

SUMMER 2016

# SUMMONS

AN  PUBLICATION FOR MEMBERS

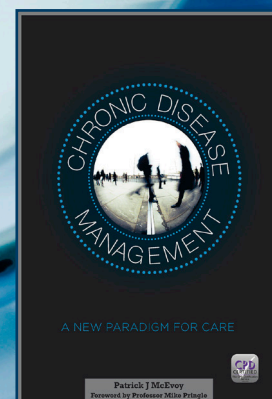
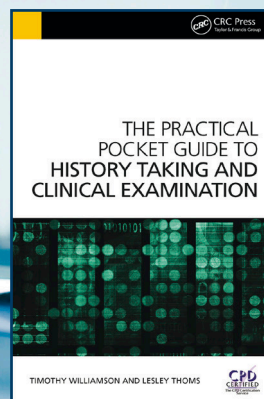
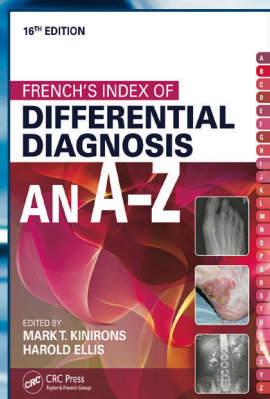
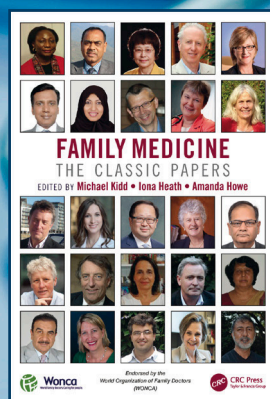
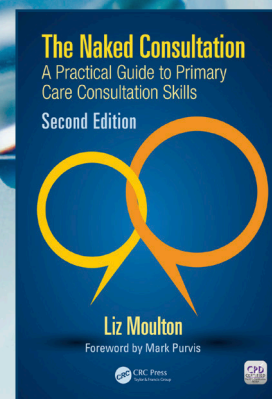
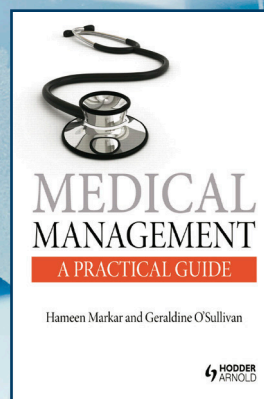
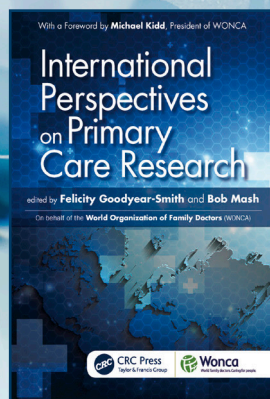
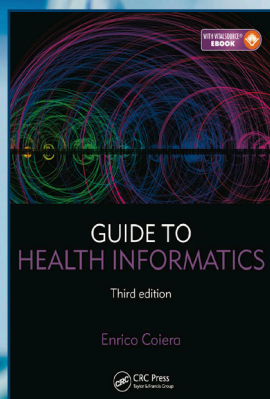
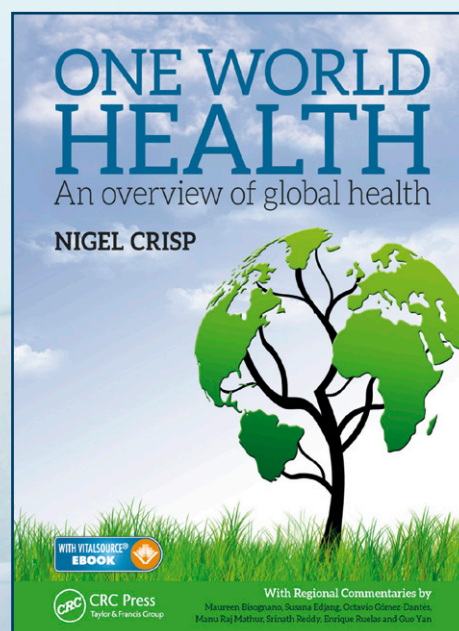
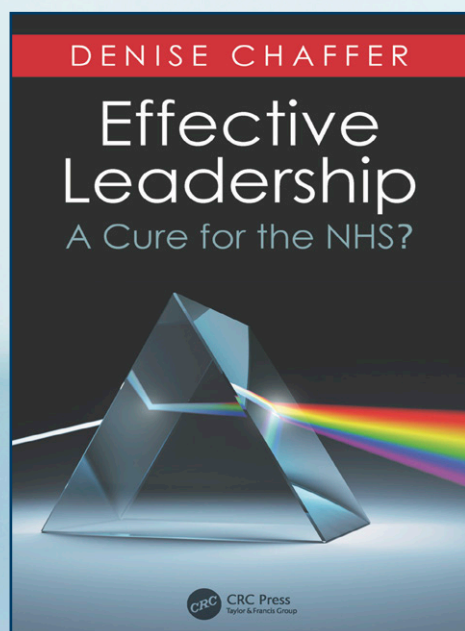


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**FROM THE EDITOR**

Scotland, poses interesting questions about the future direction of medical practice. It touches on several key medico-legal issues including the potential harms of overtreatment, guidelines and their limitations, the changing nature of the consent process and the management of clinical risk. The reference to evidence showing that doctors generally choose less treatment for themselves than they provide for their patients is particularly thought provoking. On page 10, Dr Catherine Calderwood talks to Joanne Curran about the report and her role as CMO.

Pulmonary embolism is a relatively common life-threatening condition which can be difficult to diagnose and thus poses a significant challenge to doctors. David Riding and Charles McCollum provide a helpful summary of the diagnosis and

*REALISTIC Medicine*, the recently published annual report from the chief medical officer (CMO) in

management of the condition on page 16.

MDDUS dental adviser Doug Hamilton considers the implications of a landmark legal ruling on informed consent and what constitutes relevant risk in shared decision making (p. 18), and risk adviser Alan Frame delves into a recent ombudsman report on complaints handling and draws some important lessons on the importance of a sincere apology when patient care does not go to plan (p. 14).

On page 12, Allan Gaw recounts an important milestone in modern human research ethics that emerged out of the Nazi war crimes trials in 1947 – though the Nuremberg Code was largely ignored for 20 years after its publication.

And on page 9, Deborah Bowman considers ethical obligations when changing jobs and what it means to “leave well” – the trigger being her own impending career move.

Dr Barry Parker

**10 BEING REALISTIC FOR PATIENTS**

Scotland's CMO Dr Catherine Calderwood discusses her ambitious plans for a common sense, patient-focused approach to healthcare

**12 NEVER AGAIN**

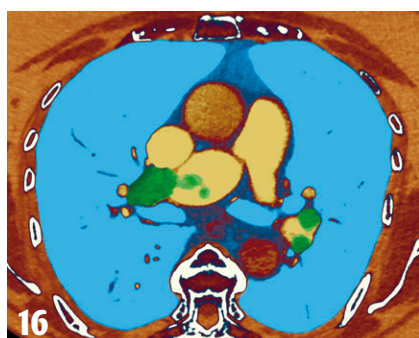
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Cover image: *Sunset Gullane Bay*, John Houston. Woodcut, 1992.

Fife-born John Houston studied at Edinburgh College of Art from 1948-54, and went on to teach there until 1989. He was married to artist Elizabeth Blackadder.

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

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## ➔ MDDUS strengthens property portfolio

MDDUS has further diversified its investment portfolio with the purchase of 50 Cannon Street in London – a 26,150 square foot office building (pictured below). In addition, MDDUS has completed a major refurbishment and re-letting of the building housing its London offices, 1 Pemberton Row, to increase rental income.

MDDUS CEO Chris Kenny commented: "These changes enable us to diversify our assets, secure significant capital growth and generate extra income, so ensuring that we provide members with the best value in their subscription. Our separate property company [MDDUS Property Ltd], which now has specific sector experience on its board, ensures that we manage our four building portfolio in the most professional way."



## ➔ Time of the essence in civil claims

WHEN on the receiving end of a civil claim in England or Wales, members need to be aware that strict time limits apply and therefore MDDUS should be contacted at the earliest opportunity.

The first step usually taken by a

claimant commencing a civil claim in England or Wales is to serve a letter of claim in accordance with the pre-action protocol for the resolution of clinical disputes. Upon receipt of a letter of claim, defendants have four months to investigate the case and serve a comprehensive letter of response denying or admitting liability. MDDUS should be contacted as soon as a letter of claim is received, as any delay in notification of the claim reduces the time available for investigation and preparation of a response. Failure to comply with the provisions of the pre-action protocol can also result in the court imposing sanctions.

Prompt notification of claims is even more vital in situations where the claimant does not follow the pre-action protocol and instead opts to immediately serve formal court proceedings. Upon receipt of a claim form and particulars of claim, a defendant has just 14 days to file an acknowledgment of service at court, indicating whether the claim will be defended. This deadline is strictly enforced and a failure to comply with it entitles the claimant to enter judgment in default, potentially depriving the defendant of the opportunity to defend the claim.

All members in England and Wales should ensure that letters of claim and/or court proceedings are reported to MDDUS as a matter of priority, to avoid the serious adverse consequences outlined above. In the event that members have any doubt about the nature of documents received, they should contact the MDDUS telephone advice line for assistance.

**Alexandra Godby is a solicitor at MDDUS**

## ➔ Flexible pricing for MDDUS members

MDDUS recognises that there is no "one-size-fits-all" when it comes to individual medical practice. This is why we offer a flexible range of subscriptions and supplements enabling members to build a membership package to meet their unique needs.

This includes the flexibility to work out of hours or in urgent care settings. GP partners and some salaried GPs – practising within England, Wales and Northern Ireland – can choose to undertake up to three of their weekly sessions in an out-of-hours setting at no additional charge. Salaried GPs, working within those parts of the UK and who joined MDDUS after June 2012, can choose to pay an out-of-hours supplement from the equivalent of just £3.85 for the first weekly session.

MDDUS also offers a range of supplements for clinicians engaged in:

- forensic medical examination
- private GP work
- occupational health
- sports medicine
- private travel medicine
- medico-legal work.

Go to our website for further details or contact the Membership Team at [membership@mddus.com](mailto:membership@mddus.com)

## ➔ Poetry for new doctors

MDDUS is pleased to be among the sponsors of a new edition of *Tools of the Trade: Poems for new doctors*, a "gift from the medical profession to its newest members" which is being distributed to all doctors graduating in Scotland in 2016, 2017 and 2018.

