

AUTUMN 2014

SUMMONS

AN  PUBLICATION FOR MEMBERS

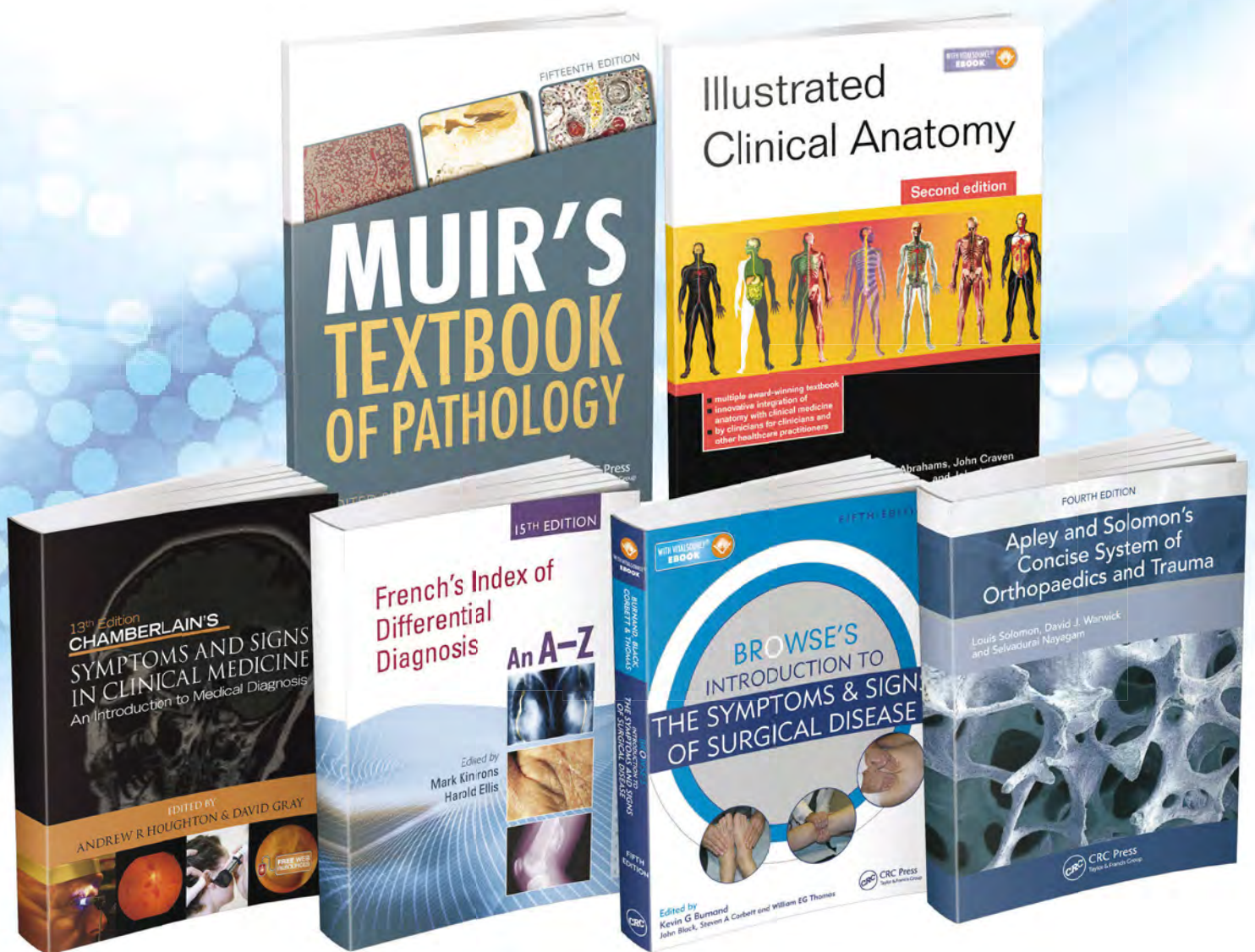


• Saying sorry • GDC responds • A most serious case indeed •

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IN THIS ISSUE

WHY do doctors find it difficult to say sorry? It's a key question in a post-Francis NHS with calls for a statutory duty of candour on top of professional obligations to be open and honest in admitting errors.

Psychiatrist Aaron Lazare – author of the book *On Apology* – wrote: "We tend to view apologies as a sign of a weak character. But in fact they require great strength. Despite its importance apologising is antithetical to the ever-persuasive values of winning, success and perfection. The successful apology requires empathy and the security and strength to admit fault, failure and weakness. But we are so busy winning that we can't concede our own mistakes."

On page 12 of this issue Dr John Dudgeon – a medical adviser at the Scottish Public Services Ombudsman – explores the need for a culture change in attitudes to acknowledging mistakes.

The GDC has been facing increasing levels of flack over proposals to raise the annual retention fee by 64 per cent – and

this on top of a recent Professional Standards Authority review in which the GDC failed to meet seven out of 10 good regulation standards in fitness to practise. On page 10, chief executive and registrar Evlynn Gilvarry addresses some of the criticisms.

MDDUS case files contain numerous examples of negligence claims resulting from failed joint and soft tissue injections – not just in technique but in poor consenting and explanation of risk. On page 16, Dr Lucy Douglas highlights new guidelines on best practice from the Primary Care Rheumatology Society.

We also have Steve Ashton from Law at Work (p. 18) discussing dental practice health and safety. Do you have risks hiding in plain site? And on page 14 Allan Gaw recounts a medico-legal case dating back to the founding of MDDUS and involving the domiciliary use of chloroform. Would the outcome have been different if ruled on by a judge today? Quite possibly not.

Jim Killgore, editor



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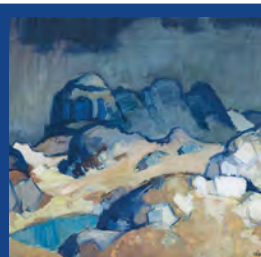
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Cover image:
Highland Landscape
by Denis Peploe

Son of Samuel John Peploe, the noted Scottish Colourist, Denis Peploe inherited a particular feeling for the landscapes of the Highlands. This

painting depicts a landscape in the Scottish Highlands: the sombre colour palette adds a melancholy mood to the vast space depicted and is reminiscent of the style demonstrated in the artist's other Highland pieces. 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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MDDUS wins eco award

MDDUS has been awarded the prestigious Carbon Trust Standard for its success in reducing carbon emissions.

A campaign spearheaded by the Union's staff Carbon Group achieved a reduction of 3.2 per cent in carbon emissions at its Glasgow headquarters between 2012 and 2013. Overall gas usage fell by 12 per cent while energy costs were slashed by a quarter. MDDUS staff vehicles for the Glasgow office also recorded a drop in fuel consumption of almost four per cent.

The Standard is a mark of excellence awarded by the Carbon Trust in recognition of a company's efforts to reduce its carbon footprint. It is valid for two years and firms who want to retain it must continue to cut emissions year-on-year.

The success follows 18 months of hard work by members of the MDDUS Carbon Group which was set up in January 2013 with the goal of implementing more environmentally friendly business practices in its Glasgow offices.

Over this period, the company and the Carbon Group have introduced a number of new measures including the installation of energy efficient lighting, a heating system upgrade, improved insulation of windows, a move to petrol company vehicles and a staff awareness campaign. It's hoped the scheme will be extended to MDDUS offices in London in the near future.

MDDUS Chief Executive Professor Gordon Dickson said: "I am very proud that MDDUS has been awarded the Carbon Trust Standard following a committed campaign

led by our staff Carbon Group over the past year and a half.

"This reflects the Union's commitment to sustainable, responsible business practices both now and in the future.

"We hope this award will be valued by both our staff and our members and will be taken as a sign that we take our corporate social responsibilities seriously."

Darran Messum, Managing Director, Certification at the Carbon Trust added: "It is genuinely impressive to see such a well mobilised internal team, focused on creating and delivering reduction strategies to achieve the Standard. We congratulate the team at MDDUS for all their hard work, which serves to show other organisations what can be achieved through a focused approach."

Caution advised over waiting list initiatives

THE NHS has been under increasing pressure to maintain and reduce the length of time patients wait for procedures. To this end many hospitals have out-sourced procedures to private hospitals. Others have used their own NHS staff to undertake extra sessions within their own and other hospitals.

Patients within the NHS are protected by NHS indemnity under various schemes. In England, trusts contribute to the Clinical Negligence Scheme for Trusts (CNST) and are thus covered by NHS indemnity. Some other private institutions may also join the CNST scheme and so become indemnified through the same scheme. There are similar schemes in Scotland (CNORIS) and Wales (WRP), and Northern Ireland has a risk-pooling scheme.

Doctors may be invited to undertake these waiting list initiatives and may be free to do so within the terms of their

contract. However, it is not true to say that NHS-type indemnity "follows the patient". Doctors must not simply assume that if these are patients undergoing procedures as NHS patients that they are automatically covered by NHS indemnity.

Members who wish to undertake this kind of extra work must be clear or have it made clear to them whether the procedures are covered by one of the NHS indemnity schemes.

If the work is not so covered, members will have to check if their current subscription is adequate and appropriate to allow them to undertake this extra work.

Members must ensure that they fully understand the terms on which they take on such work and, more importantly, carefully check the terms of the agreements or contracts for professional indemnity requirements.

Contact our Membership Team if in doubt.



Dr Jim Rodger retires from MDDUS

IN SEPTEMBER Dr Jim Rodger retired as head of professional services at MDDUS after 21 years of providing advice and support to members.

Jim joined the Union in 1993 having practiced for 18 years as a GP in Hamilton near Glasgow. His interest in medico-legal matters sprung in part from his experience working as a police surgeon. He developed this interest further by earning a Diploma in Medical Jurisprudence from the Worshipful Society of Apothecaries of London.

In 1980 Jim became MRCGP and later served on both the Scottish and UK Councils. It was through the RCGP that he met Bill Mathewson, who was then head of the medical division at MDDUS, and Jim developed an interest in the work of the Union. In 1993 a position became open at MDDUS and Jim applied.

"It was difficult leaving clinical practice," he says. "But it seemed an exciting prospect in an area I was very interested in."

