

WINTER 2013

SUMMONS

AN  PUBLICATION FOR MEMBERS



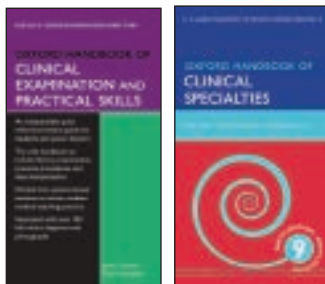
• Final days of Hugh Miller • Dental “human factors” • Profile: QC Christina Lambert •

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Highlights



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IN THIS ISSUE

HUGH Miller was a remarkable man by any standard – a Victorian populariser of science, a Brian Cox or David Attenborough of his day, though the subject being geology. He was born in 1802 and dropped out of formal education after a violent row with his schoolmaster, apprenticing then as a stonemason where the fossils he encountered sparked a passionate interest in palaeontology. Self-taught he became an expert in the field, discovering several important species of Devonian Age fish – one bearing his name, the placoderm *Pterichthys milleri* – though geology was only one facet of this complex man.

Miller ended his own life with a pistol in 1856 and the event shocked the nation and beyond, not least given his firm evangelical faith. On page 12 James Finlayson looks at one surprising aspect of that tragic event – Miller's friendship with an Edinburgh professor of surgery later criticised for overstepping professional boundaries.

On page 14 we profile QC Christina Lambert in her role as barrister representing MDDUS members facing legal and regulatory proceedings – it's a job that calls for cool nerves, quick thinking and a certain "love of performance".

Phil Highton of Terema is well known among risk consultants, applying his experience of "human factors" training as a former airline pilot to improving patient safety. On page 18 he addresses "authority gradients" in dental practices. Are staff comfortable speaking-up when they spot a potential disaster?

Our Q&A in this issue (page 10) features Professor Helen Lester who leads a team developing clinical indicators in QOF. Is it just a box-ticking exercise or has the QOF lead to significant improvements in health? And on page 16, Dr Jonathan Berry considers the fraught question faced by all GPs at one time or another – to refer or not to refer in a patient suffering with acute abdominal pain.

Jim Killgore, editor



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Cover image:
Rathmelton by
Lynn McGregor

Lynn McGregor was born in Pittenweem, Fife and trained at Edinburgh College of Art. Lynn's semi-abstract paintings are influenced by the Scottish and Irish landscape, Rathmelton

is a small town situated at the mouth of the River Lennon in County Donegal, Northern Ireland.

Art in Healthcare (formerly Paintings in Hospitals Scotland) works with hospitals and healthcare communities across Scotland to encourage patients, visitors and staff to enjoy and engage with the visual arts. For more information visit www.artinhealthcare.org.uk, Scottish Charity No: SC 036222.

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➔ GPs performing minor surgery

FOR many years, minor surgery has been a significant aspect of the service provided by GPs. As the profile of GPs, their contracts and provision of medical service changes, we feel it important to emphasise our MDDUS membership policy with regard to those GPs performing minor surgery.



Providing GPs performing minor surgery are working within the scope of their competence and the RCGP and other guidance on good practice in minor surgery, then the MDDUS GP subscription for those working at least seven sessions per week is

sufficient.

For those GPs working part-time, with a GP subscription lower than seven sessions per week, cover will still be provided as long as the minor surgery carried out is part of their contract and on patients registered to their practice. For those part-time GPs who carry out minor surgery on patients who are not registered with their practice, they should ensure they increase their membership to the GP grade of membership for seven sessions per week to ensure adequate and appropriate indemnity is in place, irrespective of the number of sessions they undertake in practice.

For information call our Membership Department on 0845 270 2038.

➔ Be alert for oral cancer

FAILURE to spot intraoral malignancy can have serious repercussions for patients – and also dentists, says MDDUS dental adviser Rachael Bell.

Mouth Cancer Action Month was held in November to raise awareness and improve understanding of oral cancer among both the public and the profession.

MDDUS is reminding dentists of the crucial role they play in the early detection of the disease through routine screening and educating patients on the risks and warning signs. Cases involving failure to diagnose and refer patients with oral cancer feature regularly among clinical negligence claims made against MDDUS members and in GDC fitness to



➔ Remote prescribing risks

TECHNOLOGY is becoming an increasingly prominent feature in medical and dental practices – with a growing number of routine patient contacts being made remotely using telephone, email, text and even video-links. However, practitioners must know the limits of such patient interactions, particularly when it comes to prescribing.

Remote prescribing is generally not encouraged but there are occasionally circumstances where it is appropriate. This might apply to rural practices, and where a delay in providing a prescription would be detrimental to patient care.

Both the GMC (since July 2012) and the GDC have banned practitioners from prescribing Botox and other injectable cosmetics by phone, email, video-link or fax.

Before prescribing Botox or other injectable cosmetics, the GMC instructs doctors to have face-to-face consultations with patients to ensure they fully understand the medical history and reasons for wanting the treatment.

And before prescribing any other drug remotely, the regulator requires doctors to adequately assess the patient's condition and states they must be confident they can justify the prescription. The GMC's *Good Practice in Prescribing Medicines* lists several conditions doctors must meet, including ensuring the treatment and/or medicine(s) are not contra-indicated for the patient, adding: "Where you cannot satisfy all of these conditions, you should not use remote means to prescribe medicine for a patient."

The GDC takes a similar line, advising dentists in a statement issued in September 2011 that "remote prescribing in dentistry is acceptable in some instances but should only be used in exceptional circumstances. It should not be used in relation to non-surgical cosmetic procedures." It adds: "Direct examination and diagnosis is preferable to remote prescribing."

When remotely prescribing any drug it is important to make a clear, contemporaneous record of all care provided and medicines prescribed. Doctors and dentists must also bear in mind that, as the remote prescriber, you retain responsibility for the appropriateness of the prescription and any potential consequences of it, whether or not you have personally spoken to the patient.

Where a practitioner is considering offering remote prescribing services, i.e. to an online pharmacy, they must ensure that, in addition to the above guidance, they are only prescribing to patients in the UK as MDDUS indemnity does not extend to overseas work.



IN BRIEF

● BMJ GROUP AWARDS

Nominations have opened for the BMJ Group Improving Health Awards 2013 - celebrating excellence in research and clinical practice in 15 different categories. MDDUS is headline sponsor of

the awards and is also proud to sponsor the Primary Care Team of the Year category. Winners will be announced at a London ceremony on May 9, 2013. For more information go to <http://groupawards.bmj.com>

● WARNING OVER PORTABLE

DENTAL X-RAY UNIT The MHRA has issued a warning concerning a portable dental X-ray unit with inadequate shielding that could give rise to unsafe radiation doses. Tests conducted on the Tianjie

Dental Falcon device made in China revealed a lack of sufficient shielding in the X-ray tube. The MHRA advises practices having purchased this or any non CE-marked (EU compliant) device to stop using it and replace with a



PERSPECTIVE



**By Dr Ivor Felstein,
Retired Consultant
Geriatrician**

Fame, fortune and arthritis

IT is not an unreasonable assumption that arthritic problems have been with the human race from the beginning, certainly since men and women became truly upright and mobile.

One of my earliest memories of my Scottish family seniors was of several aunts and uncles applying various lotions and creams to knees, feet, necks, shoulders and wrists. Less reachable areas required the help of the local district nurse (when available) or caring friends and family. They also tried pain killers, of which aspirin was the most popular and later codeine as a close second.

Heat, in the form of rubber or stone hot-water bottles or warmed cloth pads, was likewise popular to essentially the same purpose: the relief of ache and stiffness in the joints and muscles. Initially the benefits of controlled exercise were not considered at all. Gradually however, the input of physiotherapists was acknowledged and approved. Hospitals saw the growth of physiotherapy departments with experts and appropriate apparatus serving inpatient and outpatients, as well as orthopaedic day patients and the elderly medicine and day hospital blocks.

I recall that when I was about age 11

or 12 there lived in our Glasgow flats a widowed senior lady, herself a retired nurse. She stayed with her daughter (also a nurse) and claimed that "all her joints" were arthritic. She would send me to the local pharmacist to buy "methylated spirits" for her. Her intent, she explained to me, was applying it to her joints as an external rub. I was happy to help her. I did not appreciate until many years on that she also drank the stuff.

In my medical student days in the early 1950s, one of the better known arthritis experts in the UK was Frank Dudley Hart. As I recall, Hart wrote the first modern encyclopaedia of arthritis which he described as his "pocketbook of arthritis" – a modest title. Arthritis features in a range of unlikely conditions. I recall travelling to Connecticut in the USA some years ago during an outbreak of "tick arthritis" around the town of Lyme – now known far and wide for its tick connection through the condition Lyme disease. Some drugs can initiate an arthritis complaint. For example, in the years before penicillin, we used sulpha drugs. A presumed allergy to these occasionally provoked allergic arthritis.

In earlier centuries, the former apothecaries and barber surgeons spoke of "rheumatics", a more vague term which included problems of muscle, ligament, cartilage, skin, bone and even emotional upsets! The old English word "rheum" originally meant "catarrh" (though I recall the translation being rhubarb in Greek,

rather inexplicably). Again in the 1950s and earlier in my childhood days there was the fleeting and flitting arthritis with high temperature described (and feared) as rheumatic fever. The anxiety came from the risk that after the joints settled, one in three patients developed persistent heart valve and heart muscle problems. Thankfully cases in the west fell significantly after the 1960s, probably due to the widespread use of antibiotics.

