SUMMER 2015

SUMMONS

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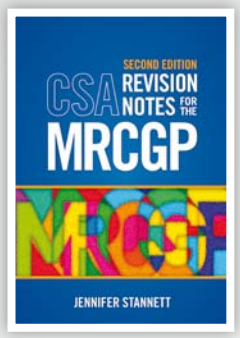

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J. Stannett

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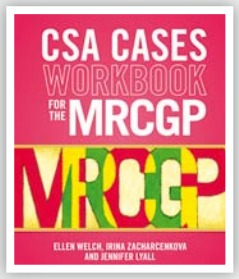

CSA Cases Workbook for the MRCGP

Ellen Welch, Irina Zacharcenkova and Jennifer Lyall

Designed to be used by GP revision groups, the ring-bound pack provides 64 cases structured around the RCGP curriculum statement areas. The book is designed to allow each member of the revision group to act as 'doctor', 'patient' or 'observer' and to take out just the pages they need ahead of the next revision session – this makes the practice consultations as exam-like as possible.

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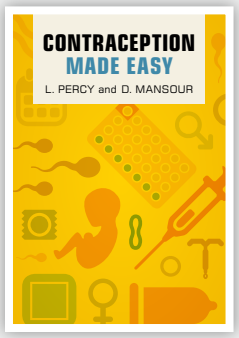

Contraception Made Easy

Laura Percy and Diana Mansour

Contraception Made Easy provides a concise overview of the subject and is especially written for non-specialists. The main audience for the book will be those working or training in primary care who want an easy-to-access, brief reference on the subject.

This book provides concise and easy access to the key areas of contraception required by primary care professionals.

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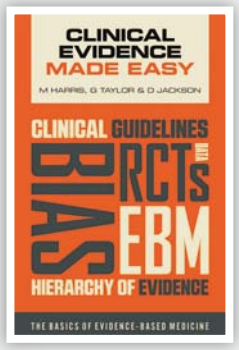

Clinical Evidence Made Easy

Michael Harris, Gordon Taylor and Daniel Jackson

Clinical Evidence Made Easy will give those working in healthcare the tools to understand the information available to them from clinical data sources, which can otherwise be hard to decipher.

Clinical Evidence Made Easy scores maximum 100 and 5 stars on Doody's (Sept 2014)!

Paperback, £18.99
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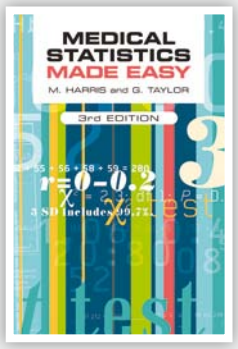
★★★★★ (3)



Medical Statistics Made Easy 3rd edition

M. Harris and G. Taylor

Medical Statistics Made Easy 3rd edition continues to provide the easiest possible explanations of the key statistical techniques used throughout the medical literature.

Featuring a comprehensive updating of the 'Statistics at work' section, this new edition retains a consistent, concise, and user-friendly format.

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★★★★☆ (5)

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FROM THE EDITOR

I AM delighted to join the *Summons* team in the role of editor with this Summer edition. As a longstanding MDDUS member, I have enjoyed the information and 'cautionary tales' offered in *Summons* over the 26 years of its publication, and it is a great pleasure to become involved in its production. Jim Killgore will continue to hold the reins as managing editor, assisted by Joanne Curran as associate editor.

The feedback we receive from members about *Summons* is very positive, thanks to the expertise of the editorial team and our many contributors. It is important, however, that we remain open to change and new ideas, and we welcome any feedback or comments members may have on content. The magazine is for your benefit, and we are keen to hear from you if there is something that you would find helpful or interesting.

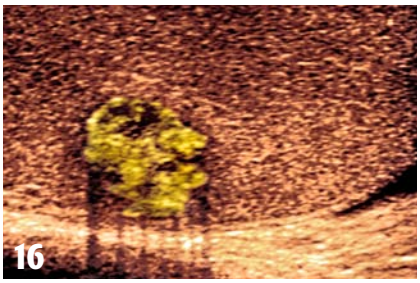
The rising tide of complaints to the GMC is a matter of concern for doctors, and in an interview in this issue, Professor Terence Stephenson, GMC Chair of Council, acknowledges that it is the greatest challenge faced by the organisation. The GMC aspiration to deal with relevant complaints only and adopt a 'right-touch' approach is discussed on page 10.

All doctors are obliged to contribute to the recognition and reporting of adverse events, and a new project, led by the RCOG, to establish a central repository of serious untoward event reports as a national learning resource is described on page 12.

The treatment of testicular cancer is one of the most remarkable advances in modern medicine in recent decades, with overall cure rates now at 95 per cent. This makes early detection particularly important, and Professor Krishna Sethia provides a helpful update on pitfalls in diagnosis and management at page 16.

Burnout is a serious occupational hazard for health professionals and on page 18 we feature one dentist's story. And to add to our regular features, Jim Killgore introduces a new book review section on page 22 which we hope you will find interesting.

Dr Barry Parker



Cover image:
'Lunan Bay'
Oonagh de Voy
Oil on canvas, 1997

Oonagh de Voy graduated from Duncan of Jordanstone in 1995. She is drawn to the sea and seascapes like this one, originally created for Paintings in Hospitals, feature widely in her work. She exhibits all over Scotland and is a contributor to community arts projects.

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.

Editor:
Dr Barry Parker
Managing Editor:
Jim Killgore
Associate editor:
Joanne Curran

Editorial review:
MEDICAL Dr Richard Brittain
DENTAL Mr Aubrey Craig
LEGAL Simon Dinnick

Please address correspondence to:

Summons Editor
MDDUS
Mackintosh House
120 Blythswood Street
Glasgow G2 4EA

jkillgore@mddus.com

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

MDDUS sees sustained growth in 2014

MDDUS saw a 9.4 per cent increase in total active membership in 2014 and as of mid-June 2015 that number was just short of 40,000. These figures are reported in the *MDDUS Annual Report and Accounts* now published at **mddus.com** in advance of the Union's AGM in September.

GP membership in 2014 increased by 10.8 per cent overall and by 16 per cent outside Scotland, with our share of the all-UK GP market now standing at over 23 per cent. Membership among hospital doctors also increased by 6.9 per cent.

Dental membership in Scotland remained stable in 2014 but we saw exceptional growth in the rest of the UK with numbers increasing by 25 per cent. It is likely that English dental membership will overtake Scottish in the course of 2015.

This sustained growth is built on a firm commitment to quality, says CEO Chris Kenny. "Throughout the year MDDUS has continued to offer the personalised, rapid and flexible service on which we have built our reputation in medico- and dento-legal advisory work, support for members in legal proceedings and day-to-day handling of subscriptions and queries."

Our Medical Advisory team handled over 9,600 telephone calls for advice in 2014, an increase of 13 per cent from 2013, and were pleased to report that 87 per cent were answered at first contact by a trained adviser able to deal with the enquiry. The Dental Advisory team dealt with 2,261 advice calls in 2014, also a 13 per cent increase over the previous year.

Calls to our Membership Department also increased in 2014, with the team handling over 37,000 telephone contacts and responding to these within 10 seconds on average.

Growth in active membership of MDDUS – along with what seems an increasingly litigious medico-legal environment – led to a significant rise in the number of claims for clinical negligence against members in 2014. The number of claims intimated against medical and dental members across the UK increased by 17.9 per cent over the previous year. This overall increase reflected a 21.9 per cent rise in claims notified against GPs, and an 18.8 per cent rise in claims notified against GDPs and hospital dentists. But on the plus side we can report that MDDUS managed to successfully conclude over 75 per cent of claims without any payment as a three-year average to 2014.

We have also seen an increase in the number of members subject to investigation by their regulatory body in 2014, and this trend was particularly marked in relation to GDC investigations, with a 37 per cent increase in case numbers on the previous year.

Indemnity for nurses in general practice in England, Wales and NI

MDDUS is changing the way that we provide indemnity for some nurses and other clinical employees in general practice in England, Wales and Northern Ireland. The changes will provide greater certainty for employed nurses, whilst ensuring subscriptions are fairer for all members.

We have launched an Associate Membership category for nurses employed within an MDDUS Discount Practice Scheme (DPS). This membership will ensure that nurses have access to the required professional indemnity for any

claim that arises from work undertaken in the normal course of duties within the MDDUS practice. As a result, from the date of members' next renewal, MDDUS will no longer consider providing indemnity for GPs' vicarious liability for nurse practitioners (including nurse prescribers), advanced nurse practitioners or other clinical staff who undertake similar roles.

Practices are able to include within a DPS scheme, at no additional cost, one nurse practitioner or advanced nurse practitioner for each GP member. Additional nurse practitioners and advanced nurse practitioners may be included upon payment of the appropriate subscription.

Practice nurses: practice nurses will now be named within the Discount Practice Scheme and GP partners remain able to seek indemnity for their share of any liability that might arise from their employment within the practice. Practice nurses will be provided with a confirmatory certificate.

Other staff: GP partners who are members of MDDUS remain entitled to seek indemnity in respect of their share of liability for healthcare assistants, phlebotomists, dispensers and non-clinical reception and administrative staff employed by them within the practice. GPs employing staff not listed above should refer to our website.

Full details and an online application

IN BRIEF

● **BOOK NOW FOR PM CONFERENCE** The popular MDDUS Practice Managers' Conference will be held this year at the Fairmont Hotel in St Andrews on Thursday 26 and Friday 27 November. Delegates attending the conference can enjoy interactive workshops covering a broad range of topics and also screening of the third instalment of our film series, *Bleak Practice*, which promises an entertaining way to learn key risk lessons in general practice. Places are limited so contact the Risk Management team now to book your place (**risk@mddus.com**).

● **NEW RISK VIDEOS ON CONSENT** Issues around consent are the focus of the latest online video presentations from MDDUS Risk Management. In two modules the risk team covers basic concepts of patient consent before taking a closer look at capacity to consent in both adults and children. The videos are available in the Risk Management eLearning Centre

form will be provided to members at the time of renewal. For more information, please visit the MDDUS website at **http://tinyurl.com/opud3uk**

MDDUS welcomes plans to cap clinical negligence legal fees

MDDUS has welcomed government plans to cap legal fees in clinical negligence cases against the NHS in England.

The proposal aims to control excessive legal costs by setting a fixed tariff for claims up to £100,000. At present there is no limit on legal fees (other than any reductions or controls imposed by court assessment procedures), even if the compensation claim is for a small amount.

MDDUS supports moves that will benefit patients who have been harmed and ensure that lawyer fees are more proportionate to the compensation received by a patient. The proposal will be open to public consultation in the autumn and it is hoped the changes will save the NHS millions of pounds each year.

MDDUS CEO Chris Kenny says: "Medical negligence awards are made for the benefit of harmed patients, not the profitability of the legal services industry.

"We welcome the government's determination to cap wasteful costs and hope that their autumn proposals take the form of a practical, comprehensive action plan, capable of early implementation."

Child protection – everyone's responsibility

THE recent GMC case into the conduct of the GP responsible for the care of Daniel Pelka has again highlighted issues in relation to child abuse. This four-year-old boy died in 2012 after having been abused over a period of time by his mother and her partner, both of whom were given life sentences for his murder.

The GP in question faced serious allegations and investigation by the GMC in relation to his professional involvement. These included a failure to act adequately when presented with information that the patient may be a victim of maltreatment and was at significant risk, failure to arrange an urgent examination and failure to share the information with the local safeguarding lead, social services or any other relevant organisation.

The Medical Practitioners Tribunal Service (MPTS) panel found that the GP's conduct in this matter amounted to misconduct. This serves as a reminder of what is expected of doctors in relation to matters of child protection. Dentists too have responsibilities in this area.

