

AUTUMN 2016

# SUMMONS

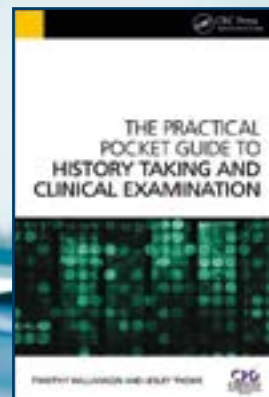
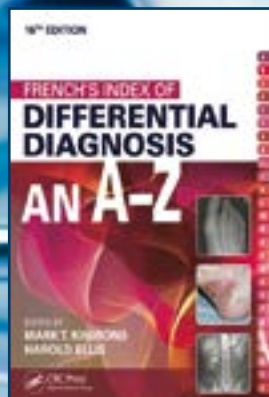
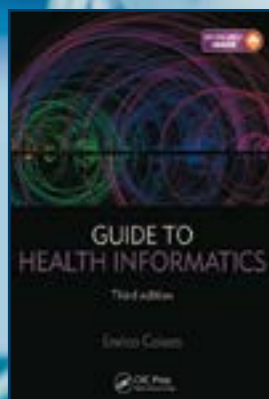
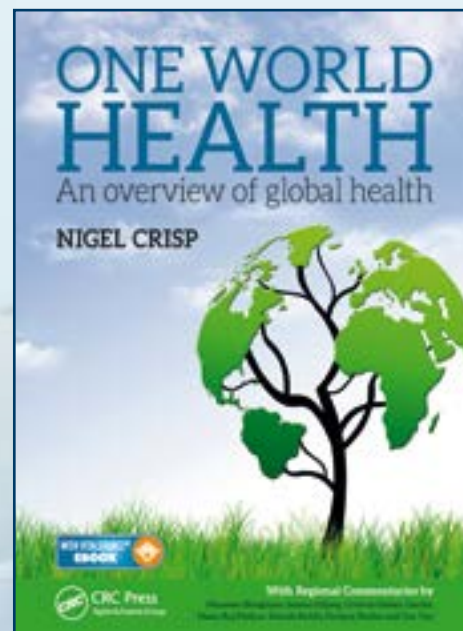
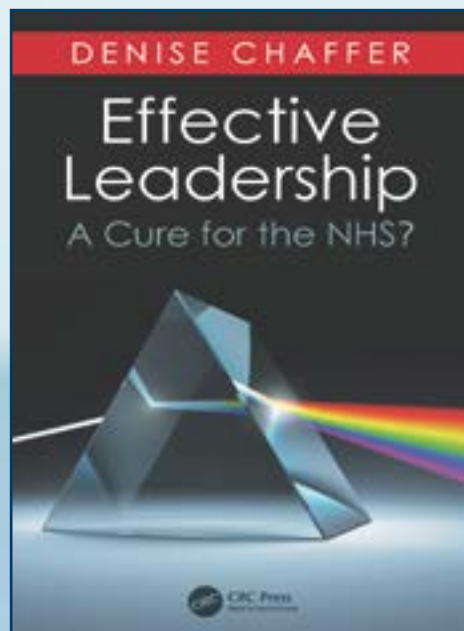
AN  PUBLICATION FOR MEMBERS



• Changing Faces • Refusing treatment • Managing the fearful child •

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## FROM THE EDITOR

judging by the number of recent articles in the medical and lay press which have voiced alarm. And yet 85 per cent of patients in a 2016 Ipsos MORI survey described their experience in general practice as 'good' or 'very good' – it is clearly a service that the public values and trusts, and it lies at the heart of the NHS.

In this issue, Professor Maureen Baker, outgoing Chair of the RCGP, provides her views on the challenges faced in funding, workforce planning and workload. She discusses the highs and lows of her tenure as Chair and her hopes that the new *GP Forward View* sets out a successful strategy to tackle the difficulties (p. 10).

Acute eye presentations can be problematic for non-specialists, and consultant ophthalmologist Dr Mark Wright's

THERE is widespread concern that general practice in the UK has reached crisis point,

article on page 16 introduces the use of algorithms in order to improve diagnostic accuracy in this field. Also in this edition, medical adviser Dr Greg Dollman reviews the difficult ethical and legal position when a patient refuses treatment (p. 12).

The rising cost of claims is a concern to all those involved in medical defence work, and in this issue, risk adviser Cherryl Adams reports on the types of claims that tend to be most costly (p. 8).

Adam Campbell describes the inspiring and invaluable work of the charity Changing Faces, which supports patients with disfigurement (p. 14), and Deborah Bowman presents some thought-provoking insights into the ethics of judgement (p. 9).

A fearful child in the dentist chair is a situation most dentists dread. On page 18, paediatric dentist Fiona Hogg provides some useful practical advice on dealing with dental phobia in children.

Dr Barry Parker



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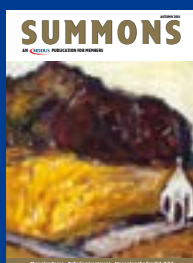
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Cover image: *Sheepcraig, Fair Isle*, Hazel Walker. Oil on paper, 1991

Hazel Walker, born near Aberdeen in 1963, studied at Edinburgh College of Art between 1981 and 1985. This colourful, almost abstract study of Sheep Rock or Sheep Craig has a dream-like nature, unlike her other landscapes which are often bleak and eerie.

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## Discounted legal advice on business matters

MDDUS has announced a new partnership with law firm Capsticks Solicitors LLP to support GP and practice manager members in England and Wales. Capsticks will provide a host of benefits including up to 20 minutes of free business and corporate legal advice, as well as access to a full range of practice and business legal services at specially discounted rates.

MDDUS Director of Development David

Sturgeon said: "Our members already have access to expert medico-legal advice from our team of highly-skilled advisers and lawyers. We are delighted to work alongside Capsticks to ensure that our members' needs will be enhanced further with access to advice on non-indemnity issues."

GPs and practice managers will be able to call on Capsticks to provide discounted legal assistance on issues such as property advice, practice mergers and acquisitions, partnership agreements and disputes, and

primary care contracts. MDDUS members can also get advice in relation to CQC inspections and health and safety issues.

Sam Hopkins, Capsticks partner and head of the firm's GP legal support team, commented: "We are very excited to be working in partnership with MDDUS and look forward to supporting their GP and practice manager members with their non-indemnity legal issues during what is a particularly challenging time."

Find out more in the Advice & Support section of [mddus.com](http://mddus.com)

## Treating transgender patients

TRANSGENDER people and those with gender incongruence could make up to 1 per cent of patients. It is well understood that these patients have complex healthcare needs, including a greater incidence of depression and risk of suicide. Access to appropriate healthcare is compounded by long waiting times to see specialists for gender reassignment treatment.

In March of this year, the GMC published new advice to help doctors support transgender patients. It is based on core guidance from *Good Medical Practice* and is also informed by relevant legislation including the Equality Act 2010. The advice followed publication of a report on transgender equality by the House of Commons Women and Equalities Committee. The report said doctors and other health professionals often lacked an understanding of how to provide effective care for transgender patients, including referring pathways and their own roles in prescribing treatment.

MDDUS has certainly seen an increase in calls from members seeking advice and guidance when treating people with gender dysphoria, and they are often concerned about delays in accessing appropriate specialist help. Many doctors have and will have transgender persons as patients but few doctors are well equipped to deal with the issues that arise. Currently medical training does not produce doctors skilled in transgender health.

There are specific risks associated with meeting the healthcare needs of transgender persons and two areas in particular are:

- Patients who self-medicate from unregulated sources.
- The risk of self-harm due to the inherent increased risk in this group,

along with the added effect of delays in accessing appropriate care.

In relation to the first point, patients may seek bridging prescriptions until they are seen by a specialist. In these circumstances, GPs may feel out of their depth and worry that they risk acting outside their level of competence and expertise. Regarding the second point, any patient with significant mental health issues may need referral to appropriate mental health services.

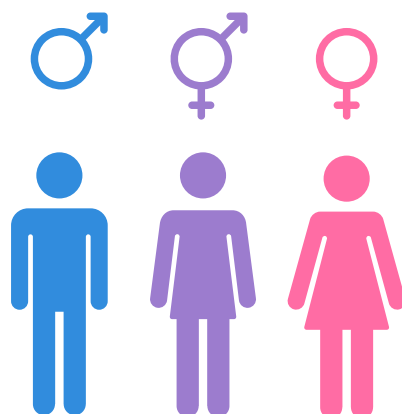
It is helpful that the GMC has entered the discussion, when many doctors who are not specialists in this field have questions about their roles and responsibilities. The GMC reminds all doctors that in relation to transgender patients:

"Do your best to understand your patient's views and preferences and the adverse outcomes they are most concerned about. It may well be that the risk to your patient of continuing to self-medicate with hormones is greater than the risk to them if you initiate hormone therapy before they're assessed by a specialist."

In regard to bridging prescriptions, a matter which generates a significant proportion of calls to MDDUS, the GMC has issued specific guidance (go to <http://tinyurl.com/grugw8z>).

It is important that all doctors dealing with the health issues of patients with gender dysphoria understand and follow the regulator's advice. The GMC guidance also provides useful links, including an e-learning module produced by the Royal College of General Practitioners and the Gender Identity Research and Education Society (GIRES).

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



## IN BRIEF

### • DENTAL TRAINING DAY

MDDUS will be running another dental training day on 20 September 2016 in Glasgow. Dental adviser Aubrey Craig will headline a varied group of expert speakers discussing key dento-legal

issues. Attendees can earn 5.5 hours of CPD accredited by NHS Education Scotland. Find out more at [risk@mddus.com](mailto:risk@mddus.com)

### • CALLING ALL GPST GROUPS

Apply for a personalised webinar by the risk education team at

MDDUS. Workshops for groups of up to 50 GPST members are being offered in which participants can ask questions, share experiences and take part in polls offering valuable instant feedback. Sessions can be arranged to suit your group.

