

SPRING 2013

SUMMONS

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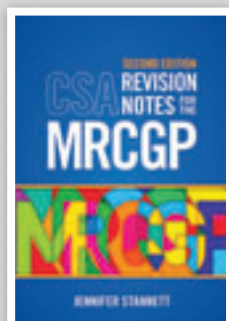


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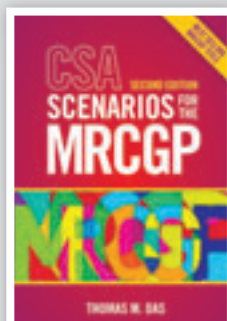
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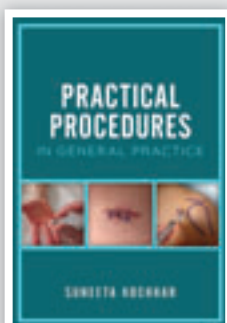
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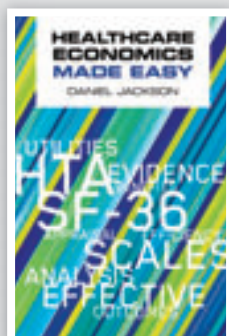
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IN THIS ISSUE

FORTH VALLEY ROYAL HOSPITAL in Larbert – opened in 2010 – sits on a hillside, bright and modern like some future vision of the NHS. And the analogy does not end there – below the main floors of the hospital in a network of corridors a fleet of box-like robot porters trundle about transporting clinical waste and dirty linen, delivering food and dispensing drugs. An automated pharmacy employs robots who take deliveries of drugs and stack them on shelves for dispensing using a barcode system.

It seems fitting that the hospital should also house the new Scottish Clinical Simulation Centre with its family of automated patient simulators – the most sophisticated among them having its own working physiology that breathes out CO₂ gas. In this issue (page 12) I report on my recent visit to the centre to watch some medical students undergo technical skills training using a patient mannequin nicknamed Reg.

Centre director, Dr Michael Money Penny, needs little prompting to imagine a day when patient simulators will walk

and talk and not appreciate being killed by trainee doctors – or consultants. "Will I dream?"

In February the GMC published new prescribing guidance after pointing out a few months previous that as many as one in 20 prescriptions written by GPs contains an error. On page 16 Dr Mary Peddie highlights some common prescribing pitfalls encountered by our medical advisers. And more pitfalls on page 18 but these to do with dental charges and the need to be up front about treatment plans and costs.

MDDUS is pleased to welcome Dame Elish Angiolini as a new non-executive director on our Board. Joanne Curran speaks to this top QC (page 14) on her remarkable career thus far – and on page 10 His Honour David Pearl provides some future vision for the Medical Practitioners Tribunal Service, the arms-length adjudication service for GMC-registered doctors.

Jim Killgore, editor



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Summons editor Jim Killgore watches a group of medical students put through their paces at the Scottish Clinical Simulation Centre

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Joanne Curran talks to Dame Elish Angiolini about her remarkable legal career and new role as a non-executive director on the MDDUS Board

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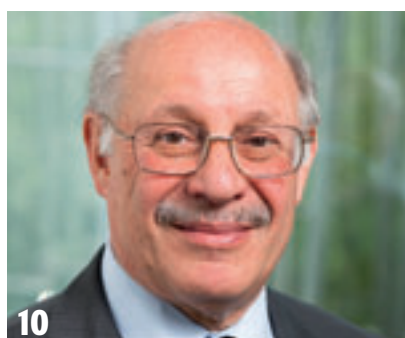
New GMC guidance targets some common pitfalls in primary care prescribing

18 HIDDEN COSTS

Disagreement over fees is an increasing source of dental patient complaints. MDDUS dental adviser Doug Hamilton highlights some common pitfalls

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Cover image:
Walking
by Lisa Harvey

The birth of Lisa Harvey's son was the inspiration for this screenprint. Finding with amazement that parenthood creates new, powerful feelings of protection, Lisa created a series of works about her desire to nurture her child's innocence for as long as possible. Lisa graduated from Duncan of Jordanstone College of Art and Design in 2000.

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
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NOTICE BOARD



➔ Former lord advocate to join MDDUS Board

THE Board of MDDUS has agreed to appoint Dame Elish Angiolini QC as a non-executive director with a view to her taking up her appointment in the Spring.

This appointment further broadens the range of expertise available to the Union. The former Lord Advocate and Solicitor General of Scotland will bring considerable knowledge and experience to MDDUS and will play an important role in strategic development at the organisation.

Professor Gordon Dickson, chief executive, said: "I am delighted that Dame Elish will be joining the Board. She brings a wealth of experience that will contribute enormously to the Board's work as the Union continues to grow and develop."

With almost 30 years' experience in the profession, Dame Elish is one of the most high profile and influential figures in the UK legal world.

She was the first woman, the first Procurator Fiscal and the first solicitor to hold either of the posts of Lord Advocate and Solicitor General. She served as a Procurator Fiscal in Airdrie and Glasgow for several years and held senior posts at the Crown Office, which oversees Scotland's prosecution service. She also advised the Westminster government on the implementation of the European convention on human rights as well as other policies and legislation relating to

the Scottish criminal justice system.

Dame Elish said: "I am honoured to be asked to serve on the board of MDDUS and I look forward to working with my distinguished new colleagues in a very dynamic and interesting field."

Read more on page 14 of this issue.

➔ Leading through uncertainty

MDDUS has announced new dates in 2013 for its popular *Leading through uncertainty* – an intensive five-day course aimed at doctors with management responsibilities.

Well-led teams are best equipped to meet increasing demands and to manage risk. With this in mind, and GMC guidance in this area, we have developed a holistic

programme that will challenge you as a leader and help you positively change the way you manage your team. It will furnish you with tools to tackle change positively and help create interdependent, effective relationships in the workplace.

The course will be held in our Glasgow office from Monday, 13 May, to Friday, 17 May, 2013. The cost is £395 for members and £450 for non-members. The workshop will have CPD approval from the Royal College of Physicians.

For more information or to book a place, contact Ann Fitzpatrick on afitzpatrick@mddus.com or call 0845 270 2034.

Please book as soon as possible as places are limited.

➔ Retired/Deferred cover

ARE you not working due to retirement, maternity, paternity leave or ill health?

If so, we can offer you Retired/Deferred Cover, which is provided free of charge and covers you for 'Good Samaritan' acts only.

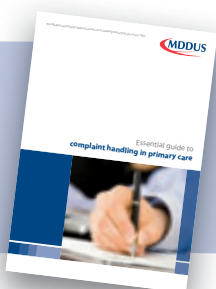
This cover is granted to members who have retired from practice or are not working for a period of three months or more in any medical or dental capacity. A condition of this type of cover is that you must have been in membership with MDDUS for a minimum period of one year.

For more details and to apply online go to www.mddus.com. You can also phone our Membership Team for details on 0845 270 2038.



IN BRIEF

● **BROWSE MDDUS RESOURCES** Members can now browse a selection of MDDUS articles and booklets published in four key topic areas: consent,



confidentiality, medical and dental records and complaint handling. You can also browse previously published articles highlighting common medico-legal

pitfalls in particular clinical risk areas - these in addition to a selection of medical and dental case studies. Just go to mddus.com and click on Resource Library.

● **DENTAL AUDIT DEADLINE** MDDUS is urging Scottish dentists

to take immediate action to ensure they meet audit requirements by the July deadline. Most NHS dentists in Scotland will be required to complete 15 hours of clinical audit by 31 July 2013. Failure to submit audits may

➔ MDDUS seeks GDP as non-executive director

MDDUS is seeking a general dental practitioner to serve as a non-executive director on its Board.

The MDDUS Board is made up of a combination of executive directors and non-executive directors. The non-executives come from a variety of backgrounds and bring their skills and experience to the governance of the Union. The Board is charged with determining strategy and policy, and monitoring the operation of the company.

We are interested in hearing from practising GDPs and would be particularly interested in any who are based in England, where our membership continues to grow steadily.

The Board meets seven times a year and in addition each Board member serves on one Board committee. The committees often meet on the same day as the Board in order to reduce the travel and time commitment. Non-executive directors receive annual remuneration and necessarily incurred locum expenses, as well as reimbursement for all travel and other costs associated with Board work.

This is an excellent opportunity for a practitioner who is keen to broaden their experience of business and support their colleagues at a strategic, Board level in an area of some considerable importance to medical and dental professionals.

Interested applicants can forward a brief CV and covering letter to Professor Gordon Dickson, Chief Executive of MDDUS at Mackintosh House, 120 Blythswood Street, Glasgow G2 4EA, or email gdickson@mddus.com. Informal enquiries are also welcome and Prof Dickson can be reached on 0845 270 2034.

To learn more about the role see our FAQ (right) with dentist and non-executive director Robert Donald.

➔ New online risk resource on consent

MDDUS has launched the second module of a free interactive online risk resource

FAQ: Being a non-executive director is...



Robert Donald is a GDP in Nairn, chair of the Scottish Dental Practice Committee (SDPC) of the BDA and a regular columnist in *Dentistry Scotland* magazine. He is also a non-executive director on the MDDUS Board. Here he provides some insight into the role.

What attracted you to becoming a non-executive director in the first place?

Throughout my dental career I have been actively involved at a local, national and UK level in striving to improve the terms and conditions of my colleagues. As a non-executive director, I am able to continue to support my colleagues at a strategic level in the company.

What kinds of matters are discussed at the board?

My main responsibility is the effective governance of the company and I discuss all of the issues that relate to this. This includes approving budgets, monitoring expenditure, agreeing the strategic plan and setting membership subscriptions.

Do you also become involved in Committee work?

All non-executive directors serve on at least one Board committee. I serve on the audit committee which meets three times a year and the nominations committee which meets less often.

