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IN THIS ISSUE

"YOU have still not claimed the compensation you are due for the accident you had. To claim then pls reply CLAIM." So reads the automated text message sent out to thousands of mobile phone users from a server in India.

Each message costs 2p to send and the mobile number of anyone who replies is sold for £5 to a UK firm. This particular reply is followed up by a call from "Andy" who discovers that the client has by chance had a recent accident – tripped on a step outside work and broke an ankle. Details are taken and the lead is eventually sold on to solicitors paying between £300 and £350 in the hope that it will lead to a lucrative compensation claim with a success fee stretching to five figures.

It's called "claims farming" and in June 2011, *The Sunday Telegraph* ran a feature exposing the practice – which is also now squarely in the firing line of proposed legal reforms published by Lord Justice Rupert Jackson. On page 10 Justice

Jackson answers questions on his attempt to address the spiralling civil litigation costs that burden the NHS and tax payers many millions of pounds each year – as well as MDDUS members.

Dealing with a compensation culture is part of the daily job of MDDUS dental adviser Claire Renton. In the second part of our series on the professionals who work with the Union (p 14) I chat with Claire about how she helps dentists face what sometimes seems a tide of blame.

In this issue we also look at the dento-legal implications of patients travelling abroad for low cost treatments (p 18). What obligations do UK clinicians have to these dental tourists? And on page 16, Professor Duncan Empey offers guidance for GPs on how to best address the vexing question of when to refer in cases of chest infection.

Jim Killgore, editor



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Cover image: Memory of an April Wood, by Lyndsay Ann Rutherford. 1997. Medium: oil on canvas. Size: 152 x 152cm. Lyndsay was born in Glasgow and graduated from Duncan of Jordanstone College of Art in 1997 with a BA (Hons) in Fine Art (Drawing and Painting). Her work is a distillation

of landscapes both as something seen and as something experienced and remembered. Art in Healthcare (formerly Paintings in Hospitals Scotland) works with hospitals and healthcare communities across Scotland to encourage patients, visitors and staff to enjoy and engage with the visual arts. For more information visit www.artinhealthcare.org.uk, Scottish Charity No: SC 036222.

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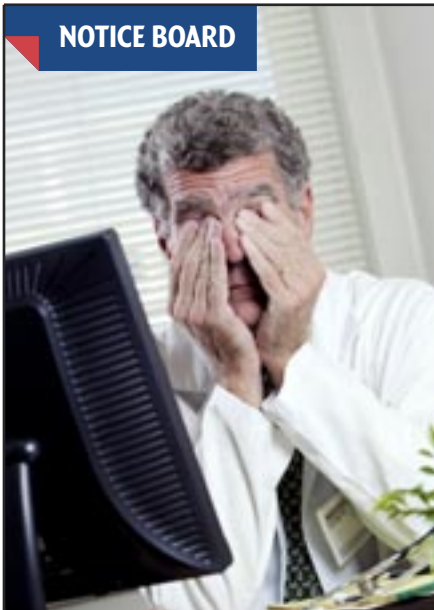
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➔ Burnout risk among clinicians

NO ONE can deny that the job of a healthcare professional is often a demanding one and that clinicians caring for their patients may sometimes neglect to care for themselves.

Doctors or dentists may think they are only hurting themselves by suffering in silence but studies have shown that ill health can lead to poor performance which in turn can jeopardise patient safety. MDDUS has dealt with a number of cases involving clinicians who have been subject to a complaint or fitness to practise proceedings relating to mistakes brought about by health problems. Often, such mistakes could have been avoided had the professional sought help sooner.

The General Medical Council has just launched a new advice website in a bid to tackle this issue. *Your Health Matters* encourages doctors who may be concerned about their health to seek help early, before the problem spirals out of control. It acknowledges that "the very qualities that make a good doctor, such as empathy and attention to detail, can also make him or her vulnerable to stresses and burnout or to turning to drugs or alcohol."

They urge doctors to register with a GP and to trust them to treat you in confidence rather than conducting unofficial "corridor consultations" with

colleagues. The guidance warns doctors not to self-diagnose or self-medicate for anything more than minor ailments.

Doctors should also pay attention to warning signs of illness and take them seriously. For example, feeling low or irritable or having poor concentration or low energy may be signs of burnout. Doctors are encouraged to try to maintain a healthy work/life balance and consider discussing concerns with family, friends and colleagues.

The GMC explains that while it aims to protect patients it is also there to support healthcare professionals. Doctors are encouraged to inform the regulator if they

have a health condition or a drug/alcohol problem that may put patients at risk. The GMC will then be able to assess the doctor and make recommendations on how to support them and help them back to safe practice.

However the guidance emphasises that only a small number of sick doctors are referred to the GMC each year and there is usually no need for GMC involvement for those who have insight into the extent of their condition, are seeking appropriate treatment, following the advice of their treating physicians and/or occupational health departments in relation to their work,

➔ Dental roadshow coming to town

DENTISTS can avoid some of the pitfalls that could lead to professional difficulties by signing up for one of nine dento-legal lectures being co-hosted by MDDUS throughout the UK in May and June of this year.

MDDUS has teamed up with dental equipment providers Wright Cottrell to host the lectures which kick off on Wednesday, May 23 in Newcastle, with further dates in Manchester, Leeds, Liverpool, Inverness, Aberdeen, Glasgow, Edinburgh and Dundee.

The sessions will feature MDDUS Head of Dental Division and adviser Aubrey Craig, who has long experience helping MDDUS members avoid situations that could lead to patient complaints, claims of clinical negligence or referral to the GDC. Experts from Wright and W&H will also lead sessions on national decontamination guidelines and how dentists can achieve a fully compliant practice.

CPD accreditation will be available. Go to the home page at www.mddus.com for a link to dates and venues for all the lectures or contact Karen Walsh at kwash@mddus.com. Tickets costs £30 with a light buffet available from 6pm and the programming commencing at 6.30pm.

➔ MDDUS welcomes new dental adviser

A new dental adviser has joined the professional services division at MDDUS. Mike Williams started in our London office in February and brings extensive experience in NHS, private and corporate dentistry. He has been a vocational trainer for a number of years, and is a former senior clinical teacher in Oral Surgery at Guys Hospital, London.



Mike qualified at the University of Dundee in 1979 (BDS), obtained MGDS in 1993, and is a Fellow of the Faculty of General Dental Practitioners. In 2009 he gained a Masters degree in the Legal Aspects of Medical Practice from the University of Cardiff. He is on the GDC specialist list for oral surgery and continues to work in a mixed NHS/private practice. We are pleased to welcome Mike to the team.

IN BRIEF

• DENTISTRY SCOTLAND

AWARDS The call is out for entries to the 2012 Dentistry Scotland awards being sponsored again in part by MDDUS. Categories include most attractive practice, best employer, best patient care, best

dental team and culminating in practice of the year, both north and south. Last year's inaugural awards ceremony was held at the Gleneagles Hotel in Perthshire and was so successful that the organisers have decided to return

there for the 2012 ceremony. For more information and details on how to enter go to www.dentistryscotland.co.uk

• HAS YOUR ROLE CHANGED?

MDDUS advisers rely on up-to-date member information to help them

provide the most relevant advice and support. If you are a doctor or dentist who has recently changed professional roles, then please inform MDDUS and we will update your personal information. This will help us provide each member with

and restricting their practice appropriately.

MDDUS is very experienced in helping doctors with health problems that impact upon their fitness to practise. Whilst the GMC's guidance does not expressly advise doctors to consult their medical defence organisation, MDDUS strongly advises members to seek our advice before contacting the GMC.

Help is also at hand for dentists suffering from health problems. The Dentists' Health Support Programme offers support to practitioners with alcohol and other addictive illnesses, while the British Doctors' and Dentists' Group, formed in 1975, is a mutual support society for doctors and dentists who need help with drug or alcohol problems.

ADAM conference to feature mock disciplinary hearing

DELEGATES attending the 2012 ADAM (Association of Dental Administrators and Managers) conference can take part in a live dramatisation of a mock disciplinary hearing, featuring an alleged case of breached patient confidentiality and misuse of Facebook. Produced by MDDUS staff, this interactive workshop will allow participants to air views and make a judgement before hearing the outcome.

MDDUS is the main sponsor of this year's ADAM conference to be held on May 18 and 19 at the Majestic Hotel in Harrogate. Among the speakers are Denplan's Roger Matthews, business planning expert Andy McDougall from Spot On Business Planning and Jann Gardner, specialist in healthcare delivery and service management. Delegates can also attend workshops on building an effective team, assertiveness skills, understanding the role of treatment coordinator, and dealing with bullying and harassment.

Go to www.adam-aspire.co.uk for further details and an application form.

Update your website to ensure GDC compliance

NEW GDC guidance on ethical advertising which came into effect in March has some very detailed requirements on how dental practices promote their services.

Among new conditions set out in *Principles of Ethical Advertising* is a checklist of information that must be displayed on practice websites. All dental professionals providing care mentioned on the site must give their GDC number, their professional qualification and the country where it was attained as in accordance with European guidance. In addition, dental practice websites must display:

- the name and geographic address at which the dental service is established
- contact details of the dental service, including e-mail address and telephone number
- the GDC's address and other contact details, or a link to the GDC website
- details of the practice's complaints procedure and information of who patients may contact if they are not satisfied with the response (namely the relevant NHS body for NHS treatment and the Dental Complaints Service for private treatment)
- the date the website was last updated.

