Summer 2011

SUMMONS

MDDUS JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND

• Tweet and be damned • James Kingsland • Care not control •

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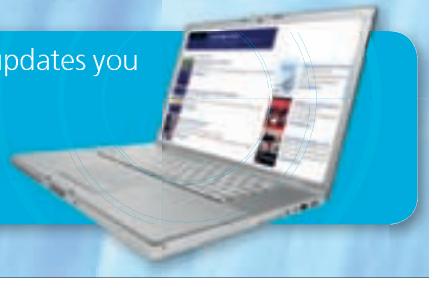

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IN THIS ISSUE

A FEW years ago some dental nurses set up a Facebook group called 'I'm a dental nurse and I hate patients because...' It was described as a forum for members "who are sick of patients and their bad attitudes, their stupid comments, their bad personal hygiene and the way they assume it's OK to burp in your face." Some 497 people joined.

Not surprisingly the GDC didn't find it quite so funny and threatened disciplinary action against any UK-registered dental nurse in the group for failing to 'treat patients with respect and dignity' and 'maintain patient confidentiality'. The informality of social networking sites like Facebook and Twitter can easily tempt healthcare professionals to dash off comments more appropriate to a chat over drinks. But beware – the internet has a tenacious memory and reach as we discover on page 14.

In this issue of *Summons* we also continue to offer a range of voices and opinions in the ongoing debate over the Health and Social Care bill. Dr James Kingsland has long been a champion of GP commissioning and on page 10 he discusses his role as National Clinical Commissioning Network Lead and the need for renewed momentum in NHS reform.

On page 18, associate editor Joanne Curran looks at the ongoing challenge of improving dental health among children and especially those in low income families. In an interview for the article Professor Jimmy Steele says: "Dentists can only do so much; parents and schools both have a role, as does wider society."

And on page 18 Professor Alistair Burns highlights the shameful fact that antipsychotic drugs are still routinely used to manage symptoms in people with dementia despite being inappropriate and potentially dangerous in the majority.

Jim Killgore, editor

REGULARS

Cover image: Permanent Bloom by Stuart Cargill. 1993. Medium: oil on canvas.
Born in Scotland, 1972, Cargill graduated form Duncan of Jordanstone College of Art, Dundee in 1993. Cargill was commissioned by the French Institute (Georges Perec Season) in 1992. Cargill won the John Milne Purvis Prize in 1993 and has exhibited throughout Scotland. 'Permanent Bloom' is one of a series of paintings inspired by literature ranging from Chekhov to Perec and aspiring towards a Matisse like quality.

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.

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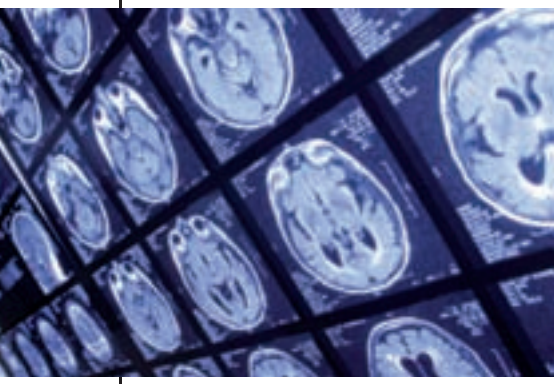


Immunity for expert witnesses removed

A LANDMARK decision delivered by the Supreme Court has effectively abolished immunity for expert witnesses against claims of negligence in providing evidence for legal proceedings.

The historic decision came in an appeal by motorcyclist Paul Jones who in 2001 was injured after being struck by the car of a drunk driver. Mr Jones launched a damages claim against the driver alleging significant physical and psychological damage and his solicitors instructed a consultant clinical psychologist, Sue Kaney, to prepare an expert report.

Dr Kaney wrote a report stating that Mr Jones suffered from post-traumatic stress disorder (PTSD) as a result of the accident and proceedings were subsequently issued with the driver admitting liability. Only the amount of damages remained at issue.

But an expert instructed by the defendant's solicitor alleged that Mr Jones was exaggerating his symptoms and the judge directed the two experts to meet and come to a joint view. Dr Kaney subsequently signed a statement denying that Mr Jones was suffering from PTSD and describing him as deceptive and deceitful.

Mr Jones claimed that this led to a significantly reduced settlement in his case and he launched a suit against Dr Kaney for negligence in signing the statement, which it was alleged she had not even read.

The case was struck out by a high court judge on the basis of a 2000 Court of Appeal decision reaffirming immunity for expert witnesses but was later referred to the Supreme Court as it was considered of general public importance.

A majority of five out of seven judges on the Supreme Court panel held that public policy could no longer justify the continued immunity of expert witnesses and allowed Mr Jones' appeal. In delivering the judgement Lord Phillips rejected the argument that experts will be discouraged from providing expert evidence in future, stating: "All who provide professional services which involve a duty of care are at risk of being sued for breach of that duty. They customarily insure against that risk."

Note that members can be reassured that MDDUS provides access to legal representation and indemnity for expert reports and testimony, provided that the individual member is in the correct category of membership. Members can contact our Membership Team on 0845 270 2038 to ensure that they have adequate and appropriate indemnity.

European medical directory – read the fine print

MDDUS is continuing to get calls from members who have inadvertently signed contracts to advertise their details in a 'European Medical Directory'.

Doctors 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. This emphasises the importance of reading all such documents carefully before signing.

MDDUS at NAPC conference

IN JUNE MDDUS was a major sponsor of the National Association of Primary Care Commissioning Conference at the Olympia in London. We had many visitors to our conference stand and MDDUS medical adviser John Holden was a speaker at the event – very timely given the recent report of the Future Forum and the responding Government announcement of changes to the NHS reform bill in England.

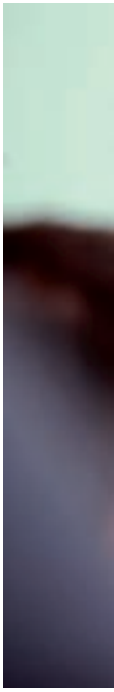
MDDUS also sponsored a booklet produced by the *BMJ* – *BMJ Guide to Commissioning For Doctors in England* – which was handed out to all delegates at the conference. The booklet provides helpful views on commissioning across the spectrum of opinion and copies are available to all MDDUS members on request. Contact Karen Walsh on **kwalsh@mddus.com**

Leading through uncertainty

MDDUS has announced new dates in 2011 for its popular 'Leading through uncertainty' – an intensive five-day course aimed at doctors in leadership positions.

The course is based on a set of competencies evolved from the General Medical Council's (GMC) guidance on *Management for Doctors* and is designed to challenge participants as leaders and help positively change the way teams are managed. It will furnish the tools necessary to ensure that doctors in leadership roles tackle change and risk positively and help create interdependent, effective relationships in the workplace.

The course will be held in our Glasgow office from Monday, November 28, 2011 to Friday, December 2, 2011 at a cost of £395. For more information or to book a place, contact Ann Fitzpatrick, course



IN BRIEF

- **BRIBERY ACT COMES INTO FORCE** The new UK Bribery Act came into force on 1 July 2011 making it illegal to request, agree to receive, or accept an inducement to act "improperly". The Act is aimed mainly at tackling major corporate corruption but it is important that medical and dental practices have adequate procedures in place to prevent overstepping the mark with freebies and hospitality. The Ministry of Justice has published a handy Quick start guide on the act which can be found at http://tinyurl.com/3bsqjx7

- **WINNER OF DENTAL EDUCATION GRANT** MDDUS is pleased to announce that the 2011 winner of our £1,000 postgraduate dental education grant is Amy Louise Harper who works as a VDP at Loanhead Dental Practice in Midlothian. MDDUS awards grants for use in any form of educational training including attendance at courses, conferences and seminars, practice training and the purchase of textbooks.

MDDUS practice manager workshops

MDDUS is pleased to present a series of workshops tailored for managers in general medical or dental practice. The programme launches on 24 August, 2011 with a session entitled 'Leadership and developing your team'. Other sessions are:

- Change management - 13 September, 2011
- Introduction to risk management - 26 October, 2011
- Recruiting, selecting and inducting new staff - 12 January, 2012
- Assertiveness - 21 February, 2012.

Delegates are welcome to attend all five days or can select individual workshops. All will be based at the Glasgow office of MDDUS and run from 10am to 4pm. The cost is £20 for members and £40 for non-members, with fees covering administration and lunch costs only.

For more information or to book a place contact Ann Fitzpatrick, Course Administrator, on afitzpatrick@mddus.com or 0845 270 2034.

MDDUS publications now online

You can now access all MDDUS print publications online by going to our new Publications page on the MDDUS website (**www.mddus.com**).

Web versions of selected articles and a digital viewer and PDFs of the full issues are available for:

- *Summons* - main membership journal
- *Practice Manager* - aimed at medical and dental practice managers
- *FYi* - magazine for final year medical graduates and foundation year doctors
- *SoundBite* - publication for final year dental graduates and postgraduate trainees
- *GPST* - publication for GP specialist trainees
- *Essential Guides* - booklets on core medico/dento-legal topics

Find articles on specific topics by searching our Resource Library at **www.mddus.com**

administrator on **afitzpatrick@mddus.com** or call 0845 270 2034.

'On hold' membership status

ARE you not working due to retirement, maternity, paternity leave or ill health?

You can put your membership on hold. We have a status called 'Retired/Deferred Membership' which is provided free of charge and covers you for 'good Samaritan' acts only. You can reactivate your membership at any time – fully or for periods of four weeks at a time.

This category of membership is granted to members who have retired from practice or are not working for a period of three months or more. A condition of this type of cover is that you must have been in membership with MDDUS for a minimum period of one year.

For more details and to apply online go to **www.mddus.com**. You can also phone our Membership Team for details on 0845 270 2038.

