



MDU

**Legal and  
ethical dilemmas**

**for consultants**

# Welcome to legal and ethical dilemmas

## for consultants

Throughout the MDU's history our team has been led and staffed by doctors with real-life experience of the pressures and challenges faced in practice.

We help members with a wide variety of problems each year; from providing telephone advice on how to deal with dilemmas about breaching confidentiality, to supporting members through GMC investigations into their fitness to practise, to defending them against claims for negligence.

We have compiled a selection of short dilemmas to illustrate some of the problems the MDU can assist consultant members with. The cases are anonymised to protect members' and patients' confidentiality, but they are all based on real cases. We hope they will give you some insight into the range of expertise available to assist members and demonstrate how committed we are to providing support and advice to members in every day practice as well as during difficult times.

I hope you will find these dilemmas topical, informative and relevant to your practice.



**Dr Christine Tomkins**  
Chief executive

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## My patient, the celebrity



**Q** As a specialist in my field, I was approached by a celebrity agent to treat the famous person they represent. Following the recent successful treatment, I have been approached by several journalists for comment. What should I do?

**A** The medical treatment given to celebrities has long been of interest to gossip magazines and newspapers.

However, this does not mean you can comment freely about your famous patient's treatment, even if the celebrity has put many of the details in the public domain already. Indeed, even confirming to the media that someone is a patient, without their explicit permission, is a breach of confidentiality.

You should always act in the patient's best interests and follow the GMC's guidance on *Confidentiality* (2017), which says that information about patients can only be disclosed with their express consent. In general, you should think very carefully before you decide to talk to the media about a celebrity patient, even with the patient's apparent consent.

If a patient asks you to issue a formal statement on their behalf, you should agree the content of such a statement together. However, being interviewed carries significant pitfalls in terms of patient consent. While you might agree general areas of discussion

with the patient, neither of you can be certain in advance of what you might be asked or how you might respond. There is a possibility that you may inadvertently reveal details that the patient did not consent to being released, such as aspects of the celebrity's medical history that are relevant to their current treatment.

***You should always act in the patient's best interests...***

If, on balance, you prefer not to comment, you may choose to explain that you are unable to do so because of the duty of confidentiality you owe to all your patients. If you are working in an NHS trust, there should already be a protocol in place about disclosing patient information to other organisations. You can also contact the trust media team or the MDU 24-hour freephone advisory helpline on **0800 716 646** for specialist media advice.

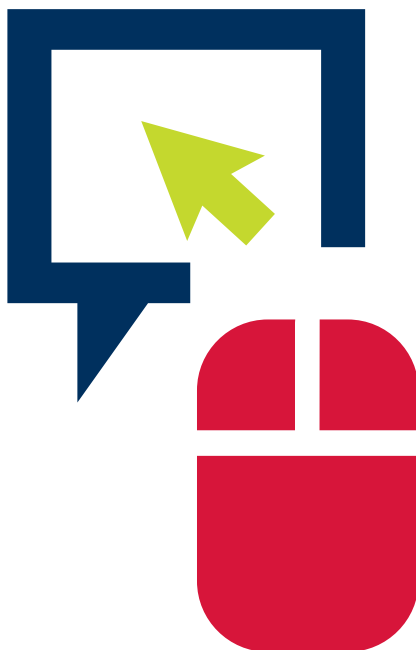
## Patient blog sites

**Q** I have come across a blog set up by the husband of one of my patients who died some years ago. The blog is principally about how he has coped with bereavement but he also makes a number of serious allegations about poor standards of care in the hospital where I work. What should I do?

**A** The husband may have already made a complaint to the hospital about his wife's care resulting in a thorough investigation. Whether this is the case or not, you may wish to consider reporting his comments to the trust via its incident reporting system. Many trusts will consider any event which might lead to adverse publicity for the trust as a significant incident.

It's important to remember that the blog is solely from the husband's perspective and is unlikely to tell the whole story. In contrast, a formal significant untoward incident investigation is likely to involve seeking the views of all staff who were involved in the care of the patient, as well as a review of the clinical records. This process is intended to ensure that lessons are learnt from the incident so that patient care may be improved. You may be asked to provide a statement to the trust investigation about your treatment of the patient and you may wish to seek MDU assistance with this. It is also possible that the press might pick up on the husband's comments.

You remain bound by your duty of confidentiality to your patient even after her death. The GMC advises in its supplementary guidance to confidentiality that 'you should usually limit your public response to an explanation of your legal and professional duty of confidentiality'.



