SUMMER 2014

SUMMONS

AN MDDUS PUBLICATION FOR MEMBERS

• A question of candour • Diabetes: diagnostic pitfalls • The general's toothache •

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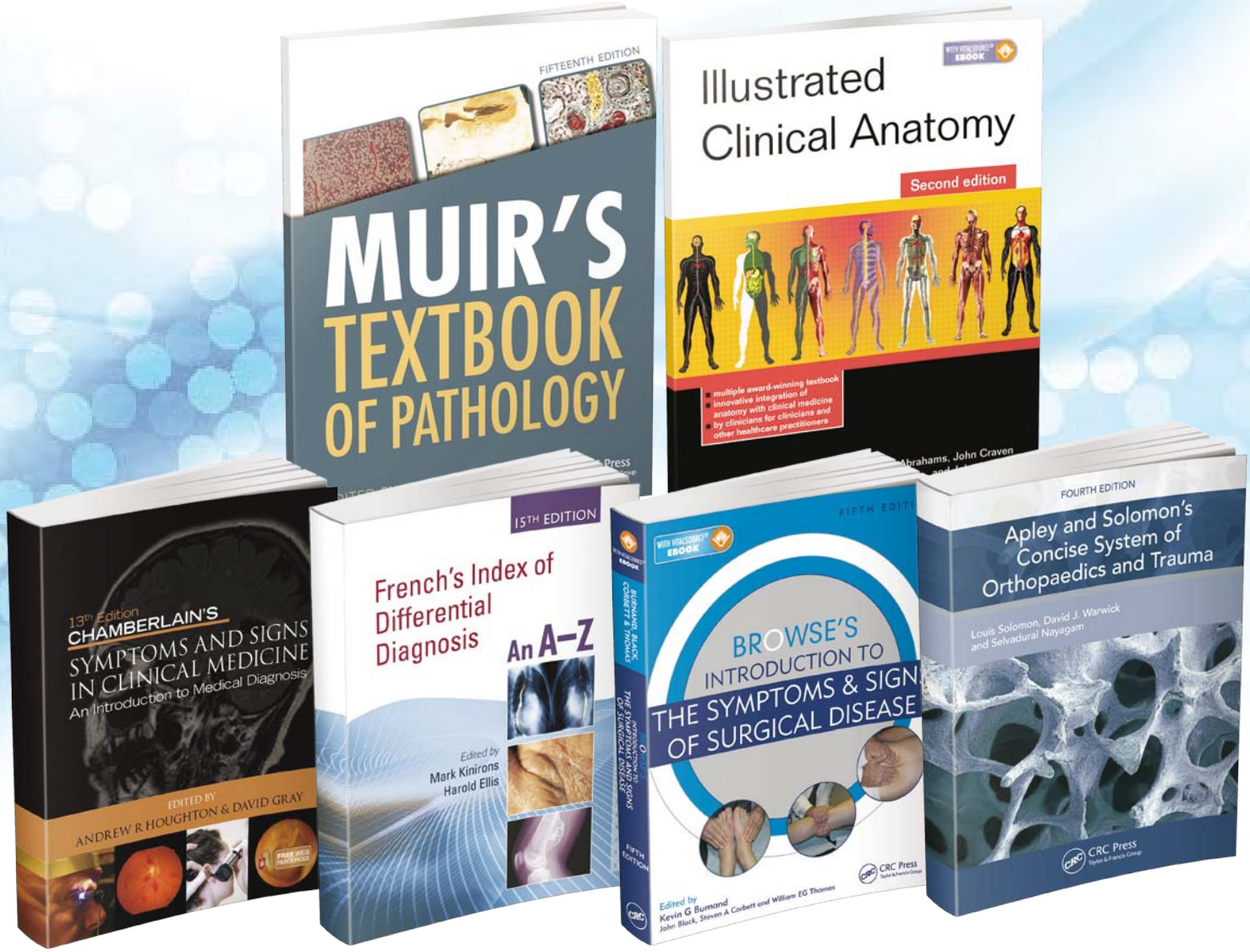

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IN THIS ISSUE

IN 2004 a 69-year-old patient named Mary McClinton was admitted for treatment of a brain aneurysm at Virginia Mason Medical Center in Seattle. During a diagnostic procedure an antiseptic solution was mistakenly injected into the patient's femoral artery. It later emerged that the hospital had recently changed its standard antiseptic from a brown iodine-based liquid to a colourless solution which looked identical to the marker dye used in vascular procedures.

Rather than going on the immediate defensive the hospital took the unusual step of making a public explanation of what went wrong and apologising to the McClinton family. This *mea culpa* was product of a policy of openness and a safety culture at the centre which has since been heralded around the world.

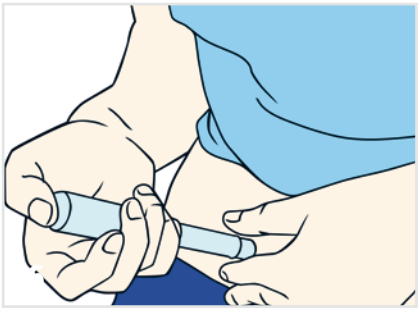
So it was no coincidence that in March of this year Health Secretary Jeremy Hunt used the occasion of a speech at the Seattle hospital to launch plans to introduce a duty of candour along with other steps to reduce avoidable medical harm. On page 12 of this issue, solicitor Majid Hassan looks at plans for a statutory duty of candour and how these might be implemented.

Our Q&A on page 10 features Professor Steve Field, currently CQC chief inspector of general practice but also a key figure in NHS reform in England. The importance of having a chaperone policy for all patients – no matter what gender – is highlighted in our advice feature on page 14. And on page 16 Professor Mark Strachan discusses why diagnosis in cases of diabetes is not always straightforward.

Page 18 features a tale from the First World War of a French-American dental surgeon who reputedly treated a toothache suffered by General Douglas Haig and earned a footnote in the history of the Royal Army Dental Corp – not to mention doing pioneering work in facial reconstructive surgery.

And on page 9 medical ethicist Deborah Bowman offers an alternative summer reading list.

Jim Killgore, editor



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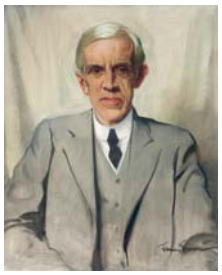

'Courtyard' by Jean Irons
Oil on canvas; 1999; 182 x 182 cm

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

Dual membership of defence organisations

MDDUS would like to remind members that they must not hold membership with any other medical or dental defence organisation. Problems may arise in the event of a claim if dual membership is held.

This means you cannot hold coverage with different defence organisations for particular professional roles, for example sessional GP work under MDDUS and locum work under another MDO.

Please contact our Membership Team on 0845 270 2038 for any clarification on this point.

Come fly with MDDUS 'Risk Factor'

MDDUS Risk Management has launched an exciting new programme format called "Risk Factor," featuring a series of specially commissioned video interviews with guest speakers discussing various risk-related topics. Each interview is hosted by one of our experienced MDDUS risk advisers and the aim is to help members understand and manage risk in their day-to-day practice and environments.

In the first interview, Mr Aubrey Craig, Head of Dental Division (above), discusses the importance of good record keeping in the light of revised and extended guidance for dentists from the GDC. Risk adviser Alan Frame poses the questions.

Alan also speaks with long-standing MDDUS collaborator Phil Higton. Phil is a former training captain with British Airways who now runs a successful training company, Terema, specialising in the provision of bespoke training to NHS clinicians on how lessons learned from examining error and human factors within the aviation industry can be transferred to a healthcare environment.

MDDUS members can find the video modules on the Risk Factor page in the Risk Management section of **mddus.com**. You will need your membership number in order to access these resources. MDDUS Risk Management can provide members with CPD verification for all of our risk video modules: just contact **risk@mddus.com** with the title of the module(s) viewed.

Are you ticking the right boxes?

DOCTORS could face a potential negligence claim by simply ticking the wrong box on patient assessment forms. MDDUS has seen an increase in calls from members facing patient complaints due to errors filling out forms – with the completion of HGV licence applications proving particularly problematic due to recent changes in the format.

While analysing MDDUS cases against GPs involving communication errors, risk adviser Alan Frame found that 10 per cent featured mistakes on assessment report forms. Some occurred simply because a doctor ticked a wrong box or missed out important information on a form.

"There is always a risk of human error – especially when resources are stretched. Our experience tells us that even routine tasks in a busy practice can have consequences for doctors," said Frame.

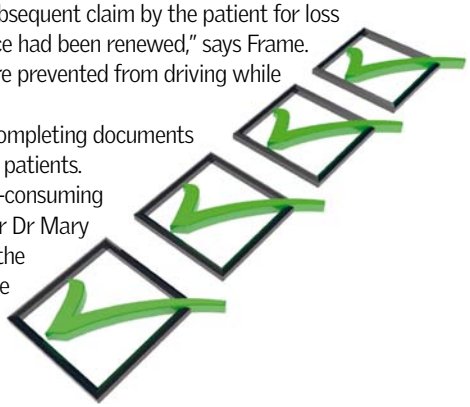
"Lapses in concentration and poor attention to detail can have a serious effect on quality and safety. The chance of a simple error occurring increases when undertaking tasks that may be repetitive and routine in nature."

Sometimes errors on forms, such as HGV licence renewals, can have serious implications for patients.

"One resulted in the licence being rescinded and a subsequent claim by the patient for loss of earnings as they were unable to work until the licence had been renewed," says Frame. "In extreme cases, patients can lose their jobs if they are prevented from driving while the matter is resolved."

MDDUS is reminding doctors of the importance of completing documents carefully when providing information about or for their patients.

"Filling out these forms may sometimes seem a time-consuming task of low priority for a busy GP," says MDDUS adviser Dr Mary Peddie. "After all, a doctor's main focus is on providing the best possible care for their patient. However, if you have agreed to undertake an assessment, this should be done in a timely manner, taking care to ensure that all relevant information is provided accurately."



Private GP indemnity

PLEASE note a separate subscription rate exists for those members working in a private GP capacity, where the GP may be seeing patients outwith an NHS setting, such as a private clinic or walk-in centre.

Likewise, our standard GP and private GP rates no longer provide indemnity for cosmetic surgery procedures, with the exception of Botox and other nonpermanent fillers.

GP members unsure of their indemnity cover or with any other questions regarding subscription rates should contact the Membership Team on 0845 270 2038.

Winners honoured at BMJ Awards 2014

THE inspirational work of doctors and their teams was showcased at the 2014 BMJ Awards in London on May 8.

Now in their sixth year, the awards took place at the Westminster Plaza Hotel, London, and were hosted by author and broadcaster Gyles Brandreth.