The poems in this short collection all "speak in some way to the experience of being a junior doctor" and some are written by doctors themselves, including Dannie Abse, Iain Bamforth, Glenn Colquhoun, Martin MacIntyre and Gael Turnbull.

The volume is published by the Scottish Poetry Library with additional support from the Royal College of General Practitioners (Scotland).

RCGP Scotland Chair Dr Miles Mack said: "It is always wonderful to welcome new



## IN BRIEF

### ● END TO ADDRESSES ON GDC REGISTER

The full addresses of dental care professionals will no longer be published on the General Dental Council website under new plans announced by the regulator. The registration

number will be used as the main method of identification and to confirm professional status. The move follows a long-running campaign by the BDA who argued the publication of full addresses was "unnecessary, and out of line

with other regulators, as well as a potential risk to registrant safety".

### ● PRACTICE AND CORPORATE SCHEME MEMBERSHIP

Members who have Practice or Corporate Scheme Membership with MDDUS should note it is

their responsibility to ensure that membership is being maintained by the practice manager or other administrator. Failure to maintain adequate cover, for example failing to inform us of a return to work following maternity or



colleagues into the profession. *Tools of the Trade* provides a great way of doing just that, emphasising how at the heart of every medical consultation sit people. The compassion these poems represent will, I hope, underpin every medical career."

The book includes a foreword by MDDUS Chairman Dr Brendan Sweeney who said: "Reflecting on poetry, and indeed on all the Arts, can produce a different sort of doctor: one who is richer and deeper as an individual."

Copies can also be purchased from the online shop at the Scottish Poetry Library [www.scottishpoetrylibrary.org.uk](http://www.scottishpoetrylibrary.org.uk).

### ➔ MDDUS response to General Practice Forward View

RESPONDING to NHS England's recent *General Practice Forward View* package that was unveiled in April, MDDUS chief executive Chris Kenny said:

"MDDUS welcomes the planned investment to improve patient care and reduce the workload on general practice. Greater resources and new ways of working will reduce risk and can address rising numbers of complaints and claims.

"We also welcome wider debate on proper resourcing and legal reform in order to reduce the costs faced by the profession. MDDUS has long believed that the object of a fair system for resolving clinical negligence claims should be timely, proper and just compensation for those wrongly damaged.

"We strongly support the introduction of a fixed recoverable cost scheme, especially for lower value claims. It is in everyone's interest to ensure that patients rather than the legal services industry benefit from properly advanced claims and settlements."

"MDDUS will continue to work together with NHS England and the Department of Health as we seek solutions to common problems. If that's delivered, then the profession will remain in control of its indemnity risk, which its own expert bodies like MDDUS are best placed to manage."

### ➔ Spotting the 'vital signs' of burnout

THE Royal Medical Benevolent Fund has developed a free downloadable online guide for doctors and their families called *The Vital Signs* by Dr Richard Stevens, which highlights common stressful trigger points for doctors, as well as signposting help and advice.

This is part of a new RMBF campaign called 'What's Up Doc?' which aims to highlight the care and support it offers to doctors who are working and living under increasing pressure. The RMBF runs a 250-strong volunteer network, which includes area visitors, medical liaison officers, phone friends and guild officers.

A survey conducted by the RMBF found that over 80 per cent of doctors know of other doctors experiencing mental health issues such as depression and anxiety. It also revealed that doctors are unlikely to reach out for fear of discrimination or stigma from colleagues (84 per cent), or are inhibited by their own "high achieving" personality traits (66 per cent).

RMBF chief executive Steve Crone says: "We know that many doctors are reticent about coming forward and seeking help, and others don't know what help is available – we want that to change.

"Last year, the Royal Medical Benevolent Fund helped 40 doctors return to work or remain in employment and provided 212 beneficiaries with financial assistance. However, we know that even more doctors and their families around the UK could benefit from our help."

The RMBF recently held an expert roundtable debate at the Royal College of Physicians – sponsored by MDDUS and attended by medical adviser Dr John Holden (below, centre) – to explore how the healthcare community can come together to help support doctors. A full write-up of this meeting has been published in the May issue of *Pulse* magazine and the highlights can be viewed at [www.rmbf.org](http://www.rmbf.org) along with a link to *The Vital Signs* publication.



paternity leave, cannot normally be rectified retrospectively. Call the Membership Team for details.

● **NEW GP IN YOUR PRACTICE?** Please note that MDDUS Membership Services require a minimum of 28 days' notice for

prospective members to apply for membership. To assess an application, we must request information from the GP's existing indemnifier and responses can take as long as four weeks. We would therefore advise new GPs in your

practice to submit membership applications at least four weeks in advance – but the sooner the better. It is important that GPs maintain alternative indemnity arrangements until MDDUS membership is confirmed.

● **SUPPORTING TRANSGENDER PATIENTS** New advice to help doctors support transgender patients has been published by the GMC, based on core guidance and recent legislation. Access at [www.gmc-uk.org/guidance](http://www.gmc-uk.org/guidance)



## ➔ Report highlights causes behind GP "crisis"

GP CONSULTATIONS have increased by 15 per cent over the past five years which is three times the growth in GP numbers, according to new research on the extent of the "crisis" facing general practice.

A report by the Kings Fund – *Understanding pressures in general practice* – found a 13 per cent growth in face-to-face consultations and a 63 per cent growth in telephone consultations, which is "contributing to stressful and highly pressurised working days for GPs".

The biggest increase in consultations was among patients over 85 (up 28 per cent), who are more likely to have more than one chronic condition. Using other members of the primary care team to triage and manage minor illness may ease demand for the practice overall but it also means that GPs tend to see the most complex cases, requiring more than a 10-minute appointment.

The report also concluded that the move to transfer patient care closer to home has not been coupled with the equivalent transfer of resources to primary care, again increasing the pressure on GPs.

Over 30 million patient contacts from 177 practices were analysed in the research along with trends in GP recruitment and retention. The authors conclude that general practice is at risk of "falling apart" unless significant additional investment is accompanied by greater recruitment and new ways of working that build on current good practice.

RCGP Chair Dr Maureen Baker, commenting on the report, said: "NHS England's recent *General Practice Forward View* provided long overdue recognition of the essential role GPs and our teams play in keeping the NHS sustainable and safe for patients. But it was also an acknowledgement of the devastating impact of a decade of chronic underfunding for general practice.

"It is vital that the pledges of increased funding and support for general practice... are put in place as quickly as possible."



## ➔ Dispute over weekend death rates in hospital

A NEW study from the University of Manchester has found that fewer patients in England die after being admitted to NHS hospitals at the weekend compared to during the week, which is contrary to the prevailing government view.

The study conducted by the Centre for Health Economics concluded that the death rate following hospital admissions at the weekend is higher only because the number of patients admitted is lower than during the week and tends to be those more seriously ill.

Publication of this research in the *Journal of Health Services Research and Policy* is significant in that NHS plans to extend hospital seven-day services are based on research showing that the rate of mortality is higher amongst patients admitted to hospital at the weekend compared to those admitted during the week. It has been assumed that this is due to reduced availability of senior staff and diagnostic services in hospitals at weekends.

Previous studies considered the overall number of patients admitted to hospital but the Manchester researchers also looked at patients attending A&E departments between April 2013 and February 2014. It found that similar numbers of patients attended A&E each day at weekends and weekdays but hospitals admitted seven per cent fewer patients at the weekend and these tended to be "sicker patients". Looking at deaths in hospital within 30 days of admission the study demonstrated that the mortality rate was higher at weekends among direct admissions due to the proportionately greater reduction in admissions relative to deaths.

Professor Matt Sutton, who led the research, said: "Hospitals apply a higher severity threshold when choosing which patients to admit to hospital at weekends – patients with non-serious illnesses are not admitted, so those who are admitted at the weekend are on average sicker than during the week and more likely to die regardless of the quality of care they receive. As a result, the figures comparing death rates at weekends and weekdays are skewed.

"The NHS has rushed to fix a perceived problem that further research shows does not exist."

## IN BRIEF

● **HI-TECH FUNDING FOR SCOTTISH DENTISTS** Grants worth £350 are being awarded to Scottish dental practices as part of plans to reduce paper and make greater use of technology. Practices can use the funding

to buy an e-signature pad or for the purchase of other computer equipment though not for ongoing maintenance costs. Practices seeking more detailed advice are advised to contact the IT facilitator for their NHS board.

● **END-OF-LIFE CARE VARIABLE** A Care Quality Commission report addressing inequalities in end-of-life care has found that one in three CCGs surveyed has not assessed the end-of-life care needs of their local

populations. The report calls for action to ensure equal access to high quality, personalised care at the end of life, regardless of factors such as location, diagnosis or social circumstances. Access at [www.cqc.org.uk](http://www.cqc.org.uk).



## ➔ Revalidation “starting to have an impact” says GMC

FOUR out of 10 doctors are changing the way they practise as a result of their last appraisal, according to a three-year study into the impact of revalidation.

Among doctors aged under 50 around half have changed their practice.

These are findings from two separate reports commissioned by the GMC and based on surveys completed by more than 26,000 licensed doctors (16 per cent response rate) and hundreds of responsible officers, along with feedback from patient and public representatives.

The research found that 90 per cent of surveyed doctors have had a medical appraisal in their career, 94 per cent of whom had had an appraisal in the previous 12 months. Around a third of doctors said revalidation has improved the appraisal process and over 40 per cent of doctors believe appraisals are effective in helping doctors to improve their clinical practice.

But a majority of responding doctors (57.6 per cent) said they had not made any changes to their clinical practice, professional behaviour or learning activities as a result of their most recent appraisal, compared to 42.4 per cent who said they had made such changes.

Niall Dickson, Chief Executive of the General Medical Council, said: “We are pleased that the findings from both reports show that revalidation is starting to have an impact. This is encouraging for patients and doctors... But we cannot be complacent – both reports highlight issues which show the system can be improved.”

## ➔ GPs overprescribing antibiotics for toothaches

MORE than half of patients visiting a GP with a dental problem in the last 10 years were prescribed antibiotics, often unnecessarily, according to a study published in the *British Journal of General Practice*.

Researchers from the Cardiff University School of Dentistry examined 288,169 dental consultations in UK general

medical practice from 2004 to 2013. They found that a significant number of patients are visiting their GP practice rather than their dentist, and 57 per cent of these consultations resulted in antibiotic prescribing.

