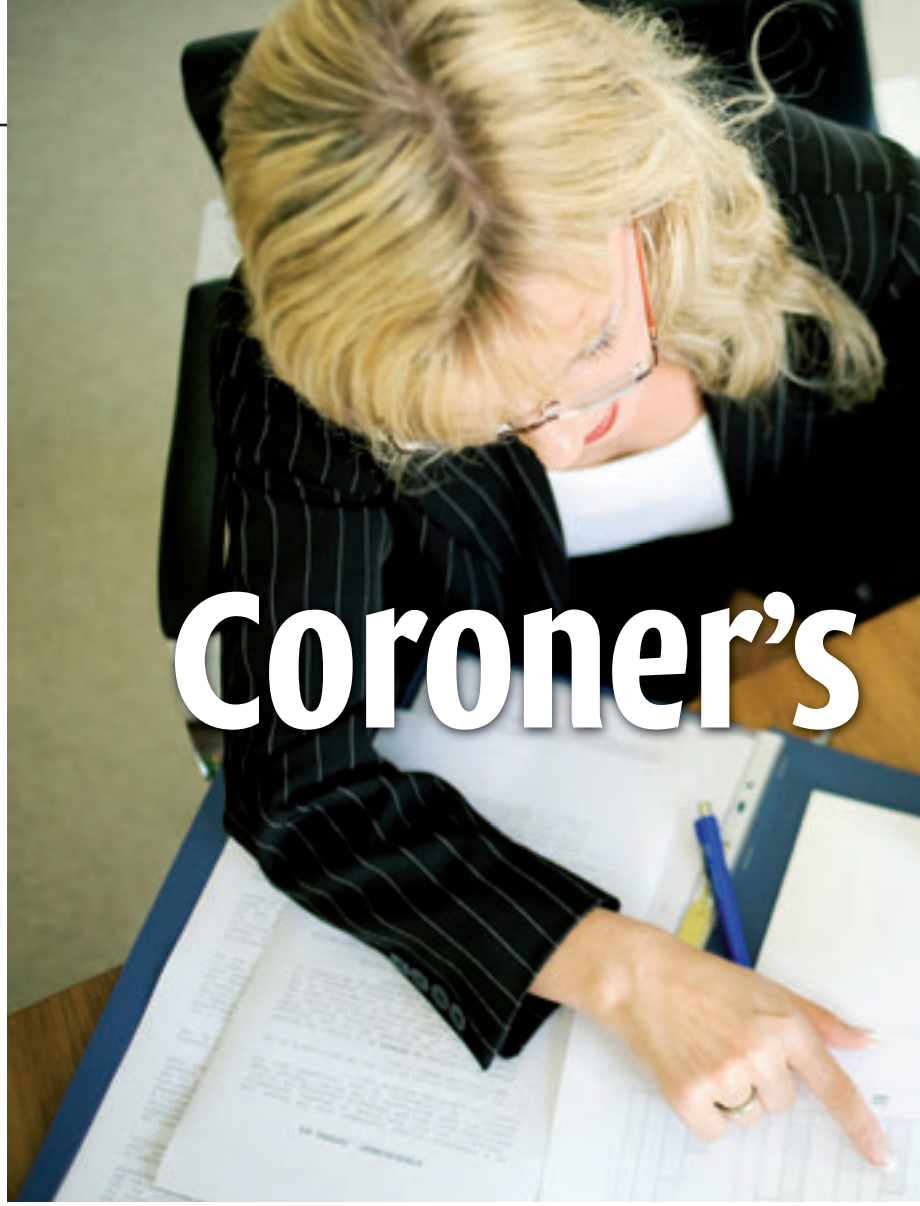
Views may have shifted considerably since social worker Sheridan Russell set up PiH 51 years ago, when the idea of brightening up the patient environment with paintings may have stretched to a few fusty portraits of famous surgeons and philanthropic businessmen. But there are still arguments to be won concerning the cost of art, however small, particularly in the teeth of a financial crisis.

"It's not as difficult as it once was to put artworks into healthcare," says Stuart Davie, "but the issue for us moving forward is financial. Healthcare sites may not wish to be seen to be spending anything on the environment when budgets are being cut."

So the credit crunch is having an effect here, as in every other walk of life. But there is a silver lining: having read in the press about the Royal Bank of Scotland's £20m art collection of more than 4,000 works, AiH contacted the bank – now 84 per cent owned by the state – and suggested the charity might help with displaying what is, after all, a public asset. "As a result, RBS are going to be lending us up to 300 pictures, which is fantastic," says Trevor Jones.

At the time of writing it's not known if these will include any of their really famous works, such as Colourist masterpieces by Frances Cadell and Samuel Peploe, but visitors to Scottish healthcare sites may be in for a surprise.

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



Coroner's

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

THE death of a patient in difficult circumstances can be traumatic enough for all concerned. But what should a doctor or dentist do on receipt of a letter from the coroner's officer asking for a statement about the death? The short answer is to telephone MDDUS and ask for advice.

Having said that, the advice will be more immediately helpful if some preliminary steps have already been taken.