MDDUS was proud to be both principal

IN BRIEF

● **ARF REMINDER** Dental care professionals (DCPs) are being reminded to pay their annual retention fee to the GDC by 31 July 2014. Payment must be received on or before that date to remain on the GDC register and be eligible to work. No payments can be processed after the deadline. Those registrants removed for non-payment will also incur further costs if they apply to restore their name to the register. Go to **www.gdc-uk.org**

● **GP TRAINING GUIDE** The RCGP has published a complete guide to GP training and the early years after. The book offers pragmatic advice and tips on all stages of training, covering hospital rotations, general practice training in the community, the transition to becoming an independent practitioner and the various methods of assessment employed by the RCGP. It also offers advice on getting a job, practice finance, locuming, appraisal and revalidation

BLOG

By Dr Gail Gilmartin, Medical and Risk Adviser at MDDUS

Records – friend or foe

Consider this scenario – several months after a consultation a patient complains to the GMC that you behaved inappropriately during an examination. You robustly deny these allegations and immediately review your records for the relevant period. You are horrified to find that there is only the briefest entry regarding a cough and clear chest on examination. You have one of those "if only...." moments.

There are no witnesses and so to ascertain the truth the matter proceeds to a panel hearing at the GMC.

You consider that the quality of the records lets you down but you must deal with this honestly and openly in any future discussions – and there will be many. Certainly the records must not be altered with a view to "improving them" retrospectively. There lies the way to jail and serious GMC sanction.

In circumstances where the patient or their representative challenges the standards of care, medical records will be scrutinised by various third parties. Also patients increasingly seek access to their notes – because they are just interested or they require information for purposes such as checking dates for insurance forms, etc.

Most practitioners do not consider that their records will be seen, analysed and discussed in minute detail by third parties such as solicitors, barristers, medical experts or panel members (for inquiries including the GMC).

Medical records will be obtained and reviewed when determining whether a doctor has acted in line with their professional and legal duties. Indeed, the first impression you make is likely to be through your records – the care demonstrated in record making will often be taken as a direct reflection of the care provided to your patient. Would you be happy for your notes to be shared and discussed amongst a group of expert lawyers and doctors? Are you happy for the patient to see what you have written?

The GMC states that notes must be:

- Detailed
- Clear
- Accurate
- Legible.

They should be dated and timed, and contain all clinically relevant information including negative findings and decisions.

Few (if any) doctors say they wish they hadn't written so much but many reflect that they wish they had written more. This is especially true where a patient brings two issues to a consultation and one is well documented but the other less so; also when a standard form of treatment is considered and rejected but this is not recorded.

The matters not included in the records are often central to a question of standard of care and it is very frustrating when the notes do not corroborate what is remembered, as referred to in the scenario set out above.

Medical records are a window onto your practice and as well as containing information directly relevant to patient care they are central evidence of standards of care.

How would your records stand up to scrutiny or help you in your hour of need? *This blog was published first on the MDDUS Risk Blog website at http://riskblog.mddus.com/. Access the site for other interesting topics.*

sponsor of the event and category sponsor for Primary Care Team of the Year. The Union's chief executive Professor Gordon Dickson delivered the welcome speech as almost 700 guests gathered to applaud the 60 teams shortlisted in 13 categories.

Taking the award for Primary Care Team of the Year was the Emergency Care Practitioner Scheme in West Leicestershire which aims to reduce the numbers of "urgent call" patients transferred to hospital. The title of Emergency Medicine Team of the year went to the Rapid Resuscitation Response Unit, Emergency Medicine Research Group, in Edinburgh. The unit works 24/7 to improve prehospital resuscitation practice, attending more than 85 per cent of all out-of-hospital cardiac arrests in the area.

The Karen Woo Surgical Team of the Year award was presented to Surgical Telementoring in Tanzania. Under the programme, surgeons at Northumbria Healthcare NHS Foundation Trust provided intensive training and telementoring to surgeons at Kilimanjaro Christian Medical Centre. Patient Safety Team of the Year was Great Ormond Street Hospital NHS Foundation Trust in London, while Bipolar Education Programme Cymru won Innovation Team of the Year.

The Lifetime Achievement Award winner was Sir Iain Chalmers. He founded The Cochrane Collaboration which works to produce accessible, evidence-based health information free from commercial sponsorship.

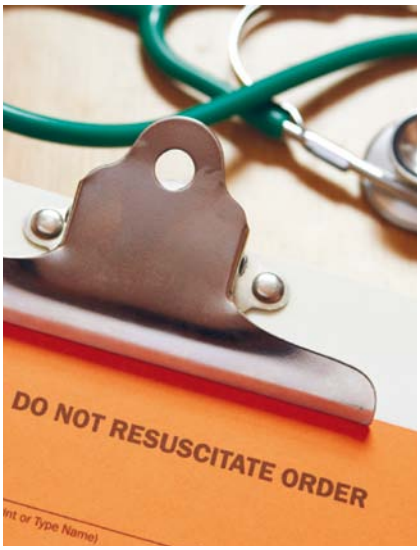
For a full list of all the winners visit **http://groupawards.bmj.com**

and CPD. It can be purchased at the online RCGP shop.

● **NEW ESSENTIAL GUIDES** MDDUS has published two

new *Essential Guide* booklets offering overviews and brief advice for members on coroner's inquests and fatal accident inquiries. The new *Essential Guides* can be accessed in the Publications section of **www.mddus.com**

● **DENTAL PRACTICE FOI UPDATE** NHS dentists in Scotland must update their publication scheme now to comply with freedom of information laws. A notice was sent out reminding practitioners to renew their current 2010 scheme by June 1. The ICO is advising dentists to visit **www.itspublicknowledge.info/MPS** for detailed guidance.



Legal duty to consult over DNR

Doctors now have a legal duty to consult with patients before placing a do not resuscitate (DNR) order in medical records.

The Court of Appeal in England made the ruling in a landmark case involving Janet Tracey, a 63-year-old care home manager who died soon after fracturing her neck in a car accident. She had also recently been diagnosed and under treatment for lung cancer.

The court found that doctors at Addenbrooke's Hospital in Cambridge had acted unlawfully in placing a DNR order without consulting her and her family. Lord Dyson ruled in his judgment that the hospital trust had violated Mrs Tracey's right to respect for her private life under Article 8 of the European Convention of Human Rights.

He said: "Since a [DNR] decision is one which will potentially deprive the patient of life-saving treatment, there should be a presumption in favour of patient involvement.

"There need to be convincing reasons not to involve the patient."

Doctors are already advised to inform patients and their families in most cases before a DNR is applied. The ruling makes this now a legal requirement.

GPs call for early warnings on violent patients

OVER three out of four GPs (79 per cent) have felt threatened by a patient at some point in their career and over a quarter within the last year, according to a survey by *GP* magazine.

Nearly 20 per cent of the 610 GPs in the survey reported being attacked by a patient at some point in their careers and over 10 per cent reported attacks on staff within the past 12 months. Over 90 per cent of GPs believe that they should be warned when patients convicted of violent crime register with practices on release from prison.

Deputy chairman of the GPC Dr Richard Vautrey commented: "There must be proper resources available and easily accessible violent patient schemes in every area, so those particularly difficult patients can receive appropriate care with the right level of support and protection for the individual who is providing that care."

But he added it is important not to place barriers to healthcare access for patients with prison records. "We need to be very careful not to pre-judge a situation and almost make it impossible for patients to register when their behaviour has been questioned."

Child tooth whitening still illegal

DENTISTS are being told they can now offer tooth whitening to patients under the age of 18 following an apparent change in position by the GDC. Under the revised rules, bleaching can be used in low concentrations on diseased teeth - but clarity is still needed on the legal position.

In a statement on its website, the GDC states: "Products containing or releasing between 0.1 per cent and 6 per cent hydrogen peroxide cannot be used on any person under 18 years of age except where such use is intended wholly for the purpose of treating or preventing disease."

The move has been welcomed by organisations including the Faculty of Dental Surgery (FDS) and the British Society of Paediatric Dentistry (BSPD) who spent two years campaigning for a relaxation of the rules. A recent FDS report on tooth whitening argued that EU legislation effectively banning the treatment in under-18s could lead to bullying in young patients with discoloured teeth. The report noted that "when it comes to considering dental bleaching for under-18s in the UK, serious dilemmas have arisen from various European Community (EC) directives and how they are interpreted."

But MDDUS is reminding members that this is professional guidance from their regulatory body and not the legal position - which remains that use of products of greater than 0.1 per cent hydrogen peroxide on under-18s is illegal. MDDUS has requested clarification from the GDC on the definition of 'disease' in this context, but provision of this type of treatment could still lead to a criminal prosecution by Trading Standards.

MDDUS would advise not offering such treatment at this time.

Complacency leads to asthma deaths

POOR standards of care in the treatment of asthma are leading to unnecessary deaths according to an inquiry from the Royal College of Physicians.

The *National Review of Asthma Deaths* found that nearly half of patients included in the study who died from asthma did not receive medical help during their final asthma attack. Among asthma deaths, some 80 per cent of children under age 10 and 72 per cent of young people aged 10–19 died before they reached hospital.

Deficiencies were found in both routine care and in the treatment of attacks, and there was widespread under-use of preventer inhalers and excessive over-reliance on

IN BRIEF

NES FUNDS DENTAL RESOURCES NHS Education for Scotland (NES) is to fund additional educational resources to dental training practices to support the learning needs of the entire dental team. The range of new materials will include an interactive programme on oral cancer and a suite of modules on communications skills. The intention is to give training practices appointed for the August 2014 to July 2015 training year priority access free of charge.

HALF OF CANCER PATIENTS SURVIVE 10 YEARS Over 50 per cent of people diagnosed with cancer today will survive their disease for at least 10 years compared to 25 per cent in the early 1970s, according to Cancer Research UK. Improvement has been measured across a range of cancers but survival rates for some cancers are still poor. Just one per cent of pancreatic cancer patients and five per cent of lung cancer patients diagnosed today are expected to survive 10 years.

GPs fear workload risks patient safety

MORE than 80 per cent of GPs worry about missing a serious condition in a patient because of their heavy workload, a new survey has revealed.

The vast majority of GP respondents – 91 per cent – also believe general practice does not have sufficient resources to deliver high quality patient care.

The views emerged in a poll by ComRes commissioned by the Royal College of General Practitioners (RCGP). When asked to what extent they were concerned about missing a serious illness because of workload, 29 per cent of GPs said they worried a great deal, and more than half (55 per cent) worried a fair amount.

Nearly all of the 251 GPs surveyed (96 per cent) said they found their job stressful with the same amount saying that morale has decreased in the past five years. Most predicted big changes to come with 70 per cent believing that the provision of general practice as we know it today will not exist in 10 years' time.

The RCGP has raised concerns about GP funding, highlighting figures showing 90 per cent of NHS patient contacts take place within general practice, yet it only receives 8.39 per cent of the NHS budget.

The College has launched a campaign with the National Association for Patient Participation (NAPP) called *Put patients first: Back general practice* calling on all four health departments of the UK to raise GP funding to 11 per cent of the NHS budget by 2017.

RCGP spokeswoman Dr Helen Stokes-Lampard said: "The fact that more than 80 per cent of GPs worry that they will miss something serious in a patient, due to their high workloads, is a damning indictment of the impact of the deepening funding crisis in general practice."