Popular topics include managing complaints, avoiding missed diagnoses and prescribing risks. Email [risk@mddus.com](mailto:risk@mddus.com)

• **MDDUS PODCASTS** Our risk team has produced a series of five podcasts based on the fictitious

## ➔ MDDUS response to Brexit

MDDUS Chief Executive Chris Kenny has commented on the referendum vote to leave the European Union.

"MDDUS is monitoring the potential impact of the referendum outcome closely. Our members' needs do not change at all as a result of the vote. We're still here to give you a professional, responsive and great value service. And that applies just as much to those members from other EU jurisdictions as it does to those coming from the four countries of the UK.

"However, we face a tougher economic climate going forward, which we will need to manage alongside the continued pressure on subscriptions from growing claims numbers and regulatory activity. We will continue to manage our resources carefully to protect the mutual fund and our services. We have the advantage of well-diversified resources, and the fact that we do operate only in the UK is also helpful.

"We are continuing to work with both UK and Scottish Government to press them to make sure that current initiatives do not undermine the business model of MDOs which have delivered the optimum protection for both patients and professionals alike in the long-term."



## ➔ NHS England pledges action on indemnity costs

NHS England has pledged funding to offset the rising cost of GP indemnity as part of new implementation plans set out in its *General Practice Forward View*.

A new Indemnity Support Scheme will be introduced in April 2017 providing a financial contribution to practices in England to alleviate "exposure to indemnity inflation in scheduled work". NHS England will provide an additional payment to each practice based on calculated estimates of the average annual inflationary increase in indemnity costs faced by GPs.

In its review on GP indemnity, NHS England states: "This amount will then be distributed amongst practices based on their list size, not on weighted capitation."

Payments will be made in April 2017

and April 2018, and the scheme will then be reviewed.

NHS England says that by basing payments for practices on the list size, the scheme will include provision for the additional indemnity premiums faced by all GPs at the practice as well as partners. GP practices will be expected to provide an appropriate share of their payment to their salaried GPs and locum GPs.

The review concludes that longer-term action is necessary to address the root causes of rising indemnity costs. It states that the Department of Health will begin an urgent piece of work to identify effective ways of addressing these causes and will continue with efforts to cap the amount legal firms can recover in clinical negligence cases.

Following the announcement, MDDUS Chief Executive Chris Kenny commented:

"We welcome the fact that the government and NHS England have found the indemnity market to be efficient and competitive. They have not reached for naive solutions with unpredictable effects in the long-term and should not be tempted to do so in the future.

"We welcome the measures to relieve immediate pressures. It is now vital to address causes, not just symptoms. So we urge the government to make rapid headway on the tort reform and recoverable costs agenda to build sustainability.

"We will continue to work with the profession and the NHS to ensure that indemnity keeps up-to-date with the needs of a changing service. We look forward to working actively with government and NHS England on the further actions detailed in the review."

case of Mrs Roberts, a 51-year-old patient diagnosed with breast cancer. Each focuses on a specific development in the case: the initial complaint handling, SEA, a clinical negligence claim and GMC investigation – with commentary

and discussion. The podcasts can be accessed in the e-learning centre of the Risk Management section at [mddus.com](http://mddus.com)  
**● 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. It is important that GPs maintain alternative indemnity arrangements until MDDUS membership is confirmed.



## Sharp rise in negligence payouts by NHS

COMPENSATION payouts and legal costs for clinical negligence covered by the NHS in England increased by more than a quarter last year, reaching almost £1.5 billion.

New figures from the NHS Litigation Authority (NHS LA) show that in 2015/16 total payments relating to their clinical schemes increased by £319 million (27 per cent) – from £1,169.5 million to £1,488.5 million.

While new clinical negligence claims in 2015/16 fell in number by almost five per cent to just under 11,000, damages paid to patients jumped 23 per cent from £774 million to more than £950 million. Claimants' legal costs saw another big increase – rising by 43 per cent, from £292 million in 2014/15 to £418 million last year.

The report said that clinical negligence costs remained a key issue last year, with contributors to the scheme (mainly NHS providers) seeing contributions to settle claims rise by 35 per cent in 2015/16, with a further increase of 17 per cent in 2016/17.

Commenting on the report, NHS LA Chief Executive Helen Vernon said: "The key to reducing the growing costs of claims is learning from what goes wrong and supporting changes to prevent harm in the first place.

"We want to reduce the need for expensive litigation. This means increasing the use of mediation in the NHS, early transparency, saying 'sorry' and demonstrating that lessons have been learned to prevent the incident happening again."



## Dentists "must apologise" when care goes wrong

DENTISTS must tell patients when something has gone wrong with their care and apologise, according to new guidance



## Treat sepsis as "urgently as heart attack"

PATIENTS showing signs of sepsis should be treated with the same urgency as those with suspected heart attacks, according to new NICE guidance.

The guidance advises NHS health professionals that they should think about the possibility of sepsis in all patients who may have an infection because "sepsis can affect anyone at any time". It acknowledges the difficulty in diagnosing sepsis as symptoms can

vary from person to person. These can range from a high temperature, to fast heartbeat to a fever or chills.

Sepsis can often be mistaken for common infections like flu. Quick identification and early treatment are key. Doctors are urged to start asking "could this be sepsis?" earlier on "so they rule it out or get people on treatment as soon as possible".

The UK Sepsis Trust estimates there are around 150,000 cases in the UK every year, causing 44,000 deaths annually. A report published last year found that in more than a third of cases (36 per cent) there were delays in identifying sepsis and many hospitals had no formal protocols in place to recognise it.

Professor Mark Baker, director of the NICE Centre for Guidelines, said: "When hospitals are well prepared, clinicians do better at responding to patients with sepsis. If there is any delay in spotting the signs we will fail patients by leaving them with debilitating problems, or in the worst cases people will die."

Access the new guidance at [www.nice.org.uk/guidance/NG51](http://www.nice.org.uk/guidance/NG51)

from the General Dental Council.

Clinicians are also required, where possible, to "put matters right" and explain the short and long-term effects of what has happened.

These requirements are set out in the regulator's new guidance on the professional duty of candour, *Being open and honest with patients when something goes wrong*, which came into effect on July 1.

The new guidance makes it clear that "candour means being open and honest with all patients, whether they have made a complaint or not". It sets out the ways in which dentists must demonstrate this, beginning before treatment is even carried out. It describes what to do when things go wrong, when and how to tell the patient and apologise.

The requirement to offer an apology has

been criticised by the British Society of Dental Hygiene and Therapy (BSDHT) which commented: "being forced to apologise, potentially a legal admission of fault, positions the clinician in professional jeopardy".

But the GDC guidance reassures clinicians, saying: "Apologising to the patient is not the same as admitting legal liability for what happened. This is set out in legislation in parts of the UK and the NHS Litigation Authority also advises that saying sorry is the right thing to do. You should not withhold an apology because you think that it might cause problems later."



## GMC to revamp medical register

DOCTORS' photos and more detailed

## IN BRIEF

### ● INCREASED MOUTH CANCER RISK WITH HCV INFECTION

Patients infected with the Hepatitis C virus (HCV) are at a greater risk of developing mouth cancer, according to new research published in the *Journal*

*of the National Cancer Institute*. Researchers in Texas found that patients with HCV seropositivity were more than twice as likely to develop either cancers in the mouth cavity or of the oropharynx. Extra vigilance is urged.

### ● ETHNICITY STILL A FACTOR

New research from the GMC has found that white UK medical graduates remain more likely to pass specialty exams than their black and minority ethnic (BME) counterparts. The report found

that the average exam pass rate for all UK medical graduates is 71 per cent but rises to 75.8 per cent among white graduates and falls to 63.2 per cent for UK BME medical graduates. Pass rates for international medical graduates

information about current job status could be included in the online medical register under new proposals from the General Medical Council.

A consultation has been launched into plans to modernise the publicly-available register which has remained largely unchanged since it was created more than 150 years ago.

The register currently lists every doctor who is licensed to practise in the UK and was searched nearly seven million times last year. It includes each doctor's name, GMC reference number, gender, year of qualification, whether they are on the specialist register and their registration status.

But the GMC believes the register says little about a doctor's actual practice and often contains out-of-date information. They are consulting on ways to improve it while also safeguarding doctors' privacy.

They recommend moving to a "two tier" approach, with tier 1 covering information that must be provided by law, including all the information currently on the register. Tier 2 would be additional information to be supplied and maintained voluntarily by the registrant. The GMC suggests this could include a registrant photo, languages spoken, higher qualifications, scope of practice and a link to the website of their place of work.

The GMC said tier 2 data would provide "a much richer description of a doctor's professional life than is currently possible", but acknowledged that this approach could lead to inconsistency in the information available as doctors could choose not to provide it.

This additional data would not be routinely verified by the GMC before being published on the register, but sample audits would be carried out to check for accuracy.

The consultation is open until early October and can be found on the GMC website.

## ➔ Dental neglect a problem in care homes

MORE than half of older adults living in care homes have tooth decay compared to 40 per cent of over-75s and 33 per cent of over-85s not in care homes, according to NICE.

New NICE guidance is calling for dental health in residential care to be given the same priority as general medical care.

It is estimated there are more than 400,000 adults living in UK care homes, 80 per cent of whom have some form of dementia. Older adults in care homes are more likely to have fewer natural teeth with resulting difficulty in eating and socialising without embarrassment.

The new guidance recommends greater focus on improving and maintaining day-to-day oral healthcare among residents and ensuring there is adequate access to dental services. All residents should have an oral health assessment as part of their personal care plan.

