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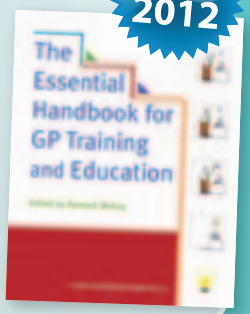

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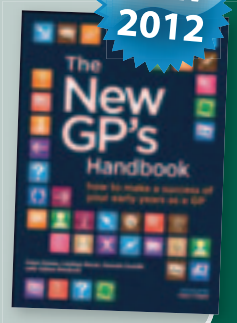

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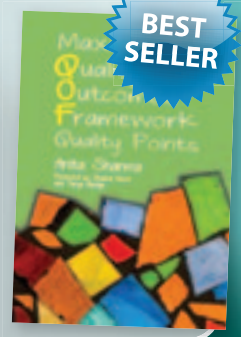

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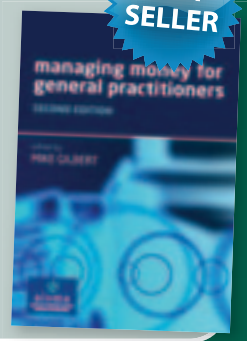

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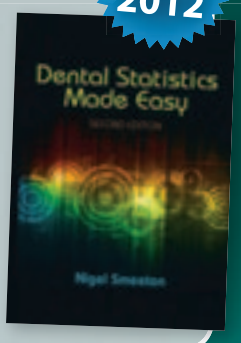

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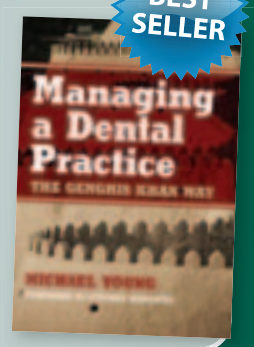

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IN THIS ISSUE

BRITISH mountaineer Myles Osborne was one of four climbers making a summit attempt of Mount Everest on 26 May 2006. That morning at 8:53 the team came upon a surprising scene. Wrote Osborne:

"Sitting to our left, about two feet from a 10,000 foot drop, was a man. Not dead, not sleeping, but sitting cross legged, in the process of changing his shirt. He had his down suit unzipped to the waist, his arms out of the sleeves, was wearing no hat, no gloves, no sunglasses, had no oxygen mask, regulator, ice axe, oxygen, no sleeping bag, no mattress, no food nor water bottle. 'I imagine you're surprised to see me here', he said."

The man was an Australian climber named Lincoln Hall, who the day before had summited Everest but on descent had collapsed from suspected cerebral oedema. Two Sherpas had tried to help Hall to safety but had no choice but to leave him on the high slope. Amazingly, Hall managed to survive the night and was rescued the next day.

Sadly ironic, Hall died recently not pursuing another wild adventure but from mesothelioma attributed to a period in his boyhood building dens with his father using asbestos sheeting. On page 12, Alan MacDermind looks at the enduring health impact of asbestos exposure – and the threat still posed by the material today.

Also in this issue Joanne Curran looks at new GDC requirements regarding dental advertising (p. 18) and we feature an interview with Dean Marshall of the BMA Scotland on the challenges facing the diverging UK health systems. Our regular clinical risk article on page 16 highlights the need for vigilance in potential cases of giant cell arteritis.

And on page 9 Deborah Bowman bids a sad farewell to Dr Gregory House MD – the maverick American TV doctor who amazingly used to be Hugh Laurie.

Jim Killgore, editor

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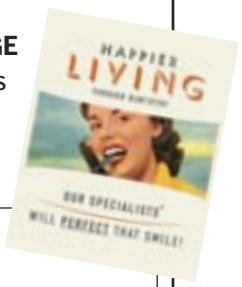

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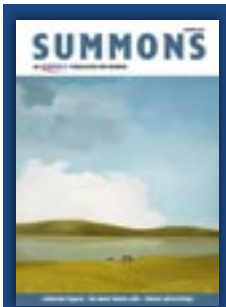

Cover image: Reflections by Elizabeth Reid 1988. Medium: oil on board.

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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CMYK Design
0131 556 2220
www.cmyk-design.co.uk

Printing and distribution:
L&S Litho

MDDUS

Summons is published quarterly by The Medical and Dental Defence Union of Scotland, registered in Scotland No 5093 at Mackintosh House, 120 Blythswood Street, Glasgow G2 4EA. • Tel: 0845 270 2034 • Fax: 0141 228 1208
Email: General: info@mddus.com • Membership services: membership@mddus.com • Marketing: marketing@mddus.com • Website: www.mddus.com

BMJ Group Awards 2012

MDDUS was proud to act once again as headline sponsor of the recent BMJ Group Improving Health Awards 2012.

Medical professionals who have made outstanding contributions to healthcare were honoured at the ceremony held at the London Hilton on Park Lane on May 23. The event was hosted by comedian Sally Phillips and saw winners unveiled in 12 categories.

New categories this year included the Karen Woo Award to recognise an individual who has gone beyond the call of duty to care for patients. It was presented to Lucy Mathen whose charity Second Sight has helped restore sight to more than 50,000 people in India. Dr Mathen gave up her job to run the charity unpaid and full-time.

Winner of the Lifetime Achievement Award was cardiologist and Nobel Prize winner Dr Bernard Lown, whose work has included developing the defibrillator. Dr Alexander Finlayson was named Junior Doctor of the Year for his MedicineAfrica project which helps educate medical students and doctors in Somaliland.

This year MDDUS sponsored the award for Clinical Commissioning Team of the Year which went to the NHS Nottingham City Clinical Commissioning Group for their work to ensure the Health Bill is shaped for the benefit of the local population.

Find out more about the awards and 2012 winners at **http://groupawards.bmj.com/**

Keep us informed of private practice earnings

IF you are a doctor in private practice your subscription is based partly on the work you do and partly on the private fees you earn. Your renewal notice will show the level of earnings upon which your subscription has been based and it is your responsibility to ensure that this is sufficient to cover expected earnings for the year to come.

Should any change be required please inform MDDUS immediately so that a revised subscription for next year can be calculated. If at the end of next year your estimate has proved to be too high or too low you will have an opportunity at that time to adjust it.

We would like to be clear that the figure used should be your gross private earnings from the practice of medicine, however delivered. In the event that you have

Dental indemnity for cosmetic treatment

MDDUS offers indemnity for dentists providing non-surgical cosmetic treatment, including Botox.

This protection is offered without additional charge as part of a standard GDP subscription but subject to certain conditions. Members must be in the '7 sessions or more' membership category for GDPs and should have graduated before 2010.

The member also must provide details of courses attended for the provision of this type of treatment, as well as plans for updating knowledge. Evidence of protocols being used for patient assessment and the monitoring of treatment provided must also be supplied.

Only procedures carried out in the immediate peri-oral area, nasal labial folds and elsewhere on the face are covered, with the neck explicitly excluded, and only non-permanent injectable cosmetic procedures are included. Qualifying members must be registered with CHKS and under the IHAS Scheme, and possess the IHAS quality mark. For more information call our Membership Department on 0845 270 2038

IN BRIEF

- **GLASGOW OFFICE EXPANSION** Building and renovation work expanding MDDUS Glasgow offices at Mackintosh House into the adjacent building at 167 Bath Street is nearly complete. The B-listed Georgian townhouse will provide much needed additional office space for staff as well as extra meeting rooms for consultations and to accommodate our growing educational programme offered by MDDUS Training and Consultancy services. Entrance to the Glasgow offices will remain at 120 Blythswood Street.
- **UPDATE YOUR CONTACT DETAILS** Do we have an up-to-date email address and mobile telephone number for you? It's important that MDDUS is able to contact members if necessary – and possibly at short notice. So please email membership@mddus.com with your name, membership number and mobile telephone number to allow us to update your contact details if necessary.

formed a company for accounting or other purposes, the relevant figure is the gross income to that company in relation to your practice of medicine.

At the heart of the principle of mutuality is the fact that all members should contribute an appropriate amount to the common fund that is held on behalf of all members. This is an important principle and we do carry out checks of gross private practice earnings from time to time to ensure that it is being complied with.

If you have any questions please telephone our Membership Department on 0845 270 2038.

New training courses at MDDUS

A NEW series of the popular MDDUS Hot Topic workshops has been announced for our Glasgow and London offices.

MDDUS Training and Consultancy are pleased to offer healthcare professionals a new range of training courses from August 2012 with subjects such as confidentiality and data protection act, GP finance, and managing team conflict.

A week-long leadership programme for doctors with management responsibilities, entitled Leading Through Uncertainty, will also take place in Glasgow from October 29 to November 2, 2012.

More information is available in the Training and Consultancy section of the MDDUS website at **www.mddus.com** or, alternatively, contact course administrator Ann Fitzpatrick on 0845 270 2034 or **afitzpatrick@mddus.com**

Patient requests to alter medical records

PATIENTS have never been more informed as they are today on health matters – this thanks to the almost limitless information now instantly accessible within a few clicks on an internet browser. Just how helpful this is to doctors and other healthcare professionals is perhaps debateable. Combine this with changing attitudes to healthcare – rising consumerism, a less paternalistic approach to treating patients – and it is only inevitable that doctors and dentists are finding aspects of their practice increasingly questioned in some cases.

The Data Protection Act (DPA) 1998 enshrines the right of access by patients to any personal information held by a practice or healthcare body. An individual can send a subject access request requiring a data holder to disclose what personal information is held and also to provide a copy of that information. Patients also have the right to request amendments to their records. These can include correcting simple errors or redacting sensitive details or may involve more fundamental conflicts over clinical content.

MDDUS deals with a growing number of advice calls to do with subject access requests under the Data Protection Act 1998. It should be made very clear to practice staff that relevant emails, text messages or other notes could someday be seen by a patient or carer and possibly challenged. Notes in records should be neutral and non-judgemental.