Healthcare professionals are usually vigilant when the possibility of child abuse arises, but timely intervention is necessary. This case highlights the serious risk to the child involved and the professional consequences which will arise. The MPTS panel did not find that the doctor's fitness to practise was impaired, but their finding of misconduct nonetheless shows that such matters are regarded very seriously.

As a body of professionals we have a duty to protect and promote the health and well being of children and young people. The GMC makes it very clear that the responsibility to act on concerns about children lies with every doctor. In *Good Medical Practice*, paragraph 27 states: "Whether or not you have vulnerable adults or children and young people as patients you should consider their needs and welfare and offer them help if you think their rights have been abused or denied."

This is further expanded upon in *Protecting children and young people*, clarifying that this means "all doctors must act on any concerns they have about the safety or welfare of a child or young person".

The GDC states in its *Standards for the Dental Team*: "You must raise any concerns you may have about the possible abuse or neglect of children or vulnerable adults. You must know who to contact for further advice and how to refer concerns to an appropriate authority such as your local social services department. You must find out about local procedures for the protection of children and vulnerable adults. You must follow these procedures if you suspect that a child or vulnerable adult might be at risk because of abuse or neglect."

MDDUS urges members to be sensitive to the welfare of children and young people and ensure you are aware of the appropriate local personnel, policies and procedures in relation to matters concerning child abuse.

Dr Gail Gilmartin, medical and risk adviser at MDDUS

at **www.mddus.com** (using your surname and membership number).

● **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: £470 + VAT. Contact **risk@mddus.com** to book.

● **NEW LAW ON REMOTE PRESCRIBING** Members are reminded that a new EU law came into effect on 1 July 2015 requiring doctors to prescribe only drugs that are licensed for use where the patient lives – for example, when they are prescribing drugs via online consultations. More details are provided in an MHRA policy document – *Selling human medicines online (distance selling) to the public* – which can be accessed at **www.gov.uk**

New guidance on duty of candour

THE General Medical Council has issued new guidance on the professional duty of candour.

Doctors are obliged to admit mistakes and apologise to patients when things go wrong and provide an explanation. But the regulator made it clear that clinicians must have the support of an "open and honest working environment where they are able to learn from mistakes and feel comfortable reporting incidents that have led to harm".

Rules have already come into force in England placing a legal duty on hospital, community and mental health trusts, as well as other healthcare bodies such as general practices, to inform and apologise to patients where mistakes have led to significant harm. These new guidelines from the GMC now place a professional obligation on individual doctors. The guidance was jointly produced by the Nursing and Midwifery Council.

Under the guidance, doctors, nurses and midwives should:

- Speak to a patient or those close to them as soon as possible after they realise something has gone wrong with their care.
- Apologise to the patient – explain what happened, what can be done if they have suffered harm and what will be done to prevent similar harm in future.
- Use professional judgement about whether to inform patients about near misses – incidents which have the potential to result in harm but do not.
- Report errors at an early stage so that lessons can be learned quickly and patients are protected from harm in the future.
- Not try to prevent colleagues or former colleagues from raising concerns. Managers must make sure that those raising concerns are protected from unfair criticism, detriment or dismissal.

GMC Chief Executive Niall Dickson said: "We recognise that things can and do go wrong sometimes. It is what doctors, nurses and midwives do afterwards that matters. If they act in good faith, are open about what has happened and offer an apology this can make a huge difference to the patient and those close to them."

Parental disregard of oral health in children

PARENTAL disregard for basic principles of oral health in children is leading to unnecessary hospital admissions and costing the NHS £22 million a year.

A new survey published by dental group My Dentist has revealed how dental disengagement has left over one million children aged eight and under still waiting for their first trip to the dentist. Additionally, over 700,000 children who have been to the dentist have had at least one filling, each at a cost of £31.

The survey of over 2,000 UK-based parents showed that many failed to take their children to the dentist early enough, with 57 per cent of respondents not going until after their first birthday. Only a quarter (26 per cent) of children brush their teeth for the recommended two minutes per session.

The survey also revealed significant parental ignorance of basic oral health messages, with 20 per cent incorrectly believing that fruit smoothies are good for their child's teeth and 13 per cent saying that fluoride is bad. Nearly a third (31 per cent) were unaware of free NHS treatments available to kids, such as fluoride varnishing.

The British Dental Association is calling for "real partnership and commitment to solve the burgeoning crisis," having pointed out that tooth decay is currently the leading cause of hospital admissions among children, with the 46,500 children admitted annually to have teeth removed under general anaesthetic.

BDA Chair Mick Armstrong said: "Tooth decay is the leading cause of hospital admissions among our nation's children, and parents, teachers and policymakers need to take their share of responsibility.

"We have to get children into the habit of good oral health, and that will require partnership and commitment on all sides. It requires an end to mixed messages. We have to be clear that sugar hurts mouths as well as waistlines."

Half of EU doctors refused UK licence

NEARLY half of European doctors who applied to the GMC for a licence to practise in the UK over the previous year were refused for not providing evidence of adequate language skills.

In June of 2014 the GMC was given new powers to ensure the English language skills of all licensed doctors in the UK, including those from the European Union. In the interim period since the new powers were introduced the GMC has prevented 779 European doctors (45 per cent of those applying) from practising in

IN BRIEF

NEW APP TO REPORT SAFETY ISSUES Drug side-effects and medical device problems can now be reported electronically to the MHRA using a new Yellow Card app. Free for smartphones and other mobile devices, the app also allows users to keep up-to-date with the latest drug safety news. It can be downloaded from the iTunes app store and Google Play for iOS and Android devices.

NON-COSMETIC TREATMENT REGULATION IN SCOTLAND Private clinics in Scotland carrying out dental and other healthcare services, including non-surgical cosmetic interventions, are to be regulated by Healthcare Improvement Scotland from April 2016. Private hospitals offering cosmetic procedures requiring surgery have been regulated since 2011 but this new legislation now extends to non-surgical treatments such as Botox, teeth whitening, laser eye surgery and dermal fillers.

the UK as they did not provide evidence of their language knowledge. Prior to the new law these doctors would have been able to secure a licence to practise.

European doctors can evidence their language skills in a number of ways, including provision of an IELTS (International English Language Testing System) certificate meeting the GMC's criteria, or proof of having obtained a primary medical qualification where all of the course was taught and examined solely in English.

Implant training among GDPs mainly "theoretical"

CURRENT dental education in the UK at both undergraduate and postgraduate levels does not instil confidence in GDPs to provide and maintain dental implants, according to a study published in the *British Dental Journal*.

Researchers from the University of Birmingham School of Dentistry surveyed 91 GDPs working in a group of practices in the West Midlands. Sixty-seven (77 per cent) stated that they learnt only "theoretical aspects" of dental implants during their undergraduate training and the majority felt the training they received was inadequate.

Barriers in dental implant provision by general dentists were identified as the risk of failure (56.3 per cent), concern over potential complications (65.5 per cent) and the cost of learning (51.7 per cent). The results were correlated to the implant competences set by regulatory organisations such as the General Dental Council and Association of Dental Education Europe.

Overworked GPs risk patient safety

GP FATIGUE due to overwork threatens patient safety on a "widespread scale", says the RCGP in a new consultation paper.

The College claims that unrelenting and increasing workload pressures are pushing GPs to their limits – having to cope with growing patient numbers and diminishing resources. It says that GPs are working longer days seeing patients, followed by many hours after surgery and at weekends trying to keep up-to-date with urgent paperwork, such as hospital referrals.

The College acknowledges that safety risks in general practice are inherently lower than those in hospitals but warns that there is considerable potential for patient harm through medication errors, mistaken patient identity and other risks.

GP consultations between 2008/9 and 2013/14 rose by 19 per cent in England alone yet the total number of GPs across the UK grew by just 4.1 per cent in that period. GPs are also seeing an increasing number of patients with multiple and chronic conditions which are more difficult to deal with in a standard 10-minute consultation.

In the consultation paper – *Patient safety implications of general practice workload* – the College offers proposals for protecting the wellbeing of GPs to prevent them becoming too exhausted to provide safe care to patients. These include regular, mandatory breaks for staff to minimise the possibility of errors and a mechanism to identify practices under extreme workload pressures – and for measures to be urgently implemented to relieve these pressures.

RCGP Chair Dr Maureen Baker said: "Few of us would voluntarily board a plane flown by a visibly tired pilot or get on a train where we knew the driver had spent too much time at the controls – yet there are no methods or systems for addressing doctor and staff fatigue in general practice.

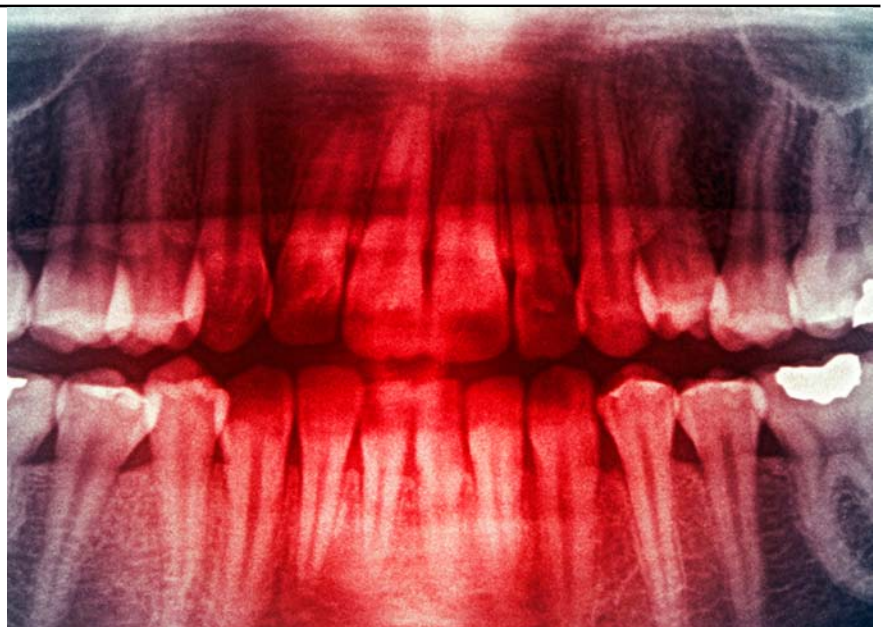
"GP fatigue is a clear and present danger to patient safety – and we urgently need to find workable solutions that will keep our patients safe now and in the future."

NICE LAUNCHES NEW CANCER STRATEGY NICE has updated and redesigned its 2005 guidelines to support GPs in recognising the signs and symptoms of 37 different cancers and refer people for appropriate tests more promptly. Tables linking signs and symptoms to possible cancers are included with simple recommendations about diagnostic testing and referrals to specialist services. Access at **www.nice.org.uk/guidance/NG12**

"CREDENTIALING" TO ENSURE COMPETENCE Doctors who have been awarded credentials in particular fields of practice would have this recorded in the medical register in new proposals by the GMC. A consultation on the process – known as "credentialing" – has been launched and the GMC is inviting views. More information can be found at **www.gmc-uk.org**. The consultation closes on 4 October 2015.

DOCTORS DEALING WITH DENTAL EMERGENCIES

Liz Price



EACH SUMMER as schools break for the holidays, MDDUS tends to see an increase in the number of calls from doctors requesting advice about how to deal with patients seeking appointments to discuss dental problems.

A common explanation for this increase is an apparent shortage of emergency dental appointments, often with patients needing analgesia or antibiotics – but other examples include patients requesting the GP to "have a look at a tooth the dentist wants removed to see whether he's right" or "my dentist has given me a private prescription but it's going to be really expensive – can you write me an NHS one please". One patient told his GP: "my dentist has suggested I ask you for a prescription for Prozac as she thinks it might help my anxiety".

