

SPRING 2015

SUMMONS

AN  PUBLICATION FOR MEMBERS



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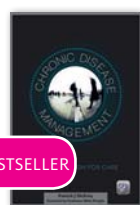


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The Doctor's Communication Handbook, 7th edition

£29.99 | ISBN: 9781846199516 | 2014

This bestselling guide has established itself as the ultimate guide to patient communication for all doctors, whatever their experience and wherever they practice.



BESTSELLER

Chronic Disease Management: A new paradigm for care

£39.99 | ISBN: 9781908911568 | 2014

In this ground-breaking work, Patrick J McEvoy connects with healthcare professionals, patients and illness to present an entirely new way to address chronic disease management.



BESTSELLER

Living Well with Dementia: The Importance of the Person and the Environment for Wellbeing

£29.99 | ISBN: 9781908911971 | 2014

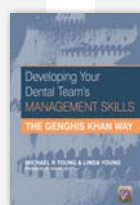
This unique guide provides a much needed overview of dementia care. With a strong focus on the importance of patients and families, it explores the multifaceted meaning behind patient wellbeing and its vital significance in the context of national policy.



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£27.99 | ISBN: 9781846199882 | 2013

A highly practical resource designed to help practice owners develop a well-integrated team within their business, ultimately leading to a first-class team and an outstanding practice.



BESTSELLER

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£34.99 | ISBN: 9781846193651 | 2013

Skills for Communicating with Patients, Third Edition is essential reading for healthcare professionals at all levels, course organisers, facilitators and programme directors.

* Prices shown are RRP and not displaying the discount. Offer applies to all Radcliffe Books when purchased from our online shop: www.radcliffehealth.com. Quote MDDUS20 at the checkout. Offer expires 01.07.2015.

IN THIS ISSUE

GOOGLE recently announced that around five per cent of queries on its search engine are for health-related information. Considering Google now processes over 40,000 search queries per second, that translates into a lot of medical advice being imparted. So it's probably safe to assume that your average patient is today better informed (or misinformed) than say 20 years ago.

Given such democratic data access, a sea change in patient expectations and the nature of what constitutes informed consent is inevitable. Not to say this was the only or even a key factor in the recent landmark legal judgment of *Montgomery v Lanarkshire Health Board*. But the Courts have now recognised that in assessing risk the emphasis must be on what a "reasonable person in the patient's position would be likely to attach significance to" and not necessarily what a "reasonable doctor" would consider risky. On page 14 Gail Gilmartin looks at the implications of the case.

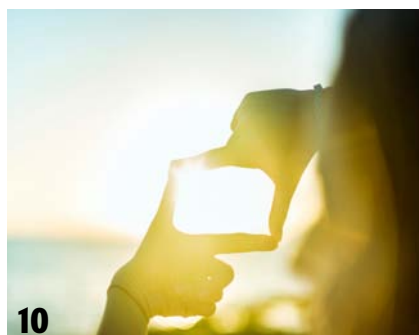
In the last issue of *Summons*, departing CEO Gordon Dickson offered his perspective on 10 years of transformation at MDDUS. On page 10, the new CEO Chris Kenny offers his view of the challenges facing the Union in the coming years.

On page 18 Doug Hamilton looks at some of the thorny ethical questions around cosmetic dental treatment. In such procedures, he points out: "there is little risk in doing nothing, other than the likelihood that patients will remain dissatisfied with their smiles". Does the answer lie in more rigorous consent?

Earlier this year Sir Robert Francis introduced his long-awaited review of whistleblowing within the NHS – *Freedom to speak up*. On page 12, I summarise some of the findings and his recommendations.

And our regular clinical risk article (p. 16) is on the diabetic foot and complications that may lead to amputation.

Jim Killgore, editor



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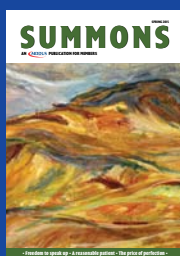
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Cover image:
'Dubh Beinn, Jura'
Julie Brook
Oil on canvas, 1999

Born in 1961, Julie graduated from Ruskin School of Art in 1983. Her early work was inspired by trips to the Hebrides and Orkney. She has been involved with educational

projects in the Highlands, and recently exhibited at the Dovecot Gallery in Edinburgh.

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

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➡ MDDUS launches new website

MDDUS is proud to announce the launch of our new website at www.mddus.com

The website has been built to the highest standards of best practice in responsive design to suit all popular desktop, tablet and smartphone browsers. It will also serve as a platform for further enhancements of MDDUS online services.

Among the many new features available is the 'Manage my membership' page which allows members to update their personal details online. The improved 'Risk management' section boasts a wide range of learning resources including video presentations, practical checklists and our risk blogs. You can also find out how to contact our advisory staff on the advice and support page and browse our magazines and advice booklets on the publications page.

➡ GP special cover

Members are required to ensure that they are in the correct membership category and paying the appropriate subscription associated with the work they undertake.

MDDUS GP subscription rates are designed for GP members treating NHS patients. Where members undertake private GP sessions or otherwise treat non-NHS patients (other than ad hoc private patients within their predominantly NHS GP list), a higher private GP subscription rate is likely to apply. Likewise, an additional rate may apply if you work in

any of the following areas:

- Forensic/police physician (FME) work
- Attendance at sporting events where remuneration is received, including treatment of athletes and players
- Private travel clinic or a private walk-in centre
- Occupational health physician work
- Cosmetic surgery procedures.

For those GPs who commonly undertake a range of relatively minor invasive procedures such as contraceptive implant or coil fitting, joint injections, or minor surgery for skin lesions and "lumps and bumps", MDDUS will extend the benefits of GP membership to include work as described above where it accounts for less than 50 per cent of a member's clinical time. Members must ensure that they work within the limits of their competence/training, and that the time spent undertaking such work is included within the sessions declared to MDDUS for the purposes of calculating their subscription.

Members undertaking more complex or specialist work, or those exceeding the 50 per cent limit set out above, should contact our membership department for a tailored quote or for general confirmation of their subscription in light of individual circumstances.

➡ Roundtable video discussions on childhood illness

MDDUS has launched the second of two video roundtable discussions exploring risks in dealing with common childhood illnesses in primary care.

In the first roundtable our panel of medical and legal experts discuss an acute case of meningococcal septicaemia. What are the pitfalls in management and how can these be avoided?

The second roundtable examines the difficulties associated with diagnosing conditions with a more slowly progressing natural history. Communication and the importance of an effective interface between GPs and health visitors are discussed, along with what can be expected of GPs in these types of cases. The panel also touches on the benefits and challenges of different types of record-keeping.

Both roundtable discussions feature downloadable case timelines, reflective guides and a glossary of relevant medical terms. Risk adviser Liz Price has also written an introductory blog for members providing background on the expert panel and inviting comment on the discussions, along with the opportunity to share good practice in dealing with these difficult cases.



IN BRIEF

● PRACTICE AND CORPORATE SCHEME MEMBERSHIP

Members who have Practice or Corporate Scheme Membership with MDDUS should note it is their responsibility to ensure that membership is being maintained by

the practice manager or other administrator. Failure to maintain adequate cover, for example failing to inform us of a return to work following maternity or paternity leave, cannot normally be rectified retrospectively.

● WARNING ON WAITING ROOM MUSIC

Doctors and dentists playing music in their practices must have relevant licences or risk legal proceedings. "There are two types of licences protecting different copyright

owners... and it is likely you will need both," says MDDUS dental adviser, Aubrey Craig. Licences are issued by both Phonographic Performance Limited (PPL) and Performing Right Society (PRS for Music). Find out more online.

Each of the roundtable discussions can be viewed as a whole or in five parts. Go to 'eLearning video modules' in the Risk Management section at mddus.com. CPD verification is available.

Practice Managers' Conference 2015

MDDUS has announced dates for its popular Practice Managers' Conference which will be held this year at the Fairmont Hotel in St Andrews.

The conference takes place on Thursday 26 and Friday 27 of November. Delegates can attend interactive workshops on a broad range of topics throughout the day on Thursday, plus additional sessions on Friday morning. New for 2015 will be the screening of the third instalment of our film series, *Bleak Practice*, which promises an entertaining way to learn key risk lessons in general practice.

As always, places will be limited so contact the Risk Management team now to register interest (risk@mddus.com).

MDDUS feels the force

MDDUS has recently purchased Hend House, the London headquarters of Industrial Light & Magic, the visual effects arm of the LucasFilm production company.

ILM moved into the grade-II listed building on Shaftsbury Avenue in 2014 and the studio is currently working on special effects for the new *Star Wars* film franchise (although the landlord has not been offered any sneak previews!).

In addition, the Union has purchased Bracton House in High Holborn. Both acquisitions – along with the refurbishment of the building housing our London office at Pemberton Row – are part of a strategy to enhance the Union's property portfolio and continue to improve the return on our investment fund.

MDDUS CEO Chris Kenny says: "These are prudent investments which help us to diversify our holdings and so achieve both security and growth for our members' resources."



Covert recording of consultations

A RECENT call to the MDDUS advisory service highlighted some confusion over a patient's right to covertly (or indeed overtly) record their medical or dental consultation.

The member in this instance was shocked to learn that he had been covertly recorded using a smartphone. He was seeking confirmation from MDDUS that he could warn the patient that this was not acceptable, that the patient could not record their consultations again without his explicit consent and that if continuing to do so they would be advised to register with another GP.