MDDUS at BMJ Group Awards

MDDUS chief executive Professor Gordon Dickson gave the welcome address at the recent BMJ Group Awards held at the Park Lane Hilton Hotel in London. MDDUS was – for the second year running – headline sponsor of the awards which recognise and celebrate excellence in healthcare across the globe.

The Union also sponsored the Primary Care Team of the Year award which went to the Rainbow Surgery, Cambridgeshire for their promising work treating people with alcohol problems. The Lifetime Achievement Award went to Professor Sir Richard Peto, Co-Director of the Clinical Trials Service Unit and Epidemiological Studies Unit at Oxford University, for his work into the effects of smoking and cancer prevention.

Go to the BMJ Group Awards 2011 website for full details of the winners.

Contact Karen Walsh at **kwalsh@mddus.com** for details of next year's grant.

- **RCPSG TRIENNIAL CONFERENCE** MDDUS will be an exhibitor at The Royal College of Physicians and Surgeons of Glasgow 2nd Triennial Conference for physicians, surgeons, dentists and associated professionals being held at the SECC in Glasgow on 10-11 November 2011. The conference offers a selection of forums including medical, surgical and dental as well as travel medicine and history. Registration and further details can be found at www.rcpsg.ac.uk
- **GP BENEVOLENT FUND** The Cameron Fund is the only medical benevolent charity which solely supports GPs and their families in times of financial need, whether through ill-health, disability, death or loss of employment. Donations are welcome from individuals and organisations including Local Medical Committees. For more information on how you can help or receive help from the Cameron Fund go to www.cameronfund.org.uk

Concerns over tooth whitening

THE GDC has published a leaflet warning patients to take a cautious approach to tooth whitening as concerns are raised within the dental profession over a clampdown on the practice.

Considering tooth whitening? advises patients to visit their dentist before undergoing whitening and suggests a list of questions to ask practitioners. The leaflet also urges patients to inform the General Dental Council if whitening is carried out by someone who is not a registered dental professional.

The regulator has made it clear that it believes only registered dental professionals should carry out whitening. Earlier this year the GDC successfully prosecuted a non-registrant for performing whitening and he was ordered to pay a fine and costs of £13,000.

A poll by the GDC in December found that eight out of 10 people choose to have tooth whitening done at a dental surgery and think it should only be carried out by registered, trained and qualified dental professionals. And 75 per cent of the people who took part in the survey also said they thought the GDC should prosecute anyone carrying out tooth whitening illegally.

Antipsychotic overuse in dementia care

THE Dementia Action Alliance has called for a clinical review of all UK dementia patients being administered antipsychotic drugs to ensure care is compliant with current guidelines and that alternative medications have been considered.

The alliance of some 50 health and social care organisations is calling for the review to be carried out by 31 March 2012. Antipsychotics are often prescribed as a first response to behavioural and psychological symptoms of dementia, such as distress or agitation, even though in an estimated two-thirds of cases use of these agents is considered inappropriate. Antipsychotic drugs are linked to serious side-effects in dementia patients, including mobility problems, sedation and sometimes death, particularly when used for longer than 12 weeks. See page 12 of this issue for more details.

To achieve a reduction in the use of these drugs, people with dementia and carers, GPs, leaders in care homes and pharmacists are being asked to sign up to commitments outlining how they can play their part in ensuring reviews take place.

To support the initiative, Dementia

General Medical Council

Broad support for fitness to practise reforms

THE GMC is claiming broad support from doctors and patients for many of the proposals detailed in its recent consultation on fitness to practise procedures, including plans that would see doctors able to accept a sanction without going to hearing.

The fitness to practise reforms consultation was launched in January this year and the GMC received 217 written responses from patient groups and individuals, as well as the BMA, Royal Colleges, CHRE, NHS Employers, individual doctors and medical defence organisations, including MDDUS.

Among the proposals is a mechanism by which doctors can accept a sanction without going to a full hearing, thus providing a quicker resolution to cases. Other proposals would see doctors with convictions for certain crimes, such as murder and rape and possibly fraud, automatically struck off the medical register. However, plans for doctors to be able to share information with the regulator on a 'without prejudice' basis will not be pursued after respondents voiced concerns.

Feedback from the written responses and from consultation events also helped the GMC identify areas where the plans should change or further work is needed, such as how to ensure the public and media have the opportunity to scrutinise decisions. It will also consider ways in which potentially vulnerable doctors can be supported during the process, including the provision of basic legal advice for unrepresented doctors in certain circumstances.

Niall Dickson, the Chief Executive of the General Medical Council, said: "We will now develop the plans in detail, working closely with doctors and patients to make sure the changes continue to ensure there is widespread confidence in our fitness-to-practise procedures."

IN BRIEF

● **NICE GUIDANCE ON MENTAL HEALTH DISORDERS** New guidance to help GPs treat patients with common mental health disorders has been launched by NICE. *Common mental health disorders: identification and pathways to care* makes recommendations on how to identify and care for patients with depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder. Access at http://tinyurl.com/6xujzab

● **NEW END-OF-LIFE CARE GUIDANCE** New guidance for healthcare professionals on end-of-life care has been published online. *Guidance for staff responsible for care after death*, produced by the NHS National End of Life Care Programme, offers best practice advice to ensure care is given in a safe and respectful way before death, at the time of death and after death. Issues covered include respecting people's wishes on organ and tissue donation and honouring the spiritual or cultural wishes of the deceased while also meeting legal

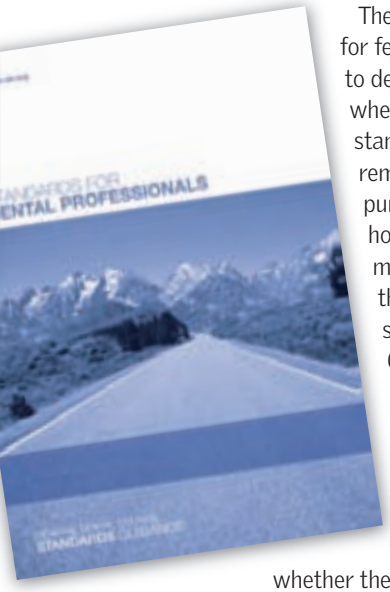
Action Alliance has produced best practice guidance on the use of antipsychotics. For copies of these resources and for more information on antipsychotics, visit the Alzheimer's Society website.

GDC reviews core standards

THE GDC is asking for feedback on its core standards for dental professionals in advance of a formal consultation.

Standards for Dental Professionals was first published in May 2005 and sets out the principles that dental professionals agree to abide by as GDC registrants. Supplementary guidance is provided in accompanying booklets on specific areas of responsibility for registrants, such as patient consent and dental team working.

This guidance applies to all GDC registrants, although it was originally drafted before dental nurses, dental technicians, clinical dental technicians and orthodontic therapists were registered with the Council.



The GDC is asking for feedback in order to determine whether the standards guidance remains fit for purpose and also how it should be made available in the future. More specifically the GDC want to know how often dental professionals refer to standards guidance, whether there should be separate guidance for each registrant group and what format is best.

A simple online questionnaire can be found on the GDC website. This exercise will be followed by a more formal consultation as part of ongoing research with professionals and patients.

VIEWPOINT

By Dr Ivor Felstein, Retired Consultant Geriatrician

It's good to talk

BACK in 1969, when Richard Nixon was the US president and Hippies wore their 'flowers for peace' in the streets of Washington DC, I arrived in the United States to speak at an International Congress on the problems of caring for an ageing population. Coming from a UK health service free at the point of delivery, I was soon enlightened on a healthcare system which demanded hard cash for all treatment of sickness and disease.

A cogent example which struck home was demonstrated when I stopped off en route to visit a relative in New York City who had a cardiac problem. She was suffering from progressive heart failure due to heart valve disease. I was well aware that this could have been improved by the new cardiac surgery of the day. However my relatives' family could not afford the costs that, in England, would have been met by the NHS.

I thought this to be a sad state of affairs but held my tongue since I was "just a visitor". Curiously, however some US citizens that I spoke to were making jibes at good medical practice being overtaken by 'socialism' or even cryptic communism in the UK!

Another example of "need to watch health costs closely" was demonstrated in my relative's regular medical consultations. She explained to me how phoning the doctor for medical advice was far cheaper than attending his surgery.

I recall this discussion now because I suspect that our ongoing financial problems in the NHS today may soon lead to an increase in similar cost-saving measures in patient-doctor interactions.

Beginning with the ability to fax information to and fro, we have moved on to email facilities and unlimited speaking and texting by mobile phone. The arrival of Skype with visualisation and sound adds still more possibilities for patient-doctor interaction and linkage for "non-presence of the body" types of consultation.

We have always taught medical students, quite correctly, that taking an assiduously careful history at the start of a consultation offers the best chance of coming to a quick diagnosis. So aren't there some all too obvious difficulties with this new and exciting rush of technology? Can the non-medical descriptive powers of the patient (or other relative or carer on their behalf) over the phone or in e-mail or text ensure an accurate list of findings is put forward? What if the patient or history teller stammers or has a strong foreign accent?

Next is the invariable loss of privacy and dignity in the course of using any electronic communication. What about patients who are hard of hearing, or unable to see clearly and well, or perhaps troubled by memory loss, or reticent to 'expose' not only their private parts but also personal habits and intimate practices on a machine?

Further, there are potential leaks of information in the constant to and fro of electronic media. That fact alone implies the need for secure file transfer methods such as server gated cryptography, or CPU throttling for 'safe' medical information transfer or whatever hack-proof solution the IT boffins can come up with.

We shall see soon enough in this new millennium if "talking" to the doctor no longer necessarily means a face-to-face consultation in a busy surgery after a sometimes long journey from home and still longer wait to be seen.