The BMA's General Practice Committee has also launched a new campaign – *Your GP Cares* – highlighting some of the pressing issues currently facing general practice. More information is available at **bma.org.uk/YourGPcares**

reliever inhalers. The report is calling for improvements so that both patients and healthcare professionals are better able to recognise the signs of deterioration in asthma and act quickly when faced with a potentially fatal asthma attack.

Dr Kevin Stewart, clinical director of the Clinical Effectiveness and Evaluation Unit (CEEU) at the RCP, said: "It's time to end our complacency about asthma, which can, and does, kill. There are important messages in this report for clinicians, for patients and their families and for policy-makers."

GDC standards on the go

THE GDC has developed a new mobile website dedicated to its *Standards for the Dental Team*.

Dentist can access the new site via mobile phone or tablet and it includes not only the *Standards* but also the interactive *Focus on Standards* content which is currently available on the main GDC site.

Recent user testing found that 93 per cent of GDC registrants found that navigation around the site easy and 89 per cent believe they would use it to read up on particular standards or guidance for future reference.

To access the mobile site go to **http://standards.gdc-uk.org**

Major trauma hubs for Scotland

PATIENTS with serious injuries in Scotland are to be treated in specialist trauma units being established at four hospitals, according to plans announced by the Scottish Government.

The units will be located at the Royal Infirmary of Edinburgh, Aberdeen Royal Infirmary, Ninewells Hospital in Dundee, and the new Southern General Hospital in Glasgow and will be operational from 2016, offering lifesaving treatment to around 1,200 patients per year.

Local hospitals will continue to care for people with less serious injuries, such as fractures and minor head injuries, and may still deal with a very small number of major trauma cases, particularly where patients are unable to reach a major trauma unit within a reasonable time period.

Health Secretary Alex Neil said: "This network of specialist centres will ensure that patients can be taken directly to the most appropriate place for treatment, and reduce any delay in receiving the treatment they need."

INCREASED CROHN'S DISEASE ADMISSIONS Cases of Crohn's disease among young people leading to hospital admission have soared in England and Wales in recent years. The Health and Social Care Information Centre says last year 19,405 16 to 29-year-olds were admitted for treatment in England – up from 4,937 in 2003/4. Experts believe junk food and too many antibiotics could be reasons for the increased cases.

MAJOR STUDY LINKS TOOTH LOSS WITH CVD Swedish researchers reporting on a study of more than 15,000 patients from 39 countries have confirmed a link between periodontal disorders (such as tooth loss and gingivitis) and increased risk of cardiovascular disease (CVD). Lower prevalence of tooth loss was associated with reduced CVD risk factors including lower cholesterol levels, systolic blood pressure and smaller waist circumference. More information at **http://tinyurl.com/pp5osmh**

WHAT DON'T YOU KNOW?

Liz Price

AS a GP partner are you confident that you know what's happening at reception whilst you're busy in surgery or out visiting patients at home?

You may feel that managing risks associated with practice systems is the day-to-day role of the practice manager. For some practices this may still be the case, with the PM maintaining a "finger on the pulse". But for many, the reality is that, as the traditional PM role evolves, they too become more isolated from other staff.

Picture this...

It's the middle of a hectic Wednesday morning surgery. Receptionists are busy dealing with calls requesting appointments – requests they have to manage as there are already no non-urgent appointments left that day. At the same time they are also fielding face-to-face and telephone enquiries on a multitude of other matters, including outstanding referrals, discharge medicines for housebound relatives and when the district nurse is likely to be calling them back.

A steady stream of patients arrives at the front desk to book in for appointments (the self-service book-in is offline), hand in specimens and collect repeat prescription requests. The receptionists juggle all these in what appears to be an efficient manner, however everyone in the office is feeling a little stretched and worried about the fact that appointments for the day are now gone.

All seems to be well until at 11:05 a receptionist takes a call from a patient who says they would like to see a doctor today. The conversation goes like this...

Patient: I'm phoning to see if I can get an appointment to see a doctor today?

Receptionist: I'm sorry but we have no more routine appointments available today. I can offer you a routine appointment on Monday or Tuesday next week?

Patient (annoyed): I can't wait until next week. I need to see someone today!

Receptionist (calmly): I'm afraid it's only emergency appointments we've got left. If you can't wait until next week, you're welcome to try again tomorrow morning. Every morning, appointments open up for that day and so...

Patient (angry): This is the third morning I've tried that and not been able to get through!

Receptionist (defensive): I'm very sorry about that but that's our system and if it's not an emergency....

Patient (defeated): Look, I've had a really sore throat and a headache for a week or so now. The last couple of days I've been feeling really rotten, been really sick and I think I maybe need some antibiotics...

> "There's really no point in coming in to see a doctor because they won't give you an antibiotic anyway."

Receptionist (sighing, relieved): Ah, well you see, there's really no point in coming in to see a doctor because they won't give you an antibiotic anyway. Everyone seems to have that virus at the moment. You'd be as well taking some paracetamol, making sure you drink plenty of fluids and wrapping yourself up with a blanket and a hot water bottle until it passes.

Patient (hopefully): Oh well, if that's what the doctors are saying about it then...

Receptionist (brightly): Great - well call us back if you're no better in five to seven days, and we'll see if we can fit you in.

At 09:25 on the following Monday morning notification arrives by telephone at the practice that the patient has died in hospital over the weekend. It looks as though he had encephalitis.

Blame the receptionist?

All practices have evolved different systems of ensuring patient access to GP consultations. In this case, the fact that no routine appointments were available contributed to the situation; however this is the reality for many practices day-to-day. The fact that the receptionist maintained that any available appointments were only to be used for 'emergencies' perhaps also contributed.

You might think that the crucial failure in the encounter occurs when the patient states his symptoms and the receptionist triages these as non-urgent, offering advice outside her sphere of competence. But it is also worth considering some additional factors at play. Could the treatment delay have been avoided if:

- The receptionist had been empowered (or felt supported) to pause the encounter after hearing the persistence of the patient's concerns, and used this opportunity to take stock with the PM or a clinical colleague?
- The receptionist had felt able to use her judgement to arrange an emergency slot given the persistence of the patient's request and previous number of contacts?
- The receptionist had asked if the patient felt he could wait another day to see the doctor instead of maintaining that available slots were only for emergencies?
- The receptionist had participated in some practice training highlighting the risks around the receptionist role as gatekeeper to GP consultations, including the need to avoid triaging simply to get around the fact that no appointments are available?

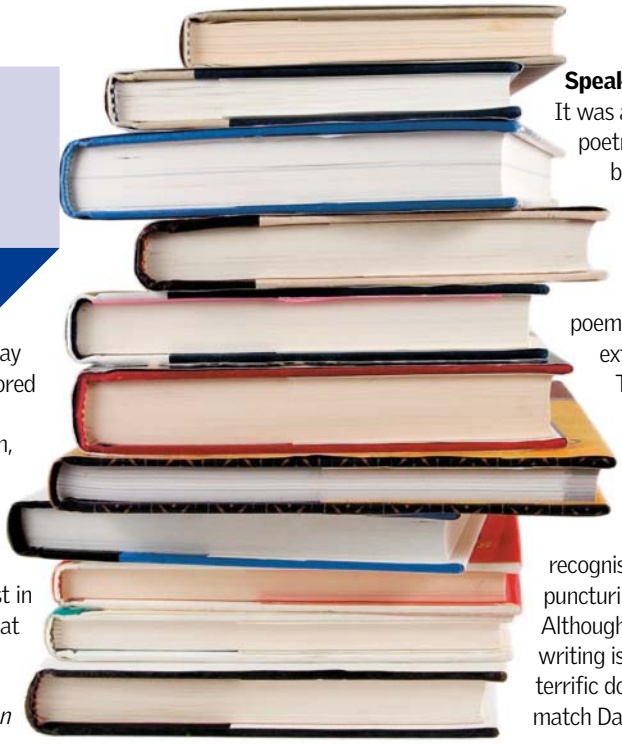
Being aware

We will never know if changing any of these or other aspects of the systems, training or levels of support available would have made a difference in this situation. It is clear though that these and other factors can and do influence what GPs are aware of happening in the practice. The more you know, the better chance you have of achieving safer practice.

■ *Liz Price is a senior risk adviser at MDDUS*

A GOOD READ

Deborah Bowman



I'M just back from a wet week at the Hay Festival where thousands of people ignored the tempest raging outside to celebrate literature, ideas and writing. Books, then, are on my mind. In the spirit of the 'summer reading' recommended by national treasures in the broadsheets, I've been thinking about what titles I'd recommend to someone with an interest in health and ethics. These are the ones that eventually made the final cut.

The Empathy Exams *by Leslie Jamison*
Collections of essays do not enjoy the same popularity in the UK as in the US. If a reason were needed to explore the essay as a form, this wonderful collection is it. It is a thoughtful and thought-provoking exploration of empathy: its character, significance and meaning. Jamison's lens is wide-ranging and she considers subjects including illness, her work as a simulated patient, travel, extreme sports and female pain. She is particularly strong on the question of simulated and sincere empathy, challenging the notion that they are in opposition. For anyone who cares for others – in whatever capacity – this is a rewarding read.

Easeful Death *by Mary Warnock*
Questions and debates about assisted dying abound and the choice for anyone wishing to read about the subject is overwhelming. This slim volume stands out as an eloquent and considered contribution. In an area of ethics where discussion often yields more heat than light, Warnock's careful and attentive approach is illuminating. Whatever one thinks about assisted dying, those thoughts will be more informed and better developed for reading this book.

The Emperor of All Maladies
by Siddhartha Mukherjee
Mukherjee's book has been shortlisted for, and won, numerous prizes, including the Pulitzer Prize. It deserves every accolade. Mukherjee carries off the challenge of creating an engaging narrative without compromising rigour in this biography of cancer. The skill with which he draws together science, social history and moral philosophy is remarkable and the result is nothing less than gripping. Mukherjee is fearless about the discomforting questions that hover persistently for those whose lives are affected by cancer. He responds with honesty and difficult truths, but always retains his wisdom and compassion.

> "The tension between personal and patient interests is credible, frightening and ultimately moving."

Doctor, What's Wrong? Making the NHS Human Again
by Sophie Petit-Zeman
Petit-Zeman's book is unlike any other I have in my office. It takes a hybrid form. The first part is fiction: the story of patients and professionals providing and receiving healthcare with more shared vulnerability than one might imagine. The second part is an analysis of the ways in which the NHS both fosters and impedes compassionate clinical practice. The combination of factual and fictional writing is affecting and effective. The copy on my shelf was published in 2005, so the book is nearly 10 years old, but it remains as prescient and relevant as ever. It is a reminder that ethical practice rarely occurs in isolation. The systems in which individuals work inevitably create a moral culture in which ethical practice may thrive or falter. It is a point that bears repeating, often.

