Winter 2010

SUMMONS

MDDUS JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND

• Expert testimony • MDDUS growth • Bisphosphonate risk •

IN BRIEF

"WE HAVEN'T had a decent courtroom drama for ages, and this one looks promising," wrote AA Gill recently in *The Sunday Times*. He was referring to the four-part BBC series *Garrow's Law* which premiered in November. The production is based on real legal cases from the late 18th century, drawn from the proceedings of the Old Bailey. Andrew Buchan plays the pioneering barrister William Garrow who championed the rights of poor defendants to adequate representation in court.

In the first episode Garrow must disprove a charge of infanticide against his client, a lowly housemaid. He manages to discredit the evidence of the prosecution witness – a surgeon – by citing use of the 'hydrostatic test' in examining the baby's lungs in order to determine if born dead or strangled after delivery. Thrilling drama – but more interesting when you consider how even 200 years ago judges had to rule on often obscure expert medical evidence.

The same is true today, as you will read on page 14 where barrister and medico-legal expert Simon Cridland discusses some of the principles modern judges must apply in deciding what weight to attach to complex and often conflicting opinions expressed by expert witnesses.

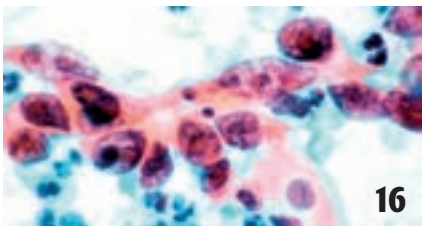
Also in this issue, Dr Alexander Crighton warns of potential dental complications associated with the use of bisphosphonate drugs (p. 18) and Dr David Farquharson looks at the pitfalls in making initial diagnoses and referrals in the most common gynaecological cancers (p. 16).

And on page 12 Professor Gordon Dickson, CEO of MDDUS, considers the results of a poll carried out on behalf of the Union to determine what members value most in the service we provide – and the implications of this as MDDUS continues to grow.

Jim Killgore, editor


12


14


16

REGULARS

Cover image: Feeding the Animals by Alison Prosser. Oil on canvas, 1994.

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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Following conflicting guidance

Interpreting medical guidelines can pose a challenge for doctors. But what should be done if two pieces of widely-accepted guidance appear to contradict each other?

The MDDUS received a call from a GP member with this very question. The doctor saw a conflict between widely-accepted guidelines on the use of aspirin to prevent thrombo-embolic episodes and a recent *Lancet* article that suggested that the risks and benefits of aspirin for primary prevention were finely balanced. While the adviser could not arbitrate between guidelines, he

reassured the doctor of MDDUS's continuing support if the issue led to legal or regulatory proceedings and offered general advice.

Apparent conflict between guidelines is not uncommon. Doctors should analyse how well each applies to the particular patient in front of them. If both seem applicable, then an analysis of the quality and evidence base of the guideline may help. (In the scenario above, there seem to be no authoritative guidelines on the use of aspirin for primary prevention.)

Remember that guidelines are just that – guidance. It is up to the doctor to decide whether to follow that guidance or not. If the doctor departs from guidance then it is prudent to record that departure and briefly to document the reasons for it. If a doctor can prove that he or she made a well-reasoned professional decision that a particular patient should not be managed according to particular guidance, a finding of sub-standard care is very unlikely.

Doctors should remember that slavish following of guidelines does not guarantee immunity from allegations of negligence. If an expert witness says in court that no reasonably competent doctor would have followed the guidance in the particular case under scrutiny, then there may well be a breach of duty of care.

Dr Des Watson, medical adviser, MDDUS

Ensure vaccine brand check

GP practices should check supplier information before administering vaccinations for specific patients. The Union recently received a call where an infant had been administered a vaccine licensed for use only in children over age 4. There are several different brands of flu vaccine and only some are licensed for use in children. Many surgeries only get one type of vaccine and, if they have children to immunise, may not check that the brand is suitable. MDDUS urges members to ensure that practice staff double-check that vaccinations are licensed for use in specific patients being treated.

Dr Mary Peddie, medical adviser, MDDUS

Read the fine print

MDDUS has had a number of calls from members who have inadvertently signed contracts to advertise their details in a European medical directory. They apparently thought that the document they had signed and returned was simply intended to confirm details for a free directory listing. But the members subsequently received invoices for payment of significant sums of money from a foreign company.

Examination of the document confirms that the final paragraph does state the terms of the contract and the charges, and this emphasises the importance of reading all such documents carefully before signing.

Dr Barry Parker, medical adviser, MDDUS

MDDUS sponsors BMJ Group Awards

MDDUS is proud to announce its headline sponsorship of the BMJ Group Awards 2010.

These prestigious awards recognise individuals, organisations and initiatives that have demonstrated outstanding contributions to healthcare. MDDUS strives for the highest standards in supporting its members throughout the UK – so we are proud to have the opportunity through the BMJ Group Awards to encourage and recognise excellence and innovation in other healthcare organisations and individuals.

Nominations have now closed and a shortlist will be announced for each of the 10 award categories. Categories include Research Paper of the Year, Secondary Care Team of the Year and the Lifetime Achievement award.

The awards are being held on Wednesday, March 10, 2010 at the Hilton, Park Lane, London. Tickets can be booked on the BMJ Group Awards website: www.groupawards.bmj.com

IN BRIEF

***PRACTICE MANAGER* LAUNCHED**

MDDUS has published the first edition of a new magazine for members who manage medical or dental practices. *Practice Manager* will appear twice-yearly and cover a broad range of issues including medico- and dento-legal advice, employment law, statutory and regulatory issues as well as topics of general interest. Email PM@mddus.com for info.

SPORTS MEDICINE COURSE

A two-day course providing training to healthcare professionals caring for an athlete or a team of athletes will be held in Hampden Park in Glasgow on March 31 and April 1, 2010. SportPromote is run by a consultant in emergency medicine and has been given educational CPD approval from the Royal College of Surgeons of Edinburgh and endorsement from the SFA. More information is available at www.sportpromote.co.uk

Review of FAI rules

A review by Lord Cullen into the legislation governing fatal accident inquiries (FAIs) in Scotland was published in November 2009. He has made a number of recommendations which the Scottish Government will have to consider before amending the legislation.

While no specific recommendations were made in relation to inquiries into deaths following medical mishaps, some will be of interest to healthcare professionals, either as factual or expert witnesses. The main recommendations of interest are:

- If possible, FAIs should be held outwith a court room with solicitors, advocates and the sheriff appearing without their wig and gown.
- The conduct of FAIs by the fiscal's office is to become more specialised. A central team will be formed, led by a senior prosecutor. This will ensure complex cases will be led by somebody with the appropriate level of skill and knowledge.
- Changes should be made to the Scottish Legal Aid Board to ensure more families can be represented.
- The procurator fiscal is to apply for an FAI at an early stage. This is to speed up the process. There should be a preliminary hearing in all cases.
- It should be normal practice for experts to meet to identify common areas and areas of dispute.
- If the sheriff, in his determination, makes recommendations then those bodies to whom these recommendations are directed will have to respond confirming that they will implement those recommendations. If they do not intend to implement, they will have to give reasons why. Responses will be published on the Scottish Government website.

Lindsey McGregor, solicitor, MDDUS

Membership of MDDUS...

"...provides assistance, advice, representation and access to indemnity for circumstances that arise out of the bona fide practice of medicine, dentistry or an allied profession and that occur during a period of membership. As a mutual organisation, MDDUS always acts in the interests of its members and offers assistance, provided the need for help arises out of the practice of a profession."

This excerpt is from the 2009 MDDUS Membership Agreement which can be found on our website **www.mddus.com** by clicking on the 'Become an MDDUS Member' web page. Members are encouraged to read the agreement.

Reporting road traffic offences

DOCTORS must not hesitate to inform the GMC if they are charged with or convicted of a traffic offence.

Any registrant who has accepted a caution, been charged with or found guilty of any criminal offence anywhere in the world are obliged to report the matter to the GMC "without delay". The exception would be where a doctor is issued with a fixed penalty notice. This might be for minor traffic violations such as not wearing a seatbelt, having a broken headlight or minor speeding offences.

If the matter is settled by paying a fine and no criminal conviction is recorded, there is no need to alert the GMC. Sometimes in speeding offences, if the speed is only slightly over the limit, the driver will be given the option of a speeding ticket and penalty points on their licence as an alternative to prosecution. But offences such as excessive speeding, causing death by dangerous driving or drink driving must be reported promptly to the GMC.

The MDDUS has provided advice in a number of cases where members have been convicted of this type of crime but have not reported it to the GMC. They have ended up being subject to investigation or being issued with a warning. In some of the cases MDDUS has been involved with, members had reported convictions but delayed doing so by a month or two and this was still the subject of criticism.

GMC guidance goes on to say that doctors must inform them if they "accept the option of paying a Penalty Notice for Disorder at the upper tier penalty level (in England and Wales) or a Fixed Penalty Notice under the Anti-Social Behaviour etc (Scotland) Act 2004." It is clear that all offences, with the exception of those settled by a fixed penalty notice, should be declared.

MDDUS encourages members to get in touch for clarification on GMC obligations in disclosure of any criminal offences apart from minor traffic violations.

MDDUS PM conference sells out

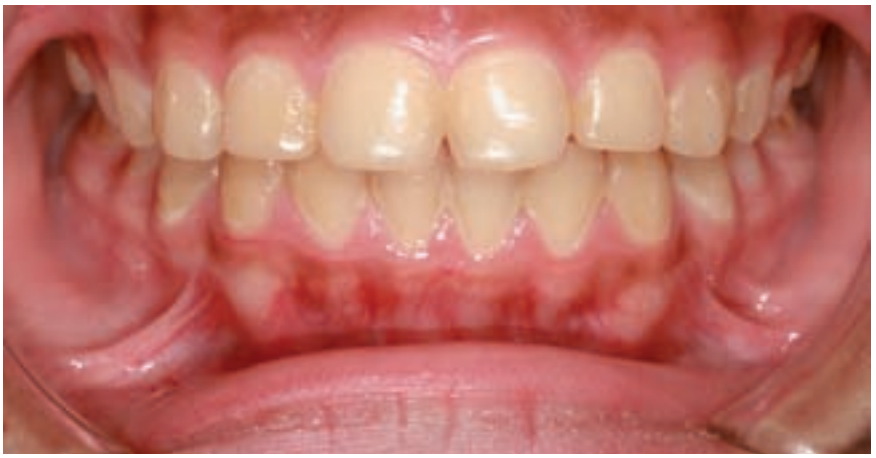
The fifth MDDUS Practice Managers' Conference being held this February has sold out. Demand for the event at the Fairmont, St Andrews has been overwhelming. Delegates can look forward to talks on communication and team work from keynote speaker Terema, a mock fatal accident inquiry, inspirational tales from storyteller David Campbell and a range of interesting workshops to help you manage your practice more effectively. To join the waiting list for a booking contact **kwalsh@mddus.com**

LEADING THROUGH UNCERTAINTY

There are still limited places available on this five-day, intensive MDDUS' training course in Glasgow in February which focuses on key areas such as communication , risk management, decision-making and delegation. Members and non-members can also register now for the next course in September. It will be held one day per month over five months in both London Glasgow. For more information contact Ann Fitzpatrick on 0845 270 2034 or email afitzpatrick@mddus.com

SPECIALTY TRAINING GUIDE

A new guide for doctors applying to specialty training in 2010 has been launched online. The *Quick Guide* explains how the recruitment process works, what is involved and where to find out more information. It can be used alongside the main applicant guide which details eligibility criteria, a full list of specialties plus hints and tips on preparing for interviews and considering and accepting offers. Access the new guide at http://tinyurl.com/ye7a6m6



Oral health in diabetics

NEW guidance has been published highlighting the importance of proper oral hygiene for people with diabetes.

