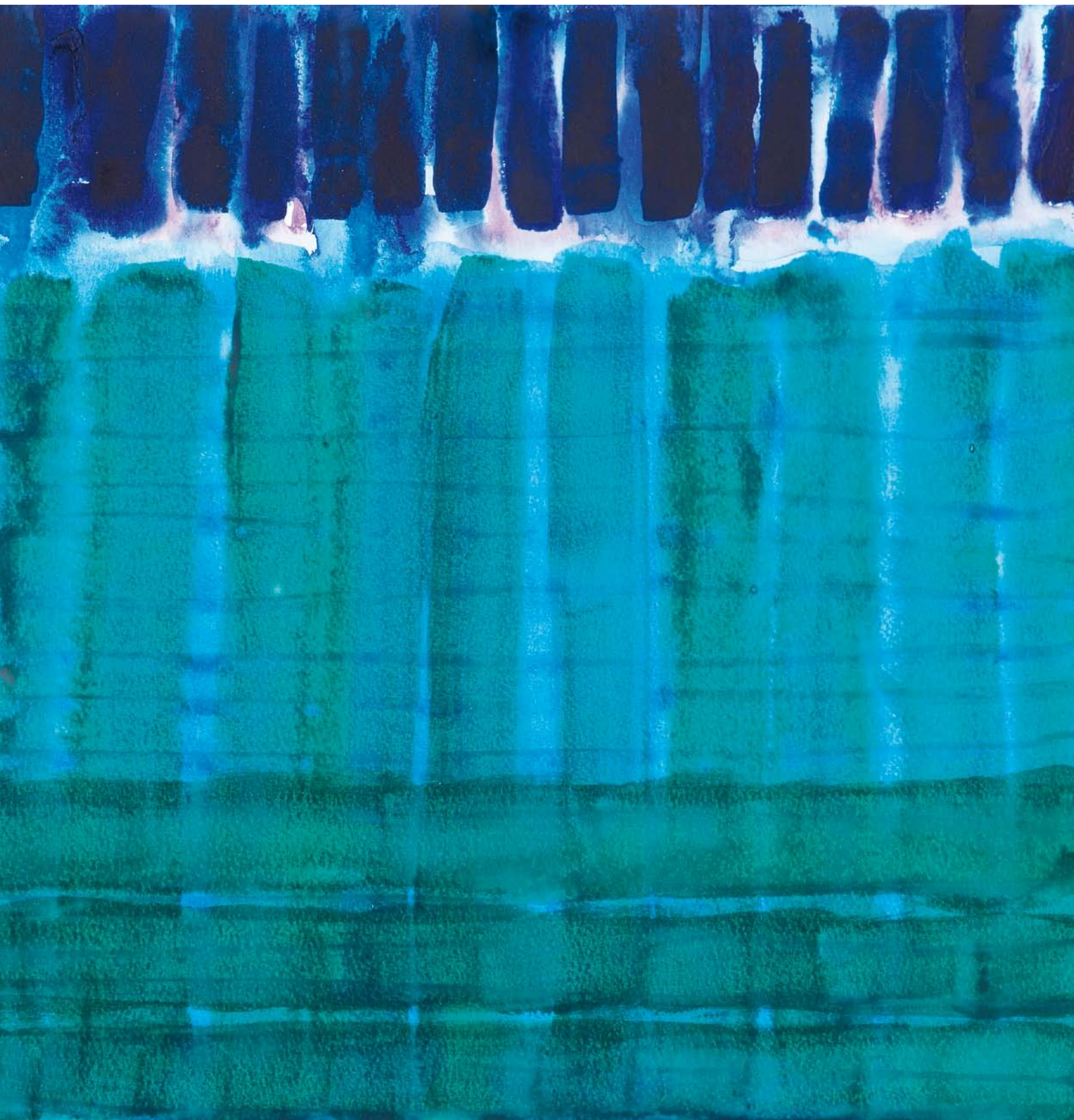


WINTER 2015

SUMMONS

AN  PUBLICATION FOR MEMBERS



• Thinking errors • A decade of change at MDDUS • Ticking dental time-bomb? •

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IN THIS ISSUE

TEN years ago Professor Gordon Dickson joined MDDUS having been vice principal of Glasgow Caledonian University and before that dean of the Faculty of Health. "Standing in my new office in July 2004 was possibly one of the strangest work experiences of my life," he writes. "My background had been as an academic in risk management but nothing can adequately prepare you for doing it for real. I had even written some textbooks on risk management and that made my transition from talking about it to actually doing it all the more 'interesting'."

Now after a decade at MDDUS – a period of unprecedented membership growth and organisational change – he is retiring as CEO. On page 8 Professor Dickson offers some fascinating insights on his time at MDDUS and the exciting opportunities that lie ahead for the organisation.

Most sufferers die with it rather than from it – but prostate cancer still poses a significant challenge to clinicians. On page 14 Professor Krishna Sethia discusses some of the pitfalls in diagnosis

and management of the condition.

Subject of recent debate in the House of Lords, peri-implantitis has been characterised as a ticking dental time bomb with an estimated 20 per cent of implants undergoing some degree of bone loss over a 10-year period. On page 18 Nicholas Lewis of the Eastman Dental Institute highlights the need for increased emphasis on preventative care to avoid implant failure.

On page 16, Joanna Bower of Capsticks LLP offers a solicitor's view of proposed changes to GMC sanctions guidance and asks is it reasonable to take account of what the public finds acceptable in regard to the level of action taken against a doctor even after "remediation".

In our regular ethics column on page 11, Deborah Bowman offers up some professional resolutions for the new year – number one being to listen, really listen. "Not second-guessing, assuming, interrupting and interpreting."

Jim Killgore, editor



8

8 REFLECTIONS AFTER A DECADE AT MDDUS

Retiring CEO Professor Gordon Dickson offers a personal perspective on his time at MDDUS and some key issues for the Union moving forward

14 CLINICAL RISK REDUCTION

Most sufferers die with it rather than from it – but prostate cancer still poses a challenge to clinicians. Here Professor Krishna Sethia explores some of the diagnostic pitfalls

16 APPROPRIATE MEASURES?

Joanna Bower of Capsticks LLP offers a solicitor's view of proposed changes to GMC sanctions guidance

18 A TICKING DENTAL TIME-BOMB?

Nicholas Lewis of the Eastman Dental Hospital highlights the risks posed by peri-implantitis

REGULARS

- 4** Notice Board
- 6** News Digest
- 11** Ethics: Ethically resolved
- 12** Risk: Thinking errors
- 20** Case studies: Not texting, Missed decay, Risking addiction
- 22** Addenda: The 50-yard dash, Oculizer, Crossword and Vignette: Dorothy Geddes, first female UK professor of dentistry



18



Cover image:
'Borealis I'
Philip Duthie

This work is of the Aurora Borealis, otherwise known as The Northern Lights. Born in Aberdeen in 1957, Philip Duthie studied at Gray's School of Art in Aberdeen, 1975-79. He has exhibited internationally and has pieces in several British collections.

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MDDUS welcomes new chief executive

MDDUS is pleased to welcome Mr Chris Kenny as its new chief executive.

Mr Kenny (above) joins the Union upon the retirement of the former chief executive Professor Gordon Dickson. He comes to MDDUS from the Legal Services Board in London where he served as chief executive and brings extensive regulatory, legal, life insurance and healthcare experience.

Looking forward to the new role, Mr Kenny said: "Under Gordon's leadership, MDDUS' reputation for service and value for its members has grown markedly and led to significant expansion for the company. I'm looking forward to building on that excellent record as the company moves to the next phase of its development."

Professor Dickson served over 10 years at the helm of MDDUS, during which time the company saw significant progress and growth with a fund of over half a billion pounds now being managed for the benefit of its 40,000 members throughout the United Kingdom.

MDDUS chairman Dr Benny Sweeney said: "The 10 years that Professor Dickson has been CEO has seen a complete transformation of MDDUS into a modern, vibrant and successful company with a growing membership, sound finances and an excellent corporate governance infrastructure.

"The Union wishes Gordon a long, healthy and happy retirement. The Board of Directors is confident that it has identified a suitable successor to Gordon, and we look forward to working with Chris Kenny."

Professor Dickson commented: "It is the right time for me to hand over the reins to a new CEO so that the Union can build on all that has been achieved and continue to sustain and grow the strong company that MDDUS undoubtedly is.

"It has been an enormous privilege to lead MDDUS and I can say without hesitation that our members are truly fortunate to be members of a company with such loyal and dedicated staff."

On page 8 of this issue Professor Dickson offers some personal insights on his time at MDDUS.

Keep us informed of private practice earnings

If you are a doctor in private practice your subscription is based partly on the work you do and partly on the private fees you earn. Your renewal notice will show the level of earnings upon which your subscription has been based and it is your responsibility to ensure that this is sufficient to cover expected earnings for the year to come.

Should any change be required please inform MDDUS immediately so that a revised subscription for next year can be calculated. If at the end of next year your estimate has proved to be too high or too low you will have an opportunity at that time to adjust it.

We would like to be clear that the figure used should be your gross private earnings from the practice of medicine, however delivered. In the event that you have formed a company for accounting or other purposes, the relevant figure is the gross income to that company in relation to your practice of medicine. In our recent experience, there are still a small number of doctors declaring their salary from their company, as opposed to the gross fees. In such circumstances we have discretion to make adjustments retrospectively to ensure adequate and appropriate indemnity is in place.

At the heart of the principle of mutuality is the fact that all members should contribute an appropriate amount to the common fund that is held on behalf of all members. This is an important principle and we do carry out checks of gross private

practice earnings from time to time to ensure that it is being complied with.

If you have any questions please telephone our Membership Department on 0845 270 2038

Bleak Practice – the sequel

A SEQUEL to our video learning module *Bleak Practice* is now available to MDDUS members.

It follows on from the characters and events introduced in the first module – this time focusing on additional risks common in general medical practice such as results handling to avoid delayed or missed diagnosis, supporting colleagues with health problems and team communication.

As with module one, a downloadable discussion guide is available to help PMs and GPs take their team through these risk areas in order to help them decide whether they need to take action to reduce their own practice risk.

MDDUS doctors and dentists can access the video eLearning module in the Risk Management section at mddus.com using their surname and membership number. Practice managers who would like to access the videos should contact risk@mddus.com to receive their unique access code. Verification for CPD purposes is available.



IN BRIEF

● **RETURNING TO WORK?** If you currently have deferred MDDUS cover, it is important that you apply to restore cover in ample time before you return to clinical practice. This can be done by completing an application form on our website at least two weeks in advance of the

intended return-to-work date. To find out more, visit the Membership section of mddus.com.