The process

A coroner's inquest is the procedure used in England, Wales and Northern Ireland (fatal accident inquiry in Scotland) to investigate a sudden death for which the cause is unknown, violent or unnatural, or which has occurred in prison. The inquest is not a trial but a limited inquiry, with or without a jury, to establish the facts surrounding the death.

It is not the coroner's function to determine any question of civil or criminal liability, or to attribute blame for the death. Nor is it his function to explore issues of potential medical negligence but that's not to say it doesn't hold risks for doctors.

Drafting a statement

The main thing that the clinician can do while the events are as clear in the mind as possible is to begin the process of drafting a statement for the coroner. This will act as the basis for the final document submitted to the coroner after discussion with MDDUS.

Remember that an inquest is an investigation into the death of a person. It aims to answer four fundamental questions and, increasingly, focuses on a fifth related question. The five questions are:

- Who was the deceased?
- When did the deceased die?
- Where did the deceased die?
- How did the deceased die?
- In what circumstances did the deceased die?

The doctor's or dentist's statement will give the coroner help mainly with the last two of these. Bear in mind that the coroner may well read out the report so it is best if it is joined-up prose with medical jargon eliminated or expanded. Because the family will be present at the inquest, some clinicians will start the report with a sentence of condolence, particularly if there has been a close connection with the deceased.

Coroners find it helpful if the report starts with a couple of sentences setting out a miniature CV. This allows the coroner to decide how much weight to put on the statement. If, for instance, the coroner is investigating a death that may be related to drugs of addiction, the statement from a GP with a declared interest and expertise in substance misuse is likely to be given more weight than one from a GP with other interests.

The clinician then needs to go on to the facts of his or her involvement with the deceased in the period leading up to the death. Sometimes there may be relevant information from many years ago, especially where occupational disease may have contributed to the death.

Unless the coroner has asked the clinician specifically to provide an expert report, the statement should confine itself to factual evidence. It is often difficult to know where facts end and opinion begins and this

inquests

is one of the areas where MDDUS advice can be very helpful. Straightforward facts include the direct recollection of the clinician as well as those events that can be reconstructed from the notes and the custom and practice of the clinician. The statement should also include the opinions of the clinician formed at the time the patient was seen but not in retrospect, as well as the contemporaneous views of others involved in the deceased's care. Below is an annotated paragraph of a fictional GP's statement:

Mrs A came to see me for the first time as an urgent patient on 29/02/2009. I remember she looked well but seemed anxious with a rapid breathing pattern [direct recollection]. Her blood pressure is recorded as CCC/DD [fact from notes]. When taking a BP, I will always take note of the pulse; I have not recorded this so I can be sure that it was normal [custom and practice]. I knew that Mrs A's usual GP felt she was prone to non-organic illnesses [contemporaneous view of another clinician]. I diagnosed that she was having an anxiety attack and did not feel that any further investigation was needed [contemporaneous personal opinion]. I now know that she had early ketoacidosis [retrospective opinion and so of no help to the coroner in understanding how the deceased came to die].

"It is not the coroner's function to determine any question of civil or criminal liability, or to attribute blame for the death"

At the end of the statement, the clinician can help the coroner by giving contact details for anyone else who might be able to assist (for instance, the "usual GP" in the paragraph above). Many doctors and dentists then close with a statement of truth. The whole statement should be typed and numbering of paragraphs is helpful to the coroner as well as to any lawyers or advisers.

Once the draft statement is complete, it should be sent to MDDUS. An adviser will look over it and, if necessary, discuss it with a solicitor. The adviser cannot help with documenting the facts but can be very helpful in making these clearer and more accessible. The adviser will also look out for medical jargon and for pieces of information that need to be expanded. An example of this might be where the deceased may have been hoarding medication with a view to an overdose. In such an instance it would be helpful to the coroner to have a detailed list of dates, drugs and quantities prescribed over the past few months.