Turning patients away

One recent call to our advice line related to a patient complaint at being sent away from the practice by a receptionist because he had requested an appointment for what he described as "maybe an abscess" on his gum. The receptionist told him that the doctors "don't see patients with dental problems" and that he should phone his dentist instead. The patient stated that he had been unable to get a dental appointment but the receptionist still refused to offer a GP appointment. Later the patient attended A&E as he subsequently started vomiting and developed a temperature. He was treated for a dental abscess which had resulted in a spread of infection. He now wanted an explanation why the GP would not examine and treat him at the practice earlier that day.

There are risks associated with doctors treating patients who have asked for help with dental problems; however, it is important that reception staff do not turn patients away just because it may be a dental problem – particularly where the patient has been unable to get a dental appointment and further when they need pain relief, treatment or advice. There is always the possibility that there may be an associated medical problem and a doctor should undertake reasonable enquiries to ascertain the nature of the patient's condition. Once it is clear that the issue is dental, advice can then be given on how to access local emergency dental services.

A question of competence

In deciding how to handle such cases it is essential to remember that dental treatment is not covered as part of the GP contract and that dentists are best qualified to deal with dental problems. All UK patients should be able to access emergency dental appointments locally, and referring the patient to these is likely to be in the patient's best interests.

Patients cannot always be relied on to provide an accurate history of their dental treatment and this, along with a lack of knowledge or expertise, may mean that a doctor is not able to offer a diagnosis or understand fully the complications which could arise from treatment. This may mean a doctor straying outside their area of competence.

GMC guidance states that in providing clinical care: "you must prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs".

Should a doctor decide that it is reasonable in the circumstances (and in the patient's best interests) to offer treatment in a dental case – perhaps with analgesia or antibiotics – they are responsible for the outcome of that decision and any follow-up required. GMC prescribing guidance states that: "if a patient asks for a treatment that the doctor considers would not be of overall benefit to them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, they do not have to provide the treatment. But they should explain their reasons to the patient, and explain any other options that are available, including the option to seek a second opinion."

In all circumstances the patient must be informed that dental advice should be sought as soon as possible and this advice should be clearly documented within the patient's medical record.

Action points

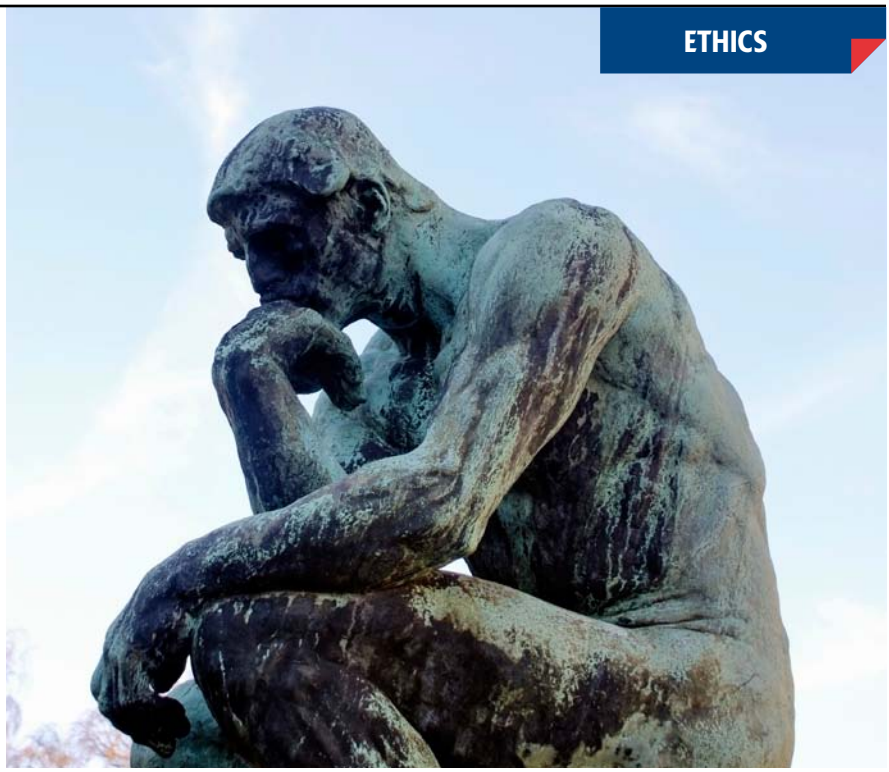
For doctors: GP staff should understand arrangements for obtaining emergency dental treatment within their local area so that they can easily pass information on to patients. When a patient is asking to be seen, ensure a clinician decides whether examination is appropriate. If the decision is made to provide treatment, inform the patient that they should seek a dental appointment as soon as possible and ensure you keep adequate records of your history-taking, examination, decision-making, the treatment you provide and instructions to the patient.

For dentists: During holiday periods, when there may be a reduction in appointment availability, dentists should ensure that emergency appointments are available to patients and that the instructions on how to access out-of-hours emergency treatment are prominently displayed.

Liz Price is a senior risk adviser at MDDUS

IT'S ALL ABOUT ... TIMING

Deborah Bowman



BY INCLINATION, I like to think things through and take my time over decisions. I realise this will do little to alter the view some readers might have of ponderous academics with ethics in their title.

In my defence, I have learned to respond quickly when required and recognise that it is sometimes necessary, but it is often an uncomfortable experience for me. I over-use the phrase "let me think about it", although at least I do always go away and think about whatever the "it" may be.

I have long been fascinated by the temporal element of ethical choices and decision-making. Is a decision mulled over and considered at length a "better" one? What relevance might time have in the perception of, and responses to, ethical questions and problems?

I first began to notice time as a factor in clinical ethics when I co-founded a clinical ethics forum at the hospital and university where I work. It seemed that the majority of cases we received for discussion were coming to the forum retrospectively. The "crisis", or at least the acute dilemma, had passed. The teams who brought the cases had entered a different phase: one of reflection and retrospection. The impulse was no longer to "solve" a pressing problem or to tackle an immediate question, but to step back and to consider the choices made.

Often, clinicians would express the view that doing so would help them if they were to encounter similar situations in future. However, the predominant impression with which I was left by these discussions was that there was an almost visceral urge to debrief in an informed, but non-judgemental space. With temporal distance, it was possible not only to ask the difficult questions, but also to face the answers that might emerge and to build ethical confidence. In these discussions, the toll of moral decision-making was often evident and I was left in no doubt that it endures long after a case has been concluded.

There is a much-read book that I keep on my shelf called *Complex Ethics Consultations: The Cases That Haunt Us*, and that title resonates with me like few others. However urgent or time-constrained an ethical decision or choice may be, its impact lingers long and has a temporal form of its own, casting a shadow (or sometimes a light) over the present and the future. Its effects will be felt by all those involved long after apparent resolution, often irrespective of whether the outcome is perceived as positive.

Time is rarely discussed in ethical decision-making, but this is, I think, an oversight. There are many ways in which the temporal dimension of moral choices is relevant. Like me, most people will have a preferred style in decision-making: are you decisive and swift in judgement or more deliberative? Most of us will have learned to adapt over time, but knowing one's preferences and considering how to work with those who take a different approach is an important first step in facilitating high-quality and inclusive ethical decision-making in a clinical service or team.

> "Is a decision mulled over a better one?"

Think about the temporal elements in an ethical question you've encountered. Did the notion of "duty of care" alter as the clinical situation unfolded? What variables were important at different stages in the case? Were there variables that warranted more attention at some points than others? How was the influence of time felt and managed? What is the legacy of that situation for you and others? How will that legacy inform your response in future?

Time also prepares us for difficult situations. As a theatre lover, I'm fascinated by the concept of rehearsal and its role in ethical practice. To know what one ought to do is often scant preparation for actually "doing the right thing", particularly in a complex, pressured and hierarchical system such as the NHS. Time spent not only talking about, but practising what kinds of response might be possible in a safe environment, is invaluable. Experience is, by definition, a cumulative process, but one that is immeasurably enriched by structured support that allows for people to develop and for confidence to grow.

My friend and colleague, Ann Gallagher, has written persuasively about the value of "slow ethics". She argues that, in a time-pressured health service, pausing to reflect and to reconnect with the fundamental virtues and values of healthcare rather than being seduced by the claims of the quick fix or simplistic solutions would raise morale of staff and patient alike. To do so would be to attend to what matters and to prioritise ethical practice that is sustainable.

Like comedy, ethics is, it turns out, a matter of ...timing.

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

Aspiring to "right-touch"

GMC Chair of Council Professor Terence Stephenson discusses some of the issues facing the regulator in this crucial era for UK healthcare

PROFESSOR Terence Stephenson took up the role as Chair of the GMC's Council in January 2015. He has spent most of his career specialising in paediatrics, having studied medicine at Oxford Medical School. He is currently Nuffield Professor of Child Health at University College London and an honorary consultant paediatrician at University College Hospital London and Great Ormond Street Hospital.

He only recently stood down as chair of the Academy of Medical Royal Colleges and is a former president of the Royal College of Paediatrics and Child Health.

Professor Stephenson is not involved in the day-to-day running of the GMC. The role of the Council – with its six lay and six medical members – is one of strategic oversight: making sure the regulator is properly managed by its executive team and fulfils its statutory duty to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

What do you see as the main challenge facing UK healthcare and the GMC as a regulator in coming years?

I think the biggest challenge facing any regulator is the fairly relentless increase in complaints over the last decade. And it's not particular to doctors – if you look outside healthcare it also applies to lawyers and other professionals. Allied with this is the fact that healthcare in the UK is in a very stressed state – most doctors, nurses and other professionals would say there is a lot of pressure on. We've had a recession, finances are tight and there are concerns over recruitment into particular specialties.

But I think for regulators the big challenge is the rise in complaints. One of the reforms ideally we would like to see is that only relevant complaints make it to the GMC. We get about 10,000 complaints a year and probably about half of those get very quickly referred back to the employer: contractual or other issues we don't really want coming to a national body like the GMC. We think they should be kept locally. They may have some substance, some issue needing investigation, but are not appropriate for the GMC.

Why are complaints against doctors rising?

I think it's a societal thing and, like I said, that's true in all professions. We have a more well-informed population and a less deferential relationship between the public and professionals like lawyers, accountants, dentists and doctors. We also have a more litigious society in general, with people more willing to make complaints across the board.

Medicine has also become more complex. It was Sir Cyril Chantler who said medicine used to be 'simple, ineffective and relatively safe'. Now it's complex and often carries risk, but saves lives. It's certainly more complex than when I was a student, with more complex therapies, more complex treatments.

Do you think there is a danger of doctors becoming over-regulated?

I think that is a very fair question and it behoves all regulators to make sure that the burden of regulation is proportionate and risk-based. We are overseen by another body called the Professional Standards Authority and they produce a regular report on the nine healthcare regulators. They have complimented us on what they called our 'right-touch' regulation – and that implies proportionality; that you are light touch where you can be but have heavy boots on the ground where it's required. And I think that is what we aspire to.

I'm a practising doctor and have twice been reported to the GMC. Nobody likes it and you feel the sword of Damocles as you go through the procedure. But I would say we are working hard to make the process more proportionate. Perhaps we haven't been as good at getting the message across to all our 267,000 doctors that the GMC has an obligation by Act of Parliament to investigate every single complaint that is brought to us. So we can be 'right touch' for the downstream of what we do but there is no discretion to say "actually that doesn't sound very serious so we won't look at that". We definitely have to look at all of those 10,000 complaints.

Has revalidation had any demonstrable effect on quality of care?

