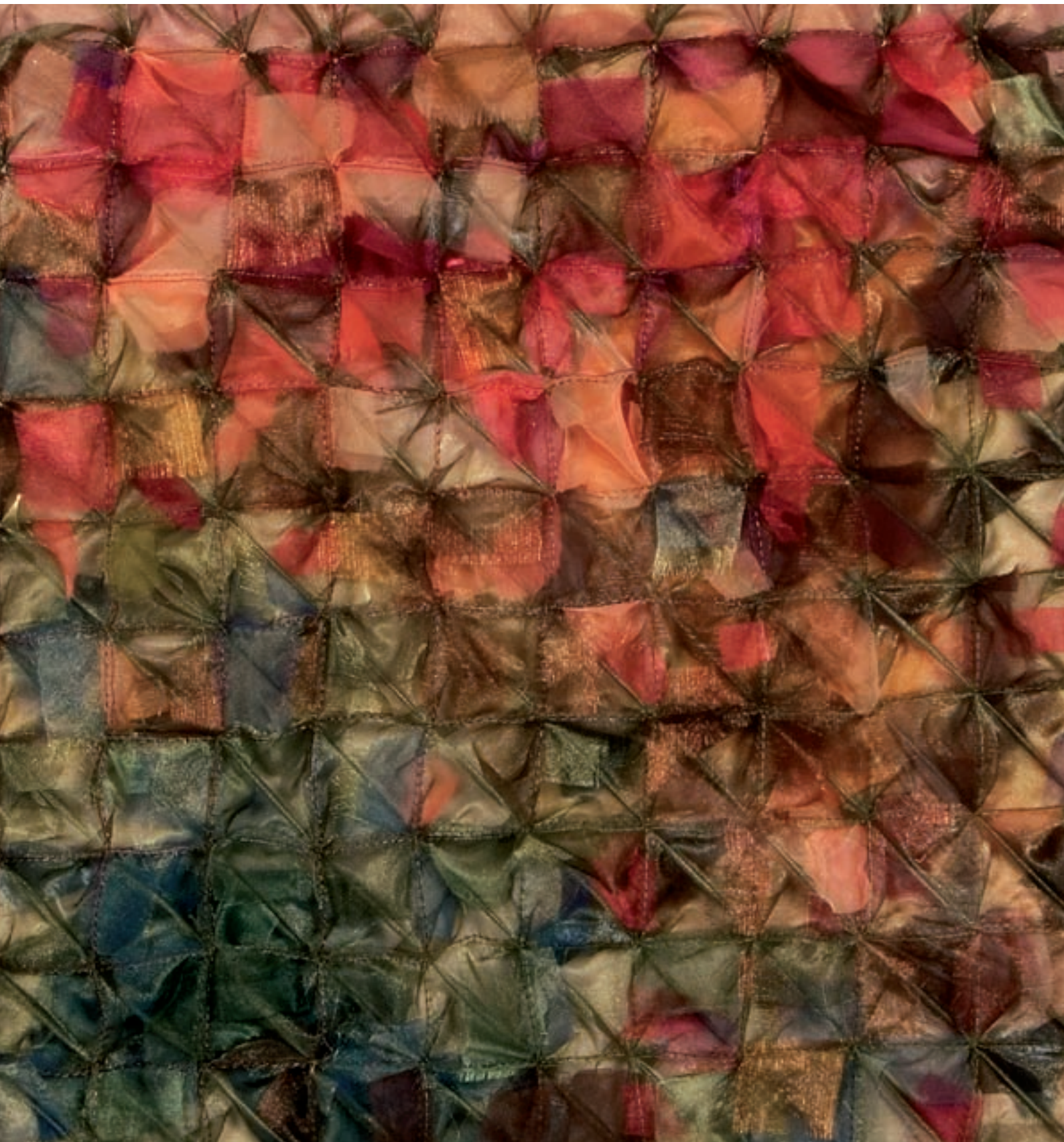


Spring 2011

SUMMONS



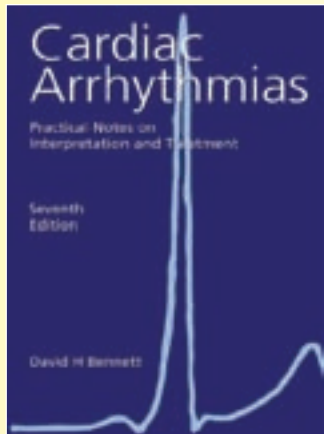
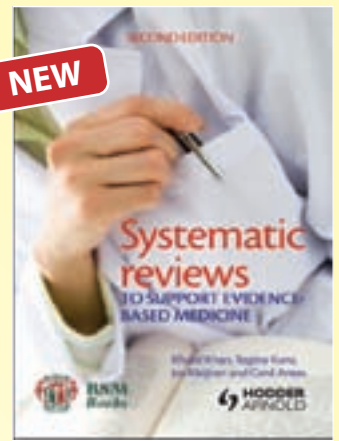
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• **Profile: Clare Gerada** • **Assisted suicide** • **Peverley on Peverley** •



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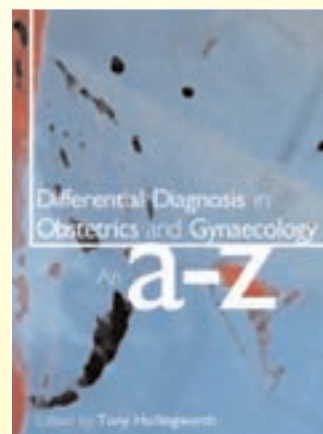
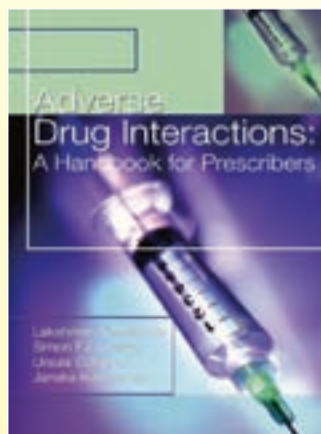
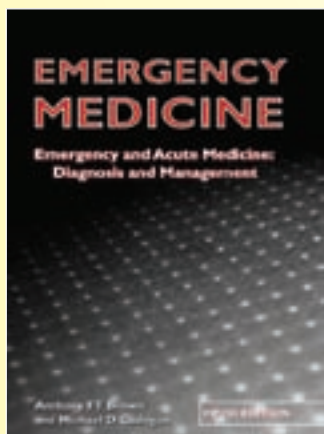
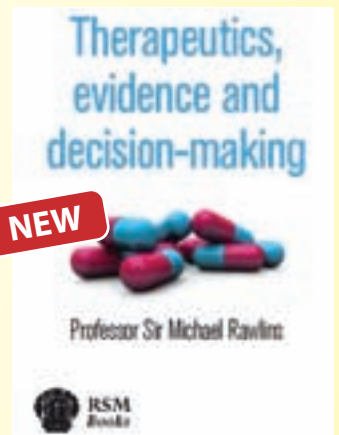
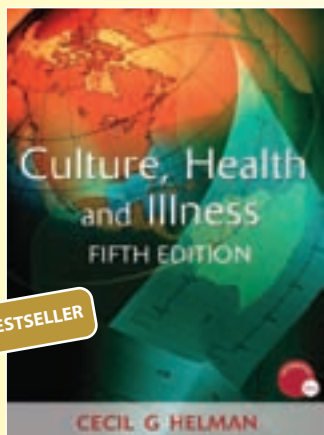
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HODDER
ARNOLD

IN THIS ISSUE

SPARE a thought for Clare Gerada – voted in as chair of the RCGP in March, 2010, just over a month before a coalition government is elected and soon embarks on the most radical reform in the 62-year history of the NHS in England. Timing – they say – is everything in politics and if it wasn't enough being the first female chair in 50 years Dr Gerada now finds herself at the centre of a debate that could shape the development of UK medicine for many decades to come.

Newspapers have cast her as an opponent of reform but that's not altogether true as Adam Campbell found out in his profile of Dr Gerada on page 14 of this issue. "I am absolutely delighted that my profession has been put at centre stage of influencing and planning the health service," she says. "Putting clinicians in that role is something we've asked for years." It's just the means and pace of change – not to mention philosophy – that have drawn her squarely into the fray.

Someone else not without an opinion or two is Dr Phil Peverley. You may not agree with everything he writes in his cutting and funny column for *Pulse* magazine but it's certainly never boring. On page 11 he spares nothing and no one in our Q&A.

On page 18 Dr Christine Goodall discusses a new initiative to encourage dentists in Scotland not to ignore obvious signs of domestic abuse in patients but to urge them to seek help. And on page 12 we get perspectives from two MDDUS solicitors on the legal risks in dealing with patients desiring assisted suicide.

Also in this issue Mr Timothy Hargreave looks at clinical risks in patients with haematuria (page 16) and we recount a dental case study (page 22) in which an upper molar extraction proves far from straightforward.

Jim Killgore, editor



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Cover image: Azalea Patch, by Jill McOwat. 1990. Medium: fabric
Size: 50 x 51 cm
McOwat's work conveys the dizzying spectacle of a patch of azaleas in full flower. Jill McOwat has exhibited in Scotland, England and Japan with the Embroiders' Guild, the 232 Embroidery Group and the New Scottish Embroidery Group. Her work is in both public and private collections in Scotland.

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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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Help us help you

THE MDDUS exists to support, protect and defend its members. It does this sensibly yet robustly when required. It can only do it, however, if members provide us with the core information that we need.

As a jobbing lawyer I have noticed in recent months that it is proving ever more difficult to persuade members to provide information needed for their own defence. Whether this is copies of medical records or a factual report on an involvement with a patient or indeed commenting on documents prepared by lawyers and experts requiring member input, it all needs to be dealt with quickly. The Court timetables are ever quicker and the penalties for non-compliance ever more threatening. It is essential if we are going to do our job that members assist us in that process.

We all know that the *Membership Agreement* and the *Memorandum and Articles of Association* require member support at all times. We also are all realistic enough to know that professional people are busy and patient care must come first.

Nevertheless can I please enter a plea to members who have the misfortune to have to use the legal services of the Union to do so quickly and turn around requests for information and assistance promptly. If you do not, it can cost the Union money but worse it might cost you your professional reputation.