Meanwhile... see/hear/touch/buzz/type /Skype/call you soon.

obligations. Access at http://tinyurl.com/662xnj2

● **SIGN APP FOR GUIDELINES ON THE GO** Smartphone and tablet users can now access clinical guidelines on the move with the new free SIGN app. The new app launches quick reference guides (QRG) of recently published guidelines on topics including early rheumatoid arthritis, venous thromboembolism, stroke, diabetes, obesity and diagnosis and pharmacological management of Parkinson's disease. Find out more at www.sign.ac.uk.

● **VACUUM STERILISERS NOT MANDATORY** Dentists in Scotland will not be required to use vacuum sterilisers as there is a lack of evidence on increased patient safety, the Scottish Health Technologies Group (SHTG) announced in a recent statement. The statement by SHTG means that non-vacuum phase autoclaves can continue to be used in primary care settings. Dr Robert Kinloch, Chair of the BDA's Scottish Dental Practice Committee, said: "The BDA applauds this commonsense decision, which has been taken on the basis of available evidence".

SWITCHING ROLES?

Janice Sibbald

Photograph © AVAVA - Fotolia.com

TIMES are changing. The days of the stereotypical family with defined, traditional roles where the man goes out to earn the money and the mum stays at home with the children are becoming less and less common. In order to accommodate this, the government has announced new paternity leave legislation, meaning that parents will be legally entitled to share time off work during their baby's first year.

Our neighbours in Europe, specifically Scandinavia, are well known for being more forward thinking and generous in relation to time-off whilst children are young, and our government is making progress in shaping our paternity and parental leave policies with this in mind. What's more, the changing demographics of today's working women may mean that it is more financially viable for some mothers to return to work and leave the main caring responsibilities to their partners.

These days, parents have to be more creative in their attempts to balance the demands of work and looking after their families. The right to take additional paternity leave (APL), which has been extended from two weeks to a maximum of 26 weeks, is now available to parents of children born after 3 April 2011. It can be taken between 20 weeks and one year after the baby is born as long as the mother has returned to work. This right also applies to parents planning to adopt. In effect, this means the mother's partner can take the balance of her maternity leave once she has returned to work, either up to the end of her maternity pay (39 weeks) or leave entitlement (52 weeks).

In order for an employee to qualify for APL they must be the child's father or the mother's husband, partner or civil partner and have, or expect to have, the main caring responsibilities for the child during the leave. So to be clear, this law is not a way for partners to take some time off work to relax! To qualify, they need to have been employed for at least six months before the baby is born and the mother needs to have returned to work. It's important to point out that APL has to be taken before the child's first birthday. Further restrictions include a requirement for the leave to be taken in a continuous block and in multiples of a week to avoid days being taken here and there. This

> "These days, parents have to be more creative in their attempts to balance the demands of work and looking after their families"

should mean less disruption for practices as they will be able to more easily plan for blocks of absence.

To qualify for additional statutory paternity pay (which is different from just leave) you must be an employed earner. That is, you must work for someone who is liable to pay the employer's share of your class one National Insurance contributions. You must also earn at least the lower earnings limit (LEL) for National Insurance contributions in force at the end of the qualifying week.

The current weekly rate for paternity pay is either £128.73 or 90 per cent of weekly earnings if this is less. So whilst it is not a significant amount of money, it matches the rate for maternity pay that the mother would receive. Whilst it may be evident from the bags under their eyes that he or she has caring responsibilities for a new baby, the partner must clearly have assumed the caring responsibilities whilst on APL. It may be wise for practices to confirm this by writing to the mother's employer to check that she is, in fact, back in the workplace.

There is concern that these new rights will put additional pressure on practices as they will be forced to manage the additional costs, absenteeism and administrative burdens that APL may bring. Like women on maternity leave, fathers or partners on APL still continue to accrue benefits such as annual leave which they will be able to take in addition to the paternity leave.

Regardless of these concerns, the legislation is now in place and employers will have no choice but to accommodate it as the UK strives to be a more family-friendly place to work. The risk to employers of a tribunal application for sex discrimination landing on their desks if they fail to comply is high. It's clear. The legislation now provides for BOTH parents to have leave to be with children when they are young.

■ ***Janice Sibbald is an HR and employment law adviser at MDDUS***

DOES FAMILIARITY BREED CONSENT?

Deborah Bowman

I AM currently putting the finishing touches to a forthcoming book on consent. It has been a chance to return to basics and revisit familiar concepts. Consent is core material in ethics. It is unthinkable that anyone wouldn't learn about the importance of consent during training. It is relevant to every clinical encounter. Yet, going back to ethical basics has been illuminating and thought-provoking, prompting the question 'does familiarity breed consent'?

There are different ways in which familiarity might inform how consent is sought and obtained. First, there is familiarity with the process of consent itself. Healthcare is increasingly systematised and mechanisms are routinely in place to seek consent. Whatever the specialty, most practitioners have a way of seeking consent that is established and familiar. It might be that a GP uses a particular form of words to explain a referral. It might be that a dentist has leaflets that are dispensed to those requiring an implant. It might be that the physician carrying out endoscopies relies on the clinic nurse to explain the procedure and ensure that standard forms have been signed. It is easy to overlook the fact that what is merely another working day for the professional is likely to be a 'red-letter' day for the patient who may have had the appointment marked on their calendar for some time and made special arrangements to attend. A 'routine appointment' is rarely part of a patient's routine.

Whatever the clinical setting, the wheels of efficient practice are oiled by established approaches to consent. However, sometimes one can become so familiar with a system that we become blind to its effects, both positive and negative. As we learn to depend on standard processes and formulaic encounters, we risk losing our critical and reflective perspectives. Whilst consent that is systematised may have many positive effects, it is only by stepping back and looking at 'the way things are done' with a fresh pair of eyes that we can know whether it is an effective system or where there might be room for development. When did you last think about the ways in which you seek consent? How do you know that your approach is effective?

> "One can become so familiar with a system that we become blind to its effects, both positive and negative"

The second way in which familiarity can shape consent is when a clinician gets to know patients over time. Again, a long-standing history of working with a patient can be an asset and contribute to trust and a strong therapeutic relationship. Many readers will, I am sure, be able to recall times when knowing an individual patient well has enhanced clinical care. Indeed, one of the oft-heard criticisms of recent healthcare reform is that continuity of care, both in the primary and secondary care settings, is increasingly rare to find. Yet, there can be other factors to consider when getting to know a patient over a long period of time. Familiarity can lead to shortcuts. It is easy to think that one knows a person sufficiently well to skip some of the niceties of seeking formal consent. After all, if someone has had the same procedure or treatment over a period of time, they do have experience that a 'novice' patient does not share. However, consent should be an ongoing process and merely because someone agreed to a procedure in the past, it cannot be assumed that he or she will do so again. Consent is about clinician and patient sharing their perspectives and experiences, without unduly privileging expert knowledge. The feeling that one already knows the patient's priorities may compromise both seeking consent and the consultation.

Many clinicians will have experienced the frustrations of shifting roles and becoming patients themselves. It is well-known that when a doctor seeks medical advice and treatment, he or she is likely to find that the consultation is influenced by assumptions about pre-existing knowledge, professional status and personal expectations. A diluted version of that phenomenon can occur when seeing patients whom one knows well. It can be all too easy to assume and anticipate, rather than to ask and explore. Whilst the interaction between a clinician and a long-standing patient will naturally evolve over time, there should be time to be thorough and to return to the fundamentals of consent. Is the patient sufficiently informed? Have things changed over time and if so, how? How does what has gone before inform and shape current and future treatment? Is the patient still finding treatment helpful? Are there new symptoms or side-effects to be discussed? What is the patient feeling six months, a year or five years down the line?

Does familiarity breed consent? Perhaps, but it may be a partial, sub-optimal version of a process that is essential to ethical practice. Might it be time to look anew at the familiar in your clinical practice?

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

Standing at a crossroads

Summons *speaks with influential Department of Health advisor on clinical commissioning* Dr James Kingsland *about the case for urgent and radical NHS reform in England*

DR JAMES KINGSLAND has long been a champion of practice-based and now GP commissioning, having worked for years as a part-time GP advisor to the Department of Health in England. He is currently the National Clinical Commissioning Network Lead – a position which gives him a direct line to Ministers.

Dr Kingsland was previously a personal advisor to Lord Darzi and was instrumental in the development and implementation of PMS policy. He served for four years as chairman of the National Association of Primary Care and is currently president of the organisation.

Having practised on the Wirral since 1989, he is a senior partner in a PMS practice in Wallasey which was an early adopter of practice-based commissioning and is now in a first wave pathfinder consortium. Among many other roles he also serves on the NICE Commissioning Steering Group and is a non-executive director of Clatterbridge Centre for Oncology Foundation Trust.

Dr Kingsland is married with two daughters and enjoys golf, football (having only recently given up playing five-a-side), music and broadcasting, being the resident doctor for BBC Radio Merseyside

Do you think the NHS in England needs revolution rather than evolution?

It depends what you mean by the words. Revolution brings to mind overthrowing regimes and bringing down governments. I've heard Sir David Nicolson say – this [NHS reform] is not a revolution but an evolution as in fish-to-man in two years. It's really somewhere in between. It's not revolutionary in dismantling everything we've built to date; it's building on the best of what has been successfully created since1948. But the urgency to improve productivity in the current financial climate, does not allow for a slow incremental change; it's got to be rapid and quite far-ranging.

What does your role as National Clinical Commissioning Network lead entail?

What we are trying to do is develop a collective understanding of the reforms right across England and connect leaders in commissioning – emerging and established. The network is system-wide in terms of geography but also in clinical disciplines– recognising that while GP commissioning boards will be led by their constituent general practices, the redesign of care services, the reform of our NHS will be delivered by a multidisciplinary team approach. Optometrists, dentists, pharmacists have a massive repository of information about local populations and individuals. AHPs, community and practice nurses are all resources in themselves, commit resources and do needs assessments – which is all part of commissioning.