But this is not to say that the inclusion or not of valid clinical opinions should be subject to debate. Department of Health guidance states: "The DPA fourth principle requires that information should be accurate and kept up-to-date. This provides the legal basis for enforcing correction of factual inaccuracies. An opinion or judgement recorded by a health professional, whether accurate or not, should not be deleted. Retaining relevant information is essential for understanding the clinical decisions that were made and to audit the quality of care."

The guidance goes on to recommend that in any disagreement over the accuracy of an entry the patient should be allowed to include a statement within the record to the effect that they disagree with the content. The patient should be further advised that if they are unhappy with this outcome they can make a complaint through NHS Complaints procedures or the Information Commissioner's Office.

In cases where both parties agree that information is factually inaccurate the record should be amended but ensuring that the original information is still legible along with an explanation of why the record has been altered. In hard copy records, text to be amended should be scored out with a single line and the correct entry written alongside. Amendments should be clear and legible and should include time, date and a signature of the individual making the change. Computer records should also allow for an audit trail identifying the date and time of any change and the person responsible.

Transparency is an oft-used word these days but in the case of healthcare records it is the best way of getting at the truth in a potential dispute arising weeks, months and perhaps even years later.

● **CHECK OUT OTHER MDDUS PUBLICATIONS** Maybe four *Summons* a year is enough for any healthcare professional. But MDDUS publishes another four biannual magazines as well as two monthly e-newsletters with news, profiles and other features covering not just medico or dento-legal topics. Go to the Publications page at mdddus.com to see digital versions. To subscribe to the MDDUS eMonthly, contact jkillgore@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.

New tribunal service launched by GMC

A NEW impartial adjudication function for doctors has been launched by the GMC as part of key fitness to practise reforms.

The Medical Practitioners Tribunal Service (MPTS) has been heralded by the GMC as the biggest shake-up of fitness to practise hearings since being first established in 1858.

The new service, based in Manchester, is part of the GMC but operationally separate from the regulator's complaint handling, investigation and case presentation and is accountable to Parliament. MPTS panels will have the power, in the most serious cases, to remove or suspend a doctor from the medical register or place restrictions on their practice. The service can also take early action to ensure patient safety by considering cases before a full fitness to practise hearing, where it is judged appropriate to place restrictions on a doctor's practice immediately or suspend their practice while investigations proceed.

Niall Dickson, GMC Chief Executive, said of the MPTS: "It represents a key part of our reforms and delivers a clear separation between investigations and the decisions made about a doctor's fitness to practise."

For more information visit **www.mpts-uk.org**

Dental fraud costs £70 million over year

DENTAL fraud cost the NHS in England over £70 million in the year 2009-10, according to figures published by the government agency NHS Protect.

The report looked at the prevalence of suspected fraud in contractor claims within NHS dental services based upon a random sample of 5,000 FP17 dental activity reports for completed treatments drawn by NHS Dental services. This was the first such exercise undertaken since the current dental contract was introduced in April 2006.

The report concludes that there was an

estimated loss due to suspected contractor fraud of £73.19 million during 2009-10 based upon an assessment of resolved treatment queries, with a potential for a further £5.31 million of loss in unresolved queries. It is estimated that during this period almost one million inappropriate claims (FP17s) were submitted.

The types of suspected contractor fraud included patients not receiving the level of treatment on the FP17 (50 per cent), split courses of treatment (27 per cent), patients not visiting the dentist (12 per cent), fictitious patients (10 per cent) and patients paying for treatment but marked as exempt on the FP17 (1 per cent).

The report estimates that without intervention a further £146.38 million could be lost to fraud before the new dental contract is in place in April 2014.

But the British Dental Association has urged caution in interpreting the results. Dr John Milne, chair of the BDA's General Dental Practice Committee, said: "These figures will need to be looked at carefully and understood to ensure that the cases of fraud are distinguished from cases where a course of treatment has been staged for legitimate reasons. It cannot be assumed that treatment that has been planned in a phased way, or had to be restarted during what was intended to be a single course, is fraudulent; that simply isn't the case. There are clinical factors that can explain both scenarios."

One in 20 GP prescriptions contains error

GPs in England make mistakes in one in 20 prescriptions, a major new study has revealed. And while most errors were classed as mild or moderate, one in every 550 prescriptions contained "serious errors".

The research commissioned by the General Medical Council found one in eight patients had mistakes in their prescriptions, with the elderly and the young worst affected.

The study looked at 15 general practices from three areas of England and analysed the records of 1,777 patients. The most common types of mistake were incomplete information on the prescription (30 per cent), dosage errors (18 per cent) and incorrect timing of doses (11 per cent). The most common type of monitoring error was a failure to request monitoring in 69 per cent of cases.

Researchers identified a number of contributing factors in prescribing errors including deficiencies in GP prescribing training, pressure and distractions at work, lack of robust systems for ensuring patients receive necessary blood tests and problems relating to GPs using computer systems – i.e. overriding important drug interaction alerts.

GDC considers direct access to dental team

THE GDC is now considering whether to allow patients direct access to other dental care professionals without the prescription of a dentist.

Such a change would mean that patients could see other members of the dental team – such as dental hygienists or

IN BRIEF

- **BNF SMARTPHONE APP** Access to the latest up-to-date prescribing information from the British National Formulary (BNF) is now available in a smartphone app launched by NICE. The app is free to health and social care professionals who work for or who are contracted by NHS England. The NICE BNF app is available via the Apple App Store and Google Play Store to users with an NHS Athens user name and password.
- **ORAL CANCER NOW "RECOMMENDED" DENTAL CPD** Improving early detection of oral cancer is now a "recommended topic" in the GDC's continuing professional development (CPD) scheme. The GDC has no mandatory CPD topics but does recommend some subjects. The council is currently reviewing its CPD policy but any new requirements will not be introduced before 2013.
- **NEW RCGP GUIDANCE ON DOMESTIC ABUSE** New guidance on recognising and responding to signs of domestic violence has been published by the RCGP. The document provides key principles to

VIEWPOINT

By Dr Ivor Felstein, Retired Consultant Geriatrician

Scope tales

As students back in pre-clinical classes in schools of medicine of the mid-20th century, we all looked forward to purchasing our own individual stethoscopes. After all, this traditional listening weapon for medics had already been in use for well over 100 years. We foolishly thought that, strung around our neck or hanging loose in front of the chest, it immediately identified us as the real medical McCoy.

The stethoscope first emerged back in France when a physician, named Rene Laennec, became fed up with twisting his head down onto his patients' chests. Like other doctors before him, he did these gymnastics so that his own ear could physically and directly pick up the presence of cardiac sounds and confirm the heart rhythm and/or the presence of undesirable murmurs. Doctors with poor head and neck flexibility, or with a tendency to vertigo or even with a dislike of the unwashed human body, loathed this ear-to-chest approach.

Monsieur le doctor Laennec, however, had a brainwave, so we are told, and rolled up some firm paper (possibly cardboard) into a hollow piece. He applied one roll end to his own ear and the other roll end to the patient's lower chest. He then found it much easier to monitor the heart sounds, while almost upright, but wondered what to call his invention.

In the tradition of doctors of that period, he was knowledgeable in Latin and Greek and the latter gave him 'stethos' (for chest) and also 'kopein' (for scrutiny), which were neatly joined in the name 'stethoscope'. I once met a physics graduate, who questioned this naming tale. Instead, he suggested the name was a mis-hearing of 'stealth-oscope' since the patient now had no surety the physician was hearing anything at all!

Stethoscope material in time moved on from hard paper to cardboard to lightweight metal. Then, in the mid-19th century, along came an American named Nathan Marsh, who instead of a single broad 'toilet roll' object utilised thin, neat, lightweight rubbery tubes for carrying sounds. These tubes were in turn held in place in both ears by firm, hollowed "buttons".

Centrally the tubes were joined to a flat piece, clock-like in shape that picked up all the heart noises, and time and rhythm. The sounds had a kind of 3-dimensional quality and the central hollowed chest piece could have twin structures of greater and lesser resonance, if required. Best of all, the patient could be flat in bed or half-sitting, or even standing for the auscultation.

Some doctors still used the traditional single piece carton-shaped metal scope for babies' auscultation. Others used a minimised version of the Marsh format, then designated it as a paediatric scope. All new scopes since that time are essentially altered or re-accommodated versions of the Marsh plan.

There are some traditional stethoscope anecdotes duly passed down by medical students. For example, a famous professorial holder of a medical school chair bequeathed his superb stethoscope (Marsh style and format) to his successor. This scope was labelled 'With best wishes'. The new professor, very impressed, wore it to his first professorial ward round.

He was asked to confirm a patient with an alleged classic murmur of valvular heart disease. "Damned if I can hear it", he told his assistant. After three more patients were also unsuccessfully auscultated, he had an idea and unscrewed the centre piece to look inside.

He smiled, as he then pulled out a large piece of cotton wool from the centre piece innards! So did we all smile. Had the old professor bequeathed his sense of humour with his 'gift'? Or was he never actually aware someone else had stuffed his own stethoscope to make it largely inaudible? You tell me...

therapists – without seeing a dentist first.

Currently both the *Standards for dental professionals* and *Scope of practice guidelines* make it clear that every member of the dental team must work on the prescription of a dentist. The only exception to this is clinical dental technicians who are able to provide full dentures to patients without the need for

a prescription.

A Direct Access Task and Finish Group has been appointed and is looking for views from dentists and other DCPs via a short 'call for ideas' questionnaire published on the GDC website. The Group has also invited a number of key stakeholders to provide evidence and has commissioned a literature review.