Simon Dinnick head of legal services, MDDUS

Insurance or indemnity to be legal requirement

NEW legislation is to be introduced making it a legal requirement for all UK doctors and dentists to have either insurance or indemnity cover as a condition of their registration.

This outcome is set out in a response from the four UK health administrations to an independent review on the matter led by Finlay Scott, the former Chief Executive of the General Medical Council. The review was established to determine whether statutory indemnity or insurance was the "most cost effective and proportionate means of ensuring that there is a means of seeking redress where a healthcare professional has been negligent".

Representatives from regulators, professional bodies, patient groups and other interested parties, including MDDUS, offered their views and the report was published in June, 2010. In a joint response to the report the four UK health administrations accepted the main principles and agreed that legislative changes to make this law should be introduced at the "next most appropriate opportunity".

The response further stated that any legislative changes must be considered in light of the new EU requirements on cross-border patients' rights, ensuring a mechanism of redress which places responsibility for cover on employing healthcare providers or individual healthcare professionals if acting independently.

On the question of insurance versus discretionary indemnity cover, Mr Scott commented: "In the course of the review, one defence organisation argued that only insurance should be accepted as meeting the condition of registration because discretionary indemnity, by its nature, did not provide the guarantee associated with a contract of insurance. Officials confirmed that both insurance and indemnity were acceptable and I did not consider the issue further."

This brings to an end the long-running issue of whether insurance, as offered by an insurance policy, or indemnity from a mutual indemnity provider such as MDDUS, should be the only method of ensuring doctors are indemnified. The Government has clearly decided that both are equally acceptable. We at MDDUS are also keen to emphasise that indemnity is only one aspect of what a medical defence organisation provides. Access to good advice, support at GMC, disciplinary events, coroner's inquests and fatal accident inquiries are just as necessary.

GPST magazine

ISSUE 2 of our new MDDUS magazine for GP trainees is now out. *GPST* features a mixture of news, practical articles, interviews, career features and other content that we hope will both help and entertain GPs progressing through their training. In this issue Dr Clarissa Fabre of the Women's Medical Federation answers to the so-called "feminisation" of general practice, while our regular careers feature considers the advantages of being a GP in the armed forces. Contact gpst@mddus.com for a copy and to subscribe.



Private practice earnings

MDDUS subscription rates for doctors and dentists with income from private practice is based on statements of estimated gross earnings from individual members as set out in the *Membership Agreement*.

Members are asked to monitor gross private earnings as their subscription year

IN BRIEF

RESPONSIBLE FOR S12 MENTAL HEALTH ACT ASSESSMENTS?

MDDUS has undertaken a review of the risks associated with doctors specialising in S12 Mental Health Act Assessments. 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.

WELCOME BACK OFFER FOR StRs We've listened to your feedback and ditched the incentive gifts in

favour of an amazing welcome back rate of just £35 for doctors in specialty registrar 1-3 posts. Reactivate your membership with MDDUS now for a saving of £15. Call MDDUS on 0845 270 2038 or email membership@mddus.com quoting your membership number.

WELCOME BACK!



Rise in calls from “risk-aware” members

AN increasingly “risk-aware” culture amongst MDDUS members and healthcare professionals in general contributed to a large rise in advice calls to MDDUS last year.

The team of medical advisers at MDDUS handled a record total of 9,779 contacts from those seeking help in 2010 up more than seven per cent on the year before.

One reason for the jump in the number of telephone calls, letters and emails to advisers is that doctors appear to be more risk aware and proactive in seeking advice at an early stage about potential problems. The rise may also in part be due to publicity from a number of recent high-profile negligence cases.

The analysis of all calls, emails and letters handled by MDDUS medical advisers during 2010 revealed the top five reasons for making contact as: patient complaints, confidentiality, general claims advice, GMC issues and difficult patients. Calls from medics raising issues about problems with their colleagues also increased during the last year.

Dr Jim Rodger, head of professional services, MDDUS

progresses and notify the MDDUS if at significant variance from the initial estimates. Gross earnings include but are not limited to fees, salaries, bonus payments and dividends before the deduction of any expenditure.

In our agreement with members the MDDUS reserves the right at any time to require evidence relating to private practice earnings and can carry out periodic audits of members’ private practice earnings. Please remember that falsifying or failing to provide full details of private practice earnings may affect the benefits of membership or result in the withdrawal of indemnity and access to other services provided by the MDDUS.



Take care with patient falls

EACH YEAR around 282,000 patient falls are reported to the National Patient Safety Agency from hospitals and mental health units in England and Wales. Over 96 per cent of these result only in minor injury or no significant harm but patient falls still account for 1,390

fractures (840 hip fractures) and 30 intracranial injuries (mostly subdural haematomas) reported per year. The true figure is likely to be much higher due to under-reporting.

These figures are cited in a Rapid Response Report (RRR) issued by the NPSA in January of this year. It also included analysis of patient safety incidents logged by the National Reporting and Learning System over a 12-month period indicating that around 200 patients with fractures or intracranial injury after a fall in hospital experienced some failure of aftercare. These included:

- delayed diagnosis of fractures from several hours to days after the fall
- neurological observations not recorded or noted at inadequate intervals, resulting in delayed diagnosis of intracranial bleeding
- sling hoists used to move patients despite signs or symptoms of limb fracture or spinal injury
- delays in access to urgent investigations or surgery.

Patient injuries due to falls can and do occur in any medical or dental setting but in-patients are particularly vulnerable

having more acute medical problems such as delirium, stroke, systemic infections or cardiovascular and musculoskeletal conditions. Medication side-effects such as dizziness and incontinence can also make hospital patients more prone to falls.

In the report the NPSA states: “When a serious injury occurs as a result of an in-patient fall, safe manual handling and prompt assessment and treatment is critical to the patient’s chances of making a full recovery.”

It stresses the importance of ensuring that local protocols and systems are in place to help staff to consistently achieve this. Access the RRR at <http://tinyurl.com/4bednfs>



● **COMMISSIONING 2011 CONFERENCE** Primary care in England is undergoing its most radical overhaul since the NHS was founded and MDDUS is keen to be at the forefront of change, representing the needs and interests of all our UK members. To that end

we are a principal sponsor of the Commissioning 2011 Conference on 14 and 15 of June at the Olympia in London. Health Secretary Andrew Lansley will be speaking at the event organised by the National Association of Primary care and a number of free delegate places are

available. MDDUS members are eligible to apply for these by visiting www.commissioningshow.co.uk.

● **WANTED: MEDICOLEGAL REPORT WRITERS** MDDUS has been requested to announce that GPs interested in providing medical reports for personal injury cases in

Scotland are currently being sought by solicitors representing the interests of several national insurers. Some level of experience is helpful though not essential as further training and mentoring will be available. Fees paid will reflect current rates. If interested, contact garretts@lineone.net

➔ Burnout common in poor performing dentists

HIGH levels of stress and burnout as well as alcohol and drug misuse are all prevalent factors leading to poor performance among dentists according to a wide-ranging literature review published by the National Clinical Assessment Service (NCAS).

The *Literature Review of factors influencing dental practitioner performance* considers previously published work by academics around the world and concludes that high caseload, health concerns, practice environment, personal crises and feelings of isolation are also contributing factors which may lead to poor performance.

NCAS' Associate Director of Dentistry, Dr Janine Brooks, said: "Dentists often experience sustained high levels of demand on their clinical expertise and, in addition, require



strong inter-personal skills with the patients they treat. If they operate alone or within small teams, they may have no-one else to turn to. It is therefore of little surprise that these practitioners sometimes suffer from personal health problems such as burnout".

She added that it will be vital for more research to be conducted to gain a better understanding of the issues affecting performance among dental practitioners. NCAS receives between 80 and 100 referrals each year from healthcare organisations needing advice and support in regard to performance concerns of dental professionals.

To read the NCAS report go to <http://tinyurl.com/4kgdwnw>.

➔ What makes a good doctor?

HEALTH professionals are being asked "what makes a good doctor" as part of a major review by the General Medical Council.

The GMC are looking to update their core guidance for doctors, *Good Medical Practice*, which sets out the principles and values that all UK doctors must follow. They have posted an online questionnaire which asks about issues such as whether the current guidance gives enough weight to patients' needs and rights and if it could be made more relevant for doctors in training and doctors in non-clinical roles.

The GMC have described the review as "the start of a wide-ranging conversation about what is good medical practice today." They are seeking the views of patients, the public and doctors through a range of online activities and face-to-face events throughout the UK.

Niall Dickson, GMC Chief Executive, said: "*Good Medical Practice* has a vital role to play in keeping patients safe and improving professional standards. The current edition has been used by countries all over the world which look to the UK as a leader in ethical principles for doctors. But we do need to make sure our guidance is up-to-date and reflects changes in the way healthcare is delivered."

A major public consultation on the new draft guidance will run from October 2011 to January 2012. To take part in the review of *Good Medical Practice* visit www.gmc-uk.org/gmp2012.

➔ Doctors fearful of reporting colleagues

ONE in three doctors not reporting under performing colleagues avoid doing so out of fear of retribution, a survey has found.

Almost one in five UK doctors has had direct experience of an incompetent or poorly performing colleague in the past three years. And while three-quarters said they raised the alarm, almost a third of those who did not were too worried about retribution and a quarter said they hadn't sounded the



alarm because they thought someone else was taking care of the problem.

The findings were highlighted in a survey of professional values published online in *BMJ Quality and Safety*. Researchers spoke to more than 1,000 UK doctors working in primary care and hospital medicine and almost 2,000 of their US peers in 2009 about various aspects of professional behaviour.

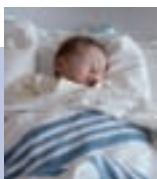
The survey revealed only eight out of 10 respondents in both countries strongly agreed that patient welfare should come before their own financial interests. And only around six out of 10 felt that they should disclose any financial relationships they had with pharma companies to their patients. Most respondents had received gifts or samples from these companies.

Not all doctors agreed that it was "never appropriate" to have a sexual relationship with a patient and when asked about ensuring competence, twice as many US as UK doctors agreed that periodic recertification (revalidation) was necessary. But only just over half of US doctors agreed with this, despite recertification having been in place for several years in the US.