This is a common question and, in truth, there is no way you can show causality between revalidation and quality of care because there are a huge number of other things going on over a five-year period [of revalidation] that might affect quality of care.

I would turn the question around. I think most people would be astonished with the idea that doctors didn't somehow have to demonstrate that they were still fit to practise. I last took a professional exam in 1986 and until I revalidated in 2013, there had never really been a formal process by which I could be called to account and asked to demonstrate I was still a fit doctor to be seeing patients. So I think that is the role of revalidation.

Trying to show that it has had an impact on quality of care would be quite difficult but we do know that we have already declined licences for a significant number of doctors; so it does again have teeth. It's not a tick box; it's not a shoe-in that everybody automatically revalidates.

Is the organisation any closer to understanding the cultural disparity among doctors subject to GMC investigations?

I think we are getting closer but are not yet at the bottom of it. We are continuing to work with organisations like the BMA and BAPIO to try and understand it better. I think if I went tomorrow to work in another country where English wasn't the main language, with a different culture and context, I would probably be more likely to

get into difficulties. I don't think that is so surprising. What we want to understand better is if BME (black and minority ethnic) doctors who are born in the UK and educated and trained here seem to be over represented in our procedures – and I think we have some more work to do on that particular point.

Researchers at Plymouth University recently published an independent review of 187 randomly selected cases and concluded that the process was fair. It was a detailed study of our decision-making during investigations. What we did find was that we didn't always spell out our reasons clearly enough. So if we found somebody's language or cultural context was wrong we should be spelling that out better.

Do you think the GMC has a duty of care to doctors being investigated?

I acknowledged to you before that I have been twice investigated and I found that very stressful, so we completely recognise that these procedures are of course an added stress and indeed could sometimes be the cause of stress. We don't doubt that for a moment. We are reviewing the tone of all our communications with doctors who are under our procedures. We don't want it to be unduly officious or heavy-handed but they are legal documents and we are obliged to investigate every complaint so can't duck our responsibility either. We just have to try and strike a balance. We need to walk that line between taking the complaint seriously and investigating but also taking a doctor's health problems into account and try and manage that as best we can.

How do you think a national licensing exam would improve patient safety?

I think there are two answers to that. First, if someone were to ask - can you assure me that every doctor graduating in all 32 medical schools in the UK is reaching a common standard – passing the same exam like a driving test or pilot's licence – I wouldn't be able to say that. I would have to say that universities examine their own students, as they do in a modern languages or a physics degree. There are some checks and balances in there: they have external examiners, they have a shared question bank. But nevertheless these are university exams. So I think we could better reassure the public with a single licensing assessment to ensure that all UK doctors reach a common standard.

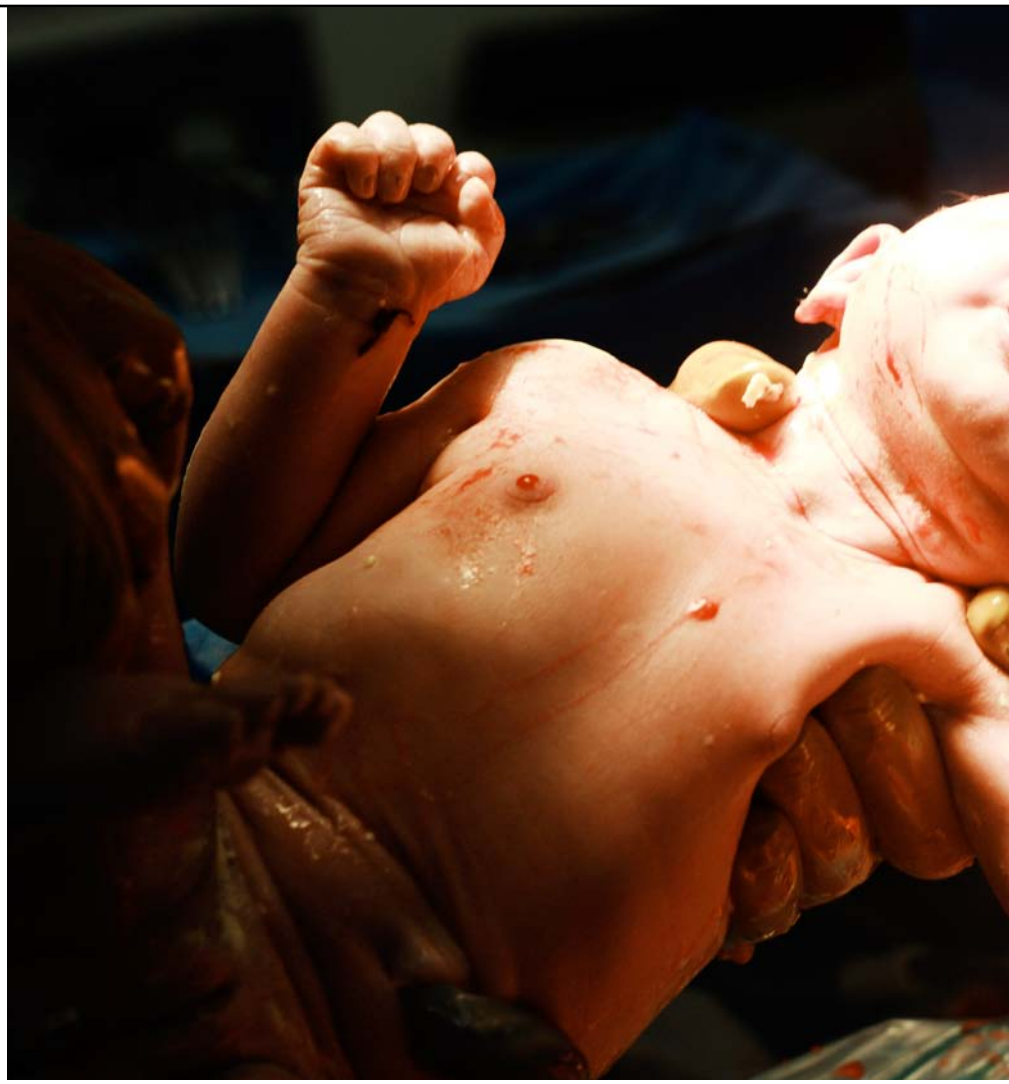
Second, at the moment some doctors coming from outside the EU take something called the PLAB exam, which is set at the level expected at the end of Foundation Year 1. But, if we had a single exam, that all our doctors have to take wherever they qualified in the world, it would make it simpler to reassure the public that doctors coming from overseas countries were reaching the same standards as our own graduates.

It would also be an exam in English – and in the context of UK practice. So all the medicines and the treatments, the consent and capacity issues, the medical, ethical and legal issues would reflect British practice.

PROJECT PROFILE

Each baby counts

Solicitor Bertie Leigh *sets out the aims of an ambitious project to reduce avoidable injury and death in labour*



EACH year in the UK between 500-800 babies die or suffer severe brain injury during birth. Many of these tragedies occur not because the babies are born too soon or too small, or because they have a congenital abnormality. It is when something goes wrong during labour.

Recently the Royal College of Obstetrics and Gynaecology (RCOG) launched a project – Each Baby Counts – that hopes to see a 50 per cent reduction in the number of babies who die or are left severely disabled as a result of adverse incidents occurring during term labour. The RCOG is proposing to provide a central repository of serious untoward incident (SUI) reports on all stillbirths at term and other serious obstetric incidents. These will be analysed and the lessons learned extracted.

A network of local reporters will be set up in hospitals – modelled on the structure of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – to collect the reports and provide a two-way chain of communication to drive improvement. Each Baby Counts will have a two-pronged approach: it will seek out evidence-based interventions via a systematic review of the literature and provide a central analysis of SUI reports to look for common themes, feeding these back to trusts.

A simple approach

Like all really good ideas, Each Baby Counts is both simple and ambitious. It is simple because the reports are comparatively short, can be easily collected and the organisation necessary to provide central peer review need not be complicated. It is ambitious because these reports collect and review serious clinical mishaps – cases where there is enormous opportunity for learning from experience. There needs to be change because SUI reports are at the moment very patchy in quality, if indeed they are completed at all.

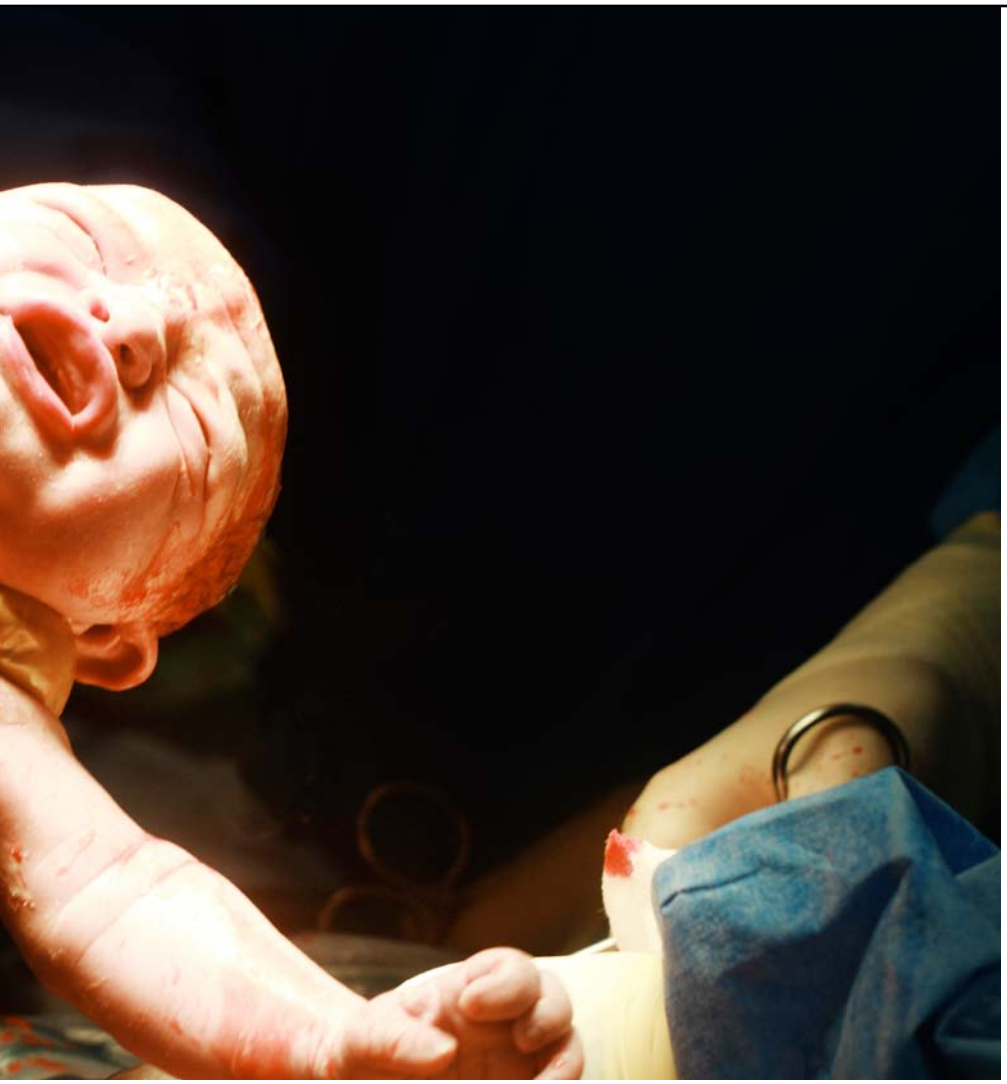
SUI reviews should take place promptly, when memories are fresh and the enthusiasm to learn from an incident is at its highest. They need cost very little because they are all done in-house, capitalising on a shared determination to learn from experience. Management should try to ensure that there is an atmosphere of minimal blame.

