SPRING 2014

# SUMMONS

AN MDDUS PUBLICATION FOR MEMBERS

• A private matter? • Working within ability • Is it melanoma? •

ELSEVIER

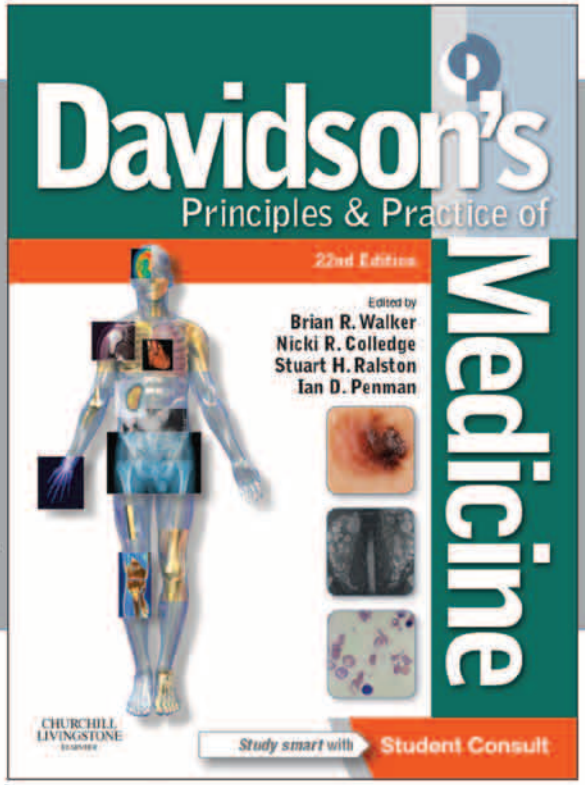
# Elsevier medical classics

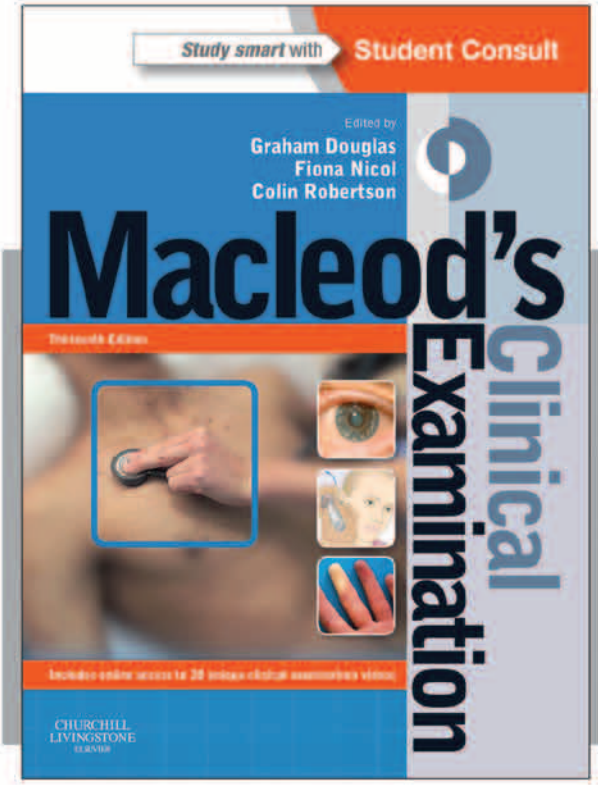
**Elsevier releases updated editions of Davidson's Principles and Practice of Medicine and Macleod's Clinical Examination**

## Davidson's Principles & Practice of Medicine

**Feb 2014 • 9780702050350**

More than two million medical students, doctors and other health professionals from around the globe have owned a copy of **Davidson's Principles and Practice of Medicine** since it was first published. Today's readers rely on this beautifully illustrated text to provide up-to-date detail of contemporary medical practice, presented in a style that is concise and yet easy to read.




## Macleod's Clinical Examination

**Jun 2013 • 9780702047282**

**Macleod's Clinical Examination** sets out clearly and concisely how to evaluate symptoms and elicit relevant physical signs. 'Highly Commended' in the 2006 and 2010 BMA Medical Book Competitions, the book is essential reading for medical students, nurse practitioners and paramedics as well as practising doctors.

★★★★★

**Macleod's Clinical Examination**

***This is the best book on clinical examination currently available.***
**British Medical Association Medical Book Competition**

★★★★★

**Davidson's Principles & Practice of Medicine**

***This book comes through where others fail: an excellent textbook, easy to read and superb value.***
**British Medical Journal**

## IN THIS ISSUE

Fifteen years ago or so I was working for a large medical publisher in Edinburgh and one day a senior executive from the US headquarters visited the office. The staff was summoned and this executive – call him Bob – informed us that the printed medical textbook was as good as dead. Bob said in five years all information would be accessed in CD-rom or online and if we hoped to keep our jobs best get with the programme.

Needless to say the printed book survived though I am unsure what happened to Bob. But for how much longer? In February, the 22nd edition of *Davidson's Principles and Practice of Medicine* was published with expectations for global print sales higher than any previous edition. In this issue (p. 14) I speak with the commissioning editor – Laurence Hunter – on the future of the medical textbook in the digital age.

The GDC is clear that a dentist must work "within your knowledge, skills, professional competence and abilities" but is the guidance explicit enough? On page 18 Dr David Cross asks if the proliferation of day and weekend specialist courses now encourages some GDPs to undertake more complex treatments than they otherwise might.

Do you use your smartphone for work? Are you aware of the potential data protection risks? Risk adviser Alan Frame asks these questions on page 8 of this issue, and on page 9 Deborah Bowman ponders what it means to be "good at ethics".

The subject of our Q&A (p. 10) was ranked fifth among the top 50 most influential people in dentistry in 2013. Judith Husband is chair of the Education, Ethics and the Dental Team Committee (EEDT) at the British Dental Association and never shy of offering her opinion on the future direction of dentistry in the UK.

Our clinical risk topic in this issue is melanoma (p. 16) and deciding – is it a simple mole or something more sinister?

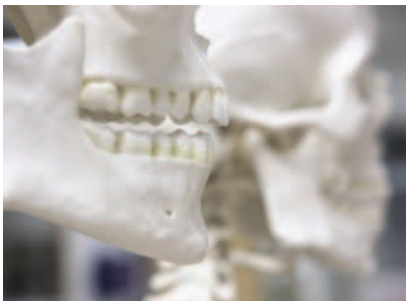
**Jim Killgore, editor**

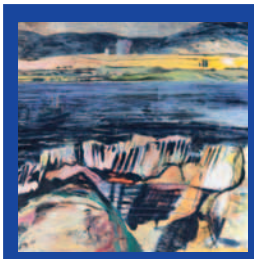




### REGULARS







Janet Melrose studied at Edinburgh College of Art under John Busby ARSA, RSW and William Baillie PPRSA, graduating in 1987 with a BA (Hons) in Drawing and Painting. Janet has exhibited in numerous solo and mixed shows throughout Scotland, as well as London and New York. Her work is in many collections, both public and private. In November 2011 she was elected as a member of the RSW.

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 Risk launches blog site


A NEW website featuring blogs on a range of risk topics has been launched by the Risk Management Team at MDDUS.

Blogs will be posted on a monthly basis, written by our highly experienced risk advisers. Aimed at doctors, dentists and practice managers, the blogs are based on real cases and risk analysis of cause of loss in claims across different areas of practice. They are designed to alert members to these risks and allow the sharing of good practice across our membership to improve patient safety.

Recently featured topics include clinical record workflow systems, telephone consultations and risks associated with DNAs. We also regularly feature guest bloggers who highlight risks within their own area of practice. If any members have some useful lessons they might be willing to share in a guest blog please contact Liz Price, senior risk adviser, via **risk@mddus.com**

Members can access the full range of blogs at **http://riskblog.mddus.com/**

## Agree levels of disclosure before emailing

DOCTORS should have consent and agree levels of disclosure before emailing or texting patients. MDDUS has recently sent out an alert reminding doctors that patients must opt-in before receiving any form of electronic communication from their doctor.

The use of email may now be part of everyday work for doctors, but MDDUS Joint Head of Medical Division Dr Anthea Martin believes doctors should not become complacent and must consider consent and confidentiality issues when sending patient data electronically. "Not all patients wish to receive emails or texts from their medical practice," says Dr Martin. "It is therefore important that only those patients who agree to communicate electronically receive information via email or text."

MDDUS has dealt with calls from members concerned over what information is appropriate to share with patients via email. "To avoid any potential breach of confidentiality, it is beneficial to agree levels of disclosure," says Dr Martin. "Does a patient want to be contacted via email or text for vaccinations, rescheduling appointments or repeat prescriptions, or for more personal matters such as test results?"

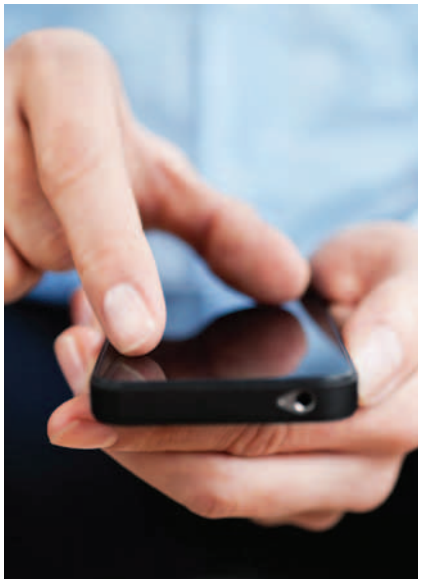
Dr Martin points out that there are still risks of confidentiality breaches even with something as straightforward as rescheduling a patient's appointment. It is important to consider who might have access to an email account or mobile phone other than the patient. "Personal circumstances and relationships within families are all different and you should not presume to know what people might want to keep private."

Healthcare professionals should familiarise themselves with policies and procedures issued by their employer or contracting body in regard to protecting patients' privacy. They must also be mindful of the Data Protection Act 1998 which requires information to be fairly and lawfully processed.

"Doctors who fail to protect patient information risk incurring a fine from the Information Commissioner's Office (ICO)," says Dr Martin. "Furthermore, failure to adequately secure electronic medical records could result in a GMC hearing or even criminal charges."

Many practices now allow for patient contact through secure password-protected online systems. Encryption can reduce some of the risks but no system can be completely secure so it is important to consider confidentiality risks in all information exchanges with patients and colleagues.

"Doctors must be satisfied that there are appropriate security arrangements in place and consider the potential for data security breaches in all electronic communications involving confidential patient data," says Dr Martin. "You should also refrain from discussing clinical issues via email. For routine inquiries, an email exchange can be a convenient way of communicating. However, it's not a substitute for face-to-face consultations. Finally, any electronic exchange with a patient should be considered part of the patient's medical records and be recorded."