IN BRIEF

• NEW TACK IN IDENTIFYING CHILDHOOD

MENINGITIS Red flag symptoms including confusion, photophobia, leg pain and neck pain/stiffness are more indicative of childhood



meningitis than headache, pallor and cool peripheries. These are key findings in new research published in the March issue of the *British Journal of General Practice*.

Researchers at Oxford looked at 1,212 children attending 15 GP

surgeries and concluded the findings should inform triage protocols used in assessing children with acute infections.

• **PENALTY FEE FOR MISSED DENTAL APPOINTMENTS** The British Dental Association is calling for the reinstatement of

the option for dentists to charge a fee for missed appointments. A survey conducted by the BDA suggests that NHS dentists in England each lose the equivalent of almost two weeks a year because patients fail to turn up for appointments and this could be

VIEWPOINT



PHOTOGRAPH: VISUALS UNLIMITED

➔ New GDC panel members to increase capacity

THE GDC have appointed 51 new fitness to practise panel members to help increase hearing capacity.

Ten dental care professionals (DCPs) were appointed along with 19 dentists and 22 lay members. The new panel members, who have been introduced since January of this year, will sit on the Interim Orders, Professional Conduct, Health, Performance and Registration Appeals Committees. No more than two new panellists will be used on a five-person panel during their induction.

Neil Marshall, Director of Regulation at the GDC, said: "We have seen an increase in complaints in recent years and are working hard to clear a backlog of cases. In addition to the new panel members we have also invested in more hearings staff and additional legal advisers in order to increase our hearings capacity.

"We're also reviewing our fitness to practise processes and procedures across the board in order to be sure that we are dealing with these matters as speedily, effectively and efficiently as possible."



**By Dr Ivor Felstein,
Retired Consultant
Geriatrician**

What's in a name – revisited

SOME time ago this writer made an ardent plea for changing the general medical title of 'consultant' to that of 'specialist'. This was not a casual suggestion or some strange whim. It was a sincere attempt to detach the relevance and importance of the work of medical consultants from non-health grandees calling themselves, say, beauty consultants or furnishing consultants. (A good friend interested in bees and honey and looking to set up an apiary claimed to have taken sound advice from a beehive consultant.)

Perhaps I was too busy looking at the top of the medical tree because I have received correspondence from several readers asking what I thought of the change in medical titles that are somewhat lower down the echelons of medical practice. Of course, some of these many titles have happily disappeared. I refer, for example, to posts such as junior hospital medical officer (JHMO) and senior hospital medical officer (SHMO), previously familiar to patients and fellow medics from the start of a new and pristine National Health Service in 1948.

In this new millennium, other than consultants, do we recognise properly the seniority and juniority (excuse the neologism) of current medical staff in hospital and infirmary settings? Fellow doctors may do so, but what about all those lay users, patients and visitors?

If some young man or woman with a dangling stethoscope and a white coat (or not) introduces himself or herself stating "Hi, hello, I am an (choose one)

F2 / FY1 / ST1 /ST2", will the patient be impressed, reassured or simply mystified? How about the even more obscure GPST, AiT or CT? It is pointless suggesting to me that the patient will either immediately seek a full explanation of this title or else will not be bothered, just as long as it is a real doctor in attendance!

I recently decided to test the water myself by asking a volunteer group of non-medical senior ladies and gentlemen, in turn, what they considered the initials FY1 and FY2 might stand for as related to a doctor in hospital. I ignored the odd impolite suggestion and compiled the following list of answers:

- FY1: first year medical school, foreign doctor here for a year, failed one year, fourth year intern, finishing year one, top young fellow (I liked that, except it should have been TFY).

- FY2 : foreign doctor here for two years, finished year two, finalist year two, favourite young doctor, second class (very smart assumption indeed).

The seniors all looked baffled or amazed when I mentioned the term Foundation Year. One said, surely the foundation year is their first medical school year. Logic not easily ignored.

Referring to the newer mulched titles formerly very familiar as registrar and senior registrars, the current joint description SpR proved less unsettling, with these interpretative suggestions from my fellow oldies: specially registered doctor, senior programme registered, specific records doctor, senior people's referral doctor and services-people-require doctor – now that's a cracker!

Was all this revamping of sub-consultant titles a classic and sad example of new (NHS) brooms sweeping clean – or a genuine effort that has failed its purpose? I am sure the Plain English Campaign would have a view.

denying significant numbers of other people the chance to access dental care.

● **NICE WEB RESOURCE FOR GENERAL PRACTICE** An online resource has been launched to help staff in general practice access NICE evidence and guidance. GPs

can view the top 10 NICE guidelines along with summaries of the key points for general practice as new guidance is published each month. There are also resources available to support the emerging GP commissioning consortia along with a range of

practical tools and support. To find out more, visit

<http://www.nice.org.uk/GP>

● **ONLINE GUIDE ON TREATING MIGRANT PATIENTS** A new *Migrant Health Guide* published by the Health Protection Agency offers a "one-stop-shop" of information

about caring for patients who have moved to the UK from abroad. The free guide offers GPs and nurses a wealth of information and resources on the health issues associated with over 100 specific countries. Access the guide at:

www.hpa.org.uk/MigrantHealthGuide

FORGET THE CARRIAGE CLOCK

Ian Watson

OCTOBER 2011 will see the abolition of the Default Retirement Age (DRA) which means that employers who had adjusted to the 'planned retirement' regime introduced in the 2006 Age Discrimination regulations will now have to reconsider how they deal with the retirement of their staff.

Under the previous regime, employers could compel staff to retire on or after their 65th birthday, provided staff were given at least six months' notice of their retirement and given the opportunity to formally request to stay on beyond the proposed retirement date. To comply with statutory obligations employers would need only meet with the staff member and give consideration to the request. Refusal to extend employment would, under the old rules, be considered a fair dismissal so long as the retirement was not exposed as a sham to get rid of staff who were not performing or attending adequately – with the employer thus avoiding the inconvenience of a protracted performance or absence management process for that employee.

From October this year, this planned retirement procedure is abolished along with the DRA and from April practices will be unable to give the requisite six months' retirement notice to staff approaching their 65th birthday before the DRA is scrapped.

Of course this does not mean that someone wishing to voluntarily retire (at any age) cannot do so – assuming that they can afford to! The provisions also have no direct connection to the state pension age. But this change does create a dilemma for employers who previously relied on the DRA to shed older staff with relatively little difficulty.

Some employers have contracts of employment or partnership agreements which make reference to 'normal' or 'contractual' retirement ages. However, they will be unable to rely on these documents in order to argue for contractual authority to compulsorily retire employees or partners at a particular age. To do so will risk a claim of



"Many employers don't bother with a fixed retirement age"

age discrimination.

It will be possible under new regulations for an employer to justify the retirement of an employee or partner – but only by showing that the business aim for doing so is legitimate and that the decision to retire the person is proportionate to that aim.

From previous case law, we have some idea as to the ways in which an employer might persuade a court that a compulsory retirement was justified. The following have been found to be 'legitimate aims' by the courts in recent age discrimination cases.

Retiring older workers:

- facilitates workplace planning
- facilitates the recruitment and retention of younger workers
- protects the dignity of older workers from undergoing rigorous performance management
- avoids an adverse impact on provision of pension and other employment benefits
- enables the sharing of job opportunities amongst generations.

However, practices should be wary of assuming that the guidance from these cases will transfer directly to their own circumstances.

Our view at Law At Work is that employers facing age discrimination

claims arising out of compulsory retirements in future will be required to produce before court detailed evidence of why they are seeking to retire employees at a particular age and why – in the case of the particular employee they are wishing to retire – this is an appropriate course of action.

In practice, there is a lot of evidence to suggest that many employers do not bother with a fixed retirement age, as they simply look at each employee's case on its merits as they approach (or in some cases go well beyond) 'normal' retirement age. If the person is physically and mentally capable of carrying on working in the job, then most employers will welcome the employee staying on for as long as they and the employer wish to perpetuate the

relationship. This is particularly appropriate when one takes into account the demographic changes in the labour force which will result in the age balance of the workforce steadily increasing in favour of older workers over the next decade.

Put simply, creating space for younger workers at the expense of older workers will potentially founder because the younger workers will simply not be available to fill the resultant vacancies.

Our clients are currently asking us to review their contractual arrangements and performance, absence and retirement policies for compliance with the new law. But, perhaps more importantly, they are also asking us to help them find ways of redesigning their retirement practice which will both meet the new legal regime and also the needs of their business in the coming years.

Practices would do well to do the same.

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



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



DON'T MENTION THE 'P' WORD

Deborah Bowman

THIS ISSUE'S COLUMN arose from an email exchange with the *Summons* commissioning editor. He asked if I might consider writing something about the proposed reorganisation of the NHS or would I consider the topic "too political". In so asking, he prompted me to return to a fascinating question – what is the relationship between ethics and policy?

The governance and practice of healthcare is an ethical matter. The values that underpin the organisation and delivery of healthcare are unavoidable and moral in character. Professionals and patients don't interact in a vacuum but in the complex machinery of the NHS as envisaged by its political masters.

Yet, healthcare and its ethics often seek and claim a position of moral neutrality. The convention for a disinterested perspective begins early. At my own institution, which trains only future clinical professionals and scientists, there are no Conservative, Labour or Liberal Democrat Societies and political affiliation, if it exists, seems to be expressed privately rather than overtly amongst the student body. In some situations, that is desirable: the therapeutic relationship would likely be compromised by stridently and inappropriately expressed personal opinions. However, the work that doctors, dentists and other clinicians do daily is an inherently political business in that the provision of healthcare is the enactment of policy. And that policy has a moral dimension: it is predicated on particular

values and it has far-reaching effects on the practice of millions.

I imagine many readers, even the avowedly apolitical, have fantasised about the ways in which the NHS could be improved. Many more have probably groaned as successive secretaries of state seek to impose their reforming vision on healthcare. Those fantasies and groans may seem at first glance to be nothing more than a healthy reflex to political meddling, but they warrant closer attention. For such responses demonstrate two ethical points. First, the vast majority of healthcare professionals care about how healthcare is provided. Second, there is a relationship between how individuals aspire to serve patients and how policy influences that daily work. In other words, clinicians can be politically disinterested but never uninterested.