Summons to appear before the coroner

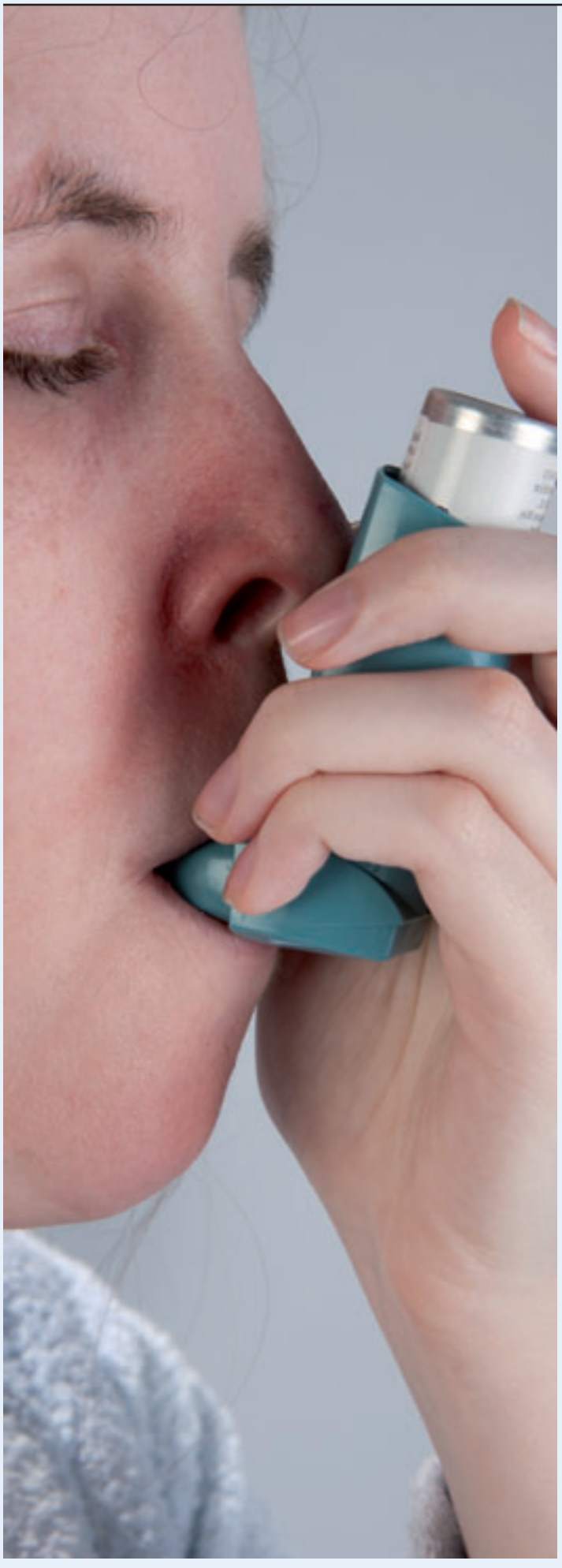
Inevitably, there are times when the coroner will ask a clinician to appear in court to amplify or explain any statement already submitted. This can happen even when the facts in the statement are not disputed in any way. Sometimes the family will be keen to have an opportunity to ask questions of a clinician involved in the death of one of their relatives. The coroner may summon a clinician who seems only very peripherally involved in the events leading up to the death if it will assist the court in understanding the processes that failed to prevent the death.

Clinicians are often concerned that such summons might mean that they are to be criticised or faced with hostile questioning in an inquest. This is an area where support from MDDUS is very important and there are a number of ways of forecasting whether or not a clinician is to be criticised.

In some cases, the coroner or the coroner's officer will directly inform the clinician that some hostility is to be expected. If you are called to give evidence, it is a good idea to phone the coroner's officer and ask if criticism is likely. The other key question to ask before the inquest is whether or not the family is legally represented. Families who bring along lawyers are usually out for a show-down of some kind so this is a key question.

Look for Part 2 of this article in the next (Summer) issue of *Summons* in which we will offer guidance on appearing at inquests and potential outcomes.

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



Asthma

Dr Malcolm Campbell *warns that it is easy to become complacent about diagnosis and management of asthma*

ASTHMA is a common condition in both general practice and in secondary care. Most patients with asthma are easily diagnosed and the management is usually straightforward. The SIGN/BTS guideline is widely read and contains sound advice on the diagnosis and management.

However it is easy to become complacent about the disease and to forget that there are around 1000 deaths per year which are attributed to asthma. Because it is such a well-recognised condition with clear guidelines, any failure to diagnose or manage the condition appropriately can become the subject of litigation and the courts will expect a higher standard of care from 'a competent doctor acting with reasonable care' than in rare conditions. Medico-legal problems can arise both from incorrect diagnosis and inappropriate treatment.

Making the diagnosis

Just as all that glisters isn't gold, all that wheezes isn't asthma. It is important to get the diagnosis right since problems can arise if other possibilities are ignored. In the case of adults the diagnosis is relatively straightforward and is suggested by the presence of more than one of the following:

- wheeze
- breathlessness
- cough
- chest tightness.

It is useful but not always possible to demonstrate reversible airways obstruction. If an increase in FEV1 of 12% or more can be demonstrated then the diagnosis is clear. However, some people have intermittent symptoms and it can be difficult to 'catch them' for spirometry when they have symptoms.

In children under five, spirometry is unlikely to be feasible and the diagnosis has to be made on clinical grounds. Once again, cough and wheeze are pointers towards the diagnosis, particularly if the symptoms are recurrent, worse in the morning, precipitated by exercise and associated with a family history of atopy.

Sometimes the diagnosis remains unclear and the best option is a therapeutic trial of a beta adrenergic or steroid inhaler. In this case it is easy to fall into the trap of assuming the diagnosis

is asthma if the patient improves. It is necessary to withdraw the treatment and confirm the diagnosis. After all, upper respiratory infections do get better with the passage of time regardless of what treatment is used. If there is a poor response to treatment, the diagnosis may still be asthma, but it is important to review the diagnosis in this situation and not to be afraid to send the patient for further assessment and investigations by a respiratory physician.

Long-term management

It is important to use the minimum doses of drugs which will keep the patient symptom-free and to step up and step down treatment accordingly. Regular follow-up is necessary to ensure that the management is appropriate. It is vital to deal with acute exacerbations expeditiously, to detect warning signs that the exacerbation is becoming severe and to safety net by agreeing an action plan with the patient based on symptoms or peak flow rates. Patients at particular risk of fatal or near fatal exacerbations are those with a history of hospital admissions, on multiple therapy and with high beta-agonist use. In addition, the risk is increased by behavioural factors such as denial, noncompliance with treatment, alcohol or drug problems, and social isolation.