● **MDDUS PRACTICE MANAGERS' CONFERENCE** Dates have been announced for the 2015 MDDUS Practice Managers' Conference which will again be

held at the Fairmont Hotel, St Andrews in Scotland – so mark your diaries. The conference will be held on Thursday 26 and Friday 27 November 2015. As always, places will be limited so to express interest in attending, email the Risk team at risk@mddus.com

● **LEADING THROUGH UNCERTAINTY** Places are available on MDDUS Risk Management's popular Leading Through Uncertainty course developed specifically for doctors with management responsibilities. The week-long programme will challenge you as a



MDDUS recruits new adviser as membership grows

MDDUS has recruited a new medical adviser in our London office, as membership continues to grow throughout the UK.

Dr Greg Dollman joins the London medico-legal team, bringing the number of new MDDUS staff recruited since the beginning of last year to 27. MDDUS has enjoyed more than a decade of undiminished growth with a 75 per cent increase in active membership since the year 2000.

Figures from the company's annual report of 2013 reveal that 58 per cent of MDDUS members are now based outside of Scotland, while our GP market share in the rest of the UK has increased from seven per cent in 2000 to 22 per cent in 2014.

Membership also increased among private physicians, hospital doctors and general dental practitioners. As of July 1 2014, total membership stood at 38,634, a rise of 9.8 per cent over the previous year, with this number estimated to exceed 40,000 by the end of 2014.

To meet the needs of this growing membership, MDDUS has continued to expand its team of medical advisers and lawyers in both Glasgow and London.

Retiring MDDUS Chief Executive Professor Gordon Dickson said: "We have seen continued growth among GPs practising outside of Scotland while, at the same time, retaining in membership the overwhelming majority of GPs north of the border.

"Increased membership brings with it an inevitable increase in cases and we have expanded our team of advisers in our London office to ensure we continue to offer members the very best service."

Dr Dollman, who has clinical experience in psychiatry and geriatrics, said: "I am delighted to join the dynamic team here at MDDUS and look forward to the challenge of providing doctors with support and advice."

Competence in interpreting hospital test results

DIGITAL reporting has increased quick access to hospital test results. This brings undoubted patient benefits in speedier diagnosis and treatment but there are also some associated risks. Consider the following scenario.

A GP registrar in consultation with a worried elderly patient accesses the results of a CT brain scan taken at the local hospital. The doctor views the result and informs the patient that there appear to be some "abnormalities", although she admits to being "unqualified to read the report" and feels that specialist input is required to interpret the findings. She advises the patient that the practice will contact the hospital consultant by letter for more information.

Two days later the practice receives a letter of complaint from the patient. Upon leaving the practice after the consultation, the patient had suffered a panic attack on the way home. After receiving assistance from a neighbour, he was helped by his daughter to contact the hospital later that day. A consultant phoned back and reassured the patient that the result was fine and that the abnormalities reported are nothing to be concerned about.

The patient is relieved by this but remains very unhappy about the unnecessary stress that the GP registrar placed on him and wants an apology.

Better and timelier access to

information about patient testing and reporting may lead a doctor, with an anxious patient in front of them, to review results which would not previously have been accessible. To do so could ease the patient's worry – particularly in areas where discharge information and reporting to the GP practice is routinely slow.

However, in our experience at MDDUS this can sometimes prove counter-productive. In such situations, it's important to pause and consider the best course of action to ensure that you work within the limits of your competence. Of course, if you have an anxious patient or one whose condition has significantly deteriorated since they were last seen at hospital, you might judge that action is required.

In the case of specialist reports it may be more circumspect to inform the patient that you will investigate the matter and agree with them the most appropriate mechanism by which you will get back in touch, once you have further information. This would allow you to review the report and discuss it with the hospital team if you feel further advice is required.

In summary, consider the consequences of accessing results which may require specialist interpretation. It may be better to await specialist input before providing specific comment on the results to the patient, unless you feel the benefits of this might outweigh the risks.

■ **Liz Price, risk adviser at MDDUS**



leader and help you tackle change positively and create interdependent, effective relationships in the workplace. The course will run from October 5-9, 2015 (inclusive) at the MDDUS Glasgow office. The cost is £450 for members and £500 for non-members. Contact the Risk

team at 0845 270 2034 or risk@mddus.com

● **NOMINATIONS OPEN FOR BMJ AWARDS** Nominations have opened for the prestigious BMJ Awards 2015, celebrating outstanding achievement in the medical profession. Now in their

seventh year, the awards will take place in London on Wednesday, May 6, 2015. MDDUS is proud to once again be the principal sponsor. Entries are being accepted in 13 different categories, including the Lifetime Achievement Award, UK Research Paper of the Year and the

award for Best Primary Care Team - also sponsored by MDDUS. Entries must be submitted online at www.thebmjaward.com by 11pm on January 21, 2015. A shortlist in each category will be announced in February and judging will take place at the end of March.

➔ Performance data of surgeons published

MORTALITY rates and other outcome data for 5,000 NHS surgeons in England are being published online as part of a drive towards "greater transparency".

The figures, covering clinicians practising across 13 specialties, are designed to "reassure patients", with mortality rates for almost all surgeons said to be within the expected range.

Other data gathered by the Healthcare Quality Improvement Partnership (HQIP) details the length of hospital stay and patient readmission rates. The information is being made available on the newly-launched MyNHS portal within the NHS Choices website where visitors can compare the performance of hospitals across the country. They can also search for information by individual consultants' names, hospital or location.

Outcomes data was first made public in 2006 with the mortality rates of cardiac surgeons. Last year data relating to 4,000 surgeons in 10 specialties was made available.

The publication was welcomed by the Royal College of Surgeons who said the data was part of being open and honest with patients. But Professor John MacFie, president of the Federation of Surgical Specialty Associations, told *BBC News*: "The publication of individual surgeons' performance data is crude and can be misleading, and does not include essential information such as duration of hospital stay and returns to theatre.

"There is now good anecdotal evidence that shows publishing this data has encouraged risk-averse behaviour, which is not in the interest of patients."

➔ Almost one in 10 trainees are bullied

NEARLY one in 10 trainee doctors have been bullied at work, according to a report by the General Medical Council. A greater number reported witnessing bullying or intimidation – including belittling or humiliation and threatening or insulting behaviour – but few chose to speak out

about it. The figures were revealed in a GMC report analysing the findings of their *National Training Survey 2014*.

It showed eight per cent of the almost 50,000 trainees who responded to their survey had experienced bullying while 13.6 per cent had witnessed such behaviour. The report said evidence suggests there is a reluctance to speak out about the issue, "both from fear of reprisals and from lack of faith that anything will be done."

"Bullying and undermining are completely unacceptable and can have a big impact on the safety of care given to patients," the report said. The GMC has pledged to work closely with deaneries and LETB training boards to find solutions to the problem.



➔ Duty of candour becomes law

NEW laws have come into force in England placing a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.

In a statement, the Department of Health said: "The introduction of the Duty of Candour is an important step in ensuring a more honest and open culture in the NHS, particularly when things go wrong. It is a major milestone in the government's response to the Francis report into Mid Staffordshire, which called for a more open culture in the NHS. It forms part of a wider package of measures designed to support this."

The Care Quality Commission (CQC) has published guidance for NHS organisations to help them meet the requirements of the new regulations.

➔ Income link in oral health

A STUDY led by researchers in Newcastle has found that oral health is markedly worse among the poorest 20 per cent of British society compared with the richest.

More than 6,000 people from England, Wales and Northern Ireland were involved in the study - published in the *Journal of Dental Research* - which found that among dental patients over 65 years old, the least well-off averaged eight fewer teeth than the richest, a quarter of a full set of teeth.

Those with lower income, lower occupational class, higher deprivation and lower educational attainment generally had the worst clinical outcomes, including having more tooth decay, gum disease and tooth gaps, as well as having less teeth overall.

Professor Jimmy Steele CBE, Head of the Dental School at Newcastle University, and lead author said: "It's probably not a big surprise that poorer people have worse dental health than the richest, but the surprise is just how big the differences can be and how it affects people."

Dr John Milne, Chair of the BDA's General Dental Practice Committee, commented: "The tools to break this pattern are neither new nor expensive. Education, fluoridation and sugar controls can all make a difference, and we must ensure dentists have contracts in place that recognise and reward work on prevention."

➔ Patients avoid considering cancer

PATIENTS may often delay consulting with GPs over early cancer "alarm symptoms" attributing these to less serious causes, according to a recent study published in the journal *PLoS ONE*.

Researchers analysed survey results from 1,724 people registered at three London general practices who were presented with a list of 17 symptoms and asked if they had experienced these in the last three months. Ten of these "alarm symptoms" featured in public cancer campaigns.

Over half (53 per cent) reported experiencing at least one alarm symptom in the past three months though only 2 per

IN BRIEF

● MHRA WARNING ON BOGUS DENTAL EQUIPMENT

The regulatory agency is warning dentists about the potential danger of buying and using counterfeit and unapproved dental equipment imported into the UK from China and Pakistan and sold on auction websites. It recently

seized items including dental X-ray machines that emit high levels of radiation and hand-piece drills that could malfunction inside patients' mouths. Dentists can contact the MHRA to report bogus equipment at aic@mhra.gsi.gov.uk or on 020 3080 7080.

● DRINK-DRIVE ADVICE SCOTLAND

December 5 saw the lowering of the drink-drive limit in Scotland from 80mg to 50mg in every 100ml of blood and the government has rolled out a campaign warning drivers that the "Best advice is none". BMA

Scotland has welcomed the move and believes that it will lower the number of deaths and serious injuries on the roads.

● PATIENT ACCESS TO DIGITAL RECORDS

Patients in England will be able to access their own GP records online from

BRIEFING



By Dr Barry Parker, medical adviser, MDDUS

Changes in death certification in Scotland

Doctors in Scotland will be aware that a new Medical Certificate of Cause of Death (MCCD) was introduced in August 2014 in preparation for significant changes required by the implementation of the Certification of Death (Scotland) Act 2011.

The new certificates require additional details such as CHI number, health board area, doctor's phone contact number and information on potential hazards such as cardiac pacemakers or radioactive material. Cremation forms are still in use at present and have not changed.

Full implementation of the Act is expected to take place on 13 May 2015, and there will be a number of important changes to the way in which death certification processes are carried out. Firstly, there will no longer be cremation forms and crematoria medical referees, and the certification process will be the same for both burials and cremations. There will be a new review system introduced and run by Health Improvement Scotland to review the quality and accuracy of MCCD completion.

Ten per cent of MCCDs will be randomly selected to be reviewed by a medical reviewer, a newly created post, and the review will take the form of an inspection of the MCCD and discussion with the certifying doctor. This is described as a Level 1 review.

In addition, a small number of MCCDs will be specifically selected for a more detailed Level 2 review, which will involve the medical reviewer inspecting the MCCD, discussing with the certifying doctor and accessing certain medical records. There will be several medical reviewers appointed across Scotland, and a single senior medical reviewer. In total it is estimated that around 6,000 certificates will be reviewed each year.

In the event that amendments are suggested by the medical reviewer, an amended certificate may be produced by the certifying doctor. Should there be any disagreement, the matter will be referred to the senior medical reviewer for further discussion. It is anticipated that agreement will be reached in the majority of cases. A flow chart of the full review process can be found on the Scottish Government website at <http://tinyurl.com/kba4yuq>

It is hoped that the new review system will not result in any significant

delay for families keen to progress with funeral arrangements. Level 1 reviews are expected to be completed within one working day, and Level 2 reviews within three working days. Families may request an expedited procedure in certain circumstances where required for burial/cremation arrangements.

