Volume 23 Issue 2 December 2007

ISSN 0952 9934

THE MDU

MDU Journal

Treating under-18s – tackling the dilemmas

How to handle violent patients

Issues of confidentiality

Reducing risk in ophthalmology

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This is the sixty-third issue of the **MDU Journal**, published for members of the MDU in the UK and the Republic of Ireland.

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Back to basics

Welcome to this edition of the MDU Journal.

Doctors often ask me what issues keep our members awake at night and keep our medico-legal advice line busy. You might assume most calls are generated by new developments – the Mental Capacity Act or the latest GMC guidance on treating children say; or that it is doctors taking life and death decisions, such as those considering whether to withdraw artificial nutrition and hydration from a terminally ill patient, who most often want legal and ethical guidance. While such important issues undoubtedly feature in calls to our 24-hour advice line, it is actually one of the most basic and ancient principles of medical ethics – confidentiality – that members frequently seek our advice on.

Confidentiality has underpinned the doctor-patient relationship since Hippocrates' time. Doctors learn early on at medical school that the success of the doctor-patient relationship is founded on trust and that, on the whole, we will not disclose information patients tell us in confidence to other people. But there are rare times when doctors may decide it is necessary to breach confidentiality in the public interest, such as informing the medical adviser at the DVLA when a patient may have a condition that could affect their fitness to drive and refuses to stop driving or inform the DVLA themselves. At other times, inadvertent confidentiality breaches can occur. I recently read in the press about a mix up of similar telephone numbers which led to a garden centre receiving faxes referring patients for treatment from a number of GP practices. The faxes should have been going to a PCT.

It is these types of dilemmas that often lead members to pick up the phone to us and, in this issue of the Journal, we examine in more detail the themes arising from 200 such calls from our members over a two-week period (pgs 6-9). We also give examples of common scenarios and advice on how to deal with such dilemmas, such as when confidentiality can be legitimately breached.

Elsewhere in the Journal, we tackle some of the important issues I mentioned earlier – Dr Brigid Simpson highlights the key points from the GMC's new guidance on treating under 18s (pg 5), while solicitor Ian Barker answers some questions on the Mental Capacity Act, which has recently come into force (pg 3). We also update members on the MDU's continuing efforts to ensure members' views are represented in consultations by the Government and other bodies. Dr Christine Tomkins explains why we continue to voice our strong opposition to the introduction of the civil standard of proof in GMC fitness to practise cases (pg 2) and Dr Matthew Lee summarises our recent evidence to the Welsh Assembly, which intends to introduce a new scheme for compensating NHS patients (pg 4).

Finally, on a seasonal note, Dr Nicholas Norwell provides a light-hearted view of one hapless GP's festive troubles (pgs 10-11). And, with that in mind, I'd like to pass on season's greetings to all our readers.

Dr Karen Roberts
MDU Journal medical editor

editorial

news

Civil standard of proof 'will lead to unfair decisions'

In the last edition of the Journal, we updated members on the Government's response to the White Paper – *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, which set out its policy for wide-ranging reform of healthcare professional regulation. One of the key proposals was to lower the standard of proof threshold – from the criminal to the civil standard – for GMC fitness to practise (FTP) panel hearings.

The GMC has since published a consultation on the draft rule and guidance and the MDU has responded by voicing our strong opposition to the introduction of the civil standard of proof. We believe such a change will lead to inconsistent and unfair decisions in many cases, which may result in a greater number of legal challenges to protect members' interests.

If the GMC goes ahead as planned it may result in many more of our members having a finding of impaired fitness to practise. This in turn is likely to lead to considerable delays and costs for both sides while legal challenges are undertaken. It can only undermine confidence in the regulatory process, which cannot be in doctors' or patients' interests. Nor can it be in anyone's interests for good doctors to be found to have impaired fitness to practise using an unfair procedure.

We have no confidence in the proposed procedure and believe that when a doctor's livelihood is at risk, only the criminal standard should be used.

We have offered to meet the GMC to discuss our objections and will keep members informed.

Dr Christine Tomkins
deputy chief executive, MDU

- **The Health and Social Care Bill 2007-08, which includes proposed legislation to require all health regulatory bodies, including the GMC and the newly established Office of the Health Professions Adjudicator (OHPA), to use the civil standard of proof, was published in November. The OHPA is a new independent body which, if the Bill is enacted, will adjudicate on GMC cases.**

The MDU welcomes the proposal that the process of deciding whether or not a doctor's fitness to practise is impaired will, in future, be independent of the GMC. We hope that the OHPA will ensure doctors get a fair hearing at the adjudication stage and we await further detail about the proposed composition of OHPA fitness to practise panels and about how they will operate. However, for the reasons set out above, we believe the introduction of a civil standard of proof will not improve patient safety and may undermine confidence in the regulatory system.

Reference points

The GMC has recently published new guidance on writing references. The MDU's medico-legal advisers regularly receive telephone calls from members concerned about writing references and we remind members about the need to be fair and objective when approaching the task.

Typical scenarios include members experiencing difficulties when writing a reference for the first time, members asking questions about the specific details they should include in a reference, and members uncertain about whether they are best placed to write a reference, perhaps because a colleague is a close friend and they are worried about being objective.

Writing References was published by the GMC in August and is aimed at helping doctors take care that references about colleagues are accurate and reliable, and that patient safety is not compromised by an inaccurate or incomplete reference. It provides fuller details of how doctors should comply with the core guidance set out in *Good Medical Practice and Management for Doctors* (2006).

The GMC's new guidance explains that references should be fair to both the candidate and the prospective employer to ensure the best person is employed for the job and that patients are not endangered.

When writing references, the guidance says doctors must:

- Only include **relevant** information, on the basis of whether its inclusion or omission could mislead an employer about the suitability of the candidate.
- Only provide comments that can be **substantiated**, and state the basis on which assessments are made. For example how long you have known the candidate.
- Provide comments which are **fair** and **unambiguous**.
- Be **objective** and avoid basing comments on personal views that have no bearing on a candidate's suitability (paragraph 7).

Find more details at www.gmc-uk.org

Dr Michael Devlin
medico-legal adviser, MDU

Mental Capacity Act — your questions answered

All doctors treat patients whose capacity is not clear-cut or who have long-term conditions which may leave them unable to make decisions for themselves. The Mental Capacity Act (MCA) 2005, which came fully into effect in October, will have significant implications for the way doctors deal with such patients in their everyday practice.

To help members understand their obligations under the Act and to clarify some of the misconceptions which have been aired in the media, MDU solicitor Ian Barker has produced a series of Q&As which focus on some of the possible scenarios which might arise. Two examples follow and they can be found in full on the MDU website www.the-mdu.com. Members can also contact the MDU's medico-legal advice line for specific advice about any dilemmas they face.

'It is recognised that emergency treatment should not be delayed for healthcare professionals to look for an advance decision if there is no clear indication that one exists.'

I have treated a patient who is unconscious after taking an overdose of paracetomol. His sister has now arrived with a copy of his advance decision refusing life-sustaining treatment. Am I legally liable for having treated him?

Section 26(2) of the MCA gives protection in these circumstances. It states that a person does not incur liability for carrying out or continuing treatment unless at the time he is satisfied that a valid advance decision exists which is applicable to the treatment.

It is recognised that emergency treatment should not be delayed for healthcare professionals to look for an advance decision if there is no clear indication that one exists. If, however, it is clear that a patient has made an advance decision that is likely to be relevant its validity and applicability should be assessed as soon as possible. Again, it is appreciated that the need to make urgent treatment decisions will make this difficult.

Section 5 of the MCA also provides a measure of protection for medical practitioners and other carers generally. Liability will not be incurred if:

- An act is in connection with the care or treatment of a patient.
- Reasonable steps are taken to establish whether the patient lacks capacity.
- The doctor reasonably believes the patient lacks capacity and that it would be in the patient's best interests to proceed.

However, this protection from liability does not cover criminal liability or liability resulting from the medical practitioner's negligence in doing the act.

My patient, who has motor neurone disease, wishes to make an advance decision refusing artificial hydration and nutrition when he is unable to eat and drink himself. Is it possible to refuse life-sustaining treatment in this way?

An advance decision to refuse life-sustaining treatment, including artificial nutrition and hydration (ANH) in such circumstances, must meet specific requirements. Paragraph 9.24 of the MCA Code of Practice says that:

- The decision must be in writing. If the person is unable to write, someone else should write it down for them. For example, a family member can write down the decision on their behalf, or a healthcare professional can record it in the patient's notes and at the patient's direction.
- The person must sign the advance decision. Again, if they are unable to sign, they can direct someone to sign it on their behalf in their presence.
- The person making the decision must sign in the presence of a witness. The witness must then sign the document in the presence of the person making the advance decision. Where the patient is unable to sign, the witness can instead witness them directing someone else to sign on their behalf and sign to this effect.
- The advance decision should include a clear and specific written statement from the patient that it is to apply to the specific treatment even if their life is at risk.
- If this statement – that the decision is also to apply to life-sustaining treatment – is made at a different time or in a separate document to the advance decision, the person making the decision (or someone directed by them to sign) must sign it in the presence of a witness, who must also sign it.

'The Code makes clear (Paragraph 9.28) that an advance decision cannot refuse actions that are needed to keep a person comfortable.'

The Code makes clear (Paragraph 9.28) that an advance decision cannot refuse actions that are needed to keep a person comfortable – the examples given including provision of warmth, shelter, keeping someone clean, and the offer of food and water by mouth.

MDU supports Welsh compensation scheme

The NHS Redress Act 2006, which has yet to come into force, outlined a faster, less 'legalistic' system for investigating potential claims and compensating patients harmed by negligence in NHS hospitals. Earlier this year the Welsh Assembly published its own proposals to introduce the scheme in Wales. The MDU submitted a response to a consultation on the proposals and in October we gave evidence to the Welsh Measure Committee which is examining the draft legislation to ensure it will fulfil its intended purpose.