Medico-legal issues

No doctor is infallible and the courts recognise this. For litigation to succeed it has to be demonstrated that no competent doctor, acting with reasonable care, would have acted in the same way. Some of the medico-legal issues are unique to asthma whereas others are more generally applicable.

Keep proper records. In many cases the patient's recollection of events will differ from that of the doctor. If the doctor makes adequate contemporaneous notes then the court is highly likely to accept this version of events. In my experience of GMC and civil litigation I have lost count of the number of times I have heard doctors say: "I did it but I didn't write it down", "I don't record negative findings", or "I always instruct patients when to seek a review of their condition". In the case of a patient with, for example, an asthma exacerbation, it is essential to record something along the lines of: *"not breathless at rest, PEF =400, Chest some exp wheeze, resp rate 14, no cyanosis, PO2 97. Given 50mg prednisolone for 5 days, review urgently if PEF goes below 300 or if significant deterioration in symptoms"*. This doesn't take long and provides good evidence of appropriate assessment and management.

Be alert to other possible diagnoses. Many conditions can be mistaken for asthma (see box). It is not always possible to get the right diagnosis first time around but we must try to avoid developing a fixed idea of the diagnosis and be ready to rethink the situation.

CASE STUDY

A 35-year-old man developed intermittent cough and breathlessness. He was treated for asthma and improved to some extent but his symptoms recurred. Spirometry was normal. The patient continued to complain of breathlessness in the absence of any abnormal findings on examination. Review by a cardiologist did not produce any diagnosis. Chest X-ray was normal. After two years of intermittent symptoms the patient collapsed and died suddenly. What do you think the diagnosis was? The post mortem diagnosis was recurrent pulmonary emboli. Although in the view of the author the patient's management did not fall below acceptable standards, clearly if the diagnosis had been considered the outcome might have been better.

Be careful with repeat prescriptions. Many patients will be on repeat prescriptions for their asthma drugs. This is fine but it is important to check on a regular basis that the patient is taking the correct drug in the correct quantities. Situations have occurred where patients have continued on oral steroids or high-dose inhaled steroids long after the need for these has stopped. The results of this can be serious and include osteoporotic fractures and adrenal failure.

Watch out for inappropriate concomitant therapy. We are all aware that beta-blockers are contra-indicated in asthma but the occasional prescription does slip through the net and would be difficult to defend. Many patients with asthma can safely take aspirin or non steroidal anti-inflammatory drugs but some patients will have an adverse reaction. It is important to explain this possibility and advise accordingly.

Maintain good communications with the patient. Ideally every patient should have an agreed action plan which would include when to step up or step down medication and when to seek medical help. This is of particular value in 'brittle asthma' but would be good practice in all asthma patients.

Reflective practice. Regular audit of asthma care, looking at the number of patients being hospitalised or requiring emergency treatment for exacerbations, will help to identify systematic problems in asthma management. Significant event analysis of hospital admissions will identify issues with the management of individual patients. Although not essential from a medico-legal point of view, such activities will be necessary for successful revalidation and will minimise the risk of litigation.

Conclusion

Asthma is a condition where the diagnosis is usually clear and treatment is straightforward but it is essential to be vigilant and not to adopt a casual approach. The presence of well-recognised guidelines makes the condition easier to manage but also makes inadequate management difficult to defend.

■ *Dr Malcolm Campbell is Senior Lecturer in General Practice in the Faculty of Medicine at the University of Glasgow*

MISTAKENLY DIAGNOSED AS ASTHMA

- Hyperventilation syndrome
- Reflux disease
- Pulmonary fibrosis
- Inhaled foreign body
- Rhinitis
- Heart failure
- Bronchiectasis

And the list goes on...

Cometh the heavy metal generation

Summons editor Jim Killgore *looks at the challenges of an ageing dental patient population*

IN JUNE of last year the Government published the Steele Review into NHS dental services in England, providing recommendations on improving oral health and increasing access to quality dental care for all patients.

One interesting set of statistics cited in the report had to do with changing population patterns among dental patients. It highlighted a "demographic bubble" of patients now between 30 and 65 who have retained much of their natural dentition but with high levels of dental disease treated by fillings and other restorations – a so-called "heavy metal generation".

In December the issue was further highlighted in a *BBC News* item in which the British Dental Association scientific adviser Professor Damien Walmsley warned that NHS dentistry faces a major challenge coping with the consequences of this ageing population.

So is UK dentistry prepared for the challenge and what are the medico-legal implications?

2020 and beyond

Concerns over an ageing dental patient population are not new. In 2003 the BDA published a policy paper entitled *Oral Healthcare for Older People: 2020 Vision,* prompted by concern that the planning of future dental services did not take account of major changes in the UK population.

It pointed out the extent to which the population is ageing. Increased life expectancy coupled with a falling birth rate means that by 2020 the proportion of people in the UK aged 65 and above will rise from a figure of 15.7 per cent (2003) to 18.9 per cent. It predicted "increasing numbers of older patients who need, and would like to have, complex restorations to ensure that they retain many of their natural teeth".