Is it very time consuming?

We have about seven to eight Board meetings a year. These are usually held on a Friday morning followed by lunch.

The committee meetings are usually held on separate days. You also need to set aside time to read the papers for each meeting!

How important is your clinical dental experience in the role?

One of our strategic aims is to deliver a service second to none, continually improve that service and to operate in a manner that most efficiently meets member's needs. With over 30 years experience as a practising dentist, I am fully aware of the pressures that my colleagues operate under. I can call upon this experience to make sure our strategic aims are delivered.

What was the steepest part of your own "learning curve" as an MDDUS director?

Some of the actuarial risk concepts and accountancy jargon can be a bit daunting at the beginning but the chief executive and the finance director regularly provide helpful support.

What do you enjoy most about the role?

Meeting and working with like-minded directors who strive to provide a unique and valued service to our members and prospective members.

designed specifically for GPs, practice managers and practice staff. This one is on basic principles of consent.

The e-Learning Risk Resource highlights some of the most common areas of medico-legal risk in general practice and offers guidance and practical advice on achieving best practice. Each module

contains a series of multiple choice questions and scenarios designed to explore your knowledge of the topic, followed by more detailed explanations to illustrate each point.

The Consent module can be accessed now in the Training and Consultancy section of mddus.com.

impact upon practice income or may even be regarded as a breach of NHS Terms of Service.

● **RCS PUBLISHES COSMETIC STANDARDS** Only qualified healthcare professionals should be allowed to carry out cosmetic

procedures, according to new standards from the Royal College of Surgeons. *Professional Standards for Cosmetic Practice* recommends that only surgeons should provide cosmetic surgery and only appropriately-trained

medical staff should provide non-surgical cosmetic treatments such as Botox. Access at www.tinyurl.com/axnmeqc

● ADDICTIVE MEDICINES

A consensus statement aimed at reducing patient addiction to

medicines such as tranquilisers and painkillers has been published by the Royal College of General Practitioners and the Royal College of Psychiatrists. Access the *Addiction to Medicines Consensus* at www.tinyurl.com/dyjh4hw



Dire warnings over antibiotic resistance

HEALTHCARE workers should be given extra training to tackle the "ticking time bomb" of antimicrobial resistance, according to the chief medical officer of England.

Dame Sally Davies said urgent work must be done "to ensure the apocalyptic scenario of widespread antimicrobial resistance does not become a reality." She warned that minor surgery and routine operations could become high-risk procedures in the absence of suitable antibiotics.

The warnings come in her annual report and include 17

recommendations to address the threat. Dame Sally said training and continuing professional development should include a specific focus on the prevention and management of infections and should be available to "all health and care professionals including managers from chief executive down."

She urged the government to put antimicrobial resistance on the national risk register and to effectively implement a five year cross-governmental strategy. She also made direct recommendations to Public Health England and the NHS Commissioning Board, urging them to monitor infection, antimicrobial prescribing and antimicrobial resistance.



the prescriber should be recorded along with date of issue, the number of prescriptions issued and to whom. In this way missing forms can easily be accounted for – at which point the matter should be reported to the designated person at the NHS Board or PCT.

Records of all serial numbers received should be retained for at least three years along with an audit trail for prescription forms - including forms completed and then subsequently not used together with forms not issued due to an error filling them out. As well as minimising the risk of prescription form theft, practices are required to act quickly if an incident of theft or fraud occurs to help reduce the resulting damage.

The NHS Counter Fraud Services (CFS) investigates fraud allegations concerning both patients and healthcare professionals and may become involved if there is a suspected incident of fraud. For further information and advice on prescription form theft from Practitioner Services in Scotland go to

www.tinyurl.com/c3n32uu



Beware dental prescription form theft

DENTAL practices are being urged to have protocols in place to minimise the risk of fraud from the use of stolen prescription forms, particularly for illegally attaining controlled drugs.

MDDUS dental adviser Rachael Bell believes the threat of fraud can be reduced by ensuring all the dental team are aware

of the consequences of prescription forms going missing.

"Prescription pads are small and easily removed from practices and handbags," says Bell. "Therefore, practices should take necessary steps to reduce the risk of prescription pads being stolen and act swiftly if an incident of theft occurs.

"Prescription form theft can result in acts of fraud, with stolen forms being used to obtain controlled drugs illegally."

Bell advises that, upon delivery of prescription forms, managers or principals should ensure a process is in place to record how many prescription pads are in stock and the relevant serial numbers. Details of



Language test for doctors

DOCTORS who want to treat NHS patients will have to prove they can speak good English.

The Department of Health announced that, from April, there will be a legal duty to ensure doctors can speak "a necessary level of English" before they are allowed to treat patients in hospitals or GP surgeries. There will also be a single national list that every GP will have to be on before treating NHS patients. This replaces the individual lists currently held by primary care trusts.

The government is also proposing to give the GMC new powers from 2014 to prevent doctors from being granted a licence to practise medicine in the UK where concerns arise about their ability to speak English. A consultation on the new powers will be launched later this year. It will also include plans to create a new category of impairment relating to deficient language skills. This would allow

IN BRIEF

● **TOOTH DECAY HIGHEST AMONG POOREST** Hospital admissions for tooth decay are highest in the most deprived areas of England, according to new figures from the Health and Social Care Information Centre (HSCIC).

Almost a fifth of admissions (18 per cent) were from the most deprived 10 per cent of the population while the least deprived 10 per cent accounted for only four per cent of admissions for tooth decay.

● **CHANGING HEALTH DEMOGRAPHICS** Noncommunicable diseases now account for 80 per cent of deaths in Europe according to the WHO's *European health report 2012*. Diseases of the circulatory

system (ischaemic heart disease, stroke, etc.) account for nearly 50 per cent of all deaths followed by cancer causing some 20 per cent of deaths. Life expectancy continues to increase (age 76 in 2010) and Europe has the lowest

the GMC to investigate concerns about a doctor's language skills and apply appropriate sanctions where concerns arise after registration.

All of these new checks will mean that for the first time there will be a comprehensive system so that European doctors wanting to work for the NHS will have to demonstrate their ability to speak English when applying for a job.

This will close a loophole that meant, while doctors from outside the EU could face language tests, those from within the EU did not.

The announcement has been welcomed by the General Medical Council. Chief executive Niall Dickson said: "If doctors cannot speak English to a safe standard then the GMC must be able to protect patients by preventing them from practising in the UK. At present we can do that for doctors who have qualified outside Europe but we cannot do it for doctors within the European Union."



Dr Andrew Goddard, director of the RCP's Medical Workforce Unit, said: "Medical registrars are the unsung heroes of hospital care. But their skills are not being used to best meet patients' needs. The NHS will soon struggle to provide the best care for patients if this situation is not urgently reviewed."

➔ Medical registrar workload crisis

THE workload of medical registrars is at crisis point and poses a "major threat to high quality hospital care", the Royal College of Physicians has warned.

The stark warning comes in the RCP's new report *Hospital workforce: Fit for the future?* Researchers found 37 per cent of medical registrars described their workload as "unmanageable", while 59 per cent said it was "heavy". This compares to less than five per cent of general practice registrars who said their own workload was either heavy or unmanageable. It raises concerns that the most talented trainees might avoid careers involving acute medical care.

The report also criticised training opportunities for medical registrars as "highly variable" and too often compromised by heavy workload. Only 38 per cent of registrars felt their training in general medicine was good or excellent compared to 75 per cent in their main specialty.

➔ GPs quick to refer suspected cancer

GPs refer more than 80 per cent of suspected cancer cases within two consultations, new research has revealed.

More than half (58 per cent) of patients were referred after the first consultation while a quarter were referred after two. In only five per cent of cases it took five or more consultations to initiate a referral.

The findings were published in a report in the *British Journal of Cancer* which used data from the *English National Audit of Cancer Diagnosis in Primary Care 2009-2010*. The report looked at the link between the length of time from first symptomatic presentation to specialist referral, and the number of pre-referral consultations. The data covered 13,035 people with any of 18 different cancers.

Patients with certain types of cancer were more likely to have a greater number of pre-referral consultations. Those diagnosed with multiple myeloma and lung cancer had high proportions of three or more pre-referral consultations (46 per cent and 33 per cent respectively). Breast cancer and melanoma patients were generally referred sooner, with only three per cent and five per cent of each patient group requiring three or more pre-referral consultations.

The researchers concluded: "Developing interventions to reduce the number of pre-referral consultations can help improve the timeliness of cancer diagnosis, and constitutes a priority for early diagnosis initiatives and research."

➔ "Phase-down" of dental amalgam

A COMPLETE phase-out of dental amalgam is not on the cards after a new UN treaty on mercury pollution calls for "phase-down" over an appropriate period of time.

The BDA has welcomed the approach as it had been feared that the treaty would require a complete phase-out of the use of amalgam, without time to develop suitable alternative dental filling materials.

Dr Stuart Johnston, who led the FDI World Dental Federation Dental Amalgam Task Team at the negotiations, said: "Dentists in the UK recognise the environmental imperative to minimise mercury emissions, but it was important that this treaty took account not just of the environmental agenda, but also of the need for dentists to care for their patients."



child mortality rates in the world (79 per 1,000 live births).