Discovering that you have been covertly recorded via smartphone or other means can be unsettling but the reality is that there is nothing to legally stop patients from doing so, nor

is there any need to seek your consent. When a patient records a clinical consultation, the information being recorded is almost exclusively relating to that patient. Under section 36 of the Data Protection Act there is an almost total exemption for individuals who are using personal data for their own domestic and recreational purposes. The DPA views this data as personal to them and that the recording of such is simply the patient processing their own personal data. Ultimately, the data is viewed as confidential to the patient but not to the consulting clinician.

Patients may record consultations for a number of reasons. They may wish to aid their memory if there is likely to be a complex or lengthy discussion. They may wish to let their family members listen to help clarify matters or keep them informed. Or it may be that they are dissatisfied with the advice they are being given and want to seek another's view. It is worth noting that covert recordings are admissible as evidence when judged as relevant to a legal case.

If a clinician becomes aware that they are being recorded covertly then inviting the patient to continue recording openly may positively influence the situation. A gentle question around their perceived need to record the consultation may help clarify matters for you and indeed the patient. A request can be made that in the future they alert you to this activity but be aware that the patient does not have to comply with this – although demonstrating acceptance and lack of defensiveness may enable the patient to be more open and overt going forward.

On the final point raised by our member, deregistering a patient for this activity alone does not adhere to NHS contractual obligations or GMC guidance on removal of patients and the usual conditions and processes would apply in this respect.

HEALTH AND SAFETY IN PRIMARY CARE

MDDUS members can enjoy special rates for a Law at Work (LAW) course on managing health and safety in GP and dental practices. The comprehensive four-day nationally

accredited course is for staff with senior responsibilities for health and safety and will be run on four consecutive Thursdays starting on 7 May in Glasgow. Costs are £475 plus VAT for MDDUS members. Book on 0141 271 5555 or email

gillian.wilson@lawatwork.co.uk.

HUMAN FACTORS MASTERCLASS

MDDUS have partnered with aviation and healthcare safety experts Terema to bring you this excellent programme based on their

experience teaching crew resource management (CRM) within the airlines. The course will be run on 5 and 6 November 2015 at Heathrow. Cost for MDDUS members is £470 plus VAT. Contact risk@mddus.com to book.



➔ Dentists face FFT requirement

DENTISTS in England are now required to offer all NHS patients attending their practice the means to provide feedback through the Friends and Family Test (FFT).

FFT was introduced in 2013 and has been rolled out across England in A&E departments, GP practices and in NHS-funded mental health and community health services. In April the test was further expanded into other areas of NHS care including dental practices, ambulance services and acute hospital outpatient centres.

In implementing the test, dental practices are required to use a standard wording in posing the question and the possible responses: "We would like you to think about your recent experiences of our service. How likely are you to recommend our dental practice to friends and family if they needed similar care or treatment?"

Patients are asked to respond: 'Extremely likely', 'Likely', 'Neither likely nor unlikely', 'Unlikely', 'Extremely unlikely', or 'Don't know'.

Practices are also required to include at least one follow-up question which allows the opportunity to provide free text. Patients do not need to be asked to respond to the FFT question after every

interaction, but they should be made aware that feedback is welcome at any time.

Data from the FFT must be submitted to NHS England each month and results should be published or displayed locally. More detail on implementing the test is available on the NHS England website.

➔ 10 minutes not enough, say GPs

A MAJORITY of GPs in the UK feel that the standard 10-minute consultation is inadequate for the needs of all patients, according to a major new survey.

Over 15,000 GPs across the UK were polled by the BMA on a variety of issues and the survey found that over two-thirds (68 per cent) believe there should be longer consultations for certain groups of patients, including those with long-term conditions. A quarter of GPs said that all patients need more time with their GP.

Workload was also a serious issue, with 93 per cent of GPs saying that their heavy workload had negatively impacted on the quality of patient services. Just over half (51 per cent) said they would be willing to explore options to improve patient access



with some form of extended hours but 94 per cent did not consider seven-day opening necessary in their own practices.

Dr Chaand Nagpaul, BMA GP committee chair, said: "GPs want to provide better services and spend more time with their patients, especially the increasing number of older people who often have a range of multiple health needs that require intensive, coordinated care.

"Unfortunately, this landmark poll highlights that GPs' ability to care for patients is being seriously undermined by escalating workload, inadequate resourcing and unnecessary paperwork."

➔ GMC granted right to appeal rulings judged too lenient

FITNESS to practise rulings judged too lenient will be subject to appeal by the GMC under new changes to the Medical Act.

Parliament has recently approved the changes which will allow the GMC to appeal tribunal rulings handed down by the Medical Practitioners Tribunal Service (MPTS), which operates separately from the GMC. This would apply in fitness to practise cases in which the regulator considers rulings do not sufficiently protect the public.

Reform of the Act will also establish the MPTS as a statutory body.

In addition, there will be changes in the way complaints about doctors are handled, including streamlining fitness to practise procedures, the introduction of legally qualified chairs for some tribunals, and giving power to the tribunals to award costs against the GMC or the doctor if either has "not complied with directions and has behaved unreasonably".

Niall Dickson, Chief Executive of the GMC, said: "The new right of appeal and the establishment of the Medical Practitioners Tribunal Service as a statutory body are major reforms in UK professional regulation. They will

IN BRIEF

● **DRUG DRIVING LAW COMES INTO FORCE** A new offence for driving with certain medications over specified blood concentrations came into effect in March in England and Wales and is intended to bring enforcement more in line

with that for drink driving. It will operate in addition to the existing law on drug-impaired driving. More information can be found on the MHRA website including advice for healthcare providers and for patients.

● **CHILDREN "EMBARRASSED TO SMILE"** Thirty-five per cent of 12-year-olds and 28 per cent of 15-year-olds said they felt self-conscious when smiling and laughing because of visible tooth decay, according to figures from

the Children's Dental Health (CDH) Survey 2013. However, there was a drop in the proportions of 12 and 15-year-olds with obvious decay in their adult teeth since the last survey in 2003. Access full results at <http://goo.gl/vP4z7t>

reinforce our separation from the tribunal service and our role as a patient safety organisation which brings the most serious cases to the tribunal service for adjudication.

"These changes will also help us streamline our investigations, reduce the time it takes to deal with complaints and make our procedures faster, fairer and more efficient."

The GMC has launched a consultation on new and amended rules which will be needed to implement changes to the law. The results will be published in summer 2015 and then presented to Parliament for approval.

➔ New powers to audit data protection in the NHS

A CHANGE in the law has given the Information Commissioner new powers to compulsorily audit GP surgeries and other public healthcare organisations to access how they handle personal patient information.

The law which came into effect on 1 February amends the Data Protection Act and allows the Information

Commissioner's Office (ICO) to enter premises without consent to check on compliance with the Act and to review areas including security of data, records management, training and data sharing.

Previously, the ICO would only undertake compulsory audits in central government departments and consent was required for audits in the NHS. The new legislation will not apply to any private companies providing NHS services.

Christopher Graham, the Information Commissioner, said: "Time and time again we see data breaches caused by poor procedures and insufficient training. It simply isn't good enough.

"We fine these organisations when they get it wrong, but this new power to force our way into the worst performing parts of the health sector will give us a chance to act before a breach happens."

➔ New website to educate patients on implants

A dedicated website with a downloadable booklet to educate patients about implants and related treatments has been launched by The Association of Dental Implantology.

Patients accessing the website (www.consideringdentalimplants.co.uk) are provided a basic overview of the implant process, along with a glossary and illustrations to explain terms and procedures, and FAQs. Patients can also request a free printed copy of the leaflet – *Considering Dental Implants?*

MDDUS advises that the website and booklet may be a helpful adjunct in educating patients but reminds members that it remains the responsibility of the individual competent dental surgeon to ensure patient consent for implant treatment is fully informed and to check leaflets or other resources made available to patients are credible and up-to-date.



PHOTOGRAPH: RAY TANG/REX SHUTTERSTOCK

➔ Tough penalties for covering up clinical failings

HOSPITALS could be fined up to £10,000 and senior staff and directors could face jail for providing false and misleading data in regard to significant clinical failings under new plans to tackle any perceived "cover-up" culture in the NHS.

New laws are expected to target directors or other senior staff at NHS organisations who "consent or connive" in the provision of false or misleading information, with individuals subject to fines or imprisonment for up to two years.

The Department of Health is also consulting on plans to require hospitals to reimburse the NHS Litigation Authority up to £10,000 for each clinical negligence case in which they have failed to demonstrate openness and honesty after a significant clinical mistake.

The new laws have emerged from recommendations made by the Francis inquiry into failings at the Stafford Hospital where misleading and dishonest information was given to regulators and the public about the trust's poor performance.

The new requirements will apply only to information specified in the regulations which includes mortality figures, data submitted to the Health and Social Care Information Centre, quality accounts, complaints data, cancer outcomes data as well as national cancer waiting times and national audits.

Health secretary, Jeremy Hunt, said: "Being open and learning from mistakes is crucial in improving patient care. The NHS is a world class health service, but when mistakes happen it is vital that we face them head on and learn so they are never repeated. This sends a strong message that covering up mistakes will not be tolerated."

● MENTAL HEALTH ACT 1983

A revised code of practice for the Mental Health Act 1983 has been published by the Department of Health to provide guidance for professionals but also to help patients, their families and carers

know their rights. The code was last reviewed in 2008 and the new revisions reflect changes in legislation, case law, policy and professional practice. Download the code at <http://goo.gl/QBcM2V>.