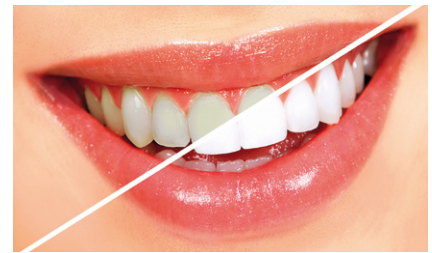
Cardiff researcher Dr Anwen Cope said: “Most dental problems cannot be comprehensively managed by a GP. This places an additional burden on already busy GPs when patients should be visiting a dentist.

“More worryingly is the potential impact on the rates of antibacterial resistance. Antibiotics save lives, and therefore it’s important we use them carefully and only when they are really required.”

## ➔ New standards for cosmetic procedures

DOCTORS who carry out cosmetic procedures must not use gimmicks such as two-for-one offers or prize giveaways to attract patients, according to new standards published by the General Medical Council.

Patients must also be given sufficient time and information to think about any proposed procedures, and consent should be obtained by the doctor who will carry out the treatment.



The guidance comes into force from June and covers both surgical (such as breast augmentation) and non-surgical (such as Botox) procedures carried out by doctors anywhere in the UK.

GMC Chair Professor Terence Stephenson said patients considering whether to have a cosmetic procedure were often “extremely vulnerable” and that: “Above all, [they] need honest and straightforward advice which allows them to understand the risks as well as the possible benefits.”

The GMC has been working closely with the Royal College of Surgeons (RCS) which has published its own set of professional standards for cosmetic surgery to supplement the regulator’s guidance. The RCS also plans to launch a new certification scheme later this year with the aim of allowing patients seeking cosmetic treatment to more easily search for an appropriate surgeon.



## ● ORTHODONTIC RESOURCE

An online resource to help patients make treatment decisions has been launched by the British Orthodontic Society. *Orthodontics for Adults* offers information on “why, how, where and who”.

Access at [www.bos.org.uk/adultorthodontics](http://www.bos.org.uk/adultorthodontics)

● **PRESCRIBING CONTROLLED DRUGS** New NICE guidance on prescribing controlled drugs has been issued, drawing together up-to-date legislation and existing

advice including information to patients about how to store and dispose of controlled drugs safely. Access at [www.nice.org.uk/guidance/ng46](http://www.nice.org.uk/guidance/ng46)

● **NEW GDC LANGUAGE CHECKS** All dentists and dental

care professionals applying to join or return to the GDC register will now have their English language proficiency evaluated. This will apply to all dentists and DCPs including those from the European Economic Area (EEA).



## AGE OF CONSENT

Gail Gilmartin



**CONSIDER** the scenario: you are asked to see a young child brought in for urgent treatment after a nasty fall at school, with cuts to hands and knees. After your initial assessment it is clear that the child needs to have the wounds cleaned and dressed. The accompanying adult also asks about the child's immunisation status and whether a tetanus vaccination is needed.

This simple scenario might be typical for a GP but similar cases do occur in hospital and questions of consent arise about the combination of immediate and elective treatment.

As in most situations, any emergency treatment to save life or prevent serious harm can be provided without consent. However, when looking at consent in general, the first factor to consider is the age of the child and their competence in relation to the treatment required.

The age of consent in the UK is 16, above that age a young person is presumed to have capacity and can consent to treatment in their own right. Below this age a young person might be able to consent to treatment depending on their maturity and understanding. The legal frameworks setting out the circumstances in which a young person under 16 is able to consent vary in different jurisdictions of the UK but in practical terms require the same type of consideration and decisions to be made. Can the young person understand the nature, purpose and possible consequences of having the investigation or treatment, and of not having the intervention? Can they retain and weigh up the information and come to a decision? Also, can they communicate that decision?

There are occasions when a patient under 16 is mentally competent and can provide their own legally valid consent to treatment. In many cases it is good practice to also involve a parent in the discussions, but where a competent young person does not want parental involvement these wishes should be respected (for example when providing

contraceptive and sexual health advice).

When children and young people lack capacity (because of age, immaturity, illness or a decision which is too complex) those with parental responsibility can provide legally valid consent for patients under 16. The patient should however still be involved in the discussions about their care, in line with their level of understanding.

Whilst parental responsibility cannot be transferred by those who hold it they can authorise others to act on their behalf – for example, when a grandparent attends with a child for immunisations. The authority must be clearly expressed and appropriate to the particular circumstances. In some instances there may be authority from a court to provide treatment or allowing another individual to consent.

**"In some instances there may be authority from a court to provide treatment"**

There are legislative differences in the UK that affect children and young people and their rights to consent on their own behalf, those who might have a legally valid proxy and what happens when there is a refusal of treatment. It is helpful to be aware of these.

**England and Wales:** refusal of treatment by a young person age 16 or 17, or a child under 16 but Gillick-competent, could be overruled if it would in all probability lead to death or severe permanent injury, but this is a matter for the courts to decide rather than one of parental consent. A young person aged over 16 but under 18 who lacks capacity is subject to the Mental Capacity Act in England and Wales and treatment decisions can be made on the basis of the patient's best interests and will likely involve discussion with the parents.

Refusal by a parent to give consent to a particular treatment can be overruled by the courts if thought to be in the patient's best interests. The Children Act also allows someone without parental responsibility but who "has care" of a child to "do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare".

**Scotland:** competent patients, even if under 16, can consent in their own right and parents do not simultaneously have a legally valid proxy. A decision by a competent young person under 18 to refuse treatment is likely to be binding and legal advice should be obtained in complex cases. Any patient aged over 16 who lacks capacity is subject to The Adults with Incapacity (Scotland) Act and all medical treatment must therefore comply with the terms of this act. In Scotland, someone who "has care" of a child cannot act in a way contrary to the known wishes of the parents – thus if a carer attends with a child and treatment is required, parental wishes should be ascertained.

**Northern Ireland:** here the situation is similar to England although there is some ambiguity about the status of someone with parental responsibility being able to consent for a competent young person who refuses consent. On these rare occasions such cases will likely need to be referred to the court. Currently there is no specific legislation regarding young people aged 16-17 who lack capacity and common law principles (those from case law and precedent) must be followed.

The GMC's publication *0-18 Guidance for all doctors* provides useful and detailed advice regarding the subject of consent and young people. All doctors should be familiar with the parts of this guidance relevant to their own practice. Members can also contact MDDUS for specific advice.

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



## ON LEAVING WELL

*Deborah Bowman*

**I AM** currently in a strange phase of transition. After nearly 17 years, I am leaving St. George's for a new role. I am excited about the approaching change, but immensely sad to be saying farewell to many friends, colleagues and students who have, since 1999, made London SW17 such a splendid place for me to be.

As I fill embarrassingly large numbers of bin liners with rubbish from my office, shred documents and begin to think about how to transport shelves of books and files (the digital communication revolution has not had much impact in my corner of Tooting) across London, I have been thinking a lot about the ethical dimension of moving on. Goodbyes and departures are common in healthcare. From significant life choices about where to work to the routine "handover", clinicians are often stepping away from decisions and care in which they have been intimately involved. What does it mean to "leave well"?

The essence of the "good" departure seems to depend on having the capacity and the will to hold others in sight. The person leaving has to be able and willing to consider what is going to happen after he or she departs and what it will be like for those who are left behind. It is a matter of moral imagination and a commitment to the interests of others, be they colleagues, students or patients.

The duties that attach to a professional

when he or she is present must be conceptualised as continuing beyond the point at which they have left the building. An individual may no longer be doing specific tasks or making decisions, but there is nonetheless a responsibility that endures, even beyond the contractual. It is a responsibility borne of virtues (regular readers will know that these are my "go to" ethical premise): those of loyalty, compassion, conscientiousness and reliability. It demands that the person who departs recognises that healthcare is inherently a team sport: the individual is always part of a group that is striving to provide consistently excellent care and that exists to serve others.

The seemingly small details are, in fact, moral choices when it comes to leaving well. Whether the notes are complete and intelligible, whether the tests have been followed up as promised, whether the information in the handover was accurate, whether the patient's questions have been answered are all matters of ethics as much as they are matters of administration or organisation. Many readers will have had the experience of taking over from someone who did not offer a good handover (or indeed, any handover at all) or beginning a job where they were clueless about what was expected and how to meet those expectations. Those may be formative experiences, but they are not necessary or desirable. Whether it is the end of a busy single shift or the culmination of a thirty-year career, leaving well requires attention to, and care for, those who remain.

In addition to the practical aspects of departing, for however long, there is, I think, an ethical disposition that is required to leave well – the recognition and acceptance that others may, and almost

certainly will, do things differently and affording colleagues and successors the discretion to make decisions and choices without the spectre of disapproval or criticism. Offering to maintain relationships can be positive, but undermining colleagues by remaining a "backseat driver" is not. Nor is leaving an opportunity to complain and diminish morale. However frustrating the circumstances may be at the point of departure, remembering that those who remain are committed to providing service in those circumstances is essential.

What of ritual and leaving well? I confess to loathing parties, speeches and what my Irish grandmother would have described as an "unholy fuss". I have spent the last few weeks imploring friends and colleagues to allow me to turn off my office lights and let me slip down the backstairs on my last day. Yet they have gently reminded me that the marking of a departure is important. What's more, they've pointed out, it is important for other people to be able to bid farewell. It is, they were too polite to say, not about me but about what I can and should be doing for other people – the people who have made the last 17 years such a pleasure and a privilege.

So, on the 3rd June, I will be gathering for a tea party. I will doubtless be emotional and the chances of that "unholy fuss" my grandmother warned me against are high. I hope though that I will be leaving well. And, before that day, each time I hand over a file, brief a colleague or shred a document, I'll remember that these are ethical acts for people I love.

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





**S**COTLAND'S Chief Medical Officer Dr Catherine Calderwood has only been in post for a year but is already causing something of a stir in the medical profession. Her first report, *Realistic Medicine*, has been widely praised, with enthusiastic discussions on social media site Twitter as well as at conferences and events across the country.

Catherine, who qualified from Cambridge and Glasgow universities, is an obstetrician and gynaecologist and continues to practise at a maternal medicine antenatal clinic at the Royal Infirmary of Edinburgh. She became a medical adviser to the Scottish Government in 2010 and has played a key role in reducing stillbirths and neonatal deaths in Scotland. She chairs a number of key committees, including the UK Maternal, Newborn and Infant Clinical Outcome Review Programme. She was the obstetrician on the panel of the Morecambe Bay Inquiry into maternity and neonatal services and is a member of the recently formed Review of Maternity and Neonatal Services in England.

