

Winter 2012

SUMMONS



JOURNAL OF THE MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND



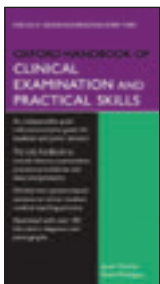
• Lister centenary • Profile: MDDUS adviser • Tooth whitening •

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Highlights



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IN THIS ISSUE

AROUND 1870 when the surgeon Joseph Lister performed an operation he was said to have often worn a blue frock-coat "stiff and glazed with blood" from the dissecting room. These were days when it was still widely believed that "miasma" or impure air was responsible for wound infections. And yet Lister had already begun to overturn such notions.

In 1865 he had begun experimenting with dressings soaked in carbolic acid to prevent sepsis in the treatment of compound fractures. It was the start of a medical revolution that is still reverberating today 100 years after his death.

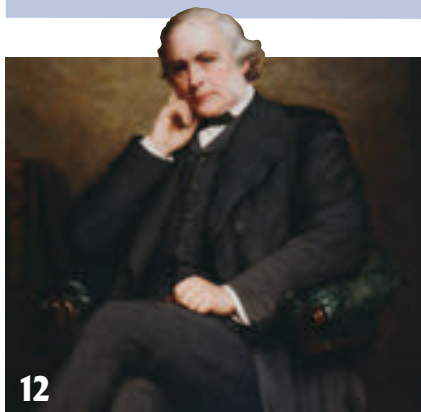
"The contribution of Joseph Lister to surgery is quite comparable in importance to the invention of radio or the internal combustion engine," says Dugald Gardner, a professor of histopathology and emeritus conservator of the Royal College of Surgeons of Edinburgh. On page 12 Adam Campbell celebrates the man and his legacy and explains how the

surgical community will be marking the Lister centenary.

Have you ever wondered what the working day is like for a medical or dental adviser at MDDUS? On page 16 we kick off a series of profiles featuring the professionals whose job it is to provide advice and legal support to MDDUS members. First off is Dr Barry Parker who works in our Glasgow office as a medical adviser – a highly specialised role combining clinical experience with legal and ethical expertise.

Shareen Larmour of the GDC discusses the latest developments in the regulation of tooth whitening on page 18 and on page 14 Professor Paul Marks offers best practice advice in dealing with suspected intracranial tumours. Our regular Q&A on page 10 provides some insight on the workings of the Scottish Intercollegiate Guidelines Network or SIGN – featuring both the chair and director.

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Cover image: North Rona, by Alan Watson. 1992. Medium: acrylic on canvas. Size: 165 x 165cm.

Art in Healthcare (formerly Paintings in

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➔ Indemnity for practice staff

A RECENT letter from the Royal College of Nursing (RCN) regarding indemnity for some of its members has been causing concern among GPs, practice managers and staff. The letter informed RCN members that from January 2012 indemnity cover for work undertaken in general practice was being removed from the range of RCN member benefits.

There has been concern that this development now means nurses may no longer be indemnified for clinical tasks undertaken on behalf of practices.

MDDUS would like to reassure members that we provide all GP and GDP partners in membership access to indemnity for any act or omission arising from the proper and authorised duties of all members of staff, including practice managers, practice nurses and any other ancillary staff not eligible for full or associate MDDUS membership. This vicarious liability will continue to apply as it has in the past. The RCN changes should also have no effect on subscription rates.

Please phone our Membership Department on **0845 270 2038** if you have any concerns regarding staff indemnity.

➔ 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 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.

We hope this is clear but if you have any questions please telephone our Membership Department on **0845 270 2038**.



➔ MDDUS coverage for London Olympics

IN less than a year athletes and spectators from all over the world will arrive in London for the 2012 Olympic and Paralympic games. A team of 5,000 doctors and other healthcare professionals will provide medical services during the games including emergency first aid.

The Olympic organising committee has confirmed that all medical coverage provided by the medical team at Olympic venues will not be covered by NHS indemnity so it is important that volunteers have adequate clinical indemnity.

MDDUS is pleased to offer access to indemnity for members working in a voluntary capacity at the games subject to the following conditions:

- The member is in active MDDUS membership and has paid a subscription for clinical work.
- The member holds a GMC licence to practise (or other appropriate professional registration, e.g. GDC).
- The member has not entered into a formal arrangement/contract to provide care for individual athletes or teams (they may however be required to treat athletes on an ad hoc basis in the course of volunteer duties).
- The member is an official London Organising Committee of the Olympic and Paralympic Games (LOCOG) volunteer.
- The member is not restricted to working in a GMC-approved practice setting.

In addition, an MDDUS member who may be in attendance as a spectator is covered for any emergency situation that may occur, classified as a Good Samaritan Act.

Please phone our Membership Department on **0845 270 2038** if you have any concerns.

IN BRIEF

• **LOOKING FOR LEADERS** A new UK-wide Faculty of Medical Leadership and Management has been set up to bring doctors together for support around leadership and management issues and to advocate the importance of

these skills within and beyond the profession. Membership of the Faculty is open to all GPs and trainees. For more information visit www.fmlm.ac.uk

• **MENTOR OR MENTEE** The Royal College of Physicians and Surgeons

of Glasgow is now actively recruiting fellows and members for its new mentoring programme. Its aim is to match those who wish to be mentored (mentees) with suitable mentors who will help them develop skills and improve

performance and job satisfaction. In the initial stages it will focus on newly appointed consultants but will later expand to include mentees at all stages of their careers. For more information or to register call the College on 0141

Leading through uncertainty

MDDUS training and consultancy is pleased to announce that its redesigned five-day leadership programme for doctors 'Leading through Uncertainty' has proved very popular with members – both GPs and hospital doctors. Having released further dates for January these filled up immediately but we are planning to release further dates soon both in Glasgow and London.

Delegates who attended in December found the programme to be "inspiring", "positive" and "enjoyable" and valued the opportunity to share five days in an "informal, friendly and supportive atmosphere" with a range of experienced doctors from a wide variety of backgrounds. Delegates commented that the group interaction "helped to focus on putting the theories into practice" and that the course provided "the tools to review actions and gain new insight".

The programme is accredited for CPD by both the Royal College of Physicians (RCP) and Royal College of General Practitioners (RCGP) Scotland. If you are interested in finding out more about the programme or would like to book a place, please do not hesitate to contact us at trainingandconsultancy@mddus.com

Dentistry Scotland Awards 2011



MDDUS Head of Dental Division Aubrey Craig (left) congratulates Yann Maidment, principal dentist at Stafford Street Dental Care – winner of the award for Best Patient Care at the Dentistry Scotland

221 6072 or email mentorship@rcps.ac.uk
MDDUS OFFICE EXPANSION
 Work is now underway on the expansion of the MDDUS offices in Glasgow into adjoining premises at 167 Bath Street. The expansion will

provide much needed additional meeting and office space along with a dedicated training suite. Work is expected to be completed by May 2012.
FYI WINS DESIGN AWARD
 MDDUS is pleased to report that

Clarity on medical services for overseas visitors

UNCERTAINTY over qualifying criteria for overseas visitors seeking access to NHS services is a common issue among GP practices according to NHSScotland Counter Fraud Services (CFS).

The CFS is a division of NHS National Services Scotland and works with all of Scotland's health boards to raise awareness of, deter and investigate fraud within the health service in Scotland. As part of this remit the organisation delivers fraud awareness presentations to practices in protected learning time events and one of the most frequently asked questions at these sessions is around the subject of overseas visitors and the qualifying criteria that allows them to access NHS services.

Whilst this area of work is not the responsibility of CFS, unless a fraud is suspected, the team appreciate the concerns of practices and aim to provide as much information as possible to facilitate an understanding of this complicated subject. If you are unsure as to the eligibility of an overseas visitor registering at your practice you can contact the primary care lead within your health board area, who will tell you the name of a designated single point of contact (SPOC) within the board. You can also contact NHS Inform on **0800 22 44 88**.

Other useful links include:

www.cfs.scot.nhs.uk
www.hris.org.uk/patient-information

www.tinyurl.com/govt01
www.tinyurl.com/govt02

Awards. MDDUS was a sponsor of the 2011 awards held at The Gleneagles Hotel on 25 November. Chairman of the judging panel and MDDUS non-executive director, Robert Donald, co-hosted the event along with the managing editor of *Dentistry Scotland*, Heather Podbury. Robert said it had "been uplifting to review such a stunning array of high quality entries, which provide both inspiration and encouragement to our colleagues."

Keynote speaker takes PM conference into orbit

WHAT DOES your average medical or dental practice share with NASA? Quite a bit when it comes to being a "safety critical organisation".

This is the theme of the keynote address to be given by Stephen Carver of the Cranfield School of Management at the 2012 MDDUS Practice Managers'



Conference being held on 1-2 March 2012 at the Fairmont St Andrews.

The full conference programme is now available and includes workshops on understanding your team and yourself using the DISC behavioural awareness tool, assertiveness skills, risk management at the primary-secondary care interface, dealing with bullying and harassment, changing employment contracts, handling media inquiries and much more.

Bookings are now rolling in so to register your interest or to find out more go to our website or contact Karen Walsh at kwash@mddus.com or on **0845 270 2034**.





➔ Targeting high-risk surgical patients

NEARLY 80 per cent of UK patients dying of post-operative complications come from a small group of high-risk patients – only half of whom receive “good” peri-operative care. These findings come from the latest National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report – *Knowing the Risk*.

NCEPOD researchers found that 21 per cent of patients undergoing elective surgery had not been seen in an assessment clinic before their operation and in only 8 per cent of patients defined as ‘high risk’ was risk of death stated on the patient’s consent form. Only 22 per cent of the high-risk group were cared for in a critical care unit with the remaining 78 per cent of patients returning to the ward.

