

SUMMER 2013

# SUMMONS

AN  PUBLICATION FOR MEMBERS

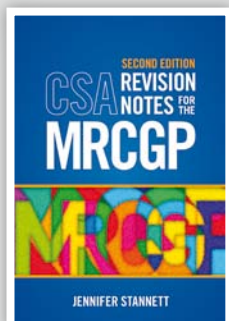


• Q&A: Julie Bailey • A good death • Dental partnership disputes •

# 25% discount for MDDUS Members from Scion Publishing Ltd.

www.scionpublishing.com/mddus

+ 44 [0] 1295 258577



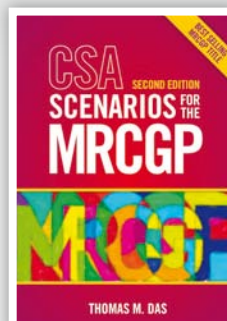
## CSA Revision Notes for the MRCGP 2nd Edition

J. Stannett

*CSA Revision Notes for the MRCGP* provides the reader with an effective framework for preparing for the Clinical Skills Assessment exam. Written by a recently-qualified doctor with fresh memories of the CSA exam, the book is an essential aid for anyone getting ready to sit the exam. The book is an essential revision source for anyone preparing for the CSA exam.

Paperback, £26.99  
**Offer Price £20.24**

★★★★★ (9)



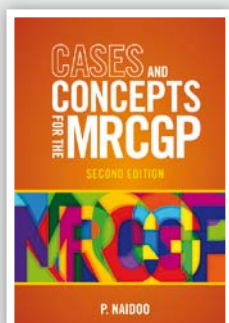
## CSA Scenarios for the MRCGP 2nd Edition

T. Das

The best-selling CSA book on the market. Using a consistent approach to over 100 scenarios, the book provides up-to-date information in a concise and accessible manner. The unique grid-based approach enables the candidate to complete any particular case within 10 minutes. This new edition continues the successful format of the first edition, but adds many new topics.

Paperback, £27.99  
**Offer price £20.99**

★★★★★ (17)



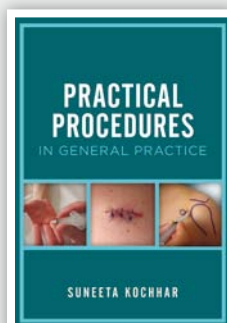
## Cases and Concepts for the MRCGP 2nd Edition

P. Naidoo

*Cases and Concepts for the new MRCGP* helps candidates prepare for CSA and CbD by familiarising them with typical questions and answers, and providing a structured approach to decision making. This new edition, now featuring over 200 "test yourself" questions, is the ideal revision guide to use alongside the practical book *Consultation Skills for the new MRCGP*.

Paperback, £26.99  
**Offer price £20.24**

★★★★★ (2)



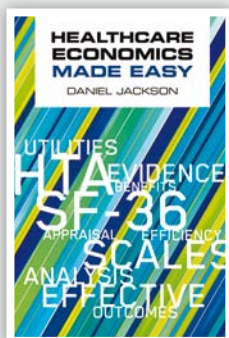
## Practical Procedures in General Practice

S. Kochhar

*Practical Procedures in General Practice* is an essential guide for any GP looking to establish a minor surgery service, and covers:

- setting up a minor surgery clinic
- advice on local funding guidelines
- patient selection and assessment
- basic operative procedures
- joint injections
- long-term contraception

Paperback, £25.99  
**Offer price £19.49**



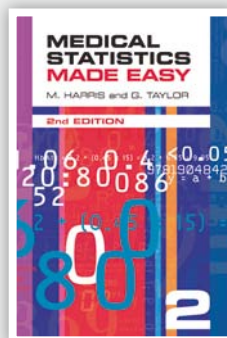
## Healthcare Economics Made Easy

D. Jackson

*Health Economics Made Easy* is a clear and concise text written for those working in healthcare who need to understand the basics of the subject but who do not want to wade through a specialist health economics text.

Paperback, £15.99  
**Offer price £11.99**

★★★★★ (9)



## Medical Statistics Made Easy 2nd edition

M. Harris and G. Taylor

*Medical Statistics Made Easy* 2nd edition continues to provide the easiest possible explanations of the key statistical techniques used throughout the medical literature.

Featuring a comprehensive updating of the 'Statistics at work' section, this new edition retains a consistent, concise, and user-friendly format.

Paperback, £15.99  
**Offer price £11.99**

★★★★★ (25)

ORDER AT [WWW.SCIONPUBLISHING.COM/MDDUS](http://WWW.SCIONPUBLISHING.COM/MDDUS)

SIMPLY ADD THE BOOKS YOU WANT TO YOUR SHOPPING BASKET AND THEN ENTER THE CODE: **MDDUS07** IN THE 'REDEEM VOUCHER' BOX.



IN THIS ISSUE

JULIE Bailey is a woman who knows the cost of pointing out uncomfortable truths. For five years the café owner's life was "on hold" with the Cure The NHS campaign which she founded after witnessing the "shocking neglect" of her elderly mother and other patients at Stafford Hospital. This led to a victory of sorts with the critical findings and sweeping recommendations of the Francis Inquiry – and also perhaps an expectation she might put the ordeal behind her.

But in June the BBC reported that she was selling the lease to her café and leaving Stafford as some locals had grown hostile, accusing her of trying to get the hospital closed down. "I don't feel safe, to be honest," she said. Certainly much of this trouble could have been avoided by just saying nothing – a dilemma faced by all whistleblowers. On page 10 Julie Bailey talks to *Summons* about what motivated her to speak out.

Also in this issue (page 16) GP and Macmillan facilitator, Euan Paterson, offers a perspective on the challenges of providing

high-quality palliative care in the community – the first instalment of a two-part article. And on page 14 solicitor Andrea James looks at new guidance from the GMC on the obligation of doctors to raise and act on concerns over patient safety, even if professional loyalties are at stake.

Dental partnerships are a bit like marriage – blissful at best, rancorous at worst. Michael Royden of Thorntons Law offers some advice on dealing with discord on page 18.

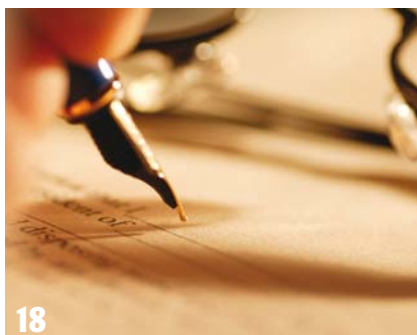
In May of this year MDDUS acted again as main sponsor of the BMJ Group Awards and a big winner on the night was the Britain Nepal Otolaryngology Service or BRINOS. On page 12, founder Neil Weir tells how the organisation was established. And on page 9, Deborah Bowman draws some curious ethical lessons from Danish political drama *Borgen*.

Jim Killgore, editor



12

**12 BREAKING THE SILENCE**  
DENT surgeon Neil Weir describes how a holiday encounter led to the founding of an innovative medical charity in Nepal



18

**14 DON'T TURN A BLIND EYE**  
Solicitor Andrea James looks at GMC guidance on the obligation to report concerns over patient safety

**16 A GOOD DEATH**  
First of a two-part series on the challenges of providing high-quality palliative care in the community

**18 TOGETHER FOR BETTER OR WORSE**  
Michael Royden offers advice on dental partnership disputes – avoid them where you can, resolve them where you can't

REGULARS

- 4 Notice Board
- 6 News Digest
- 8 Employment Law: Is obesity a disability?
- 9 Ethics: Lessons from across the North Sea
- 10 Q&A: Julie Bailey
- 20 Case studies: Broken smile, Full disclosure, A personal decision
- 22 Addenda: The eminent American, Ritter dental X-ray machine, Crossword and Vignette: Richard W Smithells, paediatrician and researcher



Cover image: Sunny Bench Italy by Tim Cockburn

Tim Cockburn was born in Sheffield in 1955 and studied painting at Edinburgh College of Art from 1974-1978. An award from the Elizabeth Greenshields Foundation in 1981 enabled him to paint in Tuscany and Umbria after which he travelled to India and Sri Lanka. The main

theme of his work at this time was landscape and this screenprint, with its strong shapes of flat, bright colour, is typical of his work during that period of his career.

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](http://www.artinhealthcare.org.uk) Scottish Charity No: SC 036222.

**Editor:**  
Jim Killgore  
**Associate editor:**  
Joanne Curran

**Editorial departments:**  
MEDICAL Dr Jim Roger  
DENTAL Mr Aubrey Craig  
LEGAL Simon Dinnick  
RISK Peter Johnson

Please address correspondence to:

**Summons Editor**  
MDDUS  
Mackintosh House  
120 Blythswood Street  
Glasgow G2 4EA  
[jkillgore@mddus.com](mailto:jkillgore@mddus.com)

**Design and production:**  
CMYK Design  
0131 556 2220  
[www.cmyk-design.co.uk](http://www.cmyk-design.co.uk)



**Printing and distribution:**  
L&S Litho



Summons is published quarterly by The Medical and Dental Defence Union of Scotland, registered in Scotland No 5093 at Mackintosh House, 120 Blythswood Street, Glasgow G2 4EA. • Tel: 0845 270 2034 • Fax: 0141 228 1208

Email: General: [info@mddus.com](mailto:info@mddus.com) • Membership services: [membership@mddus.com](mailto:membership@mddus.com) • Marketing: [marketing@mddus.com](mailto:marketing@mddus.com) • Website: [www.mddus.com](http://www.mddus.com)

The MDDUS is not an insurance company. All the benefits of membership of MDDUS are discretionary as set out in the Memorandum and Articles of Association.

The opinions, beliefs and viewpoints expressed by the various authors in *Summons* are those of the authors alone and do not necessarily reflect the opinions or policies of The Medical and Dental Defence Union of Scotland.



### Winners announced at BMJ Awards 2013

THE very best of patient care was celebrated at the BMJ Awards in London on May 9.

