Winter 2011

SUMMONS

MDDUS JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND

• Hamish Meldrum • Wrong-site surgery • The Victorian Shipman •

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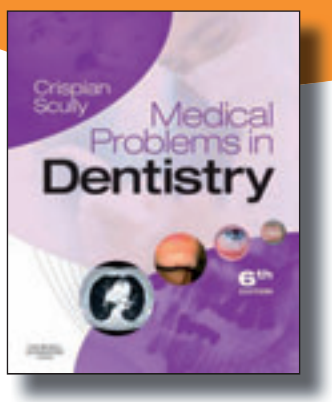

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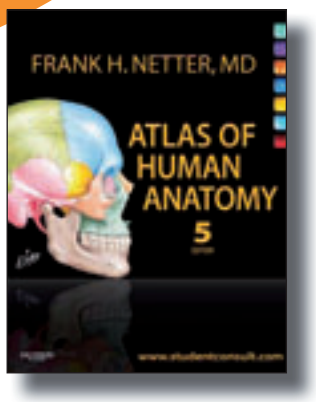

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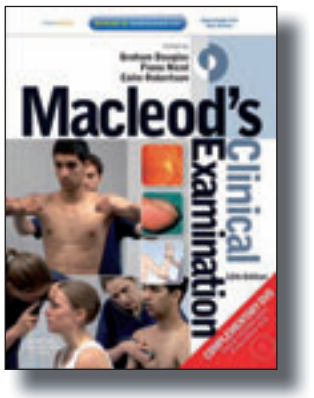

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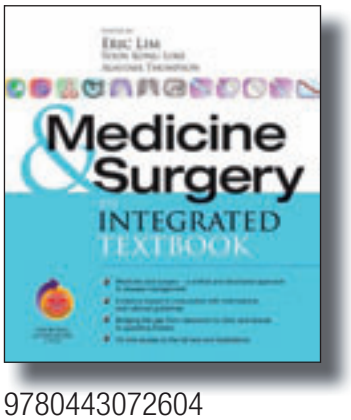

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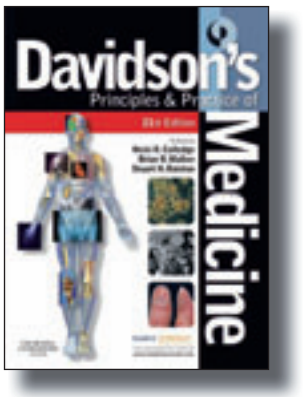

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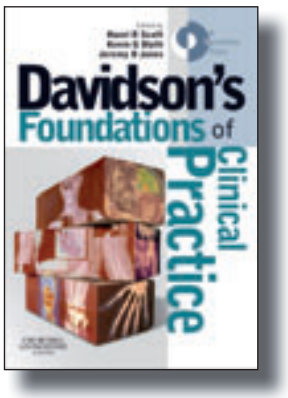

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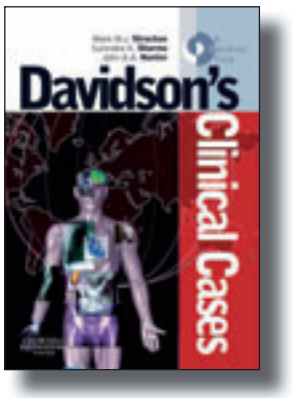

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IN THIS ISSUE

HIS job has been called the "most unenviable" in medical politics and given the upheavals facing the NHS in England and the budget uncertainties confronting the other devolved health services – the description seems apt. Dr Hamish Meldrum has held the position of BMA council chair for three years now which is itself no mean feat – a task Professor Steve Field has likened to "herding cats" given the diverse interests of BMA members.

On page 10 we feature a Q&A with Dr Meldrum in which he offers his views on the coalition white paper, the abolition of practice boundaries, NHS budget cuts and the value of competition in a national health service – as well as the personal challenge of holding a key job in London at the same time keeping his hand in as a GP in Yorkshire.

"Surgeon removes wrong kidney" – headlines like this sell plenty of newspapers with much righteous incredulity but close scrutiny often shows that such errors can be all too easily understandable. So much so that the WHO undertook a global initiative to ensure these incidents become so-called "never events". On page 16 MDDUS medical adviser Mr Riaz Mohammed looks at the common-sense approach inherent in the new Surgical Safety Checklist.

On page 14 Dr James Finlayson examines a Victorian murder with parallels to the Shipman case. In 1864 a lone medical practitioner Dr Edward Pritchard poisoned both his wife and mother-in-law and nearly escaped justice using his position to cover his tracks.

Also in this issue Dr Carole Boyle offers advice on treating dental patients with special needs (page 18) and we celebrate 50 years of the BMDST providing grants for student electives abroad (page 12).

Jim Killgore, editor


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Cover image: Huskies Private Pattern by Sarah Ogilvie, medium: screen print. This picture has been loaned to Art in Healthcare by the Royal Bank of Scotland Group. The charity has a partnership with the Royal Bank of Scotland Group, through which works from the bank's art collection are now displayed in hospitals and health centres across the country.

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.

Editor:
Jim Killgore
Associate editor:
Joanne Curran

Editorial departments:
MEDICAL Dr Gail Gilmartin
DENTAL Mr Aubrey Craig
LEGAL Simon Dinnick
RISK Peter Johnson

Please address correspondence to:

Summons Editor
MDDUS
Mackintosh House
120 Blythswood Street
Glasgow G2 4EA

jkillgore@mddus.com

Design and production:
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0131 556 2220
www.cmyk-design.co.uk

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Email: General: info@mddus.com • Membership services: membership@mddus.com • Marketing: marketing@mddus.com • Website: www.mddus.com
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Black joins MDDUS board

SENIOR executive Jim Black has joined the MDDUS board as a non-executive director.

Jim was Managing Director of Commercial and Investment Proposition at Standard Life, where he worked for 24 years. He initially trained as an actuary and qualified in 1991. Since that time, Jim undertook a number of marketing and finance roles for the company, most recently as actuarial director in the finance function during the period of de-mutualisation. He also developed the firm's marketing function to be more customer-focused and served as chief executive of Standard Life Healthcare until its sale in August.

Jim, who has significant experience in business development, said: "I am delighted to be involved with MDDUS as a non-executive director during this exciting time. I believe that my experience will provide additional support for the union in achieving its objectives."

Jim joins risk management expert Alan Fleming, MDDUS CEO Gordon Dickson and MDDUS finance director Colin Slevin as non-member, non-executive directors.

Common sense approach to winter home visits

Doctors must make every reasonable effort to make home visits to ill patients during adverse weather conditions. But MDDUS is reminding GPs to use their common sense to avoid creating further problems by becoming snowbound or having an accident while travelling.

A number of GPs have been calling MDDUS for advice about their obligations to visit patients as they face heavy snow falls, and persistent difficulties in driving due to the extreme conditions. Dr Jim Rodger, head of professional services at MDDUS, says: "It is essentially the application of common sense rather than any legal or service requirements.

"Patients who request house calls should be asked what the conditions of the roads are like in their immediate area. Main roads are being cleared but side roads, where people live, are not.

"It would be wrong for doctors or nurses to set off in adverse conditions then become stuck in snow or have an accident, and thereby render themselves 'out of action'. It is much more sensible to remain in the surgery and encourage patients to attend the surgery.

"We have had reports from GPs in badly affected parts of the country who have heroically trudged through the snow for an hour in order to see patients."

MDDUS stresses however that there will always be emergencies. Rodger adds: "It is vital for doctors to ensure they gather as much information as possible about the patient's previous medical condition and their present difficulties to allow them to decide what is in the patient's best interests.

"It may well be that ordering an ambulance, either 'blue light' or otherwise, might be the best and quickest option depending on the patient's symptoms - assuming an ambulance can get through."

As severe weather looks set to be a problem throughout the winter, Rodger concludes: "Each practice will have to make plans as to what to do in these circumstances. It may be that one or more of the doctors has a 4x4 vehicle and can actually attend non-emergency but urgent house calls.

"The general advice is to gather as much information as possible, decide on urgency, act in the patient's best interests and apply common sense."

MDDUS sponsors BMJ Group Awards

MDDUS is proud to announce its headline sponsorship of the BMJ Group Awards for a second year.

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

IN BRIEF

- **REVISED SUB RATES FOR HAND AND UPPER LIMB SURGEONS** MDDUS has undertaken a review of the risks associated with doctors specialising in hand and upper limb surgery. As a result of this review, members working within this specialty may benefit from a lower subscription band in 2011. Please contact the Membership Services Department on 0845 270 2038 for more information.
- **FY2 CAN RENEW NOW FOR ONLY £15** MDDUS have given up on the gimmicks and slashed the price of renewal for doctors moving into their Foundation Year 2 training to just £15. That's less than half the cost of last year's rate of £35. For more information on how to take advantage of this great offer, call MDDUS on 0845 270 2038 or email membership@mddus.com
- **NEW MDDUS HOT TOPICS FOR THE NEW YEAR** Sign up for new hot topic sessions in January and February aimed at doctors, dentists, practice managers, practice nurses and also administration staff. Glasgow sessions: 'Medical Record

SCOTTISH GP OF THE YEAR

Dr Monica Canning of the Hunter Health Centre in East Kilbride collects the 2010 RCGP Scotland 'GP of the Year' award from former RCGP Scotland chair Dr Ken Lawton at a Gala Awards Evening held at The Hub in Edinburgh on 12 November. The MDDUS-sponsored event celebrated the best of general practice with a number of awards, including the Caring about Carers Award and the Practice Team of the Year, and was attended by Scotland's leading health professionals including Cabinet Secretary Nicola Sturgeon.

Last year there were 780 entries and that number is set to increase. The Awards mix prizes for UK-based doctors and teams with those that are open to international nomination: six are UK-only and seven international, including the top prize, the BMJ Group Award for Lifetime Achievement.

This year there are three new awards – Medical Team in a Crisis Zone, Innovation in Health Care and Sustainable Health Care.

All awards are open to nominations from individuals/organisations or a third party. You can enter online at **www.groupawards.bmj.com** and entry is free. The deadline for entries is 24 January and a shortlist will be announced for each of the 13 award categories.

The award ceremony will be held on 18 May, 2011 at the Hilton, Park Lane, London. Early bird tickets at a substantial discount can be booked before 24 January at the BMJ Group Awards website.

The awards are already making an impact on health care. Last year MDDUS sponsored the Secondary Care Team of the Year Award which was won by Dr Stephen Hearns, Consultant in Emergency and Retrieval Medicine in Glasgow. Dr Hearns said: "The Emergency Medical Retrieval Service was subject to a decision regarding long-term funding at the time of the BMJ Group Awards. I have no doubt that winning The Secondary Care Team of the Year had a positive effect on the decision-making process in making our life-saving service permanent".