The *Guideline on oral health for people with diabetes* produced by the International Diabetes Federation (IDF) emphasises how the management of periodontal disease can help reduce the risk of developing diabetes and can also help sufferers control blood sugar levels. The guidelines encourage health professionals to make annual checks on patients for symptoms of periodontal disease such as swollen or red gums or bleeding during tooth brushing and to educate their patients with diabetes about the implications of the condition on oral health, and especially periodontal health.

Samuel Low, President of the American Academy of Periodontology (AAP), said: "Periodontal disease triggers the body's inflammatory response which can affect insulin sensitivity and ultimately lead to unhealthy blood sugar levels. Establishing routine periodontal care is one way to help keep diabetes under control."

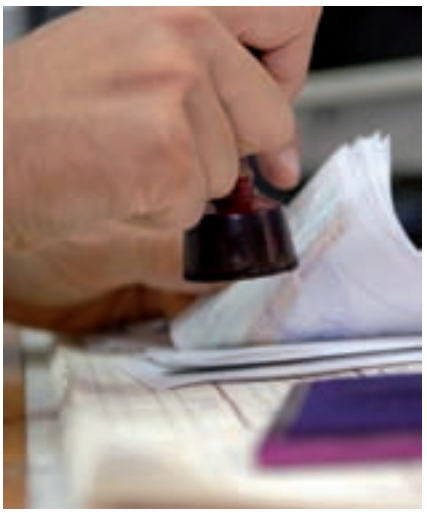
Read the guidelines at: **http://tinyurl.com/y9cgqtv**

GMC licence now in force

DOCTORS in the UK must now be both registered with the GMC and hold a licence in order to practise medicine.

The new regulations which came into force in November mean that being registered with the GMC is no longer enough for practising doctors. A licence gives doctors the legal authority to write prescriptions, sign death certificates and exercise a wide range of other legal 'privileges'. This applies to all doctors working in the UK, whether employed in the NHS or the independent sector, either on a permanent or locum basis.

Employers are also responsible for ensuring that the doctors they employ have a licence to practise if their work requires them to do so.



Professor Peter Rubin, Chair of the GMC said: 'The successful start to licensing is a major milestone towards the introduction of revalidation, a new process by which doctors will have to regularly demonstrate to the GMC that they remain up to date and fit to practise in the job they do."

Hospital prescription errors revealed

ALMOST one in 10 hospital prescriptions contain mistakes which could put patients at risk, according to new research commissioned by the General Medical Council.

The study analysed 124,260 prescriptions across 19 English hospitals and 11,077 mistakes were discovered. One in 50 mistakes were potentially lethal, such as when a patient's allergies were not taken into account. Five per cent were ranked potentially serious, for example when doses were prescribed either too high or too low. Just over half were potentially significant while the remaining 40 per cent of mistakes were minor, which includes an illegible prescription or ambiguous abbreviations.

The research also found that junior doctors and registrars make mistakes in around 8 per cent of the prescriptions they write, compared to an error rate of 5.9 per cent among consultants. But the report emphasised that most errors are picked up by pharmacists and very few caused harm to patients.

The GMC commissioned the research to examine how often Foundation Year 1 doctors make prescribing mistakes and the reasons why. It concluded that prescription errors are "not solely, or even primarily, a problem of the most junior trainees and that doctors at all levels, including consultants, make mistakes."

Mistakes, the report found, were often the result of "busy and stressful working environments" while some were blamed on complex or unfamiliar prescribing charts.

IN BRIEF

ANTIBIOTIC GUIDANCE "TOO COMPLEX" Guidance on prescribing antibiotics is often too specialist for doctors to absorb quickly, the Royal College of Physicians has said. An RCP working group looking at healthcare acquired infections has published 'top 10 tips' to help busy doctors identify the important points in effective antibiotic prescribing. Access at http://tinyurl.com/yjdvs5y

ONLINE GDP RATING The website – www.iWantGreatCare.org – has now turned its sights on dentists with the launch of a dental rating service in January. Patients will be urged to post experiences about their dentist – good or bad – and use a rating system similar to consumer websites. The service claims that feedback will be closely monitored to prevent abuse.

SPECIAL CARE DENTISTS TO JOIN LIST Dentists trained in special care dentistry are being encouraged by the GDC to make applications to the specialist list. Specialist lists are lists of registered dentists who meet certain conditions and are entitled to use the title 'specialist'. A dentist does not have to join a list to practise any

The report recommends standardised prescription charts for all UK hospitals in a bid to cut errors.

GMC chairman Professor Peter Rubin added: "Prescribing decisions in a hospital setting often have to be made quickly, so it is important that a procedure is as simple as possible to minimise the chance of an error being made."

GDC must act to protect the vulnerable

Dental professionals suspected of posing a threat to children or vulnerable adults will be reported by the GDC to the Independent Safeguarding Authority (ISA).

The GDC has set out its stance on the government's new Vetting and Barring Scheme (England, Wales and Northern Ireland) and has confirmed that it now has a legal obligation to share information about GDC registrants with the ISA. It is waiting to be advised as to exactly what information must be shared, but it is likely to be anything which could indicate that a registrant poses a risk to children or vulnerable adults.

As of October 12, 2009, it became a criminal offence for people barred by the ISA to work or apply to work with children or vulnerable adults in a wide range of posts. It is also now a criminal offence for an employer to knowingly employ a barred person in a regulated activity.

In Scotland the existing rules – from the regulatory body Disclosure Scotland – currently remain unchanged with employees working with patients requiring enhanced disclosure status. However, a new system called the "Protecting Vulnerable Groups Scheme" is being introduced in 2010 and will be similar to the ISA scheme south of the border.

OPINION

by Dr Ivor Felstein
Retired Consultant Geriatrician

I need to consult my...

Changing the name of a shop or a store is a useful gimmick. It frequently draws new custom and sales. Much better than that hopefully apologetic notice: "under new management".

But can the same be said of the growing trend of changing occupational names? Our friendly neighbourhood chemist has long since vanished in favour of the upmarket and more clinical title 'pharmacist'. The jolly corn- and callus-removing chiropodist has now a firm footage as a podiatrist. As carousels of do-it-yourself reading glasses spin round in supermarkets, the optician has changed tack to a 'primary care eye expert' or an optometrist. Even our garbage collectors have gained street credence as refuse operatives.

One notable casualty of this trend, however, is the once revered and sought-after medical title of 'consultant'. To be described in lay circles as a consultant physician or consultant gynaecologist, for example, was formerly to invite genuine esteem and admiration not to mention quiet reverence among patients. It clearly spoke to your having reached top-of-the-tree in the medical world. Not for very much longer, though, as that modern menace of dumbing down significant titles advances steadily.

You have only to look in the newspapers or on television to see what has become of the once good name of consultant. If you can apply a puff of powder and a smear of lipstick to Miss or Mrs Average you are now a beauty consultant. If you can figure out any way at all of rescuing downward floating shares or interest rates, you are a financial consultant. If you can surpass your sales target in sandwich and crisps retailing, you are a market consultant. Put together a sentence grammatically and with accurate spelling and you earn the title of literary consultant. Set up stall in a car boot sale to flog a few heirlooms and you become an antiques consultant. Most remarkable of all, if you can connect up a monitor, a scanner, a printer and a processor, you are an IT consultant.

Yet still the medical profession continues doggedly to retain the description 'consultant' to indicate full hospital training, certification and accreditation in a given specialty. Despite the fact that junior trainees for the topmost post are now renamed 'specialist registrars' and further experienced but not consultant-affirmed experts are called associate specialists, the hospital doctor reaching that final rung on the ladder is not 'full specialist' or 'whole-time or private' specialist. He or she is a consultant – yes, there alongside those other ladder-toppers in beauty, finance, marketing, literature and computers.

Why are contemporary medical practitioners waiting to lose further dignity and deserved recognition? Those older Latin-knowledgeable physicians among us will recall the words of Horace: *mutato nomine de te fabula narratur* – with the name changed, the story applies to you.

Specialist, not consultant, ladies and gentlemen please!

particular specialty but can only use the title 'specialist' if on that list. For more details go to www.gdc-uk.org

ANTIPSYCHOTICS USE IN DEMENTIA GPs in England will have to limit their use of antipsychotics in dementia patients after a report linked the drugs to 1800 deaths a year. The Department of Health report found antipsychotics were being used "too often" in treating dementia and called for use to be cut by a third. Access the report at http://tinyurl.com/yzo4pkw

SAYING SORRY The National Patient Safety Agency (NPSA) has published strengthened guidelines for NHS organisations in England and Wales on being open with patients. The new set of principles is to aid healthcare staff communicating with patients, families and carers following harm. Access at http://tinyurl.com/ye4uxtk

HOW WERE YOUR HOLIDAYS?

Ian Watson, Law at work

LAST YEAR Abigail, your practice nurse, came back from holiday with a tan – and a broken foot.

She had slipped in a rock pool in St Lucia on her second day and broken a metatarsal. She returned to the UK with her foot in plaster and was off for three further weeks, on top of her fortnight's holiday – much of which had been spent in A&E and in the hotel room, with her foot up.

The practice decided to give her the two weeks' annual leave back – as a goodwill gesture and purely at the partners' discretion – because you felt sorry for her.

But in future, goodwill gestures may not be good enough. Staff who are ill while on holiday are set to gain the legal right to take that holiday at a later date following a landmark decision of the European Court of Justice (ECJ).