The precise detail of the proposed scheme will be outlined in secondary legislation (regulations) yet to be published.

The proposed measure would enable the introduction of a redress scheme in Wales for lower-value clinical negligence claims (likely to be less than £20,000) as an alternative to patients bringing a claim for compensation through the courts. It is proposed that there will be a duty on the NHS to tell patients if they have been harmed by an incident (for example a medication error) and that they may qualify under the scheme. The incident will then be investigated, using joint medical experts (for the NHS and patient) where needed. If the patient is found to have had a compensatable financial loss as a result of negligent treatment, redress will be in the form of an explanation, an apology and financial compensation. In addition, a formal report will be produced about each case which will identify what went wrong and make proposals to ensure that similar problems are avoided in future.

The payment of compensation will still be based on the need for a 'qualifying tort'. In other words, there will still need to have been negligent treatment as defined by the Bolam Test – that the care provided was not in accordance with a responsible body of medical opinion.

While the current drafting of the measure would allow for the inclusion of primary care we understand the intention is to introduce the scheme to secondary care only in the first instance.

Our comments to the consultation and Welsh Measure Committee included:

- We support the principles and objectives of the redress scheme – that patients who have had a compensatable injury should receive compensation for it quickly and without undue hurdles being placed in their way.
- We also support the process of providing patients with an investigation into an adverse incident, so that they get an explanation and an apology, if appropriate, action to put the matter right where possible, and information about what will be done to prevent the incident from happening again. However, this is already encompassed within the NHS complaints procedure which, in our experience, resolves a high percentage of complaints satisfactorily.
- The scheme should be kept entirely distinct from the NHS complaints procedure. To mix the complaints procedure, aimed at investigating and resolving grievances, and a scheme to financially compensate patients, could lead to many patients feeling dissatisfied with the outcome. There is a danger patients making complaints under the scheme would feel their concerns had not been taken seriously if they were found not to be due compensation, under the legal tests employed, despite the complaint itself being upheld.
- It is important that the scheme retains the need for a 'qualifying tort' to be established before financial compensation is considered.
- The reporting and investigation of cases should not attribute blame to individuals. Compensation being awarded is not an indicator of poor performance on the part of an individual clinician.
- The scheme should run for a trial period in secondary care before any consideration is given to including primary care. Primary care is different in many ways, including the types of claims and claims experience, and indemnity arrangements for GPs who are independent contractors.

Dr Matthew Lee
deputy director of professional services, MDU

Major minor issues

New GMC guidance on treating under-18s tackles many of the dilemmas that can arise for GPs and hospital doctors when dealing with children and draws together the GMC's best-practice advice into one printed publication for the first time. Dr Brigid Simpson, MDU medico-legal adviser, outlines some of its main points.

The MDU opened more than 400 files last year after members asked for help concerning their treatment of children. Many more telephone queries concerning the under-18s were dealt with by the MDU's team of medico-legal advisers.

Common dilemmas (see box) the MDU hears and which are covered in the 50-page GMC guidance, *0-18 Years: Guidance for all Doctors*, published in October, include:

- Whether children and young people can refuse life-saving treatment.
- Whether doctors can provide contraceptive advice and treatment to girls under 16 without their parents' knowledge.
- Who has access to children's medical records when their parents get divorced.

Importantly, the GMC guidance highlights the principle that doctors should always act in the best interests of children and young people, and it explains how to assess best interests, stating that doctors should take into account the views of the child or young person and those close to them, and always choose the least restrictive treatment for the child's future options (paragraphs 12 and 13).

On a child's capacity to **consent**, the guidance says it is important that children can understand the nature, purpose and possible consequences of treatment or of not having treatment and be able to weigh this and make a decision based on it. It states that capacity to consent will depend on age, maturity and the complexity of the treatment proposed (paragraphs 24-26).

Communication skills needed when dealing with children are addressed; the guidance advising that the under-18s are involved in decisions about their care, and that information that is easy to understand and appropriate to a child's age and maturity is provided. Openness and honesty are stressed, as is giving children the opportunity to ask questions.

The guidance also states that children can be seen without a parent present if that is what they want (paragraphs 14-21).

The duty of **confidentiality** a doctor owes to a child patient and the circumstances in which confidential information can be disclosed without the child's consent is also discussed. For example, disclosure should be considered if it is necessary to protect the child or someone else from risk of death or serious injury. Such a scenario could exist if a child were at risk of sexual, physical or emotional abuse, if the information would help in the prevention or prosecution of a serious crime, or the child's behaviour, for example drug-taking or joy-riding, puts them or others at risk of serious harm. (paragraphs 42-52).

Treating children can occasionally be difficult if it is a question of judging whether children have the capacity to consent to treatment themselves or when making decisions about very young children who cannot communicate with you. The MDU is on hand and can advise members on these matters.

- *0-18 Years: Guidance for all Doctors* is available at: www.gmc-uk.org

THREE COMMON DILEMMAS

When a young person refuses treatment

The GMC says doctors must carefully weigh up the harm to the rights of children and young people of overriding their refusal to consent to treatment against the benefits of treatment so decisions can be made in their best interests (paragraphs 30-33). This is a complex area and one about which members are advised to contact the MDU for specific advice. However, aspects you might consider include encouraging the young person to involve their parents, bringing other colleagues into the decision-making process and seeking legal advice

When an under-16 seeks contraceptive advice

The GMC says circumstances under which a child might receive such advice without parental consent include when the child can understand the advice, when the child cannot be persuaded to tell his or her parents or allow you to tell them, and when the child is likely to engage in sexual activity without contraception (paragraphs 70 and 71).

Access to children's medical records

The GMC says that if parents want to see their child's medical records, doctors should obtain consent from the child if they have capacity. If a child lacks capacity, then both parents, irrespective of divorce or separation, can be given reasonable access to medical records so long as they have parental responsibility and access does not go against the child's best interests (paragraphs 53-55).

features

Ring of confidence

Confidentiality and disclosure problems are one of the key areas of concern for members ringing the MDU 24-hour medico-legal advice line. Over one two-week period, more than 200 calls relating to confidentiality were dealt with by the MDU's medico-legal advisers.

Most calls fall into one of the following seven areas: children, deceased patients, police requests, patient access to records, disclosure to insurance companies and employers, disclosure in the public interest and sharing information with the healthcare team (see table on pg 9). The following are fictional, composite examples of each category of call.

Children

Case example

An angry father requested access to the medical records of his 15-year-old daughter. He said he suspected his daughter had been prescribed the contraceptive pill by her GP and he had not been approached for consent. Though divorced from the girl's mother, he said he had parental responsibility.

Advice

The member was advised to explain to the father that his daughter would need to give her consent to the records being released as she was 15 and in the member's opinion mature enough to understand the nature of any treatment and therefore had a right to confidentiality. Releasing the records without the daughter's consent would be a breach of her confidentiality unless, in exceptional circumstances, there was a reason to release them without consent or when consent had been withheld. In this case the member judged there was no reason not to respect the 15 year old's right to confidentiality.

Medico-legal background

The legal age of consent for medical treatment in the UK is 16. In English law, this is defined in the Family Law Reform Act 1969, in Scotland, the relevant Act is the Age of Legal Capacity (Scotland) Act 1991, and in Northern Ireland the legislation is the Age of Majority Act (Northern Ireland) 1969. If the child is under 16 then professional judgement must be exercised and consideration given as to whether the child is 'Gillick competent', in other words mature enough to understand what is involved in a proposed treatment. If so, he or she also has a right to confidentiality, although under certain circumstances a disclosure may be considered justifiable in the absence of consent or when it is withheld. As with an adult patient, you should generally tell the child before disclosing information.

If a child is not competent then a person with parental responsibility, usually a parent, must authorise disclosure on the child's behalf. A father who has been married to the mother would retain parental responsibility if separated or divorced unless this had been removed by the courts. In considering disclosure to a parent, the best interests of the child is paramount, but either parent with parental responsibility can act independently of the other, without a requirement to inform the other that a disclosure request has been made.

Deceased patients

Case example

The ex-wife of a deceased patient at a GP practice sought disclosure of the medical records of her ex-husband. The woman's ex-husband had died while receiving treatment for Alzheimer's disease and the ex-wife claimed the man had been mentally confused when making his will and been persuaded that the adult children from his first marriage should not be beneficiaries.

Advice

The member was advised to contact the patient's surviving spouse, also a patient of the practice, to determine who was the personal representative of the estate in order to seek their authority for disclosure. The member was also advised that the ex-wife, or her children, could request disclosure of the records, in writing, and the records could be disclosed if appropriate authority was obtained subject to certain restrictions.

Medico-legal background

The duty of confidentiality remains after death and any wishes which had been expressed by the patient should be respected. In other circumstances information can be disclosed with the authority of the personal representative of the estate. In addition, anyone who may have a claim arising out of the patient's death may be entitled to see the patient records under the Access to Health Records Act 1990. However, you may deny or restrict access if you assess that

the disclosure would cause serious harm to the physical or mental health of an individual, or would identify a third party other than a health professional.

Police requests

Case example

The police asked an A&E consultant for disclosure of the accident and emergency department records of a young man who was treated for severe glass wounds to his hands and arms. They said they were investigating a shop break-in and the patient was a suspect. They indicated that section 29(3) of the Data Protection Act (DPA) 1998 required the doctor to provide this information.

Advice

The member was advised to ask whether patient consent had been obtained. For example, the patient may be in custody and it may be possible to seek consent or, if not, to consider whether it was practicable to seek consent. If the member was considering disclosure without consent, or if consent had been withheld, he would need to decide whether it was justified in the public interest if a failure to disclose would put the patient or others at risk of death or serious harm.