In 2005 Jim was promoted to head of medical advisory services and later in 2008 he

IN BRIEF

● **"NO" VOTE IMPLICATIONS**

As all members will be aware, the outcome of the Independence Referendum was a vote in favour of Scotland remaining part of the UK. At a political level this marks the start of a period of negotiation on the added powers that are to

be devolved to Scotland. MDDUS does not anticipate that there will be any great impact on our day-to-day operations. We will of course watch developments closely and consult as appropriate with key stakeholders both in Scotland and the rest of the UK to ensure that

the interests of all our members are taken into account. The Union remains as financially strong today as it was before the referendum and will continue to provide a high-quality, expert service to all our members regardless of where they practise.

● **FORENSIC OR POLICE PHYSICIAN WORK**

MDDUS has revised the pricing structure for those members who perform forensic/police physician work. In the past we have included cover for forensic/police physician work through the standard GP

BLOG



By Dr Colin
Boyd, GP at
Lochgilhead
Medical Centre

Rural practice and risk

In a recent *BMJ* article (August 14) an A&E specialist worries about deskilling and loss of confidence in carrying out procedures that used to be routine, for instance in advanced airway management because anaesthetists are increasingly called in.

It is accepted in The British Resuscitation Guidelines that non-specialists should not waste vital time attempting endotracheal intubation in cardiac arrest, due to lack of practice, relying instead on simpler ways of protecting the airway. This is a great relief to GPs such as me who work in community hospitals and may only be involved in CPR once or twice a year. But there is a wider question of how to maintain competence in infrequent problems and procedures encountered in isolated parts of the country.

Until four years ago I was a GP on a Scottish island and with five colleagues looked after a population of 7,000. As well as normal GP work we had 12 beds in the community hospital and an A&E department which had to accept all blue-light emergencies. There was no

opting out of on-call and we provided 24-hour cover, often on-call alone. The nearest district general hospital was over an hour away, including 25 minutes on a ferry which stops at night and then we had to rely on helicopter transfers. It was a very enjoyable if tiring role as a GP/hospital practitioner. I was able to do practical things such as suturing, looking at X-rays and putting on plasters, but I was also occasionally faced with complex emergencies.

Things that a main A&E department might deal with on a weekly basis we saw maybe once in two or three years. For instance, from memory, during the 13 years I reduced three or four dislocated shoulders and two fracture dislocations of the ankle, inserted three or four suprapubic catheters, carried out a ventouse delivery for delay in the second stage of labour with foetal distress, and put in an umbilical catheter in a baby born unexpectedly at 33 weeks to give glucose whilst waiting some hours for the neonatal retrieval team. More frequently we saw seriously ill patients and a few seriously injured.

Did I have the competence to do all this? I felt I had even without any supervised training in much of it, and apart from the shoulders they all had to be dealt with promptly and I was there.

Courses are a good way of developing and maintaining skills. The ATLS (advanced trauma and life support) course is one of the best for this type of work, and I attended two courses eight years apart. But we allowed ourselves

only one week postgraduate training a year so it was difficult to fit in all that was needed and impossible to keep refreshed in every procedure that might be faced.

In the ideal world we could arrange drills in the hospital to practice emergencies, for instance for CPR, postpartum haemorrhage, shoulder dystocia, etc. We did this for CPR but it was difficult to schedule for all practitioners, including the ENPs as well as midwives.

The introduction of ERMS (Emergency Medical Retrieval Service) has been a step-change for us. Not only does it provide dedicated telephone access to an A&E or intensive care consultant for advice, ERMS personnel are also equipped to come out to our hospitals, usually by helicopter. They prepare patients properly for transfer to mainland intensive care units, including being able to anaesthetise to give full airway control. On top of this they provide feedback on our individual cases and run case analysis sessions, as well as practical training days.

In the end you have to judge your own competence against the need of the patient. By attending appropriate courses it is possible to maintain skill and more importantly develop confidence. Working in a small place, your actions are discussed and judged – and you still have to shop in the Co-op!

If you can't cope with that then isolated practice is unlikely to suit you.

became head of professional services, managing both medical and dental advisers as well as still advising individual members. And it is helping members in difficult times that Jim has enjoyed most about the job.

"I think of medical advisers as doctors to doctors. We discuss, reassure and support. Counselling is part of the job profile – no matter whether you're dealing with a professor or a new medical

graduate. That's what I'll miss most."

Jim plans to continue with some of his RCGP and other professional commitments but also looks forward to spending more time with his golf and his family, including the grandchildren (though not necessarily in that order). We will all miss him at MDDUS.

Jim Killgore, editor, *Summons*

subscription rate, but depending on your exact circumstances, you may need to increase your membership cover to include these activities. Please contact Membership Services at MDDUS to check you have sufficient cover for this type of practice.

● 'FOCUS ON SPORTS MEDICINE

The latest MDDUS Risk Factor video interview addresses the topic of sports medicine with Dr Jonny Gordon, emergency medicine consultant and course director of

SportPromote. Members can find all our interviews in the Risk Management section - mddus.com

● LESSONS FROM AVIATION

Places are available at MDDUS-sponsored master class events being run Terema - who apply principles of aviation risk to

healthcare. Places are available at Heathrow on 6 and 7 of November 2014 and at the MDDUS Glasgow Office on 12 and 13 of March 2015. Costs are £470 plus VAT and delegates can earn 12 CPD points. To register interest or book a place email risk@mddus.com.



➔ Social media fuels rise in complaints

SOCIAL media and negative press coverage of the medical profession are helping to fuel a surge in complaints against doctors, a study by the General Medical Council has found.

Complaints to the GMC by the general public about doctors' fitness to practise almost doubled from 3,615 in 2007 to 6,154 in 2012. The dramatic rise prompted the regulator to commission a research team from Plymouth University Peninsula Schools of Medicine and Dentistry to investigate the trend. However, the GMC made it clear there was no evidence to suggest the rise was due to falling standards.

Researchers said increasing complaints were a result of "broad cultural changes in society, including changing expectations, nostalgia for a 'golden age' of healthcare, and a desire to raise grievances altruistically". Complaints networks and social media were also making it easier for people to complain. Clinical care remains the largest cause of complaints, but there has also been a rise in concerns about doctor-patient communication.

While attitudes towards medical professionals are "positive overall", negative press coverage was blamed for "chipping away" at their reputation, resulting in an increased number of people making so-called "me too" complaints to the GMC.

The report also noted that patients now

have greater ownership of their health, are better informed, are developing higher expectations and are treating doctors with less deference than in the past.

Lead report author Dr Julian Archer said: "[The report's findings] show that the forces behind a rise in complaints against doctors are hugely complex and reflect a combination of increased public awareness, media influence, the role of social media technology and wider changes in society.

"We found that while a better awareness of the GMC has a role to play in the increase in complaints, it did not necessarily result in an increase in complaints the GMC were in a position to deal with."

➔ Call for clarity on GDC fee rise

A MAJORITY of dentists (66 per cent) responding to a consultation on the annual retention fee (ARF) do not believe that the GDC has provided a clear account of its resource needs for 2015.

An overwhelming majority (97 per cent) of respondents rejected the need for a 64 per cent rise in the ARF to £945 per year.

The consultation on the ARF level closed on 4 September with 4,474 responses received. The GDC Council has met to consider the outcomes and broader themes that have emerged about regulation and the handling of complaints in particular.

The GDC has also commissioned the auditors KPMG to review the full range of

assumptions underlying the proposal to raise the ARF. This will focus in particular on the projected fitness to practise caseload.

The GDC has said it will study all the consultation responses and a final report, including the findings by KPMG, will be considered by the Council on 30 October, at which point a decision will be made on the level of the ARF for 2015.

In an interview in this issue of *MDDUS Summons* (p. 10), GDC chief executive and registrar Evlynne Gilvarry says: "The ARF was last increased in 2010. Since then fitness to practise (FtP) complaints to the GDC have increased by 110 per cent.

"Without further significant investment in our FtP processes we will be unable to deal effectively with the very large increase in our caseload and so we must make adequate provision."

➔ Changes in death certification in Scotland

THE first phase of changes in death certification procedures in Scotland have been implemented.

Doctors are now required to use the new paper-based Medical Certificate of Cause of Death (MCCD). Old style MCCDs and incompletely filled MCCDs will be rejected by the Registrar of Births, Deaths, and Marriages and returned to the certifying doctor or another doctor in the team to complete and issue a new form.

The new arrangements are a result of The Certification of Death (Scotland) Act 2011 which is aimed at streamlining the current process, improving the accuracy of death certification and providing better public health information about causes of death in Scotland.

A second phase of the implementation is scheduled for April 2015 and will introduce further changes including electronic completion and transfer of MCCDs and scrutiny by Healthcare Improvement Scotland, along with a new electronic system of reporting to the procurator fiscal.

NHS Education for Scotland has published tools and training resources on their website to help doctors prepare for the changes.

IN BRIEF

● DOMPERIDONE PRESCRIPTION ONLY

Domperidone will no longer be available to patients over the counter. The European Medicines Agency (EMA) recently reviewed the safety and efficacy of the drug and found a small increased risk of

potentially life-threatening effects on the heart. This follows advice issued by the MHRA in April that domperidone should no longer be used for heartburn, bloating or relief of stomach discomfort. Indications for the medicine are now restricted to nausea and

vomiting. More details at www.mhra.gov.uk.

● **UNEXPLAINED FEVER IN CHILDREN** NICE has published a new quality standard to help healthcare professionals quickly identify and treat under-5s seriously ill with fever and

reduce their chances of death or disability. Fever is the second most common reason that a child will be admitted to hospital. The standard promotes the traffic light system for identifying risk of serious illness. Go to www.nice.org.uk/guidance/QS64

➔ GPs still prescribing unnecessary antibiotics

A SURVEY of over 1,000 GPs has found that 70 per cent prescribe antibiotics because they are unsure if an infection is bacterial or viral.

It also found that 90 per cent of GPs feel pressured by patients to prescribe antibiotics and 45 per cent say that they have prescribed them for a viral infection when they knew it would not treat the condition.

The survey was conducted on behalf of the Longitude Prize, run by the innovation charity Nesta. In June the public voted for antibiotics to be the focus of the £10 million prize, the remit being "to create a cost-effective, accurate, rapid and easy-to-use test for bacterial infections that will help health professionals worldwide to administer the right antibiotics at the right time".

Last year over 50 million antibacterial items were dispensed in the community in the UK and antimicrobial resistance poses a "catastrophic threat" to health in the coming decades. Tamar Ghosh who leads Longitude Prize, explains, "Across the globe we need accurate point-of-care diagnostic tools to maximise the chances that antibiotics are only used when medically necessary and that the right ones are selected to treat the condition. In the next five years, the Longitude Prize aims to find a cheap and effective diagnostic tool that can be used anywhere in the world."



