

AUTUMN 2013

SUMMONS

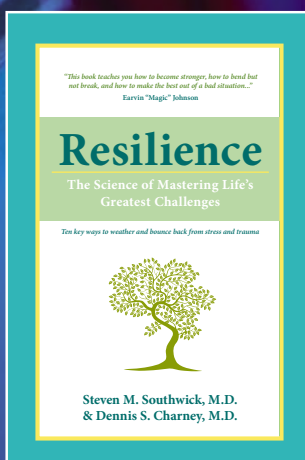
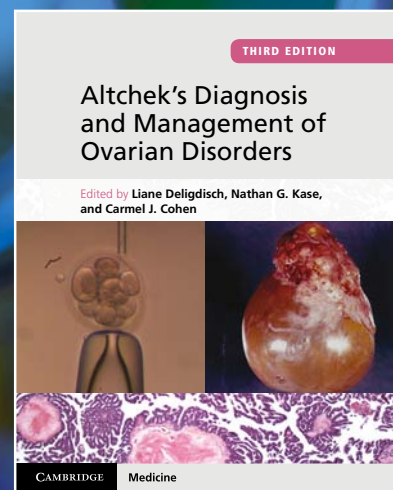
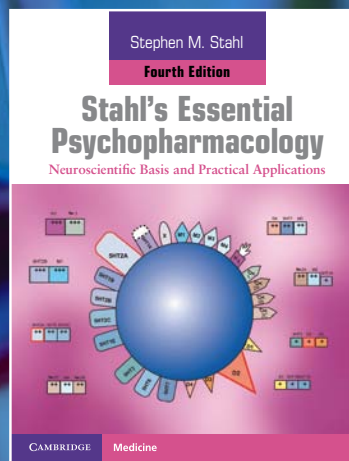
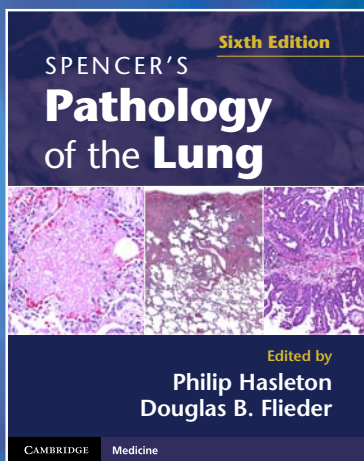
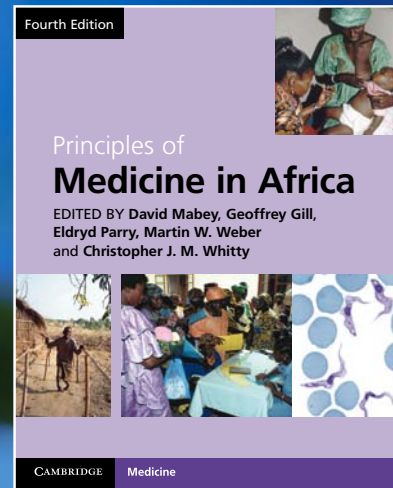
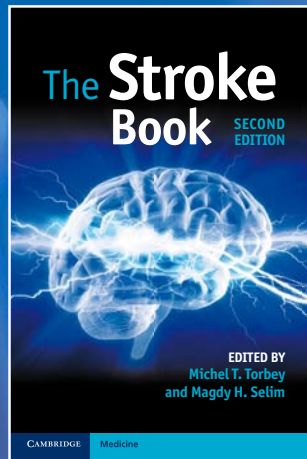
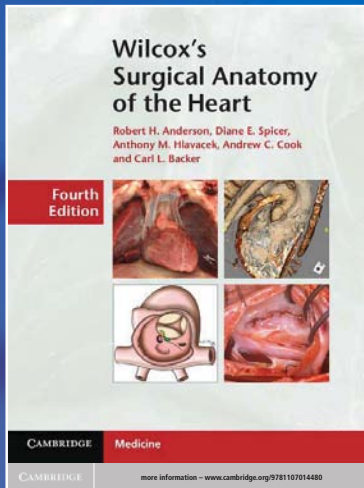
AN  PUBLICATION FOR MEMBERS



• Axing the totem pole • Presume nothing? • A good death •

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IN THIS ISSUE

IN 1977 two 747 airliners collided on an airport runway in Tenerife killing 583 people in one of the worst air disasters in history. The airport was blanketed in thick cloud and one of the pilots -- a highly experienced KLM captain -- began his takeoff without clearance from the tower. His copilot warned him that the flight had not been given clearance but despite further garbled communication with the tower the captain resumed takeoff. Neither the copilot nor the flight engineer challenged this decision and seconds later the jet collided with a Pan Am airliner.

It will never be known why the copilot neglected to challenge the captain a second time - but at least one positive outcome of the crash is that this story has become a case study in the risks of authority gradients in safety critical situations. On page 12 Dr Michael Money Penny looks at how all staff can be encouraged to challenge unsafe behaviour.

Also in this issue (page 16) GP and Macmillan facilitator,

Euan Paterson, offers the second of a two-part article on best practice in end-of-life care, considering not only clinical issues but also the fundamental need to demonstrate care. On page 14 MDDUS medical adviser Richard Brittain looks at the implications of the new Caldicott2 review on patient data in which the duty to share information is viewed to be as important as the duty to protect patient confidentiality.

In our Q&A on page 10 President of the Royal College of Physicians of London Sir Richard Thompson offers his view and that of the college on the future of hospital care in England in the wake of the Francis inquiry.

And on page 18 dental adviser Doug Hamilton observes how ensuring informed consent can be a trickier area than it might appear -- best to presume nothing.

Jim Killgore, editor



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Human factors expert Dr Michael Money Penny looks at the impact of authority gradients in the provision of safe patient care

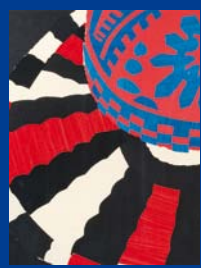
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Cover image:
Matt and bowl
by Pauline Burbidge

Award winning textile artist, Pauline Burbidge studied at London College of Fashion and St Martin's. Burbidge's work has been inspired by her love of fabric, colour and traditional patchwork quilts. She thinks of

herself as a designer, crafts person and textile artist using all these abilities on each individual piece.

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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Dental subs for direct access



DENTAL hygienists and therapists will be aware that from May of this year they can see patients without a prescription and without the patient having to see a dentist first (direct access). However, they must work within their scope of practice, be trained and competent in what they do, as well as being adequately and appropriately indemnified for this work.

The standard MDDUS subscription does not include cover for direct access and a supplement to the standard subscription will now apply, varying between £15 - £60, depending on your exact circumstances. Please contact Membership Services for further details at 0845 270 2034.

MDDUS launches new risk management service

MDDUS is currently developing new and innovative communication channels on risk management. The new service will be designed to help doctors, dentists and their wider healthcare teams manage and mitigate business and clinical risk.

It will be open to MDDUS members and

Reporting asbestos-related disease

CERTAIN specific categories of death must be reported to the procurator fiscal in Scotland. In its *Information and Guidance for Medical Practitioners* (2008), the Crown Office and Procurator Fiscal Service states that this includes "any death caused by an industrial disease or industrial poisoning". Similar regulations apply in England and Wales with reports made to HM Coroners.

Although in many cases there may be sufficient medical evidence to accurately diagnose an asbestos-related disease in life, the death must still be reported as "industrial" and it is the role of the procurator fiscal to investigate the death, examine the medical evidence and decide whether to instruct a post mortem.

If the procurator fiscal is not informed of a death, the opportunity to clarify the diagnosis by instructing a post mortem is lost. There can be legal consequences for the GP or healthcare professional in attendance at the time of death in these circumstances. Where a civil case for compensation is being pursued in respect of an asbestos-related disease, there can be difficulties in proceeding with a compensation case if the diagnosis given in life was not conclusive.

If there are conflicting medical opinions in a civil case, the case may not be able to proceed if there is not a post mortem report with retained tissue samples for further analysis. The only recourse open to the family of the deceased would be to establish why a post mortem was not instructed.

If a post mortem was not instructed because the death was not reported to the procurator fiscal by the attending healthcare professional, then the healthcare professional may find that a compensation case for loss of opportunity to pursue compensation is taken against them.

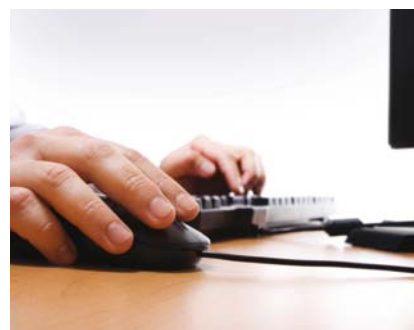
The importance of reporting a death that is suspected of being caused by industrial disease or industrial poisoning must not therefore be underestimated.

■ *Clydeside Action on Asbestos on behalf of Dr Audrey Finnegan*



will build upon our long history of helping doctors, dentists, practice managers and their teams improve the quality of processes, people and patient service. It is likely to include a variety of e-learning training tools, designed to help members reduce risk and enhance patient safety.

Check out the Risk Management section of mddus.com in the coming months for further details on our current and developing resources.



IN BRIEF

● **MDDUS 2012 ANNUAL REPORT NOW ONLINE** The MDDUS Annual Report and Accounts 2012 has been published on mddus.com. Among the highlights is a reported 8.8 per cent growth in active membership over the year 2012, the highest

yearly increase in a decade. Growth has again been mainly among GPs in England – with now an estimated 17 per cent of English GPs belonging to MDDUS. There was a 35 per cent rise in claims intimated against MDDUS members compared to

2011 and also an increase in "non-claims" referrals to the GMC and GDC. Calls to our medical advisory team also increased by 5.2 per cent. Total net assets for MDDUS grew by 273 per cent in the year.

● **HR SEMINARS** Law At Work

is running half-day seminars aimed at HR managers, line managers and small business owners – emphasising practical management skills, the impact of the law and useful tips and tricks for dealing with challenging people problems. Topics include

VIEWPOINT



Peter McDonald MS FRCS, Consultant Gastrointestinal Surgeon Northwick Park & St. Mark's Hospitals

Crisis in emergency care

SINCE GPs in England have been allowed to opt out of the out-of-hours care of their patients there have been several instances of inadequate treatment from emergency doctors. One highly publicised case at least would have led to manslaughter charges if the doctor had been resident in the UK.

As a general surgeon on emergency duty I witness the war-zone that is our accident and emergency department, crammed with the walk-ins, the critically ill and the just worried. Previously many of these cases would have been triaged by a trusted family GP who knew the patient well. A telephone call to the duty registrar would request admission, if appropriate, to the designated ward for investigation and treatment.

But now in my busy metropolitan hospital in England some patients appear to bypass the GP service altogether. Many are brought by their relatives straight up to casualty. There is the perception that the GP is no longer available at night and the logical

consequence is to cut out the middle-man. Needless to say after assessment by the surgical and medical teams, many do not have conditions that require hospitalisation.