Individuals and medical teams who have made outstanding contributions to healthcare were honoured at the ceremony at the Westminster Plaza Hotel. MDDUS was proud to be principal sponsor of the event – now in its fifth year – and the Union's chief executive Professor Gordon Dickson welcomed the 644 guests, 63 shortlisted teams and 15 winning teams who had travelled to the event from all over the UK. The awards were hosted by comedian Dara O'Briain.

MDDUS Chairman Dr Brendan Sweeney (above) handed out the MDDUS-sponsored Primary Care Team of the Year Award to Littlewick Outreach to Vulnerable Elderly

### Dental indemnity or insurance?

ALL dentists are required by the GDC to ensure that patients are "able to claim any compensation they may be entitled to by making sure you are protected against claims at all times, including past periods of practice." This is currently a professional rather than a legal requirement.

But in October 2013 a new EU directive will come into force requiring by law that "systems of professional liability insurance, or a guarantee or similar arrangement that is equivalent or essentially comparable as regards its purpose and which is appropriate to the nature and the extent of the risk, are in place for treatment provided".

A number of members have recently called MDDUS asking if this means dentists will need an insurance product rather than access to indemnity as is provided by MDDUS.

The short answer is "no". Back in June of 2010 an Independent Review Group appointed by the Government made recommendations on UK compliance to the EU directive. In its report, the group concluded that requiring healthcare professionals to have indemnity or insurance cover in place as a condition of their registration was the most cost effective and efficient means of achieving the policy objective. The group made clear that **either** indemnity **or** an insurance product would be adequate to comply with the EU directive. The Department of Health has accepted these recommendations and, therefore, there is no specific stipulation that dentists will be required to have only an insurance product in place and not an indemnity product.

Membership of the MDDUS provides occurrence-based indemnity. This means that members are eligible for assistance for all events that occur while you are a member, regardless of when an actual claim is made. You will enjoy the full support of MDDUS even if you have moved abroad, ceased clinical work or retired. Insurance products operate in a completely different way; they usually only guarantee protection if you are insured both when the incident occurred and when the claim is made. The crucial importance of this lies in the fact that medical and dental malpractice claims can be made several months or even years after the events that give rise to the claim.

Occurrence-based indemnity, as offered by the MDDUS, can meet claims that arise from treatment carried out in the past without the need for any further premium to be paid and can protect the member in perpetuity. There is no financial cap, or limit per claim, as is often the case with insurance products.

Claims-made insurance only covers you for the period for which the policy is in force. Claims from the past may have to be covered by the payment of an additional premium or run-off cover. This is in effect a "hidden" cost and risk of insurance.

Aubrey Craig, head of dental services, MDDUS

(LOVE) Project in Derbyshire who target unmet health and social care needs among over-70s. The prestigious Medical Team of the Year went to the Britain Nepal Otology Service (BRINOS) which has carried out more than 4,000 major ear operations at surgical and out-patient camps in Nepal (see page 12 of this issue).

For a full list of all the winners log on to the awards website at <http://groupawards.bmj.com>

### Keep us informed of private practice earnings

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

### IN BRIEF

● **NEW ONLINE RISK RESOURCE ON CONSENT** Check out the second module of our free interactive online risk resource designed by MDDUS specifically for GPs, practice managers and practice staff. The e-Learning Risk

Resource on consent highlights some of the most common areas of risk in general practice and offers guidance and practical advice. The new module can be accessed in the Training and Consultancy section of [mddus.com](http://mddus.com).

● **PRESCRIBING BENZODIAZEPINES - ONLINE CPD** A new online CPD learning module outlining the key risks in prescribing benzodiazepines has been produced by the MHRA. The self-directed learning package has

been approved for up to 2.5 CPD credits and covers the various types of benzodiazepine drugs encountered, risks in use and how these risks can be reduced, as well as important drug interactions. Access at [www.tinyurl.com/d64bkju](http://www.tinyurl.com/d64bkju)

## ➔ New disclosure requirements for English practitioners

MOST GPs and GDPs in England will be aware that on 1 April the new Performers List Regulations 2013 came into effect. Previously local PCTs held their own performers lists but now with the reconfiguration of primary care services in England and the disbanding of individual PCTs, one central performers list will be maintained by a new overarching NHS Commissioning Board. The list will be administered on a local level by local area teams (LATs).

MDDUS is advising members affected to familiarise themselves with the new regime if they have not already done so.

Among changes of particular significance under sections 4 and 9 of the new regulations is a requirement that practitioners on a performers list disclose certain investigations to their LAT, regardless of whether any finding has been made against them. More specifically this means that a GP must inform the LAT if he or she "becomes the subject of, or has had an adverse finding made as a result of, any investigation by any regulator or other body".

It is presumed this includes Ombudsman's, GMC/GDC and SUI-type investigations on a local level but given the lack of clarity we would urge any members who are unsure as to

whether they need to inform their LAT of an investigation to contact the MDDUS for advice and assistance. The same requirements also apply for investigations or adverse findings in previous employment.

Section 9 of the regulations also requires disclosure of involvement in a coroner's inquest. This includes anyone who falls within Rule 20(2)(d) or Rule 24 of the Coroner's Rules 1984 whose "acts or omissions may have caused or contributed to the death", or who is considered by the coroner to be a properly interested person (PIP) in an inquest. Again, this is something of a grey area as there is a lack of uniformity between coroners as to what makes a witness a PIP. We would therefore advise any member to seek assistance from MDDUS straight away in order that we can assist both with the inquest and with the LAT disclosure.

Disclosure is required within seven days of being informed of an investigation or being called as a witness at an inquest and we urge members to act without delay in complying with the regulations. If in any doubt, please contact the MDDUS for assistance.

Susan Trigg, solicitor, MDDUS

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

We would like to be clear that the figure used should be your gross private earnings from the practice of medicine, however delivered. In the event that you have formed a company for accounting or other purposes, the relevant figure is the gross income to that company in relation to your practice of medicine. In our recent experience, there are still a small number of doctors declaring their salary from their company, as opposed to the gross fees. In such circumstances we have discretion to make adjustments retrospectively to ensure adequate and appropriate indemnity is in place.

At the heart of the principle of mutuality is the fact that all members should contribute an appropriate amount to the common fund that is held on behalf of all members. This is an

important principle and we do carry out checks of gross private practice earnings from time to time to ensure that it is being complied with.

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

## ➔ MDDUS expands advisory staff

MDDUS has recruited five new advisers to meet the continued growth in members throughout the UK.

Dr Naem Nazem has taken up his role as medical adviser, joining recent new recruits Dr Caroline Osborne-White and Dr Richard Brittain in the MDDUS medical division in London where they will provide medico-legal advice and support for members.

Former practice managers Helen Ormiston and Scott

Obrzud have also joined the Union as practice advisers who will be on hand to offer telephone advice on common practice-related matters.

MDDUS has enjoyed more than a decade of undiminished growth and the staff changes are part of a programme to expand and streamline our medical advisory division. Among other changes Mr Riaz Mohammed has now retired from his position as a senior medical adviser and we are delighted he will continue to assist by providing part-time telephone advice.



● **LEADING THROUGH UNCERTAINTY** MDDUS still has a limited number of places on its popular 'Leading through uncertainty' course being held in September. This intensive five-day course is aimed at doctors with management

responsibilities. The September course will be held in our Glasgow office on 2 to 6 September, 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](mailto:afitzpatrick@mddus.com) or call 0845 270 2034.

● **THE 2014 MDDUS PRACTICE MANAGERS' CONFERENCE** will be held again at the Fairmont St

Andrews in Scotland on Thursday 6 and Friday 7 March 2014 – so mark your diaries. More details about content and prices can be found on the back cover of this issue or contact [afitzpatrick@mddus.com](mailto:afitzpatrick@mddus.com) or call 0845 270 2034

### ➔ GDC gives green light for direct access

DENTAL hygienists and therapists will now be able to offer treatment without a prescription or patients having to see a dentist first under new GDC rules.

The decision to remove the barrier to direct access for some dental care professionals was made following a GDC consultation and full discussion of the evidence at a Council meeting in March.

Under the changes, dental hygienists and therapists can now carry out their full scope of practice without prescription and without the patient having to see a dentist first, but the guidance makes clear that they must be confident that they have the skills and competences required to treat patients direct. The GDC believes that a "period of practice working to a dentist's prescription is a good way for registrants to assess this".

Also under the new rules, dental nurses will be allowed to participate in preventative programmes, and orthodontic therapists will be able to carry out index of orthodontic treatment need (IOTN)

screening without the patient having to see a dentist first.

Clinical dental technicians will continue to see patients direct for the provision and maintenance of full dentures only and will otherwise carry out their other work on the prescription of a dentist, but this decision could be reviewed in future given the potential for further training for CDTs. The work of dental technicians (other than repairs) will continue to be carried out on the prescription of a dentist.

GDC chair Kevin O'Brien said: "Registrants treating patients direct must only do so if appropriately trained, competent and indemnified. They should also ensure that there are adequate onward referral arrangements in place and they must make clear to the patient the extent of their scope of practice and not work beyond it."

The move has been condemned by the BDA's General Dental Practice Committee who said the decision "fails to promote the concept and value of the dental team, which we believe is integral to the delivery of safe, high-quality care for patients."

### ➔ Weekend surgery more risky

MORTALITY rates assessed in a review of elective surgery were 82 per cent higher in procedures performed over the weekend rather than on a Monday. These are the findings of a new study published by the *BMJ*.

Researchers at Imperial College London looked at over four million elective procedures conducted in NHS hospitals in England between 2008 and 2011 and found that the mortality rate was lowest for patients having operations on Monday and increased for each subsequent day of the week.

The odds of death were 44 per cent higher for operations on a Friday rather than a Monday and rose to 82 per cent for those performed over the weekend – though the relative number of weekend operations was small and may represent a different mix of patients.