## Indemnity for 2014 Commonwealth Games

MDDUS is pleased to offer access to indemnity for members working in a voluntary capacity at the forthcoming Commonwealth Games, subject to the following conditions:

- The member is in active membership with MDDUS and has paid a subscription for clinical work
- The member holds a GMC licence to practise (or other appropriate professional registration, e.g. GDC)

## IN BRIEF

● **FFLM INTRODUCES DIPLOMA OF LEGAL MEDICINE** The Faculty of Forensic and Legal Medicine (FFLM) is pleased to announce it is introducing a new examination leading to the post nominals DLM (Diploma of Legal Medicine). This is a knowledge test identical to Part 1 of the FFLM Membership examination but marked at a slightly lower level. The DLM will appeal to those with an interest in the wider interaction of clinical practice and the law, the regulation of clinical professionals and those who may be called upon to act as an expert witness in legal proceedings. For more information go to **http://fflm.ac.uk/**

● **LONDON LEGAL WALK** Lawyers will be gathering en masse on 15 May for The London Legal Walk – and among them some of our own MDDUS staff. The 10k sponsored walk is in aid of The London Legal Support Trust which is an independent charity raising funds for free legal advice in London and the South East. Find details at **www.londonlegalsupporttrust.org.uk**

# VIEWPOINT

**By Dr Jim Rodger, Head of Medical Professional Services, MDDUS**

## Preventing FGM – a professional duty

Female genital mutilation (FGM) or female circumcision is a very serious form of child abuse. It has been illegal since Acts banning the practice (and arranging for it to be carried out in foreign countries) were introduced in 2003. There have been few prosecutions and yet estimates put the number of victims in England and Wales at over 66,000, with more than 23,000 children at risk. These children must never become victims of this horrendous form of abuse.

The Government recently launched an initiative (Ending Violence against Women and Girls in the UK) and this clearly directs a "range of measures to combat FGM". Various agencies are involved including the NHS, and not only are health professionals duty bound to treat and support anyone mutilated in this way but they must fully engage with prevention.

The World Health Organisation has defined four main types of FGM, which include partial or total clitoridectomy, excision of labia, infibulation and narrowing of vaginal opening, and other more minor surgical procedures. These procedures have no health benefits but can and do result in pain, haemorrhage and infection in the immediate aftermath, and very serious long-term sequelae including urinary, obstetric and gynaecological conditions. It is surprising that any doctor would take part in or condone such barbaric practices.

The procedures are carried out on girls from infancy to around 15, mainly in Africa and the Middle East where it is perpetuated by a mixture of cultural, social and religious factors. Such mutilating abuse of girls has no place in our society and must be prevented by all means possible. It has emerged as a health issue in this country because of immigration from these countries.

The Government has published excellent multi-agency guidelines reflecting the statutory guidance that governs safeguarding principles and practice – the underlying principle being that "the safety and welfare of the child is paramount". While it is recognised that social, cultural and religious beliefs and practices drive this form of abuse, the guidelines clearly state that: "Professionals should not let fears of being branded 'racist' or 'discriminatory' weaken the protection required by vulnerable girls and women".

GPs and practice nurses have a clear role in identifying those girls and women who need advice, counselling and possible treatment for the results of FGM. In addition, there is also a role in identifying and protecting those who may be at risk. Obstetricians and gynaecologists are also in unique positions not only to identify FGM but deal with the consequences.

Detection and investigation are not the responsibility of health professionals but fall within the powers of social workers and police. However, doctors are required to engage and co-operate with (and if necessary disclose to) the relevant authorities where a crime may have been committed or there appear to be girls at risk. The GMC gives clear advice on the responsibilities of medical practitioners in dealing with child abuse and child protection. Indeed, there is no shortage of professional and Department of Health advice and guidelines on FGM.

So why have there been so few prosecutions? Are health professionals failing to recognise where there are risks to children? GP practices with patients from the particular ethnic backgrounds that practise FGM should be fully aware of the serious hazards and risk to young girls. Does that mean that such children are less easy to identify or are professionals reluctant to voice their concerns out of fear of being accused of racial or religious discrimination?

The practice of female genital mutilation has been condemned by the UN and clearly the intention must be to rid the world of such practices. However, in this country it must be eradicated now. All right-thinking people agree and the health profession must play its part – a central and pivotal role in the treatment but more importantly the prevention of such serious mutilating abuse of girls.

- The member has not entered into a formal arrangement/contract to provide care for individual athletes or teams (they may however be required to treat athletes on an ad hoc basis in the course of their volunteer duties)
- The member works within the limits of their competence and has appropriate training and experience
- The member is not restricted to working in a GMC-approved setting (F1/F2).

In addition, an MDDUS member who may be in attendance as a spectator is covered for any emergency situation that may occur, classified as a Good Samaritan act. If anyone has any doubts about cover, please contact the medical advisory service or our membership team.

● **LEADING THROUGH UNCERTAINTY** MDDUS Risk Management will be again running its popular LTU course developed specifically for doctors with management responsibilities. The week-long programme will challenge you as a leader and help you tackle change positively. The course runs from June 9-13 at the MDDUS Glasgow office. The cost is £395 for members and £450 for non-members. Contact Ann Fitzpatrick at 0845 270 2034 or **risk@mddus.com**

● **BMJ AWARDS SHORTLIST REVEALED** The nominees for the 2014 BMJ Awards have been announced. Now in their sixth year the awards are held in association with MDDUS and recognise excellence and innovation in patient care delivered by teams across the UK. More than 20 of the UK's most eminent physicians, academics and policy makers will judge the short-listed teams across 13 categories. See the full list of the nominees at **www.thebmjawards.bmj.com/home**

## Dental patients satisfied with care

A NEW survey has shown 96 per cent of dental patients are satisfied with the care or treatment they receive.

The GDC poll of 1,603 people across the UK also found that confidence in regulation was high, although patients are less confident that poor treatment and care is dealt with effectively.

Patients aged 15 and over were asked whether dental professionals were treating them in line with the GDC's guidance *Standards for the dental team*.

More than three-quarters of patients (78 per cent) said their dentist gave them enough information about treatment options during their last visit. However, focus groups carried out as part of the research found some patients lacked a good understanding of dental treatments, making it difficult to judge quality.

Only 41 per cent of those surveyed said their practice displayed a simple price list and only a third (34 per cent) had noticed information stating the dentist was regulated by the GDC.

A total of 86 per cent of people believe that dentists are professionally regulated, but a surprising 58 per cent had not heard of the GDC before taking part in the survey. Two-thirds believe that 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.

Respondents were less sure that appropriate action would be taken by a regulator to tackle poor care or serious wrongdoing. Thirty-nine per cent said they were not confident appropriate action would be taken in cases where patients were overcharged for dental treatment or where poor care was given to care home residents (40 per cent) or disabled patients (38 per cent).

Access the survey results on the GDC website or at **www.tinyurl.com/mjah4z2**

## Revalidation process "longer than expected"

DOCTORS are spending more hours on revalidation than had originally been expected, an official NHS report has revealed.

The report by the NHS Revalidation Support Team (RST) looked at the impact of revalidation one year after implementation and found that doctors typically spend between 12 and 15 hours preparing for and completing their appraisal as part of the revalidation process – up to six hours more than original estimates.

*The Early Benefits and Impact of Medical Revalidation* analysed findings of 3,500 survey responses from doctors, appraisers, responsible officers and designated bodies in 2013 and 2014. Previous pilot tests carried out by the RST estimated doctors would spend around nine hours on appraisal activity.

The report also found that revalidation was "not universally supported" with some doctors saying it is "not yet relevant to their needs".

It did highlight a number of positives, concluding that revalidation is "delivering value" with appraisal rates increasing from 63 per cent to 76 per cent over the two years to March 2013. It also suggests that concerns about a doctor's practice are being identified at an earlier stage.

Ralph Critchley, Director of Research and Quality Improvement at the RST said it was still "early days" for revalidation.

"We have identified a number of recommendations which will help improve the process going forward," he said. "This will be important in ensuring revalidation develops in the right way and contributes to continuing public confidence in the medical profession."

Read the full report and supporting documents at **www. tinyurl.com/l7ntnlx**

## Data protection among GPs good but...

A REPORT on data protection at GP surgeries highlights good overall practice but also failings in some areas including incident reporting and internet use.

In 2013/14 the Information Commissioner's Office (ICO) carried out advisory visits to 24 GP surgeries in England and has now issued a report on the findings. Most of the surgeries tended to have good data protection policies and awareness of key issues such as data security and patient confidentiality. But the report also highlighted areas needing improvement, including an appreciation of the need to report data breaches.

The authors commented: "Procedures were always in place to log serious and untoward incidents, but IG [information governance] incidents were rarely

## IN BRIEF

● **GDC OFFERS STANDARDS CASE STUDIES** The GDC has developed an interactive website to support implementation of the new *Standards for the dental team*, with relevant case studies, scenarios and FAQs. The resource has been designed to help registrants test their knowledge of the new standards with learning materials for each of the nine principles. Access at **www.gdc-uk.org** and go to Focus on Standards.

● **UPDATED NICE GUIDANCE ON HEAD INJURY** Time is critical in head injuries and patients should be transported directly to a hospital with resuscitation facilities where staff can investigate and commence treatment, says NICE. In updated guidance aimed primarily at hospital doctors, nurses and ambulance crews, NICE stresses the importance of early detection and prompt treatment for both children and adults who have suffered head trauma. Go to **www.tinyurl.com/q3akp7y**

distinguished. It is only through the thorough reporting of incidents that regulators can properly support organisations encountering incidents and help avoid repeats. As such, failure to report a breach is one of the factors taken into consideration by the ICO when assessing monetary penalties."

Improvements were also suggested around faxing and the risks posed by unrestricted internet access. Several surgeries allowed staff to access personal email addresses with the risk of data leakage, hacking and viruses. The ICO also highlighted security issues in regard to the use of unsecured USB sticks and other portable data devices.

Lee Taylor, ICO Team Manager in the Good Practice team, said: "The NHS processes some of the most sensitive personal information available and data breaches at GP surgeries can have significant repercussions for the individuals affected. But we were broadly pleased with what we saw during the advisory visits. Having the right policies and procedures in place is the backbone to good data protection and the GP practices we visited tended to have these."

Access the full report at **www. tinyurl.com/pffww9c**

## Call for better access to palliative care at home

TERMINALLY ill patients being treated at home need better access to care and pain relief according to a recent survey commissioned by Marie Curie.

The survey of around 1,000 GPs conducted by Doctors.net.uk across the UK found that only 39 per cent of GPs believe their terminally ill patients get adequate access to care at night and at weekends and a third of GPs do not believe their terminally ill patients get adequate access to specialist palliative care nursing.