*In Realistic Medicine you said you wanted to start a conversation with doctors about changing healthcare. What has the response been so far?*

It seems to have been universally positively received. We've received hundreds of emails and online survey responses, and it is getting 60 to 100 mentions a week on Twitter. It's been amazing. It seems to have really hit a chord with people, that they have thought it was speaking sense. It has been reassuring to find that there is such an appetite to change the way we practise medicine, with the two most common themes being shared decision making and personalised care.

*Your report raises the issue of overtreatment and notes that doctors "generally choose less treatment for themselves than they provide for patients". Why is that?*

There's a lot of research, mostly involving doctors at the end of life who have a terminal diagnosis. Figures show, for example, that 88 per cent of doctors wouldn't have haemodialysis, 95 per cent wouldn't have CPR, and 67 per cent wouldn't agree to be admitted to intensive care. Having discussed this with doctors with expertise in this area, I think it is because we have seen the downsides of

some of these treatments and know the reality of being hospitalised or admitted to intensive care. There's also evidence that doctors don't fully understand what patients want. Research has shown that doctors assume patients will prioritise living longer over anything else but, when asked, patients say they want two things: to be symptom-free and to spend time with their families.

*What are the factors involved in overtreatment and how do you think we can reduce it?*

Doctors are fixers by definition, that's the

nature of the job. It is also an individualised issue because some patients will want everything done no matter what the discussion is. Part of the reason for writing *Realistic Medicine* came from hearing clinicians tell me they wouldn't undertake their own treatment. A respiratory physician specialising in lung cancer told me that, given that diagnosis, he wouldn't have chemotherapy because he has seen the side-effects. Perhaps we should be more open and transparent with patients about the real impact of some of these treatments? That is one of the questions I am asking in my report.

# Being realistic for patients

*Dr Catherine Calderwood talks to Summons about her ambitious plans for a common sense, patient-focused approach to healthcare*





**Will doctors who (rightly) choose to “do nothing” simply end up facing more patient complaints?**

There’s definitely a perception that doctors could open themselves up to criticism for not giving enough treatment. But I’m hearing from health boards examples of complaints where a patient has had too much intervention, where the family have written afterwards to say they died in a way that is not what they would have wanted. So perhaps doctors are worried when they shouldn’t be? It all comes back to shared decision making and personalised care. If doctors have a full, properly documented

discussion with patients and their family about the available options, and then decide not to offer treatment with the patient’s consent, that doesn’t generate complaints, that generates thank you cards.

**How can we move away from the “doctor knows best” culture to one of shared decision making?**

People who come into the health service now are generally much better informed. Often they have googled their symptoms beforehand and may have reached their own conclusions, sometimes wrongly. I would welcome that change. The doctor

can then have a genuine conversation with the patient about that information, how it does/doesn’t apply to them, and fully discuss all the available options based on the level of knowledge that person has. Of course, some people have poor health literacy. A recent research figure I heard was that 49 per cent of UK working age adults do not understand the information in the bowel screening pack. This is something doctors must be aware of when explaining things, for example by avoiding jargon and double checking the patient has understood what has been discussed.

**How do you foresee the process of informed consent changing?**

What I’m interested in is the way discussions around consent are framed, because clearly it is a legal process and that raises some difficulties. But it’s about patients knowing that it is their choice as to whether or not they go ahead with treatment. A surgical trainee approached me recently on the train and said he had read my report and had already changed the way he talks to patients when consenting for an operation. He now explains that they have the option not to go ahead with the surgery, that they don’t have to do anything at all. Just because we’ve got the intervention or treatment, doesn’t necessarily mean everything is right for every person.

**Are the changes proposed in *Realistic Medicine* achievable?**

I hope so. I’ve been talking to doctors across Scotland and what they’re saying is that this is the right way to go. They do not need to be persuaded, and are asking “what can we do to help achieve it?” The conversations I’m now starting to have focus on implementation. There’s a lot of momentum behind the report; a lot of people are talking about it as an acceptable way to practice. So I think in Scotland, as a smaller country, perhaps it is more achievable here than it would be elsewhere. It’s about educating trainees to practise medicine like this, and also to make changes at a more senior level to ensure a supportive environment for those trainees as they progress in their careers. The important thing is for everybody – not just doctors – to buy into this concept and to help make the changes a reality.

■ **Interview by Joanne Curran, associate editor at MDDUS**



# Never again

Allan Gaw *recounts the origin of The Nuremberg Code on human research and considers its modern-day relevance*



**T**HE court had been in session for 139 days; it had heard the testimony of 85 witnesses and received more than 1,400 documents in evidence. Now the legal battle was over and the courtroom was hushed in anticipation of the outcome. Twenty-three defendants awaited their fate at the hands of a panel of American judges. The date was 19 August 1947; the court – the Palace of Justice in the bombed-out city of Nuremberg in occupied post-war Germany; the hearing one of the most famous in legal history – the Nazi Doctors' Trial.

In a judgement running to more than 50,000 words, pronouncing the guilt of 16 of the defendants and sending seven to their deaths, a small introductory section of around 500 words entitled, "Permissible Medical Experiments" might have been overlooked. However, this was to be the enduring legacy of the trial – 10 carefully weighed and worded standards for the conduct of human research, which have since become known as the Nuremberg Code.

The precise authorship of the Code is unknown. The trial's chief counsel for the prosecution believed it was from the hand of one of the four judges. Others have suggested that two physicians were the chief architects of the Code: Andrew Ivy and Leo Alexander.

Ivy was an eminent physician and physiologist who, perhaps because he had been actively involved in research involving prisoners, had been invited to serve as the American Medical Association's adviser to the Nuremberg prosecutors. Alexander was an Austrian-born, American physician who served first as a medical war crimes investigator and

then as medical expert to the trial.

Both men played an active role in the proceedings and they submitted several sets of ethical principles to the court. However, because of the lack of documentary evidence detailing the judges' thinking while drafting their ruling, we can only speculate as to the relative importance of each man's contribution.

## The Doctors' Trial

In the Doctors' Trial, or more formally The United States vs. Karl Brandt et al, the 23 defendants were indicted on a number of counts, including war crimes and crimes against humanity.

As the war had neared its conclusion, details of the medical experimentation in concentration camps first began to reach the world press. The public needed no convincing that the Nazi doctors involved were guilty of unethical practices and almost unimaginable cruelty. In order for them to face criminal charges, however, the American prosecutors faced a dilemma.

The defendants would claim their innocence, stating that they were acting in accordance with German military law and that their American medical counterparts were involved in similar practices. As such, it was clearly paramount to distinguish the practices of the physicians in the dock from those of Allied researchers. The prosecution also had to define what they believed to be ethically permissible experimentation and what was not.

Within the final Code three main themes were evident. First that the absolute need for informed consent is a sine qua non of clinical research; second

that a study participant's rights are given precedence over those of the investigator; and third that the investigator has clear obligations regarding the design and conduct of the study.

## Reception

The Nuremberg Code was largely ignored by the medical profession for 20 years after its publication, especially in the US and the UK. This may have been due to the circumstances that prompted the Code – a series of medical atrocities conducted by Nazis during a war – that were seen as irrelevant and unconnected with medical practices in other countries.

Although some have viewed the Code as a component of International Common Law, it carried no legal force and was at best a voluntary code of research ethics.

However, the voluntary nature of such a code may be viewed as its principal strength in that the best possible, and most liberated, scientific environments are created not within the straightjackets of legislation, but within the relative flexibility afforded by a professional guideline.

Unfortunately, against this contention is the evidence of history. Time and again we have learned that we cannot rely on the "informed, conscientious, compassionate, responsible investigator" guided merely by a voluntary code of conduct. For the safety of trial participants that investigator must also be constrained by the rule of law.

## Relevance

The Nuremberg Code has been described by many as the most important document ever written on human research ethics. Is





From left: Nazi doctors on trial for 'scientific death' experiments on prisoners; Leo Alexander points out injuries sustained by a Polish inmate of one of the concentration camps; the Nuremberg Palace of Justice – where the trials took place

this true? Although largely ignored for around two decades, by the mid-1960s a number of important events had occurred that refocused professional and public attention on the issues. These included the publication of the Declaration of Helsinki in 1964, and catalogues of unethical human research in the post-war period compiled by the American anaesthetist Henry Beecher in 1966, and the English physician Maurice Pappworth in 1967. Collectively, these events pushed forward the need for change and tighter control of medical research.

The rapidly changing social and cultural backdrop of the 1960s may also have significantly contributed to this development. Every idea has its time, and in the late 1940s the medical profession was not ready to address the ethical issues central to the Code. By the 1960s, it was.

But what would the research ethics landscape look like today if there had been no Nuremberg Code? Counterfactuals are always problematic, but this one allows us to consider the true historical importance of the Code. As the document was largely ignored after its publication it is difficult to claim that it prevented many unethical experiments from being conducted in the

1940s and the 1950s. Indeed, the scale of the unethical practices Beecher and Pappworth exposed would support the notion that the Code had no impact at all. Without the Code, however, these whistle-blowers would have had no moral yardstick. The Nuremberg Code, like all codes of practice, set a standard. Whether that standard is followed is another matter, but its very existence provides a profession, and the observers of that profession, with the means to distinguish right from wrong.

Such a code, however, already existed for the medical profession in the form of the Hippocratic Oath. What did the Nuremberg Code add to this, if anything? Both place our patients at the centre of our work, along with an over-riding requirement for beneficence and non-maleficence. The Code, however, is primarily concerned with research rather than practice and emphasises the importance and need for informed consent in that setting. This importance may be implicit in the Oath, but only the Code insists that it is the foundation stone of all human research.

### Ethical touchstone

The Code began life as a relatively minor

component of a tribunal judgment; what it then became was a touchstone for the development of modern research ethics, acquiring a significance that transcended any issue of individual authorship. The Code was almost certainly a joint effort involving Alexander, Ivy and the judges, and collectively their legacy is an important one.

The authors of the Nuremberg Code set in train a movement that has slowly but inexorably led us to the present day matrix of research ethical codes in which we work. It seems unthinkable today that the medical atrocities perpetrated in the Nazi concentrations camps could happen again, but what the authors of the Code still ask us to do is to contemplate that very possibility. Having robust codes of ethics coupled with legally binding regulations derived from the Nuremberg Code helps to ensure that the past will not be repeated.