"Politics was famously said to be the art of the possible"

What then is the ethical significance of the most recent proposals for NHS reform? First, professionals must acknowledge that political reform has a moral dimension. Whether one agrees with the specific recommendations, it is worth reflecting on the ethical assumptions embedded in the proposed changes. What do the proposals assume about fairness, equitable access, the role of the clinician and distributive justice?

Having identified the moral foundations on which the proposals are built, it is time to return to ethical basics. How will the proposed reforms inform that which is the daily bread of clinical practice? What are the implications of the proposals for the

therapeutic relationship? Will the virtuous doctor or dentist differ in the newly-envisaged NHS or are the virtues of altruism, service and inclusivity secure? How will conflicts of interest be conceptualised and understood in a new world of GP commissioning and multiple providers? What skills and competencies should medical and healthcare education develop in those new to the clinical professions and are they unaltered by the changing political landscape?

These questions can be met with widely-variable responses. That does not matter. Indeed, a range of response and divergence of opinion are usually beneficial for the quality of ethical debate. The point is that these are questions for everyone working as a healthcare professional to consider. Whether you are excited by the prospect of flexing commissioning muscle as a GP, believing it will secure better care for your patients, or uneasy about what you perceive as the conceptualisation of healthcare as a product for trade, time spent reflecting on the reasons for your position is time well spent. For those who resist the dichotomous approach and refuse either to wholly embrace or wholly reject the proposals, taking time to consider the underlying ethical dimension to policy change is instructive.

Whatever your response to Andrew Lansley's proposals, it reveals something about your moral compass and the ways in which you believe healthcare should be practised. It is via the medium of policy that fundamental ethical questions are raised. These questions matter because they are not often explicitly considered yet they shape every moment of our practising lives: what we believe the aims of healthcare to be, how the clinician–patient relationship should be, what it means to serve the public sector, the ways in which limited resources are distributed and what makes a 'good' doctor or dentist.

Politics was famously said to be the art of the possible. Whether you consider the secretary of state's proposals to be possible is a matter of ethics not merely political machinations in parliament. A considered response is essential.

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

LET THE RIGHT ONE IN

Peter Johnson

HIPPOCRATES OF KOS writing around the 5th century BC offered this advice on dealing with patients:

"...Perform all [these duties] calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition."

Though he has been called the father of Western medicine just what do you think a GMC fitness to practise panel would make of his approach to patient consent? Not to mention a civil or criminal court in regard to a potential claim of clinical negligence or assault.

In a recent presentation to MDDUS staff on risk assessment I displayed this quote from Hippocrates and posed the question: Would we want him as a member?

Of course this is completely unfair to the philosopher – judging him by the ethical and clinical practice standards of today. I was only making a point about how we as an organisation ensure that a doctor or dentist applying for membership represents an acceptable risk to MDDUS and its existing members.

And this is, indeed, a matter of importance to all MDDUS members. Remember that as a mutual organisation all members contribute equitably to a large fund which is maintained to provide legal support and indemnity. Our mutual status frees us from the need to pay dividends on cash surpluses and as such we have no profit motive.

This means that the MDDUS Board and management are in effect trustees of that fund and must ensure the organisation carefully assesses who can be allowed to

join and potentially call on our joint resources. We do not want to put the fund at risk from applicants who show a high likelihood of making calls on it at a significantly greater frequency and cost than a typical member. This leads us to the principle of risk assessment.

Risk assessment is, in broad terms, the process by which we decide to accept a risk and the conditions under which we would agree to accept it, including – in the case of a membership application – the subscription rate we need to charge in order to accept that risk.

MDDUS does not accept into membership anyone who applies regardless of what is disclosed on the application form. Viewed from a risk management perspective, the membership application form is the prime mechanism by which we assess risk exposure and consequently accept or reject the risk posed by an applicant.

Our membership and advisory teams scrutinise all application forms and assess them on various criteria. The risk assessment takes into consideration factors such as previous claims history, criminal convictions and disciplinary proceedings. We do take steps to help distinguish between serious and frivolous or irrelevant claims or complaints. Our obligation is to use a model which is effective in predicting the likely threat to our funds.

An obvious example of an applicant posing significant risk might be a surgeon working in private practice with a history of numerous expensive medical negligence payouts, or a dentist with serious disciplinary and clinical failings that have been upheld by a fitness to practise panel. All such applicants must be judged on an individual basis by MDDUS.

Over the last couple of years we have seen significant advances in the

development of our new, integrated computer systems. These systems have helped modernise what we do and helped add greater efficiency to our risk assessment processes. The systems also allow us to interrogate past data and check that consistency and equity are applied to

all prospective applications.

There needs to be consistency in our approach to vetting membership

applications and this forms a key part of our membership policy so as to reassure current members that their fund is being well protected and preserved. On the other hand MDDUS is not some exclusive club and we recognise that all healthcare professionals deal with risk everyday in their jobs and our role is to offer our broad membership access to support and protection should anything go wrong.

■ **Peter Johnson is risk manager at MDDUS**



"Would MDDUS want Hippocrates as a member?"

GP AND COLUMNIST PHIL PEVERLEY

Jim Killgore

PHIL PEVERLEY is a GP in Sunderland and best known as the acerbic contributor of a regular column to the weekly primary care magazine *Pulse*. He qualified in 1987 at Newcastle and spent five years as a wandering SHO before taking up a GP training post in Northumbria. He says: "Looking back on it, it was not until I actually started as a GP registrar that I discovered that general practice was all I had ever wanted to do."

Are you a real person as opposed to your colleague Copperfield at *Pulse*?

Yes, that's the name I was born with. That's a picture of me. I really am a Sunderland GP and my home address and phone number are in the book. Anyone can find them. I took the decision not to use a pseudonym on day one; partly because I stand by everything I write and partly because I like to see my name in the paper. Copperfield is real too, of course. Both of him*.

How did you get into writing?

Football fanzines. I'm a Hartlepool United supporter (and now their club doctor) and about fifteen years ago I used to submit articles to the Hartlepool fanzine *Monkey Business*. The first one was, as I recall, an analysis of baldy footballers in the lower divisions, with humorous pictures. This was a lot of fun but the pay (a free copy of *Monkey Business*) left something to be desired, so I wrote an 'In My View' piece for the now sadly defunct *Doctor* magazine and have been hitting, and occasionally missing, deadlines ever since.

Suppose you wake up one morning and find you're Andrew Lansley. What's the first thing you do?

Roll over and say hello to Mrs Lansley. I'm no fool. Later in the day, it's harder to say. I profoundly object to politicians telling me how to do my job, so I don't really feel comfortable reversing the situation. Possibly I'd direct some of my minions to work out just exactly what it costs to run NHS Direct and Walk-in Centres, and

compare, pound for pound, just exactly how much clinical work they do compared to traditional general practices. I know the answer intuitively but it would be nice to have the figures so that I could close the lot down in good conscience.

Do you think real patient choice is possible in a national health service?

Patient choice is nothing but a political buzzword. From the patient's point of view, it's a distraction. When we were first forced to introduce this concept, I used to ask my patients where they would like to be referred. I had a list of local hospitals, and I would ask where the patient would like to be treated. Invariably, this would be met with a look of blank incomprehension. "Er, that one" they would say, pointing at the big hospital visible from my consulting room window. I don't bother asking these days.

Do 'market principles' have a place?

A resounding no. Since I've been involved in practice-based commissioning I've become aware of the vast army of NHS administrators who are involved in doing nothing else but attempting to move money from one bit of the NHS to another bit of the NHS. This is insane; all the money comes from the same place, ultimately. Why employ literally thousands of adminidroids to argue over which specific budget it all comes out of? It frankly doesn't matter.

What threats do you see for UK general practice today?

Nurse practitioners are the worst one. As an experienced GP and a GP trainer, I know exactly how difficult and complex general practice can be. We don't let just any doctor be a GP these days. The training is long, arduous, expensive and, in the end, justifiably elitist. You've got to be bloody good to get your certificate, and rightly so. However, NHS Direct, walk-in centres, Darzi clinics and even some Judas general practitioners seem to think that nurses who have done a superficial three-month conversion course can be trusted to see unfiltered primary care problems and deal with them. This is dangerous thinking.

Sometimes in your column you seem... how to put it... rather grumpy and miserable. Is this a misconception?

If it's possible to get laughs out of Darzi

Clinics and revalidation, I'd love to know how to do it. Sometimes the subject dictates the tone. But foam-flecked splenetic ranting is a wonderful way to relax, and sometimes I sit back from the computer with bloodied fingertips and sigh "Ooh, that's better!" I get it down on the page, so it doesn't fester in my soul.

Do you have any regrets?

I've had a few. But then again ... no, there was one thing. I was a student in Newcastle in the eighties. This bloke used to come round the pubs selling his home-made magazine; I liked it and kept buying it. The magazine was called *Viz Comic* and I owned most of the first ten copies, each of which is worth literally thousands today. I regret lending them to a friend of mine, because he threw them out.

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



IN 1995 Debbie Purdy was diagnosed with primary progressive multiple sclerosis just after first meeting her husband, jazz violinist Omar Puente. Over the next few years her condition worsened to the point she began to consider the eventual option of ending her own life at a Swiss assisted-dying clinic. Fearful that her husband might be prosecuted for helping her travel to the clinic she sought clarity on the UK law on assisted suicide.

The Suicide Act 1961 makes it an offence in England and Wales to encourage or assist the suicide or attempted suicide of another person and carries a jail term of up to 14 years. But prior to Purdy's case some 101 Britons were known to have died with the assistance of Dignitas, an assisted-suicide charity in Switzerland, and none of the relatives had been prosecuted.

Both the High Court and Court of Appeal ruled that the courts could not change the law and Purdy's case was eventually taken to the House of Lords. Here the Appellate Committee ruled that the Director of Public Prosecutions (DPP) must clarify "what his position is as to the factors that he regards as relevant for and against prosecution" in cases of encouraging and assisting suicide. This landmark decision did not change the law – only Parliament has that power – but it did pave the way for the publication in February 2010 of the DPP guidance *Policy for Prosecutors in respect of Cases of*



Hastening the end

The debate is fierce and continuing – but regardless of your stance on assisted suicide, it's important for all medical professionals to have a clear understanding of current law on the matter

Encouraging or Assisting Suicide.