➔ CQC moves to targeted dental inspections

DENTAL inspections by the Care Quality Commission will be more targeted and focus on practices where there is "cause for concern," according to a recent "sign-posting" statement on potential changes to the way it regulates primary care dental services in England.

The CQC is also considering whether every inspection team should include a dental specialist adviser and people with extensive understanding of dental services, acting as "experts by experience".

The statement comes ahead of a formal consultation and the start of trial inspections in November 2014.

Dental services present fewer concerns on the whole compared with other providers, according to the CQC. For example, between April 2011 and October 2013, only one in eight dental locations were found to fall short of regulations in some way compared with one in five in adult social care. The CQC proposes to inspect only 10 per cent of dental providers, focusing attention upon those that are seen as "cause for concern".

The CQC will also be seeking views on whether to provide ratings to dental

practices after 2016.

John Milne, Chair of the BDA's General Dental Practice Committee, said: "Time and again, the CQC has shown dentistry to be a low risk sector. But for too long it adopted a costly 'one size fits' all approach to dental inspection – and so we welcome moves to a more targeted, risk-based approach.

"We are pleased that the CQC appears to have listened to reason, so we finally see dental experts on the front line for dental inspections. It's a simple, common sense move that would be seen as positive throughout the profession."



➔ Warning over care of heart attack patients

HEART attack patients who miss just one key element of care are at greater risk of

dying within a month of leaving hospital, according to new research.

A study by the University of Leeds found that this risk increased by 46 per cent while the risk of death within a year went up by 74 per cent.

The findings were based around nine key elements of care identified as: pre-hospital electrocardiogram, acute use of aspirin, restoring blood flow to the heart (reperfusion), prescription at hospital discharge of aspirin, timely use of four types of drug for heart attack (ACE-inhibitors, beta-blockers, angiotensin receptor blockers and statins) and referral for cardiac rehabilitation after discharge from hospital.

Risks increased further for those who missed a course of treatment, such as an electrocardiogram, within the first few hours of the onset of symptoms. They were much more likely to miss other types of care later on.

Researchers looked at outcomes for heart attack patients discharged from hospital in England and Wales between January 2007 and December 2010. During that period, around half of the 31,000 heart attack patients discharged had missed a course of treatment.

● NEW SEPSIS TOOLKIT FOR DOCTORS

A new RCP toolkit has been launched to help doctors on acute care wards recognise and treat sepsis more quickly. The condition kills 37,000 UK patients a year and those admitted to hospital with severe sepsis are

five times more likely to die from it than those with a heart attack or stroke. Symptoms are often not spotted meaning patients are not given lifesaving treatment in time. The guidance offers practical advice. Access the toolkit at www.tinyurl.com/okhxe2d

● ENHANCED SCRUTINY IN DENTAL ADVERTISING

The GDC has announced it will be working closely with the Advertising Standards Authority (ASA) to tackle misleading dental marketing. The two organisations have agreed on a referral process

for complaints in relation to marketing materials which may breach the Advertising Codes. All enquiries regarding potentially problematic marketing material will be directed to the ASA complaints inbox. Go to www.gdc-uk.org for more details.

WHAT ARE MY CHANCES, DOC?

Alan Frame

MOST doctors understand the concept of relative risk, but what about patients? The majority will simply grow frustrated or tune-out if a discussion aimed at joint decision-making becomes a lecture in statistics. Yet communicating risk is essential in obtaining and being able to demonstrate valid consent.

This requires meaningful dialogue with the patient, which includes a discussion about the chance or probability of things going wrong. GMC guidance for doctors, *Consent: patients and doctors making decisions together*, states that when sharing information and discussing treatment options "you must give patients the information they want or need about, amongst other things, the potential benefits, risks and burdens, and the likelihood of success for each option".

Entering a discussion about risk probabilities I am always reminded of Mark Twain's quote about "lies, damned lies, and statistics".

A very public example of patients being misled about risk probability occurred in 1995 when the UK's Committee on Safety of Medicines decided to warn doctors that a new, third-generation oral contraceptive pill doubled the risk of thrombosis. This was seized upon by a frenzied media and resulted in thousands of women stopping their contraceptive pill, even though the actual risk had merely increased from a one-in-7,000 chance of getting the disease to a two-in-7,000 chance.

Are doctors confused by statistics? A new book by one prominent statistician says they are – and this makes it hard for patients to come to informed decisions about treatment.

Gerd Gigerenzer is director of the Harding Center for Risk Literacy in Berlin and in his book *Risk Savvy* he takes aim at health professionals for not giving patients the information they need in a way in which

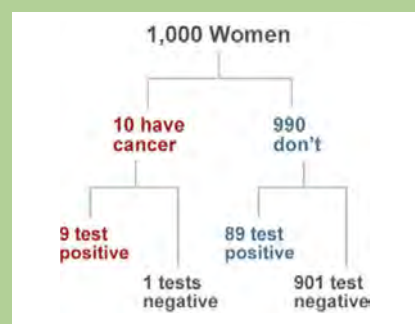
they can understand in order to make valid choices about their care and treatment.

Gigerenzer describes how in a series of workshops in 2006 and 2007 he posed the same statistical problem to over 1,000 gynaecologists relating to the results of a positive mammography screening. The doctors in the workshops were provided with additional relevant clinical information to base their answers on and in a typical session only around 21 per cent provided the correct answer. Apparently this is a worse result than if the doctors had been answering at random!

The problem then may be two-fold. It's not only being unable to produce relevant statistics for patients for every treatment option; it's also about being unable to make sense of those statistics when placed in front of you.

Part of the difficulty here may be in setting out risk probabilities as percentages, which apparently a lot of us struggle to understand. Possible alternatives are the use of simple fact boxes and tools such as option grids, which set out frequently asked questions concerning a test or procedure and then offer likely outcomes for both having and not having the test done.

Another alternative way of expressing the relative risk uses numbers of people instead, and where possible with the aid of diagrams. In Gigerenzer's example of a positive mammogram, the reality looks visually clearer if set out on a flow chart format:



Source: <http://www.bbc.co.uk/news/magazine-28166019>

Other visual aids used to communicate risk probabilities include diagrams representing percentages out of 100 stick figures. These can offer a handy short-hand of risk which

can be utilised as part of a range of complimentary data formats together providing enough flexibility to address the needs of a variety of patients.

There are other factors to consider in communicating relative risk to patients:

- Guard against over simplification of language: terms such as 'common' or 'rare' can assume a shared perspective, when in fact patients may judge risk by a different order of magnitude.
- Patients may best understand absolute risk expressed in natural frequencies, i.e. 1:200 patients suffer a post-operative complication.
- Presenting absolute risk figures alone has also been shown to lead to either an overweighting of low probabilities or an underweighting of high probabilities.

One particular study looking at probabilities of harm found that the term 'frequent' was interpreted on average as equivalent to around 70 per cent. However, the range of answers provided by participants was from 30 per cent through to 90 per cent.

What is the law, and what do the regulators say about all of this?

The landmark medico-legal case *Chester v Afshar* confirmed a duty to warn patients about risk. In the case, Ms Chester was left paralysed following surgery for a lumbar disc protrusion. The court ruled that Dr Afshar was negligent in failing to warn her of the 1-2 per cent risk of the procedure going wrong. It's interesting to note that the court's chosen method of communication here was in percentages, rather than 1:100 or 2:100 cases.

GMC guidance on consent is heavy on what is required and expected from doctors and what they must ensure has been conveyed, but silent on how the actual risk probability and impact is communicated. No two people are alike in the ability to comprehend risk so it is up to the individual healthcare professional to judge if a patient truly understands.

■ Alan Frame is a risk adviser at MDDUS

AN ETHICAL ECOLOGY

Deborah Bowman

THERE is a sign that I regularly pass. It flashes, without exception, at drivers instructing them to “slow down” irrespective of their speed. I confess that I always feel irritated by this instruction: I drive within the speed limit. While this may sound grumpy, I have tried to turn my irritation to a better purpose. It has prompted me to think about ethical discretion and the contribution of systems. What conditions or types of system make it likely that people will use their discretion well and flourish?

Sociologists have identified particular characteristics as specific to the “professions”, including specialist expertise, admission by credentials, high social status and state-sanctioned self-regulation. One of the defining characteristics of a profession is discretion. The law, regulators, professional bodies and employers may set standards and provide the framework within which that discretion is negotiated. However, on a day-to-day basis, all professionals make judgements about how to use their discretion.

Individual clinicians regularly interpret professional guidance to determine what is the best – or at least the better – option given a particular set of circumstances or variables. That is how it should be. Professional discretion recognises and allows for the complexity and particularity of clinical work. Sometimes exercising judgement involves significant, even momentous choices, such as whether to proceed in a high-risk situation. Most of the time, discretion is enacted via a series of apparently “routine”, perhaps even unnoticed, choices. Every-day questions, such as whether to give advice over the ‘phone, how to prioritise time, which

first-line treatment to prescribe and how much information to share at handovers, are matters of discretion. Yes, there are guidelines and standards but each professional will interpret those according to his or her experience, values and preferences.

Although discretion is an inherent part of being a professional, it is not always considered to be an unequivocal force for good. Indeed, professional discretion, particularly perhaps that of doctors, has often prompted suspicion and criticism, and sometimes with good cause. Since George Bernard Shaw wrote scathingly about professions being “a conspiracy against the laity”, attention has been called to the power (and abuses of the same) that comes with professional discretion. Power and privilege will likely endure. Post-

“Professional discretion recognises and allows for complexity and particularity.”

professionalism and de-professionalism are interesting (really) theoretical models, but they cannot eliminate the stubbornly constant imbalance that resides in clinical work. The patient has a problem and needs the clinician's expertise or skills. The patient is dependent in a way that the professional is not in the encounter. The trick then is not to seek to eliminate power, but to recognise its inevitability and to facilitate mutual trust.

Most of the clinicians with whom I work acknowledge both the privilege and burden of discretion. In my experience, they are acutely aware of their responsibilities. Many recount situations in which exercising discretion has been difficult. Just as clinical expertise and confidence develop with time and experience, so too does skill in recognising situations of discretion and exercising judgement. Yet if people are working in a system that is dominated by directives and instructions that are issued to everyone without appreciation of, or attention to, context and individual circumstance, what it is to be a

professional is devalued.