■ *Dr Allan Gaw is a writer and educator from Glasgow*

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*Risk adviser Alan Frame looks at how a considered apology to a patient when things go wrong can often defuse a fraught face-to-face encounter*

# For want of an apology

**S**ORRY does indeed seem to be the hardest word – or so the Parliamentary and Health Service Ombudsman (PHSO) has said in a recent report on how well GP practices in England deal with patient complaints.

Based on an analysis of 137 closed complaint cases involving general practices, PHSO investigators found that the quality of complaint handling was rated as “Needs improvement” in 36 per cent and “Inadequate” in 10 per cent. In particular the review concluded that in a third of cases staff did not provide an adequate apology where appropriate, and the apologies offered were not always sincere.

This is all the more surprising given the host of recent legislative and professional measures requiring professionals to be open

and honest with patients and to offer an apology when care or treatment goes wrong. In 2014 a statutory duty of candour was introduced applying to all healthcare providers in England and last year the GMC released new guidance on the professional obligation of all doctors to be open and honest with patients when mistakes are made that have compromised – or could have compromised – patient safety. The Scottish Parliament has also recently passed a bill with the aim of ensuring that an apology does not amount to an admission of liability and is inadmissible as evidence in certain legal proceedings.

Medical and dental defence organisations have also continually stated that saying sorry is not an admission of legal liability. Indeed, in our experience, a

sincere apology can and does prevent a patient complaint from escalating further, and saying sorry should not be viewed as a sign of weakness. In fact, most times it is the right thing to do and a genuine apology may be all that a patient wants.

## **No caveats**

So what does the PHSO consider to be a sincere apology? In the report it found that practices responding to complaints often used the phrases: “I’m sorry but” or “I’m sorry if”. While these convey an apology of sorts, it is often a very qualified one. An example cited in the report is where a practice manager apologises that she might have been “perceived” as being rude or dismissive but goes on to defend her poor attitude as a “human frailty” which

Try to avoid any temptation to apologise for a colleague or on someone else's behalf, or even worse to have someone else apologise for you. The danger here is that the complainer may feel that they are simply being fobbed off and end up even unhappier than before.

An initial apology can help establish empathy, which is important in building trust and rapport. Establishing trust is about listening and understanding, while not necessarily agreeing. Resist any temptation to collude with the complainer. This may seem like an attractive option in handling a face-to-face encounter, especially if the complainer is angry, but may only be storing up trouble for later.

### Some helpful techniques

Dealing with a verbal complaint face-to-face can give you little time to think over an appropriate response. First expressing regret can help defuse the situation. Your job now is to try to gain an understanding of how the complainer feels and what it is that they want to achieve. There are several recognised techniques which can be employed at this point:

**Consider your body language.** This should be open without appearing too casual. Non-verbal communication is an important aspect of any face-to-face encounter, especially where any conflict exists. Is your body language facilitating discussion or is it acting as a barrier?

**Demonstrate that you are not only hearing what they have to say, but that you are also trying to understand their complaint or concern.** This can be improved in conjunction with positive body language by small nodding movements or vocal encouragement and appropriate use of questioning.

**Explore further.** If you do need to intervene and explore further to gain better understanding, then consider your question construction:

**Clarifying:** "So, you are saying that...?"

**Constructing:** "What would you like to happen...?"

**Disagreeing:** "I cannot agree with that, but...?"

**Confirming:** "So, we agree that...?"

**Interpreting:** "So, you are suggesting that...?"

**Testing:** "If we did this then...?"

These types of questions can also be used effectively to sum up what has been discussed with the complainer. It can be

very helpful at this stage to clearly state what you intend to do next and gain an acknowledgement that the complainer understands the process.

**Manage your anger.** In a face-to-face encounter the complainer may be frustrated or resentful, which is manifested as anger. In such a conflict situation, it may be difficult to alter our own opinions, especially if we are feeling intimidated and stressed ourselves, but we can choose our behaviour. Meeting anger with anger as a strategy can sometimes work, by forcing the other person to "back down"; however, this is a high-risk strategy which would be extremely difficult to justify in any professional context.

**Try to avoid getting "sucked into" an argument and taking things personally.** This is difficult if you feel your own actions or those of the service are being called into disrepute. Try to remain objective.

**Resist any temptation to raise your voice in anger to match the aggressor.** You can, however, use the tone of your voice to convey a sense of increased concern and try to "match the energy levels" of the complainer. Conversely, remaining overly calm and even-toned in the face of hostility could be interpreted as you being unconcerned and disinterested about their complaint.

**Consider the setting.** If you are dealing with a complaint face-to-face think about where it is taking place. A reception area will likely involve an "interested audience", so it may be better to move the discussion to a more private area. However, there are risks associated with this as well. What is your physical position and that of the complainer in the room? Do you both have clear line of sight to an exit route? Sometimes when people are emotional they may feel trapped or cornered and their instinct may be to escape. You do not want to be in a position where they are going to have to "come through you" to achieve this. Likewise, you should also be prepared to leave if you feel that your own personal safety is under threat. Can you get to the exit unhindered? If you become trapped and can't leave, can you summon assistance?

**Remember to finish with a final apology.** You will hopefully now have a complainer who doesn't simply view you as the enemy or a part of the "establishment", and you will now have sufficient information to move on to the next stage of complaint management – the investigation.

■ Alan Frame is a risk adviser at MDDUS

everyone can be guilty of. "An apology like this, which contains a caveat, is less meaningful and valuable."

In healthcare, there is a plethora of charters, standards and promises, meaning that patients are better informed about their rights than ever before. Indeed, the GMC produce guidance on what patients should expect from their doctor. Understanding the situation along with the patient's motivation in raising a complaint is important and, indeed, it may be that you or your team has got something wrong and an apology is deserved.

Saying sorry is unlikely to do any harm by itself, as long as it is delivered in a sincere and appropriate manner. Once you have listened carefully and understood the nature of the complaint, a helpful opening gambit can be to express regret that the patient is dissatisfied, unhappy or upset. It can also help the situation to thank the individual for bringing the matter to your attention, again as long as this is done in a sincere manner.



# Pulmonary embolism

*A low threshold of suspicion is advised for this common and often fatal condition*

**P**ULMONARY embolism (PE) is a serious, common and frequently preventable condition that has potentially devastating consequences for the patient and their family. It is responsible for an estimated 60,000 deaths per year in the UK<sup>1</sup> and is the most common cause of maternal death in otherwise healthy young women<sup>2</sup>.

Although the incidence of clinically diagnosed PE has been reported at 3-4 per 10,000<sup>1</sup>, it is likely that the true incidence is much higher, as the diagnosis is frequently missed. When formally investigated, PE was suspected clinically in less than 50 per cent of patients subsequently found to have died from the condition<sup>3</sup>.

As the clinical diagnosis of PE and DVT is unreliable, these potentially devastating clinical conditions represent a significant medicolegal risk to doctors. To attenuate this risk, clinicians must have a low threshold of suspicion for PE and a coherent plan to investigate and treat any patient with a possible venous thromboembolism (VTE).

## Primary prevention

The best way to avoid the sequelae of PE is clearly prevention. All UK hospitals are now required to assess the risk of VTE in admitted patients, with most receiving prophylactic low molecular weight heparin (LMWH) and compression hosiery. LMWH prophylaxis is known to reduce the risk of hospital-acquired VTE and should be given routinely unless contraindicated. It is also important to appreciate that common risk factors such as immobility, malignancy, pregnancy, the oral contraceptive pill and obesity persist long after discharge. Increasingly, doctors prescribe VTE prophylaxis in the community, particularly for patients recovering from oncological surgery and high-risk orthopaedic procedures.

Failure to consider prolonged prophylaxis following hospital discharge may put the patient at unnecessary risk, and expose the doctor to litigation. Even with exemplary primary prevention strategies, some patients will develop VTE; as such, there should be a low threshold to assess, investigate and treat.

## Clinical assessment

Shortness of breath, usually of sudden onset, is the most frequently reported symptom in patients with confirmed PE (present in 80 per cent of cases), followed by pleuritic chest pain (52 per cent), cough (20 per cent) and syncope (19 per cent). On examination, tachypnoea is found in 70 per cent of patients, along with tachycardia (26 per cent), signs of DVT (15 per cent) and cyanosis (11 per cent).

The challenge for clinicians is to identify which patients presenting with these non-specific symptoms merit further investigation. The Simplified Geneva Score<sup>4</sup> allows a more objective assessment, and can minimise the risk of missed cases and potential harm. The score is comprised of risk factors (such as active cancer or recent major surgery) and clinical signs (heart rate, lower limb tenderness etc), and allows the clinician to stratify risk. Patients who have a negative D-dimer assay and who are classified as 'low risk' on the Simplified Geneva Score have a maximum 3 per cent likelihood of PE.

The symptoms and signs of both DVT and PE are almost always non-specific, and could represent a number of possible diagnoses, particularly post-operatively. Relying on clinical assessment alone may lead to serious errors and potential medicolegal claims.