● **FEW DENTAL PATIENTS COMPLAIN** Only two per cent of dental patients complained or considered making a formal complaint about a dental

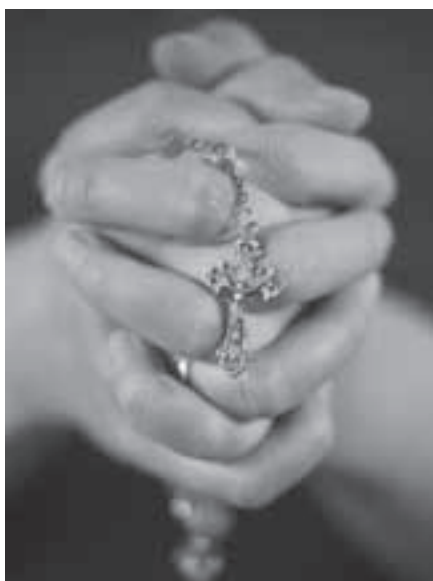
professional during the last 12 months according to a survey conducted on behalf of the GDC. The 2012 *General Dental Council Annual Patient and Public Survey* also found that 95 per cent of patients said they have never

complained and 93 per cent have never considered complaining.

● **NEW PRESCRIBING GUIDANCE FROM GMC**

Doctors face tighter rules on self-prescribing and a ban on prescribing performance-

enhancing drugs to athletes under new guidance issued by the GMC. *Good practice in prescribing and managing medicines and devices* came into effect on February 25 and can be accessed on www.gmc-uk.org



BUT I BELIEVE IT!

Ian Watson

Balancing rights in the expression of personal beliefs in the workplace

EVEN THOSE who don't follow employment disputes with the enthusiasm of this writer cannot fail to have noticed that, over recent months, a succession of cases involving freedom of speech and belief have hit the headlines.

Disputes about wearing religious symbols at the workplace, declining to carry out certain work duties for reason of religious conscience, a Christian refusing to work on a Sunday, dismissal for membership of the British National Party and someone expressing personal opinions about gay marriage on Facebook have all been addressed in courts – in both the UK and Europe. The results have important implications for all employers and their employees.

Whilst some lessons from these cases are clear, some effects are not quite so obvious. One of the consequences is that uncertainty about what opinions can be expressed (at the workplace and in the privacy of one's own home) is neither good for employees nor their employers. So let's

try to spell out what Law At Work sees as some definite conclusions to be drawn from all the legal debate on these topics.

Firstly, it is worth pointing out that virtually all the employing organisations who have been taken to court in these cases would not have anticipated finding themselves the centre of public attention for these reasons. The employers have varied from a local authority to providers of school transport services, a Hospital Trust, a voluntary sector counselling service and a Housing Association. It can be safely assumed that no employer can be considered to be immune from these issues – albeit that spats over these issues at the workplace don't normally end up in court.

Secondly, many of these cases have been hijacked by special interest groups (often with a religious agenda) for their own publicity purposes. This makes sorting out the press coverage from the reality of the court decisions difficult, and more than a question of over-simplification. Sometimes the coverage is simply wrong.

What we are sure of is that, in general, employers can justify asking staff to subjugate their personal beliefs if they conflict with the rights of other employees or customers, with safety/hygiene standards or with stated equality policies applying to service delivery, without falling foul of equality or human rights law. That is provided employers have at least looked at less discriminatory ways of imposing their policies.

Take for example the widely reported case of Shirley Chaplin, who worked for Royal Devon and Exeter NHS Foundation Trust as a nurse on a geriatric ward. The hospital asked her to remove a cross worn around her neck as it was a safety hazard when she was leaning over patients. They suggested that, if displaying the cross was of importance to the expression of her Christianity, she might wear a turtle-necked t-shirt under her uniform and over the cross and chain, but the applicant insisted that the visible wearing of the crucifix was an essential part of her religious faith.

Ms Chaplin was moved to a non-nursing temporary position which ceased to exist in July 2010. She applied to the Employment Tribunal in November 2009, complaining of both direct and indirect discrimination on religious grounds. Her complaint was rejected because the hospital could justify their actions for

health and safety reasons and people of all religions would be subject to the same safety restrictions when it came to the uniform policy. Her subsequent appeal to the European Court of Human Rights was unsuccessful – substantially for the same reasons.

What's also clear is that moderate expression of personal opinion which does not offend or intimidate others (or bring the employer's public reputation into disrepute) should be dealt with tactfully by employers and not used as a knee jerk excuse to dismiss the person concerned. For example, a Housing Association in Manchester received complaints from two gay staff members that a colleague had expressed personal views opposing gay marriage on his own Facebook profile. The Association decided to discipline the employee for this and demoted him to a lower-paid position. The employee successfully asked the court to declare this action in breach of his contract – with the High Court stating that the employee's moderately expressed views on his own Facebook page were sufficiently innocuous as to make the Association's actions excessive and therefore in breach of his contract.

In the majority of cases of conflict around expression of personal beliefs it is our experience that an informal word with the people concerned will often lead to the moderation of their language or behaviour – to restore the peace again. The employer is, after all, able to insist that tolerance is compulsory in the workplace.

Practices finding themselves challenged about these issues can ask for support from the MDDUS HR and Employment Law Advice service and, if required, from Law At Work who provide a legal advice backup service to the MDDUS advisers.

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



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

Everybody's and nobody's responsibility?

Deborah Bowman

I HESITATED before choosing the Francis Inquiry as my subject for this issue's column. Knowing that thousands of words have been written about the events that led to the Inquiry and the ensuing reports, I wondered both what I had to offer the vast commentary that has been published and whether readers would feel it was one article too many on a painful subject.

Yet, one phrase insistently played on my mind: quality of care is everyone's responsibility and can therefore all too easily become nobody's responsibility in the NHS. It occurred to me that in believing that others had provided sufficient attention to the subject, I was inadvertently mirroring the 'everybody and nobody' approach. For if we leave it to others to engage with, and reflect on, failures of care, we abrogate our own fundamental responsibilities to patients, colleagues and society. Whatever our role, be it academic, clinical, political or personal, we are all carers and patients at some point in our lives. Moreover, an exclusive focus on 'role' is too often a convenient way of protecting ourselves and displacing the difficult.

The more I have read about, and reflected on, the second Francis Inquiry report, the more I have felt that an effective response is probably a matter of both striking simplicity and daunting complexity. The simplicity lies in the report's call to compassion. In the litany of individual suffering and neglect, the common element was that each of those people deserved, but did not receive, compassion from those responsible for their care. I do not believe that there is a single instance described in the Francis Report where compassion could not have prevented the distress experienced by patients and families.

What was missing was simple and its absence was devastating. Compassion does not depend on an extensive academic analysis or years of training. And yet, there is a complexity to compassion. The concepts of 'compassion fatigue' and 'burnout' will be familiar to many and are well-documented. These are not merely

academic constructs: the demands of providing clinical care, particularly in a resource-constrained and politically-volatile system, are considerable. Add in the vicissitudes of life that are likely to influence how anyone functions at work and most professionals will be at risk of a diminution in compassion at certain points in their careers.

"Real compassion demands much of us. It requires sincerity. Compassion that is not genuine is illusory and fragile."

But, I would suggest that there is another aspect to compassion that is not much discussed, namely that compassion involves unsettling, even painful, moral imagination and emotional engagement. I realised this most recently when I asked a small group of medical students to write a first person piece imagining what it might be like to be a vulnerable patient in a particular situation. The students began the task in good humour, but I was aware of a change in mood as they wrote. When they shared their words with each other, there was a heavy silence in the room. I felt myself emotionally affected by what the students had written.

The exercise moved us all: not just emotionally, but in terms of our roles and relationships. I was no longer just the facilitator of an academic session and the students were no longer just learners. Our relationship and its boundaries were altered. We were human beings exploring new terrain in which we felt and shared strong emotions. As we collectively considered vulnerability, we became

vulnerable. And that was discomforting.

Real compassion demands much of us. It requires sincerity. Compassion that is not genuine is illusory and fragile. Compassion depends on us being willing to take risks with our own emotions and professional identities. It is hard work. Compassion demands that we put the interests of others before our own. It is an

unpredictable entity that is shaped by subjectivity and particularism: one patient's needs and preferences will differ from another's. We won't always succeed

in being compassionate, however high our aspirations, and that too is an uncomfortable realisation. It is influenced by myriad factors that characterise life in the NHS such as stress, hierarchy and politics. It is accepted by most as being fundamental to healthcare and yet, as Francis demonstrates, its absence is sometimes neither noticed nor addressed even in the face of incontrovertible evidence.

How then to reconcile the 'everyone and no one' conundrum? As a first step, we should all reflect on our own capacity for compassion. Most readers won't have worked at Mid-Staffordshire NHS Trust, but we all have a duty to engage with its lessons – in all their glorious simplicity and complexity. For, it is surely the case that compassionate care cannot become 'everyone's responsibility' unless and until we each take individual responsibility.

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



Arms-length adjudication

His Honour David Pearl *talks to Summons about the challenges in his new role as chair of the Medical Practitioners Tribunal Service*



THE Medical Practitioners Tribunal Service or MPTS was set up in 2011 as the new adjudication service for UK doctors. It provides a hearings service that is intended to be fully independent in its decision-making and separate from the investigatory role of the GMC.

His Honour David Pearl was appointed chair of the MPTS in June 2012 to steer the organisation in its crucial development stage. As an academic, he has been a lecturer in Law at the University of Cambridge and Professor and Dean of the School of Law at the University of East Anglia. He has also acted as a circuit judge, president of the Immigration Appeal Tribunal and president of the Care Standards Tribunal.

What attracted you to the post of MPTS chair and what relevant experience do you bring to the role?

I felt I had experience I could bring to this role, having helped set up the Care Standards Tribunal and sat as its president for six years. It is an exciting challenge, as I believe there is a lot of opportunity to make hearings run more efficiently and improve the consistency of our decision-making. I am enjoying it and have an excellent team around me to deliver our reforms of the MPTS.

What was wrong with the way the GMC operated before the MPTS?

There was nothing wrong with the way it operated, but the introduction of the MPTS brings further separation between adjudication and the GMC's investigation function. That was a key recommendation from Dame Janet Smith in 2004, a Government White Paper in 2007 and a further Government consultation in 2010. The Health Select Committee welcomed the establishment of the MPTS, saying they believe it will "provide greater assurance to the public about the quality of

decisions” made about doctors’ fitness to practise.