The capacity to be aware of professional discretion and to exercise judgement is inevitably diminished by a directive and controlling culture. What's more, if those directives and instructions assume that professionals are either doing or about to do “the wrong thing”, it is more than undermining and demoralising, it is a fundamental challenge to professionalism, considered practice and ethical engagement.

Some might argue that trust is earned rather than an entitlement. Others may cite high-profile examples of trust in healthcare institutions and staff being misplaced or abused. However, to create systems around “worst case scenarios” or “bad apples” is to disregard and potentially to undermine the ethical commitment and professional identity of the majority. Changes to governance and increased regulation may be understandable reactions to failures of care, but there are significant risks to systemic changes made in the

name of accountability. Ever-greater instruction and surveillance represents a diminution of trust that matters enormously if we want clinicians to reflect on their discretion and to make good professional judgements.

If reflection and discussion are replaced by unthinking obedience (or even unthinking disobedience), we will all be ethically poorer. Environments in which compromised standards are assumed and increasing numbers of commands are issued irrespective of individual conscientiousness or performance are damaging. Instructions that are unfeasible or irrelevant are more than irritating; they reflect mistrust and disregard professionalism. At worst, they create a toxic environment in which people are neither valued nor expected to behave well.

All communication has a moral dimension, even road signs.

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

Challenging times at the GDC

The General Dental Council has faced recent criticism from various quarters – not least for proposed plans to hike its annual retention fee by 64 per cent. Here chief executive and registrar Evlynne Gilvarry addresses some of the issues

A QUALIFIED lawyer and mediator, Evlynne Gilvarry became chief executive of the General Dental Council in 2010. Prior to that she had been chief executive of the General Osteopathic Council and before that she held senior policy and management roles at the Law Society.

The GDC is proposing a 64 per cent rise in the annual retention fee for dentists. Why such a steep increase and why now?

We have very clearly set out in our consultation document that in the absence of an increase we will not have enough income to undertake core statutory functions. The ARF was last increased in 2010. Since then fitness to practise (FtP) complaints to the GDC have increased by 110 per cent. Without further significant investment in our FtP processes we will be unable to deal effectively with the very large increase in our caseload and so we must make adequate provision.

Fitness to practise is the most expensive area of our work. If a case reaches a hearing, the cost is around £19,500 per day and the length of a hearing ranges from a third of a day to 35 days. We have had to recruit more casework staff and more FtP panellists to clear a backlog of cases and to process new cases faster.

Can you understand the anger among dentists with the fee rise given the recent Professional Standards Authority review in which the GDC failed to meet seven out of 10 good regulation standards in fitness to practise?

We regard failure to meet the PSA's standards as entirely unacceptable so we accept criticisms on this score. We want to reassure the profession that all our efforts are focused on tackling the problems that have resulted in us missing standards. We have increased resources to deal with the continuing surge in caseload and made other key changes to improve the performance of our teams. The achievement of a much better performance in fitness to practise is the number one priority.

What are the reasons behind the delays and other problems the GDC is encountering in the management of fitness to practise processes?

There are two key factors that have put pressure on our fitness to practise function. First, the very large increase in complaints we've received. The scale of increase over the last three years – 110 per cent – is a very significant departure from the patterns of the past.

Large increases in three successive years have inevitably resulted in pressure on our teams and it has been difficult to recruit and retain staff in sufficient numbers to handle the load.

Secondly and most unfortunately, we have not yet secured the legislative change that is necessary to improve our outdated procedures. We had hoped that new legislation, enabling wide-scale change to our procedures would have been in the Queen's Speech earlier in the summer, but this was not the case.

The Department of Health recognises that our legislation is out of date. Indeed, by an accident of history, the GDC's legislation is even more antiquated than that of other regulators, particularly regarding fitness to practise. Although wholesale change is some way off we are working with the Department of Health on an interim change – the introduction of case examiners – which will help us to streamline and speed up the initial stages of fitness to practise. We hope to see the change in place by the middle of 2015. The introduction of case examiners will not only allow us to improve the way we handle cases but will also save us up to £2m a year.

How are you working to reduce the costs of fitness to practise procedures?

We are doing a lot to reduce FtP costs, primarily through a two-strand strategy. We are achieving greater value and significant savings through tighter management of the contracts with our external law firms. We have also significantly reduced our reliance on external firms and correspondingly our costs through the appointment of an in-house legal team. This process started in January 2014. We estimate that this team – by handling up to two thirds of our legal work – will save £1.2 million per year from 2015. The next phase of the in-house development is to do advocacy in-house. We currently use an external team of barristers. This change will save even more money and we plan to have our in-house team of advocates in place by the end of the year. This will result in a 44 per cent saving on barristers' fees.

Why do you think complaints against dentists reported to the GDC are rising?

Firstly, I think the GDC, in common with other regulators and public bodies, is experiencing the effects of a more informed and demanding public. We are doing more research with patients and the public to learn more about motivation for complaining.

Secondly, information on how to complain is more readily accessible. The internet plays a major role in this and we are seeing an increasing number of complaints being submitted online. We are also seeing a greater proportion of complaints coming from sources other than directly from patients – for example, from the NHS and other professionals.

Thirdly there is evidence that the major structural change that resulted in transition from PCTs to NHS England left some areas of the country with many fewer performance managers. As a result, we believe that some cases which might have been dealt with in the past through local resolution are now finding their way to us.

Lastly, we are told by the defence organisations that a recent change in the way lawyers are rewarded for handling claims against health professionals prompted a surge of referrals to the health regulators.

"The GDC, in common with other regulators, is experiencing the effects of a more informed and demanding public."

A recent advert in the *Daily Telegraph* for the Dental Complaints Service was likened by the BDA to those favoured by "ambulance-chasing lawyers". What was the intention behind the advert?

The comparison with "ambulance-chasing lawyers" is mistaken and unfortunate. We have a duty as a regulator to ensure patients and the public, including those who receive private dental care, know where they can raise concerns if necessary. Promotion of the DCS is not a new development; we regularly run campaigns to ensure that the public and patients, as well as dental professionals and other advice bodies such as Trading Standards and Citizens Advice, are aware of the excellent service it offers.

At the heart of the DCS is the encouragement of local resolution and this happens in a large proportion of the cases it handles. The DCS consistently achieves very high satisfaction ratings with patients and with dental professionals. It is important to note that the DCS does not handle fitness to practise cases. Some of the commentary in the wake of the advertisement clearly showed confusion on this point.

The BDA has reported that in a recent survey 79 per cent of dentists were not confident the GDC was regulating dentists effectively. Do you feel the GDC has lost the trust of the profession and how will you win back the doubters?

We are determined to ensure that our performance as a regulator continues to improve. We have struggled to cope with unusually large increases in caseload in three successive years and we recognise that this resulted in our performance slipping. The measures we are taking – which include significant extra investment which must be funded by the dental profession – are precisely

aimed at being an effective regulator. We hope that the profession will acknowledge the need for this extra investment, even though it means a significant increase in their annual registration fees.

The debate that has taken place since we began the consultation on the ARF increase is an opportunity to clear up some misapprehensions about the GDC's role. Some of the commentary seemed to confuse our role with that of the BDA. We are keen to have a more active engagement with the profession on regulatory issues as we believe that this is the best way of building and maintaining trust.

It's worth noting that the GDC's 2013 registrant survey found that confidence in the GDC as a regulator remains high. More than two thirds (67 per cent) of the dental professionals who took part in the survey are confident that the GDC is regulating dentistry effectively. A corresponding survey of patients and the public said regulation of dental professionals is very important and nearly eight out of 10 (77 per cent) are confident that the GDC regulates dental professionals effectively.

■ *Interview by Jim Killgore, editor of Summons*



Why should I say

Sorry

John Dudgeon – *GP and medical adviser with the Scottish Public Services Ombudsman – calls for a culture change in attitude among doctors towards saying sorry*

SORRY might seem to be the hardest word but for doctors it shouldn't be. The Scottish Public Services Ombudsman (SPSO), the Parliamentary and Health Service Ombudsman, the NHS Litigation Authority and the General Medical Council all advise on when and how doctors should apologise. The language they use is unsurprisingly formal. I wonder, though, how much resonance their advice has with doctors on the frontline in the UK today. For me the questions surrounding the importance of sometimes saying sorry are simple: what sort of doctors do we want to be and how do we want our patients to perceive us?

What complainants want

When something goes wrong or patients think something has gone wrong they want to know that their doctor still cares and understands their concerns. They want honesty and responsibility. They want to know someone is prepared to vindicate their understanding of the error and ensure the same thing will not happen again. That is not to say that we should accept blame when the error is not ours but, even in a no-fault situation, patients still expect their doctor to empathise. My hope is that doctors in the UK care about their patients (especially when things go wrong),

always act with integrity and have the professionalism to shoulder blame when it is theirs to take.

It would be naive to think this is always the case. Indeed some evidence suggests that doctors avoid apologising up to 75 per cent of the time. Mindful of scandals like Mid Staffordshire, I find it worrying that as a profession we keep these barriers up. Doctors have traditionally been the most trusted individuals in their communities. The approach to mistakes – and acknowledging those mistakes with an apology – by some of our profession runs the risk of ruining this.

Former SPSO Professor Alice Brown has

said: "Particularly in the health service, there is a resistance to saying sorry when things have gone wrong. That is a great barrier."

There are many reasons for this resistance. An overriding concern is that by apologising you may be admitting liability. Section 2 of the Compensation Act 2006 (an act of the UK Parliament) says: "an apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty".

This particular section only applies in England and Wales. My understanding is that the law on this point is likely to be regarded similarly in Scotland. The proposed Apologies (Scotland) Bill – now under consideration by the Scottish Parliament – covers similar territory and includes protection against admissions of liability.

No such thing as perfect

There are, of course, cultural barriers to making an apology, particularly in the medical world. The elitist and macho culture that is at times present in our hospitals and surgeries has always puzzled me. If the reason for being a doctor is to help people (as we all said when trying to get into medical school), why do we maintain the culture of always having to be right? Why do we find it so difficult admitting mistakes?

Psychiatrist Aaron Lazare, author of the book *On Apology*, wrote: "We tend to view apologies as a sign of a weak character. But in fact they require great strength."

"Despite its importance apologising is antithetical to the ever-persuasive values of winning, success and perfection. The successful apology requires empathy and the security and strength to admit fault, failure and weakness. But we are so busy winning that we can't concede our own mistakes."

No doubt this will resonate with many medical professionals. So can we learn to be more rational about acknowledging mistakes?