● CALLS FOR ANTIBIOTIC REVIEW

NICE is calling for ongoing external review of antibiotic prescribing among individual healthcare providers in a bid to reduce antimicrobial resistance. It recommends setting

up stewardship teams to review prescribing and resistance data and provide feedback to those prescribing outside of local guidelines "where this is not justified". The final guideline is expected in July 2015.



WHERE DO CLAIMS APPEAR IN PRIMARY CARE?

Liz Price

OVER the last year, the risk team at MDDUS have been working to understand better the underlying patterns of risk which commonly lead to claims for negligence in general medical practice. As a mutual organisation, we feel it is important to undertake this analysis and inform members so that they may be better equipped to manage these risks in their own practice.

Two-thirds of claims against GPs relate to the diagnosis and investigation of presenting symptoms and conditions. Only a small number of cases are related to poor clinical judgement or treatment, and instead many arise due to failures in practice systems. Here I will highlight some of the common causes – and associated lessons – underlying the large group of these claims which are related to practice systems.

Delay or failure to assess

Appointment system failures

Failures here can arise from lack of available appointments in the practice or inappropriate triage and channelling of patients requesting appointments. Many practices can be over-reliant on non-clinical staff to manage patient demand, without appropriate and safe mechanisms by which they can request advice or override protocols when concerned.

Lesson: GPs should ensure that non-clinical staff are aware of their limitations and boundaries in dealing with patients requesting appointments when there is

little or no availability. The culture should be that staff can approach clinicians for advice or assistance easily via agreed mechanisms and that they should not provide clinical advice to patients as an alternative to appointments.

Inadequate record-keeping

Not utilising the clinical notes as a communication tool for the next clinician (e.g. recording positive and negative findings on examination and recording differential diagnoses) can lead to subsequent clinicians having inadequate information about a patient's condition.

Lesson: Clinicians should make adequate records for their colleagues/themselves in relation to history-taking, examination, differential diagnosis and treatment.

Delays or failures to organise tests

It can be notoriously difficult to ensure the robustness of practice results-handling systems. There is currently no one-size-fits-all solution to managing testing and the receipt and actioning of results. We have produced a checklist to help members review their results-handling procedures with their team (see below). However, the strength of this system will be dependent on the competence and effectiveness of staff interacting with it.

Arranging testing

Even before a sample is obtained things can go wrong. Failing to ensure that the patient is properly informed of the reasons for investigation can lead to their not attending for testing. Neglecting to check that a patient has attended for testing can lead to further delays – particularly where a GP has a high index

of suspicion about systems or previous experience with the patient not attending for review. These can all lead to criticism when a patient is negatively impacted.

Lesson: Clinicians should ensure that where necessary they hold (and document) a full discussion with the patient when the need for testing is identified. Individual patient needs and circumstances should be taken into account in coming to a decision about the need for more active follow-up.

Reviewing results

When results are returned to the practice there can be delays in viewing and actioning these due to factors such as clinician holidays, part-time working and overload. These delays can be problematic if the result requires immediate action – particularly with a combination of results which, when viewed together, would prompt action. Systems in which different doctors view different results for the same patient on different days can also result in a missed opportunity to avoid delay. This can occur in practices which operate a duty doctor system.

Lesson: There should be a process in place to ensure that the most appropriate clinician views results within a reasonable timescale – and if this is not possible, another clinician should screen the results in the interim for anything urgent.

Delays or failures to refer the patient for specialist review

Multi-disciplinary or multi-agency care where records are not shared can cause referral delays as the pieces in the jigsaw are often not effectively put together.

Lesson: Clinicians should undertake to meet with other healthcare professionals, such as health visitors and district nurses, to ensure the effectiveness of communication mechanisms is maximised, responsibilities are clear and records shared where possible.

The MDDUS risk team is now completing a similar analysis on private hospital and dental claims and more information on these will follow soon. We have also developed a range of risk checklists which members and their teams can use together to identify and mitigate their own risks. Access at www.mddus.com/risk-management/

■ Liz Price is a risk adviser at MDDUS

ETHICAL LESSONS FROM MY FATHER

Deborah Bowman

MY father died a fortnight ago. It was unexpected and shocking. He was 70 and, as far as anyone knew, in good health. The days and nights since have been a strange, raw and difficult time. It has been a period in which I have felt both absence from, and heightened presence in, the world. In the midst of it all, I have learned about, and reflected on, matters of ethics – some fundamental and profound and some seemingly minor but nonetheless life-altering.

First, I have been reminded that discussing an experience in the abstract rarely prepares for the moment that experience occurs. I am a proponent of what is known in the USA as “the conversation”. I prefer a series of discussions. However, I do subscribe to the view that talking about death and reflecting on our preferences, beliefs and expectations is not merely valuable, but necessary. It allows for informed decision-making, particularly when proxies and substituted judgments become involved. It facilitates the best possible care in the most difficult of circumstances. Perhaps less often-acknowledged, such conversations create space and opportunity for meaningful connections that will endure beyond death.

Yet, we must take care not to misrepresent these conversations about death and dying. They cannot and will never alter the complex emotions that ebb and flow when someone dies. It does not matter whether the death is sudden like my father's or anticipated for some time. The sense of disbelief and unfamiliarity of crossing into the terrain of the recently bereaved is unavoidable. Death and dying can be prepared for in many ways, but we cannot dodge, nor should we seek to dodge, the emotional ballast that is grief. For it is borne of love, and the loss of love cannot be rehearsed or controlled: it can only be felt.

Secondly, I have learned that there are hundreds, maybe thousands of people, making a quiet but unforgettable difference when someone dies. They are not the healthcare professionals whom I



“We cannot dodge, nor should we seek to dodge, the emotional ballast that is grief. For it is borne of love...”

have necessarily identified as significant or considered in any of the teaching or writing I have done over the years on ‘end-of-life care’. That has been a significant omission and oversight on my part; for these men and women have been transformative in improving the experience of my family in recent weeks.

I refer to the healthcare assistant who silently sat with my sister whilst she telephoned the rest of us to let us know the news. I refer to the cleaner who, on finding me in the lavatories, asked if I was okay before enquiring whether I would like her to stay or would prefer to be alone. I refer to the parking attendant who gently handed us a pass to get out of the car park when we realised none of us had change for the ticket machine. I refer to the mortuary assistant who managed to be both attentive and unobtrusive when we visited. I refer to the funeral directors who explained honestly and kindly what options were available to us whilst we waited for the coroner to report. I refer to the coroner's administrator who kept us informed, without being asked, at each stage.

These were not merely acts of kindness. They were moral acts. They were, in ethical language, demonstrations of virtue and values. These were individuals who will not be forgotten and whose faces, voices and gestures of empathy shall endure.

Thirdly, there have been moments of defensiveness or even hostility from professionals who are charged with care.

It saddens me that these few, but nonetheless bruising, encounters have been with doctors and nurses. There are, almost certainly, sound reasons why they have responded as they have: they may be exhausted, recently bereaved themselves, numbed by many years of disease and death, ill or otherwise struggling, or perhaps they were anxious about not being able to explain what happened. The institution may have communicated its own fears about an unexplained death with the concomitant possibilities of complaints or even litigation. A culture of inquiry may quickly become one of interrogation and inquisition.

I do not blame these people. I do however know afresh what courage and commitment it takes for individuals to act with integrity and openness even when they are themselves wrung out, afraid or cowed by the system within which they work.

Ethics is often represented as concerning ‘dilemmas’ or momentous decisions. It is rarely so. More often, it is a series of small everyday choices and incremental decisions about how to behave that may not even be conscious. This is as much the stuff of the ‘ethics of end of life’ as debate about assisted dying or the negotiation of advance decisions.

My father taught me that.

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



Looking ahead

MY PREDECESSOR, Gordon Dickson, produced a typically thoughtful piece in the last issue of *Summons*, looking back on his remarkably successful decade in the hot seat at MDDUS. Moving gently into his chair makes me recall the advice given to me many years ago by an old civil service mentor to “choose your predecessor with care”.

I doubt if I have ever failed to do that more thoroughly in coming to MDDUS, as Gordon has set me a remarkably high benchmark to aim at. Indeed, the only way to stay sane is to resolutely look forward, rather than keeping an eye on the rear view mirror, so as not to be too daunted by my inheritance.

Looking forward is a timely thing to do at the moment. People are looking ahead to the forthcoming general election, for example. They are looking ahead at implementation of changes following the Smith Commission Report and also at how the continued political ferment in Scotland will play out in next year's Holyrood elections. And there is also a sense of change around the NHS on both sides of the border, perhaps reflecting a move away from grand visions of change to much more practical measures to keep a vitally important show on the road at a time of continued high expectations and tough economic conditions.

More political change

Where does the MDDUS sit in the middle of all this change? I don't normally like reaching for glib management consultancy tools any more than I suspect most of you like reading about them. But one helpful way to think about the future is to look at trends in the current environment using so-called PESTLE analysis. That is a typical consultant acronym (albeit not one of three letters) for political, economic, social, technological, legal and environmental factors. What is remarkable when we look at each of these features is that all are fluid at the moment.

I have probably said enough about politics already, but you certainly do not need me to tell you that health issues are going to be a decisive factor quite possibly in both general elections. What will be interesting to see, beyond the noise, is how much different parties actually have surprisingly common visions.