It is important to emphasise that the guidance available for how the cause of death itself is described on death certificates has not changed, and this guidance is available at <http://tinyurl.com/qxyxojw>. Furthermore, there is no change to the arrangements for reporting deaths to the Procurator Fiscal (<http://tinyurl.com/lhtd5b6>). Doctors may be able to discuss certain aspects of certification with medical reviewers, but if contemplation is being given to reporting the death to the PF, then a direct approach to the PF office is still required to obtain advice on this.

One final change will be the introduction of electronic MCCD forms. This will be rolled out to GP practices from May 2015 onwards, and then to other healthcare settings. This may facilitate completion, but there will still be a requirement to print off the completed form to be signed and passed to the representative of the deceased in the usual way.

cent of these cited cancer as a possible cause. Cancer attributions were highest for "unexplained lump" (7 per cent) but changes in bladder habit, persistent unexplained pain and unexplained weight loss were rarely acknowledged to be cancer symptoms.

A higher proportion of patients (23 per

cent) were concerned their symptom might be "serious", ranging from 12 per cent for change in a mole to 41 per cent for unexplained pain. The survey found that over half of the patients had contacted their doctor although this varied by symptom. Lead researcher Dr Katriina Whitaker, senior research fellow at

University College London, said: "Even when people thought warning symptoms might be serious, cancer didn't tend to spring to mind. This might be because people were frightened and reluctant to mention cancer, thought cancer wouldn't happen to them, or believed other causes were more likely."

spring 2015 and will have full access to care records by 2017, according to a report published by the National Information Board. NHS 'kitemarks' will indicate trusted smartphone apps which will help patients access services and take more control of

their health and wellbeing. Plans also call for a "digital red book" for child care records in 2016. Access the report at <http://tinyurl.com/p2tetmd>

● DOCTORS URGED TO PRESCRIBE ANTIVIRALS

Patients suffering from severe

flu this winter should be treated with antivirals despite concerns over efficacy. Early use of antivirals is urged for patients with proven or suspected seasonal influenza who are considerably unwell or are in a high-risk group. New guidance

from Public Health England follows concern that reports suggesting antivirals are not effective for influenza have caused confusion and could impact the prescribing of these drugs. Access the guidance at <http://tinyurl.com/m2bpnro>.

Reflections after a decade at MDDUS

Retiring CEO Professor Gordon Dickson offers a personal perspective on his time at MDDUS and some key issues for the Union moving forward

I THINK it was the middle of September when one of my grandsons first mentioned Christmas. It must have seemed an eternity to him to have to wait from then until the 25th December. I have no such problem with the passing of time! Certainly the last 10 and a half years have simply flown past for me at MDDUS and at the end of December my time as CEO will come to an end when I retire.

New Year is a time for reflection on the past and resolutions for the future and so as I come to the end of my time at MDDUS, I wanted to use this short article, my last piece for *Summons*, to share a few reflections. Outgoing CEOs can feel a little less restrained in what they are able to say and so this piece is more by way of a personal comment rather than a company view.

Standing in my new office in July 2004 was possibly one of the strangest work experiences of my life. My background had been as an academic in risk management but nothing can adequately prepare you for doing it for real. I had even written some textbooks on risk management and that made my transition from talking about it to actually doing it all the more “interesting”. I remember saying to a risk management colleague at the time that it was a bit like having written a book on how to ride a bike, having never ridden one, and then someone gives you a bike and says: “on you go, ride it”. Looking back, I am pleased I did make the leap. Some of the theory does work – and I shouldn’t really sound so surprised. What I would say to undergraduates who are working away on topics that they think may not be all that relevant in later life is that they are and so keep at it.

Minding the gap

A good example of theory meeting practice is in the nature of the protection we offer at MDDUS. Students of risk grapple with the technicalities of occurrence-based protection and claims-made wordings. The latter is by far the more common and applies to our house insurance and motor insurance policies, for example. You have a policy and you have to make the claim during the period of the policy. That is relatively easy to operate as there is seldom any gap in time between the occurrence of the fire or motor accident and you knowing there has been a fire or accident.

The same is not of course the case for clinical negligence claims. It can be days, weeks, months or even years after something was caused before it comes to light. A missed diagnosis is a good example. A considerable gap in time can open up before the impact comes to light. Our longest gap between occurrence and claim was 36 years after the birth of a child. Lawyers acting on behalf of the now elderly parents alleged negligence at birth was the cause of their son’s severe disability. We successfully defended our member, at some considerable cost, but it underlined to me the huge weight of risk our doctors carry for many years to come and the very real value of the protection we offer. Contrast this to the case of a prescribing error resulting in hospital admission later that same day and death that night. It is hard to think of other professions where today’s judgements and decisions can have both an immediate impact and one felt decades later. Perhaps because of that potential for something untoward coming

"We need to encourage society to stop thinking that there must always be someone to blame."

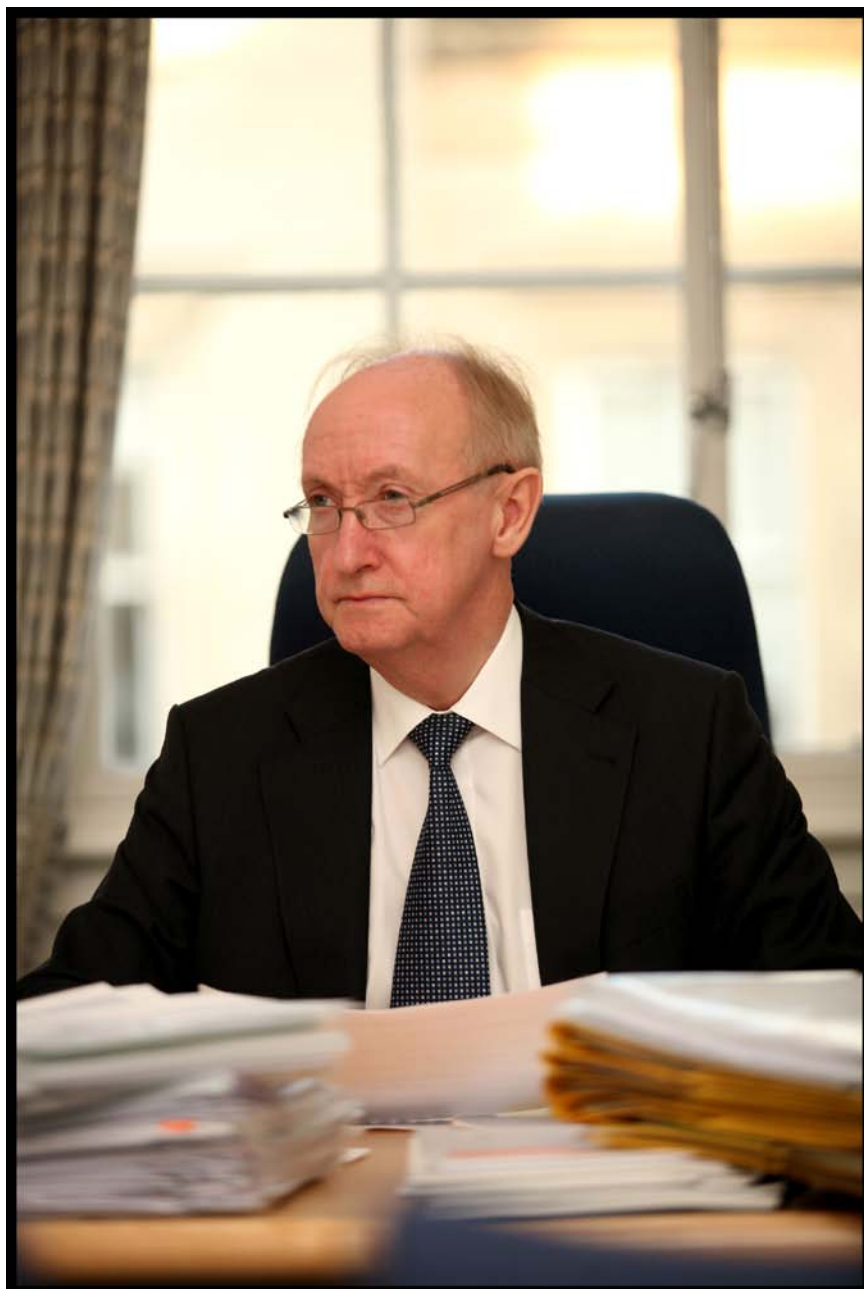


to light, what strikes you immediately upon arriving at MDDUS is just how often members telephone for advice. Well over 15,000 times in total last year and the topics cover a huge range of things from the very simple to the highly complex. It is difficult to think of many professions where decisions are so crucial, matters so complex, outcomes so life-threatening that there is a need for a twenty-four-hour-a-day resource such as we offer. The role of the doctor or the dentist as a decision-maker, often in extremely difficult circumstances, can never be understated.

No fault compensation

As I do look back, perhaps with a slightly philosophical tinge to my reflection, there are certainly a few issues where I have stopped to think and to ask, why are things like that?

Take for example the steadily rising costs of clinical negligence claims. The Union met its first £1m settlement back in 1990 and now such cases are almost commonplace. Our largest settlement to date has been £7.5m with legal costs on top of that. Why is the level of damages so high? Many argue that one factor probably stems from an Act that came into force one year before I was born: The Law Reform (Personal Injuries) Act 1948. In brief, a claimant is entitled to look to private providers for their continuing



healthcare needs. In the case of claimants who have long life expectancy but who will require a high level of continuing care, you can see how the costs of private care can so easily mount to a very significant sum. The NHS was launched in July 1948 and some argue forcibly that this particular section of the Law Reform Act needs to be repealed.

A broader question for society is why we leave it to a tortious, adversarial system at all to provide for the continuing healthcare needs of those injured as a result of clinical negligence. Would it not be a hallmark of a civilised society to look after those who need care regardless of how it is caused? Over my 10 years I have often contrasted the outcome for infants who suffered as a result of clinical negligence at birth with those who, for example, suffered a fall that resulted in a similar level of devastating injury. Why are these two cases felt to merit a quite different approach?

This kind of thinking leads to the notion of compensation not

based on fault. I recall as a student in the early 1970s reading of The Royal Commission on Civil Liability and Compensation for Personal Injury, better known as the Pearson Commission. Pearson believed that the traditional role of compensation had become outdated with the rise of the welfare state. However, his recommendations to move to a no-fault scheme for road traffic and industrial accidents were not acted upon.

Since then the debate continued periodically but no action has been taken. The latest work has been the Scottish Government's consultation on no-fault compensation for clinical cases. I have to admit to a certain moral appeal in the idea. It would have to be managed carefully and in that management there would of course be a role for the expertise that currently resides in a defence body such as MDDUS.