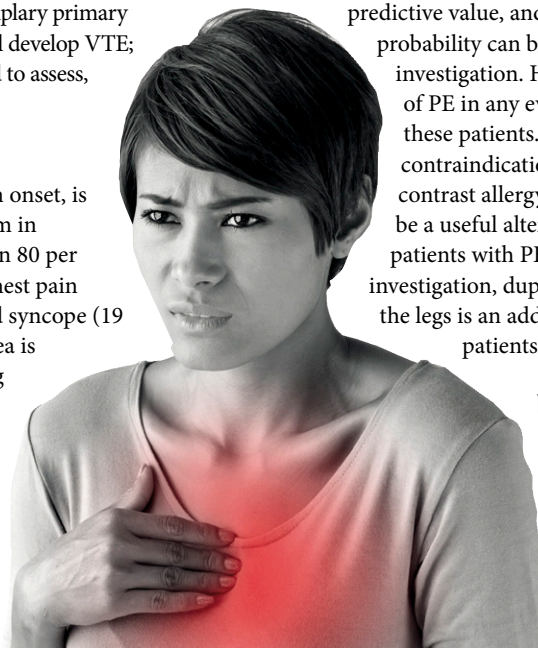
## Investigation

Initial assessment depends on whether the patient is haemodynamically stable:

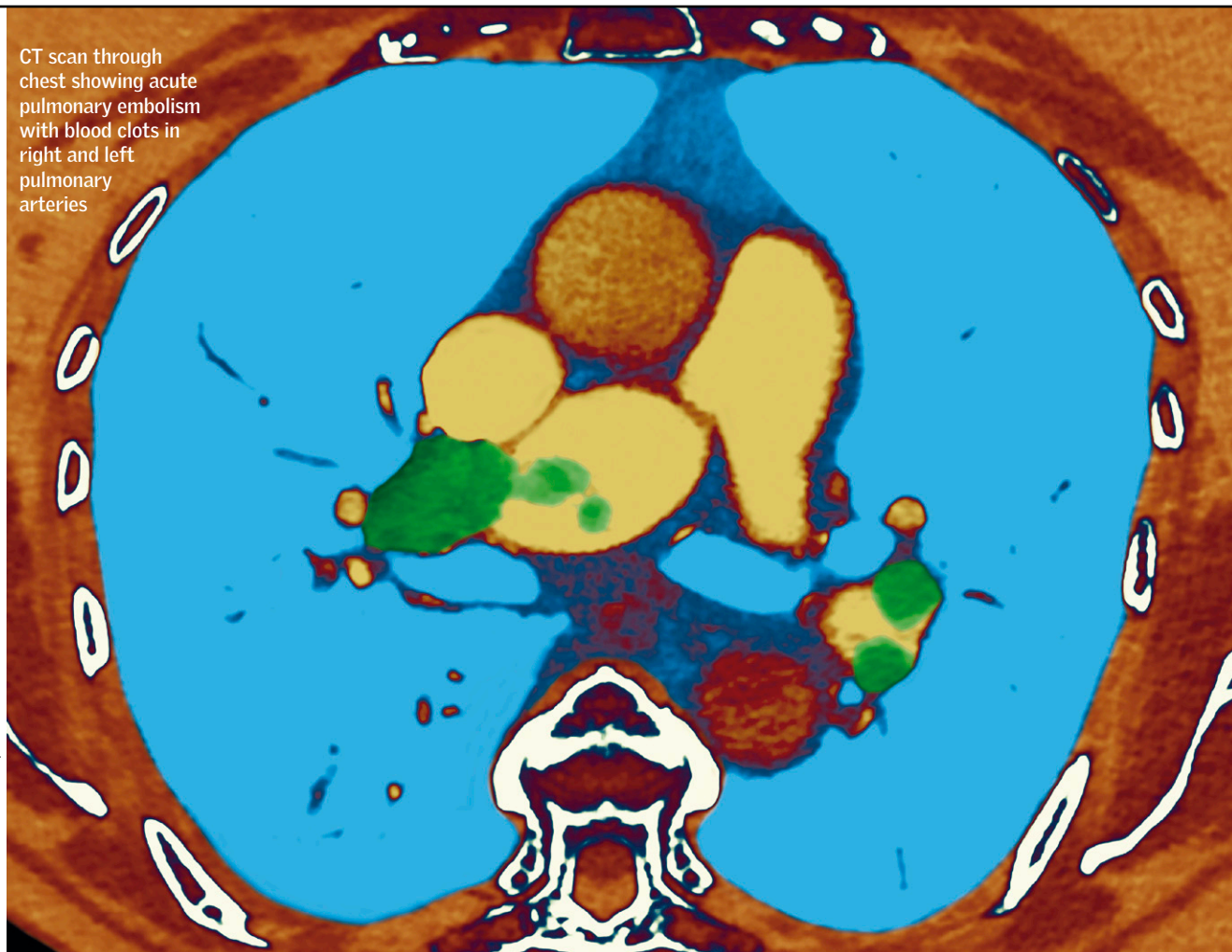
- **Suspected PE in a shocked patient.** CT pulmonary angiogram (CTPA) is the appropriate initial investigation in all patients with suspected PE. However, if the patient is shocked, bedside echocardiogram avoids the inevitable delay in transferring the patient to the radiology suite. This will identify the acute pulmonary hypertension and right ventricular overload characteristic of large PEs and should be sufficient to confidently initiate treatment. Alternative diagnoses such as cardiac tamponade, acute valve failure or aortic dissection may also be excluded. CTPA can then be used to visualise thrombus and confirm the diagnosis once the patient has been stabilised.
- **Suspected PE in a haemodynamically stable patient.** In low probability patients a D-dimer assay can be used to refine the clinical risk of PE. A normal D-dimer has a strong negative predictive value, and in combination with low clinical probability can be used to avoid unnecessary further investigation. Hospital inpatients have a 'high' probability of PE in any event and CTPA should not be delayed in these patients. In patients where there is a contraindication to contrast CT (such as renal failure or contrast allergy), ventilation perfusion lung scanning may be a useful alternative. Although only 30-50 per cent of patients with PE have evidence of DVT on full investigation, duplex ultrasound imaging of the deep veins in the legs is an additional, appropriate investigation for patients with suspected PE who cannot have CTPA.

## Management

- **Treatment of PE in the shocked patient.** Severe hypotension due to PE is a medical



CT scan through chest showing acute pulmonary embolism with blood clots in right and left pulmonary arteries



PHOTOGRAPH: PR MICHEL BRAUNER/SCIENCE PHOTO LIBRARY

emergency, and any delay in treatment increases the risk of mortality. Vigorous resuscitation, thrombolysis and (in most cases) urgent transfer to the intensive care unit are essential. Thrombolysis rapidly improves haemodynamic function, and is most effective when administered within hours of the onset of symptoms. In modern practice, pulmonary thrombectomy is usually reserved for patients who have contraindications to thrombolysis such as recent surgery, any bleeding risk or recent stroke.

• **Treatment of PE in the stable patient and secondary prevention.** As soon as the diagnosis is considered likely, LMWH at a full anticoagulant dose should be administered without delay. Under these circumstances, the inevitable delay in arranging CTPA to confirm the diagnosis does not put the patient at risk of further PE. Traditionally, Vitamin K antagonists (usually warfarin) have been prescribed concurrently, with a target INR of 2-3. Once this has been achieved, subcutaneous LMWH can be withdrawn. Novel anticoagulants (predominantly the Factor Xa inhibitors 'xabans') are now replacing warfarin as they do not require the same costly and inconvenient monitoring. In most cases, anticoagulation should be continued for 3-6 months to reduce the risk of VTE recurrence.

As with all treatments, experienced clinical judgement is required to assess the individual patient's risk and benefit, and to advise the patient and their family whether shorter or longer periods of anticoagulation should be considered.

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■ Professor Charles McCollum is Professor of Surgery at the University of Manchester

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*Dental adviser Doug Hamilton tests the waters after a landmark legal ruling on shared decision making in consent*

# Sea chan

**D**UE perhaps to the generally torpid nature of medical law, the seminal case of *Montgomery v Lanarkshire Health Board* has prompted many fevered commentaries and opinion pieces. The facts surrounding this ruling are probably well known. Nevertheless, it is worth reminding ourselves, very briefly, of the decision which, although it related to an obstetrics claim, has impacted upon the consenting practices of virtually all healthcare professionals.

The claimant in the case – Mrs Montgomery – experienced complications during the birth of her son. The baby's head failed to descend properly due to shoulder dystocia – a rare complication where the baby's shoulder lodges behind the mother's pubic bone and essentially becomes stuck. This led to a 12-minute delay between the baby's head appearing and delivery during which time the cord was completely or partially occluded. Sadly, the baby

suffered significant cerebral palsy.

Mrs Montgomery was only just over five feet tall and diabetic. She alleged negligence, saying that, before the birth, she should have been warned about the possibility of shoulder dystocia.

Initially Mrs Montgomery lost her case at trial and later on appeal, but she went to the Supreme Court and won.

The Supreme Court clearly recoiled from the 'paternalistic', though doubtless well-intentioned, attitude of the treating physician. As a result, the prevailing 'prudent doctor' standard was abandoned. It is no longer a matter of what the reasonable clinician thinks the patient ought to know. Instead, healthcare professionals are now required to treat their patients "...so

far as possible as adults who are capable of...

accepting responsibility for the taking of risks affecting their own lives..."

Whilst few would dispute its wisdom, one might still question whether this doctrine is required, or even workable, in every healthcare environment. Take, for example, an NHS dental practice. Financial survival depends to an extent on reasonably fast care delivery. Many of the procedures are routine and are relatively low-risk. GDPs will often be well acquainted with their regular patients. Must there always be a comprehensive exploration of the patient's wishes prior to treatment at every dental appointment?

## Risk of endocarditis

Consider the hypothetical patient who pitches up in the middle of a typically busy session with a painful upper 1st molar. The patient expects speedy and efficient pain relief. The tooth is heavily compromised. The patient in question has never shown the slightest interest in conservative dentistry. There is no obvious risk of maxillary sinus involvement. Might the practitioner in these circumstances simply confirm that an extraction would be acceptable before proceeding?

To make the case more "interesting", imagine our patient has had a previous episode of infective endocarditis (IE). (To be clear, this is a dento-legal thought experiment and not a clinical article.) Probably, at some point in the past, this patient would have received prophylactic antibiotics prior to invasive dental procedures. However, following the publication of the relevant NICE guidelines in 2008, this practice would have been discontinued.

It is difficult to imagine a dentist who continues to work within NICE guidelines being criticised. However, practitioners will have read recent reviews by NICE and another authoritative body, the European Society for Cardiology, of their

# ge in consent

respective endocarditis guidelines. Contrary to NICE, the ESC maintains that prescription of prophylactic antibiotics for high-risk patients is the safer approach.

It is important to acknowledge that a causal link has not been established between the withdrawal of cover since 2008 and the apparent rise in IE cases. Nevertheless, the question is begged whether, in the new era of patient autonomy heralded by Montgomery, both sides of the debate should be discussed with this patient. Remember that the law, as it now stands, places the dentist "...under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment". The all-important test of materiality is "...whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk".

It does seem quite reasonable to presume that a patient with a previous episode of endocarditis may attach significance to the view of the ESC. So, there may be some dentists, possibly emboldened by the sentiments conveyed in Montgomery, who

**"There may be plenty for the dentist to explain ... prior to carrying out a seemingly routine extraction"**

feel compelled to offer the choice of antibiotic cover to our hypothetical patient. Doubtless, this would be based upon well-informed reflection and would be the result of factual, neutral and very well-recorded advice.

Before I remove my toe from these very troubled waters, please let me emphasise that MDDUS is not endorsing the provision of prophylactic antibiotics. Whilst slavish adherence to best practice guidelines is not mandatory, members must be aware that NICE remains a voice of authority and refuge lies within its parameters.