So what about famous arthritis sufferers? The doctor, Thomas Addison, gave his name to several illnesses. He suffered from depression as well as rheumatoid arthritis but had no answer to what ailed him. Even so he helped establish the fame of Guy's Hospital and himself. The brilliant writer George Orwell suffered back pains as well as arthritis in his wrists. This did not stop his completing his classic bestseller, *1984*. Another modern writer, Joseph Heller of *Catch 22* fame, also suffered from arthritis.

Among outstanding film stars and entertainers with arthritis, I recall James Coburn retiring because of rheumatoid arthritis. There was also Lucille Ball, Rosalind Russell, Edith Piaf and Kathleen Turner. Sammy Davis Jr, singer, actor and tap dancer later became restricted by bilateral joint complaints yet still managed some public appearances to demonstrate his former brilliance on the dance floor.

No doubt this helped his mobility too.

practise investigations.

Proper examination and good record keeping are essential. Says Rachael Bell: "The only defence to a claim made following delayed diagnosis is if adequate examination of the patient was made, backed up with proper notes in the

dental record.

"Where there is an allegation of failure to diagnose an oral malignancy, we would be looking for notes in the records of an extra-oral examination, soft tissues being examined and the findings – even if the findings are that the tissues are healthy.

The notes also need to reflect whether smoking cessation and alcohol-related advice has been given and what was said. If there is any doubt about an intraoral lesion then refer early, keep a copy of any referral letter and any response from maxillofacial services."

suitable CE-marked alternative. For more details go to www.tinyurl.com/d9vk3c5
● DELIVERING DIGNITY GRANTS The Queens Nursing Institute Scotland (QNIS) is to fund nurse-led quality

improvement projects from 2013-2015. Grants of up to £10,000 will be awarded to projects "carrying out or implementing new research into practice in community settings in Scotland". Community settings are defined as places where older

people live – at home, in care homes or community hospitals. To find out more visit www.qnis.org.uk
● ATTENTION 1963 GLASGOW DENTAL GRADUATES A Golden Anniversary Reunion is being

planned for University of Glasgow Class of 1963 BDS graduates on 11 and 12 June, 2013. If you graduated from Glasgow in 1963, or know someone who did - please Contact Richard Day on rm.day@virgin.net or 0141 942 3182.



➔ Action needed on illegal tooth whitening

THE British Dental Association has called on dentists, Trading Standards officials and the GDC to join forces to put an end to teeth whitening treatments being supplied illegally by non-qualified individuals.

October 2012 saw the UK implementation date of the European Council's Directive on Tooth Whitening Products. The new directive means that tooth whitening products containing up to 0.1 per cent of hydrogen peroxide will continue to be freely available to consumers on the market but for products containing between 0.1 per cent and 6 per cent of hydrogen peroxide, a clinical examination and treatment plan by a dentist is required. The first cycle of treatment must be carried out by a dentist or an appropriately trained individual working under their direct supervision and within their competence and scope of practice. Detailed, accurate and contemporaneous notes are an essential requirement of this first visit. Patients will then be able to continue the treatment unsupervised, although the use of these products by persons younger than 18 years will not be allowed.

Tooth whitening products containing more than 6 per cent of hydrogen peroxide will continue to be prohibited.

The new directive should signal an end to non-dentists providing powerful whitening treatments but the BDA is

concerned that some individuals might choose to flout the legal position on the supply of products. The BDA is calling on dentists to be vigilant and report non-dentists offering tooth whitening to both their local Trading Standards department and to the GDC, and for both agencies to take robust action in response to such reports.

Dr Stuart Johnston, a member of the BDA's Principal Executive Committee, and Chair of the Council of European Dentists' working group on whitening products, said: "Dentists must be diligent in reporting any non-dentists performing whitening, and Trading Standards and the GDC must put safety first and take action to protect the public."

➔ Health risks significantly higher in diabetics

PEOPLE with diabetes are 65 per cent more likely to suffer heart failure than the general population, according to new results from the ongoing National Diabetes Audit.

In 2010/11, 45,000 people with diabetes in England and Wales suffered heart failure which is 17,700 (65 per cent) more than the number expected (27,300). The audit also found that diabetics have a 40 per cent higher death rate than the general population and that increases to 135 per cent in patients with Type 1 diabetes. Women with diabetes are at a greater relative risk of death than men with the condition.

The National Diabetes Audit is now in its eighth year and thought to be the largest of its kind in the world. The findings are standardised to take into account differences between the general and diabetic population.

The audit has also found that diabetics are 25 per cent more likely to suffer a stroke and 144 per cent more likely to need dialysis or a kidney transplant. Minor amputations (part of foot) are 331 per cent more likely among diabetics and major amputations (below or above knee) are 210 per cent more likely.

Audit lead clinician Dr Bob Young, consultant diabetologist and clinical lead for the National Diabetes Information Service, said: "These results highlight the huge impact of diabetes on disability and premature death. Much can be done to reduce these risks if all health care sectors work together with people who have diabetes. Some districts have appreciably lower diabetes related complications than others. Improving treatment for diabetes should be a top priority for all clinical services."



➔ Charter to combat dental fraud in Scotland

THE British Dental Association in Scotland has pledged to help stamp out dental fraud in a new charter signed jointly with Counter Fraud Services.

The charter aims to encourage a working partnership between CFS and dental professionals and promote a counter fraud culture in the delivery of dental services. In the document the BDA and CFS pledge to work on revising policies, procedures and systems to minimise any fraud risk and establish arrangements to maximise transparency and minimise any conflicts of interest.

Another crucial aim is to clarify the distinction between deliberate fraud and

IN BRIEF

● GMC 2013 ARF FROZEN

The GMC Annual Retention Fee has been frozen at £390 for all registered and licensed doctors and at £140 for registered doctors without a licence to practise. Fees paid by trainee doctors will see

a slight reduction to £185, with the provisional registration fee for foundation trainee doctors also down to £90.

● UK DENTAL RATED BY

PATIENTS Dental treatment in the UK is well explained, provides value

for money and delivers high levels of satisfaction, according to a new BDA report. A survey of 1,000 people found eight out of 10 who had seen a dentist in the previous two years were highly satisfied with their treatment. The figures

were revealed in *Public perceptions of choice in UK dental care*. Read more at

www.tinyurl.com/bmmluwj

● **PREGNANCY CHECKS IN THE UNDER-16** Doctors unsure of the best approach in checking for



GMC whistleblowers helpline launched

A CONFIDENTIAL helpline for doctors to raise concerns about patient safety has been launched by the General Medical Council.

The new service allows doctors to contact the regulator directly for advice on a range of issues and is a means of raising serious patient safety concerns for those who feel unable to do so at a local level. An online decision aid has also been launched on the GMC's website to support whistleblowers.

The initiatives are part of the GMC's commitment to create a more open and transparent working culture where all staff feel able to speak out. They follow the publication earlier this year of new GMC guidance *Raising and acting on concerns about patient safety*. The new guidance underlines the duty of all doctors to put patients' interests first and act to protect them at all times, adding that this "overrides personal and professional loyalties".

The helpline (0161 923 6399) will be manned by specially trained advisers who will act on information about individual doctors or organisations that can be investigated by the regulator. Callers may also be directed to other organisations such as the Care Quality Commission.

GMC chief executive Niall Dickson said: "Being a good doctor is more than simply being a good clinician. It requires a commitment to improve the quality of services and a willingness to speak up when things are not right – this is not always easy, but it is at the heart of medical professionalism."

The GMC services follow the launch earlier this year of a free government-funded whistleblowing helpline (08000 724 725) and of a national charter, *Speaking Up*, to protect NHS whistleblowers.



considering chemotherapy, the figure was actually only 56 per cent.

The authors found evidence that once patients are properly informed about the risks and benefits of treatments, they often make different decisions about treatment. For example, when men are told of the risks of sexual dysfunction following surgery for benign prostate disease, 40 per cent fewer said they preferred surgery.

The report argues that doctors cannot recommend the right treatment without understanding how the patient values the "trade-offs", but adds that preference misdiagnosis generally goes unnoticed. The authors highlight the fact that a patient's treatment preference is "just an opinion based on what the patient knows at that moment" and may change as they learn more information. They recommend seeking out "patient decision support tools" to assist in the process.

The authors conclude: "Evidence from trials shows that engaged patients consume less healthcare. More work is needed to understand the magnitude of this potential benefit, but it is tantalising to consider that budget challenged health systems around the world could simultaneously give patients what they want and cut costs."

You can read the study at www.bmj.com/content/345/bmj.e6572

unintentional error to avoid any possible confusion or ambiguity.

Martin Fallowfield, chair of the BDA's Principal Executive Committee, said: "Fraud by dental professionals is very rare, but where it does occur it takes money away from where it is most needed: front-line patient care. The BDA is pleased to re-affirm the profession's support for the work of NHS Scotland's counter fraud activities."



Doctors misjudge patient preferences

DOCTORS frequently misjudge patients' preferences regarding treatment, according to research from the US and Wales.