The authors of the study suggest the findings could reflect differences in the quality of care at the weekend. Lead researcher Dr Paul Aylin of the School of Public Health at Imperial said: "The first 48 hours after an operation are often the most critical period of care for surgery



patients. So if the quality of care is lower at the weekend as some previous studies have suggested, we would expect to see higher mortality rates not just for patients operated on at the weekend, but also those who have operations towards the end of the week, whose postoperative care overlaps with the weekend. That is what we found.

"Unlike previous studies, we included both deaths in hospital and deaths after discharge, so this eliminates a potential bias of counting only in-hospital deaths. We tried to account for the possibility that different types of patients might have operations at the end of the week, but our adjustment made little difference. This leaves us with the possibility that the

differences in mortality rates are due to poorer quality of care at the weekend, perhaps because of less availability of staff, resources and diagnostic services."

### ➔ Nearly half of GPs risk burnout

A RECENT survey carried out by *Pulse* has revealed that 43 per cent of GPs are at a high risk of suffering burn out.

Over 1,700 GPs were assessed using the Maslach Burnout Inventory tool which was adapted with input from the Royal College of General Practitioners. It contained questions assessing three key areas signalling a high risk of burnout – emotional exhaustion, depersonalisation and a low level of personal accomplishment.

The survey found that 43 per cent of GPs showed a high risk in all three areas and 99 per cent in at least one. Of particular concern was the finding that 97 per cent of GPs do not believe they are "positively influencing other people's lives or accomplishing much in their role".

Doctors who suffer from burnout should seek help before patient safety is compromised, says MDDUS medical adviser Dr Barry Parker.

"While doctors are caring for patients,

## IN BRIEF

### ● FEVER IN CHILDREN

Febrile children with tachycardia should be considered to be at "intermediate risk" at least for serious illness, according to updated NICE guidance, which also provides greater clarity on the use of paracetamol and ibuprofen

in children with high temperatures. The updated guidelines retain most of the original recommendations, including use of the traffic light system to predict the risk of serious illness in febrile children. Access at <http://guidance.nice.org.uk/CG160>

### ● UK ORGAN DONATION RISE

Organ donations in the UK have increased by nearly 50 per cent in the last five years according to statistics released by NHS Blood and Transplant (NHSBT). The number of deceased organ donors increased from 809 in 2007/8 to

1,212 in 2011/12 while total organ transplants from deceased donors increased 30.5 per cent from 2,385 in 2007/8 to 3,122 in 2011/12. The findings mean that the target of a 50 per cent rise in organ donors set by the Department of Health's Organ Donation Taskforce

they can sometimes neglect to care for themselves," says Dr Parker.

"Speaking to a colleague or their own GP about these issues should not be seen as a sign of weakness. More and more doctors are suffering from stress or health problems as workload increases. Doctors who are concerned about a colleague's wellbeing are advised to be sensitive and encourage them to seek help."

### ➔ **New sharps regulations take effect**

NEW regulations requiring UK healthcare employers and contractors to have effective arrangements for the safe use and disposal of sharps have come into force this month.

Under The Health and Safety (Sharp Instruments in Healthcare) Regulations employers will be required to have clear arrangements for the safe use and disposal of sharps, including using 'safer sharps' where reasonably practicable, restricting the practice of recapping of needles and placing sharps bins close to the point of use.

The regulations also call for the provision of necessary information and training to workers, and a responsibility to investigate and take prompt action in response to work-related sharps injuries.

The Health and Safety Executive (HSE) introduced the new regulations in compliance with a European Directive. Guidance for healthcare employers and employees is available from the HSE website ([www.hse.gov.uk](http://www.hse.gov.uk)).



### ➔ **More regulation needed in cosmetic interventions**

THE MULTI-BILLION pound UK industry providing surgical and non-surgical cosmetic interventions is inadequately regulated according to an independent review published by the Department of Health in England.

Led by NHS Medical Director Professor Sir Bruce Keogh, the review found that despite the popularity of Botox, dermal fillers and laser hair removal – which account for nine out of 10 procedures in the UK – these non-surgical interventions are subject to almost no regulation.

Recommendations outlined in the report *Review of the Regulation of Cosmetic Interventions* include making all dermal fillers prescription only and ensuring practitioners are properly qualified for all the procedures they offer, from cosmetic surgeons doing breast enlargements to people offering "injectables", such as dermal fillers or Botox. The review also recommended that there should be an ombudsman to oversee all private healthcare including cosmetic procedures.

The government commissioned the

review following the PIP breast implant scandal, which exposed significant lapses in product quality, aftercare and record keeping. It also drew attention to widespread use of misleading advertising, inappropriate marketing and unsafe practices across the sector.

Professor Sir Bruce Keogh, said: "At the heart of this report is the person who chooses to have a cosmetic procedure. We have heard terrible reports about people who have trusted a cosmetic practitioner to help them but, when things have gone wrong, they have been left high and dry with no help. These people have not had the safety net that those using the NHS have. This needs to change."

Other recommendations in the review include making providers ensure that potential patients are aware of the implications and risks of any procedure and giving them adequate time to consider this information before agreeing to surgery. There should also be an advertising code of conduct with mandatory compliance and indemnity products should be developed to protect patients in the event of product failure or provider insolvency.



in 2008 has been met.

● **JULY ARF PAYMENTS**  
Dental partners and managers are reminded to ensure all dental care professionals employed in practices have paid their GDC annual retention fee by 31 July 2013. Payment must be received on

or before that date if DCPs want to remain on the GDC's register and be eligible to work. The ARF is £120 for dental nurses, dental technicians, dental therapists, dental hygienists, clinical dental technicians and orthodontic therapists and can be paid by post, by phone or online

at [www.eGDC-uk.org](http://www.eGDC-uk.org)

● **DIAGNOSING SERIOUS BOWEL CONDITIONS**  
Draft NICE guidance advises doctors to use a simple stool test to reduce misdiagnosis of serious bowel disorders. The faecal calprotectin test helps to distinguish between illnesses

such as irritable bowel syndrome and more serious inflammatory bowel diseases such as ulcerative colitis and Crohn's disease. *The draft diagnostics guidance for faecal calprotectin tests for inflammatory diseases of the bowel* is available at <http://guidance.nice.org.uk/DT/12>

## IS OBESITY A DISABILITY?

Ian Watson

**THE COURTS** have recently reopened a debate which has been raging for some time in the UK courts and amongst employers. Is obesity a disability in itself – qualifying the person concerned to protection under UK discrimination law?

Given that an increasing number of citizens are overweight, this is obviously an issue of concern to medical practices, not simply as primary care providers but also as employers.

A survey of 2,000 HR managers by the personnel profession's magazine, *Personnel Today*, found that most preferred to offer jobs to workers of a "normal weight". This survey indicated a potentially worrying attitude towards overweight employees and/or job applicants, but the important question is whether there is any legislation offering protection to such workers.

Many aspects of discrimination have been tackled by legislation. For example, job applicants and/or employees can bring employment tribunal claims if they are discriminated against on the grounds of their sex, race, age, sexual orientation, religion, marital status, gender reassignment or maternity/paternity. However, there is no employment law in the United Kingdom which directly addresses discrimination against obesity.

This is in contrast to US law. For example, in California legislation has been passed which outlaws discrimination on the grounds of height or weight.

Nevertheless, some elements of UK employment law can be used to help protect overweight job applicants and employees. The most obvious avenue is protection against discrimination on grounds of a disability.

Disability is one of the few areas of discrimination where protection is only available if the person passes a 'test' – based on the medical (as opposed to the

social) model of disability.

The definition of disability in the Equality Act is that "... a person has a disability ... if he has a physical or mental impairment which has a substantial and long term adverse effect on his ability to carry out normal day to day activities ...". Therefore, if a person's obesity (or, importantly, subsidiary health conditions attributable to obesity) has lasted at least 12 months and substantially adversely affects their ability to perform everyday activities then it could be classed as a disability.

### "The appeal tribunal likened obesity with alcoholism"

In a recent disability discrimination case considered by the Employment Appeal Tribunal (EAT), the judge found that an obese employee was disabled and therefore could bring a disability discrimination claim against his employer. The employee in the case, Mr Walker, weighed 137 kilograms (21 ½ stones) and suffered from "functional overlay" compounded by his obesity, which caused him symptoms such as asthma, knee problems, diabetes, high blood pressure, chronic fatigue syndrome, bowel and stomach problems, anxiety and depression.

The original decision of the employment tribunal was that Mr Walker was not disabled because medical professionals could not find a physical or mental cause for his ailments, other than obesity. They found this because there was no single significant physical or mental impairment that caused his symptoms. The appeal tribunal overturned that decision: finding that the tribunal judge was wrong to concentrate on the literal meaning of "physical or mental impairment". Instead of focusing on the cause of the condition, the tribunal should have considered its effect on Mr Walker.

The EAT highlighted that, in considering whether an impairment is classed as a disability, the focus should be on the nature of the impairment itself rather than the cause of the impairment. It clarified that, while obesity itself is not considered a disability, the effect of the condition can give rise to ailments which could be classed as a disability.

The appeal tribunal likened obesity with alcoholism, a disease which is expressly excluded from the definition of a disability under the Equality Act. While an alcoholic may not be disabled solely because of their alcoholism, if they go on to develop liver failure as a result, the medical impairments they would suffer would make them disabled for the purposes of the Equality Act.

Importantly, although this case was specific to its facts, if obese employees (or applicants for employment) are covered by this protection they can potentially claim discrimination in recruitment processes if they are refused a job purely because of their condition. They may also claim adverse treatment whilst they are employed (such as harassment, on grounds of their obesity, by colleagues) or unfair dismissal, if this was purely related to their disability.

Guidance on disability discrimination under the Equality Act does say that account should be taken of how far a person can reasonably be expected to modify their behaviour to prevent or reduce the effect of any impairment on day-to-day activities. However, an employer must still be sensitive to the complicated issues that can cause a person to be overweight and not simply assume that it is just a matter of dieting and exercise.

Put simply, employers need to be aware of the potential for unfair treatment of workers with obesity and put in place measures (such as training for staff and fair recruitment practices) to reduce the likelihood of legal claims from obese people who are treated badly in the workplace.