No other review provides feedback that is either local or prompt. The confidential enquiry reports from MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and NCEPOD come long after the event and the lessons are generic, in the sense that they are nationwide. They are admirable for giving advice to the profession about how to deliver obstetrics more safely, but a long way from being tailor-made to each hospital's problems. By the time the reports are received, the staff involved have often moved on. The same is true of litigation. Characteristically, the NHSLA does not receive claims arising from events within a year or two.

Many of the cases I see do not get an SUI investigation when they clearly should. If the only result of Each Baby Counts is to emphasise that SUIs are necessary and to create a cadre of local reporters who will advocate for that proposition in each hospital, it will be useful.

Questions of quality

The NHS Ombudsman has recently reported that SUI reports are



extraordinarily inconsistent. Some are high-quality learning exercises, but others fail to highlight what appear to be fundamental learning points and errors. Others are so excessively self-critical that it seems the authors have apparently lost the capacity to be fair to themselves and each other.

A third group we review in litigation also seem to be so factually flawed that we wonder if the authors ever read the clinical notes properly. Reports need to be done professionally and at the moment it is nobody's day-job. There is no real training available. There is not enough clarity about who should do them, what materials should be assembled and what preparation the witnesses should have.

A central audit could be valuable in raising the quality of the reports. People who write them need training and guidance and Each Baby Counts will bring this to national and local attention. Constructive criticism of each report from properly informed peer review should be helpful.

The action plans that arise from SUIs are also often lost and poorly followed up. There are shared themes running throughout these reports that can be better identified in a centralised review. Even if the willingness to learn will be maximal in the hospital where an incident has happened, there is nevertheless a national willingness to learn from mistakes that have happened elsewhere.

A modest start

At present the proposal does not involve the College receiving the clinical notes or any documentation from the Trust other than the SUI report itself. We do not know how the process will develop: experience may reveal that it is difficult for reviewers to recognise the report that is wrong in its identification of the factual matrix and that this inhibits the quality of the review. We may call for reports from the lead clinicians and a copy of the clinical notes, like NCEPOD. It may be so successful that we can justify the resources needed for such a change. Or in a few years we may recognise that the advantages of economy and speed outweigh the value of assembling the base data. It is a good idea to start modestly and see how things develop.

The fact that Each Baby Counts is to be the work of the profession is enormously attractive. Advice from senior obstetricians and midwives, people who have been there themselves and are concerned only to help the clinicians to do better in the future, is much more acceptable and likely to be much more constructive than advice from an external bureaucracy. It will also be much cheaper and more direct.

Above all, this is an example of the profession seizing the initiative in seeking to raise the quality of clinical care that is delivered in hospitals. We know that this combination of professional altruism and authority is one of the great resources of the NHS and we should congratulate the RCOG on finding a way to harness it in pursuit of an objective that is both simple and worthwhile.

■ ***Mr Bertie Leigh (Hon FRCPCH, FRCOG ad eundum) is Consultant at Hempsons Solicitors and Chair of NCEPOD. He has been a legal advisor to the RCOG for 30 years and is a member of the independent advisory group to Each Baby Counts***

Alan Frame *looks at the benefits and risks of patient access to online medical records*

THE UK Government has pledged that as of April 2015 all GPs in England should offer their patients online access to summary information in their records. Data published in May of this year by the Health and Social Care Information Centre (HSCIC) showed that over 97 per cent of patients in England can now take advantage of online services (including appointment and repeat prescription requests). This is a huge increase from 3 per cent in April 2014 and is welcomed by many patients.

There are some obvious advantages for patients in being able to easily access personal medical information – and also potential benefits to practices who now manually manage increasing numbers of subject access requests under the Data Protection Act 1998. But is some caution advised?

Simply making a medical record available online does not negate the responsibility to comply with requirements of the Data Protection Act, especially in relation to the lawful processing of "personal sensitive data" as defined by the Act.

Current arrangements for responding to subject access requests, for example, mean that data controllers must take steps to ensure that accessed or copied medical records are appropriately redacted of any inappropriate third party identifiers, and also information that could cause serious harm to the patient or other individual if they became aware of it. These requirements will continue to exist even where patients have full unrestricted online access to their medical records. And there are other specific issues that need to be considered in our new cyber-world.

Clear medical utility

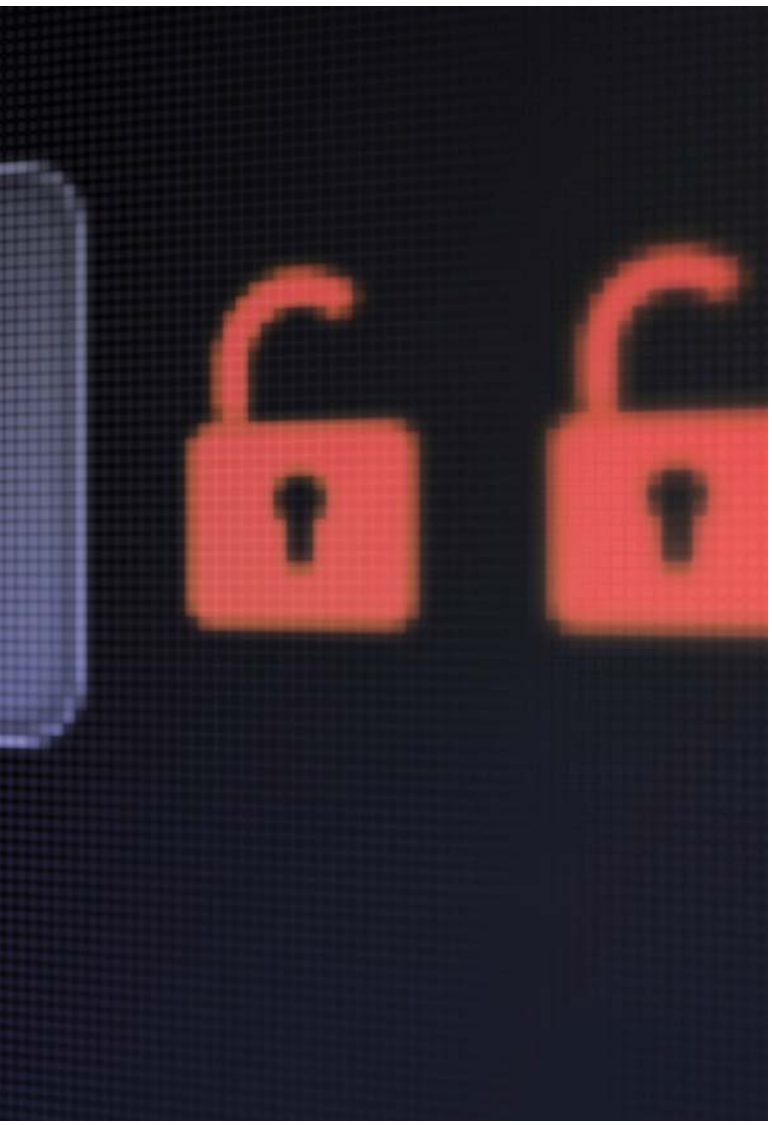
Researchers from the Institute of Child Health, Queen Mary University of London, and the University of Bristol have recently highlighted concerns about the potential for unintended harm in providing patients online access to records. They expressed concerns over the possible adverse effect on vulnerable patients in accessing their personal data. They recommended limiting online access to recent information that has "clear medical utility, such as test results, referral letters, clinic letters, current medication and allergies".

The researchers also cautioned that online access to full medical records should be implemented slowly in a staged process and with thorough evaluation. This all suggests that practices will now still have to "go through the burn" of inspecting each medical record thoroughly before it is made available for online access by the patient. Such an approach seems to be fairly logical and risk-averse, but I am presently unaware of many protests from data controllers in this respect, which does make me wonder how many practices are actually undertaking this task before making a record available online.

Of course, there is a plus side to inspecting records for online access in that once it's done it's done, meaning that in the longer term practices may become less burdened with responding to written subject access requests. Practices will of course still have to find ways of ensuring that any new entries in the patient record comply with redaction principles.

Access by whom

The researchers were also particularly concerned about the



potential for coercion, when patients may feel pressured to give others access to their online medical record. Older people, teenagers and those with learning difficulties could be most at risk from this: for example, from overt threats or physical force in an abusive relationship, or under the guise of helping a vulnerable relative, especially older people or those with learning disabilities.

This is an important consideration as traditional subject access requests are made in writing, which may provide an additional safety net to vulnerable patients as the practice or data controller will at the very least take steps to ensure that the individual claiming to make a request on the patient's behalf has a legitimate right to do so. Where coercion is suspected, steps can then be taken to investigate the matter further, but this important opportunity is likely to be lost where the medical record can be accessed remotely online on an ongoing or frequent basis, simply by providing a user identifier and password.

Parental rights of access also come under the microscope, with current proposals suggesting that parents will not have automatic access to a child's record after age 12. However, the risk here is that teenagers may still find it difficult to refuse parental requests for access if they are worried it may look like they have something to hide. And what happens when a parent still has access when a competent teenager attends on their own, without their parents' knowledge, and the practice "forget" parental access is no longer valid. Such a prospect suggests that practice managers and GPs may be in for some interesting conversations with parents who suddenly find that they are automatically blocked online from accessing their child's medical record.

"Patients will rightly expect their personal data to be correct and up-to-date"

Another issue of concern identified by the researchers relates to the clinician who may be worried about coercion or third-party information leakage within households and may play safe by not recording anything deemed to be sensitive, including early concerns about abuse or maltreatment. This may impact on care of the patient – and the use of the medical record as a communication tool between clinicians – causing early warning signs to be missed before concerns are raised.

Going digital

So what practical considerations could help manage these significant changes? It is important that practices consider:

- Providing patient information leaflets about online access arrangements with an explanation regarding various items in the record. This should include a process for patients to follow with a note of whom to speak to if they are concerned/confused about anything they find in their online record.
- Reviewing notes before allowing access, specifically relating to third-party and seriously harmful information. As medical records are routinely updated, practices will also require processes in place for ongoing review.
- Devising an identity verification and consent process, including the management of proxy access.
- The importance of the data quality of records in the knowledge that patients are going to be viewing their data online. Patients have long been able to request access to their records, but ease of online access will increase the numbers of patients who consult their records.
- Patients will rightly expect their personal data to be correct and up-to-date. Confusion and concern may be caused by abbreviations, euphemisms, technical language or administrative data. It is important therefore that all staff involved with recording clinical information in the practice are aware and alert that patients will be more likely to read what they record.