The gap between what patients think about treatment options and doctors' perceptions of patients' priorities is often considerable, researchers found. They say this so-called "preference misdiagnosis" is a common problem that is damaging patients as well as increasing healthcare costs.

The analysis, published on bmj.com, found that in one study only seven per cent of breast cancer patients rated keeping their breast as a top priority. In contrast, doctors thought the majority of their patients (71 per cent) would rate this as the most important factor when deciding on treatment. And although doctors thought that living as long as possible would be the top priority for 96 per cent of breast cancer sufferers

pregnancy in under-16s can consult a new resource produced by the Royal College of Paediatrics and Child Health (RCPCH). Pregnancy checking is required before surgical or radiological procedures but can be problematic in patients

below the age of consent. The new guidance document supports a consistent approach and includes templates for local production of materials and scripts. Go to www.tinyurl.com/ayrk9ag

● DENTAL CPD REMINDER

Fewer than eight months remain until nearly 40,000 dental care professionals (DCPs) will reach the end of their first five-year CPD cycle. DCPs must have completed 150 hours of CPD by 31 July and have declared those hours by 28

August or risk losing their GDC registration. So far 4,425 DCPs (11 per cent) have logged no hours. The GDC is urging employers to remind DCPs of the coming deadline. More information can be found at www.gdc-uk.org

AMENDING CONTRACTS

Janice Sibbald

SETTING aside important considerations relating to patient care, medical and dental practices are fundamentally businesses with the same budgetary considerations as any other. And as the difficult economic conditions continue to bite, practices are increasingly looking for ways to reduce costs.

While having an efficient and productive workforce is not an area to scrimp on, there are ways of looking at how this can be achieved cost-effectively. One solution is to amend employee contracts and benefits, but is this a straightforward process? The short answer is "no". And any changes you are considering to employees' contracts need to be looked at carefully.

The terms of a contract are the rights and obligations which bind the parties together and can be express terms (agreed explicitly and in writing or verbally) or implied terms which have occurred over time through custom and practice.

Let's take employee sick pay as an example of an express term. In the past, many workers were given very generous sick pay terms, sometimes up to six months at full pay then six months at half pay. Unfortunately there will always be certain members of staff who take advantage of this and have high absence levels. For employers, the first step in dealing with this issue is to proactively manage such absences (although it could be argued that very generous sick pay terms can in themselves encourage higher absence).

Sick pay is classed as a fundamental term and cannot simply be cut in order to reduce costs or as a means of targeting employees with high absence levels. In order to change a term of an existing

contract, consultation and agreement are required and it is unlikely that employees would agree to less sick pay (although this may depend on the strength of your negotiation and consultation skills).

What we advise is that when you recruit new staff into the practice you offer them less generous terms and then it is up to the individual, at point of offer, whether they wish to accept those terms. Be aware that although it is not illegal to employ staff on varying terms and conditions, once such a discrepancy becomes known it can create tension between staff members.

"Is amending an employee contract a straightforward process? The short answer is 'no'."

Adopting this approach means that over time, as employees leave the practice, you will reduce the number on enhanced schemes and therefore cut costs.

Another standard reason for a change in practices is the need to vary staff finishing times, perhaps to open the surgery earlier or later on certain days. The reference to this in the employment contract does not allow for any flexibility so the best approach is to seek agreement from your staff.

The first step is to consult with the employees and let them know what change you are proposing and why, ensuring they have the opportunity to ask questions. It is worth asking staff if anyone would volunteer to have their hours varied as this may suit some people's work-life balance better. If all employees

agree to the change then the practice simply needs to confirm it in writing.

However, if they refuse, one option the practice has is to impose the change. A risk associated with this approach is that it may lead to a breach of contract claim if the change is deemed to be fundamental, or a constructive dismissal claim if staff feel the practice has acted unreasonably and they cannot continue working there.

Another option open to employers where agreement isn't reached is to terminate the original contract, giving proper notice and offering re-engagement under a new contract on new terms. Again this isn't without risk because the termination of the old contract will constitute a dismissal, leaving the practice open to an unfair dismissal claim.

If this claim were to reach a tribunal then the panel would look at several factors to ascertain if the practice has acted reasonably. But what exactly does "reasonably" mean? It will likely take into account what the business reasons were for making the change, the employee's reasons for refusal, if any alternatives were considered prior to dismissal, if a fair procedure had been followed and whether the majority of other employees accepted the change.

In summary, altering employee contracts is an area that can prove problematic and, if in doubt, employment advice should be sought.

■ **Janice Sibbald is an employment law adviser at MDDUS**

YOU THINK WHAT?

Deborah Bowman

SEVERAL apparently unrelated experiences have prompted me recently to think about disagreement. First, I led a session for clinical teams on ethical erosion in clinical practice and professional training. It was a memorable and moving session in which doctors at all stages in their careers shared stories, sometimes verging on confessions, of moments when they wished that they had challenged a colleague whom they perceived to have acted inappropriately or even unethically.

We explored why these doctors perceived "ethical challenge" as distinct from, and more difficult than, other sorts of disagreement. One participant explained that, for him, questioning ethics can sometimes appear to challenge the core of a person's belief system and therefore identity. As such, sometimes even gentle debate and constructive challenge can feel, if not personal, certainly uncomfortable.

The second experience that has caused me to reflect on disagreement has been my preparations to welcome Debbie Purdy to St. George's for an event organised by the Ethics Society. Debbie will be well-known to many readers both for her legal action and campaign in relation to the law on assisted dying. I first met Debbie when we appeared on an episode of Radio 4's *Inside the Ethics Committee* together. I had been particularly struck when Debbie said during the course of that recording that she had an excellent relationship with her GP, even though they each had diametrically opposing views about changes in the law relating to assisted dying.

Debbie explained that she and her GP enjoyed a therapeutic relationship that was built on trust and respect; a relationship that accommodates abject disagreement about one of the most emotive subjects in healthcare ethics.

It is possible for individuals to disagree irreconcilably about highly-sensitive subjects. Indeed, I would go further and say it is inevitable and desirable that dissent is not merely felt, but expressed and heard. I would argue that uncertainty, complexity and plurality of approach are signs of ethical competence not incompetence.



"Uncertainty, complexity and plurality of approach are signs of ethical competence not incompetence."

The confidence to acknowledge and express that uncertainty and plurality (and to accept its expression in others) is, for me, what it means to learn and to practise ethics.

Finally, I have been listening to the second of Michael Sandel's wonderful series *The Public Philosopher* on Radio 4. No matter what the topic or who has the floor or which direction the discussion may take, Professor Sandel is a patient, thoughtful and intelligent facilitator. Effective inquiry thrives because of his personal commitment to creating a respectful and inclusive atmosphere in which everyone's voice is afforded equal attention irrespective of perceived status, personal biases or lazy assumptions. Michael Sandel is a role model for anyone who wants to create a safe environment in which ethical disagreement can be not just explored but harnessed to generate meaningful discussion in which everyone, irrespective of their views, is enriched.

The content is, of course, fascinating and stimulating, but it is Professor Sandel's personal qualities – virtues or values if you will – that, for me, make these programmes uniquely worthwhile. His curiosity, enthusiasm, wit, humour, fairness and intelligence imbue every stage of the process. His gentle steer produces nuanced discussions that are rare in their quality and richness. And he does so by beginning with disagreement.

Disagreement is inevitable and it will often feel threatening. This is neither unexpected, nor is it unique to medicine. Few people (including me) like to be challenged or relish having the weaknesses in our arguments revealed. It is exposing and, if not done carefully, can result in feeling alienated and inhibited. Yet disagreement should be celebrated, especially in healthcare ethics. Homogeneity is not merely unrealistic, it is potentially dangerous: it compromises learning, reduces moral awareness and, at worst, can lead to the dysfunctional cultures in which individuals either do not speak out

about poor practice or are ostracised for doing so.

When I was an under-graduate at university, I had an influential tutor who advised that I

should always be sure to surround myself with those who disagreed with me. After one bruising tutorial too many, I was not, initially, persuaded of the value of such an approach. However, over 20 years later I can see the wisdom of that advice. Indeed, I believe that deliberately seeking out those whom I anticipate will disagree with me is vital. I also think I have learned that it is possible to disagree well. To do so requires patience, courtesy, sensitivity, fairness, self-awareness, empathy, intelligence and respect. No wonder we find it so difficult. Yet, everyone has an interest in creating a safe and effective environment in which disagreement can be explored and expressed.

So, perhaps now is the time to think about where, when and how disagreement occurs in your working life. Would you agree?

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



Professor Helen Lester, *clinical lead in QOF development, talks to Summons about what goes into a clinical indicator*

Where quality meets outcomes

THE QOF or Quality and Outcomes Framework has been much in the news lately with the recent launch of a 12-week consultation on proposed changes to the GMS contract – there now being the risk of a Government “imposition” of QOF changes should negotiations with the GPC in England fail. QOF is a system for the performance management and payment of general practitioners in which quality and outcomes are incentivised. The clinical indicators against which performance is measured are developed by a group of external contractors led by Helen Lester, professor of primary care at the University of Birmingham. She is also a practising GP.

Eight years down the line from the 2004 contract do you think that QOF has achieved its overarching goal? Is the UK a healthier nation?