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

**LAW**  
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](http://www.lawatwork.co.uk)*



# LESSONS FROM ACROSS THE NORTH SEA

Deborah Bowman

ETHICS



**I AM NOT** a woman who has her finger on the cultural pulse. So, I came to Scandinavian dramas later than most in the UK. Last night I finished watching *Borgen*. This morning, I am bereft. As I ponder life without Birgitte, Kasper and Katrine, I'm reflecting on what *Borgen* has to teach about ethics. Not convinced? Read on (it is spoiler free, I promise).

## Lesson 1: Idealism and ethical erosion

Birgitte begins her term of office as Danish Prime Minister with the confidence, energy and idealism that is reminiscent of healthcare students in their early years. Over time, she is exposed to a range of political practice and demands. She meets role models and cautionary tales. Birgitte's values and political aspirations are interrogated, mocked and forgotten. The experience of ethical erosion is well-documented in healthcare. It describes the process whereby individuals who were originally altruistic and committed become disillusioned or cynical about their work. It is closely associated with compassion fatigue and burnout.

It is, in my experience, rare that a clinician is or becomes 'unethical' or 'indifferent'. Rather, ethical erosion occurs because there is a significant gap between ethics in the abstract and its enactment in the daily provision of care. Being ethical is easier in theory. Yet clinical ethics is a practical pursuit and it is the practice of ethics that is most difficult. The challenge is to continue to embody ethics, values and virtues.

What is the difference between those who are able to remain true to their ethical values and those who are silent and unable to challenge others when they are ethically discomforted? It's a question that has long occupied bioethicists but it is the field of business (as well as fictional Danish politics) that offers a useful explanation for why putting ethics into practice can be so difficult. Mary Gentile, a professor working in the fields of business and leadership, has developed the 'Giving Voice to Values' project. Drawing on research published after the Second World War that explored why some individuals acted as rescuers of those threatened by the Nazis, Gentile argues that speaking out and being loyal to ethical precepts is a skill

that requires practice like any other professional skill. And that is, I would argue, as true of British healthcare professionals as it is of American business leaders and fictional Danish politicians.

## Lesson 2: Compromise and ethical integrity

Birgitte learns quickly that compromise, particularly in coalition politics, is unavoidable. She negotiates the boundaries between pragmatic trade-off and effective political negotiation. She is regularly called upon to judge whether she should compromise or hold the line. We are all required to work within systems and groups that demand that we compromise. Indeed, as I wrote in a previous column, the facility to listen and to respond constructively in the face of disagreement

"Ethical erosion occurs because there is a gap between ethics in the abstract and its daily enactment in care"

is, in itself, an ethical imperative. Yet, knowing when and how to remain steadfast is fundamental too. What ethical principles or values are essential to you and your practice? Put another way, what moral line(s) will you not breach and why?

Your response is likely to draw on a range of sources, including professional guidance, personal reflection and clinical experience, all of which are sound bases for developing your ethical priorities. Given that, like the political machine in which Birgitte works, the NHS is a complex system that makes multiple demands on

its employees, how do you determine when compromise is indicated and when you should hold your ground? Are these reactive decisions? Or are they guided by a moral framework?

## Lesson 3: The public and the professional

Birgitte's personal and professional worlds are intertwined and sometimes collide. She is constantly navigating the shifting sands of public and private. The professional healthcare bodies demand that practitioners are alert to conduct, whilst on or off duty, that may compromise trust in the profession and diminish its reputation. Yet, for most, the ethical challenges are subtler but nonetheless important. Fortunately, few people will find themselves before the regulator, but most, if not all, professionals will have times in their careers when they are less effective than they would like because of an event or stressor in their private lives.

Being alert and responsive to personal vulnerability is essential – a quiet, constant and necessary negotiation required of us all – but is too rarely considered and discussed. How do you draw boundaries between your personal and professional roles? What influences the balance? Professional boundaries are there to protect both parties in a therapeutic relationship. We are all susceptible to, if not boundary-crossing, boundary-pushing, and sometimes our boundaries will be more fragile than we would like.

See? That DVD box-set can be ethics CPD. And you thought it was just a television drama.

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

# Curing the NHS

*Campaigner Julie Bailey has fought to improve NHS patient care since her mother's death in Mid Staffs hospital. She tells Summons about her experiences and her hopes for the future of the health service*

**J**ULIE Bailey will never forget the last two months of her mother Bella's life in Mid Staffs Hospital. It was September 2007 and the 86-year-old had been admitted for a routine hernia operation. Concerned at the poor care provided at that time, Julie slept next to her mother's hospital bed and watched as her condition slowly deteriorated until she eventually passed away eight weeks later.

Since then Julie, who runs a café in Stafford, has been a vocal critic of the care her mother received, describing how she witnessed the "shocking neglect" of both her mother and other vulnerable patients there. The experience prompted her to set up the group Cure The NHS in December 2007, whose campaigning helped secure a public inquiry (led by Robert Francis QC) into the failings at Mid Staffs and the wider NHS.

Cure The NHS continues to offer support to people concerned about the care they received in the NHS, campaigning for greater accountability within the health service as well as for the implementation of the Francis report's recommendations. Julie has also written a book on her experiences, *From Ward to Whitehall*.

**What prompted you to set up Cure The NHS?**

What I saw in the eight weeks I spent with my mum Bella in hospital will live with me forever. After she died I tried to raise the alarm about what was happening at the hospital but nobody listened. I knew I had to find other people who had had similar

experiences as nobody believed what I was saying. I put a letter in our local newspaper with a plea for others to get in touch, and they did.

**How has your life changed since your mother's death?**

My life has changed considerably as not a day goes by where I don't listen to a relative who has lost a loved one in the NHS, unnecessarily. My life has been put on hold and I think it will be until I feel that others won't suffer in the way my mum and other vulnerable people did.

**What do you think has gone wrong with NHS care?**

The NHS has lost its way and we have forgotten what it is for, the patient. I think it has become so big and unwieldy and we haven't had leaders to manage the changes. Sadly I have found that the NHS is full of managers but has very few leaders. It has been subject to a command and control style management from the top and this has filtered all the way down to the frontline.

We have lost sight of what is important and instead of looking at the needs of the patient and their experience we have instead focused on outcomes and what's measurable. Whatever NHS boards have wanted to see to satisfy themselves, this has become the focus of the frontline, their priority.

**Can doctors or nurses be held accountable for poor care if rotas are under-staffed?**

The ward where my mother was treated



was starved of staff. I would say that 40 per cent of them ran around like headless chickens trying to help the patients as best they could while the other 60 per cent shouldn't have been in a nursing role at all. Some today should be in prison instead. But even if you had doubled the staff it wouldn't have made much difference. It is the calibre of staff, their skills and behaviours that matters.

**What is your opinion on the NHS' treatment of whistleblowers?**

Frontline staff have a responsibility to report that they are unable to do their job safely; it is in their code of conduct. Doctors and nurses have a legal duty to speak out and champion the patient. Sadly what we have found is that those who do are mistreated by other staff who would rather keep the boards happy than their



PHOTOGRAPH: PRESS ASSOCIATION

patients safe. Often when people do try to speak out they are bullied or more covert tactics are used, like ostracising or making the individual feel as if they are the only ones who cannot cope with the demands.

I also believe the unions, both medical and nursing, have failed the frontline. At Mid Staffs the unions knew the wards were desperately short of staff and should have done more to tackle this. They should also be more proactive in reminding staff of their duty to act as a patient's advocate and to speak out if patient safety is compromised.

**What do you think should be done to improve patient care?**

I believe we need to turn the NHS the right way up, with the frontline staff taking the lead and the managers offering advice. At the moment, the Government decides the NHS priorities and that is wrong.

The frontline knows what is best for their patients and they should be allowed to lead.

To achieve that, the NHS first needs a leader that inspires and galvanises the workforce. We need a quality and safety system, standardised operating procedures and zero harm and "right first time" as our guiding philosophy.

I'm not sure if some health professionals have lost their compassion with patients. I think the problem could be in the recruitment of nurses and doctors. We heard at the Mid Staffs public inquiry that the priority was to fill the university places and not the values of those we were recruiting. We should start to recruit for the values we want the NHS to uphold and not what it has become.

**What is your reaction to the Francis report?**

I was pleased with the Francis report

as it addressed the key areas but disappointed that it had so many recommendations.

I would have preferred there to be around 20 manageable and achievable recommendations. I am disappointed too that he blames the system, which I suspect will be used for other failings and already is. Without accountability I believe the NHS will allow a small pool of failure to swim which will continue to blight the NHS.

■ *From Ward to Whitehall by Julie Bailey is published in the UK by Cure The NHS. Copies are available from [www.curethenhs.co.uk](http://www.curethenhs.co.uk) for £7.99 +P&P*

■ *Interview by Joanne Curran, associate editor of Summons*

*Next issue: how is the NHS addressing the key concerns raised in the Francis report?*

# Breaking the silence

*The big winner at this year's BMJ Group Awards was the Britain Nepal Otolaryngology Service or BRINOS. Here ENT surgeon Mr Neil Weir describes how a holiday encounter led to the founding of this innovative charity*

**A**T the end of a holiday in Nepal in March 1987 I decided to make a visit to a local hospital and was directed to the Tribhuvan University Teaching Hospital in Kathmandu. Here I met Rakesh Prasad who, at the time, was the only person in Nepal trained in modern microsurgical ear techniques. He introduced me to his legendary father, Dr LN Prasad, who after gaining diplomas in ophthalmology and ENT from the Royal College of Surgeons of England became for a time the only eye and ENT surgeon in Nepal.

Dr LN Prasad told me of a disability survey which he had directed in 1981 (the Year of the Disabled) and of his surprise that deafness was the single greatest disability in Nepal. He had a vision of bringing ear care to people living outside the reach of the Kathmandu valley but with only his son and no funds for equipment he needed help.