However, when they are admitted into the hospital, they are squeezed into any bed available. Patients with pus-producing abscesses may lie alongside fractured hips. Those with agitated dementia may sleep close by youngsters with acute appendicitis. It is not surprising that being "on-take" is seen as a burden for surgeons and physicians, especially as emergency work has never attracted the financial rewards it deserves.

In these days of super-specialisation where generalists are a dying breed, it is all too predictable that many consultants want to leave this service to others to pursue their specialist elective interests. In my field of general surgery the breast surgeons and the vascular surgeons are leaving the general surgery on-call rota in droves as I write this. Only the gastrointestinal ones like me are left and we feel under great pressure as the NHS calls for all patients to be assessed by a consultant within hours of admission.

This weekend coming I will be in the hospital at 8am on Friday and will not leave until 9pm in the evening and then be expected to cover from home all night. I will repeat the same process on Saturday and Sunday and hope I will be fit enough to work in my outpatient clinic and operating list on Monday.

But all this is to change very soon. Suddenly has come the call to appoint consultant emergency surgeons and physicians to replace us all. In the old days we might have called these younger men and women senior registrars but these new doctors will not be temporary or moving on to easier climes. They will be both the bosses and the workhorses seeing both the simplest of cases and

operating on the most complex ones at the same time. To add an analogy from the airline industry it will be as if the pilot of the plane must fly it and serve the coffee at the same time.

Will all this lead to safer and better emergency care? I doubt it. I fear we are about to make the same mistake as the GPs as we allow our most highly trained consultants to opt out of the most dangerous and important group of patients, i.e. the emergency ones. And this is not just a surgical problem. The same is happening in general medicine and all the other acute specialities.

And what of the quality of the work of these new emergency consultants? They will work in shifts organised by bureaucrats. They will have few ties with the local medical community. They will be outside the mainstream culture of the hospitals they work in. Some may have been trained abroad and unfamiliar with the NHS culture they find themselves in. My judgment is that it will not take them much time before they seek a different sort of work.

Unfortunately I am not sure there is an alternative solution if the status quo is non-viable. The problem has always been with us. I remember a lecture I attended in 1975 by a Department of Health doctor. She headlined it - "Who will do the night work?" Today that would be transmogrified into "Who will cope with the emergencies?"

But now the culture of overwork is no more and we have yet to work out how 168 hours-a-week can be condensed into just 40 hours.

And why might this be of interest to the readers of *Summons*? Simply that it has long been known that emergency patients generate more medical negligence claims than elective ones. So even the MDDUS may one day feel the brunt of these impending changes that so worry an old surgical dog like me.

dealing with workforce stress and employment law. Go to www.lawatwork.co.uk/focus-on for more information. MDDUS members enjoy client rates on all training events.

● **2014 MDDUS PM CONFERENCE** The 2014 MDDUS

Practice Managers' Conference will be held 6-7 March 2014 at the Fairmont, St Andrews. Learn from the experience of one unlucky practice manager faced with a series of unfortunate events. Delegates will watch the drama unfold together

then explore the key issues through attending a series of four risk masterclasses. Click on the link on the mddus.com home page for more details.

● **ICO GUIDE ON SUBJECT ACCESS REQUESTS** A new

guide to help practices and other organisations deal with requests from individuals to access personal data has been published by The Information Commissioner's Office. Find *Subject access code of practice* at www.tinyurl.com/k6z6fy6



➔ Technology failures significant in OR errors

A SYSTEMATIC review of studies related to errors or adverse events in the operating room (OR) has found that nearly a quarter are due to equipment or technology failures.

Researchers at Imperial College London conducted full-text reviews on 28 studies and found that equipment/technology errors accounted for a median 23.5 per cent of total errors in the OR. In eight of the studies in the review it was possible to further categorise failures into equipment availability (37.3 per cent), configuration and settings (43.4 per cent) and direct malfunctioning (33.5 per cent).

The researchers found that those procedures relying more heavily on technology showed a higher proportion of equipment-related error. Checklists (or similar interventions) reduced equipment error by mean 48.6 per cent (and 60.7 per cent in three studies using specific equipment checklists).

The authors concluded: "There is clear benefit in the use of preoperative checklist-based systems. We propose the adoption of an equipment check, which may be incorporated into the current WHO checklist."

'Surgical technology and operating-room safety failures: a systematic review of quantitative studies' was published online in *BMJ Quality and Safety*.

➔ New updated GDC standards

THE GDC has published new updated standards for dental professionals.

Standards for the Dental Team sets out the conduct, performance and ethical standards that dental professionals are expected to follow at all times. It also sets out what patients can expect from dental professionals. If a complaint is made about a GDC registrant it is against the principles set out in this document that their behaviour/conduct will be measured.

GDC Standards for dental professionals was first published in May 2005 when dental nurses, dental technicians, clinical dental technicians and orthodontic therapists were not registered. The revised document takes account of these new registrant categories.

Among changes in the standards are stand alone principles on communication and personal behaviour, a greater emphasis on softer skills and new requirements to display indicative prices for treatment. The document is supplemented by a number of additional documents, including guidance on the use of social networking and guidance on reporting criminal proceedings.

Janet Collins, Head of Standards at the General Dental Council said: "Developing the new *Standards for the Dental Team* has been a lengthy and in-depth process.

We listened to what people said throughout the process and made key changes on the basis of that feedback. Each section of the new document includes the relevant patient expectations. We heard about the importance of communication from both patients and registrants and we now have a standalone principle on communication.

"Registrants also told us that they wanted more clarity and we have strengthened the language and included more prescriptive guidance. 'Must' and 'should' are used throughout the document so that registrants know exactly what we expect from them."

The standards and supporting guidance can be downloaded at www.gdc-uk.org.

➔ Proposed language checks

THE GMC will be given new powers to check the English language skills of any doctor before being allowed to practise in the UK under new draft proposals unveiled by the Department of Health.

In a consultation document the Government proposes that the GMC would carry out assessments before an overseas doctor is allowed to treat patients. The new checks would be enforced where the GMC has cause for concern about a doctor's language ability. This would apply to doctors from both in and outside Europe.

The new powers would also allow the GMC to assess a doctor if language concerns arise during a fitness-to-practise investigation – even if a doctor has been practising for some time. At present, the GMC has no power to require a doctor to undertake such an assessment during a fitness to practise investigation – regardless of nationality.

The GMC has also launched its own three-month consultation to seek views on changes which will allow it to check the language skills of doctors from the European Economic Area (EEA) when a concern is raised during their registration process.

Niall Dickson, Chief Executive of the General Medical Council, said: "The safety of patients must always come first. That means doctors wanting to practise in this country must be able to speak English clearly and

IN BRIEF

● **EARLY DETECTION IN ACUTE KIDNEY INJURY (AKI)** New NICE guidelines on AKI have the potential to save thousands of lives and many millions of pounds in care costs to the NHS. Acute kidney injury is seen in 13–18 per cent of hospital

admissions in the UK with significant related inpatient mortality. The new NICE guideline places emphasis on early detection of AKI before the condition becomes critical. Access at www.nice.org.uk.

● **UPDATED CHILD PROTECTION**

WEBSITE *Child protection and the dental team* has been relaunched following an update and re-design, and now puts greater emphasis on early intervention in suspected abuse. The updated website also addresses the impact of wider family issues on

children (such as parental mental health issues and domestic violence) and the guidance on dental neglect has been revised. Access at www.cpd.org.uk/

● **OUTDATED HIV BAN LIFTED** Doctors, dentists and other skilled

➔ New tooth whitening website

A NEW website that aims to educate the public and the dental profession on safe and legal tooth whitening was launched earlier this month.

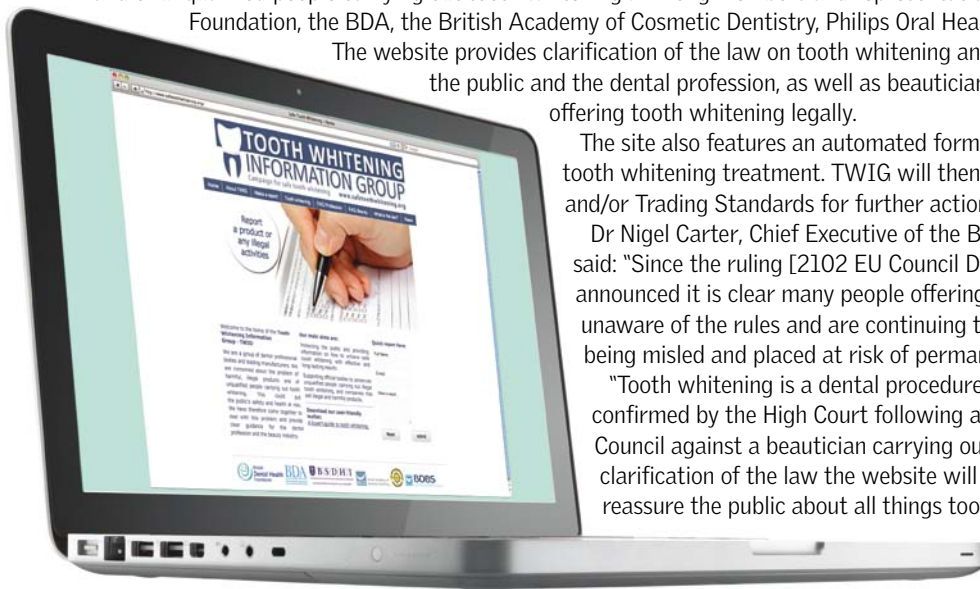
The website (www.safetoothwhitening.org) is the home of TWIG – the Tooth Whitening Information Group. This is a group of dental professional bodies and manufacturers who are “concerned about the problem of harmful, illegal products and of unqualified people carrying out tooth whitening”. Among members and representatives are the British Dental Health Foundation, the BDA, the British Academy of Cosmetic Dentistry, Philips Oral Healthcare and Henry Schein.

The website provides clarification of the law on tooth whitening and includes FAQ sections aimed at the public and the dental profession, as well as beauticians who may believe they are offering tooth whitening legally.

The site also features an automated form for users to report any illegal tooth whitening treatment. TWIG will then pass this information to the GDC and/or Trading Standards for further action.

Dr Nigel Carter, Chief Executive of the British Dental Health Foundation, said: “Since the ruling [2102 EU Council Directive on tooth whitening] was announced it is clear many people offering tooth whitening are still unaware of the rules and are continuing to practise illegally. The public are being misled and placed at risk of permanent damage to their teeth.

“Tooth whitening is a dental procedure. This has recently been confirmed by the High Court following action by the General Dental Council against a beautician carrying out tooth whitening. Following this clarification of the law the website will help to inform, educate and reassure the public about all things tooth whitening.”



communicate effectively. If a doctor cannot do this we should be able to prevent them from practising in the UK.”

More information at www.gmc-uk.org.

➔ Significant failings in sepsis care

NOT enough is being done by doctors and other healthcare staff to save the lives of sepsis patients, says the Health Service Ombudsman in England.