Yes. I do think some of the improvements in health we’ve seen in the last few years in people with long-term conditions are associated with QOF. Part of the problem of answering that question with absolute conviction though is that back in 2003/4 when QOF was being dreamt up and negotiated I am not certain that anybody formally wrote down what the purpose of it was. And I think some of the problems that have

come to light since then are related to the absence of that very simple task. If QOF was there as a GP pay rise then it achieved its goal in the short term but not in the long term because I think there have been elements of claw back – really since 2005 once the Government realised that GPs were going to receive a significant increase in their income. If the goal was to improve patient care then, yes, it did indeed achieve that but at quite a slow pace. I think we could have done it much more quickly had that been the stated clear primary aim.

What is your role in the QOF?

I lead the external contractor group and have done so since 2005. What we do is devise the clinical indicators – not the organisational ones. We are a collaboration of people working in the University of Birmingham and also the University of York. The cost effectiveness of the indicators is developed by YHEC [York Health Economics Consortium] and the clinical elements of the indicators – the wording, the feasibility, the face validity, the reliability of them, looking for unintended consequences and piloting them – that’s my group based in Birmingham. Since NICE took over the development of QOF in 2009 we have produced 75 indicators.

How is a typical indicator first conceived?

Well they all come out of NICE guidance. There is a board called the NICE Advisory Committee who discuss whether they think a particular clinical area is a good area to go to QOF or not. I'll give you a real example. Rheumatoid arthritis (RA) is not currently in QOF. RA came to the committee about 18 months ago as a clinical area. They discussed it and decided that, yes, it was common enough. Yes, it was important enough in terms of morbidity. We, as indicator developers, said that we could see some indicators that could be developed in the area and in the end we were told to go away and do that.

We then worked with a group of senior clinicians who are experts in the area of RA, based in Keele. We asked – what are the key issues? And they said you need to think about things like cardiovascular morbidity because people with RA are much more prone to heart attacks. You need to think about fracture risk. You need to think about having annual reviews.

In the end we created five clinical indicators and put them through our 35 pilot GP practices for six months – and the results of the pilot were sent back to the Advisory Committee along with recommendations as to whether they should go forward or not. The Advisory Committee don't have to take our recommendations but pretty much always do – I hope because they represent the views of frontline GPs – and these then go on to the NICE menu of short-listed indicators and get sent to the negotiators.

What makes a clinical area QOFable?

There are a whole range of different factors but it does have to be a condition that is both common and important. Coughs and colds are common but people on the whole don't tend to die of them. Motor neurone disease is incredibly important but very rare. So that's why coughs and colds and motor neurone disease are not in QOF. It also has to be something that any GP in the land is able to do. So if it relies on a service that is only available in three parts of England, then that's not going to make a good indicator, although this is not an automatic bar to piloting or even inclusion in the NICE menu now. The condition also has to have a significant impact on the patient's life. Above all, indicators have to be evidence-based. One of the reasons why I hang on in there with QOF is because it's evidence-based medicine. The moment we start putting things in that are not evidence-based is the moment you need to start worrying about QOF.

Are indicators designed to have a finite life span?

No, but one might argue that indicators ought to be removed once they've run their course and patient level improvements have occurred. But removing indicators is a political negotiation. Some indicators, some process measures, were removed from QOF earlier this year.

What the evidence base says is that indicators work very well for a couple of years. So you get an improvement in achievement and then that achievement plateaus. You can't get an achievement much above 92 or 93 per cent. But traditionally the indicators have tended to stay in and not be removed.

"One of the reasons why I hang on in there with QOF is because it's evidence-based medicine."

Of course, if you take an indicator out that creates more workload for primary care. So it's not always a terribly popular move to remove an indicator where everyone is achieving very good scores and then putting in a new indicator where there is fresh work associated. But if you want to improve patient care, that's what you need to do. So your question was: do they have a finite life span? No they don't but I personally think that they should probably stay in a couple of years and then be removed.

One criticism heard among GPs is that the QOF is a box-ticking exercise that focuses only on what's easy to measure and ignores the "softer aspects" of what it takes to be a good GP. Is that fair?

A good indicator has to be valid and reliable. If you put in an indicator that is not tightly defined then that means there is huge room for interpretation and therefore also room for poorer care as well as improved care. So I would love to be developing psychosocial indicators because one of the joys and part of the art of being a GP is the less auditable 'softer' side of what we do. But if you want to improve blood pressure management, ultimately the indicator has to be whether blood pressure is below the target level. So I would argue that in QOF, we are not taking any of the art away but we are paying against the science.

What do you find most challenging about your role in the QOF?

The politics. You send your "children" out there, your indicators, and they get mixed in this political maelstrom of whatever the Government initiative of the day is and sometimes they come through the other side and sometimes they just get lost. I love the people that I work with. I love the actual process. I love working with the pilot practices. The only frustration is the politics at the end.

■ Interview by Jim Killgore, editor of *Summons*



The final days of Hugh Miller

Hugh Miller – self-taught geologist and popular writer – was a Victorian celebrity known throughout the UK and beyond. Here James Finlayson looks at his tragic final days and draws a lesson on the importance of separating the roles of doctor and friend

PHOTOGRAPHS: THE NATIONAL TRUST FOR SCOTLAND



Top: Hugh Miller.
Left: Devonian Age fish *Pterichthys milleri* named after Hugh Miller
Opposite: Professor James Miller

THE books of Hugh Miller are well known to the frequenters of a shrinking number of Scottish second-hand bookshops. Innumerable editions – solid, heavy, products of the mighty Victorian Edinburgh publishing industry – sit often forlorn on upper shelves.

Miller is still read; indeed, a surprising number of his books have been recently republished. One volume, *The Testimony of the Rocks*, first published in 1857, even has a foreword from the eminent Harvard evolutionary biologist Stephen Jay Gould. Opening a first edition of this book, one will find on the first few pages a frontispiece featuring a magnificent photograph of Miller along with a notice that the book was published posthumously. There is also a dedication to JAMES MILLER, ESQ. F.R.S.E., PROFESSOR OF SURGERY IN THE UNIVERSITY OF EDINBURGH. These facts considered together testify to a fascinating strand in the tragic story of Hugh Miller's final days.

A fearful dream

On a December night in 1856, Hugh Miller, writer, man of science and leader of the church arose from his bed and wrote a message to his wife. "My brain burns. I must have walked and a fearful dream rises upon me. I cannot bear the horrible thought. God and Father of the Lord Jesus Christ have mercy upon me. Dearest Lydia, Dear Children farewell. My brain burns as the recollection grows, my dear wife farewell. Hugh Miller."

Then using the revolver he habitually carried, Miller ended his life.

Suicide is a terrible thing. Many readers of this article will have experience of a patient's suicide and all will surely agree that it is one of the most difficult experiences in the life of a doctor. Some people, indeed, will have the tragedy and trauma of the suicide of a loved one. To all who knew Hugh Miller and to the many readers of his books and articles this was a shocking tragedy.

Sense of wonder

Miller was one of the best known men in Scotland at that time. He was born in the town of Cromarty in Ross-shire, on the edge of, but not in, the Gaelic-speaking

Highlands. His sea-captain father died when he was young and he was brought up by his mystical Highland mother. He describes his childhood in a wonderful memoir, *My Schools and Schoolmasters*. In it he claims to have learned little during his somewhat rebellious time in the local school, instead receiving his education from listening to the tales of old people, ferocious reading of the few books available and the patient instruction of intelligent relatives. He grew up with a sense of wonder about the natural world and man's place in it.

He became a stone-mason, working in summer in different parts of Scotland and returning home in the winter to read his books and to think about what he observed. He was fascinated by the structure of the rocks he worked with and the embedded fossils. He had been brought up in the Calvinism of the Scottish church, eventually finding an evangelical Christian faith. He tried to reconcile the testimony of the rocks with the testimony of the Bible, rejecting on the one hand the young age of the earth (espoused still by creationists) and on the other the evolutionary theories of the pre-Darwinians, pointing out the absence of intermediate species in the fossil record.

Church controversy

He published a book, *Poems written in the leisure hours of a Journey-man Mason*. Unfortunately the quality of the poems does not match the wonderful title. He did, however, develop a distinctive prose style – dignified but not heavy. He published other books on the legends of the Highlands and came to public attention when he entered into the disputes of the Church of Scotland. When first established by John Knox, the church had been profoundly democratic but the Scottish elite hated this and gradually the power of appointing ministers, instead of being vested in the people, was exercised only by the land owners. The Popular, or Evangelical Party, within the church struggled against this but failed to carry the day and in 1843 the church split.

Miller was asked to become founding editor of a newspaper, *The Witness*, established to support the evangelical cause. However, *The Witness* did not just deal with church politics but wider social



PHOTOGRAPH: EDINBURGH UNIVERSITY LIBRARY, SPECIAL COLLECTIONS DEPARTMENT

"The professor was publicly criticised for not having arranged for Miller's gun to be taken into safe keeping."

and scientific issues. Miller wanted to have an intelligent faith, a faith that combined a trusting view of the Bible with the latest scientific discoveries.

Miller produced a monumental amount of work. At the time of his death he was working on the proofs of his most ambitious work, *The Testimony of the Rocks, Or Geology in its Bearing on the Two Theologies, Natural and Revealed*. He had written the dedication to Professor James Miller, who was not a relation but a very close family and church friend.