It also found that only four in 10 GPs believe the majority of their terminally ill patients' pain is relieved completely. GPs were asked to indicate factors that are likely to reduce quality of pain control. Three out of five GPs (59 per cent) cited a lack of anticipatory (just in case) prescribing, 53 per cent expressed concern about over-prescribing medication and 39 per cent considered poor availability of pain relief out of hours a determining factor.

Over eight in 10 GPs rated access to 24/7 specialist palliative care rapid response teams as a key answer to improving access to pain control at home.

The issue surrounding around the clock care is highlighted in a new report published by Marie Curie, called *Difficult Conversations with Dying People and their Families*. Families reported having to chase after prescriptions, nurses waiting hours for vital drugs to arrive and locums unable to prescribe.

Dr Bill Noble, Medical Director of Marie Curie, said: "GPs are best placed to ensure effective co-ordination of palliative care. If their patients are to get the care they need to be at home in their terminal illness, NHS, social services and voluntary sector professionals all have their part to play."

## Does fear of being sued stifle innovation?

DOCTORS are being asked if they avoid using pioneering treatments because they are afraid of being sued.

A consultation has been launched by the Department of Health on the proposed new Medical Innovation Bill 2014 which aims to encourage doctors to innovate in medical practice.

Health secretary Jeremy Hunt said: "We want to make sure doctors are not held back if they want to use pioneering treatments to offer a lifeline to dying patients. Innovation has always been at the heart of the NHS and is essential for improving treatments and finding new cures."

The Bill, which applies in England and Wales, seeks to encourage "responsible medical innovation and help prevent irresponsible innovation".

It states: "It is not negligent for a doctor to depart from the existing range of accepted medical treatments for a condition... if the decision to do so is taken responsibly."

A responsible decision is defined as one based on the doctor's opinion that there are "plausible reasons why the proposed treatment might be effective".

Doctors would be expected to make decisions based on a process that is accountable, transparent and allows full consideration by the doctor of all relevant matters.

The consultation runs until April 25.

**DECREASE IN HEART DISEASE AND STROKE** New cases of coronary heart disease in Scotland have decreased by 27 per cent over the last decade according to new statistics. ISD Scotland also reports that new cases of cerebrovascular disease (CVD or stroke) have fallen by 21 per cent over 10 years. The figures show the mortality rate for heart disease decreased by 44 per cent across all deprivation levels, with the gap between most deprived and least deprived narrowing.

**ALERT OVER COUNTERFEIT DENTAL DEVICES** Dentists are being warned about the risks of buying dental equipment online after reports of a counterfeit product for drilling and cleaning teeth shattering while being used to treat a patient. The MHRA issued a medical device alert to dentists in response to an apparent rise in the number of counterfeit and non CE-marked dental products for sale on the internet. Access the MHRA alert at **www. tinyurl.com/pqghppm**

# BRING YOUR OWN DEVICE(BYOD)

*Alan Frame*

**SMARTPHONES** are becoming an increasingly common resource in the delivery of patient care as healthcare professionals take advantage of text and picture messaging or refer to one of the many clinical apps.

But while the use of personal smartphones at work has advantages, it also poses a threat to patient confidentiality that employers must be mindful of. This includes not only the transmission of written patient identifiable information but also the sharing of still and moving images for diagnostic advice purposes.

A recent survey published in the *Postgraduate Medical Journal* concluded: "There is a need for guidance on how patient information can be safely secured and transmitted using smartphones, their appropriate use, and any restrictions on the use of these devices in certain clinical settings."

Right on cue, the Office of the Information Commissioner (ICO) subsequently produced new and imaginatively titled guidance on this subject called *Bring Your Own Device (BYOD)*.

The guidance is aimed at data controllers and raises a number of important considerations when permitting the use of personal devices (which the organisation has no direct control over) to process personal data (for which they are responsible).

It addresses a number of concerns that can arise when a device is owned by the user (i.e. the doctor) rather than an organisation. It acknowledges that under the Data Protection Act personal data must be processed lawfully and in line with the seventh data protection principle that: "appropriate technical and organisational measures shall be taken against accidental loss or destruction of, or damage to, personal data."

The Information Commissioner notes that it is crucial that data controllers ensure all processing of personal data under their control remains in full compliance with the DPA. He emphasises that organisations should remain mindful of the personal usage of devices and that measures employed to protect personal data must remain proportionate to and justified by any real benefits that will be delivered.

Many organisations receive requests from employees to use personal smartphones to carry out their jobs. This means corporate/clinical information, as well as the individual's own private data, will be accessed, processed and stored on a single device.

*BYOD* emphasises that the data controller must remain in control of the personal data for which he is responsible, regardless of who owns the device used to process it. Consideration needs to be given to the type of data being held, where it may be stored and how it is transferred. The potential for "data leakage" and any blurring of lines between personal and business use should also be assessed.

> "A number of concerns can arise when a device is owned by the user rather than an organisation"

Further consideration includes what to do when a personal device owner leaves their employment, and how to deal with any loss, theft, failure and support of a device.

The Information Commissioner points out that "an effective BYOD policy can lead to a number of benefits, including improved employee job satisfaction, increased job efficiency and increased flexibility. By considering the risks to data protection at the outset, a data controller has the opportunity to embed data protection at the core of its business activities and to raise overall standards, for example by specifying the types of personal data that can be stored and processed on particular devices".

A good place to start could be an audit of the types of personal data you are processing and the devices, including their ownership, which will be used to hold it. This should clearly identify what personal data can be processed on a personal device and which must be held in a more restrictive environment.

Conversely, the use of employees' own devices may also mean that the employer ends up processing non-corporate information about the owner of the device and possibly others who use it, such as family members. In a nutshell the employer must consider whether the controls in place are appropriate and proportionate for any sensitive personal data being processed.

The *BYOD* guidance also addresses the practical and technical risks of connecting personal devices to organisational IT systems and the importance of individuals fully understanding their responsibilities in this area.

It is also worth mentioning the issue of monitoring at work. The ICO has previously published guidance for employers on this topic, which reminds us that employees have legitimate expectations that they can keep their personal lives private and that they are entitled to a degree of privacy in the work environment.

Employers who wish to monitor their workers should be clear about the purpose and be satisfied that the particular monitoring arrangement is justified by real benefits.

Therefore, when drafting your own BYOD acceptable use policies, it is useful to also take into account the ICO's *Employment Practice Code*.

Access the full guidance on the ICO website at **http://tinyurl.com/p7zfc2t**

■ ***Alan Frame is a risk adviser at MDDUS***

# BEING GOOD AT BEING GOOD

*Deborah Bowman*

**THERE** is a pile of unmarked essays – about which I have begun to dream guiltily – awaiting attention on my desk. My to-do list is crammed with assessment activities: scenarios to be created for stations in an objective structured clinical examination (OSCE), exam papers to be approved from institutions for which I am an external examiner and a viva voce report for a doctoral candidate to be completed. The question of what it means to be "good at ethics" is, at the moment, preoccupying.

Traditionally, and as one might expect, academics have assessed and therefore rewarded a particular form of engagement with ethics which is largely intellectual. Those who could demonstrate an ability to absorb moral theories and apply analytic tools and models to complex ethical questions or problems were successful. The traditional essay and other long-form written exercises endure because they afford authors an opportunity to develop, refine and show that they have acquired knowledge and skills in analysis and argument.

I believe, like the majority of my academic colleagues, that such assessments continue to be an effective way to explore someone's facility for conceptual thinking, their aptitude for interrogating ideas and ability to construct a logical argument. However, I also believe that those who achieve the highest marks in these sorts of tasks are not necessarily the best, or even "good", at ethics. Yes, they are skilled in some aspects of the subject, but what does that mean for ethical practice in a career that may span a further 40 years?

Most medical schools and postgraduate exams have a practical component in which clinical interactions are simulated to assess how candidates behave with patients (or those playing the role of patients). My own institution is no exception. Next month, I will evaluate hundreds of anxious final year medical students as they carry out tasks and conduct consultations with standardised patients in a week of OSCE exams. Despite the uniformity of the teaching the students have had, it is fascinating to see the different ways in which candidates approach a common scenario. The marking system is, as the description of the exam implies, largely objective and structured. However, there is also an expectation that an examiner will use his or her judgement to assess the candidate "globally" and indicate where someone appears to be outstanding.

In nearly 20 years of examining in such assessments, what constitutes an exemplary performance is a question that fascinates me. From a personal perspective, it is when someone does more than simply interact in the ways they have been taught are "correct". It is when there is demonstrable warmth, attention and responsiveness. It is the candidate who sees the interaction as more than an instruction to, for example, seek consent or assess capacity. Perhaps it is something about sincerity or authenticity. It is someone who is not merely adept at "ethics in practice" but embodies ethical practice by an interest in, and commitment to, those there to be served.

> "Ethics is what you do when no one is watching"

Away from the high-stakes, one-off assessments, there are of course other ways in which we evaluate an individual's ability in ethics. Daily interactions when working in a clinical team inform end-of-placement sign-offs and references. Portfolios and reflective exercises are a feature of most training programmes, albeit not always popular. However, again, such exercises are limited in what they can and do capture. Many years ago, I heard the aphorism that "ethics is what you do when no one is watching". How then do we begin to obtain any insight into what people do when they are unobserved without entering into some Orwellian nightmare of ethical surveillance?

The answer, it seems to me, is to acknowledge that being ethical is both simpler and more complex than any examination or assessment can capture, however well-constructed. It is an inherently human endeavour that will always depend on systems that make it possible to behave well and create cultures in which individuals are valued and value others.

As I came into work this morning, I noticed in the distance, one of the students who will be sitting my carefully-crafted ethics examinations as part of his clinical finals next month. He looked tired and the early hour suggested he had just finished a night-shift as part of his last AHO placement. A short distance ahead of him, an elderly woman was leaning heavily on her walking frame and appeared confused, maybe even distressed.

I watched as the student stopped and gently led the woman to a nearby seat. He sat next to her and, as I approached, I heard him ask how he could help her. He didn't notice me, so focused was he on listening to this frail woman. And I knew I had just seen someone who was "good" at ethics.

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

# Insights on a changing profession

*Dentist* Judith Husband *discusses her varied career and shares her thoughts on the future of dentistry*

JUDITH Husband's professional experiences are varied to say the least. She has practised privately, within the NHS and also in prisons. She works to improve educational standards, has an interest in ethics and also has a prominent presence on the social media site Twitter.

*Dentistry* magazine ranked her number five on their 2013 top 50 most influential people in dentistry and she is currently chair of the Education, Ethics and the Dental Team Committee (EEDT) at the British Dental Association. Having qualified from Liverpool Dental School in 1997, she has practised in almost all spheres of dentistry, most recently as principal dental surgeon in Bullingdon Community Prison.

### What are the main issues facing dentists today and in the future?

Dentists are all very different and issues vary but one issue we all face is increasing burdens of regulation. This may be due to contracting requirements, professional regulation or changes to legislation.