A new report highlights “significant failings in the diagnosis and treatment of severe sepsis” in 10 cases investigated by the Ombudsman where patients died.

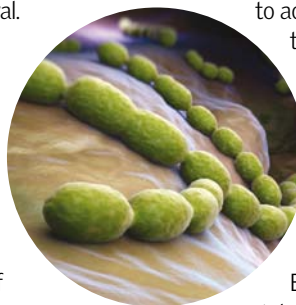
Sepsis accounts for 100,000 hospital admissions each year, with an average cost of about £20,000 each, according to the UK Sepsis Trust. Around 37,000 people are estimated to die of sepsis each year. The most common causes of severe sepsis are pneumonia, bowel perforation, urinary

infection and severe skin infections.

In its report the Ombudsman found that care failings seem to occur mainly in the first few hours after arriving in hospital, when rapid diagnosis and simple treatment can be critical to the chances of survival.

Among shortcomings noted were a lack of timely history and examination (including adequate nurse triage) on presentation, lack of necessary investigations, failure to recognise severity, inadequate first-line treatment and physiological monitoring of vital signs, and delay in source control of infection. The report also cites delays in senior medical input and a lack of timely referral to critical care.

Recommendations include improving the recognition of sepsis and treatment, along with improvements in auditing and research.



The Health Service Ombudsman, Julie Mellor, said: “In the cases in our report, sadly, all patients died. In some of these cases, with better care and treatment, they may have survived. It is time for the NHS to act to save lives by improving the care of patients with sepsis.

“We have worked closely with NHS England, NICE, UK Sepsis Trust and Royal Colleges to find solutions to the issues identified in our report. NICE and NHS

England have already agreed to take forward the recommendations of our report. We know it is not easy to spot the early signs of sepsis, but if we learn from these complaints and work to improve diagnosis and provide rapid treatment, then lives can be saved.”

Access at www.tinyurl.com/q3loc4u

healthcare workers undergoing treatment for HIV will be able to take part in certain medical procedures from which they are currently banned. CMO Professor Dame Sally Davies announced that outdated rules will be modernised

in line with the most recent science. The CMO also announced that people will be able to buy HIV self-testing kits once the kits comply with regulations. Removing the ban on the sale of self-testing kits will make it easier for people to get tested as

early as possible and get the best treatment available.

● **7,500 PLUS DOCTORS REVALIDATED** The GMC has announced that over 7,500 doctors have been revalidated in the first six months of its new system of

checks. By the end of this year the GMC expects to confirm that up to 30,000 UK doctors have revalidated. The aim is for the vast majority of the UK's 235,000 licensed doctors to go through the process by 2016.

WRITING A COMPLAINT RESPONSE

Dr Naeem Nazem

MOST doctors or dentists, at some point in their career, will find themselves either subject to a complaint or assisting in the investigation of a complaint. It is important to recognise a complaint as an opportunity for reflection and development, even if you feel you did everything right.

Complaints most often arise due to a breakdown in communication. It may be that the complainant misunderstood what they were told or felt they were not given enough information. Responding to a complaint is an opportunity for you to provide a further explanation of your actions and hopefully put the complainant's mind at ease. Our experience at MDDUS is that providing a comprehensive response to a complaint is much more likely to lead the complainant to feel that they have been heard and their concerns have been taken seriously. A detailed and carefully worded response is more likely to satisfy the complainant and

and are taking them seriously.

2. **Keep it factual.** Try to provide a factual chronology of events that relate to the concerns raised. You may be assisted by the relevant medical or dental records in writing a timeline of events.
3. **Apologise where appropriate.** Often acknowledging when things have gone wrong and saying sorry is enough to resolve a complaint. In *Good Medical Practice*, the GMC recommends that doctors should apologise when things have gone wrong. The law (Compensation Act 2006) also makes it clear that providing an apology in such circumstances will not be considered an admission of liability if there is a subsequent legal claim.
4. **Address every area of concern.** A complaint may raise queries about several events. It is important to review the letter of complaint carefully to ensure you have
5. **Don't forget the detail.** Remember to include all your positive and negative findings that led to your clinical management. Including what you looked for and failed to find is just as important in explaining why you reached a particular clinical decision.
6. **Highlight the source of your comments.** When writing your response state

responded to each concern. If there are numerous concerns, or they are very similar in nature, you can group them together and provide a more general response.

"Often acknowledging when things have gone wrong and saying sorry is enough to resolve a complaint."

dissuade them from referring their concerns to other bodies such as the GMC or GDC.

Here are some general tips on writing a good response. In addition you should contact an MDDUS adviser directly for advice on wording and content before sending your response.

1. **Keep it conciliatory.** A complainant may be upset and angry. It is important not to antagonise them further by appearing dismissive or offended by their complaint. Adopting a more polite and conciliatory tone is more likely to make the complainant feel you have understood their concerns

whether each significant comment you make is based on your personal recollection of events, reading of the contemporaneous records, or usual practice. You may find it helpful to use phrases such as "I can remember..." or "From the medical records I note that..."

7. **Write in the first person.** This will provide a more personal style and show the complainant that you are responding to their concerns. For example, instead of writing "It was noted during the consultation that..." try re-phrasing to something along the lines of "I noted during our consultation..."
8. **Avoid jargon.** Although abbreviations are commonly used between healthcare professionals, they are often misunderstood or misinterpreted by patients and their relatives. Your response should be easily understood by any member of the public. You should therefore avoid the use of medical/dental abbreviations and acronyms. It is also helpful to explain any observations or results (for example a blood pressure recording or laboratory result) so the complainant understands its significance.
9. **Avoid speculating.** It is important to restrict your comments to matters of fact within your own scope of knowledge. Try and avoid speculating or criticising the actions of other healthcare professionals in your response.
10. **Offer to meet.** Some complainants may have further queries arising out of your response or feel you have not addressed a particular matter fully. Consider ending your letter with an invitation to meet with the complainant should they have any outstanding concerns once they have read your response. You may also want to provide the contact details, for example of your practice manager or secretary, with whom they can arrange an appointment to meet with you.
11. **The ombudsman.** Complainants are entitled under the NHS complaints procedure to refer their concerns to the relevant health service ombudsman if they remain dissatisfied at the conclusion of local resolution. The NHS complaints procedure recommends that complainants are advised of this right. You might therefore consider including a final paragraph in your letter providing the contact details of the relevant ombudsman.

■ Dr Naeem Nazem is a medical adviser at MDDUS

TOO GOOD TO BE TRUE

Deborah Bowman

I RECENTLY completed a series of psychometric tests and attended a feedback session to receive my results. Among some of the points to emerge was a suggestion that I am perhaps “too trusting”, along with a “strong preference for taking time to consider her choices” and “scoring unusually highly on sensitivity”.

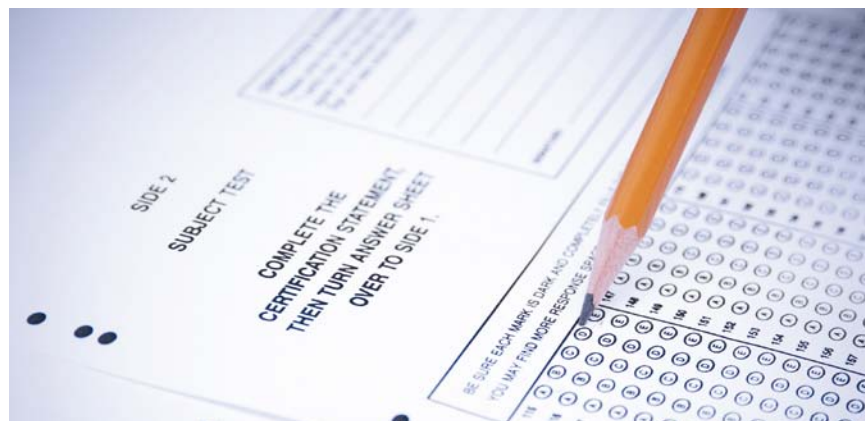
The patient woman charged with explaining such results to an inquisitive academic noted, in passing, that my profile may be helpful in pastoral work or caring roles but might be a hindrance in situations where performance management or difficult and time-sensitive decisions are required. In other words, “trusting” could be considered naïve, “thoughtful” might manifest as ponderous and “sensitivity” may appear as fragile.

The fact that I accepted the results and have ruminated on their meaning suggests that at least two of the characteristics attributed to me – being trusting and preferring to think at length about things – have been accurately captured despite my best efforts to resist definition by data. And, the experience has prompted me to reflect more on a particular approach to ethics, namely virtue ethics.

As some readers will know, virtue ethics is an approach in which particular characteristics or traits are identified as desirable and likely to lead to positive moral outcomes. It is an ancient philosophy, described by Aristotle who argued that the pursuit of *Eudaimonia* or human flourishing was the proper function of “living well”. In a virtue-based approach, the human and relational aspects of healthcare practice are acknowledged and emphasised. Thus it is that virtues such as integrity, compassion, fairness, humility and respect are prioritised to inform the moral choices and behaviour of clinicians.

Irrespective of the issue or moral problem at hand, clinicians, it is argued, should strive to respond in a virtuous way in which they attend as much to the process of a response as to its content. It is an approach that can equally well elucidate the moral dimensions of routine clinical practice as well as significant questions of life and death.

As with any ethical theory or philosophy,



“The notion of the unquestionable virtue is contestable: almost all virtuous traits have the potential to become damaging if they are excessively developed or inappropriately applied to a situation.”

a virtue approach has its limitations. For some, it might suggest a sense of “motherhood and apple pie” in which positive attributes or traits are offered as meaningless or even patronising panacea to any ethical question or moral challenge. For others, the complexity and context that inform the definition of the virtues renders it a frustratingly slippery and relativist approach to moral reasoning. For those interested in exploring virtue theory, I recommend the work of Alasdair MacIntyre and Christine Swanton. For those seeking a better understanding of how virtue ethics might shape the work of a practising clinician, Peter Toon’s writing on virtue and general practice is excellent.

Following my encounter with the post-psychometric test feedback process, I am reminded that most virtues, if unchecked or applied indiscriminately, can become if not vices, then a hindrance. Research profiling practitioners who find themselves in difficulty at work (such as that led by Jenny King of Edgecumbe Health for the National Clinical Assessment Service) reveals that these are not, for the most part, dysfunctional or “bad” people set on causing problems. Rather, it is often the case that desirable characteristics have become problematic when the practitioner has encountered difficulties or stressors. As such, conscientiousness becomes critical perfectionism, thoroughness turns into inflexibility, sensitivity develops into brittleness and altruism yields to burnout.

The notion of the unquestionable virtue is

contestable: almost all virtuous traits have the potential to become damaging if they are excessively developed or inappropriately applied to a situation. But surely, you may be shouting (if shouting at magazines is something you do), there are some virtues that are inherently desirable. I have, as befits a woman who tends to think too much, been ruminating on this question for some time over the summer. I’ve concluded that it is difficult to identify such a trait.