When it looks like things have gone wrong, correctly interpreting what has happened is important for both sides. Complainants are often unable to differentiate between poor service and negligence, and doctors often don't distinguish between making a mistake and being negligent. We all make mistakes. They are an inevitable part of being human, especially when practising a high-risk

profession like medicine.

Doctors do not get sued (successfully) for making mistakes – they get sued for being negligent. So if you have made a mistake, own up. Be honest and say sorry. It won't do any harm and it may do a lot of good (apart from being the right thing to do). Doctors do sometimes get sued for practising below an acceptable standard of care – if that substandard care results in harm to a patient for whom we have a duty of care. Remember that if you have been negligent, evidence has shown that a heartfelt apology can reduce the likelihood of legal action – but some form of intervention may be inevitable no matter what you do. To my mind that is fair enough.

Apology – a reasonable response

While many doctors have good communication skills and make appropriate apologies, I think there needs to be a cultural change within the UK medical fraternity for apologies to be more widely accepted. One change that may help is teaching our undergraduates the importance of being able to recognise their mistakes and say sorry for them.

As well as working as a GP, I am a medical adviser to the SPSO. The vast majority of

reviewer this, and often the complaint will not be upheld.

A genuine apology when a mistake has happened is usually thought to be part of acting reasonably. To have not apologised properly will, at times, weigh the case against the doctor. Making a proper apology is a frequent recommendation from the ombudsman. If this has already been done then the ombudsman may feel there is nothing to be achieved by investigating the complaint further.

In my opinion, until we change the perception of apology from an admission of failure that may ruin our reputation to a sign of professional and emotional strength, we will still see patients pursuing complaints and legal actions that would never have happened had the doctor just said sorry and meant it. When a complaint comes in or a mistake is noticed, I would urge my colleagues to act with integrity and professionalism.

Take a deep breath and try to see both sides of the issue. If the patient has been upset or harmed, acknowledge this and let them know how genuinely sorry you are that they have suffered. If you can see that your actions have contributed to a mistake, acknowledge this and let the patient know

"Doctors often don't distinguish between making a mistake and being negligent. We all make mistakes. They are an inevitable part of being human"


complaints that are escalated to the SPSO, having failed to be resolved at a local level, would in my opinion never come to us if the doctors involved had sat back and tried to see things from the complainant's point of view. If we could allow our defences to drop and consider our patient's position I am convinced the number of complaints being referred to the SPSO would reduce.

We understand that having a complaint sent to the ombudsman is stressful for doctors. The ombudsman uses the standard of reasonableness – what would we have expected a reasonable doctor to do? The ombudsman's medical advisers all work in the NHS and have good insight into the different perceptions doctors and patients have. If an adviser finds that a doctor has acted reasonably they will tell the complaints

you are genuinely sorry. Explain what happened and how you plan to ensure it does not happen again. I am convinced that this empathic and professional approach will be more likely to result in the hurt and anger around a complaint dissipating without further action being taken.

NHS Education for Scotland and the SPSO have developed an online module about apology. I recommend taking the 20 minutes required to work through it. It will leave you well informed about how to make an apology that your patient will appreciate.

■ **Dr John Dudgeon is a GP and medical adviser with the Scottish Public Services Ombudsman**



A most serious case indeed

What began with a simple work-related injury in 1902 would end a year later with a death, a court case and a piece of medico-legal history. Allan Gaw investigates

IN April 1902, Andrew Gillies, a joiner from the small Scottish town of Stewarton in Ayrshire, injured his left arm. He likely developed a haemarthrosis with adhesions which his GP, Dr John Cunningham, advised needed manipulation under anaesthesia. Hesitant about this course of action, Gillies sought a second opinion from a doctor in Glasgow who concurred with his GP.

Three months after his initial injury and with little sign of improvement, Gillies agreed to the procedure which would be performed in his own home under chloroform. Exactly what happened in the Gillies household that Sunday evening in July 1902 is open to question as those present subsequently disagreed on their stories. What is clear, however, is that Gillies, then aged 52, did not survive the procedure. His death certificate listed “syncope” as his cause of death, which was most likely a cardiac arrhythmia induced by the chloroform.

Five months later Gillies’ widow sued Dr Cunningham, demanding damages of £1,000 (approximately equivalent to 10 years’ wages of her dead husband). Dr Cunningham sought the support of the newly formed Medical and Dental Defence Union of Scotland (MDDUS), and indeed his was the first medico-legal case they considered at their inaugural Central Committee Meeting in January 1903.

The MDDUS had been set up in May 1902 in the interests of the medical and dental professions in Scotland. Cunningham had submitted details of the action against him on 14 January 1903 – the same day he had also applied for membership. As he had not been a member when the patient’s death had occurred some six months earlier, the MDDUS officers, concerned about the setting of

precedent, understandably decided that they could provide no further assistance. Cunningham then chose to retain the Union’s law agents, Turnbull and Findlay, to represent him.

Utmost propriety

Two months later the case against Cunningham came to court and revolved around three grounds of fault: that he should have had a skilled medical assistant, that his method of chloroform administration was outdated and dangerous, and that he had anaesthetised Gillies without having resuscitation equipment at hand, including a hypodermic syringe and appropriate drugs.

These allegations were systematically addressed during the two-day trial and a parade of expert witnesses were brought forward to support Cunningham’s clinical approach to the problem. Although these men often stated they might have done things slightly differently, they found his actions, by and large, to be consistent with current practices. One expert witness, Dr Joseph Bell from Edinburgh, who had some years earlier served as the model for a fictional detective created by his former student Arthur Conan Doyle, even said Cunningham had treated the patient, “with the utmost propriety”.

The nature of Gillies’ death was scrutinised and a great deal of emphasis was placed on the post mortem findings which showed no evidence of asphyxia, but which were consistent with syncope. The method of chloroform administration used by Cunningham had involved not a mask but a towel applied to the face doused in the anaesthetic. Cunningham claimed to have used a method

whereby his hands kept the towel above the face and allowed free respiration, but others present refuted this account.

The relatively poor understanding of the toxicology of chloroform at the time was revealed by the testimony of another expert witness, John Glaister, the Professor of Medical Jurisprudence at Glasgow University. He could shed no light on the exact cause of Gillies' death and pointed out that "there was no subject which was giving rise to more controversy in the medical profession than the cause of death under the influence of chloroform".

Such was Cunningham's personal belief that no malpractice was involved that he claimed on the stand that he "would pursue the same course again in similar circumstances".

The judge instructed the jury at length and emphasised that this

"What today would be malpractice may a century ago have been standard practice."

was "a most serious case indeed," especially to Dr Cunningham. In conclusion, he informed the jury that in law "a person was not liable in the exercise of his profession for a mere mistake...[t]here must be what in Scotland was called gross negligence, or in England crass negligence". It was clear from his charge to the jury that he thought there was neither in this case. It took the jury only 45 minutes to decide unanimously in Cunningham's favour.

Standards of the day

The challenge at the centre of all medical history lies in the danger of judging past actions by present day standards. This is especially true if those actions have an ethical or legal dimension. What today would be malpractice may a century ago have been standard practice. The use of domiciliary anaesthesia, for example, is now a thing of the past, but in 1902 it was commonplace amongst GPs. Chloroform was the most readily available anaesthetic and although its dangers were well recognised, its use was widespread. Indeed, Dr Cunningham had treated at least two other patients of his with the same orthopaedic problem as Gillies and had done so successfully using chloroform anaesthesia.

Looking back at the details of this case it is easy to be critical of how the procedure was carried out. If Andrew Gillies was being treated today he might have been anaesthetised, but this would have taken place in a clinical facility fully equipped for modern resuscitation, the attending doctor would not have been alone and, of course, chloroform would not have been the drug of choice. But, if there is no understanding of cardiac arrhythmia and its effective treatment and if the standard and accepted practice of the day is to anaesthetise a patient on a Sunday evening in their upstairs bedroom using a towel and a bottle of chloroform, should we be so quick to condemn?

A re-evaluation of the case by a contemporary judge in 2000

suggested a modern jury, if presented with the same evidence and the same allegations, would likely also find in favour of Dr Cunningham. There would, however, be some differences. Today, such a case would probably take not three months to come to court, but as much as three years due to the pressures of business in the Court of Session.

The same case today would also be heard by a judge alone, rather than the judge and jury that presided in 1903. And the modern test of negligence would be whether the defender had adopted a course of action which no professional person of ordinary skill would have taken if he or she had been acting with ordinary care. However, as was the case with Dr Cunningham, the results of such a contemporary test would also depend upon the testimonies of other professionals in the same field, to define exactly what "ordinary skill" and "ordinary care" are.

The case of *Gillies v Cunningham* is notable for several reasons. Not only was it the first medico-legal case laid before the new MDDUS, it was also the first medico-legal case in Scotland involving anaesthesia. It is also a useful example of how we might prejudicially review the past through modern eyes and with modern values. And finally, it should be a reminder to all practitioners that it is too late to join your defence union after the patient has died.

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

ACKNOWLEDGEMENTS

I am indebted to Dr Iain Levack who has conducted much original research on this case and allowed me access to his files.

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JOINT AND SOFT TISSUE Injections

Lucy Douglas *highlights new guidelines from the Primary Care Rheumatology Society*

JOINT and soft tissue injections are commonly used to help ease the discomfort and loss of function associated with musculoskeletal disorders. They are a safe and effective treatment option for many patients and generally perceived to be a low-risk intervention. However, complaints and claims against doctors performing such injections are not infrequent.

There is little firm evidence on which to base best practice in this area and as a result there is variability regarding exactly how and when such injections are used in clinical practice. But there are certain considerations which can enhance patient safety and help clinicians avoid some of the medico-legal pitfalls. The following article is based on guidelines for joint and soft tissue injections which have recently been developed by the Primary Care Rheumatology Society.

Before treatment

As with all medical procedures, any clinician undertaking joint and soft tissue injections must be adequately trained and have up-to-date clinical skills. Ensure all medication or other equipment is appropriate for the intended use and in date. For example, some steroid preparations vary in clinical indication yet the packaging and constituents can be similar.

Ensure enough time is available to explain the procedure. Consent for joint injection requires the same rigorous attention to detail as other interventional medical treatments. The patient must be informed about the nature of the injection, relevant risks and benefits and alternative treatment options. A patient information leaflet can aid patient understanding and decision-making and also helps ensure that no important contraindications or adverse effects are overlooked. A suggested leaflet is available on the PCRS website.