Speak, Old Parrot *by Dannie Abse*
It was a joy to hear Dr Abse talk at a poetry festival in honour of his 90th birthday. I could have recommended any of his books, but this collection is a stunning evocation of aging, loss and the inherently moral character of medicine. The poems speak both to the internal and external, literally and metaphorically. The changing nature of the body and its facility to engage with the external world are beautifully rendered, but so too is the private adaptation that must occur. He has a unique ability to recognise the value of medicine whilst puncturing any tendencies to grandiosity. Although the themes are often weighty, the writing is deft and witty. There are many terrific doctor-writers, but for me, few match Dannie Abse.

Bodies *by Jed Mercurio*
The original novel is subtler than the televised version and better for it. An affecting story of a doctor in the earliest years of his career who encounters the bruising realities of life on the wards. Mercurio's own experience as a doctor seeps into the story and his exploration of medical mistakes, whistleblowing, tribalism and the tension between personal and patient interests is credible, frightening and ultimately moving.

Granta 120: Medicine
This is an outstanding collection of essays, poetry, stories and images about illness and its treatment. Contributors include fine writers such as Alice Munro, Rose Tremain and Chris Adrian. It is difficult to choose a favourite piece such is the standard, but M J Hyland's essay about living with multiple sclerosis is extraordinary. As someone who also has MS, I have never read anything as lucid and truthful about the experience of early symptoms, diagnosis and eventually learning to live with the new neurological normal.

Wishing you all a restorative summer – happy reading!

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

An inspector calls

Professor Steve Field *speaks to* Summons *about how the CQC wants to "raise the bar" in quality primary care*

PROFESSOR Steve Field joined the Care Quality Commission as chief inspector of general practice in October 2013 but has long been a key player in NHS reform in England.

In 2011 he chaired the NHS Future Forum which led to key changes in the bill that became the Health and Social Care Act. He then took on the role as deputy national medical director of the NHS Commissioning Board, with lead responsibility for addressing health inequalities in line with the NHS Constitution.

Professor Field was also chairman of council of the Royal College of General Practitioners between 2007 and 2010.

He continues to practise as a GP at Bellevue Medical Centre in Birmingham and is also chairman of the National Inclusion Health Board which is working to improve health outcomes among the homeless, migrants, sex workers and other vulnerable groups. He is an honorary professor at both the University of Birmingham and the University of Warwick and received a CBE for his services to medicine in the 2010.

How do you think the new approach to general practice inspections by the CQC will lead to improvements in primary care in England?

When I became chief inspector of GPs last year, for me the focus of CQC inspections was very much about looking at and reporting on what GP practices were doing wrong or could improve on rather than celebrating the good and outstanding in the sector. Although there will always be a place for identifying inadequate care to protect people at risk, I think by also celebrating the best we can help raise the bar for others and help them to serve their communities better.

We must not tolerate inadequate practice. The vast majority of practices are trying to provide good care. I

hope by sharing good examples, we can encourage and promote better practice across the sector.

What was the main element lacking in the old inspection regime?

One change that we are currently piloting is for a clinician to always be part of the team, therefore having an experienced GP present and where possible a practice nurse or practice manager as well. This way we can ensure that at inspection we are asking the right questions and that we are focusing on the things that truly matter to patients: is the practice safe, effective, well-led, caring and responsive to people's needs? And not just checking that a particular practice has the correct processes and procedures in place.

What are some of the typical failings the pilot inspections are revealing?

As wave one of our GP practice inspections have started recently, it is a little too early to be able to report back on this yet.

What one thing do you think would lead to a significant improvement in GP out-of-hours services?

The one area that keeps coming up during inspections and seems to really define a good service is strong clinical leadership that is responsive and a service that understands and reaches out to local communities. As well as this, attempts to work with other agencies like Macmillan nurses or local hospitals to share intelligence and good practice are also important.

A recent RCGP poll found that 96 per cent of GPs feel that morale has decreased in the past five years. How do you think that can be addressed while also ensuring the high standards of primary care aimed for by the CQC?

There are many reasons why GPs have low morale – our old approach did not normally include GPs on inspections and the guidance on how to be compliant was not written specifically for GPs. We hope that a new model which is being developed with the sector and will include GPs on every inspection will be better and more tailored to general practice, and will take into account the context of general practice. We will also be celebrating good and outstanding practice and sharing that widely.

Worries have been expressed that the new inspection regime with Ofsted-style ratings will be demotivating for GPs. Do you think this is a valid concern?

We will highlight where practice is good or outstanding and will celebrate good practice as well as identifying inadequate practice. There isn't one overall rating – the ratings we intend to apply, subject to consultation, will reflect the complexities of general practice and will highlight within each practice what is working well and what might need to improve.

Some GP leaders have also responded negatively to plans for CQC inspectors to sit in on some GP consultations. Is this a "step too far"?

I think it's important to emphasise a couple of things here. The power to observe care being given was granted in the Health and Social Care Act 2008 (which came into force for GP practices last April) and it can be used as part of evidence gathering during inspection as well as reviewing records, policies and other documents, listening to staff, and pathway tracking patients through their care.

Although it is a power we have, it's one that has only been used very, very rarely especially in our inspections of GP practices. (I personally am not aware of one occasion where it has been used since last April). If we were to use it then it would only be with the express consent of all those involved and the care would also be observed by the experienced GP who will always be on a CQC inspection of a practice.

> "Ratings will reflect the complexities of general practice and will highlight what is working well and what might need to improve"

Do you think health inequality is growing within the UK? How is the CQC helping to address this issue?

One of the key lines of enquiry that we will be looking at in the new inspection regime will be the prevention of ill health for all people. Also the population group focus of our inspections enables us to look at how services are provided to all people. My old role before coming to CQC, was the deputy health director for NHS England leading on addressing health inequalities. I continue to chair the National Inclusion Health Board, which champions the health of vulnerable people including the homeless, sex workers and travellers.

While CQC cannot tackle social determinants of health directly, we can ensure that practices provide care that is safe, effective, well-led, caring and responsive to all people's needs, including vulnerable people.

Can you tell us of any changes planned for dental care inspections?

I have recently appointed a deputy chief inspector, Janet Williamson, who will have responsibility for dental care. We are currently recruiting for a senior national dental advisor. We are looking at the way that we inspect dentists in much the same way that we have looked at and begun to make changes to GP practice inspections. There will be what we call a 'signposting document' outlining changes later in the year and I would encourage keeping an eye out for that publication.

You still see patients as a GP. How do you find the time with all your other commitments?

I continue to work part time in a GP surgery, seeing patients on a Friday morning. I do this because I love general practice. It keeps me grounded, and the feedback from patients is that they would like me to continue. It is of course very difficult continuing in clinical practice, but I have very supportive partners and staff in the surgery, and my scope of practice has reduced over the years.

A question of candour

Solicitor Majid Hassan *looks at Government plans for a statutory duty of candour in healthcare*

IN April 2006, John Moore-Robinson attended the A&E department at Mid Staffordshire General Hospitals NHS Trust following a mountain biking accident. He was examined by a junior doctor who did not suspect anything serious and discharged him with advice to take analgesia. Sadly the patient died of a ruptured spleen at another hospital the following day.

A statement written for the coroner by a trust A&E consultant that was critical of the treatment was not given to the coroner on the advice of the trust's in-house solicitors. They believed that it dealt with issues concerning liability and was not appropriate for the inquest, which was a fact-finding exercise. Although the claim for negligence was settled out of court the family did not find out about the consultant report until the first Mid Staffordshire Inquiry.

The case of John Moore-Robinson was used by Robert Francis QC to highlight the inadequacy of current professional and ethical obligations for healthcare staff to be honest and open with patients when mistakes are made. In his view, what was needed was a statutory duty of candour backed by criminal sanctions against both organisations and individuals.

Intent to mislead

The actions of the trust in failing to pass on the consultant's statement were not considered unlawful as at the time there was no legal duty to disclose the document. Nevertheless, it was felt that the trust's in-house solicitors were "simply at the wrong starting point' with their intention of withholding information which was not in the best interests of the trust to disclose.

The Francis Inquiry recommended that, where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, full disclosure must be given to the patient or their representatives whether or not they have asked for it. Furthermore, it recommended that it should be a criminal offence for any registered medical practitioner, nurse or allied health professional to knowingly obstruct someone in the performance of these duties or to provide information to a patient or relative with intent to mislead them about an incident, or to make an untruthful statement to a commissioner or regulator knowing that they are likely to rely on that statement.

Since the Francis Report was published in February 2013, much has been said about the pros and cons of a statutory duty of candour backed by criminal sanctions. Professor Don Berwick in his report did not agree with the need for an "automatic" duty of candour where patients are told about all errors, including near misses. In its final response to the Francis Report the government agreed to introduce an explicit duty of candour as a Care Quality Commission (CQC) registration requirement for organisations, but it did not accept the need for a criminal offence for any individual healthcare professional found to be in breach of the statutory duty of candour. This duty will very likely come into force in October 2014.

It should also be appreciated that existing obligations for doctors around openness and honesty are set out both in the *NHS Constitution* and the GMC's *Good Medical Practice*. In so far as NHS Trusts are concerned, the *NHS Standard Contract* which came into force in April 2013 contains (at Service Condition 35) a contractual obligation of candour which states that providers must tell a patient (in writing, with all of the facts and an appropriate apology) about any unintended or unexpected incident that could have or did lead to moderate or severe harm or to the death of a patient.

New legal landscape

Subject to parliamentary approval of the Care Bill, the draft regulations due to come into force in October will impose on health and social care providers a duty of candour for any harm to a service user resulting from their care or treatment above a certain "harm threshold". For healthcare providers this threshold will include harm classified as "moderate" or "severe", or where "prolonged psychological harm" has arisen. Duty of candour will also apply in cases of death, if the death relates to the incident of harm rather than to the natural course of the patient's illness or underlying condition. One advantage of using this threshold is that it is the same as the harm threshold used in the contractual duty of candour (with the exception of the inclusion of "prolonged psychological harm").

Where the harm threshold has been breached, the service provider would need to:

- Notify the service user (which includes someone lawfully acting on their behalf where necessary) that the incident has occurred. This notification will include an apology.
- Advise and, if possible, agree with the service user what further enquiries are appropriate.

- Provide all information directly relevant to the incident.
- Provide reasonable support to the service user.
- Inform the service user in writing of the original notification and the results of any further enquiries.

In assessing whether harm is low, moderate or severe, guidance can be obtained from the publication *Seven Steps to Patient Safety*, where the example given to illustrate the differences is a patient who suffers a perforation of the bowel during surgery. If recognised at the time, repaired, washed-out and antibiotics given, this would be classed as low harm. If the mishap was not picked up during the operation and resulted in septicaemia, with the patient requiring a return to theatre for repair, this would be moderate harm. Should the patient end up requiring a temporary colostomy and subsequent major operations this would constitute serious harm.

There will invariably be issues over categorisation of harm and one recent recommendation was to use the composite threshold of "significant harm" to cover moderate and serious harm and death. It is hoped that the final wording of the regulations can provide further clarity on this point.