The results from this call for ideas will be analysed and considered by the group at its meeting in July.

help GPs and healthcare staff respond quickly and effectively to patients who disclose domestic abuse. It encourages practice managers to build strong partnerships with local domestic abuse services and ensure domestic abuse training for the practice team. Access at http://tinyurl.com/6q9mxov

- **PAIN IN ADVANCED DISEASE UNDER-TREATED** Pain caused by advanced disease remains under-treated despite a range of opioids being recommended for use in the NHS, according to clinical guidelines produced recently by NICE. The new guidelines are intended to ensure safe and consistent prescribing of opioids as a first-line treatment option for patients receiving palliative care for chronic or incurable illnesses. The guidelines offer recommendations on discussing patient concerns such as addiction, tolerance, side-effects and fears that treatment implies the final stages of life. It also provides advice on starting treatment and maintenance therapy. Access at www.nice.org.uk

OLYMPIC FEVER

Liz Symon

IT IS ONLY a few weeks now until our television screens will be ablaze with one of the biggest events of the sporting calendar – the Olympic and Paralympic Games. With all the excitement looming, there will be staff issues to consider for practices whose employees are looking for time off during the event.

Employees may request time off to attend events or to work as a volunteer, but there is no legal obligation to grant these requests.

Volunteers will have been notified by now and it would be advisable to check with employees if any of them have been accepted so you can start planning for their absence. Each volunteer will spend a minimum of 10 days working at the events and will have to attend three training sessions prior to this.

Some options to consider for employees who plan to attend/volunteer at the Games include:

- taking annual leave
- making up time at later date
- allowing flexible working during the Games
- granting special leave – paid or unpaid
- a combination of the above.

Under employment law terms, there is no obligation to give paid time off unless there is something in the contract that states this will be granted, which is unlikely.

With annual leave, it would be advisable to discuss the matter now to establish how many employees plan to take time off during the Games.

If an employee is requesting annual leave, the practice must comply with its obligations under working time regulations. For every day of holiday required, employees should give employers at least twice as much notice, so to request two days' leave they need to give four days' notice. There may be different provisions set out in your contract or holiday policy and these should be adhered to.

If the practice cannot accommodate the request, the employee should receive counter notice of the refusal as soon as possible to avoid disappointment. In the absence of any practice policy on the matter, the counter notice must be given at least one day in advance for every day of leave requested, i.e. two days' counter notice if refusing a request for two days' annual leave.

> "Another important issue for practices to consider is unauthorised absences which may be higher than normal during the Olympics"

If you have a number of employees competing for time off, this may already be covered in the practice's holiday policy. If not, then you can deal with the requests on a 'lottery' basis and pick names out of a hat to ensure fairness or deal with the matter on a first come, first served basis.

It is important to avoid any allegations of unfair or discriminatory action by being consistent, transparent and thinking about how you will manage annual leave requests.

Another important issue for practices to consider is unauthorised absences which may be higher than normal during the Olympics. Any cases of suspected unauthorised absence should be handled as a misconduct issue and dealt with in accordance with the practice's disciplinary procedure. For clarity, both disciplinary and absence procedures should state that unauthorised absence will constitute misconduct that is likely to lead to disciplinary proceedings.

Another consideration for managers during the Games is the possibility of poor performance amongst employees, perhaps due to overly enthusiastic post-event celebrations, and employees should be advised that this behaviour is not acceptable.

Practices should also be alert to the possibility of employees trying to watch lengthy coverage at work on TV or on their computers. It is worth advising staff that this is not acceptable and those who want to watch the Games may request to alter their hours on a temporary basis. Practices will need to consider what flexible working arrangements are in place and if this can be accommodated in the short term.

There will be employees who have no interest at all in the Olympics and it is essential for the practice to consider this so that managers are not left open to accusations of showing favouritism towards those who are interested in the Games.

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

Note: this article first appeared in *Practice Management* magazine

HOUSE HAS LEFT THE BUILDING

Deborah Bowman

Our ethics columnist mourns the passing of an iconoclastic TV medic

ARTWORK: MICHELLE BROWN WWW.MICHELLEBROWN.CA

DR GREGORY HOUSE MD: medical maverick, damaged diagnostic genius and a colleague without an ounce of collegiality, yet the man others longed to impress.

The flawed healer has made his final ward round. Of course, House doesn't actually do ward rounds, preferring instead to watch pornography in his office, throw oversized tennis balls at his staff and steal food from the canteen.

Yet, House has caught the imagination of medics and patients alike around the world. I have heard him discussed at conferences, read papers in journals about him (conclusion: he's not a great role model) and know that medical students hold '*House* parties' where, rather than treading crisps and spilling beer into carpets, they gather to watch Hugh Laurie pretend to be an American doctor.

And, I admit it, I too have been seduced and remain fascinated by Greg House, and I will mourn his loss.

So why has this misanthropic doctor captivated millions of viewers? It isn't the most realistic of medical dramas, particularly for a UK audience – the glamour of Princeton-Plainsboro hospital, and the role of diagnostician, are alien to anyone used to the NHS.

And the medicine of *House* is deliberately exotic. Medical students are taught that when they hear hooves, they should think horses not zebras, but *House* was all about the zebras (a piece of *House* trivia – its original working title was *Chasing Zebras, Circling the Drain*).

Who can forget the nun who appeared to have stigmata but turned out to be allergic to copper or the woman with maternal mirror syndrome or the man who wept blood? I could go on...

Intriguing as the symptoms and diagnoses on *House* may be, it is the universal questions that the programme asks that, for me, explain its appeal. At the heart of the series is Gregory House himself.

We know he is brilliant and we know he is an addict who self-medicates to control his own pain, the physical if not the existential kind. We know he brings unmatched clinical acumen and breath-taking rudeness to each encounter. House makes us laugh with each savage riposte and feel ashamed at laughing.

This is the trick of *House:* it exposes the complexity of motives in medicine and in life. It rejects the notion of doctor as altruistic and omniscient hero, but never the value of medicine. That House continues to strive, and that patients continue to come to him, is never in doubt.

The relationships in *House* are rarely easy and are often discomforting. In reality, House would have been struck off long ago. But the relationships that House has with his colleagues, students, patients, friends, family and lovers do feel authentic. They are messy and complex. These are interactions that are mediated as much by need, dependence and fear as by love, respect and friendship.

When characters are simultaneously drawn to and repelled by House, we understand. Anyone who has followed a consultant on a ward round, or sat in a hospital bed whilst the doctors speak about, but not to, you, will recognise the hierarchies and power play that are part of being on House's team.

Above all, *House* is a programme that had the courage to show the essence of medicine. The science is represented as a quest in which first principles and deductive reasoning prevail. And the programme is brilliant at capturing the wonder and miracle of basic medical science, often with extraordinary images of cells going hay-wire, organs eroding and bodily fluid racing to where it doesn't belong.

But *House* was equally attentive to the human aspects of medicine. It didn't offer an idealised version of the therapeutic alliance (those are easy to find elsewhere on TV). No, House's approach to the human dimension of medicine was fearless, unsettling, dark and demanding.

House's constant refrain that 'everyone lies' was explored endlessly but never resolved. Time and time again, patients, colleagues and families who were quick to defend trust and truth were shown to be deceiving, denying or colluding. In *House,* it is the fallibility of people – doctors and their patients – that makes medicine much more than the sum of its scientific parts.

Medicine in *House* was uncertain, surprising and thought-provoking. It was part scientific quest and part study in human nature. It was original and unsettling. It wasn't just that *House* reflected some aspects of medicine in an entertaining way. It was more fundamental than that: this programme explored the essence of life itself.

House never let its characters or viewers forget that, as well as the possibility that 'everyone lies', there is also the certainty that 'everyone dies'. And yet still, Dr. Gregory House, his colleagues and his patients strived, every day, to live.

As do we all.

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

Note: This column was first broadcast on *Night Waves*, BBC Radio 3, on Wednesday 23 May

Standing up for GPs

PHOTOGRAPH: BMA

SPEAKING up for the rights of GPs has been a major part of Dr Dean Marshall's career. He qualified in 1994 and was elected chair of the British Medical Association's Scottish General Practitioners Committee (SGPC) in 2006. He is now a member of the UK negotiating team of the General Practitioners Committee which is responsible for negotiating the UK GMS contract. Based in Dalkeith, Midlothian, Dr Marshall leads on revalidation and clinical and prescribing issues for the GPC team. He is a member of BMA Council and a Director of the BMA.

Debate over health reform in England has dominated political discourse in the UK over the last year or so. What do you see as the major implication of the divergent approach to healthcare delivery in Scotland and England?

The diverging health system in England is likely to cause significant pressure on the UK GMS contract as it is likely that contractual means will be used to try and force GPs into engagement with the changes. This is despite clear messages from GPs that they do not support the direction of travel of the health service in England.

Do you think the demise of a UK-wide GP contract is now inevitable?

My view has always been that at some point the Scottish Government would decide they did not wish to continue with a UK GP contract. It now seems more likely that England will be the prime mover and will decide in time that they do not wish to negotiate on a UK level. This will result in us having to quickly negotiate a new contract for GPs in Scotland instead of taking time to plan and make sure that any new contract improves on what we currently have in place.

Are you supportive of the Scottish Government's decision to say 'no' to private providers in primary care?

GPs in Scotland are very supportive of the

BMA Scotland's Dr Dean Marshall *talks to Summons about his views on the future of general practice*

Scottish Government's policy of excluding private providers from primary care. We have seen the problems with private providers in England and the lack of evidence of any benefit to patient care. We believe GP practices should be run by those working in them and have a connection with their patients rather than being employed by private providers with a responsibility to their shareholders to increase profits.

How do you think the squeeze in government funding will most affect the NHS in Scotland?
The Scottish Government have argued that the current financial situation will result in improved efficiency and therefore improved quality. Those of us who actually work in the NHS are well aware that there comes a point where we have reached maximum efficiency and if demand continues to rise, in a climate of stagnant or reduced resources, then quality of care begins to suffer. I believe we are at that point now.