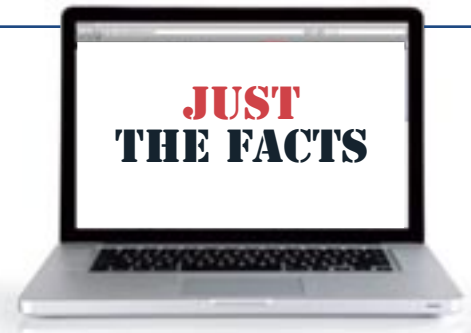
This information must be updated regularly. The guidance also states: "A dental practice website must not display information comparing the skills or qualifications of any dental professional providing any service with the skills and qualifications of other dental professionals."

In addition, the guidance addresses practice advertising, stating that dentists must ensure that any information uses clear language that patients can understand and all claims are backed up by facts. It also says that practices should "avoid statements or claims intended or likely to create an unjustified expectation about the results you can achieve."

In regard to specialist titles the guidance states: "Only dentists who are on a GDC specialist list may use the title 'specialist' or describe themselves as a 'specialist in...'. Dentists who are not on a GDC specialist list should not use titles which may imply specialist status, such as orthodontist, periodontist, endodontist etc.

"Registrants who are not on a specialist list should not describe themselves as 'specialising in...' a particular form of treatment but may use the terms 'special interest in...', 'experienced in...' or 'practice limited to...'" The guidance further adds that no specialist lists exist for dental care professionals, and DCPs should avoid misleading patients by using titles such as 'smile specialist' or 'denture specialist'.

The GDC makes clear that the onus is on dental professionals to be honest in their presentation of skills and qualifications. It states: "If you make misleading claims, you may have to justify your decisions to the GDC through our fitness to practise procedures."



a more personalised service. Contact our membership department on 0845 270 2038 or at membership@mddus.com
● BROWSE MDDUS CASE STUDIES ONLINE Over 100 MDDUS medical and dental case

studies drawn from our case files and covering a broad range of topics can now be browsed in the Resource Library at www.mddus.com. Cases are organised by topic area and have been anonymised to protect confidentiality.

● LONDON 'HOT TOPICS' Places are still available on MDDUS Hot Topic workshops being held in our London office in Pemberton Row. Topics include managing team conflict, confidentiality and data protection, problem solving and

decision making, and leadership and developing your team. For more information go to the Hot topics web page at www.mddus.com or contact Ann Fitzpatrick at afitzpatrick@mddus.com or 0845 270 2034.



Hospital continuity of care 'poor'

OVER a quarter (28 per cent) of consultant physicians rate continuity of care at their hospital as poor or very poor according to a survey carried out recently by the Royal College of Physicians.

In addition, 27 per cent judged their hospital as poor or very poor at delivering stable medical teams for patient care and education.

The RCP believes the results reinforce previous concerns of the increasing pressures NHS Trusts are facing due to the rise in acute admissions, an ageing population with increasingly complex conditions, and cuts in budgets and staffing. In order to address all these issues, the President of the RCP is setting up a Commission on the Future Hospital to be chaired by Professor Sir Michael Rawlins.

Professor Rawlins said: "I am delighted to chair the Future Hospital Commission, which could not come at a more appropriate time. As the Commission begins, it will be able to take into account the changes to the commissioning and care delivery processes of the NHS arising from the Health and Social Care Bill, and the conclusions of the Francis Inquiry, both

of which will underpin our work in improving care for the medical patient."

The commission is expected to report in Spring 2013.

BDA expresses concern over online patient feedback

NHS Choices allows serious but unsubstantiated anonymous allegations to be made about dental practitioners and is often too slow in moderating inappropriate comments, according to the BDA.

The "Patient feedback" feature on the NHS Choices website allows for individuals in England to comment on the dental care they receive or that of a friend or family member. It is not intended as a formal complaint procedure.

The BDA has appealed to NHS Choices following feedback from a number of BDA members about the way that the site allows unsubstantiated critical comment to be made about practitioners anonymously with an often-slow process for moderating inappropriate comments.

The BDA is also concerned that many primary care trusts appear to be retaining the editing rights for practice profiles on the website, despite previous assurances that the ability to edit would be opened up to practices as the feedback functionality on the site was rolled out.

Dr John Milne, Chair of the BDA's General Dental Practice Committee, said: "Dentists have very reasonable concerns about the way that malicious or even fictitious feedback can be given anonymously via the NHS Choices website. We're asking NHS Choices to take those concerns on board and act to ensure that this facility isn't abused and that the way the site is moderated and edited is fair and efficient."

"Gagging clauses" unacceptable says GMC

DOCTORS should not sign contracts with "gagging clauses" to stop them from raising concerns about poor quality care according to new GMC guidelines.

In a guidance document published in February – *Raising and acting on concerns about patient safety* – the GMC instructs doctors that they "must not enter into contracts or agreements with your employing or contracting body that seek to prevent you from or restrict you in raising concerns about patient safety. Contracts or agreements are void if they intend to stop an employee from making a protected disclosure."

It further points out that The Public Interest Disclosure Act 1998 protects individuals making disclosures that 'tend to show' that the health or safety of a person is or may be endangered.

Niall Dickson, Chief Executive of the General Medical Council, said: "These clauses are totally unacceptable. Doctors who sign such contracts are breaking their professional obligations and are putting patients, and their careers, at risk."

The GMC has also published new guidance on *Leadership and management for all doctors* highlighting how registrants also have responsibility for the safety and well-being of patients when performing non-clinical duties – including when they are working as a manager. Both guidance documents came into effect in March.

Access at www.gmc-uk.org



IN BRIEF

• **DENTISTS PREFER ONLINE CPD** A recent survey conducted by the GDC found that online learning is the preferred learning style of over half of dental registrants. Almost 6,000 registrants responded to the survey as part of an ongoing review of attitudes

towards mandatory CPD. The survey also found that 85 per cent of registrants feel they understand the GDC's current CPD requirements but 26 per cent want the GDC to be more prescriptive about CPD requirements in the future. View the full survey at

www.tinyurl.com/778qrgf

• **END-LIFE-CARE SUPPORT**

Practical toolkits for physicians and recommendations for trusts to improve end of life care have been published by the Royal College of Physicians (RCP) as part of a new report which recommends that all

physicians discuss options for end of life care early on so that patients and their carers have more time to make choices. Access at www.rcplondon.ac.uk

• **WOMEN IN FORTIES MOST DENTAL PHOBIC** Researchers at Sydney University in Australia have

VIEWPOINT



By Dr Barry Parker,
medical adviser at
MDDUS

Abolishing practice boundaries brings risk

GOOD communication is one of the cornerstones of high-quality patient care. As a defence union, we see the outcomes of communication failures, such as delayed referrals, result-handling problems and prescribing errors, on a fairly regular basis. Whilst some of this may be attributable to the highly demanding nature of work in the health professions and the inevitability of human error, risk can be minimised by ensuring that systems are tight. The benefits of having a core primary care team with good communication where everyone understands each other's roles and is aware of the systems in place and how to operate them, need hardly be emphasised. We have developed this model of primary care in the UK over many decades, and it is still the envy of the world.

The latest assault on this tried and tested model comes in the form of the Government proposal in England and Wales to relax practice boundaries for

patient registration. In the first model proposed, out of area patients will be allowed to register with a participating practice, presumably near their workplace, and cease registration with their home practice. A separate service will require to be provided should out of hours care be needed when at home. The second model allows attendance as a 'day patient' in a participating practice out of area, but retaining registration at the home practice.

These models are to be piloted in London, Manchester and Nottingham and are heralded as examples of increased convenience and patient choice. This may be the case, but if one were tasked with creating confusion, fragmentation of care and communication failure, it would be difficult to think of a better plan.

There are clear and obvious concerns whenever Dr A does not know what Dr B is doing, and they are both trying to treat patient C. Systems for investigation, referral and follow-up may vary between practices, and there may be lack of clarity in terms of accountability for the overall care of the patient. The BMA has emphasised the value of one GP practice knowing a patient well, understanding the social context and environment behind an illness, and if necessary assessing in the

home. There may be particular problems in patients with drug addiction in terms of monitoring supply of prescriptions, and there may also be difficulties protecting vulnerable patients such as children at risk due to lack of continuity and proper support and monitoring.

It seems likely that for those who are not too severely ill and still able to get to work, it may be convenient to be seen for treatment of a short-term acute problem while out of area. For those with complex problems, whether physical or psychological, the fragmentation of care could be positively damaging. Patients may be treated under two separate management plans with either duplicated or conflicting medication regimes. Unless the sharing of medical records between all participating practices is extremely efficient, the potential for confusion and mismanagement is considerable.

GPs are a resilient and adaptable group, and I am sure those in the pilot sites will do everything they can to make the system work. It can only be hoped that they will be given sufficient support in terms of communication technology to keep fully informed of each patient's progress in a timely manner, so that the inherent risks of this new venture are minimised.

More changes in dental fitness to practise

THE GDC is proposing the appointment of case examiners with statutory powers to make decisions in fitness to practise cases.

The case examiners would be drawn from a pool of dental professionals and lay people and would have powers to conclude a case without further action, issue a letter of advice or warning, or refer a case to a relevant GDC committee.

Details are provided in a consultation document and the proposed changes will require legislative amendment. They follow a range of measures already introduced to help improve the FtP system.

The case examiners would not replace the Investigating Committee (IC) but, over time, would be expected to reduce the numbers of cases referred to the IC. The overall aim of this new role would be to ensure that resources are properly applied

to cases of impaired fitness to practise and that process are transparent and sufficiently flexible to enable a tailored approach according to seriousness.