Concerns have also been informed by predictions based on data obtained from four Adult Dental Health Surveys that have been conducted every 10 years since 1968, with the last undertaken in 1998. The latest survey is underway with results due in the autumn but predictions from previous data are that in 15 years an expected 40 to 50 per cent of patients over 65 will be dentate with 21 or more natural teeth.

So why are more older people keeping their teeth now?

"Predominantly because dentists are not taking them out," says Angus Walls, Professor of Restorative Dentistry at Newcastle University and an expert on oral and dental problems of older people.

"It sounds like a stupid thing to say, but it's true. Back at the inception of the NHS in 1948 and 1949 there was a huge unmet need for managing uncontrolled dental disease and the simplest and most reliable method for doing that was to take the teeth out. So you have this huge bubble of people who have no natural teeth slowly working their way through the population. And we are now getting to a stage where that bubble is in its 60s to 90s and the wave behind have natural teeth."

The experience of this edentulous generation, he adds, has not been lost on younger patients.

"Most people realise now that dentures are an appalling replacement for teeth in terms of function, aesthetics, comfort and quality of life. Keeping teeth is a vastly preferable option."

Nothing lasts forever

An ageing heavy metal population keen to retain 'natural' dentition brings some special challenges. Dental fillings and crowns are not permanent, despite patient expectations, and need to be repaired or replaced as further affected by decay, restoration failure or loss due to the weakened state of the restored tooth. A restoration lasting 10–20 years would be considered a good outcome.

Says Professor Walls: "Dentists are going to have to think about and learn how to manage failing crown and bridge work, as it can be a technical and mechanical nightmare with very complex treatment management decisions."

Other factors come into play in dealing with older teeth. Gingival recession can expose the dentine root of the tooth, which is mechanically softer and has a higher critical pH for dissolution than the enamel of the crown. This makes the exposed root much more susceptible to decay than the crown. Treating root caries is often difficult and can easily result in loss of the tooth.

Oral hygiene can also be a problem in old age, says Professor Walls.

"With gingival recession the exposed shape of the tooth changes, with larger interproximal gaps and more places for plaque to accumulate. Patients need different hygiene techniques to clean those shapes effectively. And one thing dentists aren't very good at is re-educating patients.

"Allied to these difficulties is that as people grow older they become less physically able to do small dexterous tasks. They

develop arthritis in their hands; they lose fine motor control and become fatigued when doing fine motor tasks. So the physical act of brushing and cleaning becomes more of a challenge."

One telling statistic from the last dental survey was that 78 per cent of over-65s years had visible plaque on their teeth – higher than any other age group. But 93 per cent reported that they brushed their teeth at least once daily, which suggests a lack of technique rather than motivation.

Reduced salivary flow is another common risk factor among the elderly – often a side-effect from common medications or polypharmacy. Dry mouth increases susceptibility to acid-mediated disease, both decay and tooth wear.

And for some elderly people it can simply be a question of health priorities.

> "All of these problems are largely preventable by getting back to the good old-fashioned basics..."

"The frequency of dental attendance falls with increasing age," says Professor Walls. "But this may not be just from lack of access. Teeth are probably a low priority for somebody who has cardiovascular disease along with problems with their bunions and rheumatoid arthritis."

Preparing for the future

Prevention rather than more dental treatment is a common theme in most of the reports addressing the issue of ageing dentition. A major priority in carrying forward the recommendations of the Steele Review will be to encourage dentists to carry out more preventive work.

"All of these problems are largely preventable by getting back to the good old-fashioned basics of brushing the teeth twice a day and keeping sugary snacks to mealtimes," says Professor Damien Walmsley.

Educating older patients in proper brushing technique, he adds, along with the increased use of fluoride-containing toothpastes and mouth rinses would make a vast difference in the oral health of elderly patients.

It is also a matter of educating dentists, says Professor Walls.

"Not just young dentists in training but those age 35 or older for whom a lot of this information wasn't available when they were undergraduates. It's a continuing education problem as well as an undergraduate challenge."

Medico-legal risks

What of the growing medico-legal risks in treating an ageing population?

"The elderly today don't tend to be particularly litigious," according to Claire Renton, a dento-legal adviser at MDDUS. "But as younger, more litigious generations grow older there's every reason to assume that will change."

The main risks lie in failing restorations and more difficult treatments such as root caries. To avoid problems, she encourages members to consider increased provision of preventative measures for elderly patients.

"Rather than just dentists being more risk aware we should be informing patients of the changing pattern of decay in elderly teeth, and encourage them to come for regular checkups. Practices might want to introduce a preventative programme aimed specifically at the elderly."

Consent is another area of potential risk when dealing with elderly patients. It is important to ensure accuracy of understanding in consent among the elderly. Even impaired hearing can make this problematic. And as always, good record keeping is essential. Take accurate notes of all treatment and advice provided to patients, says Mrs Renton.

"That way, older patients will be protected from decay and dentists from allegations of failure to properly advise."

■ *Jim Killgore is editor of MDDUS Summons*

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

CHALLENGING PATIENT: RELATIONSHIP BREAKDOWN

BACKGROUND: Mr N attended his dental surgery complaining of toothache and was seen by dentist, Miss O. Due to a complex medical condition, it was agreed the problem tooth should be extracted at the community dental centre.