## Ear surgery camps

I offered to bring a British team of two surgeons, an anaesthetist and two nurses to join with a Nepalese team in order to conduct an outpatient and surgery camp twice a year in the extremes of the country. This idea was met with great enthusiasm and after setting up a charity and a limited company and raising the funds for sufficient equipment to run two operating tables, the first BRINOS ear surgery camp was held in Pokhara in 1989.



Mr Neil Weir (right) with Dr Dinesh Mishra

In subsequent years we have worked at both the eastern and western ends of Nepal in 50 camps and have examined over 40,000 people and performed over 4,000 major ear operations. The last 38 camps have been conducted in the southwestern Terai at Nepalgunj, mostly in an old 'Victorian' palace which originally had been given by a family to house an eye hospital.

Conditions in the hospital are basic. The recovery ward is on the first floor adjacent to the theatre but the main ward is temporarily located in a large bicycle shed. The electricity supply is supported by a generator but there is no running water, instead two large plastic vats are supervised by a waterman. Since 2008 we have found space for a third operating table. The camps have provided an ongoing surgical training programme for young Nepalese ENT surgeons, nurses, and technicians.

## Bottom-up care

It was pointed out to us early on in the project that we were treating the end



Senior CEA Puran Tharu conducting ear examination



PHOTOGRAPHS: BRINOS/NEIL WEIR

Health education given by volunteer ear care assistant.

“The recovery ward is on the first floor adjacent to the theatre but the main ward is temporarily located in a large bicycle shed”

product of ear disease and that we should be concentrating on prevention. In 1991 BRINOS conducted a nationwide survey of deafness and ear disease in which 16,000 people were surveyed by a joint British and Nepalese team. The survey found that 14.2 per cent of the population of Nepal were significantly deaf (2.7m individuals including 1.9m school age children out of a population of 19m) and 860,000 individuals had middle ear infection. Of the 395 individuals aware of ear problems who had attended a local health clinic, two-thirds were dissatisfied with their treatment. We also found that 50 per cent of all ear disease is preventable.

Initially we thought that by training general health workers in ear disease and providing them with the necessary equipment we could reach out to the people at village level. This was not successful as ear disease came low on their priorities. There was a vital link missing. So in 2000 we established community ear assistants (CEAs), who are health workers trained exclusively in ear disease.

CEAs are equipped with examination

instruments, portable re-chargeable suckers and field audiometers and, in turn, train female volunteer ear care assistants (now numbering over 1,000) who live in the villages covered by them. The care is ‘bottom up’. The volunteers, who teach ear care and disease prevention (to 16,000 villagers in the last five years), find the patients and call in the CEAs who then diagnose and treat common ear conditions. Before this time villagers were totally unaware of the significance of deafness or ear discharge; they assumed it was either normal or their burden in life. Those cases considered for surgery join our ‘waiting list’ which is never longer than six months. The aftercare of the operated patient is entrusted to the CEAs.

### Success and new challenges

Since 2000 over 98,000 school children have been screened for deafness and ear disease, 86,000 patients have been examined in the villages and a further 27,000 in the daily Nepalgunj clinic where in the last five years 1,200 hearing aids have been fitted. This form of primary ear care

delivery has been accepted as the model for the country by the Society of Nepalese ENT surgeons and the project has contributed to two important developments: the people of Nepal are now much more aware that ear disease can be treated and there has been a marked increase in young doctors wishing to study ENT.

But there are additional challenges. Recognising the limited space in which our CEAs perform their vital work, BRINOS and our sister NGO the BRINOS Ear Health Community Service have acquired a site on which to build the BRINOS Ear Care Centre. Preliminary site works have started and BRINOS is actively seeking funds to continue the work. For further details please visit [www.brinos.org.uk](http://www.brinos.org.uk)

■ Mr Neil Weir MD MA FRCS is an ENT surgeon and founder director of BRINOS

■ MDDUS was the principal sponsor of the 2013 BMJ Group Awards at which BRINOS was named both Karen Woo Surgical Team of the Year and Medical Team of the Year

# Don't turn a blind eye

*Solicitor* Andrea James *looks at revised GMC guidance on reporting concerns over patient safety*

**E**ARLIER this year the General Medical Council released a wide range of new guidance which came into force on 22 April 2013. The main development was the publication of an updated version of the GMC's core guidance, *Good Medical Practice* (GMP), which had not been revised since November 2006. The GMC also published 10 pieces of "explanatory guidance" to demonstrate how the principles set out in GMP might be applied in practice.

One key aspect of the updated guidance is the GMC's strengthened focus on raising and acting on concerns about patient safety. This is entirely separate to the new contractual duty of candour in the NHS, which applies to providers of services to NHS patients. A doctor's GMP obligations are broader than this and apply to all doctors holding GMC registration, whether they work in the public or private sectors.

Within my recent practice I have encountered a number of instances of the GMC opening investigations into doctors who, in its opinion, failed to take sufficient action in respect of colleagues who posed a risk to patient safety. Here are some examples.

*A locum registrar was appointed to cover a period of holiday leave in an extremely busy A&E Department. The registrar had GMC conditions on his registration following a previous fitness to practise case. He disclosed his conditions to the trust prior to his appointment and stated he was complying with them. When a serious clinical incident involving the registrar occurred, the patient's family complained to the GMC. At that stage, it became apparent that the registrar had not, in fact, been fully complying with the existing GMC conditions on his registration. The GMC took further action against the registrar. However, the GMC also opened fitness to practise investigations into the trust's medical director and the clinical director for A&E, alleging they were at fault for failing to independently verify that the registrar was complying with his GMC conditions.*

*Dr X and Dr Y were the medical director and deputy*

*medical director of a trust where the Care Quality Commission (CQC) uncovered serious patient safety issues. A number of doctors and nurses at the trust were referred to the GMC and Nursing and Midwifery Council by CQC. There was no evidence that Dr X or Dr Y had specifically been informed of the patient safety issues. However, the GMC commenced fitness to practise investigations into both of them on the basis that the errant conduct had happened on their watch.*

*Dr Z was the senior partner of a four-partner GP practice. He heard receptionists gossiping about one of the practice's GPs being involved with a patient. Several years later, when it transpired that the GP had been involved in a sexual relationship with a vulnerable patient, Dr Z told the GMC about the gossip he had heard but had done nothing about. The GMC opened an investigation into Dr Z's conduct.*

The message from the GMC is clear: if you fail to raise and/or act upon concerns about patient safety when necessary, you are placing your own professional registration at risk. Ignorance of the guidance will not serve to protect your position, as the updated version of GMP specifically refers to doctors' responsibility to be familiar with and follow both GMP and its supporting guidance.

Of course, many doctors feel extremely reluctant to raise concerns about their colleagues. A 2011 study published in *BMJ Quality & Safety* found that, of nearly 3,000 doctors questioned, approximately 40 per cent did not believe they should report "all instances of significantly impaired or incompetent colleagues".

The purpose of this article is to draw together the various strands of guidance set out in GMP and its explanatory guidance to ensure that you are aware of your responsibilities relevant to the thorny issue of problem colleagues and patient safety.

## **Duty to act**

The key message is that set out at paragraph 1 of the GMC's *Raising and Acting on Concerns about Patient*



*Safety*, namely: “All doctors have a duty to act when they believe patients’ safety is at risk, or that patients’ care or dignity is being compromised.”

The most relevant segment of GMP itself can be found at paragraph 25, which provides: “You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised”. The guidance goes on to state that if a patient is not receiving basic care to meet their needs, you must “immediately” tell someone who is in a position to act “straight away”. Should patient safety be at risk because of inadequate premises, equipment or other resource issues, you should put the matter right if possible, or raise concerns in line with GMC guidance and your workplace’s policies, making a record of the steps taken.

Should your concerns involve a colleague who may be putting patients at risk, you should ask for advice from a trusted colleague, your defence body or the GMC. GMP further states: “If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.”

The GMC has also introduced explanatory guidance regarding sexual boundaries. *Sexual Behaviour and Your Duty to Report Colleagues* states that if a patient “tells you about a breach of sexual boundaries, or you have other reasons to believe that a colleague has, or may have, displayed sexual behaviour towards a patient, you must promptly report your concerns”. Any suspicion of sexual assault or other criminal activity must also be reported to the police.

All of the guidance above should be balanced against your GMP obligations relating to teamwork, which require doctors to work “collaboratively with colleagues”, treating them fairly and respecting their skills and contributions. In each case you must use your professional judgement, as real-life situations are rarely black and white.

### **Raising concerns**

In the event that you do need to raise a concern the GMC

advises doing this first with a manager or consultant. Should the matter involve a GP partner, it may be better to raise it outside the practice – for example, with the local medical director or clinical governance lead. Doctors in training might consider speaking with a postgraduate dean or director of postgraduate general practice education.

It is essential to be “clear, honest and objective” about the reason for your concern and you should acknowledge any “personal grievance that may arise from the situation”. Again it is important to keep a record of the steps you have taken to deal with the issue.

You should contact the GMC directly – or another body with authority to investigate the issue – in the following circumstances:

- If you cannot raise the issue with the responsible person or body locally because you believe them to be part of the problem.
- If you have raised your concern through local channels but are not satisfied that the responsible person or body has taken adequate action.
- If there is an immediate serious risk to patients, and a regulator or other external body has responsibility to act or intervene.

You might consider making your concerns public if you have exhausted all avenues where you work, or with an external body, and have good reason to believe that patients are still at risk of harm. However, such disclosures must comply with the Data Protection Act and not breach patient confidentiality.

Raising a patient safety concern, or receiving such a concern, is never easy. However, in the 2013, post-Francis world, it has never been more important to keep patient safety uppermost among priorities in your everyday practice.

Remember that the advisers at MDDUS are available to discuss any concerns you may have over complying with GMC guidance.

■ *Andrea James is a partner at JMW Solicitors*  
See guidance at [www.gmc-uk.org](http://www.gmc-uk.org)



# A good death

*In the first of a two-part series Euan Paterson, a Macmillan GP facilitator, discusses the challenges of providing high-quality palliative care in the community*

**R**OBERT is 75 and dying of metastatic lung cancer. He presented late and no further treatment is possible. He has become housebound due to breathlessness, weakness and pain. His wife has made six house call requests in the last four weeks and Robert has been seen by five different doctors. He has not been seen by a community nurse.