The consultation will run until 30 April 2012 and the GDC is keen to hear from all stakeholders who have an interest in the future of fitness to practise procedures, including patients, registrants and professional organisations. Respond to the consultation on the GDC website.

found that women in their forties comprise the demographic most likely to be incapable of having a filling, extraction or even a routine check-up without general anaesthetic or other sedation. "Dental anxiety is very real and complex and it should never be

downplayed," said study co-ordinator Dr. Avanti Karve. She hopes the study will help identify specific triggers of dental phobia with a view to finding a drug-free remedy. *Source: Dentistry.*



NEW NICE GUIDANCE APP

A new app has been launched allowing users access to NICE guidance from Android or iPhone smartphones. The free app can be downloaded from the

NICE website (www.nice.org.uk) and features over 760 items of NICE guidance arranged topically by conditions and diseases, and public health topics. Users can rapidly search and bookmark sections, and also receive updates and new guidance as soon as it's published.

DISCIPLINARY MATTERS

Liz Symon

DEALING with poor attitude and performance or repeated short-term absence are among the least favourite aspects of a manager's job as they can often lead to formal disciplinary action against an employee. In addressing disciplinary matters, it is essential that the facts are fully established and that all employees are treated consistently.

Not all matters may result in immediate disciplinary action. For first-time issues, such as time keeping or less serious performance issues, having an informal meeting to discuss areas of concern and advise the employee that their performance will be monitored may be enough.

However, where this approach fails and there are still issues, disciplinary action may need to be invoked. In the first instance, it may be necessary to conduct an investigatory meeting, so that all of the facts are obtained. This may include interviewing and gathering signed witness statements.

Suspension should only be used in exceptional circumstances, either where there is a serious risk to others if the employee remains at work whilst under investigation or in some cases of potential gross misconduct, such as suspected theft. Any suspension period would be paid. There is no right at the investigation stage for the employee to be accompanied, unless stated in your procedures.

Once an investigation has been completed and the matter is progressed to a disciplinary hearing, the employee needs to be advised in writing – stating where and when the hearing will take place, what the hearing is about and, in potential gross misconduct dismissal cases, what the possible outcome of the hearing may be. Any documentation that will be referred to at the hearing should be included with the letter so that the employee has the full information and can prepare their defence. There is no set time on how long an employee should be given between the invite letter and the disciplinary meeting, but they should be



given enough time to prepare. Where possible, someone independent, who has not been involved in the investigatory process, should conduct the disciplinary hearing and a note-taker appointed.

At any formal disciplinary hearing, the employee has the right to be accompanied by a work colleague or a trade union representative – not by a solicitor unless in very exceptional cases. The representative may confer with the employee at the hearing and ask questions but cannot answer questions on the employee's behalf.

At the hearing, the employee should be advised of the issues, concentrating on the actions or behaviours that have caused concern and going through the facts and examples, along with any witness statements. It is important that the employee is given an opportunity to put forward their case and to provide any mitigating reasons for their performance or behaviour.

Once all issues have been discussed, the hearing should be adjourned for all the information to be considered. In cases of possible gross misconduct, it is recommended that the hearing is adjourned overnight. At the re-adjourned meeting, the employee should be advised of the decision verbally and the outcome should then be confirmed in writing. The letter should advise the level of warning given, the timescales of how long the warning will remain on file, the behaviours expected in the future, the consequences if there is no improvement or further misconduct and the right to appeal the decision.

A practice's disciplinary process and

warning levels should be set out in a policy document and it is usual to have the following possible outcomes:

- no sanction awarded
- first written warning
- final written warning
- dismissal – with notice
- dismissal – without notice.

It would be normal to follow this pattern of warnings and if there is no improvement, the employee will eventually have their employment terminated as you work through the process. However, there may be cases where the employee's conduct is serious enough to jump levels but advice should be sought before making final decisions. Gross misconduct dismissals without notice will only be applicable for serious breaches – such as theft, fighting, being under the influence or serious insubordination.

Dealing with disciplinary issues can be a daunting prospect but carrying out an investigation so that you have all the facts and following the correct process should help alleviate any feelings of anxiety.

Recent articles in the press have highlighted some potential changes in employment law that the Government are looking to introduce, one being a review of the ACAS code on disciplinary procedures to make the dismissal process easier. So watch this space.

■ **Liz Symon is an employment law adviser at MDDUS**

TO ERR IS ETHICAL?

Deborah Bowman

THIS morning I was cornered by a colleague. Had I drafted the job description we'd discussed earlier in the week? I looked blank, then embarrassed and finally apologetic. No, I hadn't done as I had promised. In fact, I had forgotten I had ever promised it in the first place, despite making a note on a growing 'to do' list. I was fortunate. Drafting a job description in an academic department is not the sort of error that impacts on human life (although it probably did little for the stress levels of my colleague). In medicine and dentistry, readers will not need reminding that mistakes hover like a professional sword of Damocles over all practitioners.

If error is inevitable, the ways in which we conceptualise error is not. For a long time, the medical profession, in particular, has been criticised for the ways in which it responds to error. Last month, the website TED posted a talk by Dr Bryan Goldman, a Canadian physician specialising in emergency medicine, in which he described his own experiences of medical error during his career and argued that the profession continues to be poor at being truthful about its mistakes. Dr Goldman's talk has been viewed 299,561 times since it was posted. This week, Professor James Reason presented a programme on Radio 4 – *Doctor, Tell Me the Truth* – that looked at the ways in which a culture of 'deny and defend' has evolved and more open approaches to clinical error are emerging. It is available on iPlayer and is highly recommended.

The ways in which clinicians understand and respond to error are ethical judgements. The conceptualisation of what constitutes a mistake has a moral dimension. About a decade ago, I conducted research in which I asked general practitioners about error. It was a thought-provoking and often moving experience. I have been fortunate to be involved in many fascinating projects, but that work remains amongst the most memorable. As GPs shared their experiences, I learned that the ways in

which error was understood varied considerably. For some, an error was about demonstrably poor outcome. Others included near misses and disasters averted, often by luck rather than design, when talking about mistakes. Finally, there were those who felt that the term error encompassed more than that which was easily measurable including, for example, poor communication and breakdowns in the doctor-patient relationship. What does it mean to you to make an error?

I heard about the burden on those who make a mistake. Emotions ran high in many of the interviews and even recollections of events that happened

"Caring for those who have made mistakes does not equate to a closed cover-up or a defensive approach to error"

many years ago were often vivid and haunting. We rightly talk about the moral obligations owed to the patient or family following clinical error but we tend to pay little attention to supporting the person who erred. Critical and significant event analyses, if well-facilitated, may have the potential to support the clinician, but the ways in which individuals spoke about such processes and formal debriefing suggested that, in practice, they provide little in the way of support. Caring for those who have made mistakes does not equate to a closed cover-up or a defensive approach to error. Rather it acknowledges that error affects clinicians too and that

there is a duty to ensure that professionals are themselves well enough to continue to practise safely and with confidence.

Finally, there was considerable difference of opinion about the extent to which error should be admitted and shared with patients and families. Where it was clear that things had gone awry and there was a defined process within which to meet patients and families, disclosure was seen as inevitable, if not always welcome. Yet, where patients were perhaps unaware that an error had occurred or there was pressure from colleagues to cover up, or at least remain silent, about a mistake, there was little appetite for candour. Perhaps it is these sorts of findings that inform the campaign for the law to be changed to establish a statutory 'duty of candour'. How might such legislative change affect your practice? Are there mistakes that you have not shared with patients?

It would be misguided to believe that legislation will address the ethical challenges of putting someone else's interests before one's own personal and professional interests. To do so is difficult, painful and frightening. It is also a challenge that will face every single clinician at some stage in his or her career. Unless and until that is acknowledged, all the patient safety initiatives, clinical risk seminars, policy documents, legal reform and compulsory training will be of limited effect. A duty of candour should perhaps begin with honesty about the inevitability and complexity of clinical error. That is the ethical challenge for us all.

■ **Deborah Bowman is Professor of Bioethics, Clinical Ethics and Medical Law at St George's, University of London**





PHOTOGRAPH: PHOTOSHOT

Curbing litigation costs

Summons speaks to Lord Justice Rupert Jackson on reforms aimed at easing the burden of excessive legal costs in clinical negligence cases

SUCCESS FEES, claims farming, after-the-event insurance premiums – it has long been recognised that some legal firms routinely milk the system for high profits. In the context of healthcare, excessive legal fees cost the NHS and taxpayers many millions of pounds each year. To mutual indemnity providers such as MDDUS it means higher payouts and greater upward pressure on the subscription fees paid by doctors and dentists. In 2008 Lord Justice Rupert Jackson was asked to undertake a fundamental review of excessive civil litigation costs in England and Wales. His report, published in 2010, outlined a raft of reforms that could provide “significant cost savings”.

Lord Jackson was educated at Christ's Hospital and Jesus College, Cambridge, and called to the Bar in 1972. He was appointed a Deputy High Court Judge in 1999 and a Lord Justice of Appeal in 2008. He lives in Surrey with his wife who is a prominent local solicitor.

What prompted the review of civil litigation costs?

RJ: The former Master of the Rolls, Anthony Clarke, asked me to undertake a fundamental review of the rules and principles governing the costs of civil litigation. His request reflected his concern about the growing problem of costs not being proportionate to the value of the sums at stake in a claim, and in some cases dramatically exceeding it. There was also a concern about the growth in satellite litigation on the issue of costs rather than the substance of a case.