Staff should be competent to perform routine daily mouth care for those who may not be able to do this for themselves, including brushing natural teeth with fluoride toothpaste twice a day, daily oral care for full or partial dentures and daily use of mouth care products prescribed by dental clinicians.

Professor Elizabeth Kay, Foundation Dean of Peninsula Dental School, Plymouth University, said: "Everyone should be able to speak, smile and eat comfortably, but all too often this is jeopardised by poor oral health which can have a significant negative effect on a person's wellbeing and quality of life.

"Awareness of oral health needs to be raised within care homes and we want to see more staff given training about what they can do to help."

Access the guidance at [www.nice.org.uk/guidance/ng48](http://www.nice.org.uk/guidance/ng48)



(IMGs) – those doctors who qualified outside the UK and EEA – are 41.4 per cent.

● **NEW CAPACITY AND CONSENT TOOL** A new interactive mental capacity decision-support tool has been

launched by the GMC. It can be used across the UK and includes a case study at each stage of the decision-making process to show how GMC guidance applies to the clinical situations doctors may face. Access at [www.gmc-org.uk](http://www.gmc-org.uk).

● **NO ADDRESSES ON GDC REGISTER** Location details of dental professionals will be removed from the GDC register. The decision follows a public consultation which received responses from over 2,500 people.

The registration number will become the primary identifier sometime after October of this year on formal approval of the change. The full consultation response will be published shortly on the GMC website.

## PAYING A HIGH PRICE

Cherryl Adams

A QUICK look at MDDUS files reveals that there are hundreds of active cases being managed by our advisory and legal teams at any one time. The causes vary widely and the estimated costs of resolving each one can range from as little as £100 to more than £5,000,000.

While so-called "high value claims" are mercifully rare, they can have an enormous impact on the lives of all involved.

### Causes and outcomes

Failure to diagnose a condition or refer for investigation of symptoms are the most common causes of negligence claims, with over two-thirds of MDDUS cases falling into these categories. Further analysis demonstrates that high-value claims often share causal similarities to lower value ones. The systemic or human factor issues which contribute to the alleged failures in these cases can be the same – it is in the outcome and impact on the patient that they differ. For example, failure to refer someone for investigation of symptoms which ultimately are diagnosed as chronic migraine has a very different outcome to a missed brain tumour.

### Missed and delayed diagnosis

Missed or delayed diagnosis, resulting in late treatment and subsequent life-changing sequelae, are a particular feature of this group of claims. More than a third (38 per cent) of our current high-value claims feature conditions which have resulted in brain injury (e.g. meningitis, hydrocephalus, stroke and tumour), while 29 per cent feature conditions resulting in spinal injury (e.g. cauda equina syndrome, tumour and undiagnosed fracture). Cauda equina syndrome appears relatively frequently within spinal injury claims, making up 12 per cent of our current total of high-value claims. Similarly, delayed diagnosis of cancers of any type sits at around 11 per cent of the total.

Particular themes have emerged from our analysis of high-value claims and it is useful to note common failings include inadequate examination and/or

consideration of symptoms, poor communication, failure to recognise or act upon red flags, and lack of adherence to available guidelines. Systemic factors also feature and include issues such as poor record keeping and failures in the results handling process.

### Meningitis and meningococcal disease

Meningitis is often a difficult condition to diagnose in the early stages, with symptoms often resembling common viral illnesses like flu. Of our cases involving patients with meningitis and meningococcal disease, almost 60 per cent involve contacts made with clinicians in the out-of-hours setting and more than 70 per cent feature children under three years old.

A typical scenario involves a parent or carer seeking advice via telephone consultation and the clinician then failing to pick up on reported red flag symptoms. A repeated factor in cases involving young children is the clinician attributing symptoms to seasonal viral illnesses (something that's "going round"), even when the presenting symptoms do not quite fit the picture of that seasonal illness. This advice can provide false reassurance to patients and carers, who may potentially delay seeking further advice even when the illness appears to progress or change.

### Cauda equina syndrome

Missed or delayed diagnosis of cauda equina syndrome is the most common single condition featuring in large claims. Again, this condition often presents with commonly encountered symptoms suggestive of less serious disease.

Particular features in these cases include multiple consultations with

increasing and changing symptoms, despite analgesic therapy and/or physiotherapy. Again, lack of recognition or appreciation of red flag symptoms contribute to the adverse incident. In a number of these cases, even where the patient indicates symptoms of saddle anaesthesia – a clear red flag – the clinician does not act upon this information. Other common features include inadequate safety netting and a failure to communicate the need to seek urgent emergency treatment should symptoms worsen.

### Key learning points

The main factor that distinguishes a high-value claim from one of lower value is the severity of injury sustained and the life-changing consequences for the patient. But closer analysis reveals a number of factors common to both types of claim that provide valuable learning points. In terms of systems, MDDUS has found that comprehensive record keeping together with effective results handling and prescribing systems are key to minimising clinical risk. On an individual level, it is invaluable to ensure skills and knowledge are up-to-date, to use effective two-way communication (in particular listening skills), and to widen the scope of diagnosis in the presence of indicators that support doing so.

- Access a wide range of practical learning resources, including videos, interactive modules, checklists, webinars and articles, in the Risk Management section of [www.mddus.com](http://www.mddus.com)

■ *Cherryl Adams is a risk adviser at MDDUS*



## A MATTER OF JUDGEMENT

*Deborah Bowman*

**IN** these most tumultuous of times, the concept of judgement has been much on my mind. I make no comment on recent political events but, as I listened with increasingly wide eyes to the latest twist in an epic saga of tribalism and ambition, the theme of judgement has recurred.

Judgement is integral to healthcare practice. No matter how much medical students might wish it were otherwise, clinical practice cannot be definitively captured by a list of learning objectives, however enormous and far-reaching. On qualification, the messy and ambiguous realities of clinical practice can be startling and discomforting. The place of judgement quickly becomes apparent, even to those who have denied and resisted it as undergraduates. Yet judgement is itself a layered and complex concept which warrants further exploration.

Judgement is the essence of ethics. It resides in situations that are often contested and where there are multiple possible ways to proceed. Judgement is the tool of choice where discretion exists. Sociologists characterise the professions as occupational groups that self-regulate and enjoy discretion over specialist knowledge and expertise. Discretion is often concerned with the moral dimensions of care. Daily questions such as what constitutes sufficient information for a particular patient to make a meaningful choice and give consent or how to work with families who disagree about the best course of action for an incapacitated individual are ethical choices in which discretion is embedded.

Recognising these as questions of ethics, and therefore judgement, is important in itself: accepting that equally well-motivated and well-qualified individuals can reach different judgements. By acknowledging discretion, one also becomes aware of relative power in therapeutic relationships. The discretion often rests, albeit unarticulated, with the professional. Its implicit nature depends on differential knowledge and occurs in an environment where emotions are

unequally distributed. Openness about discretion, and therefore judgement, in clinical practice provides support to colleagues: it creates space for reflection and permission for discussion about difference. It allows for exploration of difficult features of clinical practice such as uncertainty and risk.

Judgement, or more accurately its absence or misdirection, is a concern in professionals. To show poor judgement is an indictment on someone's competence or suitability for a role. In recent weeks, politicians' careers have been derailed by that most damning of assessments: he or she lacks judgement or showed poor judgement in something said or done. What does this mean? If judgement is about discretion and is naturally required when a situation is contested or uncertain, does poor judgement or a lack of judgement mean anything other than someone has acted in a way that differs from that which we would have done?

There seem to me to be two examples that suggest that criticisms about absent or poor judgement are more than merely disagreements. The first example occurs when someone appears not to recognise that they are operating in the arena of discretion at all: situations in which individuals speak or act without appearing to notice that they are within the realm of judgement. It is an absence of care and of thought that matters most, not the decision or choice that an individual has made. The inability to recognise that judgement is required is, in itself, important; as is the capacity to demonstrate that one is making a choice in the context of discretion and with regard to those who may do differently.

The second example is when facts elide with values or preferences without acknowledgement, leading to claims that are overblown, excluding or unsustainable. We are all susceptible to mixing questions of knowledge with our values and preferences, especially when seeking to

persuade others. Statements about what constitutes 'futility' may be a composite of clinical information and experience coupled with beliefs about quality of life. What we choose to include, emphasise or omit when explaining treatment options may reflect, often unconscious, our own preferences and beliefs, perhaps particularly if we or someone we love have had similar experiences.

Even that which is represented as knowledge is underpinned by values to some extent: the research that is funded and the evidence of which care is predicated reflect the priorities and choices of organisations and individuals. That is inevitable, but judgement depends on recognising the limits of knowledge, the place of interpretation and being honest



about the implications of the same. Where facts and values collide without insight or openness, judgement may be impaired or even said to be absent.

Judgement then is unavoidable. Whether in referenda or the clinic, it is a necessary, challenging and significant part of the choices and decisions we take. The real risk with judgement is that we fail to recognise its importance: that we thoughtlessly place our cross, literally or metaphorically, in a box without realising that matters of judgement cast long shadows.

■ *Deborah Bowman is Professor of Clinical and Mental Health Ethics at The Tavistock and Portman NHS Foundation Trust*

# Taking a *forward* view

**I**N NOVEMBER of this year Professor Maureen Baker will step down after three testing years as Chair of the Royal College of General Practitioners, making way for her successor Dr Helen Stokes-Lampard.

Professor Baker worked for over 15 years as a GP in Lincoln and was Honorary Secretary of the RCGP from 1999 to 2009. In 2007 she joined NHS Connecting for Health (CfH) and was Clinical Director for Patient Safety at the Health and Social Care Information Centre. She has also held appointments with the National Patient Safety Agency, NHS Direct and the University of Nottingham.