Tragic mystery

Many reasons have been given as to why Hugh Miller ended his life. The Victorian one was that his brain had been turned by the excess mysticism of his mother. A more modern view is that he could not cope with the difficulties of reconciling his faith with the discoveries of geology. Perhaps he had a psychotic depression. It has even been suggested, albeit without supporting evidence, that he had tertiary syphilis.

Miller was a complex and vulnerable person. He had written of times of deep

depression as a young man. Like all stone-masons of the time, he had significant pulmonary problems and had been unwell in the weeks leading up to his death, complaining of terrible headaches. He had become very suspicious – at times bordering on paranoia – and felt completely exhausted. He saw his family doctor but his wife called in their friend Professor Miller. The professor thought that Hugh was overworked and advised cooling baths and cutting his hair. Two days later Hugh Miller was dead.

Professor Miller subsequently performed a post mortem on his deceased friend and found "a diseased brain". One wonders how he felt when he read the fulsome dedication in his friend's book. The professor was publicly criticised for being negligent in not having arranged for Miller's gun to be taken into safe keeping when he saw him.

Separate roles

We cannot know what was wrong with Hugh Miller. His symptoms would surely suggest today that an organic cause be carefully excluded. We also cannot be critical of Professor Miller for not having access to modern brain scanners.

However, was the professor wise to be his friend's doctor? Could he be objective? Would he have been reticent about asking Miller if he was suicidal or if there had been some personal matter troubling him? If he had doubts about his faith would Miller have told the professor, a fellow churchman? Hugh Miller's relationship with his wife was complex. Would he have been able to speak to his respectable friend about any sexual difficulties present? Did their friendship blind the professor to the need to objectively assess the risks of the situation? Was James Miller, as a surgeon, the most appropriate medical specialist to be involved?

Miller's writings can still be read with pleasure and profit – and I believe we can still learn from his life and death. His tragic end shows, I am convinced, the necessity to clearly separate the role of doctor and friend, and the dangers of combining the two.

■ Dr James Finlayson is a psychiatrist and medico-legal expert who lives on the Isle of Skye

Taking sides

In the final article in a series of profiles on legal professionals who provide assistance to MDDUS members Jim Killgore speaks to QC Christina Lambert on the role of the barrister



PHOTOGRAPH: LIZ GOOD/GOOD IMAGING

IMAGINE you are a patient just diagnosed with a serious illness. You enter into an unfamiliar and frightening territory of complex tests and investigations, risk assessments and shared decision-making over a range of treatment options with varying statistical prognoses. This is often similar to how doctors or dentists feel when faced with clinical negligence claims or regulatory proceedings. A sense of helplessness and lack of control is almost inevitable.

The law can seem a dense and sometimes arcane realm to the uninitiated. Part of the great value of a medical or dental defence organisation is having ready access to an experienced legal team should you find yourself thrust into that realm. Over the past four articles in this series we have looked at the role of the medical and dental adviser, the in-house solicitor and the clinical expert. Here we speak with QC Christina Lambert on assessing evidence and speaking up for members at legal proceedings in the role of barrister.

The day I meet Christina she is in our Glasgow office to attend a conference on an upcoming GMC fitness to practise hearing involving one of our members. The potential consequences could

hardly be more serious. An adverse ruling could lead to the doctor being struck off the Medical Register and barred from practising his chosen profession. Years of training and experience lost as a result.

“There is emotion in every case conference to a greater or lesser extent but this tends to be heightened in GMC cases because the stakes are so very much higher,” says Christina.

Long hours are spent going over the evidence in the case – the records, expert reports, potential witnesses. They discuss tactics for the upcoming hearing. “You are looking to deploy to the best effect the arguments that you have,” says Christina. All this background work is essential to help prepare for the day she must stand and argue the member’s case before a GMC panel.

A robust defence

In-house solicitors at MDDUS appoint or “instruct” an external barrister like Christina when it is clear that a case is to be litigated in an upper court or before a regulatory panel. Barristers specialise in courtroom advocacy on behalf of clients – presenting cases, examining and cross-examining witnesses, summing up all the

relevant evidence and arguing reasons why the court should support their conclusions. But they also provide expertise in the run up to hearings, advising on relevant law and assessing the strength of a client's legal case, based often on a considerable amount of research.

Christina has been a barrister for over 20 years and a Queens Counsel (QC) or "silk" since 2009. She is one of the UK's top experts in clinical negligence, acting for both claimants and defendants, along with her professional regulatory work. About 80 per cent of barristers are self-employed practitioners and belong to sets or chambers – groups of barristers who share accommodation and administration including clerks.

Christina belongs to one of the most prestigious – One Crown Office Row chambers based at Temple in London.

Christina's involvement in a case usually begins with a telephone call to her clerk from one of our solicitors. Her workload is always heavy with numerous clients at any one time and a range of cases at different stages – but if space can be found in her schedule she will take on a new case.

"The great excitement is when the box of papers arrives and you immediately open it to find out what the case is all about," says Christina. All this material must then be read and digested in order to prepare for the case conference.

"If it's a civil case there will be experts there and you'll thrash things out and look for areas of strength and weakness in the evidence. Then you will give the solicitor and the member the best advice as to whether or not you think there is a robust defence."

Such advice is invaluable to the legal team when considering whether it would be prudent to pursue a settlement or fight a case in court, and these decisions are always made in consultation with the member.

"If it's a GMC case then it's a rather more tactical discussion you'll have. Not just focused on the evidence," says Christina. "The point is that a GMC case is going to go ahead no matter what."

Days in court

A good barrister will be able to digest and analyse a huge amount of information at relatively short notice, says Christina. Even more important the job requires an ability to get at the heart of the matter in every case.

"There's no point having a barrister who can't see the wood for the trees," she says.

But the barrister's skill is most on show when before a court or hearing. It calls for steady nerves and a high degree of intellectual flexibility.

"Evidence as it emerges in court can be very different from the evidence that exists on paper before you start, and therefore you

need to be adaptable," says Christina. "You need to think on your feet and expect the unexpected."

Sometimes the evidence can be quite complex – especially in medico-legal cases. In one recent case involving spinal surgery Christina spent hours with a medical expert learning spinal anatomy and handling surgical instruments used in the procedure.

"You rely absolutely on your expert to take you right back to the anatomy and the physiology, to treat you as though you're a medical undergraduate and to try and build up the layers of knowledge you need to have in order to be able to argue the case."

Cross-examining "hostile" witnesses who may be leading experts in their

field can at times be nerve-wracking, she admits. "No barrister who is worth their salt would say they are not apprehensive when a case starts. But you need that adrenalin in order to remain alert and adaptable to do your job properly."

Born performers

When I ask Christina whether a good barrister is born or made, she replies: "I think a bit of both. There has to be a degree of enjoyment of performance – it goes without saying that you can't be afraid of the sound of your own voice. But at the same time I think a good barrister is made."

Christina herself did not start out in law. After studying history at Cambridge she worked for three years in a publishing company in Newcastle, indulging her passion in modern poetry. But the law had always been an interest and in particular the notion of being an advocate. So she pursued a one-year law conversion course at City University in London before being called to the Bar in 1988.

Later she decided to specialise in medical and dental legal work – her interest fostered by the fact that both her parents were GPs in Newcastle. But she never considered being a doctor herself. "I'm far too squeamish."

Christina's work as a barrister and QC is not limited to clinical negligence and medical and dental regulatory cases but also extends to coroner's inquiries, professional negligence and aspects of employment law. Recently she was appointed counsel to Dame Janet Smith's review of culture and practices at the BBC during the Jimmy Savile era.

The job offers Christina limited free time apart from at weekends when she leaves London and travels to her cottage near Alnwick in Northumberland. "I feel my blood pressure drop as I go further and further north," she says.

But it's a career path she rarely regrets, adding: "It's a fascinating job. It is absolutely."

■ Profile by Jim Killgore, editor of MDDUS Summons

Acute abdominal pain in general practice

GP Jonathan Berry considers when to refer in acute abdominal pain

As a hospital junior over 30 years ago, working in a busy general surgical and then gynaecology unit, I had quite good diagnostic skills with regard to acute abdominal pain. We rarely took out a "normal" appendix, and never operated for a probable ectopic pregnancy without finding some significant acute gynaecological problem requiring surgery, even if not an ectopic. A careful history, examination and simple tests, such as urine dip and a full blood count, almost invariably gave the correct answer. And it was easy to observe a patient for a few hours if there was uncertainty and we never sent home a patient who returned seriously ill within a few days.

Familiarity with the common acute abdominal presentations was probably the key. We didn't rely on diagnostic tests and there was no on-call ultrasound scanning in any event. A few years after becoming a GP, I was amused to receive a discharge letter critical of my having admitted a patient as a possible appendicitis. The final paragraph stated that histologically the appendix was normal! I don't think I was wrong to admit. Was an appendectomy warranted? Well, the operating surgeon thought so.