Vicente Pereda, a Spanish worker, fell ill before his scheduled annual holiday was due to start and did not recover and return to work until after his holiday would have ended. His request to reschedule his holiday was refused, and he challenged the decision in the Spanish courts. They referred his claim to the ECJ for their guidance, based on the EU Working Time Directive.

The European Court ruled that a worker who cannot take a scheduled holiday because of illness (or whose holiday is disrupted by sickness) is entitled to take the holiday at a later date, even if that means the holiday has to be taken in the next holiday year.

It seems certain that workers in this position, who try to exercise their right to apply for replacement holidays in the same holiday year, will succeed. However, the picture is less clear in respect of those who try to carry the 'compensatory' holidays into the next holiday year. Public sector workers can almost certainly enforce this right directly, without a change to UK legislation, but private sector workers may have to wait for the Working Time Regulations to be changed to take the ruling into account.

"Scope for discretion to 'refund' holiday in these cases is now more limited"

In any event, employers' previous scope for discretion to 'refund' holiday in these cases is now more limited, as the employee can point to the Pereda case as foundation for their request to restore leave 'prevented' by sickness.

So future 'Abigails' might have a strong case for demanding 'restoration' of their holiday – as opposed to relying on the goodwill of the practice.

Business organisations have raised concerns that some staff may attempt to abuse this new right. It will be for employers to decide what evidence of illness they require – particularly where the claimed sickness has lasted for fewer than seven days, which would normally be subject of self-certification by the worker.

Thankfully, if a holidaymaker is hospitalised or given private medical treatment abroad (or even in their home country), they generally require some evidence of that treatment in order to claim on their holiday insurance. This may give employees an incentive to obtain evidence of the medical services they required while on holiday. Copies of this evidence can also be used to demonstrate to their employer that they are genuine in their claim for a 'holiday refund'.

However, it would seem reasonable to ask employees in this position for something more substantial than their own statement – that they were 'really sick while on holiday' – before agreeing to reinstate their spoilt annual leave.

It may therefore be sensible to amend any contractual or staff handbook guidance, for example in your sickness reporting and annual leave request procedures, to forewarn staff that some supporting evidence will be required before holidays will be restored in these situations.

In any event, you might reasonably take a slightly tougher line with staff whose enjoyment of their holiday in Malia was spoilt by serial over-indulgence and substance abuse!

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

10 TACTICS TO REDUCE RISK

Dr Malcolm Thomas

YOU MIGHT THINK that the best way for a clinician to reduce the risk of being sued would be to improve clinical practice. But this can be difficult – not least because now most clinical care is delivered by teams and this requires the cooperation of many people to reduce risk.

It turns out that the way a clinician responds to an individual patient during a consultation can be a major risk factor for being sued or complained about. In one US study, only 3% of negligently harmed patients took their case to a lawyer, and only about a fifth of all the cases brought to a lawyer were from patients with clearly negligent harms. As the authors said, "If you have been sued, it is unlikely you did anything wrong, and if you did anything wrong, it is unlikely you have been sued".

Bunting and colleagues reviewed the evidence and found predisposing factors for being sued, which included (amongst others) miscommunication (mainly related to explaining) and the clinician appearing apathetic.

We recommend 10 tactics to maximise accuracy and minimise patient alienation.

1. *Listen carefully at the start of a consultation.* It is tempting to want to explore the clinical story as soon as it emerges. This runs the risk of important patient information being suppressed. It is also very good for rapport if the patient's first experience of talking is that of being fully listened to. GP studies have found that letting the patient finish their opening remarks does not add time to a consultation but it does increase the chance of the most important clinical matter being raised and addressed.

2. *Recap the patient's opening remarks.* This leads to early agreement about key facts and demonstrates you have been listening. For example, "So what you are telling me is first x, then y and now z...is that about right".

3. *Find out the full range of issues.* Patients may not tell you everything that is important. Some US researchers have found that the phrase "Is there some other concern that you planned to raise today?" is most likely to elicit the full list. The beauty of this question is that it allows other important agenda items (common in GP) or underlying concerns (common in hospital practice) to emerge.

4. *Make an early explicit empathic observation.* Consultations with at least one explicit expression of empathy produce higher patient satisfaction. For example: "I can see you look a bit worried about this".

5. *Summarise the clinical history before examining the patient.* Doing this ensures that you and the patient are in explicit agreement about the clinical story. This enhances both accuracy and rapport.

6. *Signposting.* Use explicit 'signposting' statements, such as "Can you hang on a minute while I just find this letter in your notes?" One US study comparing law suits among family physicians found that those doctors who had never been sued used three times as many signposting statements – and it does not make consultations longer.

7. *Explain your examination.* Some of our examination protocols are not obvious, for example examining the breasts of a woman with an axillary lump. It takes no extra time to offer a brief explanation of what you are examining (and why). You can keep this up throughout the exam in most cases.

8. *Find out what the patient wants to know.* Before offering a well-polished mini-lecture by way of explanation, it is useful to find out if the patient has any specific information needs or questions. One thing that is very appealing to patients is to write the questions down on a sheet of paper. This tactic can promote accuracy, vastly increase the chance of the patient's questions being answered and it does seem to keep explanations focused – in our experience it can reduce the risk of a never-ending series of patient questions in more complex explanations.

9. *Explicitly check patient understanding.* Asking "Are you with me?" is not enough. In order to be clear, we need to encourage the patient to tell us what they have learned from our explanation. My own practice was something along the lines of: "We've talked about a few things and I'd like to see how well I have explained them to you. Can you tell me the main points you have understood from what I have said?"

10. *Set a safety net.* We often rely on patients to execute a management plan and we need them to report back to us if things aren't turning out as well as we expected. A recent consensus suggests the following elements to a good safety net:

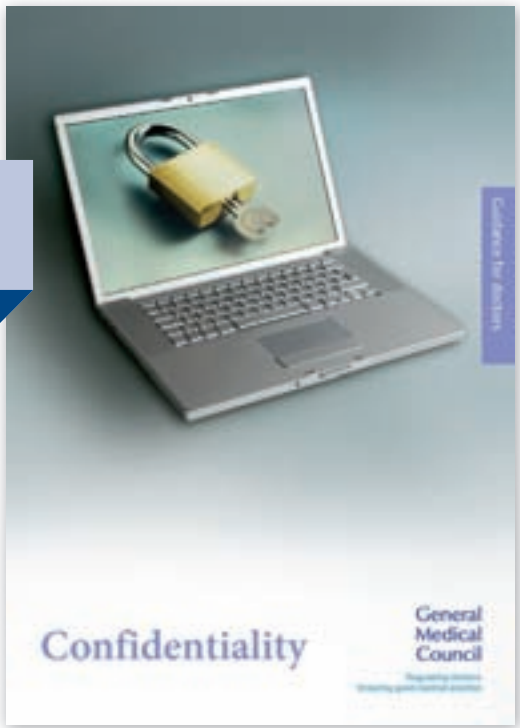
- Clarify that there is some uncertainty.
- Predict the future course, with timescales, as accurately as the situation allows.
- Specify what symptoms the patient should look for.
- Specify how the patient should get back in touch (GP, A&E, telephone etc).

These are not the only consultation behaviours that can enhance clinical effectiveness and reduce medico-legal risk but they are our "big 10" and form a useful bedrock.

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

TO DISCLOSE OR NOT TO DISCLOSE

Michael Keegan, GMC



ALL DOCTORS are familiar with the duty of confidentiality and its importance in the doctor-patient relationship; but in practice it's not always easy to decide where the limits of the duty lie. It is an area of ethics which continually challenges doctors and, perhaps not surprisingly, it tops the list of ethical enquiries received by the GMC's standards and ethics team.

Whether deciding to inform the police about a patient with knife wounds, or tell a patient's partner that they are at risk of acquiring a sexually transmitted infection, a doctor's dilemma remains the same: how can they decide if the public interest in disclosure of a patient's personal information outweighs both the patient's and the public interest in a confidential health service?

New GMC guidance, *Confidentiality,* which came into effect on October 12, provides a framework of principles within which doctors can exercise their professional judgement to address these and similar challenges. It has been drafted following extensive consultation with patients, doctors and the public with the aim of providing clear guidance covering doctors' day-to-day problems regarding confidentiality. It explains how doctors must balance their duty of confidentiality with the benefits of sharing information – most obviously when it can protect others from risks of serious harm. As doctors know, this does not allow them to break patient confidentiality routinely, but instead requires the exercise of judgement on a case-by-case basis.

The new guidance has advice for doctors considering whether to disclose confidential information about a patient's genetic illness to members of the patient's family. *Confidentiality* acknowledges that most patients will readily share information about their health with their children and other close relatives; but some may be reluctant to do so for a variety of reasons. They may refuse to allow their doctor to share information that could help relatives get preventative treatments or interventions, make use of increased surveillance, or simply prepare for potential health problems.

The GMC's guidance explains that, if a patient can't be persuaded to inform others, their doctor might still disclose information in the public interest: to protect those who may be at risk from a potentially life-threatening condition, if there are direct health benefits for those being informed. An example might be where a woman finds she has the BRCA genes known to increase the risk of breast cancer, but refuses to tell her daughters. In such a situation, her doctor should explain the risk of her daughters inheriting the disease and encourage her to inform them of the risk, or allow her doctor to do so.

Deciding on the best course of action is particularly difficult because of uncertainties around the chances of inheriting particular genes, the risks they pose to health, and because only a few can be tackled with useful intervention. Fortunately, this is likely to change as we improve our understanding of genetic inheritance and as more treatments become available.

There are other cases where doctors may have concerns about whether to breach confidentiality. GPs often wonder when to pass on concerns about patients to the Driver and Vehicle Licensing Agency (DVLA). If a patient fails to inform the DVLA and cannot be persuaded to stop driving when advised that they may be medically unfit, the GMC's guidance says that doctors should contact the DVLA. There is sometimes confusion about this, probably because it is the driver's (and not the doctor's) legal duty to inform; but doctors' concern for pedestrians and other road users means that disclosure without consent may be appropriate if nothing else has worked. The DVLA publishes information on a variety of conditions that can impair a patient's fitness to drive, and their medical advisers can offer further advice.

Confidentiality is central to trust between doctor and patient, and the guidance is chiefly concerned with preserving this cornerstone of medical ethics; but there are sometimes cases that demand for an exception to be made. That's pretty straightforward when disclosure is required by law, or if the patient consents. But these few examples demonstrate the difficulty doctors can encounter in making decisions about whether the benefits to an individual or society in disclosing information without consent outweigh both the patient's and the public interest in keeping it confidential – the public interest test. We hope that *Confidentiality* helps doctors to make the right decisions, legally and ethically, and provides some clarity in an area that often confuses.