She is originally from Scotland and studied medicine at the University of Dundee.

## **How have we come to the current state of “crisis” in general practice?**

I do think it's largely because of the consistent, repeated underfunding of the service over the last 10 years. There have been a variety of reasons for this. There was an abreaction following the 2004 contract where the press kept going on about GP pay and how GPs had done too well out of that – which in no way justifies not investing in the service adequately. Also I think there has always been this short-term reaction to the part of the system that makes the most noise. Generally over the last 10 years that's been the acute sector. Pressure on the acute sector becomes very visible with pictures of ambulances queuing outside A&E departments and patients made to wait many hours. What was happening in general practice wasn't hitting the headlines; so it wasn't picked up and addressed.

## **Do you think NHS England is on the right track with its *General Practice Forward View*?**

Yes. I do. I think it's a hugely ambitious

## *Summons speaks with Professor Maureen Baker about the challenges facing general practice and the highlights and frustrations of her time as Chair of the RCGP*

statement of confidence in the service of general practice and we were very pleased to welcome it. Is it enough? Well I hope so. I certainly hope it is enough to turn around the fortunes of general practice and the profession, and to be able to build on from there. I do think the direction is absolutely right in terms of addressing the fundamental issues of funding, workforce and workload.

## **Do you think there should be an equivalent *GP Forward View* in Scotland?**

I think there should be a plan to address these three key issues in every nation of the UK.

## **What do you think is the highest priority for the NHS in addressing recruitment in general practice?**

In England, I think the GP Workforce 10 Point Plan set us off in the right direction – looking to see what is working and how we can build on that. For instance, the financial incentives to recruit trainees into under-doctored areas: initial impressions suggest that this is having an effect. So if that works it might be extended. Recruitment roadshows are also important: spreading a positive message about general practice and helping to dispel some of the myths. In his foreword to the *GP Forward View*, Simon Stevens writes: “There is arguably no more important job in modern Britain than that of the family doctor”. Now

that's a hugely powerful statement coming from the head of the NHS. So I don't think it's any one initiative: it's putting them all together and applying them at the same time. The aggregation of marginal gains – the Team GB Cycling approach – is what we need to bolster the workforce.

## **Could the rise of primary care specialties help encourage more doctors into general practice?**

For me there is something very important about the expertise of the generalist. We talk about GPs as the expert medical generalist – the last bastion of clinical medicine. Where else in medicine are you making decisions based on your clinical skills, the patient history, doing something there and then without a panoply of other colleagues or the ability to get instant investigations? But generalists, almost by definition, have a wide range of interests. Therefore it is not at all surprising that people might like doing some of the things they learned in hospital and applying those in the community setting. For many people it's an added attraction. So, for example, people who like doing minor surgery can do that in general practice.

## **Considering the talk around mass resignations how can the government best retain the GPs it does have working in the NHS?**

Again, by addressing the fundamental issues of funding, workload and workforce. It has to be an enjoyable, worthwhile job and if it doesn't feel like that, people won't stay.

## **Do you think that GP induction and refresher schemes could be improved to boost GP numbers?**

They are much better than they were. But the one in England, which I'm most familiar with, still has a huge number of hoops to be jumped through. It's not very



"I think we always need to come back to GPs being hugely valued by the public"

well integrated and could be very much more streamlined, and I think we could support people through it much better. We are keeping the pressure on NHS England and HEE to try and do that.

**Do you worry that recruiting physician associates and similar initiatives to address GP shortages could undermine the profession?**

I do think there is a case for extending the workforce in general practice and for introducing additional skills; for instance, having practice-based pharmacists is a very good example of this. In terms of physician

associates in general practice, we're neutral. They have never really taken off in general practice and I'm not sure why that is. On the other hand, if practices feel that having a PA works for them and that they are valuable members of the team – that's great. Why would you stop that? But I think the jury is out in that we haven't yet had much experience of this role in general practice to determine whether it's useful or not.

**Are GPs misunderstood in general and more particularly by the media?**

I think we always need to come back to GPs being hugely valued by the public.

That is undoubtedly the case – the most highly valued public service by far. But we are also an easy target and certainly the media in recent years has really jumped on the GP-bashing bandwagon. No denying there are problems – one of the issues they get very agitated about is access and that is a legitimate problem. There is more demand than there is supply when it comes to GP appointments. I think recently the media have maybe started to realise that the issues around access are not because GPs aren't working flat out; it's just that there aren't enough of us.

**What is your take on Brexit and the implications for healthcare in the UK?**

Certainly the most immediate implications are on the wider NHS workforce – EU nationals who work with us in general practice or in the wider NHS or in nursing or care homes. The next thing I would say is economic stability. It's hard enough in the NHS without more economic difficulties and this will undoubtedly add more pressure on the NHS and general practice.

**What do you feel was the high point of your time as Chair?**

Publication of the *GP Forward View*. We've been campaigning for the best part of three years and this is the response to just about everything we have been asking for in our *Put patients first: Back general practice* campaign. It was a really important moment.

**What has caused you most frustration?**

It's very frustrating to get lots of grief for things you have no responsibility for or remit in. As an example, we get quite a lot of criticism when there are problems with pensions. We've got nothing to do with pensions; it's not our remit. It's nothing to do with patient care. That's just one example.

**What would be your one piece of advice to your successor in the job?**

It's a marathon not a sprint. The term is three years and you have to pace yourself and give time for things: work something up, sell the idea, get it rolled out, get it evaluated and start seeing it take root. You can't expect to change the world of general practice in three months, six months or a year.

■ Interview by Jim Killgore

# The right to choose

**A** MIDDLE-AGED patient is diagnosed with a recurrence of a cancer. The doctor explains the treatment options, including one rather taxing regimen with excellent clinical outcomes. The patient returns with a decision not to undergo any further treatment. He says: “Enough is enough. We all die eventually.”

A 28-year-old pregnant patient with placenta previa signs a directive refusing any blood products in accordance with her beliefs.

Doctors can find it difficult to accept when patients choose to refuse treatment; particularly when beneficial or potentially life-saving treatment is available. Such “inaction” can seem to run counter to the professional instinct to help someone in difficulty or suffering: the desire to preserve life or to avoid the perceived failure that comes with a patient’s death. Whatever the reason, the GMC reminds us that we must set aside our own beliefs when making the care of patients our primary concern.

Sometimes the law provides a solution to such dilemmas, particularly when a patient refusing treatment is assessed to lack the capacity to make such a decision. The Mental Capacity Act (MCA, England and Wales) and the Adults with Incapacity Act (AWIA, Scotland) both require that decisions about medical treatment are directed by a patient’s best interests – in other words what would be of overall benefit to that person, taking into account both clinical and non-clinical considerations. This may not be a straightforward decision in itself (or a foregone conclusion that treatment is in that person’s best interests), and a doctor may feel more comfortable with a team approach to decision-making rather than individually facing a patient refusing treatment.

## An absolute right to refuse treatment

But what about the more challenging scenario of a competent adult patient who refuses treatment? Firstly, case law clearly sets out the rights of patients and duties of doctors in this regard. While doctors are not obliged to provide a requested treatment which they believe, after appropriate assessment, is not clinically indicated or of overall benefit to the patient (notably in the case of *Burke v GMC*), they certainly are obliged to respect a competent person’s decision not to consent to treatment (considered in *Re MB (An Adult: Medical Treatment)*). In the latter case, the court held that such a person has

an “absolute right” to refuse medical treatment “for any reason, rational or irrational, or for no reason at all,” even where this choice may result in their death.

Secondly, statute in England and Wales entrenches the right of an individual to refuse treatment through an advance decision. Although the AWIA does not include a similar right for persons in Scotland, a valid and applicable advance directive (its terminology north of the border) is likely to be respected if challenged in court.

The MCA allows a person, aged 18 and over whilst still competent, to make an advance decision about the treatment and care that they wish for a time in the future when they may lack the capacity to consent to or refuse that treatment. Individuals can only make advance decisions to refuse treatment (rather than demand treatment) and cannot refuse in advance basic or essential care needed to keep them comfortable.

The MCA specifies very little formality in regard to the format of an advance decision, apart from when the decisions relate to life-sustaining treatment (these must be in writing and witnessed). All other decisions may be written or verbal, and a clinician may record a verbal advance decision in a patient’s medical notes.

## Good medical practice

When a patient refuses treatment, a practitioner may explore the reasons for this – as the patient allows – also considering if (and how) the patient’s physical comorbidity, mental health and social circumstances are affecting decision-making.

Communication remains crucial in such cases, and the GMC’s *Good Medical Practice* reminds doctors that they must give patients the information they want or need to know in a way they can understand, taking care



*A patient refusing treatment can present a difficult ethical dilemma. Medical adviser Dr Greg Dollman examines options and obligations in such cases*

not to make assumptions about the same. Doctors should involve others (healthcare professionals and those close to the patient) when breaking bad news (as far as is appropriate), ensuring that information is relayed in a balanced way.

GMC guidelines on *Consent: patients and doctors making decisions together* and *Treatment and care towards the end of life* provide helpful guidance to doctors facing difficult conversations with patients. A patient should be involved in all decision-making, as far as they choose, with the doctor-patient partnership based on openness, trust and good communication.

Doctors must consider the patient's views of their condition, as well as their needs and priorities, and should establish whether patients have understood the details they have been given and whether or not they require or wish more information prior to or after making a decision. Patients have the right to change their mind about a decision at any time, and doctors must keep them informed accordingly.

Doctors making recommendations about treatment options must be cautious not to sway inappropriately a patient's decision making. They must take care not to express personal beliefs in a

manner that may be seen to put pressure on the patient, cause distress or exploit their vulnerability.