## **More routine risks**

Thankfully, most patients are not at risk of IE, so there is no need to consider antibiotic cover. However, the loss of this particular tooth might well lead to reduction in function, denture retention or aesthetics. These problems might be remediable, but only by means of treatments such as bridgework or an implant, both of which involve their own risks not to mention significant cost. Having been so advised, the patient may well decide that conservative options, though possibly less durable or predictable, are worth exploring. Of course, the patient is always entitled to refuse or delay treatment.

So, there may be plenty for the dentist to explain and for the patient to consider prior to carrying out a seemingly routine extraction.

## **No risks?**

Moving further down the excitement scale, it may be that the cause of the presenting symptoms was simply cervical sensitivity. No need for extractions or endodontics: this problem might be treatable by means of something as mundane as topical fluoride application. Surely, little in the way of warnings is needed? Perhaps not – but this does open the door to a related cautionary tale involving younger patients.

I had a call from a member recently who had been engaged by his area team to visit a local primary school with a view to applying fluoride varnish. A letter was sent to each parent in advance which contained very limited information but did ask if their child suffered from asthma, and, if so, the severity. These forms were reviewed and fluoride was not applied to the dentition of any children with a history of severe asthma.

Later and following discussion on a well-known parenting forum, a number of complaints were received at the school. In summary, some parents completing the consenting form did not realise that there were a variety of possible adverse reactions to the varnish.

The dentist's approach (based largely upon guidance from his area team) was not without logic. Fluoride application represents an efficient means of reducing dental disease. Complications are very rare with, arguably, the only serious outcome being exacerbation of severe asthma.

Nevertheless, it must be remembered that the physicians' "... advisory role cannot be regarded as solely an exercise of medical skill without leaving out of account the patient's [or their 'legal proxies'] entitlement to decide on the risks to her health which she is willing to run".

Unsurprisingly, many parents attached significance to the possibility, however slight, that the application of fluoride varnish could have led to unpleasant side effects, such as gastric disturbance or allergic reaction. Had they been given the full picture, as they should have been, consent may have been withheld.

## **Securing reliable consent**

If the treatment of choice is obvious, even the most fastidious dental practitioner may be tempted to offer advice which is incomplete or slightly skewed. This is not done to actively mislead patients. Instead, it is generally the result of a mental calculation, based upon extensive expert knowledge, which is designed to offer the most helpful and digestible amount of advice in a reasonably time-efficient manner.

Yet this approach fails to recognise that different facets of planned treatment will have significance for different patients. Information which might appear to be irrelevant or superfluous to the practitioner may be very important to a patient undergoing treatment. Therefore, discussion is almost always needed in order to secure consent upon which dentists can subsequently rely.

■ *Doug Hamilton is a dental adviser at MDDUS*



# CASE studies

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

## DIAGNOSIS: TUBAL PREGNANCY

**BACKGROUND:** Ms P is 32 years old and attends her GP surgery complaining of abdominal pain. Dr R records a history of long-standing iliac fossa pain not related to the patient's menstrual cycle. The pain is intermittent – a few times a week – and lasting five or so minutes. Dr R examines Ms P and takes a vaginal swab. He informs the patient that a laparoscopy might be considered if the swab is negative. A week later the swab comes back negative and Ms P is contacted for an appointment but does not attend.

Two weeks later Ms P is back at the surgery still complaining of cramps. She informs Dr R that she recently took a home pregnancy test which proved positive. The GP estimates that she must be around four weeks pregnant going by the date of her last period. The pain is intermittent and "not like period cramps". She has also noticed some brownish spotting on wiping.

Dr R examines the patient and then advises her that if the pain or bleeding increases to contact the practice and he will arrange an ultrasound. He then refers Ms P to a midwife for antenatal care and also requests that Ms P provide a urine sample for analysis but this shows no sign of urinary tract infection.

Two weeks later Ms P returns to the surgery. She reports still having some minor bleeding and the cramps have returned. Dr R examines the patient and finds her not particularly unwell and arranges for her to be seen the next morning at hospital in the early pregnancy assessment unit. But that night Ms P's husband drives her to A&E suffering with extreme abdominal cramps and a bloody vaginal discharge. The examining physician records lower abdominal tenderness with brownish blood and tender cervix on internal examination. She is put on IV fluids and referred to the on-call gynaecologist. A scan reveals a large amount of free fluid in the pelvis and a diagnosis of likely ectopic pregnancy is made.

Ms P is taken to theatre for a laparoscopy and is found to have a ruptured left tubal ectopic pregnancy. She undergoes a left salpingectomy and requires a blood transfusion. She makes a good recovery and is discharged four days later.

Five months later Dr R receives a letter of claim from solicitors representing Ms P claiming clinical negligence in her treatment. It is alleged that the GP breached his duty of care on her first visit by failing to ask when her last period was and whether it was normal and if she had any other bleeding. The letter further alleges that on the second visit the GP failed to record the patient's blood pressure and pulse rate to establish if she was haemodynamically stable and also failed in not referring Ms P for an emergency ultrasound scan. This in turn led to a significant delay in diagnosis, leaving surgery as the only viable treatment option.

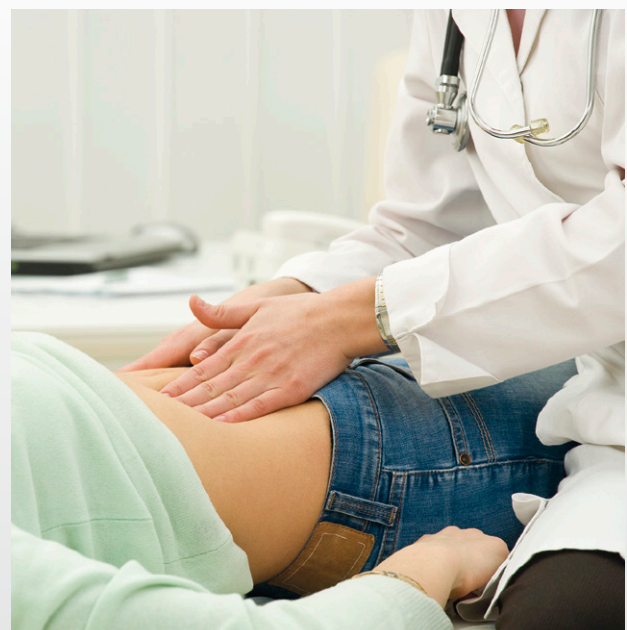
**ANALYSIS/OUTCOME:** MDDUS assesses the case against Dr R and commissions expert reports from a primary care physician and a specialist in obstetrics and gynaecology. The primary care expert is somewhat critical of the GP's failure at the first consultation to record a menstrual history and the date of last period. In regard to the second consultation he is of the opinion that it was not unreasonable for Dr R to judge that the intermittent and radiating pain reported by the patient was a continuation of that previously reported as it was atypical of ectopic pregnancy. But he is critical of the GP in not recording a BP and pulse and referring the patient for an ultrasound, most likely for a suspected miscarriage.

The O&G expert is of the opinion that a scan carried out at this stage would have shown the lack of intrauterine gestation sac, with serum HCG level testing confirming a probable ectopic pregnancy and allowing the option of non-surgical treatment with methotrexate.

Given the vulnerabilities in defending the case, MDDUS, in agreement with the member, negotiates a settlement.

### KEY POINTS

- Ensure that examination findings are recorded in the notes.
- Have a low index of suspicion for ectopic pregnancy in women of reproductive age presenting with unilateral iliac fossa pain.





## PRESCRIBING REASONABLE TREATMENT GOAL

**BACKGROUND:** Mr T is 38 years old and has a history of temazepam addiction. He attends his local GP surgery for substitute doses of diazepam but has yet to consult with staff from the substance misuse team (SMT), despite repeated requests and missed appointments. One of the doctors contacts MDDUS for advice on a draft letter informing Mr T that the practice will discontinue providing diazepam prescriptions unless he makes and keeps an appointment with the SMT.

**ANALYSIS/OUTCOME:** An MDDUS adviser reviews the draft letter and advises the GP to first highlight the importance of the matter and urge Mr T to read it carefully. It must then state clearly that the treatment goal is to gradually reduce the substitute medication under supervision from the SMT – and without consultation with the team there will be little alternative but to discontinue issuing the prescription for diazepam. The letter should then urge Mr T to make and keep an appointment for his own benefit.

Further action should be discussed among the team to ensure

it is clinically justified and this reasoning should be recorded in the patient notes.

### KEY POINTS

- Ensure that any decision to deny access to medication is clinically justifiable (see GMC prescribing guidance).
- Keep clear records of the reasoning behind such decisions.
- Make all reasonable efforts to encourage the patient to re-attend for discussion.



## CONSENT A HIGH SMILE

**BACKGROUND:** Ms G is dissatisfied with her “gummy” smile and consults with a private dental surgeon – Dr B. On examination the dentist notes a high smile line with the upper lip approximately 3mm above gingival margins. Dr B advises the patient that a crown lengthening procedure on the upper eight front teeth followed by the provision of porcelain veneers would remedy the condition.

The dentist takes impressions for study models and Ms G re-attends the surgery for a discussion of the wax-up. The patient agrees to the procedure which is carried out one month later. A full thickness buccal flap is reflected and gum and bone tissue removed. Mattress sutures are applied interproximally. The patient later reports significant pain and an inability to eat for days after the procedure.

Three months later veneers are fitted and Ms G continues to suffer upper quadrant pain with inflammation and bleeding, along with food packing in her gums. She attends Dr B for numerous reviews and subsequently undergoes a gingivectomy in order to alleviate the chronic inflammation.

Ms G then consults another dentist for a second opinion and is referred to a periodontal specialist for ongoing treatment.

A year later Dr B receives a letter of claim for clinical negligence in his treatment of Ms G. It is alleged that the dentist failed to inform the patient of the benefit-versus-risk of the crown lengthening procedure and the later gingivectomy; nor did he carry out these procedures to accepted standards or refer Ms G for specialist treatment and advice when clinically indicated. This has resulted in ongoing pain and suffering along with eating difficulties.

**ANALYSIS/OUTCOME:** MDDUS instructs an expert in dental surgery to provide an opinion on the case. The expert assesses

the clinical notes and all associated papers along with clinical photographs and the wax-up models. In the opinion he is critical of Dr B on a number of counts. He believes the records do not demonstrate adequate discussion of the crown lengthening procedure with the patient – including the risks-versus-benefits.