Access *Confidentiality* online at **www.gmc-uk.org**

■ ***Michael Keegan is Policy Adviser Standards and Ethics at the GMC***

DEPUTY FIRST MINISTER OF SCOTLAND AND CABINET SECRETARY FOR HEALTH & WELLBEING

NICOLA STURGEON MSP

NICOLA STURGEON became an SNP MSP in the first elections to the Scottish Parliament in 1999. She began as the party's spokeswoman for justice, later education before becoming health secretary. She led the SNP for three years before First Minister Alex Salmond was elected back to the Scottish Parliament in 2007. She has a law degree and worked as a solicitor in Glasgow before becoming an MSP.

"Poor health is not inevitable and we should not accept it."

How did you come to be health secretary?
I have always been passionate about the NHS. I was shadow health spokeswoman for a time and that gave me the opportunity to find out more about the issues affecting the Scottish health service. I have family members who work in the health service and this has also given me a valuable insight into the work of the NHS.

Did you ever consider a professional career in medicine?
No, I studied law at university, but although I never considered going into one of the health professions, I have always had a keen personal interest in it.

Why are you opposed to private health firms providing primary care in Scotland?
My priority is to increase capacity in the NHS, not the private health sector.

Our health service exists to reduce health inequalities and put the patient first, not to risk increasing them by promoting private healthcare. The Tobacco and Primary Medical Services Bill will introduce a requirement that those who are members of a contract-holding body for providing primary medical services must provide services themselves – they can't be sleeping partners. I want to make sure that GPs in Scotland continue to be part of a mutual NHS and we can achieve this by making sure that those who hold contracts have a day-to-day involvement in patient care.

How do you think healthcare in Scotland rates compared to that south of the border?
Scotland is a very different country to England with different health needs – such as larger remote and rural populations – and because of this it is entirely right that the NHS reflects those different needs and priorities. However, Scotland has led the way in a number of areas, including banning smoking in public places, tackling alcohol misuse, introducing free personal care and scrapping prescription charges.

How would Scotland be a healthier nation under independence?
Given that the NHS is devolved, the Scottish health service is a beacon showing what an independent Scotland could achieve. The benefits that the country is reaping thanks to an independent health service show what could be achieved under independence.

What do you see are the main priorities for Scotland's healthcare system in the next decade?
Scotland is a healthier place now than it has ever been before but there is no room for complacency. Tackling health inequalities underpins all we are doing to improve the health of Scotland. Developing a healthier relationship with alcohol remains one of our biggest challenges and that is why we are taking forward a range of radical measures in our Alcohol Bill, which was published in November. We will continue our fight against Healthcare Associated Infection. Scotland's ageing population and how to make care sustainable in the long term is also a major challenge and work is underway to address this.

Why has the Scottish government embarked upon an investigation of no-fault compensation?
No-fault compensation is simpler, less expensive and quicker. An expert group is currently considering whether such a scheme should be introduced in Scotland and, if so, how this would work alongside the existing clinical negligence arrangements. International evidence suggests that no-fault compensation reduces the administrative and legal costs of handling claims, is less expensive and quicker in resolving cases. In New Zealand straightforward cases can be resolved within weeks, and all cases have to be determined within nine months.

If you had the power to solve one health issue today, what would it be?
Eradicating health inequalities would make the biggest difference. It is not acceptable that in the 21st century the life expectancy of people in different parts of our biggest city varies by almost 20 years between the least and most deprived areas. We have already taken significant action to address alcohol consumption, prevent people from smoking, encourage active living and healthy eating and promote positive mental health. *Equally Well: Report of the Ministerial Task Force on Health Inequalities* has shifted the emphasis of our approach from dealing with the consequences of health inequalities to tackling the underlying causes such as poverty, employment, support for families and improving physical and social environments. Poor health is not inevitable and we should not accept it.

Stamping out healthcare-associated infection would also make a huge difference and is one of my top priorities. We are working very hard to reduce rates of so-called superbugs like C.diff and MRSA in our hospitals and that is why we have invested £54 million over three years to fund a range of initiatives to tackle this problem. ■

Being there

What do doctors and dentists want from a defence organisation? CEO of MDDUS Professor Gordon Dickson *highlights results of a recent survey and the broader implications*

A letter awaits you one morning at the surgery with the return address of a local firm of solicitors. You open it to find that a patient in your practice is alleging negligence. Anxious over the matter you press on with the morning's consultations. Later you take a break to phone your defence organisation. The last thing you need at this point is to have to work through a menu of options and sub-options, only then to have to listen to some 'musac' until a real person responds.

No one just decides one morning to phone their defence body. If you phone MDDUS we take the view that you need to speak to an experienced medico- or dento-legal adviser as soon as you can – and so you should.

MDDUS has long been aware anecdotally of what our members and healthcare professionals in general value most in a defence organisation but recently we decided it would be helpful to gather some real evidence on what services and benefits doctors and dentists value and expect. We commissioned a survey through the independent market research agency, GfK Healthcare.

A total of 690 randomly selected doctors and dentists across the UK (unaware that we were prompting the survey) were contacted online. Among a number of questions, the survey asked participants to rate 14 listed services/benefits in terms of their usefulness on a scale from one to ten. Unsurprisingly, fast and prompt 'response to phone enquiries' was rated highest, even higher than price. This goes back to the scenario above and the comfort and peace of mind members derive from their membership. When you need to speak to us, we need to be there to provide that prompt response. In the last twelve months we have dealt with over eight thousand advice calls – and this was in addition to the twelve thousand calls made to our membership line.

In a broader sense, thinking about the Union as a whole, what we draw from this result is that when it comes to selecting and remaining with a defence organisation, quality of service is of prime concern. Cost, while seen by those responding to the survey

"When you need to speak to us, we need to be there with a prompt response."

as less important, cannot however be ignored and at MDDUS we pride ourselves on combining quality and price to offer what we believe to be excellent value for money to our members. The survey confirmed that the pursuit of an ever-improving value-for-money service should be the continuing goal for MDDUS.

Responding to growth

Over the past few years the Union has been successful in steadily increasing its membership as doctors and dentists throughout the United Kingdom recognise the value offered by MDDUS. The number of members in active practice has grown by over a third since 2000.

This growth does of course lead to an increase in the number of professionals using our services, in particular our telephone advice line. We do encourage members to call for advice, as the earlier advice is sought the more likely it is that preventative or risk-reducing steps can be taken. The challenge to the Union is to ensure that we continue to meet member expectations in terms of speed and quality of service as we continue to grow. To do so we have over the past year appointed three new staff to our medical advisory team in Scotland, as well as three new members to our team of dental advisers.

But the majority of our growth has been outside Scotland and this is perhaps inevitable given the very strong position we have always had and continue to enjoy in Scotland. The number of GP members outside Scotland, for example, has more than doubled since the year 2000. In response to this growth, we have also recently appointed three new medical advisers to be based in our London office to work alongside our existing London legal team. Policy on healthcare delivery and the mechanisms for providing care, particularly primary care, are now quite different in Scotland and elsewhere in the UK and we recognise the importance of having advisers experienced in the different systems.

All of the new advisers are experienced medical or dental practitioners who bring a deep understanding of modern practice and the pressures and challenges being faced on a daily basis by our members.

To accommodate the new staff and allow for further growth the Union's London office will be moving to larger and newly refurbished premises at 1 Pemberton Row in early 2010, not far from our current offices at Bell Yard. Extra meeting and seminar rooms will also allow for expanded MDDUS educational and training activities more convenient to members in southern England.

Outreach

Growth by itself has no particular merit but controlled growth leading to increased financial benefits of scale and greater presence, with the consequent influence we can exert for our members, are all valuable. The need to maintain steady growth and remain responsive to the needs of existing members at MDDUS is reflected in some changes to our marketing department.

MDDUS has appointed three new marketing staff to spend more time in medical and dental schools, GP and dental practices and hospitals. They will meet and talk with existing and prospective members in order to keep in touch with changing needs and concerns, as well as promote MDDUS. It is particularly important to be out among students and trainees, as they represent the future membership of the organisation. We also continue to fund a teaching post in medical ethics and law, based at Glasgow University but working with all medical schools in Scotland.

Another way of reaching different segments of the membership is through targeted publications. The MDDUS flagship publication is *Summons* but we also now publish two additional magazines. *FYi* is a bi-yearly publication for Foundation year medical trainees and final year medical students. In December we also launched a new publication called *Practice Manager* with news, features and practical risk advice directed at primary care managers. Next year we plan to launch two additional magazines aimed at trainee dentists and specialist trainees in general practice.

Member satisfaction

One particularly gratifying result from the survey was in regard to overall member satisfaction. Respondents who were members of a medical or dental defence organisation were asked to rate on a scale of 1 to 10 how satisfied they are with the 'services/resources' provided. MDDUS scored higher than the average satisfaction levels among members of both of our two main rival medical defence organisations.

I am sure that the doctors and dentists who founded the Union over 107 years ago would hardly recognise the medical and dental world of 2010. But the need that they identified for a body offering sound advice and access to protection is as clear today as it was at the start of the last century. Our belief in the mutual principles that were at the very heart of the Union in 1902 is as strong now as then. As a mutual organisation we serve no other master than our members and they deserve the highest possible level of service, a service that is prompt in its response and competitively priced. We take our continuing growth as a modest sign that we are moving in the right direction. ■

Trusting the experts

Medico-legal cases sometimes rest on complex and conflicting medical evidence. How do judges weigh one expert opinion against another? Barrister Simon Cridland *offers some helpful insight*

TRADITIONALLY the courts have expressed scepticism of the need for expert evidence. In a court case from 1877 *(Thorne v. Worthing Skating Rink)*, Sir George Jessel opined:

"Now in the present case I have, as usual, the evidence of experts on the one side and on the other, and, as usual, the experts do not agree in their opinion. There is no reason why they should. As I have often explained ... the opinion of an expert may be honestly obtained, and it may be quite different from the opinion of another expert also honestly obtained. But the mode in which evidence is obtained is such as not to give the fair result of scientific opinion to the Court. A man may go, and does sometimes to half a dozen experts ... He takes their honest opinions: he finds three in his favour and three against him; he says to the three in his favour; 'Will you be kind enough to give evidence?' And he pays the ones against him their fees and leaves them alone; the other side does the same ... I am sorry to say the result is that the Court does not get the assistance from the experts which, if they were unbiased and fairly chosen, it would have a right to expect."