Why is there so much opposition to the health reform bill among GPs?

There has been a lot of scare-mongering, misinformation and misunderstanding, and – sometimes – a mischievous interpretation of what's required. I think the narrative – articulating exactly what it is that we expect GPs to do – has also been lacking. I hear GPs say: 'yes, we want patients to be involved, to be the source of control in the system rather than the current inherent managerial control, and yes, we would like to have more say in how NHS budgets are deployed. We do want to improve outcomes for patients and be involved in care pathway design – but we don't like the reforms'. I can only reply: 'well what you have just described is exactly what the reforms are for. So why don't you like them?' And the answer is: 'that's not what we've been told. We've been told we're going to have to manage contracts, procure new services and take on complex roles previously performed by PCTs thus taking us out of practice, and we're going to have all this extra bureaucracy'. Well, I say: 'who ever told you that is either being very divisive or is poorly informed'.

People misunderstand the word 'commissioning'. What healthcare managers mean by commissioning is the procurement of health services and contract management. But for clinicians, commissioning focuses on the first part of

the cycle which is about needs assessment and securing the best service against that need within the available resources. So when people ask – can GPs commission? I say we do that anyway. It's called consultation and referral. The act of sitting with a patient and taking a history – that's a need assessment. And then saying your needs can be best met with hospital and a referral – that is commissioning.

Some critics ask if it is really necessary to abolish PCTs. Why not just add more GPs to PCT boards?

Yes. I've heard that protectionist outlook and mainly from personnel currently working in PCTs. But that's just plastering over the cracks. What the bill is for – is legislation for outcomes and accountability. Now that's saying we've got to have a major cultural and behavioural change in the delivery of care in our NHS. And that ain't going to happen by just supplanting a few managers with doctors, or adding a few doctors to the current structures. It's been recognised that our NHS needs major change.

There's been, for a long time, year-on-year growth in the NHS budget. In 1995 the turnover of the NHS was around £32 billion; by 2010 it was over £100 billion. If a company was guaranteed that sort of growth over a15-year period, whatever their annual outturn and outcomes, they might just get complacent or not be as efficient as possible. In the NHS we've had this massive investment but not the concomitant improvement in outcomes. We still have areas of poor health and inequalities, urgent care is broken and long-term conditions are largely managed in the wrong sector. Using international comparative data – I think our report would be 'could do better'.

Is competition a good thing in a national health service?

Competition within the market has always been a good thing – and it's there inherently within the 'NHS family'. Hospitals compete against each other; GPs do too. This established competition has worked to drive up quality and is desirable. The more contentious issue is competition for the market. And that's something new in terms of increasing the plurality of care provision. I think we'll get it right by saying competition for the market is desirable when commissioners find a gap, or poor or inadequate provision in local services. Or we as commissioners – the clinical community – start to describe a care pathway to which a current provider says: 'sorry we can't deliver that for you'. Or there is no one to deliver it. Therefore what do you do? Do you continue with poor provision or do you find a new provider for the market through the any-qualified-provider route?

Do you think the reforms will mean more private industry in healthcare provision?

I don't. If you understand the any-qualified-provider programme – it's not always that attractive for new entrants. People tend to think it's hands up anybody who wants to do NHS work and we'll give you a contract and a load of dosh. It's not. It's saying where there is a need to develop a new service or the current service does not meet the needs of patients, then let's have a new provider – if they meet NHS standards and can supply the estate and the staff at their own set-up costs and can deliver a full care pathway, not cherry pick a part of the care pathway. They may be awarded an NHS contract without having to tender – but so may others in competition for patients. And importantly that contract does not guarantee any volume of work or income. Payment is made on a cost-per-case basis using PbR and the national tariff for the service provided. Some may wish to do this. Many won't.

Do you think 2013 is a reasonable timescale for implementation of the bill?

Oh absolutely. There is a lot of talk in the NHS about waste of resources, of time and space, all of which are important – but if we waste spirit, the current enthusiasm and innovation, that would be unforgiveable, because we may never turn that back on. This is the last chance to refresh the NHS and rejuvenate clinicians in terms of being proactive in the management of the public purse. If we lose that, I think that will be the end of an NHS free at the point of need and not based on your ability to pay. We are just starting to see some concern and despondency in the profession due to the pause. We're certainly losing some of the spirit in our NHS management, but that we can salvage. But if we lose the spirit of the people delivering the service, we'll never recover. Any longer than 2013 would be very damaging.

There is a big appetite out there for change; the blue touch paper has been lit. If we start to say, oh, let's think again, not do it, and we lose the momentum already gained particularly within the clinical leaders, and turn off that leading edge which is already starting to re-engineer local services. If we lose that, we haven't got a chance.

■ *Interview by Jim Killgore, editor of*

Antipsychotic drugs are still routinely used to manage symptoms in people with dementia despite the fact that the majority are inappropriate and potentially dangerous. Professor Alistair Burns ***is part of an initiative to change this***

Care, not control

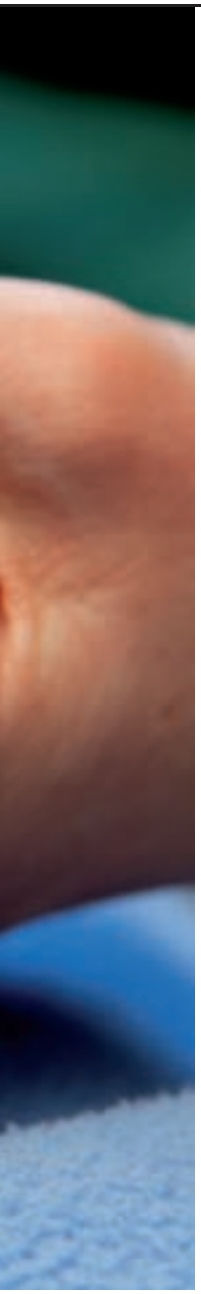
DEMENTIA is one of the greatest health and social care challenges facing the world today. An estimated 35 million people globally suffer from the disease, a figure expected to rise to over 100 million by 2050. Seven hundred and fifty thousand people in the UK have dementia and the number affected by the disease can easily be multiplied by two, probably by three and possibly by four if one takes into account carers and family members. The cost of caring for dementia patients is estimated at £20 billion a year, a figure dwarfing that for stroke, heart disease and cancer.

Some stark statistics help to underscore the scale of the challenge facing UK health and social care services in dealing with the condition. Two-thirds of people in care homes have dementia and around 25 per cent of general hospital beds at any one time are occupied by people with the condition (around 40 per cent among older people) – a significant proportion of whom would not need to be there were it solely for their medical condition.

In a 2009 publication entitled *Counting the Cost*, The Alzheimer's Society reported the results of a survey of carers and hospital staff showing that 97 per cent of nurses claimed contact with people with dementia and 50 per cent of carers felt that admission to hospital had a detrimental effect on the mental and physical health of dementia sufferers.

One issue of particular concern was the over-prescription of antipsychotic (neuroleptic) drugs for people with dementia. Nearly 80 per cent of nursing staff said that antipsychotic drugs were used always or sometimes to treat people with dementia in the hospital environment. Other studies have reported that an estimated 180,000 people with dementia are on these medications, and in nursing homes prescription rates are between 20 and 30 per cent, with just over five per cent of all people over the age of 65 on antipsychotics.

The commonest reason for the prescription of these drugs is agitation or aggression – which are really non-specific signs (akin to fever) often indicating the presence of an underlying (and often undiagnosed) physical condition or something in the environment that triggers a response from an individual. Only about 20 per cent of people with dementia suffer from symptoms of psychosis (the presence of delusions,



misperceptions or hallucinations) and the prevalence of schizophrenia in people over the age of 65 is low (probably around one per cent).

Dangerous side-effects

Drugs like thioridazine and chlorpromazine were widely prescribed for dementia in the 1970s and 1980s but the severe side-effects of these medications prompted the prescription of newer, less harmful antipsychotic drugs such as risperidone and olanzapine. The most common side-effects are cardiac (prolongation of the QT interval) and extrapyramidal Parkinsonian signs and symptoms.

In 2002, the Canadian Healthcare system identified excess mortality in patients treated with risperidone, which was confirmed a year later by the US Food and Drug Administration (FDA) and followed by a warning the next year from the European Medicines Agency for olanzapine and the UK Medicines and Healthcare Products Regulatory Agency (MHRA) for both drugs. The FDA extended the warning to the drug aripiprazole in 2005 and in the same year identified a 1.7 times increase in mortality for all the novel neuroleptics.

In November 2009 an independent report by Professor Sube Banerjee (*Time for Action*) commissioned by the Department of Health estimated that 1,800 deaths and 1,600 strokes were prompted by the prescription of these medications in the UK. This toll is in addition to the well-documented deleterious effects they have on cognitive function and also their contribution to precipitation of falls. With these recognised dangers, there is significantly increased awareness of the need for caution in the prescription of antipsychotic drugs in people with dementia.

Alternatives to antipsychotics

The evidence base for alternatives to antipsychotic drugs is somewhat patchy. A range of complimentary treatments are often cited as being effective in dementia care and while small studies often do show significant benefits for interventions such as bright light therapy and aromatherapy, generally the results are disappointing and insufficient to recommend their wholesale introduction into practice (a quick scan of the Cochrane database attests to this).

Alternative drugs are often prescribed and a variety have been suggested to be of help, such as clonazepam for people with a specific REM sleep disorder often seen in people with dementia, or memantine which appears to have some beneficial effects on dementia patients who have behavioural disturbances. Other medications with a patchy evidence-base include trazadone, clomethiazole and propranolol (sometimes used in people post-head-injury to control agitation). Antidepressants such as citalopram have been used with some benefit. Reverting to older neuroleptics showing an evidence-base for less harm is not justified as they are likely to have a similar side-effect profile to the newer agents.