A final reflection on damages is why a GP practising in England should be roughly three times more likely to have a claim made against them than one practising in Scotland? Why this should be so is open to much speculation and there is a PhD in there for someone. One of the most authoritative comments I have seen is from Sheriff Taylor in his 2013 review of the funding of civil litigation in Scotland when he looked at several forms of personal injury claim and found that they all exhibited far lower rates of frequency in Scotland than in England. He concluded that there was possibly a different culture in Scotland with regard to litigation. Why that might be, if it is indeed the case, remains a question but my own belief is that the increasing privatisation of healthcare outside Scotland, the treating of healthcare as a consumer product and the rise in claims management companies will all play a part in the attitudes of patients and hence their propensity to claim.

Mutual strength

And so, what about MDDUS? As we move from 2014 to 2015 we have a steadily rising membership (especially outside Scotland where we already have the vast majority in membership), a very healthy balance sheet, a cohort of extremely loyal and committed



"We have no masters
other than our members, no
need to generate a profit for
anonymous shareholders"

staff and a Board focused on providing the very best service possible to members at the most competitive price. The signals are all positive and so the future is bright. Competition will continue, but competition is good in any free market. New providers may well continue to appear in the market, thinking that they can turn a profit quickly and, like others in the past, they will realise that this is not the case and then move on to other ventures.

The MDDUS derives considerable strength from its mutual status and I believe our members are well served by this model. We have no masters other than our members, no need to generate

a profit for anonymous shareholders, no incentive other than to keep the weighty promise we make all members that if they need us, no matter when that is, we will be there to assist. Mutuals have enjoyed a mixed press in recent years but I believe very firmly that our members are well served by the kind of membership mutual our founding fathers envisaged in 1902 and that we continue to operate today.

Where do we go from here? Someone else has the responsibility to think about that but a few pointers. We need to continue to exert influence wherever we can to bring an element of practical realism to the level of damages being awarded. We need to encourage society to stop thinking that there must always be someone to blame. We need to keep under control the costs associated with medical and dental regulation, and most of all we need to recognise, and say loudly, that 99.9 per cent of doctors and dentists are doing their very best every day, often in difficult circumstances, and that we will be there to assist, support and represent them where necessary.

Very best wishes to all at MDDUS – members, staff and directors.

■ *Professor Gordon Dickson is the retiring CEO of MDDUS*

ETHICALLY RESOLVED

Deborah Bowman



AS I WRITE, the first few windows on the advent calendar are open and I am hovering somewhere between guilt and anticipation as I prepare for Christmas. I love the rituals and traditions. One of the most established winter traditions is that a few days after Christmas, I'll engage ambivalently with the idea of resolutions for the New Year. Will the seductive fantasy of disciplined improvement trump realistic cynicism? Perhaps the solution is to eschew the usual resolution suspects. Instead, I have come to wonder, what might my ethical resolutions be and, more importantly, will I be able to keep them beyond Twelfth Night?

1. I resolve to listen, really listen, to those with whom I disagree

Ethics is inherently contested. That is part of its joy. The diversity of perspectives and opinions makes it a rich field of inquiry. However, listening to those with whom we disagree, really listening to their ideas and arguments, is more difficult than we like to admit. As we hear their words, or even certain trigger words, we are busy constructing our counterargument or dismissing their claims as poorly conceived, badly presented, misguided or downright foolish. We've rehearsed this conversation – sometimes in discussion or in writing, sometimes just in our heads. We infer, assume and leap ahead. Then there's the background noise of confusion, frustration and even disbelief: the emotional effect of disagreement is fascinating and inhibiting. Is anyone really listening? Just listening? Not second-guessing, assuming, interrupting and interpreting. I don't do it often enough. I need to do it more.

2. I resolve to return to classic texts

Every year I read hundreds of books and papers about ethics (broadly defined). That tally may even be in four figures. Yet, I too rarely return to the classic texts; those that I read when I first encountered philosophy and ethics. My engagement with those titles now tends to be based on what I teach and the limitations of the same. This is the year that I will blow the dust of my copies of Aurelius' *Meditations*, Spinoza's *The Ethics* (Parts I-V since you ask), Hume's *An Enquiry Concerning Human Understanding*, Rawls' *A Theory of Justice* and Foot's *Virtues and Vices*. I'll be in my study if you want me.

3. I resolve to seek out the experiences and perspectives of those who are too rarely heard in ethics discussions

In the last five years, I have spent more time working with, and learning from, those who don't work in healthcare settings or universities. I have been part of a philosophy for schools programme. I have spoken at festivals and at events organised by Carers UK, the University of the Third Age and Medicine Unboxed. I have been doing research on the phenomenon of death cafes. These meetings and conversations have been transformative, reminding me that the "ethics of the everyday" are too rarely considered in the mainstream of ethics debate and discourse. Discussions of moral questions and ethical problems are too often shaped and led by those with professional status and expertise. Ethics, as a field of inquiry, must become more inclusive and imaginative in its approach. It must attend to those whose experiences and voices are not being heard. There is much to do and much to learn.

4. I resolve to spend time on the areas of ethics I don't enjoy

I love my subject and my job. I don't know what it is to dread going to work. At the risk of sounding horribly like an academic Pollyanna, I consider myself privileged to be paid to do something that I enjoy so much. Yet, there are areas of medical ethics that don't excite me. In fact (whisper it), there are one or two subjects that leave me cold. I am fortunate to have a colleague who is, by happy coincidence, interested in the areas of ethics that make me sigh. The downside though is that it has become too easy for me to resist thinking about questions that may not appeal to me, but are nonetheless important and deserve attention. So, 2015 will be the year that I read properly the journal papers I'd usually skim, go to the conferences that I'm inclined to skip and learn to love questions of research ethics and resource allocation.

So, there you have it: a public statement of intent. That the list is not longer is not just a consequence of word limits and editorial direction. I have enough self-knowledge to realise that managing expectations matters. However, this short list is not, I hope, without significance. It reflects a sincere commitment to change and to small but meaningful improvement. Might you join me? What would your ethical resolutions be?

I wish you all a peaceful, healthy and happy new year.

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

Thinking ERRORS

Risk adviser Alan Frame considers errors in diagnosis and why doctors make them

WE ALL know that mistakes can happen in medical practice and thanks to our ongoing 'cause-of-loss' analysis here at MDDUS we now have a greater insight into the nature of these errors. Our research recently revealed that around 60 per cent of negligence claims against our GP members are related to alleged failure to diagnose.

So the next logical question is why do these errors occur? While some incidents can be blamed on system errors, such as the misfiling of a test result, many can be attributed to what are known as 'thinking errors'.

Psychologists have identified several reasons why we humans make mistakes in our thought processes, despite possessing the knowledge and ability to think correctly. In 2003, the journal *Academic Medicine* listed examples of thinking errors, including:

- **Anchoring bias** – locking on to a diagnosis too soon and failing to adjust to new information.
- **Availability bias** – thinking that a similar recent presentation you have encountered is also happening in the present situation.
- **Confirmation bias** – looking for evidence to support a pre-conceived opinion or notion, rather than looking for information to prove oneself wrong.
- **Diagnosis momentum** – accepting a previous diagnosis without applying sufficient scepticism.
- **Overconfidence bias** – over-reliance on one's own ability, intuition and judgement.
- **Premature closure** – similar to confirmation bias, but more like jumping to a conclusion.
- **Search-satisfying bias** – a "eureka" moment that stops all further thought on the matter.

The most common thinking error in the practice of medicine is said to be the anchoring bias, where doctors may jump to premature conclusions by assuming that they're thinking about things in the right context when they may not be. This may lead to a failure to undertake a broader search for other possibilities.

Zebras or horses?

A recently closed MDDUS claim illustrates some of the above points in action. The case involved the failure to diagnose a 22-week gestation pregnancy in a 16-year-old presenting with symptoms of vomiting and amenorrhea. The girl denied having had sex and a pregnancy test was not carried out. She went on to deliver a healthy baby but developed post-natal depression. She raised a claim against her GP arguing that, had she known of the pregnancy, she would have requested a termination. MDDUS sought an expert opinion on liability which suggested a "weak defence" and a settlement was agreed before trial.

An important feature in this case was that the patient had presented on several occasions to out-of-hours services and other GPs complaining of the same symptoms. An existing three-year history of sinusitis was assumed to be the cause of her difficulties early in the encounter, and this was diagnosed as the reason behind her nausea and vomiting. A period of three months then passed during which several consultations took place, before a home pregnancy test proved to be positive.

Our expert made a number of observations about her care. He noted an over-reliance on previous diagnosis and explanations offered by other doctors (confirmation bias, anchoring bias, diagnosis momentum) and an over-reliance on the patient's denial of sexual activity made in the presence of her mother, who was evidently "very involved" in her daughter's care (overconfidence bias, premature closure).

The expert commented that it seemed strange that when confronted with a 16-year-old having missed periods on several occasions the GP did not question whether the girl might be pregnant.

Our member conceded that he had not considered the possibility of pregnancy but he pointed out that other doctors had not either. There had been no mention of missed periods at this time and he was also not aware that the girl was sexually active.

So how can we guard against the thinking errors illustrated in this case? Some experts support greater use of information technology to help us overcome our natural biases and hopefully avoid diagnostic errors. But health IT has its own biases as well.

Remember GIGO – garbage in, garbage out!

Diagnostic tools such as template charting provide an illustrative example. A patient tells a clinician: “I’ve been vomiting and my chest hurts.” If the clinician plumps for a template for vomiting, gastroenteritis or abdominal pain too quickly, they could easily lead themselves up the garden path, overlooking the fact that what the patient really meant to say was: “I started having this really heavy chest pain and have been vomiting ever since.” Using the template first selected could lead to the patient being discharged with an undiagnosed MI.

Jumping to conclusions

Consider another case. An overweight lady on the contraceptive pill presents to her doctor complaining of pain in her left calf. GP A is unsure of the diagnosis but appears to consider and eliminate the possibility of a deep vein thrombosis (DVT). The patient then consults GP B at the same practice seven days later and now also complains of chest pain on deep inspiration. GP B treats the patient with a non-steroidal drug and sends her on her way.

Later that same evening an out-of-hours doctor suspects a pulmonary embolism and admits her to hospital. The diagnosis is confirmed and fortunately the lady is treated successfully and makes a full recovery. An allegation of medical negligence is subsequently made against both GPs, claiming that they failed to note the gravity of the situation and that such a failure was not reasonable.

An MDDUS expert witness is asked to review the care provided. The patient was overweight and on oral contraceptives, both known risk factors for DVT. Our expert notes that GP A, while having no specific recall of the consultation, was sure that she would have considered a DVT as a possible diagnosis as she had taken and recorded a measurement of the calf circumference in each leg. She was apparently reassured that the circumferences were equal and that there was no heat, redness or oedema present. There was a rash noted on one of her feet but it was not recorded on which one.