This document, which applies in England and Wales, was the result of a public consultation exercise with almost 5,000 respondents commenting on interim guidance produced in September 2009. It provides a list of factors for prosecutors to consider in cases of assisted suicide – 16 in favour and six against. Some of these factors are clearly relevant for doctors.

In particular among those tending in favour of prosecution are:

- Victim under 18 years of age
- Victim did not have capacity (defined in Mental Capacity Act 2005) to reach an informed decision to commit suicide
- Suspect giving encouragement or assistance to more than one victim, and these victims being unknown to each other

- Suspect acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer, or as a person in authority, such as a prison officer, and the victim being in his or her care.

Among factors tending against prosecution are:

- Victim had reached a voluntary, clear, settled and informed decision to commit suicide
- Actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance
- Suspect had sought to dissuade the victim from taking the course of action that resulted in his or her suicide
- Actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide.



Debbie Purdy with husband Omar Puente after losing her assisted suicide case in 2008

PHOTOGRAPH: PA

The policy makes clear that each case must be considered individually on its own facts and merits and a prosecution must be deemed “in the public interest”. But these factors do seem to indicate that there may now be a lower threshold for prosecution of doctors.

Risks to doctors and health professionals

So in what circumstances is a doctor likely to fall foul of the law and are the risks increased with the new guidance? The most obvious circumstance is when a patient directly requests assistance to commit suicide, for example the means by which to end his or her life. This is very distinct from a request for a doctor to take action to end a patient’s life – in which case the offence of murder would be relevant.

Doctors may also be asked to provide medical reports or copies of records in circumstances where a patient may be contemplating assisted suicide and it is possible that provision of this information could at a later date fall within the offence of assisted suicide. The advice to any doctor faced with requests from patients who (it is apparent) may be considering suicide has to be to consult their defence organisation, particularly taking into account the DPP’s emphasis that each case must be considered on its own facts and merits.

Application of the guidance

Only a few cases have been considered since publication of the guidance and none have ended in conviction. One case involved Dr Michael Irwin, who accompanied a patient with pancreatic cancer to a Dignitas clinic in 2007 and paid £1,500 as a “contribution” to the costs. The prosecutor in the case concluded that the patient was a strong-minded man with the

capacity to make an informed decision and “clearly did so without any pressure from Dr Irwin or anyone else”.

Another case involved an 84-year-old retired GP named Libby Wilson – a founder of the pro-euthanasia group, Friends at the End (Fate). She was questioned by police on suspicion of aiding, abetting, counselling or procuring a suicide for a multiple sclerosis sufferer of many years who died at home after speaking to the doctor twice by phone. It was decided to be not in the public interest to proceed against the doctor as her involvement was found to be “minimal” and out of “compassion” contributing only to the suicide victim’s “preparations”.

Falconer Commission

Perhaps it is no coincidence that organisations such as Fate or Dignity in Dying are behind moves to change the law. Last November saw the launch of The Commission on Assisted Dying, chaired by the former lord chancellor, Lord Falconer, which will examine how relatives may be able to have lawful permission to assist a loved one to commit suicide. This will include considering whether it might be appropriate to obtain a medical opinion or whether patients should apply to a judge for a court order.

In addition to Dignity in Dying, the Commission is supported by pro-euthanasia supporter, author Terry Pratchett, and this has led to questions on the independence of the Commission from disability charities and those working in palliative care. But it does seem likely that changes to the law will be proposed which may lead to assisted suicide being permitted, subject to certain safeguards. What the doctor’s role in these new arrangements will be is unclear but there may be legal obligations to be met. It will be interesting to see how these will sit with the moral and ethical obligations of medical practice.

Scotland and assisted suicide

The Suicide Act 1961 does not apply in Scotland, and although assisting a suicide is not a statutory offence it is still illegal north of the border. An individual suspected of this may be liable to prosecution under the common law of culpable homicide. The new DPP guidance is of no real assistance in understanding when or why the Crown office in Scotland is likely to pursue a charge of culpable homicide in cases of assisting a suicide and there is no similar guidance available from the Lord Advocate in Scotland. Just as in England, the test for the Crown office and procurator fiscal service in every criminal case is whether or not a prosecution is in the public interest.

Our advice to members practising in Scotland is nevertheless the same as in the rest of the UK: medical professionals should exercise real care when considering requests for medication, medical reports or copies of medical records, where there is a suspicion that the purpose of the requests is to gain the means or information with which to assist a patient’s suicide. Members are advised to contact MDDUS promptly for advice in such circumstances.

■ *Clare Pearce is a solicitor at the MDDUS office in London*

■ *Denise Ritchie is a solicitor at the MDDUS office in Glasgow*

Dr Clare Gerada

WHEN Tory Prime Minister Harold MacMillan was asked by a journalist what is most likely to blow governments off course, he famously said, “Events dear boy, events.”

I am reminded of his pithy reply when I speak to Dr Clare Gerada exactly three months to the day since she assumed the position of Chair of Council of the Royal College of General Practitioners. For while she has been in post just 90 days, she was voted in before the last general election on a medical manifesto that nowhere mentioned health secretary Andrew Lansley and the handing of control of £80bn worth of health spending to the group of doctors she was elected to represent.

So have political events – what many are calling the biggest shake-up in the NHS’s history – blown her off course? “Yes they have, to a certain extent,” she concedes. “I, like everyone else, believed there was going to be no new top-down reorganisation of the NHS. I still have the aspirations which I

Adam Campbell speaks with the new RCGP chair of council on the challenges she faces at this pivotal moment in the direction of general practice and the NHS

was voted in on, but clearly a reorganisation of the NHS where my profession has been put at centre stage has brought tremendous responsibilities. Ninety per cent of my time at the moment is spent doing commissioning.”

“Doing commissioning” has involved getting to grips with the detail of the new government’s plans for the NHS in England, understanding their potential impact and responding to them on behalf of the RCGP. The reforms include

abolishing all Primary Care Trusts (PCTs) and Strategic Health Authorities by 2013 and replacing them with ‘consortia’ of general practices. Primary care doctors in these consortia will then take charge of the NHS budget for mental health, hospital and community services.

While she has no doubt GPs will be able to handle any new responsibilities that come their way – and in fact has already set up the RCGP Centre for Commissioning to help them develop the skills they will need – Dr Gerada has questioned

the need for such root-and-branch reform.

"I am absolutely delighted that my profession has been put at centre stage of influencing and planning the health service," she says. "Putting clinicians in that role is something we've asked for years and at the College we welcome that. It's just that you could have achieved exactly the same thing by merging PCTs, capping management costs and putting GPs in the majority on the board. These things could have been achieved much more easily and more cheaply."

Voicing concerns

Dr Gerada has also expressed concerns at the speed at which the reforms are being pushed through, the potentially increased fragmentation of care, a reduced ability to provide co-ordinated comprehensive services and the fact that they will produce "a perverse postcode lottery that is based not on need but on resources".

What's more, she believes that GPs, with their hands on the purse strings, may well be put into the public firing line when it comes to sticky financial issues such as health cuts or winter crises.

Voicing these concerns has pitched her into the middle of the political fray and garnered controversial headlines, describing her as an "outspoken opponent of reform". In one article she was quoted as suggesting the moves will signal the "end of the NHS as we know it".

Does she stand by that? "It will be the end, in a sense. We'll see what the legislation says, but if you line the ducks up, so you have the commissioning consortia as the insurer, Any Willing Provider, patients able to register with any consortium, and with a personalised health budget, you've lined up an insurance-based model of a health service."

Ultimately, though, and despite the headlines, she remains hopeful. "I think the money is on that the outcome is not going to be altogether different from where we started, with GPs helping the commissioning agenda but not doing it," she says. "And I think, with GPs having the authority, things will be done without significant consultation, whereas in the past managers may have felt unable to deliver change because they were worried about GPs' reaction. So it's not a bad thing in that respect."

Daughter of a local GP

The government's health agenda is a fact of life that must be faced, but Dr Gerada is also determined to make progress on her own agenda, the one she was elected on – which talked of preserving the role of the generalist, encouraging leadership in general practice, extending the length of GP training from three to five years, looking after troubled doctors and addressing social and health inequalities.

The latter, in particular, is a subject very close to her heart. It has run through her whole career as a GP – as a partner of a group of practices that specialise in providing care to deprived, inner-city populations – and stretches back to her upbringing in Peterborough, where on home visits with her GP father she witnessed first-hand the delivery of healthcare amid serious poverty and slum conditions.

Originally from Malta, her father brought the family to the UK from Nigeria in 1963 and set up as a single-handed doctor. At first his practice was in the front room of the family home – "Our

front door was the entrance to the surgery, so I have always been immersed in patients" – and she started accompanying him on home visits at the age of nine. He would talk her through the cases and this helped lay the foundations for her future career.

At the same time he instilled in her an understanding that the GP was very much a part of the community. "People would come round who were struggling and you would help them. I would sometimes go and sit with them and babysit their kids. That's what being the local GP's daughter was."

She loved what her father did and there was never any question but that she would study medicine. After finishing at University College London, she did house jobs at the Whittington before training in psychiatry. At the Maudsley and Royal Bethlem psychiatric hospitals, she developed a strong interest in treating patients with addiction problems.

But even as she progressed in psychiatry she kept finding herself setting up and working in community-based services. Finally the penny dropped. "Every job I did just drew me more and more towards general practice. I missed looking after kids and pregnant women. I used to run a service for pregnant drug users, and I thought, why am I doing this? And then I ran a barefoot service for drug users, providing GP services in a street agency. And you know, that's general practice – so I decided I might as well do that."

She joined the Hurley Clinic in Lambeth and as part of her work there immediately set about developing the Consultancy Liaison Addiction Service, a shared-care substance misuse service providing support to GPs in delivering effective care to drug users. It is a service that has since been replicated across the country.

Wide view

Perhaps because she has always taken the widest view of what general practice is about, Dr Gerada has throughout her career made 'extracurricular' medical contributions, whether it was sitting on her LMC, acting as a senior policy advisor to the Department of Health or being on the board of the South London Faculty of the RCGP. "I've always done national stuff, middle stuff and GP stuff, all at the same time," she says. "I don't know why. I think it's just because it's there."