My favourites for the title of ‘most inherently desirable virtue, 2013’ are wisdom and sincerity. Why so? I think it is because these are two virtues that capture not merely characteristics but also particular behaviours. Wisdom implies, to me, judgement based on an awareness of self, others and experience. It encompasses ideas of discretion and flexibility depending on context and circumstance. Similarly, sincerity, for me, suggests an engagement with others and care that is authentic and responsive. It is a virtue that recognises that the personal and the professional always coalesce in clinical relationships. Sincerity demands that the professional is present both physically and otherwise. It is the bedrock of caring.

So, whilst you may never take a psychometric test, what characteristics do you have that might be considered virtuous, or maybe even too virtuous? And are we all sometimes too good to be true?

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

Addressing Francis

President of the Royal College of Physicians of London Sir Richard Thompson offers his view of the future of hospital care in England in the wake of the Francis inquiry

IN September the Royal College of Physicians of London published its full response to the Francis inquiry into failings at the Mid Staffordshire NHS Foundation Trust. Perhaps no organisation has more to say in the wake of the inquiry than the RCP, with many of its members and fellows certain to be directly involved in any reform of hospital services in England. One key figure in formulating the RCP response was the College's president, Sir Richard Thompson.

Sir Richard has been in that post since 2010 and prior to that was the RCP treasurer. He trained in natural sciences and medicine at Oxford and St Thomas' Hospital Medical School, and worked as physician and gastroenterologist at St Thomas' Hospital until his retirement in 2005. He also ran an active clinical research laboratory for over 30 years.

[How has the RCP contributed to the Francis inquiry?](#)

The Royal College of Physicians was a core participant and attended the inquiry almost every day. We gave detailed written evidence, and the RCP's Registrar, Dr Patrick Cadigan, also gave oral evidence.

On 3 September the RCP launched a 35-page response, detailing the actions the RCP will take in future to address the concerns of the final report of the inquiry. The actions cover standards, education and training, commissioning and information. We also included challenges to other stakeholders that are crucial to raising quality in the NHS.

Also, as a result of our close involvement, the need to address the concerns raised by the inquiry has been a touchstone in developing our other health policies over the past two years, and was one of the reasons I decided to set up an independent Future Hospital Commission in March 2012 to improve the care of medical patients. Its report, *Future Hospital: Caring for medical patients*, was published on 12 September and its recommendations place the patient experience back into the heart of healthcare.

[The Francis report highlighted failures of leadership and a 'lack of ownership' in dealing with problems at all levels.](#)

[How can this best be addressed on the ward?](#)

The RCP believes that more and better clinical leadership is the key to adopting a culture throughout the NHS that delivers high-quality care for patients. All doctors are leaders; they all manage patient care, and registrars and consultants manage clinical teams.

The RCP already does a great deal to develop leadership competencies among doctors, via the Joint Royal Colleges of Physicians Training Board (JRCPTB), which works to ensure that leadership is part of doctors' curricula, and in partnership with the Academy of Medical Royal Colleges to ensure that elements of leadership are part of the curriculum for physicians. We also run a number of medical leadership training and education programmes for both senior and junior doctors. These include an MSc in Medical Leadership, specific programmes for educational supervisors and programmes directed at senior trainees.

The RCP supports the concept of a single responsible clinician for each patient. In future, we shall improve the emphasis on leadership within doctors' training and continue to work to engage doctors in leadership training above and beyond what they learn in their curricula. We shall also seek to ensure that leadership competencies are developed around the needs of the vulnerable, including older patients.

[Do you think there is a need for a statutory duty of candour?](#)

The RCP supports the principles of a duty of candour, which doctors already have as part of the requirements of their registration with the GMC. The RCP recommends that patients and carers should receive an explanation or an apology from the responsible doctor early on in the complaints process, which would help to avoid litigation in most cases. In fact, the RCP recommends there being two patients and an elected doctor on trust boards, who would be responsible for ensuring that the board are aware of, and address, concerns. The RCP is working with the government and other relevant stakeholders on the development and implementation of the duty of candour policy.



How can the problems highlighted in the Francis report be addressed by training and realigning the specialist mix?

The RCP is currently reviewing doctors' education and training to ensure that it will continue to meet patients' needs as they change in the future, such as those due to demographic changes. Indeed, many of the problems identified by Francis relate to the care of frail older people – a rising population in hospitals.

More physicians need to train in (general) internal medicine to be able to manage the growing number of patients with multiple long-term conditions; to do this, the specialty needs to be more attractive to trainees. Doctors dealing with acutely sick patients need to have a broad knowledge base from which to practise, for otherwise they may admit more people to hospital 'just to be safe'. While this is often appropriate behaviour, it has undesirable and unintended consequences both for bed occupancy, costs and exposure to the risks of being in hospital.

The RCP believes that doctors should be trained to lead on holistic care, including taking responsibility for aspects such as compassion, dignity, pain relief,

hydration and nutrition. More (general) internal medicine experience in different settings may help to deliver this.

An RCP survey reported that 28 per cent of consultant physicians rated their hospital's ability to deliver continuity of care as poor or very poor. How best to address this problem?

The publication *Future Hospital: Caring for medical patients* recommends that care should be organised to maximise the continuity of care provided by the individual consultant physician and key members of the clinical team, with staff rotas organised to deliver this. Once assessed in hospital, patients should not move beds unless their clinical needs demand it. When a patient is cared for by a new team or in a new setting, arrangements for transferring care (through handover) will be prioritised by staff supported by direct contact between staff, and information captured in the electronic patient record. Physicians will provide continuity not only during the hospital admission, but also embed this into follow-up consultations and arrangements.

How are the demands of patients changing?

Patients admitted as emergencies are particularly likely to be older and have two or three co-morbidities, which makes their care more complicated. Patients and their families are also rightly more critical of poor care or a poor experience for themselves or their relatives.

How do you think the NHS could better ensure dignity and patient-centred care among hospital staff?

There should be a named consultant responsible for the care delivered to each patient, every day, who should work with a ward manager and assume joint responsibility for ensuring that basic standards of care are being delivered, and that patients are treated with respect, compassion, kindness and dignity.

What do you see as the key challenges facing NHS hospital care now and in the future?

As set out powerfully in our 2012 report *Hospitals on the edge?*, our hospitals are struggling to cope with the challenge of an ageing population and increasing hospital admissions. The report described the systematic failure to deliver coordinated, patient-centred care, with patients forced to move between beds, teams and care settings with little communication or information sharing. The NHS struggles to deliver high-quality services across seven days, particularly at weekends, and there is a looming crisis in the medical workforce, with consultants and medical registrars under increasing pressure, and difficulties recruiting to posts and training schemes that involve general medicine.

Add to that the imperative to reduce NHS funding overall, and it is obvious that we need the kind of radical change envisioned by the Future Hospital Commission.

■ Interview by Jim Killgore, editor of *Summons*

Axing the totem pole

Are you afraid to challenge decisions by senior colleagues – or to acknowledge challenges from juniors? Here Dr Michael Money Penny asks doctors to consider the consequences of authority gradients

IN 1999 the Institute of Medicine – an American medical NGO – published an influential paper entitled ‘To Err is Human’ in which it reported that between 44,000 and 98,000 people die in the US every year due to preventable medical errors. The paper led to a push for patient safety in the US with the goal of a 50 per cent reduction in errors over the next five years.

Sadly this goal has yet to be achieved but the paper is also notable for the first mention in the context of healthcare of a term more commonly associated with the aviation industry – *authority gradient* (AG). The IOM paper called for the need to “develop a working culture in which communication flows freely regardless of authority gradient”.

Today authority gradients are much discussed in connection with patient safety. A seminal paper on the subject written in 2004 defined authority gradient as “a significant difference (between two people) in experience, perceived expertise, or authority”¹ (see diagram). The terms “power gradient” and “power distance” are also used interchangeably with AG.

Just as the authors of the 2004 paper make clear, it is important to keep in mind that the AG is a perceived gradient. It may be that a person has a great amount of authority over another, but the actual authority gradient may be shallow and dependent upon how the two people interact over time.

As all of us who work in healthcare appreciate, the various professions (medicine, nursing, midwifery, etc) are hierarchical and authority gradients exist in many of our daily interactions. AG is important, both as a concept and as a term to add to our vocabulary, because it is a major cause of morbidity and mortality in healthcare.

AGs are important

A child is admitted to the emergency department with chickenpox. One of the doctors is concerned that the child is developing a life-threatening complication. He shares his concern with a senior doctor, but his senior tells him to send the child home. The child dies later that night due to varicella complicated by streptococcal fasciitis.

A junior doctor is pressured by his senior to administer intrathecal vincristine. Despite voicing his concerns and against his better judgment the junior carries out the injection. The 18-year-old patient dies.

A medical student tells two surgeons she thinks they are operating on the wrong side. The student is ignored and the healthy kidney is removed. The patient dies a month later.

In a simulator-based study more than 50 per cent of anaesthetic trainees administered blood to a Jehovah’s Witness at the instigation of a consultant, despite knowing that the “patient” did not wish to receive blood.

These are all real examples where harm or potential harm resulted from a steep authority gradient. Put bluntly, steep authority gradients mean that those who consider themselves subordinate will not speak up or will too readily acquiesce to a senior’s demands. The result is patient harm.

Challenging unsafe behaviour

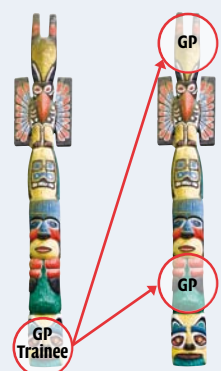
Steep AGs are dangerous because they may lead to an unwillingness in subordinate staff to challenge a superior’s poor or erroneous decisions. A number of practical tools have been developed to provide a standard, step-wise approach to challenging unsafe behaviour. One such tool is **PACE** in which concerned staff are encouraged to follow four steps:

1. **Probe:** ask for information or clarification.
2. **Alert:** point out why you are concerned.
3. **Challenge:** Openly disagree with a given decision or action.
4. **Emergency:** Act to stop the given decision or action.

Another tool from the aviation industry now being promoted in healthcare is the two-challenge rule. This involves three steps:

1. **Challenge the decision or action.** If not happy with result then:

Steep and shallow authority gradients





2. Challenge the decision or action again. If not happy with result then:

3. Act to stop the decision or action.

Other mnemonics for providing a framework (as opposed to a stepwise approach) to challenging an action or behaviour include:

- CUSS: I am Concerned. I am Uncomfortable. This is a Safety issue. Stop.
- DESC: Describe the behaviour. Express your concerns. Suggest an alternative. Consequences are stated in terms of impact on patient or team.

AGs and a safety culture

Most of what you have read so far looks at AGs from the subordinate's perspective. There are also steps which the senior can take to ensure that AGs do not prevent people from speaking up about unsafe practice. The first step is to acknowledge AGs exist and that the senior's perceptions of the steepness of these gradients often do not match that of their subordinates. In a 2011 study conducted by researchers in the US, 100 per cent of senior surgeons felt that juniors could question their decisions while only 55 per cent of their juniors agreed².