Such judicial scepticism notwithstanding, modern litigation has seen a proliferation and significant increase in the calling of, and reliance upon, expert evidence. The courts have become increasingly dependent on expert testimony, and the accelerating process of scientific change enhances that tendency. Indeed, it is arguable that it is only with the readiness of today's modern courts to receive expert evidence and their ability to grapple with it, that an enormous proliferation of specialised tribunals has been avoided. Today's judges must be efficient in weighing and evaluating scientific opinion as evidence. But how do they go about that process? Even when there is a fundamental divergence of view between the parties' experts, the court is still required to reach a decision.

Expert not advocate

Any expert who fails to comply with his primary duty to the court (see box on opposite page) will have his evidence rejected. In a 1981 case involving a baby who suffered brain damage during a difficult birth *(Whitehouse v. Jordan)*, Lord Wilberforce stated: "expert evidence presented to the court should be, and should be seen to be, the independent product of the expert, uninfluenced as to the formal content by the exigencies of litigation. To the extent that it is not, the evidence is likely to be not only incorrect but self-defeating".

It logically follows that the expert should never be one party's advocate but a person who, having understood the parties' relevant allegations, can see

"Even when there is a fundamental divergence of view between the parties' experts, the court is still required to reach a decision."

whether they correctly define the issues to which his expertise is to be directed and – pinpointing any discrepancies – can put that expertise impartially at the disposition of the judge to assist him to perform his task of correctly deciding the issues.[1] Expert testimony which fails to comply with this advice will be rejected by the court or tribunal.

In another case concerning brain damage in infants alleged to be as a result of the administration of pertussis vaccine *(Loveday v. Renton)*, Stuart–Smith LJ set out the principal considerations for the court when determining which expert testimony to prefer:

"In reaching my decision a number of processes have to be undertaken. The mere expression of opinion or belief by a witness, however eminent, that the vaccine can or cannot cause brain damage, does not suffice. The court has to evaluate the witness and the soundness of his opinion. Most importantly, this involves an examination of the reasons given for his opinions and the extent to which they are supported by the evidence."

Stuart–Smith LJ went on to explain that a judge has to decide what weight to attach to opinion expressed by an expert witness by examining:

- the internal consistency and logic of his evidence
- the care with which he has considered the subject and presented his evidence
- his precision and accuracy of thought as demonstrated by his answers
- how he responds to searching and informed cross-examination
- the extent to which a witness faces up to and accepts the logic of a proposition put in cross-examination or is prepared to concede points that are seen to be correct
- the extent to which a witness has conceived an opinion and is reluctant to re-examine it in the light of later evidence, or demonstrates a flexibility of mind which may involve changing or modifying opinions previously held
- whether or not a witness is biased or lacks independence.

Scepticism of the process

Some commentators have expressed scepticism as to how satisfactorily the use of the expert witness works in practice and the long-term social utility of the process. In the text *Experts in the Civil Courts*[2] Sir Louis Blom-Cooper QC writes:

"In cases where the evidence of expert witnesses is in conflict, a judge (even one who has some, even nodding acquaintance with scientific methods) may not fully comprehend the expert evidence, simply because it is too complex or recondite. The judicial tendency is to decide the case between competing opinions on an artificial basis. Which of the experts was more qualified? Who explained the scientific issues with greater clarity and simplicity? Whose reasoning was more logically appealing? Or is the fact that the expert gives his services free on the grounds that he supports a pressure group for some social reform, less than independent? Or is there sound basis for endorsing the prevalent view among professionals, and querying the radical view? Are judges at fault for using such techniques? It may not be wrong, in terms of judicial decision-making, for a judge to prefer one expert rather than another, because he or she has the more impressive credentials or has a commitment to some social or political cause. But it is highly unsatisfactory, if only because these are factors that do not pronounce on the scientific problems?"

Perhaps the answer to such criticisms lies in the use of court-appointed assessors rather than experts instructed and called by the individual parties to the litigation. Most, however, would agree that it should not in the main be for the courts to seek to determine scientific controversies or somehow pronounce on scientific truths. Rather, judgments should reflect the current accepted mainstream scientific and medical state-of-art.

The power of expert evidence should not be underestimated. It is open to the court to prefer expert testimony over that given by the witnesses of fact where a conflict between the two exists. In such circumstances, the judge must ask himself whether he can reconcile the evidence. If not he must consider whether there may be an explanation for the conflict and make a considered choice which evidence to accept. Equally it is important for the parties to get the expert evidence right first time round, for on an appeal, the appellate court will be notably reluctant to set aside the decision of the judge at first instance on the quality of the expert witnesses he has heard.

■ *Mr Simon Cridland is a barrister in London at 3 Serjeants' Inn*

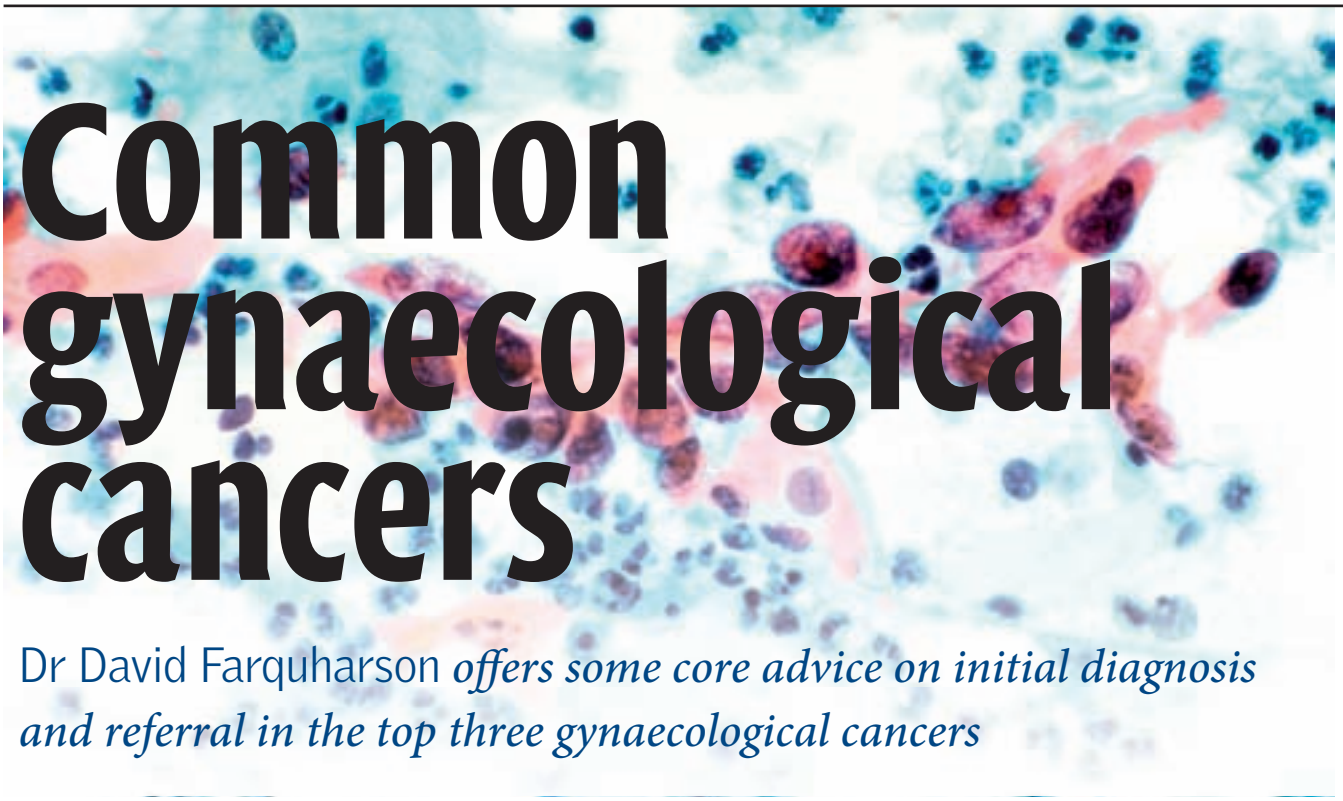
EXPERTS – THE OVERRIDING DUTY TO THE COURT

1. It is the duty of an expert to help the court on matters within his expertise.
2. This duty overrides any obligation to the person from whom he has received instructions or by whom he is paid.

SOURCES

1 HHJ Adrian Head 146 New Law Journal 1996

2 Blom-Cooper L. Experts in civil courts. London: Oxford University Press; 2006



Common gynaecological cancers

Dr David Farquharson *offers some core advice on initial diagnosis and referral in the top three gynaecological cancers*

IMAGE: NATIONAL CANCER INSTITUTE / SCIENCE PHOTO LIBRARY

Ovarian and uterine cancer are the fourth most common cancers in females in the UK in 2006, each making up 5% of cancers in females. By far the most common cancer is breast (31%) followed by colorectal (12%) and lung (11%) cancer. There are about 4,500 new cases each of endometrial and ovarian cancer in the UK each year with the incidence of endometrial cancer increasing. Worldwide, cervical cancer is the second most common cancer to affect women, with 3 out of every 4 of these cancers occurring in women in the developing countries.

The mortality from cancer and the morbidity from cancer treatment can be reduced by general population screening, early diagnosis and familial screening. With increased life expectancy in the UK the prevention of gynaecological cancers and early assessment and diagnosis of symptoms are becoming an increasingly important issue.

Cervical cancer

The UK Cervical Screening Programme has been highly successful in reducing the incidence and deaths from cervical cancer, mainly due to population coverage and the introduction of computerised call and recall in 1988. However, in 2007 there were 941 deaths from cervical cancer in the UK, and the failure to prevent this disease can lead to medical litigation.

Cervical screening will never be 100% accurate and false negative results have led to some laboratories being subject to considerable media interest. The development of liquid based cytology (LBC) involves taking the smear with a plastic device from which the cells wash off more readily than from a wooden spatula. Thin layer cytology based upon the liquid sample has the potential to reduce both the number of false negatives and unsatisfactory smears.

In order to ensure adequate sampling of the cervix, it is essential that the whole of the cervix is identified on speculum examination with a good light source. If the smear is taken in the correct fashion then the incidence of an inadequate sample will be around 2.9%. If the cervix cannot be identified then the patient should be referred to secondary care and sometimes to a colposcopy clinic depending on local arrangements.

The aim of the programme is prevention through the detection of cervical dysplasia rather than frank disease. Whilst the majority of women found to have an abnormal smear will not go on to develop cervical cancer, the loss of the opportunity to treat a patient with pre-invasive disease (usually by loop diathermy to the cervix), necessitating more radical treatment later such as hysterectomy or chemoradiotherapy, is likely to result in patient discontent. This is particularly likely where a patient has lost her ability to conceive.

Early stage cervical cancer may be asymptomatic and detected on smear or loop excision of the cervix. However the classical symptoms of irregular vaginal bleeding, especially post coital, requires urgent evaluation.