The report also found that 16 per cent of hospitals did not provide pre-admission anaesthetic clinics, 27 per cent did not have a critical care outreach team and 34 per cent did not have a policy to prevent peri-operative hypothermia.

Co-report author Dr George Findlay, NCEPOD Clinical Co-ordinator and Intensive Care Consultant, said that pre

and post-operative care in the UK was in a poor state across the board: “There appears to be a serious lack of awareness of the degree of mortality risk to patients, and we have to ask if the Health Service really does appreciate the level of risk that surgical patients face? If we don’t identify the risks to patients, then how can we provide the best pre and postoperative care?”

Among recommendations made in the report is the introduction of a UK-wide system for the rapid identification of patients who are at high risk of post-operative mortality and morbidity. All elective high-risk patients should be seen in a pre-assessment clinic and patients should be told of the mortality risks associated with surgery and this should be recorded on the consent form. Trusts should analyse the volume of work considered to be high risk and quantify the associated critical care requirements and make provision for appropriate post-operative care.

➔ Dentists warned over discount deals

DENTISTS who offer discounted treatment deals must not forget their responsibilities to patients, the General Dental Council has said.

The GDC issued the reminder in the wake of the increasing number of cut-price offers made available via email and online by companies such as Groupon and Living Social.

The regulator highlighted its guidance that warns dental professionals not to make claims that could mislead patients and requires practitioners to be trustworthy and honest, ensuring financial interests are not prioritised ahead of patients’ interests.

Dental professionals who breach guidance could face action to restrict or stop them practising, the GDC added.

The regulator said: “If a GDC registered dental professional offers a treatment deal he or she must assess the patient, obtain valid consent, obtain a medical history and explain all the options before carrying out any work. Registrants must put patients’

interests before their own or those of any colleague, organisation or business.”

The GDC is currently drawing up draft guidance on ethical advertising as part of its review of *Standards for dental professionals*. Go to www.gdc-uk.org for details.

➔ GMC cuts fees for doctors

THE GMC is to cut annual fees for all doctors for the first time since 1970.

From April 2012, practising doctors will pay £390 a year instead of £420 – a saving of £2.50 per month. Registered doctors who don’t have a licence to practise will pay £140 instead of £145 – a saving of 42p per month. Provisionally registered doctors will make a similar saving, paying £95 instead of £100. The move follows a decision last year by the GMC to freeze its annual fees.

The regulator will also increase the earnings threshold entitling doctors to a 50 per cent fees discount from April. Any doctor whose total gross annual worldwide income from all sources is less than £30,000 will qualify, compared to the current threshold of £26,000.



The GMC said the reductions were possible thanks to £8million of efficiency savings made in 2011. These include an expansion of the in-house legal team, a cut in the number of panel members from five to three and greater use of e-communication rather than paper.

The GMC is encouraging doctors to pay their annual retention fee via GMC Online. Find out more at www.gmc-org.uk

IN BRIEF

● **NICE ON ANAPHYLAXIS** A new guideline on initial assessment and referral following emergency treatment for a suspected anaphylactic episode has been published by NICE. Estimates suggest that approximately 1 in 1,300 of the population of England

has experienced anaphylaxis at some point. Recommendations include querying the circumstances to identify possible triggers and offering an appropriate adrenaline injector as an interim measure before referral. Access the guideline at <http://guidance.nice.org.uk/CG134>

● **NEW GMC TRIBUNAL SERVICE** The GMC’s new Medical Practitioners Tribunal Service (MPTS) will begin service in the summer of 2012 under the chairmanship of His Honour Judge David Pearl. The MPTS will manage all fitness to practise hearings for doctors and it is a key element of the

GMC’s plans to reform its adjudication work, introducing a “full separation” from its investigatory role.

● **WEEKEND HOSPITAL MORTALITY RATES** A new report has found a “worrying” spike in death rates among patients admitted to hospitals in England at the weekend.

VIEWPOINT



**By Simon Dinnick,
General Counsel at
MDDUS**

Down in the ministry something stirs

As someone who has spent (almost) a career defending doctors and dentists against litigation claims, the last few years have been some of the least fair that I can recall. Litigation in England and Wales at least (and increasingly in Scotland I suspect) have been not only firmly tilted in favour of the claimant, but also strongly tilted in favour of the remuneration which claimant lawyers can derive from clinical negligence claims. Whilst there are a number of reasons why this is so, two can perhaps be highlighted and are finally being addressed.

Firstly, lawyers' charging rates are calculated traditionally so as to provide quite reasonably a profit return for the partners owning the law firms taking the risk. There is no problem with that. Where there has become a problem is in the concept of conditional fee add-ons – "success fees" which can permit charging rates to be marked up often by 100 per

cent in the event of success. A typical specialist firm in London might be allowed to charge in the order of £400 an hour for a partner rate and to achieve a success rate of 100 per cent on that figure, making the hourly charge some £800. Wouldn't we all like to be that lucky?

Secondly, in recent years there has been the development in our field of an "after the event" insurance industry which has the effect of offering policies to protect a claimant against the financial cost of losing by insuring that risk. In the event that the claimant is successful that premium (often and usually many thousands of pounds) will be recovered from the defendant (or his defence organisation).

The combined effect of these two practices has been not only that a claimant can litigate against a doctor without fear of being financially penalised in the event that he loses, but also that he effectively hands the conduct of his claim to the solicitor he instructs who in turn has the interest in achieving success with heavy mark up on his hourly rate and knowing that an insurance company will pay his costs in the event that he loses the case. That culture is not a healthy one.

By virtue of reforms going through

Parliament at the moment, these weaknesses should be eradicated. Firstly, the kind of success fees referred to above will be abolished and secondly the insurance premiums of after-the-event insurance will no longer be recoverable from the defendants. There will be a change in the calculation of damages to provide for an increase out of which litigation funding can be provided for claimants. Claimants' solicitors will be allowed to charge a contingency fee to their clients to be recovered out of any successful damages.

In this way a degree of equality of arms should return to the litigation canvass and the costs of litigation should come down, not only to the benefit of doctors, dentists and their defence organisations but arguably in the broader public interest to ensure that costs do not become the dominant feature in the resolution of medical disputes.

There have been many false dawns in the need for reform, but following a comprehensive review by Lord Justice Jackson over the last couple of years, the Government has accepted these recommendations amongst others and has found Parliamentary time to ensure that they will be delivered. Roll the day and roll the dice.

Rise in complaints about private dental care

COMPLAINTS about private dental care made to the Dental Complaints Service (DCS) have risen by almost a quarter since 2009.

New figures show complaints jumped by 24 per cent from 1,180 in 2009/2010 to 1,559 in 2010/2011. The DCS also revealed that of the 1,559 complaints made between May 2010 and the end of April 2011, 67 per cent were resolved within a week.

The most common non-clinical reason for complaint in 2010/2011 was failure of

treatment (862 complaints) followed by concerns from patients that they were 'uninformed' (158). Others complained about post-operative pain (121) or that



they were ignored (110). Clinical complaints were most commonly made about crown treatments (239) followed by root canal (142). There were 126 complaints made about bridge work while 112 complaints were made about amalgam fillings.

Dentists were the focus of the overwhelming majority of complaints (1,519) followed by dental technicians (17) and hygienists (13). Clinical dental technicians were the subject of eight complaints while dental nurses prompted only two complaints.

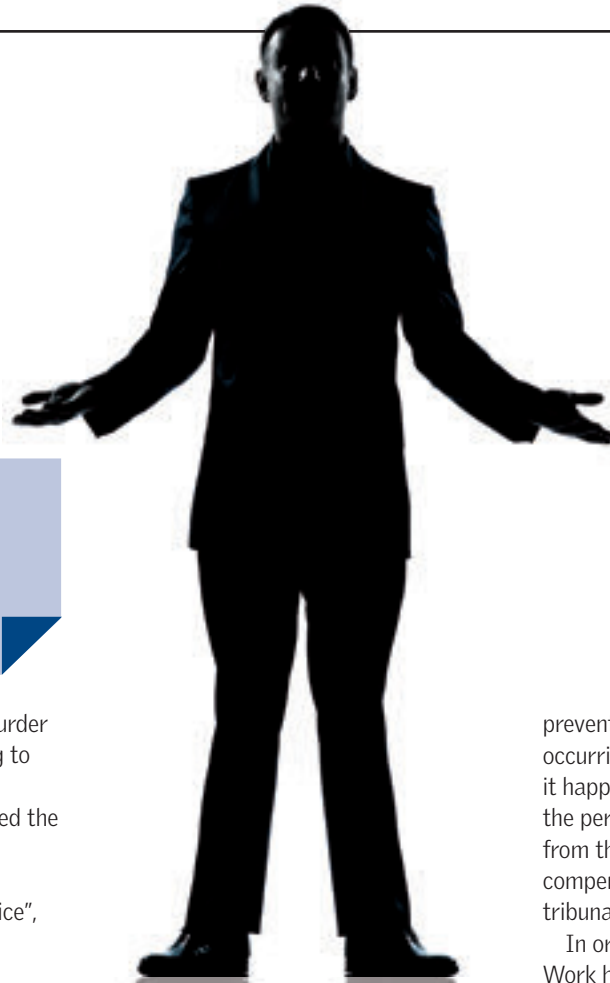
The health information company Dr Foster reports in the tenth edition of its *Hospital Guide* that patients admitted to NHS hospitals for emergency treatment during the weekend are almost 10 per cent more likely to die than those admitted during the week and in

some trusts rates were found to rise 20 per cent or more.