This may be in circumstances where disclosure would assist in the detection or prosecution of a serious crime, generally crimes against the person. The member, in discussion with the MDU adviser, did not consider that a disclosure was justified under these circumstances.

Medico-legal background

When a request is received from the police, doctors should consider their legal and ethical duties of confidentiality to the patient. Under section 29(3) of the DPA, doctors can in certain circumstances disclose information for 'crime and taxation purposes'. However, this is an 'enabling' provision and does not require or oblige the doctor to disclose such information, nor does it override the ethical duty of confidentiality to the patient.

You should seek patient consent in most cases, though the GMC recognises there may be situations where this is not practicable. It gives examples at paragraph 23 of *Confidentiality: Protecting and Providing Information* (2004) which includes where the patient has been, or may be, violent, or obtaining consent would undermine the purpose of the disclosure (eg disclosures in relation to crime).

The GMC advises that confidential information may be disclosed in the public interest, without the patient's consent, or exceptionally when it is withheld, where the 'benefits to an individual or to society of the disclosure outweigh the public and the patient's interest in keeping the information confidential'. Disclosure may be necessary to protect the patient or others, where failure to do so would put the patient or another 'at risk of death or serious harm'.

Patient access to records

Case example

A patient with a history of mental health problems and drug abuse asked to see her medical records, claiming that a medical report to a life insurance company resulted in her being refused cover. The GP was concerned about the content of the earlier records, as he felt the patient may be distressed on reading it and the records also contained child case-conference reports, which referred to third parties.

Advice

As the member was concerned about distress, but did not consider that disclosure would actually cause harm to the patient, he was advised there was no reason to withhold access to the records. However, it was suggested he could arrange to read through the records with the patient at his practice, which would enable him to explain or answer any queries. However, he was also advised that unless he could obtain the consent of the third parties referred to in the records (other than healthcare professionals), these parts of the records should be withheld, unless there was a justification to disclose without consent, and that it was advisable to explain this to the patient.

Medico-legal background

Under the DPA patients are entitled to have access to their medical records. There may be rare cases where you believe that disclosure of all or part of the record may cause serious harm to the physical or mental health of the individual or any other person and in such circumstances all or part of the record may be withheld. There is no requirement to tell the patient that you have withheld access to part of the records, but it is good practice to do so.

Doctors may also withhold access to part of records that contains third-party information (other than information from other healthcare professionals) unless they have the consent of the third party or can justify release without consent. In making a decision as to whether it is reasonable to disclose without the third-party consent points to consider include:

- Any duty of confidentiality owed to the third party.
- Any steps taken to seek consent.
- Whether the individual is capable of giving consent.
- Any express refusal of consent by the third party.

Insurance companies and employers

Case example

An insurance company requested access to a report from the GP of a male patient

in his mid-30s on long-term sick leave from work with depression. The man had seen his GP two years before with the same problem and had been prescribed antidepressants. The patient asked to see the medical report the GP was planning to send to the insurance company. The patient asked the GP to omit reference to the earlier diagnosis and treatment of depression, as he had not told the insurance company about this when he had initially applied for permanent health insurance, and the company had therefore not asked for a medical report at the time of his application.

Advice

The GP was advised that, though his patient could add his comments to the medical report, or even refuse permission for it to be disclosed, he could not amend the details as they were correct. If the patient wished, the GP could add the patient's comments to the report, explaining he disagreed with the contents.

Medico-legal background

You must have express patient consent to provide a report for an insurance company and patients have a right to see the report under the Access to Medical Reports Act 1988. The GMC gives guidance at paragraphs 63-69 of *Good Medical Practice* (2006). Paragraph 65 states: 'You must do your best to make sure that any documents you write or sign are not false or misleading. This means that you must take reasonable steps to verify the information in the documents, and that you must not deliberately leave out relevant information.'

Public interest disclosure

Case example

A GP was consulted by a patient seeking help and advice about his 'blackouts'. The man was referred to a neurologist who diagnosed him as having epilepsy and he was prescribed antiepileptic medication but he continued to have fits. The GP was concerned that the man was still carrying out his job, operating heavy plant machinery, having failed to persuade him to inform his employers or get a transfer to a job where he did not operate machinery. The patient had made it clear that he did not want to inform his employers.

Advice

The member was advised that he had to balance his duty of confidentiality to the patient against the public interest in protecting both the patient and others who could be hurt should the patient have a blackout while operating machinery. The GP might wish to have a further conversation with the patient and seek the opinion of the patient's neurologist. He was advised that if the patient could not be persuaded to inform his employer and he decided to disclose the information, he should do so to an appropriate person at his place of work, for example, an occupational health adviser. The member should however tell the patient of his decision to inform the employer, before disclosure. He was also advised to keep clear and comprehensive records of his conversations, including the steps he took to obtain consent and his reasons for disclosure and he should only disclose the minimum information necessary.

Medico-legal background

The GMC makes it clear that you will only disclose information where patient consent has been withheld in exceptional circumstances. It goes on at paragraph 24 of its guidance *Confidentiality: Protecting and Providing Information* to state, 'in cases where there is serious risk to the patient or others, disclosures may be justified even where patients have been asked to agree to disclosure, but have withheld consent'. It points out that ultimately the public interest can only be determined by the courts, but that it will require a doctor to justify their actions if a complaint is made about disclosure without patient consent.

Situations in which disclosure may be justified are those 'where failure to do so may expose the patient or others to a risk of death or serious harm'.

Sharing information within the healthcare team

Case example

An obstetrician dealing with the specialist healthcare of a pregnant woman who was hepatitis C positive wanted to make the midwives in his team aware of the patient's hepatitis C status. The patient was unwilling for the information to be shared among anyone else in the team.

Advice

The obstetrician was advised to discuss this again with the patient to ensure that she understood that in the member's opinion it was in her best interests that the information be shared with others providing care. However, ultimately an adult competent patient can refuse to allow such information to be given, even if this might put the patient or her unborn child at risk. The member could not disclose information without the patient's consent unless she judged that failure to do so would put others at risk of death or serious harm.

Medico-legal background

The GMC advises in *Confidentiality: Protecting and Providing Information* 'You should make sure that patients are aware that personal information about them will be shared within the healthcare team, unless they object, and of the reasons for this. …
You must respect the wishes of any patient who objects to particular information being shared with others providing care, except where this would put others at risk of death or serious harm.' (paragraph 10)

Dr Karen Roberts
medico-legal adviser, MDU

In just one two-week period …

An analysis was undertaken of more than 200 consecutive calls related to confidentiality and disclosure issues over a recent two-week period. The table below categorises the calls and shows how many of each type were received, giving examples for each category.

Category of call	Number of calls	Examples of calls
Children	35	• Estranged fathers asking for information or access to child's medical records (18 calls) • Concerns about child abuse or other harm to children
Deceased patients	30	• Disputed wills • Life insurance
Police requests	28	• Allegations of crimes committed by patients (15 calls) • Following a patient's death, but unrelated to a coroner's inquiry • Murdered patients (3 calls)
Patient access to records	21	• Patient requests for information to be erased • Doctor's concerns that entries, particularly older ones, may cause distress to the patient if disclosed, or referred to third parties
Disclosure to insurance companies or employers, and completion of medical reports	18	• Release of medical information which the patient has asked be withheld or if it is not clear whether patient consent has been obtained
Disclosures without patient consent in the public interest	17	• Disclosures to the DVLA without patient consent (5 calls) • Patients who had threatened to harm others (3 calls)
Disclosures to other third parties	16	• Requests for records from NHS counter-fraud squad or a court • Requests from employers with suspicions that a sick note had been altered
Sharing information within the healthcare team	9	• Patients objections to GPs sharing information with hospital colleagues
Miscellaneous issues	31	• Storage and security (6 calls) • Patients with incapacity (3 calls) • Breaches of confidentiality (3 calls) • Follow up calls relating to previous contacts (11 calls)

A festive fantasy

Especially for Christmas, the diary of an MDU member*. By Nicholas Norwell.

On the first day of Christmas my true love gave to me – a partridge in a pear tree.

I thought it would look nice in the waiting room, but the tree's leaves wilted and the partridge made a terrible mess. On top of all that, a patient sued me for allegedly causing him to contract bird flu.

So I shot the damn thing (the partridge, not the patient) and gave it to the staff for their Christmas party. Now Holly and Ivy, my receptionists, are complaining that it gave them Salmonella and we're very short-staffed all of a sudden.

On the second day of Christmas a patient gave to me – a headache, accompanied by a letter of complaint.

This is another patient, not the one with the bird flu. I've got more than one. Patient, I mean, not letter of complaint. Anyway, the complaint was that I hadn't treated her food allergy. More Ali G than allergy I'd say. She went to this expert in London who's charging her £100 a prescription. They are obviously working wonders – she ate and drank at her office party with no problems. So it must have been my fault. I rang her up and told her in no uncertain terms that it was all in her mind, she should pull herself together and stop being a victim. Curiously, this made her angrier and the PCT have insisted I write a 'proper' response, otherwise the Healthcare Commission might become involved – whoever they are.

On the third day of Christmas a patient gave to me – a fever, a chesty cough and extreme lethargy.

In short, flu. Can I carry on? You bet I can. Can't leave that scoundrel, my partner Marley, to run the practice without me. I'll get by though, with an occasional snifter from the bottle in my desk; and I've got those left-over morphine tablets for any muscle pains.

On the fourth day of Christmas the clinical governance lead at the PCT gave to me – a visit.

I was at medical school with Rodney – he was a pompous old fool even then. Came round here, poking his nose into all sorts of places. Had the cheek to ask if my health was OK, asked me if I had been drinking. He took away a few sets of notes, 'for a real-time ongoing overview', he said. Not that I really need all the notes I have – I've got a terrific memory, always have had.