Some stats

In today's NHS we are rightly asked to reduce waste and especially to cut down on unnecessary unscheduled care admissions. A recent study by Brekke and Eilerston¹ found that of 26 per cent of patients seen in general practice with acute abdominal pain and admitted, nearly half had appendicitis and many of the remainder had gynaecological, biliary tract or peptic ulcer disease. Very few had no significant diagnosis made. It is arguable, therefore, that these admissions were warranted; from a commissioner's point of view and from a medico-legal point of view, there can be little to fault the decision to admit.

The GP's risk though might well lie amongst those patients not admitted. The

differential diagnosis of acute abdominal pain is wide. In the Brekke and Eilerston study, over 10 other conditions were diagnosed, the commonest being urinary tract infection and gastroenteritis. The *UK Map of Medicine* suggests 13 conditions applicable to either sex, with two additional suggestions for men, three for children and no less than five additional suggestions for females of child bearing age. Many of these conditions require significant diagnostics to confirm or even make a diagnosis. This is not the stuff of general practice. What is required is the ability to select those patients who require admission, or at least an opinion, thereby ensuring that the patient is safe and, in the process, minimising medico-legal risk.

History and examination

As always a good history, appropriately recorded, is essential. This may give the likely diagnosis or at least suggest the probable need for admission or not. Severe pain and/or marked systemic features can be very helpful, but elicitation and recording of important negatives can become crucial – especially if the decision is not to admit.

General questions with regard to the onset and progression of symptoms, particularly pain and any migration of pain, are a good starting point together with more generalised questions with regard to nausea, vomiting, bowel action

"Elicitation and recording of important negatives can become crucial - especially if the decision is not to admit"

and urinary symptoms. In women of child bearing age, a menstrual history, date of last period, sexual activity and contraceptive history are important. The presence or absence of vaginal discharge or intermenstrual bleeding may also be required. For children, the presence or absence of a history of sore throat should be elicited. For all a brief past

history, especially of recurrent symptoms or significant co-morbidity is required.

An appropriate and appropriately recorded examination is also required – perhaps even more so where the decision is not to admit. The general appearance and demeanour of the patient tells me a lot. The presence of a pyrexia or tachycardia can be helpful, but are not invariably present in significant abdominal pain, especially in the early stages. Is there a foetor? The abdominal examination is probably most important. Is there tenderness and where? Is there guarding, a mass, an acutely tender gall bladder and (for me especially) is there rebound tenderness? Are the loins and hernial orifices clear?

With regard to intimate examination, cognisance of any working diagnosis together with the likelihood of the examination furthering the diagnosis and the availability of appropriate equipment and chaperone all need consideration. Where ectopic pregnancy is suspected, then vaginal examination should be avoided. However, a working diagnosis of pelvic inflammatory disease together with appropriate facilities including the option to take swabs (especially where the patient's general condition is not suggestive of the need for admission), suggests examination and prompt treatment in the community may be beneficial. Where a decision to

admit has already been made, then rectal examination need not be performed. If there is doubt with regard to admission, then a rectal examination

may be helpful, perhaps revealing significant tenderness, or unexpected blood, mucus or pus. When not minded to admit then testicular examination should be performed, especially in young men.

Urinalysis, especially using sticks and including leucocytes and nitrite, can be helpful but the timeliness of other



examinations, often with poor sensitivity and specificity (for example full blood count and CRP), makes their use in the community for urgent cases less helpful and may delay an appropriate admission.

To admit or not admit

The decision to admit a patient with acute abdominal pain, and to even form a definitive diagnosis, can be a very easy one. Classical appendicitis or an acute perforated duodenal ulcer may be obvious, but the presentation of retro-caecal appendicitis or a diverticular perforation can be difficult. The safe handling of the patient is paramount and on occasion this will lead to admission where little is subsequently found.

The decision not to admit requires consideration of appropriate follow-up and possibly laboratory or other tests. Safety netting is crucial. A patient with acute abdominal pain not admitted but ill enough to require reassessment the same day (unless a child) probably does need admission – not least because a surgeon assessing such patients regularly will have greater current experience than most GPs.

Today most hospitals have an acute ultrasound service for both general surgical and gynaecological purposes. Whether patients with a classical presentation require such investigation is a different story for commissioners. But as a GP, I will continue to be guided by my patient's history, examination findings and on occasion intuition. This is likely to provide the best care for my patients and allow me to sleep at night – but if something does turn out wrong I will have a defensible stance.

■ ***Dr Jonathan Berry is a general practitioner in Trafford and a healthcare management consultant***

¹ Brekke M, Eilertsen R K. Acute abdominal pain in general practice: tentative diagnoses and handling. A descriptive study. *Scand J Prim Health Care*. 2009; 27(3): 137–140



Consider your dental co-pilot

Risk training consultant and former pilot Phil Highton highlights the importance of encouraging dental team members to voice concerns on patient safety issues

MANY people will be familiar with the comparisons that have been made between the world of aviation and healthcare, especially for anaesthetists and the operating theatre, but could the analogy also be applied to dentistry? Here the typical scenario is based around two people, a shared task, a difference in skill sets between them, with one clearly leading and being held responsible and the other supporting.

Consider the following real-life example

Shortly after midnight on January 3, 2004 a Flash Air aircraft took off from Sharm-el-Sheikh for the 50 minute journey to Cairo. The night was clear and cloudless.

The departure routing required a south-westerly take-off followed by a very long left hand turn to track north-westward towards Cairo. As the turn progressed and the limited lights around Sharm were replaced by the blackness of the Red Sea and featureless desert the pilot became disorientated and he started to lose control of the aircraft with an ever increasing bank angle. The other pilot was aware of the deteriorating situation but seemed inhibited in his response. In fact the worse the situation became the less he contributed. The aircraft crashed seven miles south of the airport killing all on board.

A one-off or part of a pattern? In 1999 the crew of a Korean cargo aircraft taking off from Stansted became disorientated and crashed. Two Kenya Airways aircraft

crashed for similar reasons in 2000 and 2007, as did one from Ethiopian Airlines in 2010.

To air safety professionals, what is particularly interesting in these incidents is that in every one the most experienced pilot was flying the aircraft at the time. The captains lost control of the situation and the cockpit voice recorders suggest that the co-pilots were aware of the divergence from a safe condition but failed to either express their concern or intervene effectively.

Statistics show that worldwide captains operate flight controls for about 60 per cent of the time but they operate the controls in 90 per cent of accidents that feature the catastrophic loss of control seen in our examples above.

In Western Europe/North America we

would like to be smug and say that it couldn't happen with our standard procedures and crew dynamics built around Crew (team) Resource Management best practice, but life doesn't come with guarantees. The best we can do is to stack the odds in favour of success.

We train to understand and apply best human factors practice and two areas are highlighted in the accidents that I have described.

Thinking and doing

The first is what we call a Think/Do conflict. In essence our grey matter has to exercise control over motor functions (the "do" bit) while undertaking sense making and cognitive processing (thinking) using a shared resource. Most of the time we don't notice the conflict because we have only moderate demands from either source and lack an objective measure of performance for either function.

There are lots of opportunities to see the conflict in action if we can use speech as a proxy for cognitive effort. Conversation stops when manoeuvring into a parking space. Drivers find themselves in the wrong lane at a junction or roundabout because they were using an approved hands-free telephone as they approached – their hands may be free but their brain is tied up.

If you are still unconvinced try this little exercise.

1. Take a tennis or cricket-sized ball and throw and catch it repeatedly aiming for a consistent height of about 1.5 metres. This is motor function and as repetitive activity should become easier with practice.
2. Hold the ball and recite the alphabet from A to Z out loud. This is cognitive activity in that you are retrieving information from memory, and speaking it out loud is a proxy for the effort involved.
3. Try to do both at the same time. Depending on your skill at catching and your fluency with alphabet recollection you may be able to do both with reasonable aplomb but my guess is that the catching becomes erratic and the alphabet more laboured because it is the sum of the two demands that matters.
4. Now explore overload. Repeat the

ball catching and alphabet recitation together but this time recite the alphabet backwards from Z to A. Watch and listen to the resulting performance. When the sum of the two demands exceeds your capacity both functions will be affected. You will become incompetent (make unforced errors in the ball catching) AND your judgement will be compromised (in this exercise you may retrieve and utter information poorly).

"The authority gradient is a perception of the instantaneous power difference between two people."

In aviation the best practice is to divide thinking and doing between the pilots such that one pilot handles the aircraft and autopilot to control the flight-path (doing) and the other exercises overall control but metaphorically sits on their hands (thinking). This is in stark contrast to the old ways of a "one man band" operation where the ability to cope with the combined workload played to the ego but resulted in very fragile performance as we have seen. If there is only a single pilot present we separate the demands temporally by doing as much thinking as possible before the activity starts or reducing activity to allow deeper thought.

Are there parts of your job as a dentist where the Think/Do conflict poses a risk to clinical care? Can you think of ways to spread the load within your team to mitigate that risk? Communicating effectively when the workload is high is critical to safety, but creating the appropriate environment in which the communication can take place has to be undertaken before the workload increases. This relates to the second challenge – the so-called authority gradient within a team.

Authority gradient

Addressing the issue of a fellow professional failing to raise their concerns

effectively is an important concern in any safety critical activity. Folk wisdom has it that the onlooker sees more of the game and it does not require a great leap of the imagination to propose that appropriately trained colleagues with low activity demands will be able to make good sense of unfolding events.