Raising awareness

The Department of Health in England has embarked on a series of strategies to promote awareness and encouragement for reduction in the use of antipsychotic medications in dementia care. These priorities are being mirrored in the devolved nations. A care pathway is being developed which should be of help to people in primary care and others, emphasising the need to look at preventative strategies (early awareness, the opportunities for non-pharmacological interventions), the importance of person-centred care in the management of individuals with dementia and the key role that short-term medication, including antipsychotics, can play.

A series of audits is being conducted to gain high-quality information, and some specific audits, such as the Royal College of Psychiatrists Prescribing Observatory for Mental Health-UK (POMH-UK), should play a key role in driving down the use of neuropletic medications, even if just by raising the threshold whereby a prescription is given.

The Dementia Action Alliance (DAA) - which includes the Alzheimer's Society and the Department of Health – recently announced that it wants all prescriptions for antipsychotics to be clinically reviewed by the end of March 2012.

Jeremy Hughes, Chief Executive of the Alzheimer's Society, said: "It is essential we bring an end to this chemical cosh and empower people with dementia and carers with the information they need to ensure they are not prescribed these drugs inappropriately."

Some local measures

There have also been some notable local initiatives that have proved successful. In 2010 the Orders of St Johns Trust initiated a policy of requesting information on which of its care home residents had medication reviews completed by a GP over a two-month period. If reviews had not taken place, the home was asked how the issue would be addressed. The policy has resulted in a 16.6 per cent reduction in antipsychotic drug prescribing over a six-month period.

In Cornwall, health officials have developed a Dementia and Medications STAR Campaign. STAR (Stop, Think, Assess, Review) is a county wide, multi-agency educational toolkit aimed at reducing the use of inappropriate medication in people with dementia. It was developed by the local PCT, Royal Cornwall Hospitals Trust and Cornwall Care. It provides information regarding behavioural and psychological symptoms of dementia (BPSD), explanations of contributing factors and alternative strategies to medication. It also promotes a three-monthly checklist to review, monitor and reduce prescribing.

Such initiatives replicated across the UK should help bring about a change in attitude and practice in dementia care at a time when the older population is expanding year on year. For more information on the DAA initiative go to **www.tinyurl.com/6guz5lu**

■ ***Professor Alistair Burns is National Clinical Director for Dementia (England) at the Department of Health, Professor of Old Age Psychiatry, University of Manchester and Honorary Consultant Psychiatrist at the Manchester Mental Health and Social Care Trust***

Tweet and be damned

Social networking can often blur the boundaries between private and professional life. So what are the implications for doctors and dentists? Paul Motion *and* Lindsay Urquhart *of bto solicitors offer some insights*

A HUGE number of people are now engaging with the world through the internet. The benefits of the internet revolution are well documented and easily identified. Less well understood are the downsides. What are the risks associated with internet postings and what can you do when it all goes wrong?

The collective reputations of the professions are reinforced by ethical codes which are not simply a matter of personal choice. These codes are also used as a standard against which professionals are assessed and judged. A professional's reputation is of fundamental importance, reaching wider than professional ethics and crossing the boundary with personal integrity. It is perhaps in this area that social networking poses the greatest risks for doctors and dentists.

Most internet content is generated in one of two ways – either an individual can create and post it themselves or it may be created and posted by a third party. Some programmes and web spiders go further, replicating, blending and aggregating content from several search engines.

We may not think there is any risk associated with our own postings but bloggers and social networkers should beware. The good news is professionals can manage the risks of self-authored information with a little self discipline.

Comment with care

No doubt it can sometimes be useful for professionals to express their views online but they should exercise the same level of editorial control and self criticism as if they were placing their comment in a professional journal. The GMC provides guidance for doctors on providing or publishing information about services or otherwise putting information into the public domain (see 'Additional resources').

Comment posted online could potentially reach a far wider audience of professional peers and patients than a journal article. The ease with which blogs and forum posts are made can lead to an informality inappropriate for the expression of professional views. Internet postings can remain as cached information on search engines and sites for a long time, leaving the embarrassed professional dealing with the fallout of an ill-considered remark for longer than anticipated.

Social networking sites that encourage spontaneous comment, such as Facebook and Twitter, require particular

care. A message of 140 characters allows ample space to tweet a disparaging remark which may in fact be defamatory. If you have a Twitter profile which mentions your employer, it is a good idea to indicate that views expressed are personal.

Privacy settings

Professionals should be wary of having publicly accessible profiles which contain information connected with their private lives. If they have private profiles they should consider using the highest security settings to control content and access. On sites such as Facebook we recommend professionals take a similar approach to online friendships as they do to real-life friends. Before accepting a proposal for online friendship from someone who is not a trusted friend in real life, professionals should consider if this will expose private information to a wider audience than they would like.

It is now common practice for employers to conduct internet searches of job candidates, consequently our internet reputations have the ability to impact upon our professional lives.

Third party comment

This is potentially a dangerous area for healthcare professionals. Unfortunately not all patients have a positive view of their treatment and care, and this can be the case even where care is good and the practitioner's approach is professional. Some patients, perhaps without justification, may feel aggrieved and look to publicise their views, which can be a particular problem in patients with mental health complaints.

Most complaints made in the press are subject to editorial control which provides a degree of comfort. The GMC's guidance for dealing with criticism in the press encourages doctors to restrict any response to an explanation of their legal and professional duty of confidentiality. The GMC state that if a press report might cause patients to be concerned about a doctor's practice, the doctor may give general information about their normal practice but must be careful to avoid disclosing any personal information about the patient or their care. Comment in the press must not go beyond a simple denial and should provide no additional information (for further GMC guidance see 'Additional resources').

Where a complaint is mainly or solely aired online, meaningful regulation is very much harder. What should a doctor faced with these allegations do?

ADDITIONAL RESOURCES

- GMC *Good Medical Practice: Providing and publishing information about your services* **www.tinyurl.com/67hnkkh**
- GMC *Good Medical Practice: Writing reports and CVs, giving evidence and signing documents* **www.tinyurl.com/3hezttx**
- GMC *Confidentiality: responding to criticism in the press* **www.tinyurl.com/6equwx2**

The first port of call for practitioners experiencing online attack should be their medical defence organisation to see what support and advice is available.

We do not encourage clients to engage in discussions with or respond to the individuals making allegations as this can often make matters worse. There are however some situations where statements made about our clients are so malicious that they feel compelled to take action.

Our first approach would normally be to check the terms of service for the host site. Frequently comments which are defamatory in nature will be posted anonymously. Many sites do not tolerate anonymous posting and will remove these comments on request. Sites will also in some circumstances remove comment which is defamatory on the basis that this is a breach of their terms of service. Negotiation with site moderators can be required since the assessment of what is offensive can vary, as can the amount of evidence needed to effect a takedown. Some sites require the signature of legal documents certifying the information in the complaint as true. Sometimes a site will require production of a court order.

It is possible to raise proceedings for defamation wherever content is viewable and, theoretically, one can forum-shop for the location likely to award the highest damages. This may be of limited practical use if the individual posting the information will not have financial resources to meet the claim. Orders for interdict (injunction in England and Wales) and non-harassment may be of more immediate use. In both types of action it is possible to seek interdict against the person posting the defamatory comment to provide immediate protection from further posting.

Experience shows that while such orders are granted against the individual making the posting, many websites will remove content when presented with evidence that a court order has been granted. A doctor seeking a non-harassment order will not be able to seek any compensation for the damage to their reputation in a non-harrassment case; however, we often find that our clients are more concerned about preventing a recurrence than seeking damages. Non-harassment orders are registered on the police national database. Should a breach of the order occur, that becomes a criminal matter, and if sufficient evidence is obtained the police will report the breach to the Crown to prosecute.

Non-legal solutions are offered by a number of internet firms who can optimise positive comment, relegating negative comment to the lower pages of search results. While such services can be part of a useful dual-pronged approach, these companies usually do not arrange for removal of content from the web.

■ ***Paul Motion, Partner, and Lindsay Urquhart, Associate, are members of the dedicated Internet Reputation Team at bto solicitors in Edinburgh, who have acted for a number of clients in ensuring the removal of negative internet comment and have obtained orders for the disclosure of the identity of anonymous bloggers and also non-harassment orders. They also have experience of dealing with host sites beyond the jurisdiction of the Scottish or UK courts and a network of international law contacts.***

Need to know

Informed consent is a core principle of medical and dental care but few patients want a lecture in statistics

MOST people know the story. In 1998, an article was published in *The Lancet* by Dr Andrew Wakefield and 12 other authors suggesting a link between the MMR vaccine, autism and bowel disease, based on a study of only 12 children. In a subsequent press conference Wakefield called for the suspension of the vaccine until further research could establish its safety.

The resulting scare led to a drop in MMR vaccination rates in the UK from 92 per cent to below 80 per cent and a consequent resurgence in measles that is still being felt today, with a recent outbreak bringing a ten-fold increase in the disease in England and Wales in the first four months of 2011.

Even now, despite the research being discredited and Wakefield himself struck off the GMC register, MMR inoculation rates still stand below 90 per cent. The case well illustrates how the notion of risk in medical procedures is not just a numbers game – it's as much about attitudes and perception.

Just how patients perceive risk is a crucial factor in the regulatory duty of healthcare professionals to engage in shared decision-making with patients and obtain informed consent. MDDUS case files contain numerous examples of doctors and dentists failing in this regard and facing civil court judgements and disciplinary action by the GMC and GDC.

One typical case dealt with a 71-year-old woman diagnosed with a L4/L5 disc protrusion compressing the L5 nerve root, causing her severe hip pain. The surgeon recommended surgical decompression and briefed the patient on the procedure but did not bother to discuss the slight risk of deep post-operative infection (spondylodiscitis/osteomyelitis).