It may be useful (and eye-opening) to carry out anonymous surveys of the employees at your place of work with questions such as:

- Do you feel able to speak up about things which may impact on patient care?
- Are you afraid to ask questions?
- Do you feel able to question the decisions of those with more authority?
- Have you ever seen a mistake which could have harmed a patient but did not speak up about it?

Additionally it may be useful for the senior person to admit to errors made in the past in order to show junior personnel that no one is infallible. Lastly, the IOM report and a number of other studies have emphasised the utility of simulation-based team training in reducing authority gradients and improving teamwork.

Shallow authority gradients

AGs are not all bad; without any kind of AG, roles may become blurred and decisions cannot be made. In the Scottish Clinical Simulation Centre (SCSC) poorly performing teams often lack leadership because participants at a similar level of training may fail to establish an authority gradient. Teams must therefore aim for an optimum AG where effective, timely decisions can be made and followed, while allowing for the possibility of challenging decisions by any member of staff.

Sharpening the axe

Some may wonder how we develop a safety culture which acknowledges authority gradients and appreciates their necessity, while ensuring that they are only as steep as they need to be. It is the responsibility of both ends of any authority gradient to ensure that patient care can still be effective, efficient and safe. This will take courage: juniors must have the courage to speak up and seniors must have the courage to allow their authority to be challenged.

In their 2012 paper 'How can leaders influence safety culture?', Michael Leonard and Allan Frankel state that "culture is behaviour over time..." The behaviour of healthcare personnel creates the culture we all want to see. Just as importantly, we are all or will become patients of the healthcare system one day. Why not make it as safe as possible now? Let's bring down those totem poles.

■ *Dr Michael Money Penny is a consultant anaesthetist and expert in the field of human factors in healthcare. He is also director of the Scottish Clinical Simulation Centre*

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Is sharing caring?

In April of this year the Caldicott2 review was published urging a new approach to sharing patient information. Here MDDUS medical adviser Richard Brittain highlights some of the key recommendations

SIXTEEN years ago the chief medical officer of England commissioned a review of NHS information governance to be headed by Dame Fiona Caldicott, a former president of the Royal College of Psychiatrists. It was to address, among other issues, the rapid development of information technology and concerns over data protection and a perceived threat to patient confidentiality.

In December of 1997 the Caldicott review was published and in subsequent years has had a profound effect on medical information governance. It established six key principles of data management and created the role of 'Caldicott Guardians' – individuals whose responsibility it is to apply these precepts within healthcare organisations.

Last year the Government asked Dame Fiona Caldicott to revisit the subject as part of the Future Forum's recommendations on NHS reform. There was an impression that the philosophy surrounding information sharing had changed over the preceding years, with the medical world becoming more nervous and reluctant to share appropriate information. It was also recognised that the nature of data technology had changed along with the public's expectation of access to their data.

This is the context to Caldicott2, a new 140-page review that was released in April 2013, addressing appropriate sharing of health information in England but with principles widely applicable across the United Kingdom.

In September the Government published its response to Caldicott2. Most of the recommendations were accepted and the document set out how these are to be implemented.

In the Government's response, Health Secretary Jeremy Hunt said: "In the past,

information governance rules have prioritised systems over people. Too often they have been seen as an insurmountable obstacle and an excuse to avoid sharing information. We outline a new approach here."

It's good to share

A prime motivation behind Caldicott2 was a growing impression within the NHS that the 1997 review was being used as a reason for not sharing information. To address this concern the emphasis of Caldicott2 is that appropriate sharing of information should be the rule, not the exception.

One area of confusion addressed is the model of implied consent to the sharing of information between healthcare professionals. This principle is not challenged but patients' understanding of how information is shared is questioned. In order to use the implied consent model on an ongoing and legitimate basis, the review concludes that patients should be better informed as to how their information is used in the healthcare setting. This information might be included in a practice's 'new patient' leaflet, for example.

In its response the Government agrees and proposes that a 'consent management standard' should be developed which will be applicable across all NHS and care systems in order to record decisions regarding disclosure consent. How this will work in practice is not yet clear.

The review also recommends that a standard template sharing agreement should be published by the Department of Health in order to reduce duplication of effort within the NHS. However, familiarity with standard consent forms should not result in a lack of consideration of the appropriateness of each request.

A reluctance to share data between public and private organisations and between local authority and healthcare bodies is also addressed within the review. This reluctance is not warranted where data protection principles are appropriately applied by both parties. The Government is quite clear in its intentions to encourage sharing between health and care bodies. So much so that part of the recently announced £3.8 billion Integration Transformation Fund must be used locally to enhance data sharing.

Other issues

How to handle standard third party



information is addressed in detail within the review. This includes information about another individual (e.g. family history) and from another identifiable individual (e.g. a family member giving information about a patient). This information may itself be confidential and should not necessarily be disclosed to the patient, even though it is contained within that patient's medical records. The review recommends that third parties should be told that their identity may be apparent if notes are disclosed and be given the opportunity to decline to provide information.

The issue of preventing inappropriate disclosure to bodies such as insurance

companies is also covered, including safeguards to minimise such disclosure. Current legislation and guidelines require that only the minimum necessary information is sought and that disclosure should be appropriate and relevant. As such, the generation of automated reports would usually include too much information. Doctors should be confident that any consent is properly informed, meaning that the patient knows what information will be provided, to whom and for what purpose.

The review highlights the Health and Social Care Information Centre's controversial role in patient data analysis. The importance of being able to opt out from this type of data sharing is emphasised, although how this is to be achieved is yet to be seen. A code of practice is currently being developed. Other issues addressed in the report include lack of data sharing as a major factor in child protection failures and the limiting of automatic parental access to the records of children over the age of 12.

Training in information governance is seen as crucial in the review. The issue of 'tick-box' training is discussed and the feeling that such training does not involve education. The panel recommend that professionals should be educated in aspects of information governance which are relevant to their clinical focus, with specific focus on appropriate information sharing.

Data breaches

While emphasis is on the sharing of data, the review does consider the issue of inappropriate disclosure and information release. The Information Commissioner's power to impose civil monetary penalties (fines) on organisations for data protection breaches has been prominently reported in recent months. The review seeks to allay this fear by pointing out that no fine has yet been imposed on an organisation for the "formal" sharing of information between data controllers (as opposed to the inadvertent loss or disclosure of data).

In the period of June 2011 to June 2012,

186 serious data breaches were reported to the Department of Health. Two-thirds of these breaches related to data loss or theft. The review recommends that every organisation publishes details of any breaches on an annual basis. The Government acknowledges in its response that local care providers may be too small to produce annual reports and sets out that commissioners should "deal with data breaches".

The review highlights the prominent issue of inappropriate data disclosure through "blagging". This is where information is sought by a third-party, ostensibly acting as another healthcare professional or family member. Despite NHS guidance dating back to 2003, this type of disclosure still occurs. The review recommends that individuals should be informed when a breach has occurred and offered an explanation and apology. Local policies should be put in place in order to avoid inappropriate disclosures, for example including a requirement to confirm a fax number from a second source (such as a practice website) before sending any confidential information.

Confidence to share

In summary the Caldicott2 review panel states that health and social care professionals should have the confidence to share information in the "best interests" of their patients. This is an interesting choice of words as this term is usually associated with patients who lack capacity to make decisions. This is clearly not the intention of the panel but it highlights the importance of careful wording when it comes to making data-sharing decisions.

The ultimate outcome of the review is that the six pre-existing principles have been updated and a new sharing information principle has been incorporated: "The duty to share information can be as important as the duty to protect patient confidentiality".

■ *Dr Richard Brittain is a medical adviser at MDDUS*

A good death

In the second article of a two-part series Dr Euan Paterson considers not only clinical issues for patients at the end of life but also the fundamental need to demonstrate care

In the first part of this article we looked at advanced care planning in dying patients. Here we consider clinical competencies in quality end-of-life care – and more.

Perhaps the first matter of importance in caring for patients near the end of life is considering what the near future holds for each individual. This is a combination of probability and possibility. Consider for instance the elderly frail co-morbid care home resident with advanced dementia who is very likely to develop infection, or the patient with advanced COPD or lung cancer who is likely to become increasingly breathless. Recognising these likelihoods enables at least some degree of anticipatory planning.

Thinking about less likely possibilities can also lead to more proactive care. The patient with advanced prostate cancer and spinal metastases might develop malignant spinal cord compression, and warning the individual of the early symptoms could mean the difference between ambulatory continence and bed/chair bound incontinence for the last months or, indeed, years of life – massive quality differences.

This process is really no different from how the care of all patients should be approached: just a simple extension of basic healthcare principles into the end-of-life period.

Frameworks and pathways

A number of systems and processes have been introduced to guide end-of-life care – some more helpful than others. One very useful primary care tool is The Gold Standards Framework Scotland (GSFS) developed by Professor Keri Thomas. To some extent it has been superseded by the Palliative Care Designated Enhanced Service, which is perhaps unfortunate as the GSFS has a huge amount to offer. Indeed, for healthcare professionals working in any care setting its simple '7 Cs' approach provides an ideal, loose non-prescriptive framework

for palliative/supportive care. The 7 Cs of the GSFS are: communication, co-ordination of care, control of symptoms, continuity of care, continued learning, carer support and care of the dying (patients in the last few days of life).

Another helpful process for GPs to consider in community settings is Just in Case (JiC) prescribing, which involves early provision of medications that dying patients are likely to require. For example, few patients will be able to swallow in the last few days of life and so subcutaneous medications should be considered. JiC prescribing with information support tools within GP clinical systems and dedicated JiC paperwork and containers have been shown to prevent significant delays in treatment.

Common symptoms needing medication that can be anticipated are pain (opioid), breathlessness (opioid and anxiolytic), nausea and vomiting (anti-emetic), respiratory tract secretions (anti-secretory) and terminal restlessness (anxiolytic). It is important to remember also to provide complete instructions for administration. Palliative care specialists can be consulted if any extra advice is needed. Patient/carers should also understand whom to contact in the event of symptom deterioration or swallowing difficulties as this may reduce call-to-treatment time from several hours to as little as 15-30 minutes.

Closely linked to JiC is the consideration of route of administration and syringe pump use. If patients are requiring non-enteral treatments then early consideration of a syringe pump can help ensure good symptom relief with minimal patient disturbance.

In the community, appropriately trained registered nurses provide verification of expected death in the out-of-hours period. This simple system provides a more rapid service and can have increased continuity for the relatives/carers.

Unwanted interventions

Scotland's national Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy was introduced in 2010 and similar policies have been established across the UK. In the context of palliative care they aim to ensure that futile and unwanted interventions are not attempted and thus the patient is allowed a natural death. It is helpful to consider the individual steps in the Scottish framework.

Firstly, is a cardiopulmonary arrest anticipatable? In a community setting it is possible that any death could be considered a cardiopulmonary arrest and so it is important to consider this in all dying patients.