I hope it gives doctors additional confidence in the independence of our decision-making; that we are protecting patients and ensuring doctors receive a fair hearing.

Is the common perception of “doctors protecting their own” at the GMC a real problem or more one of public perception?

I do not believe people have that perception - but the clearer separation we have created between the GMC and the MPTS is important. MPTS panels listen to evidence presented by both the GMC and the doctor and reach independent decisions. Our panels are made up of lay and medical members. Our hearings are in public (unless a doctor’s health is under discussion) and are fully transparent, with decisions published online.

What happened to plans in 2010 to establish the Office of the Health Professions Adjudicator (OHPA)?

The current government decided not to continue with the establishment of OHPA and the GMC took forward plans to develop a clearer separation of investigation and adjudication. The result was the formation of the MPTS as an operationally separate body.

It means that MPTS panellists who make decisions on doctors’ fitness to practise are recruited and trained separately from GMC investigators.

Quality assurance of decisions and appraisal of panellists all takes place within the MPTS. I hope that this separation will ensure the confidence of the medical profession, as well as patients and public.

How separate can the MPTS really be when its funding comes from the GMC?

The MPTS is operationally separate from the GMC and we have established an effective working relationship. The MPTS/GMC Liaison Group meets regularly, where I and senior MPTS staff discuss matters with the GMC chair and chief executive.

Doctors’ fees pay for all GMC activity, including the MPTS. This means we are independent of government. It is important for the integrity of the medical profession and for public confidence that fitness to practise concerns are dealt with efficiently and fairly.

What are you doing to improve the efficiency of case management at the GMC to ensure no doctors are left in a “procedural limbo”?

I believe hearings often take too long. There are too many delays, many of which we can prevent. We are currently awaiting government approval for some changes to our rules, which we consulted on last year. These changes will improve the way our hearings are run, for instance by allowing witness statements to stand as evidence-in-chief, rather than insisting they are read in to the record. This is standard practice in other jurisdictions.

The changes will also allow for better case management – which is key to ensuring hearings are run more efficiently. Case managers will make binding decisions on what evidence can be presented, cutting out lengthy legal argument.

“I believe hearings often take too long. There are too many delays, many of which we can prevent.”

Are you planning any other changes?

There are a number of changes we are working on that will require further consultation and legislation. These include giving the GMC a right of appeal against MPTS panel decisions, allowing us to appoint legally-qualified chairs for some cases, and giving the MPTS a formal role in statute.

I think there is also an argument for allowing the MPTS to impose cost sanctions on both the GMC and defence if there are unnecessary delays. This is common in other tribunals and works effectively. Again, this would be subject to consultation with bodies like the MDDUS.

One reform you support is providing the GMC the right to appeal a decision by your own panels. Why do you think this is necessary?

At present, if a doctor disagrees with a MPTS panel decision, he or she can challenge it in the High Court in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern

Ireland. The GMC has no such right. As the MPTS is now operationally separate, it would be appropriate for the GMC to be able to appeal. It will enhance our operational separation and is the logical expression of that separation.

I am pleased that the Health Select Committee and the Professional Standards Authority (the former CHRE) have all expressed their support for this. The government has expressed its intention to bring forward the necessary legislation by 2015. We are working with officials to expedite this, and hope to have the changes in place by mid-2014.

Did you have any special interest in medicine before you took on the job at MPTS?

My background is in academia, and I taught medical law at Cambridge and UEA. I also co-wrote a book on blood tests and HIV back in 1990, so I have had an interest in this area for some time. I was a circuit judge from 1994 to 2012 and for six years was president of the Care Standards Tribunal, hearing appeals from decisions taken by regulators, including medical regulators like the Care Quality Commission. Aside from my MPTS role, I still sit as a judge for the Mental Health Review Tribunal, with a panel comprising of a psychologist and a lay member.

Do you think the MPTS has brought a culture change to the GMC?

We are trying to change the culture of hearings, for instance moving away from criminal rules of evidence and using civil rules. It is not acceptable that so much time is lost to panels having to adjourn to read documents for the first time during a hearing. Documents need to be ready on time and panels should have the opportunity to read them beforehand.

The rule changes that will come into effect this year will end the need to read out allegations and witness statements – everybody in the room has read them, they can just be agreed.

Outside of hearings, the Quality Assurance Group is reviewing decisions and providing panellists with learning and best practice. Ultimately this will improve the quality and consistency of our decision-making.

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



Meet the mannequins

Summons editor Jim Killgore watches a group of medical students put through their paces at the Scottish Clinical Simulation Centre

PETER Oliver won't wake up. The patient had been admitted to an acute ward the night before, intoxicated and suffering from a minor assault. A wedding party had got out of hand and Peter's arms and face show minor bruising and he has a contusion on his forehead. Someone in A&E mentioned a pool cue.

Earlier that morning he complained of pain and was given a small dose of morphine but now nurses cannot rouse him. Two foundation year doctors along with two medical students attend the patient. One calls in a loud voice: "Mr Oliver. Are you with us?" But the patient's eyes remain shut and he snores loudly.

One of the medical students checks his BP: 172/90; another draws bloods. A foundation year doctor – Victoria – checks his pupils. The left is fixed and dilated; the right normal.

The other FY shouts again: "Mr Oliver!" But the patient snores on – except he is not actually doing the snoring. I am watching this scenario from a one-way mirrored control room. Sitting next to me in front of a bank of computer screens with multi-angle audiovisual feeds is Alistair Geraghty, doing a surprisingly credible imitation of snoring into a desktop microphone.

In reality Peter is not a live patient but an automated mannequin and this scenario is part of a technical skills course being

conducted in one of two multipurpose simulation suites at the Scottish Clinical Simulation Centre (SCSC). Alistair is a simulator fellow at the centre which is based at the Forth Valley Royal Hospital in Larbert not far from Edinburgh.

The SCSC is the only high-fidelity simulation centre in Scotland and was established in 1998 with part-funding by NHS Education for Scotland. The Centre provides training for over 1,000 doctors and other healthcare professionals each year through a variety of courses both on-site and out in the field in hospital wards, emergency departments, resus rooms and even ambulances.

Course participants range from paramedics, ambulance crew, midwives, nurses, advance care practitioners to trainees in various fields, such as paediatrics, emergency medicine, anaesthesia and obstetrics. Training is conducted on a range of mid and high-fidelity mannequins including adult, child and baby simulators which can be programmed to mimic different medical conditions, replicating the appropriate physical response to particular interventions and drugs.

On the day of my visit Alistair is running a course for a group of fourth and fifth year medical students. Centre stage is an automated mannequin, nicknamed Reg. His chest rises and falls as he breathes. A course participant listening with a stethoscope will

hear heart and breath sounds over his chest, and bowel sounds over his abdomen. Watching the computer monitor I can see his simulated vital signs – heart rate, ECG, oxygen saturation. Alistair can change parameters with a simple drop-down menu – give Reg a wheeze or a heart murmur or put him in cardiac arrest.

Today the course objective is assessing acute medical problems on the wards. Says Alistair: “The focus of the scenarios are things that are very common like sepsis, or things that are rare but very serious such as anaphylaxis. The main focus is having an ABC [airway, breathing, circulation] approach and getting to a differential diagnosis and making sure they have the correct management in place.”

In the case of Peter (or Reg) – so far, so good.

Safe environment

Director of the SCSC is consultant anaesthetist Dr Michael Money Penny and I speak to him later in his office. He was appointed to the job in June of 2012 and in addition to his medical qualifications Michael is an expert in how “human factors” contribute to medical error. He is also, unsurprisingly, an enthusiastic advocate for simulation in ongoing medical training. I ask him what are the advantages of using simulation alongside learning on real patients.

“One major advantage is the centre offers a safe environment,” he replies. “Safe for the learner and safe for the patient. The mannequin doesn’t die. You can make mistakes on him, you can give him the wrong drugs, you can give him too much adrenalin.”

“Our ethos here is that you will make mistakes and that’s acceptable because we all do and we can all learn from them. But you’re better off making the mistake here on this mannequin than on a patient.”

Another advantage is repeatability. Staff at the centre can create whatever clinical situation is required, be it acute asthma or myocardial infarction or pneumothorax. “And you can do it again, again and again,” says Michael. “It will not change. It’s the same scenario for a hundred people.”

This reduces any potential bias and is of great value in assessment. Simulation also allows healthcare professionals to deal with clinical conditions they might see only once or twice in a career.

Stan the man

Reg – the mannequin the students are working with – is a medium-fidelity simulator. Lying unused on a gurney in the second simulation suite is the centre’s most advanced mannequin – Stan (short for Standard Man). Costing over £100,000, Stan is attached by wires and tubes to a large metal box containing a powerful computer and sensors as well as a bellows to drive his lungs.

“The reason he is so expensive is because he has a true physiology,” says Michael. “Sophisticated computer algorithms work in the background which means that if we give him 500 ml of fluid and tell the computer, this will bring his BP up a little bit. His heart rate will come down and his central venous pressure will change. He’s an extremely complicated piece of equipment.”

Stan is used mainly for anaesthetic training and actually breathes out CO₂ into a mask which can be visible on a trace using an anaesthetic machine. He also absorbs anaesthetic agent and reacts in the same way as a living patient. In the simulation suite



Far left: Dr Michael Money Penny (right) checks the pulse on patient simulator, Stan. Left: watching a scenario from the control room.

anaesthetic trainees have access to everything they would find in a real surgical theatre – tubes, cannulas, masks, simulated blood and fluids. All this adds to the realism of the training sessions.

“We tell people it’s not pretend,” says Michael. “They don’t say, oh, I would take a blood gas now, they go and do it.”