A constant drive to control, measure and report is undermining the very nature of being a profession. This is not unique to dentistry – we live in a cynical, questioning world where mitigation of perceived risks is taking priority over the traditional values and ultimately our ability to serve our patients.

Uniting and facing the challenge as one profession is key, together with engaging the public directly and ensuring we retain their trust in us.

### Are you concerned about the trends thrown up in the latest Dental Working Patterns Survey suggesting dentists are working longer hours, doing more paperwork and taking fewer holidays?

Very concerned. Even on a personal level, in my

surgery each year more time is spent on administration, with increasing costs impacting on overall profit. We are risking poor health and increased stress, all dangerous for our patients and their care.

Fair funding for NHS teams and reasonable expectations from commissioning bodies are essential. The BDA continues to fight in this key area. Legislative changes must clearly benefit patient care and be supported by additional funding.

### The dental workforce has changed dramatically in recent years. How should the profession adapt?

For about the past 20 years undergraduate dental schools have been admitting increasingly higher proportions of women. Looking at the General Dental Council register we are now a predominantly female profession, with most of our DCP colleagues female.

Research has consistently demonstrated women dentists tend to see fewer patients, spend more time with patients, are less likely to own practices and will take career breaks. Society and legislation have moved to support both partners in relationships with caring responsibilities with paternity leave.

The generally accepted trend is that the profession will be less productive in terms of volume of clinical work and this has significant impact for workforce planning.

More controversially, women tend to be less likely to be involved and join unions. The risks are twofold. Without protection and support, working conditions and remuneration can easily deteriorate. Without engagement from all, representation will become more focused on narrow groups who do get involved. This can become a downward spiral of disengagement from significant sections of the profession, one that would ultimately undermine us all with the loss of negotiating powers and professional support.

### There have been increasing calls for CPD to be more "valuable". How can it be improved?

Professional development is fundamental to being a dentist and has been codified by our regulator. However, the basic tenet of ensuring we are fit to practise and develop new skills cannot be divorced from being a professional and should not be undermined by legislation. Reducing CPD to merely counting hours or, worse, a narrow range of subjects was not the intention of the legislation but has sadly been one of the results to date.

CPD must be owned and directed by the individual. Some form of protected time and regular review would also be the ideal. We are at a crossroads. The changes that are currently being proposed to our existing CPD scheme are a clear step towards revalidation, an area for which our medical colleagues have had financial support. The changes must be reasonable, relevant and not add to the burden or regulatory red tape that our profession is increasingly suffering from.

### Are increasing patient expectations putting pressure on dentists?

The trend of patients engaging fully in their care is not in itself a pressure but a reasonable development in society's attitudes. The informed patient is often a joy to work with and the classic Parsonian role is less common now. This is helpful because working in partnership with patients engenders mutual respect and engagement, with better health outcomes and fewer complaints.

The pressure perhaps comes from some patients expecting unreasonable results driven by partial information, usually from the media, a desire for quick fixes and a consumer mindset.

> "A drive to control, measure and report is undermining the nature of being a profession"

### What is prison dentistry like?

I initially got involved by accident, due to a job offer, but it soon became an area that was interesting and challenging. We all manage demanding patients: fear is often the biggest issue and prison is no different. Our patients have very poor oral health and minimal experience of dental care in general. They attend in severe pain or with infections – breaking the cycle is essential to improving their health. Through education, we aim to empower our patients to take charge of their health and understand their decisions. Chaotic lives, addictions and mental health problems combine to offer very challenging patient management needs. It is incredibly rewarding when we do see improvement and engagement.

### As a regular Twitter user, is social media a valuable professional tool?

The GDC guidance is there to ensure a practitioner's social media presence is professional with some very robust warnings to registrants, but the realities are very different in my view. This relatively new form of communication is changing the way we all express ourselves and I believe there are huge opportunities for patient engagement on open social media platforms

For me, using social media simply as a means to disseminate information rather misses the point. The value both to individuals and organisations is the interaction, building relationships and debate. When we use social media, we must always be conscious of our responsibility to patient confidentiality and our profession, just as we do in normal life.

### You have been named among the most influential people in dentistry. Are there particular ways in which you have helped shape the profession?

Many of the issues are ongoing and develop over time, the work is never complete. Most issues are interrelated and very complex and the key is to be well-informed and aware of the potential future developments. Influencing these takes huge amounts of time and patience. To name or take credit for a particular subject would be disingenuous as it's always a team of BDA staff and dentist colleagues on committee.

### Tell us about your work with the BDA.

The EEDT Chair is an additional responsibility to being an elected member of the BDA principal executive committee. We cover a huge variety of interlinked areas. Highest profile areas would be regulatory issues and GDC, foundation training and workforce planning. Almost all issues have an ethical dimension and so the remit of the group enables us to explore and become involved in all aspects of our profession.

### Describe a typical working week.

Each week is very different and never typical. My clinical work is usually across three or four days, most evenings and weekends are devoted to BDA work, with usually a day of physical meetings in London. The vast majority of my work is electronic - it's difficult to comprehend the time before email, perhaps the world moved at a slower pace.

■ ***Interview by Joanne Curran, associate editor of MDDUS publications***

# A private matter?

*MDDUS medico-legal adviser* Dr Susan Gibson-Smith *considers when it's okay to disclose patient details without consent*

HIPPOCRATES wrote in the 4th century BC: "Whatever I see or hear, professionally or privately, which ought not to be divulged, I will keep secret and tell no one."

Confidentiality is the bedrock of the relationship between doctor and patient and has evolved to become a key principle of good medical practice as enshrined in guidance issued by the General Medical Council. The therapeutic relationship is one based on trust and doctors must take care not to undermine that trust by failing to keep personal details and discussions confidential. But that's not to say all cases are clear cut. Consider the following scenario:

*I had been seeing Mrs Smith for several months in regard to mild anxiety symptoms. This consultation was for a 'cough and spit', routine enough but she was very reluctant to be examined, asking simply for an antibiotic and a fit note for her work. In view of the pleuritic chest pain she was complaining of I persuaded her of the importance of my examining her chest. The bruises on her chest wall were several and fist-sized and the welt on her lower back was raw. With some encouragement she went on to show me her arms and legs, peppered with further bruises and some cigarette-shaped burn marks.*

*"He was really bad at the weekend. He thought I had been flirting when we were out on Friday. When he has had a drink there is no reasoning with him. I was really worried this time he might kill me."*

*I asked her if she had considered reporting this to the police. She said she would never do that it. She said he really didn't mean it and it was only when he had had too much to drink that he became violent. What duty do I have to respect her right to confidentiality or to breach it against her consent but for her own benefit?*

Confidential medical care is recognised in law as being in the public interest and it is a patient's right to expect that information about them will be held in confidence. However, whilst there is a clear public good in having a confidential medical service, it is also recognised that confidentiality is not an absolute duty and there can be circumstances in which it is entirely appropriate to disclose confidential information. These circumstances can be grouped under three broad headings.

## Disclosure with patient consent

Obviously if a patient consents to the disclosure then it is entirely appropriate to share that information. However, it is advisable to check that the patient has been given sufficient information about the scope, purpose and likely consequences of the disclosure to be sure that the consent is fully informed. It is also worth checking the date when the consent was given as this can expire over time. If in doubt it is always worthwhile to check again with the patient.

> "You should usually abide by a competent adult patient's refusal to consent to disclosure"

## Disclosure as required by law

Doctors must adhere to certain specific statutory requirements under which patient consent may not be required, for example notification of a known or suspected case of infectious disease. Various regulatory bodies, such as the Ombudsman or the GMC, also have statutory powers to access patients' records without consent as part of their duties to investigate complaints, accidents or a health professional's fitness to practise. If you are asked to provide information about a patient it is your responsibility to satisfy yourself that such disclosure is required by law or can be justified in the public interest. Even in cases where patient consent is not required GMC guidance states that you should inform the patient about such disclosures unless doing so would undermine the purpose of the disclosure.

Doctors also must disclose information if ordered to do so by a judge or a presiding officer of a court (e.g. sheriff or magistrate) but do retain the right to object if they believe the information they are being asked to disclose is irrelevant, such as information about a patient's relative who is not involved in the proceedings. It is important to ensure that anyone ordering disclosure has the power to do so, for example solicitors cannot compel disclosure.

## Disclosure in the public interest

In certain circumstances there will be a clear public interest in disclosing confidential information, such as in protecting individuals or society from risk of serious harm.

The GMC advise that:

"Personal information may, therefore, be disclosed in the public interest without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential."

Examples of this would be disclosing confidential medical information to the DVLA of a patient with epilepsy or dementia who is persisting to drive, or informing sexual contacts of patients with serious communicable diseases, or informing the police about knife and gun crime. The GMC provides supplementary guidance on these and other confidentiality matters at **www.gmc-uk.org**.

The bottom line is that doctors have the responsibility to weigh the harms that are likely to arise from non-disclosure of information against the possible harm both to the patient, and to the overall trust between doctors and patients, arising from

the release of that information.

The guidance goes on to say that even if you are considering making a public interest disclosure you should still consider obtaining consent from the patient and inform them that a disclosure will be made in the public interest, unless you believe that to do so would put you or others at risk of serious harm, or would undermine the purpose of the disclosure.

If you do make a public interest disclosure you must document in the patient's record your reasons for disclosing this information without consent and also any steps you have taken to seek the patient's consent, to inform them about the disclosure and your reasons for not doing so. This is very important as you need to provide evidence of your decision-making process so that you can justify your reasons should you be called upon to do so at a later date.

## Back to Mrs Smith

So how does this help me decide what to do with Mrs Smith?

***I clearly do not have her consent to go to the police with this information and there is no legislation which would compel me to breach her confidentiality. I must therefore decide whether the benefits of disclosure outweigh both the public and Mrs Smith's interest in keeping the information confidential. On reflection I consider that the disclosure might protect Mrs Smith from harm but not society in general, as there is no evidence that her husband is a threat to any other adult and I know that there are no children involved, so there is not a child protection issue.***

***GMC guidance on disclosures to protect the patient is quite clear: "It may be appropriate to encourage patients to consent to disclosures you consider necessary for their protection, and to warn them of the risks of refusing to consent; but you should usually abide by a competent adult patient's refusal to consent to disclosure even if their decision leaves them but nobody else at risk of serious harm. You should do your best to provide patients with the information and support they need to make decisions in their own interests, for example by arranging contact with agencies that support victims of domestic violence."***

***On balance I decide not to tell the police as I believe it is in Mrs Smith's best interests that she continues to have trust in me as her doctor at the present time and to destroy that would cause more harm. Over the next few months I continue to see her and with the support of a counsellor she eventually decides to leave her abusive husband.***

If you are ever in any doubt about confidentiality or whether you should disclose personal information about a patient without consent then please do not hesitate to pick up the phone to a medico-legal adviser at the MDDUS who, doctor-to-doctor, will guide you through your decision-making.