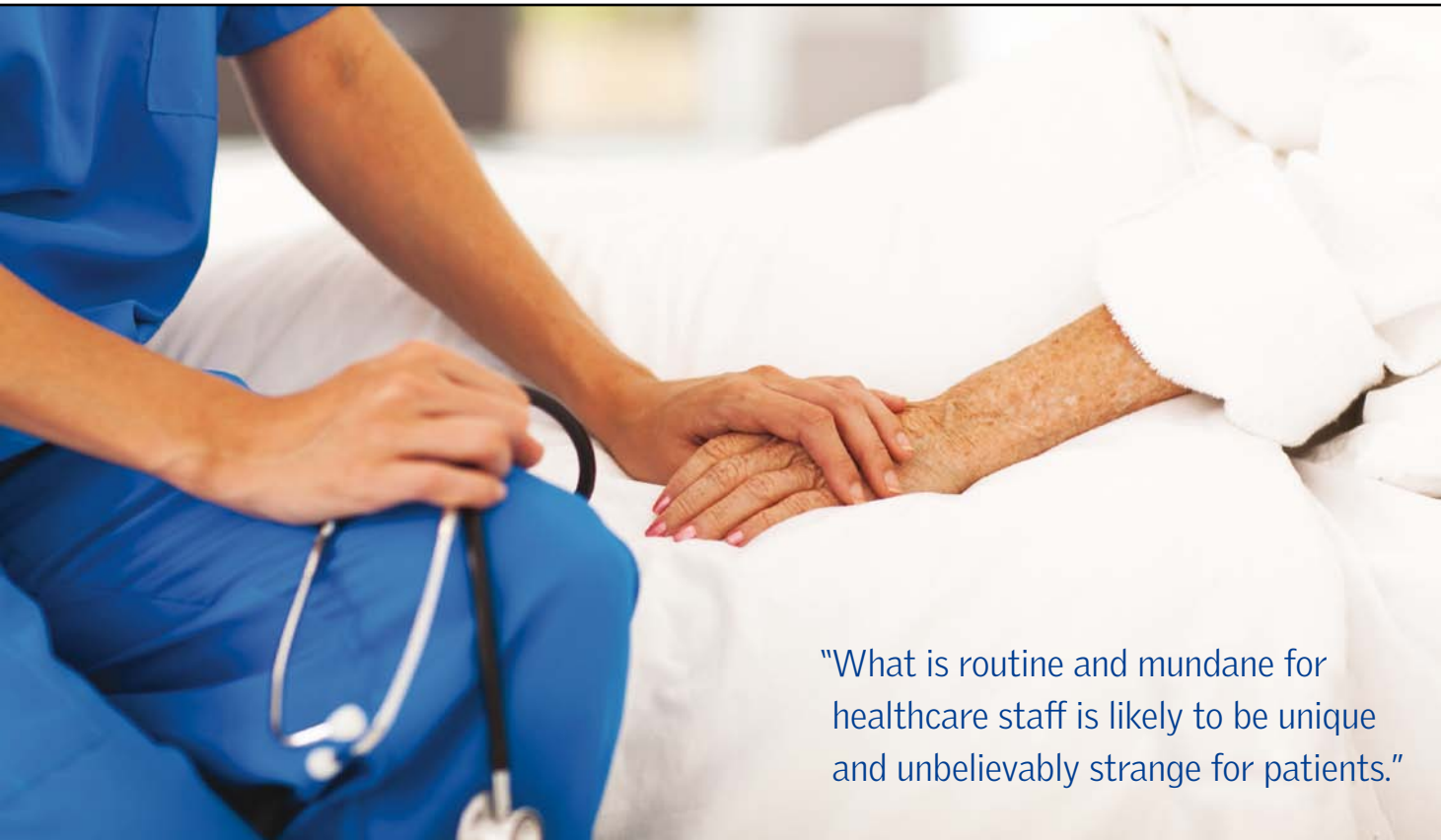
Secondly, is CPR likely to have a successful outcome? CPR that is judged likely to be a futile intervention should not be offered. This is a clinical decision arrived at by the team caring for the patient and it does not involve the views of the patient or their loved ones though the decision should be communicated in a sensitive and compassionate fashion. However, if it is felt that CPR might have a successful outcome then communication is essential as the decision lies solely with the patient.

The DNACPR decision should be documented on the proper form which should be reviewed regularly and whenever there is any significant change in the patient's condition or the locus of care. It is crucial that all conversations around DNACPR are in the context of trying to ensure a good and dignified death.

Patients and their families/loved ones need to be aware that this policy only deals with attempted CPR and not any other possible interventions that could be seen as resuscitative. It is very important that the CPR/DNACPR decision is communicated to all those who need to know.

Communication between professionals

Clearly good communication between the



"What is routine and mundane for healthcare staff is likely to be unique and unbelievably strange for patients."

various professionals involved in the care of the dying patient is vital. In Scotland both the electronic Palliative Care Summary (ePCS) and the Key Information Summary (KIS) facilitate information transfer (including DNACPR orders) from in-hours general practice to other services including out-of-hours primary care services, acute services such as accident and emergency departments and receiving units and the Scottish Ambulance Service.

It must be borne in mind though that this is fundamentally a unidirectional transfer of information "written to" only by in-hours primary care and "read only" in all other settings. This coupled with the total absence of information provided by the patient or their family/loved ones means that it can unfortunately not be considered as an anticipatory care plan – an all too frequent misconception.

Showing you care

Apart from the clinical competencies and processes outlined above, the importance of not just caring but demonstrating caring cannot be overemphasised. Dying patients and their loved ones are extremely vulnerable and good trusting relationships between all those involved are crucial to their wellbeing.

There are two key issues that promote a trusting relationship. Firstly, the patient has to think that the professional is competent. Secondly, the patient has to feel that the professional genuinely cares. It is hard to

think of any time more critical than the end of life when it is important to demonstrate not just caring for the patient but about the person – the need for compassion, the need to recognise the humanity in the individual under their care.

Why does "lack of compassion" feature so frequently in patient complaints? It is unlikely that most doctors lack the interpersonal skills necessary to demonstrate that they care. Perhaps the answer lies within the attitudinal domain. Do doctors remember the vulnerability that patients are likely to be experiencing? In palliative care the patients are, as the late Professor Kieran Sweeney says in a uniquely moving YouTube video clip, "at the edge of the human predicament".

This is likely to be far removed from where doctors are in their own lives. What is routine and mundane for healthcare staff is likely to be unique and unbelievably strange for patients. The need to empathise underpins compassionate care. To metaphorically put on the patient's shoes and walk about in them – think what they might be thinking and feel what they might be feeling – will afford a glimpse of the patient's likely vulnerability. All doctors will have some experience of vulnerability and trying to remember how that felt will lead to more compassionate care.

Demonstrating care can be relatively straightforward. Indeed a risk is that this is so obvious it may get overlooked,

particularly in the increasingly busy, indeed hostile, work environment. Opening a door for someone, waiting to sit till the patient is seated, helping someone on with their coat – politeness and the simple courtesies can go a long way. By careful attention to their own interpersonal behaviours the doctor can openly show interest in the individual. Adding "a little touch" to each encounter by doing something that is not task orientated but simply nice, an "unbidden act of human kindness", will help the patient to feel genuinely cared about.

Doctors can also make care much more personal by offering a "shared kindredness" with the patient: allowing them to see the human behind the professional façade. And giving as freely of time as is possible – the unrequested home visit when the GP 'pops in' or the consultant just pausing at the patient's bedside – can be extremely powerful and therapeutic demonstrations of that individual's importance. Even the lack of time can be used advantageously. Patients know doctors are busy and so being the recipient of such a scant resource will further promote their sense of self-worth.

Unquestionably, doctors do not lack the knowledge or skills necessary to demonstrate that they care. However, one question remains – will doctors choose to use their abilities? Will they choose to care?

■ *Dr Euan Paterson is a GP facilitator with Macmillan Cancer Support*

Obtaining informed consent may seem painfully routine but dentists can still be caught out, says MDDUS dental adviser Doug Hamilton

Presume nothing?

“IN modern law, medical paternalism no longer rules....” Presumably, Lord Steyn’s declaration in the landmark medico-legal case *Chester v Afshar* was designed to discourage the few healthcare workers who, even in 2004, still adhered to the “doctor knows best” approach to patient management. At the very least, his words acknowledged the emergence of an era of patient autonomy in which, amongst other things, proceeding with any medical intervention simply on the assumption of competent consent is no longer acceptable.

This is now one of the legal and ethical default settings in all areas of healthcare, including dentistry. Inadvertent departure from this doctrine has resulted in litigation or a GDC investigation against even the most skilled and caring practitioner and, with the advent of direct access, it may prove to be a stumbling block for the unwary hygienist or therapist. It is therefore scarcely surprising that the critical importance of securing valid, informed consent prior to virtually any intervention forms an integral part of the dental undergraduate curriculum and is constantly re-emphasised, often by defence organisations, to dentists and DCPs alike.

In reality, many dental professionals will regard the notion of ever proceeding without consent as being so archaic and incompatible with their own philosophy that these constant warnings are completely redundant. This is, however, a trickier area than it first appears and it is not uncommon for MDDUS to assist in cases which involve the issue of presumed consent. In the overwhelming majority, the non-consensual treatments in question were usually minor and beneficial. However, such is the stringency with which this facet of healthcare is regarded, that the operator’s excellent dentistry and good intentions did little to mitigate their failure

to fully inform their patient.

In order to illustrate this harsh reality, it may be worth providing a brief description of a couple of relevant cases with which MDDUS recently assisted.

Failed marriage, failed consent

In the first case, patient A attended with a fractured tooth LR4. The patient had a poor dental history and had previously declined anything other than the simplest conservative dentistry. As a result, she had upper and lower acrylic dentures, replacing 12 natural teeth. Her dentist therefore presumed that she would wish to have LR4 extracted and gained the patient’s consent to this procedure without discussing any alternative treatments.

The extraction was unremarkable, but, as Sod’s Law would have it, the patient subsequently had a dry socket. Some weeks later, our member received a solicitor’s letter, claiming that the dry socket had been the result of negligence and had caused patient A’s marriage to break down. There was a temptation to respond by suggesting that this patient’s home life was in the same state as her dentition. However, MDDUS replied to the effect that a dry socket was generally an unavoidable complication and that, in any event, we doubted that a causal link between this condition and the claimant’s impending divorce could be established.

We then received a further letter of claim, this time arguing that, based upon examination of the pre-operative radiograph, patient A’s LR4 could have been restored with a post-crown. Having been so advised, it was perhaps unsurprising that patient A had instructed her solicitors that she would have consented to a crown, if only she had been offered this option.

Unfortunately, our member’s records

contained no evidence of a crown being discussed. In fact, he advised MDDUS that, in view of the patient’s history of complete disinterest in all things restorative, he had simply presumed that she would only agree to another extraction. We ultimately had to accept that patient A had (for the most logical of reasons) been incorrectly consented and the claim was settled for around £4,000.

Taking care of business

Next comes the case of patient B, who presented at an out-of-hours emergency clinic when our member was on duty, complaining of a fractured, carious UL7. To complicate matters, patient B was about to depart for America on a business trip.