Are GPs in Scotland being given adequate resources to support the shifting balance of care from secondary to primary?
We have had no real investment in general practice in Scotland for five years and there is no evidence of any funding being transferred from secondary to primary care despite clear evidence of a significant transfer of work. GP practices are struggling to cope with this unfunded workload and there is no sign the situation will improve.

Given Scotland's reputation as the "sick man of Europe" – what more can general practice do to reduce the nation's health inequalities?
Politicians regularly complain that the GMS contract has failed to address health inequalities, which is unfair as that was not its purpose. The Quality and Outcomes Framework, however, has led to a significant improvement in the health of the UK population. In my view, general practice can do little to address the majority of health inequalities as these are largely linked to social issues.

Are extended opening hours the answer to improving patient access to GP surgeries?
GPs were not supportive of the introduction of extended hours as we saw no evidence that they would improve access to those at most need and we made it clear to government that there were better ways to spend scarce NHS resources. Our experience of extended hours has confirmed those views. While there may be some areas of the country with a high number of commuters who would like to see their GP in extended hours, the majority of the country does not have this type of population and there is no sense in GPs in remote and rural areas sitting in empty surgeries in the extended hours period.

> "Most health inequalities are largely linked to social issues"

Do you think the GMC is getting closer to a workable system of revalidation for GPs?
I am very concerned about the situation we find ourselves in with less than a year to go before the introduction of revalidation. While I support the concept of revalidation, I remain to be convinced that the proposed process is deliverable and will be of benefit to doctors or patients. We still have major problems to resolve such as difficulties experienced by locums in collecting the required data and the issue of who will pay for the remediation of doctors who fail to be revalidated.

The Scottish Government is opposed to NHS pension cuts but claims it is being held to ransom by Westminster. What is your view?
The proposed changes to doctors' pensions by the UK government will result in us paying significantly more for our pensions than civil servants on a similar income. The Scottish Government says it is opposed to these changes and has started discussions with the health unions but so far has failed to offer any alternative. I am unconvinced by their defence that they are powerless to act and believe they are hiding behind the UK proposals.

Do you think there is public sympathy for doctors striking over pension cuts?
I hope the public understands that we have taken this step very reluctantly and only because the government will not engage with us to even try and find a fairer way forward. NHS staff agreed to major changes to their pensions in 2008. As a result the scheme is delivering £2billiion to the Treasury each year and staff have taken on sole responsibility for covering increases in costs due to improvements in longevity in the future. Now the government wants to tear up a deal reached through genuine negotiation and impose these further, unnecessary changes.

How do you balance the demands of being a practising GP with your busy role at the BMA?
During my time as SGPC Chair I have continued to work in practice two days a week as required by the role. I believe it is vital that those responsible for representing GPs are still in active practice. This is particularly important in establishing credibility with colleagues, politicians and the public.

I have only been able to do my BMA role because of the incredible support of my partners who have put up with me being away from the practice for considerable periods of time. In my view without such support it would not be possible to maintain both roles.

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

Asbestos – still paying the cost

Alan MacDermid looks at the enduring ill-effects of asbestos on UK health

FEW people in this country, apart from mountaineering enthusiasts, would have heard of Lincoln Hall until his recent obituary.

Hall was one of Australia's most celebrated climbers and is perhaps best known for an ascent of Everest six years ago, after which, on the way down, he collapsed suffering from cerebral oedema, one of the most serious manifestations of altitude sickness.

Two Sherpas with him tried valiantly to help the delirious Hall until he lost consciousness, at which point the expedition leader ordered their withdrawal from what would have been a futile sacrifice. Incredibly, Hall managed to survive the night at 8,600 metres, apparently with the aid of transcendental meditation. He was rescued the next day by four climbers from another expedition.

Given his strenuous career in the most pitiless of the great outdoors, it was sadly ironic that Hall should have succumbed at the age of 53 to a disease more associated with heavy industry, shipbuilding, engineering and construction – asbestos-related mesothelioma.

It may also seem a puzzle that one so young should have been afflicted by a disease whose gestation period can be up to 50 years from exposure. In fact, it was attributed to contact he had as a boy in his back garden in Canberra, building dens with his father, presumably using asbestos sheeting.

Hall's death is a salutary reminder that the asbestos story will continue to dog us even though it is years since imports were banned in this country.

Peak still to come

According to the Health and Safety Executive (HSE), asbestos is the single greatest cause of work-related deaths – from mesothelioma, asbestosis and lung cancer - in the UK. Although asbestos has now been banned, certain materials were still manufactured and used until 1999. It is estimated that at least 50 per cent of all asbestos used in the construction of buildings in the UK is still present.

Cases of asbestos-related diseases will continue to increase, with mesothelioma deaths alone now expected to peak at 2,500 a year by 2015, thanks not only to the long latency period but also the emergence of a new generation of victims. The burden of disease suffered by workers in asbestos manufacture and heavy industry has been inherited by workers in other trades associated with the building industry, with a far wider geographical spread. Life expectancy is also having an effect. People who once would have died from other things are living long enough for the disease to develop. So is this a time bomb for a National Health Service already under pressure with restricted resources?

The answer is probably no, but for reasons which are hardly a cause for celebration. The sad fact is that the NHS has little to offer mesothelioma patients beyond palliative care, which itself will be of limited duration given the rapid course from diagnosis to death taken by this brutal disease.

"It is potentially still a big problem - we are in the unknown territory of gauging the effect on the trades who have been suffering secondary exposure to asbestos products," says Mark Britton, Professor of Respiratory Medicine at Surrey University, and Vice-President of the British Lung Foundation.

"Generally, though, the cost is going to be in human rather than financial terms."

Poor prognosis

Treatment offers little hope for mesothelioma patients. Because the condition presents quite late, surgery - pleurectomy - has not produced encouraging results.

Professor Britton says: "Without wishing to sound negative, because the patient dies fairly quickly – mean survival being less than 12 months – there is not a long chronic disease phase. There is not a huge resource issue from the chronic care point of view."

Chris Clark, a consultant chest physician working in the West of Scotland, says: "I started out years ago hoping that some effective treatment would emerge but it's not there yet.

PHOTOGRAPH: SCIENCE PHOTO LIBRARY

"The tumour forms a bulk around the lining of the lungs and constricts the ability to expand and contract, so that the patient progressively becomes more breathless."

Radiotherapy has nothing to offer and although there is a new drug on trial – pemetrexed – Dr Clark says patients are often reluctant to enter trials at the risk of blighting their last few months with side-effects, with limited benefit. Treatment then is "best supportive care" – in effect painkillers like morphine, which also eases breathlessness but affects consciousness levels.

Other conditions

Among other asbestos-related conditions encountered by clinicians are asbestosis, pleural plaques and thickening, and asbestos-related lung cancer.

"In my experience there are not nearly as many cases of asbestosis as there used to be," says Professor Britton. "It needs a high dose of exposure and the latency period is not so long, so these cases are diminishing in number. I have seen one new case in the past month."

Pleural plaques, he says, will indicate that a patient has been exposed to asbestos but they present no greater risk of developing mesothelioma than someone exposed to asbestos not displaying plaques. The key advice for GPs is to ensure that any patients with pleural plaques who become breathless should be sent for chest X-ray.

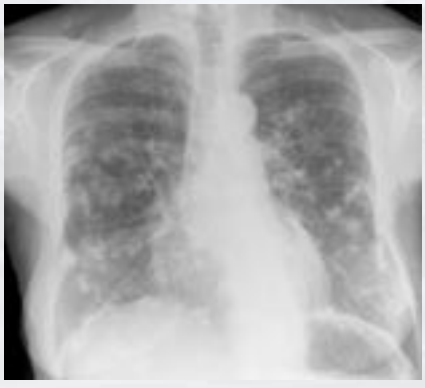
An estimated mortality rate of 2,000 per year puts asbestos-related lung cancer on a par with mesothelioma. Certainly cigarette smoking and asbestos can form a deadly combination. "Smokers are staggered when you tell them that asbestos exposure increases their risk of lung cancer eight-fold," says Dr Clark.

Sleeping dogs

Today typical patients suffering with asbestos-related conditions are no longer the older laggers and shipyard workers, and the people who manufactured asbestos products, but maintenance workers such as carpenters, electricians, plumbers, heating and telephone engineers.

"Now it can be secondary exposure – handling and working with asbestos products – and that can happen anywhere," says Professor Britton, who sits on the Industrial Injury Advisory Council.

> "The cost is going to be in human rather than financial terms"



In public buildings and office blocks where asbestos has been used, a policy of "let sleeping dogs lie" has often been followed. Asbestos products are still around in buildings and still being handled, sawn and drilled. Even when the material appears to be in a stable situation, accidental damage can introduce risk.

Not even teachers and office workers have been immune nor, presumably, GPs, dentists and their staff and patients in older buildings. It is worth noting that every commercial building is now required to have an asbestos register in place and available for inspection by employees or trades people working on site.

The HSE tells us: "If you're responsible for maintenance of non-domestic premises, you have a duty to manage the asbestos in them, to protect anyone using or working in the premises from the risks to health that exposure to asbestos causes."

Failure to comply can result in fines, imprisonment, refusal of employers' and public liability insurance, and refusal by public utilities to conduct repairs to essential services (see **www.tinyurl.com/smnsasb**).

So the message for doctors is be aware – asbestos-related disease is by no means a thing of the past.

■ ***Alan MacDermid is a freelance writer and former health correspondent with The Herald***

Support at the sharp end

In the third of a series of profiles featuring MDDUS professionals Jim Killgore *speaks with in-house solicitor* James Doake *on his work with members facing clinical negligence claims*

JAMES Doake brought a unique perspective to the job of in-house solicitor at MDDUS when he started in 2008 – that of an adversary.