Whatever her reasons, it was a drive that resulted in her proudest achievements to date. In 2000, she established the RCGP's groundbreaking Substance Misuse Unit as well as the Certificate in Substance Misuse, which has now trained over 4,000 GPs. And then in 2008 she helped to establish the Practitioner Health Programme, a confidential service for doctors and dentists in London with mental or physical health concerns and/or addiction problems.

And even now, she continues to combine 'national stuff' with 'GP stuff' and runs four to six clinical sessions a week with two groups of patients – sick doctors and drug users. It is something that, in some ways, distinguishes her from her predecessors in the RCGP role, many of whom have been educationalists.

"What I need to make sure during my chairmanship is that I don't lose the clinical side of it," she says. "Understanding what it's like to be a lonely GP going out on a home visit."

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



Haematuria

Mr Timothy Hargreave *provides advice on a common clinical conundrum*

HAEMATURIA (blood in the urine) may be visible (macroscopic) or microscopic. Visible haematuria is dramatic and most patients will not allow the matter to be ignored! All patients with macroscopic haematuria should be investigated.

In clinical and medico-legal practice it is usually microscopic haematuria that causes problems because for every person with macroscopic haematuria there are hundreds with lab or dipstick-positive microscopic haematuria.

Everyone has blood in the urine

The average normal person has about 1 million red blood cells in the urine each 24 hours which equates to about one red blood cell per high power field when the urine is examined under the microscope. An excess of red blood cells in the urine can occur with various pathological conditions of the kidney and bladder. One of the most common is urinary tract infection and thus microscopic haematuria is a relatively frequent occurrence in women because they are more prone to such infections. Potentially life-threatening conditions such as bladder cancer can also cause macroscopic or microscopic haematuria. The diagnostic challenge is to distinguish those people with amounts of blood sufficient to require further investigation and

not to miss serious and life-threatening conditions such as bladder cancer.

The most frequently used method to test for blood is the chemical dipstick. In general the threshold for dipstick testing is designed to show negative when there are very low (normal) numbers of red cells in the urine and positive if more than normal, but with any lab test which involves thresholds there are false positives and negatives. In the interests of safety the threshold for the dipstick test tends to err on the side of false positive results. This results in relatively large numbers of people having positive dipstick tests for blood in the urine who then go on to further investigations which all turn out to be normal.

To avoid massive over-investigation it is normally recommended that in the absence of any other urinary symptoms or indicators (see my red flags opposite) referral for specialist opinion or investigations (cystoscopy and ultrasound imaging of the kidneys) should be deferred until after at least two positive dipstick tests. A less selective policy would be prohibitively expensive and probably do more harm than good. Although cystoscopy is a low-risk procedure there are nevertheless some risks, such as introducing urinary infection (or very rarely urethral trauma), and these have to be considered when dealing with large numbers of people. Most instances of chemical haematuria are of no significance and it is this dilemma that is a recurring source of litigation.

Processing urine specimens

Ideally patients should be given clear written instructions or directed to an

appropriate website (e.g. [www.patient.co.uk/health/Midstream-Specimen-of-Urine-\(MSU\).htm](http://www.patient.co.uk/health/Midstream-Specimen-of-Urine-(MSU).htm)). For those who are asked to provide a repeat sample following an initial positive test it is worthwhile re-emphasising collection instructions as people tend to take a lot more care for any repeat test. For detection of true positive blood it is best to collect a midstream sample taken during the first void after waking.

A common error which can result in litigation is the single positive test which is then forgotten, filed, ignored or simply written off as a false positive because of the lack of any symptoms. Another problem is failure of communication between health screening clinics, occupational health clinics and general practice so that results are not collated and nobody identifies that more than one urine test has been positive. It is always a good idea to advise the patient that there is a positive for blood urine test and that the test needs to be repeated and that the patient should chase the matter up if arrangements fail. Written advice to the patient is particularly helpful when different agencies are involved.

Red flags

There are a number of indicators which would lower my threshold for investigation or would indicate the need for a third urine test three to six months later in a situation where the first test is positive and the second test negative.

- *More than one positive for blood urine dipstick test or more than one positive for blood urine lab test.* Further investigation is normally indicated in this situation.
- *Proteinuria and in particular casts (if microscopy has been performed) may indicate renal disease.* To confirm proteinuria it is often appropriate to repeat the urine test taking particular care about urine collection, especially in women. Other indicators of possible renal disease include hypertension and raised blood urea or creatinine. There is a trap for the unwary in patients with indicators of renal disease and macroscopic haematuria as renal disease may co-exist with bladder pathology such as transitional cell carcinoma. The general rule is that all patients with macroscopic

haematuria should have a cystoscopy and upper tract imaging by ultrasound. There has been litigation when a more advanced bladder cancer has been found after several years of medical treatment for renal impairment.

- *Ask about symptoms.* With the exception of obvious urinary infection (e.g. frequency, dysuria and positive urine bacterial culture), any other symptoms such as dysuria, pain and tiredness should be a red flag. Debris or bits and pieces in the urine, particularly in an older person, should not be ignored.
- *Regard men with suspicion!* Men are generally less prone to urinary infection than women and microscopic haematuria is less frequent. Older men may get urinary infection in association with prostate obstruction and residual urine but microscopic haematuria may also occur with prostate cancer.
- *Beware of smokers.* There is a strong association between tobacco smoking (particularly cigarettes) and transitional cell cancer of the bladder. This is the fifth most common cancer in the UK (twice as common in men) and in its early stages can be treated through a cystoscope or by intravesical chemotherapy and without the need for major ablative surgery or radiotherapy. Missed bladder cancer despite two or more positive blood urine tests is a recurring source of avoidable litigation.
- *Consider occupation.* Modern health and safety legislation restricting the use

of carcinogenic chemicals in the rubber and chemical industries has made occupation a less important consideration. However, previous exposure to organic chemicals or mention in the patient history of past surveillance urine tests by an industrial occupational health service are indicators that the person may be at risk.

- *Recurrent urinary infection.* Do not dismiss positive urine blood tests in the patient (often an elderly woman) with recurrent urinary infections, as squamous cell carcinoma of the bladder is associated with chronic urinary infection.

NICE guidelines

Current NICE guidelines (www.nice.org.uk/CG027) on referral for suspected urological cancer are more or less in accord with my own red flags although I take particular note of cigarette smoking. But the guidelines do not address the common situation where there is one positive test and then a repeat test 2-3 weeks later that is negative.

My bottom line advice is:

- **One positive test with no other indicators:** wait 2 weeks and repeat test taking care to emphasise proper collection of the sample. If still positive refer for investigations. If negative discuss with patient and advise to come back if any symptoms or any change in urine colour OR arrange repeat urine test in 3-6 months; if 3-6 month repeat test negative no further action. Arranging the repeat test in 3-6 months has the advantage of not relying on the patient.
- **One positive test with a red flag indicator:** the choice depends on the red flag indicator but is either to refer for investigation or repeat the urine test. If the repeat test is negative then I would organise a third repeat test in 3-6 months and of course advise the patient to come back if any symptoms.

■ **Mr Timothy Hargreave MS FRCSEd FRCPEd FEB(Urol)** is a senior fellow in the Department of Surgery at Edinburgh University and a former consultant urological surgeon at the Western General Hospital, Edinburgh

INNOCENT CAUSES

Innocent causes of microscopic haematuria include:

- Menstruation – repeat the urine test when not menstruating
- Haemorrhoids – be careful attributing haematuria to haemorrhoids; unlikely in men, may sometimes confuse in women.
- Strenuous exercise – may cause haematuria in younger people but diagnosis made only after investigations have excluded other problems

Make it your business

Dentists are in a unique position to help victims of domestic abuse. Here Dr Christine Goodall of Medics against Violence describes a new training programme to make it easier

DOMESTIC violence has recently been described by a senior Scottish police officer as “a badge of shame for Scotland”. Over the last Christmas and New Year period 9,812 incidents were reported to the police, nearly 2,000 more than the previous year. While this, to an extent, reflects efforts being made to encourage victims to report violence it is still an alarmingly high number. Every 10 minutes the police in Scotland deal with an incident of domestic abuse but it takes around 35 previous incidents of abuse before the victim feels able to make that call to the police or support services. In 2008-9 alone 11 murders resulted from domestic abuse.

Domestic abuse is essentially about one individual exerting control over another and this may take the form of verbal, physical, emotional or sexual abuse. Many victims find it difficult to leave an abuser for a variety of reasons, including issues associated with their family and finances. While the majority of victims of domestic abuse are female, it can affect anyone regardless of their gender, sexual orientation, age, disability, ethnic background or social class and this is an important point to remember.

The elephant in the room

Have you ever sat in your surgery after a patient has left and asked yourself how she really got that broken upper incisor or that black eye? Did she give you a story that didn't quite ring true? Were you too embarrassed to ask more questions? Did you think it was none of your business? Well, you are not alone. Domestic violence is something notoriously hard to deal with and raising the issue is something that many dental professionals find extremely difficult. This often means that a victim may leave the surgery without being asked about abuse.

So how is domestic violence relevant to dentistry?

Most victims of domestic violence suffer injuries to the head or neck; in fact facial trauma in women is more likely to be due to domestic violence than any other cause. Dentists often form long-term relationships with their patients and their families so are in an ideal position to notice changes in someone's appearance or behaviour and signpost victims towards appropriate help.

However, there are barriers. A study from the USA in 2001 found that although 47 per cent of dentists suspected that a patient had been a victim of domestic abuse, 87 per cent never screened patients for domestic abuse. Unfortunately this often means that the 'golden' moment where help could be offered is lost. Very real barriers do exist and they include lack of training and time but also fear of offending the patient, embarrassment and a lack of awareness of what to do to help. Research shows that as many as 85 per cent of women visiting their dentist with signs of abuse were not asked about it, and the same study showed that 70 per cent of patients who sought help wished the dentist had asked them about it. Sometimes just asking is enough to encourage the victim to seek help.