Endometrial cancer

Most of these cancers occur in patients over the age of 50 and the most common presentation is postmenopausal bleeding, although 20 to 25% of women are premenopausal at diagnosis and approximately 5% are diagnosed in patients who are less than 40 years of age. The overall 5-year survival rate is high reflecting early presentation, and early referral for investigation is mandatory. About 10% of women with postmenopausal bleeding will be found to have endometrial cancer. A pelvic examination is essential to exclude a vulval or cervical lesion. The cervical smear history should also be checked.

Local arrangements for the management of patients where there is concern regarding the possibility of endometrial cancer varies. However, a transvaginal ultrasound scan for measurement of endometrial thickness and identification of ovarian masses is the investigation of choice. A thin endometrium has a high negative predictive value for endometrial cancer and in about 40% of cases it is possible to avoid hysteroscopy and curettage if the rest of the pelvic examination is normal. An endometrial biopsy can correctly diagnose endometrial cancer in around 80% of women.

Tamoxifen is an anti-hormone which is used for the adjuvant treatment of breast cancer in postmenopausal women. However, tamoxifen has a paradoxical proliferative effect on the endometrium and is associated in about one third of cases with endometrial pathology including hyperplasia polyps and

cancer. This increased risk continues after cessation of the drug. No screening strategy has been found to be useful for these women and evaluation usually with hysteroscopy is required in women who have abnormal vaginal bleeding.

Pelvic mass

Some of the common causes of a pelvic mass are seen in the table (below). Although examination will help to ascertain the origin and aetiology of a mass, further investigations with imaging and laboratory tests are almost always necessary.

The following investigations should be considered:

1. In any woman of reproductive age, a urine or serum beta HCG test should be checked to rule out pregnancy.
2. Tumour markers. In a young patient who has been found to have a pelvic mass, germ cell tumour markers should be checked and these include alpha-fetoprotein (AFP), HCG, lactate dehydrogenase (LDH) and CA125 level. In perimenopausal and postmenopausal women, CA125 and CEA levels should be checked.
3. Ultrasound – transvaginal and transabdominal ultrasound scans are often the most efficient, accurate and least expensive imaging modality in the evaluation of a woman found to have a pelvic mass.

In perimenopausal and postmenopausal women ovarian cancer needs to be excluded and the Risk of Malignancy Index (RMI) can be helpful in triaging these patients. The RMI uses CA125 levels and ultrasound features and can be helpful to triage patients into low, moderate and high risk groups for ovarian cancer. Prompt referral into secondary care is required where there is the possibility of ovarian cancer.

Familial screening

Ovarian cancer

There have been only modest improvements in the survival rate for patients with ovarian cancer and this is mainly due to the late presentation of the disease, with 70% of women having disease outside the pelvis at diagnosis.

Symptoms of abdominal bloating, increasing abdominal girth, change of bowel or bladder habit, abdominal or pelvic discomfort in a perimenopausal or postmenopausal woman may be the first symptoms of ovarian cancer and there should be a low threshold for arranging a CA125 and ultrasound scan in this group of patients.

Although most ovarian cancers are sporadic, about 5 to 10% arise because of a genetic predisposition. Mutations in the BRCA1 and BRCA2 genes account for the majority of inherited ovarian cancers. Most regional genetics centres provide a service for families with a history of cancer that seems to be in excess of what might be considered due to chance.

Women who have completed childbearing and are found to be at high risk of ovarian cancer should be offered bilateral salpingo-oophorectomy as this has been shown to significantly decrease the risk. Because ovarian cancer is often not diagnosed until the advanced stages, the opportunity of reducing this risk by prophylactic salpingo-oophorectomy should not be missed. In women who have not completed childbearing they should be counselled about screening using CA125 and ultrasound scanning although no definite conclusions on the effectiveness of this strategy are available. The contraceptive pill has been shown to decrease the risk of ovarian cancer by up to 50% in women at high risk.

Endometrial cancer

The hereditary nonpolyposis colon syndrome is predominantly a colorectal cancer syndrome but is associated with an increased risk of endometrial and ovarian cancer. The role of surveillance of endometrial cancer remains unclear but referral to a regional genetics centre would be appropriate for counselling.

Risk reduction

The cause and biology of the three most common gynaecological cancers in the UK is different and specific strategies for prevention and early diagnosis are required for each cancer site. Four key points to remember are:

- Good administration of the cervical screening programme will ensure prompt evaluation of abnormalities.
- Vague abdominal symptoms in a peri- or postmenopausal woman should be investigated to exclude ovarian cancer.
- Consider referral for genetic counselling if there seems to be a family history of cancer.
- Endometrial cancer is not confined to postmenopausal women and the diagnosis can usually be made on outpatient endometrial biopsy.

■ *Dr David Farquharson is a consultant gynaecologist at the Edinburgh Royal Infirmary*

COMMON CAUSES OF A PELVIC MASS

Site	Cause
Ovary	Benign/functional cyst Malignant tumour/cyst (including fallopian tube carcinoma) Endometrioma
Uterus	Pregnancy Fibroids
Fallopian Tube	Hydrosalpinx Tubo-ovarian abscess Ectopic pregnancy
Bowel	Appendix abscess Diverticular disease Carcinoma Constipation
Miscellaneous	Urinary retention Pelvic kidney Lymphoma

IMAGE: PROF. P. MOTTA/SCIENCE PHOTO LIBRARY

Take care with bisphosphonates

Be wary of dental complications in the use of bisphosphonate drugs. Dr Alexander Crighton *examines the latest guidance*

In the past ten years the number of patients taking bisphosphonate drugs has increased dramatically as the benefits they offer to patients with a variety of medical problems have become clear. The potency of the newer products has also increased and with it their clinical effect. As well as the traditional use to help reduce hypercalcaemia and bone deposits in cancer patients, there is good evidence that bisphosphonates dramatically reduce the fracture complications associated with familial or drug-induced osteoporosis and help reverse the effects of established osteoporosis.

As such, bisphosphonates reduce both the morbidity to the patient of vertebral or long-bone fractures and have the potential to offer the NHS a significant cost-to-benefit advantage. This has been recognised by NICE in their guidance issued in recent years for both primary and secondary prevention of osteoporosis, recommending use of bisphosphonates above other classes of osteoporosis prevention drugs.

Dental risk

As the number of patients in primary care taking bisphosphonates increases, the dental practitioner must be aware of the possible implications of these drugs for dental care. In some patients there seems to be an enhanced effect of the drugs on the mandible and the maxilla resulting in the risk of bisphosphonate-induced osteonecrosis of the jaws (BONJ). However, the incidence of this is rare at about 0.05% of patients taking oral bisphosphonates, and it is important when planning dental care that this risk is kept in perspective as it is unusual and unpredictable.

Additionally, there seems to be no evidence that the dental care by itself precipitates the problem although this remains a possibility in some patients. More likely patients have developed bone necrosis through the medical therapy and this bone is then exposed by a dental extraction. Although the patient and the dentist will feel that the dental care has been the trigger, the fact that many BONJ patients develop spontaneous lesions of the oral mucosa without an extraction points to the medical therapy as being the sole cause in most cases. However, it is important that the dentist appreciates the issues for dental care in patients taking this medication and discusses with the patient the implications of the drug therapy for their oral care.

Mechanism of action

Bisphosphonates alter bone turnover by reducing bone loss whilst allowing new bone formation to continue. This leads to a gradual increase in bone mass over time. However, they do this by reducing the

number of osteoclasts in the bone and these are important in bone remodelling and repair. As a result, any patient taking a bisphosphonate can expect an extraction socket to take longer to heal and remodel.

Similarly, orthodontic movement would be impaired and any child with a bone fragility syndrome is likely to be taking these drugs. In extreme cases, the bone turnover reduces to such an extent that the bone cells themselves die and the bone becomes avascular and acellular. This is the situation when an extraction socket fails to heal – the bone is dead and so cannot repair. The socket will then become chronically exposed to the mouth and colonised by oral bacteria.

"Dentists should be proactive in explaining the issues with bisphosphonates to their patients"

Be proactive

Dentists should be proactive in explaining the issues with bisphosphonates to their patients. The key to this is identifying the risk to individuals through a thorough and regularly updated medical history. Drug therapy can change weekly and so medication changes should be noted at every dental visit. Obviously, if there is less need for invasive dental care then the risks to the dental patient of BONJ are reduced and it is important that this patient group, as with all medically compromised patients, are given access to a high intensity preventative dental regime. This should stress the importance of diet control, oral hygiene and use of fluorides to minimise the need for extractions.

When a patient starts on a bisphosphonate, there is a delay of several years before there is a significant risk of BONJ. This is shorter when an intravenous drug is used, but is about three years for oral bisphosphonates. During this time, the oral implications of the drugs should be discussed with the patient to gain their cooperation. Any extractions or surgical procedures will have delayed healing but should settle with time and should be undertaken as clinically indicated. This is a good time to ensure that the patient's dental health is optimal and any teeth of poor prognosis considered for removal.

When a patient has been taking bisphosphonates for some years it is better to avoid extractions and surgical procedures if at all possible. Endodontics may be used and the success of this is unaffected by the drug use. If an extraction is unavoidable, then the correct plan will be determined by the urgency of the treatment. There is evidence that a 'drug holiday' from the bisphosphonate can result in a reduction in BONJ risk if the medication is stopped for about three months before the extraction and not restarted until three months after the extraction.

Therefore, if an extraction is needed but can be postponed, liaison with the patient's medical practitioner can allow a reduction in the risk of BONJ occurring. If the extraction is urgent it must proceed accepting the slightly higher complication risk. In both circumstances the issues with the bisphosphonate must be discussed with the patient, making clear the low risk of problems, the unpredictable nature of BONJ and the potential for delayed bone healing.

When a surgical procedure becomes unavoidable, it is more important to allow the 'drug holiday' period if at all possible. Elective surgical procedures such as implants cannot be recommended without a specialist's opinion.

Is treatment possible?

At present there is no evidence that the risk of BONJ can be reduced with the use of antibiotic prophylaxis or chlorhexidene rinsing. This condition is different in its aetiology and pathology from infective or post-radiation osteomyelitis, and the preventative treatments often used in these conditions are ineffective in preventing BONJ.

When a patient presents with an established or suspected BONJ lesion, it is important that the patient is referred to a dental specialist familiar with this condition. Previously, surgery was used to try and remove the dead bone, but this is now accepted as unnecessary and may result in a larger area of exposed dead bone. It is more important to instruct the patient to keep the area clean. Stopping the bisphosphonate drug at this stage is recommended for those taking oral preparations, but when the treatment is for cancer therapy often the medical need will outweigh the oral issues.