Robert has little idea of what is happening and no idea what to expect. He and his wife are becoming very anxious. He now finds everyday activities a struggle. He can no longer get out of bed and can barely swallow his medication. It is a week since he was last seen but his wife is reluctant to call as she feels they are a burden.

Robert wakes at 03:00 on Saturday morning with worsening pain and increasing anxiety. Despite all her best efforts his wife cannot manage to get him to swallow his painkillers.

She phones NHS 24 and a visit is arranged. A GP arrives 90 minutes later and, though very attentive, clearly has no idea of Robert's treatment up to this point.

An injection of diamorphine alleviates Robert's pain but he is unable to swallow diazepam and his mouth is too dry for lorazepam s/l. A prescription for midazolam is written and the OOH service contact the on-call pharmacist. At 06:15 the medication arrives via the palliative care taxi and a community nurse administers midazolam s/c. Robert's anxiety is relieved.

The following day a syringe pump is commenced and Robert remains symptom free. Four days later his wife wakes at 05:15 and finds him cool. She 'panics' and phones her daughter who isn't sure what has happened and so tells her mum to dial 999. Robert's wife is told to start CPR. An ambulance arrives 18

minutes later and the futile CPR is stopped. The ambulance crew contact the OOH service and a doctor attends. Robert is pronounced dead. His wife feels angry, guilty, sad and confused. She doesn't know whom to turn to.

Would you consider Robert's death a good one for both him and his family?

What do you think went wrong and more importantly why did it go wrong?

For many doctors, palliative care is one of the most important and difficult aspects of their job. Though the number of dying patients an average clinician will treat may be relatively small, the impact of a death for all those affected by it cannot be over emphasised.

When thinking about how to provide high-quality palliative care it is helpful to consider two broad headings – competencies



and caring. Consideration of the first is probably more commonplace and to some extent easier. There are structures and processes and initiatives and programmes that have been introduced in efforts to improve care of the dying and these have led to very significant changes.

The other factor – caring – is more nebulous. Even if our competencies are excellent, in isolation these will not be enough to ensure a good death if ‘caritas’ is not present and demonstrated.

### Identifying the dying patient

Not all patients facing a serious life-limiting illness are in need of immediate supportive and palliative care. Identifying those patients who have reached that stage is a key challenge, particularly in patients with non-malignant disease. Certain factors need to be taken into account, including the underlying disease process, the current condition of the patient and their rate of decline.

A number of resources have been developed to help identify this group of patients, including The Scottish

patient is suffering with, say, a long-term condition or is nearing death. Palliative care may be viewed simply as good care for people who happen to be dying. One recently introduced process, The Key Information Summary (KIS), may aid in this area by encouraging focus on clinical need rather than proximity to death, but it should always be borne in mind that identification of palliative care needs is not a simple matter. The experience and intuition of the healthcare professionals involved are vital.

### Advance/Anticipatory care planning

Having identified those patients needing supportive and palliative care the next step is to ensure adequate planning of that care. Increasingly the term advance or anticipatory care planning (ACP) is being used. Though the impression may be that it is some new system/process, it is really just an extension of basic healthcare planning into the end-of life-period and should be no different, in principle, to how all patient care is approached. ACP tends to be viewed in three domains – medico-legal, clinical and

in care planning. A useful communication tool called *My Thinking Ahead & Making Plans* (MTA&MP) can help in this area. It was developed initially by Dr Kirsty Boyd and Professor Scott Murray of the University of Edinburgh and is intended to promote a clearer understanding and sharing of patient priorities. Increased use of such tools coupled with a more open acceptance of the inevitability of death can help to encourage patients in the creation of an advance statement – a verbal communication or a written record of what the patient would wish to happen in certain circumstances.

Such statements may contain a number of elements. First, it might detail information regarding aspects the person considers important, for example what makes life worth living, spiritual beliefs and so on. This is sometimes referred to as ‘a statement of values’. Second, it may identify preferences and priorities for practical things to be done to inform future care (e.g. ‘I would like to be cared for at home as long as possible’). This may be described as ‘a statement of wishes’.

Third, an advance statement may describe particular treatments or procedures that the person would not wish, for example cardio-pulmonary resuscitation. These are referred to as ‘advance decisions to refuse treatment’ (ADtRT) and under English and Welsh law are legally binding. No similar statute exists in Scottish law but it is likely that a rigorously prepared ADtRT would be viewed in court as legally binding.

Finally, an advance statement may also indicate who the patient would wish to be involved and consulted in the decision-making process. It must be remembered that, in the event of loss of capacity, the named individual has no powers to make decisions unless a welfare power of attorney is legally granted.

A clearer awareness and indeed an understanding of what lies behind the wishes of the patient should make it more likely that these wishes will, where possible, be acted upon. It will also help clinicians to care *about* and not just *for* the patient. This ‘being with’ the patient may go a long way towards a feeling of ‘spiritual care’ that is so important at these critical times.

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

Part 2 in the next issue of *Summons* will look at clinical competencies in palliative support and also further consider the demonstration of care and compassion

“It could be argued that quality of care should be the same for all, whether the patient is suffering with a long-term condition or is nearing death”

Prognostication Indicators Tool (SPICT) and *The Quick Guide to Identifying People in Need of Palliative Care*, developed by London-based Dr Patrick McDaid, which includes the “surprise question” – would you be surprised if this patient was to die in the next six months?

The drawback of these tools is that they can generate large numbers of patients needing palliative care. A balance needs to be struck between taking into account only those patients at the very end of their life and being over inclusive. Palliative care can be considered from first diagnosis in many conditions but there is a risk that viewed in this fashion the patient cohort may be too large to allow clinicians to focus on those patients most in need.

In addition some people with non-malignant but incurable conditions may struggle with the concept of palliative care and indeed may be reluctant to even see themselves as having a life-limiting condition. This makes ‘labelling’ the patient even more difficult.

It could be argued that quality of care should be the same for all, whether the

patient issues – however this separation is artificial and there is huge overlap.

### Capacity

Probably the most important medico-legal aspect of care planning is capacity, or the ability to use and understand information to make a decision. Patients facing a possible loss of capacity in the near future should be encouraged to consider granting both welfare (health) and continuing (financial) powers of attorney (PoA). If capacity is lost and no such arrangement is in place then an application for guardianship or an intervention order may need to be considered.

Next of kin does not carry any legal status, and though it is important to be aware of the views of the patient’s family, there is no obligation to act on these views if not judged to be in the patient’s best interests. This is a complex and potentially fraught area often requiring legal expertise.

### Wants and wishes

Being aware of the wishes of the patient, their relatives and carers is hugely important

Michael Royden of *Thorntons Law* offers some advice on dental partnership disputes – avoid them where you can, resolve them where you can't

# Together for better or worse

**P**RIOR to the introduction of the Dental Body Corporate in 2006, the vast majority of dental practices were operated as a partnership, and that is still the case today.

One of the fundamental aspects of a successful partnership is trust, and many dentists whom I act for recognise that the relationship with their partners is an incredibly close one – perhaps second only to the relationship with their spouse (and some spouses might disagree).

However, like any relationship, partnerships can be tested and some will survive the difficult times whilst others won't be so lucky. Whilst you cannot predict complications that may arise during a partnership, there are ways in which practitioners can try to avoid disputes, or at least minimise their impact when they do appear.

## Put it writing

One of the first things we say to any partnership is that they should have an appropriately worded partnership agreement in place, which is a contract governing their relationship. In the absence of an agreement, the partnership legislation implies certain arrangements between the partners, many of which will be entirely unsuitable and unacceptable to the partnership as a whole.

Having once become embroiled in a partnership dispute, clients often say it was

never felt necessary to have a partnership agreement, as each of the partners trusted the others. Unfortunately, if there is no agreement, the outcome of a fallout can often be unexpected and undesirable. The other benefit of doing an agreement at the outset is that it will allow the partners to consider a range of issues which may never have occurred to them previously.

There are different styles of partnership agreements and it's important that, whatever style is chosen, it reflects the circumstances of the individual practice. We often see agreements which are adapted from a particular source or template and which have not been adequately drafted. For example, they might have provisions in them which are relevant to property ownership, when in fact the practice premises have been leased. I would recommend that you seek both your lawyer's and your accountant's advice when producing a partnership agreement to ensure that it fits your specific requirements.

The agreement should cover a range of issues including the decision-making process – how are decisions reached regarding the management of the practice and how they are implemented. It should also set out in very clear terms exactly how the profits of the practice are shared.

Another important area to cover is retirement. Whilst it might seem odd to be recording provisions for this at the outset,

just like death and taxes, the end of a partnership is inevitable and unless all of the partners choose to sell out at the same time, there is likely to be the need to address the departure of one or more partners at some stage. Some of the issues to consider in relation to retirement include how much notice needs to be given before a partner retires. How will the patient list be dealt with? If the premises are jointly owned, how will they be dealt with and what value will be placed on them?

Another important factor to discuss is restrictive covenants – this will prevent the departed partner from setting up a practice nearby, thus devaluing the continuing practice. Restrictive covenants are often felt to be unnecessary and unenforceable, however if one is not in place it can cause a great deal of anxiety to the continuing partners, particularly if a partner leaves the practice following a fallout.

Another key area is ownership of the practice premises. In some cases the partners and the owners of the property differ. In this scenario, the property owning partners will be the landlord and the partners as a whole are the tenant. In theory this should not necessarily cause any significant difficulties, however this does create two camps within the practice – property owning and non property owning – and there is the potential for this to cause tension.



Having considered the issues which need to be addressed in a partnership, an agreement should be put in place which is appropriate to the practice and gives a good framework for addressing a number of issues which could arise in the future.

### **Prevention best cure**

An agreement in itself does not necessarily avoid disputes arising and the best practices will have a number of simple ways in which to minimise the risk of issues becoming a real problem.