● **GDC ACTS TO SPEED UP CASE HANDLING** An increase in the number of decision meetings and hearings to clear a backlog of cases and an improved process to fast track the most serious ones are

among a raft of changes announced by the GDC to improve the handling of complaints against dental professionals. A GDC statement released in October says the changes mark the first phase of a complete overhaul of its complaints handling (fitness to practise) processes.





IT WAS JUST BANTER!

Ian Watson

AT THE RECENT Steven Lawrence murder trial one of the defendants, admitting to having made a series of lurid racist statements at his workplace, described the comments as "merely part of routine banter on the building site".

"It was done in jest and not in malice", he told the jury.

Whilst most exchanges at the workplace are unlikely to be as offensive, explicit or discriminatory as those evidenced in this court case, it is not uncommon these days for risqué or tasteless comments at work to be described by the perpetrators as "banter" – as if this excuses the offence caused and effectively portrays any complainer as having no sense of humour.

Paul MacInnes wrote recently in *The Guardian* pointing out how ubiquitous "banter" has become – particularly amongst young men.

"While a lot of men.... might revel in any opportunity to quip, nobody would want to be forced to do it. Yet as the term and the practice become ever-more ubiquitous ... the tyranny of banter begins to grow."

Robert Lawson, an expert in socio-linguistics at Birmingham City University, says: "I don't think that banter is something that all men (or women) can do, but I think that it's certainly something that's 'marketed' as something that a) all men can do, and b) all men should do.

"If there is enough of a critical mass of societal pressure that banter makes you 'look good' to your mates or interlocutors, then that can be enough to make people feel they have to adopt that kind of conversational behaviour."

But employers, concerned about the

impact of potentially offensive comments at the workplace, cannot afford to assume that apparently changed societal attitudes to banter will exempt their staff from legal action by victims of their "humour".

One person's humour could well be another person's uncomfortable embarrassment or revulsion. Whilst this may not surprise those who attend some comedy gigs (or view "edgy" comics on TV) – indeed many may say that they actually go along assuming that their tolerance limits for such abusive language will be tested – it's clear that the law requires employees to be more careful about joking with work colleagues.

More importantly, employers cannot afford to forget that, in addition to individual offending employees risking dismissal for discriminatory language or horseplay, the organisation itself could be held to be vicariously liable for the actions of their delinquent employees. This puts excuses like "It is only banter" into stark relief for the management of employing organisations.

The only way in which employers can avoid this vicarious liability for their employees' discriminatory behaviour is to invoke the statutory defence outlined in the Equality Act. If the employer can show that they took all reasonable steps to

prevent the offending behaviour from occurring – not that they took action after it happened – they may be able to leave the perpetrator alone facing legal action from the victim (and paying any compensation ordered by the employment tribunal).

In order to invoke that defence, Law At Work has been asked by many of our clients (including several medical and dental practices) to assist in drafting Dignity at Work policies for distribution to staff, and to provide in-house training for practice staff to explain their rights and responsibilities under discrimination law.

Clearly these organisations want to establish professional standards in their workplaces – firstly so as to avoid the risk of litigation from staff who are offended (or frightened) by extreme and unwelcome discriminatory behaviour by colleagues but, secondly, to ensure that their practice is a pleasant and welcoming place to work.

Banter in the comedy club is one thing (you can choose whether or not to expose yourself to potential offence, after all) but the workplace should be a banter-free zone – for everyone's benefit

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

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

TREAT ON NEED NOT ELIGIBILITY

Jim Killgore

ASYLUM seekers and undocumented migrants pose a growing challenge to local healthcare resources across the UK. In a recent article published in the *BMJ* Dr Paquita de Zulueta made a heart-felt plea to medical colleagues to "overcome bureaucratic barriers and register patients irrespective of their residential status."

She likened some of the vulnerable people she sees as a GP and clinical volunteer for a health advocacy programme in London as "Dante's lost souls", trapped in a bureaucratic limbo. "Many of them have not sought medical help for several years despite serious medical problems, some brought on by the lives they lead or the trauma they have experienced."

MDDUS often receives calls from doctors and dentists in regard to their obligations toward asylum seekers and refugees. Are they obligated to register such patients? Should practices check the immigration status of patients wanting to join their lists? What about patients who have been refused asylum and/or are living in the UK illegally?

No doubt these questions cross over into the ethical duties of healthcare professionals towards patients. It is a bedrock principle that doctors and dentists have a duty of care to all people seeking healthcare. But what does the law require?

Earlier this month the BMA issued a helpful guidance document on access to healthcare for asylum seekers and refused asylum seekers (see www.tinyurl.com/d2kwj8z). Among first principles in the document was the view that doctors should not be expected to police the eligibility of patients for free NHS care.

NHS regulations in all four devolved health administrations allow for asylum seekers and refugees to register with a GP and to receive free NHS hospital treatment. GP practices also retain the discretion to register refused asylum seekers to the same extent they can register any patient regardless of residency status.

The BMA guidance states: "Practices are not required to check the identity or

immigration status of people registering to join their lists and there is no obligation on prospective patients to provide evidence in this regard. There may be practical reasons why GP practices might want to confirm the identity of patients registering at a practice but practices must ensure that any requests for identification are asked of all patients who register to avoid discrimination."

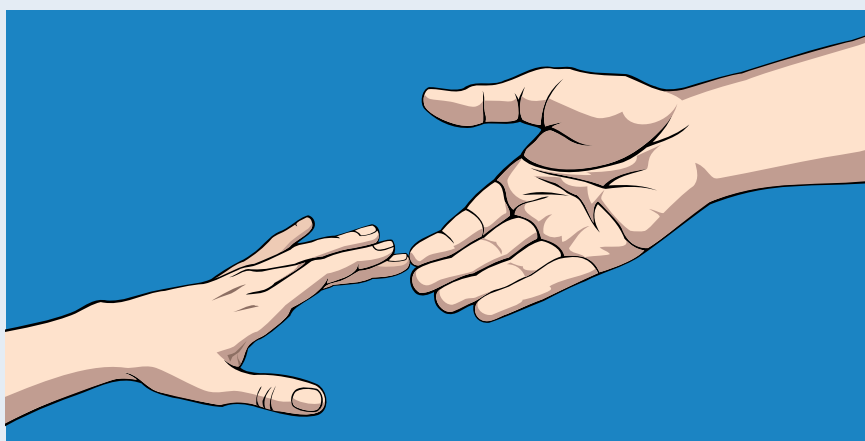
Refusal to register asylum seekers and refugees must be on "reasonable grounds" just as with any patient to avoid being judged discriminatory. This might include an oversubscribed practice which has closed its list to new applicants but even in this circumstance GPs are still obliged to provide any treatment considered to be "immediately necessary".

The GMC in *Good Medical Practice* makes no specific reference to asylum seekers and refugees but under the duties of the doctor it states that you must "make the care of your patient your first concern" and "never discriminate unfairly

Entitlement to free hospital care is subject to different legislation than that of primary care and each of the devolved nations has its own regulations based on whether a patient is "ordinarily resident" in the UK. This would normally cover patients entering the UK as asylum seekers but not those who have been refused asylum or are living illegally in the UK – though some NHS services are free to all patients irrespective of residency status, including accident and emergency services and the treatment of certain communicable diseases (measles, tuberculosis and pandemic flu) and sexually transmitted diseases (for HIV and AIDS, only immediate diagnosis and counselling).

But it is the view of the BMA that no doctor should be asked to make judgments as to the eligibility of patients for NHS care. Such assessments should be made by other non-clinical staff, such as an overseas visitors manager (OVM).

No doubt refugees and asylum seekers can bring many added challenges to general practice surgeries and other treatment



against patients or colleagues". Later in the section on decisions about access to medical care it further states: "You must give priority to the investigation and treatment of patients on the basis of clinical need, when such decisions are within your power".

Similar professional principles apply to dentists. The GDC in its *Standards for dental professionals* states: "Treat patients fairly and in line with the law. Promote equal opportunities for all patients. Do not discriminate against patients or groups of patients because of their sex, age, race, ethnic origin, nationality, special needs or disability, sexuality, health, lifestyle, beliefs or any other irrelevant consideration."

centres – not only language and cultural barriers but also social and psychological problems associated with their plight. However, making judgements on eligibility to necessary treatment should not be a primary concern of doctors faced with sick patients. Indeed MDDUS has defended cases on behalf of members where refusing or delaying treatment on the basis of eligibility has led to claims of negligence.

In short MDDUS advice is to prioritise the treatment of patients on the basis of need rather than considerations of legal eligibility.

■ Jim Killgore is editor of MDDUS Summons



Above: Dr Sara Twaddle (left) with Programme Director Dr Roberta James on receiving an eHealth award for the SIGN app. Left: Dr Keith Brown



Translating evidence into practice

For nearly 20 years the Scottish Intercollegiate Guidelines Network or SIGN has been producing evidence-based clinical practice guidelines for the NHS in Scotland. Here Summons speaks to SIGN Chair Dr Keith Brown and Director Dr Sara Twaddle

DR KEITH BROWN became the Royal College of Psychiatrists' representative on the SIGN Council in 2001 and was appointed Chair in 2007. Dr Sara Twaddle is a health services researcher and economist by background and had worked in the NHS in a variety of roles since 1988. In 2000 she joined a SIGN guideline development group as an economist and subsequently became the network's part-time economics adviser. In 2003 she was appointed Director.

What do you see as the prime remit of SIGN?

KB: SIGN's remit remains the same as it was back in 1993, to produce high-quality, multi-disciplinary, evidence-based recommendations for NHS Scotland.

Is it the Scottish equivalent of NICE?

KB: We have the same remit as the guideline development arm of NICE, but other NICE responsibilities are picked up by Healthcare Improvement Scotland (HIS), of which SIGN is a part.