If an oral bisphosphonate is discontinued, most patients will gradually heal, although this can take one to two years. The use of teraparatide to enhance the rate of bone healing in BONJ cases is a possibility but not yet evidence-based. An alternative preventative treatment for osteoporosis will usually be necessary when healing is complete, and strontium ranalate seems associated with fewer oral complications than bisphosphonates.

In summary

There are well-recognised oral issues with the use of bisphosphonate medication. However, these are rare for oral preparations and there is a lag between starting the drug and the problems arising. This time is best used to optimise the patient's oral heath and when a medical practitioner is starting a patient on these drugs it would be sensible to advise the patient to attend a local dentist for assessment.

A dental practitioner should place great emphasis on preventative care for patients taking bisphosphonate drugs and try where possible to avoid extractions. Other forms of dental treatments can be continued unaltered.

However, both medical or dental practitioner groups should contact their local oral medicine or oral and maxillofacial surgery unit for advice if any individual issues arise with patient care.

■ *Dr Alexander Crighton is a consultant in oral medicine at Glasgow Dental Hospital and School*

CASE studies

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

TREATMENT

A numb lip

MR P ATTENDED his dentist having lost the crown of the LL5. The remaining root was fractured at gum level and root canal treatment had to be carried out one month later. The procedure was uneventful. The post-treatment X-ray showed the canal was filled to the apex. Two days later the patient returned complaining of swelling and severe pain. His lip region was still numb following the treatment. Antibiotics were prescribed but the patient returned again and two days later the LL5 was extracted. The patient was advised that the numbness may be due to pressure from an abscess and was referred for a specialist opinion. The sensation never returned.

The patient sued his GDP on the basis of failure to follow the European Endodontic Guidelines which advise taking a pre-cementation radiograph. In addition, by failing to record the working length, and in the absence of a working length X-ray, there was no evidence to prove that the working length had in fact been established. The notes, it was said, were indicative of careless methodology. By failing to follow the appropriate guidelines, it was said that the numbness had been caused either by instrumentation of the inferior dental nerve, by irrigants passing through the canal or by extrusion of sealer or gutta percha into the periapical tissues or the inferior dental canal. The patient sought reports from a consultant maxillofacial surgeon and a consultant in restorative dentistry.

Analysis and outcome

MDDUS defended the case on behalf of the member. The GDP was adamant that he had used an apex locator to identify the working length and the post-operative X-ray showed a perfectly well-filled root canal. An expert GDP was instructed on behalf of the member who argued the treatment was carried out appropriately with a very acceptable clinical result. A pre-cementation X-ray would be a sensible precaution in some cases but at the time, with a canal which appeared straightforward, it was not negligent to omit the X-ray.

When the case progressed to a court hearing, MDDUS argued that the *Hunter v Hanley* test (Bolam test in England and Wales) applied – a GDP is required to be judged by a fellow GDP and not by a consultant (the test dictates that all medical/dental practitioners are judged on the standard to be expected of an ordinary competent practitioner in their area of expertise). It was also submitted that the patient hadn't proved how the failure to take a pre-cementation X-ray had caused his injury. This X-ray would have been taken after the root canal had been filed, cleaned and dried prior to filling and therefore could not have prevented the damage which occurred.

The GDP was found not negligent as the taking of a pre-cementation X-ray was not required. The sheriff also held that the patient's expert witnesses were not able to satisfy the *Hunter v Hanley* test as they were not GDPs.

Key Points

- Full and comprehensive notes are essential.
- If accepting instructions as an expert, always ensure the instructing solicitor sets out clearly the basis for your instructions and your remit.
- Consultants who are asked to comment on the actions of a GP or GDP should highlight fact that they may not be the appropriate expert to comment on breach of duty.

RECORDS

Docman glitch

A PATIENT in England contacts his former GP practice in Scotland regarding the recent transfer of his medical records. The photocopy of the records he requested included a number of documents relating to other patients which had been incorrectly filed in his Docman electronic record. The practice investigated and found two separate misfiling incidents within the Docman system: two pages had gone through as one; and five pages had gone through as a single multi-page document.

Outcome and analysis

Fortunately, no sensitive medical information was disclosed in the documents relating to other patients. The patient's new practice in England also admitted mistakenly giving him the photocopied records without first checking them thoroughly.

Key points

- Always be vigilant with all parts of a patient record.
- Check electronic files prior to transfer.

DIAGNOSIS

Delayed referral

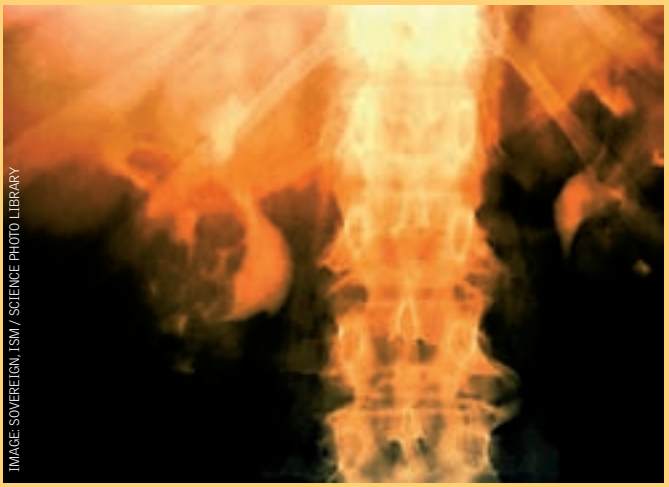


IMAGE: SOVEREIGN, ISM / SCIENCE PHOTO LIBRARY

SIXTY-YEAR-OLD patient Mr L visits GP A complaining of a skin condition on the perianal area. This is treated but the patient mentions a problem with his urine. GP A orders an MSU test, querying possible haematuria on the request form. He forwards the slightly abnormal test results (raised RBC's) a few days later to GP B, who is Mr L's registered GP.

The results are not acted on by GP B for several weeks – due to a possible system failure – by which time the patient's condition has significantly worsened and is giving considerable pain. Mr L had returned to GP B in the months following his first visit complaining of back pain but it is not until four months after his first visit to GP A that GP B urgently refers the patient with a suspected renal tumour.

A CT scan confirms the tumour, by which time Mr L's condition has further deteriorated and treatment options become very limited. He later dies, just weeks after the referral from GP B. Later, solicitors for Mr L's family begin legal proceedings alleging negligent patient management.

Outcome and analysis

An expert opinion on the case was solicited by MDDUS. He advised that Mr L's management was likely to have fallen below acceptable levels. The expert concluded that if the abnormal MSU results had been followed up correctly, Mr L could have eventually been referred to hospital three months earlier. While it is accepted that the patient would still not have survived the cancer, he could have had the option of alternative cancer treatments sooner. His family believed these would have prolonged his life and alleviated his suffering. In the end, MDDUS acknowledged a practice failure and agreed to settle the case.

Key points

- Ensure practice systems are fail-safe – especially in regard to urgent test results.
- Be alert to the symptoms of renal carcinoma.
- Ensure NICE referral guidelines for suspected cancer are adhered to.

PRESCRIPTIONS

Discoloured teeth

A 17-YEAR-OLD girl attended her GP surgery with a resistant form of papulopustular acne with some scarring. GP A referred the girl to a local hospital dermatology clinic.

The dermatologist examined the girl and prescribed the tetracycline antibiotic minocycline at 100 mg daily. However, due to a systems error at the GP surgery, the girl was maintained on twice that dose.

Over time the girl and her family began to notice a blue/grey discolouration in her teeth which was also noted by her dentist. Her father did some internet research and discovered that "staining" in adult teeth was a rare but recognised side-effect of minocycline.

The family contacted the practice and demanded reimbursement for the costs of dental work including teeth whitening treatment.

Analysis and outcome

An MDDUS adviser reviewed the patient notes and found that the girl had been maintained on the excess minocycline dose for over three years. Expert opinion on the matter was unclear as to whether the increased dosage would have made staining any more likely in the case and it was decided that to argue the case in court was not in the interests of the member and the membership.

MDDUS agreed on behalf of the member to pay for the necessary dental treatment which amounted only to a few hundred pounds.

Key points

- Ensure practice systems allow for ongoing monitoring and review of repeat prescriptions including dosages.
- Ensure patients are made aware of potential side-effects of long-term drug treatment.
- Consider using the services of a community pharmacist to assist in the monitoring of prescribing practices.

From the archives: no legal freebies

Law courts have long relied on evidence from medical experts and often under consideration of generous fees – but not always as the following case illustrates.

In 1897 a barrowman was hit by a van in Newgate Street London and sought to recover damages of £50 against the driver's employers. He had suffered an injury to his hand and was taken to St Bartholomew's Hospital and treated by one of the surgeons, who was subsequently called by the court to give evidence. In addressing the assistant judge before being sworn in, Dr Grace wished to make it clear he had not been paid any fee for giving "special evidence" in the case. He advised the judge he was only willing to give evidence as to "questions of fact".

Such special evidence often earned surgeons fees of over 50 guineas but in this case Dr Grace was only entitled to an appearance fee of one guinea. He was clearly not pleased at being compelled to attend court and wasn't minded to offer any legal freebies. A journalist covering the case reported:

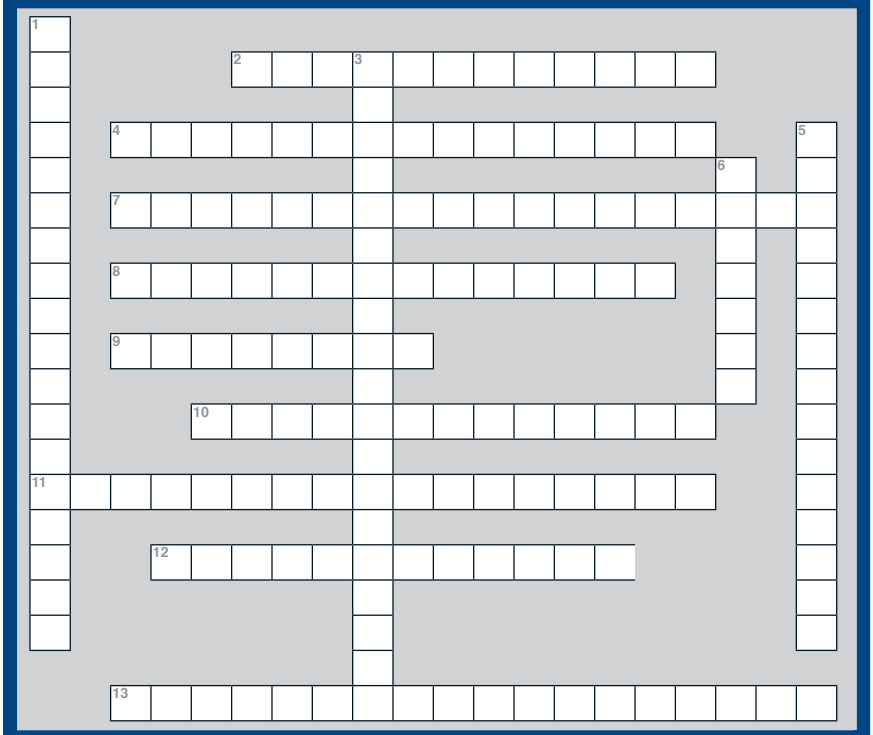
"Dr Grace, in answer to questions… could not say whether the plaintiff could or could not move his fingers back, because he did not know – he could not tell – whether the plaintiff tried to move them. Mr Lynch for the defence, called the doctor's attention to the fact that the jury were men of the world. If Dr Grace really could not express an opinion it was well that the authorities at St Bartholomew's Hospital should know it."