The patient subsequently suffered a severe post-operative infection that took many painful months to clear with antibiotics. A claim of negligence based on the fact that the patient had not been informed of the infection risk was lodged and eventually settled by MDDUS on behalf of the surgeon.

Shared decision-making

Consent is a bedrock principle for healthcare professionals and both the GMC and GDC have separate guidance documents devoted to the topic. In *Consent: patients and doctors making decisions together*, the GMC states: "You must work in partnership with your patients. You should discuss with them their condition and treatment options in a way they can understand, and respect their right to make decisions about their care."

But this is sometimes easier said than done when you consider the wide range of patients that doctors interact with and their varying ability to understand sometimes complex medical procedures, not to mention the reluctance of some patients to even engage in the decision-making process. The GMC advises that doctors should "not make assumptions about what information a patient might want or need, the clinical or other factors a patient might consider significant and the patient's level of knowledge or understanding of what is proposed".

Baseline consent calls for healthcare professionals to provide patients details of any uncertainties over diagnosis and prognosis and options for treating the condition, including 'not to treat'. The purpose of any proposed investigation or treatment and what it will involve should be explained along with potential benefits, risks and burdens, and likelihood of success. In private care, dentists and doctors must also make clear to the patient the nature of the contract for care including all charges and the probable costs of further treatment.

One key passage in GMC guidance regarding informed patient consent states: "You must tell patients if an investigation or treatment might result in a serious adverse outcome, even if the likelihood is very small. You should also tell patients about less serious side-effects or complications if they occur frequently, and explain what the patient should do if they experience any of them."

Stick men and smiley faces

Communicating risk to patients can be problematic at the best of times. Just as the MMR vaccine example above demonstrates, decision-making among patients is not always "rational". Research has shown that people often use shortcuts to simplify decision-making and risk, such as categorising something as either "dangerous" or "safe." One commonly cited example comes from the mid-1990s when the press publicised results of a study reporting a 100 per cent increase in the risk of thromboembolism in women using a particular contraceptive. The actual risk was still slight but thousands of British women panicked and stopped taking the pill leading to an increase in unwanted pregnancies.

Most doctors and dentists understand risk according to basic concepts such as relative risk (RR) or absolute risk reduction (ARR) or number needed to treat or harm (NNT or NNH). But many patients will grow frustrated or simply 'turn off' if a discussion aimed at joint decision-making becomes a lecture in statistics. Nor can risk be treated in too simplistic a fashion. Descriptive terms such as 'common' or 'rare' assume a shared perspective when in fact patients may judge risk by a different order of magnitude. One study looking at the probabilities of harm and benefit from treatments found that the term "frequent" was interpreted on average as equivalent to around 70 per cent but with a wide range from 30 to 90 per cent.

Common wisdom is that people will usually best understand absolute risk expressed in percentages or natural frequencies, such as one in 200 patients suffer a particular post-operative complication. Such figures can be presented in comparison with everyday risks such as the chance of having a car crash while driving over a certain distance. Presenting absolute risk figures alone has been shown to lead to either an overweighting of low probabilities or an underweighting of high probabilities.

Some centres have found most success by communicating risk using visual representations, such as diagrams displaying 100 stick figures or other graphic elements designed to represent patients and possible outcomes. Such devices offer a handy short-hand of risk and can be utilised as part of a range or "shopping basket" of complementary data formats with enough flexibility to address the needs of a variety of patients. These might include other "decision aids" such as leaflets and booklets, websites, CDs and interactive computer programmes.

> "Terms such as 'common' and 'rare' assume a shared perspective when in fact patients may judge risk by a different order of magnitude"

Life is a risky business

A common feature of USA magazine advertisements for proprietary drugs is screeds of additional text listing in minute detail every possible contra-indication and attendant clinical risk. No doubt this keeps lawyers and regulators happy but it also serves to highlight another dilemma facing healthcare professionals seeking informed consent. No medical procedure is completely risk free so when is a particular risk likely or severe enough to merit being divulged to patients?

Law courts tend to support a 'test' based on what a "reasonable doctor" would divulge in similar circumstances but this still leaves a grey area when it comes to low risks with severe consequences as in the spinal surgery case example above. Robert Heywood, a lecturer in law at Sheffield Hallam University, commented in an article on risk disclosure: "It now seems the profession have 'got together' and taken it upon themselves to set professional standards of disclosure at around all risks within the 1-2 per cent region and above." This was the specific risk factor cited in the landmark medico-legal case of *Chester v Afshar*, which established that a doctor is liable if he fails to warn of a known risk of harm which then occurs. But the figure has never been formally suggested as benchmark for risk disclosure.

Clearly what the GMC considers a "serious adverse outcome, even if the likelihood is very small" or "less serious side effects or complications if they occur frequently" is subject to interpretation. It is probably best to air on the side of disclosure if in doubt and be willing to back-up any decisions made with comprehensive notes recorded in the consent process.

Ask colleagues if in doubt or seek advice from MDDUS – the decision to disclose a risk may be yours but there is no need to make it alone.

■ ***Article by Dr Gail Gilmartin, MDDUS medical adviser, and Jim Killgore, editor of*** **Summons**

At the root of the problem

What can be done to tackle the persistent problem of dental decay in children? Joanne Curran *investigates*

THE figures make for grim reading. Dental decay affects more than 40 per cent of UK children by the age of five and in some parts of the country 75 per cent of pre-school children have rotting teeth. The statistics have barely changed in 20 years and, to top it all, there is still no conclusive evidence for the most effective approach in managing decay.

The reasons why poor child dental health has persisted for two decades are many. One explanation may be that some parents struggle to find an NHS dentist to treat their children as more practitioners opt for private practice. In the last Dental Health Survey in 2003, a quarter of parents of 12 to 15-year-olds and a fifth of parents of five to eight year-olds claimed they had trouble finding a dentist for their child.

Professor Jimmy Steele, head of the school of dentistry at the University of Newcastle, told *Summons* that children's oral health has "improved enormously in the last few decades, but there is still room for improvement." He believes the reasons for poor oral health are "the same as they have always been: poor diet, a lack of awareness and perhaps an attitude that accepts that dental decay is a normal part of growing up."

Damaging factors

The rise in tooth decay has also been blamed on changing dietary trends, as fizzy drinks, fast food and bottled water (which lacks fluoride) become increasingly popular. And sometimes a parent or carer's own fear or mistrust of the dentist may prevent them seeking care for their child.

Janet Clarke, president of the British Dental Association, said some parents believe the health of their children's milk teeth is not important. In an article in the *Times*, she said: "A lot of people think that baby teeth don't matter but they are hugely mistaken. Children can have severe pain in milk teeth, which then have to be removed. Because baby teeth hold a space open for adult teeth to come through, if they have decaying or removed teeth, that space gets smaller and there isn't enough room. This can lead to growth problems later, and mean that they have to wear a brace."

Income level can also be a factor when seeking dental care for children. Figures published by the Audit Commission in February 2010 show that tooth decay is a greater problem in low income communities. Over 150,000 more children have decayed, missing and filled teeth in deprived areas compared with the rest of the country, a gap which has increased dramatically over the last ten years.

Lack of awareness is another factor. Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, said: "Dental disease is the most common preventable childhood disease and good education at an early age can have a significant impact. Parents are very much responsible for helping their children to develop a good oral health routine and ensure regular visits to the dentist."

Future hope

Despite the gloomy figures, there have been concerted efforts in recent months to tackle the problem.

This includes recommendations made by Professor Jimmy Steele in his 2010 review of NHS dentistry in England – some of which are now being implemented. In April 2011, it was announced that a pilot project of a new dental contract is being launched across 62 practices in England that will reward practitioners according to the quality of care they deliver for patients rather than the number of treatments carried out. It is Professor Steele's belief that NHS dentistry should be more about quality outcomes and disease prevention than simply measuring units of dental activity (UDAs).

"Dentists can only do so much; parents and schools both have a role, as does wider society"

He wants dentists to focus more on prevention than simply treating symptoms. Under his plans, dentists will be encouraged to identify patients at high risk of developing dental disease and spend more time giving them advice on brushing, flossing and diet. This will be combined with improved chairside IT systems that will help practitioners identify and manage high-risk patients.

Professor Steele said: "The existing system does need to change and we need to help dentists do what they want to do and look after the oral health of their patients. We are going in the right direction but there will be tough times ahead and we will need to keep our nerve to make the changes we need." But he added: "Dentists can only do so much; parents and schools both have a role, as does wider society."

There are also initiatives underway in Scotland to improve child dental health. Around 150 dentists in the Lothians have signed up to the Childsmile scheme aimed at helping under-fives. Under the scheme, children will have fluoride varnish applied to their teeth every six months and will be monitored during regular check-ups. Promoting the project, NHS Lothian's Robert Naysmith said: "Encouraging the parents of very young children to register them with a dentist will bridge the gap between birth and nursery."

Managing decay

Meanwhile, new research commissioned by the National Institute for Health Research Health Technology Assessment (NIHR HTA) programme hopes to finally uncover conclusive evidence of the best way to manage child tooth decay. The £2.87million FiCTION study will assess three different methods. The multi-centre trial is taking place in Cardiff, Dundee, Glasgow, Leeds, London, Newcastle and Sheffield and the methods being assessed are:

1: Using only preventive techniques recommended in national guidance (better toothbrushing, less sugar in the diet, application of high fluoride varnish and fissure sealants).

2: Conventional fillings with preventive techniques.

3: Biological treatment of the decay (sealing the decay into teeth with filling materials or under crowns, generally without the need to use injections or dental drills) with preventive techniques.

Dr Nicola Innes, of the University of Dundee Dental School and one of the lead researchers for the trial, said: "Conventional clinical opinion is that baby teeth showing decay should be filled, yet the majority of cavities in young children are left unrestored. There is, as yet, no conclusive evidence for the most effective approach to managing decay in baby teeth. With this trial we are looking to provide that evidence."