MDDUS endures the big freeze

In early December central Scotland endured record snowfall and low temperatures but we are pleased to report there was little or no effect on our quality service to members – with our membership teams and medical and dental advisers in both Glasgow and London providing members the usual prompt telephone assistance and advice.

MDDUS CEO Professor Gordon Dickson said: "Many of our staff managed to negotiate the tricky conditions and make it into the office – and others who didn't were able to work remotely thanks to the investment we have made in recent years in our computer systems. The conditions provided a good test of MDDUS ability to maintain high service levels through some exceptionally difficult circumstances. But this won't stop us hoping for an early Spring."

Keep us in the loop

MDDUS was recently contacted by the National Clinical Assessment Service (NCAS) in regard to several cases in which practitioners have failed to upgrade their indemnity subscriptions in line with changes in their practice, particularly when changing from registrar to full GP status or when increasing the number of sessions they provide. NCAS was concerned that although employers check for membership of a defence organisation they do not routinely check that the level of cover provided is commensurate to specific roles. Disputes over indemnity can be a complicating factor in cases involving concerns over medical performance.

For this reason we would like to highlight the importance of ensuring that the information held by MDDUS about a member is correct and that if circumstances change, members are obliged to inform us. Failure to do so may affect or cancel access to all benefits of membership, including indemnity.

Members are required to ensure that they are in the correct membership category and paying the appropriate subscription associated with the clinical work they undertake. You must also advise the MDDUS of any change of address or if you are unable to work for an extended period of time.

You can update MDDUS by contacting the Membership Services Department on 0845 270 2038.

Management', 'Managing and Understanding Results' and 'Influential Communication'. London session: 'Tackling Employee Issues within the Law'. For more information and dates or to book a session go to the Training and consultancy pages on our website or email afitzpatrick@mddus.com

- **DENTISTS TRAINED TO SPOT DOMESTIC ABUSE** Dentists are being shown how to spot the signs of domestic abuse as part of a new pilot scheme. The initiative has been launched in Ayrshire in the west of Scotland in a joint partnership between Strathclyde Police's Violence Reduction Unit (VRU) and the charity Medics Against Violence (MAV). If successful, the programme will be rolled out nationwide and may even be included in undergraduate training at Scottish dental schools. To find out more about the project visit tinyurl.com/29cvdqe

MEDICS AGAINST VIOLENCE

Government scraps independent health adjudicator

THE GOVERNMENT has announced that the independent Office of the Health Professions Adjudicator (OHPA) is to be abolished and the GMC is to retain overall responsibility for adjudication in cases involving doctors.

The move follows a public consultation on the future of the OHPA, which was established following recommendations made by the Shipman Inquiry.

Niall Dickson, the Chief Executive of the GMC, said: "We welcome the Government's decision. We are committed to taking forward a programme of major reform to create an efficient and modern adjudication function which operates independently from our other work.

"We plan to separate entirely our investigation activity and the presentation of cases from adjudication by creating a new tribunal service. This will have its own Chair, appointed through an independent process, who will report directly to Parliament on an annual basis."

He went on to say that the new approach will save doctors and taxpayers millions of pounds but will also deliver tangible benefits, to assure both doctors and the public that the system is fair and proportionate as well as providing good value for money.

More adults retaining natural dentition

A MAJOR dental survey has shown continuing improvements in adults' oral health but with implications for future care.

The *2009 Adult Dental Health Survey* found that people are increasingly retaining at least some of their natural teeth later into life, with 86 per cent of adults having 21 or more natural teeth compared to only 74 per cent in 1978.

Researchers interviewed around 6,500 adults across England, Wales and Northern Ireland who had their teeth examined as part of the survey and were asked about their attitudes to dental hygiene and treatment. The report is published every 10 years by the NHS Information Centre.

The findings have been welcomed by the BDA. Their scientific adviser Professor Damien Walmsley said: "This survey confirms that the condition of people's teeth overall has got much better since this survey was first carried out. Fluoride toothpaste, greater awareness of the importance of a healthy diet and regular visits to the dentist have all undoubtedly contributed to the better dental health we see in adults today.

"While the growing number of patients retaining more of their teeth into later life is, of course, excellent news, this improvement brings its own challenges. The way that teeth are cared for will need to evolve to ensure that these challenges

are met."

The survey also confirms a strong link between low socio-economic status and poorer oral health and it highlights that a greater percentage of adults in Wales have dental problems compared to England and Northern Ireland.

Read the full survey report at **www.ic.nhs.uk/pubs/dentalsurvey09**

EU regulators work to improve patient safety

AN agreement on ways to tighten rules on the movement of doctors in Europe has been signed by 25 EU medical regulators.

A number of proposals have been drawn up for the European Commission to consider regarding the directive that ensures mutual recognition of medical qualifications among European countries. The EC will be reviewing the directive in 2012.

Proposals include allowing regulators to assess migrant doctors' language and clinical skills. There have also been calls to improve information sharing about doctors by making it mandatory for medical regulators to respond to all queries from fellow EU countries. It's also recommended that an alert system is set up to quickly inform member countries about regulatory action taken against doctors.

The move follows concerns that regulators have not always shared information with other countries about problem doctors. Only voluntary agreements currently exist between regulators to share information about doctors on their registers.

Niall Dickson, the chief executive of the GMC, said: "This joint submission is a significant step forward. It shows that regulators throughout Europe share the goal of securing improved patient safety and are committed to helping refine the current rules so that free movement of doctors can go hand in hand with proportionate, effective and targeted regulation."

IN BRIEF

- **REVALIDATION SET FOR 2012** The GMC and the devolved UK health departments have issued a joint statement saying that revalidation will get underway for doctors by the summer of 2012. The statement follows publication of the GMC's response to its consultation, *Revalidation: The Way Ahead*, in which there was broad support but also concerns that the proposed programme should be simpler – a view the GMC said it shared.
- **GDC DEADLINE FOR CPD DECLARATIONS** Dentists are being reminded to submit their annual or end of cycle CPD declarations by 28 January. For 2005 registrants, the five-year cycle will end on 31 December 2010 and the GDC will be asking them to complete an end of cycle declaration form or by checking and amending the hours on their eGDC account. Other registrants must submit an annual statement of CPD hours. Declarations can be made by post or via the eGDC website **www.eGDC-uk.org.**

VIEWPOINT

Wood for the trees

By Dr James Douglas, GP at Tweeddale Medical Practice, Fort William

OVER the last few months The General Medical Council has been sponsoring an innovative project that explores the attitudinal relationship between doctors and their patients with learning disabilities. It is in the form of a play entitled *Wood for the trees* by Susie McDonald and I recently attended the touring production in Glasgow as a GP with an interest in medical education.

The format is a drama followed by active participation of an audience of doctors, carers and people with learning disability. The central character is named Marie and is played by an actress with Down's Syndrome. Marie normally has a happy and fulfilled life, living independently with support. She has a job in a local garden centre and is in a relationship. But her mother died last year leaving her with unhappy memories about doctors and she has recently become unwell with vomiting and headache.

The play takes the audience through her consultation with doctors in the company of her carer. The classical medical characters are all played out in turn: young Dr Busy in A&E with other lives to save, Dr Nice who misses the main diagnosis in general practice and Dr Patronising, the consultant unable to communicate effectively with his patient. The diagnosis remains unresolved as Marie won't let the doctors examine her, given the recent experience with her mother.

The production reinforced a personal professional belief I hold that there is a direct relationship between continuity of care and patient safety and well-being. But continuity is one thing the modern NHS now finds difficult to deliver. In general practice, continuity is now too valuable to squander on everyone and we have to prescribe and organise it into our structures for a limited number of patients but clearly these should include adults with learning disabilities.

Capacity was also discussed in the production, as was documenting this in care plans and sharing the information – an important NHS, legal and ethical procedure. However, one of my personal learning points from Marie was that capacity can easily become overwhelmed by pain and symptoms despite the care plan. Our clinical judgments as doctors can become so defensive around capacity that we can miss things and wrongly return responsibility back to patients.

Several unresolved questions deliberately hung in the air. Just how would we touch and examine the frightened and vulnerable patient who may have a life-threatening illness? The facilitator asked if doctors were afraid of people with learning disability. I personally enjoy my consultations with learning disabled people. They are usually good fun and a relief from many other consultations. However, the communication is complex with all the various agendas to satisfy in 10 minutes. My empathy comes easily when I consider the patient's unlucky cut of the genetic cards or difficult journey in the world. They always seem to appreciate what little I can actually do to improve their lot in life.

However, I can imagine junior doctors being afraid of patients with learning difficulties in a similar manner to being afraid of babies in A&E. Education will help but the old adage that you will never understand babies in general practice until you have had one of your own probably holds true. Until you have provided long-term care for a few people with learning disability as a doctor they will probably always be a bit scary.

The learning disability community is very keen to get involved with undergraduate and postgraduate training and this play is an excellent example of what a positive experience sharing understanding between patients and doctors can be. My only regret is that in an audience of 50 people there were only four doctors. I had only heard of the play by accident and when I raised this with the GMC staff they commented that they had difficulty communicating directly with doctors because of IT governance! What a modern paradox to end with.

GDC launches major guidance review

THE GDC is reviewing its core guidance for dental professionals.

The council has said it intends to "go back to square one" in its review of *Standards for dental professionals*, which was last updated in 2005. The council also plans to review its guidance *Scope of Practice – who can do what in the dental team.*

Both reviews will take place throughout 2011 and the GDC is inviting comments and suggestions on how the original guidance can be improved. Consultations, focus groups and a working group are all planned for next year and GDC staff will be attending events across the UK to hear directly from interested groups.

Dental technician David Smith, chair of the Standards Committee, said: "The reviews of both of these documents could result in a radical redesign of the GDC's guidance for registrants and it's therefore extremely important that we hear from everyone who'll be affected and make the right changes."

Go to the GDC website **(www.gdc-uk.org)** for more information on the consultations and how to submit your comments.

• PATIENT SAFETY FEARS IN JUNIOR DOCTOR TRAINING A critical report has found that patients are being put at "unnecessary risk" because trainee doctors are working beyond their capabilities. The review into the effectiveness of the two-year Foundation Programme raised a number of concerns around design, content, safety and quality of junior doctors' training. It warned: "We are extremely concerned that some foundation trainees are expected to practise outside their level of competence and without appropriate supervision."