Mr N returned several weeks later following the extraction and said the dental officer who had extracted his tooth recommended a bridge be fitted to fill in the gap. However, Miss O explained the patient must wait at least six months for the extraction site to heal before a bridge could be fitted. And if such treatment was to be carried out under the NHS, it would also require prior approval.

The patient was angered by this advice and there was a heated discussion between him and Miss O over how to proceed. Miss O felt the patient had been verbally abusive and refused to carry out any further treatment on him. She decided he should be immediately deregistered from her practice,

citing verbal abuse on her health trust's deregistration form.

Mr N objected to accusations of abuse and raised a complaint against Miss O accusing her of defamation of character and of breach of contract due to the refusal of further treatment.

ANALYSIS/OUTCOME: MDDUS analysed Mr N's dental records which made mention of the exchange between him and Miss O. It emerged the dentist had not followed the procedure for immediate deregistration fully and there was some question over the reason given to the patient for his removal. Following extensive discussions, it was agreed that any reference to Mr N's alleged verbal abuse would be removed from the deregistration documents and the case was closed.

KEY POINTS

- Take care to follow the correct procedures as set out by the NHS when considering the deregistration of a patient.
- Do not hesitate to seek advice from MDDUS in matters concerning removal of a patient from your practice list.
- Always keep full records of exchanges with any patient whom you feel is being abusive or aggressive towards you or your practice staff.

PRACTICE SYSTEMS: PHOLCODINE REACTION

BACKGROUND: Mr A attended his GP with a persistent cough and was diagnosed with an upper respiratory tract infection. Dr Z subsequently prescribed pholcodine linctus to treat the cough. Unfortunately, the doctor failed to note that he had an allergy to codeine and opiates. The patient suffered a severe reaction to the medication that required several days of hospital treatment, including time in intensive care. The patient eventually made a full recovery.

A complaint was made about the doctor on the basis that Mr A's allergy was documented in his medical records. Dr Z explained that during her consultation with Mr A an initial computer alert about the allergy wasn't noted and no further alert was raised by the system when she later decided to prescribe the drug. Dr Z subsequently tested the practice computer and said there was a fault in the prescribing system that should have stopped her from completing a pholcodine prescription for Mr A. Dr Z was certain she would not have prescribed the opiate if the appropriate alerts had been built into the computer system.

ANALYSIS/OUTCOME: MDDUS sought an expert report on the case which found that the computer system was not designed to identify pholcodine as part of the codeine drug group. It was agreed with the software company that future alerts for codeine drugs would include pholcodine. However, the expert did find that Mr A's paper and computer records both clearly documented his allergy to codeine and opiates and there was no evidence of a systems failure in the practice. He concluded that in prescribing pholcodine to a patient with a clearly documented allergy, Dr Z's care fell below an acceptable level. MDDUS ultimately decided the case could not be defended and agreed a modest settlement on behalf of Dr Z.

KEY POINTS

- Always be aware of possible drug allergies when prescribing medication.
- Do not rely solely on automated systems to alert potential contraindications in prescribed drugs.

RECORDS: **DENTAL TREATMENT PAST**

BACKGROUND: A dental practice received notification of a claim of damages by a patient in the placing of a post crown which perforated the sidewall of a tooth. In addition the patient also claimed damages relating to crowns placed on front teeth.

The dentist concerned contacted his dental defence organisation (DDO) in regard to the recent post crown but the patient's records established that the work done on the front teeth had been undertaken over 25 years ago. Three separate dentists at the practice were involved in the patient's treatment at that time – none of whom were still with the practice. One had retired, another was deceased and the third dentist, Mr T, who had been a member of MDDUS at the time, had long moved abroad.

A settlement was negotiated by the DDO of the current dentist. Later MDDUS received a letter from that DDO claiming that Mr T was responsible for the dental work carried out on the front teeth and demanding that MDDUS cover a percentage of the negotiated settlement. It was claimed that by working out the chronology of treatment according to various initials on the notes it could be proved that Mr T carried out the crown work on the front teeth.

ANALYSIS/OUTCOME: The MDDUS adviser replied that in regard to responsibility for the alleged negligence it would be difficult to prove by studying the records which dentist carried out the crown work. Certainly memory could not be relied upon. In regard to the competence of the dental work – no matter who carried it out – the adviser replied:

"As you are fully aware, research has shown that advanced restorations have an average lifespan of 10-12 years and therefore the crowns, if fitted by Mr T, have lasted well outside that of any published research on this topic."

MDDUS refused to contribute to the settlement costs and the other DDO reluctantly accepted this position.

KEY POINTS

- Occurrence-based indemnity as offered by MDDUS provides protection no matter how long after alleged negligence took place.
- Records of dental treatment carried out and by who should be unambiguously clear.
- Memory cannot be relied upon in legal defence.

TREATMENT: **HAZARDOUS DRIVING**

BACKGROUND: A GP receives a letter from the DVLA advising that one of her elderly patients has had his driving licence withdrawn on the grounds of advanced senile dementia.