In the absence of such conclusive evidence, there are various pieces of clinical guidance available to dentists. One of the most recent is *Prevention and Management of Dental Caries in Children* published by the Scottish Dental Clinical Effectiveness Programme in April 2010.

Their list of priorities for dental teams includes:

- encouraging the parent/carer to take responsibility for their child's oral health
- focussing on prevention of caries in the permanent dentition before management of caries in the primary dentition
- if caries in the permanent dentition does occur, diagnosing it early, and managing it appropriately
- managing caries in the primary dentition using an appropriate technique that maximises the chance of the tooth exfoliating without causing pain or sepsis, while minimising the risk of treatment-induced anxiety
- identifying as early as possible those children where there is doubt about a parent/carer's ability to comply with dental health preventive advice, support or treatment uptake, and to contact and work collaboratively with other agencies, especially the child's named health visitor, school nurse or general medical practitioner.

The aim should be to work *with* families and offer support, as well as taking a rigorous approach to follow-up appointments.

For further information, read *British Society of Paediatric Dentistry: a policy document on dental neglect in children* at **www.bspd.co.uk**

■ ***Joanne Curran is associate editor of*** **Summons**

CASE studies

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

DENTAL CHARGES: PRIVATE OR NHS CARE

BACKGROUND: A 38-year-old woman – Mrs P – presents at a dental surgery with a broken upper incisor. The dentist agrees to treat her on a private basis as is standard with all non-registered patients to the practice attending on an emergency basis. He notes acute pulpitis in the tooth caused by gross caries. The patient agrees to root treatment and the dentist builds up the tooth with composite as an interim measure. He advises Mrs P that a crown will be necessary and also stresses the importance of improving her oral hygiene.

Mrs P says she is satisfied with the treatment and pays the charges without comment.

Two months later Mrs P returns to the surgery complaining of the loss of the composite material and demands a refund. The dentist explains again the temporary nature of the treatment provided and the need for a permanent crown. He refuses to refund the fee and Mrs P leaves the practice seemingly satisfied with the explanation.

A month later the practice receives a letter from Mrs P complaining of her treatment and also claiming that a large sign in the practice window advertises "NHS Dentistry". She claims to have requested her treatment on that basis and demands to be refunded all charges. She also complains that she was not provided a treatment plan.

The practice refuses to refund the costs and Mrs P writes to complain to the local primary care trust. When it is established that the treatment was provided on a private basis, the PCT complaints officer advises her to contact the GDC.

The dentist later receives a letter from the GDC stating that the matter will be considered by the Investigating Committee of the Council which will decide if the case should be referred to the Professional Conduct Committee. An explanation in writing from the dentist is required.

ANALYSIS/OUTCOME: MDDUS assists the dentist in drafting a response. The GDC is also provided with full patient notes and a copy of the practice policy on NHS treatment which was displayed in the waiting area of the dental surgery. It explains on what basis NHS care is provided to registered patients only. A note in the file confirms that when Mrs P enquired about further treatment under the NHS the dentist advised her that she would have to find another dentist to carry this out.

The GDC responds with a letter to confirm the dentist will not be called before an Investigating Committee but drawing his attention to guidance about the duty to explain clearly treatment and costs and also that the onus is on the dentist to make clear to the patient what contract they are to be treated under and that a treatment plan should be provided.

KEY POINTS

- GDC guidance states dentists must always "make clear to the patient the nature of the contract, and in particular whether the patient is being accepted for treatment under the NHS or privately".
- Make clear to patients the charge for an initial consultation and the probable cost of further treatment.
- Ensure that any signs and practice notices do not have the potential to mislead patients on costs.

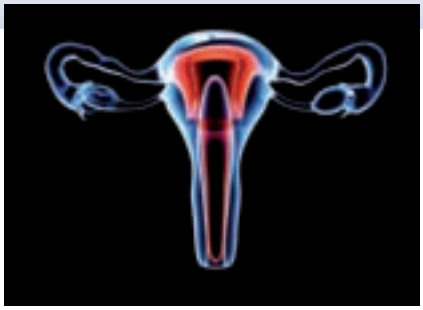
CONSENT:
RIGHT TO DECIDE

BACKGROUND: Mrs J has a long history of abdominal and pelvic pain and is referred by her GP to a private specialist. The 42-year-old is seen by a consultant gynaecologist, Mr S, who after numerous diagnostic tests discusses the possibility of performing a total hysterectomy. Mrs J agrees on the understanding that her ovaries – which she has been told appear healthy – will be conserved if possible.

While performing the hysterectomy, Mr S identifies signs of endometriosis and thickening of the fallopian tubes and decides to remove both ovaries. Subsequent tests reveal the ovaries and tubes are both normal and Mrs J continues to suffer pain. She also now requires HRT for early onset menopause and this leads to depression.

Mrs J lodges a complaint against Mr S alleging clinical negligence and a failure to obtain informed consent for the removal of her ovaries. It is alleged that Mr S should not have removed the ovaries without a more thorough assessment of their condition. It is also argued that Mrs J only consented to a hysterectomy on the basis that her ovaries would not be removed unless there was an urgent need to do so during surgery and this should have involved further discussion of the matter with her. A copy of the consent form signed by Mrs J cannot be located and only the medical note written before the operation is available for reference.

ANALYSIS/OUTCOME: MDDUS, acting on behalf of Mr S, commissions an expert report from a consultant gynaecologist. The report concludes that Mr S was not justified in removing the ovaries, particularly as the pre-operative medical note suggests Mrs J thought they would be conserved unless absolutely necessary. The member accepts that the case is indefensible and MDDUS negotiates a settlement with Mrs J.



KEY POINTS

- Always fully explain the risks and benefits for each treatment option, including potential lifestyle changes.
- Be clear about the circumstances under which you might decide to proceed to more radical treatment when carrying out surgical procedures, i.e. to save life or avoid significant deterioration such as in cases of uncontrollable bleeding or malignancy.
- Make a clear and comprehensive note of discussions you have had with the patient about consent before any procedure.

DIAGNOSIS AND TREATMENT:
FOLIC ACID ONLY

BACKGROUND: A 32-year-old woman attends her GP – Dr H – complaining of nausea and acid indigestion. Dr H had been aware that the woman had a history of urinary tract infections and anaemia for which she had been prescribed iron tablets. He was also aware that she had two previous negative pregnancy tests.

On this occasion Dr H diagnoses reflux oesophagitis for which he prescribes Pariet – a proton pump inhibitor that acts to decrease the production of stomach acid.

One week later the patient returns to the practice complaining of severe abdominal pains and passing vaginal blood and tissue. She suspects that she may be pregnant and having a miscarriage.

Dr H records in his notes: "?Early spontaneous abortion" and calculates that the patient is six weeks pregnant going by her dates. He tells her that at such a date the miscarriage is likely to be complete but should there be further severe pain or heavy bleeding to contact the surgery or go direct to A&E.

Two days later the patient is admitted to hospital with abdominal pain and PV bleeding and it is noted that she was nine weeks pregnant. An ultrasound scan confirms a complete miscarriage and the patient is discharged after the pain and bleeding have settled.

A year later Dr H receives a letter from solicitors acting for the patient claiming medical negligence. The patient alleges that Dr H had been aware of the fact that she might be pregnant and yet had still prescribed Pariet which is contraindicated in pregnancy.

ANALYSIS/OUTCOME: Dr H contacts MDDUS for assistance and strongly refutes the patient's claim that she discussed the possibility of being pregnant. No mention is made of this in the notes and Dr H states that had pregnancy been mentioned or suspected he would routinely prescribe no drugs other than iron or folic acid.

However, with pregnancy not explicitly ruled out in the notes, it becomes a case of his word against the patient's.

A solicitor acting for MDDUS examines the file and forms the opinion that the case against Dr H is weak – not just on the disputed timing of the reported pregnancy. The key issue is causation. Guidance on the prescription of Pariet does indicate that it is contraindicated in pregnancy and breast feeding but there appears to be no data linking it with an increased risk of spontaneous abortion. Proving a connection would be difficult on the balance of probabilities.

This view is communicated to the patient's solicitors and a few months later the case is dropped.

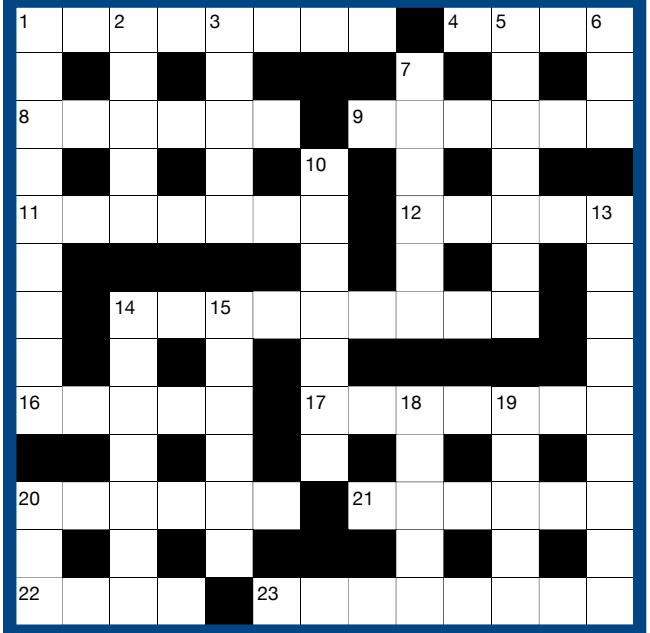
KEY POINTS

- Consider the possibility of pregnancy in any woman of child-bearing age to ensure there are no contraindications to prescribing particular drugs.
- Record asking the question.
- Evidence must support causation in medical claims.