• DATABASE TO REDUCE INAPPROPRIATE REFERRALS NICE has launched a recommendations database covering referral advice for a range of conditions from suspected cancer to psoriasis. The initiative is aimed at reducing costs in inappropriate referrals to NHS secondary care, as well as helping eliminate 'postcode' lotteries in local and regional care. Access the database at http://tinyurl.com/2bso72y

HARASSMENT BY PATIENTS

Ian Watson

THE IDEA that practices can be legally liable for the delinquent discriminatory acts of their staff is a difficult one to grasp. The thought that medical and dental practices could be liable for acts of harassment by their patients and visitors is an even more scary prospect. But that is a consequence of the 2010 Equality Act, which came into effect on 1 October this year.

So-called 'third party' harassment originally arose in legal cases heard over the last few years where staff, subjected to unwelcome attention or discriminatory comments from performers (including Bernard Manning) at events where they were working, pursued claims against their employers for failing to protect them from these harassers. These cases produced a variety of different outcomes for the employers concerned – so the Government decided to clarify employers' liability in these situations in the Equality Act. The Act now makes it clear that employers will be liable for acts of harassment by third parties when the unwelcome treatment of their staff is related to gender, race, disability, sexual orientation, religion or belief, age or gender reassignment.

Once an employee reports two instances of such harassment (either by the same or two different harassers), the practice will be liable for a third incident if they have failed to take reasonable steps to prevent acts of harassment against the staff member taking place.

In order to use this 'reasonable steps' defence, the practice will need to demonstrate, for example, that it has a written policy on dignity at work which includes reference to harassment by third parties and which makes it clear to staff that they need not put up with such behaviour from patients, contractors and visitors. It may be appropriate to tell staff that they will not be disciplined for refusing to deal with an abusive patient and encourage them to report any incidents which give them cause for concern to the practice manager or a partner.

However, it is not sufficient for an employer just to have a policy on these matters. The policy must be communicated to staff and, arguably, in some way to patients and other visitors – for example, through notices explaining that any harassment of staff will be taken very seriously. Staff should be given training about how to deal with incidents of harassment and discrimination by third parties and how the reporting and complaints procedure operates in the practice.

Ideally, the partnership should have a policy for how delinquent patients should be dealt with, how any warning system should operate and what to do about unrepentant and persistent offenders. Once such a policy is agreed upon it should be operated consistently and promptly by the practice.

It is, of course, possible that individual staff members will not complain formally (or at all) to practice managers or partners. Nevertheless, it will be both good practice and sensible, from a prevention point of view, for managers to be vigilant in looking out for incidents of inappropriate behaviour and to step in to protect staff and make it clear to harassers that their behaviour is unacceptable. Some staff may be particularly vulnerable to acts of sexist, racist, homophobic or religious harassment and it will make sense for managers to look out for signs of embarrassment or stress in these staff and to encourage these employees to talk to their manager if they are uncomfortable about patients' behaviour.

The stakes are high for practices here because, apart from unwelcome publicity arising from complaints to an employment tribunal, there is no financial cap on compensation that might be awarded in the event of the practice being unable to extract itself from vicarious liability for third party harassment and being found guilty of discrimination.

So if the customer was ever 'right', they cannot now be regarded as such if their behaviour puts them outside the law. Taking prompt steps now to produce appropriate up-to-date policies and putting in place processes to train staff in these matters and to encourage them to report incidents formally will pay dividends for medical and dental practices in the event that they are ever threatened with legal action by staff.

Practices can get guidance from the MDDUS HR Advice service on these new liabilities and how to deal with them.

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

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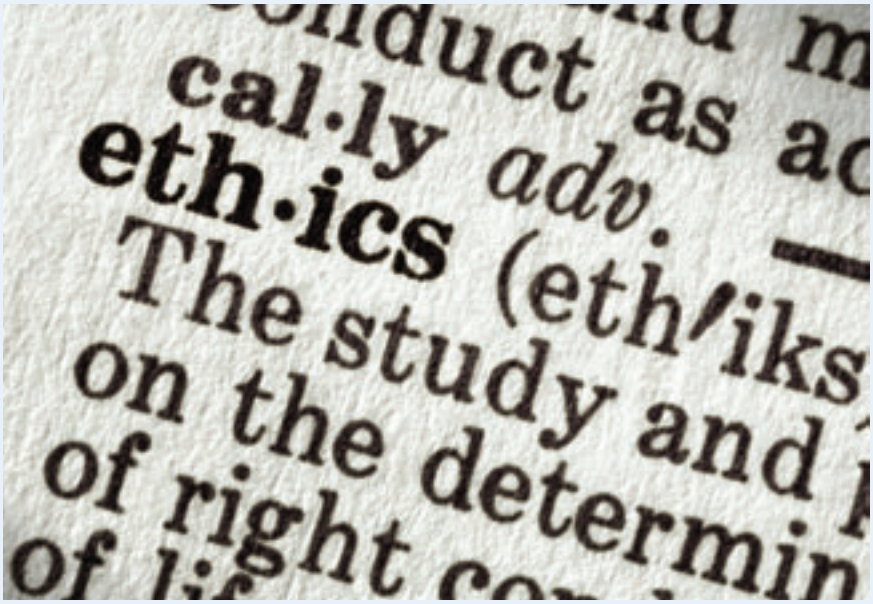


EXPERTISE AND EXPERIENCE

Deborah Bowman

THE NOTION of what constitutes 'expertise' in ethics is fascinating. It is a relatively young discipline and those working in the field are drawn from a wide range of backgrounds. People with training in medicine, law, philosophy, social sciences, medical humanities and theology rub along, for the most part, happily together under the broad umbrella of 'ethics'. The subject's disregard for disciplinary boundaries is one of the features that first attracted me to the world of ethics and I continue to learn much from those whose backgrounds differ from mine.

I am often asked by students and clinicians what they should do to pursue their interest or develop a career in ethics. For those who are dipping a tentative toe in the ethical waters, I often suggest some time observing or, if a vacancy exists, participating in a local clinical ethics committee. For those who are more certain of their interest in ethics, there are myriad educational opportunities ranging from short courses to masters and doctoral programmes. Although curricula differ, a good course will provide a space in which to reflect on values, discuss the moral dimensions of medicine and engage with the theoretical literature that underpins contemporary medical ethics. Yet, in common with medicine, the practice of ethics is a lifelong endeavour that becomes meaningful when it moves beyond the pages of a text or the debates of a lecture theatre.

The relevance of expertise and experience was illustrated for me recently. I have long-provided clinical ethics support for several NHS Trusts and last month agreed to work with another hospital, partly as a member of the Clinical Ethics Committee and partly in the clinical setting with teams. The Committee encourages its members to complete the UK Clinical Ethics Network Competency Log which is a self-assessment tool to evaluate personal competence against a series of descriptors that were agreed via a national consultation process.

It was an interesting exercise. I feel, as I should given my role, confident about my familiarity with ethical principles, core concepts and a wide range of analytic frameworks and tools. I felt similarly comfortable about the skills I use when applying my knowledge but realised that those were not skills I had learned as part of my training in medicine, ethics or law. The skills I use most often in supporting clinical ethics are derived from what I have learned to become an educator, an accredited mediator and counsellor. The ability to respond to emotion, contain conflict, reconcile multiple perspectives, listen carefully, facilitate participation, foster trust and maintain neutrality in the face of competing agendas and hierarchies is as much part of ethics expertise for me as my formal qualifications.

When I reached the part on the questionnaire that asked about my confidence in understanding and responding to the local needs, culture and preferences of the hospital with whom I will be working, I ticked 'novice'. I realised that no amount of knowledge or skills, be they derived from studying philosophy, law and medicine or practice-based training such as mediation, teaching and counselling, was sufficient to consider myself anything other than a beginner in my new environment. To be effective, I need to understand the priorities, preferences and predilections of my clinical colleagues. All hospitals and clinical teams work, superficially, in similar ways yet each has its own identity, delights and quirks.

Ethics is an inherently human business and that is rarely captured in lecture theatres, textbooks, academic papers or seminar rooms. Theoretical frameworks and analytical tools are useless without the ability to understand and engage with the people who deliver and experience healthcare. Irrespective of one's brilliance, or otherwise, at recognising and explaining a moral problem, it is the professional hierarchies, personal alliances, tribal loyalties and professional rivalries that bring the ethical dilemma to life. Like the old woman in Bernstein's Operetta *Candide*, an ethicist must be "easily assimilated". Each time I meet a new team or am invited to work in a different organisation, I return to novice status and begin the process of meeting, observing, listening and enquiring. Personable inquisitiveness is the order of the day. There is no substitute for taking the time to learn about the context in which ethics is to be practised, nor is it something that can be replicated in a formal educational setting or a postgraduate degree.

Even if one acquires the heady heights of 'expert' in the field of ethics, the knowledge, skills and experience that underpin such expertise are necessary but not sufficient. To practise ethics requires practice and cannot be done alone. Without the support and trust of colleagues and patients, expertise counts for little. Ethics is embodied, literally, by those who claim expertise and we must all prove our worth to those we serve.

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

PHOTOGRAPH: BMA

BMA Council Chairman Dr Hamish Meldrum *talks to* Summons *of the political upheavals facing both doctors and the NHS today*

Giving doctors a voice

DR Hamish Meldrum was elected chairman of the BMA council in 2007 but has long been active in medical politics. He first joined the General Practitioners Committee (GPC) in 1991 and was part of the team that negotiated the current GMS contract, serving as GPC chairman from 2004 to 2007.

In November he was ranked third in the *Health Service Journal* 100 most influential people in health, moving up from 32 on the 2009 list with the BMA now having a crucial voice in debate over proposed NHS reform in England. Professor Steve Field, former chair of the RCGP, writes in the *HSJ100:*

"The fact Hamish has held the position of council chair for three years is no small feat and says much for his abilities. I have seen him in action, he is incredibly skilled and the BMA is stronger because of him."

Dr Meldrum graduated from Edinburgh in 1972 and in 1978 became a GP in Bridlington, East Yorkshire where he still practises one day a week. He is married with three children and two grandchildren. He has been a member of MDDUS since he qualified.

Back in July of 2010 you described the Government White Paper on NHS reform as a curate's egg – "good in parts, bad in parts, unclear in parts and even internally inconsistent in parts." Have your views changed over the past few months?

Not really, the BMA has sent in a detailed response, outlining the areas we support, those with which we have concerns and those where we need far more information. The government is due to respond just before Christmas with a bill coming out early in the New Year. We will see whether the curate's egg has improved or turned more rotten!

In its response to the White Paper the BMA has spoken out against a "market-based approach" to healthcare? Do you think any form of competition is useful in a national health service?