■ *Dr Susan Gibson-Smith is a medico-legal adviser at MDDUS*

# The medical textbook

*With the iconic* Davidson's Principles and Practice of Medicine *now in its 22nd edition is there a future for student textbooks in the digital age?*

IT'S hard to imagine what Stanley Davidson would make of medical education today with the vast ocean of information now available at a student's fingertips.

In the preface to the first edition of his renowned *Principles and Practice of Medicine*, published in 1952, he wrote: "no attempt should be made to describe every rare disease or syndrome, but to devote most of the space available to those disorders more commonly encountered in practice".

There can be little doubt it is the comprehensive yet encapsulated nature of the book – now in its 22nd edition – that has been a key factor in its enduring success.

"Students like to see the scope of what they need to know," says Pauline Graham, commissioning editor of another highly successful textbook, *Kumar and Clark's Clinical Medicine*. "They think, right, in five years I need to know that and I don't need to worry about anything else. Because there is so much information out there – their biggest problem is filtration."

I have come to the Edinburgh office of Elsevier to discuss the future of textbook publishing with Pauline, and Laurence Hunter, the commissioning editor of the last five editions of *Davidson's*. Both books are published by imprints of Elsevier.

"It's also about being authoritative and accurate," says Laurence Hunter. "Although students can quickly look up a topic on Wikipedia they also want to validate that information against another source like a textbook from a reputable publisher."

## Countering a trend

February 2014 saw the launch of the 22nd edition of *Davidson's* – a textbook that over its 62-year history has been owned by well over two million medical students and other health professionals around the world. Stanley Davidson held the Chair of Medicine at Edinburgh University from 1938 until his retirement in 1959 and was a gifted teacher. His typewritten systematic lecture notes – given out to students – formed the basis of the first edition of *Principles and Practice of Medicine*.

Generations of medical students have relied on the textbook to provide a solid foundation in clinical medicine. Over the decades the book has grown and developed with increasing input from its main "users" – students. The current edition of 1,392 pages was produced with a core team of four academic editors assisted by 56 contributors across the world. Sales of the last edition were higher than any other previous and expectations are that the current edition will exceed this figure. Much of the success in recent years can be attributed to growing international sales, especially in India.

But it would seem that a textbook like *Davidson's* is countering a trend. Sales of print products including books have steadily declined as more and more people get their information online. Journals were the first to make the transition and Elsevier was at the forefront of this revolution.

"The whole journals business went online easily," says Hunter. "With the dawn of eBooks and Kindles there was an assumption that there would be a similar transition to digital books. This was the future. But it hasn't worked out like that. It's proved much more complicated."

## An expensive luxury

Elsevier and other large book publishers have certainly had to respond to the new digital paradigm, says Hunter. "Many large professional-level clinical textbooks have moved to online delivery of content with the opportunity to keep these up to date much more easily."

The range of smaller medical textbooks for students and trainees has reduced considerably with much of this material being now free and easily accessible online. But the decline in print books for students and young doctors – at least those produced by larger publishers – is not all to do with technology.

"The average debt for a London medical student is now around £90K, and outside of London it's between £40K and £60K," says Pauline Graham. A shelf full of medical books has become a luxury many students can no longer afford.

"Everyone's focus is now on the bare minimum," says Hunter. "There are 120 pages in *Davidson's* on cardiology so students now ask why do I need a separate cardiology book? Plus the time that students spend in many clinical rotations has been reduced or completely removed. Subjects like surgery have almost become a postgraduate topic."

Another factor is the decline of the academic bookshop. Says Hunter: "Gone are the days when you could go into a campus bookshop and browse to see what was available in, say, paediatrics. That has had a considerable effect. Amazon tries very hard to replicate this with the 'Customers Who Bought This Item Also Bought' and 'Look Inside' facilities. But you still need to know what you're looking for."

With so many print titles now facing extinction is there still a requirement for "door-stop" medical textbooks like *Davidson's* and *Kumar and Clark*?

"Absolutely," says Pauline Graham. "Was it Twain who said rumours of my death have been exaggerated? It's exactly the case for medical textbooks. We've all be waiting for them to die. But as long as students perceive the need for an encapsulated, authoritative, one-stop shop that doesn't rely on electricity or a need to be insured to be taken out of the building, the printed textbook will

# is not dead

persist – though the number of titles and units will almost certainly shrink for developed markets."

## Digital future

Graham believes the future of the textbook will increasingly be hybrid products marrying up print with interactive digital content. The current 8th edition of *Kumar and Clark* is sold with access to an impressive online version featuring the full text and images, along with 30 extra short chapters covering additional non-core topics such as malaria, envenoming and HIV. It also provides animated practical procedures, such as lumbar puncture or arterial cannulation, an audio player for heart and lung sounds and interactive surface anatomy. The online version won first prize in the 'Digital and online resources' category of the 2013 BMA Book Awards.

Users can access the textbook via Elsevier's Student Consult website, which recently underwent a major upgrade in collaboration with eBook platform provider, Inkling. Apart from enhanced interactive features, one big plus of the new platform is that it is device neutral, allowing students to access the content from laptops, tablets or smartphones. *Davidson's* is also available on Student Consult.

However, print is still very much an important element of this hybrid, says Graham. "That's what's been so interesting. It's not us holding things back and being dinosaurs; instead students are saying 'I don't want my Davidson's or K&C only in electronic form. I do want it online so I don't always have to carry the book around, but this [the printed version] is my insurance policy for the lights going out or my laptop getting stolen or damaged."

Predicting just how textbook publishing might evolve further is not easy but cost is likely to be a major factor.

"There are already signs of change," says Laurence Hunter. "Students (outside of Scotland) having paid their tuition fees and turning up on their first day are handed a reading list and told to go off and buy a list of books. And they are saying: 'Hang on a minute. I just paid £9,000. Don't I get this as part of the package?' I think universities are going to have to up their game in information provision and might look to provide this as part of their service to students."

Such a development might mean selling libraries of content and allowing faculty to create their own course materials. Says Graham: "There would still be a future for the information we produce but the universities might take on the printing and distribution costs within their institutions and students will still get the information they want."

But both editors agree that no one model is certain. Recently Pauline Graham spoke at a Royal College of Physicians seminar on the future of medical publishing.

"One of the things I said at the RCP was that the short-to-midterm future of books is indicated by what's happening in schools now, as that will determine how the next generation of medical students expect to receive information. If it's by a mix of White Board, database, Wiki-sites, library and individual printed copies, that hybrid-delivery expectation will come with them to tertiary education."

So maybe the death of the medical textbook has indeed been exaggerated.

■ *Jim Killgore is editor of Summons*

# Is it melanoma?

Dr Niall Cameron *highlights some of the pitfalls in assessing the simple mole*

TOWARD the end of a straight-forward consultation, your tenth patient that afternoon adds: "by the way doctor my wife said I should show you this". "This" being a small slightly pigmented spot on his shoulder. "I think it has always been there but I'm not sure if it has changed. I wasn't going to bother you but you hear a lot about skin cancer these days." Some minutes later and now running late you have come to the conclusion that it probably is really nothing, but a dictaphone is at hand and a referral ensues.

Some weeks later a dermatology clinic letter informs you that a wide excision biopsy revealed a superficial spreading melanoma that has been completely excised. How to react? Congratulate yourself on your razor-sharp clinical acumen, have a philosophical discussion over coffee with colleagues about complexity and managing uncertainty or anxiously try to recall all the patients with equally benign looking skin lesions that you have simply reassured?

Very few GPs will not have experienced doubt or anxiety when a patient presents with what on first inspection appears to be a simple mole. Moles are extremely common – present either from birth or appearing later in life. Some can be relatively large and unsightly but the vast majority will be benign and require no intervention.

However, malignant melanoma is a relatively common cancer and it is also likely that most GPs can remember a patient who presented with an obvious melanoma. Differentiating between potential melanomas and simple pigmented lesions is a challenging but important task for GPs. The dilemma is how to ensure you don't miss a melanoma whilst not referring every pigmented lesion encountered.

## Knowing the risk

In 2003 it was reported that 95 per cent of skin lesions referred to a dermatology specialist were benign and a more recent study reported that GPs only recognised 66 per cent of skin malignancies. Appropriate referral has obvious clinical and resource implications. Failure to refer or arrange appropriate review is not an uncommon cause of complaint or even litigation. Unfortunately this is often exacerbated by a failure to make appropriate notes of the consultation.

The incidence of malignant melanoma has risen in most Caucasian populations over the last 30 years, and Australia and New Zealand have the highest incidence in the world. Malignant melanoma is the

third most common tumour in people aged 15-39 but the incidence increases with age and melanoma is most often diagnosed over the age of 60.

Melanomas can develop both in normal skin and existing moles. The majority of moles appear later in life and are classified as acquired melanocytic naevi. Moles which have been present from birth (congenital naevi) can be quite large, typically over 1 cm in diameter, tend to get bigger through life and are often dark and hairy. However, the risk of malignant change in pre-existing moles is well recognised and assessing the significance of this change is perhaps the most important challenge for GPs.

Melanoma is the least common form of skin cancer but it is the most serious and likely to spread. Prognosis can be significantly improved by early detection and this has resulted in an emphasis on early recognition and referral of suspicious pigmented lesions.

The main risk factor is sun exposure – particularly in childhood. It is worthwhile asking about time spent abroad when young and the association is greatest with a history of severe sunburn. Sun bed use should also be considered. People with fair skin that burns easily or never tans, blonde or red hair and blue or green eyes also have an increased risk of melanoma. A freckled complexion or more significantly large numbers (over 100) of common naevi are recognised risk factors. The presence of more than two atypical moles (bigger than usual with irregular shape or colour) is also significant. Other recognised risk factors include a family history of melanoma, particularly in first-degree relatives.

## Making a diagnosis

Melanomas can present in a wide range of colours, including light or dark brown, black, blue, red, light grey and occasionally can be non-pigmented; however, most melanomas will begin as a darker often small area of skin with the appearance of a slightly unusual freckle or mole. In women, melanomas occur more commonly on the legs (40 per cent) whereas in men the most common site is the back (40 per cent).

Suspicion should be raised if there is a change in size, particularly over a short period such as weeks or a few months. Melanomas are often asymmetrical in appearance, have a ragged border and although initially flat become thickened and raised. Any change in colour or the presence of inconsistent pigmentation is significant. Bleeding and crusting are late signs but are often present in advanced lesions. In contrast benign moles usually grow slowly, are round and even, and have a uniform colour and edge.

| Major Features | Minor features |
|---|---|
| ■ Change in size | ■ Oozing |
| ■ Irregular shape | ■ Change in sensation |
| ■ Irregular colour | ■ Inflammation |
| | ■ Diameter >7mm |

As in all areas of medicine, careful history and examination can help to reduce diagnostic uncertainty and ensure appropriate referral. The emphasis on early diagnosis has led to the development of useful guidelines to aid prompt recognition of suspicious changes. Reference to the criteria in these guidelines will also help to reduce the risk of complaint as they highlight features that should be recorded and signpost essential patient advice.