Clear documentation must be made of the above discussion and that the patient has consented to the treatment. Signed consent is not required in the UK but may be used in addition to the above documentation. Further information regarding consent can be found on relevant MDDUS and GMC web pages.

Contraindications to joint and soft tissue injections include:

- allergy to local anaesthetic, steroid, skin cleanser or dressing
- local or systemic infection
- active rash/broken skin at site of injection
- uncontrolled coagulopathy
- fracture/unstable joint
- tendon regions at risk of rupture

- injection into a prosthetic joint or surgical metal work in situ
- imminent surgery at the site of or close to the proposed injection.

Anticoagulant therapy is not a contraindication to joint injection but precautions apply. You should discuss the risks of continuing or stopping anticoagulation with the patient and ensure a management plan is in place should a bleeding complication occur.

Several studies suggest that joint and soft tissue injections can be safely carried out provided the INR is within the therapeutic range. This should therefore be checked prior to the procedure. For patients taking novel oral anticoagulants, given the shorter half-life, consideration should be given to avoiding interventional procedures during peak drug activity – for example for rivaroxaban this peak would be 2-4 hours after the last dose.

Procedure and associated risks

When positioning the patient, be prepared for the possibility they may faint during or after the injection. Ensure that they will not get injured should this occur. When marking the skin, avoid using an ink marker directly at the site where the needle is to be inserted or a permanent tattoo may result. Potential risks associated with joint and soft tissue injections include:

- infection
- soft tissue atrophy and local depigmentation
- tendon rupture
- nerve damage
- menstrual disturbances
- disturbance in glycaemic control in diabetics
- allergic reaction.

Infection

Infection is considered a rare complication of joint and soft tissue injection, however the consequences can be catastrophic. The patient should be warned in advance about the serious consequences of infection, what symptoms may occur and how to seek immediate medical attention if required.

Dust covers on vials of medication are not necessarily adequate to ensure sterility of the outside of the vial top. Therefore swabbing the vial with a sterile alcohol swab is recommended for some medications.

Skin preparation is generally recommended prior to surgical procedures to reduce the numbers of skin bacteria – although there appears to be little published information on infection rates when no skin cleaning has been carried out prior to joint injection. There have been rare recorded incidents of infection resulting from contaminated topical antiseptics. All skin cleansers should be used strictly in accordance with the manufacturer's instructions. Consideration should be given to single-use skin preparations labelled as sterile.

Once the skin has been prepared, use a 'no touch' technique when injecting unless full sterility is observed.

Soft tissue atrophy

Soft tissue atrophy and local depigmentation are uncommon complications of steroid injection. Although these are predominantly cosmetic effects, at some sites such as the heel pad, atrophy can be clinically significant and may persist for years. Atrophy may be due to the persistence of steroid crystals in the tissues and seems less likely to occur with more soluble preparations, e.g. hydrocortisone and methylprednisolone. These are therefore preferred for soft-tissue, small-joint and superficial injections. Should concerning soft-tissue atrophy occur, referring the patient for a course of local injections of saline may be helpful.

Tendon rupture

The risk of tendon rupture attributed to steroid injection, for example at the shoulder, is somewhat controversial. However, it has been demonstrated in animal studies that intra-tendinous injections of steroid can result in collagen necrosis and weakening of the tendon, potentially lasting for several weeks. Therefore if injecting in peri-tendinous regions where there is a risk of suboptimal needle placement, avoid injecting if resistance is encountered and consider the use of image guidance if available. Generally avoid injecting regions where concern regarding the risk of tendon rupture is high, for example at the Achilles tendon.

Nerve damage

Ensure you are familiar with the anatomy of the injection site to avoid inadvertently injecting a nearby nerve. In neuropathies (e.g. carpal tunnel syndrome) the affected nerve may be swollen and therefore anatomical landmarks may be less reliable. Before injecting, ask the patient to report symptoms of nerve activation when the needle is inserted. Withdraw and reposition the needle

if this occurs. Avoid local anaesthetic at such sites if this may prevent the patient reporting symptoms of nerve irritation. Consider image-guided injections.

Menstrual disturbances

Effects on the hypothalamic-pituitary axis are thought to be responsible for the menstrual irregularities or vaginal bleeding seen in some women after steroid injections. It is important to warn of this effect, which may persist for several weeks, to avoid unnecessary alarm or investigations.

Facial flushing may also occur follow a steroid injection. This is not an allergic reaction and does not preclude future injections. This side-effect generally affects women and can be dramatic and distressing, particularly if not forewarned.

Glycaemic control

Small increases in glycaemia lasting a few days may be seen after steroid injections in diabetic patients. The increase is generally not clinically significant but again it is sensible to warn patients.

Allergic reactions

Although allergic reactions are rare, full resuscitation equipment must be readily accessible and staff available and trained to use it in all locations where injections are performed. According to the Resuscitation Council UK website, cardiopulmonary arrest resulting from injected medication predominantly occurs up to 20 minutes post injection. It would seem sensible therefore for patients to remain on site for this time.

PCRS guidelines

Comprehensive guidelines on joint and soft tissue injections can be found in the Resources section of the Primary Care Rheumatology Society website: www.pcrsociety.org

■ *Dr Lucy Douglas is a GP with special interest (GPwSI) in musculoskeletal medicine and rheumatology*



Hiding in plain

Steve Ashton considers some risk areas in dental practice so obvious they become invisible

DENTISTRY isn't especially high risk. Most of the things that cause injury or ill health are reasonably well understood within the profession. With a little bit of thought and effort, appropriate controls can be used effectively. The problem generally isn't that the issues are not obvious; it's that they're so obvious those working in the environment day-to-day tend not to think about them. People become complacent and oblivious to risks that only seem obvious with hindsight in the aftermath of an incident.

Slips, trips and falls

This is the easiest place to start in any workplace and is the most overlooked area of danger, causing injury (and sometimes death) to thousands every year. Patients, visitors and staff walk into the practice every day. How often have you seen the damaged tiling just inside the entrance and promised yourself you would do something

about it "tomorrow"? How often has the splash of coffee at reception been left to dry on the floor instead of being immediately mopped away? It is so obvious it seems unnecessary to even think about. But therein lies the problem.

If your practice does not have a culture embedded in the mind of every employee to recognise and to do something about the small problems that arise each and every day then, sooner or later, somebody will slip or trip. And the outcome can be serious. While the most likely consequence may be bruised pride, slip, trip and fall incidents in the UK cost 40 workers their lives in 2009 and cost society an estimated £800 million each year. In addition to the fatalities, there were over 15,000 major injuries attributed to this single hazard.

A well-planned inspection programme will help you to remove the "blinkers" and control the most obvious hazards that may otherwise go unrecognised and unresolved.

A fresh pair of eyes (sharing the inspections with someone from another practice, for example, or bringing in a consultancy) may see far more where familiarity has created blind spots.

Infection control

This is a key risk area for the dental profession. Very high standards of cleanliness and scrupulous procedures for disinfection in the surgery are (quite rightly) expected and (generally) achieved. The need for inoculation against hepatitis (and to confirm the effectiveness of the treatment) for anyone undertaking invasive procedures is generally well understood.

But when was the last time you reminded ancillary staff that they should stay away from work when suffering from a simple head cold or perhaps a stomach upset? Are your reception staff aware of the standards expected or are they waiting at the desk with a welcoming sneeze for all



sight

the incoming patients? Are your domestic cleaners routinely disinfecting the taps in patient area washrooms or are they leaving a trap for the unwary?

If your standards are not communicated effectively to everyone in the business there could be a risk of disease transmission. The British Dental Association (BDA) recognises that all members of the dental team have a responsibility to follow infection control guidelines to ensure safe practice. They have published detailed guidance, including topics such as surgery design, cleaning and disinfection. In addition, the Department of Health has published a technical memorandum on decontamination. These should be translated into clear, simple policies and staff guidance written in language your whole team can understand.

Gas scavenger systems

Following the cessation of general

anaesthetics in dental practice there has been an increase in the number of practices offering relative analgesia.

It is important that gas scavenging systems are properly serviced and maintained to prevent leakage and transient escape into the working space. Exposure to nitrous oxide gas for patients is intended to be at (relatively) high concentrations for short periods of time. Exposure for staff at much lower concentrations for prolonged periods has a completely different impact – which may cause problems especially for staff of childbearing age who could be at increased risk and whose potential exposure must be assessed and managed appropriately.

Skin problems – occlusive gloves

How well do you manage skin care measures in your practice? Have you or any of your staff suffered problems from itching, flaking and reddening skin? Have you ever even asked the question? Severe allergic reaction to the wearing of natural rubber latex gloves is (thankfully) now far less common than it used to be as manufacturers introduce ever-safer unpowdered, low-free-protein formulations. Nitrile and vinyl gloves are available that are suitable for some tasks but even these can cause allergic skin reactions for some people and are certainly not the answer for all applications.

Perhaps the bigger problem – the one more commonly overlooked – is the need for a good skin-care regimen whatever glove is worn. Wearing any impermeable (occlusive) glove for prolonged periods can cause hyperhydration and a predisposition to subsequent skin problems including infection and/or physical damage. The science of skin care is developing rapidly. How much time do you have to keep up with developments outside your own specialism, and how do you ensure the standards you are working to conform to best practice? Access to an external advice and update service will often be easier and less costly.

Amalgam toxicity

The debate over chronic toxicity of mercury dental amalgam may have some distance to go. With the increasing availability of social media, just two or three vociferous campaigners can make (and have made) a huge impact on the public perception – and it seems the calls for removal of dental amalgam will not go

away any time soon. However, regardless of any potential impact on health, what is your policy on waste segregation and management?

The Landfill Directive introduced in July 2004 made it almost impossible to legally dump mercury or mercury contaminated products in the UK, resulting in a massive growth in recycling and consultancy services. How accurately do you measure your inventory – and how confident are you that you are fully compliant with your waste management obligations?

Clinical sharps

It seems redundant to emphasise that sharp blades and needles can cut or puncture staff as easily as they cut and puncture patients undergoing treatment. Yet sharps injuries do still occur, with all the consequential risks. Last year the UK introduced laws specifically requiring health workers to manage the risk. Do you know your obligations under the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013? Have you reviewed your policies and practices to ensure that collection bins are never overfilled? And who handles these from first opening to final collection? Do you need to do anything more to prevent reduce or manage the risks of accidental inoculation or laceration?