Your report covered the broad range of civil litigation. What is driving up legal costs for defendants in clinical negligence cases?

RJ: I found some common factors in the dramatic rise in costs, to which clinical negligence was by no means immune – the scale of success fees, referral fees and after-the-event insurance premium recoverable from losing defendants being key drivers. Another feature that I received many complaints about directly in relation to clinical negligence was the very high pre-action costs such cases have been incurring – I made general and specific recommendations to address this.

Who are the winners and losers in the current system?

RJ: It is always difficult to provide a broad answer on that as cases are won and lost on their merits. There are clearly a number of beneficiaries of the current system given the dramatic rise in costs, and not all of those are adding materially to the process – for example payments are made by solicitors via referral fees to ‘buy’ cases from third parties who add no value. The losers will not just be those who face paying disproportionate costs, but the system as a whole and the public at large – for example through facing much higher insurance premium payments.

What are conditional fee arrangements (CFAs) and how do they contribute to excessive costs in civil litigation?

RJ: CFAs, often called ‘no-win, no-fee’ cases, are agreements between a lawyer and client whereby in cases where the lawyer wins, they are able to charge a success fee. This and certain other costs of pursuing the case are then currently recoverable from a losing party. Clients have no financial stake in the setting of such costs, which have often been extremely high – I received no evidence in the Review to suggest the current levels of success fees charged were necessary to cover the loss of income from cases lost under CFAs for which solicitors forego fees.

Critics of the reforms say that abolishing success fees and after-the-event insurance premiums will discourage lawyers from taking on difficult cases even when claimants might have a legitimate case. How do the reforms answer that?

RJ: My reforms form a coherent package which taken together provide a remedy to the current ills of high costs. The proposal to increase general damages by 10 per cent is the key counterweight to the abolition of recoverability – an academic economist has forecast that a majority of claimants will be better off under these reforms. Clearly law firms – like judges – will need to adapt to the new costs regime. I have recognised the unique high early costs in clinical negligence claims and pressed hard for legal aid to continue to be available to fund disbursements, but that is a matter for Government to determine.

Do the reforms provide more encouragement to settle cases early out of court?

RJ: My final report looked at alternate dispute resolution (ADR), and is strongly in favour of its greater use as a means of reducing costs. I think my reforms will encourage ADR in the sense that clients will have more of a stake in keeping costs down, and there is a reduced profit incentive for solicitors in cases running to full trial. Sometimes a patient is seeking an apology or a course of treatment rather than compensation, and ADR is highly suited to resolving those disputes.

Does the need for often detailed expert evidence inhibit the use of ADR?

RJ: Early stage detailed expert evidence can make ADR more difficult in terms of people becoming overly wedded to their case, which they feel expert testimony is

“The current growth rate of civil litigation costs is unsustainable”

strongly supporting, and there is more material to disagree over than in other areas of law. However, equally, expert evidence may prove that neither case is without contrary interpretations and that litigation is more risky, which may encourage parties to seek ADR.

How would fixed costs for so-called “fast track” cases under £25,000 help reduce costs in clinical negligence cases?

RJ: Fixed costs in the fast track would help to reduce costs by providing a ceiling and certainty on the costs of conducting litigation, especially in an area like clinical negligence where there is a danger of a proliferation of expert witnesses being produced. Having greater clarity on known costs means that both parties are better placed to make assessments of their prospects, and to see the value of mediation in resolving disputes.

What are the implications if litigation costs are allowed to continue to rise?

RJ: My own view is that the current growth rate of civil litigation costs is

unsustainable. For all the criticisms of my reforms, there are very few people who would not agree that costs are disproportionately high, and that something must be done to address them. To use a clinical analogy, everyone agrees the patient is ill, it is just the treatments they cannot agree on.

What is happening now with the proposed reforms?

RJ: The major reforms to abolish recoverability of success fees, after-the-event insurance premiums and referral fees are all contained in a Bill currently before Parliament as they require primary legislation. They are a matter for Parliament to resolve. However, with 109 recommendations in total there are many areas that the judiciary and others can take forward, and these are being pursued through the use of pilots, drafting of new court rules and training of judges.

I have been asked by the senior judiciary to continue to play a major role in implementation, as far as my judicial sitting duties permit. I am giving a series of lectures available on the judicial website (www.judiciary.gov.uk) to help the professions prepare for the new costs landscape, and I attend a great many events as well as liaising with other bodies to drive the reform process along.

Have the last two years of debate been tough?

RJ: I have had to develop something of a thick skin, as many specific and general reform proposals have not found favour with a number of groups. I recognise that some of the criticisms are founded on strongly held conviction and principle and not just on commercial self-interest. No two people would have come up with the same package of proposals, but having looked exhaustively at this issue for a full year and been exposed to all of the arguments and evidence produced, I am confident my conclusions and recommendations are sound and will address the problems I was asked to tackle. Like all judges I thrive on well-conducted arguments, although normally I am able to sit back and adjudicate rather than be on the receiving end!

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

A humbling dedication – the return



In Spring 2009 MDDUS medical adviser Mr Riaz Mohammed wrote of his visit to a hospital providing healthcare among a desperately poor population in North India. Here he recounts his recent return to the Duncan Hospital

THREE YEARS following my first visit to the Duncan Hospital, in Raxaul, North India – to experience “real medicine” in a very poor and destitute part of the world – I decided it was the right time to return and see what progress has been made.

On this trip I travelled with consultant surgeon Mr Ian Hutchinson, an MDDUS member and friend who was also making a return visit. In addition we were accompanied by three of his colleagues, two consultant paediatricians from Airedale and a FY2 trainee who was of Indian origin and, importantly, spoke Hindi fluently. The final member of the group was an engineer.

Following my previous excursion much has happened. In particular an extremely generous charitable donation of over £500,000 had been gifted to the Duncan Hospital by another MDDUS member from Stirling. It really is amazing the generosity of the Scottish people – one of whom, of course, had started the hospital in 1930 in the first place. This money was used to complete the new Mother and Child Building at the hospital which had come to a complete halt due to a significant decrease in charitable donations from the wealthier west. The global recession has more to answer for than just depressed high-street sales!

Small islands of change

We flew to the New Delhi airport which was an extremely impressive modern building of considerable size – no doubt upgraded for the Commonwealth Games held in Delhi in 2010. However, the rest of the journey by train to Bihar soon brought things into proper perspective! Rural India was as deprived, poor and dirty as I remembered it. Nothing had changed. I could see no improvements in the lives lived by the poor in Bihar. It was like going back in time.

The recently completed new Duncan Hospital building, however, was extremely modern and impressive – a definite improvement over the much-loved, but no longer fit-for-purpose, old building.

Unfortunately in some ways, we soon began to realise again what “real medicine” actually is. The building was great, some of the equipment was modern and up to western standards but there was a major problem – namely lack of staff. For example, the paediatric/neonatal unit treated over 45 babies in any one day with two to three deaths, many of which could have been prevented had the child been brought to the hospital sooner. There was only one paediatrician in the hospital on duty 24/7, 365 days a year. Dedication or what?



Far left: Mr Ian Hutchinson and Mr Riaz Mohammed. Clockwise from above left: visitors and medical staff at the Duncan Hospital; more staff at the Duncan; the new Mother and Child Building now finished

Greatest resource – people

This dedication reminded us all that at the end of the day “real medicine” is delivered by caring, trained and experienced members of the medical, nursing and ancillary staff, all of whom are essential in providing quality of care that saves lives and limbs. No matter how wonderful a modern building might be it is the people delivering the service that count.

The efforts of our two paediatricians and indeed the FY2 doctor in helping the indigenous staff over the relatively short period of our visit was amazing to watch. “When the going gets tough – the tough get going” and we saw that for ourselves as these doctors rolled up their sleeves and got on with the job at hand. It was also a privilege to take much needed equipment and even ordinary pens for distribution at the hospital. In addition, a kind donor had made available very high quality theatre gowns and sheets for use by the surgical team at the Duncan. Again, all this was much appreciated.

Nowhere in this life is perfection found – and so it also proves in Bihar. In recent years the improved standards at the Duncan Hospital had attracted government support for initiatives to help the lives of those under the poverty line. One way forward was to offer a “payment” card so that the poorest would not have to pay for maternity services or any necessary medication. Outside the hospital are a

“No matter how wonderful a modern building might be, it’s the people delivering the service that count”

number of stalls selling medication to anyone at a reduced price, though it is difficult to know if the medications being sold are genuine or otherwise. The stall-holders were very unhappy over the new payment card, fearing that their business would be adversely affected by patients no longer needing their “services”.

Hospital management staff at the Duncan had to seek assistance from the local police to prevent a possible riot over the issue. However, they remained resolute in their commitment to assist the poor in an honourable and legal fashion. It’s not easy being in hospital management – anywhere!

Humbling sites

Our journey back was supplemented by visits to such wonderful sites as the Taj Mahal, the Red Fort, India Gate and the Parliament of India. All worth seeing. Nothing, however, could match the joy of observing new-born babies being saved by the skill and dedication of the staff at the Duncan. Who knows what even one of these lives saved will achieve in the future? “We can only leave that to God”, as they would say at the Duncan.

You will not be surprised to read that all the doctors on the trip were keen to return to the Duncan in the near future to see what else they could contribute to that deprived part of the world. They also would be doing their best to encourage others to consider how they too could help. If you would like to know more please feel free to get in touch with me at MDDUS.