All the parties, in England at least, seem to be interested in making the boundaries between primary care and hospital services rather more fluid. If done well, that could be a good thing for patients in terms of continuity of care – and it may also benefit professionals, bringing new, stimulating challenges. But if done badly, it could add pressure to a system which already can appear close to overheating. Whatever the outcome, things will occasionally go wrong and we will continue to stand behind our members and to find the right, fair solution as quickly as we can.

New CEO, Chris Kenny, offers a perspective on some of the challenges ahead both for MDDUS and UK healthcare in general

Economics at all scales

Of course, it is to some extent the economics of healthcare which will determine how far and how fast progress is made. The political noise about how green and numerous the shoots of recovery


are will no doubt continue for the next few months, but it is clear that budgets will continue to be constrained. That might stimulate fresh thinking with some of the benefits I have talked about earlier, but it may also lead to more pressure. At the MDDUS, we are very mindful of the fact that many of our members continue to see a squeeze on their incomes and we will therefore continue to price our services as competitively and effectively as we can, making sure our rates properly reflect genuine risks rather than additional padding. We will also be as rigorous in challenging our own costs as we know you have to be in challenging yours.

One reason for growth in activity at MDDUS is that we continue to live in a period of social change where patients are less and less deferential and more willing to challenge their doctor or dentist, sometimes with good justification though sometimes on a more tenuous basis. Overall, a better informed, more engaged patient base can only be a good thing for the practice of effective evidence-based medicine. We will continue to help equip our members to develop their practice through the production of more risk-based educational material and the enhancement of our newly launched website. But we will also continue to stand robustly behind you when the social forces driving the so-called “litigation culture” lead to members being unfairly pilloried either in the court system or the regulatory process.

Technological and legal challenges

Technology, considered more widely, is a two-edged sword. It opens new possibilities for clinical practice and for communication with patients but also makes possible new kinds of “innocent” error and new ways of accusing practitioners. At MDDUS we are constantly alert to how we can improve our own digital services and how we can also help our members to work effectively in a digital age, both, for example, by increasing our own use of social media but also (as we did recently) warning our members about the dangers of inappropriate use of Facebook, Twitter and the like.

The world of legal change is where I have just come from. As Chief Executive of the Legal Services Board in England and Wales, I was constantly pushing the legal profession to open itself up to greater competition and to put the consumer at the heart of the services being offered. But I was also very mindful of the need to maintain the highest professional standards. There is an awful lot of continuity here with the challenges faced by our ever-expanding legal team at the MDDUS. We have to keep our members at the heart of the work, whilst maintaining our own professional



"A better informed, more engaged patient base can only be a good thing for the practice of effective evidence-based medicine"

standards and duties to the Court which can sometimes mean giving bad news about the best way forward.

But it also means being tough in the extreme when we see cases which should never have been brought. That's why we welcome some of the changes brought about by the Jackson Report in England and the Taylor Report in Scotland. We think changes to Court process and funding mechanisms, far from obstructing access to justice for worthy claims, will allow those claims to be addressed more quickly by helping remove from the system those challenges which are frankly tendentious and mischievous and whose existence simply causes unnecessary anxiety to doctors and dentists doing their best on behalf of their patients. We will therefore continue to encourage legal reform in our areas of expertise, seek to continue to improve our own methods of legal working, but, above all, stay true to the highest standards of

professional integrity as we do so.

I think I have to pass on trying to find an environmental theme for MDDUS (although we are doing our level best to adopt the highest carbon management standards) but as I write this, trying to look forward, I am conscious that so much of what I have said actually has been in the life blood of the Union, not simply under Gordon's distinguished tenure, but since our beginning in 1902.

Being tough, realistic and driven by value (in every sense of the word, not just financial) is absolutely what the Union has stood for and will continue to stand for. So maybe I can occasionally risk looking in the rear view mirror, with a view to feeling inspired by what has been achieved so far, rather than being intimidated at having to live up to it!

■ *Chris Kenny is CEO of MDDUS*

Speaking freely

Jim Killgore *reports on proposed new measures to protect whistleblowers*

LINDA Reynolds had not been working long as a GP partner at the Brooke Surgery in Hyde before she noticed something odd about the number of cremation forms being countersigned for a nearby single-handed practice on Market Street.

Brooke Surgery had a list of about 9,500 patients – three times that of the neighbouring surgery – yet over a period of three months it had only 14 patient deaths compared to 16 deaths among patients treated by the GP at 21 Market Street. There was a pattern to these deaths – mainly elderly women dying at home, out of bed and fully dressed, later followed by cremations.

Nigel Reynolds – Linda's husband – recalled his wife's indecision over contacting her defence organisation for advice. "We had a conversation the night before she made the phone call. I said: 'Do you really think he is killing his patients?' and she said 'no' to begin with and then she said 'I know he's killing his patients'."

"We discussed the fact that if it got out and she was wrong she probably would not practise again in that area. But at the end of the day when she did it she didn't have any doubts about it because it was the only course of action."

Linda Reynolds reported her suspicions to the coroner but after a flawed police investigation the matter was dropped. Six months and another three deaths later suspicions arose over a changed will for a deceased elderly lady – Kathleen Grundy. This patient had not been cremated and her body was exhumed. An autopsy found traces of diamorphine. The patient's GP – Harold Shipman – was later convicted of Mrs Grundy's murder and that of 14 other patients although he was implicated in many more deaths.

Had Linda Reynolds not overcome her concern over the possible consequences of speaking up, more patients would certainly have been killed. In her fifth report of the Shipman Inquiry – a far-reaching review prompted by the case – Dame Janet Smith identified failings in the way whistleblowers are supported within the NHS. She wrote:

"I believe that the willingness of one healthcare professional to take responsibility for raising concerns about the conduct, performance or health of another could make a greater potential contribution to patient safety than any other single factor"

It is with this quote that Sir Robert Francis QC introduces his long-awaited review of whistleblowing within the NHS – *Freedom to speak up*. In the report, launched in February of this year, Francis acknowledges that since the Smith review and his own more recent report into the events at Mid Staffordshire NHS Trust, a range of initiatives have been put in place to foster a more open and honest culture in the NHS. "However, problems remain," he writes. The new review recommends a package of measures to ensure that NHS staff feel free to speak up about patient safety concerns.

Extreme retaliation

Francis was asked to lead the inquiry by Secretary of Health Jeremy

Hunt after he met with six NHS health professionals who had claimed to have suffered "extreme retaliation after raising serious concerns about patient care," as one of them, Dr David Drew, put it in a *Guardian* newspaper article.

The review heard from over 600 people and around 19,000 staff responded to an independent online survey. Responses were also submitted by 43 organisations and the review consulted with many other people through meetings, workshops and seminars.

In the inquiry Francis found that NHS staff want to speak up and there are numerous examples of organisations supporting them to do so. But he also heard how staff can be put off raising concerns for fear of victimisation. Others may fail to speak up out of doubt that their concerns will be listened to.

He writes: "Many respondents described a harrowing and isolating process with reprisals including counter allegations, disciplinary action and victimisation. Bullying and oppressive behaviour was mentioned frequently, both as a subject for a concern and as a consequence of speaking up. They also spoke of lack of support and lack of confidence in the process. Many of the contributions described cases that are recent or current. This indicates that there is still a real problem."

Law can go only so far

Currently, legislation providing protection for whistleblowers is contained in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998 (commonly known as PIDA). A worker making a protected disclosure has the right not to be subjected to any detriment by his employer for making that disclosure. Francis believes this legislation is limited in its effectiveness for a number of reasons.

"At best the legislation provides a series of remedies after detriment, including loss of employment, has been suffered," he states. "Even these are hard to achieve, and too often by the time a remedy is obtained it is too late to be meaningful."

Recent years have seen a range of measures to encourage or impose a responsibility on staff to speak up. These include the Fit and Proper Person Test and the new Care Quality Commission's (CQC) inspection and ratings regime. The government also recently introduced a statutory duty of candour requiring NHS bodies to inform patients or their representatives when an unintended incident has resulted in death, or severe or moderate harm.

Kim Holt is a consultant paediatrician and co-founder of Patients First – an organisation set up to raise awareness for whistleblowers and which made a significant contribution to the Francis review. She commented: "An organisational duty of candour might make a difference in that there's an expectation on the organisation to be honest. But we feel very strongly that unless professionals are properly supported and protected there will still be problems."

This was borne out in a 2013 NHS staff survey which showed

that only 72 per cent of respondents were confident that it is safe to raise a concern. Francis also believes any new legislation can only go so far. In the report he speaks of a 'just culture' as opposed to a 'no blame' culture and states that raising concerns should be part of the normal routine business of any well-led NHS organisation.

Holt – also a former whistleblower – agrees: "It's around the raising of awareness and remembering we are there for patients. We must try and focus on the patients first. Any anxieties about how this might reflect on the organisation or on the team – we have to try and put those aside.

"All that patients want is for people to acknowledge when things have gone wrong and to learn. And if we start doing that now the health service will become safer step by step and the culture will gradually change. Basically it's just being brave enough to take that first step."