The patient had correctly informed the DVLA upon his initial diagnosis and the DVLA had contacted the GP for further information. It had also arranged for the patient to undergo a driving assessment. The assessment determined that the patient's condition posed a risk and his licence was revoked.

A month later the GP sees the patient drive into the practice car park to attend an appointment. She later phones the MDDUS to ask for advice on how to deal with the issue.

ANALYSIS/OUTCOME: The MDDUS adviser recommends that the GP contact the patient to say he must stop driving or she will contact the DVLA and the police if necessary. She is also advised that should it seem uncertain whether the patient intends to comply, she should inform him of her intention to the contact the DVLA with or without his consent. Prompt disclosure here would be justified on the grounds of public interest.

KEY POINTS

- Patients with dementia must by law inform the DVLA.
- Doctors are entitled to breach patient confidentiality without consent in cases of overriding public interest.
- If possible, inform the patient first of your intention to breach confidentiality in such cases.

TREATMENT: **CRYOTHERAPY COMPLICATION**

BACKGROUND: A 52-year-old woman, Miss C, was diagnosed with warts on her hand by her GP. Dr R arranged for her to undergo treatment with liquid nitrogen in the practice.

On her fourth visit to the clinic, Miss C was seen by a foundation year 2 doctor, Dr L. The FY2 had been trained in using liquid nitrogen by Dr R and was deemed competent in the procedure. However, following this latest cryotherapy treatment, Miss C developed blisters on her hands on top of the warts with surrounding redness and was prescribed antibiotics by Dr R.

A few days later they had still not improved and Miss C sought help from her local A&E where the blisters were surgically cleaned and dressed. She was unable to work for several weeks while the wounds healed.

IMAGE SCIENCE PHOTO LIBRARY

ANALYSIS/OUTCOME: Miss C's GP practice carried out a significant event analysis following the incident and found that the length of liquid nitrogen treatment in the fourth visit fell outside the recommended guidelines. This prompted them to review their procedures. Miss C lodged a complaint of negligence against both Dr R and Dr L in relation to the cryotherapy. MDDUS lawyers advising Dr R agreed with Dr L's representatives on a modest joint settlement to the patient in regard to Dr L's actions under supervision of Dr R.

KEY POINTS

- Doctors in training share responsibility for their own actions or omissions, even if following processes advised by seniors.
- Ensure safe working practices are in place for treatments using liquid nitrogen.

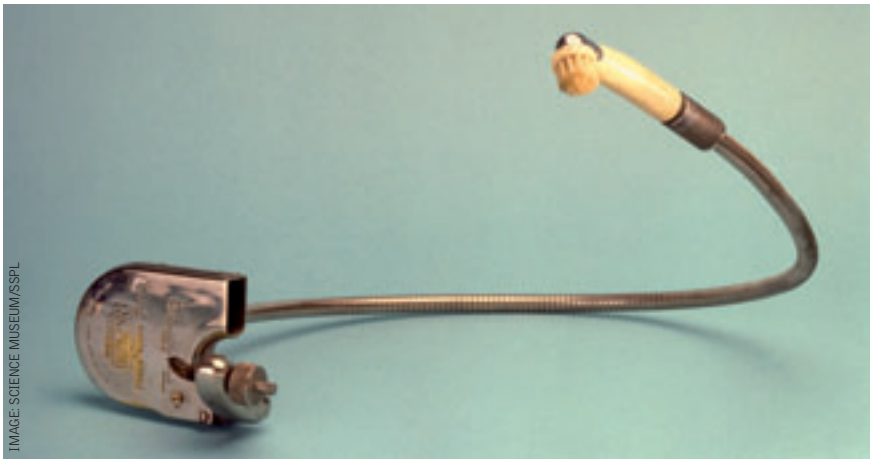


IMAGE: SCIENCE MUSEUM/SSPL

Object obscura:
hydraulically powered toothbrush

This 'Kavor' hydraulically powered toothbrush was manufactured around 1932 by Jenkins Productions Ltd of Dereham, Norfolk.

Medical Wordsearch: causes of wheeze

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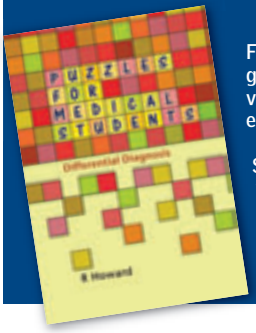

Find 8 causes of wheeze in the grid. Words can go horizontally, vertically and diagonally in all eight directions.

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

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)

From the archives:
the long arm of coincidence

Dr John Nicholson graduated in 1935 and was on his first house job at Sutton and Cheam Hospital. A young male patient was admitted to have a hernia operation. It was the custom in those days to stay in hospital after such an operation for fortnight. At the end of this period the young man was duly discharged in the morning, to return home. He had very distinctive features, with red hair and moustache.

The same evening about 8 o'clock, Dr Nicholson was called to casualty because there had been a motorcycle road traffic accident and a young man had been brought in unconscious with a head injury. The night sister and the doctor began to clean him up and both recognised the individual as the man who had been discharged that morning. His rucksack lay on the floor with his initials on it, which tallied with the name they remembered. The doctor felt very annoyed and planned to give him a piece of his mind.