I now understand what the saying “you can take the boy out of the Duncan, but you can’t take the Duncan out of the boy” means. How true, how true.

■ *Mr Riaz Mohammed is a senior medical adviser at MDDUS*

Dentist to dentist

In the second of a series of profiles featuring MDDUS professionals, Summons editor Jim Killgore chats with dental adviser Claire Renton

PHOTOGRAPH CLAIRE MILLAR

“ANY DENTIST who has been in practice long enough,” says Claire Renton, “will know what it means to deal with a difficult patient or to be on the receiving end of a complaint.”

Indeed this is somewhat of a guiding principle to Claire in her work as a dental adviser at MDDUS. We chat during a morning off from taking advice calls in her Glasgow office.

“We’ve all carried out treatment for patients that for one reason or another just hasn’t worked,” she explains. “But that doesn’t mean you set out to do things badly.”

Claire joined the dental advisory team at MDDUS in 2009 and in that time has dealt with many distressed members. She says:

“A lot of our work is dealing with patient complaints against members. It can be difficult for dentists because in most cases they will have been bending over backwards, doing their very best for somebody. Quite often it’s the patient seen at lunch time or out of hours. So the dentist – quite rightly – feels aggrieved when they subsequently make a complaint.

“And patients complain not only about the dental work itself – a crown not fitting or falling out or breaking – but often add on things like ‘and I spent hours at your surgery and I want you to compensate me for my time off work’. So there can be a lot of emotional baggage attached to complaints.”

Dealing with that emotional baggage is all part of the job as an adviser and requires a high degree of understanding and empathy. Just as with all the professional advisers at MDDUS Claire brings a broad range of experience to her role.

Legal interest

Claire qualified as a dentist in 1985 after graduating from the University of Glasgow. Her first job was as a house officer at the Glasgow Dental Hospital and then an SHO in oral surgery at the Victoria Infirmary. After working as a registrar, she accepted a five-year lecturing post in Adult Dental Care at Glasgow University.

In the meantime she married her husband Rod, also a dentist, and they had three children. On completing her university contract Claire decided to go part-time as a GDP and eventually went to work with her husband in their practice in Bearsden, north of Glasgow.

In that period she also rekindled an old interest in law and ethics. Claire says: “I had always been quite interested in legal matters. Even as a student I thought I might do law. But my Dad was a dentist and I think that’s probably why I plunked for dentistry in the end.”

In her limited spare time Claire undertook a three-year part-time Masters in Medical Law at the University of Glasgow. Not long after completing the course a job at MDDUS became vacant and the organisation was keen to appoint a dentist with her breadth of experience.

Being pragmatic

The dental advisory team at MDDUS operates out of two offices in Glasgow and London. Part of the job involves fielding calls



"Much of the job is just knowing how to be a pragmatic, sensible dentist. What would you do in the same circumstances?"

from members phoning into a 24/7 advice service. In 2011, dental advisers at MDDUS dealt with around 2,500 advice requests. Among the most common topics are those relating to difficult patients, dealing with complaints, dental record keeping, problems with colleagues and treatment planning.

"There is certainly an important preventative element to the work we do," says Claire. "And we welcome calls at the earliest outset of a problem. It's really heartening when a dentist phones up and says: 'I've had a patient in today. They haven't complained, they haven't said anything yet but I'm just concerned something is going to happen.' This is quite helpful because you can advise them maybe to get a second opinion or ask if they have thought of this or that."

"In fact much of the job is just knowing how to be a pragmatic, sensible dentist. What would you do in the same circumstances? The advice we give may be based on a knowledge of rules and regulations but you must translate that into a practical solution."

In the hours not spent on telephone duty Claire works with an in-house legal team managing cases that have escalated beyond a complaint to either a civil claim or disciplinary action from a health authority or the General Dental Council. Typical cases might involve problems with treatment such as a failed implant or a dentist neglecting to obtain clear informed consent for a procedure, or a dispute over charges. Here the dental adviser acts both as a facilitator and brings their clinical dental experience to the case.

"We are the main contact with the member," says Claire,

"moving things forward and acting as a liaison with the lawyers. We also look at the dental issues and help form a defence, if possible, directing the solicitors to current dental guidelines and regulations. We assess the case initially and judge the possible outcome."

Advice and reassurance

Dentists facing professional difficulties will often meet with an adviser either face-to-face or via video link to discuss evidence and what processes are involved in legal and regulatory cases. Often an adviser will attend hearings with the member to offer advice and reassurance. Says Claire:

"I think one major frustration for dentists in these circumstances is the time it takes to resolve a case. It can be months or even years from the initial solicitor's letter to getting it all settled. And that can be quite stressful for dentists. It's always churning at the back of your mind. So a lot of our job is to reassure the member that we'll handle it, take the heat out of things and sort it out for them."

Asked about what sorts of cases she finds most difficult to deal with, Claire replies: "The ones where the members don't engage with the process – take a head-in-the-sand approach. It's difficult to get them to participate and have some insight into the situation. Either they are scared by the whole process or just have no concept of the seriousness of it."

But most members cooperate fully to help resolve cases as quickly as possible. This includes providing a comprehensive account of the facts of a case supported by the patient records.

"Records are hugely important," says Claire. "Because cases are defended on what's written down. You might say that my usual practice is to say this or do that, but if it's not in the records it's subject to reasonable doubt."

Claire is philosophical about much of what crosses her desk in the course of a week. Dentists do sometimes make mistakes but she has no doubt that the vast majority want only to do the best job possible for their patients. Many complaints and cases she feels are simply the product of a growing blame culture.

"Everyone in this country knows that in order to keep your teeth you need to brush twice a day and floss. And yet some patients still ignore this basic preventative advice and when things go wrong look for someone to blame. Dentists are slightly sitting ducks in that regard. It's often a nonsense but that's the world we live in."

And the job of professionals like Claire is to provide some redress against this tide of blame.

■ Profile by Jim Killgore, editor of MDDUS Summons

Adult chest infections

Professor Duncan Empey *addresses the sometimes difficult question – when to refer in an adult patient presenting with chest infection?*

CHEST infections are one of the commonest reasons for consultations in primary care, and for most patients with viral acute bronchitis, symptomatic treatment and reassurance are all that is needed. However, at the opposite extreme, for a small number of others, the outcome can be a severe pneumonia with a high risk of death.

Community acquired pneumonia (CAP) affects between five and 11 per 1,000 of the population each year with an overall mortality of around one per cent. Most patients are successfully diagnosed and managed in primary care. However, each year MDDUS receives complaints and claims of clinical negligence related to delayed referral to hospital of patients in whom the diagnosis of CAP has been missed or not adequately treated. Hospital mortality is between 13 and 15 per cent and rises from 22 to 49 per cent for patients admitted to ICU, with worse outcomes for those whose admission is delayed.

As with many conditions, good decision-making for patients with pneumonia depends on careful assessment and clinical acumen rather than severity scores, algorithms or other guidelines.

Diagnosis

The presenting symptoms of pneumonia may be cough, with or without sputum production, fever or pleuritic pain. Examination of the chest may not reveal any abnormality, or there may be localised signs such as crepitations heard on auscultation. Often patients with pneumonia produce little or no sputum, and chest examination may reveal no abnormality, so cough, fever and feeling very unwell may be the only clues. Particularly in older patients, a fever and tachycardia may be the main or even the only abnormal observations with little to point directly to a chest problem.

In the absence of a completely reliable combination

of symptoms and signs by which to define and diagnose pneumonia it is often necessary to perform a chest X-ray to confirm or exclude the diagnosis, particularly in older patients or smokers.

Atypical pneumonia nowadays accounts for 20 per cent of CAP in some localities, particularly caused by *Mycoplasma pneumoniae* or *Chlamydophila pneumoniae*, the latter being common in student groups living together in halls of residence. *Legionella pneumophila* is fortunately much rarer. Physical signs in the chest in atypical pneumonia may be absent, and even on X-ray there may only be a small area of consolidation (hence the name “atypical”). Remember that patients who have contact with birds risk psittacosis (caused by *Chlamydophila psittaci*), a very severe form of atypical pneumonia, or the type of hypersensitivity pneumonitis caused by allergy to bird antigens which can sometimes present with cough and fever, imitating infection.

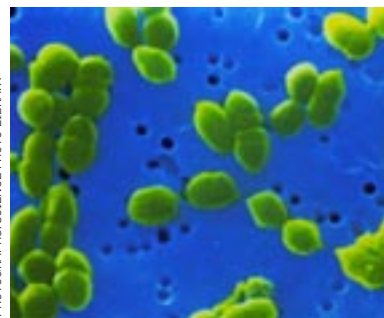
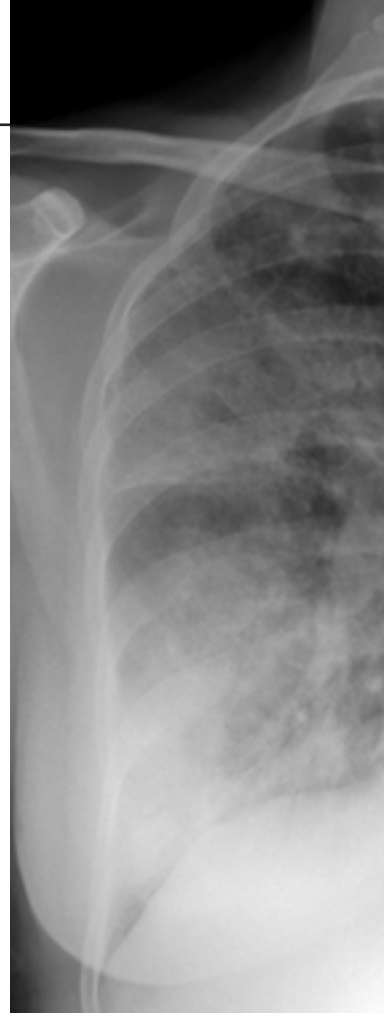
Patients with pre-existing conditions such as diabetes, significant heart, liver, kidney or lung disease, or neuromuscular problems or taking immune suppression (including oral steroids) must be assessed as much for the effect of an infection on their overall condition as for the severity of pneumonia itself.