Whether they share information or voice concerns is influenced by what we refer to as the authority gradient. This represents the difference in power between the parties. Sources of power can be knowledge, confidence, strength of character or personality or result from position or role. Culture in Australia and North America can be characterised as having shallow authority gradients exemplified by high challenge coupled with high respect. Many Asian cultures have steep gradients. Individuals display deference to authority or are unwilling to express their opinion for fear of causing upset or losing face if they are wrong.

In practice the authority gradient is a perception of the instantaneous power difference between two people and shifts according to circumstance. In aviation we encourage a shallow gradient by sharing information, inviting comment, agreeing vocabulary to be used when raising concerns and being explicit about roles and expectations. Clearly there is an option to "pull rank" in a crisis and a steep gradient may be used as a short intervention.

Consider the authority gradient in your practice. Do your team members feel empowered to speak up with any concerns? Creating an open environment in which healthcare staff feel confident to express concerns could provide an important safety net.

Safety is not a single event or even something that we "do". Safety is a notion which should inform our every action. Both medicine and dentistry can draw valuable insights from the long experience of the aviation industry in managing human factors. It requires that practice teams – no matter how small – consider their unique work environment and mould these principles to fit.

■ *Phil Highton is director of training with healthcare training firm Terema*

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

COMPLAINTS: A MATTER OF OPINION

BACKGROUND: A pregnant patient, Mrs D, arranges a consultation with her GP, Dr C, to discuss her preference for a home birth. She intends to ask about the risks and benefits of such a delivery compared to a hospital birth.

Dr C believes it would be in Mrs D's best interests to give birth in a hospital setting and spends several minutes explaining the various risks associated with a home birth, highlighting the fact that the outcome for mother and baby in the event of unexpected complications can be far worse in home births.

Four days later, Dr C receives a letter of complaint from Mrs D regarding her manner and the nature of the advice offered during the consultation. The patient explains that Dr C's insistence in arguing against a home birth left her feeling "bullied" and ill-informed and that the doctor did not offer balanced information about the options available. Mrs D's complaint references recent research highlighting

the benefits of home birth for low-risk patients and states that Dr C did not adequately explain these. She says she felt Dr C talked down to her and was only interested in persuading her not to have a home birth. Dr C, she says, should consider changing her attitude when dealing with future patients.

ANALYSIS/OUTCOME: Dr C is surprised to receive the complaint as she believes she was acting in Mrs D's best interests by encouraging her to have a hospital birth. Dr C contacts MDDUS for advice and a medical adviser helps her draft a response.

In her response, Dr C expresses concern that Mrs D was unhappy with the consultation and goes on to explain that, based on her understanding of the relative risks and benefits, she does not support home births for any of her patients. She apologises for not noticing Mrs D's distress during the consultation and invites her to discuss

the matter further. She closes the letter by informing the patient of her right to contact the health service ombudsman regarding the complaint.

Mrs D responds by reiterating her concerns regarding Dr C's determination to dissuade her from a home birth and, while accepting the apology, Mrs D decides to de-register from the practice. The complaint is taken no further.

KEY POINTS

- When discussing issues of care with a patient it is important to provide balanced information on the various options available and to actively listen.
- Remember to take into account a patient's treatment preferences when discussing a course of action, rather than being guided solely by your professional medical views/experiences.



DIAGNOSIS: BLEEDING GUMS... AGAIN

BACKGROUND: Mrs M, 48, attends her dental surgery for a routine check-up with a newly qualified associate dentist, Mr A. She complains of intermittent swollen gums and is a smoker with a history of periodontal disease. Mr A explains smoking can exacerbate gum problems and she says she plans to quit.

Mrs M attends the surgery four weeks later as an emergency having lost a filling in UL6. Mr A places a crown but the following week Mrs M returns complaining of swollen gums, pain and bleeding localised around UL6. Mr A finds that some excess cement was left in place when the crown was fitted which might be exacerbating her pre-existing gum condition. He removes the cement, cleans the area and prescribes a chlorhexidine (CHX) mouthwash.

The patient attends the practice again the following month complaining of bleeding gums. Mr A reassures her that the



bleeding should soon settle if good oral hygiene is maintained and again advises her to quit smoking. He prescribes CHX mouthwash for five days.

ANALYSIS/OUTCOME: Three weeks later the practice receives a letter of complaint from Mrs M about the treatment given by Mr A. She says she had referred herself to the dental hospital and was diagnosed with periodontal disease as well as an abscess and evidence of cement and pus in her gums where the crown had been fitted at UL6. She was prescribed an antibiotic and told her gum disease required immediate treatment.

Mrs M claims Mr A failed to diagnose and treat her



DIAGNOSIS: JUST A TUMMY BUG?

BACKGROUND: A mother attends an emergency appointment at the GP surgery with her four-year-old son Sam. The child had seen his regular GP two days before with vomiting and abdominal pain and was diagnosed with viral gastroenteritis. Sam's mother was advised that the condition would soon run its course but in the past 24 hours the boy's symptoms have not improved.

Sam is seen by another GP – Dr J. Upon entering the consulting room the boy grows extremely distressed, crying hysterically and clinging to his mother. She explains that Sam is afraid of doctors. Eventually Dr J gives up trying to examine the boy, though he does manage to determine by touch that Sam is not feverish.

The boy's grandmother is in the waiting room and Dr J suggests Sam wait with her. Dr J observes Sam jump into his grandmother's lap with no obvious signs of pain or tenderness. In the consulting room, Dr J suggests the boy is still suffering from viral gastroenteritis and advises his mother to keep him hydrated and treat any fever with paracetamol.

Two days later Sam attends A&E with extreme abdominal pain which turns out to be appendicitis. Following surgery, Sam spends four days in hospital recovering. One month later



the practice receives an angry letter of complaint from Sam's mother.

ANALYSIS/OUTCOME: In the letter of complaint Sam's mother alleges that Dr J failed to properly examine the boy and dismissed her concerns that he might be suffering with something more serious than a "tummy bug". As a result Sam suffered for an additional two days before being diagnosed and undergoing surgery.

Dr J contacts MDDUS and an adviser assists him in drafting a letter of response to Sam's mother. In his response the GP states that when Sam came into the consulting room he was distressed and an adequate examination was very difficult. Even if the examination had been forced it would not have been possible to adequately assess the child for tenderness as the abdominal muscles were tensed with stress.

He states that in his experience

children with acute appendicitis tend to lie still with their legs drawn up. In observing Sam wriggling about and climbing into his grandmother's lap he concluded that it was unlikely to be a serious problem.

The GP expresses his sincere regret for Sam's additional suffering but explains the difficulty sometimes in diagnosing appendicitis, especially in a distressed child. The GP states further that since receiving the letter he has reviewed his understanding of the presenting features of appendicitis and his approach in examining distressed children. He offers to meet with the family to discuss the matter further.

Sam's family respond to say they are satisfied with the GP's explanation and the case is closed.

KEY POINTS

- Have a high index of suspicion in symptoms persisting beyond the normal course of a viral infection.
- Develop strategies for coping with distressed children – for example using distractions such as toys or rewards or allowing time for the child to calm down before attempting the examination later.
- Explain clearly to the parents the limitations of the consultation and advise an early return if the symptoms don't improve.

periodontal disease and her gums are now in a "deplorable state with irremediable bone loss".

In his written response to the complaint, Mr A states that on first seeing Mrs M he was aware of her history of periodontal disease. In his initial examination the dentist recorded "no gingival swelling" and the treatment plan remained focused on monitoring the patient's oral condition.

He states that the problem with the crown at UL6 was identified and remedied and that he also provided detailed advice on smoking cessation. Mrs M's decision to self-refer to the dental hospital and her refusal to see Mr A again meant he was unable to provide any further advice and treatment.

Mrs M is not satisfied with the practice response and refers the case to the health ombudsman. An investigation is undertaken and the ombudsman upholds certain aspects of her case in regard to dental charges for the treatment but not in regard to the failure to diagnose and treat her periodontal disease.

In examining Mrs M's dental records an independent clinical adviser finds that the patient was informed of the poor state of her gums on numerous occasions in previous years and that she had undergone some treatment with the practice hygienist but had also failed to attend numerous appointments.

The adviser can only fault the practice in perhaps not communicating effectively with Mrs M on the significance and importance of gum disease and the necessary routine care to prevent the condition getting worse.

KEY POINTS

- Ensure that patients understand clearly the significance of periodontal disease and the likely outcomes should treatment advice be ignored.
- Avoid the charge of "supervised neglect" by using every appointment as an opportunity to remind patients with gum disease of the need to maintain good oral hygiene.

From the archives: Principled sacrifice?

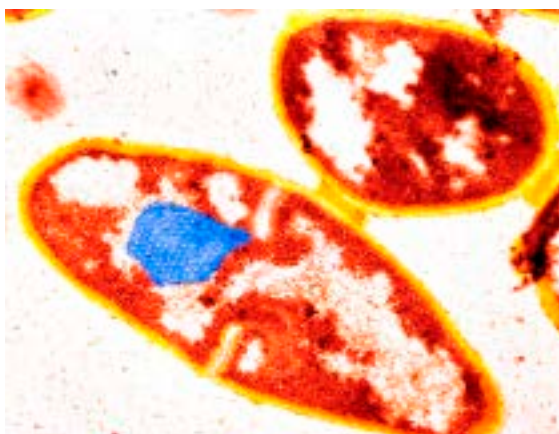
IMAGE COURTESY OF SCIENCE PHOTO LIBRARY

A CLASH between personal views and a professional duty of care is nothing new – in fact it's as old as Hippocrates. Consider a newspaper report from 30 October, 1924, announcing the acquittal of Dr Walter Robert Hadwen on charges of manslaughter before the Gloucester Assize Court.