I think healthy competition between clinicians, based on good-quality data on their performance, is fine. What we object to in many of the recent policy developments in England is the fragmentation, increased bureaucracy and increased administration costs of the market-based approach. It also runs counter to the principle of social solidarity on which the NHS is based.

You said recently that some of what has been proposed by the Government is what doctors have been demanding for years. Can you expand on this?

There is no doubt that clinicians feel that they have become relatively detached from the decisions that affect the way they practise. In principle, giving doctors more say in the design and running of services, greater patient involvement and a focus on high-quality outcomes rather than crude targets can only be a good thing.

The recently published NHS Atlas of Variation exposed a postcode lottery in some key treatment areas such cancer and diabetes. Will GP consortia with 'localised' decision-making improve or worsen this situation?
I would hope that with improved data on outcomes this will help to narrow the quality gap but the recent announcement potentially to lessen the input from NICE in determining which treatments will be available could undermine that.

Do you think the White Paper plans would inevitably open the door to some form of privatisation?
There is no doubt that some of the proposals – all hospitals moving to FT status, the idea of "any willing provider" and the economic regulator being asked to encourage competition – are all very worrying signs that there could be increasing private provision of NHS services. Another concern is that, in a time when funding is constrained, patients may be encouraged or even forced to "top up" their treatments from private sources and the NHS will cease to be comprehensive.

What if any benefits do you see in eliminating practice boundaries in primary care?
Very few and those that there may be – such as increased choice for patients – may be greatly outweighed by additional bureaucracy, loss of continuity, fragmentation of care and funding allocation problems.

Do you see any dangers in the diverging approaches to healthcare provision among the devolved UK national governments?
Well, we no longer have a UK NHS; we have four national NHSs with many distinct differences. There are worries about moving away from UK terms and conditions for doctors and devolution of training, education, workforce and regulation which would create unnecessary cross-border tensions.

Do you think a £20 billion cut in spending in the NHS is achievable and where do you think savings could be achieved?
The suggestion is that the service needs to identify £15-20 billion to reinvest to meet rising demand. As yet, we do not have a narrative, either national or local, which might suggest how this could be done and the NHS has never achieved such savings in the past. Getting rid of the bureaucracy of the market would be a good start, as would trying to reduce the expensive impact of the PFI. The NHS workforce has already agreed to accept a two-year pay freeze so NHS employees are already doing their bit.

Is the public sector bearing an unfair burden in the economic crisis?
In the sense that it didn't create the problems, yes, and there is no doubt that there have to be some reductions in public spending together with some increase in taxation, but I think the public sector still feels it is being made to pay, unfairly, for other people's mistakes.

"I certainly had no burning ambition to be chairman of the BMA... but I enjoy a challenge"

Is the EWTD (European Working Time Directive) dead in the water now that the Government seems to have stopped monitoring compliance?
No, the EWTD remains part of EU law. Although its introduction may have exacerbated some problems in junior doctor cover and training, it didn't cause them and simply ignoring the legislation or attempting too repeal it, will not work and would be retrograde. Addressing the problems of junior doctor training is a complex business and the EWTD should not be used as a scapegoat for long-term failings in this area.

Do you think the GMC is getting close to a workable revalidation system?
It's often seemed a case of one step forward and two steps back over the 12 years that revalidation has been on the cards. It is absolutely vital that any system is not over-ambitious, has the confidence of the vast majority of doctors and is properly resourced both in terms of the revalidation process itself and any remedial issues that arise from it.

Professor Steve Field has described your role as chair of the BMA council as the most unenviable job in medical politics and likened it to herding cats. What inspired you to take on the role?
Whether it was inspiration or more a case of being in the wrong place at the wrong time, I don't know! Seriously, wanting to try to make a difference rather than just complain from the sidelines is what got me into medical politics in the first place. I certainly had no burning ambition to be chairman of the BMA, or any expectation that I would end up there but I enjoy a challenge and want to try to do what is best for doctors and the wider NHS in which most of them work. Luckily, most of the time, these two ambitions share much common ground.

No doubt you are very busy – can you describe a typical week?
I still try to spend one day a week in my East Yorkshire practice – usually a Monday which I try to keep free of BMA activity, not always successfully! I travel down to London on Monday evening and my week consists of office work, meetings – both internal and external, conferences, speaking engagements, media and parliamentary works as well as chairing Council and several other major committees in the BMA. Many people forget that the BMA has a much-respected professional side covering ethics, science and international issues as well as a very successful publishing group. As chairman of the BMA I have a role in overseeing all of these. I suppose I deal with 100-150 emails a day and that, together with associated reading and evening meetings and (sometimes working!) dinners, doesn't leave a lot of time to spare. I try to spend most weekends at home, though there is still a lot of paperwork to catch up on plus quite regular phone calls, but if there is a window of opportunity, I try to squeeze in a game of tennis – in a vain attempt to get rid of the side effects of the working dinners!

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

Broadening – the BMDST

Adam Campbell *celebrates an organisation supporting student electives abroad for over half a century*

REACHING the ripe old age of 50 is always a cause for celebration, and the British Medical and Dental Students' Trust (BMDST), a charity that provides travel scholarships to medical and dental students going abroad for their electives, is certainly in the mood to celebrate.

"We're very proud it's lasted as long as it has, and to feel we are contributing to a broadening of medical and dental education," says Dr John Bootes, who has been a trustee of the charity for the whole half-century since its inception.

Things have changed quite a bit since the beginning when, as a representative of Barts Hospital on the British Medical Students' Association, Dr Bootes took part in the vote that set up what was then the British Medical Students' Trust (the dentists came on board in 1985). In those days, the idea was to allow students to travel to a medical school in Europe.

"The most important thing was the opportunity to experience a different training programme," says Dr Bootes. "In 1960/61 we were giving away three guineas – you could go to Paris on that."

Outward-looking students

Of course, these days three guineas would barely get you from one side of a city to the other, and 50 years on the students being funded by the Trust with grants of up to £1,000 are going a lot further than France – anywhere in the world, in fact, from North America to South Africa, Malawi to Malaysia, and beyond.

The Trust still holds to its outward-looking ethos that to work in health services outside the UK is a valuable learning experience that is worth supporting. But rather than simply experiencing a different university programme, nowadays students receive grants on the basis that they will be carrying out specific projects in whatever country they choose to travel to.

As the current chairman of the Trust, dentist Andrew Lamb, himself a trustee since 2002, explains: "We don't support people who go abroad just to do an attachment to a unit. That's not an inferior option, but it's not the purpose of the Trust. So as part of the evaluation of student applications, we make sure there is a proper research protocol and that the staff and facilities where students are proposing to go are capable of supporting them.

"The protocol has to give an indication of the aims of the project, the methods of the study, how the results will be analysed and what the conclusions are likely to be. We would expect them to have a pretty clear idea of how they're going to do the project and what it might throw up."

Grant applications are scrutinised by the trustees, who include a representative of each of the Councils of Deans of medical and dental schools, as well as two medical students and one dental student elected by their representative bodies.

The onus is on the student to find a suitable institution to

PHOTOGRAPHS COURTESY OF GRAHAM JOHNSON

horizons at 50

support their elective. "Usually students will be quite interested in a particular topic, whether it's malaria or diabetes or HIV, and will hunt out an appropriate place themselves, or sometimes a supervisor in the UK might have links with an overseas institution," says Andrew Lamb.

Donations key

Like any charity, donations are the key to its survival and the BMDST raises around £40,000 every year from donors in the pharmaceutical industry, such as GlaxoSmithKline and Abbott Laboratories, and interested associations such as the BMA and the BDA, among others.

According to Mr Lamb, donors like the fact that they can contribute to the welfare and education of medical and dental students without having to do the day-do-day administration. "It's convenient for them to allow us to do it on their behalf. It really makes their contribution cost-effective," he says.

And thanks to arrangements such as that with the MDDUS – which administers the grant applications – the trustees are able to distribute a staggering 95 per cent of everything they raise to students, around 60 of whom benefit every year.

It's a statistic Mr Lamb is particularly proud of, and one that he believes is very attractive to donors, who like to know their money is going directly to the students. "We try very hard to keep our overheads down as low as possible."

Profile: Graham Johnson

Dr Graham Johnson (second from right) remembers his elective in Trinidad & Tobago in 2004 with fondness. Travelling with two friends from Birmingham University, he learned a great deal, saw cases he was unlikely to see in the UK and found the whole experience hugely beneficial. And it was a trip, he says, he wouldn't have been able to afford had he not received a grant from the BMDST.

"We had a great project sorted out, and it was only when we started costing up how much it was going to be that we realised, if we're going to be able to do this we're going to have to get some funding," says the 28-year-old, now an A&E registrar in Derby.

After a little research, they came across the Trust and three of them subsequently applied for and got grants, which allowed the trip to go ahead. "The BMDST grant really helped us to get there."

A supervisor put Graham in touch with the orthopaedic department at Port of Spain General Hospital where, among other duties, he would carry out his project looking at post-trauma pain management in fracture patients, comparing patient perceptions there with a cohort in Birmingham.

"We found that people in Trinidad appeared to be a lot more tolerant of pain," he says. "Here, a lot of people will be sent home with three painkillers. Over there they were getting paracetamol and, if they had something absolutely horrendous, they would get diclofenac. And actually their pain scores were a lot lower.

"It taught me something about patients' expectations. In the UK, the expectation is that you will take a painkiller and have no pain at all. Over there they think: 'Right I'll take these and feel a bit better.'"

There were plenty of other differences too. Work at the orthopaedic clinic, for example, "started at the crack of dawn. You were in clinic for 6.30am, I think because of the temperature, but then everything wound-up at around 11.30am."