Implications for hospital doctors

Recent consultations on the statutory duty of candour have sparked debate about how it will operate, what it will cover and whether the draft regulations will be applied consistently. But what is clear is that a statutory duty on service providers will be implemented.

For the individual hospital doctor, the best advice is to ensure that they follow existing GMC guidance in telling patients when things go wrong and a patient is harmed. A prompt and full explanation of the short and long-term effects of the mistake along with an apology will not be seen as an admission of liability. The existing ethical duty on doctors is wider than the proposed statutory duty of candour, or indeed the contractual duty, so a doctor following this should be open and transparent with his patients in any case. However, as the statutory duty is likely to tie-in with the current contractual duty, it is also paramount that all hospital doctors understand and follow their organisations' procedures for reporting patient safety incidents. Careful note-taking and documentation of any discussion explaining a mistake is also vital.

Where there are uncertainties over specific cases, advice should be obtained by contacting MDDUS.

■ ***Majid Hassan is a partner in clinical law at Capsticks Solicitors LLP who advise MDDUS on legal claims***

Chaperone essential

Not all healthcare organisations have established chaperone policies despite the risks both to doctors and patients

INTIMATE physical examinations – those of the breast, genitals and rectum – are a routine part of clinical assessment and diagnosis for many clinicians but can be embarrassing and uncomfortable for patients. It is necessary to offer a chaperone for patient reassurance and also protection and medico-legal cover for both the patient and the doctor.

Awareness of the need to offer a chaperone was emphasised by the case of Dr Clifford Ayling. In 2000 Ayling was convicted of 13 counts of indecent assault on female patients in his care. Following a public inquiry in 2004 into the misconduct of this criminal doctor, there was an increased call for the greater use of chaperones by several professional bodies, including the GMC and various medical defence organisations.

Recommendations from the inquiry regarding the use of chaperones were made in a subsequent report and aimed at trusts, encouraging them to develop chaperone policies and also instructing proper chaperone use among individual doctors. Allegations similar to those made against Ayling have been continually reported to the GMC. An FOI request made to the regulator in 2009 revealed that 35 complaints were attributed to inadequate chaperone use from March 2006 to August 2009, and MDDUS deals with numerous complaints and claims each year.

Protecting patients and doctors

Despite this, many doctors are still not regularly using chaperones for examinations and a study by Metcalfe in 2010[1] showed that almost half of acute NHS trusts in England had yet to initiate a chaperone policy. When chaperones were used, the vast majority of doctors did not record their use[2]. Together these put patients at risk of assault and doctors liable to medico-legal proceedings.

The number of trusts with a chaperone policy has increased since the publication of the Ayling inquiry but by 2010 many trusts still did not have a policy nor did they intend to put one in place. There may be several reasons for the lack of implementation such as: increasing financial difficulties, lack of awareness or interest in applying the Ayling

recommendations and the continued perceived belief that there is nothing wrong with the morals and actions of most doctors, thus a chaperone policy is not required. However, a policy can minimise the expense incurred in following-up complaints relating to the lack of a chaperone and reduce the number of complaints made at a local and GMC level.

The topic of chaperones is becoming increasingly relevant in this litigious and health-and-safety-conscious era and it should be recognised that chaperones are not only for patient protection. The provision of a chaperone policy is an inexpensive, comprehensive way of addressing patient and doctor safety during consultations. All trusts should implement a chaperone policy and resource the policy efficiently, including staff training and advertising.

Of the trusts which already have a chaperone policy, patients are commonly informed verbally during their consultations. However, using methods such as leaflets and posters in clinic waiting rooms would allow patients to consider their options beforehand. This may also increase chaperone use among consultants as it does not solely rely on the doctor remembering to offer a chaperone.

Gender and other issues

Another 2010 study of consultant use of chaperones[2] revealed that, at an individual level, chaperone use among consultants was not consistent from patient to patient, particularly for male patients. In a hospital setting, doctors who routinely conducted intimate examinations consistently used chaperones for female patients but it was as low as 28 per cent for male examinations, though there was a wide variation between hospital specialties. Examining physicians were less likely to offer a chaperone if the patient was male which may be why male intimate exams are frequently performed without a chaperone.

The higher use of chaperones for female patients may indicate there is a perception that these examinations are 'high risk' and thus doctors are more cautious. Regardless of the reasons, all doctors should make sure to offer a chaperone to every patient and not discriminate between genders.

Despite many trusts not having a formal chaperone policy, 97 per cent of consultants reported that a chaperone was 'always' or 'usually' available and cited other healthcare professionals as appropriate chaperones[2]. Consultants also agreed that chaperones should be trained and most importantly it was recognised that administrative staff are not suitable, which corresponds with GMC guidance. However, the documentation surrounding chaperone use was poor with 80 per cent of consultants not documenting the presence of a chaperone including their name and identity. Irrespective of whether a chaperone is present or used, the offer should be documented in the patient notes.

In general practice the pattern is similar, although overall chaperone use is lower. There are two factors that likely influence chaperone use in primary care: (1) the availability of another healthcare professional and (2) the gender of the GP[3]. In the community it is less likely that another healthcare professional would be available to chaperone an exam and there is also the 10-minute time constraint put on GPs during consultation which together hinder the ideal use of chaperones. When GPs use chaperones for an intimate exam on a patient of the opposite sex, male GPs are more likely to use a chaperone than female GPs[4]. Overall there is more caution taken for female patients and particularly by male GPs.

> "Examining physicians were less likely to offer a chaperone if the patient was male"

GMC guidance

Recently updated GMC guidance – *Intimate examinations and chaperones* (2013) – recommends that a patient should be offered a chaperone whenever there is a need to carry out an intimate exam. Key points from the guidance include:

- A chaperone should be offered regardless of the gender of the doctor or the patient.
- Patients should be reminded that chaperones are confidential.
- Any discussion of chaperones should be documented in the patient notes even if the offer is declined. If a chaperone is present, their name and identity should be recorded.
- A trained healthcare professional is the ideal chaperone and they should be present and witness the whole exam. Receptionists and administrative staff, for example, are not suitable.
- Friends and family members are usually not suitable as chaperones because they are not impartial or bound by confidentiality but they may be permitted if the patient desires and the doctor is comfortable to proceed.
- Because friends and relatives don't offer the doctor protection, then a possible solution is to request a healthcare professional to chaperone as well if you are concerned.

In conclusion...

The number of chaperone policies has increased and chaperone use among doctors is good but there are deficiencies in some areas and improvements could still be made in the offering and recording of chaperones. GMC guidance and the Ayling Inquiry recommendations have not yet been fully integrated into clinical practice which is leaving doctors and patients vulnerable but it is hoped that in realising the importance of a chaperone and understanding the available guidance that this can be overcome.

■ ***Neil Metcalfe is a practising GP in York and Nathan Griffiths is a medical student at Manchester Medical School***

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DIABETES MELLITUS
Making the diagnosis

Professor Mark Strachan *highlights some pitfalls for the unwary diagnostician*

MAKING a diagnosis of diabetes is, on the face of it, easy. One needs simply to demonstrate that an individual has an elevated blood glucose concentration. However, there are potential pitfalls for the unwary and I shall consider several of these in this article.

Using HbA1c as a diagnostic test

The traditional diagnostic criteria for diabetes (a fasting plasma glucose ≥ 7.0 mmol/l and/or a random or two hour post glucose-challenge plasma glucose ≥ 11.1 mmol/l) are based around epidemiological data that essentially identify individuals at a higher risk of diabetic retinopathy. The World Health Organisation has also approved glycated haemoglobin (HbA1c) as a diagnostic test for diabetes, with the diagnosis confirmed if HbA1c is ≥ 48 mmol/mol (6.5 per cent).

HbA1c is more familiarly used as a tool to monitor the degree of glycaemic control in individuals with confirmed diabetes. Glucose binds irreversibly to haemoglobin in red blood cells in direct proportion to the prevailing plasma glucose concentration. Red blood cells have an average lifespan of 120 days and so HbA1c broadly gives a measure of average glycaemic control over that period.

There are very strong epidemiological data linking HbA1c to risk of diabetes complications and the HbA1c level is a powerful driver in making alterations to antidiabetic treatment. Therefore, it makes logical sense that HbA1c should also be used as a diagnostic test for diabetes. HbA1c has the additional advantages that it can be measured without the need for fasting and obviates the need for a glucose tolerance test. Many areas of the country are already using HbA1c as a diagnostic test for diabetes, despite its increased cost in relation to plasma glucose, and it is likely that its use will become more common.

The implications of making a diagnosis of diabetes for an individual can be profound – the individual is turned into a "patient". Getting travel insurance, life assurance and critical illness cover may be more difficult and more expensive and there may be an impact on employment. It is important to get the diagnosis right and it must be remembered that HbA1c is not a perfect diagnostic test.

Anything that alters haemoglobin or the lifespan of a red blood cell will alter the relationship between HbA1c and average glycaemia. Thus, haemolytic anaemia, haemoglobinopathies, acute blood loss, splenomegaly and some antiretroviral drugs can result in an artificially low HbA1c. The result may also be lower in renal dialysis patients and be altered by iron and vitamin B12 deficiency. HbA1c will also give a falsely reassuring result if there has been a recent rapid rise in blood glucose; therefore it cannot be used as a diagnostic test for gestational diabetes, steroid-induced diabetes and type 1 diabetes.

Whatever diagnostic test for diabetes is used, it is important to send a second confirmatory test in asymptomatic individuals. Samples can be mislabelled and laboratory errors can occur. To avoid confusion in interpretation, the second confirmatory test should be the same as the first, i.e. if HbA1c has been used on the first occasion it should also be tested on the second. Do not delay seeking an urgent opinion though (waiting on a second confirmatory test result) if the individual is ill, has significant symptoms or is a child.