Independent "guardians"

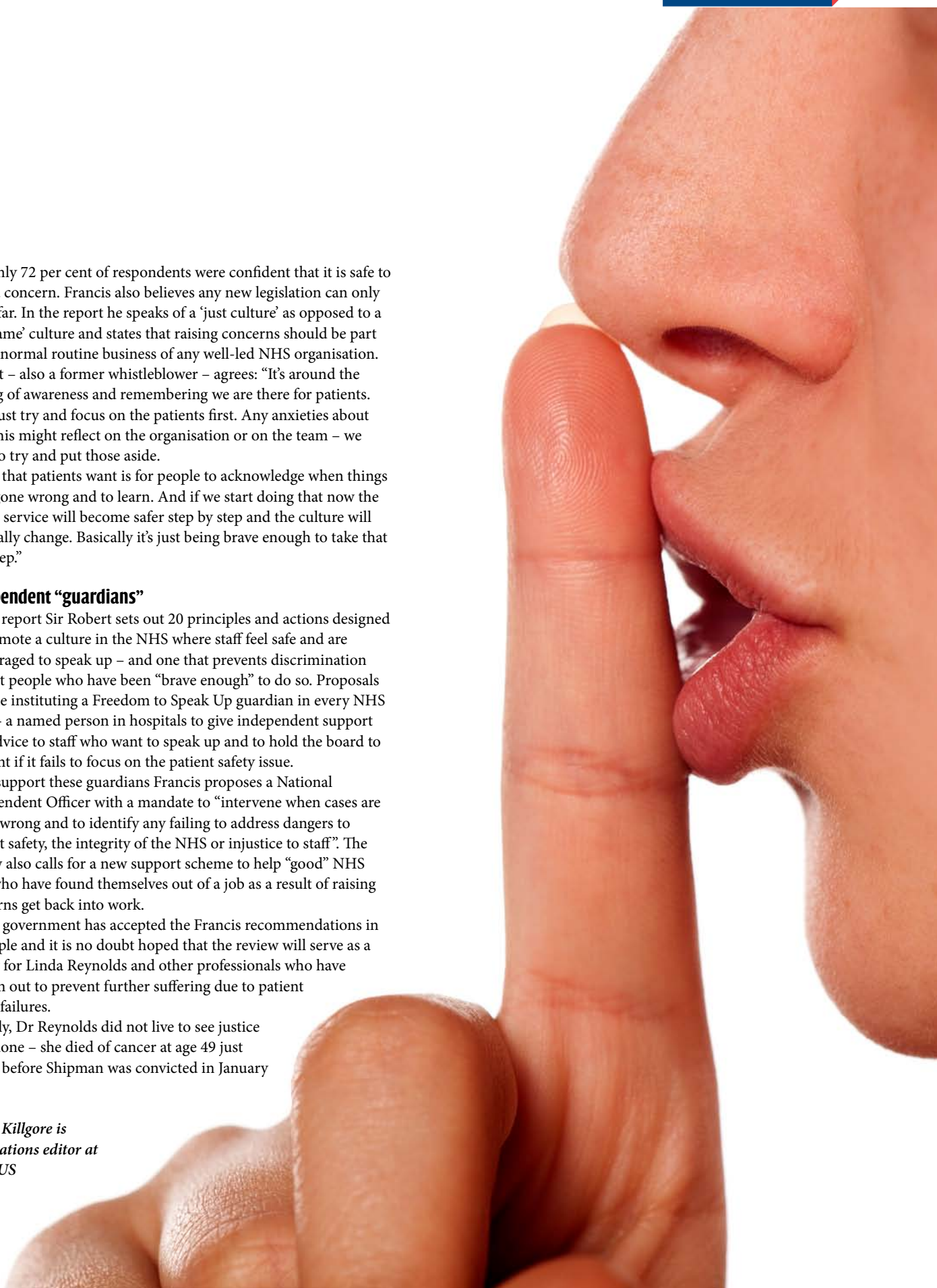
In the report Sir Robert sets out 20 principles and actions designed to promote a culture in the NHS where staff feel safe and are encouraged to speak up – and one that prevents discrimination against people who have been "brave enough" to do so. Proposals include instituting a Freedom to Speak Up guardian in every NHS trust – a named person in hospitals to give independent support and advice to staff who want to speak up and to hold the board to account if it fails to focus on the patient safety issue.

To support these guardians Francis proposes a National Independent Officer with a mandate to "intervene when cases are going wrong and to identify any failing to address dangers to patient safety, the integrity of the NHS or injustice to staff". The review also calls for a new support scheme to help "good" NHS staff who have found themselves out of a job as a result of raising concerns get back into work.

The government has accepted the Francis recommendations in principle and it is no doubt hoped that the review will serve as a legacy for Linda Reynolds and other professionals who have spoken out to prevent further suffering due to patient safety failures.

Sadly, Dr Reynolds did not live to see justice fully done – she died of cancer at age 49 just weeks before Shipman was convicted in January 2000.

■ *Jim Killgore is
publications editor at
MDDUS*



A reasonable patient

A case argued before the Supreme Court in London has clarified the legal position of informed consent. Here medical adviser Dr Gail Gilmartin looks at the judgment

THE Supreme Court recently published its judgment on a landmark medico-legal case in Scotland. *Montgomery v Lanarkshire Health Board* involved allegations in relation to birth-related injuries and has attracted a lot of publicity because of the £5.25 million award. But the case is also highly significant in medico-legal terms in that it crystallises the law in relation to consent – more specifically issues around the amount of information a patient is entitled to be told before making a treatment decision.

The case arose in 1999 when Nadine Montgomery gave birth to her son, Sam, at the Bellshill Maternity Hospital in Lanarkshire. Staff had to resort to a forceps delivery aided by symphysiotomy after the baby's head failed to descend due to shoulder dystocia. Twelve minutes passed between the head appearing and delivery, during which time the cord was completely or partially occluded. Sam was diagnosed with significant cerebral palsy.

Later Mrs Montgomery – acting on behalf of her son – raised an action against the health board alleging negligence in that she should have been given advice regarding the risk of shoulder dystocia, being just over five feet tall and diabetic. She also alleged that it was negligent not to perform a caesarean section when abnormalities were noted on the cardiotocograph (CTG) traces.

The main focus of the appeal was in regard to the information given to Mrs Montgomery when she had expressed concern about being able to deliver her baby vaginally – though she had not asked specific questions regarding shoulder dystocia. Maternal diabetes is known to increase the risk of complications such as shoulder dystocia – which occurs in around 10 per cent of babies born to diabetic mothers. In around 70 per cent of cases it can be overcome by simple manoeuvres but a small proportion (much less than 1 per cent) result in permanent injury.

The consultant involved in the case did not advise Mrs Montgomery of the risk of shoulder dystocia as in her view – supported by obstetric opinion – this was not warranted given the low probability of permanent harm. Mrs Montgomery argued that had she been fully advised of the risks, she would have elected for a caesarean section.

Initially Mrs Montgomery lost her case before the Outer House of the Court of Session in Edinburgh and then again on appeal before the Inner House. She then took her case to the Supreme Court in London where she was successful and her appeal allowed.

Material risk

This case is important to all doctors and dentists involved in consent discussions with patients as it sets out very clearly what



is expected in terms of information disclosure: the focus being on matters the patient would regard as significant which may not be the same in the clinician's opinion.

The key statements in the judgment pull together previous case law and guidance from, amongst others, the GMC. There is a move away from non-disclosure of a risk based on percentages: "... it follows ... that the assessment of whether a risk is material cannot be reduced to percentages".

The judgment also states that it cannot be left to the doctor to determine what is reasonable to disclose; the move is to what a patient would attach importance to. In addition, the Courts have the final say in "determining the nature and extent of a person's rights....not the medical profession's".

At paragraph 87 the judgment states: "An adult person of sound mind is entitled to decide which, if any, of the available forms of



"It cannot be left to the doctor to determine what is reasonable to disclose; the move is to what a patient would attach importance to"

There are some exceptions: where the patient has made it clear they do not wish to be informed of risks of injury, where the disclosure would (in the reasonable exercise of medical judgment) be seriously detrimental to the patient's health, and in an urgent or emergency situation.

Whilst this specific judgment is about an obstetric case, the principles apply to consent in all fields of practice.

Consent more than routine

The judgment makes specific comment about what is expected in the dialogue with the patient and the doctor's role, when at paragraph 90 it states:

"This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form."

All doctors involved in discussions with patients about consent will therefore need to be sufficiently well-informed and trained in how to obtain fully informed consent. They must be able to identify when a patient may need more information and a greater understanding in order to make a decision about the treatment they agree to have.

The judgment runs to 38 pages and clearly this article provides only the briefest commentary – but at paragraph 107 the message is very clear: "This case has provided us with the opportunity, not only to confirm... [that the need for informed consent was firmly part of English law], but also to make it clear that the same principles apply in Scotland."

This judgment provides the stimulus for doctors and dentists to reflect on their practice regarding consent. As usual we would advise that members keep clear, relevant and unambiguous notes of consent discussions and carefully check any proformas or standard information leaflets that are in use.

Should a member have any questions or concerns regarding consent please contact the MDDUS for specific advice as necessary.

■ *Dr Gail Gilmartin is a medical and risk adviser at MDDUS*

treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

The patient does not have to ask specific questions – and it has been pointed out that it is unreasonable to expect a lay person to know what questions to ask – but if they are expressing some concerns the questions which would naturally flow from those concerns must be explored and answered fully.

The forgotten foot

Professor Graham Leese *looks at pitfalls in identifying diabetics at risk of lower limb complications leading to amputation*

THE national prevalence of diabetes is over five per cent, and recent studies indicate that about 20 per cent of all hospital in-patients and nursing home residents have diabetes. This means that all involved in healthcare need to know something about diabetes, and in particular which patients with diabetes are “at risk” of coming to harm in the short-term.