History and clinical presentation, together with radiographs, all indicated that a simple dressing would suffice and the patient was very happy to consent to this treatment. Unfortunately, subsequent caries removal exposed the pulp. Although extraction would at this stage have been a reasonable option, our member genuinely believed that it would be in patient B’s interests to retain UL7 and proceeded to extirpate the pulps without further discussion.

Some weeks later, a letter of complaint was passed to our member by the emergency clinic. It seems the patient’s UL7 had become acutely symptomatic while he was abroad and the consequent need to seek further emergency care had severely disrupted his business schedule.

Our member did not contact MDDUS at this stage, but wrote back explaining that the need for first stage endodontics had been unexpected, but had been necessary if UL7 was to be retained. Patient B’s response was that, in view of the importance of this trip, he would have requested the extraction of UL7 if the pulp

exposure and its ramifications had been explained to him.

Our member had incorrectly presumed that, having consented to one conservative treatment stage, patient B would surely have consented to the next. After a lengthy exchange of correspondence, the patient eventually accepted our member's sincere expression of regret. However, the initial failure, albeit for the best of reasons, to re-consent the patient for root canal treatment proved to be very stressful for dentist and patient alike.

No moral complexity

We can therefore see from these cases, which are by no means unique, the dangers of assuming that patients would, if informed, concur with the practitioner's judgement. It is also evident that this approach need not be the product of arrogance or thoughtlessness, but can nevertheless lead to practical and legal difficulties.

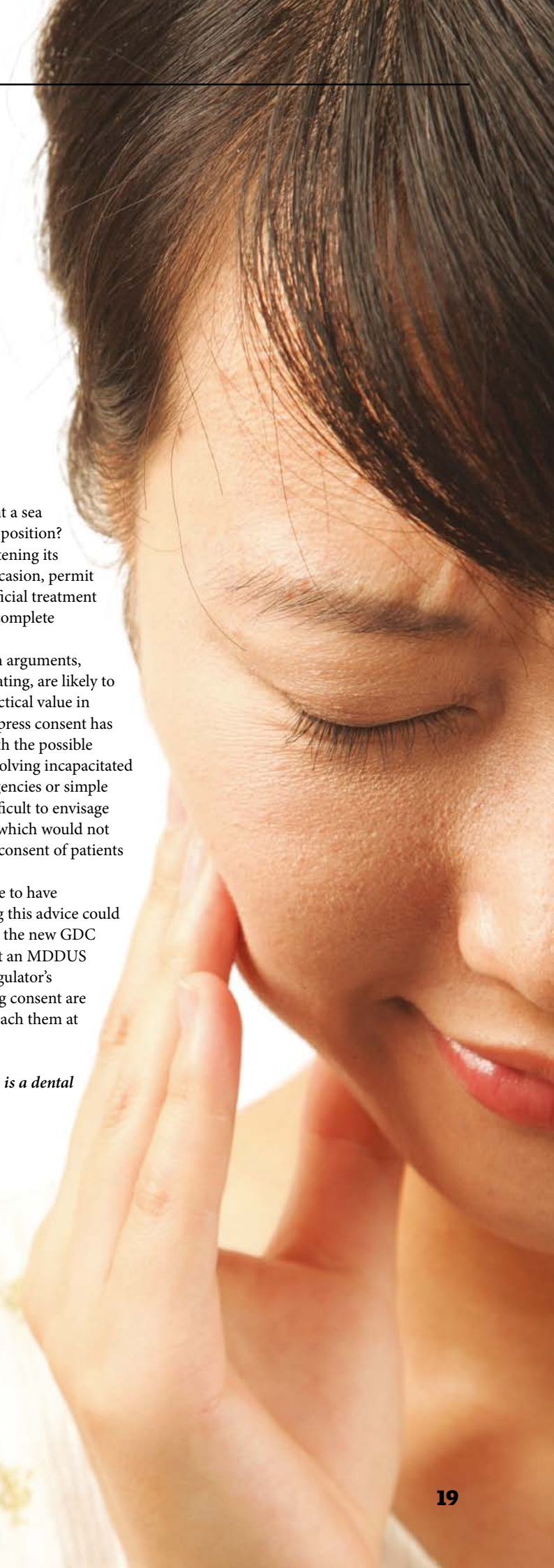
Dentists who face such problems may cite certain morally complex medical situations where this doctrine is tacitly accepted or even enacted into law. One prime example is the new legislation in Wales (which reflects laws already enacted by many European countries) governing organ donation. On the face of it, consent to organ removal following death will be presumed in the absence of an expression of wishes to the contrary (though there will doubtless be many safeguards incorporated into the legislation).

Could this represent a sea change in the current position? Perhaps the law is softening its stance and will, on occasion, permit the provision of beneficial treatment without the patient's complete knowledge?

The fact is that such arguments, while certainly fascinating, are likely to be of very limited practical value in dental cases where express consent has not been secured. With the possible exception of cases involving incapacitated adults, medical emergencies or simple examinations, it is difficult to envisage any dental treatment which would not require the informed consent of patients or their proxies.

Those who continue to have reservations regarding this advice could do worse than to read the new GDC standards – or contact an MDDUS dental adviser. The regulator's expectations regarding consent are uncompromising. Breach them at your peril.

■ *Mr Doug Hamilton is a dental adviser at MDDUS*



CASE studies

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

Details have been changed to maintain confidentiality



PRESCRIBING: UNRESOLVED INFECTION

BACKGROUND: Mrs G attends her local GP surgery with a warm/painful left breast. She had given birth to her daughter three weeks previous and is breast feeding.

Dr B examines the breast and makes a diagnosis of mastitis. A prescription for amoxicillin is issued and Mrs G is advised to continue breast feeding.

Seven days later Mrs G phones the practice having completed the full course of antibiotics. She tells the receptionist the discomfort in her breast has grown worse. No appointments are available that day and the receptionist tells Mrs G that it is not possible for her to speak directly with a doctor but says she will have a word with Dr B and phone back. A further prescription for amoxicillin is then issued which Mrs G collects from the surgery.

Three days later Mrs G attends the local out-of-hours service and is examined by the GP on-call. He notes that the mastitis is worse, showing erythema and swelling, with a broader area of induration. It is warm and tender to touch. The GP changes Mrs G's medication to flucloxacillin and advises her to return if there is no improvement.

A day later Mrs G returns to the out-of-hours clinic complaining that the swelling in her breast has "burst" with blood and pus coming out. The attending GP notes: "Lt breast inner quadrant red/indurated. Swollen/tender & 2 inches from areola burst opening, now closed. Consult surgical SHO".

Mrs G is sent to the local A&E and admitted to hospital. One day later she undergoes surgical incision and drainage of the abscess. The wound requires regular dressings and is slow to heal.



Six months later the practice receives a letter from solicitors representing Mrs G alleging clinical negligence against Dr B. Among the specific allegations is breach of duty in failing to identify that mastitis is usually caused by a penicillin-resistant staphylococcus and thus amoxicillin was an inappropriate choice of antibiotic. The letter further states that Dr B should have called Mrs G in for review or arranged for her to be attended at home before issuing the repeat prescription for amoxicillin.

It is further alleged that had Mrs G been given the appropriate treatment on first attending Dr B the mastitis would have resolved without progressing to an abscess, leading to hospitalisation and a long recovery with residual scarring and tenderness.

ANALYSIS/OUTCOME: Dr B contacts an MDDUS adviser and provides an account of his treatment of Mrs G. A report commissioned from an expert in primary care medicine is critical of Dr B's actions in the case. The expert cites clinical guidelines stating that the

recommended treatment for unresolved mastitis is flucloxacillin or erythromycin – the rationale being that mastitis is most frequently caused by a penicillin-resistant staphylococcal infection. The expert is also critical of the failure to re-assess Mrs G's condition before issuing the repeat prescription. In terms of causation the expert offers the opinion that had the patient been given an appropriate antibiotic at the initial consultation the mastitis would have resolved and there would have been no need for later hospitalisation and surgical treatment.

Having considered the expert report and discussed the case again with Dr B, MDDUS contacts the patient's solicitors and offers a modest settlement which is accepted.

KEY POINTS

- Keep up to date with latest clinical guidelines.
- Ensure repeat prescriptions are not simply a matter of routine.
- Ensure practice appointment systems do not act as a bar to potential emergencies.



DISCLOSURE: A RISK ON THE ROAD

BACKGROUND: MRS D is an 81-year-old woman who suffered a stroke five years ago. She has recently been consulting her GP, Dr F, complaining of problems with her eyesight. Dr F referred her to a consultant ophthalmologist who diagnosed Mrs D with macular degeneration.

Both Dr F and the hospital consultant agree that Mrs D is no longer fit to drive and have explained to her the dangers of getting behind the wheel. They also explained she has a duty to notify the DVLA of the impairment.

However, Dr F is concerned when Mrs D arrives for her latest appointment in her own car. He is worried that she will continue to ignore medical advice but is unsure if it is appropriate to inform the DVLA at this stage.

ANALYSIS/OUTCOME: Dr F discusses the issue with an MDDUS adviser who advises that in these circumstances patients should

be given a chance to stop driving voluntarily.

In general, where a patient continues to drive when they may not be fit to do so, the General Medical Council advises doctors to "make every reasonable effort to persuade them to stop." A doctor could, if the patient agrees, discuss concerns with friends, relatives or carers.

In this case, as a first step, the MDDUS adviser recommends Dr F raise his concerns with the patient in writing and assists with the drafting of a letter. The letter addresses her poor eyesight and the risks this poses when driving, and advises Mrs D that she must stop driving or he will inform the DVLA.

Should Mrs D continue to drive, the GMC makes it clear that in these circumstances doctors "should contact the DVLA or DVA immediately and disclose any relevant medical information". The disclosure can be made in the public interest as the patient poses a risk to fellow road users. If a



disclosure is made, the patient should be informed in writing.

KEY POINTS

- Doctors can breach patient confidentiality without consent if it is in the public interest to do so. First, advise the patient of their responsibility to stop driving if they are unfit.
- If the patient continues to drive try to inform them of your intentions to disclose. If they continue to drive against medical advice, alert the DVLA promptly and inform the patient of this action.
- Seek advice from an experienced colleague, the DVLA's medical officer or an MDDUS adviser if you are unsure about appropriate action regarding a patient's fitness to drive.



CONSENT: NEEDLE PHOBIA

BACKGROUND: A dentist with a large urban practice – Mr T – receives a letter from the GDC regarding a patient complaint that has been referred to the council's Investigating Committee. Enclosed is an assessment sheet detailing allegations from a Mrs Y who had attended the dental surgery six months previous. These involved a failure to obtain informed consent before administering a local anaesthetic.

In her statement the patient claimed she made an emergency appointment with Mr T to treat a broken tooth. The dentist took X-rays and asked Mrs Y to make an appointment in order to have the tooth restored. Four days later the patient arrived for her appointment late and flustered having not been able to find a parking space.