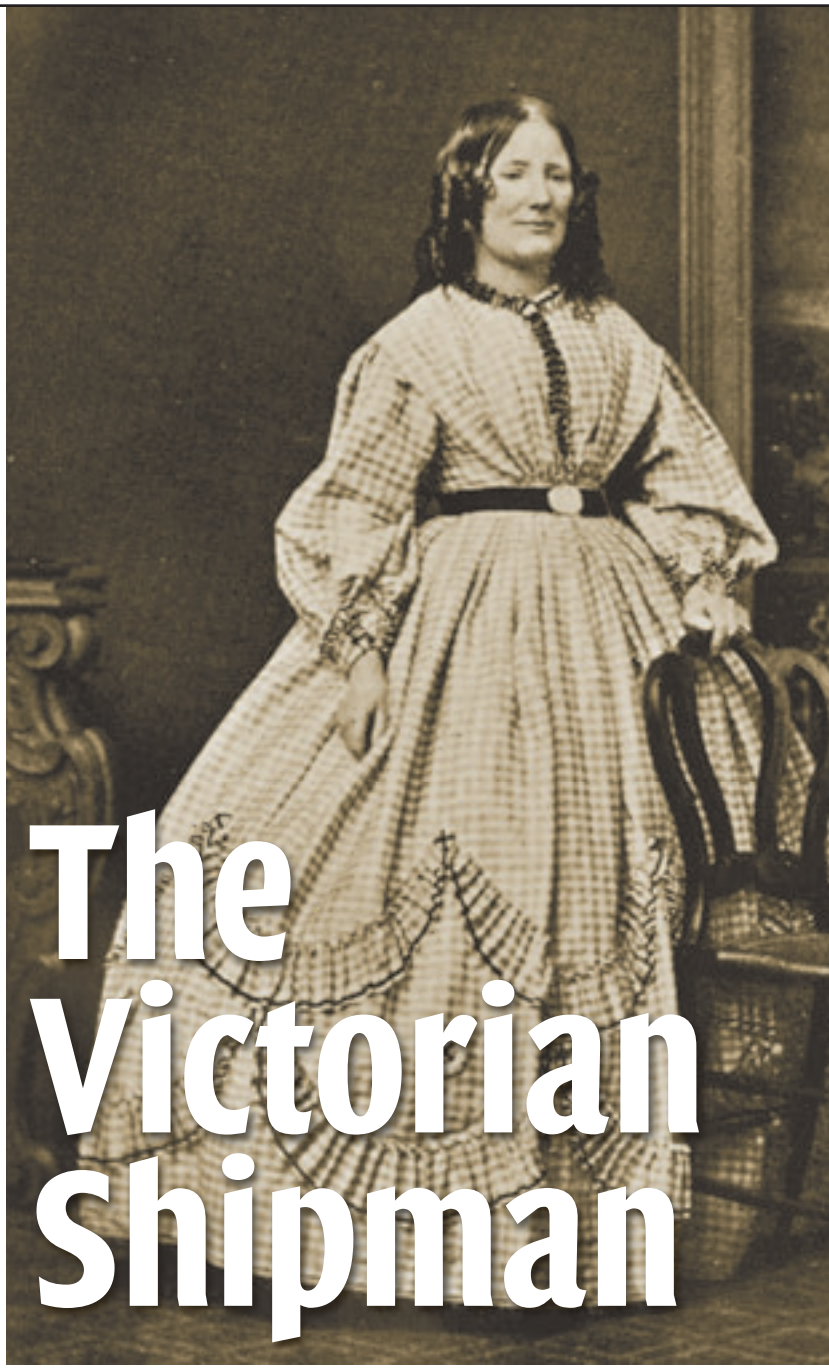
The types of pathology were also unusual. In addition to gunshot and stab wounds, as well as cases of acanthosis nigricans, he remembers a man who had had an open wound for 15 years.

"He'd fractured his lower leg initially, splinted it himself and then presented months down the line with this horrible wound that they just couldn't get to heal. Years later, he was still able to walk but it was the most bizarre-looking thing I'd ever seen. You'd never see anything like that here."

It is hard work, altruism on the part of the trustees and donors, and statistics like these that have helped the Trust to endure over the past 50 years, but what about the next 50? Mr Lamb has no doubt it will continue to endure and says simply: "It's been going for 50 years and it's still in good health. Long may it continue."

For more information on the British Medical and Dental Students' Trust, visit www.bmdst.org or call the MDDUS on 0845 270 2034.

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



The Victorian Shipman

A chance purchase gives Dr James Finlayson *an intimate perspective on a notorious murder case*

AT EIGHT O'CLOCK on 28 July, 1865, a condemned prisoner was led onto Glasgow Green and before a crowd said to number 100,000 became the last person to be publicly hanged in Glasgow. His name was Dr Edward William Pritchard and he had been convicted of poisoning his wife and mother-in-law.

Probably most readers of this magazine will have never heard of Edward Pritchard. I certainly had not until two years ago when I spotted an item in that potent troubler of elderly doctors' marriages – a second-hand bookseller's catalogue. The entry described a volume consisting of reprints of *Scotsman* newspaper articles from the time of the trial of Dr Pritchard, along with a few other items bound in the back relating to his life.

Singularly untruthful

Pritchard was born in Hampshire in 1825, the son of a captain in the Royal Navy. After an apprenticeship in Portsmouth he became a Navy surgeon and in 1846 a member of the Royal College of Surgeons. In 1851, having married Mary Jane Taylor, the only daughter of a successful silk merchant in Edinburgh, he became a practitioner in Filey in Yorkshire. Here he was later described as "fluent, plausible, amorous, politely impudent and singularly untruthful".

In June 1860 Pritchard moved his family to Glasgow and established a practice in a fashionable area but the medical fraternity must have regarded him with some suspicion as several attempts to gain admittance to the Faculty of Physicians and Surgeons of Glasgow were rejected. Three years later in 1863 a fire occurred where Pritchard and his family were living in Berkley Terrace in which a servant girl died. Following his subsequent murder conviction there was suspicion that the fire was no accident and might have been raised by Pritchard himself to cover the murder of the wretched domestic.

Later Pritchard purchased a large house in Sauchiehall Street (just around the corner from the present offices of MDDUS) with the help of a loan from his mother-in-law who always expressed great admiration for her doctor son-in-law. Soon after moving there the unfortunate vacancy for a housemaid was filled by a 15-year-old girl named Mary MacLeod. Later it came out that while his wife was away on holiday Dr Pritchard started an affair with the girl, subsequently terminating the consequent pregnancy.

Main: Mrs Mary Pritchard, who died of poisoning. Far left: Dr Edward Pritchard, convicted and hanged for her murder

Suspicious deaths

In October 1864 Pritchard's wife Mary began to be unwell, suffering from nausea and vomiting, an upset bowel and increasing lassitude. On trips to visit her family in Edinburgh she always seemed to improve but on returning home to Glasgow her condition deteriorated.

Concerned for Mary's health, her mother, Mrs Taylor, came to Glasgow to nurse her daughter. She was described as a particularly strong and fit woman but on 25 February became suddenly ill and died. Mary continued to deteriorate and on 17 March she also died. The death was certified by Pritchard as being due to gastric fever and when his wife's body was transferred back to Edinburgh the doctor exhibited a great deal of fervent feeling, kissing his dead wife on the lips.

However, the Procurator Fiscal had received an anonymous letter raising suspicions about Dr Pritchard. The authorities investigated and post mortems were carried out establishing poisoning as the probable cause of death in both cases.

During the subsequent trial the prosecution were meticulous in establishing their case. Dr Pritchard was shown to have purchased large quantities of poisons (more antimony was purchased by him than all his medical brethren in Glasgow combined). A large amount of poison was found in Mrs Pritchard and her mother.

> "Dr Pritchard was shown to have purchased large quantities of poisons ... a large amount of poison was found in Mary Pritchard and her mother"

Pritchard's motives for murder were clear – his obsession with the servant girl Mary McLeod – and by vigorous examination of the other servants in the house it was established beyond doubt that the doctor had given the poisons to the unfortunate women. The only defence Pritchard's counsel could muster was to blame Mary MacLeod.

Victorian forensics

A number of things struck me on reading of the trial. Many living in the present tend to think all past ages as dark and filled with ignorance and crime. Yet Victorian newspapers seem to do a much better job than our present media of providing accurate information to their readers. The account of the Pritchard trial was printed almost verbatim.

I was also struck by the way in which the legal authorities established their case and with the meticulous forensic investigations carried out on the bodies of the deceased and on the various materials obtained from Pritchard's residence. I had been unaware of how knowledgeable and skilful Victorian scientists were and in particular how they recognised their own limitations and the need for cross-checking.

Against this scientific accuracy, however, stands the ignorance and pride of the doctors who attended the ladies before their demise. One Dr Paterson, who attended Mrs Taylor, testified that he had no doubt that Mary Pritchard was being poisoned by her husband. He claimed that medical etiquette meant that it was impossible for him to do anything about it.

The Lord Justice Clerk, Lord Inglis, in an amazingly comprehensive summing up at the end of the trial, criticised Dr Paterson severely in words that we could probably all read with benefit today: "I care not for professional etiquette or professional rule. There is a rule of life for consideration that is far higher than these – and that it is the duty of every citizen in this country, that every right-minded man owes to his neighbour, to prevent the destruction of human life in this world. A duty I cannot but say that Dr Paterson failed".

An interesting discovery

On receiving my copy of the report of the trial of Dr Pritchard from the bookseller I was fascinated to discover personal documents relating to the case bound in the rear of the volume.

First there was a letter written by Dr Pritchard himself in December 1864 to the parents of a medical student who was staying with him. During the trial, it emerged that this student had also suffered symptoms of poisoning. In this letter Dr Pritchard writes to the student's parents encouraging him to return: "Tom bolted off without asking me for a note to you. He must not be running away after every illness – I was most anxious and careful about him".

There was also a long manuscript, in an unknown hand, recording the visits of a Dr Dewar, who lived in Blythswood Square and was a surgeon to the Glasgow jail, detailing his visits "for purely Christian motives" to Dr Pritchard in his condemned cell. The notes record that Pritchard had told Dr Dewar he had procured abortions for Mary MacLeod on three occasions, although he did not believe the children were his. He also claimed that the girl "had complete command of him, sometimes locking him in a room" and that she had encouraged him to "try stronger poisons if the ones used were not effective".

The final document appears to be a letter written by Pritchard from his condemned cell to his lawyer giving notice of money due him by various patients and asking to be brought "a small bottle, square and flat with scented olive oil to adorn hair," presumably for his execution.

The case of Dr Pritchard should perhaps make us think again about the special risks posed by some doctors. When Dr Harold Shipman was found guilty of his terrible crimes it was often said, by doctors, that he was just a bad man who happened to be a doctor. I am by no means certain that this was the case. It does seem likely that doctors are over-represented among serial or multiple killers. Clearly doctors have a particular expertise with poisons and other dangers to the human body, and there are aspects of a doctor's role involving power and control that can give rise – in susceptible individuals – to some very dangerous thoughts and actions.

■ *Dr James Finlayson is a consultant psychiatrist in Inverness*

Wrong-site surgery

Operating on the wrong limb or organ or patient may seem improbable – and yet it still happens. MDDUS senior medical adviser Mr Riaz Mohammed *FRCS looks at routine steps to ensure these errors become "never events"*

IN OCTOBER of last year the National Patient Safety Agency revealed that hospitals in England had reported a total of 111 so-called "never events" affecting surgical patients in the year 2009/2010.