## Assisting at a charity sports event

**Q** I have been asked to attend my son's school rugby tournament as the event doctor. What issues do I need to take into consideration?

**A** Doctors are often asked to provide medical cover at amateur and charity sporting events. In smaller events with spectator numbers of less than 2000, this may involve providing medical care to players and the crowd. The types of medical problems which an event doctor may be faced with can range from acute traumatic injury of a participant, including spinal injury, to facial injuries or cardiac arrest.

Doctors should have appropriate qualifications, skills, experience, equipment and support to undertake such work. Paragraph 14 of the GMC's *Good medical practice* guidance (2013) states 'You must recognise and work within the limits of your competence.'

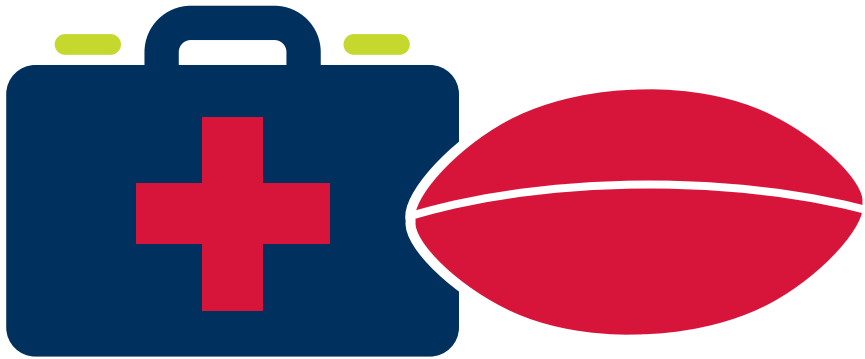
This guidance applies even if you are providing your services on a voluntary basis, such as at the school rugby tournament. You will need to ensure that your skills and experience are appropriate for the task. For example, you will need to be expert in areas such as cardiopulmonary resuscitation, airway maintenance and spinal fracture immobilisation. You will also need to ensure you have the right equipment and support. If you are not sure what you may need, many sporting organisations publish guidelines on equipment levels

and clinical protocols and you will need to make sure you comply with these where they are available. The school will probably have an event organiser who should be able to help you to ensure you have what you need.

***'You must recognise and work within the limits of your competence.'***

You are required to have indemnity for any claims arising from attendance at a sporting event. Paragraph 63 of *Good medical practice* (2013) states 'You must make sure you have adequate insurance or indemnity cover so that your patients will not be disadvantaged if they make a claim about the clinical care you have provided in the UK.'

Some professional sports organisations or organising bodies provide indemnity for doctors acting in a professional capacity, and you should check this before the event. If the school cannot provide you with indemnity, please contact us to check whether your current membership will indemnify you for this. This is equally important whether you are paid or planning to attend voluntarily.



If a medical problem should occur during the event, your ethical responsibilities, such as the need to obtain consent and to maintain confidentiality, remain the same as in any other aspect of your medical practice. Consent for examination or treatment can be written, verbal or implied and you have a duty to keep all information about patients confidential unless you have their consent to disclose that information.

It may be helpful to familiarise yourself with the local health services, in particular the ambulance service, in the event that a serious injury requiring hospital transfer occurs. You should also keep detailed notes of any incidents and the medical care you provide.

Acting as an event doctor is quite separate from Good Samaritan acts, where a doctor attends an event in a non-professional capacity and is called upon to provide medical care in an emergency. GMC guidance makes it clear you have an ethical duty to

give what assistance you can in the circumstances. *Good medical practice* (2013) paragraph 26 states 'You must offer help if emergencies arise in clinical settings or in the community, taking account of your own safety, your competence, and the availability of other options for care. You must provide what assistance you can, working within your competence unless there is no reasonable alternative'.

If you just turned up at the rugby match and no doctor was there and one of the players was injured, you would be expected to treat the patient. As an MDU member you would have access to indemnity for Good Samaritan acts. Make sure you keep a note of the incident.

## Private patient fee disputes

**Q** A patient attended my private clinic requesting treatment for acne scarring. I performed laser treatment after careful examination and a detailed history-taking. Before the procedure I told the patient that laser treatment was commonly performed and generally safe but there could be side effects and potential complications which I outlined in detail. I documented this discussion in my notes as usual and the patient signed a consent form that mentioned the potential complications. The procedure was uneventful and I arranged to see the patient for follow up ten days later. On routine review, the skin appeared to be healing well and the patient did not express any concerns so no further follow up was arranged. However, three months later, I have now received a letter of complaint from the patient stating that she is dissatisfied with the aesthetic results including some persisting redness in the treatment area and a slight change in her skin pigmentation next to the treated region.