Mrs Y sat in the chair and opened her mouth as requested and "before she knew what was happening the dentist was injecting her with a local anaesthetic". She waved her hands to indicate for the dentist to stop. The needle was withdrawn and Mrs Y was left "shocked and shaken".

Mr T asked the patient if she wanted to continue and although Mrs Y wanted to

"rush out of the room", she composed herself and let the dentist proceed with the restoration without anaesthetic. Later Mrs Y became so upset the practice manager had to take her into the staff room. Mr T spoke to her and it was then alleged that the dentist told her that he did not routinely ask patients if they wanted an injection as it "only made people upset".

Mrs Y left the surgery shocked and angry at having to pay £50 for such a "frightening ordeal".

ANALYSIS/OUTCOME: Mr T contacted MDDUS immediately on receipt of the GDC letter and forwarded it along with a copy of the patient notes and his own account of what happened.

In his statement Mr T claimed he explained to Mrs Y that before starting treatment he would numb the tooth. Mrs Y offered no reply and there was no indication in the notes that she was fearful of local anaesthetic. First he applied a topical agent to numb the mucosa and



after two minutes inserted the needle. Mrs Y raised her hand and the needle was immediately

withdrawn. Later in the staff room she accused the dentist of using "sleight of hand" in inserting the needle which Mr T firmly denied along with the allegation that he rarely asked patients if they wanted anaesthetic.

MDDUS assisted Mr T in drafting a letter to the Investigating Committee and a few months later the GDC replied stating they were satisfied with the dentist's account and would not be proceeding any further with the matter.

KEY POINTS

- Explain to patients what you are going to do even in the most routine procedures.
- Ensure patients have listened and understood.
- Do not presume an open mouth is consent to treatment.
- Work out in advance a "stop" signal with phobic patients.

From the archives: A certain operation

IN August of 1876 the *BMJ* published the sad account of an inquest into the death of a 34-year-old woman in Chelsea – the cause of which was an “illegal operation” so scandalous the journal dared not even refer to it by name.

The story was a familiar one. A Miss Handford newly arrived in London from Australia attended a Dr Harrison. In the course of the consultation she said to him: “If I tell you a secret will you keep it?”. The doctor said yes and the woman confided her belief that she was pregnant. In a later consultation this was confirmed and Miss Handford asked if the doctor would perform a “certain operation”. Dr Harrison refused the request and Miss Handford then offered him a blank cheque to “fill in for any amount”. The doctor again refused and advised Miss Handford to let nature take its course.

A month later Miss Handford attended the doctor’s surgery

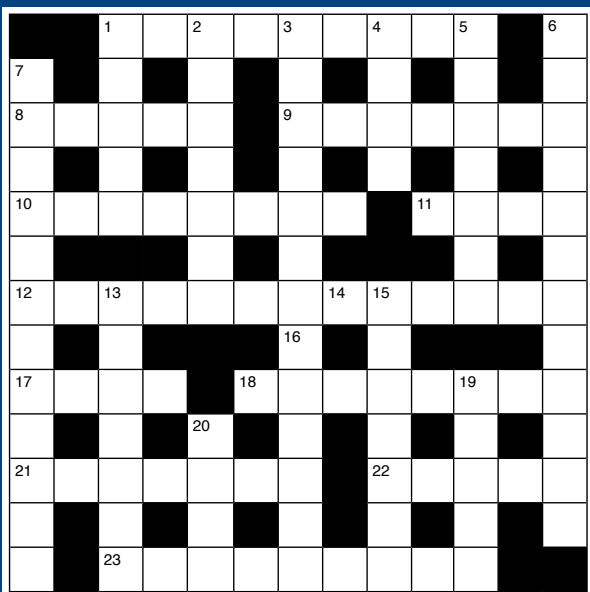
feeling poorly. She was helped to a couch and immediately fainted. The doctor and nurse moved the woman to a bedroom in the house. Later that evening she asked the attending nurse to take down a statement in which she said: “this morning, feeling desperate, I went to a doctor in town – his name I refuse to mention – and he did something to me, and told me I should be all right; and as I walked toward home I turned faint and decided to go in and see Dr Harrison and he allowed me to lie down.”

Miss Handford spent the night at the doctor’s residence and the next day had a miscarriage. Her condition grew worse and a specialist was called in. He again asked her who performed the procedure but she refused to provide a name nor how much she had paid to have it done. The next day Miss Handford died.

The jury at the inquest returned a verdict of “Wilful murder against a person or persons unknown” and added: “We wish to take some appreciative notice of the unselfish and Christian humanity of Dr. Harrison.”



Crossword



ACROSS

1. Took too much medication (9)
8. Cervical cancer test (5)
9. Substance inducing immune response (7)
10. Monument (8)
11. Disease caused by HIV virus (4)
12. Excessive fluid around cells (6)
14. Protein that catalyses chemical reactions (6)
17. Strongly chelating crystalline acid (abbr.) (4)
18. Clouding of lens (8)
21. Softening of bones through vitamin D deficiency (7)
22. Largest artery (4)

23. _____ chorea, neurological manifestation of rheumatic fever (9)

DOWN

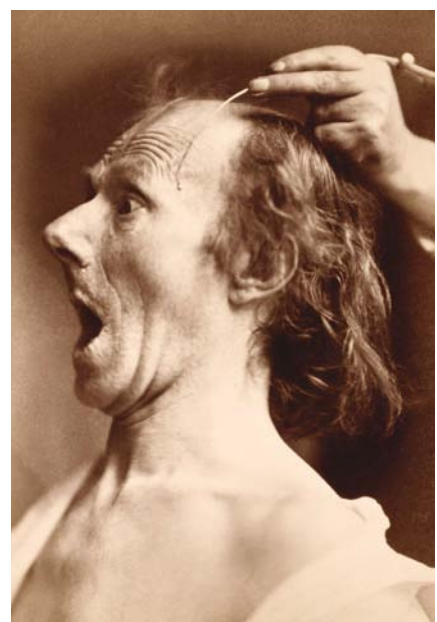
1. Large body of water (5)
2. Error in printing (7)
3. Don't resuscitate (abbr.) (6)
4. Satisfy hunger (4)
5. Being worthy of honour (7)
6. Not necessary (3-9)
7. Psychological measurement (12)
13. Discovers (7)
15. Canadian waterfall (7)
16. Type of plum (6)
19. Behind which Polonius hid (5)
20. Heavy metal (4)

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

Object obscura: Physiognomy study

PHOTO: SCIENCE PHOTO LIBRARY

THIS photograph is from the 1876 edition of *Mecanisme de la physionomie humaine* (*The Mechanism of Human Physiognomy*) by the French neurologist Guillaume Duchenne (1806-1875). Duchenne used the new technique of photography to record idealised facial expressions thought to reveal the emotions of the soul. Here the frontalis muscle is stimulated by an electrical probe, showing amazement.



Vignette: physician and epidemiologist

Sir Richard Doll (1912 - 2005)

PHOTO: WELLCOME LIBRARY, LONDON



THE link between smoking and lung cancer had long been suspected before Sir Richard Doll conclusively proved it in a landmark study published in 1954.

The discovery had an enormous impact on public health policy, prompting the first statements against smoking by UK government officials.

But this achievement may not have been realised had Doll pursued his first intended career. The son of a physician and a concert pianist, he was a natural mathematician. It was only his failure to secure a mathematics scholarship that led him to instead pursue medicine. He went on to combine both his mathematical and medical skills by developing a keen statistical approach to public health problems, becoming the doyen of 20th century epidemiology.

Doll was born into a privileged background and raised in Knightsbridge, but his experiences as a medical student in London during the depression made him acutely aware of the links between poverty and disease. He joined the Communist Party and participated in the Jarrow March in 1936. He later recalled witnessing one of the marchers take the ham from a sandwich and put it in an envelope to send home to his starving family. Such experiences undoubtedly shaped his attitudes, and he was to spend half his life as a Communist and the remainder committed to social change as a means to prevent ill health and premature death.

Although he made many contributions, he is best remembered for his lung cancer research. From the 1920s there had been an upsurge in the number of such cancers and by the 1940s the UK had the highest rates in the world. A variety of reasons were proposed for this including increased toxic exhaust from cars, improved diagnosis rates and even the tarring of roads—the latter initially favoured by Doll himself. To unravel this, Doll, working with the eminent statistician Austin Bradford Hill, conducted a retrospective case-control study. This showed a strong statistical association between smoking and lung cancer, but whether this was a causal association remained open to dispute. Such retrospective studies are

vulnerable to many possible biases—systematic problems that may distort the results. To overcome these, Doll and Hill took the next step, and decided to replicate and validate their findings prospectively.

In 1951, they designed and conducted the British Doctors Study—a prospective study of the health effects of smoking in more than 40,000 physicians specifically designed to rule out the issue of recall bias. By 1954 this study confirmed conclusively the excess of lung cancer among smokers reported earlier. Remarkably, Doll continued the study of his cohort of physicians and published a 50-year follow-up in 2001. This further confirmed the link between smoking and lung cancer and showed that prolonged cigarette smoking from early adult life tripled age specific mortality rates, but stopping at age 50 halved the hazard, and stopping at age 30 avoided almost all of it.

Thus, Doll was a pioneer of the prospective case-control study, which has become an important tool in modern medicine and his work remains an inspiring example of what can be achieved through the rigorous application of statistics to medicine. Among his many awards and honours, Doll was made a fellow of the Royal Society in 1966 and knighted in 1971.

However, remarkable as it was, Doll's life was not without controversy.

After his death scrutiny of his papers, now held in the Wellcome Library in London, revealed that he had been the recipient of generous personal funding in the form of

paid consultancies from various industries—the same industries he had often defended in public and in the courtroom. His former colleagues have been quick to dismiss these claims as smears, but no one has said they are inaccurate. What is contentious is whether such financial associations might have influenced his findings. Those who worked most closely with him find this suggestion nothing short of repellent. Doll himself always claimed that one must work closely with industry to have ready access to the necessary data.

In this context, it is perhaps interesting that the Clinical Trial Services Unit, which is now housed in the Richard Doll Building at Oxford University, states that it has “a staff policy of not accepting honoraria or other payments from the pharmaceutical industry”. Times have changed, as have professional standards, and while it is tempting to judge past actions by today's norms, it can also be misleading.

What is certain, however, is that it is difficult to overstate the importance of Doll's identification of smoking as a causal factor in lung cancer. An increasingly common fatal disease quite suddenly became largely avoidable through smoking cessation. This has had far-reaching consequences for both public health, and has served as a model for studying the impact of other lifestyle factors on health.

As we consider legislating to place cigarettes out of sight in our shops and to place them in plain packaging to further discourage their use, we should not forget that the reason we know unequivocally that tobacco is harmful is because of the meticulous work of a physician who could count.

Doll once said that his ambition was “to be a valuable member of society”. Having almost singlehandedly saved millions of lives, he most assuredly achieved that.

■ *Dr Allan Gaw is a clinical researcher and writer in Glasgow*

Sources:

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Kuper S. *Financial Times* October 26, 2012.

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