Human touch

Simulators or mannequins do have some obvious drawbacks in terms of realism. “For example, mannequins don’t go the blue deathly colour that you get in real patients,” says Michael. “Some of them have cyanosis but it’s so unrealistic it actually throws people off. They go blue but it’s an LED type of blue glow as opposed to the pallor of approaching death.”

He acknowledges this lack of realism can be a problem in some scenarios. Mannequins don’t move for the most part and although someone can speak for them via a mike there can be a crucial “disconnect” or lack of “human touch”. To overcome this some centres use part-task trainers such as cannulation arms or chest drain prosthetics strapped onto real actors in order to get a more genuine doctor-patient interaction.

Michael believes that in the future with advanced robotics, patient simulators will get better. “But for the moment mannequin-based simulation is more about emergency management,” he adds. “The patient is not irrelevant but you are looking at maintaining physiology, maintaining life, as opposed to how they are feeling about their anaphylactic reaction.”

Debrief

Back in the simulation suite Victoria decides to phone out from the ward for some assistance in assessing Peter’s condition. In the control room Michael plays the role of the medical registrar. Victoria summarises her observations over the phone including the head injury and the blown pupil. “We’re thinking CT scan,” she says and Michael agrees and tells her to phone for a neurological consultation.

Five or so minutes later Alistair calls time on the simulation and the group moves back to a classroom where two other groups of medical students have been watching the action on a video feed. He then leads the team in a debrief using a white board with video playback – assessing how they used their ABCs to start focusing in on the diagnosis of raised intra-cranial pressure due to subdural haemorrhage.

And this harkens back to something Michael Money Penny said to me earlier in the day. “The actual stuff in the simulator is not that important. You have to do it – but the most important thing is the debrief when you all go back into the room and have a chat about what’s happened, what went wrong, what went well and how we can do it better next time.”

■ *Jim Killgore is editor of Summons*

Blazing a trail



Former Lord Advocate and Solicitor General for Scotland Dame Elish Angiolini joins the MDDUS board this Spring. She talks to Summons about her new role and her remarkable legal career

FOR one of the most high profile and influential figures in the UK legal world, having overseen some of the most significant changes made to the Scottish criminal justice system, Dame Elish Angiolini QC is remarkably self-effacing.

She was the first woman, the first Procurator Fiscal and the first solicitor to hold either of the posts of Lord Advocate and Solicitor General for Scotland. During her 30-year career she has held senior jobs at the Crown Office, which oversees Scotland's prosecution service, and has advised the Westminster government on a raft of major policies and legislation.

But despite her considerable achievements, the 52-year-old does not regard herself as a pioneer. "I think some people would classify me more accurately as an irritant," she says. In the classic tale of *The Emperor's New Clothes*, Dame Elish likens herself to the character who points out the glaring problem when others do not. It is a trait that stems, she says, from "a Glasgow earthiness of just

saying it like it is" and from a desire to "make our prosecution system the very best".

Humble beginnings

Much has been made of the impressive career trajectory of this "girl from Govan" whose interest in the law began as a teenager handing out information leaflets and trying to find solutions for poverty-hit families living in sub-standard housing. The daughter of a coal merchant from a working class shipbuilding community, she had no connections to the legal profession but became the first in her family to go to university. The youngest of four children, she received a full education grant to study law at Strathclyde University and met living costs by working part-time as a check-out girl and barmaid.

An unswerving drive and determination helped her succeed where many young people from similarly modest backgrounds could not. "I was very fortunate to have parents who were passionate about learning

and they made sure my siblings and I had all the opportunities they could make available to us," she says. "They gave us tremendous support and affection and all four of us have done well in our careers."

She fears opportunities for young people from poorer backgrounds to enter professions such as law and medicine nowadays may be under threat. "In my generation, lots of people came into university from poorer backgrounds because of full funding and my concern now is that might slow down. Although Scotland is different from England in terms of university fees and funding, there's no doubt the prospect of getting into debt is more daunting for those from less well-off backgrounds.

"I'm not sure that I would have gone to university now, I might have just gone out and got a job instead."

Reaching out

Married with two teenage sons, Dame Elish remains grounded and has a down-to-earth manner that belies her accomplished position. The sense of social justice that first sparked her legal career has never left her. She believes passionately in a fair judicial system that has the confidence of the public and responds to their needs. She has worked continuously to improve the support offered to vulnerable victims and witnesses, and many of the changes she oversaw in the Scottish judicial system aimed to improve the service it provided, particularly to women, victims of sexual crimes and minority communities. She is also patron of the charity Law Works Scotland which sources legal advice for people from poorer backgrounds.

She says: "When I was making changes to the way the prosecution system operated, some critics thought it was all about sentiment, about being nice to people, but while compassion has an important part to play in the criminal justice system, treating people decently is

also a vital part of encouraging confidence in the system. We were in a situation where rape and child abuse victims were not coming forward because you don't come to an organisation that looks remote and hard from the outside. The view that an independent organisation cannot be willing to communicate or listen is both short-sighted and shallow."

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"I was very fortunate
to have parents who
were passionate
about learning."

Dame Elish's main role these days is as Principal of St Hugh's College, University of Oxford, which is determined to widen access to education to those from less privileged backgrounds. As part of this role she will be speaking at a number of secondary schools in Glasgow's poorer east end areas. She explains: "I want to encourage them to raise their expectations, and to say Oxford is a tremendous place to be and it's for you, not for someone else. A significant new range of bursaries and scholarships should mean no brilliant student is deprived of an undergraduate place."

Bringing strength

It is the benefit of her considerable professional experience that Dame Elish will bring to her role as non-executive director at MDDUS, where she will play an important role in strategic development. She first came into direct professional contact with the Union about two years ago when she represented several members in the public inquiry into the *C. difficile*

deaths at Vale of Leven Hospital during which, she says: "I was very impressed with the MDDUS personnel and the way in which the organisation responded".

Ever since her first role as a junior procurator fiscal in 1983, Dame Elish has been involved in the investigation of sudden deaths and has been "surrounded by medicine" in both a forensic context and also in relation to standards. She has always had a "genuine interest in medical cases and medical matters", admitting in typically modest style: "Part of me was a frustrated doctor but I wasn't clever enough so I became a lawyer". And while her role at MDDUS will not involve providing legal advice, this long-standing interest in the medico-legal field will clearly be of benefit.

She says: "I will be coming to MDDUS having been the leader of a large organisation for 10 years, one which has a significant public profile.

"I will also be looking to the future development of MDDUS, hoping I can assist in ensuring its sound stewardship and best practice in terms of representation and dissemination of information. I hope to help ensure members continue to be as well represented and advised as they can be in an area which is very dynamic.

"The most successful boards tend to have a diverse range of skills and I hope to further enhance the board's effectiveness."

Dame Elish is also a visiting Professor of Law at Strathclyde University and hopes to produce courses for prospective medical witnesses about appearing in court or tribunals.

"A lot of people are very anxious about the prospect of going to court but if you strip away some of the mystery then it becomes easier to deal with," she says.

Pioneer or "irritant", Dame Elish looks set to continue blazing a trail in pursuit of a system that is the best it can be.

■ Interview by Joanne Curran, associate editor at MDDUS



Prescribing pitfalls

New GMC guidance targets some common pitfalls in primary care prescribing

A REPORT published in 2012 by the GMC yielded some startling statistics in regard to primary care prescribing. Researchers found that as many as one in 20 prescriptions written by GPs contains an error. In England alone, with 900 million items prescribed each year, that amounts to 45 million errors. Although most of these errors were classed as mild or moderate, around one in every 550 prescription items was found to contain a serious error – equating to 1.6 million potentially dangerous prescriptions per year across England.

These findings highlighted some areas of needed improvement and also set the scene for the publication in February 2013 of the GMC revised guidance – *Good practice in prescribing and managing medicines and devices*.

Certain prescribing errors are obviously more likely than others. In the GMC report the most common types of errors were incomplete information on the prescription, dose/strength errors, incorrect timing of

doses and failure to arrange appropriate monitoring of prescribed drugs. The risk also increased according to the number of medicines a patient was taking (each additional medicine increased error risk by 16 per cent), patient age (children and over-75s were twice as likely to have an error) and the type of medicine prescribed. Another study published in 2007 found that just four classes of drug are associated with around half of preventable medication-related hospital admissions: antithrombotics (e.g. aspirin), anticoagulants (e.g. warfarin), NSAIDs and diuretics.

Prescribing errors feature commonly in MDDUS case files either as patient complaints or more serious legal claims of clinical negligence, or GMC actions against

members. Prescribing is also a common subject in the many thousands of advice calls handled each year by MDDUS medico-legal advisers. Some of the issues can be complex but more often than not doctors and practices are caught out by “simple” errors – an incorrect dose, or prescribing the wrong antibiotic.

Below are some common pitfalls in prescribing encountered by our advisers – by no means complete or comprehensive but just a reminder of what to consider in your daily practice.

Missed or missing information

One common element in many MDDUS cases involving prescribing errors is missing or missed information from patient files. These often involve a failure to consider cautions and contraindications, such as a prescription of allopurinol in a patient with impaired renal function, or prescribing NSAIDs to a patient on warfarin. Even obvious errors such as prescribing penicillin-based antibiotics to patients with documented penicillin allergy occur with surprising regularity.

Good patient records with appropriate alerts in place are an obvious essential but doctors should also be extra vigilant when dealing with high-risk drugs in high-risk patients. Most practices today rely on hazard alerts in electronic record systems but this can pose a risk with high “signal-to-noise ratios” leading GPs to sometimes ignore vital alerts. However, they have been proven to reduce the number of prescribing errors.