The GMC reminds doctors to act within the scope of their competence, seeking expert review from a colleague when appropriate. Patients have a right to seek a second opinion should they have concerns about their care, and practitioners should remind them of this.

The GMC requires doctors to be insightful and to reflect on the various situations they encounter in their everyday

practice. Doctors should discuss complex clinical matters with colleagues, who may be able to assist them through what is potentially a distressing period for all parties involved.

### Conscientious objection

The GMC expects doctors to treat patients fairly and with respect, whatever their life choices and beliefs. The GMC does recognise, however, that doctors hold their own beliefs and values. Its supplementary guidance, *Personal beliefs and medical practice*, states that doctors may practise medicine in keeping with their beliefs, provided that they act in accordance with the law and professional guidance.

Should a doctor feel unable to be part of a clinical team where a patient refuses potentially life-saving treatment, they must explain to the patient this conscientious objection, informing the patient of their right to see another doctor or actively seek a suitable practitioner to take over that patient's care. Doctors must not imply or express disapproval of the patient's choices or beliefs.

### "I don't want to talk about it, doctor"

Patients who refuse treatment may choose not to communicate further about their decision, or may ask someone else to make decisions on their behalf. Doctors should follow the guidance as set out in *Good Medical Practice*, and discussed above, if faced with the former scenario. In the latter case, the GMC reminds doctors that while patients may ask family or close friends to play a significant role in decision-making, no one else can make a decision on behalf of a competent adult who has capacity.

If, despite all attempts, a patient still does not want to know about their condition or management, a doctor should respect their wishes as far as possible. The GMC states that doctors are still obliged to engage with these patients as best they can, offering even basic information as the patient allows and reminding them of their right to change their mind at any time.

So in summary, the law entrenches a patient's right to say "enough is enough" in any treatment, and professional guidance directs a doctor how to proceed in these invariably complex cases. But please do not hesitate to contact an adviser at MDDUS if you are uncertain how to proceed when a patient refuses medical treatment.

■ Dr Greg Dollman is a medical adviser at MDDUS



Adam Campbell *learns how this innovative charity is working to make life more manageable for people with facial or other disfigurements*

**T**O WALK down the street, oblivious to those around you, except perhaps for the occasional glance from a passer-by, is an everyday occurrence for most people. For Linzie, who grew up in Fife in the 1970s and now lives in Kirkcaldy, such anonymity would be nothing short of a luxury. Born with a double hare lip, a cleft palate, hydrocephalus and three missing fingers, she has always attracted more than a little interest from passers-by – and frequently it has been negative.

From a young age, she says: “I would dread going out. It was like, ‘Am I going to actually get to where I’m going and back without being bullied?’ It was constant. I’d come in and, you know, I’d be really upset. My mum would be the one who I would scream at. At school I was bullied very much because of looking different. Thankfully I was born before all the mobile phones and that kind of bullying started. But it got quite bad.”

Linzie had operations all through

childhood and into her 20s, helping to change her appearance and stabilise her medical situation, but for a long time she remained extremely nervous about interacting with people she didn’t know well. “I used to be so shy. I couldn’t speak to anybody without getting really embarrassed.”

### Society obsessed with appearance

James Partridge, the founder and CEO of the charity Changing Faces, understands Linzie’s predicament better than most. In 1970, at the age of 18, he was involved in a car fire that left him with 40 per cent burns on his body and face. His recovery was prolonged and he remained profoundly disfigured. With much understatement, he describes first facing the difficult business of going out into the world: “I suddenly thought, I actually have to walk down the street. I have to try and rejoin this society, which is rather appearance-focused – and I’m not looking at my best, as it were.”

It was the realisation that the rehabilitation he required went far beyond the surgery and the dressings that ultimately led him, in 1990, to write a book, *Changing Faces*, about his experiences. It was well received and before he knew it he was setting up a charity of the same name, to pass on his unique insights and fight for the rights of people with disfigurement.

“It was a very small, tiny thing, with two

goals. One was to support individuals and their families to regain or build confidence and to have the health system helping them to do that. The second was to transform public attitudes from being rather uninformed and, dare we say it, stigmatising to being positive and inclusive.”

Twenty-four years later, Changing Faces is a £1.8 million charity employing around 30 people and supporting the estimated 540,000 people in the UK with a disfiguring condition to their face, hands or body – be it from birth, accident, cancer surgery, skin and eye conditions, facial paralysis or medical accidents.

### More than physical needs

One of the fundamental reasons for setting up Changing Faces, says James, was to address the gap he perceived in the available therapy for people with disfigurement: the need for a psychosocial aspect to what was already very good physical care.

“It’s clear that around 30 per cent of people cope quite well and quickly, but actually 60-70 per cent really don’t, and some never do. Time isn’t necessarily a great healer. People have come to see us 20 years later saying, ‘Actually my life has been pretty horrible. I’ve felt isolated, I’ve been distressed and I’ve been on antidepressants.’ That, in my view, is a failure of the medical system.”

As part of its support for individuals, the charity has developed a care package called



Linzie, far left, underwent extensive surgery to improve her condition. James Partridge, left, set up the charity Changing Faces in 1990

FACES. It is a psychosocial toolbox for people with disfigurement, which helps them to find out about their condition and its treatment, to develop a positive outlook for the future, to deal with the complex associated feelings and to learn strategies for coping with negative reactions when out and about in the wider world.

“So if you’re walking down the street and somebody’s staring at you, that’s par for the course I’m afraid. But there are ways of dealing with it. You might, on some days, want to step back or wave, or in certain circumstances you might want to say something. Having strategies for dealing with other people’s reactions is absolutely fundamental and shouldn’t be left to the person to dream up on their own.”

But you need more than a package, says James, you also need someone to deliver it. This is where the Changing Faces Practitioners (CFPs) come into their own. Trained by the charity, these specialists in disfigurement almost always come from the caring professions – they might be nurses, counsellors, assistant psychologists or social workers. People with disfigurements can gain access to CFPs directly through Changing Faces, but the charity is increasingly succeeding in its bid to have them embedded in the health system.

“So, for example, we have three CFPs working with kids and families embedded

in children’s hospitals in Scotland, one in Sheffield Children’s Hospital, one in Great Ormond St and one in Salisbury in the head and neck cancer team.”

It’s all part of the goal to have both the physical and psychosocial needs of people with disfigurement addressed as part of the patient care pathway, particularly in specialities such as plastic surgery, burns, dermatology, maxillofacial surgery and neurology.

### **Educating clinicians**

The growing number of CFPs are one route to achieving that goal, but there are others too – among them a call to clinicians to think about the psychosocial element when first assessing patients. As James explains: “Consider the GP who sees somebody coming in with a Bell’s palsy – it might take three months to go away but it might not. Is it okay just to say: ‘Here are some steroids, it’ll be fine, come back and see me in three months if it doesn’t go away?’ We think not – we think that the initial diagnosis needs to take account of psychosocial concerns.”

Changing Faces is also active in research, through its 18-year partnership with University of the West of England in the Centre for Appearance Research, which is developing a considerable evidence base for the psychosocial consequences of disfigurement. At a policy level, too, the

charity is trying to influence, with some success, NICE guidelines, clinical reference groups and medical curricula. “For example, we’re trying to get to plastic surgeons when they’re being trained, so they can’t become a consultant unless they’ve done a module on psychosocial issues. And the plastic surgeons are very open to this – they’re definitely in the lead.”

In addition to their work in healthcare, Changing Faces advocates for people with disfigurements in schools, by raising awareness among and offering guidance to teachers, teaching assistants and anyone working in education. They are also pushing for real equality in the workplace and more positive and inclusive portrayals of disfigurement in the media. Their ‘face equality’ campaign aims to transform opinions in a similar way to the campaigns for racial and sexual equality.

Back in Kirkcaldy, Linzie is living proof of the charity’s beneficial effects. Though it came along too late to help in her own medical care, her association with it has nevertheless helped to boost her self-confidence.

Attending their workshops, doing role-plays and learning strategies to deal with social situations have all played their part. Since becoming a media volunteer in 2010, she’s gone from strength to strength, sometimes talking to groups of up to 200 people. She has even appeared live on a TV chatshow.

“I had about four days’ notice. We should have been on the day before and it was going to be recorded. But then I was told, you’re going on live. It was absolutely petrifying!”

“But,” she says, laughing at the memory – and this is the important part – “it was a really great experience as well.”

■ **Adam Campbell is a freelance writer in Edinburgh and a regular contributor to MDDUS publications**

[www.changingfaces.org.uk](http://www.changingfaces.org.uk)



# Pathways in sight

*Dr Mark Wright champions the use of a unique set of diagnostic algorithms for non-specialists faced with common ophthalmological complaints*

**M**OST UK physicians including GPs and accident and emergency doctors will have had between two and 12 days ophthalmology attachment during their entire undergraduate training<sup>1</sup>, leaving them inexperienced and wary of dealing with patients presenting with eye problems.

Red eye is a common presenting complaint in patients attending A&E, optometrists and GPs and has been reported to account for 0.9–1.5 per cent of GP consultations.<sup>2</sup> Making the correct diagnosis can be difficult for non-experts, given the diversity of possible diagnoses ranging from self-resolving bacterial conjunctivitis to sight-threatening acute angle closure glaucoma (AACG).