On the fifth day of Christmas my PCT gave to me – a letter.

It said they were aware of several complaints about my practice, some from my own staff, and I was being referred to the Performance Review Group – chaired by my old friend Rodney (of course). They want to arrange a formal visit to 'make a 360-degree assessment of the practice around issues of concern'. I wish they would speak English.

On the sixth day of Christmas my GP gave to me – a nearly clean bill of health.

Well, actually, he was a bit concerned was George, but he doesn't realise how tough I am. My gamma GT (funny it's called that, considering it measures alcohol damage) is only a little raised. Oh, I know my blood pressure was high but I'd had a busy surgery. And when I really concentrate, my diabetes can be perfectly controlled. George asked me to subtract seven from a 100 – what does he think I am, a school kid? I told him 94, 87, and so on. Easy.

On the seventh day of Christmas my true love gave to me – a weekend at a health spa (with the old girl herself, of course).

Really recharged my batteries, that did. Some lovely six-course gourmet meals, lots of vintage Champagne, an opportunity to relax by a log fire watching the rugby. Far too cold to venture outdoors. I got back to the practice raring to go. Once I get rid of these headaches and sort my blood sugar out I'll be fine.

On the eighth day of Christmas an old man gave to me – pause for thought.

The police asked me to see an old duffer who had been involved in a mild RTA – not hurt, just shook up. He was taking some Christmas presents to children and insisted on carrying on. He became very indignant when I suggested perhaps he shouldn't be driving. 'I'm perfectly safe,' he said, 'I've been delivering presents to children for years, always on time, always without fail. They rely on me!' I thought – yeah, old man, you're right. Who am I to lecture? That bottle in my desk … those pills … told Rodney about the incident and he looked at me strangely.

On the ninth day of Christmas the PCT sent to me – another letter.

The PCT say on the basis of what they know from the staff, patients and colleagues, they are considering removing me from the list – *'contingently'*. I looked that up and I think it means *'conditionally'*. I'll tell the CEO he needs to read more and, indeed, get out more. Anyway, they want me to attend a meeting in the new year – to hear from me why they shouldn't suspend me, presumably.

On the tenth day of Christmas the GMC gave to me – a shock.

The PCT have written to the GMC who invite my comments but they say I don't have to provide them. Confusing. Rodney tells me the PCT always refer GPs to the GMC in these circumstances – he means when a doctor is making a complete Horlicks of everything. But he's given me some good ideas for smartening up the practice.

On the eleventh day of Christmas a stranger gave to me – some of my confidence back.

** This is a work of fiction. Any resemblance to any MDU member, past or present, is, of course, entirely coincidental.*

A man came running into the surgery saying his girlfriend was giving birth in the bus shelter just outside. Somehow we managed to get her into the treatment room. Boyfriend said they were travelling through – they had tried to get into the local B&Bs but they were all full. I delivered the baby – a breech presentation – by the Mauriceau Smellie Veit manoeuvre. Was *I* proud? Was the *mother* proud? Is the pope Catholic? Like riding a bike, it was. Took me back to my early years as a GP when I delivered several babies a week. They called the boy Kevin. Suddenly the treatment room was full of social workers bringing gifts for the little lad – clothes, a cot, a teddy bear … Even wise man Rodney turned up to offer his congratulations – partly to the couple, but mainly to me.

On the twelfth day of Christmas the MDU gave to me – the greatest gift of all: Hope.

Rodney, bless him, suggested I ring the MDU. Best thing I ever did. I've got an appointment early in the new year with one of those MDU advisers. She sounded a bit fierce on the phone, but nice. She says we can discuss Minimising Risks, learning from Serious Untoward Events and sorting out issues of Professional Competence. See, I'm even learning the language! Rodney says he'll come along and help out at the meeting. It's a big task; there's hard work to be done.

But, hey! … I think I'm going to enjoy Christmas after all.

Dr Nicholas Norwell
medio-legal adviser, MDU

Winning ways with sports medicine

Most professional sportsmen and women now have access to state-of-the-art medical care, including a doctor specialising in sports medicine. And many amateurs involved in sports have access to doctors at sporting events. Here Dr Stephen Green, head of risk management at the MDU, gives advice for members involved in sports medicine and provides an update on medico-legal developments in the field.

Members regularly seek our advice on ethical dilemmas and their indemnity position in relation to the treatment of sportspeople or their attendance at sporting events. Common issues raised include whether doctors need separate indemnity from their employing club and potential conflicts between a doctor's duty to his patient – the sportsperson – and to his employing club, such as when a club asks for information which the player has asked the doctor to keep confidential.

This article focuses on doctors providing treatment or advice in relation to sporting activity including:

- Consultants and specialists, such as orthopaedic surgeons, who are referred sportspeople to treat either privately or as NHS patients.
- Doctors attending sporting events, such as at their local rugby or football club, in a professional capacity (which may be a paid or voluntary role).
- Specialist sports medicine doctors, employed by sports clubs in an occupational health role.

Consultants treating sportspeople following a referral

A recent Court of Appeal judgment (see box) has highlighted the significance of ensuring that, when treating individual professional sportspeople, the arrangements made do not lead to the creation of an additional duty of care to the club or team as well as to the individual patient receiving treatment. To ensure it is clear that the doctor's duty of care is to the patient, not the club, the MDU advises members not to enter into an arrangement where their treatment of the sportsperson may result in an express or implied contract with, or a duty of care to, the sporting body or club. It is advisable, for example, only to accept referrals directly from other healthcare professionals such as the sportsperson's GP or a team doctor, and not as part of a contractual arrangement with the club. In addition, any correspondence, or invoices for fees, should be addressed to the patient, not the club.

This is important as the professional indemnity insurance policy provided by the MDU to our members provides contractual cover for claims notified up to a total £10 million in each policy year, subject to the terms and conditions of the policy. This limit reflects the fact that we have never settled a claim against a member for a sum greater than £5 million and such large awards are usually made when patients, often babies, have sustained severe brain damage and will need a high level of care for the rest of their lives.

While the MDU Board has the discretion to award sums in excess of the insurance policy limit, and each case would be judged on its individual merits, it is unlikely, that the MDU's Board would exercise its discretion to compensate a sports club (as opposed to an individual patient) in the event that the level of compensation awarded exceeded the £10 million policy limit.

Doctors attending sporting events

The MDU expects doctors working at sporting events in a professional capacity to have appropriate qualifications, skills, experience, equipment and support as well as expertise in areas such as cardio-pulmonary resuscitation, airway maintenance and spinal fracture immobilisation. In addition, we advise that equipment levels and clinical protocols used should conform to the guidelines published by the relevant professional and/or sporting body. Members should always check with the specific sporting or other governing body running an event about the level and nature of qualifications needed.

Attending a sporting event in a professional capacity – whether paid or not – is distinct from acting as a Good Samaritan where doctors help out in an emergency when they are off duty. Good Samaritan acts worldwide are covered by the MDU's insurance policy, but sports doctors need to ensure they have appropriate indemnity in place for any 'anticipated' sports medicine work.

As some professional sports organisations and clubs provide indemnity for doctors attending sporting fixtures, members should check the exact nature of any cover before undertaking clinical duties. MDU members not separately indemnified should contact our Membership Department on freephone 0800 716 376 to notify the MDU of their planned involvement and discuss their indemnity requirements.

Specialist sports medicine doctors

Sports medicine doctors employed by clubs, effectively as occupational health physicians, owe a duty to the club as their employer but also have a professional responsibility, as set out in GMC guidance, to make the care of patients, the sportsmen and women, their first concern. This can sometimes present a conflict of interest, particularly with regard to consent, confidentiality and the patient's long-term health.

Examples of dilemmas faced by sports medicine doctors include:

- A doctor being asked by sportspeople not to pass on details of poor performance in fitness tests to their coaches/managers.
- Team managers asking doctors to disclose information about an aspect of the sportsperson's health in the absence of patient consent.

- Pressure on doctors either from managers or sportspeople to 'patch up' an injured sportsperson to allow them to get back into competition quickly.

In such situations, the guidelines from the Faculty of Occupational Medicine (FOM) and relevant GMC guidance will apply. Occupational health physicians have duties to patients and their employers. A doctor working in a capacity as an occupational health physician should explain their role in safeguarding the health of the sportspeople to both. Normally patients must be told beforehand that the occupational physician will report the results of a consultation to the employer.

FOM guidelines say it is usually appropriate only to give information about the results of a health assessment and not clinical details. Where a doctor needs to give more details, the guidelines say this can only be with the patient's consent.

Occupational health physicians should seek consent to disclosure at the start of the consultation and record this in the clinical record.

If a team member pressurises a sports doctor to say they are 100 per cent fit for competition when in the doctor's opinion that is not the case, the FOM says doctors have responsibility to record their findings and any advice given. They can refer to the results of any assessment when asked about the fitness of the sportsperson. If the patient will not give consent to discuss a specific issue, a doctor should not discuss it with their employer.

In addition, in *Good Medical Practice* (2006), the GMC states: 'You must not write or sign documents which are false or misleading because they omit relevant information.'

If the club asks for more details, the FOM guidelines say this can only be with the patient's consent. Consent should be written and for it to be valid, the patient must know the reason for and the extent of the disclosure, the fact that relevant information cannot be concealed and the likely consequences of the disclosure. If the patient will not give consent to discuss a specific issue, you usually cannot discuss this with the club manager or other member of club personnel.

In most cases, decisions about whether a player is fit to compete will be made after consultation between medical staff, coaches and the sportsperson, so the doctor is unlikely to bear sole responsibility. Most clubs are unlikely to risk a valuable player if they are not fit to compete but if the club decides to ignore the doctor's professional opinion that a player is not fit to compete, he or she should make a note of the advice given and the discussion in the clinical notes.