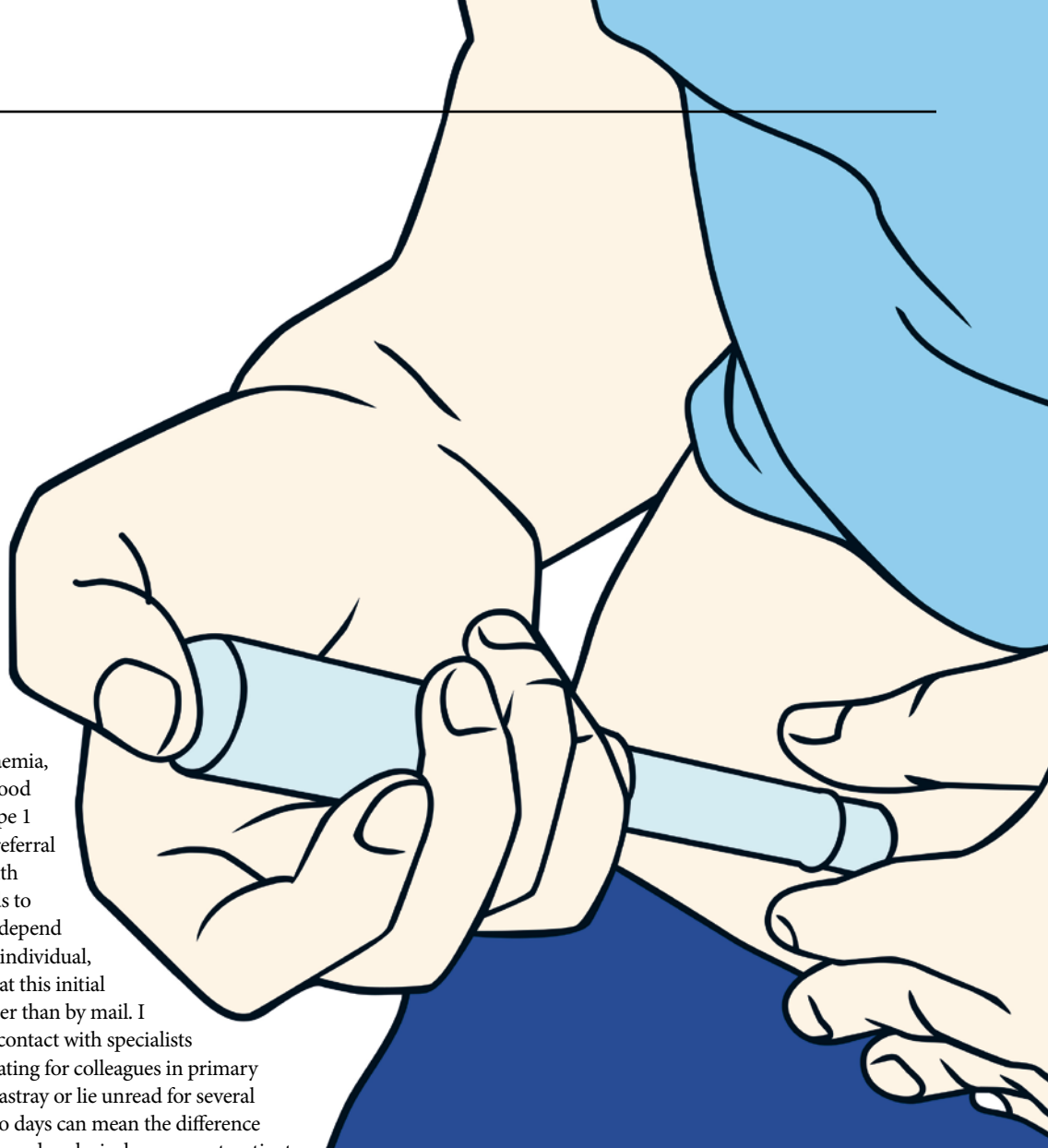
What type of diabetes?

Confirming that an individual has diabetes is only part of the job. The key question to answer next is: "what type of diabetes does this person have?" At its extremes, diabetes is a consequence either of insulin deficiency or insulin resistance, though many individuals with diabetes probably have a bit of both.

Insulin deficiency is the hallmark of type 1 diabetes, where there is autoimmune destruction of the insulin-producing cells of the pancreas. Type 1 diabetes classically presents in children and young adults and there is often a short history of increasing osmotic symptoms and weight loss. Central obesity is the commonest substrate of insulin resistance and predisposes to type 2 diabetes, with its trusty lieutenants of hypertension and dyslipidaemia.

It is important to be alert to other potential causes of diabetes: pancreatic pathology (most commonly chronic pancreatitis or post-pancreatic surgery, but more rarely tumours), drugs (including steroid therapy and some antipsychotic medications), endocrine disorders (classically Cushing's syndrome, acromegaly and phaeochromocytoma) and the reasonably common monogenic forms of diabetes. Monogenic diabetes, often referred to as maturity onset diabetes of the young (MODY), is inherited in an autosomal dominant fashion and classically presents in young adults, with hyperglycaemia that can be managed with dietary modification or oral antidiabetic therapy.

I always say to my registrars in diabetes and endocrinology that, when seeing an individual with newly diagnosed diabetes, they should ask themselves: "Why has this person developed diabetes?" Type 1 diabetes can occur in overweight individuals as well as slim people and can present at any age. The consequences of missing a diagnosis of type 1 diabetes can be extremely serious because insulin deficiency can lead to diabetic ketoacidosis. Therefore, testing for elevated urine or blood ketone concentrations is essential in all people with newly diagnosed diabetes.



Making the referral

The finding of ketonuria or ketonaemia, in conjunction with an elevated blood glucose, is highly suspicious for type 1 diabetes and mandates an urgent referral to a diabetes centre. The timing with which the individual actually needs to be seen in the diabetes centre will depend on the age and clinical state of the individual, but I would always recommend that this initial referral happens by telephone rather than by mail. I appreciate that making telephone contact with specialists can be time consuming and frustrating for colleagues in primary care, but letters and emails can go astray or lie unread for several days and a delay of even one or two days can mean the difference between a patient who can be managed exclusively on an out-patient basis and one who is admitted to hospital with severe metabolic decompensation.

If the patient does not have elevated blood or urine ketones, then there is usually less urgency about initiation of treatment. If the individual has central obesity and evidence of hypertension and dyslipidaemia, a diagnosis of type 2 diabetes can be made but remember the rare possibilities of Cushing's syndrome and acromegaly. If an individual is slim (body mass index <25 kg/m2), then type 2 diabetes is a less plausible diagnosis and that is when real consideration needs to be given to some of the other potential causes listed above. By definition, if the individual is slim, then there must be a degree of insulin deficiency rather than insulin resistance. One caveat to that is ethnicity. Individuals of South Asian origin have more central obesity (and thus more insulin resistance) for a given body mass index (BMI) than individuals of Caucasian origin. Thus, in insulin resistance terms, a BMI of 23 kg/m2 in a South Asian man is roughly equivalent to a BMI of about 25 kg/m2 in a Caucasian man.

Do not presume that because an individual is young that they must have type 1 diabetes. Type 2 diabetes used to occur exclusively in middle-aged and older adults, but in our increasingly obese societies we are now seeing young adults and even teenagers presenting with typical type 2 diabetes.

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Key points

- HbA1c or glucose can be used to diagnose diabetes, but there are certain situations where HbA1c may be unreliable.
- Obtain a second, confirmatory test in asymptomatic patients but never delay therapy in symptomatic patients, children and individuals who are ill.
- Type 1 diabetes can occur at any age and in individuals who are overweight.
- Check urine or blood ketone levels in all people with a new presentation of diabetes. Phone your local diabetes centre for advice if you suspect someone has type 1 diabetes.
- Always think to yourself: "Why has this person developed diabetes?" Make the correct diagnosis of the type of diabetes and do not presume that an older individual has type 2 diabetes and that a younger individual has type 1 diabetes.

The general's toothache

Jim Killgore *recounts a curious First World War tale involving a flamboyant dentist, his motor car and the eventual establishment of the Royal Army Dental Corps*

PHOTOGRAPH: BONHAMS

IN July of last year a rather exquisite automobile came up for auction at Bonhams. A 1913 Rolls-Royce 'Silver Ghost' London-to-Edinburgh Tourer – in mint condition – sold for £718,300.

Apart from its rarity, what also made this car special was a well-deserved footnote in World War One history – and most particularly in the eventual establishment of the Royal Army Dental Corps (RADC).

The Silver Ghost was first owned by a wealthy Londoner but later sold in October 1915 to Charles Auguste Valadier, a flamboyant dental surgeon working in Paris. Valadier was born in the city in 1873 but was taken as a boy to live in America where he became a naturalised citizen. Later he attended Philadelphia Dental College and qualified DDS in 1901. He practised in New York City for a number of years before returning to Paris in 1910 to study at the Ecole Odontotechnique de Paris and earned the certificate of Chirurgien Dentiste from the Faculty of Medicine of Paris University. Soon he was married and settled and operating a successful dental practice.

At the outbreak of war in 1914 Valadier was keen to offer his skills as a dental surgeon to the French army but was rejected, not being a national. So he approached the British Red Cross Society in Paris who accepted his services and sent him to the town of Abbeville on the River Somme near the front. Here the tale takes a curious turn.

The army that bites

In August of that year, after the declaration of war, the British Expeditionary Force (BEF) landed in France eager to fight. Sailing across the English Channel with the BEF were elements of the Royal Army Medical Corps but not a single dental surgeon. This is curious considering the British Army's experiences in the Boer War when over 2,000 soldiers had to be evacuated back to the UK on dental grounds and almost 5,000 declared unfit for duty due to a lack of dentures. The old adage being: "an army that cannot bite, cannot fight".

The state of general dental health in 1914 Britain had much improved over the previous century but it was estimated that at the time over 70 per cent of British recruits were in need of dental treatment. It was inevitable that many soldiers in the field would suffer from a variety of dental ailments – and not just infantry men in the trenches but also officers. So it happened that in October 1914 General Douglas Haig was said to have developed a severe toothache while commanding First Corps of the BEF around the time of the First Battle of Ypres. Finding that there was no dentist available in the British Army to offer treatment, word was sent to Paris to summon a French dentist.

That dentist is thought to have been none other than Charles Valadier. Later that same month he was formally accepted for duty with the BEF making him the first dental surgeon to provide treatment officially for British troops serving in France. It's also perhaps no coincidence that in the November after General Haig suffered his toothache, 12 dental surgeons arrived in France from the War Office having been given temporary commissions with the Royal Army Medical Corps. And this was only the beginning. The importance of having an army that bites had again been recognised. Numbers gradually increased to 463 in December 1916 and then year-on-year until a total of 849 dentists were serving at the time of the Armistice in 1918.

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Glittering spurs

Early in 1915 a young British ENT surgeon with the RAMC named Harold Delf Gillies was sent to France to work with Valadier who had organised a new medical unit to help treat the growing number of soldiers suffering serious facial trauma. Medicine had never before seen traumatic injury on such a scale. Trench warfare and

SCIENCE MUSEUM / SCIENCE & SOCIETY PICTURE LIBRARY

Page opposite: Charles Valadier's 1913 Rolls-Royce Silver Ghost (above) and WWI stretcher bearers (below). *Left:* facial reconstruction after war wound at the Somme in 1916.

the use of massive artillery bombardment exposed the head and face to horrific injuries from gunshot wounds and shrapnel. This forced pioneering advances in plastic and reconstructive surgery and Valadier and Gillies were among surgeons at the forefront.

Gillies later wrote of his first encounter with Valadier and the famous 1913 Silver Ghost: "In Boulogne there was a great fat man with sandy hair and a florid face, who had equipped his Rolls-Royce with dental chair, drills and the necessary heavy metals. The name of this man whose high brown riding boots carried equal polish to the glitter of his spurs was Charles Valadier. He toured about until he had filled with gold all the remaining teeth in British GHQ. With Generals strapped in his chair, he convinced them of the need of a plastic and jaw unit, and one was set up nearby in the lovely little town of Wimereux. I was invited by Valadier to accompany him to assist in his initial incision."