Hadwen was president of the British Union for the Abolition of Vivisection (BUAV) and an active campaigner against vaccination, being a firm disbeliever in the germ theory of disease.

The case centred on his treatment of a young girl named Nellie Burnham. She had presented with signs of diphtheria but Dr Hadwen had insisted on a diagnosis of lobar pneumonia "consequent upon a chill which the child caught in going down in her bare feet and night dress to get water".

The accusation was that he must have been aware that



diphtheria was the most reasonable diagnosis given her symptoms but that he refused to administer diphtheria anti-toxin - first on the grounds that he did not hold with the "theory" that diphtheria was caused by a bacillus. "I look upon it as the result of disease and not as its cause," he said. Second as an anti-vivisectionist he was vehemently

opposed to the manufacture of diphtheria anti-toxin which involved the inoculation of horses with the diphtheria toxin and their subsequent bleeding to obtain the antibody-containing serum.

Nellie Burnham did not improve with Hadwen's prescribed treatment and another doctor was called in but by then it was too late to save the girl. It also transpired that this doctor had been one of Hadwen's bitter opponents in the press. This resulted in Hadwen being arrested and charged with manslaughter in the death of the child. In court the prosecution alleged that the doctor, as a result of his zeal, had "shut his eyes to the symptoms" and that this fell within the range of criminal neglect.

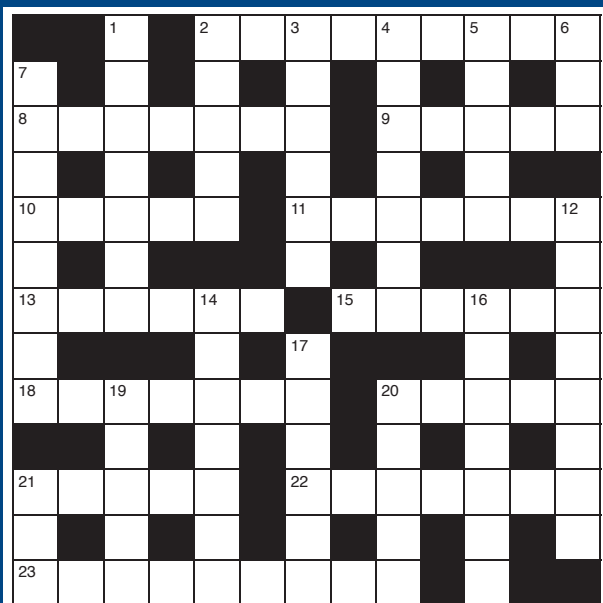
But the presiding judge in the case Mr Justice Lush disagreed. While accepting that negligence might be proved in civil court he said: "Unless the negligence was of so gross a character as to make one say it was a wicked negligence it could not amount to manslaughter."

Hadwen's acquittal in the court was greeted with rousing cheers and outside he was so mobbed by the press and supporters he could not reach his car. He announced: "I feel the triumph the greater because, although I had so many medical men pitted against me, the jury have given their verdict solely upon my own evidence."

"I can only say that conscience as far as I understand it, is that principle implanted in man which leads him to decide before God what is right and what is wrong. Therefore for me to give anything which I believe to be wrong would militate against my conscience as before God."

Just what a GMC panel would make of that today is perhaps without doubt.

Crossword



ACROSS

2. Inability to move (9)
8. Encases the testes (7)
9. Major _____, part of the kidney (5)
10. Enzyme immunoassay (acronym) (5)
11. Out of place, as in pregnancy (7)
13. Victorian geologist (6)
15. Infirm toilet (6)
18. Complex polysaccharide antithrombotic (7)
20. Tooth (5)
21. Cardiac muscle (5)
22. Relating to spasms (7)
23. Over-the-counter laxative (9)

DOWN

1. Pertaining to the military (7)
2. Greek bread (5)
3. Butted (6)
4. Found person (7)
5. Orchid flour (5)
6. Gender (3)
7. Revered (8)
12. Legal agreement (8)
14. Irregular (7)
16. Colour range (7)
17. As new (6)
19. Internal images (1-4)
20. Related species of acacia or wattle (5)
21. Stove top (3)

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

Object obscura: Roman vaginal speculum

PHOTOGRAPH: SCIENCE & SOCIETY

THIS bronze vaginal speculum was found in the Lebanon and dates to 100 BC-400 AD. It shows the relatively sophisticated instruments that were in use in Roman medicine. The earliest major work on the diseases of women was written in Roman times, about 100 AD.



Vignette: doctor and pharmacologist

Sir James Whyte Black (1924-2010)

PHOTOGRAPH: SCIENCE PHOTO LIBRARY

TO father one life-changing drug is admirable, but to develop two is truly remarkable. Such an achievement can be credited to Scottish-born doctor and pharmacologist James Black, who was awarded the Nobel Prize for Medicine in 1988. This was in recognition of his work leading to the development of two of the world's biggest selling prescription drugs, propranolol and cimetidine.

Propranolol has been hailed as the greatest breakthrough in heart disease treatments since the 18th century discovery of digitalis, while stomach ulcer drug cimetidine was the first of a new class of drugs – the H₂-receptor antagonists.

When Black began his research in the 1950s the idea that drugs could be designed to change biochemical processes on cell receptors was new. Propranolol, a beta blocker, interrupts the action of the stress hormone adrenalin and relieves angina, while cimetidine, launched under the brand name Tagamet, prevents excess acid secretion in the stomach.

Black was born in Uddingston, Lanarkshire, but grew up in Fife where his father worked as a coal mining engineer. After school at Beath High, he won a scholarship to read medicine at St Andrews and Dundee. His elder brother was a doctor but that career seemed dull to James' restless, enquiring mind. Instead he turned to physiology to address such questions as the effect on blood pressure from substances absorbed through the gut. He only stayed a year in the department of RC Garry, choosing to work in Singapore at the University of Malaya to repay his student debt.

Returning to the UK in 1950 he soon secured work from William Weipers, director of the Veterinary School of Glasgow University. During the next eight years Black established a well-equipped physiology department where he carried out ground-breaking work on adrenalin. In 1948, Raymond Ahlquist in America had postulated that different alpha and beta receptors in smooth muscle were the sites where hormones such as adrenalin relaxed



or contracted smooth muscle. Black saw that drugs could be developed to modulate the action of receptors. This was beyond the scope of a university department and prompted his move to ICI with whom he would make propranolol and prove that it blocked beta receptors. That done, he was eager to explore further the action of H₂ receptors and search for an effective blocker of these histamine receptors in the gut wall. ICI were not interested but Smith, Kline & French gave him that opportunity and by 1972 cimetidine was created and, under the brand name Tagamet, was approved in the UK in 1976.

In 1973, Black was appointed professor of pharmacology at University College, London where he established a new undergraduate course in medicinal chemistry. However, he found that what he had gained in academic freedom he lost in applied science, so he gladly accepted an invitation to work at the Wellcome Laboratories as director of therapeutic research in 1978. His work in analytical pharmacology continued with a new generation of scientists. In 1984 he was made professor of a small academic research unit at King's College London, again with funds from Wellcome, but independent of industrial control. Funding from Johnson & Johnson in 1988 of a James Black Foundation gave him the

resources for laboratory research with a large staff of scientists.

Pharmacology has become an essential part of our brave new world. Propranolol remains popular today and has uses beyond the treatment of angina, particularly in the treatment of high blood pressure, as Black appreciated. Cimetidine has also been a worldwide commercial triumph. Both owe their existence to the clear thinking of James Black and both drugs significantly changed patients' lives.

Black's achievements were honoured by FRS in 1976, a knighthood in 1981, Order of Merit in 2000, but above all by Nobel Laureate in 1988 with Gertrude B Elion and George H Hitchings for "discoveries of important principles for drug treatment". A very private man who did not seek out publicity, Black was said to be horrified to discover he had won the Nobel Prize.

His final career move was back to Scotland to be chancellor of the University of Dundee in 1992. The university awarded him two honorary degrees, the second of which was Doctor of Science in 2005. His happy connection with the University of Dundee was marked the following year with the launch of the £20 million Sir James Black Centre for the promotion of interdisciplinary research in the life sciences.

Black claimed that his most important influence as a schoolboy was a book by Victorian polymath D'Arcy Wentworth Thompson, *On Growth and Form*, about the chemistry of crystals. His time at St Andrews also broadened his outlook and enthusiasm for academic study that proved so satisfying, if not financially rewarding. Black met his first wife Hilary Vaughan at a university ball in 1944. They married in 1946 and had a daughter, Stephanie, five years later. Following Hilary's death in 1986, Black remarried in 1994 to Professor Rona MacKie. He died aged 85 after a long illness and was hailed as "one of the great Scottish scientists of the 20th century".

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



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In association with **MDDUS**

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