In the eight years after starting out in law in 2000 (formally qualifying in 2006), James worked exclusively for claimant solicitors doing family law, personal injury cases and later representing patients pursuing clinical negligence cases against doctors and dentists. His "change of allegiance" – not untypical of solicitors working for medical and dental defence organisations – offered the Union valuable insight into the way claimant solicitors operate in pursuing clinical damages on behalf of clients.

"It's useful to understand the sort of pressures claimant solicitors are under in terms of funding and how they run a claim. And what pressures they will be under from their client as well," says James. "I think I also know better when a claimant is trying it on – just doing a hopeful letter of claim to see if anything comes back."

Clinical negligence can be a rich source of revenue for law firms working on "no win no fee" agreements (also known as conditional fee agreements or CFAs) with the basic principle being that a client is not charged by a solicitor for time spent working on a claim unless it is successfully settled or won in court.

"A firm might investigate 10 claims but only advance three or four of them because the others fall short of the necessary legal liabilities," says James. "So you know the cases they do advance have to make a lot of money. Often defendants don't appreciate why legal fees can be so high."

Dual interests

It is the job of James and the other solicitors at MDDUS to assess alleged clinical negligence claims against our members and decide on the best course of action in answering these claims. Sometimes the legal and clinical details of such cases can be very complex. Certainly a basic understanding of biological processes can be a help in medical or dental cases.

James took his first degree in physiology at Edinburgh University. He then went on to do two years of postgraduate study in law at Leicester and then York.

"Biology was my main interest and I toyed with the idea of being a doctor but it never seemed right for me," he says. "Law was a bit of change – but I wanted to specialise in medical law to keep my interest in both areas."

The job at MDDUS proved the perfect match for his ambitions as a lawyer. Based in our Pemberton Row offices in London, James also provides legal support and representation to doctors and dentists subject to GMC and GDC actions or at coroner's inquests or other proceedings, but 60 per cent of his job involves case law – from dealing with letters of claim all the way through to potential court hearings.

Forming a view

In a typical case a member having received a letter of claim will first get in touch with an MDDUS adviser. The adviser will get the member's initial response and might solicit the opinion of a clinical expert. This information would then be passed on to James or another solicitor to form an initial view on whether the claimants have a reasonable case.

"We would also review the file and provide advice about how much we think it needs to be reserved for in terms of estimated damages," says James.

"Depending on how severe the injury is you consider what effect it's had on the claimant. Have they had to stop working as a result? Care claims can be a big part of it – if someone requires 24-hour care in an extreme example then you know it could be in the millions. But it's a fairly broad brush exercise at this stage."

Other important factors that must be considered are liability and causation. Was the member responsible for a breach of care of duty and if there is proven negligence did it have an adverse impact on the patient?

Says James: "You have to review all the opinions and decide whether you think it's a vulnerable case that we may lose if taken to trial. And if it is clearly a case where we are in trouble in both breach and causation then we would always advise early commercial settlement. But we would explain this to the member and would always try to settle a case with no admission of liability – and sometimes with a confidentiality clause if appropriate."

In dispute

In cases that can be disputed James will draft a letter of response denying breach of duty and causation, based upon the member's comments and the expert reports. It is then sent to the member to check for factual accuracy and to ensure they are happy to proceed on that basis. The ball is then in the claimant's court in terms of the decision to issue formal court proceedings but that still doesn't mean a hearing is inevitable.

"It's very rare to go to trial these days," says James. "Only about one per cent of cases make it to court, if that."

Legal reforms over the last decade or so have been aimed at avoiding the need for costly trials. A key stage in the process is the case management conference, which is arranged by the court with only legal representatives in attendance. It is normally held by phone, except in high court cases, and will involve the solicitors along with the barristers or QCs lined up to argue the case in court.

"At that meeting you agree directions for the management of the case – and exchange witness statements and expert evidence so no one is surprised by what the other side has," says James. "The main purpose is to try to narrow down issues without going to trial, to cooperate and find constructive ways of settling the case."

James admits that managing a case can be a game of nerves with both tactical and commercial considerations in the balance. "Going to trial is extremely expensive," he says. "You are talking hundreds of thousands of pounds in legal costs."

> "It's very rare to go to trial these days. Only about one per cent of cases make it to court, if that"

Sometimes cases can settle right up to the week or day before a court date. "One of my cases was settled on the morning of the trial," says James. "It's not an ideal system. But your job is to look after your client's best interests. That's the primary focus."

Going to trial

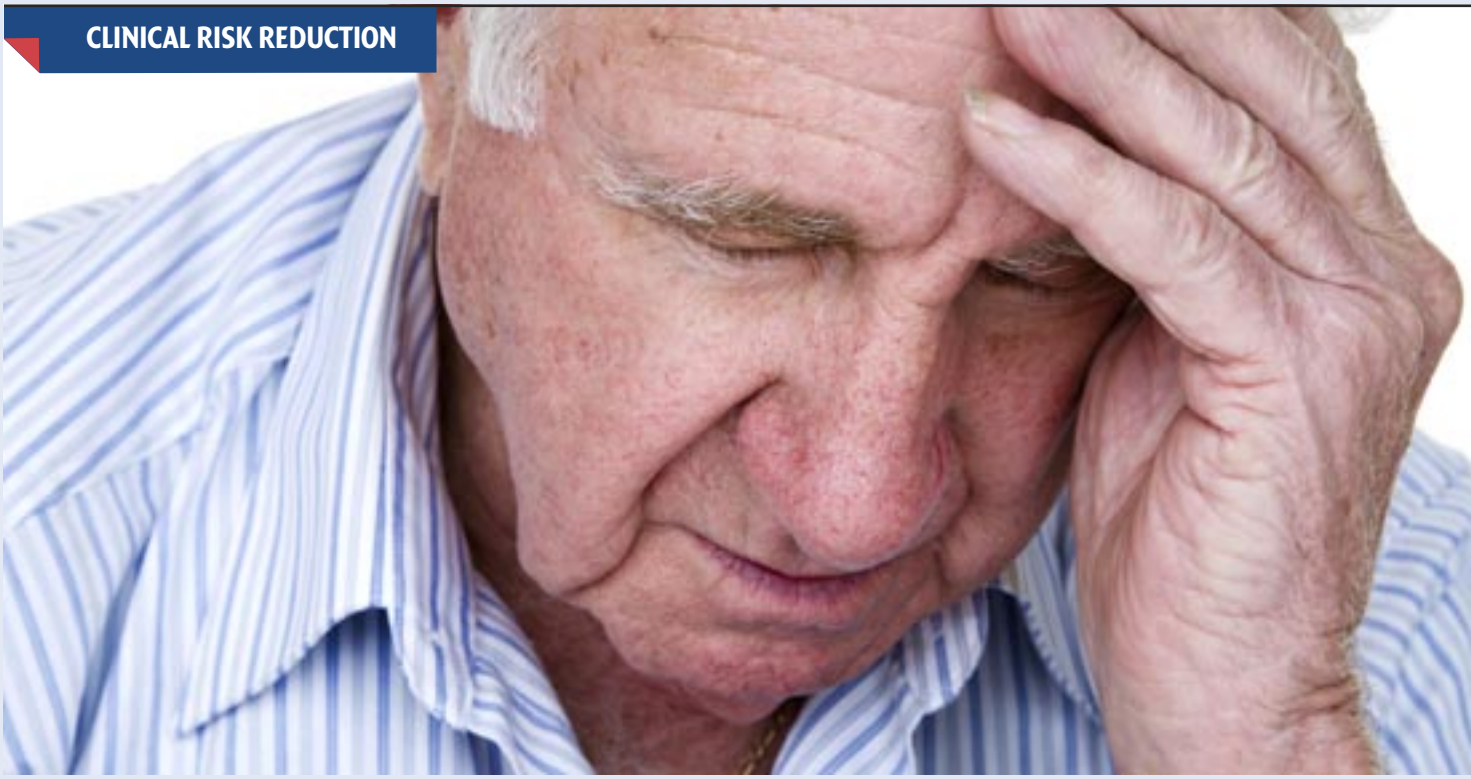
In cases where neither side yields James will prepare the case for trial – get all the evidence together and liaise with all the parties to ensure they attend and all the proper documents have been served. During the trial he will discuss tactics with the barrister or QC between sessions – how things are going and what questions need to be asked of the claimant's experts or other witnesses. He will also advise the member on their appearance in the witness box.

"We tell them what to expect and how to come across – what kind of information to offer. You run through the main issues and what to be prepared for in terms of cross examining and questioning. But you can't coach too much; you can't tell a member what to say."

No matter how well prepared a legal team is for any case there is always a risk in going to trial, says James. "The judge can find for either party on the day. It just depends on which expert he prefers."

So for James the least desirable outcome is a dramatic day in court.

■ *Jim Killgore is editor of MDDUS Summons*



Giant cell arteritis

Dr Rajan Madhok and Dr Nicola Alcorn offer advice on avoiding the potentially devastating consequences of GCA

GIANT CELL ARTERITIS (GCA) is the commonest systemic vasculitis. Inflammation affects the extracranial branches of the carotid artery in patients older than 50 years of age. The aetiology is unknown but granuolomatous inflammation is seen on arterial biopsy. The most recognisable presentation is that affecting the temporal arteries with visual loss being a feared complication. The ultimate concern is of irreversible visual loss in a treatable condition, so giant cell arteritis is regarded as a true medical emergency.

Each year the MDDUS receives complaints and claims of clinical negligence in relation to the delayed or missed diagnosis of GCA. As with many conditions there is not one definitive sign or test upon which to irrevocably base the diagnosis but a careful history and clinical assessment coupled with an awareness of the atypical manifestations of this condition may prevent mistakes.

Epidemiology

GCA is very rare before the age of 50, with the mean age of onset in the seventh decade. It is at least twice as common in females and is commoner in northern climates and Caucasians.