How do you decide on topics for guidelines?

ST: This depends on whether we already have a guideline covering the topic, or whether it is a totally new topic.

For our extant guidelines, we look at the requirement for review at three years post

publication. We look at the new evidence published since the last guideline and assess the degree to which it would alter the recommendations. We then consult on the review reports with clinical experts in the field to ensure that we have correctly interpreted the new evidence.

Anyone can make a proposal to SIGN for a new guideline topic (by downloading a form from www.sign.ac.uk). These are then assessed within SIGN to ensure that they are suitable for a clinical guideline. We do this by considering whether the topic involves more than one discipline and whether it is actually a clinical topic. Once this is established we work with the proposer to develop a more detailed

proposal, including looking at the size of the evidence base and evidence of variation in practice. These proposals are then reviewed by SIGN Council, which is made up of the representatives of all the Royal Colleges, professional organisations and lay members. If SIGN Council supports the proposal we submit these to the process within HIS which allocates budgets for pieces of work.

What goes into guideline development?

ST: Essentially, the main elements are a multi-disciplinary guideline development group including patients and carers, a review of published literature, recommendations for clinical practice



based on available evidence along with open consultation and peer review. Full details of the methodology are available on our website (www.sign.ac.uk).

Why is evidence graded and how do healthcare professionals make use of that?

KB: All SIGN recommendations are graded to reflect the underlying quality of the evidence which supported the recommendation. Most importantly the grade of the recommendation does not reflect its clinical importance. For example, in our postnatal depression guideline we have a recommendation that 'PND and puerperal psychosis should be treated'. This is clearly the most important recommendation, but it is a Grade B recommendation, reflecting the fact that randomised controlled trials comparing treatment with no treatment don't exist and are unlikely to be carried out in the future.

How do you avoid bias in guideline development?

KB: Research shows that guidelines are less susceptible to bias if they are developed by multi-disciplinary groups involving all the relevant specialties, recommendations are based on a systematic review of the evidence and all declarations of interest are recorded and acted upon. We base our methodology around these principles.

How long does it normally take between proposal and publication?

ST: A long time! Once we've had agreement to develop a guideline we need to find a 'slot' in the guideline programme and then identify the chair and the guideline development group. The development process for a new topic then takes around two years, so it may take up to four years from proposal to guideline. We agree this is too long, but what we can do about it is another matter – all guideline developers have this sort of issue.

What is a SIGN ROCKET?

ST: SIGN ROCKETS are online summaries of our guidelines that allow you to manoeuvre, click by click, quickly around the clinical content to help you find the specific piece of information that you are looking for. ROCKETS are based on our quick reference guides, but may contain additional supporting material from the full guideline.

How has the focus at SIGN shifted from guideline development to implementation?

KB: Over the last few years we have recognised that an implementation strategy based around sending hard copies out to healthcare professionals isn't really the best. We therefore looked at the literature on implementation support and have come up with an approach which is multi-faceted. Most importantly we actively involve the multi-disciplinary group in thinking about implementation support during the development process, rather than as an add-on at the end. We also

"All SIGN recommendations are graded to reflect the underlying quality of the evidence..."

publish an implementation strategy for each guideline at the time of launch.

You recently launched You Tube broadcasts for patients. How does the SIGN remit extend to patients?

KB: Everything we do is ultimately for the benefit of patients, so provision of information about guidelines and our work in easily accessible language is important. We have patient involvement in everything we do, led by Karen Graham our Patient Involvement Co-ordinator, who supports the patients and carers on our groups. We provide patient versions of many of our guidelines in both electronic and paper form and we are about to provide our first Smartphone app designed wholly for patients. We are advised that YouTube is a good way of reaching a wide range of people, so watch this space for more broadcasts.

Congratulations on your recent award from eHealth for the SIGN guideline app. How does this work and how did the idea come about?

ST: Thank you. As part of our refocusing on implementation support we recognised that we need to produce guidelines in lots

of different formats to maximise dissemination. Credit for the original app idea should go to Safia Qureshi, our previous Programme Director, but Stuart Neville, Publications Coordinator, and Roberta James, Programme Director, were the team who worked with an app developer to get it in its current form. The app is based on the quick reference guide of each guideline, with some additional material. It is available free of charge for Apple phones, iPads and Android phones. We now have more than 31,000 downloads, so the message is getting out there.

What do you enjoy most about your job?

ST: Two main things – firstly the opportunity to make a difference to the healthcare of thousands of patients every year by working with front-line clinicians to produce high-quality, Scottish-relevant, recommendations for clinical practice. Secondly, working with the SIGN team, who are a great bunch of people and are all willing to go the extra mile to produce a fantastic product.

KB: The opportunity to work within an organisation as internationally respected as SIGN.

What do you find most frustrating?

ST: NHS bureaucracy!

KB: Ill-considered change which is more of a challenge than an opportunity.

Are there any special challenges to providing healthcare guidelines in Scotland?

ST: Scotland is a small country and when embarking on a specialist topic, forming a guideline development group may result in inviting all of the specialists in Scotland onto the group. Obviously this has consequences for the service but also creates the possibility of bias in the process. More challenging is managing expectations – we would all love to have completely up-to-date guidelines on every topic, but this is just not possible given the resources available to us. Other challenges aren't particularly Scotland specific, such as problems with people being released to work on guidelines, which is true of all national activities.

■ *Interview by Jim Killgore*

Celebrating a surgical legacy



A century has passed since the death of the great surgical innovator Joseph Lister. Here Adam Campbell looks at the man and his lasting influence

PHOTOGRAPHS: ROYAL COLLEGE OF SURGEONS EDINBURGH

“IN THE field of observation, chance favours only the prepared mind,” said microbiologist Louis Pasteur in a lecture in 1854. Eleven years later the surgeon Joseph Lister was to exemplify this observation perfectly when he undertook his early trials with antiseptic agents at Glasgow Royal Infirmary.

Lister, whose father was a microscope maker, had long been a

keen experimenter, having carried out numerous studies on the eye, hair, the inflammatory process and coagulation, among others. It was to the attention of this ‘prepared mind’ that his colleague, Dr Thomas Anderson, a chemistry professor, brought the recent work of Pasteur, who had shown in experiments on wine that tiny living organisms could ruin the fermentation process.

Lister repeated some of Pasteur’s experiments and was soon convinced that the sepsis that so often wreaked havoc among surgical patients was not, in fact, due to an ‘impure’ state of the air, as was generally believed, but to the ‘germs’ in Pasteur’s theory. He thus set about preventing these germs from entering surgical wounds by erecting barriers composed of dressings saturated in carbolic acid – a compound then used in the treatment of sewage – and covered with a tin cap.

These initial trials, carried out on patients with compound fractures, which were often fatal traumatic injuries, yielded hugely successful results – to Lister’s surprise, of the first 11 cases, 10 survived, with only one requiring amputation.

It was the start of a medical revolution that is still reverberating today – and which explains why, 100 years after his death, the surgical community will be marking the occasion with a series of centenary celebrations.

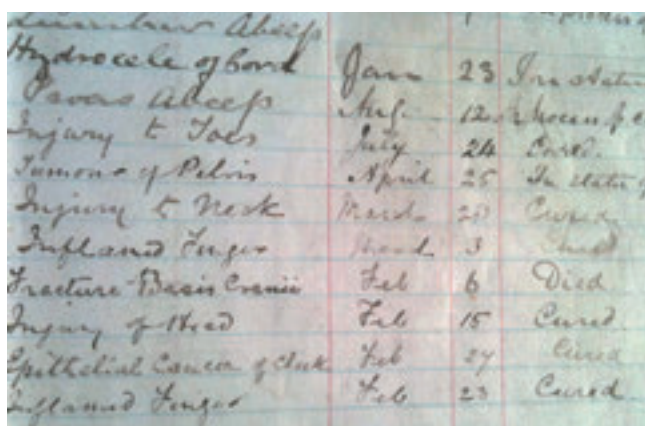
Learning from Lister

“The contribution of Joseph Lister to surgery is quite comparable in importance to the invention of radio or the internal combustion engine,” says Dugald Gardner, a professor of histopathology and emeritus conservator of the Royal College of Surgeons of Edinburgh (RCSEd), who has written on Lister’s life and work.

As part of the celebrations, the RCSEd will be throwing their doors open for a conference celebrating the life and work of their illustrious former fellow as well as placing it in a contemporary context. King’s College Hospital in London, where Lister was professor of clinical surgery from 1877 to 1893, has also teamed up with The Royal Society and The Royal College of Surgeons of England to host a conference entitled ‘Learning from Lister’.

“Lister remains relevant today because his work helped to change the practices of surgery, making them safer and more effective,” says Brian Hurwitz, professor of medicine and the arts at King’s. “The conference will provide an opportunity for all those interested in the development of hospital healthcare policy and translational practices, to discuss their respective approaches to surgery today.”

Lister was an important figure in the Royal Colleges not just by



Hydrocele of Scrotum	Jan 23	In statu
Painful Abscess	Aug 12	Discharge
Injury to Testis	July 24	Cured
Tumour of Pelvis	April 25	In statu
Injury to Neck	March 20	Cured
Inflamed Finger	March 3	Cured
Fracture Basis Craniae	Feb 6	Died
Injury of Throat	Feb 15	Cured
Epithelial Cancer of Clitoris	Feb 27	Cured
Inflamed Finger	Feb 23	Cured

Detail from Lister's ward book (left) at the Edinburgh Royal Infirmary and his pocket operating set (right) - both from the collections of the Royal College of Surgeons of Edinburgh.



reputation but because over the course of his career he studied, practised and taught in the UK's three great surgical centres. He trained at University College London before moving to Edinburgh in 1853 at the age of 26 to become dresser and later house surgeon to James Syme, professor of clinical surgery. He married Syme's daughter Agnes and the pair moved to Glasgow in 1860, where he had been appointed chair of surgery and where his 'system' was conceived. Lister returned to Edinburgh in 1869 to be professor of clinical surgery and finally went back to London, to King's, in 1877.