**“Do not allow issues to fester; they will only become bigger and potentially irreconcilable... and avoid involving lawyers if at all possible”**

Regular discussion on partnership matters is key to maintaining a good relationship. As dentists are very busy and spend most of the working day seeing patients, it can be very difficult to find time to meet and debate business issues. However, investing that time can help to maintain a good working and personal relationship.

If one of the partners has a concern within the practice, my advice would be to be open and to raise it with the other partners. Some of the worst scenarios we encounter are

situations where a partner has allowed a problem to develop over a considerable period of time, without having raised it. In their mind, that issue has become a very significant one and sometimes it can be impossible to achieve an amicable resolution. So do not allow issues to fester; they will only become bigger and potentially irreconcilable.

### **Some simple rules**

It might seem odd for me to say this as a lawyer, but I would advise dentists to avoid involving lawyers if at all possible. Whilst

I do not mean that they should not take legal advice, as that can often be a useful way of getting an independent perspective, involving a lawyer in correspondence can be counterproductive. Receiving a letter from a lawyer on behalf of a co-partner can often heighten the tension quite considerably and obviously it would be better if that can be avoided.

Sometimes partnership issues which arise prove to be irreconcilable. With the best will in the world, relationships can break down

to such an extent that there is no way forward, regardless of whether or not there may be a possible commercial resolution. Where this is the case, it's important to follow some simple rules which will hopefully assist to bring the situation to a suitable conclusion.

**Seek advice.** Speaking to an experienced dental lawyer, who will have seen similar situations, will help you to put a perspective on the situation and help to find a resolution.

**Try to avoid the blame game.** In the majority of disputes that we see there is a degree of fault on both sides and it's important not to get too carried away in arguing blame rather than trying to reach a commercial resolution.

**Put the practice first.** Your working relationship with your partners is one of the most important aspects of work life, and when it goes wrong it can become the main focus. However, a partner who becomes involved in a dispute should try to avoid it taking over his or her life. You have to recognise that you still need to run a practice, carry out dental treatment to the best of your ability – and, not least, maintain the goodwill of your patients.

■ *Michael Royden is a partner in the specialist dental practice team within the Scottish legal firm, Thorntons*

# 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



## INFORMED CONSENT: BROKEN SMILE

**BACKGROUND:** Paul is 54 and works as a manager with a major hotel chain. He attends a dental clinic wanting to improve the appearance of his smile and consults with one of the dental partners – Mr K. On examination the dentist notes that Paul's teeth are discoloured and somewhat malpositioned with gaps.

Mr K discusses treatment options with Paul including tooth whitening of the upper and lower teeth, or whitening of the lower teeth with provision of crowns and veneers in the upper teeth. Paul is keen to have both his upper and lower teeth veneered in order to have a uniform smile.

Five days later Paul attends the clinic for an extended examination. Pre-operative photographs and radiographs are taken and study models made. Mr K notes no particular abnormalities in the dentition. A consent form is signed and a treatment plan agreed for the provision of veneers at UR4, UR3, UR1, UL1, UL3, UL4 and LR4 to 1 and LL1 to 4, along with crowns at UR2 and UL2.

The patient later attends the clinic to view the diagnostic wax up and agrees some further revision to the treatment plan. Five days later he re-attends and veneer and crown preparation is carried out under local anaesthetic.

Four weeks after the initial consultation the temporary restorations are removed and the veneers and crowns are fitted as per the treatment plan. A few days later Paul attends the clinic complaining of roughness and Mr K carries out some occlusal/incisal adjustment.

Three weeks later Paul phones the clinic for an emergency appointment. The veneer at UL4 has de-bonded. Mr K re-cements the veneer and again adjusts occlusion to "ease pressure on the tooth". Two days later Paul is back at the clinic with UL4 having de-bonded again. Mr K re-cements the veneer and discusses the possibility that Paul may be grinding his



teeth at night. The dentist agrees to make a splint for the patient. Two days later Paul returns to clinic now with both UL4 and UR1 having de-bonded. They again discuss teeth grinding and a lower soft splint is provided. Two days later LR3 de-bonds and must be re-cemented.

Paul attends a different dental clinic concerned now with the quality of Mr K's restorations. The examining dentist finds cracks in UR3 and LR4 and composite fillings are placed. Later that week LR4 de-bonds and is re-cemented by the new dentist.

**ANALYSIS/OUTCOME:** The dental clinic receives a letter of claim from solicitors acting on behalf of Paul alleging negligence and breach of contract against Mr K. It is claimed that the dentist failed to obtain valid informed consent in the provision of veneers in that he neglected to advise the patient of the elevated risk of treatment failure due to his bruxism or teeth-clenching habit.

It is also claimed that Mr K failed to use reasonable care and skill in the assessment, diagnosis and treatment planning of the restorations carried out. More specifically the dentist failed to identify or note significant incisal and buccal edge tooth surface loss due to the patient's bruxism. It is alleged that had Paul known of the elevated risks due to his bruxism he would not have gone ahead with the proposed treatment.

Mr K contacts MDDUS and an expert report is commissioned from a consultant in restorative dentistry. The expert is provided with the patient records including all available radiographs, photographs and study models.

Examining the pre-treatment study models the expert notes attritional wear along the incisal edges of the lower incisor teeth "more than one would expect as being normal for a patient of this age". Evidence of wear is also obvious in the radiographs. He judges that this should have warranted further investigation of the possibility of bruxism. This observation is particularly relevant as in his view the failure of the veneers was, "on balance, related to the claimant's bruxism habit." A more appropriate treatment option in the opinion of the expert would have been the provision of a mouth guard before considering veneers or even better full coverage crowns.

MDDUS advises that given the expert view the best option is to settle the claim for a modest sum based on the costs for remedial treatment and ongoing care.

### KEY POINTS

- Discuss with the patient all major risks and contraindications for treatment.
- Do not assume patients are necessarily aware of habits or behaviours that compromise treatment success.
- Establish and follow thorough protocols in treatment planning.



## CONFIDENTIALITY: FULL DISCLOSURE



**BACKGROUND:** A practice manager receives what appears to be a court order for the release of medical records relating to the mental health of a patient, Mr G, over the previous six years. The order is on behalf of the patient's estranged wife, Ms D.

The manager arranges for the records to be copied and sent off to Ms D's solicitors.

Two weeks later, the practice receives an angry letter of complaint from Mr G demanding to know why his entire medical record – including details of a previous

sexually transmitted infection – was sent to Ms D's solicitors without his consent. The practice manager re-checks the court document and is shocked to discover it is merely a notification of intent to apply for a court order, rather than an actual order. The practice realise that not only did they not have the authority to release Mr G's record, the court order would only have required sections of the record relating to his mental health from the previous six years.

In his complaint letter, Mr G says the accidental disclosure has caused him considerable distress and he has also incurred solicitors' fees.

The practice partner Dr H contacts MDDUS for advice on how to proceed.

### ANALYSIS/OUTCOME:

An MDDUS adviser assists Dr H in drafting an appropriate reply to Mr G in which he explains how the error came about and profusely apologises. He accepts the practice should have read the court correspondence more carefully and says measures have been put in place to ensure the error is not repeated. MDDUS agrees to a modest settlement with Mr G to cover his legal costs.

### KEY POINTS

- Always carefully read documents relating to requests for disclosure of patient records.
- Be sure to provide only the minimum necessary information to meet the terms of any request/court order.



## CAPACITY: A PERSONAL DECISION

**BACKGROUND:** A practice sends out a letter to a 42-year-old patient, Miss B, inviting her to attend for a cervical smear test. Miss B has learning difficulties so her mother responds on her behalf a few days later to say she will not be undergoing the test. GP, Dr N, notes that Miss B has never had a smear before and believes it would be in her best interests to have one now.

However, he is unsure about whether or not he should accept the mother's response or pursue the matter further. There is no indication in Miss B's record that her mother (or anyone else) has previously made healthcare decisions for Miss B, nor is there any note of a formal authority to make decisions on her behalf.

He contacts an MDDUS



medical adviser for assistance.

**ANALYSIS/OUTCOME:** An MDDUS adviser tells Dr N that he must first establish whether Miss B is capable of consenting to or refusing this treatment. It would be advisable to invite Miss B to attend the practice, accompanied by her mother if she wishes. Dr N should discuss the issue with Miss B

(and her mother, if she attends) and determine whether Miss B understands the treatment being offered, the reasons for the treatment and any potential side-effects or consequences. Miss B must be able to retain the information long enough to make a decision and be able to clearly communicate her decision, with support where necessary.

Should any disagreement arise with the patient's mother then every attempt should be made to reach a consensus. This might include such measures as seeking a second opinion or involving an independent patient advocate but much will depend on the patient's capacity. All discussions should be clearly documented in Miss B's notes.

### KEY POINTS

- Where a relative/carer seeks to make healthcare decisions for a patient, first check whether the patient has capacity to decide for themselves.
- Make every attempt to reach a consensus with relatives/carers regarding the healthcare of patients with potential capacity issues.
- Keep a clear record of all discussions.

## From the archives: the eminent American



EXPOSING medical fraud is as much a professional duty today as it was over a century ago. Consider a case reported in the *British Medical Journal* of December 17, 1872. A "physician" named William H Hale was charged with conspiracy and fraud in "obtaining sums of money from the public by false pretences".