Symptoms

The patient complains of an abrupt onset of headache which is often unilateral but not always. Around 75 per cent of individuals will complain of headache which may be found in a new position and is of different or unusual character. The quality of the pain has been described as boring and of moderate severity compared to a simple headache. The pain is commonly felt in the temple but also rarely in the occiput if the occipital artery is involved. Associated scalp tenderness and jaw or tongue claudication are common features and show the highest positive predictive value for a positive temporal artery biopsy.

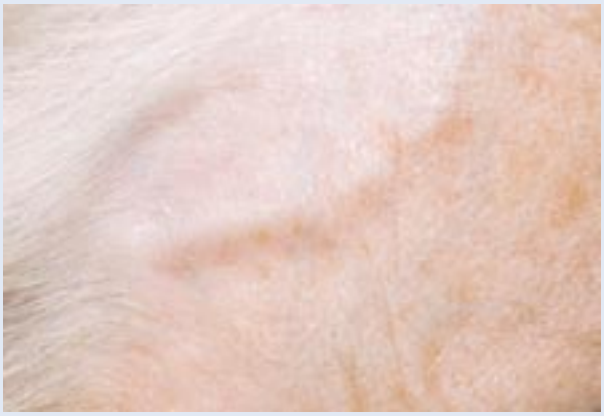
Almost all patients with GCA will experience at least one systemic feature, such as weight loss, fever, anaemia, fatigue and depression. As there is a close association with polymyalgia rheumatica, proximal limb girdle pain and stiffness may also be prevalent.

Visual symptoms are seen in around a quarter of presentations. The most frequent being aumorosis fugax, unilateral visual loss, double vision and blurred vision. Visual loss is the most worrying complication and can occur in up to a fifth of cases. If one eye is affected then the chances of a second eye being involved can be between 20-50 per cent. Therefore a high index of suspicion is needed and a judicious use of treatment as this is a preventable cause of visual loss.

Signs

Clinically the patient may seem unwell and have scalp tenderness as well as a palpable beaded or tortuous temporal artery. The temporal arteries may lose pulsation and visual field loss may be demonstrable. Fundoscopy may reveal a pale

or swollen optic disc or retinal artery occlusion. A swinging afferent papillary defect can also occur.



Prominent artery with arteritis on the temple of a 76-year-old woman

Investigation

An elevated ESR greater than 50 is one American Society of Rheumatology classification criterion (see box), but it should be noted that lower ESRs can occasionally occur. Temporal artery biopsy is thought to be the most sensitive test and does have a high negative predictive value. However, the lesions are not confluent and if GCA is still strongly clinically suspected after a first negative biopsy a second may be performed.

Treatment

This is a common treatable cause of blindness. If there is a strong clinical suspicion of GCA, immediate treatment with glucocorticoids is indicated. Many laboratories will do an urgent ESR which will be available the same day, which may help to confirm clinical suspicions. If ESR is normal the glucocorticoid prescription can be reviewed. An urgent referral to a specialist centre with the aim of performing a temporal artery biopsy within the first week is advised. Local services vary and it is important to be aware of the relevant receiving specialty as it can be either ophthalmology, rheumatology or vascular surgery. Temporal artery biopsy is important because a positive result will have prognostic implications and confirms the need for long-term glucocorticoid therapy.

If it is uncomplicated GCA (no visual change or jaw claudication), 40-60 mg of prednisolone per day is advised until symptoms resolve and inflammatory markers decline. If there is evidence of evolving visual loss, an in-patient assessment may be required and i.v. methyl prednisolone is recommended for three days. If there is established unilateral visual loss, 60mg once daily of prednisolone should be prescribed to protect the other eye.

At initial presentation inflammatory markers and chest X-ray (if possible) should be performed. The CXR is to assess if there is involvement of the thoracic aorta. Consideration should also be given to starting aspirin (some evidence to support reduction in visual loss), as well as calcium, vitamin D and bisphosphonate and gastroprotection, particularly in those over 65 years of age.

A suggested steroid tapering regimen is 40-60mg prednisolone continued for four weeks (until resolution of symptoms and laboratory abnormalities), then dose reduced by 10mg every two weeks to 20mg, then by 2.5mg every two to four weeks to 10mg, then by 1mg every one to two months provided there is no relapse.

Recording the ESR within the case records and ensuring that the symptoms do resolve on glucocorticoids treatment is vital. As always it is recommended that the clinician keeps good legible notes of the consultation and these will be essential should any subsequent medico-legal issues arise. A relapse is considered if there is a rise in ESR to greater or equal to 40 and recurrence of symptoms. Most patients will require glucocorticoids for two to three years and should have their ESR monitored throughout this time.

Conclusion

As with many clinical emergencies it is often the initial clinical assessment of GCA that is the most important factor in determining the long-term outcome. As detailed above there are a number of pitfalls in the diagnosis, particularly in the atypical presentations. However, an awareness of the condition and current guidelines outlined, coupled with a careful history and examination makes falling into these pitfalls much less likely. In short, the prompt diagnosis of giant cell arteritis and appropriate action will in a good proportion of presentations of this condition save sight.

■ *Dr Rajan Madhok is a consultant physician and rheumatologist at the Centre for Rheumatic Diseases at the Glasgow Royal Infirmary*

■ *Dr Nicola Alcorn is a physician at the Centre for Rheumatic Diseases at the Glasgow Royal Infirmary*

CLASSIFICATION

The American College of Rheumatology (ACR) classification criteria for GCA

- Age at disease onset >50 years: development of symptoms or findings beginning at the age of >50 years
- New headache: new onset of or new type of localised pain in the head
- Temporal artery abnormality: temporal artery tenderness to palpation or decreased pulsation, unrelated to arteriosclerosis of cervical arteries
- Elevated ESR: ESR>50 mm/h by the Westergren method
- Abnormal artery biopsy: biopsy specimen with artery showing vasculitis characterised by a predominance of mononuclear cell infiltration or granulomatous inflammation, usually with multinucleated giant cells

Patients require three out of these five criteria to fulfill a diagnosis of GCA by these guidelines

IMAGE: THE ADVERTISING ARCHIVES

Sending the right message

Dentists must be careful not to mislead patients when promoting their practice

ADVERTISING is becoming an increasingly common part of dental practice in the UK as more and more practitioners seek to promote their services and treatments on websites, fliers and in newspapers.

The General Dental Council makes it clear that any unsupported or misleading claims made by dental professionals could lead to a warning or possibly an appearance before a fitness to practise hearing.

And in March 2012, the regulator published new guidance, *Principles of ethical advertising*, which provides more detailed advice regarding the nature and content of all information or publicity material relating to dental services. This includes adverts for services, leaflets and websites as well as the use of specialist titles.

Consider the following examples of promotional material:

"Guaranteed results from the city's leading denture specialist!"

"Forget the rest, our dentists are the best in the Union Street area"

"Our experienced periodontist offers treatment for a range of gum complaints"

Some of the unacceptable assertions made here may be more obvious than others. Clearly, guarantees of treatment outcomes should never be offered to patients and it is unacceptable to claim your practice, its dentists, or the treatment they offer, is any better than anyone else's. Less obvious may be references to specialist status. GDC rules mean the word "specialist" must be used only by dentists who are on a GDC specialist list. In this example, the use of the phrase "denture specialist" or even referring to a "periodontist" would not be allowed.

Information flow

The GDC does accept that advertising "can

be a source of information to help patients make informed choices about their dental care" provided it is "legal, decent, honest and truthful". However it warns: "Advertising that is false, misleading or has the potential to mislead patients is unprofessional, may lead to referral to fitness to practise proceedings and can be a criminal offence."

Concerns have been raised recently by the Office of Fair Trading (OFT) that some UK dentists are not providing patients with enough information on topics such as charges and treatment options. Amongst the key findings of an OFT report on dentistry, published in May 2012, is that: "Dental patients often do not benefit from timely, clear and accurate information to make active, informed decisions regarding their choice of dentist and dental treatment."

While the research does not specifically address the topic of dental advertising, it highlights the importance of practices keeping patients informed about various issues relating to their dental treatment, via leaflets, posters and websites. The report goes on to call for more patient information to be provided online, including by organisations such as NHS Choices and NHS 24.

The OFT is also supportive of the creation of new dental practices who it says are more likely to embrace innovation. The report states: "Research… found that only 53 per cent of dental practices which had not experienced a recent change of ownership were using a website to inform and attract patients, compared to 86 per cent of dental practices established within the last four years."

Inform not mislead

Both the GDC and the OFT agree it is important for dentists to keep patients up-to-date with details of the latest available dental treatments, fees and practice information as well as highlighting practitioners' professional qualifications and experience. But while the financial downturn has increased competition amongst dentists, it is crucial that any advertising or publicity material does not make exaggerated claims.

It is important to bear in mind that the GDC's additional guidance expects you, the practitioner, to ensure that adverts mentioning your name are accurate and not ambiguous – even if the ad was created by a colleague.

The GDC expects adverts to be current and accurate, include dentists' GDC registration numbers, avoid jargon, back up any claims with facts, avoid ambiguous statements and "avoid statements or claims intended or likely to create an unjustified expectation about the results you can achieve."

Adverts and other practice publicity also have to inform patients whether a practice is NHS, mixed or wholly private and products should only be recommended if they represent the "best way to meet a patient's needs."

Principles of ethical advertising also provides similar guidance on information that must be included on dental professionals' websites. This includes their GDC number, professional qualifications and the country where those qualifications are from. Practices must include five further pieces of information including the practice name, location and contact details; the GDC's contact details; information on the practice complaints procedure and the date the website was last updated. Websites must be kept accurate and up-to-date.