Answering his critics

Though Lister was celebrated in his lifetime – he was Britain's first medical baronet and the Jenner Institute of Preventive Medicine, which he had helped to found, was renamed in his honour in 1898 – it was not so at first. There was a mixed reception to his first series of papers, varying from condemnation through tolerance to enthusiastic support. For some opponents, it was the radical nature of his proposals that was the problem. For others, it was sheer animus – in Edinburgh James Young Simpson, who had introduced chloroform in 1847, was no fan of Professor Syme, Lister's mentor and father-in-law. "Simpson not only criticised Lister verbally, he published fairly abrasive notes in medical journals, saying you shouldn't believe that chap," says Professor Gardner.

But Lister could give as good as he got and in 1870, after leaving Glasgow, he published a summary of the results of his antiseptic method in *The Lancet*, along with a stinging attack on the Glasgow Royal Infirmary, whose wards, he wrote, were converted "from some of the most unhealthy in the kingdom into models of healthiness" thanks to his techniques.

The directors there responded in kind, suggesting that much of the improvement documented by Lister had, in fact, to do with "better ventilation, the improved diet and the excellent nursing, to which the directors have given so much attention of late years".

Such arguments did not distract Lister from being a constant experimenter and innovator. As well as developing and adapting his system over the years with less irritative compounds, better dressings and his famous antiseptic spray, with which he attempted to create a protective field over the operative site, he went on to introduce absorbable ligatures and drainage tubes into surgery. In addition, Lister was a prodigious lecturer and writer of scientific papers. He was in touch with the leading scientists of the day, among them Pasteur and Robert Koch, who isolated the tubercle bacillus in 1882, and soon achieved international acclaim.

Paradigm change

With the long view of history it is possible to see Lister's ideas on antiseptics as the beginning of a paradigmatic change, but it was really a generation before the whole surgical community were on board. And in fact what they were on board with was the post-Listerian idea of asepsis, which had surpassed his original theories, advocating not the direct application of disinfectant to wounds but the rigorous eradication of germs from the whole operating theatre. Indeed, by 1890, Lister himself had renounced the use of his carbolic spray.

But none of this diminishes Lister's importance, argues Michael Worboys, professor of the history of medicine, who will be speaking at the King's College conference. "He represented the modernisation of medicine, technical innovation. To be a London surgeon at that time, the most important thing was to be a gentleman. You could get your hands dirty in the surgery but not outside. So he came from a different ethos. In Glasgow and Edinburgh, the medical schools were closely tied to the universities so he would have hung out with scientists in a way that the clinicians in London, apart from at University College, didn't.

"If you go back to the early 19th century, the cutting edge of medical knowledge was made in the clinic. By the end of the 19th century cutting-edge medicine came from the laboratory. Lister is a clinical figure who makes that transition."

Gus McGrouther, professor of plastic and reconstructive surgery, who will also be a speaker at the King's College conference, agrees: "I think Lister's major contribution was to change thinking rather than any specific one thing he did in terms of antiseptics."

There is an additional legacy, too, he adds, which has to do with the role model Lister offers to doctors everywhere. "He was learning from the microbiologists of his day. There wasn't a eureka moment in the bath where he suddenly thought, 'There are bugs causing this.' He knew about Pasteur's work. We need to have doctors who are scholars, not just technicians. There's a great drive to make us all into technicians following guidelines, but if you want to actually move things forward, doctors have got to read, understand and innovate."

For more information on the celebrations go to the King's website (www.tinyurl.com/7uonow4) and that of the RCSEd (www.lister2012.com).

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

Brain tumours

Professor Paul Marks *offers some key insights in dealing with suspected intracranial tumours*

THIS article will highlight some of the difficulties that can arise when managing patients with intracranial tumours. Neuro-oncology is a complex and constantly evolving subject but nevertheless certain fundamental principles apply which if attended to will avoid or minimise clinical and medico-legal problems. Interested readers are advised to consult standard texts and, in particular, the relevant NICE guidelines – *Improving outcomes for people with brain and other CNS tumours* (www.nice.org.uk/csgbraincns).

Scale of the problem

It is important to point out that primary CNS tumours are rare, and the average general practitioner will be unlikely to see more than a handful of cases throughout his practising lifetime. CNS tumours account for 1.6 per cent of cancers in the UK.

Despite their relative rareness, there are many histological subtypes and classification is complex. The use of terms such as benign or malignant which have a readily understandable and clear-cut meaning when discussing tumours outside the CNS are less helpful when considering brain tumours.

Benign tumours tend to be extra-axial, that is they do not arise in the substance of the brain but rather from the meninges, cranial nerves or other structures and produce their effects by compressing the brain from without.

There are of course histologically benign intra-axial tumours such as low-grade pilocytic astrocytomas which arise within the substance of the brain. Malignant tumours which can be primary or secondary tend to be intra-axial.

Glioma is a generic term which suggests that a tumour arises from one of the lines of glial cells such as astrocytes, oligodendrocytes or ependyma. High-grade gliomas, such as glioblastoma multiforme, are common malignant tumours that arise in adults and have a notoriously poor prognosis.

A meningioma, which is a benign tumour, can nevertheless prove fatal if it causes raised intracranial pressure or leads to status epilepticus. Pituitary adenomas are also benign and can cause blindness by compression of the optic apparatus.

It will be readily appreciated that the classification of brain tumours is complex but the WHO 2007 classification is the most comprehensive and accepted system currently employed*.

Treatment is complex and should always be discussed in a multidisciplinary team setting but may consist of surgery alone or supplemented by adjuvant means such as radiotherapy or chemotherapy. The gamma knife which provides focused irradiation in a single session is finding increased use, especially in the management of metastatic disease and small benign tumours such as acoustic neuromas in suitable patients.

Presentation of brain tumours

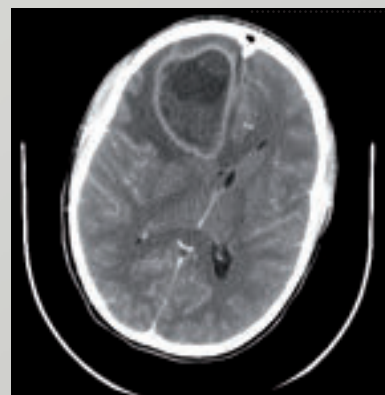
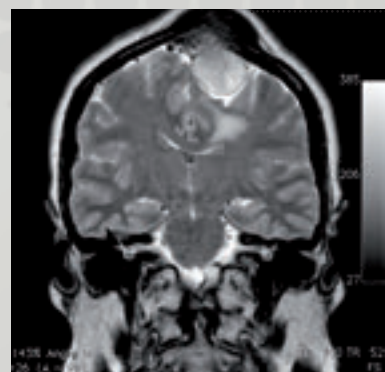
Clinical presentations of brain tumours include:

- Symptoms and signs of raised intracranial pressure
- Epilepsy
- Focal neurological deficit
- Endocrine disturbance
- Incidental finding.

Headache due to raised intracranial pressure typically has a diurnal variation and is worse in the morning. It can be associated with vomiting, and examination of the fundi may reveal papilloedema.

Focal deficit is obviously variable and will be determined by which area of the brain is involved. For example, a tumour in the right occipital lobe can produce a left homonymous hemianopia, a pituitary adenoma can cause chiasmatic compression, a bitemporal hemianopia or a left temporal lobe tumour may be associated with dysphasia and so forth.

Epilepsy of new onset in an adult patient should raise suspicion of an underlying tumour and investigation is mandated by CT or MRI scanning of the brain. If such tests suggest that the lesion is likely to be a metastasis then further imaging directed at locating the likely primary site is carried out and this typically should include a CT scan of the thorax, abdomen and pelvis.





Pitfalls in diagnosis

The two cases presented here highlight some of the pitfalls in the diagnosis of brain tumours.

Case 1

A 54-year-old woman had been attending her GP for over 10 years and periodically pointed out a lump on her head which was increasing in size. She was reassured and told it was a lipoma despite being hard. The lump increased in size and over a period of three months she started to develop progressive weakness of her left leg. She mentioned this to a general surgeon who was seeing her for an unrelated problem and he found a bony lump in the parietal region. An MRI scan was organised which showed a large parasagittal meningioma associated with a large overlying bony exostosis (Fig. 1). Following neurosurgical referral, the lesion was excised and she made a good recovery.

Learning points:

- Lesions of the skull may be associated with underlying intracranial pathology.
- Investigation or referral should occur in the face of a lesion which is changing in size.
- Earlier referral would have resulted in the lesion being detected before it had started to cause neurological deficit.

Case 2

A 72-year-old man presented with a two-week history of headache and had a grand mal fit which brought him to hospital. A CT scan was performed which showed a mass lesion with irregular ring enhancement (Fig. 2). His case was discussed at the local neuro-oncology MDT meeting where it was held that the radiological appearances were more in favour of an abscess than a malignant tumour and immediate transfer for biopsy

was recommended. Unfortunately, due to problems with communication this did not occur and he remained at the local hospital where it was assumed that no action was advocated as the lesion was a malignant brain tumour with a hopeless prognosis. He deteriorated and died four days after the MDT meeting and at autopsy, a brain abscess which had terminally ruptured into the right lateral ventricle was found.

Learning points:

- Neither CT nor MRI scanning is tissue specific.
- Communication between clinicians managing patients is vital especially when different institutions are involved.
- The prognosis of a cerebral abscess and a malignant brain tumour are entirely different and would have been distinguished by biopsy.