Diabetes is the commonest cause of lower extremity amputation in the UK, usually as a result of the combination of two lower limb complications: neuropathy and peripheral vascular disease. Patients with neuropathy have numb feet and frequently do not notice or complain of problems. Several cases have been highlighted in the press over recent years involving individuals who developed foot ulceration whilst being an in-patient or in a nursing home and then went on to require a major amputation. This has often been a tragic sequelae to otherwise exemplary and successful in-patient care for some other condition. It is equally tragic in that it is often avoidable given a little knowledge, thought and some straightforward action.

If diabetes features low in the medical “problem list” this can potentially result in a greater risk for the individual patient, as clinicians may be distracted by other seemingly more important issues. In 85 per cent of cases, amputations start with a foot ulcer and the vast majority of these are preventable. However, which patients with diabetes are at greatest risk?

Identifying risk

By far the strongest predictor of foot ulceration and amputation (see table) in a patient with diabetes is a history of a prior ulcer¹. Nearly all patients are able to recall reliably whether they have had an ulcer or not – and it is very easy to ask! Other key risk factors include assessing whether the patient has neuropathy, absent foot pulses and nephropathy. This takes more effort but is relatively straightforward.

Neuropathy is usually assessed by detecting

sensation to tuning fork vibration or 10g monofilaments. However, it is well recognised that these are often difficult to find on a busy ward. Although it is probably not as well validated as the aforementioned tests, a new test called “touch the toes” (<http://goo.gl/M4086F>) has been shown to be useful for detecting neuropathy (developed by Gerry Rayman and a team at Ipswich Hospital). This involves lightly touching the first and fifth toe of the right and then left foot and then lightly touching the middle toe on each foot. If the patient cannot feel two or more toes being touched, they are deemed as having neuropathy. Research has found that the test correlates fairly well with monofilament testing and other neuropathy assessments and is easy and convenient for ward use.

Asking the patient if they have had a previous ulcer, and examination for neuropathy (after excluding existing ulcers) will identify most of the patients at high risk of developing foot ulcers and amputations. About four per cent of people with diabetes have had a previous ulcer, and about 20 per cent have numb feet in the community², although this proportion is probably higher in the diabetes population found within a hospital setting.

How well do we actually do in practice? An audit in November 2013 of 1,040 patients in hospital with diabetes across nearly every health board in Scotland was not impressive³. Of all in-patients on any ward in Scottish hospitals only 44 per cent of patients had had their feet checked, and of those checked 36 per cent had neuropathy and were thus “at risk” of hospital-acquired ulceration. Of



patients with neuropathy, in only 41 per cent had some effort been made to protect the foot. Of patients with current foot ulcers, 35 per cent had not been referred for treatment and 2.4 per cent of all foot ulcers had developed whilst the patient was in hospital. Similar findings were identified in an ongoing in-patient audit in English hospitals. There is clearly a need to improve on this.

Frailty, malnutrition and foot deformity are also important risk factors to consider for a hospital in-patient. This is particularly important if the patient has neuropathy. Although the whole foot is vulnerable, the heel is particularly susceptible for poorly mobile patients. Unfortunately, heel ulcers are the most difficult to resolve, and thus prevention is best.

What action to take

Once patients at risk have been identified, what can be done about it? Within Scotland an initiative entitled CPR for feet has been developed to try and help healthcare professionals reduce the risk of patients developing foot ulceration. This involves checking (C) patients for visible problems and neuropathy, providing protection (P) for those at risk, and referring (R) those with active problems, such as ulcers or gangrene (see figure right). Checking the feet for problems includes removing all dressings, as this is frequently not undertaken. Dressings often cover a major problem, which usually gets worse if not attended to.

A number of pressure-relieving devices are available to avoid heel complications for patients at risk. These include heel pillows, heel protection boots, repose devices, PODUS boots, PRAFO or LEEDer splints and many more, which are usually available at orthotic departments. Pressure-relieving mattresses are another approach which may help. However, specific devices are usually preferable for patients at high risk of foot ulcers, although the two can be combined and may be especially useful for the frail patient who is also at risk of pressure sores.

In summary, nearly all wards and residential or nursing homes will have patients with diabetes who are at risk of amputation. This will be the case for about a third of all in-patients, and they are easily identified by asking them if they have had a previous foot ulcer, checking their feet for ulcers (including under any dressing) and looking to see if they have numb feet, e.g. by using the touch the toes test. "At risk" patients should be provided with pressure relieving devices, and such patients should have their feet checked regularly. It sounds simple but frequently these measures are not taken in

practice, thus putting patients at risk of unnecessary amputations and clinicians at risk of unnecessary litigation.

Key points

- About 20 per cent of hospital in-patients and nursing home residents have diabetes.
- Around a third of these will have neuropathy and be at risk of foot ulceration and amputation.
- History of prior ulcer is the strongest predictor of future ulcer – so ask!
- Always look under a dressing for the presence of a current ulcer.
- A number of pressure-relieving devices are available for those at risk.

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FIGURE PUBLISHED WITH KIND PERMISSION OF THE SCOTTISH GOVERNMENT

Have your patients with diabetes had:

CPR for their Feet?

C

Check

Check both feet:

- Is there an ulcer or gangrene?
- Is neuropathy present?
- Is action required?

P

Protect

Protect feet if at risk due to:

- Neuropathy
- Previous ulcer or amputation
- Bed bound or fragile skin

R

Refer

Refer all patients with a foot ulcer, gangrene or other major concern to the podiatry department or diabetes team.

Ext

Patients with diabetes at greatest risk of foot ulceration and amputation


MAJOR RISKS

- Patients who have had previous ulcers or amputations
- Patients with neuropathy

Although prior ulcer and neuropathy are both risk factors, in most studies history of a prior ulcer predicts the onset of foot ulcer 10 times greater than the presence of neuropathy

OTHER RISKS

- Patients with absent pulses
- Patients with structural foot abnormality
- Patients with nephropathy or other renal disease
- Frail patients



Is it fair to criticise the so-called “destructodontics” of aesthetic dentistry?
MDDUS dental adviser Doug Hamilton offers a perspective

“BEAUTY is power; a smile is its sword”

THE words of 17th century naturalist John Ray remain one of the most poetic endorsements of beautiful teeth. Ray’s aphorism has particular resonance considering it came at a time when conventional tooth brushing methods were scarce. A complete, flashing smile would have been a rare and valuable commodity. Mind you, since life expectancy in Ray’s time was 36 one suspects there was little to smile about.

Nowadays, those in the developed world can expect to live at least twice as long, with increasing numbers of the population dentulous. We live in an age which is not only healthier, but also more affluent and image conscious. Fewer people are content with simply keeping their teeth. They also want them to look good.

A new art form

Dentistry, once the preserve of amalgam, plastic dentures and GA extractions, has risen to the challenge. Increasingly sophisticated ceramics have enhanced the aesthetic appeal of crowns which can now be swiftly created using CAD CAM technology. Less invasive alternatives include veneers and adhesive restorative materials. Malaligned anteriors which might previously have required extractions followed by months of wearing fixed appliances, can now often be straightened with

The price of

rapid orthodontic techniques.

On the face of it, dentistry is becoming an art. Yet, these new techniques have not met with universal acclaim. While there is little opposition to the use of innovative, recognised means of restoring diseased, fractured or missing teeth, ethical concerns emerge in non-therapeutic cases. Initially, criticisms were euphemistic, even humorous – elective veneer preparation may have been described as “treatment for hyper-enamelosis”. Recently, however, less subtle neologisms such as “destructodontics” and “mutilectomy” have appeared in journals, often submitted by respected clinicians. Why, in the midst of this apparently positive trend, do we read such dire warnings?

It cannot be denied that cosmetic dentistry involves a degree of risk. A significant percentage of pulps become non-vital following crown preparation. While veneers are certainly less destructive, studies suggest they have a relatively high failure rate and, with each replacement, further tooth tissue may be removed. In contrast, rapid orthodontics involves little if any enamel loss. However, the almost inevitable fracture or de-bond of permanent

retainers, which are often required due to the inherent instability of the aligned teeth, necessitates further intervention. Even bleaching, which at first seems ultra-safe, can result in sensitivity and may necessitate replacement of restorations. Also, if you overdo it, you have many years of drinking strong coffee and smoking Gauloises to reverse the process.

Proponents of these techniques might argue that virtually all dental treatment, from bitewing radiographs to implants, are risky. There is no reason to distinguish cosmetic treatments. Yet, when a patient presents with, for example, a carious or fractured tooth, the advantages of intervention are usually palpable, whereas doing nothing is often the riskiest approach. Purely cosmetic cases are a different kettle of fish. Here, the argument runs, there is little risk in doing nothing, other than the likelihood that patients will remain dissatisfied with their smiles. All the tangible risk lies with the interventionist approaches in their various guises. Some in the profession have expressed profound reservations regarding such treatments.

An oft-cited example involves cases where dentistry is carried out on sound teeth solely for the purpose of matching them with restorations placed to improve neighbouring teeth. In experienced, skilled hands the results can be superb. However, there is a body of opinion that regards preparing healthy teeth in order to satisfy the subjective and possibly transient concept of the “perfect smile” to be beyond ethical boundaries.

The argument is often captured by the so-called “daughter test”. Would you carry out this treatment on your daughter? No? Well don’t do it on someone else’s daughter. This test, in many instances, provides the practitioner with a valuable yardstick. Yet, it does not offer an ethical nirvana.

perfection

Patient autonomy is now a cornerstone of modern healthcare delivery. Therefore, whether you would provide a treatment to your daughter may not be the point. What if your daughter, if competent and properly consented, wished to undergo elective cosmetic dentistry? She may be delighted, even empowered, by the resulting improvement. Surely, denying her all that modern dentistry has to offer because you regard it as morally unacceptable smacks of paternalism, the scourge of today’s medical ethics? Even if you remain unwilling to carry out the desired treatment, your daughter might reasonably expect a referral for further assessment. Failing this, she may go elsewhere.