MDU members contracted or employed to provide advice or other medical services to sports clubs can be reassured that their professional indemnity insurance policy from the MDU will generally extend to clinical negligence claims arising from this work. Any such cover is subject to the terms and conditions of the policy and is dependant on the MDU having been informed, in advance, of the work you are undertaking and agreeing to indemnify this work. If you have any questions about the extent of cover provided under the policy or your membership with the MDU then our Membership Department would be happy to speak to you on 0800 716 376.

- *Guidance on Ethics for Occupational Physicians*, Faculty of Occupational Medicine, sixth edition, May 2006.

Case example

West Bromwich Albion Football Club claimed compensation for its financial losses from orthopaedic surgeon Mr Mohamed El-Safty following his treatment of injured midfielder Michael Appleton.

Mr Appleton had been forced to retire when surgery failed to improve his injury.

The Court of Appeal upheld the finding of the High Court that Mr El-Safty did not have an express or implied contract with the club, nor did he owe a duty of care to the club in law. Accordingly, he could not be liable for the club's financial losses resulting from his negligent advice that Mr Appleton should have knee surgery.

While the player is entitled to compensation for his losses incurred as a consequence of the doctor's negligence, to hold the doctor liable for the club's losses as well would have been an unwelcome and expensive extension to current law. ***[2006] EWCA Civ 1299***

Tackling violent or abusive patients

Recent surveys have revealed that many doctors have encountered violent or abusive patients. Here we summarise the practical steps doctors can take when dealing with the aftermath of such an incident.

As part of an initiative to tackle violence against healthcare staff, the Department of Health has earmarked £97million to be spent on 30,000 safety alarms for lone community workers including GPs, better training on safety techniques and more investment in prosecutions.[1]

A poll of nearly 900 GPs by *Pulse* magazine earlier this year revealed that one in three had been physically attacked by a patient at some point in their career.[2]

A Healthcare Commission survey also revealed that a third of NHS staff experienced violence or abuse in 2006.[3]

Doctors or other members of the healthcare team should be able to practise without fear of violent or abusive patients and the NHS counter fraud and security management service has brought successful prosecutions in the past. The MDU is often asked by members for advice on disclosing confidential information about violent or abusive patients and about removing patients from general practice lists. Some key points of our advice are set out below:

- All patients have a right to confidential medical treatment. However, there may be times when a doctor can pass on confidential information without consent, or even against a patient's wishes. This may arise when it is in the public interest to disclose information, such as when you or a member of your team has been subject to violence by a patient.
- If information needs to be disclosed to third parties, such as the police in the public interest, it should be the minimum necessary to allow for proper investigation of the facts by the authorities.
- If a patient has a history of violence, try to avoid seeing them alone or at their home. Ideally, the PCT or Trust will have arrangements so the patient can be seen at a suitable, safe location. If this is not possible, try to arrange to be accompanied by a colleague and make sure that your whereabouts is known before beginning the visit.
- If in general practice, a decision is made to remove a patient from the practice list because of violence, it is important to remember to report the incident to the police first and obtain an incident number, before notifying the PCT in writing, either immediately or within seven days in order to comply with contractual commitments. It is important that your decision can be seen to be fair, in order to comply with ethical guidance from the GMC in *Good Medical Practice* (2006) (paragraphs 38-40) and to ensure that arrangements are made promptly for the continuing care of the patient, including passing on the patient's records without delay.
- If your practice decides to remove a patient from the list, it remains a contractual requirement to write to them, giving reasons for the removal, unless to do so would be impractical, detrimental to the physical or mental health of the patient, or put at risk the doctor or any member of their staff.
- Where possible, the patient will be required to re-register with another practice, often one that is a designated practice for dealing with violent and aggressive patients. Guidance about removing patients from practice lists is available from the Royal College of General Practitioners. (www.rcgp.org.uk)

Dr Michael Devlin
medico-legal adviser, MDU

1. '£97 million boost to tackle violence against NHS staff', Department of Health press release, 25 September 2007 www.gnn.gov.uk

2. 'One in three GPs has been victim of patient attack survey reveals', *Pulse,* 20 September 2007

3. Annual NHS staff survey, Healthcare Commission, 30 March 2007, www.healthcarecommission.org.uk

membership news

Manage your membership online

The MDU website continues to go from strength to strength and you can now request changes to your membership via the site. We've introduced a range of new forms to help you manage your membership online, securely and at a time convenient for you.

On the site you can now:

- Update your contact details including address, phone and email
- Let us know about a change of working circumstances including change of duties, working abroad or retirement
- Notify us when you will be working in GP practice as part of your GP registrar or GPST training or request proof of contributions for your reimbursement
- Request a membership receipt or details of the last seven years' contributions for tax purposes
- Request details of group scheme members

The forms are designed to capture all the information we need so we can deal with your request as quickly as possible.

In addition the MDU website continues to provide a range of services, including:

- An online advice centre covering a range of medico-legal topics
- An online risk-assessment tool
- A wide range of case histories
- Medico-legal publications to order or download
- Discounts on a range of courses and books

Find the new forms in the membership section at **www.the-mdu.com**

Free CPD modules with onexamination.com

The MDU has developed a new online training tool to help members with legal and ethical dilemmas and earn CPD points in the process.

Forming part of a series of online CPD modules produced by onexamination.com, the MDU *Ethics and Law* CPD module will be free to members and provides the opportunity to answer tricky dilemmas, set by MDU experts, on a range of medico-legal areas. The scenarios, which are based on those notified to the MDU by members, are designed to help improve knowledge and clinical decision-making and cover areas such as:

- Consent
- Whistleblowing
- Removing patients from general practice lists
- Death certification
- Medico-legal aspects of insurance reports
- Disclosing patient information to the police

MDU members can receive the MDU *Ethics and Law* CPD module, along with another module of their choice, free of charge by visiting the onexamination.com website **(www.onexamination.com)**. The module has been developed primarily for those in general practice but the principles are relevant for both primary and secondary care.

In addition to the ethics and law training, the onexamination.com website has more than 30 clinical modules for GPs and hospital doctors including those on arterial disease, chronic obstructive pulmonary disease, chest x-ray challenge and acute coronary syndromes.

Each module is worth one hour of CME/CPD and a certificate of verifiable CPD can be printed off for your portfolio when it is completed.

To get your free CPD modules simply sign up at **www.onexamination.com**, select the *Ethics and Law* CPD module plus one other and quote **MDU07** when you go to checkout. You will receive these completely free.

Please note, your additional free choice module must be selected at the same time as your *Ethics and Law* module. You cannot return later with the same code.

MDU members can also benefit from a 33 per cent discount with onexamination.com on their online revision resources for specialist exams such as MRCS and DRCOG.

New faces

The MDU contact centre has appointed an additional contact centre manager, Siobain Bowyer, to work with Amanda Clark (MDU Journal Volume 23 Issue 1 June 2007) in ensuring our members receive a first-class service.

Siobain has a wealth of experience in both public and private sectors, having worked for Nissan, Vodafone and Transport for London over the past 15 years. She will work with Amanda to manage the membership services team which dealt with 135,000 calls from members in 2006.

GP members in the south-west of England who have questions about their membership or would like to arrange a medico-legal educational meeting for their practice can now contact our new GP liaison manager for the region – David Ireland. David, who will be meeting GPs from Penzance to Reading over the coming months, has previously worked for Organon Laboratories as an executive GP representative, and Boots as a primary care services manager.

Some of the practice seminars available from the MDU's team of GP liaison managers include:

- Medication errors
- Handling complaints
- Telephone skills
- Adverse incident reporting

For more details of the practice seminars available or to make a booking visit the 'Our services' section of the MDU website **www.the-mdu.com** or call **020 7202 1569** or **1570**.

Siobain Bowyer
Contact centre manager
MDU

David Ireland
GP liaison manager
MDU

Communications courses for members

MDU members can benefit from a 30 per cent discount on our Communication Skills for Doctors and new Advanced Communication Skills for Doctors courses run in association with Success Courses.

Both one-day courses have been developed and are led by a team of consultants with extensive and varied experience in the field of communication dynamics. They have been developed specifically to meet the needs of hospital doctors.

Communication Skills for Doctors introduces a practical model for verbal and non-verbal communication in clinical situations. The course examines why communication 'gaps' occur and looks at how to improve interaction with colleagues and patients. Other topics it covers include breaking bad news and preventing litigation in medical practice.

Advanced Communication Skills for Doctors offers delegates the opportunity to build further on their communication skills. The course introduces a framework for communication assessment, explores body language and rapport building, and it includes a video consultation role-play with detailed feedback and a personalised action plan.

For further information about the courses and to book your place visit **www.successcourses.org** or call Success Courses on **0845 094 2704**.

MDU Education & Training

Success Courses

Book discounts for members applying for GPST roles

ISC MEDICAL
Interview Skills Consulting

MDU members applying for GPST posts can access a new range of publications to help with the interview process at a discounted price. ISC Medical, a leading provider of interview skills consulting for medical professionals, produces a number of publications to help take some of the stress out of the interview process. The newly published series of books include:

- Multiple choice questions for shortlisting
- Extended matched questions for shortlisting
- Situational judgement tests and professional dilemmas
- Role plays

MDU members receive a 20 per cent discount on the books and across the complete ISC medical postgraduate range of products. For further details on the comprehensive range of postgraduate interview services, including interview skills coaching for doctors, applying for ST, GPST, GP and consultant posts, visit **www.isc.medical.co.uk**.

Tracking MMC

As highlighted in our June issue, a new career structure was implemented under the Modernising Medical Careers initiative (MMC) as of 1 August 2007, a scheme that had the potential to affect many of our hospital doctor members.

To minimise any concerns about MDU membership we pro-actively contacted 36,000 members to confirm that we had their correct details on file. In most cases, we are delighted to say that we did.