Remember AVDR

Medics against Violence, a Scottish charity, was founded in 2008 by three individuals with dental qualifications who felt we should do more to help prevent the violent injuries we see in our day-to-day practice. To this end we researched what, if any, programmes for domestic violence were available for dentists. We came across AVDR (Ask Validate Document Refer) developed by Dr Barbara Gerbert and her coworkers at the University of California, San Francisco, School of Dentistry. This programme had been designed, evaluated and found to be

PHOTOGRAPH VISUALS UNLIMITED

SOURCES

- Love C et al (2001). Dentists' attitudes and behaviors regarding domestic violence. The need for an effective response. J Am Dent Assoc. 132(1):85-93
- Gerbert B et al (2000). Simplifying physicians' response to domestic violence. West J Med. 172(5): 329-331
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"Sometimes just asking is enough to encourage the victim to seek help"

effective, so with Dr Gerbert's permission we adapted it for use in Scotland. The first cohort of dentists in Scotland received training in the use of AVDR in November 2010.

So how does it work? The programme is very simple and doesn't require any additional skills; nor does it require the dentists to get involved with trying to deal with the abuse or the abuser. There are four steps:

1: ASK The most important and first step is to ask the patient about possible abuse. Asking in a non-judgemental, caring way will often encourage a victim to disclose. Always ask in private and reassure the patient that everything they tell you is confidential. Even if a patient denies any abuse at this stage don't be discouraged as the fact that you as a trusted healthcare professional have raised the issue may encourage them to seek help once they have left the surgery. Routine screening for domestic abuse has already been introduced in key medical settings including maternity services, mental health and emergency medicine across Scotland so you may decide to include this in your routine medical history for all patients.

2: VALIDATE Telling your patient that abuse is wrong and totally undeserved is the next step. Many victims believe that the abuse is somehow their fault and these validating messages can provide them with the confidence to do something about it. It also lets them know that you care about their safety; even if they chose not to disclose the abuse to you it is still important to let them know that you feel abuse is wrong.

3: DOCUMENT It is very important to document the signs and symptoms of any injuries as well as any disclosures that the patient makes about abuse carefully in your notes. Use the patient's own words if they tell you about the abuse and be as accurate as possible. Diagrams, photographs and radiographs (for example, if required for management of broken teeth) can also be very helpful if a case goes to court.

4: REFER Finally you can refer a patient or signpost them towards help. There are many organisations experienced in dealing with domestic abuse that are best placed to provide detailed advice and help to victims. Dealing with the details of the abuse, the abuser and providing a holistic solution is not the dentist's role so referring patients on to specialist services by having phone numbers of help lines available in the practice is the best way to support your patient.

When the police become involved

Sometimes your support may encourage a victim to report the abuse to the police. If this happens, the police will respond immediately and the abuser will be detained in police custody until the matter can be investigated. If you have seen the patient following an injury you may be asked for a statement, your notes will be taken as evidence and you may be required to attend when the case comes up in court. If your statement and notes are clear and factual it may be possible for the defence and prosecution to agree your evidence without you being present in court, so good clear note taking is of the utmost importance.

For more information on the Domestic Violence Initiative visit www.medicsagainstviolence.co.uk. We provide free training in the use of AVDR to large groups and will soon have a number of teaching materials available via our website which can be used in practice settings.

You can also phone an MDDUS dento-legal adviser for guidance in dealing with specific cases.

■ *Dr Christine Goodall is a senior lecturer and honorary consultant in oral surgery at Glasgow University's Dental School and co-founder of Medics against Violence*

CASE studies

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

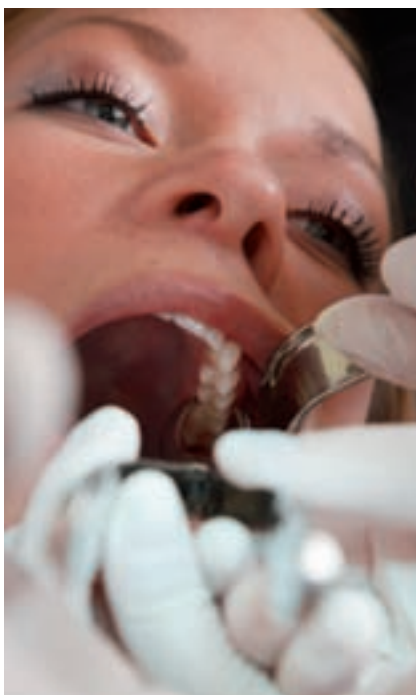
TREATMENT AND REFERRAL: PROBLEMATIC EXTRACTION

BACKGROUND: A 53-year-old woman – Mrs P – attends her dental surgery complaining of a sharp pain in an upper right molar when chewing. The dentist removes a large amalgam filling from the tooth and notes a fracture line running along the base of the cavity, close to the pulp chamber. He places a temporary filling but the patient returns two weeks later still in pain.

The dentist discusses treatment options including root canal therapy but explains that the prognosis for any restoration may be poor if the fracture extends into the pulp chamber. Mrs P opts to have the tooth extracted. During the procedure the crown fractures off the tooth. The dentist decides not to carry out a surgical procedure but instead divides the roots using a surgical bur to extract them separately. He notes that the roots are very close to the maxillary sinus as he can identify the sinus lining at the apex of the extraction site. A periapical radiograph is taken to ensure all the roots have been removed. Sutures are placed to assist with wound closure. Mrs P is sent home with a prescription for antibiotics and is advised "not to sneeze".

Just over a week later Mrs P returns complaining of tenderness in the area and the dentist removes four sutures and some necrotic tissue and prescribes a further course of antibiotics. Over numerous visits in the next two months it becomes clear the extraction site is not healing. Mrs P also reports "feeling air" in the socket and that when gargling she finds mouthwash trickling out her nose. The dentist confirms the presence of an oro-antral fistula and records that the patient should be reviewed every six months with eventual referral to hospital if necessary.

Five months later the patient attends a different dentist who notes that the oro-antral fistula is still present. She is referred to hospital where further X-rays are taken



showing a significant loss of alveolar bone. Radiographs on the unaffected left side also reveal that Mrs P has a low-lying maxillary sinus that would make any upper molar extraction problematic.

Over the next six months Mrs P undergoes three surgical procedures attempting to repair the fistula but all end in failure. Given the degree of alveolar bone loss only a graft, probably from the hip, offers any chance of success.

Solicitors acting for Mrs P contact the dentist regarding a claim for dental negligence. Among the specific allegations is a failure to obtain informed consent for the extraction. Mrs P claimed that she was pressured into the procedure as the dentist told her that treating the tooth with root canal therapy could "cost thousands" and with no guarantee of success. She claims also that no mention was made of the associated risks of extracting an upper molar.

It is further alleged that there was a

failure of reasonable care and skill in not taking a pre-operative radiograph to assess the risk of an oro-antral fistula. Had the dentist done so, the low-lying nature of the maxillary sinus would have been noticed and Mrs P could have been referred to a specialist and been made more aware of potential complications. The claim also cites a failure to refer Mrs P in timely fashion after it was clear the defect was not healing thus avoiding a long period of pain and suffering.

ANALYSIS/OUTCOME: The dentist contacts MDDUS and a dento-legal adviser commissions an expert report from a specialist in oral surgery. He examines the patient records and all relevant notes and finds fault with the dentist's treatment in a number of respects.

In failing to take a pre-operative radiograph in order to judge the degree of difficulty of the extraction, the dentist was not able to provide Mrs P with an adequate assessment of the risks such that she could give informed consent. Knowing the risks of extraction might have affected her decision to not opt for root canal therapy. The surgeon could also see no justification in the long delay before referring Mrs P to hospital.

Given the criticisms by the expert it was deemed best by the MDDUS adviser and lawyers to negotiate a modest settlement with Mrs P's solicitors.

KEY POINTS

- Take pre-operative radiographs to assess risk for dental extractions, if appropriate, and ensure that taking such a radiograph can be justified.
- Make a timely referral in any case of a non-healing oro-antral fistula.
- Ensure patients are fully aware of the risks and potential complications before assuming consent.



GMC: MISSED ARF PAYMENT

BACKGROUND: Dr N had recently moved house and was going through an exceptionally busy time. He had made arrangements for a neighbour to collect his mail from his former home and forward this to his new property. In the large bundles of mail that he received on a fortnightly or monthly basis, he failed to take proper notice of letters from the GMC reminding him that his Annual Retention Fee (ARF) was due for payment. The deadline for payment passed and the GMC wrote to Dr N to advise him that his name had been erased from the GMC register. Dr N received this letter some days later, in a bundle of mail forwarded by his neighbour. He realised that he had been working without registration and even though he informed his employer and ceased working immediately, his employer regarded this as gross professional misconduct and terminated his employment.

Dr N applied to have his name restored to the GMC register but discovered that the GMC did not consider this to be a simple administrative process. Not only did Dr N have to pay an additional 'administrative fee', he also had to wait until the GMC undertook various investigations into his fitness to practise. As a result of a dispute with his former employers, certain concerns were communicated to the GMC and Dr N was advised that he would have to attend a hearing before the GMC's Fitness to Practise Panel. It was for him to satisfy the Panel that his fitness to practise was not impaired, even though the GMC had not been provided with evidence which cast any doubt at all over his clinical skills.



ANALYSIS/OUTCOME: MDDUS assisted Dr N with preparation for and representation at the GMC hearing. During the course of the hearing, the Fitness to Practise Panel was asked by the GMC to consider whether Dr N's apparent inability to cope with administrative responsibilities during busy periods in his personal life brought his fitness to practise as a doctor into question. Fortunately, Dr N's application for restoration to the GMC register was successful at the end of the hearing but he had by this time been unable to work for a period of some nine months.

This case demonstrates the importance of ensuring that administrative responsibilities are taken seriously. The GMC do not consider it sufficient for doctors to have strong clinical skills; they want to be assured that doctors can discharge all of their professional responsibilities efficiently even during busy periods. MDDUS would encourage its members to always take notice of GMC correspondence, and also to consider arranging for the ARF to be collected by the GMC by way of direct debit.

KEY POINTS

- Ensure system in place for maintaining yearly ARF payments.
- Consider a direct debit for the ARF but still check payment made.
- Take administrative responsibilities seriously.



CHILD PROTECTION: SERIOUS CONCERNS

BACKGROUND: A 31-year-old patient on methadone substitution therapy appears at her GP surgery along with her two-year old daughter. Calling out her name in the waiting room Dr B notices that the woman is clearly drunk. She admits as much when asked during the consultation which is for a skin infection.