> "Avoid statements or claims intended or likely to create an unjustified expectation"

The GDC goes on to warn dentists not to make statements comparing their skills or qualifications with those of another dental professional and they also take a tough stance on the use of specialist titles. Dentists are told not to "mislead patients by using titles which could imply specialist status such as 'smile specialist' or 'denture specialist'." Dentists who are not on a specialist list should also avoid using the phrase "specialising in…" but can use phrases like "special interest in…" or "experienced in…"

Similarly, caution is advised when referring to honorary degrees or memberships of professional associations/societies as this may give the impression that it "represents a particular level of academic achievement."

In practice

This may sound complex and may cause concern for some practitioners but the GDC insists the sorts of issues being dealt with are the same as those previously considered under *Standards for Dental Professionals*. It has also pledged to take a "proportionate approach", allowing dentists enough time to familiarise themselves with the requirements and make any necessary changes to ensure compliance.

Tim Wright, project and implementation officer at the GDC, said: "This is the first time that we have published such clear guidance about advertising and it is important to strike the right balance between protecting patients and giving registrants the opportunity to remedy any problems.

"We are mindful that there may be registrants who are unwittingly not operating within the spirit of the guidance at present. If we deem it appropriate, we will send a written notice advising them to review their arrangements in line with the guidance."

However dental professionals should not be complacent. Formal investigations would be initiated in more serious cases involving repeated complaints over time or "aggravating factors", such as where dentists have lied about their qualifications or exaggerated the benefits of certain treatments.

Principles of ethical advertising is available at **www.gdc-uk.org** or for more specific advice, contact an MDDUS adviser.

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

CASE studies

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

TREATMENT: WAS THAT UL5 OR...

BACKGROUND: A patient contacts the surgery to make an appointment with his regular dentist – Mr T. A tooth is causing him considerable pain and he asks to be fitted in that day if possible. The receptionist informs the patient that there is no appointment available for Mr T but that he can see Mr V who is working as a VDP at the practice.

Later an appointment does become available with Mr T at an earlier slot so the receptionist cancels the appointment with Mr V but neglects to inform the patient, who turns up later to find he now has no appointment. He is annoyed and distressed as the tooth is very painful. Fortunately Mr V has had a DNA and is able to see the patient.

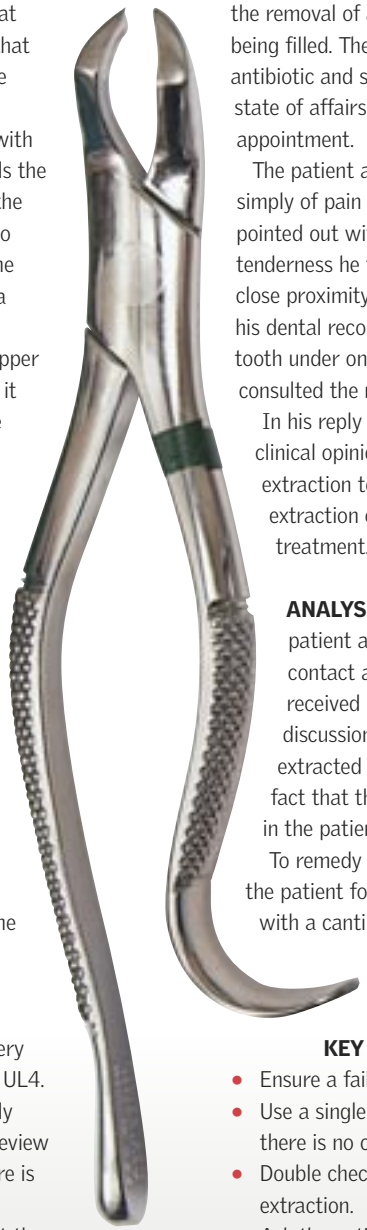
The patient complains that the pain is in the upper left quadrant and Mr V examines UL5 and finds it very tender on percussion. The tooth has a large restoration and Grade 1 mobility. The adjacent tooth UL4 is also tender but UL6 is fine.

Mr V diagnoses irreversible pulpitis in UL5. The patient is adamant that he wants the tooth extracted as the pain is "unbearable". Confirming the patient's consent the dentist administers a local anaesthetic and extracts the tooth. Post-operative instructions are given to the patient who leaves satisfied.

An hour later the patient returns to the surgery and complains to the receptionist that he is now convinced that the wrong tooth has been extracted. Mr V sees the patient again immediately and also summons the senior partner in the practice. The senior dentist reassures the patient that Mr V has extracted the tooth he believes was causing the pain. He arranges for the patient to return for a review appointment.

Two days later the patient returns to the surgery now complaining of sharp pain in the remaining UL4. His regular dentist Mr T finds it to be moderately tender to percussion and extracts the tooth. A review appointment to discuss the provision of a denture is arranged.

Eight days later a letter of complaint arrives at the practice from the patient expressing anger over his treatment. He states that the tooth which should have been removed – UL4 – had been the subject of ongoing treatment with his regular dentist Mr T. A few months previous he had attended for the removal of a fractured cusp with the remainder of the tooth being filled. The tooth later grew painful and Mr T prescribed an antibiotic and suggested it may need to be extracted. This was the state of affairs when the patient attended for the emergency appointment.



The patient also disputes the contention that he spoke to Mr V simply of pain in his upper jaw – but rather he states that he pointed out with his finger the "offending tooth". He adds that the tenderness he felt with "tapping" on UL5 was simply due to its close proximity with the infected UL4. He expresses surprise that his dental records would not provide Mr V a clear indication of the tooth under ongoing treatment and wonders if the dentist had even consulted the records prior to the examination and treatment.

In his reply to the patient's letter Mr V states again it was his clinical opinion that UL5 had irreversible pulpitis and required extraction to which the patient agreed. The subsequent extraction of UL4 had no bearing on his diagnosis and treatment. He apologises for the distress caused to the patient.

ANALYSIS/OUTCOME Another letter arrives from the patient a month later in which he states his intention to contact a solicitor in regard to the "negligent treatment" he received by Mr V. Mr T contacts MDDUS for advice and in discussion it is agreed that there is no denying that Mr V extracted the wrong tooth and that nothing can mitigate the fact that the problems with UL4 had been clearly documented in the patient notes.

To remedy the complaint the practice partners agree to refer the patient for restorative treatment. A single implant is placed with a cantilever bridge restoration and the patient is satisfied with the final result.

KEY POINTS

- Ensure a fail safe system in all planned tooth extractions.
- Use a single form of tooth notation in all treatment to ensure there is no confusion.
- Double check the patient's clinical notes and radiographs before extraction.
- Ask the patient to state which tooth they believe is being treated and cross reference with written notes.

PRESCRIBING: A DANGEROUS DOSE

BACKGROUND: Mr S, 68, has been seeking treatment for osteoarthritis for more than six years. In the past two years the condition has worsened, causing considerable pain in his back and legs. During that time, his GP Dr B has prescribed 10mg morphine sulphate tablets (MST) – two pills to be taken twice daily.

Mr S visits the practice for a repeat prescription and the request is dealt with by Dr N who then handwrites out a prescription for 100mg MST, two tablets twice daily. Mr S fills the prescription at the pharmacy and proceeds to take two tablets before going to bed. He wakes up during the night feeling unwell and is violently sick the next morning. His wife calls for an ambulance but he is pronounced dead in his home a short time later.

Several months later, a claim of clinical negligence is lodged by Mrs S against Dr N, accusing him of causing or contributing to the death of her husband and seeking payment of damages. A claim is also lodged on the grounds of vicarious liability against Dr N's two fellow GP practice partners, as well as against the pharmacist who failed to spot the dosage error. Dr N and his partners are MDDUS members and seek advice on how to proceed.

ANALYSIS/OUTCOME: MDDUS asks Dr N for his account of the events surrounding the repeat prescription issued to Mr S. He explains that he had been under considerable pressure in the practice that day and was struggling to work through a large number of patient requests for repeat prescriptions. He admits that, while the printed repeat prescription request was for the correct dosage, he made an error when copying the information by hand onto the prescription itself. He adds that he has also since apologised in a phone call to Mrs S.

MDDUS instructs an expert opinion from a cardiologist regarding how Mr S died. Its findings are considered alongside the official cause of death which is stated as coronary artery disease but with the vomiting induced by the high dose of morphine acting as a contributing factor.

Following discussions with Dr N, MDDUS informs representatives of Mrs S that Dr N accepts liability in Mr S's death but it is disputed that Dr N's error caused Mr S's death. After further lengthy legal discussions, MDDUS agrees a settlement with Mrs S for a sum of compensation, the cost of which is partly shared with the National Pharmacy Association, representatives of the pharmacist who dispensed the MST.

KEY POINTS

- Have a low threshold for double-checking prescriptions when dealing with high-risk drugs, particularly dosage calculations.
- Encourage a good level of knowledge and understanding of medicines in patients with chronic conditions.

CONSENT: CRYOTHERAPY RISKS

BACKGROUND: Ms C is a diabetic and attends her GP, Dr N, complaining of pain in her right foot. Dr N examines the foot and diagnoses a plantar wart. He explains three different treatment options and the associated risks of infection and delayed healing due to her diabetes. He recommends liquid nitrogen treatment as he believes it to be the quickest and most efficient option and refers her to his colleague Dr E.

Dr E administers liquid nitrogen treatment on several occasions over a number of weeks but after the third application Ms C complains that the pain has returned. Dr E administers a final treatment of cryotherapy and refers Ms C to a podiatrist who diagnoses her with infection in her foot and prescribes a short course of antibiotics.

At a follow-up appointment with the podiatrist two weeks later, the consultant identifies a deep cutaneous slough on Ms C's right foot as a result of the repeated liquid nitrogen treatment and a foot ulcer. The ulcer worsens and eventually requires her to be admitted to hospital for treatment of the infection. Ms C's foot does not heal for another 10 weeks and causes her considerable pain when standing or walking. Once the infection clears, she is left with a residual area of impaired sensation on her right foot.