In addition to our demanding summer workload and the 18,801 calls we received during August, we have updated some 7,500 members' records to reflect their new posts and specialties.

Moving experience?

Members are reminded that if they are moving house they should provide us with two forms of identity checks.

This is essential so that the membership team can comply with data protection requirements and go ahead with amending your personal details on our computer systems. Suitable identity checks include telephone number, date of birth, email address, your old address or your professional regulatory body number.

advice line dilemmas

The MDU's freephone 24-hour advisory helpline is available to answer members' medico-legal queries and can provide support in difficult circumstances. Dr Jim Brown, an MDU medico-legal adviser, shares some dilemmas about chaperones that arose recently.*

The dangers of a missing chaperone

The scene

Three days into his new post in an accident and emergency department of a large hospital, a junior doctor reviewed a female patient who gave a history of shortness of breath. The doctor carried out an examination which involved removing the top half of the patient's clothing. No chaperone was present.

Later, the hospital received a complaint from the patient alleging indecent conduct during the consultation. The patient complained that no chaperone had been offered and that she had felt uncomfortable during the doctor's chest examination. She also alleged that the doctor had inappropriately pressed his groin into her back.

The hospital asked the doctor for a report of his consultation.

The member called the MDU advice line and the following points were discussed:

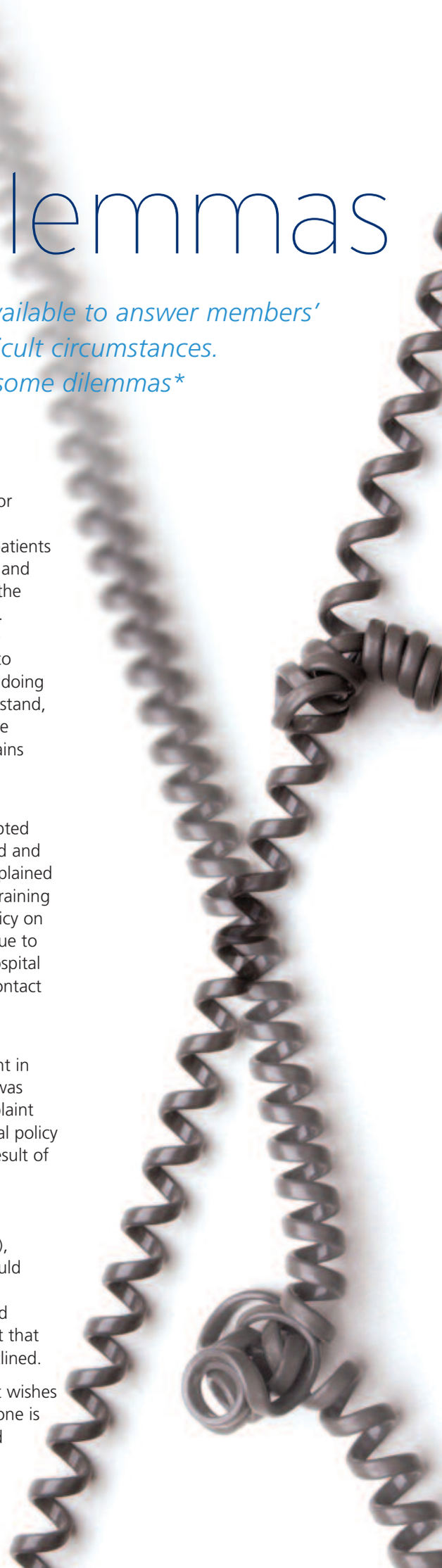
- Whether a chaperone had been offered to provide the patient with reassurance and support. Though the presence of a chaperone alone doesn't provide a doctor with a guarantee of protection against a complaint or legal action, it can discourage unfounded allegations of improper behaviour. The GMC's recently updated guidance on chaperones reiterates that doctors should usually offer one for intimate examinations.
- Whether the patient had been properly informed of the nature of the examination. Effective communication is the key to preparing patients for intimate examinations. The GMC requires that doctors explain to patients why an examination is necessary and what it will involve, giving them the opportunity to ask any questions. The MDU advises that during the examination a doctor may need to further explain what he or she is doing and why. Patients may not understand, for example, why both breasts are examined when a patient complains of a lump in only one.

With MDU assistance the member responded to the hospital. He accepted that no chaperone had been offered and apologised for this. However, he explained that he had received no induction training and there was no departmental policy on chaperones. He also clarified that due to his stature and the height of the hospital trolley, the inappropriate physical contact alleged was not physically possible.

The hospital accepted the doctor's explanation and wrote to the patient in the same terms. No further action was taken by the hospital and the complaint was resolved. The A&E departmental policy on chaperones was changed as a result of the complaint.

Consider this:

- In *Maintaining Boundaries* (2006), the GMC states that doctors should record in the patient's notes the discussion about a chaperone and who the chaperone is, or the fact that a chaperone was offered but declined.
- If either the doctor or the patient wishes a chaperone to be present but none is available, the consultation should



**These dilemmas are composite, fictitious cases based on actual MDU records.*

be rearranged for a later date where possible. The GMC states that chaperones do not have to be medically qualified and can be a relative or friend of the patient.

Read on:

Maintaining Boundaries, GMC, 2006, www.gmc-uk.org

When a patient says 'No'

The scene

A 17-year-old woman obtained an on-the-day appointment at her GP practice. When she arrived for her appointment later in the day she was seen by a male GP who noted that she was in a distressed state. The patient reported that she had had unprotected sex a few days earlier and was now suffering from a vaginal discharge as well as discomfort in the genital region.

The doctor advised that an examination would be necessary and suggested the practice nurse be present to act as chaperone during the procedure. The patient refused to have anybody else present, saying the less people knew of her complaint the better. She also refused to return to the practice at a later date with a chaperone of her own choice, saying there was nobody else she wanted present and she wanted the doctor to carry out the examination on his own without further delay.

The doctor was unhappy proceeding without a chaperone and rang the MDU to see if he could refuse.

The MDU and the adviser discussed:

- That patients can't be forced to have a chaperone, and doctors must respect patients' right to make their own decisions about medical care. However, the GMC requires doctors to offer one as a matter of course for intimate examinations of the genitalia and breasts.
- Whether the patient would agree to a chaperone being present if the GP explained that all staff had a duty of confidentiality.
- If the patient still refused, and the GP felt an intimate examination was needed urgently or the patient couldn't be persuaded to return later with a friend or relative to act as a chaperone, the GP may need to go ahead and perform the examination without one. In any event, the patient's refusal should be recorded in the clinical notes.
- The role of the chaperone. It was pointed out to the GP that though the presence of a chaperone was there to safeguard both the patient and the doctor, the presence of a chaperone alone does not provide a doctor with a guarantee of protection against a complaint or legal action. In fact, there have been a few cases dealt with by the MDU over the past 120 years where allegations have been made in spite of the presence of a chaperone.
- That the key to preparing patients for intimate examinations is communication, including a full explanation of what is involved in the examination.

The GP considered the advice and decided to proceed with the examination having first ensured that the exact nature of the procedures were outlined to the patient and that full consent was obtained.

Consider this:

- A model chaperone framework published by the NHS recommends that every primary care organisation should have a chaperone policy in place. It suggests that, 'a chaperone is present as a safeguard for all parties (patients and practitioners) and is a witness to the continuing consent of the procedure.'
- Recently updated GMC guidance on chaperones says that doctors should usually offer one for intimate examinations. In *Maintaining Boundaries* (2006), the GMC states that if either the doctor or the patient wishes a chaperone to be present but none is available, the consultation should be rearranged for a later date, if possible. When carrying out intimate examinations, doctors should give patients privacy to undress and keep discussion relevant, avoiding any personal comments.

Read on:

Guidance on the Role and Effective Use of Chaperones in Primary and Community Care Settings: Model Chaperone Framework, NHS Clinical Governance Support Team, June 2005

Maintaining Boundaries, GMC, 2006, www.gmc-uk.org

claims trends

An insight into ophthalmic claims: Over a recent five-year period the MDU opened about 150 files related to ophthalmic conditions reported by members, and many more queries were answered. Ophthalmologist and MDU Board member Mr Paul Riordan-Eva examines where difficulties can arise and how some of these can be avoided. In this issue he considers a case of failure to diagnose giant cell arteritis in general practice. In the next Journal, he will look at a case arising in independent ophthalmic practice.

Approximately two per cent of consultations in general practice[1] and around three per cent of cases notified to the MDU by GPs relate to ophthalmic conditions. Over a five-year period, the MDU settled 51 claims arising from ophthalmology in primary care. The average settlement was around £90,000, with the highest being £700,000, including legal costs, in a case involving delayed diagnosis and severe visual impairment. The size of these settlements results from the loss of earnings and cost of care payable to claimants who have lost their sight.

Though the most common cause of GP ophthalmic cases settled by the MDU is delayed diagnosis of retinal detachment, the second most common cause, delayed diagnosis of giant cell (temporal) arteritis (GCA), is responsible for the largest value settlements, mainly because of the ability of GCA to cause rapid severe visual impairment in both eyes.

GCA is uncommon, most GPs encountering no more than one or two cases during their careers. Permanent visual loss in one or both eyes has been reported to occur in 10-60 per cent of cases[2]. Prompt treatment with high-dose systemic steroids usually does not result in improvement in vision but should prevent further deterioration, especially in an eye that has not yet suffered any visual impairment.

Prompt institution of systemic steroid therapy is therefore crucial. In general, it is preferable that some patients receive a short course of treatment unnecessarily than others suffer further loss of vision due to delay in treatment.

GCA usually presents with typical features – including severe headache and scalp tenderness. Jaw claudication is a highly specific symptom that may progress to the extent that the patient stops eating any solid food. Other presenting features are polymyalgia rheumatica, systemic malaise and weight loss. The superficial temporal arteries may be tender or pulseless.