> "Melanoma is the least common form of skin cancer but it is the most serious and likely to spread."

The Glasgow seven point checklist was introduced in 1991 and identified major and minor suspicious features that should be looked for *(see table above)*.

The ABCDE checklist followed and offers a useful template for documenting a consultation with a patient with a pigmented lesion.

- Asymmetry – uneven or asymmetrical shape
- Border – a ragged outline
- Colour – inconsistent pigmentation
- Diameter – >6mm and usually continues to grow
- Evolving – any new symptom such as itching or change in size, shape or colour.

Not all patients will present with these signs and where patients have a number of moles they may share a broadly similar appearance. However, a melanoma will often have a different pattern than other naevi and this has been described as the "ugly duckling sign" and should prompt referral.

## Making the referral

Suspicious lesions should be referred urgently for specialist review within two weeks and most dermatology clinics offer an urgent pigmented lesion service. Removal with wide excision biopsy allows accurate staging if melanoma is diagnosed. Staging and prognosis are dependent on the thickness of the melanoma, whether the surface is ulcerated and evidence of local or distant spread. Prognosis is good in lesions confined to the dermis but penetration beyond the dermis and distant spread indicates a high risk of recurrence and a poor prognosis.

Patients with an atypical naevus (the ugly duckling) or a large number of common naevi should be referred for specialist assessment, and annual photographic surveillance is now commonly used. Patients with obviously benign lesions can be reassured but should be given clear advice about self examination and sun protection.

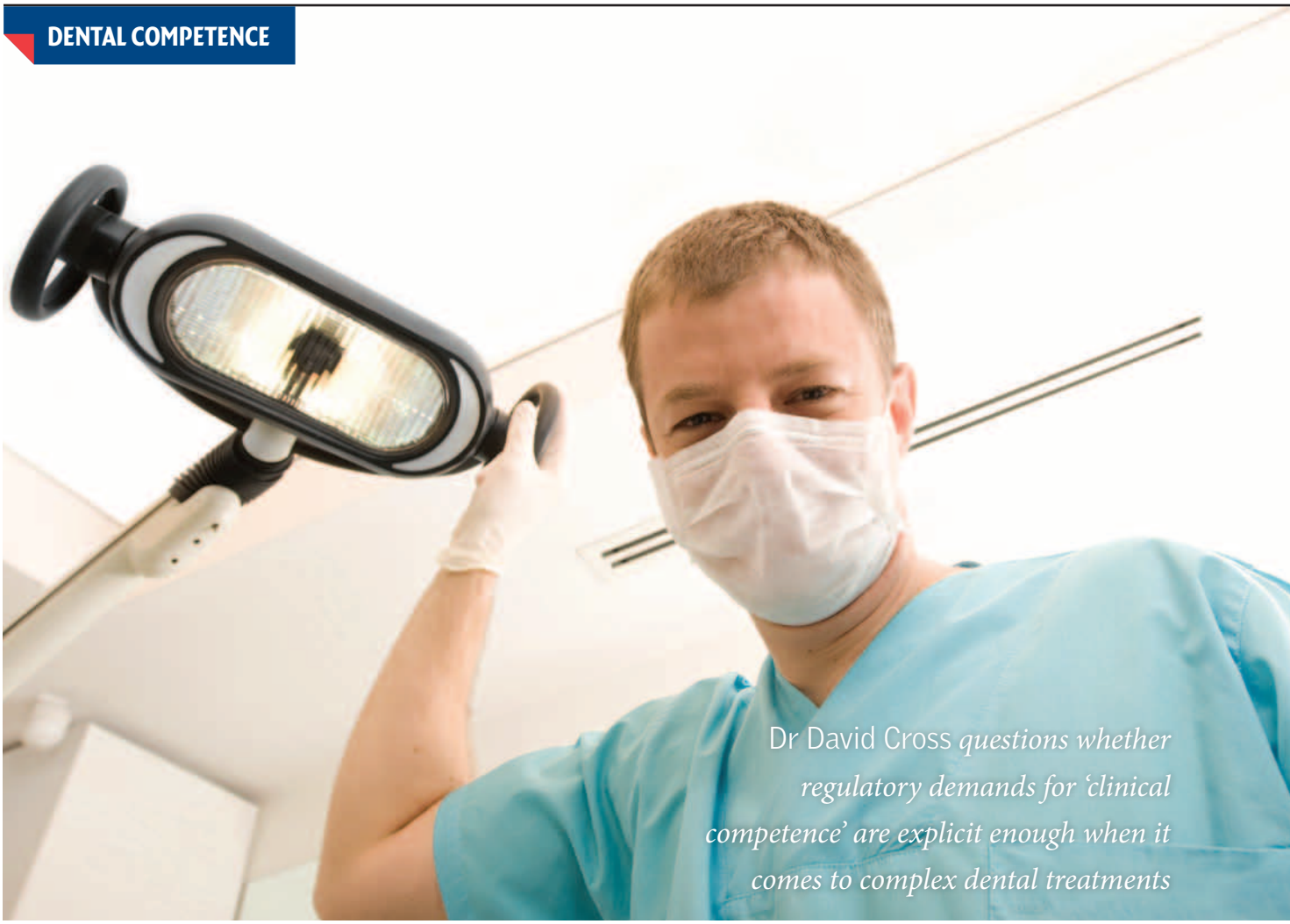
Patients without an obvious melanoma at first inspection may need follow-up in primary care, and careful recording of the appearance of the lesion including measurement is important. The timescale for arranging review is likely to be dependent on the level of doubt and patient anxiety. The possible rapid progression of melanoma should be borne in mind and follow-up arrangements should be clear and documented. Digital photography against a ruler is a reasonable precaution. Dermoscopy (an illuminated magnifying device) is commonly only used by doctors with a special interest in dermatology who have been trained in the technique.

Biopsy of pigmented lesions is inappropriate in general practice unless the doctor has received proper training and appropriate facilities are available. Moles should never be treated with cryotherapy.

Managing uncertainty in general practice is a perennial and challenging problem that is exacerbated by continuing pressure to refer appropriately whilst minimising risk. When dealing with pigmented lesions GPs should continue to refer for specialist review where doubt exists.

■ ***Dr Niall Cameron is a GP and medico-legal expert in primary care***

PHOTO: JOTI/SCIENCE PHOTO LIBRARY



Dr David Cross *questions whether regulatory demands for 'clinical competence' are explicit enough when it comes to complex dental treatments*

# Working within ability

THE GDC recently published its *Standards for the Dental Team* – a revised version of the document that governs behaviour and provides guidance that all members of the dental team must adhere to. These standards are divided into nine main principles that could all be said to flow from Principle One which is "Put patients' interests first". Throughout the *Standards* document the term 'must' is used where the duty is compulsory.

The clinical standards laid out in the GDC document under Principle Seven require that: "You must provide good quality care based on current evidence and authoritative guidance. Work within your knowledge, skills, professional competence and abilities. Update and develop your professional knowledge and skills throughout your working life".

Further help in interpreting the guidance can be found in note 7.2.1 which states:

"You must only carry out a task or type of treatment if you are appropriately trained, competent and indemnified. Training can take many different forms. You must be sure that you have undertaken training which is appropriate for you and equips you with the appropriate knowledge and skills to perform the task safely."

At first glance this seems reasonable and appropriate. After all, the aims of the GDC are to protect patients and regulate the dental team. However, on reflection, problems exist with the GDC's wording of the clinical standard. Whereas the use of the terms 'must' and 'should' are clearly defined in the standards document, there is no definition of clinical competence.

## Rigorous training in complex skills

According to the *Standards*, it is left to the individual practitioner to decide on the appropriateness and level of training that establishes clinical competence. It is therefore up to the individual to decide on all aspects of the training, for example the duration, content and whether clinical or non-clinical. Finally, it is also up to the individual to decide upon what method of assessment, if any, will be used to establish their clinical competence.

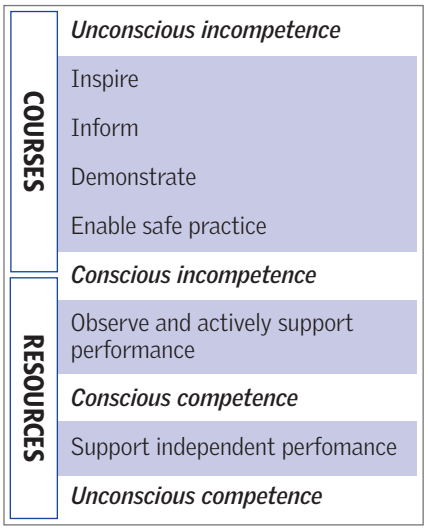
This approach is appropriate for minor skills and refreshing every day clinical techniques but is inadequate to establish clinical competence for more complex skills. In order to be deemed competent at any particular complex clinical task, such as orthodontics, dental implants or IV sedation, a more prolonged period of clinical training under supervision followed by assessment is necessary to adequately ensure competency has been achieved. The clinical knowledge required to use these new skills adequately in complex cases can only be achieved through clinical practice and experience over time.

For example, in higher specialist training in the UK the trainee first has to gain entry to

the specialty, which is increasingly competitive. There then follows three to five years of training under close clinical supervision with assessments throughout before a final examination is undertaken at one of the Royal Colleges. These examinations undergo rigorous standard setting to ensure fairness and validity.

This training is often linked with a higher degree at university so that research training is undertaken at the same time. This has the benefit of introducing the candidate to skills in critical appraisal, enhancing the newly qualified specialist's ability to continue life-long learning through reading the latest research and studies. The practitioner can then make a judgement on newly published scientific information for the benefit of their patients. These postgraduates have learned the necessary clinical skills and have been assessed competent by an external examining authority.

This rigorous training has to be compared to that provided by short courses in some areas of special interest. These can range from a single day or weekend courses, or extended tuition over several weekends throughout a year. The majority of such courses are an essential part of life-long learning and can stimulate interest and invigorate practice, allowing the practitioner to develop new skills and interests. However, some of these courses promise more than they can deliver and encourage the general practitioner to undertake more complex treatments than they otherwise might. More often there is no assessment of competence of these new skills and little or no local support if things go wrong during subsequent treatment. With no assessment of competence how can practitioners claim to be competent in these complex skills?




**The Four Stages of Competence (after Clive Shepherd[1])**

## Progression to competence

According to the Conscious Competence Learning Model (see figure), there are four stages in progressing from incompetence to competence in a skill. The 'unconsciously incompetent' stage is where everyone starts with regard to a new skill. Although the person is bad at the new skill they are completely unaware of how bad they are. Indeed, it is not uncommon for them to think they are actually pretty good at it.