Patient choice

This leads us nicely to the next controversy. Most of those in primary healthcare settings tend to rely upon patient satisfaction and return business to pay the bills. General practices remain afloat by catering not only for patients’ needs but also (within limits, one hopes) their wishes. But that certainly does not mean dentistry should be patient-led. Even the most enthusiastic

patient request will not validate unsuitable or unrecognised treatment choices. However, if dentists are unable or unwilling to offer conventional, applicable cosmetic techniques, patients may vote with their feet, taking their chequebooks with them. Therefore, at some point, even the most risk-averse, conservative dentist may be tempted to undertake cosmetic procedures.

Yet, the refuseniks are not necessarily troubled by the image of a dentist reluctantly bowing to a patient’s demand for wall-to-wall veneers. Quite the contrary – the focus of their concerns is the possibility that patients may be beguiled or induced into such treatments, perhaps with the aim of maximising revenue. The irreversibility and unpredictability of certain procedures, which look so straightforward on carefully edited TV makeover shows, might be underplayed. The likelihood that costly replacement or even extension of the initial work will be required in the future might be lost in translation.

“Before” pictures look as though the patient has been photographed under a 40-watt bulb just after being told that the cat has died. In the “after” picture, the patient has clearly had a professional makeover and, judging by her smile, is holding the winning lottery ticket. I have little doubt that the vast majority of practitioners aim to employ impeccable consenting methods. However, patient expectations combined with financial pressures make the slope that bit more slippery.

The critical importance of patient autonomy is undeniable and may well dictate that it should be the competent patient and not the dentist who decides whether the risks associated with elective cosmetic interventions are acceptable. Yet, this argument evaporates where the patient’s decision is based upon incomplete or inaccurate information. Lest we forget, the subjective nature of what constitutes a good aesthetic outcome already increases the chance of disappointment and conflict. Where the consenting process has strayed, perhaps inadvertently, from explanation to seduction, complaints, claims and GDC referrals may well follow.

Obviously, in the course of the subsequent investigation, the practitioner’s treatment planning and execution will come into play. However, it is the issue of consent which is often subject to the most forensic scrutiny. Therefore, members should, if challenged, be able to produce (in addition to excellent records) a bespoke consenting document (quite separate from the costing schedule) which must recap on the patient’s presenting complaint and the resulting discussions. It must also accurately describe the agreed procedure, its limitations and the recognised complications in layman’s terms. Visual aids which provide a realistic concept of the aesthetic outcome are most helpful. Finally, other approaches must be set out. This must include the most obvious yet frequently overlooked alternative – the option of doing nothing. If a consensus cannot be reached and the document remains unsigned, treatment should not proceed.

Even the most gifted operator employing well-accepted techniques will have to deal with problems such as non-vital pulps, failed restorations and disappointing aesthetic results. However, where there has been a scrupulous, pragmatic consenting process, the essential relationship of trust should remain intact.

■ *Doug Hamilton is a dental adviser at MDDUS*

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



CONSENT: OPERATIVE RISK

BACKGROUND: Mrs K is 36 years old and presents at her GP surgery complaining of chronic abdominal and back pain. She also reports having heavy and painful periods and discomfort during and after sex. She is worried and depressed and it is affecting her marriage. The GP suspects Mrs K is suffering from endometriosis and refers her to a gynaecologist.

A week later Mrs K attends a private hospital for a consultation with a gynaecologist – Ms T. The consultant confirms a history of deep dyspareunia and post-coital ache. The uterus is found to be very tender on pelvic examination. Ms T recommends a laparoscopy to find the exact cause of the pain and possibly treat. She discusses what is involved in the procedure and offers Mrs K a date within a few weeks.

Early on the morning of the procedure Mrs K meets the consultant briefly for a pre-operative discussion and signs a standard consent form for: "Diagnostic laparoscopy +/- adhesiolysis +/- endometriosis treatment". The procedure is carried out later that morning. A small area of endometriosis is noted in the Pouch of Douglas and lateral to the utero-sacral ligament. The endometriosis is cauterised with a helium beam coagulator. Mrs K recovers well from the anaesthetic and is discharged home later that evening.

An on-call GP attends Mrs K the next day. She is suffering from severe abdominal pain and vomiting. An ambulance is called and she is transferred to an NHS emergency department. Here she is assessed and the history and examination is suggestive of peritonitis. Later that evening she undergoes an emergency laparotomy. Free fluid and fibrous exudate are found in the peritoneal cavity caused by leakage from the bowel. Further exploration reveals two small "through and through" perforations in the ileum about 60cm from the ileo-caecal junction.

The perforations are repaired and the peritoneal cavity lavaged with a drain left in situ. Mrs K undergoes a protracted recovery and is in hospital for another week with IV antibiotics. In subsequent visits over the next few months to her GP she complains of abdominal pain with tiredness and low mood.

Six months later Ms T receives a letter of claim from solicitors representing Mrs K, alleging clinical negligence. In the letter it is claimed

that the surgeon did not take reasonable care when carrying out the operation and also that she did not properly inform Mrs K of the risks involved in the procedure, including the risk of bowel perforation. She is seeking damages for loss of earnings in her time off work and also compensation for physical and emotional harm.

ANALYSIS/OUTCOME: MDDUS in acting for Ms T commissions an expert report from a consultant gynaecologist who judges that, given the patient's history and the findings upon examination, it was entirely appropriate to advise a laparoscopy.

In regard to consent, the expert notes that the standard form used did not include an explicit record of discussion of the risks involved in the particular procedure. In her retrospective account of the case Ms T described her standard consent procedure with a discussion of risk-benefit and mention of the small risk of bowel perforation. But the details of this discussion are recorded neither in the patient notes nor on the standard consent form.

Bowel perforation is a well-recognised complication of laparoscopy though relatively rare. In his assessment of the case the expert finds no evidence of breach in the duty of care by Ms T in regard to the decision to operate or in the conduct of the procedure and the patient's post-operative care. His only concern is in regard to the contemporaneous documentation regarding consent and pre-operative discussion of the risks of the procedure. Specific written evidence of such discussion is lacking in the patient records.

MDDUS lawyers write back to the patient's solicitors robustly countering the claims of negligence against Ms T. After further correspondence the claim is eventually dropped with no further action.

KEY POINTS

- Medical complications are not necessarily matters of clinical negligence.
- Ensure that records concerning pre-operative consent include specific discussion of serious and common risks for the particular procedure.
- Contemporaneous records of treatment discussions tend to carry greater legal weight than later statements of "usual practice".





PRESCRIBING: RELUCTANT TO REVIEW

BACKGROUND: A 53-year-old patient, Mrs B, has been on a repeat prescription for diazepam for the past 10 months. She has been invited for a medication review on two occasions but has failed to respond to letters and phone calls from the practice.

Her GP, Dr D, is growing increasingly concerned about the potential consequences of continuing to prescribe the drug without being able to sufficiently monitor the patient's health. He is also worried about the impact of stopping the repeat prescription and contacts MDDUS for advice on how to proceed.

ANALYSIS/OUTCOME: An MDDUS adviser acknowledges the challenge of treating patients who fail to attend for review and highlights GMC guidance which states that, when prescribing, doctors must have adequate knowledge of the patient's health and be satisfied that the drugs or treatment prescribed serve the patient's need. Doctors reviewing a repeat prescription must make sure that suitable arrangements are in place for monitoring, follow-up and review. Medication reviews are considered particularly important in patients who may be frail or with multiple illnesses. Guidance also requires doctors to give particular consideration to those medicines with potentially serious or common side-effects.

In re-prescribing a medication, doctors are advised to ensure the prescription is safe and appropriate and to agree with

patients how their condition will be managed, including dates for review. The guidance also requires a doctor to ensure that clear records are made in relation to prescribing.

Mrs B's refusal to attend for review presents a difficult situation. The doctor is advised to clearly record all attempts to invite the patient in for review and to keep copies of all correspondence. There should be a note in the patient records alerting other practice staff to the need for an opportunistic medication review the next time Mrs B attends the surgery.

Should she continue to default, the risks and benefits of continuing to prescribe without review should be weighed up and a decision made and fully documented. The doctor is advised to consider inviting Mrs B in for a face-to-face discussion before making any decision about stopping the prescription as there may be other reasons behind her refusal to attend. Dr D is also encouraged to discuss the matter with practice colleagues to agree on a course of action that takes into account the patient's individual circumstances.

KEY POINTS

- Ensure the practice has an adequate system to review repeat prescribing.
- Use all practical means to invite patients for review.
- Give careful consideration in managing repeat prescribing, taking account of individual circumstances.



CONFIDENTIALITY: A WRONG MESSAGE

BACKGROUND: Mrs M attends her dentist, Mr A, complaining of pain in an upper tooth. They discuss treatment options and she agrees to undergo private treatment, including root filling and the fitting of a new crown. The treatment is carried out without incident and Mrs M pays part of the bill before leaving that day.

The practice sends out an account detailing the remaining total but, three months later, no further payments have been made. Mr A issues another written account to Mrs M but is then contacted by Mr M who says he is assuming responsibility for the bill.