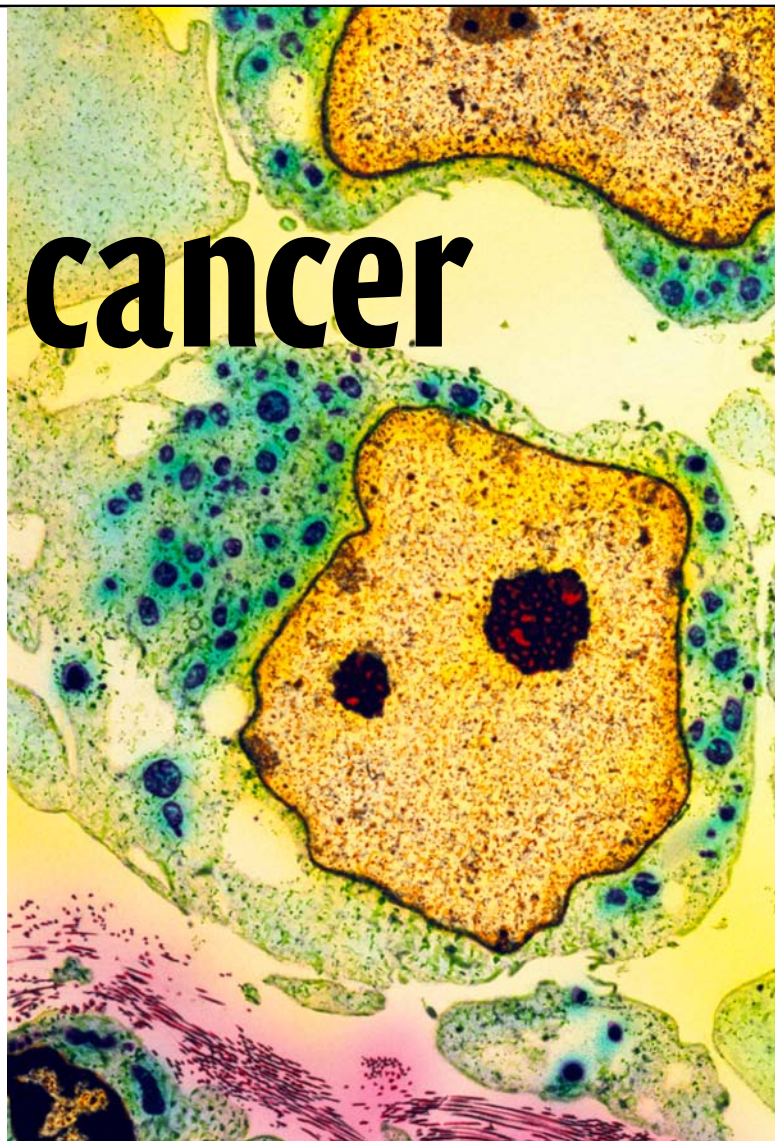
Time will tell if online access makes life easier for practices in the long term. NHS England is certainly convinced. National Director for Patients and Information Tim Kelsey has said: "Giving patients access to their full medical records online is a world first – it opens the NHS up to those who use it.

"It will be so much easier for people to navigate the NHS. When online banking started back in 1998, people were distrustful. Now more than 22 million people are using it.

"These kinds of changes don't just reduce costs – they also empower people and allow them to take more control."

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

Testicular cancer



Professor Krishna Sethia *explores some of the pitfalls in the diagnosis and management of testicular cancer*

OVER 2,000 new cases of testicular cancer are diagnosed in the UK every year. The majority of these occur in men aged between 15 and 45, making it the commonest tumour in this age group. However, 25 per cent of cases occur in men over the age of 45 and 6 per cent in men over the age of 60. Germ cell tumours, seminomas and teratomas are common in the younger age group; in older patients the diagnosis of a lymphoma should be considered.

Whereas 50 years ago most of the germ cell tumours proved fatal, advances in chemotherapy since 1970 have resulted in overall cure rates of 95 per cent, rising to 99 per cent for patients with stage 1 disease. Given the potential for some tumours to grow quickly, early diagnosis and referral is therefore important in maintaining this success.

Presentation

Men with testicular cancer commonly present having noticed either a painless swelling or enlargement of the whole testicle. A history of trauma is present in about 10 per cent of cases – where this has happened it is important to realise that it is usually the injury that has brought the swelling to the patient's attention rather than the swelling being the result of the trauma. Occasionally, with hormone-producing tumours, patients present with gynaecomastia.

Testicular cancer is not usually painful but is associated with some discomfort in about 20 per cent of cases – often this is a dragging sensation due to its increased weight. If the testis is obviously painful and/or tender it may be due to epididymo-orchitis, but the possibility of a testicular torsion must also be considered. Where there is any doubt the patient should be referred to hospital as an emergency.

A few men present with symptoms due to metastatic disease. General malaise or back pain may occur, as well as a mass in the neck due to enlargement of supraclavicular lymph nodes.

The risk of developing testis cancer is increased if there is a history of an undescended testis, infertility (especially with a small testis) or a first-degree relative with the disease.

Clinical examination

It is important to note that over 95 per cent of men presenting with testicular swellings have benign disease. The common differential diagnoses include hydrocele, epididymal cyst and varicocoele. Most of these can be distinguished from a tumour by accurate clinical examination, noting particularly the anatomical relationship of the swelling to the body of the testis and whether the swelling transilluminates. Tumours are always within the body of the testis so if a swelling can be separated from the body it is almost certainly benign.

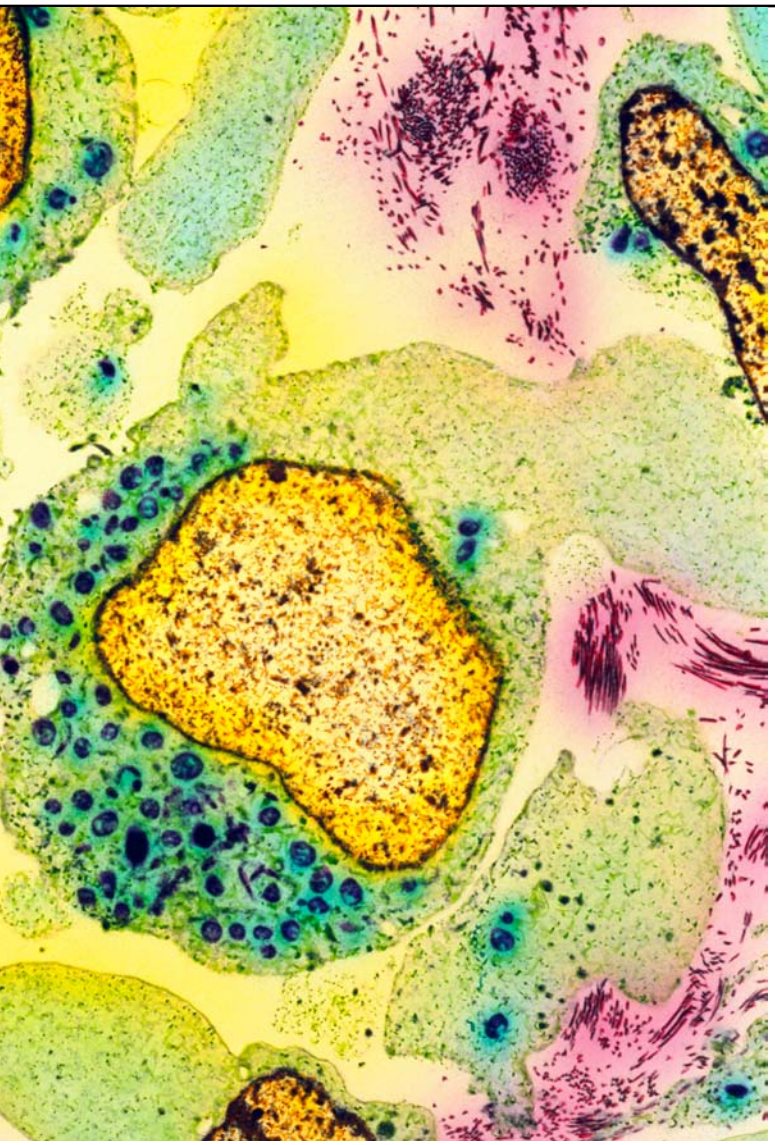
Comparison with the normal side is useful, noting particularly differences in the size, shape and consistency of the testes, any of which may indicate malignancy. In particular, the presence of a small testis should not automatically be assumed to be due to atrophy as it may simply reflect abnormal enlargement of the contralateral testis or, if the small testis itself is abnormally firm, a tumour in a previously atrophic organ.

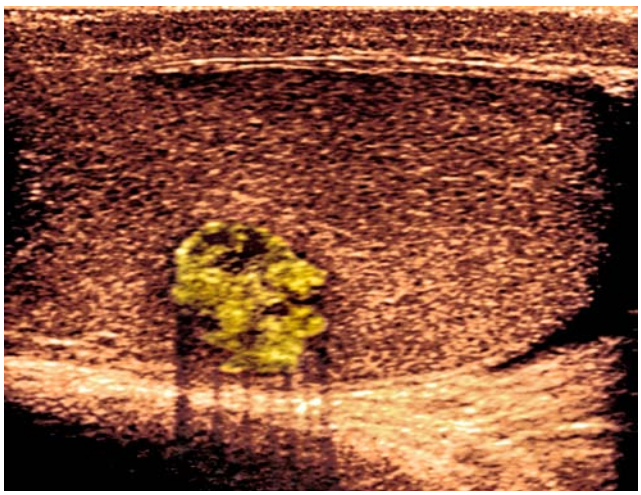
A swelling that transilluminates is likely to be a hydrocoele but in some men this may be associated with the presence of a tumour – it is therefore important for the clinician to confirm that the body of the testis itself feels normal. Where there is any doubt, an urgent ultrasound scan should be arranged.

As described above, metastatic testicular cancer forms part of the differential diagnosis of neck, especially supraclavicular, swellings and gynaecomastia. In either of these scenarios examination of the genitalia is essential.

Investigation

In experienced hands, the diagnosis of a tumour can usually be made by clinical examination alone but in the primary care setting the clinician needs to be confident that a tumour has been excluded. If there is any doubt, an urgent scrotal ultrasound





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Main: coloured transmission electron micrograph of a section through teratoma cancer cells in a testis. Above: coloured ultrasound of testicle with teratoma.

scan should be arranged or the patient should be referred under the two-week rule for suspected cancers. Ultrasound is usually diagnostic but there are a small number of lesions which remain equivocal even when Doppler studies are included. In addition, ultrasound has a small false-positive rate with some benign conditions (e.g. epidermoid tumours, infarction) capable of mimicking cancers. If the scan shows a tumour or if it is inconclusive, an urgent referral to the local urology department is mandatory, again under the two-week pathway.

Serum α-fetoprotein (αFP) and β- Human chorionic gonadotrophin (βHCG) levels are valuable markers for germ cell tumours, being elevated in 50-70 per cent of patients. These markers can provide useful prognostic information and must be measured wherever there is a suspicion of a tumour. In the case of uncertainty, raised marker levels may also aid diagnosis.

Management

Where the ultrasound scan leaves doubt about the nature of a testicular abnormality and the tumour markers are normal, it is reasonable for a urologist to monitor a lesion by arranging a further ultrasound in 6-8 weeks' time. However, before adopting this strategy the scans must be discussed and agreed in a multidisciplinary team (MDT) meeting. The outcome of this meeting should be clearly recorded in the patient's notes, and both the patient and his GP should be informed. If the lesion remains stable, continued observation may be justified but any enlargement of the lesion requires that the testis be explored.

There are a small number of patients who present acutely ill with advanced, possibly life-threatening, metastatic disease. These patients should be referred immediately to an oncologist as they may require immediate chemotherapy before any treatment for the primary tumour. For the majority, however, radical inguinal orchiectomy is the treatment of choice.

Apart from the complications of infection and bleeding, patients should be warned of the small possibility that the testicular lesion may be benign – a scenario which frequently gives rise to litigation. At operation the spermatic cord is clamped at the internal ring and the testis delivered through the groin incision. Where there is a history of increased risk (e.g. small testis, maldescent) biopsy of the contralateral testis should be considered. The risk of postoperative pain can be reduced by taking care not to damage the ilioinguinal nerve during surgery. Postoperatively, αFP and βHCG levels should be re-measured – persistence of raised levels suggests the presence of distal disease.

In patients with only one testicle, if the lesion is small and tumour markers are normal it may be possible to perform a partial orchiectomy thus maintaining some hormone production and avoiding the need for testosterone replacement therapy.