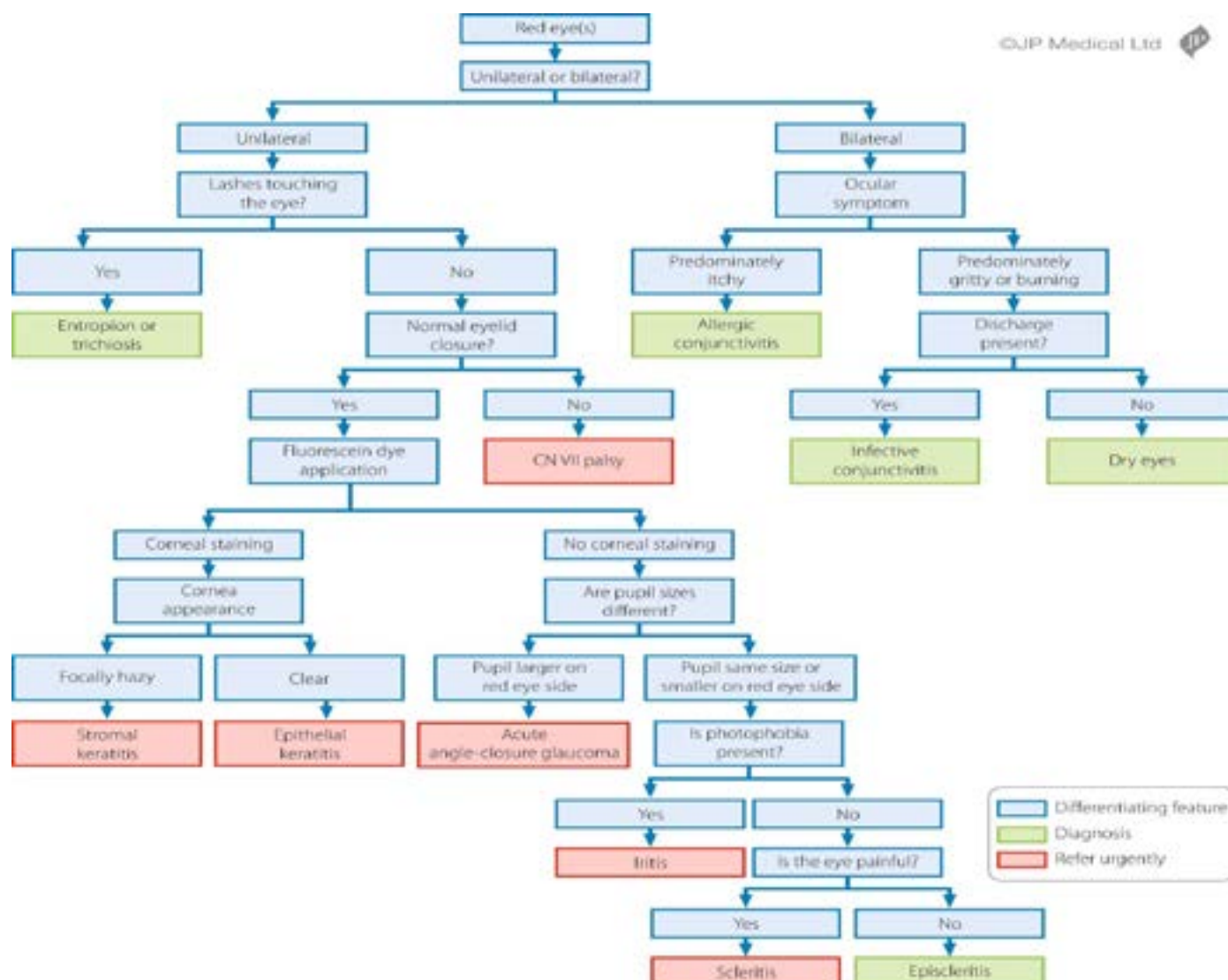
There are many excellent ophthalmology textbooks which give the novice the appropriate knowledge, however very few indicate how to apply it. For this reason I have developed along with colleagues a series of diagnostic algorithms (Edinburgh Diagnostic Algorithms) for the three

most commonly encountered scenarios: red eye(s), visual loss and diplopia.

## Diagnostic frameworks

These diagnostic algorithms allow the inexperienced clinician (in ophthalmological terms) to start to utilise and build upon their existing knowledge by consulting a framework which represents the thought processes of their more experienced colleagues. Algorithms are, therefore, simply a user-friendly version of these diagnostic and/or treatment thought processes.

Algorithms are always a compromise between having enough detail to cover the most commonly encountered diagnoses while remaining simple enough to use. They rely upon the clinician being able to clarify the history and elicit the clinical signs which act as signposts on the road to diagnostic nirvana. How successful are the Edinburgh Diagnostic Algorithms?



### Improved accuracy

Baseline diagnostic accuracy for non-ophthalmologists with patients presenting with AACG has been demonstrated as 21 per cent (GPs) to 64 per cent (A&E),<sup>3</sup> and 44 per cent for iritis (GPs).<sup>4</sup> When equally inexperienced observers (GPs 35 per cent, A&E nurse practitioners 23 per cent, opticians 18 per cent) assessed patients presenting with red eye(s) using the Edinburgh Red Eye Diagnostic Algorithm, the diagnostic accuracy for AACG rose to 100 per cent (4/4 cases) and for iritis it rose to 82 per cent (9/11 cases).<sup>5</sup>

These are the first diagnostic eye algorithms to be subjected to scientific analysis and demonstrate significant improvements in accuracy by inexperienced clinicians in the three most commonly encountered ophthalmic scenarios. Take diplopia as another example: the baseline diagnostic accuracy of non-ophthalmologists including optometrists, hospital doctors and GPs was 24 per

cent, indicating a need for a diagnostic aid. The overall diagnostic accuracy of the Edinburgh Diplopia Algorithm is 82 per cent, even when used by very inexperienced clinicians.

The diagnostic improvement resulting from the use of these algorithms should result in more accurate triage of patients referred to the hospital eye service. This should help prevent delayed presentations of serious eye conditions and reduce morbidity from delayed treatment.

### Access other algorithms

A number of open access learning tools including downloadable copies of the five diagnostic algorithms and narrated lectures accompanying the algorithms are available on a dedicated Edinburgh University web page. Access at [tinyurl.com/ht69sag](http://tinyurl.com/ht69sag)

■ Dr Mark Wright is a consultant ophthalmologist and honorary senior lecturer at Edinburgh University

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# Treating the fearful child

*Paediatric dentist Fiona Hogg offers advice on dealing with dental anxiety in young patients*

**H**ANDS UP who has experienced a little stress when managing an anxious child patient. Okay, maybe more than a little stress. Treating the fearful child can be one of the most difficult challenges we face in dentistry and is experienced by both general dental practitioners and paediatric dentists alike. Is this stress avoidable?

Despite improvements in children's dental health, caries continues to affect around one third of young children in the UK and with this challenging situation comes the need to consider how we can best manage treatment for the anxious child.

## Establishing trust

From the first appointment, the dental practitioner should aim to establish a positive relationship based on trust with the child and parent. The triad of communication between dentist, parent and child can become complicated: young children tend to concentrate on only one individual at any given time. A smiling, welcoming dental team who show empathy to parent and child is the best start to the initial appointment.

Always make eye contact with the child, use their name and talk to them as opposed to talking over them – and aim to say something that will make them smile. These simple suggestions are excellent

rapport builders and can help ensure a child is more likely to co-operate with treatment plans.<sup>1</sup> It will come as no surprise that fear experienced in previous unhappy dental visits has been related to poor behaviour at future visits, and there is certainly merit in parents bringing children for routine dental exams from infancy so that the surgery environment becomes more familiar.<sup>2</sup>

## Managing anxiety

Dental anxiety is common and occurs as a result of the reaction of the patient to perceived danger – known in physiological terms as the “fight-or-flight response”. Dental phobia is essentially a stronger reaction to the same fear, where the symptoms of the fight-or-flight response occur even when just thinking about the threatening situation. Children with a vivid imagination can create an overwhelming physical response by thoughts alone.<sup>2</sup>

Dental anxiety can be initially addressed when taking a child's dental history. Ask questions about previous dental pain and reactions to past dental treatments. In children over eight years, a validated scale such as the Modified Child Dental Anxiety Scale (MCDAS) can be a useful assessment of the child's level of anxiety and helpful in planning appropriate treatment strategies. The MCDAS

consists of a simple 40-point scale, with children rating their level of anxiety in regard to eight specific questions on a scale of 1-5. Scores of 27-40 indicate severe dental anxiety or phobia.<sup>3</sup>

Guidelines produced by the British Society of Paediatric Dentistry describe a full range of behaviour management techniques and suggested situations for use in dental anxiety.<sup>2</sup> The chosen management technique should be based on individual circumstances; no single method will be applicable in all situations.

### Mild to moderate anxiety

Fear of the unknown can often be easily diminished with good rapport building and empathy. The following techniques can be useful:

**Positive reinforcement.** Use stickers, colouring sheets or simply verbal praise to reward the child when they co-operate well. Keep praise and rewards specific: "Well done for keeping your mouth open so well" is more effective than "good boy". Asking the child how they are doing during treatment, communicating with thumbs up, has been shown to be more effective than reassurance.

**Tell-show-do.** Although requiring time at the initial treatment appointment, this technique is an excellent way to introduce patients to new experiences, increasing the chance of future co-operation. This might include using the three-in-one on the child's hand prior to drying teeth or demonstrating the slow-speed on a finger-nail prior to caries removal. Should the child ask to see the local anaesthetic prior to injection, show them the individual components and emphasise how fine and thin the needle is and how little of it needs to touch the gum.

**Voice control.** This is especially helpful with young children who respond better to tone of voice rather than actual words, switching to a different, slightly sterner tone when necessary to improve attention, compliance and establish authority.

**Distraction.** Short-term distracters are useful, for example chatting and pulling the lip taut to distract from the sensation of local anaesthetic (and always dry mucosa before using topical, allowing four minutes for it to work!). If facilities allow, playing a cartoon on a ceiling television screen during treatment has been demonstrated as being effective.