Object obscura:
dental instrument set

THIS ornate 17th century dental chest is covered with bullion embroidery showing the arms of the Bacon Family of Redgrave, Suffolk. The dental instruments include four silver descalers used to remove plaque and other tooth deposits. The handles of the instruments and the tops of the bottles are decorated with boars or pigs, a pun on the family name.

Crossword



ACROSS
1. Loss of cognitive ability (8)
4. Kingsland is president of (abbr.) (4)
8. Nakedness (6)
9. Di-methyl homologue of benzene (6)
11. Permission (6)
12. Ant (archaic) (5)
14. GP commissioning groups (9)
16. Heroic tales (5)
17. Health secretary (7)
20. UK's largest domiciliary care provider (6)
21. Quantum of electromagnetic energy (6)
22. Celebrity (4)
23. Ancient Greek remedy (8)

DOWN
1. Brand of danazol (9)
2. Maker of instrument trays and containers (5)
3. Saltpetre (5)
5. Congenital absence of skin (7)
6. Swelling of macula (abbr.) (3)
7. Brand name ADHD drug (6)
10. Ambles (7)
13. Rapid breathing (US spelling) (9)
14. Exchange of genetic material between chromatids (7)
15. Intersection of frontal and two nasal bones (6)
18. Erwin _____, Nobel-winning biophysicist (5)
19. Corpora _____, temporary endocrine structures in mammals (5)
20. Britain's largest employer (abbr.) (3)

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

From the archives:
a tragic waste

IT'S a sad fact that doctors and dentists are well known for not seeking help in times of personal distress. Rates of suicide and depression among healthcare professionals are notoriously high when compared with the general population. But this is nothing new.

In July of 1928 *The Scotsman* newspaper reported the case of a young doctor in Essex. Dr Noel Maudsley was 27 and a popular physician in the Ilford district. He had been called as a witness at Stratford Police Court in the case of a woman who had been charged with obtaining money by deception from the Friendly Society. She claimed the money was to help care for her ill husband and it was alleged in the court that Dr Maudsley had given a certificate of unfitness without having examined the man.

Strong criticism of the doctor's behaviour was made by the Chairman of the Bench and the case was adjourned to enable the Society to communicate with the Medical Council. Later that day after the doctor returned home the maid reported hearing a groan from the front bedroom. There she found him stretched unconscious with a glass and bottle of prussic acid beside him on the bedside table. Another doctor was called but he arrived to find Dr Maudsley dead.

At the corner's inquest the doctor's widow said her husband had been much depressed during the past few weeks but had never spoken of suicide. The afternoon of the court case she rang the Chairman of the Bench and another magistrate to ask them to come and reason with her husband and tell him there was nothing to worry about. Neither were available at the time.

The coroner later returned a verdict of "suicide whilst of unsound mind".

Vignette: ECG pioneer, Sir Thomas Lewis (1881-1945)

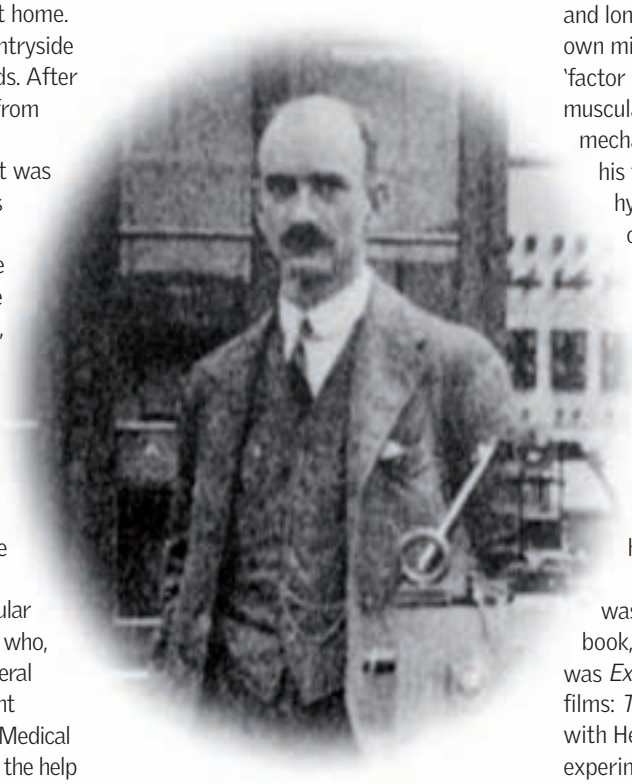
DUTCH doctor and physiologist Willem Einthoven may be well known for inventing the first practical electrocardiogram but it was a British cardiologist who pioneered its use in the clinical setting.

Thomas Lewis spent his early years in Wales where his father was a mining engineer. Except for one year at Clifton College, Bristol, he was educated at home. He had freedom to explore the countryside and became a keen observer of birds. After a first degree (BSc with Honours) from University College, Wales, he was attracted to medicine (he claimed it was because of the skills of two doctors who were magicians) and chose University College, London. Soon he had published his first paper on the haemolymphatic glands and spleen, a part of a DSc (Wales 1905). He was invited to work in Professor E H Starling's laboratory at University College. Posts at the City of London Hospital and the Seaman's Hospital gave him some income, supplemented by a practice in Wimpole Street.

He was encouraged to study irregular heart action by Dr James Mackenzie who, after years observing patients in general practice, was doing research at Mount Vernon (a hospital purchased by the Medical Research Council). Lewis also sought the help of the pioneer of electrocardiography William Einthoven in Leyden. The electrical wave forms were carefully analysed and correlated with heart actions. Lewis was one of the first to characterise the appearance of human atrial fibrillation and most other cardiac disrhythmias. Years later, when Einthoven was awarded a Nobel prize he acknowledged the contribution Lewis had made.

In 1910 Lewis was made lecturer in cardiac pathology at University College Hospital, a new red brick building opposite University College. He visited America and physicians from there spent time in his laboratory. Lewis set high standards of diligence from his students and was a fierce editor. He was somewhat taciturn, blue eyed with an intense gaze, a moustache and a receding hairline.

Apart from long hours in the laboratory and teaching Lewis spent time writing. He founded and edited the journal *Heart* and over the rest of his life wrote books, too many to list here, which illustrate how his interests changed. In each field he made important contributions to medicine. His first book, in 1909, was *Mechanism and registration of the heart beat.* His *Diseases of the heart* (1933) was very popular. *The soldier's heart and the effort syndrome* (1918) described the effects of stress on soldiers.



PHOTOGRAPH: SCIENCE PHOTO LIBRARY

Post war he was appointed Physician in Charge of the Cardiology Department funded by the MRC. He found laboratory research was too limited and in a letter to the *Morning Post* he wrote about the lack of access to observe patients in hospital. His interests and thoughts turned to the reaction of skin to injury. He described the triple response of red line, flare and weal and hypothesised that a substance was released in the skin. Following discussion with Henry Dale, the pharmacologist, he thought a compound similar to histamine was likely and named it substance H.

From 1922 he sought to understand the mechanism of muscle pain and nerve paralysis during ischaemia. His co-worker George Pickering described how he tackled the problem – "using no apparatus more complicated than a blood pressure cuff and a tuning fork...This was Lewis at his best, the Lewis who gave up cardiology because he grew tired of answering the kind of questions the instruments could answer and longed for adventures suggested by his own mind." He postulated a metabolite 'factor P' was the trigger for pain and muscular ischaemia and identified the mechanism of Raynaud's disease. Not all his theories were believed. In 1937 his hypothesis that a 'nocifensor system' of nerves in the skin was the cause of hyperalgesia was only validated a half century later when he was no longer alive.

Another war loomed and Lewis gave aid to German Jewish scientists who had emigrated. When war came UCL evacuated the medical school to Wales and put Lewis in charge with the help of his devoted assistant, John Honour. During the second world war Pain was published in the USA. His last book, published in the year of his death, was *Exercises in Physiology*. He also made films: *The signs of venous congestion* and with Henry Dale, a vivid recreation of the experiments of William Harvey.

Aged only 45 he had suffered a first heart attack but was reluctant to believe the diagnosis; a third myocardial infarction in 1945 was fatal. He received many honours including the University of London Gold Medal, CBE, Knight Bachelor for his work in WW1, the Copley Medal of the Royal Society. Prestigious lectures included the Harveian Oration on Clinical Science in 1933. He married in 1916 and had three children. He had helped to revolutionise cardiology and increase medical understanding. Diagnoses like 'rebellious palpitations' had vanished.

Source: Thomas Lewis: Pioneer Cardiologist and Clinical Scientist *by A Hollman, Springer 1997*

■ ***Julia Merrick is a freelance writer and editor in Edinburgh***

EARLY BIRD OFFER

MDDUS Practice Managers' Conference

Fairmont, St Andrews 1 – 2 March 2012

The SIXTH MDDUS Practice Managers' Conference is once again returning to the recently refurbished Fairmont, St Andrews (formerly known as St Andrews Bay Golf Resort & Spa) on 1 – 2 March 2012.

The full programme is currently being finalised but as delegate places are limited you can book **now** to secure your attendance and benefit from our recession busting rates.

Book before 30th September to take advantage of the early bird offer.

Conference fees (all prices include VAT)

Residential single room	**Early bird – DPS**	**£249**
	Early bird – non DPS	**£279**
	Standard fee – DPS	£279
	Standard fee – non DPS	£299
Residential double room	**Early bird – DPS**	**£219**
	Early bird – non DPS	**£239**
	Standard fee – DPS	£239
	Standard fee – non DPS	£259
Residential triple room	**Early bird – DPS**	**£209**
	Early bird – non DPS	**£229**
	Standard fee – DPS	£229
	Standard fee – non DPS	£239
Day delegate	**Early bird – DPS**	**£119**
	Early bird – non DPS	**£139**
	Standard fee – DPS	£139
	Standard fee – non DPS	£149

To receive your early bird application form, email kwalsh@mddus.com or call Karen Walsh on 0845 270 2034