Conclusions

It is always difficult to provide advice on uncommon conditions, especially when they present in an unusual or atypical manner. Headache is a very common symptom in general practice but brain tumours are rare. It would be completely inappropriate to refer every patient who presents with headache for a specialist opinion on the basis that they might harbour serious intracranial pathology.

Are there any pointers or “red flags” which should arouse suspicion of intracranial tumour and prompt investigation or referral?

Remember if you don’t consider the diagnosis you will not make it! Despite modern imaging techniques, the era of clinical methods is not yet dead. There is no substitute for taking a detailed history and performing a thorough physical examination. Persistent or progressive symptoms should always raise suspicion of serious underlying pathology and prompt referral to a neurologist or neurosurgeon.

■ Professor Paul Marks is a consultant neurosurgeon at Leeds General Infirmary and Visiting Fellow in Law, St Chad’s College, University of Durham. He also serves as HM Deputy Coroner, West Yorkshire (Western District)

* The 2007 WHO classification of tumours of the central nervous system. Louis DN et al. Acta Neuropathol (2007):114:97-109

Fig. 1 A coronal MRI scan which shows a large mass lesion arising from the skull vault which is associated with an underlying parasagittal meningioma.

Fig. 2 A contrast-enhanced CT brain scan showing an irregular ring-enhancing mass lesion in the frontal region which turned out to be an abscess rather than a high-grade glioma.

DIAGNOSIS

When to consider the diagnosis of intracranial tumour

- Headache arising in a person with no history of headache that persists especially if associated with nausea.
- Progressive neurological deficit.
- New onset of epilepsy or alteration of pre-existing epilepsy.
- Visual disturbance not explained by refractive error.
- Symptoms of raised intracranial pressure in a person with a past history of malignant disease.

Summons editor Jim Killgore kicks off the first in a series of profiles featuring the professionals whose job it is to provide advice and legal support to MDDUS members. Here he talks with Dr Barry Parker about his role as an in-house medical adviser

On the line



SEEK out Dr Barry Parker at his desk in the Glasgow office of MDDUS and you will rarely find him off the telephone in his job providing medico-legal guidance to members or discussing ongoing cases. But just three years ago his main contact with the Union was on the other end of the phone as an occasional user of the advice service. He was then working as a GP partner in a busy practice in Stockbridge in Edinburgh

“I was very happy there,” he says. “It was a really good team and I enjoyed the job. But I’d done clinical work exclusively for almost 20 years and felt the need to try something new.”

So in 2009 he applied for an opening at MDDUS as a medical adviser. He had already gained significant experience working in an advice and support role as a GP appraiser and had also attained an MSc in Primary Care. Out of a strong field of candidates he was appointed to the job and joined an experienced team of professional advisers.

“I had a less usual route into the field than a lot of medical advisers who get their MPhil or Masters first,” says Barry. “But I’m now in my third year of a Masters in Medical Law at the University of Glasgow.”

Just like Barry all the professional advisers at MDDUS are qualified doctors and dentists who come to the role with significant clinical experience supplemented with specialist medico-legal training. MDDUS prides itself on a personalised doctor-to-doctor/dentist-to-dentist service of support and advice. The Union may exist primarily to provide access to legal support and indemnity for members who find themselves the subject of complaints or claims of clinical negligence but the 24/7 service provided by Barry and the other advisers is an essential element in the proactive risk management philosophy of the organisation. The prime ethos is to avoid costly and distressing negligence claims or fitness to practise proceedings by providing timely advice to members so that what may be minor issues do not escalate into major difficulties.

Phone advice

So what is a typical week like for an MDDUS medical adviser? “The week is quite variable depending on case work and teaching commitments,” says Barry, “but we each have a number of regular half-day sessions providing phone advice to members.”

In the six months up to June 2011 MDDUS medical advisers in two offices in London and Glasgow handled over 3,400 calls on a wide range of topics. A trainee doctor might be worried about whether she is obligated to inform the GMC of a traffic offence. A practice manager might be seeking advice on the wording of a response letter to a patient complaint. A consultant surgeon could be phoning to say that he has been called as a witness in a coroner's inquest and is worried that his actions may come in for criticism. Or it may be a simple matter of confirming vicarious indemnity coverage for general practice staff offering flu vaccinations.

“The single commonest issue we get called about is doctor-patient confidentiality,” says Barry. “Examples include – can you show the records of a child to an estranged father? How do you assess parental responsibility? What about someone who is not medically fit but wants to continue to drive? When do you contact the DVLA? What can and can't you tell police about a patient's health details? It covers a wide range of possible scenarios.”

Most advice calls to MDDUS are put through directly to an adviser from a secretary. The advisory team strives to avoid call-backs though at busy times, such as Monday mornings, this may not always be possible. There are no case handlers or triaging of calls. A doctor phoning MDDUS for advice will always speak with a doctor and the same goes for dentists.

“Doctors like to talk to doctors,” says Barry. “They like the reassurance of speaking to someone who is medical and understands the clinical scenario they've found themselves in.”

In addition to his weekly phone sessions

Barry also does an out-of-hours rotation for a week every couple of months. This involves carrying a mobile phone and taking any emergency calls.

“Calls are usually for acute situations such as a casualty doctor phoning because there is a patient attending who has doubtful capacity to consent to treatment, or a doctor who is about to be interviewed by police regarding a clinical incident.”

Sometimes advisers get calls they cannot answer immediately. In such cases they will call back having consulted other resources including written policies and procedures, GMC and other regulatory guidance. Each week the advisory team also meets in formal sessions to go over more difficult cases and pool knowledge.

“We have some very experienced senior colleagues who offer a wealth of information. Our in-house legal teams are also always available to consult.”

“Doctors like to talk to doctors... We are the first point of contact”

Member support

When not handling advice calls Barry spends much of the rest of his time in case management. Cases generally involve claims of negligence or investigations by the GMC in regard to a professional's fitness to practise.

“At MDDUS we make sure it is a medical adviser dealing with medical colleagues right through all of these things,” says Barry. “We are the first point of contact and take members through the process, telling them what is going to happen at each stage.”

An adviser will correspond with the member over the course of a case, facilitating requests for information and arranging any necessary meetings with solicitors or counsel in advance of hearings or panels,

either in person or via video link. Advisers will also attend GMC hearings to support members and offer representation in hospital or primary care disciplinary proceedings. MDDUS considers such contact vital. Part of the role of an adviser is to provide members with an understanding of the processes and procedures they may face when dealing with the GMC or in court. This includes explaining what will be involved in a hearing and the type of questions that might be asked.

“It's important just to reassure members that at the end of the day, all that they are expected to do is give an honest account of what has happened. That's all that's being asked,” says Barry.

Another aspect of the job is outreach and education. Each week MDDUS receives numerous requests for advisers to give talks or run workshops in practices or hospital departments or at medical meetings.

“We give presentations to everyone from medical students up to consultant grades on a whole range of topics including confidentiality, consent, clinical negligence claims, fatal accident inquiries, coroner's inquests, recent changes in death certification. Pretty much anything people ask us to cover as long as it has a medico-legal slant to it.”

Advisers also participate and comment on consultations for initiatives or guidance produced by the NHS or GDC and GMC, including the current and ongoing review of *Good Medical Practice*.

It makes for a busy and at times challenging role, but Barry hesitates only a moment when asked if he misses clinical medicine.

“Occasionally,” he replies. “I think you inevitably miss something you've done for most of your life. But you can't go on being a clinician forever. All I've done is stepped out of it 10 or 15 years earlier. And now I'm doing something new which I find really stimulating and rewarding.”

■ *Jim Killgore is editor of MDDUS Summons*

Whiter than white

Head of illegal practice prosecutions at the General Dental Council, Shareen Larmour, discusses the latest developments in the regulation of tooth whitening

THERE has been a lot of press coverage about tooth whitening in the last 12 months, some of it positive and some of it just plain wrong. I would like to state from the outset that the GDC's stance remains the same: tooth whitening may only lawfully be provided by those who are registered dental professionals.

Whether or not it is appropriate for any particular dental professional to be involved in tooth whitening is set out in our *Scope of practice* document. The GDC currently states:

- Dentists can carry out tooth whitening.
- Dental hygienists and dental therapists can carry out tooth whitening on the prescription of a dentist as an additional skill.
- Dental nurses can, as an additional skill, take impressions and make bleaching trays to a dentist's prescription.

Any registrant who undertakes work for which they are not sufficiently trained and competent risks fitness to practise proceedings, which may affect their registration.

Ethical issues arise in treating patients, whatever the legal position. GDC registrants must:

- act in the best interests of the patient in providing a high standard of care
- obtain fully informed consent for treatment, which they must be competent to carry out
- obtain a medical history of the patient before starting treatment
- give necessary explanations about

benefits and risks.

These and similar issues can arise in connection with any dental treatment proposed or carried out, including treatment designed to improve the appearance such as tooth whitening. They apply whether the registrant personally delivers the treatment or gives advice to patients about the use of home kits. It is open to patients to complain to the GDC about these matters, as with any form of care or treatment.

I think it's worth pointing out that the GDC has been reviewing its *Scope of practice* document this year. The guidance was first published in January 2009 and clearly sets out the skills and abilities that each registrant group should have, as well as listing the additional skills registrants may develop after registration.

In the introductory section of the guidance it states that the lists will be reviewed regularly to ensure that they are still relevant to the dental team and that is exactly what we're doing. All the feedback we've received this year, including any views regarding tooth whitening, will feed into the development of the formal consultation that we'll be running in the coming months.