**Giving control.** Be honest with the child. If you set up a stop-signal, promising that you will stop if the patient indicates for this to happen, you must adhere to it. Not doing so can have disastrous consequences with the breakdown of trust between patient and dentist.

### More severe cases of anxiety

If it becomes clear during the initial appointment that the patient has more severe anxiety, additional strategies will be necessary. These might include conscious sedation, general anaesthetic or non-pharmacological techniques such as cognitive behavioural therapy or hypnosis. It may be

appropriate to refer the patient to the local public dental service or paediatric dental department for further assessment.

### Other points for consideration

**Avoidance.** Consider when treating children that your aim is not only to prevent and treat dental disease but also to avoid treatment-induced anxiety. Consider the holistic needs of the child when treatment planning. For example, a child with pulpitis in one primary molar may well have a number of other carious teeth that also need to be taken into consideration. Take appropriate radiographs and consider how other carious teeth will be managed. Prioritise prevention of caries in permanent molars and where possible avoid carrying out an extraction at the first dental appointment.

**Parent in or out?** Some dentists prefer one-to-one interaction with a child without the parent/carer present. Research suggests, however, that co-operation is widely unaffected by having a parent present in the surgery or not. In the case of pre-school children, however, behaviour tends to be better when a parent is with them.

**Watch your language.** Take care with your choice of words. "Don't be scared, I'm not going to hurt you" will unfortunately do little to alleviate anxiety. Negatives like "Don't" and "not" tend to be bypassed by the mind – a little like telling a child not to look out the window, it becomes the first thing that they do! Focus instead on positives: "You will manage this just fine" and "lift up your hand if you need a break and I'll stop".

**Failed appointments.** Dental anxiety is often cited as a reason for not attending dental appointments. However, children deserve access to dental care and require a responsible adult to get them there. It can help by explaining via letter or telephone that the first visit is for assessment and planning only. If a parent or guardian is repeatedly failing to bring their child to their scheduled appointment or only bringing the child when they are in pain, discuss your concerns with an appropriate colleague. All concerns should be fully documented and local health board protocol followed.<sup>4</sup>

Check out [www.dental.lltff.com](http://www.dental.lltff.com) for valuable downloadable resources aimed at dental practitioners, young people and their parents on coping with dental anxiety, including leaflets on how to prepare children for their dental visit. The website was produced by a team of researchers in the UK, experienced in research and treatment regarding anxious young people.

Treating children can certainly bring its challenges, but careful planning and management can go a long way towards easing the stress for patient and dentist alike.

■ **Fiona Hogg** is a specialty registrar in paediatric dentistry at Glasgow Dental Hospital and the Royal Hospital for Children, Glasgow

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# 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



## TREATMENT: A BLEAK OUTLOOK

**BACKGROUND:** Mr M visits his GP, Dr C, complaining of difficulty sleeping and anxiety which is exacerbated by painful swelling on his face. The 61-year-old, who has a recent history of insomnia, heart problems and various minor medical complaints, is diagnosed with suspected facial cellulitis. Dr C prescribes medication for the cellulitis and further medication for his insomnia and anxiety.

Mr M consults with another doctor at the practice on several occasions over the following two months, continuing to complain of insomnia, anxiety and occasional tightness in his chest. In addition to the strain of recovering from cellulitis, he highlights a number of stressful personal issues he is struggling with and fears he is at risk of a heart attack. The GP prescribes beta blockers and antidepressants and reassures the patient there are no other issues of concern. The doctor also discusses using a self-help guide to reduce anxiety. On two occasions the GP adjusts Mr M's medication dosage in response to reports of minor side effects and later diagnoses him with depression. He switches the patient to a different antidepressant and a different drug for insomnia.

Four months after their initial consultation, Mr M returns to Dr C. He is still feeling anxious and finds it difficult to concentrate, but there is a slight improvement in his sleeping patterns. Dr C makes no changes to the patient's medication and advises him that the insomnia and anxiety could potentially continue for up to two years, but there should be improvement if his personal issues can be resolved.

One week later the practice is informed that Mr M has committed suicide. His widow complains to the practice about the treatment he received in the months before his death. In particular, she questions whether his prescription medication and the bleak prognosis delivered by Dr C increased his risk of suicide.

Following a practice significant event review, Dr C writes to Mrs M apologising for the manner in which he gave Mr M's prognosis and offering his sympathies over the patient's death. An investigation carried out by a local health authority suggests the clinical treatment provided was appropriate but Mrs M is not satisfied and complains to the General Medical Council.

**ANALYSIS/OUTCOME:** Dr C informs MDDUS he is one of two doctors at the practice being investigated by the GMC following the patient's death and a medico-legal adviser helps him prepare a response.

An independent expert report commissioned by the regulator into Dr C's handling of the patient's care is supportive of his clinical decision making, describing it as "adequate and appropriate". It states there was no indication for Dr C to obtain a more detailed medical history or for him to arrange or conduct any further tests or investigations in the consultations leading up to the patient's death. The report supports the GP's actions in prescribing and reviewing Mr M's medication. The

expert adds that there was no indication that Dr C did not adequately inform Mr M about potential medication side effects and that it was "quite appropriate" for the GP to advise that his anxiety and insomnia could persist for up to two years.

Based on the evidence provided, the GMC concludes the case with no further action.

### KEY POINTS

- Be conscious of a patient's state of mind/mental health, particularly when delivering bad news or a bleak prognosis.
- Fully discuss treatment options, potential risks and side effects – tailored to individual patient circumstances.





## DIAGNOSIS: TWO TEETH TOO MANY

**BACKGROUND:** Adam is nine years old and attends the dental surgery with his mother for a regular check-up, having been a patient at the practice for the last four years. His dentist – Dr G – notes (for the first time in the records) that Adam still retains his upper baby central incisors (A/A), although the contralateral lower adult incisors have erupted. Examining further she finds the unerupted adult upper incisors (I/I) are palpable buccally. In the notes she records: "Watch I/I".

Six months later Adam is back at the surgery for another check-up and his mother expresses concern that he still hasn't lost his front baby teeth. Dr G exams the teeth again and finds they are "slightly mobile" and she advises there is no call to intervene just now but to keep monitoring the situation.

Nearly a year later Adam returns to the surgery still with "wobbly front teeth" and in an appointment two weeks later Dr G extracts A/A under local anaesthetic. Dr G tells Adam's mother that the boy's adult incisors should erupt soon.

Ten months later Adam is back in the surgery for an emergency appointment with a toothache in a back molar. Dr G restores the carious tooth. She notes that I/I are still unerupted and arranges for a referral to the local dental hospital.

Adam is now age 12 and attends the dental hospital. Radiographs reveal impacted central incisors caused by two upper supernumerary teeth (sn/sn) – one is palatal to unerupted I/ and the other is in the /I position with that adult incisor significantly ectopic, lying horizontally close to the floor of the nose. A treatment plan is formulated to remove sn/ to allow for eruption of I/, and to surgically expose /sn and in time apply a veneer.

A letter of claim is received two months later from solicitors acting on behalf of the patient claiming clinical negligence on the part of Dr G for failing to diagnose the presence of the supernumeraries so they could be removed allowing normal

eruption of the adult incisors. The delay has meant that /I has been pushed so far out of line by /sn that is now impossible to align this tooth. It is alleged that Adam now faces the prospect of having unnecessary surgery including future removal of /I with replacement by a single tooth implant at around age 18.

**ANALYSIS/OUTCOME:** MDDUS commissions an expert report from an orthodontist who examines the patient records from the practice and the dental hospital. He is of the opinion that there were several missed opportunities by Dr G to take radiographs when it was clear there was delayed eruption of the adult upper incisors (normally between ages six to nine years). Guidelines from The Royal College of Surgeons of England call for intervention in cases when eruption of the contralateral teeth occurred six months previously or there is deviation from the normal sequence of eruption (e.g. lateral incisors erupt prior to central). The expert believes these conditions applied at the time of Adam's first consultation with Dr G regarding his upper front teeth.

Radiographs taken at this time would have revealed the supernumerary teeth and allowed for extraction (along with the deciduous teeth) with a reasonable chance that the adult incisors would have come down normally into position.

Given the unsupportive expert opinion it was decided in consultation with the member to settle the case for a sum commensurate to the cost of future remedial treatment.

### KEY POINTS

- Ensure treatment decisions are backed up by appropriate diagnostic investigations.
- Re-consult guidelines when uncertain over treatment course.
- Be prepared for the unexpected.



## CONSENT: NO BLOOD WANTED

**BACKGROUND:** Mr J is a fit and healthy 46-year-old company director who lives and works in Birmingham. He makes an appointment with his local GP surgery to discuss a "confidential matter". In consultation with the attending GP – Dr K – he states that he is a Jehovah's Witness and requests to have a refusal of blood products card added to his patient records. Dr L contacts MDDUS for advice on the matter.

**ANALYSIS/OUTCOME:** An MDDUS adviser discusses the matter with the GP by phone and follows up with an advice letter. The England and Wales the Mental Capacity Act 2005 entrenches the right of an individual to refuse treatment through an advance decision and as such the practice is advised that it should include the

document (or documentation of the decision) in the medical records as it relates to the ongoing care of the patient.

It is unlikely that the practice will be required to intervene acutely where urgent care with blood products might be required but it may be contacted by a secondary care provider seeking clarification of the patient's advance decision. The practice is also advised to document any discussion about this decision, noting the patient's capacity to make such a decision.