Trivial hazards, serious incidents

Thankfully, for most practices, these risks will never be realised. No one will be injured, there will be no catastrophic fires and everyone will assume the place is safe. Unfortunately, the absence of consequence does not mean the absence of risk. If any workplace simply assumes it is safe because no one has yet fallen victim to an unidentified risk then it can only be a matter of time before the luck runs out. Even apparently trivial hazards can cause serious incidents.

A specialist health and safety service, such as the one available at Law at Work, can assist in the identification and management of a whole range of issues. Dentistry does not need to be high risk, but sometimes things go wrong and it can be reassuring to know you have done all you can to prevent harm.

■ *Steve Ashton is head of health and safety services at Law at Work*

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



DIAGNOSIS POST-OP COMPLICATIONS

BACKGROUND: Ms T is 51-year-old HR manager with two teenage children. A recent echocardiogram has revealed progressive ventricular enlargement due to long-standing aortic regurgitation. A cardiothoracic surgeon – Mr A – advises aortic valve replacement and Ms T elects to undergo the procedure privately.

Ms T is admitted to hospital and Mr A replaces her aortic valve with a bileaflet mechanical prosthesis. Routine peri-operative antibiotic prophylaxis is administered IV (flucloxacillin) followed by gentamicin eight-hourly for three doses. The operation is routine and Ms T is transferred to the ITU for recovery.

Next day the surgeon notes that Ms T's vital signs are normal though with a slightly elevated temperature. A few days later Mr A again notes the elevated temperature and orders blood cultures which yield coagulase negative staphylococcus from one bottle in four. This is thought to be a skin contaminant and not sign of infection.

Seven days after the operation Ms T's temperature is noted at 38.2 and both her CRP and ESR are slightly elevated. Mr A attributes this to pericardiotomy. The next day she is discharged with a follow-up appointment in six weeks.

Ten days later Ms T presents at the local A&E complaining of shortness of breath, tachycardia and severe backache. She is seen by an SHO who notes her history of valve replacement. Ms T reports that she has been unwell since the operation – tired, listless and sweaty with shortness of breath. Her pulse rate regulates and she is found to be afebrile. She is diagnosed with "panic attack".

Two days later she returns to A&E again with backache and a racing pulse

and is sent home with a prescription for diazepam to ease anxiety. Next day she returns with worsening symptoms and also nausea and vomiting. She is referred to the physician on-call. Urgent blood tests reveal an elevated white cell count. Septicaemia and possible endocarditis are suspected. Immediate treatment with IV antibiotics is commenced. Transthoracic echocardiography reveals no vegetations but there is severe regurgitation through the prosthetic heart valve.

Ms T is transferred to the ITU and later that night suffers a fatal cardiac arrest. Four months later both Mr A and the hospital are contacted by solicitors acting for the family of Ms T claiming clinical negligence in her treatment. It is alleged that Mr A was negligent in discharging the patient from the hospital with a positive blood culture and raised CRP and ESR in combination with an intermittently elevated temperature. Suspected infective endocarditis should have been a clear concern.

ANALYSIS/OUTCOME: MDDUS provides support to Mr A in regard to the claim over Ms T's private treatment. Legal support for the hospital is provided via the NHS. An expert report is commissioned from a professor of cardiac surgery who examines the patient records and other evidence associated with the case.

No fault is found in the competence with which the procedure was conducted and with the use of prophylactic antibiotics – though it is acknowledged that infection most likely occurred at the time of the operation. The expert notes there was a positive blood culture in only one of multiple bottles and also confirms that

elevated CRP, ESR and temperature are not uncommon after open heart surgery. Clinical records show that Mr A had considered the possibility of infective endocarditis and took measures to exclude this diagnosis.

Considering all the evidence the expert concludes that the post-operative management of the patient was reasonable. He does state that in hindsight it might have been prudent to give the patient temperature charts for home use after discharge from hospital with follow-up in two weeks rather than six. Another expert on the case finds fault with the treatment Ms T experienced in A&E and concludes that had the prospect of endocarditis been acted upon with onward referral to cardiology and appropriate antibiotics commenced then cardiac arrest could have been averted.

Considering all the facts in the case it is decided that there would be risk in taking the case to court. A settlement is negotiated and MDDUS contributes 10 per cent on behalf of Mr A.

KEY POINTS

- Have a high index of suspicion in possible post-operative infection.
- Patient anxiety can mask more serious critical signs.





CONSENT: CAPACITY TO CONSENT

BACKGROUND: Mr D is a 73-year-old man who was diagnosed with dementia several years ago. His condition has deteriorated in recent months and an application to the court of protection is being considered that would allow decisions about his financial affairs to be made on his behalf.

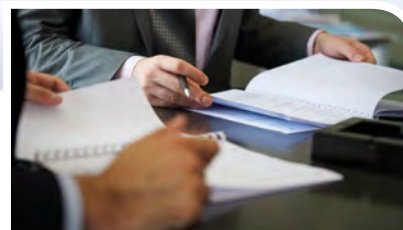
His GP, Dr H, receives a letter from a solicitor's firm acting on the patient's behalf seeking the doctor's opinion as to his capacity to manage his personal affairs. The request is accompanied by a consent form signed by Mr D.

Considering Mr D's dementia, Dr H is unsure if this is valid and if the patient fully understood the implications when signing it. The doctor is reluctant to discuss these concerns with the solicitors for fear of breaching patient confidentiality. She contacts

MDDUS for advice.

ANALYSIS/OUTCOME: Before responding to the solicitor, Dr H is advised to speak with the patient to assess his capacity to consent to the disclosure of information. His capacity may be impaired but it is possible he is still able to provide valid consent in these circumstances. If Dr H determines the patient lacks sufficient capacity to consent then, in the absence of a welfare attorney/court appointed deputy, Dr H should discuss the matter with an appropriate relative or close friend. It can be helpful to involve family members in these matters to ensure they are not likely to object, but this should be handled carefully as there may be conflicts of interest.

If Mr D is deemed to have sufficient



capacity then the disclosure can be made. If not, the doctor should proceed on the basis of the patient's best interests which would normally involve discussions with a patient's relatives or carers.

KEY POINTS

- Never assume a patient lacks capacity to make a decision based solely on a factor such as a medical condition or mental illness.
- Patients with diminished capacity may still be able to make simple decisions about their care, even if they are unable to decide on more complex matters.



COMPLAINTS HANDLING: LUNCHTIME FRACAS

BACKGROUND: A receptionist sits at the front desk of a dental surgery reading a magazine in the last five minutes of an hour-long lunch break, during which time the surgery is closed. A few patients have turned up early and wait outside the locked entrance. One of the patients – Ms A – starts to rap persistently on the glass door. The receptionist goes to the door and unlocks it and Ms A pushes angrily passed her into the surgery.

She demands to know why the surgery is locked when she has an appointment at 2. The practice manager hears shouting and comes out of her office and asks what is the difficulty. Ms A complains that she came on time for her appointment only to find the door locked and what kind of customer service is that? The PM asks her to calm down and explains that the lunchtime closing is practice policy.

Ms A shouts loudly that she "will not calm down" and thrusts two fingers in the PM's face as she rants about the "rude ****ing staff". The PM backs away and tells her that the practice does not tolerate such aggressive behaviour and that she will be reporting the incident to the dentist.

Ms A shouts: "Please do!"

Later before treating Ms A the dentist explains that the office is locked over the lunch period for reasons of staff security. The patient says she was not happy having to "wait outside in the cold". The dentist replies that this is no excuse for her aggressive behaviour.

Later at a practice meeting the dentist learns the receptionist had been left frightened and in tears by Ms A's behaviour. It is decided by the practice to write to Ms A informing her that she is no longer welcome at the surgery. A few days later Ms A replies by letter objecting to the practice's "overreaction" to the incident and further complaining about the inconvenience of the lunchtime closing. The PM contacts MDDUS for advice.

ANALYSIS/OUTCOME: An MDDUS practice adviser discusses the issue with the PM and agrees that it is entirely unacceptable for practice staff to be subjected to verbal and physical threats by a patient – and that removal from the practice list is a reasonable response. The practice is advised to send a second letter informing Ms A that her complaint will be discussed at the next practice



meeting but that the removal from the list still stands.

The letter also advises Ms A that if she further objects to the decision she is free to take up the matter with the ombudsman. Contact details are provided.

KEY POINTS

- Adopt a zero-tolerance policy to physical and/or verbal aggression against practice staff.
- Immediate removal from the practice list is justified if a patient has been violent and/or verbally abusive.
- Ensure practice opening times are prominently displayed to avoid such complaints.

From the archives: Fatal self-confidence

A CENTURY ago prescribing errors no doubt posed a greater risk to patients than today – and sometimes even to doctors. An article in *The Scotsman* newspaper from September 1899 reports on an inquest into the death of Dr John Dick at Eastbourne in Sussex.

The doctor had been called out to the home of Mrs Greer. No reference is made to the pretext of the visit but he brought along a liquid medicine that he had made up in his dispensary. Later at a subsequent visit Mrs Greer complained that the medicine had made her ill. She testified that on taking the solution she had felt like a "peg-top rolling around" and then had lost consciousness with her muscles "drawn up like a crowbar".

Mrs Greer gave the medicine back to Dr Dick saying it was

poison and this made the doctor angry. He insisted there was nothing wrong with it and to prove this he drank some.

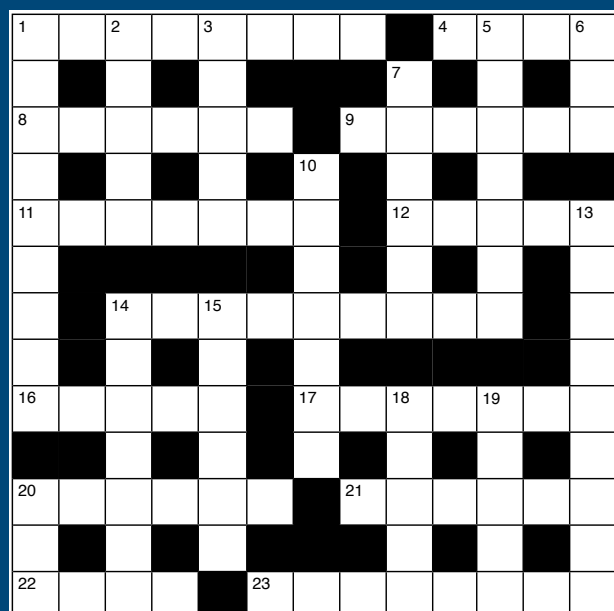
Miss Catherine Dick – the doctor's sister – reported that on his return to the surgery he fell against the street door. She found him there foaming at the mouth and staring wildly. He gasped: "My God. I believe I have been poisoned." Miss Dick brought out the stomach pump and then ran to fetch a neighbouring doctor. On her return Dr Dick said: "Tell him it's strychnine poisoning. I feel sure by the symptoms."