Never events are defined as "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented". Primary care trusts are required to monitor and report their occurrence on an annual basis.

Just over half of these never events (57) were related to wrong-site surgery. The NPSA defines this as surgical intervention performed on the wrong site – be it the wrong organ or joint or eye or even the wrong patient. Reports in the press of catastrophic errors such as removing a healthy kidney in place of a diseased one or amputating the wrong leg seem to stretch credulity. And yet such things have happened in even the most up-to-date and "efficient" surgical wards. It has been estimated that one out of four orthopaedic surgeons in practice in the USA for more than 25 years will have performed at least one wrong-site surgery.

Such cases are often the result of multi-system failures. These might include errors in patient notes or a misread radiology report. It might involve GPs, nurses, radiologists, anaesthetists but in the final analysis, and from a medico-legal point of view, it is still the surgeon taking up the scalpel who bears ultimate responsibility. Such errors are indefensible and yet the risks are probably greater today than ever with more day surgeries and waiting list initiatives, meaning that surgeons are much more likely to be operating on patients they may not have seen before.

Surgical Safety Checklist

The recent NPSA 2010 report on never events has attracted particular attention as it comes just 10 months after the agency ordered the implementation of the Surgical Safety Checklist in every hospital in England and Wales. The checklist was devised by the World Health Organisation after a year-long global pilot of nearly 8,000 surgical patients across eight countries. The findings from this pilot study were compelling – adherence to the checklist resulted in a one-third reduction

in surgical deaths and complications.

Back in January 2009 the NPSA made three key recommendations with actions to be completed within one year:

1: Ensure an executive and a clinical lead are identified in order to implement the surgical safety checklist within each organisation.

2: Ensure the checklist is completed for every patient undergoing a surgical procedure (including local anaesthesia).

3: Ensure the use of the checklist is entered in the clinical notes or electronic record by a registered member of the team, for example, surgeon, anaesthetist, nurse or operating department practitioner (ODP).

Central to the WHO checklist is a core set of standards that can be applied universally within any healthcare setting to address issues including correct site surgery, haemorrhage risk, antibiotic prophylaxis, airway management and the risk of allergies. A designated checklist coordinator must be made responsible for checking the boxes on the list; most often this will be a circulating nurse but it could be any clinician or healthcare professional participating in the operation.

The checklist itself is divided into three phases – sign in, time out, sign out – but it is obviously in the first two phases where the risk of wrong-site surgery is addressed.

Sign in

Sign in is the period prior to induction of anaesthesia and includes the pre-surgical briefing at which the surgeon, anaesthetist and scrub nurse should all be present. The checklist calls for the patient to be involved in confirming identity against the hospital wristband, confirming the site of surgery and ensuring that informed consent for surgery has been given. Should confirmation by the patient be impossible, a carer or significant other can support this process.

Next the surgical site should be marked and ideally by the operating surgeon performing the procedure or, if appropriate, a nominated deputy who must be present in the operating theatre when the procedure is carried out. It is essential that the operative site is confirmed by the surgeon with the team prior to the start of surgery.

The following recommendations on marking surgical sites were published in 2005 by the NPSA and the Royal College of Surgeons of England.

How

- Use reliable documentation and imaging (if applicable).
- The mark must be an arrow that extends to, or near to, the incision site and remains visible after the application of skin preparation.
- In some circumstances it may be appropriate to note the procedure to be undertaken.
- An indelible marker pen must be used that is suitable to the patient's skin type and the type of skin preparation to be used.

When

- The surgical site must be marked in the designated area prior to surgery, e.g. ward or pre-admission area prior to pre-medication being administered if applicable.

Where

- Surgical site must be identified and marked accordingly although some exceptions may apply, e.g. some gynaecological and urological procedures that do not require external marking for surgery on singular internal organs (uterus, bladder).
- Surgical procedures that involve side (laterality) must always be marked with particular consideration to specific digits of hands, feet and spinal levels.

Time out

Time out is the phase prior to the start of the actual surgical intervention (e.g. skin incision). Here the checklist makes a number of further specific recommendations. The checklist coordinator should ensure that all team members have introduced themselves by name and role, including information regarding level of experience. Students and visitors or observers should also be introduced and particular attention should be paid when regular team members may be absent due to shift changes.

Next the surgeon, anaesthetist and registered practitioner must verbally confirm patient, site and procedure. This is the standard "time out" or "surgical pause" and should include confirmation of the name of the patient using the wristband, what surgical procedure is to be performed, the site and the positioning of the patient to avoid operating on the wrong patient or the wrong site.

This box should not be checked until the anaesthetist, surgeon, circulating nurse and patient (if not sedated) verbally confirm agreement. Only then can the operation go forward. A record of having used the checklist should be entered in the clinical note or electronic record.

Other specific interventions

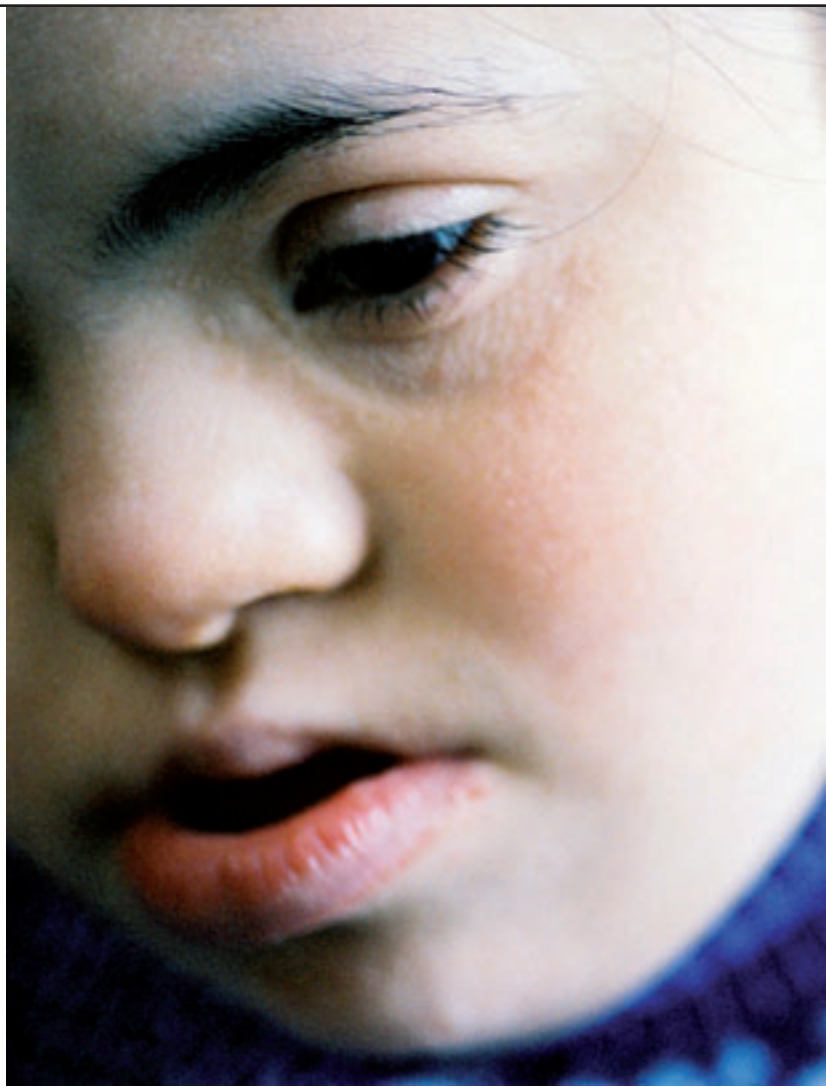
The NPSA has collaborated with the Royal College of Radiologists to produce a checklist specifically adapted for radiological interventions where wrong-site and other errors are a risk. A collaborative project with the Royal College of Ophthalmologists has also resulted in a checklist specific for cataract surgery where there have been cases of the wrong eye being operated on. These can both be found on the NPSA website along with general guidance on the Surgical Safety Checklist.

It is clear that strict adherence to local procedures based on the WHO checklist will help ensure wrong-site errors become truly never events. In medico-legal terms, evidence that such procedures have been implemented will be essential in defending future claims of medical negligence in surgery and any subsequent disciplinary or GMC proceedings.

Despite the wide media coverage they attract, instances of wrong-site surgery remain rare. One recent case reported in the *BMJ* concerned a healthy 23-year-old man who presented for cataract surgery. In pre-op he expressed some concern that the surgeon was clear which eye was to be operated on. Later after numerous routine site verifications the patient lifted his surgical cap and said: "Had I realised all these steps would be taken, I wouldn't have done this." Shaved into the short hair on the side of his scalp was a large arrow pointing to the correct eye – better safe than sorry!

■ ***Mr Riaz Mohammed FRCS is a senior medico-legal adviser at MDDUS***

Taking special care



Treating patients with disabilities can present a challenge for dentists. Dr Carole Boyle *offers some advice on sedation techniques and the issue of consent*

ONE of the most difficult decisions I face as a consultant in special care dentistry is deciding how best to provide dental care for patients with learning disabilities who are referred to me for treatment. They can often have complicated medical histories or a physical or mental disability which makes it difficult for them to cooperate with dental care. In addition to their disabilities, they may also be anxious about dental care.

Traditionally, general anaesthesia (GA) was the first choice to manage pain and anxiety for people with special needs. But, following a number of deaths of children under anaesthesia in the 1990s, the use of GA was limited to a hospital setting in 1999. Current provision of dental care under GA varies around the UK and in some areas only oral surgery is available, while other centres are limited to day-case GA.

An alternative method of managing behaviour in special care patients is conscious sedation. It gives the option of providing more complex dental treatment over a number of visits rather than a 'one-hit GA'. It also allows examination and preventative care on a regular basis.

Sedative drugs may be administered by a variety of routes:

Inhalational sedation (IS) uses a mixture of nitrous oxide and oxygen delivered in varying concentrations by a dedicated machine via a nasal mask. It works well for people with mild learning disabilities who are able to understand the semi-hypnotic suggestions, which are important for the success of the technique. It is less successful in those with more severe disabilities who may not be able to cooperate with placement of the mask or breathe only through their nose.

Intravenous sedation (IVS) can be used for people with learning difficulties but requires cooperation with cannulation. The main difficulty once sedated is determining the level of sedation in someone with little or no verbal communication. The dental team must rely on observations: non-verbal signs of sedation and acceptance of dental care.