### KEY POINTS

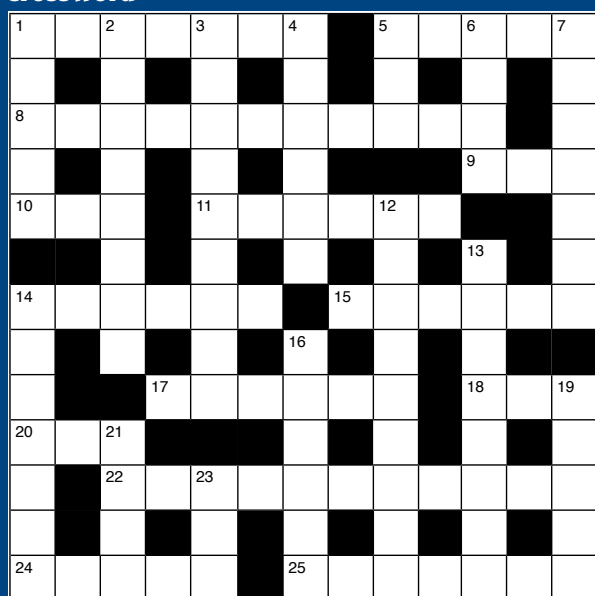
- Respect any competent patient's right to refuse particular forms of treatment.
- Ensure advance decisions regarding treatment and any discussion are highlighted in the patient notes.

## Object obscura: powered toothbrush

This 'Kavor' hydraulically powered toothbrush was manufactured around 1932 by Jenkins Productions Ltd of Dereham, Norfolk. The first practical electric toothbrush – the Broxodent – was invented in 1954 by Dr Phillippe Woog in Switzerland.



### Crossword



#### ACROSS

- 1 Betrothed (7)
- 5 Incontrovertible principles of faith (5)
- 8 Politician, piece of paper in hand (11)
- 9 Record label, owner of Abbey Road Studios (3)
- 10 Scarlet resinous secretion from insects (3)
- 11 Grouped according to ethnicity or allegiance (6)
- 14 Curve upwards in the middle (6)
- 15 Without elegance or grace (adverb) (6)
- 17 Prevents vessel from drifting (6)
- 18 Medical workplace or dog (abbr.) (3)
- 20 Rest upon one's posterior (3)
- 22 Assumed traits based on ethnicity or religion (11)
- 24 Violent spasm or pang (5)
- 25 Dogs, humans and whales (7)

#### DOWN

- 1 Perform beyond expectations (5)
- 2 Pressure build-up in eye (8)
- 3 Intermediary (2-7)
- 4 Proponent of evolution by natural selection (6)
- 5 Long polymer containing genetic code of lifeforms (3)
- 6 Basic functional unit of heredity, made from 5 (4)
- 7 Nervousness (7)
- 12 Set of rules for calculation (9)
- 13 Double vision (8)
- 14 Permission (7)
- 16 Secretion of mucus, bacteria and debris (6)
- 19 Plays music outdoors for small change (5)
- 21 Person appointed by government to advise on policy (4)
- 23 To supplement with great effort (3)

See answers online at [www.mddus.com/news/notice-board](http://www.mddus.com/news/notice-board)

## Book review:

### The Gene: An Intimate History

By Siddhartha Mukherjee  
Bodley Head, £25 hardcover  
Review by Jim Killgore, managing editor

"IT has not escaped our notice that the specific pairing we have postulated immediately suggests a possible copying mechanism for the genetic material." This example of "supreme understatement" can be found in the 1953 *Nature* article by James Watson and Francis Crick detailing the molecular structure of DNA and it is just one towering milestone celebrated in Siddhartha Mukherjee's artful new "intimate history" of the science of genetics.

Mukherjee is an assistant professor of medicine at Columbia University and a stem cell biologist and cancer geneticist. He is also a talented science writer and his *The Emperor of All Maladies: A Biography of Cancer* won a Pulitzer Prize in 2011.

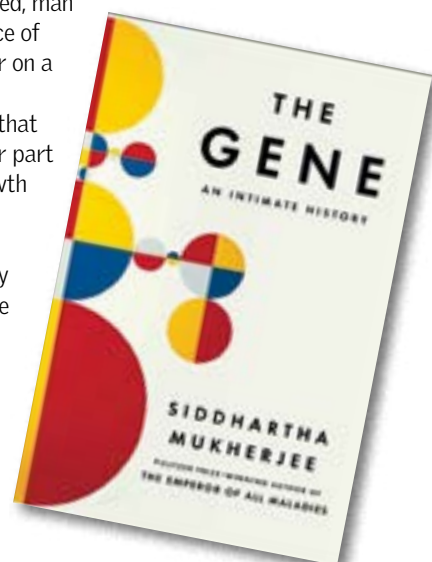
This new book is "intimate" first in its focus on key personalities involved in the epic discovery and elucidation of the gene, from the early observations of inborn "likeness" by Greek scholars to the meticulous work of the Augustinian monk Gregor Mendel demonstrating inheritance in pea plants (carried out at the same time as Darwin postulated his theories of evolution through natural selection) to further work on genetic traits in the fruit fly by cell biologist Thomas Morgan and the subsequent search for the "missing" biochemical mechanism that makes it all possible, in which Watson and Crick were so instrumental.

"Message; movement; information; form; Darwin; Mendel; Morgan: all was writ into that precarious assemblage of molecules."

Mukherjee's history is also intimate in his account of the interplay of genetics in his own family where there is a history of schizophrenia, such that he felt compelled to inform his fiancée. "It was only fair... that I should come with a letter of warning."

The structure of the book is chronological, covering the major developments in genetics by scientists working in partnership or competition or sometimes – as with Mendel – in painful isolation. Mendel's seminal paper was not "rediscovered" until 1900, after his death, by the English biologist William Bateson who later wrote: "When power is discovered, man will always turn to it...The science of heredity will soon provide power on a stupendous scale."

It is a prescient observation that Mukherjee explores in the latter part of the book, looking at the growth of biotechnology, the vast and "dangerous" potential of recombinant DNA, gene therapy and the sequencing of the entire human genome, recording our evolutionary history in the carcasses of inactivated genes "littered throughout its length, like fossils decaying on a beach". This is a profound and engrossing book.



## Vignette: pioneering family planning practitioner and sex therapist Helena Rosa Wright (1887-1982)

**B**ORN in late-Victorian London, the daughter of a Polish-Jewish immigrant, Helena Rosa Lowenfeld said she wanted to be a doctor from the age of six. Against her middle-class family's wishes, she went on to study at the London School of Medicine for Women (now part of the UCL Medical School). Her father, still opposed to her career choice but hopeful that she might see sense, said that if she left university and gave the London Season a try for a year, he would withdraw his objection. She agreed to the deal, but after the year went back to medical school and graduated MB, BS in 1915.

During her career, she was in turn a junior civilian surgeon in a military hospital, a gynaecologist and missionary in China, a family planning practitioner and sex therapist in London and founder member of the International Planned Parenthood Federation. She was also an esteemed educator and outspoken champion of contraception throughout her long life. Indeed, she worked closely with Marie Stopes, whom she had first met in 1918 and whose handbook *Wise Parenthood*, she read in manuscript and claimed to have taken out "all the nonsense". It is perhaps testament to both her conviction and her powers of argument and persuasion that in 1930 she addressed the Lambeth conference of the Church of England, persuading the assembled bishops to give modified approval to the use of contraceptives within marriage.

In 1929, in addition to her work in two London family planning clinics, Wright setup in private practice to advise those who were "too shy or embarrassed to visit a clinic". She continued this practice until her 89th year in 1975, by which time she had cared for some 20,000 patients. During this period she developed her own approach to women's sexual problems and, unconventionally for the time, counselled that her patients should take responsibility for their own arousal and satisfaction, emphasising the importance of clitoral



stimulation.

In the 1930s, the term sex therapist was unknown, but Wright is now retrospectively regarded as one of the earliest practitioners in this field. Her first work on this topic, published in 1930, was called *The Sex Factor in Marriage* and its success meant three printings within the first six months. In 1935, she also wrote a handbook for patients, entitled *Birth control: advice on family spacing and healthy sex life*. She was driven by a desire to help women plan their pregnancies and enjoy their sex lives and to achieve what she called "positive health" as a result. This approach has been regarded by some as an early form of well-women clinic.

She was also keen to address what she saw as a significant unmet need in the inter-war years. The atrocities of the Great War had not only claimed the lives of thousands, but had left many of the men who returned home traumatised and impotent. Wright claimed that she had hundreds of married women patients who were desperately seeking to become pregnant, but whose husbands were unable to father children. Wright allegedly addressed this need with a simple solution.

She found a willing and virile young man called Derek who would serve as a surrogate. Between them they provided a secret fertility service, and Derek is said to have discretely visited around 500 of Wright's patients between 1916 and 1950, leaving 496 pregnant.

As well as arranging for women to become pregnant, Wright made no secret of the fact that she had also arranged for illegal abortions since the 1940s. As a result, she was the subject of a police enquiry in 1947. In the 1950s, she was also instrumental in arranging the adoptions of unwanted illegitimate children. This brought her again into conflict with the authorities and in 1968 she was prosecuted. Although she pleaded guilty, she was given an absolute discharge. Throughout her life she was out of step with societal norms and establishment mores, but far from this causing her concern she was proud of saying: "Today's cranks are tomorrow's prophets".

Her attitudes to sex were liberal and outspoken. Her own marriage to a fellow surgeon was open, and she strongly advocated pre-marital sex and extra-marital affairs at a time when such things were considered by much of society as immoral. She expressed these views plainly in her final book in 1968, *Sex and Society: a New Code of Sexual Behaviour*.

In her obituary, the *BMJ* described her as "the 'mother' of family planning in the UK". Although Wright was first and foremost a doctor, she would probably not have objected to the maternal description. She fought hard through a lifetime of work to improve women's health and is said to have referred affectionately to her many patients as her "chicks".

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

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