Efforts to save Dr Dick failed and the cause of death was determined to be "congestion of the vital organs by the action of strychnine, probably on the nervous system". In the time he was still coherent Dr Dick insisted he had made no error in formulating the medicine. An expert witness later testified at the inquest that the deceased must have mistaken a bottle containing a solution of strychnine for another almost identical bottle containing chloroform water – a constituent routinely used in some oral solutions. He added that the bottle dispensed contained sufficient strychnine to kill 12 people.

The jury in the inquest returned a verdict of misadventure though Miss Dick still insisted that her brother had made no mistake.



Crossword



ACROSS

1. Nags (8)
4. Cause of infection (4)
8. Latin American chaplains (6)
9. Painful swelling on toe (6)
11. Kettledrums (7)
12. Memorise (5)
14. Pertaining to something that effects a closure (9)
16. Sharp pains (5)
17. Waste away (7)
20. _____ scream, band (6)
21. Mutate into new form (6)
22. Broad ribbon (4)
23. Drugs used to treat inflammation (8)

DOWN

1. Inflammation of the liver (9)
2. Type of diabetes (abbr.) (5)
3. Solution introduced into rectum (5)
5. Remove hairs (7)
6. Males (3)
7. Central parts (6)
10. In name only (7)
13. Recently married people (9)
14. Reproductive glands (7)
15. Computerised axial tomography (abbr.) (2,4)
18. Default dog name (5)
19. Insect sense organs (5)
20. Purulent fluid (3)

See answers online at www.mddus.com.

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PHOTOGRAPH: SCIENCE PHOTO LIBRARY

Object obscura:

Scarificator

THIS six-bladed scarificator was made in France around 1900 and used to create wounds on the surface of the skin for wet-cupping – a form of bloodletting. It employed a spring-loaded mechanism with gears to snap the blades out through slits in the front cover. Blood-letting was still used by some doctors up until the early 20th century to treat a range of ailments by removing surplus bodily "humours".

Vignette: Medical publisher Charles Hawkins Craig Macmillan (1902 – 1984)

TODAY it seems almost quaint to think of the keen student of the 20th century carrying his heavy medical textbooks under one arm, or the consultant eagerly waiting for the latest journal to drop through his letter box. Print was the medium of choice to convey information then and Charles Macmillan was a publisher who grew the Edinburgh firm of E & S Livingstone from small beginnings to become a major producer of medical textbooks and journals worldwide.

Charles Hawkins Craig McMillan was born on 25 June 1902 – his long name incorporating that of the doctor who delivered him. He later changed the spelling to Macmillan, a name better known in England. His parents were Plymouth Brethren and Charles was taught the bible, from which he could quote or adapt phrases to suit most situations.

On leaving school Charles joined one of his sisters at the printing firm of Nelson's (a brother was a bookbinder). At age 17, he moved to the medical publisher and bookseller E & S Livingstone, founded in 1864 in a building opposite the old medical school. Charles started at the bottom but his abilities were obvious and by 1935 he was appointed general manager and then joint managing director with Alfred J Scott. It was a very paternalistic organisation with annual outings for staff, widows and children. "Blind children and motherless bairns" were entertained and the needy received Christmas gifts.

The Second World War turned industries at home upside down, including E & S Livingstone. Even basic materials like paper and ink were rationed. Macmillan was in a reserve occupation but he lost staff to the services and authors were committed to the war effort and had little time to write. A bomb destroyed stock in a warehouse of their distributor in London and 1943 and 1944 were full of disasters. A fire at a printing factory destroyed 90 per cent of the company's illustrations, a promising young author's ship was torpedoed on the way to South Africa and Alfred Scott died suddenly.



Macmillan became the sole managing director.

Macmillan's great skill was engaging with people. He toured England in September 1941 to visit his authors, such as Watson-Jones and Hamilton Bailey, and to recruit more. He met secretaries, nurses and booksellers. He chatted with doctors at their residency who found in him a friend. He reported back: "This is the place where you get all the secrets about your books, and these young doctors were very ready to talk about a variety of subjects which I have carefully made a note of for future reference." Ten years later a young Stanley Davidson gave him his lecture notes which became a best seller: Davidson's *Principles and Practices of Medicine* (1952).

In 1948 Macmillan agreed to publish two journals which were to prove very successful: the *British Journal of Bone and Joint Surgery* (its American subscribers made it a good dollar earner) and the *British Journal of Plastic Surgery*, a brave venture at the time and not expected to do

so well. The *British Journal of Urology* came later and was also a great success.

Macmillan made sure his authors had copies of the firm's books and gained much good publicity thereby. He had even sent a copy of *Child and Adolescent Life in Health and Disease* to the Queen in 1946. He also went to book exhibitions and medical congresses around the world, and hosted and attended dinners. A particularly long trip in summer 1954 was to the USA and Canada where the publisher had sales agents. He summed up his attitude to success:

"If you are a good publisher then, like a good farmer, you can't help making money. If you publish to make money you can't help losing and you can almost smell a good manuscript."

The firm grew with the turnover in 1962 nearly 20 times that of 1944-45, of which foreign sales were more than half. A new warehouse was built in West Crosscauseway to store some of the 400 plus titles. So the firm had good reason to celebrate its centenary at a dinner in the North British Hotel, Edinburgh in 1963. Staff and authors including Professor John Bruce and Sir Derek Dunlop were invited.

Macmillan was more than a publisher. Among other appointments he served as chairman of the Edinburgh, Mid- and East Lothian Disablement Advisory Committee and was also on the Finance Committee of the Princess Margaret Rose Hospital and was director of the Edinburgh Chamber of Commerce and Manufacturers.

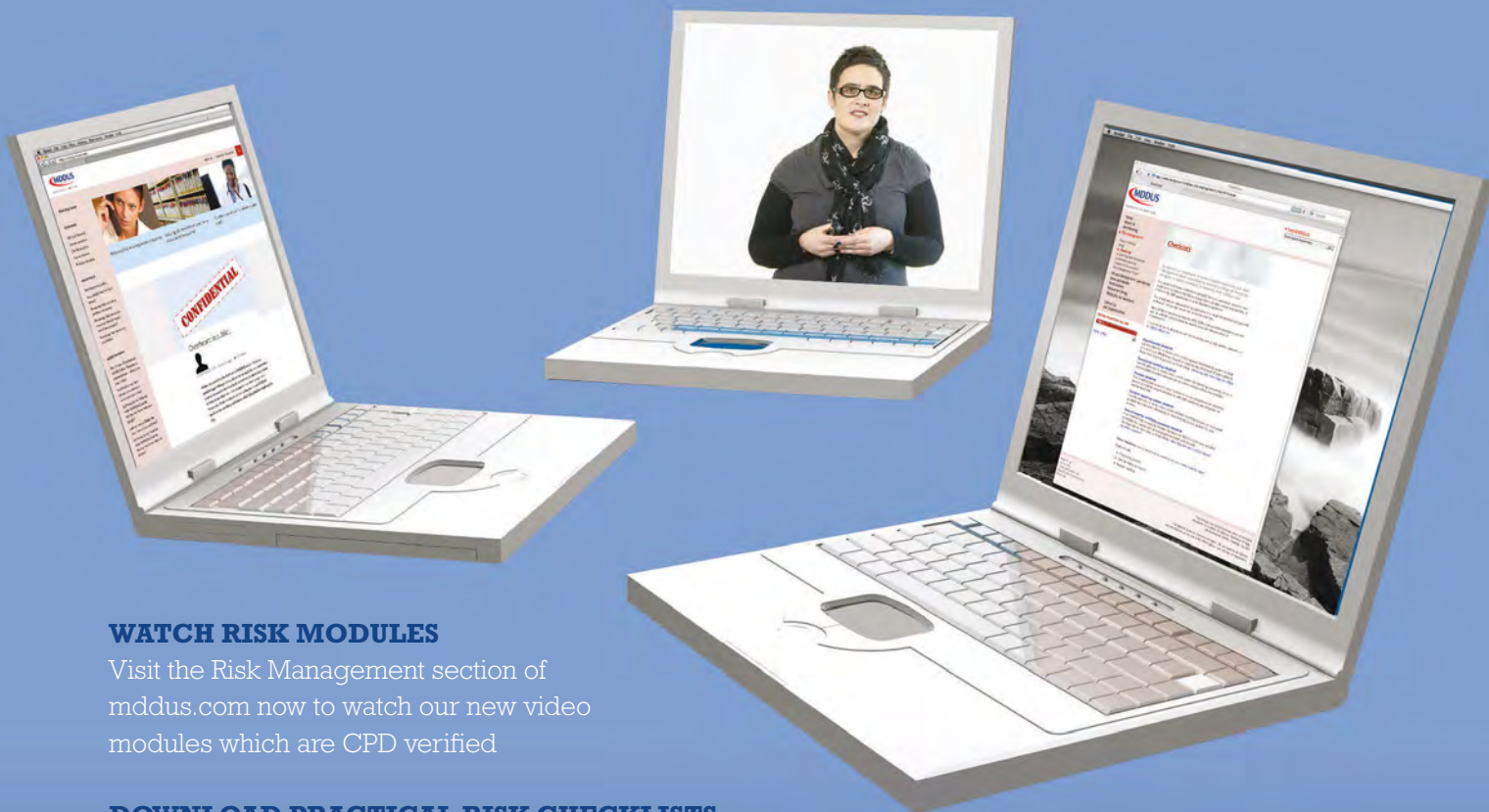
Macmillan retired in 1967 and E & S Livingstone later merged with J&A Churchill of London to form Churchill Livingstone, now an imprint of Elsevier which still maintains editorial offices in Edinburgh. In 1970 Macmillan was honoured with an OBE for services to exports and to medical publishing. He had time to play as much golf as he wanted at the Glenlockhart Club, and time for the nineteenth hole. He and his wife Isabella, who predeceased him, had four children, two girls and two boys. He died October 25, 1984.

■ Julia Merrick is a freelance writer and editor in Edinburgh

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