Dr B finds on the patient's records that she has been subject to a child protection order for the neglect of an older child. He notices that the little girl with her is wearing soiled clothes and a jumper inadequate for the cold weather outside. Dr B grows concerned and asks the patient if she has seen a social worker in recent months. The woman becomes annoyed and tells him to



mind his own business. She then grabs the young girl who begins to cry and storms out the practice.

A closer look at the patient files reveals that the patient's current partner is also on methadone. Dr B is worried by the situation and phones MDDUS for guidance.

ANALYSIS/OUTCOME: The MDDUS adviser reminds Dr B that GMC guidance states that doctors play a crucial role in child protection and must always consider and act in the best interests of children and young people. The parents of a child potentially at risk may not want information disclosed about them if fearful that will mean they are denied help, blamed or made to feel ashamed. But the implicit advice to doctors is that "you must

not delay sharing relevant information with an appropriate person or authority if delay would increase the risk to the child or young person or to other children or young people".

Given the circumstances it is clear Dr B is justified in reporting his concerns to the local social work office or child protection lead and if necessary without the consent of the woman. Indeed he would be in breach of GMC regulations and liable to censure without a clear justification for not sharing his concerns.

KEY POINTS

- Promptly inform appropriate authorities should you suspect a child may be at risk of abuse or neglect – with parental consent if possible.
- Have a clear understanding of local child protection procedures to ensure no delay in necessary intervention.



PHOTOGRAPH: SCIENCE MUSEUM/SSPL

From the archives: my dear boy doctor

DENTAL CHAIR flirtations can so often go sour. An article from the *Manchester Guardian* of 3 June 1897 reports an action brought against a dental practice by a Miss Ida Orme, an American “public singer and song writer” seeking damages for an alleged “unskilled dental operation performed upon her by servants of Messrs. Eskells, Limited, dentists, carrying on business in the Strand, London”.

Miss Orme agreed to pay £7. 7s to have three teeth seen to and asked for a Mr Paget whose name was on the door. Instead she was treated by a “mere boy, scarcely twenty-three or twenty-four years of age”. In court she claimed the operation was very painful and badly done but six months later she attended the practice again and asked to see the same young man. She was disappointed to hear he had gone to America.

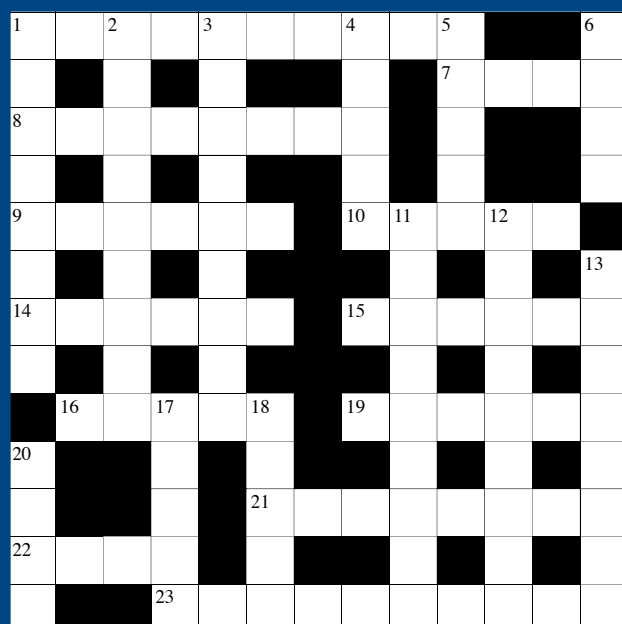
The patient was attended by another young dentist who Miss Orme claimed, “despite her protestations, tried to knock out the root of her tooth with a steel hammer” which she later discovered had split the stump. The operation left her ill from nervous prostration and suffering professionally, “more especially as a report was started to the effect that she was insane”.

Under cross examination in court Miss Orme admitted having written a letter to the dental practice saying “the teeth are all lovely, thanks to the boy dentist”. It was also established that she had not made any complaint about her treatment until asked for the balance of her bill. Another “indiscreet” letter from Miss Orme to the young dentist was read out in court: “My dear boy doctor, – I really cannot come, I am so ill, but as soon as I am able will be in that chair of yours, for to tell the truth I am quite homesick to see you again”.

In court that day was the boy doctor himself, newly returned to London. Asked by the lawyer for the defence whether he had been surprised to see the letter, he answered: “Yes. I was very surprised.” And when asked if he had answered it, replied: “Certainly not.”

Despite evidence by another dental expert attesting to the genuine injury done to Miss Orme’s gums, the jury found in favour of the defendants.

Crossword



ACROSS

1. Sympathomimetic drug used to treat cardiogenic shock (10)
7. Medicine (4)
8. Disorder of the eye (8)
9. Anterior uveitis (6)
10. Female reproductive gland (5)
14. Visual aphasia or word blindness (6)
15. Groin (6)
16. Twin as of Dolly (5)
19. Malignant neoplasm (6)
21. Posterior tendon of the leg (8)
22. Considers ethics of research projects (abbr.) (4)
23. Blood in urine (10)

DOWN

1. Swiss euthanasia group (8)
2. Model of perfect beauty (4,5)
3. Adept planner of tactics (9)
4. Insect in sexually mature phase after metamorphosis (5)
5. How Americans spell dropsy (5)
6. Jelly used in petri dishes (4)
11. Person skilled in the use of words (9)
12. Type of connective tissue (9)
13. Personal magnetism (8)
17. Mountain spinach (5)
18. Rub out (5)
20. Fluid secreted in liver (4)

See answers online at www.mddus.com.
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PHOTOGRAPH: MARK THOMAS/SCIENCE PHOTO LIBRARY

Object obscura: anatomical eye model

THIS model was made by Louis Auzoux and was used for demonstration purposes in the 1930s. Here the sclera has been opened to reveal the internal structure.

Vignette: paediatrician and pioneer in neonatal care, Dr Beryl Dorothy Corner (1910-2007)

WITH a budget of £100, Dr Beryl Corner established a premature baby unit in a tiny room in Southmead Hospital, Bristol in 1946. Only one other such unit existed in Britain at the time – in Birmingham – but this innovative project that promised great advances in neonatal care was greeted with hostility from the hospital's obstetricians. Undeterred, Beryl finally won their support and admiration by halving the mortality rates for babies in the first year and for successfully caring for the world's first quadruplets born by Caesarean in 1948.

The "Good quads" – Bridget, Frances, Elizabeth and Jennifer – became the focus of national and international media attention and earned Beryl worldwide acclaim for her groundbreaking work as a paediatrician. Three of the babies had been delivered easily but the fourth was not breathing. It was down to Beryl to find a way of bringing the child back to life. She explained: "We had no resuscitation equipment then such as we know it now. But I had a sucker that I sucked with a rubber tube down the baby's throat, and after about four or five minutes the baby cried and breathed; and she lived". Beryl nurtured the girls through their first months and stayed in touch with the Good family throughout her life.

An outstanding teacher, Beryl spent the majority of her career at the forefront of the development of paediatric medicine and made a significant contribution to modern neonatal care with her work on retinopathy of prematurity and kernicterus. Born in Bristol in December 1910, she qualified in 1934 at the Royal Free Hospital Medical School in London at a time when hospital boards refused to appoint women registrars and female consultants were thin on the ground. She was kept on as a house physician and then house surgeon before spending a year as a consultant paediatrician at Brompton Hospital from 1936 to 1937. She returned to Bristol Children's Hospital where she

spent the rest of her career.

Beryl's career was an illustrious one and she earned many accolades. With the help of her team, she diagnosed and treated the first "rhesus baby" in 1943 and was one of the first four women to be admitted to the British Paediatric Association in 1945. She later became



president of the paediatric section of the Royal Society of Medicine. In the early post-war years, she was paediatric consultant to Bristol Zoo where she contributed to the successful breeding programme for orangutans. This experience proved useful when setting up the premature unit at Southmead.

In 1959 she was one of the founders of the Neonatal Society which established the specialty as it is today. As part of a government committee on prematurity, she promoted premature baby units throughout Britain, extending their scope to help all babies born with health problems. She set up schemes in the late 1960s for specialist nurse training, published numerous research papers and

three books on neonatal disease and even saved the life of television presenter Jill Dando when she suffered a heart disorder as a tiny baby. In 1967 she was elected to Fellowship of the Royal College of Physicians.

Beryl achieved extraordinary results in neonatal care despite the basic equipment available – in the 1940s there were no incubators, piped oxygen, plastic materials, electronic monitoring or micro-methods for biochemistry. But Beryl was never one to be defeated and improvised by adapting standard cots containing hot water bottles and a thermometer.

She established meticulous aseptic nursing techniques and paid close attention to every detail of the babies' care.

She was also not afraid to break down barriers during her career. Small and fierce, Beryl championed women in the medical profession and helped female registrars by acting as their careers adviser from 1971 to 1988. Although she was tiny, she was known for her grit and determination and was not afraid to stand up to her male colleagues – even when they were twice her size. An obituary in the *Independent* described her as "bossy, difficult, bad-tempered, demanding and irascible. And yet her trainees loved working for her and held her in enormous respect and affection. Her peers adored her."

Beryl, who never had children of her own, continued working even after she retired, advising hospitals in India, serving as a magistrate and governor of her old school and as president of the Medical Women's Federation. She played the violin, collected art and antiques and was appointed OBE in 2006 in recognition of her pioneering work.

In his tribute, Dr Martin Crossley Evans described Beryl as: "Generous with her praise, wise, warm, compassionate and gregarious, her many friends, while poorer for her passing, have been greatly enriched by her example of loyalty and dedicated service."

**EARLY
BIRD OFFER**

MDDUS Practice Managers' Conference

Fairmont, St Andrews 29 February – 1 March 2012

The SIXTH MDDUS Practice Managers' Conference is once again returning to the recently refurbished Fairmont, St Andrews (formerly known as St Andrews Bay Golf Resort & Spa) on 29 February – 1 March 2012.

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

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

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	Early bird – non DPS	£279		Early bird – non DPS	£229
	Standard fee – DPS	£279		Standard fee – DPS	£229
	Standard fee – non DPS	£299		Standard fee – non DPS	£239
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	Standard fee – DPS	£239		Standard fee – DPS	£139
	Standard fee – non DPS	£259		Standard fee – non DPS	£149

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or call Karen Walsh on **0845 270 2034****