Importantly, in her record of the consultation, GP A did not say what she considered to be the diagnosis or even if she had a working hypothesis. Our expert also observes that with “even the most careful clinical examination of a patient such as this, it is very difficult to exclude a DVT by examination alone, and that most ordinary competent GPs should know this”. Our expert considers that GP A would have been wise to arrange for the patient to be assessed that day at the local hospital. He also expresses “some surprise” that GP B, seven days after the initial presentation, did not immediately fear that the lady had suffered a DVT and then a pulmonary embolism. He remarks: “What else would give rise to a sore calf and later pain in the chest on inspiration?”

Our expert concludes that it would be difficult to defend GP A’s actions in failing to arrange for an urgent hospital admission. He also finds it difficult to understand why GP B did not make the diagnosis seven days later.

So what thinking errors were at play here? GP A apparently considered a diagnosis of DVT at the initial consultation as evidenced by her taking

calf measurements. But for some reason this diagnosis was discounted. What reassured her? Was it the uniformity of the measurements, the lack of any apparent heat, redness or oedema?

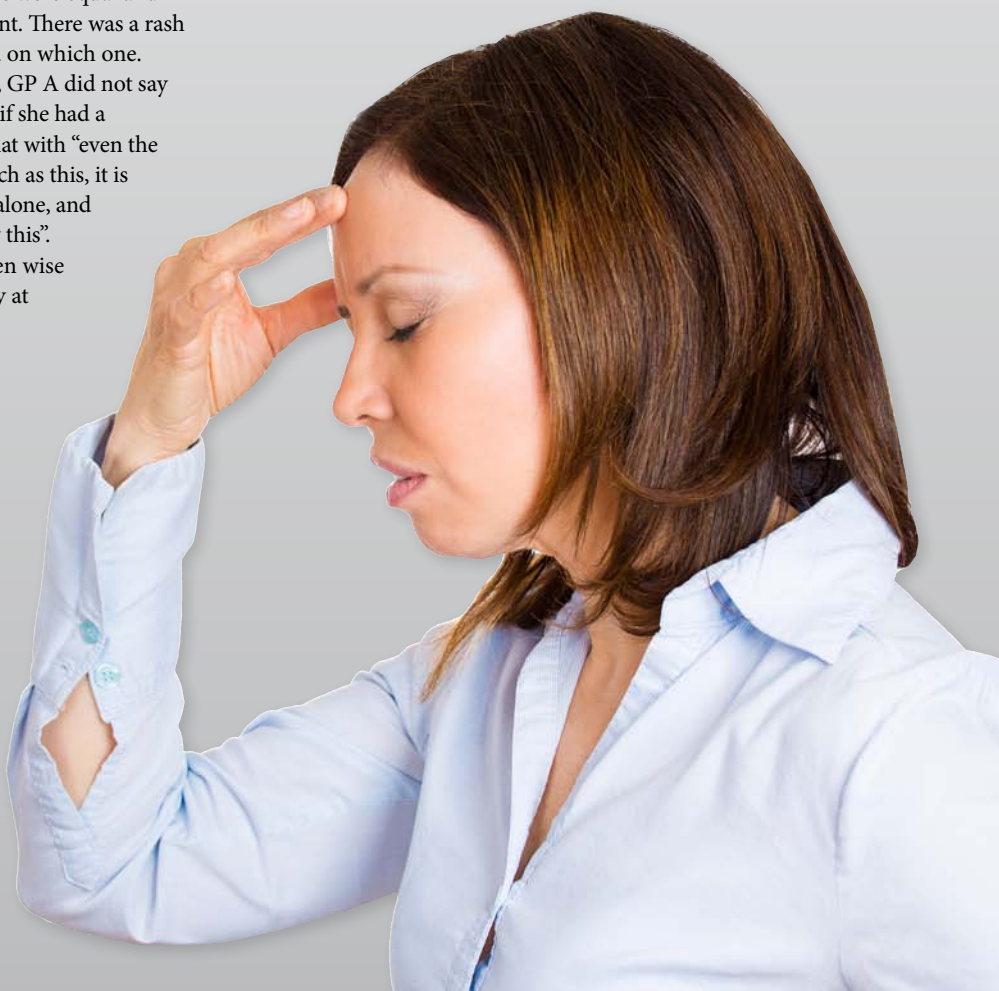
Our expert witness identified significant risk factors that should have set alarm bells ringing. Was there an issue with an inadequate history which would have flagged up the likelihood of a DVT before any physical examination actually took place? We will never know in this particular case, largely due to GP A’s poor memory recall and an absence of any reference to history taking in the consultation notes.

We can only speculate why this may have happened. Confirmation bias is a common thinking error where a doctor may look for evidence to support a preconceived opinion or notion. Closely related to this is the concept of premature closure, which involves more of a “jumping to a conclusion”, i.e. did the equal calf circumference measurements rule out the option of a DVT in the doctor’s mind?

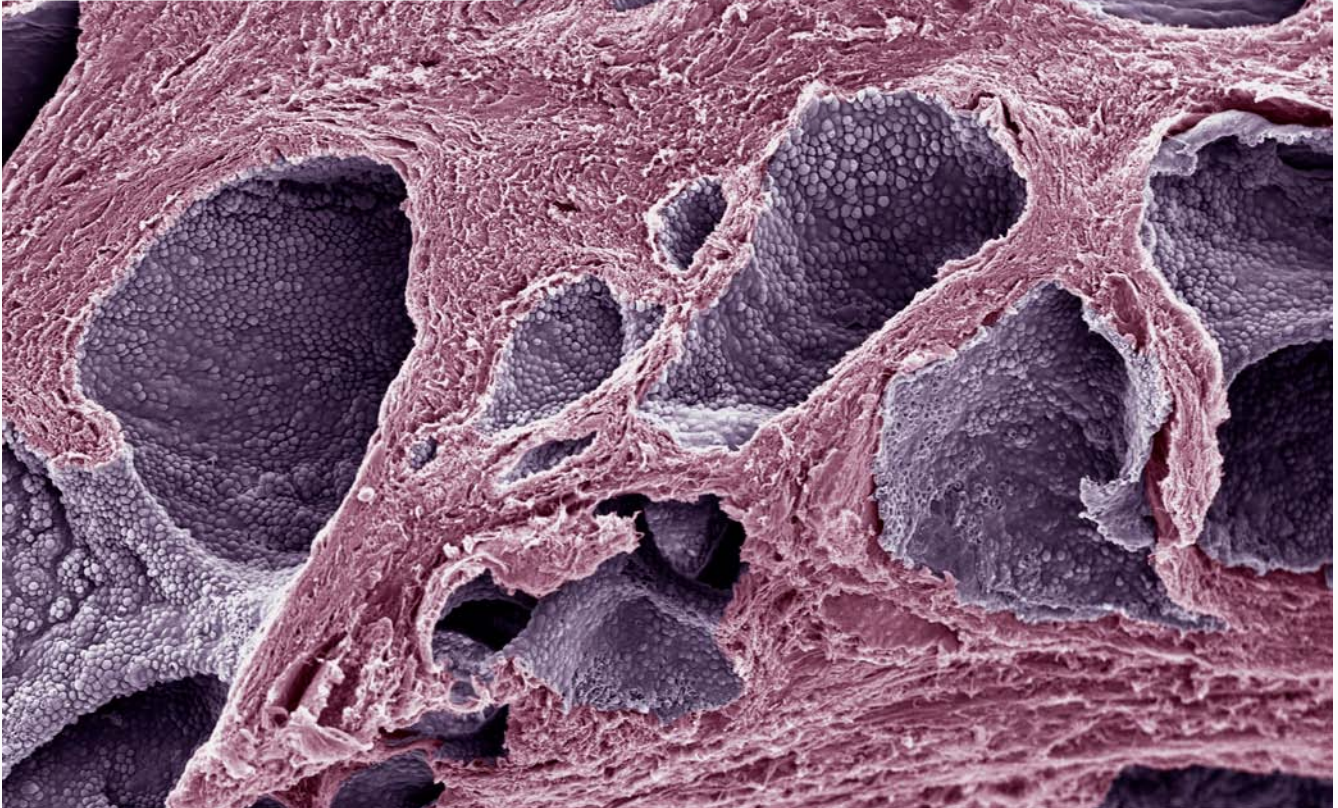
Doctors typically generate several possible diagnoses early in their encounter with a clinical problem. Premature closure can occur when a conclusion is reached before it has been fully verified. The tendency to apply closure to the problem-solving process can result from vivid presenting features that may be convincing for a particular diagnosis or by anchoring on to salient features early in the presentation.

Such thinking problems can be at least partially avoided by simply being aware that they exist and, of course, there is no substitute for experience.

■ *Alan Frame is a risk adviser at MDDUS*



Prostate gland showing acini (glandular ducts) lined with cancer cells (coloured SEM)



PHOTOGRAPH: STEVE GSCHEITIS/NEWS/SCIENCE PHOTO LIBRARY

Prostate cancer

Most sufferers die with it rather than from it – but prostate cancer still poses a significant challenge to clinicians. Here Professor Krishna Sethia explores some of the diagnostic pitfalls

PROSTATE cancer is the commonest tumour in men with over 35,000 new diagnoses and 10,000 deaths each year in the UK. The lifetime risk of a man developing prostate cancer is approximately 20 per cent and this risk is increased significantly if there is a first-degree relative who developed the disease under the age of 70. Despite this, the chance of a man dying of prostate cancer is only 2.8 per cent as the disease is often slow to progress. The majority of patients are elderly at presentation and often have significant comorbidities which result in death before the prostate tumour has escaped control. These facts, combined with uncertainties about the role of radical treatment in many patients with localised disease, create significant problems in advising and managing men with early cancers.

Diagnosis

Over 90 per cent of cases of prostate cancer in the Western world are now diagnosed on account of a raised serum prostate specific antigen (PSA), an abnormal digital rectal examination (DRE) or both.

PSA is a glycoprotein produced only by prostate acinar cells. The serum PSA should be <3.0 ng/ml in men under the age of 60, <4.0 aged 60-70 and <6.0-6.5 in men aged over 70. A small rise in PSA may be seen after DRE or ejaculation. A more obvious rise can also occur in conditions other than cancer, most notably benign prostatic hyperplasia (BPH), inflammation and retention.

When there is evidence that a PSA elevation could be due to a benign cause, it is reasonable to repeat the test after 4-6 weeks rather than make an immediate

specialist referral. If there are symptoms of prostatitis, a course of antibiotics may be indicated and the PSA should fall rapidly as symptoms improve. If the PSA level does then fall significantly, further monitoring is reasonable for a similar period, but if it has not returned to the normal range within three months the patient should be referred for specialist assessment. It should also be remembered that PSA levels are lowered by approximately 50 per cent in patients on 5 α -reductase inhibitors – the threshold for referral of these patients should be correspondingly reduced.

Failure to refer on account of an abnormal PSA level is one of the commonest causes of litigation in men with prostate cancer.

Approximately 20 per cent of men with prostate cancer have a normal PSA but the majority will have an abnormal DRE. Thus

although DRE alone is a poor predictor of prostate cancer it is a mandatory part of the assessment if cancer is to be excluded.