All patients undergoing orchiectomy should be offered insertion of a testicular prosthesis as part of the same procedure. They should be informed that the prosthesis will provide only an approximate match to the remaining normal testis and that it may tend to ride high in the scrotum – this can be improved by gently manipulating the testis downwards daily in the postoperative period. They should also be warned of the risk of infection which could result in the prosthesis having to be removed.

As both the surgery and any subsequent treatments can impair fertility, patients should be offered sperm cryopreservation before orchiectomy, and they should also be informed that fertility rates using thawed sperm fall with increasing age of the female.

Following surgery all patients require CT scanning and then should be referred to the regional testicular cancer MDT meeting for consideration of adjuvant treatment.

■ ***Professor Krishna Sethia is a consultant urologist and medical director at Norfolk and Norwich University Hospitals and an honorary professor at the University of East Anglia***

Surviving the slow

A recent BDA survey found almost half of GDPs report low levels of life satisfaction and 60 per cent experience significant anxiety. How can this affect everyday practice? Here is one dentist's story

IT ALL kicked off when I came back from holiday in July 2011. I was working as an associate in a new practice and got a phone call from the senior partner. He asked me to meet him in the practice before I returned to work that Monday.

In the meeting he said he wasn't happy with the treatment provided to a few of my patients and wanted me to take some time off from work and reassess things. He then subsequently reported me to the health board as being unfit to practise and terminated my contract.

I didn't see it coming the way it did, to be honest. I had gone through some pretty stressful times in the years building up to 2011. The last couple of years had been particularly hellish. I knew I had taken my eye off the ball a little bit but hadn't realised by how much. I was at a low point and was no longer enjoying being a dentist but I didn't think it had affected my clinical ability.

To be honest, at that stage I thought I had got through the worst of it. When I returned from holiday I felt the best I had for years – refreshed and actually looking forward to getting back to work. My first thought after being told not to come back was that this was it: I'll never work as a dentist again. In those first few days I started thinking I could just walk away from it. My wife's thought was that if dentistry was making me that unhappy then do something else.

But then something strange happened. It took me maybe a couple of weeks but when I realised I would have no more dealings with patients, I knew I would miss it. I would miss it very badly.

Letter of complaint

More immediately I phoned the MDDUS for advice and met with one of the dental advisers. He looked at some of my record cards and pointed out deficiencies and tabled them into what I needed to improve upon. I also self-referred for remediation with an NHS education programme and formulated a PDP to improve on areas of practice including treatment planning and clinical record keeping. We devised an action plan and I presented it to one of the dental advisers from the health board. We had a meeting in November of 2011 and on the back of that they were happy to award me a new list number and let me work again.

I went back to work initially part-time in December 2011 and then eventually full-time again. I also changed tack and started working in the salaried service rather than as a general practitioner. I found this much less stressful. Also my attitude was different by that point; I had kind of sorted myself out.

In the meantime I received a letter of complaint from a patient who had been trying to get in touch with me for months but my former practice had not passed on contact details. Before I could check the records to respond to the complaint she contacted the GDC. I felt at the time that

burn

she could have been recompensed for her remedial treatment and the only reason she referred the issue to the GDC was because no one was listening to her complaints. I was angry that the issue had not been dealt with better but also felt guilt, shame and disappointment that I had let one of my patients down.

The GDC conducted an investigation and then in 2013 they asked for records of patients that I had treated since returning to work in 2012. They picked up on a number of issues with some of the patients, such as absent or inadequate BPEs and subsequent periodontal treatment, missing radiographs and poor record keeping. It was decided that there was enough cause to investigate my fitness to practise.

One thing I have learned in all of this is that anger is just wasted energy. There was certainly no time to feel sorry for myself so I resolved to prove my ability as a dentist to everyone. Once I realised remediation was an option I decide to immerse myself completely in the process. I accepted I needed to change. It's sort of like being an alcoholic – until you realise you have a problem you don't seek help.

Dark focus

My MDDUS adviser helped me devise an action plan to respond to the GDC criticisms. It was a long process. I produced lots of audits of the patients I was seeing. I would present them to the adviser and my appointed mentor thinking they are great and then they would point out the deficiencies. An audit that had taken two or three months to prepare would be shredded and I would have to do it again on a different set of patients. It was frustrating but I just had to get on with it.

The MDDUS adviser also put me in contact with an educational tutor at the NHS who helped with my remediation plan – that was before the GDC case. We looked at postgraduate courses relevant to my action plan and I attended these before I went back to work. I also did CBT (cognitive behavioural therapy) but the one course that had the biggest impact on me was called *Surviving the Human Zoo*. It is designed to help professionals understand the implications of stress and occupational burnout and how to avoid this or reduce its effect.

Thinking about the years before 2011, I didn't realise how low I was. I ticked all the boxes for burnout. I dreaded going into work in the morning. I would look at my day list and there would always be something that worried me more than anything else. I ended up focusing on the dark side of everything: if I was going to be taking a tooth out it might break, or if I was doing root treatment it wouldn't be straightforward. Driving home from work became the best part of the day.

> "One thing I have learned in all of this is that anger is just wasted energy"

The CBT helped explain why I had ended up where I was but it didn't really explain it all for me. And that's where *Surviving the Human Zoo* helped. It made me realise that how you react to major life events is dictated by your personality and not by the event itself. Your personality is how you are wired. So you don't try and change someone's personality you allow for their personality. People like me need to feel in control and before 2011 I had lost control in my work situation.

One thing that causes a lot of stress for me is facing a task but not having enough time to do it. Now in the salaried service I have the opportunity to book an hour-and-a-half appointment to do endodontic work. I wouldn't be able to do that in private practice.

Born again

Looking back, it was only after the GDC case concluded that I realised how much that whole process had been in my thoughts every day, probably every minute. The MDDUS dental and legal advisers were brilliant and hugely supportive, especially initially when the complaint arose. I was very embarrassed by some of my X-rays and the lack of detail in the records but at no point were they judgmental.

The process has made me a very defence-minded dentist. I do everything by the book and record absolutely everything. I am not religious but I'm kind of like a born-again Christian. I have a second chance at work that I thought I would never get and I'm enjoying it again.

I am also much more aware of life-work balance. There was one morning I was driving to work and I came up over a hill and there was a glorious sunrise in the mist. It was the perfect picture. So I stopped to look at it. I carried a camera for a week waiting for it to reappear but it never did.

It just made me think how in the past issues at work had become the most dominant thing in my life. Now I was enjoying being a dentist and I would certainly miss it if I had to stop – but it's not the be-all and end-all.

■ *As told to Jim Killgore*

CASE studies

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

DIAGNOSIS: MISSED APPENDICITIS

BACKGROUND: Mr H attends his surgery complaining of pain in his abdomen and back that has been ongoing for three days. He is seen by Dr R who notes the 49-year-old had attended three months previously for similar abdominal pain and was seen by another GP at the practice. At that first consultation, a stool sample had been analysed for M, C and S and confirmed as normal and the pain eventually resolved without treatment.

Based on this previous episode, Dr R believes the pain may be caused by a recurring problem such as irritable bowel syndrome (IBS). The GP advises Mr H that appendicitis is unlikely due to his age and the lack of other related symptoms. A urine sample is tested but found to be clear. Dr R prescribes a drug to treat the suspected IBS and advises paracetamol for the pain. He tells the patient to return if his condition worsens.

Four weeks later, the practice receives a letter of complaint from Mr H. Several days after his consultation with Dr R, the patient was admitted to hospital suffering severe abdominal pain and it was found that his appendix had ruptured. Due to complications, Mr H had to undergo two separate surgical procedures requiring a hospital stay of two weeks. The practice responds, apologising for Mr H's ordeal and the matter appears to be settled.

Thirteen months later a letter of claim alleging clinical negligence arrives at the practice. It is claimed that Dr R failed to carry out a physical examination of Mr H and did not take a sufficiently thorough medical history. Had Dr R done these things, it is alleged that his condition would have been diagnosed much sooner and treated more easily, saving Mr H the pain and distress of severe appendicitis and the subsequent hospital procedures.

ANALYSIS/OUTCOME: Dr R contacts MDDUS and explains that he does not have a good memory of his consultation with Mr H. When asked about his usual practice, the doctor is sure he would have carried out an abdominal examination but this is not reflected in his very brief medical notes.

There is also no reference in the notes to the length of time the pain had been present, whether it was intermittent or continuing, and the presence/absence of other relevant symptoms such as bowel upset, nausea or fever.

Dr R adds that, as appendicitis tends to affect those aged 10-30, and due to the lack of other relevant symptoms, he did not consider it at that time. In hindsight he admits the diagnosis of IBS may have been premature.

MDDUS commissions a GP to analyse Dr R's treatment of Mr H and produce an expert report. The expert is broadly supportive of the doctor's actions. She states that a working diagnosis of IBS would not have been unreasonable given the previous incidence of abdominal pain and the lack of other symptoms associated with an alternative diagnosis. She agrees that when Mr H was seen by Dr R, his symptoms may not have been serious enough to warrant a referral. However, the expert states that a failure to carry out a physical examination would constitute negligence. While Dr R is certain one was carried out, the patient disputes this and there is no confirmation in the notes.

On this basis, MDDUS believes the case would be difficult to defend and agrees a settlement (with the agreement of Dr R) without admission of liability.

KEY POINTS

- Poorly written notes provide a significantly reduced prospect of defending allegations of negligence.
- Do not rule out a diagnosis simply based on patient profile.
- Ensure sufficient safety netting when unsure of diagnosis, including clear advice to patients on when/how to seek further help if needed, and document this in the records.

CONFIDENTIALITY:
A MOMENTARY OVERSIGHT

BACKGROUND: Mr T visits his practice asking for written confirmation proving that he is a registered patient. He requires the documentation for a government application relating to the immigration status of him and his wife. The practice manager, Ms L, is busy and Mr T is in a hurry so, to save time, she prints off consultation summaries which are then stamped with the official practice stamp and signed. Later that day Mr T returns to say he would rather not use these documents as they contain some sensitive information. Ms L then agrees to write a letter on practice headed notepaper to confirm that Mr and Mrs T are both registered patients.

Two days later a letter of complaint arrives from Mrs T alleging the practice breached confidentiality by disclosing parts of her medical records to Mr T without her consent. Amongst the information given to him was a note of an abortion she underwent three years ago which her husband was unaware of. Mrs T states that her husband has previously been abusive towards her. She fears knowledge of the termination will prompt a violent reaction from him and she has been forced to flee the marital home and stay with a friend. She has also suffered considerable stress and anxiety that has apparently sparked other health problems.

An MDDUS adviser assists the practice in responding to the complaint. However, a short time later a letter of claim arrives from solicitors representing Mrs T. They are seeking compensation in relation to the breach of confidentiality and the subsequent problems it caused both for Mrs T's health and personal circumstances.

ANALYSIS/OUTCOME: MDDUS reviews with Ms L the sequence of events that led to the confidentiality breach. The manager admits that she failed to follow protocol in responding to Mr T's request, mainly due to a very busy workload and the fact the patient was also in a hurry. She accepts she had not stopped to double check the information that was printed and given to Mr T which she blames on a "brief lapse in concentration". She emphasises that the practice has learned valuable lessons from the incident and that measures have been taken to avoid a repeat of the error.

MDDUS discusses the matter with Mrs T's solicitors and they agree to a small settlement, in recognition of the distress and anxiety caused by the breach.

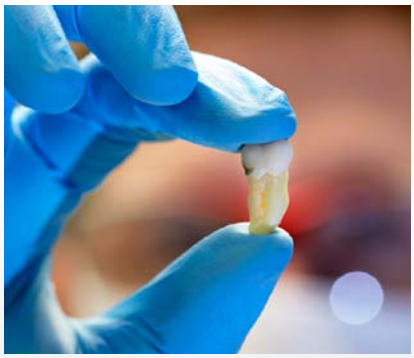
KEY POINTS

- Ensure appropriate data protection protocols are in place for handling access to records requests.
- Carefully check records before disclosure, respecting rules on third-party information.
- Don't be tempted to take shortcuts when disclosing patient information, even during busy periods.