The Scope of Practice Working Group met in October this year and will present proposed changes to the document to Council at its meeting in December. We will then run a consultation on the proposed changes – probably running through until March 2012. The group will then meet again at the end of March to consider the research, evidence and feedback and make any final changes. The document will then finally be proposed to

Council in May and hopefully approved at that meeting.

The GDC's new *Scope of practice* document is likely to be published next year and it's possible some of the currently listed duties for each of our registrant groups will change.

Developments this year

So what's changed in the ever-growing tooth whitening industry this year?

Well, in March the GDC successfully prosecuted a non-registrant for performing tooth whitening. Under the Dentists Act 1984 it is an offence for non-registrants to practise or be prepared to practise dentistry and the GDC's view is that this includes tooth whitening.

Paul William Hill, 48, of Warrington, Director of PW Healthcare Consulting Limited, pleaded guilty to four offences including practising dentistry while not registered as a dentist or dental care professional between 2 October 2010 and 11 March 2011.

Following on from the success of the prosecution, we launched a new publication entitled *Considering tooth whitening?* in which we warn the public against tooth whitening conducted illegally by unregulated people. In the leaflet we advise patients to always visit a dentist before having tooth whitening so the dentist can assess whether the treatment would be right for them. In addition we suggest they speak to other patients, get a second opinion and always ask for a written treatment plan and price estimate.

We also advise them to carry out their own research and ask some basic questions.

For example:



- What types of tooth whitening are available and what are the differences between them?
- What sort of results can I expect?
- What are the risks? Will it hurt?

You can help us to spread the word by putting copies of the leaflet in your waiting rooms. Copies can be ordered through the GDC's website (see

www.tinyurl.com/cc7qtga).

We were also pleased to find that in the results of some research carried out on our behalf, 8 out of 10 people would choose to have tooth whitening done at a dental surgery and think it should only be carried out by registered, trained and qualified dental professionals. Seventy five per cent of the people who took part in the survey also said they thought the GDC should prosecute anyone carrying out tooth whitening illegally.

Changes from Europe

And finally in September 2011, the GDC welcomed the Council of the European Union's decision to amend Directive 76/768/EEC, which relates to the percentages of hydrogen peroxide used in tooth whitening or bleaching products (see box).

All of the GDC's registrants have a responsibility to "maintain their professional knowledge and competence" as explained in our *Standards for Dental Professionals* document. Standard 5.4 states: "Find out about laws and regulations which affect your work, premises, equipment and business and follow them."

■ *Shareen Larmour is a solicitor and head of illegal practice prosecutions at the GDC*

"Tooth whitening may only lawfully be provided by those who are registered dental professionals"

Agreement on whitening products

THE European Council reached an agreement in September 2011 over the use of tooth whitening products by dentists. It was agreed that regulations would be put in place stating that products containing or releasing more than 0.1 per cent hydrogen peroxide cannot be provided directly to the consumer.

Whitening products between 0.1 and 6 per cent hydrogen peroxide will only be available to patients following an examination and a first episode of treatment provided or supervised by a dentist. This is to ensure that patients are able to use products provided to them properly at home.

The move was welcomed by the British Dental Association who had campaigned for clarification on the rules governing tooth whitening by dentists.

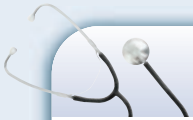
Early in 2011, trading standards officers in Essex County Council launched a crackdown on the use of whitening products which temporarily restricted the supply of hydrogen peroxide-based products to dentists. An agreement was then reached in June 2011 when trading standards eased restrictions, allowing GDC registrants to use the products.

The European Council's September agreement served to further clarify the issue for dental professionals. But the agreement did not change the official position on products containing more than 6 per cent hydrogen peroxide which remain illegal to use.

■ *Joanne Curran, MDDUS*

CASE studies

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



CHAPERONES: CROSSING THE LINE

BACKGROUND: Miss A suffers from gynaecological problems and has been seen several times in the course of the past year by her GP, Dr F, for drug treatments. Each time she is seen by Dr F he administers the drug treatment and then carries out an internal examination – all without a chaperone present.

Miss A becomes concerned at both the frequency of the internal examinations and at Dr F's conduct during the examinations. She feels it is unnecessary to undergo so many examinations and believes Dr F has inappropriately touched her during them. She discovers that a patient has complained about him previously for similar conduct and the practice had agreed to have a chaperone present for future intimate examinations carried out by Dr F.

Miss A is concerned by the fact she had never been offered a chaperone for her consultations with Dr F. She raises a claim against Dr F who is a member of another medical defence organisation.

She also raises a claim against Dr F's former practice partners Dr H and Dr P, alleging they negligently failed to act on a previous complaint against Dr F which then allowed him to inappropriately examine Miss A.

Dr H is an MDDUS member but Dr P is a member with another medical defence organisation.

ANALYSIS/OUTCOME: MDDUS defends Dr H against the allegations of negligence and agrees to share any costs with Dr P's MDO. An expert legal opinion is sought and concludes that while a charge of negligence is unlikely to be established against the practice partners, they could be held vicariously liable for Dr F's inappropriate conduct towards Miss A. This is in light of the fact that his inappropriate behaviour towards Miss A occurred during the ordinary course of business in the surgery and also because the partners had previously been aware of a complaint about Dr F's behaviour.

GMC guidance *Raising concerns about patient safety* clearly states that doctors "must protect patients from risk of harm posed by another colleague's conduct, performance or health". It explains that if doctors have good reason to think patient safety may be "seriously compromised", they should "put the matter right if that is possible."

It goes on to say that doctors who have a management role have a duty to "respond promptly and professionally to incidents and complaints", adding: "Do not delay [reporting concerns] because you yourself are not in a position to put the matter right."

GMC guidance *Maintaining Boundaries* also emphasises that medical professionals "must protect patients from risk of harm posed by another colleague's conduct... and take appropriate steps without delay so that [any] concerns are investigated and patients protected where necessary."

MDDUS continues to defend Dr H but eventually Miss A decides to no longer pursue her case against him.

KEY POINTS

- Offer a chaperone for intimate examinations, even when doctor and patient are of the same gender, in line with GMC guidance *Maintaining Boundaries*.
- Chaperones need not be medically qualified but should respect patient dignity and confidentiality.
- Be aware of the duty to protect patients where there is a suspicion of inappropriate/unprofessional behaviour in a colleague. Practice partners may be held vicariously liable for a colleague's wrongful actions.





PATIENT CONFIDENTIALITY: LOST AND FOUND

BACKGROUND An MDDUS adviser receives a distressed call from a Dr B who is a community paediatric specialist registrar. She has been summoned to a disciplinary hearing of her employing foundation hospital trust to answer to an allegation of breached patient confidentiality.

A data stick belonging to Dr B had been found by a cleaner in a local health centre and had been returned to the director of postgraduate training. On the unencrypted data stick were a number of named patient assessments with details of a highly confidential nature.

On being confronted, Dr B admitted that she had first suspected the USB stick might be missing a week before it was found. But she had been convinced the stick was somewhere in her flat and would "eventually turn up". Only after four or five days had Dr B begun to grow increasingly worried and decided to look for it in a few "logical" places, including the health centre, before reporting it missing.

A letter from the trust confirms that Dr B had been made aware of the trust's security policy and had attended an induction session where it was made explicit that personal

data keys were prohibited items for use in storing patient data. In the same session it was made clear that any loss of confidential data must be reported immediately to the trust and an educational supervisor.

ANALYSIS/OUTCOME The MDDUS adviser accompanies Dr B to the disciplinary hearing where a number of issues are raised. Evidence is provided that Dr B failed to maintain the security of the information on the stick by having it encrypted with password protection and failed to ensure that the disk itself was kept in a safe place. But even more fundamental she breached trust policy in the first place by using a personal USB stick to store highly confidential information.

In addition Dr B did not report the stick missing until after it was found by the cleaner.

Dr B is found to be in serious breach of trust policies and procedures in relation to



patient confidentiality and data security. She is issued with a final written warning and is subject to additional supervision in regard to issues of probity and patient confidentiality.

The matter is also referred to the GMC and two case examiners conduct an investigation resulting in a formal Rule 11 warning from the regulator.

KEY POINTS

- Ensure you know and follow the data security policy and procedures of your employing trust or health authority.
- Use only authorised encrypted USB drives or other devices to store confidential patient information.
- Authorised USB data devices should in general only be used on an exceptional basis where it is essential to store or temporarily transfer data.



CLINICAL NEGLIGENCE: HARD TO SWALLOW

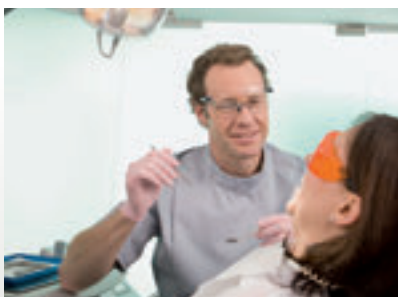
BACKGROUND: A 32-year-old patient, Miss D, undergoes root canal treatment from her dentist, Mr F. During the procedure Mr F drops a small metal instrument which slips down the patient's throat. He finishes the root treatment and then immediately refers Miss D to hospital with a note explaining what has happened.

At the hospital, the patient undergoes exploratory procedures under general anaesthetic and X-rays and the instrument is finally found in her abdomen. She spends the night under observation in hospital and is discharged the next day under instructions to stay at home until the instrument passes from her system. She is off sick from work for a week and eventually passes the instrument several days after she swallowed it.

Mr F receives a letter of complaint from Miss D who accuses him of negligence for

failing to prevent her from swallowing the instrument. She intends to make a claim for compensation for loss of earnings and other out-of-pocket expenses related to her hospital stay.