Keeping up-to-date is also essential. The new GMC prescribing guidance states: “You must maintain and develop the knowledge and skills in pharmacology and therapeutics, as well as prescribing and medicines management, relevant to your role and prescribing practice.” Doctors are expected always to take account of new treatment guidance from bodies such as NICE and SIGN and updates and alerts from the MHRA – and an up-to-date copy of (or online access to) the BNF is a must.

Repeat prescribing errors

GPs often do not check repeats as closely as one-off prescriptions – that’s just a fact of life. Faced with a pile of repeat prescriptions to sign it can be difficult to ensure you are giving each one careful attention though most will be routine. Yet errors involving repeat prescribing are sadly common in MDDUS files – a potent corticosteroid cream prescribed over many years leading to local atrophy and systemic steroid

side-effects, or medication addiction due to long-term benzodiazepine or analgesic prescribing.

The GMC is clear on the matter: “You are responsible for any prescription you sign, including repeat prescriptions for medicines initiated by colleagues, so you must make sure that any repeat prescription you sign is safe and appropriate.”

Good practice systems for repeats can offer a safety net for this fundamental requirement. The GMC requires that procedures ensure:

- the right patient is issued with the correct prescription
- the correct dose is prescribed, particularly for patients whose dose varies during the course of treatment
- the patient’s condition is monitored, taking account of medicine usage and effects
- only staff who are competent to do so prepare repeat prescriptions for authorisation
- patients who need further examination or assessment are reviewed by an appropriate healthcare professional
- any changes to the patient’s medicines are critically reviewed and quickly incorporated into their record.

Monitoring patients is particularly important in high-risk patient groups, such as the elderly, those on multiple drugs and in cases of hepatic or renal impairment where drug metabolism and excretion may be reduced leading to drug toxicity. Patients who refuse to attend for follow-up are an understandable cause of concern for GPs and a source of calls to MDDUS, the question being: should treatment be stopped? There is no blanket answer to this – an assessment of each patient’s individual circumstances is required. It is a matter of balancing the risk of continuing to issue a repeat prescription without review or monitoring against the risk of stopping treatment. More expert clinical advice may be needed from an appropriate specialist before making the decision.

In and out of hospital

Errors are common at the primary-secondary care interface and often occur with prescription changes when patients are discharged from hospitals or are seen at out-patient clinics. These could be alterations in medication or dosage and it is important that this information is safely transcribed and checked by qualified

clinical staff. The GMC states: “If you are the patient’s general practitioner, you should make sure that changes to the patient’s medicines (following hospital treatment, for example) are reviewed and quickly incorporated into the patient’s record. This will help to avoid patients receiving inappropriate repeat prescriptions and reduce the risk of adverse interaction.”

Shared care between primary and secondary also comes with risks to doctors and patients. It is important again to remember that you are responsible for any prescription you sign even if on the recommendation of a hospital specialist. The GMC advises that you must “satisfy yourself that the prescription is needed, appropriate for the patient and within the limits of your competence.” Hospital doctors are also similarly obligated to ensure GPs are provided with appropriate information about new or unfamiliar drugs and to answer any questions or otherwise assist in the care of the patient.

Self-prescribing

MDDUS has handled a number of cases where practitioners have been subject to fitness to practise proceedings for either self-prescribing or for prescribing to a family member or friend. Be aware that the GMC takes a very dim view of this and not just for drugs of misuse but also for doctors, say, prescribing their own BP medicine without seeing a GP who would be monitoring the treatment and keeping necessary records.

The GMC is clear that you must not prescribe a controlled medicine for yourself or someone close to you unless no other person with the legal right to prescribe is available to do so and the treatment is immediately necessary to save a life, avoid serious deterioration in health or alleviate otherwise uncontrollable pain or distress. Should it be necessary to prescribe for yourself or someone close you should make a clear record justifying your decision. With the widespread availability of OOH services in most of the UK, the need to prescribe for yourself or your family is likely to be rare.

These are just few of the pitfalls involved in prescribing. Should MDDUS members have any queries regarding a medico-legal or ethical aspect of prescribing our medical advisers are available to take your call on 0845 270 2034.

■ *Article by Dr Mary Peddie, MDDUS medical adviser, and Jim Killgore, editor of Summons*

Hidden costs



Disagreement over fees is an increasing source of dental patient complaints.

MDDUS dental adviser Doug Hamilton highlights some common pitfalls

A TRIP to the dentist is challenging enough for most people – but being hit with an unexpectedly high bill afterwards can only make matters worse.

General dental practitioners earn their living principally through collection of fees from patients and, as a result, they are perhaps more likely to be faced with disputes in relation to money than other healthcare professionals.

In recent years, MDDUS has been asked by its members for assistance in an increasing number of fee-related complaints. And while this could be partly blamed on the current economic climate, a more immediate cause may be publicity surrounding the 2012 Office of Fair Trading report on UK dentistry. Amongst the findings were significant levels of dissatisfaction in dental patients regarding the clarity, accuracy and punctuality of costing information.

This dissatisfaction was related largely to alleged misinformation about the range of treatments that can be provided under the NHS. However, concerns were also raised over “the failure by some dentists to provide basic, requisite

information to dental patients regarding proposed dental treatment, including the cost, prior to the dental treatment being provided.”

Transparency

Knowledge of treatment availability and potential costs are essential components of the consenting process and the conduct flagged up by the OFT, if deliberate, could scarcely be condoned. The fact is, however, that most practices are careful to maintain transparent costing policies, not only as a reflection of high professional standards, but also because it makes good commercial sense. Even so, there may be occasions where administrative errors, time pressures or even a reluctance to broach the tricky subject of fees leads to patients being presented with bills which are unexpectedly high or simply unexpected. In many such instances, a complaint will follow and MDDUS will always endeavour to support our members who seek assistance in providing a response.

The fact is that both private and NHS dentists are compelled to provide clear, written guidance to patients regarding the recommended treatment, the basis on which it is being provided and the likely costs. Failure to comply will not only undermine any attempts to rebut a patient's complaint, but may also lead to investigation by the member's NHS board or PCT and/or the General Dental Council.

Necessary forms

Considering NHS treatment first, patients must be provided with a standard estimate form (FP17DC; GP17DC), or equivalent, before treatment commences. This shows diagrammatically which teeth require treatment and the anticipated costs.

The estimate form rule is relaxed only in very specific circumstances, usually when the proposed care is very simple. Therefore, in England, if no items from Bands 2 or 3 are clinically indicated, an FP17DC estimate form is not required. In Scotland, the cut-off is slightly more complex. Put very simply, where treatment is limited to less than three permanent fillings, periodontal visits or extractions, production of a GP17DC is not obligatory. However, these exceptions do not apply to the first course of treatment - all new patients must receive an estimate form. An estimate and plan must also be produced at the specific request of a patient and should be updated if the proposed treatment plan is to be varied. Perhaps most importantly, a separate section must be completed and signed by the patient where the plan, however straightforward, includes any private dentistry.

Obviously, this final caveat clarifies for the patient the basis on which certain treatment items are being provided and therefore also helps to provide a record that consent to non-NHS treatment has been secured. However, the patient's signature does not completely obviate subsequent challenge. Firstly, private and NHS treatment cannot be provided on the same tooth. This is of particular relevance in Scotland, where

"Knowledge of treatment availability and potential costs are essential components of consent."

items such as bonded molar crowns and posterior composites are generally not available on the NHS. For example, recording an NHS root filling and private crown on an upper first molar might render the GP17DC invalid.

NHS or private?

Secondly, patients cannot be misled as to the availability of NHS treatment. In Scotland, a patient who insisted upon a posterior resin, having been given all relevant information on which to base this decision, could quite correctly be advised that a private fee applied. This would be recorded in the notes and on the countersigned GP17DC. However, in England, treatment items are not restricted by a Statement of Dental Remuneration. All that is required is that the patient's oral health is secured which could, quite conceivably, involve placement of non-amalgam restorations for a Band 2 fee. The private/NHS distinction only becomes completely clear once services such as bleaching or implants are considered.

Thirdly, agreement to private treatment cannot be secured by denigrating the quality of care which is available on the NHS. In fact, to do so would be contrary to reason, as practitioners would effectively be casting aspersions on their own clinical standards. Great care must be taken at the consenting stage if entanglement in these regulations is to be minimised. If practitioners wish to avoid their clutches altogether, they must work completely outside the NHS.

Private practitioners are not required to provide forms like GP17's and FP17's which, apart from saving a few trees, relieves them of a significant administrative burden. Yet, since private treatment tends to involve higher costs, many practitioners would agree there are even stronger business and ethical arguments for providing an initial estimate, perhaps accompanied by details of payment plans.

This notwithstanding, the results of the OFT survey suggest that some patients commence treatment without sight of an itemised treatment estimate. Private practitioners may explain, quite truthfully, that costs had been agreed verbally. However, this argument is always torpedoed by the GDC's consenting guidance, which requires that all patients are given a written treatment plan and cost estimate after an examination or assessment has been completed. Without such a document, defending a financial complaint against a private dentist is often very difficult (see box).

While the findings in the OFT sparked furious public debate, they are not revelatory. The need to set out expected costs has, for some time, been subject to very prescriptive regulatory and legislative rules, the contravention of which may limit the defence of a subsequent complaint or even lead to third party investigation. It is therefore critical that patients not only understand the financial implications of their treatment, but that this is documented in the notes and on the requisite estimate form.

■ Doug Hamilton is a dento-legal adviser at MDDUS

Guidance

GDC guidance on contractual consent

- 1.5 Always make clear to the patient:
 - the nature of the contract, and in particular whether the patient is being accepted for treatment under the NHS or privately; and
 - the charge for an initial consultation and the probable cost of further treatment.
- 1.6 Whenever a patient is returning for treatment following an examination or assessment, give them a written treatment plan and cost estimate.
- 1.7 If, having agreed an estimate with the patient, you think that you will need to change the treatment plan, make sure you get the patient's consent to any further treatment and extra cost, and give the patient an amended written treatment plan and estimate.