It is well-recognised that men can develop significant cancers without symptoms attributable to prostatic enlargement. However, the rapid onset of symptoms of bladder outflow obstruction, concomitant back pain or unexplained weight loss raise the possibility of prostate malignancy. These men should have both a PSA checked and DRE performed and be referred for specialist assessment if any abnormality is found.

Screening

Screening for prostate cancer has been a controversial subject for over 20 years. Current evidence suggests that screening of populations does reduce the death rate from the disease by about 20 per cent but, surprisingly, overall survival is not affected. A major concern is the number of men who may undergo unnecessary investigation or receive treatment for cancers detected by screening which would never have caused them any harm.

Recent publications show that for every death prevented, 780 men are screened and between 20 and 30 of these will undergo radical treatment. Apart from the anxiety and risk of significant harm that this creates there is a huge financial cost to the system. Despite this, patients often ask to be screened and although this is not standard policy in the UK it is considered appropriate to share information about the risks and benefits of screening and allow the patient to make his own decision. Useful patient information can be found at: <http://www.cancerscreening.nhs.uk/prostate/prostate-patient-info-sheet.pdf>

Investigation and management

In men with a 10-year or greater life expectancy, radical treatment may improve prognosis – it is therefore important that these patients are referred for a specialist opinion under the two-week suspected cancer pathway. Patients with a shorter life-expectancy will usually not benefit from aggressive treatment but with the advent of new treatments, and given a natural degree of patient anxiety, the default position should be to refer these patients similarly. Having said that, there is a group of patients, typically the very elderly and frail, where the only intervention that may or may not be indicated is hormonal manipulation. There is no absolute need to refer these patients to hospital but it is

sensible to discuss individual cases with local urologists if there is any doubt.

The diagnosis of prostate cancer is usually made on the basis of a transrectal ultrasound scan and biopsies. Current evidence is that the traditional sextant biopsies miss many tumours and therefore at least 10 biopsies should be taken. Given that this creates a significant risk of systemic infection (and that there is even a very small mortality associated with biopsies as a result) the patient must be fully informed of the risks and the procedure must be covered with appropriate antibiotics. Negative biopsies do not absolutely exclude cancers so under these circumstances it is important that a PSA test is repeated after 3-4 months. If the level remains high further, more extensive biopsies may be indicated. If a patient becomes pyrexial and/or systemically unwell following biopsy they must be aggressively treated with appropriate antibiotics and other supportive measures. If there is any doubt about clinical progress the patient should be admitted to hospital as an emergency.

Whilst there are several available management options for localised prostate cancer there is scant scientific evidence of the superiority of any particular approach. It is therefore essential that the specialist gives a clear explanation both of this full range of management possibilities and of the advantages and risks of specific procedures, which must be explained clearly to patients at all stages of their pathway. Investigation and treatment recommendations should be made by the urological MDT but it is the responsibility of the consultant urologist to ensure that patient preferences have been given due

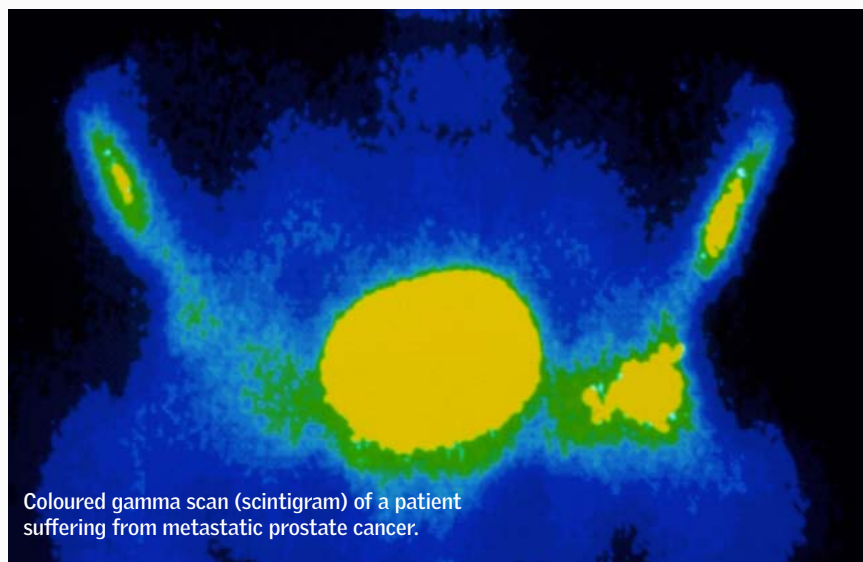
weight in deciding on a particular management plan.

In this context, patient information leaflets can be extremely valuable and their issue should be documented in the clinical notes to support evidence that the patient has been appropriately counselled. Similarly, when treatment is planned it is important that consent is accurately documented and includes precise evidence of the information that the patient has been provided. Given that many treatments carry a significant risk of serious side-effects, it is important to be able to demonstrate that patients have received sound advice if potential litigation is to be successfully defended.

Follow-up

Once a patient has received radical treatment or is established on hormone manipulation, they may (by local agreement) be discharged back to primary care. When this happens it is important that general practitioners have clear instructions about indications for re-referral. These would normally include development of new symptoms or signs possibly attributable to the cancer (e.g. obstructive voiding, bone pain, reduced renal function) or a rise in PSA above a previously agreed value. Rarely a patient may develop difficulty in walking with or without back pain – this is a clinical emergency as it may indicate spinal cord compression and require urgent surgical or oncological intervention if paraplegia is to be avoided.

■ **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



Coloured gamma scan (scintigram) of a patient suffering from metastatic prostate cancer.

PHOTOGRAPH: GULP/SCIENCE PHOTO LIBRARY

Appropriate measures?

Joanna Bower *of Capsticks LLP offers a solicitor's view of proposed changes to GMC sanctions guidance*

WHEN things go wrong a doctor should have a right to explain why and learn from those mistakes – and mitigating factors should be considered in any fair process. However, the GMC believes that doctors and patients want to see stronger action and tougher sanctions when patients are harmed. A recent GMC consultation on changes to the sanctions guidance closed in November 2014. In the consultation document, the GMC states that: “A doctor’s findings may be so serious or persistent that, even if they have fully remediated the concerns, the public may find it difficult to accept that no action is taken”.

Is it fair to judge a doctor by what the public may find acceptable? Some would suggest that this is akin to subjecting doctors to flogging by public opinion.

Indicative sanctions guidance

In guiding the regulator as to what sanctions to take against doctors who face fitness to practise hearings and to ensure that the decisions taken by the Medical Practitioners Tribunal Service (MPTS) panels are fair, transparent and consistent, the GMC developed the *Indicative Sanctions Guidance* which evolved following the Shipman, Neal and Ayling inquiries. The GMC is now influenced by the Francis report following the Mid-Staffordshire inquiry which is resonant in the current consultation. The status of the current *Indicative Sanctions Guidance* is for MPTS panels to consider the following questions:

- How serious are the allegations?
- Is there a need to protect the public from further harm?
- Has a doctor undermined confidence in the profession?
- Is the doctor suitable to work in future?
- Has the doctor shown insight?
- Has the doctor undertaken remediation steps?
- Are there any mitigating or aggravating factors for the doctor’s behaviour?
- What is a proportionate response?

In the current consultation – *Reviewing how we deal with concerns about doctors* – there are 24 proposals. The most significant of those are considered here as they cause concern to lawyers who defend doctors at the GMC.

Look forward, not back

One of the most effective ways in defending a doctor is to show remediation such that a doctor recognises their own failings and has addressed any shortcomings in their practice, for example by retraining in an area and demonstrating that they do not pose a risk to future patients. An established line of case law confirms that the GMC should look forward, not back, and should not discipline a doctor for past misconduct where the doctor has fully remediated and the risk of recurrence has been removed. However, a proposed change is for the GMC to take action “even where the

doctor has remediated if the concern was so serious or persistent that failure to take action would impact on public confidence in doctors" (Proposal 3).

It was established in the case of *Raschid and Fatnani v The GMC* (2007) that the function of the panel is quite different from that of a court imposing retributive punishment. The panel is centrally concerned with the reputation or standing of the profession rather than punishment of the doctor. It is important, therefore, that any proposed changes to the sanctions guidance comply with these authorities, and that the GMC is not simply punishing doctors because the public wants to see tougher sanctions. Who determines what the public considers is acceptable in terms of confidence in the medical profession? Is the media influencing what should properly be left to a fair legal process where the full evidence is considered and tested, and an appropriately trained tribunal applies the law?

Proportionality

Another proposal (Proposal 1) in the consultation is for the panel "to consider taking appropriate action without being influenced by the personal consequences for the doctor". Procedural fairness should afford the doctor not only an opportunity to explain the circumstances surrounding the actions taken at the time, but also in determining the appropriate sanction according to the personal situation of the doctor now.

To remove consideration of the doctor's personal circumstances is inconsistent with proportionality, a fundamental principle of human rights law, which the current *Indicative Sanctions Guidance* enshrines – weighing the interests of the public with those of the practitioner. The panel should consider the sanctions available and start with the least restrictive.

Panels have historically looked at aggravating and mitigating

"Is the media influencing what should properly be left to a fair legal process where the full evidence is considered and tested, and an appropriately trained tribunal applies the law?"

factors when considering sanction. Mitigation can include not only evidence of the circumstances leading up to the incident but also the character and previous history of the doctor. Doctors have relied on testimonial evidence showing good character either in writing or by character witnesses being permitted to address the panel in person. Proposal 13 calls for the GMC to introduce robust verification processes to check the authenticity of testimonials, and to ensure that those who write the testimonials are aware of the concerns about the doctor – which should be a pre-requisite for a testimonial in any event.

However, it is Proposal 14 that causes concern as it suggests that a panel (rather than the doctor) can decide whether a testimonial is relevant to their decision. The panel may decide to exclude testimonial evidence by considering the relationship between the author and the doctor and how long they have known each other. It can be the case that professional colleagues are also personal friends, and the panel can now exclude evidence of good character on the basis that personal friendship constitutes a conflict of interest.

Failure to report colleagues

The Francis inquiry has influenced Proposal 4 which envisages more serious sanctions where doctors have failed to raise concerns about a colleague where they may present a risk of harm to patients. The updated version of *Good Medical Practice* introduces a duty to take prompt action where a doctor considers that patient safety, dignity or comfort is or may be seriously compromised. The proposed change is to not only consider a more serious sanction, but to remove or suspend doctors from the medical register in the most serious cases if they fail to whistleblow.

Failure to apologise and evidence of lack of insight

It has always been part of *Good Medical Practice* that doctors "must be open and honest with patients when things go wrong and offer an apology when a patient under their care suffers harm or distress". Proposal 11 would allow a panel to decide whether to require doctors to apologise where patients have been harmed. The consultation document suggests that an apology may be considered evidence of insight as part of the process for monitoring a doctor's progress with remediation, yet it goes on to state: "...where a patient has been harmed as a result of a doctor's actions or omissions, a doctor's failure to apologise is evidence that they lack insight ... This change would allow panels to hold doctors to account where they fail to apologise for harms caused to a patient, and increase consistency in our decision making when considering the role of insight".