Oral sedation offers a significant advantage in that it avoids the need for intravenous access and requires little patient cooperation to administer. Midazolam provides safe and effective sedation with a rapid onset and can be added to any drink: tea, coffee, soft drinks etc. The usual adult dose is 20mg and peak plasma levels are generally achieved in 30 minutes so that dental treatment can usually start 15 to 20 minutes after administration. One difficulty we have found is acceptability: a patient may drink the midazolam on their first appointment but the second time they attend may be reluctant to take the funny tasting drink again.

Oral sedation can be unpredictable and unusual reactions are even more likely in someone with a learning disability. The sedationist must be able to cannulate and staffing and equipment must be of the same standard as that required for IVS.

Intranasal sedation (IN) has changed the way I manage patients with learning disabilities. It requires little cooperation from the patient and has a rapid onset. The standard adult dose is 10mg and using concentrated midazolam (40mg/ml midazolam with 20mg/ml lignocaine) requires only 0.25ml

PHOTOGRAPH: SCIENCE PHOTO LIBRARY

delivered by a mucosal atomisation device. IN midazolam is very easy to administer but it is not titrated against the patient's response and requires venous access once the patient is sedated for administration of additional midazolam or reversal with flumazenil. It is an appropriate technique for the experienced sedationist and provides a safe effective way of administering dental care to people with special needs.

Choosing anaesthesia

There are no set rules for providing care under GA or sedation and patients need to be assessed individually. The following factors need to be considered in making the decision:

- Is the patient in pain?
- Amount of treatment required
- Are intraoral examination and radiographs possible?
- Level of care available post treatment
- How far do the patient and carers travel? Are they willing to attend for a number of visits under sedation?
- Complexity of medical history – suitable for treatment in an outpatient setting or better managed in hospital?
- How long are GA and sedation waiting lists?

Assuming both sedation and general anaesthesia are available then patients fall into three categories:

1: Those who will not allow even an examination when awake and who present in pain. In this group, it can be difficult for carers to ascertain whether the person is suffering dental pain. GA is probably better than sedation for most cases to ensure treatment can be carried out to deal with the source of pain at the first appointment. This provides particular challenges for the dental team who must devise a treatment plan in theatre and ensure the availability of all necessary dental equipment and materials. In addition, consent must be obtained for all necessary treatment including extractions.

2: Those for whom sedation is partially successful: examination and cleaning are possible but not operative dentistry. This group can have sedation on a regular basis for recalls and oral hygiene measures but will require GA for more advanced care.

3: Those for whom sedation does allow examination but this reveals either a great deal of treatment or more complex dentistry is required, e.g. removal of wisdom teeth. For these patients the initial examination under sedation will help the team plan treatment and allow them to discuss this with the carers when obtaining consent. It allows efficient use of theatre time.

Consent

Consent should be obtained at the assessment visit. In England and Wales, an adult, even a parent, cannot give consent for another adult and treatment can only be carried out if it is in the patient's best interest. However, those who care for the patient should be involved in the decision-making process. 'Best interests meetings' can be organised to decide if the treatment proposed is appropriate. The Department of Health produce Consent Form 4 for adults who are unable to consent to investigation or treatment. It includes details of an assessment of the patient's capacity and best interests. There is space for those close to the patient and for two healthcare professionals to sign the form. For those without relatives or friends the Mental Capacity Act (2005) allows for appointment of an independent mental capacity advocate (IMCA).

In Scotland there are specific procedures and regulations to follow, governed by the Mental Health (Scotland) Act 2003, which involves issuing a certificate of incapacity.

It is reasonable that the risks of general anaesthesia are discussed with the patients and carers. It is not necessary to tell patients that they might die under GA but you can explain that current mortality rates in the UK are about 1 in 100,000 anaesthetics. This risk is considerably less than being seriously injured in a road accident. The limitations in the scope of dental care that can be provided under GA should be discussed and that teeth with extensive caries will be extracted and not restored.

Deciding on GA or sedation requires weighing up a host of factors and requires experience. There is a need for all means of controlling pain and anxiety to be available for people requiring special care dentistry. Sedation extends the range of dentistry possible for these patients and a move away from GA can only lead to an improvement in oral health for this group. However, there are still a significant number for whom GA will be the only option.

■ *Dr Carole Boyle is a consultant in special care dentistry at King's College London Dental Institute at Guy's, King's College and St Thomas' Hospitals. Email: carole.boyle@kcl.ac.uk*

CASE studies

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

DIAGNOSIS AND REFERRAL: SCREENING NOT 100 PER CENT

BACKGROUND: A mother attends a GP surgery with her three-year-old son – Peter – who has a soft swelling near the navel. She sees the family's regular GP, Dr L, who suspects an umbilical hernia. He explains to Peter's mother that the condition is probably not serious but he will refer the boy to a paediatric surgeon. In the same consultation the mother expresses some concern about Peter's walking posture and Dr L notices that the boy seems rather flat-footed. He mentions this also in his letter to the paediatric surgeon.

Peter sees the paediatric surgeon a few weeks later who confirms the umbilical hernia but takes the view that it is not of immediate concern. He also notes the boy's flat feet and recommends instep supports. A six-month follow-up is arranged and when Peter returns to the surgical clinic his parents report that the insteps seemed to improve the boy's gait only for a short period and he is now walking with a limp.

The surgeon arranges a hip X-ray and the result shows a congenital dislocation of the right hip (CDH). Peter is referred to an orthopaedic surgeon for treatment including traction, open reduction and a pelvic osteotomy. The boy heals fully from the procedure but there is need for a proximal femoral realignment as the femoral head remains slightly subluxed. The orthopaedic surgeon explains to Peter's parents that late CDH of this sort can be problematic to correct.

A few months later Dr L receives a letter from solicitors representing Peter's parents intimating a potential claim for medical negligence in the late diagnosis of the CDH.

ANALYSIS/OUTCOME: Dr L contacts an MDDUS adviser who arranges for a medical expert to review Peter's notes. Here it is noted that that the boy underwent routine checks at 7 and 14 months with specific mention that the hips were normal. Peter was also observed by a health visitor to be walking well at 16 months including up and down stairs. In his first three years Peter was seen numerous times at the practice for minor infections and vaccinations. First reference to the gait problems is when Peter attends for the umbilical hernia.

In her report the medical expert comments: "Screening procedures are designed to pick up early signs of particular problems, especially those, such as congenital dislocation of the hip, where early intervention may make a considerable difference to the outcome. However, they are not 100 per cent guaranteed and, despite careful examination, can miss the condition being screened for. It is always unfortunate when this occurs, but the GP, having carried out the examination in the recognised manner, cannot be considered negligent if it unfortunately presents at a later date."

The expert only questions the actions of the paediatric surgeon in delaying further investigation of Peter's gait abnormality by six months but her report is in reference to Dr L's actions alone. MDDUS replies robustly to the solicitors in regard to Peter's treatment by Dr L and the case against the GP is not pursued.

KEY POINTS

- Ensure clear records are kept of all examinations including negative findings.
- To establish medical negligence it must be proved that a doctor is guilty of a failure that no doctor of ordinary skill would commit if acting with reasonable care.
- Have a high index of suspicion in gait abnormalities beyond age 3.

GDC:
WHAT DID YOU CALL YOURSELF?

BACKGROUND: Mr B and his two partners have just made a substantial investment in new premises for their dental practice and decide to 'rebrand' the business. A web company is hired and meets with the practice manager to be briefed on the services to be promoted. Among the details passed on to the company is that Mr B and one of the partners both have extensive training and experience in providing implants for patients.

The site goes live and Mr B gives it only a cursory look. Two months later a letter arrives from the General Dental Council to say that Mr B has been referred to an Investigating Committee in regard to his fitness to practise. An accompanying assessment sheet states that another local dentist has informed the GDC that the new practice website is misleading as it incorporates the strap line: "Specialists in Dental Implantology".

The GDC correspondence states: "There is no specialty in Dental Implantology recognised by the Council" and as such the practice website could "mislead patients and potential patients".

ANALYSIS/OUTCOME: Mr B contacts MDDUS and discusses the matter with a dental adviser. He expresses his extreme frustration over the matter saying that by training and experience he and his partner clearly are specialists in implantology. The adviser explains that the GDC is very specific on use of the word 'specialist'. Such a title is only permitted for dentists registered on one of 13 GDC specialist lists and there is no list for implantology. The specific policy states that: "Specialist expertise is indicated by the presence of a dentist's name on our specialist lists. Dentists who imply that they have specialist expertise in an area for which they are not on our specialist lists, or which is not covered by our specialist lists, are misleading patients."

The dental adviser helps produce a draft representation to the GDC to answer the allegations against Mr B in which it is explained how the strap line was posted without the dentist's final approval and later corrected within an hour of the mistake being pointed out.

A month later the GDC informs Mr B in writing that the Investigating Committee has considered the matter and does not deem it serious enough for an inquiry before the Professional Conduct Committee but that it will issue a formal warning to the dentist which will be published on the GDC website for a period of six months. The GDC letter states that the onus is on a registrant to ensure that any promotional material referring to professional status or practice is accurate and not misleading to the public in any way.

KEY POINTS

- Dentists must ensure no promotional material refers to them as a 'specialist' unless registered on one of 13 specialist lists maintained by the GDC.
- Look out for new GDC guidance on ethical advertising to be published early in 2011.

REFERRAL:
A NECESSARY VISIT?

BACKGROUND: A 59-year-old woman, Mrs B, has been suffering from abdominal pain and vomiting for two days, prompting her husband to request a home visit from her GP. He is worried because his wife has a number of other health problems including high blood pressure, heart disease and diabetes. She also had bowel surgery 10 years ago with a colostomy.

Mr B tells the GP, Dr D, that his wife's vomit is dark and foul-smelling and mentions again her abdominal pain and diarrhoea. Dr D diagnoses gastroenteritis over the phone but does not visit Mrs B, instead leaving a prescription for the husband to collect at the practice. Mrs B's condition worsens overnight so Mr B contacts the out-of-hours doctor, Dr A, who makes a home visit. He notes Mrs B's vomiting and diarrhoea ("settling"), and that she is drinking plenty of fluids. He also diagnoses gastroenteritis and a possible chest infection and prescribes an antibiotic and anti-sickness medication. But just a few hours later, Mrs B dies. The post mortem reveals a small bowel infarction and obstruction resulting from abdominal adhesions.

The family raises a claim of medical negligence against Dr D, an MDDUS member, and Dr A, who is a member of another medical defence organisation. It is alleged that had Dr D visited Mrs B and undertaken a proper examination leading to an urgent referral, she would have been provided appropriate life-saving treatment. It is also alleged that Dr A failed to properly examine and refer Mrs B: had he referred her urgently, it is claimed she would have survived.