The next stage is 'conscious incompetence', where they have realised that there is much more to what they are trying to do. At this stage the person may become overwhelmed by what seems to be a vast area of knowledge that they were previously unaware of.

Then comes the stage of 'conscious competence', where the person has started on the path of learning and their skills improve but they are slow at tasks. Eventually the individual reaches the stage of 'unconscious competence' where they possess all the necessary skills and can utilise these with ease and speed. From the figure it is clear that short courses on complex clinical skills can inspire and inform but leave the individual at the unconsciously incompetent stage with regard to these new skills.

> "With no assessment of competence how can practitioners claim to be competent in these complex skills?"

## Risk to patient and dentist

The GDC will not act unless a complaint is made but patients could be at risk from ill-judged and over-confident treatment planning. Meanwhile the over-confident unconsciously incompetent practitioner is also at risk from litigation as a result of negligence if things go wrong. The standard of care in any resulting claim for negligence will be judged against what any reasonable practitioner of equal knowledge, skills and experience would provide. If specialist treatment is being provided, the standard of care would be what a specialist would provide. It is likely to be easy to prove that this standard was not met if clinical experience is limited and the practitioner has embarked upon an over-ambitious treatment outwith their skills and experience.

The GDC *Standards* also states in paragraph 7.2.2: "If you are not confident to provide treatment, you must refer the patient to an appropriately trained colleague". This means that if you refer a patient for treatment you have a duty to refer them to someone who has had the appropriate training and 1.7.6 states: "you must make sure that the referral is made in the patients' best interests rather than for your own, or another team member's financial gain or benefit". In the eyes of the GDC, the incompetent practitioner and the referring practitioner will be at fault.

The number of clinical negligence claims and referrals to the GDC is on the rise with an increasing cost to the profession. The MDDUS has observed a 16 per cent increase in civil negligence claims year on year for the past five years, and the number of cases brought before the GDC has increased 39 per cent year on year for the last five years. These trends are unlikely to change whilst the clinical standard with regards to competency, set by the GDC, remains vague. Can the defence societies continue to afford to provide indemnity for everyone regardless of skills or experience?

Currently MDDUS provides a scale of indemnity for members depending upon their procedures undertaken. In the future, it may be necessary for practitioners to declare their training and experience each year to allow their risk profile to be accessed and an appropriate subscription applied. High-risk practitioners with little or no experience may find it costly to find indemnity with any provider and very high-risk practitioners may find they have to reply upon insurance policies at high cost. The prohibitive cost of such insurance policies may mean high-risk practitioners are unable to practice in these more complex areas, but on the plus side patients will be protected.

■ ***Dr David Cross works part-time in specialist orthodontic practice and is a senior clinical university teacher at the University of Glasgow Dental School and an honorary consultant in orthodontics***

## Reference

1 http://clive-shepherd.blogspot.co.uk/2011/02/fresh-thoughts-on-competence-and.html

# CASE studies

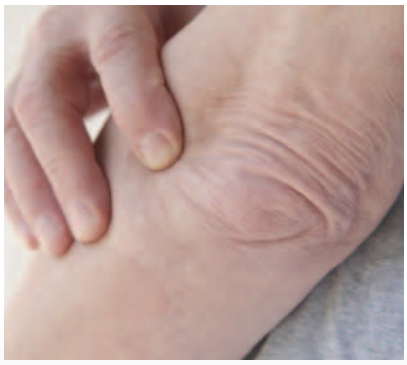
These studies are based on actual cases from MDDUS files and are published in *Summons* to highlight common pitfalls and encourage proactive risk management and best practice. Details have been changed to maintain confidentiality

## TREATMENT
## PAINFUL ELBOW

**BACKGROUND:** Mr D is a keen golfer and attends his local GP surgery complaining of a very painful elbow with limited movement. He is seen by one of the senior partners – Dr L – who makes a diagnosis of epicondylitis. Dr L discusses treatment options with the patient and, given the severity of the pain, recommends a steroid injection. This is administered in the joint along with an anaesthetic.

Two months later Mr D re-attends the surgery with "dimpling" and texture changes of the skin around the injection site. Dr L explains to the patient that this is caused by loss of fatty tissue (atrophy) and is a recognised complication of soft tissue steroid injection.

Six months later the surgery receives a formal letter of complaint from Mr D in regard to Dr L's "substandard" treatment. He states that in the weeks and months after the injection he has experienced pain and discomfort, and that the skin over the injection site has "shrunk" and grown discoloured.



Mr D also complains that he had not been warned of the risks associated with the procedure.

**ANALYSIS/OUTCOME:** MDDUS provides Dr L with advice on his response to the complaint. In the letter the GP expresses his sincere concern and regret for the complication. He states that he has performed many such procedures in the past and has never had a patient suffer steroid-associated fat atrophy.

His understanding was that this complication was most commonly related to superficial injections and that he was confident his standard technique avoided the possibility. For this reason he did not routinely inform patients of the risk of fat loss.

In closing Dr L again offers an apology for the incident and states in future he will inform patients undergoing steroid injections of the full risks attendant to the procedure. He also informs the patient of his right to take the complaint to the local ombudsman if dissatisfied with this response and provides contact details.

Mr D later emails the surgery to say he is satisfied with Dr L's response and will not be pursuing the matter further.

**KEY POINTS**

- Ensure that relevant risk factors are part of routine consenting for procedures.
- Often a sincere apology is enough to prevent a complaint escalating into a legal claim.

## PRACTICE POLICY
## ENTITLED TO CARE

**BACKGROUND:** A PATIENT, Ms D, has been undergoing treatment for pancreatic cancer for several weeks. Her practice has recently been informed by the UK Border Agency that she failed in her bid for residency a number of months ago and, as such, is officially an "illegal immigrant" who is not legally entitled to free NHS care.

The practice has a policy of checking all patients' identification and any relevant visas in order to provide NHS care only to those who are entitled to it. Unaware of Ms D's status, however, the practice had registered her, and her GP then referred her for secondary care.

The practice manager, Mr L, has since been contacted by a hospital official who is seeking confirmation that, given Ms D's illegal status, the practice will fund her care. Mr L is unsure of how to proceed with providing care for Ms D and contacts MDDUS for advice.

**ANALYSIS/OUTCOME:** An MDDUS adviser discusses the issue with Mr L and agrees that it would be unreasonable to expect the practice to fund Ms D's secondary care. The practice are advised to continue providing any immediately necessary treatment to the patient and Mr L should contact the local clinical commissioning group (CCG) to clarify

## RETAINED CANINE

**BACKGROUND:** A 13-year-old boy, Jack, has attended the same dentist – Mr A – since he was a toddler with no major treatment issues. His family moves to a different city and Jack goes to a new dentist – Ms T – for a routine check-up.

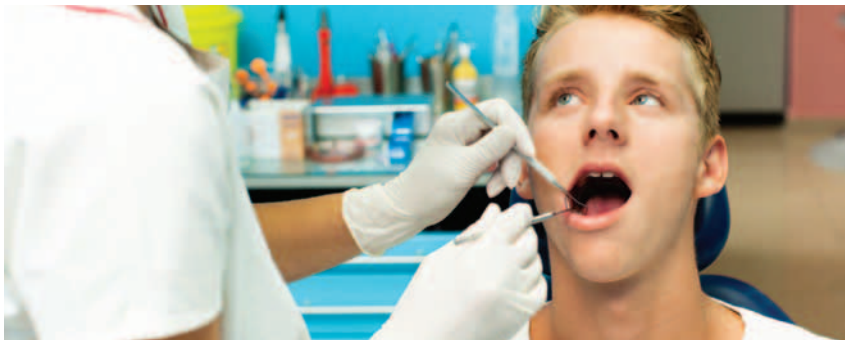
Ms T examines Jack and takes an X-ray. She finds the upper right canine (13) is unerupted and fused in the bone. A possible cyst is noted at the side of the tooth. Ms T refers Jack to the local dental hospital.

Further clinical and radiological examination confirms the presence of a canine tooth retained in the alveolus with a possible associated cyst. It is also clear there has been extensive apical root resorption of the adjacent teeth 11 and 12.

Jack returns to the outpatient unit at the hospital where the buried tooth is surgically removed and the associated cyst enucleated under general anaesthesia. Jack then returns to Ms T and is fitted with a single tooth upper denture to fill the gap.

Jack and his mother are also informed that the prognosis for teeth 11 and 12 is very poor and that extraction and replacement by implants may be necessary. Should the tooth need to be extracted before his eighteenth birthday a temporary removable denture will be necessary to allow for tissue to heal and the full development of the upper arch.

One year later a letter from solicitors acting on behalf of Jack is received by Mr A – the boy's former dentist – in pursuit of damages in relation to the unerupted tooth. It is alleged that Mr A neglected to carry out a visual examination or take radiographs that would have detected the ectopic canine.



**ANALYSIS/OUTCOME:** MDDUS acting in support of Mr A commissions expert reports in regard to Jack's treatment. Patient records show that Jack visited the dental surgery at regular six-month intervals from the age of three until he moved from the practice at age 13. These were mainly for check-ups but also three small fillings were provided over the period. There are no written records for dental visits after the age of nine but NHS claim forms confirm Jack attended for regular check-ups over that period. There is no record of any radiographs taken of Jack by Mr A.

A consultant orthodontist offers the opinion that around the time Jack reached the age of 10 Mr A should have checked and recorded the presence of unerupted canine teeth. This would have included a visual examination and palpation of the area. Mr A counters he does that routinely with all his young patients. But the expert also states that if a canine could not be palpated then radiographs should have been taken.

On the question of whether the root damage to 11 and 12 was caused by the missed diagnosis the expert believes it is impossible to say. Root resorption could have occurred before the age of 10 but it is also possible that early intervention may have prevented or reduced the amount of damage. Without contemporaneous radiographs it can only be speculation.

The expert concludes that the treatment provided by Mr A fell below a reasonable standard in not carrying out a proper clinical examination. The lack of adequate clinical records or radiographs also makes it impossible to determine if this negligence contributed to the damage.

Given the clear uncertainties in the case, MDDUS offers to settle the case with agreement from Mr A.

### KEY POINTS

- Assessment of presence/position of upper canines should take place at 9-10 years and certainly before age 11.
- Inability to palpate canines before age 11 calls for further investigation.
- Clear records of each consultation are essential not just in adequate ongoing clinical assessment but also ensuring a sound legal defence.

what this level of treatment would involve. The CCG should also be able to explain who is responsible for the cost of providing Ms D's care.

Until the CCG reaches a decision, the practice should continue to keep Ms D on their list and to meet her clinical needs as far as possible under the circumstances. The practice is reminded of General Medical Council guidance which states that doctors must "never discriminate unfairly against patients or colleagues", adding: "You must give priority to the investigation and treatment of patients on the basis of clinical need, when such decisions are within your power".