Apologising at an early stage can reduce the risk of legal action by dissipating anger and upset, knowing that the doctor is genuinely sorry. Guidance from the NHS Litigation Authority confirms that an apology is not an admission of liability; a concern that some doctors have about apologising. Guidance in *Good Medical Practice* states that an apology should be offered, but it is more important that the doctor explains fully and promptly what's happened, and what are likely to be the effects in both the short and long term.

Motives for change

So why has the GMC embarked upon this reform of sanctions guidance? There is political motive for the GMC being seen to be tougher. For example, in 2012 the GMC received 10,347 enquiries, 60 per cent of which were closed at triage with no further action. Only 10 per cent were referred on to a fitness to practise panel, and 26 per cent of those resulted in erasure. The GMC is grappling with media and public perception that doctors have been "getting away with it" and that the regulator may be losing political powers to the CQC.

Dr Clare Gerada, formerly Chair of the RCGP and currently Chair of the Clinical Board, Primary Care Transformation, NHS England, has expressed concerns that tougher sanctions in some cases could "traumatise and put in additional fear for the vast majority of doctors who go in every day to do a good job". She added: "Thousands of doctors are being referred to the GMC... they sometimes lose their livelihood... in some cases, they take their life".

Doctors are already under enormous pressures particularly with the recent government pledge for GP surgeries to be open seven days a week. The threat of tougher sanctions by public pressure will surely add to the burden at a time when we need to encourage, not discourage, people to enter and to remain in the profession.

■ Joanna Bower is an associate at Capsticks Solicitors LLP

A ticking dental

Nicholas Lewis *of the Eastman Dental Hospital highlights the risks posed by peri-implantitis*

PERI-IMPLANTITIS is a chronic inflammatory process affecting both the hard and soft tissues around dental implants. It has now been well established that all implants may be at risk over the longer term and in recent years this problem has been highlighted both within the dental press in the UK as well as published dental literature.

It is estimated that up to 20 per cent of implants may undergo some degree of bone loss over a 10-year period, with a usual lag period of around 6-8 years. The pathogenesis of peri-implant disease follows a similar course to periodontal problems around natural teeth, although it is well recognised that the two disease processes are distinct. Initial soft tissue inflammation around implants, termed peri-implant mucositis, is regarded as a reversible stage where active intervention and management can prevent progressive bone loss occurring around the implant fixture and the development of the established lesion, termed peri-implantitis.

Regular follow-up of patients with dental implants to ensure early diagnosis of peri-implant mucositis offers the opportunity of preventing progression of the disease. Such prevention requires the maintenance of a high level of oral hygiene by the patient in addition to ensuring that any implant has stable keratinised gingival tissue.

Risk factors

A number of risk factors have been identified that may predispose patients with dental implants to peri-implantitis. These include poor hygiene around the peri-implant tissues, cigarette smoking, type 1 diabetes, non-keratinised gingival tissue and a past history of periodontal disease around the natural teeth. Smokers may be further at risk in the treatment of established peri-implantitis lesions. It is therefore important for all clinicians to discuss the relevant risk factors with potential implant patients as part of the overall consent process. Patients identified to be at a higher risk must be made fully aware of this to ensure appropriate informed consent is obtained, and all communication should be documented in the clinical records.

Some of the identified risk factors may be modified in order to

reduce the likelihood of developing peri-implant disease.

Treatments may include soft tissue grafting, smoking cessation advice and reinforcing the importance of supportive periodontal therapy over the longer term to mitigate the risk of peri-implant disease. Ongoing clinical and radiographic follow-up in addition to patient specific hygiene programmes are also important management strategies to help to minimise the risk of peri-implant complications.

Diagnosis

The diagnosis of peri-implantitis is usually made by a combination of clinical and radiographic assessment. Clinical findings around implants with peri-implant disease may include soft tissue inflammation, bleeding on probing (an important marker of risk) and occasionally there may also be suppuration when probing. Radiographs will usually show evidence of bone loss around the top of the implant and sequential radiographs can be compared to those taken previously to assess any changes in the bone levels occurring over time.

The process of progressive bone loss around dental implants has been likened to the similar process that develops around teeth when periodontal disease is present. While the microbiological flora are similar to those found in periodontal pockets there have been some clear differences identified in the nature of the organisms involved in peri-implantitis lesions. This is not surprising given the biological differences in the periodontal attachment between natural teeth and dental implants.

The inflammatory cell infiltrate in peri-implantitis lesions is usually larger and extends more quickly when compared to similar lesions of periodontitis around the natural dentition. This commonly presents as 'crater-like' defects around implant fixtures. Based on the modified soft tissue attachments around dental implants the tissues would appear to be more susceptible to plaque-induced inflammation that may subsequently develop into peri-implantitis-type lesions and this reinforces the importance of meticulous plaque control by patients with dental implants in addition to close follow-up and regular hygiene visits.

time-bomb?

Management options

The treatment of peri-implant infection focuses on the management of the infected lesion, decontamination of the implant surface and, ideally, an attempt at regeneration of the lost hard tissue resulting from the inflammatory process. It is still not wholly clear as to the best way to manage peri-implant disease as treatment options can involve both surgical and/or non-surgical options, and the current clinical data suggests that the management of peri-implantitis is unpredictable.

The use of chemical agents such as chlorhexidine has only a limited effect on the microbiological aspects that may influence the ongoing progression of peri-implant disease but its use is still advocated to help decontaminate the colonised implant surface. It is however generally accepted that the establishment of a healthy and non-inflamed peri-implant soft tissue environment is critical in order to prevent progression of these lesions and progressive bone loss around the implant fixture.

One of the significant difficulties in the management of peri-implantitis lesions is the problem of decontaminating dental implants when corrective treatment is being attempted. Dental implants are developed with roughened surfaces with a view to ensuring good osseointegration at the time of fixture placement (see figure). However, when bone loss does occur this roughened surface becomes exposed to the mouth and rapidly contaminated with dental plaque. A number of options have been put forward for the management of peri-implantitis and these include:

- mechanical debridement with or without systemic antibiotics
- mechanical debridement with local antibiotics
- mechanical debridement with laser decontamination, air-abrasion and proprietary acids to try to remove biofilm from implant surface
- surgical debridement including decontamination of the implant surface with antiseptic agents such as chlorhexidine
- surgical debridement of lesions with bony recontouring and guided bone regeneration.

Despite the range of potential options, the management of peri-implant lesions remains unpredictable even in specialist hands.

Maintenance and follow-up of dental implants

Recent years have seen a steady rise in the number of dental implants placed in UK patients and this trend is only likely to continue – although the UK remains behind some European countries in the number of implants placed per capita. With this inevitable rise in the provision of dental implants it is likely that peri-implant disease will become an all too common presentation for general dental practitioners and specialists to diagnose.

Given the unpredictability of treatment, peri-implantitis is likely to continue to present an ongoing challenge in restorative dentistry. From a medico-legal perspective it is even more important to ensure that patients undergoing dental implant therapy – even under specialist care – have appropriate follow-up both clinically and radiographically to ensure that any peri-implant mucositis or more advanced peri-implantitis is appropriately managed. Ongoing follow-up will ensure that any peri-implant problems can be identified early in order to help prevent progression of these lesions.

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PHOTOGRAPH: VOLKER STEGER/SCIENCE PHOTO LIBRARY

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



COMPLAINT HANDLING NOT TEXTING

BACKGROUND: A letter of complaint is received by a practice manager (PM) from the mother of a two-year-old girl – Zoe – who attended the surgery suffering with an earache. In the letter the mother – Mrs G – complains that the attending GP – Dr L – did not provide adequate treatment for her daughter and showed a lack of regard for her concerns, at one point in the consultation reaching for her smartphone to text someone.

The PM pulls the patient's files and speaks with Dr L to investigate the complaint. She learns that Mrs G had phoned the surgery that previous Monday morning requesting an emergency appointment. Zoe was seen by Dr L who first took a history. Mrs G told the doctor that the child began to complain of an earache on Friday and by Saturday she was in constant tears with the pain. Mrs G took her to A&E on the Saturday night, was given amoxicillin and told to attend her GP if Zoe was still in pain.

That Monday she attended the GP surgery and stated that the medication supplied by A&E had not worked. She

had looked up middle ear infection on the internet and insisted that the GP prescribe a different agent. It was at that point Dr L reached for her smartphone but it was not to text. There was no record yet of an A&E attendance in the medical notes, so she wanted to check if information had been received electronically but not yet filed. To do this she needed to retrieve her username, which she kept stored under password protection on her smartphone.

Checking the record from A&E she then examined Zoe and noted inflammation in the ear canal and some discharge. She advised Mrs G to persist with the amoxicillin in addition to ibuprofen and paracetamol. She also explained that most ear infections clear up after a few days without need for antibiotics. Mrs G seemed to accept this advice.

ANALYSIS/OUTCOME: The PM contacted MDDUS who provided advice regarding the letter of response to Mrs G's complaint – making special mention of the fact that Dr L had not been texting during the consultation. It



was suggested that Dr L contribute wording to justify her treatment decision, citing evidence on the efficacy of antibiotics in the treatment of otitis media and current guidance.

It was also suggested that the letter include a statement of regret saying that Dr L was sorry if Mrs G felt she was not paying sufficient regard to her concerns. The PM offered to meet with Mrs G to discuss the matter if necessary – and provided contact details for the ombudsman in case Mrs G wanted to take the complaint further.

The practice hears nothing more in regard to the complaint.

KEY POINTS

- Consider what actions taken during a consultation might lead to misunderstanding.
- Ensure that you can explain clinical decisions in such a way that a patient without a medical background can understand.
- An apology or expression of regret at patient dissatisfaction can often defuse a complaint.



TREATMENT: MISSED DECAY

BACKGROUND: Mr B attends his dentist Ms L to have a bridge fitted to three of his lower right teeth along with a crown on his lower left 5. Six months later he returns complaining of pain in UL5. The dentist notices it is tender to percussion and takes a periapical radiograph. She proceeds to root fill the tooth and takes a post-operative radiograph before later placing an amalgam restoration. Seven months later Mr B again returns to Ms L complaining of pain. She finds UL5

has fractured and the patient consents to an extraction as well as having a crown fitted on the neighbouring tooth after appropriate healing of the extraction socket.

Over the course of the next three years, Mr B attends the surgery on a number of occasions complaining of toothache. Ms L takes several radiographs and carries out a number of root fillings, including restorations on various upper and lower teeth, as well as two restorations on LR6 over the

course of 18 months.

Mr B then changes dentists and begins to receive treatment from Mr C. He continues to experience tooth pain and, over the course of four years, Mr C carries out X-rays on several occasions. He provides various treatments including a bridge at UL56, a crown to UR6 and restoration of UR5. On three occasions Mr C provides root canal treatment.