Dr Grace then grudgingly examined the man's fingers and admitted they were stiff and could not be moved back. When asked what might cause the stiffness he turned to the judge and asked whether he had to answer the question. To which the judge replied: 'I think so'.

In addressing the jury with his summary, the defence attorney "deprecated in strong terms the course which Dr Grace had chosen to adopt. The plaintiff was only a poor fellow, earning 15s. to 18s. a week". In the end the jury found for the plaintiff and damages were assessed at £10 which was awarded with costs.

Source: Manchester Guardian August 20, 1897

Medical Crossword: causes of rashes and lesions



Across

2 Itchy, erythematous vesicular rash in response to allergens (6, 6)

4 Condition with principal features being purple 'heliotrope' rash around the eyes along with muscular weakness (15)

7 Flesh-coloured lesion with characteristic pearly-rolled edge and found mainly on the side of the nose (5, 4, 9)

8 Erythematous rash attributed to constant exposure to radiant heat (8, 2, 4)

9 Symmetrical hypopigmented patches linked with autoimmune conditions (8)

10 Non-invasive malignant, red scaly lesion (6, 7)

11 Inherited disorder with characteristic 'café-au-lait' lesions with axillary freckling (17)

12 Itchy, purple, flat papules on the wrist and appear when taking sulphonamides (6, 6)

13 Symmetrical target lesions on the back of the hands, palms and forearms, which can occur post-herpes simplex infection (8, 10)

Down

1 Transient pink merging rings on the trunk of individuals with rheumatic fever (8, 10)

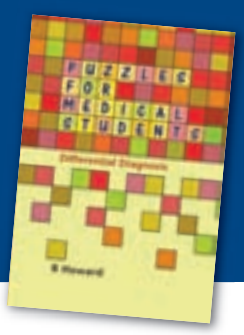
3 Ulcers with blue/red necrotic edge located on the calf, abdomen or face and can be a complication of inflammatory bowel disease (8, 11)

5 Salmon-pink, silvery scaling lesions on the scalp and extensor surface of the body, e.g. of the knees and elbows (6, 9)

6 Distribution of chronic, erythematous papular rash on the cheeks, nose and chin mainly affecting middle-aged, fair-skinned women (7)

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

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



Object obscura: early X-ray

IMAGE: WELCOME LIBRARY

This image of the bones of a hand with a ring on one finger is a photoprint from an early radiograph by W.K. von Röntgen. He took the image of his wife's hand in 1895 a week after discovering the basic principle behind "X-radiation" (the X standing for 'unknown'). In a recent poll conducted by the London Science Museum the public voted the X-ray machine as the "best invention ever for having made the greatest impact on the past, present and future".

Vignette: dental historian and teacher Dr Henry Noble (1925–2004)

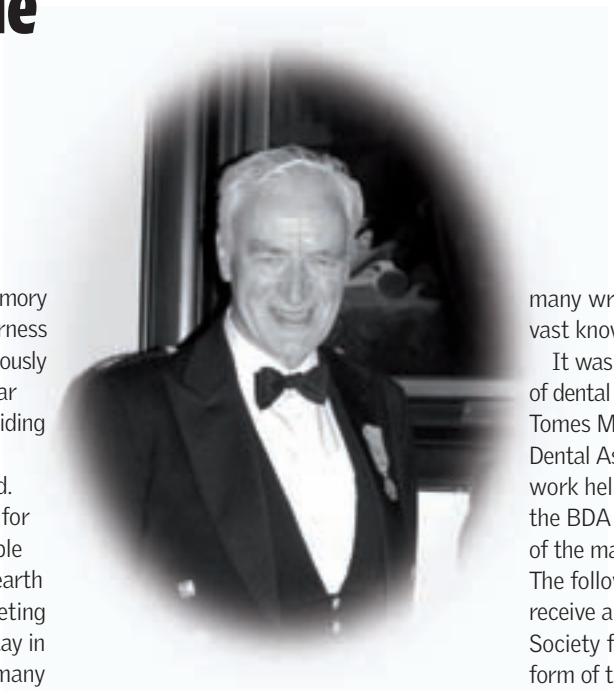


IMAGE COURTESY MRS AUDREY NOBLE

DOUGLAS ALLAN HAS A particular memory of Dr Henry Noble – in the dusty wilderness of the Jordanian desert, perched precariously on a pile of cushions in the boot of a car facing to the rear with map in hand, guiding a site-seeing tour back to Yarmouk University in the northern town of Irbid.

It was an unorthodox way to travel for such an accomplished scholar, but Noble was known for his hands-on, down-to-earth approach. Professor Allan recalled meeting the Glasgow dental lecturer during a stay in Jordan in the 1980s – one of Noble's many international expeditions to teach dentistry. In Yarmouk he helped establish a new dental school, training staff and delivering lectures in anatomy and histology.

Other trips took Henry Noble to the University of the West Indies in Trinidad in 1991 and he was also appointed external examiner at the University of Malaya, Kuala Lumpur. His dedication to his field never stopped wherever in the world he was – even on his many caravan trips to Portugal or Austria with his wife of 50 years, Audrey. Work colleagues could always depend on Noble to respond almost immediately to their emails.

Henry William Noble was born in Glasgow, 1925, and attended Dunoon Grammar School as a war-time evacuee. His passion for dental education began when he started studying dentistry in Glasgow in 1942. His year was the last of the 'diploma dentists' to qualify before Glasgow University took over the granting of degrees in 1948. As a house surgeon in Glasgow Dental Hospital, he also undertook teaching duties as a demonstrator in pathology and dental bacteriology and subsequently in dental histology. This field was to become his life's work.

With the exception of two years' national service in the RAF, Henry served Glasgow University as lecturer and then senior lecturer in dental anatomy and histology for 36 years. He was awarded the HDD of the RFPSG in 1948 (the predecessor of the Fellowship); obtained a fellowship in dental surgery from the Royal College of Physicians and Surgeons of Glasgow in 1967; and became a Fellow of the British Association of Clinical Anatomists in 1978. Henry also found time to serve as president of Glasgow Odontological Society in 1972 where he was editor for years before becoming an honorary member in 2002.

Noble was a born teacher. He would enthral students with his dramatic lecturing style that always incorporated the latest methods and embraced the newest technology. Lessons were never dull as Noble often punctuated them with group microscopy, audio-visual presentations or computerised instruction. For many years he organised the student electives. Never one for self-publicity, he applied a boundless energy and unstinting enthusiasm in guiding generations of young dentists through the early stages of their career.

Even retirement didn't stop Henry from breaking new ground. He founded the History of Dentistry Research Group at Glasgow University in 1996. It flourished under his leadership and remains one of the largest and most active in the field. Henry contributed many articles to its newsletter and its members have also produced articles and doctoral theses – many written with the benefit of Henry's vast knowledge and support.

It was Henry's dedicated work in the field of dental history that earned him the coveted Tomes Medal in 2003 from the British Dental Association. He had done remarkable work helping with the redevelopment of the BDA Museum, often answering some of the many enquiries the museum received. The following year he was told he would receive a second accolade from the Lindsay Society for the History of Dentistry in the form of the Lillian Lindsay Memorial Medal. While Henry knew of his impending award, he sadly did not live long enough to accept it personally. His wife Audrey has since become secretary of the History of Dentistry Research Group, continuing the Noble family's dedicated work.

The Emeritus Professor Stanley Gelbier paid tribute to Henry following his death, remarking: "His breadth and depth of knowledge were amazing. I cannot remember asking Henry any question that he was unable to answer. It is no surprise that Henry's advice was always sought by the Museum of the British Dental Association when it was unable to respond to a query."

Henry was highly regarded for his academic achievements, but above all he was known as a true gentleman who never knew how to do things by half-measures. His enthusiasm and commitment to the study of dentistry has earned him his own place in the history of dentistry. He was much loved by his wife Audrey, their four children and 10 grandchildren.

Professor Sir David Mason perhaps summed it up in his tribute when he said: "The example of his life and work will live on in the hearts and minds of those of us who were privileged to know him as a friend and colleague."

Source: *History of Dentistry Research Group Newsletter* November 2004

http://tinyurl.com/ylkatoj

New Hot Topic workshops for 2010

MDDUS is launching the first three workshops of a new programme of Hot Topics for 2010 aimed at healthcare professionals and the wider healthcare team.

These sessions will focus on **Problem Solving and Decision Making, Influential Communication** and **Healthcare Assistants: Risk in Practice.** Workshops will develop core skills in each area, highlighting practical techniques for effective practice.

Each Hot Topic workshop will run for one day in both Glasgow and London from 10am-4pm and lunch will be provided.

COST: members and their teams £80+VAT, non-members and their teams £95+VAT

A discount of 10% is available where two or more workshop places are booked together.

Problem Solving and Decision Making

Monday 8th February 2010 – Glasgow
Wednesday 3rd March 2010 - London

- Explore problem-solving models and techniques
- Understand models of convergent and divergent thinking
- Explore creative techniques to identify solutions
- Understand decision-making models
- Practise techniques on real problems

Influential Communication

Tuesday 9th March 2010 – London
Friday 12th March 2010 - Glasgow

- Understand the power of influence
- Rehearse skills including:
  - Positive communication
  - Active listening
  - Establishing and maintaining rapport (in a safe environment)
  - Assertiveness
  - Persuading
- Building and maintaining the commitment of others

Healthcare Assistants: Risk in Practice

Tuesday 9th February 2010 - Glasgow
Tuesday 16th March 2010 – London

- The changing role of the HCA
- Accountability in practice
- Clinical negligence
- Record-keeping
- Confidentiality
- Consent
- Chaperoning
- Results handling
- Health & safety

For more information contact Ann Fitzpatrick on afitzpatrick@mddus.com or 0845 270 2034