ANALYSIS/OUTCOME: MDDUS, acting on behalf of Dr D, commissions a report from both a GP expert and colorectal surgeon. The GP expert concludes that Dr D's actions did not depart from usual and normal GP practice. But the surgeon's report finds that Mrs B should have been referred to hospital where she could have been further assessed for emergency surgery.

Considering the conflicting expert reports, MDDUS decides to agree an early settlement with Mrs B's family on economic grounds, without admitting liability. The settlement is shared equally with the other MDO.

KEY POINTS

- Consider carefully the need for a home visit in patients with multiple health issues.
- Have a high index of suspicion in patients having had previous bowel surgery.
- Be sure to conduct the appropriate examinations and document relevant positive and negative findings.

ADDENDA

PHOTOGRAPH: SCIENCE MUSEUM/SSPL

Object obscura: wax anatomical model

THIS incredibly detailed and rather macabre wax anatomical model dates from 1818. The full head and torso was made by Francesco Calenzuoli in Florence along with a wooden display cabinet and would have been used as a teaching aid.

From the archives: doctoring on the high seas

OVER 1,000 journals and diaries compiled by Royal Navy surgeons who served on HM ships from 1793 to 1880 were recently made accessible online by The National Archives as part of an extensive cataloguing project supported by the Wellcome Trust. These fascinating documents detail medical conditions and treatments for everything from venereal disease and scurvy to shark bites and lightning strikes.

One particular journal recounts a voyage made by surgeon P Power on the ship *Elizabeth* conveying Irish emigrant settlers from Cork to Quebec in 1825. Power describes the unusual case of Ellen McCarthy, aged 12, whose symptoms included "disease or hurt, pain in the bottom of her belly, increased on pressure, abdomen hard and swollen, picks her nose, starts in her sleep, bowels constipated, pyrexia, tongue foul, pulse quick, skin hot, great thirst". She was first put on the sick list on 15 June at sea when her mother brought the surgeon a 'lumbricus' (worm) which the child had vomited. It was 87 inches long.

First he gave the child Calomel, a mercury compound popular at the time. "She took three doses to no effect," Power records. He then states on the 18 June: "In the night she had one motion in which two worms were discovered – one 13 1/2 inches and the other 7". But the next day Mary is much worse with "dilated pupils, total insensibility, pulse 140, involuntary discharge of Slime, refuses drink".

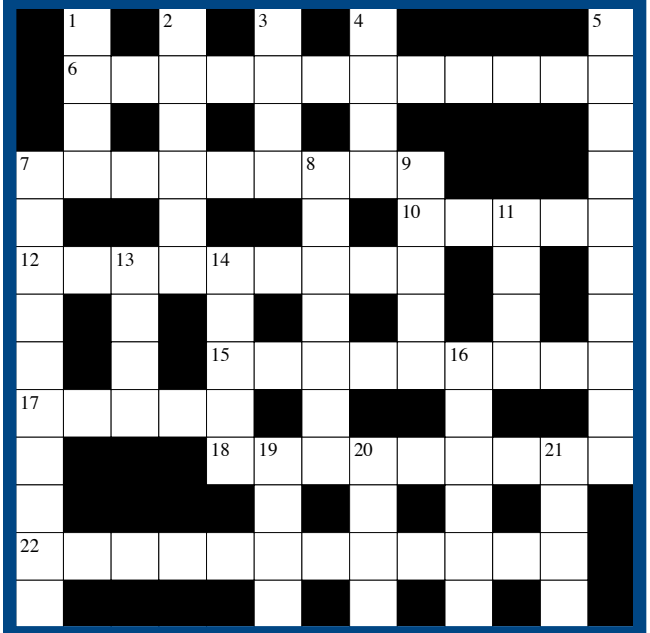
So Power administers an injection of "ol Tereb" – probably turpentine – and next day reports "a pleasing and evident improvement this morning". Mary makes a steady recovery and later Power states that he would have "no hesitation in adding his testimony to others in favour" of his treatment.

Many more such tales can be found in archives which can be accessed at www.nationalarchives.gov.uk/surgeonsatsea/

IMAGE: THE NATIONAL ARCHIVES UK

Sketch made by naval surgeon on the *Barrosa* convict ship in 1839

Crossword



ACROSS
6. Sympathomimetic amines (12)
7. Devices to hold teeth in position (9)
10. Autoimmune disease more common in women (5)
12. Brachial plexus paralysis (4,5)
15. Build up of plaque on the tooth (9)
17. Abdominal pain in infants (5)
18. Instrument for internal inspection (9)
22. Topical analgesics or liniments (12)

DOWN
1. Back of neck (4)
2. Atomisers (6)
3. Average (4)
4. That studied by trichologists (4)
5. _____ dogs, used to aid persons with disabilities (10)
7. Trained to use muscles for new behaviours to replace lost functions (10)
8. Intertwined (6)
9. Passage between walls, esp. monasteries (5)
11. Suffix meaning "around" (4)
13. Spirit worshipped as deity (4)
14. To position (5)
16. Entrepreneur (6)
19. Publishes guidelines on clinical practice - acronym (4)
20. Hippocratic ____ (4)
21. Prefix meaning "after" (4)

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

Vignette: groundbreaking professor of orthopaedics, Sir Herbert Seddon (1903 – 1977)

THERE are few surgeons of Sir Herbert Seddon's generation who have made such an important contribution to their specialty.

The gifted and dedicated professional was a pioneer in two fields of surgery – first making groundbreaking advances in the understanding and treatment of tuberculosis and poliomyelitis, where many of his patients were children. He then went on to make great advances in the repair of peripheral nerve injuries that improved the lives of thousands of wounded soldiers.

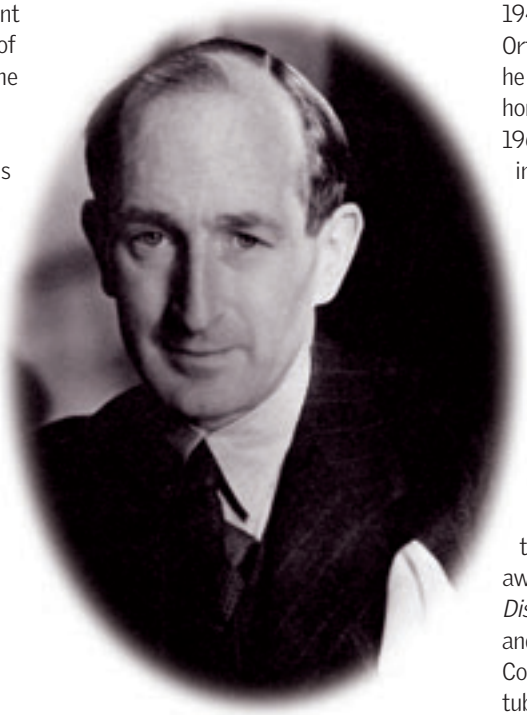
His extensive clinical research in the 1930s also produced valuable contributions on the nature of spinal tuberculosis that inspired a new surgical approach and dramatically improved the prognosis.

During the war years Sir Herbert advised the British Government on polio epidemics and also helped many developing countries deal with their orthopaedic problems. During his appointment as Nuffield professor of orthopaedic surgery to the University of Oxford from 1939, he set up the most important peripheral nerve injury unit in Britain where his experiences in treating the wounded from World War 2 helped him become a master at repairing peripheral nerve injuries.

His scientific approach, meticulous recording, precision, objectivity and honesty uncovered vast knowledge in the field of peripheral nerve injury and he went on to write the seminal *Surgical Disorders of the Peripheral Nerves* which became the standard textbook on the subject for many years. His many remarkable achievements have been detailed in a book by Julia Merrick, *Sir Herbert Seddon and the book he nearly didn't write*, whose title references his *Surgical Disorders* book which was 30 years in the making.

In her biography, Merrick describes how Sir Herbert made the Royal National Orthopaedic Hospital internationally renowned, adding: "He worked hard, influenced a generation of young surgeons, travelled widely" and exported "highly qualified orthopaedic surgeons."

Sir Herbert – known to friends as Jim – was born in July 1903 in Derby and spent his childhood in Manchester before studying at the medical college at St Bartholomew's Hospital, graduating MB, BS London University in 1928 and in the same year gaining the FRCS. In 1930 he took up the post of instructor in surgery at the University of Michigan where he met his future wife Mary Lytle. The couple went on to have two children, Sally and James.



He returned home in 1931 when he was appointed resident surgeon to the Royal National Orthopaedic Hospital in Stanmore, Middlesex.

The increasing problem of polio reached epidemic proportions in 1938 and it was in researching this disease that Sir Herbert would do some of his most important work. His knowledge and practical experience in treating the disease was in demand even beyond the UK and in the early 1940s he travelled to Malta and Mauritius to lend his expertise.

During this period he also made important discoveries surrounding spinal tuberculosis, defining two types of paraplegia – acute due to pressure on the cord from an anterior abscess and late onset due to gliosis. These concepts led to the development of the anterolateral approach – an operation in which Sir Herbert became very skilled – which dramatically improved patient outcomes. Another of Sir Herbert's great contributions to medicine was the work he engaged in to convince the next generation of medics the value of basic research.

Sir Herbert's career achievements were many. He became the first professor of orthopaedics at the University of London in 1948, he was president of the British Orthopaedic Association from 1960-1961, he was knighted in 1964 and made an honorary fellow of Worcester College in 1966. His work took him around the world, including on extensive tours of Africa as a member of the Advisory Medical Council of the Colonial Office.

And while he spent long hours working in his specialist field, Sir Herbert also found time to indulge his other interests. He was a keen climber, gardener, photographer and painter who became accomplished in these pursuits by employing the same determined approach he used in his work. Even in retirement his contribution to medicine continued with the long-awaited publication of his book *Surgical Disorders*. He spent a lot of time planning and implementing the Medical Research Council's investigation into the treatment of tuberculosis of the vertebral column, with centres set up across the globe in Korea, Hong Kong, Bulawayo and South Africa. The end result was one of the most valuable pieces of clinical research ever completed for the council.

In a tribute to Sir Herbert in the *BMJ* following his death, one colleague wrote: "Jim was not always deep in thought: he could be the centre of wit and humour of any dinner party. A pause for a moment for reflection may enable us to catch a fleeting glimpse of the breadth and depth of this personality, which sought increasingly to unravel the secrets of medical science by exposure of factual truth and simultaneously to preach the Gospel from a fountain of undoubted faith."

Sir Herbert Seddon and the book he nearly didn't write (2010) by Julia Merrick is available at Blackwell's Bookshop, South Bridge, Edinburgh and also on Amazon.co.uk

The BMJ Group Awards 2011

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