Hale first attracted notice when he placed an advert in the *Liverpool Courier*:

*The Doctors in Liverpool, – Services will be rendered, first three months, free of charge. A staff of eminent German and American physicians have permanently located in Liverpool. All who visit these eminent doctors will receive services, first three months free. All kinds of chronic diseases are treated, especially male and female weakness, catarrh, catarrhal deafness, etc, but no*

*incurable cases will be accepted. The doctors will examine you thoroughly free of charge and, if incurable, will frankly and kindly tell you so.*

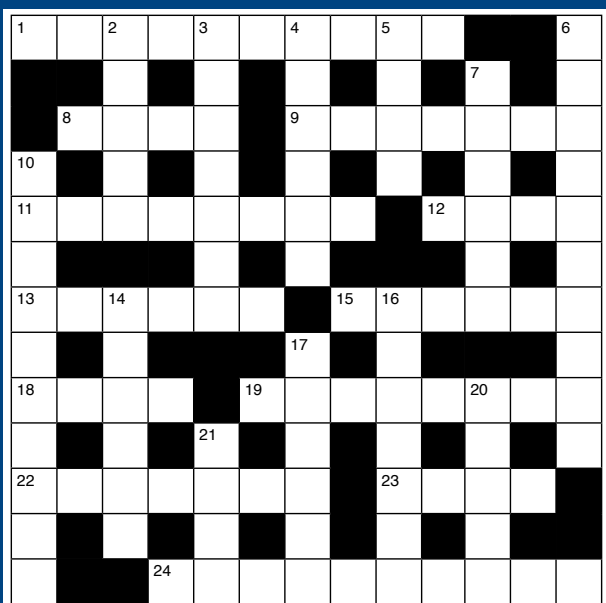
A number of people answered the advert including a "traveller" named Boggiano. He was told that his heart was badly affected and Hale promised to cure him for seven guineas. Boggiano paid the fee and was given a bottle of medicine which he took without any good effect. On his next visit the man was told he was showing signs of Bright's disease and wasting of the nerves which would take three or four months to cure. A further fee of five guineas was paid. Other patients were given the same medicine which was later proved to be water with a tincture of morphine and some vegetable colouring.

Twenty five days after placing his advertisement Hale left Liverpool in some haste and turned up next in Glasgow where similar adverts were published in local newspapers and "patients" treated. He then moved on to Dublin and set up premises in Rutland Square.

Here a doctor and surgeon named Smith saw the advert and suspected quackery. He visited Hale posing as a farmer complaining of pain in his left ear. Hale diagnosed "thickening of the drum of the ear, catarrhal deafness and congestion of the middle ear, also acute laryngitis" and promised a cure for the price of two guineas. Dr Smith replied that he was well acquainted with the symptoms of the complaints ascribed to him and had none of the diseases.

Hale made another quick exit – this time to Belfast. But his luck ran out when he was arrested on warrant and taken back to Liverpool. An account book confiscated from Hale showed that the con had netted nearly £400 – a tidy sum in those days. The jury at his trial found Hale guilty and he was sentenced to 18 months hard labour.

### Crossword



#### ACROSS

1. Between gallbladder and bile duct (6,4)
8. State of unconsciousness (4)
9. Microscopic substance dispersed through another (7)
11. Inflammation of a gland (8)
12. Western military alliance (abbr.) (4)
13. Voice box (6)
15. Unit of electrical current (6)
18. Syndrome, inability to concentrate (abbr.) (4)
19. Manifestation of herpes simplex virus infection (4,4)
22. Produced in the pancreas (7)
23. Acid used to dissolve limescale (abbr.) (4)

24. Incision made to create drainage of antrum (10)

#### DOWN

2. Essential cream tea component (5)
3. Language of Dante (7)
4. Untruth (6)
5. Sect (4)
6. Evaluates hearing loss (10)
7. Vitamin supplement in early pregnancy (6)
10. Care in late-stage cancer (10)
14. Go over old ideas (6)
16. Enrages (7)
17. Habitual complainer (6)
20. Prefix, of the bone (5)
21. Tribe (4)

See answers online at [www.mddus.com](http://www.mddus.com).  
Go to the Notice Board page under News and Events.

### Object obscura: Ritter dental X-ray machine with extendable arm



THIS machine was introduced in the 1920s by the Ritter Dental Company. To power the machine two separate groups of transformers were used in order to cope with the various voltages and frequencies of the time. Both patient and the operator had to stay 12 inches from the high voltage wire which ran outside the arm from the transformer cabinet to the X-ray head.

PHOTOGRAPH COURTESY OF SCIENCE PHOTO LIBRARY

## Vignette: paediatrician and researcher

# Richard Worthington Smithells (1924-2002)



IN 1965 a paper was published in *The Lancet* suggesting a link between folate deficiency in pregnancy and neural tube defects (NTDs) in babies. It reported on a study showing that a higher proportion of mothers giving birth to children with NTDs were folate deficient compared to the mothers of unaffected newborns. Subsequent work in this area led to the promotion of routine folate supplements in pregnant women or those planning to have children, thus drastically reducing occurrence of this tragic condition. The co-author of that paper was a paediatrician named Richard Worthington Smithells.

Smithells was born in Bushey near London, received a public school education at Rugby and went on to study medicine at St Thomas' Medical School (MB BS Lond 1949). He passed his membership examination in Edinburgh. His interest was in paediatrics (DCH 1950) but he served with the RAMC in Germany for two years of National Service before returning to junior hospital posts in Leeds and Bradford. He spent another period in London as a senior registrar at Guy's before taking up a consultant post in the Department of Child Health at the University of Liverpool.

Here Smithells set up a congenital abnormality register and noted with growing concern the teratogenic effect of an antiemetic drug taken by pregnant women. In December 1961, thalidomide was withdrawn from the market and Smithells began systematic investigations into the link between use of the drug during pregnancy and birth defects. In 1961 he published a research paper in *The Lancet* called 'Thalidomide and malformation in Liverpool' which confirmed findings from Germany and Australia demonstrating the teratogenicity of the drug. His findings contributed to the establishment of the Committee on Safety in Medicines.

Smithells had also started to investigate possible links between maternal vitamin levels and health of the foetus, with a particular focus on neural tube malformations such as in spina bifida.

There was a 50 per cent rise in infant deaths from congenital malformations in Liverpool in the 1950s although infant mortality had fallen by a third.

With Elizabeth Hibbard he explored the link between folate metabolism and birth defect. The question was whether there had been a problem at embryogenesis. After the preliminary publication in *The Lancet*, trials of folic acid supplements for women before conception and during pregnancy were started and looked hopeful but more studies were needed. Funds came from Action Medical Research and after the Medical Research Council had reported their trials in 1991 the Government acted to ensure flour was fortified with folic acid. NTDs in the foetus soon became rare.

In 1964 Smithells was made medical superintendent at Alder Hey Hospital. His book *The early diagnosis of congenital abnormalities* had just been published and it described diagnostic methods before the rise of ultrasound investigations. During his time in Liverpool he published papers on the harmful effects of rubella on the foetus following maternal infection. He later demonstrated the value of vaccination in reducing such disabilities.

In the 19th century Smithells' maternal grandfather was Professor of Organic Chemistry at the University of Leeds and a great uncle (who was a chemist) became pro-vice Chancellor at the university. Smithells carried on this family academic

tradition when in 1968 he was appointed Professor of Paediatrics and Child Health at Leeds, a post he held for 20 years.

In his inaugural lecture he spoke of the hazards facing infants as "being born too soon, being born too dangerously, and being imperfectly formed". It was this last problem that he addressed, not by promoting abortion (the Abortion Act had been passed in 1967) but by prevention of the causes of malformation. To make this work possible he created a laboratory in Leeds to study the effects of drugs and nutrition on the early development of the embryo and foetus. Much of his work was done at the General Infirmary where specialist services could be provided for children. Smithells was not purely an academic but saw that his ideas were translated into action. Driven by his warm, energetic character, a genetic counselling service was set up.

He also actively supported charities such as the NSPCC and wrote a book of playful poems, *Alphabet Zoop*, for children to be sold in aid of the society. He also gave his spare time to The Thalidomide Trust, the Family Fund and Martin House Hospice for Children and his advice was widely sought by such organisations. In 1985, Action Research for the Crippled Child recognised his contribution with the Harding award.

Meadows and Smithells *Lecture Notes on Paediatrics* was a successful textbook which was described as friendly and useful; he was a good teacher. Concern for the status and training of paediatricians led to his involvement in the establishment of the Royal College of Paediatrics and Child Health. In 2000 he received the International Research Award of the Joseph P Kennedy Foundation. The British Paediatric Association awarded him the the James Spence Gold Medal in 1992.

Smithells married when he was a student and enjoyed family life. His hobbies included walking in the Lake District and bell ringing in church.

■ *Julia Merrick is a freelance writer and editor in Edinburgh*

THURSDAY  
6th March

PRACTICE MANAGERS' CONFERENCE 2014  
WATCH AS YOUR

FRIDAY  
7th March

# WORST NIGHTMARE

PLAYS OUT IN MARCH 2014

Fairmont St Andrews,  
Thursday 6th & Friday 7th March 2014

Imagine your worst day in practice ... staff down, system failures, serious incidents, GPs behaving badly.

Attend the 2014 MDDUS Practice Managers' Conference and learn from the experience of one unlucky practice manager faced with a series of unfortunate events. Delegates will watch the drama unfold together then explore the key issues through attending a series of four risk masterclasses.



[www.mddus.com](http://www.mddus.com)

**Day 1 A series of unfortunate events**

Four risk masterclasses covering areas including the management of clinical systems, medico-legal risk management of critical incidents and managing difficult situations with staff and doctors.

**Day 2 Interactive workshops**

Select from a range of interactive workshops and engage in discussion on risk topics relevant to your own practice. Each session explores a current risk area within general practice and will allow delegates to share best practice in order to mitigate these risks.

**BOOK NOW**

and take advantage of our Early bird rates available until the end of September 2013

**Conference fees**

<b>Residential single room</b>	Early bird - DPS*	<b>£275</b>
	Early bird - non DPS	<b>£300</b>
	Standard fee - DPS	<b>£300</b>
	Standard fee - non DPS	<b>£325</b>
<b>Residential double room</b>	Early bird - DPS*	<b>£225</b>
	Early bird - non DPS	<b>£255</b>
	Standard fee - DPS	<b>£255</b>
	Standard fee - non DPS	<b>£285</b>
<b>Day delegate (Thursday only)</b>	Early bird - DPS*	<b>£125</b>
	Early bird - non DPS	<b>£145</b>
	Standard fee - DPS	<b>£145</b>
	Standard fee - non DPS	<b>£165</b>

\*DPS: Discount Practice Scheme