From *Principles of Patient Consent*. General Dental Council 2005

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

CONSENT: AGGRESSIVE REFUSAL

BACKGROUND: A GP practice receives a letter of complaint from Mrs T, the sister of 52-year-old Ms R who died at home of a perforated duodenal ulcer. Ms R was a chronic alcoholic and patient with the practice. In the letter Mrs T explains how a neighbour had called in a few days before her sister's death and found her very unwell with constant vomiting. She phoned an ambulance and the paramedics arrived but Ms R refused to be taken to hospital.

Two days later the neighbour called in again and found Ms R collapsed on the bathroom floor. She phoned the practice and the on-call GP – Dr K – attended the patient at home. Ms R said that because she had not been feeling well she had not drunk any alcohol for the last few days. Dr K diagnosed alcohol withdrawal syndrome and tried to help Ms R off the floor and back into bed but the patient refused and became aggressive. The neighbour then phoned Mrs T who lived in a distant city and she spoke to Dr K requesting that he have Ms R sectioned but the doctor said that was not possible. He then left the flat with Ms R still lying on the bathroom floor.

The neighbour found a blanket for Ms R to make her more comfortable and returned later after work to find she had died.

In her letter of complaint Mrs T alleges that Dr K was dismissive toward her sister and did not adequately examine her in order to make a diagnosis, nor did he put sufficient effort in trying to convince Ms R of the seriousness of her condition.

ANALYSIS/OUTCOME: The practice contacts an MDDUS adviser who requests a response from Dr K setting



out his account of the case. In his note Dr K confirms that he did attend Ms R in her flat and found her lying on the bathroom floor. He offered to help her back to bed but the patient pushed him away saying that she wanted to be near the toilet. When Dr K persisted she became abusive and refused any attempt at examination.

Dr K attempted to reason with Ms R, telling her he thought it essential that she be admitted to hospital for diagnosis and treatment but the patient claimed that once she left the flat the Housing Association would be in to give it away to another tenant. Over time Ms R grew increasingly abusive and demanded that the doctor leave.

Dr K then asked the neighbour if Ms R had any close family and that was when the phone call was placed to Mrs T. The GP explained to the sister that he thought Ms R was suffering alcohol withdrawal symptoms and that she refused to be examined and would not consider hospitalisation – and in the circumstances there was little else he could do, especially as he had been told to leave the flat. He suggested that perhaps Ms R would listen to her sister

if she were to visit. Before departing he agreed with the neighbour that she should look in again and phone if Ms R's condition grew worse. The next he heard the patient had died.

The MDDUS adviser helps the practice manager draft a response to the letter of complaint in which Dr K's account of the events is presented. In reply to the claim that the GP should have had Ms R sectioned it is pointed out that this is only possible if a patient is judged to be lacking legal capacity to consent. Patients have the right to make bad decisions about their health and refuse treatment.

The manager further informs Mrs T that the practice will carry out a significant event analysis and look at how they might better deal with such situations in future. An offer of a meeting to further discuss the issue is ignored and the case is closed.

KEY POINTS

- Competent patients who persistently refuse advice or consent leave doctors few options when it comes to care.
- Patience and persuasion are all that a clinician can rely on in such cases.



TREATMENT: FIRM REBUTTAL

BACKGROUND: A 43-year-old woman, Mrs L, attends her dental practice for an emergency appointment



complaining of a severe toothache and swelling. She is seen by Mr B who on examination finds a grossly decayed and infected lower left

molar with swelling of the associated tissues indicating infection spreading into her jaw. Extraction of the tooth is clearly indicated and the dental records state: "ext LL6 with forceps uneventful". Mr B also prescribes an antibiotic for the infection.

Three weeks later the dental practice receives a letter from the Citizen's Advice Bureau (CAB) written on behalf of Mrs L. It states that later in the evening after her visit to the dentist she experienced symptoms of sickness and high fever. Her husband

brought her to the local A&E where she was diagnosed with blood poisoning and admitted to hospital. She was discharged three days later.

In the letter Mrs L alleges that it is clear the blood poisoning was a result of her dental treatment and she demands a refund of the dental fees and recompense for three days lost earnings from her job as a cleaner.

ANALYSIS/OUTCOME: Mr B sends the CAB letter to the MDDUS along with a suggested draft reply. A dental adviser liaises with the dentist on some of the wording.

In his reply Mr B expresses his regret that Mrs L had been hospitalised. He confirms that she did attend his surgery for an emergency appointment at which a molar was extracted following detailed discussion and with her consent. He explains that in most cases extraction is sufficient to resolve the symptoms and alleviate

pain and swelling but sometimes infection is too deep-seated and additional treatment is required. This is especially the case where infection is already present and the patient is a smoker with poor oral hygiene.

Mr B points out that Mrs L has a history of neglected dentition and that she rarely attends her dental practice except for emergency appointments. For these reasons he refuses to refund the treatment fees or offer compensation for the days off work. He further suggests that Mrs L be advised to regularly attend for dental treatment in order to prevent similar problems in future.

KEY POINTS

- Advise high-risk dental patients of any potential complications after treatment.
- Record advice to patients on the importance of proper dental hygiene.



PATIENT COMPLAINT: COLD REPLY

BACKGROUND: Mrs C, 53, has been unwell for several days, feeling weak and vomiting frequently. She has long-standing health problems, including a history of cancer, and has attended a number of hospital appointments over the previous 12 months. Fearing her health may be deteriorating, her husband calls her GP practice to request a home visit.

He speaks to his wife's regular GP, Dr M, who provides a phone consultation instead of a home visit. He writes a prescription for Mrs C with an increased dose of her existing medication for pick-up at the practice. Over the next few weeks Mrs C's condition does not improve and Mr C makes further calls to the practice. Dr M continues to consult by phone but on two occasions the duty doctor makes a home visit.

Initially Mrs C appears to be responding well to medication but on the second visit she is referred to hospital. Her condition deteriorates further and she dies two weeks later.

The practice receives a formal complaint from Mr C regarding the

standard of treatment his wife received in the months before her death. In particular, he is angry that Dr M ignored his requests for a home visit and insisted on telephone consultations.

The practice responds by detailing the numerous contacts Mrs C had with the practice shortly before her death, concluding that Dr M acted appropriately in all instances. Mr C is unhappy and forwards his complaint to the health service ombudsman.

ANALYSIS/OUTCOME: Dr M seeks advice from MDDUS on how to respond to the ombudsman. An adviser explains that the practice's initial response to Mr C's complaint appears purely factual and lacking in empathy and did not address the specific concerns regarding the standard of care provided. She helps Dr M draft a suitable response that explains their clinical decision-making, including why home visits were denied. She advises the letter should also express concern



at the factual nature of the original response and explain that the practice will ensure future complaint responses fully address the concerns stated. It should also mention that the practice

held a significant event analysis in order to learn from the mistakes made.

The ombudsman identifies a number of failings in Dr M's clinical decision-making and in the practice's complaint handling but they accept the practice have taken steps to address these issues. The practice is advised to apologise in writing to Mr C and the matter is taken no further.

KEY POINTS

- Ensure complaint responses address the complainant's concerns and are not simply a list of factual statements about treatment provided.
- Seek advice before responding to patient complaints as an ill-conceived response risks further difficulties with the health service ombudsman.

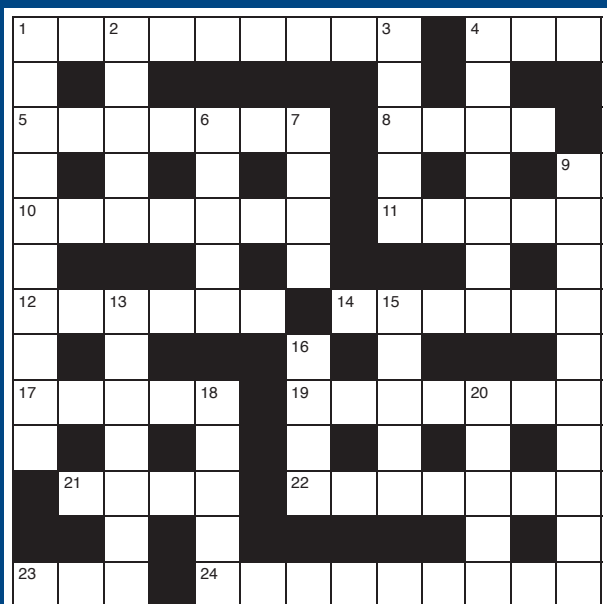


Object obscura: Skull saw

PHOTOGRAPH: SCIENCE & SOCIETY

THIS skull saw dates from the early 20th century and would have been used in preparation for brain surgery. A crank handle moves the blade.

Crossword



ACROSS

1. Famous medical whistleblower (9)
4. Gives guidance on prescribing of medication (abbr.) (3)
5. Peptide hormone (7)
8. Now known as Diabetes mellitus type 1 (abbr.) (4)
10. Adverse reaction to gluten (8)
11. Vertebral column (5)
12. Mucus of the respiratory system (6)
14. Pertaining to the seven articulating bones in the foot (6)
17. Disease named after a Democratic Republic of the Congo river (5)
19. Diameter of a tube or cylinder (7)
21. State of unconsciousness (4)
22. Mental retardation (7)

23. Frequently the abbreviation of a government department? (3)

24. Neurological disorder affecting co-ordination (9)

DOWN

1. Ethics (10)
2. Gang of hunters (5)
3. Flags down a taxi (5)
4. Film villains (7)
6. Fibbing (5)
7. A pleasant acronym for NHS standards body (4)
9. He sang of Laughter in the Rain (4,6)
13. Sentinel (7)
15. Askew, out of kilter (5)
16. Prefix meaning "eight" (4)
18. Bestow (5)
20. Neurotoxin used for cosmetic procedures (brand name) (5)

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

From the archives: A sharp exit

TODAY we refer to some clinical errors as "never events" – though sadly not because they never happen. In 1935 such errors were no less inexcusable. An article from the *Guardian* newspaper in December of that year reports on a dentist in Congleton, Cheshire, who removed three teeth from a patient without her consent.