However, in many cases the features are atypical. In some cases, the presence of typical symptoms is not recognised by patients until systemic steroid therapy has resulted in their resolution.

The following is a fictitious claim based on salient features of actual cases handled by the MDU on behalf of its members.

Case study

A 75-year-old woman lived alone, without the need for any help from social services or her family. Over three months, she presented on three occasions to different GPs, complaining of stiffness in the neck and shoulders, and occipital headache. On the first occasion, neck examination revealed no abnormality apart from mild stiffness and mild limitation of movements. Cervical spondylosis was diagnosed and reiterated at the subsequent consultations. At the last consultation, the GP also documented pain in the right jaw.

Ten days later, on a Saturday morning, the patient presented to the A&E department of the local hospital with a one-day history of painless loss of vision in her right eye. The A&E trainee doctor elicited the three-month history of neck symptoms and occipital pain but not the history of jaw pain, and noted that visual acuity in the right eye was limited to counting fingers with an abnormal fundal appearance. ESR was 45 mm/hr.

The case was discussed with the on-call ophthalmology trainee. It was decided that the patient probably had a central retinal artery occlusion. Arrangements were made for the patient to be seen on the following Monday afternoon in the ophthalmology department.

The patient was brought to hospital by ambulance on the Monday morning having developed visual loss also in her left eye. Visual acuity was limited to counting fingers in the right eye due to central retinal artery occlusion, and hand movements in the left eye due to optic nerve infarction (anterior ischaemic optic neuropathy). The right superficial temporal artery was not tender but pulseless. The left superficial temporal artery was pulsatile and not tender. CRP was elevated at 40 mg/L.

GCA was diagnosed. The patient was admitted and treated with intravenous methylprednisolone followed by high-dose oral steroids, together with osteoporosis prophylaxis, long-term management being supervised by a rheumatologist. Temporal artery biopsy was positive. The patient's

vision did not improve and she was certified severely visual impaired. Unable to return to her home, she had to be rehoused, with extensive support from social services. Treatment was subsequently required for diabetes mellitus and systemic hypertension.

Six months after the patient's admission to hospital, each of the GPs received a letter from solicitors acting on behalf of the patient indicating the likelihood of a claim for clinical negligence. The subsequent letter of claim alleged that each had been negligent by:

- *not considering the diagnosis of GCA*
- *not arranging urgent investigations or urgent hospital referral*
- *not instituting systemic steroid therapy*

It was also alleged that the patient's diabetes mellitus and systemic hypertension were a direct consequence of the GPs' negligence.

The GPs had a group membership with the MDU. A GP expert, instructed by the MDU to provide a report on breach of duty, was critical of the GP who had elicited the history of jaw pain. He considered that it would be difficult successfully to defend the failure to refer on this date.

An ophthalmology expert concluded that institution of oral systemic steroid therapy at any time before the onset of visual loss in the right eye would probably have prevented any visual loss in either eye. He criticised the hospital's failure to institute high-dose systemic steroid therapy on the day of presentation to A&E, which would probably have avoided any loss of vision in the left eye.

A rheumatology expert advised that the development of diabetes mellitus and systemic hypertension would have happened in any case and could not be ascribed to the delay in starting systemic steroid therapy.

The case was settled jointly by the MDU, on behalf of the GPs, and the hospital on the basis that there had been unreasonable delay in diagnosis and institution of treatment of GCA by both the GPs and the hospital. A large settlement was necessary because of the patient's rehousing and care needs.

Learning points

- Though giant cell arteritis mostly affects patients over 60, the incidence continuing to increase with increasing age, GPs may need to consider the diagnosis in any patient over 50 with new onset severe headache or sudden visual loss.
- Jaw pain has a variety of causes, notably dental problems. In older patients, GPs may need to consider the possibility of jaw claudication, which is almost always due to GCA. Asking the patient to describe the characteristics of the pain when it first started will usually clarify the temporal relationship to chewing developing after chewing has started, increasing in severity as chewing continues, and gradually resolving once chewing has stopped.
- ESR and CRP are usually elevated but may be normal in GCA.
- The most definitive diagnostic test for GCA is superficial temporal artery biopsy, a positive result providing important justification for the necessary long-term systemic steroid therapy and its attendant risk of adverse effects, but arranging the biopsy should not delay the institution of systemic steroid therapy.
- In the first instance, the diagnosis of GCA is based upon clinical features. GPs may need to institute systemic steroid therapy urgently, or as an emergency if there are visual symptoms.

References

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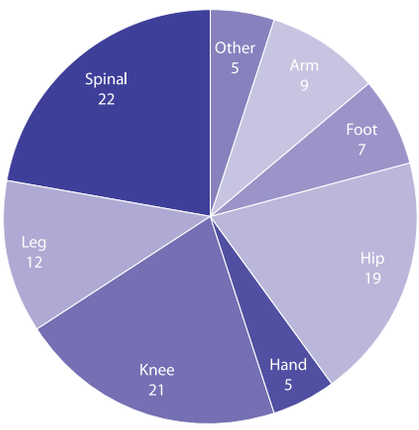
The bare bones of orthopaedic risk: An orthopaedic specialist in independent practice might expect to be notified of a claim every eight years, according to MDU research. This compares with a claim every 35 years in anaesthetics, for example. Dr Karen Roberts, MDU medico-legal adviser, looks at the steps that can be taken to help reduce the risk of a complaint or claim.

Though the proportion of settled claims in orthopaedics is small compared with the number of successful orthopaedic procedures undertaken in the private sector, the specialism does give rise to a higher number of claims compared with others. This analysis looks at 255 claims settled on behalf of MDU members practising orthopaedics in the independent healthcare sector over a recent 10-year period in which the damages paid to compensate patients, excluding legal costs, ranged from just over £800, for a retained swab, to more than £1 million, awarded to a patient who suffered partial paralysis in the arm following shoulder surgery.

The level of compensation is not related to the 'gravity' of any alleged negligence but calculated according to how much it would cost to restore patients to the position they would be in had the negligence not occurred.

Site of surgical procedure

Claims relating to spinal and knee surgery were most prevalent in the 10-year period considered, with the management of spinal problems the most expensive category of claims. The settled claims in this category cost nearly £9 million in total damages, including legal costs, a reflection of the severe damage that can occur when things go wrong in spinal surgery and the extensive private medical care patients may need for the rest of their lives



Percentage claims by anatomical location

The spinal procedures involved included decompression of the spine, discectomy and spinal fusion. In one case, a patient claimed that there had been nerve damage during a discectomy that led to bowel and urinary problems. The claim was eventually settled for £180,000 plus legal costs.

Unsurprisingly, two of the most common procedures performed by orthopaedic surgeons – knee replacements and arthroscopies – were also the most common knee procedures that resulted in settlement of a claim. In one typical case a patient alleged that the surgeon had failed to spot ligament damage during a knee arthroscopy. The claim was eventually settled for just over £6,500 plus legal costs.

Hip surgery was the third site most likely to lead to a claim being settled, with most settled claims in this category resulting from hip replacement procedures. Reasons included post-operative dislocation of the joint and unequal leg length following the operation.

Reasons for claims

By far the most common primary reason patients had for the orthopaedic claims (see table) that resulted in settlement was an unsatisfactory outcome (49 cases). In a number of cases, patients required corrective surgery as a result of technical problems during a procedure that orthopaedic experts considered amounted to negligence. However, in some cases it also highlights the need for better pre-operative counselling to ensure patients have realistic expectations of what surgery can achieve and the likelihood of complications. This is borne out by the 12 claims in which failure to obtain full informed consent was cited as a primary factor.

Main reasons for claim

Unsatisfactory outcome	49
Diagnosis	33
Nerve damage (inc Cauda Equina)	32
Wrong side/wrong site	17
Pain	17
Infection	16
Post-operative complication	15
Dislocation	15
Consent	12
Retained item	9
Wrong operation	9
Other	8
Mobility	8
Tissue damage	7
Burn	6
Scarring	2

Doctors may wish to consider the following risk management points:

- Ensure consent is obtained by an appropriate member of the surgical team, ideally the surgeon who performs the operation.
- Advise patients of the risks and benefits of surgery, other treatment alternatives, the option of no treatment, and the complication rates, and document this.
- Diagrams and other written information may help patient understanding.

- Check patients understand and assess for unrealistic expectations.
- Ensure patients are aware of the possible post-operative complications and know what steps to take if problems arise after discharge from hospital.

Diagnosis

There were 33 cases in the review period where a diagnosis was allegedly missed or delayed, or the wrong diagnosis was made, including fractures and dislocation, deep vein thrombosis, cancer and cauda equina syndrome.

It can sometimes be difficult to make a diagnosis on clinical grounds alone and expert advice in these cases found some recurring themes, which included:

- Inadequate patient examination and delays in arranging further investigation.
- Inadequate recording of clinical history, particularly following a trauma.
- Diagnoses that were considered, but appropriate steps not taken to exclude them.

Failure or delay in making a diagnosis is not necessarily negligent but the following risk management recommendations may help doctors to reduce the risk of this occurring:

- Take a thorough clinical history.
- Conduct a thorough examination of all areas that could have been injured and make a note of this.
- Make a note of the initial diagnosis and management plan in the record and be prepared to review and reassess the diagnosis if symptoms fail to improve as expected.
- Ensure that appropriate investigations, x-rays and other tests are carried out, the results reviewed and action taken where necessary.

Wrong site surgery

The MDU's analysis revealed a small but significant number of claims relating to errors involving the wrong operation site or side (17 cases), and incidents where the wrong procedure was performed (nine cases). Such cases are generally difficult to defend successfully.