The expert notes on the clinical photographs that Ms G has a very high smile line and it is debatable if the procedure as planned would have remedied her tooth-gum junction being visible. A wax-up in itself is not particularly helpful as the lip line cannot be assessed. It also did not show the extent of preparations carried out in the procedure which were quite “invasive” in terms of tooth volume removed and thus it is questionable whether consent was fully informed.

In his report the expert also contends that the use of composite provisional veneers would have allowed Ms G to see possible improvement with no or minimal preparation of the teeth. The need for gingivectomy is also questioned as there was nothing in the records to show Ms G had increased pocket depths or the need for papillae width reduction. The expert believes the bleeding and inflammation were more likely due to inadequate plaque control and gingival irritation along the veneer margins.

In view of these vulnerabilities in any potential defence MDDUS solicitors in agreement with Dr B settle the case with no admission of liability.

### KEY POINTS

- Record discussions of risks-versus-benefits with any procedure to ensure informed consent.
- Treatment decisions should be justified in the notes.
- Ensure consent is an ongoing process.

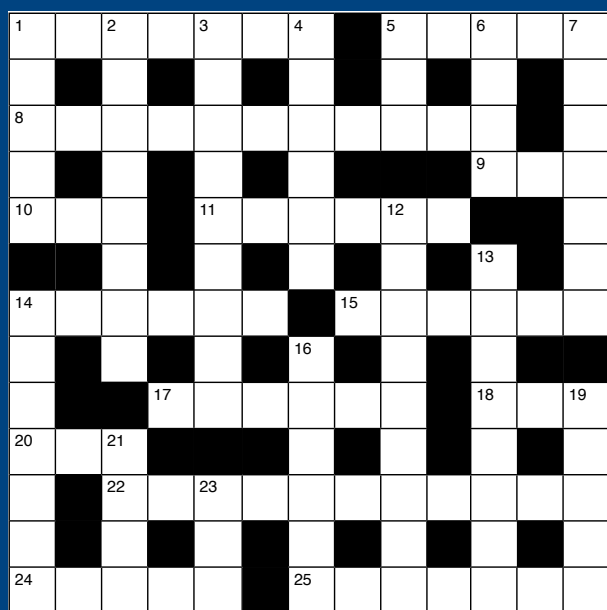




## Object obscura: Pomander

THIS eight-sectioned spherical pomander of gold and silver was used to carry fragrant scented petals and herbs with the aim of freshening the air and preventing disease. Some of the segments are inscribed with the name of the contents: 'Rosen, Ruten, Moscat, Canel and Rosmarin'. Date unknown but probably 15th or 16th century.

### Crossword



#### ACROSS

- 1 Instructed (7)  
5 South Asian country (5)  
8 Surroundings (11)  
9 Everything (3)  
10 The second number (3)  
11 Cope (6)  
14 Principles (6)  
15 Territorial division (6)  
17 Pay no regard to (6)  
18 Organ of hearing (3)  
20 Emulsion into which crudités are plunged (3)  
22 Medical oath (11)  
24 Voluminous (5)  
25 Sets down in writing (7)

#### DOWN

- 1 Cure (5)  
2 Pulmonary \_\_\_\_\_, terminal  
3 end of the respiratory tree (8)  
4 Location of post-WW2 trials (9)  
5 Eating out (6)  
6 Frozen water (3)  
7 Robotic character in Star Trek TNG (4)  
8 What patient-complainers seek (7)  
9 Decorated with regular lines or shapes (9)  
10 Like Logie-Baird or Alexander Graham Bell? (8)  
11 "New" medical duty (7)  
12 Hue (6)  
13 Frameworks for storing items (5)  
14 Parliamentary health complaints body (abbr.) (4)  
15 Variety of lentil (3)

See answers online at:

[www.mddus.com/news/notice-board](http://www.mddus.com/news/notice-board)

## Book review

### When breath becomes air

By Paul Kalanithi

Vintage, £8.99 paperback

Review by Greg Dollman, medical adviser, MDDUS

PAUL Kalanithi died from metastatic lung cancer, aged 37, and in this book, published posthumously, he asks: "What makes human life meaningful?" It is a deeply moving story of the boldness of the human spirit, limited by the frailty of our bodies.

Life and death were concepts Paul encountered on a daily basis as a doctor – and they had consumed his thoughts for years before he ventured into medicine. When his studies in literature and philosophy at Stanford and Cambridge failed to provide the answers he sought, he immersed himself in medicine. Then, only months away from completing his neurosurgery residency, Paul faced a different form of death: his own.

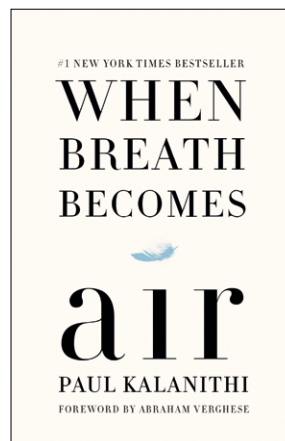
It was in medicine that Paul found "the messiness and weight of real human life" that were lacking in literature, morality and the formal ethics of analytical philosophy. He also pondered religion as his cancer took hold. In the end, he concludes that "no system of thought can contain the fullness of human experience". For Paul, life is a mixture of science and art, a personal journey that must be lived fully to be understood.

Paul tells of life with his high-achieving family and his wife Lucy and his daughter Cady, born eight months before his death. His story is real, warts and all, rather than some abstract contemplation of what life should be. Lucy, in her epilogue, describes Paul's cancer diagnosis as a nut cracker, which revealed the true interior of a facade hardened by life (and life as a doctor).

Paul recalls his journey through medical school to his final graduation, acknowledging his human failings – he remembers wishing a Cheyne-Stoking patient would die so that he could return to bed on a week-long set of on-call shifts, and rescuing a melting ice-cream sandwich from the warm resuscitation bay where a family congregated around their just-dead relative. This was real life (of a doctor with the best intentions), intermingled with death.

After his diagnosis, Paul wryly accepts that he has been given the ultimate opportunity to better understand the particularities of death. He chose his neurosurgery career "in part, to pursue death: to grasp it, uncloak it, and see it eye-to-eye, unblinking." In the epilogue, Lucy gives a raw and personal description of Paul's final moments: "I asked him whether he needed more morphine, and he nodded yes, his eyes closed".

This is a very human story of life and death, which challenges patients and doctors alike to consider the impact they have on each other. Beautifully written, the message is simple yet exceptionally powerful.



## Vignette: Neurosurgeon and polymath Sir Victor A H Horsley (1857-1916)

VICTOR Horsley was a bold and inventive neurosurgeon. In 1908 he developed along with Robert Henry Clarke a revolutionary stereotactic frame. The Horsley-Clarke apparatus located fine points within the skull and brain using geometric measurements. His work at the Brown Institute contributed to the surgical and medical treatment of thyroid disease and he was also partly responsible for the eradication of rabies from England. In addition he was an energetic and aggressive medical political reformer, sometimes blunt and offensive to colleagues but gracious to his patients.

Victor Horsley grew up in a prosperous, artistic and musical family in Kensington. Naturally left-handed he became ambidextrous, an asset for a surgeon. He was educated at Cranbrook School as a day boy and developed his own strong views. He was firmly against tobacco and alcohol and observed that women were as capable as men and later supported many causes including franchise and registration of nurses. He was at ease in French and later learned German and published in both languages.

At University College London he studied medicine and won the Gold Medal for anatomy, then first class in physiology. He experimented on himself with ether, chloroform and nitrous oxide, carefully observing the sequential effects of the drugs on the brain and nervous system. By 1881 he had qualified as a scholar and held the Gold Medal in Surgery. After graduation he spent a year in Germany and was awarded FRCS in 1883.

Between 1884 and 1890 Horsley was superintendent of the Brown Institute, initially founded as a laboratory and hospital for veterinary purposes but also the home of human and experimental pathology. As such it was subject to legal regulation but Horsley was later attacked by anti-vivisectionists. With others, Horsley expanded understanding of the brain and spinal cord, respiratory rhythm, circulation through the carotids, as well as the effects of gunshots and many other topics. After 1890 he was made Professor



of Pathology at UCL and started a novel course of pathological chemistry.

As a student he had worked with many pioneers of neurology at the National Hospital Queen Square. In 1886 he was awarded FRS and was given the first appointment of a surgeon there. At that time, Louis Pasteur was doing exciting work in Paris on rabbits to diagnose and prevent rabies. Victor, a fluent French speaker, went to study and to work with the great man, and was given a sample of rabid spinal cord for animal studies in England. That and the pursuit of muzzling of dogs and quarantine of animals eradicated rabies from the UK.

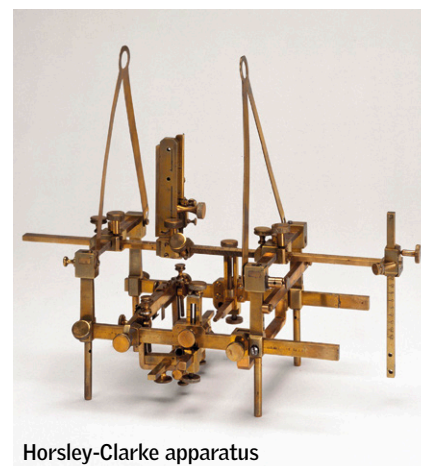
Returning to surgical work he located the focus of epileptic fits and cured the patient by removing the scar. "Bold when sure" he performed complex operations including thyroid cases and removal of tumours and even some daring laminectomies and surgical procedures for trigeminal neuralgia. In 1902 he was made Professor of Surgery at University College Hospital and the same year he was knighted.

Horsley also found time to question and reform the Medical Defence Union (MDU), BMA and GMC. He considered that the recognition of those suitably qualified to practice should be decided by the GMC and not the MDU. At the BMA he chaired reform of its constitution, leading to a large increase in membership. He promoted public health reform, medical inspection and treatment of school children and the state registration of nurses. He formed policy for coroners and death regulation. In his passion for causes he was often careless of offending opponents.

He was an RAMC captain at the outbreak of war and in 1915 was appointed surgeon to the Mediterranean Expeditionary Force in Egypt, then volunteered to go to Mesopotamia where hospitals were ill-equipped. He describes this in a letter to a colleague: "It is very difficult out here some hundred miles up the Tigris on a burning mud flat in the middle of cholera, dysentery, diarrhoea etc etc..." At Amerah he succumbed to heat stroke and died the next day at Rawal Pindi Hospital aged only 59.

He had married Eldred Bramwell in 1887 and they forged a happy family life with three children and found time for family holidays.

■ *Julia Merrick is a freelance writer and editor*



Horsley-Clarke apparatus





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