ANALYSIS/OUTCOME: Mr F contacts MDDUS for help after receiving the letter of complaint. When asked by an adviser, the dentist admits that he did not use rubber



dam. On that basis, the adviser concludes that the situation is indefensible and seeks to reach an agreement with the patient over compensation. Following discussions, a modest settlement is agreed to cover loss of earnings and expenses but no admission of liability is accepted on behalf of Mr F.

KEY POINTS

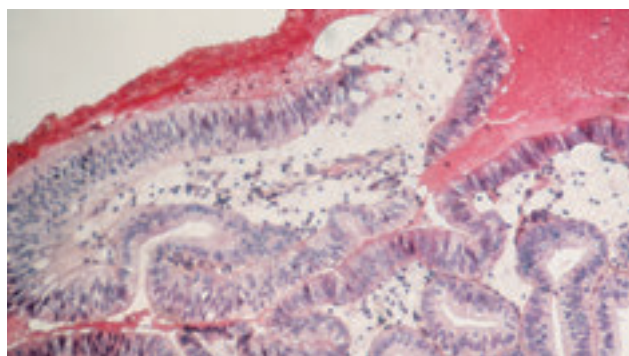
- Always use rubber dam when carrying out root treatment to avoid swallowing of dental instruments.
- If a dental instrument is swallowed, or if you suspect an instrument has been swallowed, immediately refer the patient for hospital treatment with a letter explaining the situation.
- Make a clear note of the incident in the patient's records, outlining the treatment given and whether a referral was made.



Object obscura: carbolic acid spray

THIS carbolic acid spray device was used by the surgeon Joseph Lister (1827-1912) for sterilising the operating environment. Lister discovered that carbolic acid (already used for drain cleaning) killed germs that could lead to post-surgical infection and septicaemia. His methods greatly reduced mortality from surgery. Lister later abandoned the carbolic acid spray deciding that airborne microorganisms were of less consequence than those on the surgeon's hands and instruments. Find out more on page 12 of this issue.

From the archives: an explanation "hardly satisfactory"



ISSUES of class are less apparent (if not common) in UK healthcare today than a century ago. One case recorded in the October 1904 Minute Book of the MDDUS Council tells of an Edinburgh doctor who was called to attend the house-keeper of a well-to-do lady. Upon examining the woman the doctor suspected uterine cancer. A joint consultation with a consultant was arranged and a biopsy was taken. The tissue sample was sent to the laboratory of the Royal College of Physicians of Edinburgh for examination.

The doctor was going on holiday and informed his colleague that the lab results should be sent to the consultant and appropriate action taken.

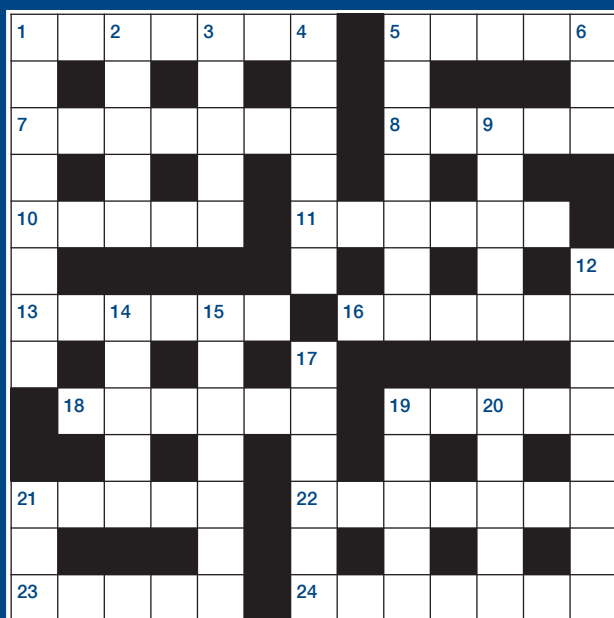
One month later the lady of the house wrote to the doctor expressing her dissatisfaction that nothing had yet been done in regard to the house-keeper's condition. Enquires at the laboratory revealed that the pressure of work and the unavailability of a skilled pathologist had resulted in no examination of the biopsy material.

The lady wrote: "Your explanations are hardly satisfactory. Perhaps my meaning will be best expressed by what many men have said – that you would not have dared to have treated their wives or themselves in such a manner".

The doctor was outraged and wrote asking that MDDUS obtain an apology. In its minutes the advisory committee of the Union formed the opinion that it was the pathologist primarily at fault and that the "representative of the Laboratory should have said that they could not undertake the work – September being their holiday month."

As for the doctor and his desired apology, he was tactfully advised not to press his luck in the matter. Nothing more is recorded regarding the fate of the housekeeper.

Crossword



ACROSS

1. Instrument to expand an opening (7)
5. Painful muscle contraction (5)
7. Stitches (7)
8. Old name for Type II Diabetes (abbr.) (5)
10. Biological units of heredity (5)
11. Process of getting older (6)
13. Vomiting (6)
16. Womb (6)
18. Digestive enzyme (6)
19. Spherical bacteria (5)
21. Brand name disinfectant (5)
22. Drug that binds to receptor of a cell (7)
23. Poisonous substance (5)
24. Produces calcitonin (7)

DOWN

1. Planned (7)
2. Archaic language (5)
3. Words or expressions (5)
4. Rogue (6)
5. Permission (7)
6. Small long-haired dog (3)
9. Arabian currency (5)
12. _____ suicide, as practised by Dignitas (8)
14. Equalises (5)
15. Formed in the islets of Langerhans (7)
17. Unbroken (6)
19. Old companion (5)
20. Capital of Egypt (5)
21. Auction item (3)

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

Vignette: diabetes researcher, John James Rickard Macleod (1876-1935)

BEFORE 1922 a diagnosis of diabetes mellitus meant certain death for many patients. That year a research team in Toronto managed to isolate a product of the pancreas key in the control of sugar metabolism and insulin* was first put into clinical use to treat diabetic patients. This team was led by a Scottish physician and physiologist named John James Rickard Macleod (JJR).

JJR was born in Perthshire, Scotland, the first son of Free Church minister Robert and his wife Mary. They moved to Aberdeen and he studied medicine at Aberdeen Marischal College. JJR graduated with Honourable Distinction in 1898 and went off to Leipzig to study physiological chemistry on a two-year scholarship. Restless, after only one year he returned to Aberdeen to study creatinine metabolism and then to London to demonstrate physiology at one hospital and to lecture in biochemistry and pathological chemistry at the Pathological Institute. He added a Diploma in Public Health to his accomplishments, published on a wide variety of subjects and at an unusually young age was appointed an external examiner in physiology at Aberdeen.

In 1903 he was appointed Professor of Physiology at the Western Reserve University in Cleveland, USA – he was only 27 and had just married his second cousin Mary McWalter. From 1906 he concentrated on carbohydrate metabolism. Claude Bernard (in France) had identified glycogen as the compound that stored sugar in the liver. Von Mering and Minowski had shown in 1898 that a dog whose pancreas had been removed would develop fatal diabetes. JJR confirmed this and thought it likely that a pancreatic secretion metabolised dextrose. Islet cells had been identified in 1869 by Langerhans. JJR reviewed the subject in a series of publications from 1907-1917 *Studies in experimental glycosurea* and in a monograph *Diabetes: its pathological pathway* in 1912. He was a good clinical observer of diabetes mellitus and an

established expert in carbohydrate metabolism.

During WW1 JJR was asked to work on gas masks and food preservation. In 1918 he published *Physiology and Biochemistry in Modern Medicine*, the first edition of a classic. War prevented him from visiting



Scotland and perhaps he had not felt comfortable as an expatriate in the USA so he welcomed a move to Toronto as Professor of Physiology.

In 1921 a young researcher named Frederick Banting came to JJR with a request for laboratory space to attempt to isolate a compound in the pancreas that was thought to control sugar metabolism. Experimenting first with dogs Banting was helped by medical student Charles Best. Others joined the team, including biochemist James B Collip.

JJR used his experience and encyclopaedic knowledge to guide the young team to rigorous proof of the existence and function of insulin. By the spring of 1922 a limited supply of purified insulin from ox and calf pancreas was in clinical use. JJR arranged

for insulin to be patented in Collip and Best's names. Eli Lilly was the commercial distributor in the USA. For the UK the Toronto authorities offered rights to the Medical Research Council.

The achievement earned Banting and Macleod the 1923 Nobel Prize for Medicine and Physiology but by then relations within the team had soured amid arguments over who deserved credit for the discovery. Banting shared his prize money with Best while Macleod shared his with Collip. Over time the acrimony in Toronto with Banting and his supporters became unbearable to the publicly reticent character of JJR, so he was delighted when he could step into the shoes of his teacher in the Regius Chair of Physiology at Aberdeen. He was also made honorary consultant physiologist to the Rowett Research Institute and the Torrey Fishery Station where he did more useful research on metabolism.

JJR was an eloquent and clear speaker and writer and received numerous invitations and honours: elected FRS Canada in 1918, London 1923 and Edinburgh 1932. He gave the Harvey Lecture in New York in 1914 and was President of the American Physiological Society for 1922-23. He gave his Nobel lecture in Stockholm in 1925 - *The Physiology of Insulin and its Source in the Animal Body*. Ill health in 1934 prevented him from giving the Croonian Lecture at the Royal Society. He died in Scotland the following year.

* The name insulin was chosen by JJR although he later apologised to Sharpey-Shafer in Edinburgh who had actually coined it earlier.

Source:
J. J. R. Macleod: *The Co-discoverer of Insulin* Michael J Williams. Proceedings of the Royal College of Physicians of Edinburgh July 1993 Vol 23 No 3 Supplement No. 1

■ Julia Merrick is a freelance writer and editor in Edinburgh

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