The adviser also cautions Mr L that MDDUS has defended cases on behalf of members where refusing or delaying treatment on the basis of eligibility has led to claims of negligence.

### KEY POINTS

- Patients must be treated on the basis of clinical need, rather than on their eligibility for free NHS care.
- Ensure that any requests for identification, etc, are made of all patients equally.
- Assessments of eligibility for care should be made by non-clinical staff such as the CCG/trust/health board

# From the archives:
## The Peculiar People

**PARENTS** refusing medical treatment for children is certainly nothing new to legal courts. In August of 1874 the *Scotsman* newspaper reported on the case of a "working man" named Thomas Hines who was tried at the Central Criminal Court in London on the charge of manslaughter in the death of his two-year-old son Joseph.

Thomas belonged to a puritanical religious sect known as the Peculiar People. It was an offshoot of the Wesleyan denomination founded by John Banyard in 1838 – the name taken from the book of Deuteronomy to denote 'chosen people'. The sect practised faith healing and did not believe in seeking medical care.

The court heard that Joseph took ill with "inflammatory symptoms" and his father neglected to seek medical assistance. The presiding judge – Mr Baron Pigott – expressed doubt at the outset of the case and remarked that "at one time it was considered that when death arose from the administration of homeopathic medicines it amounted to the worst description of manslaughter".

Witnesses testified that Thomas Hines attended to the child in every respect apart from calling a doctor. Medical evidence was provided by a Dr Sharp who said that in treating the child he would have employed leeches and probably calomel with the object of reducing the inflammatory symptoms. Pressed by Mr Piggot the doctor admitted that many medical men would object to administering calomel, and homeopathic physicians would think it madness to use leeches.

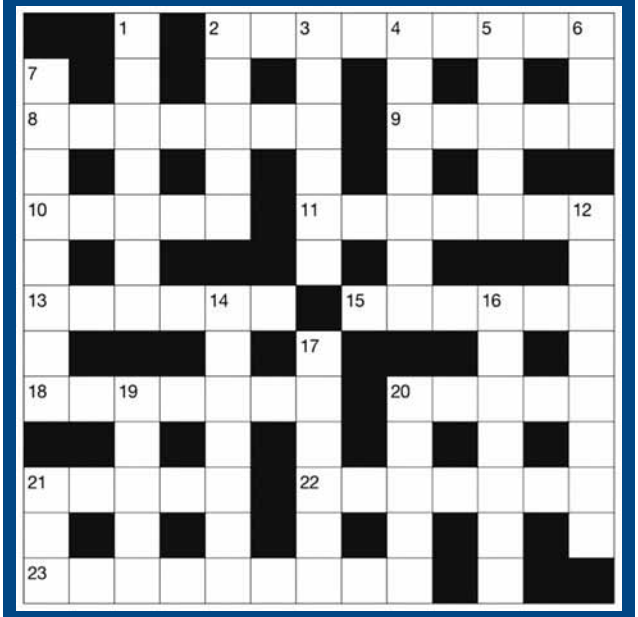
Baron Piggot, at the close of evidence, expressed his opinion that "no culpable negligence" had been proved and he directed the jury to return a verdict of not guilty. Thomas Hines was ordered to be discharged.

But other cases involving the Peculiar People exposed inconsistencies in the way courts dealt with such cases at the time. In 1875 another member of the sect named Robert Downes was found guilty of manslaughter in not calling for a doctor to attend his sick child but relying on the power of prayer. Presiding judge Bramwell cited statute law in ruling on the case: "When any parent shall wilfully neglect to provide adequate food, clothing, medical aid, or lodging for his child, being in his custody, under the age of fourteen years, whereby the health of such child shall have been, or shall be likely to be, seriously injured, he shall be guilty of an offence punishable on summary conviction."

Bramwell further ruled that there was "an absolute duty upon parents, whatever their conscientious scruples may be. The prisoner, therefore, wilfully – not maliciously, but intentionally, disobeyed the law, and death ensued in consequence. It is, therefore, manslaughter".

*R v Downes* was a landmark ruling often cited in later cases involving medical neglect of children.

## Crossword



**ACROSS**
**2.** Free floating cell (9)
**8.** Extreme fatness (7)
**9.** Longest part of small intestine (5)
**10.** Virus deadly to primates and humans (5)
**11.** Measurement of optical power in lens (7)
**13.** Solid excreta (6)
**15.** Hard tooth covering (6)
**18.** Frankness (7)
**20.** Birthmarks (5)
**21.** Genetic syndrome (5)
**22.** Surgical scraping instrument (7)
**23.** Collections of pus from bacterial infection (9)

**DOWN**
**1.** Trembling effect (7)
**2.** Porcelain (5)
**3.** Capital of Saudi Arabia (6)
**4.** Mythical one-horned beast (7)
**5.** Moved with stealth (5)
**6.** Type of tree (3)
**7.** Scientific method applied to crime solving (8)
**12.** Major waterway in NW California (3,5)
**14.** An inspection (colloq.) (7)
**16.** Eminent conductor (7)
**17.** Rumpus (6)
**19.** Amphibians (5)
**20.** External parts of nostril (5)
**21.** Computer privacy law (abbr.) (3)

See answers online at www.mddus.com.
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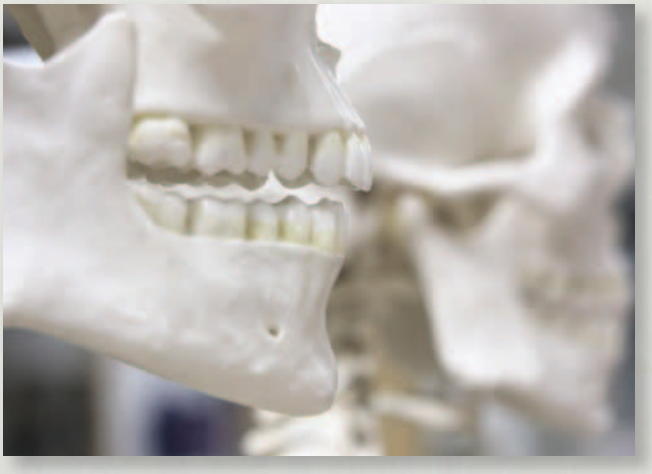
# Object obscura:
## Chest pencil

**IT IS** estimated that over 41,000 British service men lost one or more limbs in the First World War. Most of these patients could be fitted with standard prosthetic limbs but sometimes makeshift solutions were required for soldiers with more severe injuries in which no limb stump remained. This crude invention was made for a man who had lost both arms at the shoulders. A pencil attached to a wooden dowel fixed on a disk was strapped around the chest. The man could (with no doubt great difficulty) write messages on a fixed sheet of paper using the motion of his torso.

PHOTO: SCIENCE MUSEUM, LONDON, WELLCOME IMAGES

# Vignette: pioneering forensic odontologist Warren Harvey (1914-1976)



ON the morning of August 7, 1967, a 15-year-old schoolgirl was found murdered in a small Scottish town. She had been beaten and strangled, and her right breast appeared to have a bite mark. If a single case can define a career, what was to become known as the Biggar murder would define that of Dr Warren Harvey.

Born in Staffordshire, Harvey was the elder son of a doctor. He was educated at Shrewsbury and then moved south to obtain his medical and dental degrees at Guy's Hospital. He spent the war as a dental officer in the RAF and afterwards built a successful private dental practice in London, as well as being consultant dental surgeon to the Royal Masonic Hospital in Hammersmith. In 1962 he was diagnosed with the throat cancer that would force his early retirement two years later. He moved from the bustle of London to the Ayrshire coast, but his retirement was short-lived. Soon after moving to Scotland he was recruited by the Glasgow Dental Hospital as locum consultant and as lecturer in the Department of Dental Surgery at Glasgow University – posts he would hold for the next 10 years.

It was while working in Glasgow that he was asked to consult on the Biggar murder – a case which the judge would describe as "grave, serious and in some ways unique". The victim, Linda Peacock, from the small Lanarkshire town of Biggar, had been assaulted in the town cemetery. Although she had not been raped there was clear evidence of a sexual motive for her attack – in particular the bite mark on her right breast was the most important clue. The bite, because of its shape, was obviously not that of an animal and could not have been self-inflicted because of its position. The investigating team quickly realised that the girl's killer had left his dental "fingerprint" behind.

The close proximity to the murder scene of an approved school for juvenile convicts presented an obvious line of enquiry for the police. Some 29 inmates and staff were identified as suspects and dental impressions were taken of their teeth. These impressions were anonymised and Harvey and his colleagues studied them, excluding all but five suspects, who gave further impressions.

A single set – Number 11 – was consistent with the bruising on Linda Peacock's breast. Only at this point was the code broken and Harvey informed that these were the impressions of 17-year-old Gordon Hay. Harvey sought a warrant to examine Hay's teeth for a third time, which was granted by the sheriff.

The main evidence linking Hay with the murder was the unusual pattern of bruising associated with the bite mark – small, ring-shaped contusions with pale centres. Hay's teeth showed signs of cuspal maldevelopment with a raised circular edge – exactly the pattern that might have caused the unusual bruises. But if the court was to be convinced of Hay's guilt, Harvey would have to show that such a dental defect was uncommon. Harvey studied 1,000 canines in almost 350 boys aged 16-17 and found only two teeth with pits similar to those of Hay and none in opposing canines in the same mouth.

At the trial the following spring, Harvey presented this evidence along with detailed expert testimony on the links between Hay's impressions and the bruising. He had spent over 400 hours preparing the case and would spend almost five hours in the witness box.

It took the jury just two and a half hours to find Hay guilty of murder and because he was under 18 he was not given a life sentence but ordered to be detained at Her Majesty's pleasure.

This was the first case in Scotland where the Crown relied on forensic odontology and the first in the UK where a murder conviction was secured based on the characteristics of a bite mark. Forensic dentistry was not completely new to the courts but it was still contentious. In his instructions to the jury the judge counselled: "the law must keep pace with science...it usually lags a little behind but it does progress as scientific knowledge itself advances."

Harvey's continued ill-health finally forced him to retire properly in 1974 and he moved back close to his roots in the Welsh hills, where he died two years later.

His long-awaited textbook, *Dental Identification and Forensic Odontology*, was published just two weeks before his death. Unfortunately, he did not live to see it hailed as a classic, but his commitment to clinical research continued to the end and he bequeathed his body to medical research.

Despite being debilitated for 14 years by his cancer and its treatment, Harvey was able to develop and dominate a second career. He is rightly regarded as one of the founding fathers of forensic odontology in the UK and his work on the Biggar murder case as a watershed for that specialty.

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

## Sources


- F.G McDonald
- Obituaries: The Probe July 1976 and British Dental Journal June 1976.
- Harvey W et al. The Biggar Murder. J Forensic Sci Soc. 1968; 8:157-219.
- Archives, University of Glasgow

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