The CRB65 Score

The CRB65 system has been devised as a guide to the severity of pneumonia, but this type of severity score must not be relied upon alone – decisions must be based on overall assessment and clinical judgement. In the CRB65 system one point is given for:

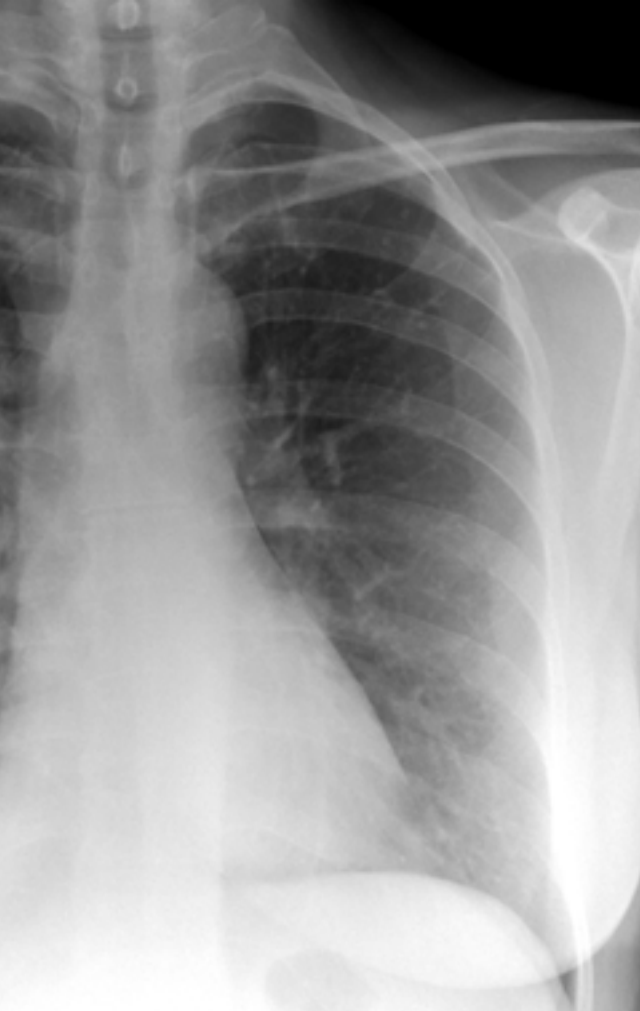
- Confusion (assessed by an abbreviated mental test, or the appearance of new disorientation)
- Respiratory rate > 30/min
- Blood pressure (SBP < 90 or DBP < 60 mmHg)
- Age > 65 years.

A score of 0 for a patient less than 50 years with no



PHOTOGRAPHS: SCIENCE PHOTO LIBRARY

Top: X-ray showing pneumonia affecting the right lung. Above: False-colour SEM of *Streptococcus pneumoniae* (pneumococcus)



co-existing disease usually indicates a good prognosis with home treatment. A score of 1 or 2 indicates an increased risk of death, particularly with a score of 2, and hospital referral should be considered. A score of 3 or 4 indicates the need for urgent hospital admission.

The CRB65 score is useful for highlighting the need for referral for those with a higher score, but a low score is not completely reassuring. A young breathless patient with a CRB65 score of 1 but feeling very unwell with a respiratory rate of 40/min definitely warrants hospital treatment. Or a patient in his late fifties with bilateral basal crepitations could score 0, but clearly has extensive infection, would be at high risk of developing severe pneumonia and should be referred.

Beyond the CRB65 Score

More information can be obtained by using a pulse oximeter, which are widely available these days. Cyanosis is an unreliable clinical sign, but the pulse oximeter can give useful information – for a patient with pneumonia an oxygen saturation (SaO₂) level reduced below 94 per cent is an adverse feature indicating the need for oxygen treatment in hospital.

An otherwise fit patient with suspected pneumonia, a low CRB65 score and who is not too unwell can usually be treated at home, but a chest X-ray is still advisable and a review within 24 to 48 hours is essential, as well as advising the patient to go to A&E if there is any deterioration.

Breathlessness with wheeze may be seen in patients with a history of asthma, and increased treatment for their asthma will be needed as well as antibiotics for the pneumonia. Any patient with known asthma or

COPD must have their spirometry, or at least peak expiratory flow rate, measured and the results compared with their usual values. Worsening asthma or an exacerbation of COPD may be an indication for hospital referral even if the pneumonia is not thought to be severe.

Breathlessness in any patient at any age with no past history of chest disease who has symptoms suggesting pneumonia is a very worrying combination. There may be few signs in the chest but for the patient to be breathless the pneumonia must be extensive and urgent referral is needed.

Social factors may also influence the decision to refer, as will the patient's own preferences. It goes without saying, of course, that if a sick patient declines referral to hospital this must be fully documented and the patient followed up at home to ensure a good response to treatment, or to suggest again that they should go to hospital (see case study on page 20).

Bear in mind that sometimes other diseases such as pulmonary embolism, pulmonary oedema, pneumothorax, fibrosing alveolitis and lung cancer might be confused in their early stages with chest infections.

Giving antibiotics

A review of when to prescribe or not prescribe antibiotics is beyond the scope of this article but fit younger patients with a viral acute bronchitis do not usually need them. Older patients and those with a history of lung disease such as asthma, COPD, emphysema or bronchiectasis, or a history of previous pneumonia should have the benefit of a lower threshold for prescribing as they are at increased risk of developing pneumonia. The clinical assessment should include consideration of the effects of the pneumonia on these conditions and also the effects of an infection on any other chronic conditions which may be present. Again, a relatively low threshold for prescribing antibiotics or referring to hospital may avoid later problems in vulnerable patients.

Conclusion

Recognising pneumonia and then deciding whether the patient is suitable for home treatment or should be referred for hospital review is a common but complex scenario. Severity scores such as CRB65 may help, but clinical judgement is much more important. History taking and examination must be thorough, record keeping accurate and existing medical conditions must be taken in to account. If suitable for home treatment, follow-up review in 24 to 48 hours is important. Any cause for concern – significant malaise, fever, tachycardia, breathlessness or confusion – must result in referral for hospital assessment.

■ *Professor Duncan Empey is a consultant respiratory physician and Professor Emeritus in the School of Postgraduate Medicine at the University of Hertfordshire*

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Tales of the non-accidental tourist

Dental adviser Doug Hamilton offers a pragmatic view on patients seeking dental treatment abroad

MANY of us will have sought medical attention for injuries or conditions arising while we are on holiday, but the expectation that the NHS will provide comprehensive and free healthcare dissuades most patients from seeking elective treatment out-with the UK – or at least this was true until recent years.

Lengthening waiting times and developments in European legislation, together with the advent of almost universal access to the internet and cheap air travel, have made it no longer unusual for patients to undergo certain procedures in foreign hospitals. The fact that dentists, particularly those in central Europe, have been one of the main beneficiaries of this new development does seem logical bearing in mind the shortage of NHS surgeries in certain parts of the UK and the increased costs of private treatment.

These factors, combined with the reality that dental treatment is often non-urgent and seldom impacts upon mobility, have galvanised patients to seek cheaper and more accessible treatment abroad. An estimated 20 to 35,000 dental patients do so each year and that number is rising.

Advising patients

In recognition of this new trend, the GDC have produced a document which offers general guidance and suggests that prospective dental tourists seek more detailed advice from their UK practitioner before travelling abroad. Responding to such enquiries requires a degree of tact and insight. Dentists are ethically obliged to respect their patient's choice and must be careful not to offer excessively pessimistic or even misleading information. However, there are valid concerns which should be raised, both to assist the patient's decision-making process and also protect the UK dentist from recrimination should anything go wrong.

Obvious as it may seem, a useful starting point for such a discussion would be to highlight the importance of communication. Admittedly, the language skills of Europeans would put many of us in the UK to shame, with some countries even teaching dentistry in English. Nonetheless, patients must make certain that the dentist whom they plan to visit can explain the technicalities of the proposed treatment in order to secure informed consent and provide ongoing reassurance.

Cost implications

Another fundamental area that should be addressed is the tricky issue of finance. Encouraged by numerous websites, magazine and newspaper articles it's not surprising that some patients decide that being treated abroad represents the most cost-efficient means of achieving the outcome they desire. However, as no two cases are the same, patients must at least consider the possibility that the guideline charges which are often quoted in the media may escalate once an examination





has been completed.

Even if an agreement is secured with regard to all dental charges, multi-stage treatment or unforeseen complications may necessitate a longer stay or return visits, incurring additional costs and possibly loss of earnings. Therefore, patients who are initially attracted by the potential discounts frequently quoted in the popular press and website testimonials must remember to factor contingencies such as these into their financial calculations.