TREATMENT:
ERRONEOUS EXTRACTION

BACKGROUND: A 15-year-old boy – Jake – is referred by an orthodontist to his regular dentist – Dr G – with a treatment plan involving lower and upper fixed appliances (braces). The treatment also required a number of extractions including UL6, UR6, LL6 and LR5.

Dr G carries out the extractions in two separate appointments without incident. Two months later Dr G is informed by the orthodontist that he has removed LL7 in error. Checking the notes again the dentist subsequently discovers that Jake had attended another dentist in the practice – Dr K – six months previous complaining of pain in LL6. In consultation with the orthodontist Dr K had extracted LL6.



It now was clear that Dr G had removed LL7 in error, mistaking the tooth for LL6. He arranges a meeting with Jake and his parents and apologises for the error. Five months later the practice receives a letter of claim alleging clinical negligence against Dr G in the removal of LL7. The letter states that in addition to the unnecessary pain and suffering, the error has meant that Jake's orthodontic treatment instead of taking 16 months will now extend to 30 months. The claim also details the eventual need for an implant replacement for LL7, with periodic renewal of a crown in future.

ANALYSIS/OUTCOME: Two expert reports are commissioned by solicitors representing the claimants – one from an oral surgeon and the other from a consultant orthodontist.

In his opinion on the case the oral surgeon states that Dr G should have realised that at age 15 there should be two molar teeth in each quadrant unless there had been previous extractions. He concludes that it is apparent the patient records had not been adequately checked, as this would have revealed the previous extraction – and this clearly amounts to negligence.

The orthodontist in his report challenges the claim that the extraction of LL7 will affect the boy's orthodontic treatment stating it should not necessitate prolonged wearing of the brace.

MDDUS negotiates a settlement on behalf of Dr G significantly below the valuation claimed by the claimant solicitors, reflecting the fair costs of remedial treatment.

KEY POINTS

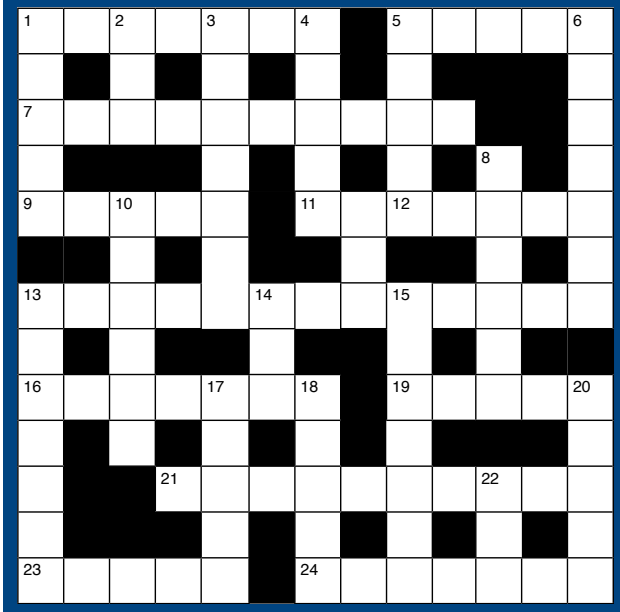
- Ensure you carefully check notes before any extractions.
- Use only one form of notation when referring to teeth.
- Ensure you have correct clinical documentation to hand before carrying out treatment.

PHOTOGRAPH: SCIENCE & SOCIETY

Object obscura:
Roman denture

This is a copy of an original Roman denture dating from 400 BC Satricum, (Conca), Italy. Roman dentists made bridges of gold to hold extracted teeth without roots, or false teeth of ivory or metal. These techniques were learned from the Etruscans, who were the first people to make false teeth around 700 BC.
Source: *Science Museum*

Crossword



ACROSS
1 Journeys (7)
5 Brushed (5)
7 Male only cancer (10)
9 Validate (5)
11 Casual tops (1-6)
13 "Accreditation of competences" – GMC (13)
16 Albums (7)
19 Colours made from black and white (5)
21 Manage a complex activity (10)
23 On which we put bums (5)
24 Suffered with overwork (7)

DOWN
1 Takes part in election (5)
2 Affirmative (3)
3 Spy (7)
4 Prevent from growing (5)
5 Collision (5)
6 American cardiologist, Helen _____ (7)
8 Flattery (6)
10 Business providing a service (6)
12 Stick attached to foot for winter sport (3)
13 Floor coverings (7)
14 Silently agree (3)
15 Worse than the Hulk? (7)
17 Upper coverings of buildings (5)
18 Newly-qualified doctor (US colloq.) (5)
20 Exhausted (5)
22 Gone by (3)

See answers online at www.mddus.com.
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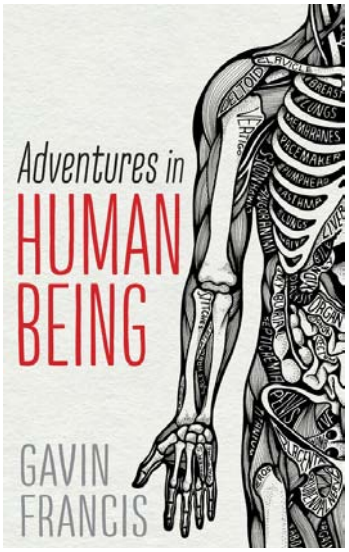
Book review:
Adventures in Human Being

By Gavin Francis
Profile Books; £14.99 hardback
Review by Jim Killgore, managing editor

"AS a child I didn't want to be a doctor, I wanted to be a geographer," writes Gavin Francis in the first line of the prologue to his new book *Adventures in Human Being*. It is almost by way of explanation as to why the author and GP would follow two popular travel adventures – first in the Arctic (*True North*) and then as a resident medic on a remote British ice station (*Empire Antarctica*) – with a fascinating riff on human anatomy and medicine.

Here Francis turns his geographer's eye inward on a "journey through the most intimate landscape of all: our own bodies". In a series of linked essays ordered from head to toe "like certain anatomy texts" Francis explores how culture "continually reshapes the ways we imagine and inhabit the body". It is both an eclectic collection of medical curiosities and a thoughtful and sometimes moving account of his own encounters with the human landscape in his varied career as a doctor.



Starting in chapter one he describes first attending neuroanatomy lab as a medical student ("forty brains in buckets") and finding the pineal body which Descartes described as the "seat of the soul" – that leading into an account of his later training observing a neurosurgeon mapping "eloquent" tissue on the surface of the brain to preserve speech function in a woman undergoing a procedure to treat severe intractable epilepsy.

So it goes with each part of the body: an account of how Leonardo da Vinci's meticulous dissection and drawings of facial muscles in cadavers echoed his earlier appreciation of human expression as captured in his painting of *The Last Supper*, or a motorcycle accident leading to a consideration of shoulder injury as depicted by Homer in the fall of Troy.

The broad sweep of the material is subtly handled and never feels laboured or over intellectual. It is also quite funny in places. In the chapter entitled 'Wrist & Hand: Punched, Cut & Crucified', Francis asks an emergency room patient with a smashed fist of questionable origin:

"What's your job?"

"I'm a pickpocket," he says with a wry smile. "What's it to you?"

To which Francis replies: "Just checking you weren't a concert pianist."

Vignette: GP and Britain's first Asian mayor Chuni Lal Katial (1898-1978)

THE meeting of Mahatma Gandhi and Charlie Chaplin on the sofa of a Canning Town living room seems unlikely, but this is exactly what happened in September 1931. The sofa in question was owned by Dr Chuni Lal Katial, a London GP, and it was he who had engineered the meeting. Katial's story is one of immigration, medicine and politics and stands as a testament to the impact one man can have on a generation.

Chuni Lal Katial was born in the Punjab on New Year's Day 1898. He studied medicine at Lahore and served for five years in the Indian Medical Service. He decided to acquire further training in public health and tropical medicine and travelled to England in 1927, where he studied in Liverpool. Two years later, after obtaining his diploma, he moved to the East End of London where he put up his plate in Canning Town. He later moved his practice to an equally working-class area in Finsbury, North London, and it was while there that he would also realise his political ambitions.

Katial was a committed socialist and member of the Labour Party. In 1934 he was elected to the Finsbury Borough Council and rose quickly to become its deputy mayor in 1936, and then, in 1938, Britain's first Asian mayor.

At first glance, Katial's political ambitions may seem to have overtaken his clinical ones. However, while he was chairman of the Public Health Committee of Finsbury Council, he was able to combine the two successfully in one of the most celebrated medical projects of pre-war Britain.

His borough needed regeneration and this afforded him and others the opportunity for radical change. Katial's vision was one of centralised, integrated healthcare and he argued for the creation of a new health centre that would incorporate, under one roof, a number of key services including general practices, a specialist TB clinic, dental services and a women's clinic. Although commonplace today, this approach was unheard of in the 1930s.

PHOTOGRAPH: ISLINGTON LOCAL HISTORY CENTRE

Controversially, Katial commissioned the progressive modernist architect Berthold Lubetkin to lead the building project. A Russian émigré, whose personal motto was "nothing is too good for ordinary people," Lubetkin designed a remarkable building, which opened in 1938.

But, the radical style of the architecture of the new Finsbury Medical Centre was only a reflection of the equally radical approach to integrated healthcare that it embodied – a concept driven by Katial that anticipated the formation of the NHS by more than a decade.

During the war, Katial worked as a civil defence medical officer, but afterwards he returned to politics and was elected in 1946 to the London County Council. In recognition of his public work, he was awarded the Freedom of the Borough of Finsbury in 1948. His later years were spent in India where he served as Director General of the Employees' State Insurance Corporation of India. He returned to the UK in the 1970s and died there in 1978.

But what of that sofa in Canning Town? The newspapers of the day reported on the meeting which, rather than the "quiet and informal chat" that Katial had imagined and both Chaplin and Gandhi had requested, became a media circus. Katial was at the time an active member of the India League, a political organisation that campaigned for Indian self-rule. In 1931, when Gandhi visited England for talks on the future of India, Katial stepped forward and offered his services as Gandhi's aide and even chauffeur. It was in this capacity that he was able to stage-manage the meeting in his own home.

The Daily Express noted, "Mr. Gandhi ... said he would look in about 6.15 p.m. The British public arrived about 4.45 p.m. They began by breaking the railings by accident. They were perfectly good-humoured, but heavy on the brickwork."

Despite the excitement, and the inadvertent vandalism, the meeting went ahead and the two celebrities apparently had an in-depth discussion on the contrasting reliance on machinery in the East and West.

Improbable as it seems today, this meeting of two of the twentieth century's most famous men in an East End house was a perfect example of Chuni Lal Katial's approach to his life and work. Whether it was building not one but two careers in a foreign, and probably not always welcoming, land, or crafting a new approach to healthcare or even political matchmaking, Katial got things done. He was energetic, enthusiastic and passionate about his causes, and as his legacy we have a remarkably modern approach to healthcare that he not only championed, but also made a reality in Finsbury, before the outbreak of the Second World War.

Katial will always be remembered as Britain's first Asian mayor, but we should not forget that he was also a remarkable pioneer of modern public health.

Sources

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- *Br J Gen Pract*. 2007 October 1; 57: 827–834.
- British Library http://www.bl.uk/learning/timeline/item124211.html

Dr Allan Gaw is a writer and educator in Glasgow

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Fairmont, St Andrews
26-27 November 2015

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- For further information visit Risk Management at mddus.com
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