Certainly this must be one of the first examples of a motorised mobile dental unit. Later in 1916 the first fully equipped mobile dental laboratory was kitted out in a modified ambulance and deployed by the army in France. This meant that soldiers could be treated in the field without having to be returned to a casualty clearing station. Eventually each of the five armies in France had similar mobile units.

Valadier ran the facial trauma unit in Boulonge over the course of the war. British authorities gave him a free hand at first and he equipped the unit largely at his own expense employing technicians in Paris to construct the dental appliances needed in treating jaw fractures.

Many of his ideas later proved surgically sound, according to dental surgeon and historian J E McAuley. Valadier recognised the importance of closing facial wounds as soon as possible to avoid retraction in lacerated flaps. To combat infection – a major cause of mortality in WWI – he devised a mobile apparatus for irrigating wounds that was pressured by a bicycle pump and known on the wards as the "fire engine". In 1917 he published a report on his methods based on the treatment of more than 1,000 cases.

> "There was a great fat man who had equipped his Rolls-Royce with dental chair, drills and the necessary metals."

Towards the end of the war Valadier's surgical activities were curtailed – given his "lesser professional status" – and the unit at Wimereux became more a clearing station with complicated cases being transferred to a unit run by Gillies at Queen Mary's Hospital in Sidcup. Another ENT surgeon performed emergency procedures with Valadier assisting. The French-American seemed to alienate quite a few of his contemporaries. Just after Armistice the unit was closed down and Valadier left to salvage his own equipment.

Postscript

Valadier was later recognised by Britain for his contributions to the war effort and after being granted a certificate of naturalisation he was awarded a knighthood in 1921. He returned to his successful Paris practice and lived extravagantly, indulging a weakness for gambling. Later he developed a blood disease, possibly leukaemia, and had to retire from practice – though the gambling continued and he died impoverished in 1931.

One legacy that Valadier can claim a part of was the recognition of the serious wastage of fit soldiers through lack of proper dental care as highlighted during World War One. This led to the formation of the Army Dental Corps in January 1921. It was later granted the Royal prefix in 1946 and the RADC today is responsible for the maintenance of dental health among personnel serving throughout the world.

What about the Silver Ghost? Valadier sold the automobile after the war and towards the end of the 1920s it was converted into a breakdown vehicle, complete with jib crane at the rear. It continued in use as a recovery vehicle until around 1948 when the magneto burnt out. Fortunately it was bought and carefully restored in the 1960s and ended up in private ownership – later being rallied extensively throughout Britain and Europe in subsequent years.

May it last another hundred.

■ ***Jim Killgore is editor of Summons***

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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

DIGNOSIS: UNTREATED DIABETES

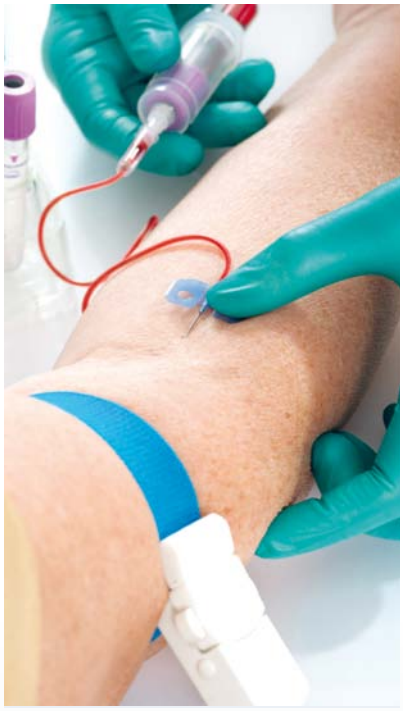
BACKGROUND: Mrs G is a 48-year-old bank teller and attends her GP surgery complaining of swollen ankles. She weighs 15 stone and suffers from hypertension. The patient sees Dr W who notes ankle swelling with bilateral pitting oedema. Her BP is 180/110. The GP issues a prescription for furosemide in addition to her regular medication for hypertension. He requests Mrs G re-attend the surgery for blood tests.

A week later Mrs G sees the practice nurse who takes blood and also performs a urine dipstick test. Traces of blood and glucose are found in her urine. The blood test results later show a normal full blood count, thyroid, liver and renal function but her blood sugar is raised at 15.8 mmol/l.

Mrs G returns to the surgery to discuss the results with Dr W and is told that she may have diabetes. The GP advises the patient to provide a fasting blood sample. Mrs G arranges an appointment but the surgery later calls to cancel because the practice nurse is not available on that day. The receptionist says that the practice will contact her again to re-book a new appointment. Mrs G hears no more from the surgery and assumes the matter is not important.

Two years later Mrs G has begun to feel increasingly lethargic. She also notices some hard skin under her right great toe. The skin becomes loose in the shower and she removes it with some bleeding. She applies a plaster and Germolene but after a week it becomes obvious the toe is not healing well. Mrs G attends Dr W at the surgery. He examines her toe and prescribes an antibiotic. He also again requests the patient provide a fasting blood sample.

Mrs G sees the practice nurse who takes the bloods. She comments: "So I see you're a diabetic." The patient replies that she has never been told that for certain. The blood



test later reveals a fasting glucose of 20.2 mmol/l and a raised HbA1c of 13.8.

Two days later Mrs G sees Dr W who informs her that she is a diabetic. He prescribes metformin and also further antibiotics for her toe – which he examines but without removing the dressings. An appointment is made for Mrs G to see the diabetic nurse but a mix-up in scheduling means that the nurse has inadequate time to provide a full diabetic induction. The nurse is also unable to examine the patient's feet. Mrs G again mentions the infection in her foot. The nurse tells her to persist with the antibiotics and see Dr W if there is no improvement.

A week later Mrs G returns to the surgery. Her toe has turned black and there is now a smell. Dr W asks her to remove her shoe and also notes the smell. He does not remove the dressings but refers the patient immediately to A&E. Later in hospital she undergoes amputation of her right great toe. She is commenced on insulin and IV antibiotics. The surgical wound is slow to heal and Mrs G later develops ulceration under both feet.

Four months later the practice receives a claim of damages for medical negligence in the delayed diagnosis of Mrs G's diabetes leading to the loss of her toe and further diabetic neuropathy.

ANALYSIS/OUTCOME: MDDUS, acting for Dr W, commissions a report from a primary care physician with expertise in diabetes. He is supportive of the GP's initial management of the patient in arranging for a fasting blood test to confirm the suspicion of diabetes but he finds fault in the obvious system error in failing to rearrange the cancelled appointment. This led to a delay of two years in commencing management of the patient's diabetes.

The expert is also critical of Dr W's actions in not properly examining Mrs G's toe upon confirming her diagnosis of diabetes. In addition, fault is found in the failure of the diabetic nurse to prioritise examination of the patient's toe considering her longstanding uncontrolled diabetes.

In terms of causation it is obvious that the delayed management of Mrs G's diabetes contributed to the eventual loss of her toe and subsequent complications. MDDUS solicitors in discussion with Dr W agree to settle the case out of court.

KEY POINTS

- Ensure practice systems flag the need for follow-up on all abnormal results.
- Follow-up missed or cancelled appointments – especially for crucial tests.
- Be wary of all foot infections and injuries in diabetics.

DISCLOSURE:
OUT OF DATE CONSENT

BACKGROUND: A 15-year-old patient with a history of mental health problems lives in a residential care home. Her social worker contacts her GP, Dr A, and asks for access to the girl's medical records so that her file can be updated. Dr A asks the social worker to put the request in writing and to also provide evidence that the patient has consented to the release of her medical records.

The next day the practice receives a faxed request for copies of referral letters to psychiatric services. This is accompanied by a consent form, signed by the patient but dated almost two years ago. Dr A is concerned about the length of time that has passed since the form was signed and contacts MDDUS for advice.

OUTCOME/ANALYSIS: An MDDUS adviser discusses the issue with Dr A and agrees that the consent is now so old as to be no longer valid. While there is no specific or official time limit on consent taken in advance of treatment or for other purposes such as third party disclosure of confidential information, it would be advisable to review it in this case.

The adviser highlights GMC guidance on consent which encourages decisions about treatment to be reviewed where "significant time has passed since the initial decision was made". The guidance also clearly states that patients have the right to "change their mind about a decision at any time".

As the consent in this case is out-of-date, there is no good reason for the GP to grant access to the patient's records. Dr A is advised to request an up-to-date signed consent form.

KEY POINTS

- Ensure consent is up-to-date.
- When sharing patient information with a third party, ensure the consent given is sufficient and relevant to the request being made.

TREATMENT:
INSTRUMENT FAILURE

BACKGROUND: Mr Z attends his dental surgery with a history of pain in a lower right tooth (LR6), especially on biting and chewing. The dentist – Ms J – takes X-rays and notes irreversible pulpitis due to infection. She discusses options with the patient: root treatment or extraction. Mr Z opts for root canal treatment.

Two weeks later Mr Z attends the surgery. Pre-treatment X-rays are taken and Ms J proceeds to remove the MOD restoration and then the pulp using a barbed broach. Next she employs a lentulo spiral filler to spin Ledermix into the canal but the instrument fractures and part of it is retained in the canal.

Ms J attempts to use another spiral filler to remove the fragment but this is unsuccessful. She abandons the procedure and the tooth is dressed with sedanol. A second radiograph is taken confirming the presence of the fractured instrument and Ms J informs the patient (though this is later disputed). An appointment is made for a week's time.

The second attempt to remove the fractured instrument is also unsuccessful. The patient later alleges that Ms J told her that there should be no problem leaving the broken instrument in the tooth as it is sterile. The dentist places an MOD amalgam restoration in the tooth and tells Mr Z she will refer him to the dental hospital if there is persistent pain.

A few weeks later Mr Z returns to the surgery complaining of discomfort though not severe pain in the tooth. Ms J makes a routine, nonurgent referral which is sent by post but not received at the dental hospital. Two months on Mr Z phones the dental surgery to say he has not heard from the dental hospital. He is now suffering persistent pain in LR6 so an urgent appointment is arranged.

Mr Z attends the dental hospital and is treated by Mr K who removes the amalgam filling and locates the fractured instrument but fails to remove it. A second attempt is made one month later but also fails. The only remaining option is extraction of the tooth. Six months later Ms J receives a letter of claim from solicitors acting on behalf of Mr Z alleging clinical negligence.

ANALYSIS/OUTCOME: A report has been produced by a restorative dentist that is critical of Ms J's treatment of the patient. MDDUS advisers and solicitors review the report along with the records.

It transpires that Ms J's record keeping is very poor. There are no written treatment plans or references in the notes

to the radiographs taken. No note can be found to refute Mr Z's claim that he was not informed of the instrument failure until a follow-up appointment. The expert is also critical of the dentist's suggestion that the tooth would be okay because the instrument had been sterile.

Further discussion with Ms J regarding the paucity of notes also reveals that she did not use an apex locator to estimate working length. There is no record of use of rubber dam or any instrumentation or irrigation prior to the use of the spiral filler. This casts doubt on the actual standard of root canal treatment. Considering these weaknesses a settlement is negotiated based on the cost of a single implant.