Five months after the initial appointment still no further payment has been made. Mr A phones Mr M at home to discuss the matter. There is no answer but the phone switches to an answering machine, identified as belonging to Mr and Mrs M. He leaves a message asking Mr M to contact the practice about the unpaid bill.

One week later, Mr A receives a cheque for £150 from Mr M along with a promise that more money will follow soon. It is also accompanied by a letter of complaint from Mr M who is angry that the dentist disclosed information about the unpaid bill in the answering machine message. His daughter had dropped by while he was out and heard it, causing him considerable embarrassment.

Mr A sends a written apology to Mr M and agrees to let him pay the bill off over the next two months.

A short time later, however, Mr A is notified by the General Dental Council that a complaint has been made against him alleging a breach of confidentiality.



ANALYSIS/OUTCOME: Mr A calls MDDUS for advice. It is recommended he writes a further letter of apology to Mr M, accepting that sensitive information about the unpaid bill should not have been disclosed in the phone message and that practice procedures have been changed to avoid a repeat of this error. It is also suggested that Mr A waives the outstanding sum owed to the practice in recognition of the distress caused by the breach.

The GDC case is eventually closed with no action taken against Mr A.

KEY POINTS

- Only contact patients by telephone with their express consent.
- Never disclose sensitive patient information in telephone messages.
- Be aware of the potential for third parties to intercept messages, even on personal mobile phones.



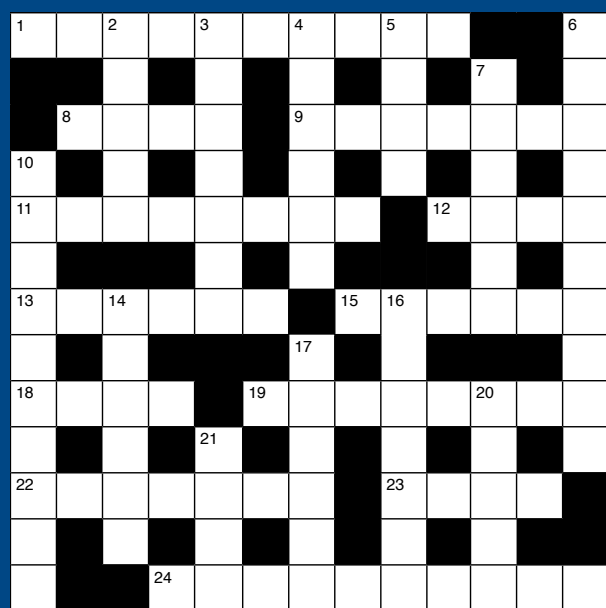
Object obscura: Herbal remedies

THIS medicine chest of herbal remedies produced in Italy around 1875 is attributed to Cesare Mattei, an Italian count with an interest in homeopathy. Mattei believed that fermented plants gave off "electrical" energy and that every illness had a cure provided in the vegetable kingdom by God. He began to develop his system from 1849 with the ingredients remaining a secret. The vial labelled "Canceroso 5" was used for bruises, cancers and hair loss among other conditions. Mattei's system was popular but mostly dismissed by the medical profession as quackery.

Source: Science Museum

PHOTOGRAPH: WELLCOME FOUNDATION

Crossword



ACROSS

1. Sloughing of necrotic inflammatory tissue (10)
8. Shock lung (acronym) (4)
9. Cosmetic dental devices (7)
11. One of three germ layers in an animal embryo (8)
12. Protein filament grown from follicles (4)
13. Viral disease contracted from animal bites (6)
15. Factors in analysis (acronym) (6)
18. Tooth centre or Mr Cocker's crew (4)
19. Promotes the production of urine (8)
22. Windpipe (8)
23. Kim ____, founder of Patients First (4)

24. Chronic lung condition caused by exposure to fireproof material (10)

DOWN

2. Gem weight (5)
3. Small amount remaining (7)
4. Inn (6)
5. Has legal title to (4)
6. Revival (10)
7. Pour from one container to another (6)
10. Neural complication of diabetes (10)
14. Folk song (6)
16. Hearing range (7)
17. Preserved grass (6)
20. Stories (5)
21. Specific thing indicated (4)

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

From the archives: Cancer dreams

SOMETIMES the quackery of a century ago seems more than a little familiar today. Consider a case from the year 1900 of an inquest held at Mirfield Memorial Hospital into the death of Annie Taylor, the wife of a local pub landlord.

Mrs Taylor died from breast cancer and had been treated by an unqualified practitioner named Benjamin Balme, who described himself as a medical herbalist. Balme stated to the coroner that Mrs Taylor consulted him and his wife at their house – and that Mrs Balme had diagnosed the cancerous tumour while in a hypnotic sleep. She advised that it was possible to "scale" the cancer away and they sold Mrs Taylor medicine and an ointment to rub on her breast.

Weekly hypnotic sessions followed where Mrs Balme monitored the treatment – though Mr Balme claimed to have advised the patient to get further advice as it was a "bad case".

A post-mortem later determined that Mrs Taylor died from cancer of the breast with secondary deposits in other organs. The examining doctor stated that, in his opinion, had the woman been surgically treated in the earlier stages of the disease she would be alive today with a good chance of a "perfect cure". In instructing the jury, the coroner said it had to decide whether in persisting with the treatment offered by the Balmes the "deceased had been prevented from attending elsewhere. If so, it amounted to manslaughter."

The jury returned a verdict in just half an hour that no blame could be "attached to anyone" in the case. The *Leeds Mercury* newspaper commented that the case "read more like a tale from the Middle Ages, when ignorance and credulity went hand in hand, than a sober account of events which have taken place within a few weeks of the opening of the twentieth century".

Source: *BMJ* Dec 1, 1900.

Vignette: Doctor and poet

Robert Seymour Bridges (1844–1930)

ONLY one medical graduate can claim the honour of being named Poet Laureate of the United Kingdom – and that was Robert Bridges.

Bridges was born on October 23rd in Walmer, Kent, the penultimate child in a large and prosperous family. His mother was from Yorkshire. When Robert was only nine his father died and his mother remarried the Reverend Dr John Molesworth, vicar of Rochdale, Lancashire. Immediately he was sent to Eton where he received a privileged education. He enjoyed rowing and cricket at school, but it was his aesthetic sensibility and interest in language that attracted him to poetry. He continued his education at Corpus Christi College, Oxford. There he read the Greats and became friends with the poet Gerard Manley Hopkins.

Bridges almost chose the church for a career but decided that medicine was his vocation. In 1869 he was admitted as a student at St Bartholomew's Hospital in the city of London, graduating in 1874. Victorian London was smoky and overpopulated, and by 1876 Bridges was a physician at Barts and faced with the impossible task of regularly sifting more than a hundred patients in a morning clinic of the Casualty Department. Dr G C Cook (Wellcome Library for the History and Understanding of Medicine) vividly describes the chaos:

"Bridges considered that it was totally impossible to combine the diagnosis of this large number of patients, with efficiency. The prevailing system was in fact virtually inoperable! People were also ignoring good country doctors (GPs) and, instead, making pilgrimages to St Bartholomew's. A further criticism was directed to extraneous noise, which precluded adequate auscultatory diagnosis."

Patients were often sent away with a bottle of iron tonic. Rheumatic fever was common and could be accompanied by excruciating joint pain. Bridges published



a paper in the *St Bartholomew's Hospital Reports* on the use of splints on a patient "who seemed to be dying of sheer pain". Morphine was also used. He was critical of doctors who did not treat the pain but merely watched the effects on the heart.

In 1876 he moved to The Great Northern Hospital, in the Caledonian Road. This was a charity hospital devoted to the care of the sick poor of the district. That same year he acted promptly and effectively to control an outbreak of smallpox; some patients were evacuated to Homerton hospital and the remainder were vaccinated. Two years later he became a physician at the Hospital for Sick Children, Great Ormond Street. His poem "On a Dead Child" combines tenderness, faith and clinical observation.

Bridges fell ill with pneumonia and empyema in 1881. His recovery was helped by a tour of Italy but he decided it was time to retire from medicine and write poetry in the fresh air of the country. His mother joined him at the Manor of Yattendon, Berkshire. There he co-produced the *Yattendon Hymnal*. He

married Monica Waterhouse, the daughter of an architect, in September 1884. They had a son and two daughters. He named his son Edward after a brother who had died when he was a student. In the early years of the 20th century the Bridges family moved to Oxford.

His first volumes of poems were published privately, but he was recognised by Smith and Elder as a poet of note and when the Oxford Press published an edition of *Poetical Works* in 1912 he became famous. He was appointed Poet Laureate to King George V the following year. He was a founding member of the Society for Pure English. It aimed to guide education authorities and influence popular taste.

At the outbreak of war Bridges sent a poem to *The Times*, it was printed September 24th 1914 in the TLS. "Hell and Hate" was inspired by a painting in his bedroom. Personal suffering when Edward was wounded strengthened Robert Bridges' patriotism and focused it on an anthology of prose and poetry for war time, *The Spirit of Man*.

The first line of one of his best known poems "I love all beauteous things, I seek and adore them" is a theme throughout his work. "London Snow" shows a contrast to the noisy clamour he knew:

*When men were all asleep the snow
came flying,
In large white flakes falling on the city
brown,
Stealthily and perpetually settling and
loosely lying,
Hushing the latest traffic of the drowsy
town;*

Shortly before his death he completed a long philosophical poem "The Testament of Beauty" which was reprinted again and again in its first year.

Among many honours, it was FRCP given in 1900 that was dearest to him.

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

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