Ms C files a claim of clinical negligence against Dr E alleging that he treated her without explaining the risks. While Dr N is a member of MDDUS, Dr E is represented by another indemnity organisation.

ANALYSIS/OUTCOME: Representatives of Dr E contact MDDUS to query the role of Dr N in the initial consultation and referral of Ms C. They question whether Dr N gave Ms C appropriate advice and whether he sufficiently explained all the available treatment options and their associated risks.

An MDDUS medico-legal adviser contacts Dr N asking him for an account of his involvement in the case and, in the absence of a detailed medical note, what his normal practice would be in such consultations. Dr N confirms that his normal practice would have been to carefully explain the associated risks of all three treatment options, taking into consideration Ms C's diabetes.

MDDUS informs Dr E's representatives of Dr N's position and confirms that he will have no further involvement in the claim.

KEY POINTS

- Clearly explain treatment options and associated risks, taking into account existing conditions such as diabetes, when referring patients.
- Ensure patients referred to you for treatment understand treatment and associated risks before carrying out the procedure.
- Take clear, comprehensive notes of patient discussions and agreed treatment plan.

From the archives:
A man of ordinary skill

GALLOWGATE in Glasgow was the unlikely site of a medico-legal milestone in 1951.

A patient named Jemima Hunter had been under treatment for chronic pulmonary symptoms by a Glasgow GP – Dr John Hanley. The GP had administered a course of penicillin injections and on the final injection the needle broke and became lodged in the patient's right hip. Dr Hanley immediately informed the patient of the mishap and sent her off to the A&E Department at Glasgow Royal Infirmary with a letter of explanation.

The doctor on duty at the hospital – presumably to ensure compliance with his treatment advice – implied to Mrs Hunter that the broken needle could meander through her body and eventually reach her heart where it would prove fatal. Mrs Hunter rushed back to Dr Hanley in distress. He tried to reassure her but without success.

Mrs Hunter obtained legal aid to pursue a claim of damages of £2,500. Dr Hanley was an MDDUS member and the Union provided legal support and representation in the subsequent trial by jury. It was alleged that the needle used for the injection was unsuitable. In July 1954 a unanimous verdict was returned in favour of Dr Hanley but this was followed by an immediate motion for a new trial on the basis that the jury had been misdirected.

Seven months later Lord President Clyde considered the motion and delivered his now famous judgment on determining liability in negligence cases. His ruling stated: "To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care."

In the end Lord Clyde did order a new trial at which Dr Hanley was again found not liable by the jury to pay Mrs Hunter damages. The case – *Hunter v Hanley* – is still cited in Scottish case law today. No mention is made of what happened to the offending needle but it was still embedded in Mrs Hunter's hip at the trial four years later.

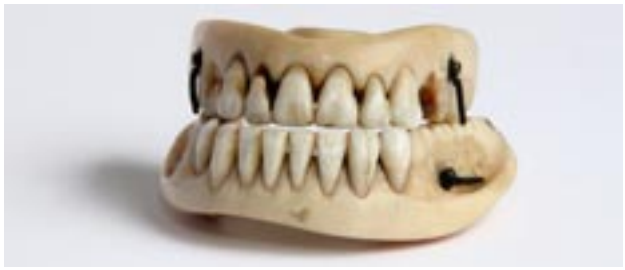
Source: A Century of Care, published by MDDUS

Crossword

ACROSS
1. Induce vomiting (7)
5. Laurie's fictional doctor (5)
7. Spherical bacteria (5)
8. Total decrease in oxygen (6)
10. Windpipe (7)
11. Moon of Saturn (4)
12. _____ v Hanley, landmark negligence case (6)
14. Inflammatory disease of the airways (6)
17. Female reproductive cell (4)
19. Hypersensitivity disorder (7)
22. Tendon deserts kneecap to make Spanish dish (6)
23. Childhood respiratory condition (5)
24. Closed sacs of air or fluid (5)
25. Poisonous element. As (7)

DOWN
1. Shield (10)
2. Fetter (7)
3. Like Bono or Terry Wogan? (5)
4. Beetle (6)
5. Defence Secretary 1999-2005 (4)
6. - Heep, Dickens character (5)
9. Movement started by Ludwig Guttmann (10)
11. Rodent (3)
13. Scottish men's bonnet (3)
15. Whaling weapon (7)
16. Tropical fruit (6)
18. European mountains (5)
20. Guitar riffs (5)
21. "... poor Yorick" (4)

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



Object obscura:
Waterloo teeth

PHOTOGRAPH: BRITISH DENTAL ASSOCIATION MUSEUM

IN the 19th century replacement teeth were traditionally made from ivory but these did not always look natural and deteriorated more quickly than real teeth. More robust and natural were dentures made with an ivory base and then set with real human teeth. Such dentures have subsequently become known as Waterloo teeth as some were scavenged from dead soldiers on battlefields. Others were taken by resurrectionists who dug up corpses. Contamination was an issue with the only method of sterilising being boiling water. The practice was more common in the early part of the nineteenth century but Waterloo teeth were still appearing in dental supply catalogues of the 1860s, shipped across in barrels from the American Civil War.

Vignette: neurologist and founder of the Paralympic Games, Sir Ludwig Guttmann (1899-1980)

PHOTOGRAPH: NATIONAL SPINAL INJURY CENTRE

AMONG the many events planned to mark the 2012 Olympic and Paralympic Games in London was the unveiling of a statue in honour of a pioneer in the field of rehabilitation of spinal injury patients, who has been admired by disabled athletes the world over.

Sir Ludwig Guttmann was a man of courage and determination who worked tirelessly to prove that patients once dismissed as "hopeless cases" could have active lives as productive members of society. Such determination can be traced back to his early experiences.

Guttmann grew up in Königshütte, 100 miles from Breslau. As a young man he led a youth group, enjoyed sport and choral singing. During World War I he volunteered as a medical orderly in the Accident Hospital for Coal Miners and there met his first paraplegic patient, a young miner with a fracture of the spine. As he began to write up his notes, he was told: "Don't bother, he'll be dead in a few weeks." Sure enough, the young man succumbed to an infection five weeks later, but Guttmann never forgot him.

A septic throat kept Guttmann from active service and in 1918 he started medical studies at the University of Breslau where he was taught by, amongst others, the excellent Professor Otfried Foerster. This was followed by an MD in 1924 from the University of Freiburg. Invited back to Breslau to work with Foerster, he performed complex surgery, researched methods of 'electrodiagnosis' and therapy and the physiology of sweat glands.

He gained more experience in charge of a special neurosurgery theatre in a psychiatric hospital at Friedricksburg, before unforeseen circumstance caused Foerster to beg him to return to Breslau. Although the Nazi threat to Jews was rising, Foerster was no anti-Semite and always remained a friend of Ludwig.

Anti-Jewish legislation forced Guttmann from his post and he moved to the Jewish Hospital in Breslau. Nazi atrocities grew but he declined offers of work abroad as he was "determined to resist as much as possible that system of suppression and cruelty". However by 1938, now married with two

young children, he finally accepted that his family would have to flee Germany. They arrived in England in 1939 with few possessions and little money.

With the sponsorship of leading neurosurgeon Hugh Cairns and support from charitable groups, Guttmann started his research at Oxford. In 1941 George Riddoch from the Medical Research Council selected him to review the treatment of spinal injuries. His knowledge of new work by Theodor Kocher and by Wilhelm Wagner (once employed at Königshütte) combined with his own experience proved impressive. Guttmann was made the director of a new unit for patients with spinal injuries at the Stoke Mandeville Hospital, treating an increasing number of World War II casualties. By 1947 the unit had expanded to 90 beds with a team of well-trained staff.

The rehabilitation programme conceived by Guttmann was groundbreaking and showed a deep understanding of the psychology of his patients. His philosophy was "to transform a hopeless and helpless spinally paralysed individual into a taxpayer."

Determined to reverse the trend of fatal sepsis in these patients, Guttmann also instructed staff to turn patients every two hours, to catheterise them regularly and he arranged for active physiotherapy and social activities. In Guttmann's words "the purpose of all remedial exercises in the period of reconditioning of the paralysed is to develop new tricks for making muscles move parts of the body formerly moved by other muscles".

Sport was therapeutic and soon patients were playing basketball, table tennis and archery first within the hospital and then in matches organised outside. The competition grew and the first annual Stoke Mandeville Games for the Paralysed were held in 1948, with the motto "Friendship, Unity and Sportsmanship". In 1952 a Dutch team of paraplegic war veterans visited making the Games international. As their success grew, the next step was to hold the Games in the country hosting the Olympics, which first happened in Rome in 1960. And so the Paralympic Games were born.

The Paralympic Games (as they were officially named in 1980) have since become a worldwide phenomenon, enjoyed by a global audience of millions. At this year's London 2012 Games, the Guttmann Stadium at Stoke Mandeville will play an important part in welcoming many teams, especially as a training centre. A life-sized bronze statue of Guttmann, affectionately known as Poppa, now stands outside the National Spinal Injuries Centre in Stoke Mandeville where he was director for 22 years from 1943.

Guttmann's pioneering work influenced rehabilitation centres around the world. He was naturalised a British subject soon after the war. An OBE in 1959 was followed by a CBE and he was knighted in 1966, the year before he retired. FRS in 1976 brought him the most joy.

Determined to the end, when the Spinal Injuries Centre was threatened with closure in the 1970s, Guttmann countered with a vigorous appeal supported by patients who chained themselves to their beds. The late Sir Jimmy Savile also supported the centre, raising £10million in three years. The centre was eventually rebuilt in 1983 with Sir Jimmy as its patron.

References

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- *The specialty of spinal injuries in the UK.* Silver JR. J R Coll Physicians Edinburgh 2009:39. 79-67

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