At that stage, he and the night sister decided to take a look at his abdomen to check the hernia wound. To their consternation, there was no sign of a recent operation scar. They could make no sense of it, until a junior night nurse came in and said that he was a twin brother! The twins were identical and could rarely be told apart. To further confuse the issue, this twin had borrowed both his brother's rucksack and his motorcycle – and then was brought into the same hospital, the same day that his twin brother had been discharged. Such is the long arm of coincidence

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

Vignette: unsung pioneer of pain relief
Dr Robert Michael Maher (1901-1989)

ROCHDALE SEEMS AN UNLIKELY location for a medical milestone but it was here in 1957 that Dr Robert Michael Maher created the world's first clinic for the treatment of patients suffering from the chronic intractable pain of progressive malignant illness – an achievement perhaps more widely recognised in the USA than within the British medical establishment.

Maher was born in Liverpool and studied medicine at Liverpool University, attaining BSc in 1923. During World War II he served as an army medical officer in the Middle East and Italy. On his return he opted for a career in hospital medicine, specialising in neurology.

In 1957, this writer, as the new resident medical officer at Rochdale hospitals, came under his tutelage. Maher was then senior consultant physician and described himself as 'Liverpool-Irish', though with a deep, booming voice that was difficult to categorise. A Member of the Royal College of Physicians, he eschewed a career in a 'teaching hospital' favouring the 'ordinary' general hospitals of Lancashire, first in Oldham, then Rochdale. At interview for the Rochdale RMO post, Maher assured me I would achieve a broader knowledge of medicine in that 'ordinary' hospital. He was right.

My fellow junior doctors advised me that Dr Maher had eccentricities. He always addressed juniors by surname and rarely with doctor attached. His regular ward rounds were invariably late afternoon or early evening; no mornings. I recall a patient cheekily asking on a 7pm ward round: 'Doctor, have you no home to go to?' His reply was: 'Just take your pyjama top off...'

He expected junior doctors, no matter how busy the Unit, to read the weekly *BMJ* conscientiously and answer his questions on articles therein. He periodically directed you to its 'rival', the *Lancet*, if his own work had been published there.

His legendary absent-mindedness in parking his car affected hospital staff, his own family and even the Rochdale police (ever helpful in finding where his car was

PHOTOGRAPH: BMJ

left). Yet he was always on time for outpatients or home visits. Eccentricities notwithstanding, he was liked and admired by patients and staff, because he not only cared but listened.

Maher also had an open and analytical mind when it came to medicine. In the late fifties, against the general view, he insisted neither stress nor diet caused peptic ulcer. Long before *Helicobacter pylori* was discovered, he insisted an 'infective agent' caused peptic ulcers. Remarkably too, in retrospect, though milk and carbonates were 'ulcer therapy', he doggedly used bismuth as a protective and possible healing agent (and was again proved right ahead of his time). Who knows what else he might have achieved with the back-up of a teaching hospital?

Fortunately for medical practice, his special concern was for patients suffering with chronic intractable pain related to poorly responding or progressive malignant illness. This had lead to his creating in Rochdale, just before my own arrival in 1957, the first ever clinic specifically for treatment of chronic pain. Although this makes him, effectively, the 'father of pain relief clinics' in modern medicine, this role was not much recognised in Britain.

Maher's specialist knowledge of neuropathology led to initial trials in the use of intrathecal phenol in chronic pain relief. First, he gained permission to 'practise' on cadaveric spinal column sites. Then, encompassing newer neuronal understanding of pain carriage in the spinal cord fibres, he utilised hyperbaric phenol solution in glycerine, injected at the appropriate segmental level. This produced effective pain relief in the chronic situation. In all my years working alongside Maher, I never saw him fail a spinal puncture at any level.

As well as providing pain relief to cancer patients in his own catchment area, he took medical referrals from towns outside Rochdale doing the same, travelling with his own equipment and often at his own expense.

In 1955, the *Lancet* published the first major account of this remarkable break-through in pain relief. A major follow-up account came five years later. Maher's extraordinary work at a non-teaching hospital, with no university grants or commercial back-up, was particularly admired by American researchers in pain relief. So much so that, in retirement, he was invited to give several 'lecture tours' in various American states. Across the Atlantic, Maher's contribution to pain relief was rewarded by many accolades for which he was very grateful.

Back in England, anaesthetists – the newer experts at injection of the 'spinal cord' – took on an essential role in later pain relief clinics, as Maher had predicted. Remarkably, no official gongs were forthcoming from the British establishment for Maher's achievements and he was prone to assert that his own remarkable discoveries in pain relief were being adapted and evolved by the anaesthetists without proper acknowledgement of his original work. But on his 74th birthday Maher was given the distinction of a first honorary vice-presidency of the Intractable Pain Society.

In retirement, Maher moved to Preston and his health deteriorated in his late 80s. I visited him in hospital and we could still smile at tales of his absent mindedness. Like the day he asked me to drive his car to a garage for a 'little repair job'. In heavy rain, I got in the car and sat down. My feet were wet and I looked down to see no floor in the driver's section.

Dr Ivor Felstein

MDDUS Employment Advisory service

MDDUS are proud to announce an exciting new service soon to be available

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– Legal fee protection
– Employment tribunal award protection

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