Mr B then begins to consult a third dentist who X-rays the patient's mouth and finds evidence of numerous carious



PRESCRIBING RISKING ADDICTION

BACKGROUND: A 41-year-old man, Mr C, with a history of back pain attends his GP complaining of severe pain that is limiting his mobility and preventing him from sleeping. Dr A examines him and notes that he has recently ended a course of co-codamol for the same problem. He believes the pain could be caused by a slipped disc and prescribes an anti-inflammatory drug and a muscle relaxant to relieve the pain.

Less than a fortnight later, Mr C returns to the surgery again complaining of severe back pain as well as showing signs of depression and anxiety. He is seen by Dr B who prescribes an opiate analgesic as well as an anti-inflammatory and a drug to counter his insomnia. Four days later, Mr C is briefly admitted to hospital with extreme pain where morphine is added to his drug regimen. The following week Mr C returns to see Dr B, still in considerable pain, and the GP prescribes a combination of drugs including morphine.

The following month, Mr C is seen at the surgery by Dr E complaining that he is now addicted to his medication. Attempts to stop taking the pills, he says, resulted in stomach cramps, mood swings and sweating. He reports an extremely low mood, lack of confidence and anxiety. Dr E refers him to a clinic where he receives help in withdrawing from his medication over the course of several months, during which time he resigns from his job due

to poor health.

The practice receives a letter from a solicitor acting for Mr C alleging the GPs were negligent in their prescribing, causing Mr C to become drug dependent. Mr C claims the risks of addiction weren't explained to him and is seeking compensation for loss of earnings, emotional distress and for the services provided by friends and family during his dependency and withdrawal.

ANALYSIS/ OUTCOME: The GPs involved in providing Mr C's care are all MDDUS members. In reviewing the patient's medical records, the medico-legal advisory team can find no note to confirm he was warned of the risk of

addiction when the medication was prescribed. An expert GP opinion is sought and it is confirmed that, despite the relatively short length of time that Mr C was taking the medication, addiction could feasibly have occurred.

The expert is critical of the number of repeat prescriptions issued to Mr C by the practice GPs without consultation. He also highlights Dr B's poor record keeping and his failure to justify continuing to prescribe morphine. He believes Dr B should have more closely monitored the patient's response to the medication, but concedes that an ordinary GP would not have expected a patient to become dependent in such a short timeframe.

After further discussion and analysis, it is agreed that the case would be difficult to defend and a settlement is negotiated without admission of liability. The payment takes into account the loss of earnings, the distress caused by the dependency/ withdrawal process and the practical and emotional support the patient required during this process.

KEY POINTS

- Clearly explain to patients any risk of addiction relating to prescribed medication. Be sure to note this in the patient's records.
- Closely monitor and review patient medication, especially where there is a risk of dependency

lesions, an unrestorable tooth and caries around and under his restorations and crowns. The dentist also states that the bridgework is of poor quality and root treatments have not been carried out to the correct standard. He states the prognosis is poor for many of Mr B's teeth, recommending several extractions and implants.

ANALYSIS/OUTCOME: Ms L and Mr C receive letters of claim from Mr B alleging negligence. An expert report is

commissioned by MDDUS which is largely critical of the care provided by both dentists. Reviewing the many X-rays taken throughout Mr B's treatment, there is clear evidence of the presence of caries which neither dentist acted upon in a timely manner. The expert also agrees that the crown and bridgework provided is not of an acceptable standard and mistakes have also been made in the root canal treatments. Record keeping by both dentists is also poor, offering little

evidence with which to defend the accusations. A settlement is reached with the patient in recognition of pain endured and the avoidable remedial work he underwent.

KEY POINTS

- Take adequate treatment notes as poor records lead to poor defence.
- Advise patients of clinical and radiographic findings ensuring they fully understand proposed treatment including risks/benefits.

From the archives: The 50-yard dash

HAEMORRHOIDECTOMIES were not always mundane procedures failing to catch the interest of audiences in the surgical operating theatre....at least not when Mr Frank E. Jardine, consultant surgeon in Edinburgh Royal Infirmary in the 1940s, was the operator. When "piles" were to be treated by him, the gallery was usually full and there were two lines of medical students lining the corridor outside.

The reason? "Frankie" used the method of "clamp and cautery". Long-handled clamps with blades about two inches long – metal on the upper surface and bone on the under surface to prevent accidental skin burns – were applied around the base of each haemorrhoid.

The cautery was achieved by means of soldering irons heated to red heat on the kitchen stove of Ward 19 about 50 yards away. When the desired heat was achieved and the great man

was ready, relays of medical students ran down the corridor each brandishing an iron aloft, presenting it to the surgeon poised waiting to sear the offending tissue. Perhaps half a dozen irons were required for each patient.

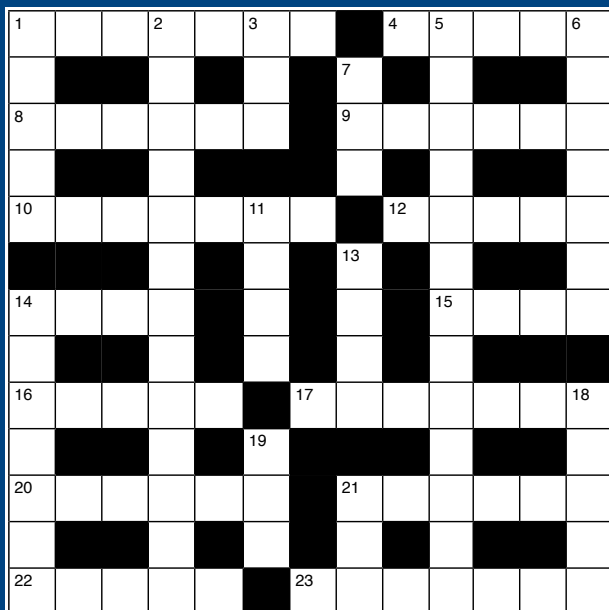
The results were good – no bleeding, no infection and early discharge of the patient. Today it may all seem unsophisticated but it worked and it was good theatre.

From A Century of Care – A history of the Medical and Dental Defence Union of Scotland edited by Norman Muir and Douglas Bell



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Crossword



ACROSS

1. (and 21) Reveals bad practice (7,6)
4. Backbone (5)
8. Allergic respiratory condition (6)
9. Solid passages (6)
10. Testicle sack (7)
12. AIDS screening test (abbr.) (5)
14. Liquid-filled sac (4)
15. Nevus (4)
16. Posterior tooth (5)
17. Anti-platelet discovered by Pasteur (7)
20. Shed skin (6)
21. (see 1)
22. Dandruff (5)
23. Rubella (7)

DOWN

1. Erodes (5)
2. Master or mistress (13)
3. Meadow (3)
5. Announcements (13)
6. Put into bondage (7)
7. Prostate cancer indicator (abbr.) (3)
11. Elbow bone (4)
13. Regular, six-faced object (4)
14. Obliges (7)
18. Standards (5)
19. Small food scrap (3)
21. Insect (3)

See answers online at www.mddus.com.

Go to the Notice Board page under News and Events.

Object obscura: The Oculizer

IN QUACK medicine it was claimed that poor vision could be remedied with eyeball exercises and that devices such as this Neu Vita Oculizer would negate the use of spectacles. The Oculizer used a crank and pulley system to rotate soft rubber eyecups which would be placed over the patient's eyelids. It is made from rubber and plastic and dates from around 1920, England.



PHOTOGRAPH: SCIENCE PHOTO LIBRARY

Vignette: First female UK professor of dentistry Dorothy Geddes (1936-1998)

WHEN you ask Dorothy Geddes' former colleagues and students about her, it's surprising what you hear.

Her career in academic dentistry was distinguished by any standard and was punctuated by a series of firsts: in 1963 she was the first woman to be awarded the Fellowship in Dental Surgery of the Royal College of Surgeons of Edinburgh, in 1990 the first woman to be appointed to a chair in dentistry in the UK when she became Professor of Oral Biology at the University of Glasgow, and in 1992 she became the first female dean of a faculty of dental surgery of any royal surgical college in the UK and Ireland.

With such a curriculum vitae you might expect the backdrop to be a story of ruthlessness, a hunger for power, even a Thatcherite rise through a world dominated by men. What you hear, however, is the story of Dot – the modest, quiet woman with a wicked sense of humour, who is remembered with universal affection and more than a little awe.

Dorothy Ann Malcolm Geddes was born in Alloa and educated at Brechin High School, where her father was the rector. A career in dentistry might not have been an obvious choice for a young woman who was both dyslexic and left-handed, but it offered her the chance to combine her love of science and artistry and she overcame any difficulties to graduate from the University of Edinburgh in 1959.

She decided to specialise in oral surgery and worked first in Edinburgh and then in Birmingham, where she was a senior registrar. At the time, she could see that the prospects of obtaining a consultant post were very poor. Undaunted, she decided to change paths and change continents. She moved to the Eastman Dental Center in Rochester, New York, where she began her research into dental caries – an area to which she would contribute significantly throughout her career. She returned to the UK to take a post funded by the MRC in Newcastle where she stayed for six years before moving in 1975 to take up a lectureship at the University of Glasgow, where she



would remain for the rest of her career.

Reflecting later in life on her convoluted career path she said: "No one nowadays should have such a long run-up to a consultancy as I did, but I do not consider these years wasted. I enjoyed the varied experiences and benefited from them personally and professionally." This was characteristic of her optimistic approach to life and her dignified approach to setbacks.

As well as being a distinguished researcher, she is also remembered as an excellent teacher, but one who would not suffer fools or sycophants. One student recalls her periodontology clinic teaching where a fellow student, when asked a question, waffled on while she waited silently. At the end she said: "You don't know the answer, do you? Have you ever considered saying: 'I don't know the answer?' You are a student, I am a teacher, this is a school— I would then teach you what you don't know or don't understand. That's how it works."

She cared about teaching and taught her students their craft, but also reminded

them of the importance of showing concern for their patients. One thing she emphasised early on was to write down something personal of note said by the patient at the first consultation. In subsequent consultations they then felt you remembered and knew them for you could initiate the treatment with a friendly chat.

After she took early retirement in 1995 the honours continued to be heaped upon her. She was awarded an OBE and an honorary FRCS by the Royal College of Surgeons of Edinburgh, the highest honour the College could bestow. However, her retirement, which should have been one devoted to her loves of opera, painting, gardening and cats, was to be a short one— in 1996 she was diagnosed with cancer and she died just two years later.

Just a few weeks before her death, it was with genuine surprise and customary humility that she learned she had won a major European award: the ORCA-Rolex prize for her research in dental caries and her leadership in postgraduate dental education. That she was honoured both for her research and her teaching was entirely fitting. The award citation stated that she had "inspired a younger generation to follow a career in dental research". That inspiration continues today.

In 2012, as part of a major development of the Glasgow Dental Hospital and School, what was once an old biochemistry laboratory was refurbished at a cost of £500,000 to become a state-of-the-art multi-media teaching facility. This new suite was appropriately named the Dorothy Geddes Multimedia Laboratory in her memory.

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

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