KEY POINTS

- Ensure full records are kept of treatment plans and discussions with the patient.
- Be open and up-front with patients when complications occur.

From the archives:
Counting swabs

TODAY such cases are known as "never events" but they were no less uncommon 76 years ago. In April 1938 *The Guardian* newspaper reported an action against a Manchester surgeon and his theatre sister brought by the mother of a young man suffering from a perforated duodenal ulcer. He was admitted to Davyhulme Park Hospital for abdominal surgery. The procedure carried out by a Dr Osborne and assisted by Miss Ashburner was routine but the patient grew unaccountably worse over the next few weeks until the stitches on the wound burst.

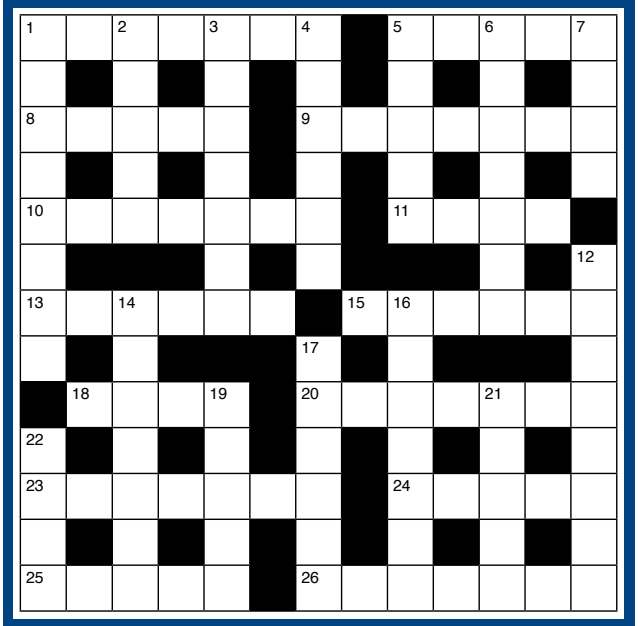
A second operation was carried out by another surgeon during which an 8-by-10 inch swab was found in the man's abdomen. Toxaemia had set in and the patient died the next day.

Dr Osborne denied negligence claiming that during the operation a note was kept on a blackboard of the number of swabs used. He testified that the number of swabs was counted before and after the operation by the theatre sister. Swabs can be hard to see when saturated with fluid and also difficult to detect by touch. Counting swabs meant that a surgeon did not have to risk harming the patient with an extensive wound search.

The surgeon expressed the opinion there must have been a miscount of swabs. Another theory was that possibly two swabs where given to him at one time but Dr Osborne admitted that he had not felt around for any swabs before closing.

Summing up, the judge advised the jury that ultimately it was the surgeon who had failed to reasonably ensure all the swabs had been removed. Miss Ashburner was found not guilty of negligence contributing to the death. The jury found against Dr Osborne and he was ordered to pay damages of £616 along with costs. A rider was added to the opinion stating the surgeon had been working under difficult circumstances during the operation.

Crossword



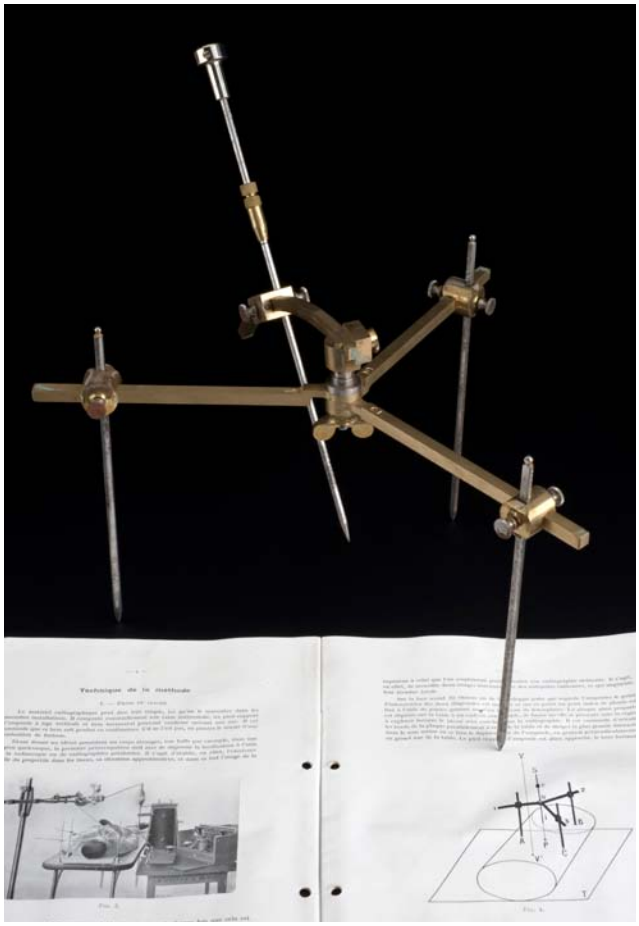
ACROSS

1. Duty of _____ needed, says 9 (7)
5. Relative on spouse's side (2-3)
8. Treat a boil (5)
9. Mid Staffs report author (7)
10. Tableland (7)
11. Follow (4)
13. Among (6)
15. Metabolic molecule (6)
18. Catch sight of (4)
20. Poisonous element (7)
23. Money holders (7)
24. Dry-hopped beer (5)
25. Filleted (5)
26. Italian rice dish (7)

DOWN

1. Chris Martin and chums (8)
2. Feudal, Japanese martial artist (5)
3. First batsmen (7)
4. Acid _____, gastroesophageal disorder (6)
5. Not suitable or appropriate (5)
6. Fortunately (7)
7. Sagacious (4)
12. Writer of medical dramas (8)
14. Peptide hormone (7)
16. Settles snugly (7)
17. German emperor (6)
19. Financial return (5)
21. Time of darkness (5)
22. Absorbent pad (4)

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



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Object obscura:
Hirtz's compass

THE Hirtz compass was invented in 1907 by EJ Hirtz, a French medical officer and head of physiotherapy at a military hospital. The brass device was used to locate bullets in war wounds, especially in the brain. It was said to be accurate to within one or two millimetres. Bullets could then be removed surgically with precision, reducing damage to surrounding tissues. X-rays were also used to guide the surgeon. The device was used extensively during the First World War.

Vignette: Surgeon and expert on war wounds
Archibald Young (1873-1939)

WHEN the Regius Chair of Surgery at the University of Glasgow fell vacant in 1924, the University Court were obliged to find a successor to a lineage which had recently included Lord Lister and Sir William Macewen. They found their man in Macewen's former assistant, Archibald Young. In his inaugural lecture, Professor Young promised to advance the reputation of the University of Glasgow and to keep its surgical school on the map; a promise which he amply fulfilled over the next 15 years.

Young served in two wars: the Boer War (second conflict, 1899-1902) and the Great War of 1914-18. In the former, he was attached as a civilian surgeon to field hospitals in Rondesbosch, Kroonstad and the Transvaal. The experience he gained there of treating war wounds confirmed surgery of the nervous system as his choice of specialty and resulted in the publication of 'Injuries of the Peripheral Nerves'. This paper, one of his many contributions to surgical literature, was the only independent account from a civilian surgeon included in the official surgical report of the war. After his discharge, Young returned to Scotland to begin pioneering work in the reduction of fractures using metal plates. More controversially, he also experimented with the relief of peripheral pain by periarterial sympathectomy, ganglionectomy and sympathetic trunk resection in the treatment of Raynaud's disease, Hirschsprung's disease and arthritis.

Archibald Young was born in Carnarvon Street, Glasgow on 10 November, 1873. He was educated at The High School of Glasgow and the University of Glasgow where he graduated in science before incepting in medicine in 1893. He also studied abroad at schools in Berlin, Heidelberg and Breslau. Commenting on Young's undergraduate record, the Glasgow surgeon James Nicoll revealed that he achieved "first class honours in nearly all his classes and carried off the medal or prize in six of them." His early post-graduate work was no less stellar: the kind which "falls to few men." Young secured coveted houseman appointments at Glasgow Royal Infirmary and the Western (under Macewen) and the position of private class assistant to the renowned pathologist Joseph Coates. From

PORTRAIT OF ARCHIBALD YOUNG BY JAMES GUNN, ROYAL COLLEGE PHYSICIANS AND SURGEONS, GLASGOW

these early days, and throughout his career, he was noted for his reserved manner and devotion to duty, always attending his cases with meticulous care and precision. Nevertheless, in the summer of 1896, he appears to have relaxed somewhat by taking a summer job as a ship's surgeon on the S.S. Canterbury.

After his return from the South African War, Young was a member of staff at the Western Infirmary for 37 years. He was a gifted, generous teacher and the Professor of Surgery at Anderson College from 1913. At the outbreak of the Great War, Young was attached as a neurological expert to the 4th Scottish General Hospital, Glasgow District, Scottish Command. The wartime Medical Research Committee instructed him to use the "present opportunities for special studies of nervous injuries and affections connected with the war." Young obliged with a study of gunshot wounds which was read to the International Congress of Surgery in 1923. Later he was invited to speak at the Cairo Congress of 1936, where he complained that his work in periarterial neurectomy had been unfairly neglected. He was so confident in this procedure that he had had his own brachial artery stripped as one step in the treatment of X-ray dermatitis and ulceration but with mixed results.

Young's rigid devotion and his similarly uncompromising attitude to his colleagues and professional assistants – the latter were required to follow his methods without question – may indicate an overbearing, dour temperament but his private life suggests otherwise. He and his wife Anna Stuart had two sons and the couple entertained frequently and lavishly at their magnificent town house in Park Circus. The family were honoured to entertain Marie Curie on her visit to Scotland. Young was also a traveller. Fluent in Italian and French, he was a sought-after speaker and received many invitations from abroad. He was one of the few foreign members of The Royal Academy of Physicians in Rome.

Archibald Young's health had never been robust. He died on July 23, 1939 at the relatively young age of 65. The week before his death, he had risen from his bed to attend a ceremony in the University's Hunter Hall, where he received a portrait of himself by James Gunn (pictured here). Young's dry humour was evident on that occasion when he referred to his terminal illness, remarking: "One is more or less sure of today; one was less sure of tomorrow."

As expected after the death of an academic of such calibre, obituaries appeared in the *Lancet* and the *British Medical Journal* but it is perhaps a better measure of the affection in which Young was held that the popular Scottish newspaper *The Sunday Post* also printed a review of his life. Archibald Young was clearly respected by the ordinary folk of Glasgow. The *Post* noted that Young had joked that his epitaph should be: "He was kind to his fractures." The newspaper article confirmed the truth of this by referring to Young's former patients who recalled his unexpected visits to their bedside, always greeting them with the same gentle enquiry: "All well?"

Dr Jo Cummins is a dental surgeon and Honorary Research Fellow in History of Dentistry at the University of Glasgow. She is also an editor and writer

SOURCE

The Young Family Papers, Archive and Heritage, RCPSG

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