Mrs M Harrison attended the dentist to have a single tooth in her upper jaw removed and to arrange for two artificial teeth. The dentist advised her against the artificial teeth as he believed the wires would decay the adjoining teeth. In his view Mrs Harrison would get a better result if she had all the remaining teeth in her upper jaw removed in order to fit a set of dentures.

The patient agreed and at her next appointment was administered gas and on regaining consciousness discovered that three teeth from her lower jaw had been removed. In the later court case the solicitor acting for Mrs Harrison related: "The plaintiff was terribly upset and at once told Mr Millington [the dentist] that he had done wrong; that he had no right to touch her bottom teeth and that she never asked him to do so. Millington replied, 'I know I have made a mistake'. Then before Mrs Harrison had even had her mouth washed out, Millington put on his hat and coat and left the premises."

The counsel for the defence tried to argue that the three teeth removed from the lower jaw were decayed and that Mrs Harrison had instructed the defendant to remove them. But the presiding judge did not buy this explanation and Mr Millington eventually admitted that he was in a hurry on the day in question and that he might have confused Mrs Harrison's case for another one.

The judge found for the plaintiff and Mrs Harrison was awarded £55 and legal costs.



Vignette: research ethicist and medical educator, Maurice H. Pappworth (1910-1994)

PHOTOGRAPH: COURTESY OF NGAIRE AND HILARY WATSON



MAURICE H. PAPPWORTH was accused of washing his profession's dirty linen in public when he blew the whistle on unethical research practices in the 1960s, but is now recognised as one of the pioneers of modern research ethics.

Pappworth was born in Liverpool in 1910, the second son of an Eastern European family of Jewish immigrants. He went on to study medicine at the University of Liverpool and passed his MRCP in 1936. He hoped to make a successful career as a consultant physician in a London teaching hospital, but he was never to realise that ambition. Whether this was because of his abrasive and outspoken attitude or whether it was because of anti-Semitism (he was told at one job interview in the 1930s that "no Jew could ever be a gentleman") is debatable, but it meant that he felt no professional constraint to hold his tongue when he later suspected wrong-doing amongst his peers.

He opted to put up his plaque in Harley Street as a private physician and to become a tutor, coaching students for the MRCP examination. As gifted a teacher as he was a student, Pappworth angered those at the Royal College who felt he was interfering with their business. At a time when the pass rate for the MRCP examination was less than 15 per cent, Pappworth's students had much greater success. Understandably irked, one examiner once asked him "what exactly do you teach these fellows?" Pappworth replied, perhaps with a mind to his view of the College's exam format, "I just teach them tricks."

Pappworth's concern with medical ethics began in the 1950s. He was troubled by tales of unethical clinical research, recounted to him by his students, which took place, seemingly at large, in London hospitals. The promotion of a junior doctor in a large teaching hospital at the time depended heavily not on his or her clinical ability, but on their published works. Pappworth felt this contributed to poor research practices and the compromise of patient safety.

He first wrote on the subject in a magazine article in 1962, but carefully named no names. Five years later, he changed his tack and chose to name and shame, even including in his groundbreaking book, *Human Guinea Pigs*, an alphabetical list of those involved. He targeted studies conducted on vulnerable groups, such as children, adults suffering from mental illness and prisoners. The common feature he identified in these experiments, and his main complaint, was deception. The patients were rarely told of their participation, and their valid informed consent was never sought. Some patients found themselves being used as convenient subjects to evaluate new treatments or tests, none of which would be of any personal benefit.

Shortly before his book was launched, he described receiving anonymous phone-calls urging him not to publish "for the good of the profession". By this time, however, he firmly believed that his profession's good would be best served by transparency and debate. And, if possible the censure of those involved.

Predictably, his profession closed ranks and he was ostracised. His former secretary, Helen Bamber, tells of the fear and isolation he expressed at the time. "He had a lot to protect," she recalled. He was a father of a young family, self-employed and reliant on the referral of patients for his livelihood, and his publications could very well have destroyed everything. It is easy to forget the personal price paid by whistleblowers. Driven by the need to right a wrong they may place themselves and their families in the firing line. While ethics is the foundation of all we do in medical research, it is far from being an academic exercise. Ethics in action can be an ugly affair; pitting colleague against colleague, destroying careers and lives in the process.

Pappworth was not forgiven until three decades later when in 1993, the year before his death, he was invited to become a Fellow of the Royal College of Physicians, an honour normally accorded any

physician who had been a member for 10-15 years. Pappworth had been a member for 57 years. When his name was called at the ceremony his profession, which had kept him at arm's length for a lifetime, gave him an ovation.

What did he achieve? It is hard to imagine that the current system of rigorous ethical review of research would be in place without Pappworth. He found the charge that he had simply washed his profession's dirty linen in public unacceptable. In one of his last articles he wrote: "My opinion remains that those who dirty the linen and not those who wash it should be criticised. Some do not wash dirty linen in public or in private and the dirt is merely left to accumulate until it stinks."

Interestingly, Pappworth, who had been ousted from his Harley Street consulting room in the early 1960s for breaking his lease by using it for teaching, had been forced to set up shop elsewhere. One former Australian student, Antonia Bagshawe, now a retired physician, recently recalled that venue: "He was 'relegated' to the basement of Seymour Hall...underneath (or even within) a laundry." That Pappworth should have found himself teaching in a laundry seems appropriate. Where better, perhaps, to wash a profession's dirty linen?

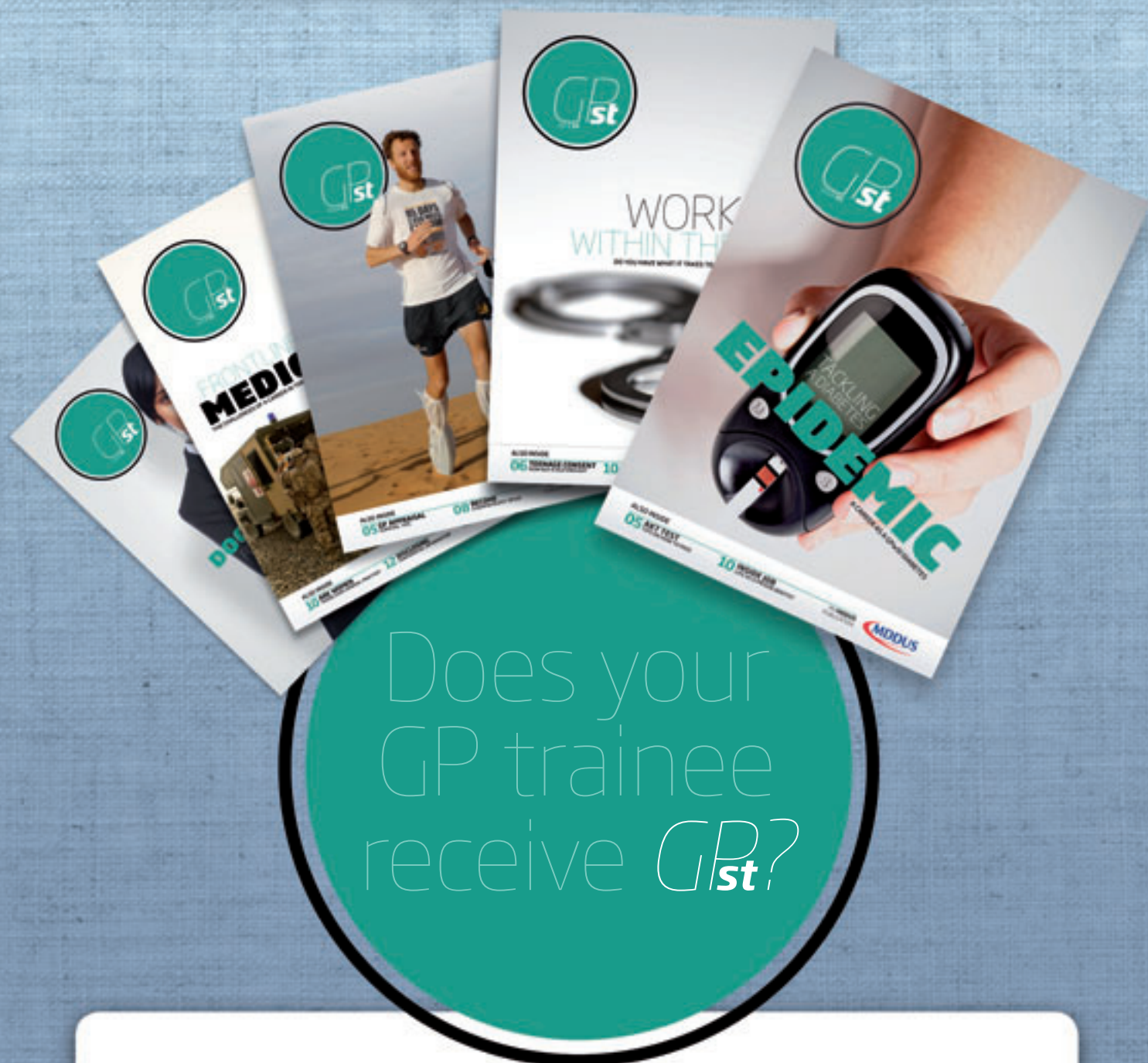
■ **Dr Alan Gaw is a clinical researcher and writer in Glasgow**

Sources

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Human Guinea Pigs and other books and papers by Maurice Pappworth

Is your practice a training practice?



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