Ensuring quality and professionalism

Trips abroad for dental care tend to be most economically viable when involving fairly extensive treatment such as implants. Admittedly, adverse outcomes in relation to treatment of this complexity are not unknown in the UK. However, such clinical complications are arguably less likely in this country because the GDC operates a stringently policed register of specialists and censures registrants who do not work within their scope of competence.

Numerous obligations restricting the administration of intravenous sedation in anxious patients also apply in the UK, and general anaesthesia is simply not permitted in general practice. Such controls are not guaranteed outside the UK and the degree of regulation in some countries is variable and often difficult to research.

Websites such as Health Regulation Worldwide offer some insights into the professional bodies that oversee dentistry in other countries but it would appear that there is no umbrella organisation which offers comprehensive assistance to patients who wish to satisfy themselves that their treatment abroad will be efficient and safe. An overseas dentist may lack the experience or qualifications that would be required in the UK and this could lead to an unsuccessful or even a harmful outcome. Patients seeking compensation in another country might find that their legal position is very difficult to establish. Even if the relevant legal system is understood, pursuing a claim in negligence in another country will undoubtedly have logistical and financial implications.

Remedial work in the UK

Another common question is to what extent a UK dentist is responsible for rectifying failed work which has been carried out abroad. Faced with such a case, most practitioners will feel a degree of empathy with their patient's plight. However, in such instances, the UK dentist is not required to bear any of the costs of remedial work. In fact, correcting unsuccessful dentistry is often more complex than carrying it out in the first place and practitioners must not, through some misplaced sense of obligation, involve themselves in work that is beyond their ability.

"Correcting unsuccessful dentistry is often more complex than carrying it out in the first place"

Instead, the presenting condition must be carefully assessed and scrupulously recorded, making use of photographs and justifiable radiographs where applicable, before a written estimate is given for work which the dentist feels will be beneficial. At this stage, it is up to the patient to decide whether to proceed on this basis or return to the dentist who provided the original treatment.

The advice thus far, while perfectly valid, does tend to reinforce the stereotypical view that standards of care and professionalism in other countries lag behind those of the UK. Yet, to endorse this position without qualification is to disregard the many excellent courses of treatments which are received by UK patients in European practices each year. It also ignores the possibility that failings in the patient's existing dentistry might complicate treatment at an overseas practice, in which case it may be the UK dentist who ends up facing awkward questions. Therefore, dentists who are offering advice to prospective dental tourists should ensure that their own treatment to date will withstand scrutiny by a foreign colleague.

In conclusion...

Dental tourism is an inescapable facet of modern dentistry and it is an option increasingly explored by patients hoping to save money on the more complex components of their dentistry. In dealing with these patients UK dentists should explain the potential for additional costs and clinical complications which may result from having treatment abroad. However, regardless of the advice provided, they are not obligated to rectify any adverse outcomes.

■ *Doug Hamilton is a GDP and dental adviser at MDDUS*

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



REFERRAL: WAIT AND SEE?

BACKGROUND: MR L visits his local GP surgery complaining of feeling generally unwell with shooting pains in his neck and down his left side. A young locum GP examines the patient and diagnoses musculoskeletal pain for which he prescribes naproxen.

Over the next four days Mr L grows increasingly unwell. His wife phones the surgery and reports that her husband is suffering from fever and nausea along with shortness of breath and dizziness. He has also developed a dry cough. She reports the naproxen has done nothing to ease the pain which is made worse by breathing and the slightest movement.

One of the other GPs in the practice – Dr A – attends Mr L at home. On examination she finds that the patient has a temperature of 38.6 C and a pulse of 110/minute regular. On auscultation of the chest, crepitations are heard at the left base. The patient also reports tenderness on palpation of the left lateral chest and in his left shoulder and arm.

Dr A diagnoses a chest infection and prescribes amoxicillin along with codeine for the pain. She advises Mr L to phone the surgery if his condition grows any worse.

Three days later Mrs L phones the surgery and Dr A again attends the patient at home. Mr L's condition has not improved. His temperature is still elevated and he is suffering severe pleuritic pain on coughing. Dr A listens to his chest and notes crepitations and a possible rub on the left side.

In addition Mr L reports nausea and vomiting but this is not recorded in the notes. Dr A advises the patient that a trip to hospital might be necessary but Mr L is very resistant to the prospect. Again this discussion is not recorded in the notes. As the patient has shown no improvement the GP issues an alternative prescription for ciprofloxacin and also prochlorperazine for "dizziness" and arranges for a review in three days with consideration of a chest X-ray or bloods if no better.

Three days later Dr A again attends Mr L and finding no improvement arranges an urgent chest X-ray at the local hospital which reveals a left-sided severe pneumonia with pleural effusion and a likely empyema. Mr L is admitted to hospital and over 400 ml of fluid is aspirated and a chest drain inserted. Intravenous antibiotics and painkillers are administered but a few days later it is judged that surgical intervention is necessary as Mr L still has localised areas of pleural fluid trapped in the lungs. An open thoracotomy is undertaken with decortication of the pleura and Mr L is returned to the ward with two chest drains. Recovery is slow but uncomplicated and a week later he is discharged from hospital.

Six months later Dr A receives a notice of claim by solicitors representing Mr L. Among the allegations is a failure to urgently refer the patient to hospital for an X-ray after the second home visit when it was clear that his condition had deteriorated. Had Mr L been admitted then it is alleged he would have been started on intravenous antibiotics and on the balance of probabilities would have avoided developing empyema with the need for a thoracotomy.

ANALYSIS/OUTCOME On behalf of Dr A, MDDUS instructs a medical expert to write an opinion on the case. The expert examines the notes in regard to a number of issues. Mr L had claimed that Dr A was informed of his nausea and vomiting which if significant would have meant the prescription of oral antibiotics was inappropriate. But the notes make no mention of vomiting although it is significant that Dr A issues a prescription for prochlorperazine, which is commonly used to treat nausea and vomiting.

On the allegation of negligence in not arranging an urgent referral the expert concludes that Dr A would have had no valid reason to do so unless the patient was severely unwell and unable to "keep down" oral antibiotics. His view is that Mr L was treated in a manner appropriate with his symptoms and diagnosis. It is only after the expert has submitted his report that Dr A admits having discussed the possibility of hospital admission with Mr L.

MDDUS advisers and lawyers confer over the matter and decide that the contradictory claims over whether Mr L had reported vomiting while under treatment with oral antibiotics pose a significant risk if the case were to go to court. It is also felt that Dr A's later statement that she had discussed the possibility of hospital with Mr L could be interpreted as a "de facto" admission that the situation had grown serious. It was decided to explore settling the case for a modest amount without any admission of liability.

KEY POINTS

- Keep notes of all discussions with patients in order to justify decisions made.
- Consider if oral antibiotics are appropriate in any seriously unwell patient.
- Err on the side of caution in any persistent infection.
- Consider hospital admission if symptoms are deteriorating rather than improving as expected.





INVESTIGATIONS: NOT ON THE X-RAY

BACKGROUND Mr D – a 64-year-old man – makes an appointment at his GP surgery complaining of persistent pain in his lower back made worse by gardening. Mr D has no previous history of low back pain but just over a year before he had undergone a total left hip replacement.

One of the partners – Dr G – examines the patient and finds nothing of note. He gives Mr D guidance on proper lifting technique and advises use of over-the-counter analgesia at the maximum recommended dose.

A month later Mr D returns to Dr G with a three-week history of pain in his left hip. He also complains that his foot is falling funny when he lies down flat in bed. The GP notes "restricted hip flexion on knee extension/pain in left pelvic rami". Dr G is concerned that Mr D's symptoms might indicate early failing of the hip replacement due either to loosening or infection. He orders an X-ray and again advises Mr D to persist with the analgesia.

Two weeks later Dr G receives the results of the X-ray: "Left hip prosthesis noted and appears satisfactory. Right hip normal." Mr D attends to discuss the result

and Dr G explains there appears to be nothing amiss on the X-ray. He advises the patient to persist with the analgesia and return in two weeks if the pain has not settled. No other tests are arranged as they are not indicated by the X-ray results.

Three months later an out-of-hours GP refers Mr D to hospital having developed an abscess on his hip. Further investigation reveals an infection around the hip replacement. Mr D remains in hospital for another six weeks and has a further hip replacement which fails again due to infection. Six months later Dr G is contacted by solicitors representing Mr D, investigating a claim of

negligence. It is alleged that Dr G should have requested further investigations or blood tests considering Mr D's persistent hip pain.

ANALYSIS/OUTCOME Dr G contacts an MDDUS medical adviser and the GP is asked to provide a copy of the patient records and also to provide an account of the case. In his reply Dr G relates a full chronology of his encounters with the patient including a justification for the treatment decisions made. On the question of blood tests he writes: "In my judgement it was not necessary or helpful to order blood cultures as the X-ray did not indicate any problem. Even a raised ESR could be due to any number of causes in this age group."

MDDUS lawyers draft a robust response to the allegations and the action is subsequently dropped.

KEY POINTS

- Be aware that infection can be a possibility even with a normal X-ray.
- Other complications of hip replacements include loosening of the joint, dislocation, DVT and pulmonary embolism.



GDC: JOURNEY HOME

BACKGROUND A dentist is driving home from the surgery one night and decides to take an alternate route to avoid temporary traffic lights on the main road. She is following a slow moving lorry on the unfamiliar road and looks away from the road for a moment to check her rearview mirror. Just then the road makes a sharp turn and the car drifts over the centre line sideswiping an on-coming vehicle.