Automated patient identification systems are being developed to help prevent such incidents but it is also vital to perform simple manual identification checks as well, as indicated in these risk management points:

- Avoid using any abbreviation which refers to side, site or anatomical location and avoid ambiguity about fingers and toes.
- Check patients' referral letters against clinical records, consent forms and the operation list to ensure they are in agreement.
- Confirm with patients that details are correct at all stages: on admission, when leaving the ward en route to theatre, on entering the theatre suite etc.
- A member of the surgical team should mark the correct surgical site on the ward or in the day case area using an indelible marker.
- Ask patients to state (rather than simply confirm) their full name, date of birth and the anatomical location of the intended procedure.
- The operating surgeon should see the patient before the administration of anaesthesia and ensure correct clinical documentation is available.
- The operating surgeon must be satisfied of the intended site, side or level of surgery before patients are draped and marks must be clearly visible after drapes are put on.
- Carry out a final check with the theatre team before the procedure starts.

Post-operative complications

Several reasons for claims can be categorised as post-operative complications. These include nerve damage, including cauda equina syndrome (32 cases), healthcare related infections (16 cases), dislocation (15 cases) and mobility problems (eight cases). Other post-operative complications, such as haematoma and deep vein thrombosis accounted for a further 15 claims.

Claims which cite nerve damage as the primary reason may be due to a number of factors including inadequate surgical technique and failure to warn the patient that nerve damage is a recognised complication. Careful post-operative monitoring is essential to pick up problems in good time. Monitoring is also important to prevent delays in diagnosis and treatment of infection.

Retained items

Nine of the settled claims involved a retained item following an orthopaedic procedure, including swabs, pins and drains. Problems can be minimised by ensuring all equipment is maintained and serviced regularly; that swab, instrument and needle counting policies are strictly adhered to; and that disposable items are checked before use.

'On average, one in three claims brought against MDU orthopaedic members is settled, the other two-thirds being discontinued by the claimant or successfully rebutted'

Analysis inevitably highlights areas where mistakes are more common or costly, but the MDU has not found evidence that the number of such errors is increasing. In addition, it is worth pointing out that on average one in three claims brought against MDU orthopaedic members is settled, the other two-thirds being discontinued by the claimant or successfully rebutted. Also, many of the cases the MDU settles are the result of system failures, rather than individual error.

However, if something does go wrong, doctors are advised to give patients a prompt and sympathetic explanation of what has happened, including an apology if appropriate, and take steps to arrange prompt and appropriate ongoing care. They can also provide information about what will be done to try to prevent a recurrence. Members should also contact the MDU for advice.

A version of this article first appeared in 'Independent Practitioner'.

case histories

Failure to adequately monitor liver and lung function

A GP faced a claim for damages which alleged that his failure to carry out routine periodic blood tests on a patient prescribed long-term anti-bacterial treatment resulted in liver damage and other complications.

A middle-aged woman with longstanding urinary problems for which she was self-catheterising had recurrent urinary tract infections. Her urologist spoke to her GP and recommended that she be started on long-term prophylactic nitrofurantoin 50mg nocte. The GP, an MDU member, began the treatment and as the consultant had specified the dosage did not check with the British National Formulary (BNF). Repeat prescriptions were issued by him and his partners in the practice and the patient seen from time to time.

The patient returned to see another GP in the practice two and a half years after the first prescription was issued, complaining of shortness of breath, cough, tiredness and weight gain. The GP organised routine blood tests. The liver function tests (LFTs) were abnormal and the patient was immediately advised to stop taking the nitrofurantoin and to avoid alcohol and paracetamol while the LFTs were repeated. However, a few days later she became clinically jaundiced and she was referred urgently to a gastroenterologist.

Nitrofurantoin-induced associated chronic active hepatitis was diagnosed and the patient was treated with prednisolone and, later, an immunosuppressant azathioprine was also prescribed.

Two months later the patient developed headache and blurred vision and she was referred to a neuro-ophthalmologist. Visual acuity was reduced to counting fingers and her visual fields were severely restricted. Spheno-ethmoidal aspergillosis was eventually diagnosed and a sphenoid-ethmoidectomy and biopsy was performed. A dramatic improvement in the patient's visual acuity followed and her vision gradually returned to normal. However, she lost her sense of smell and taste permanently. She was started on amphotericin and there was a transient deterioration in her renal function.

The patient brought a claim for damages against the GP who initially prescribed nitrofurantoin as well as all his partners in the practice, alleging failure to heed the advice in the BNF that patients on long-term nitrofurantoin should have regular monitoring of liver and lung function.

It was further alleged that the patient should have had liver and lung function monitored at least three-monthly, and that if such monitoring had taken place the abnormal liver function would have been picked up at an early stage. The drug would then have been stopped and the liver function would have returned to normal without the need for the steroids and immuno-suppressants which led to an aspergillosis infection.

The GP member asked the MDU to assist him with the claim.

How the MDU responded

Expert advice was sought from an experienced GP who confirmed that although this was the advice contained in the BNF, it was not widely known. However she said that prescribing a drug in a way that was unfamiliar to her would have led to her looking it up.

She also pointed out that the BNF made no reference to the frequency needed for the monitoring. The relevant edition of the BNF stated:

'For long-term treatment monitor patient closely for appearance of hepatic or pulmonary or neurological symptoms and other evidence of toxicity …. chronic active hepatitis occasionally leading to hepatic necrosis is generally associated with long-term therapy (usually after six months). The onset may be insidious.'

An expert hepatologist confirmed that on the balance of probability the liver disease was related to the use of nitrofurantoin, and that the treatment with steroids and azathioprine was appropriate.

An expert clinical pharmacologist commented that although the BNF records the need to monitor periodically, the exact definition of periodically is not given. In his view it should have been at least every six months. While he could support the decision to use nitrofurantoin, he thought most doctors would be unaware of the need for monitoring and it was probably rarely done in practice.

A conference with counsel was held at which considerable sympathy was shown by the experts for the prescribing member's position. In the light of the advice in the BNF which was available for all GPs to refer to, however, it was advised that the case would have to be settled.

The claim was settled for more than £50,000, with general damages for the short-term visual loss and permanent loss of taste and smell. Special damages were paid to cover loss of earnings as well as the private medical expenses incurred.

Learning points

1. Prescribing practice

Doctors are **legally responsible** for any prescription they sign, so it is important to be familiar with the drug being prescribed. The GMC's guidance *Good Practice in Prescribing Medicines* (2006) (www.gmc-uk.org), states:

'When prescribing medicines you must ensure that your prescribing is appropriate and responsible and in the patient's best interests. To do this you must … ensure you are familiar with current guidance published in the British National Formulary

and BNF for Children, including the use, side-effects and contraindications of the medicines that you prescribe.'

2. Repeat prescriptions

Many of the prescriptions generated in general practice are repeat prescriptions and this is an area where, in the MDU's experience, mistakes often happen. It is important to consider the robustness of the systems in place to **review** and **monitor** repeat medication regularly, all the while:

- Checking that your **computer system** cannot be over-ridden if it allows a set number of prescriptions to be issued before review.
- Ensuring that all staff receive **training** in the repeat prescribing procedure.
- **Informing** patients about the practice's repeat prescription procedure, for example through practice leaflets or surgery posters.

3. Incident reporting

The MDU advises practices have an adverse incident reporting system in place so that they can learn from any mistakes or near misses that do occur. The MDU has issued guidance for members on *Adverse Incident Reporting and Significant Event Audit* that is available at www.the-mdu.com.

Glynis Parker
senior medical claims handler, MDU

The hazards of foreign travel

A GP was accused of delay in diagnosing deep vein thrombosis after failing to spot the condition in a woman who, following an exotic holiday, attended her practice with a spider bite to the leg.

A patient who had just returned from a holiday in Africa attended her GP practice immediately she arrived home as she had suffered a spider bite on her leg while away. The doctor she had seen while abroad had prescribed antibiotics and anti-inflammatories.

The GP was sufficiently concerned to ring the local consultant in infectious diseases who advised that there was no specific treatment for the spider bite.

The GP also examined the patient's leg, specifically looking for signs of a deep vein thrombosis (DVT) in view of the long journey the patient had undertaken. She found none but she did observe cellulitis and generalised oedema of the lower leg. She also established that the patient had taken the anti-malarials she had been prescribed prior to travel.

As there was no fever and no other systemic symptoms at the time, the GP advised review in one week or earlier if the condition of the leg deteriorated.

Two days later, as the swelling was worse and the leg more painful, the patient arranged to see an out-of-hours doctor who referred her to hospital, where a DVT in the leg was diagnosed. The patient was given anticoagulants and discharged.

A claim was made against the GP, an MDU member, alleging delay in the diagnosis of the DVT.

How the MDU responded

A consultant in infectious diseases said that the relevance of the bite to the DVT was difficult to comment upon as significant tissue swelling can follow spider bites. He said that although venous thrombosis is associated with spider bites in very rare cases, the association is not clear and only a venom specialist could be sure. The air travel was probably much more significant a factor, he concluded.

In the event, the claim was not pursued against the GP, possibly because the claimant was advised that the short delay in the diagnosis of the DVT had not caused any harm.

Learning points

- With patients travelling to more exotic places, doctors will probably wish to consider the possibility of tropical diseases and ensure, as in this case, they are excluded. If necessary, GPs may need to seek the advice of more experienced colleagues, such as a consultant in tropical medicine
- The GP gave the patient clear advice about what to do if their condition didn't improve. The GMC requires doctors in *Seeking Patients' Consent* (1998) to tell patients 'how and when [their] condition and any side effects will be monitored or reassessed' (paragraph 5).
- The GP had kept clear, accurate and contemporaneous notes. She had recorded in detail the differential diagnosis, the examinations that had taken place, and the management plan, including the advice given to the patient about follow up. The GP would have been able to rely on the records in defending the claim.

Glynis Parker
senior medical claims handler, MDU

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