No one is hurt in the accident but the dentist is later convicted under Section 3 (careless driving) of the Road Traffic Act and ordered to pay a fine and her licence endorsed. A routine letter is sent from the criminal records department to inform the GDC of the conviction, which subsequently

contacts the dentist in regard to her professional conduct. The GDC letter states the information will go before a Preliminary Proceedings Committee and suggests it would be "helpful" for the committee to have her "observations" on the matter.



ANALYSIS/OUTCOME The dentist contacts MDDUS and an adviser helps to draft a letter explaining the circumstances of the accident and the fact that the dentist has an otherwise unblemished licence. She expresses remorse and insight, stating that she is a more cautious driver as a result of the incident.

The dentist later receives a warning letter which she acknowledges in writing.

KEY POINTS

- Follow guidelines on reporting convictions and contact MDDUS before replying to GDC correspondence.
- Give a clear and honest account of any incident, showing insight.



Object obscura: card notice and surgeon's waistcoat

THIS card notice and satin waistcoat belonged to the surgeon Henry Hill Hickman (1800-1830). He was an early pioneer of anaesthesia and studied medicine at Edinburgh University before setting up practice in Ludlow in Shropshire. Here he conducted controversial experiments on animals using carbon dioxide as an anaesthetic agent. He died of tuberculosis at age 30 with his work largely unrecognised.

Crossword



ACROSS

2. Inflammatory condition of the lung (9)
8. Poisonous metalloid (7)
9. Cervical screening test (5)
10. Female gonad (5)
11. Softening of bones from vitamin deficiency (7)
13. They focus light in the eye (6)
15. Constitutes 55 per cent of blood (5)
18. Epileptic fit (7)
20. Painful muscle contraction (5)
21. Spherical bacteria (5)
22. Frankness (7)
23. Collections of pus in tissue cavities (9)

DOWN

1. Scorn (7)
3. Copper coin (5)
3. Repeat performance (6)
4. Melodic (7)
5. Uncle's daughter (5)
6. Other means of settling legal disputes (abbr.) (3)
7. He sat beneath a precarious sword (7)
12. Photographers (8)
14. Learned (adj) (8)
16. Harbour town (7)
17. Encloses or handles stolen goods (5)
19. Ancient Peruvians (5)
20. Ice-cream holders (5)
21. No-win, no-fee, for instance (abbr.) (3)

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

From the archives: the case of the missing teeth

DENTAL phobia in children adds risk to any treatment – even with careful reassurance and modern anaesthetics. Spare a thought though for dentists operating a century ago. In 1907 the *Guardian* published an account of a court case in Manchester in which negligence was alleged in the treatment of an eight-year-old girl named Frances Harriet. The girl worked after school in her widowed mother's grocery shop. On August 30 Frances was taken to a local dental practice to have several teeth removed. Her mother told the dentist – Mr Grundy – that if gas were used, three teeth might be removed; otherwise only one.

The *Guardian* correspondent writes: "No anaesthetic was administered, but while the girl was seated on an ordinary chair three teeth were taken out. The girl screamed, and began to cough. Only one of the teeth could be found after extraction, and when the defendant's attention was called to this fact he accounted for it by saying that his pup must have been in the room and picked the others up. He accounted for the cough by saying that the girl had probably swallowed a little blood."

Mrs Harriet later testified that she had not seen a dog in the room. She paid Mr Grundy his fee but protested that he had been "hard" on the girl. The dentist agreed and gave Frances thruppence for a bottle of ginger beer. On reaching home the girl complained of a pain her chest. A day later she became delirious with fever and a doctor was summoned. Given the symptoms he concluded that a tooth must have slipped down the girl's throat as she gasped or screamed during the extraction. The girl's condition quickly deteriorated and she later died from pneumonia.

No post-mortem examination was carried out. A lawyer for the dentist suggested that Frances had already developed bronchial pneumonia as a consequence of the abscesses in her mouth – and this rather than a swallowed tooth led to her death. But a medical expert called as a witness expressed his strong view that the child's death was "due to the passage of a portion of a tooth into the trachea, setting up septic pneumonia".

No further details are given as to the outcome of the case.

Vignette: pioneering geneticist, Julia Bell (1879-1979)

THE renowned human geneticist, Julia Bell, was born and schooled in Nottingham, where her father was a printer and bookseller. She had nine older and three younger siblings, most of whom survived to adulthood. Julia grew up amid the hurly-burly of home life and the sound of music being played. Photographs show a slim young woman with a cloud of fine blonde hair.

Her intelligence and diligence earned her a place at Girton College Cambridge where she read mathematics. Illness prevented her from sitting the final examinations but her noted ability earned her a rare aegrotat. Discrimination against women in Cambridge forced her and others to travel to Trinity College, Dublin to graduate. There she was awarded BA and MA in 1907.

Julia was enthralled by the beauty of mathematics and the power of statistics and for the next six years as a postgraduate she provided the mathematical know-how that physicists lacked. She conducted studies on solar parallax at the Cambridge Observatory and also performed calculations on the physics of the earth's crust.

At Girton, Julia had heard lectures by Professor Karl Pearson, who was an applied mathematician at University College London and director of the Galton Laboratory for National Eugenics. Pearson actively encouraged social and intellectual equality among men and women and sought bright young women from Girton to assist him. Thus Julia came to London to start a life-long career in genetics. In London she also joined the suffragette marches.

A key researcher in genetics was JBS Haldane. Studies in *Drosophila* had yielded genetic charts but the lower genetic variation and poorly defined chromosomes made similar studies in mammals difficult. He bravely attempted a search for human genetic linkage. He enlisted the skills of Julia Bell and together

they demonstrated linkage between haemophilia and colour-blindness and published their findings in 1915.

Peter S. Harper comments: "The paper is a marvellous example of thoroughness, detailed mathematical skill in maximising information from the data, and foresight in defining general principles that would determine the pattern of research for the next 40 years. It combines clarity with mathematical rigour... a model of how to study linkage for any genetic character or disorder."

As Julia grew more interested in observing family characteristics, Pearson encouraged her to study medicine. She qualified with the MRCP LRCP in 1920 from the London School of Medicine for Women (later renamed the Royal Free) and St Mary's Hospital and practised one day a week for the next decade of her life. She was awarded membership of the Royal College of Physicians in 1926 and elected FRCP in 1938. In 1932 she served on the genetics committee of the MRC and between 1933 and 34 was a permanent member of the MRC scientific staff.

From 1908-14 Bell had honed the use of statistics in a series of investigations on heredity as interpreted by Pearson. She now began to make important contributions to a large project at the Galton Laboratory to record pedigrees of human hereditary disease and unusual features. It was published in five volumes between 1909 and 1958 as *The Treasury of Human Inheritance*. The monographs by her on hereditary diseases of the eye (1922-33), nervous diseases and muscular dystrophies (1934-48, with J Purdon Martin and Arnold Carmichael) had clear



introductions and were headed with literary quotations that showed her empathy with patients.

Data on brachydactyly occurring in a family in Wales was the source for an important section contributed by Bell in volume V (1951-3) on digital anomalies. She also contributed studies of the Lawrence-Moon syndrome to that volume. Studies of an

English family in which low intelligence was inherited as an X-linked trait and therefore produced an excess of retarded males was published in 1943, yielding the term Martin-Bell syndrome. A "fragile site" can now be demonstrated on the X-chromosome.

Aged 62 Julia received the Weldon memorial prize and medal for biometry from Oxford University. Her interests were wide – the subject of one early paper was the long bones of the English skeleton, another was on oral temperature in school children with special reference to parental environment and class difference. Her last paper, published in the *BMJ* when she was 80, was on rubella in pregnancy. Her final years were spent at St George's Nursing Home where she died aged 100 years.

Sources:

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- *Landmarks in medical genetics*. Ed. Peter S Harper. Oxford 2004
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Top ten tips on avoiding trouble for dental professionals



Join MDDUS and Wright Cottrell
for an evening session of handy
hints and tips to help you avoid
some common dento-legal pitfalls



Session dates and venues

- Wednesday 23 May 2012
St James Park, Newcastle
- Wednesday 30 May 2012
Mandec, Manchester
Dental Hospital
- Thursday 31 May 2012
Weetwood Hall, Leeds
- Thursday 7 June 2012
Liverpool Crowne Plaza,
Liverpool
- Tuesday 12 June 2012
Drumossie Hotel, Inverness
- Wednesday 13 June 2012
The Marcliffe Hotel, Aberdeen
- Tuesday 19 June 2012
MDDUS Offices, Glasgow
- Wednesday 20 June 2012
RCP of Edinburgh, Edinburgh
- Thursday 21 June 2012
Wright Cottrell offices,
Dundee



Contact **Karen Walsh**
at **kwalsh@mddus.com** or
call **0845 270 2034** for further
details and an application form

How to avoid complaints, claims and the GDC

Presented by Aubrey Craig,
dento-legal adviser, MDDUS

Being on the receiving end of a claim, complaint or referral to the GDC is an expensive, time-consuming and stressful experience. Every year we assist members who find themselves in these situations and this session will draw upon our considerable experience to provide you with practical advice on how to avoid professional difficulties.

Decontamination de-mystified

Presented by the local W&H territory
manager

Let Wright and W&H demystify the national decontamination guidelines. This one-hour session will enlighten you to the realities of what is expected and provide the know-how to achieve a fully compliant practice.

A light buffet will be
available from 6pm and
the programme will
commence at 6.30pm

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