She has requested a refund of the cost of the treatment. I initially contacted the patient to say I would be happy to review her again in clinic to assess the pigmentation and discuss whether it could be rectified.

The patient has declined my offer and reiterated her demand for a reimbursement of her costs. What should I do?



**A** It may be helpful to offer the patient an explanation of the treatment she received and consider apologising for the fact that she is dissatisfied with the results. Although the NHS complaints procedure does not apply to independent practice, we advise members to apply the central principle, namely that patients who complain should receive a full explanation for the care they received and an apology where appropriate. Furthermore, paragraph 61 of the GMC's *Good medical practice* guidance (2013) states that 'You must respond promptly, fully and honestly to complaints and apologise when appropriate. You must not allow a patient's complaint to adversely affect the care or treatment you provide or arrange'.

Complaints about cosmetic procedures are more common than complaints about other surgical procedures, possibly in part because of unrealistic patient expectations. It is important to ensure that patients have a realistic idea of the potential results before treatment. Some patients who are dissatisfied may go on to request reimbursement of their costs.

In this case, the decision as to whether to refund costs is a matter of personal discretion for the private surgeon concerned. This type of payment is known as an ex-gratia payment, which is a payment made as a goodwill gesture, without admission of liability.

It is important to ensure careful wording of any correspondence and we can assist you with your response.

It may reassure you to know that the Compensation Act 2006 makes it clear that an apology, offer of treatment or other redress does not of itself amount to an admission of negligence or breach of duty. It should be noted that, even if you make an ex-gratia payment to the patient, there is unfortunately no guarantee that this will prevent the matter from proceeding to a claim for alleged negligence.

Detailed and contemporaneous note-keeping and careful documentation of the consent process, such as information given and questions asked and answered, could be very helpful in mounting a robust defence if a claim were made.

## Advertising services

**Q I would like to include patient testimonials and before and after photographs on a new leaflet advertising my services. Can I do this and are there any restrictions?**

**A** When publishing information about your services it must be factual, verifiable and must not make unjustifiable claims about quality or outcome, nor must it exploit patients' vulnerabilities. Whenever patient information, be it photographic or otherwise, is to be available to third parties, you must have written consent from the patient even if they are not identifiable. The patient must not be put under any pressure to agree. In seeking consent, you will need to tell patients how you intend to use their photographs, what sort of audiences the material will be shown to and how long it will be in circulation. Patients also need to be told that once their image has been published it may not be possible to fully control its future use. Any images of patients should not compromise their privacy or dignity.

Patients will need to see the photographs in the context in which you intend to use them (e.g. leaflet or website) and you must make it clear that they can withdraw their permission at any time, and that it will not in any way affect the care they receive. You will need to answer any questions patients ask, in addition to the details that you have provided. GMC guidance on this topic can be found in *Good medical practice* (2013) in paragraph 70 under the heading 'Communicating information'.

If you wish to advertise NHS services, you should refer to the Code of Practice for the promotion of NHS funded services (March 2008) which is available on the Department of Health website [dh.gov.uk](http://dh.gov.uk)

In particular, paragraphs 35-41 deal with testimonials and endorsements. These must be, among other things, 'based on genuine experience, given freely without financial payment or other inducement...'

Finally, advertising must also conform to the Advertising Codes enforced by the Advertising Standards Authority. Further information is available on their website [asa.org.uk](http://asa.org.uk)

## Bigger but not better

**Q** At a private clinic I saw a 30 year old woman who wanted a breast augmentation. After the procedure, the patient said she was happy with the results. Later on I read a newspaper article about cosmetic surgery that had gone wrong and was shocked to see my patient featured prominently, complaining she had failed to achieve the size of breasts she wanted and was getting depressed. To my surprise, a year later she came back asking for another augmentation, saying she was initially happy with the outcome of the first operation but now wanted to be 'bigger'. Am I obliged to carry on treating her?

**A** You should consider whether the patient is suitable for a breast augmentation procedure now. It is important to follow the GMC's *Guidance for doctors who offer cosmetic interventions* (2016). If you believe that the operation is unlikely to deliver the desired outcome, you must explain this to the patient. Give her adequate time for reflection and keep a careful record of your conversations. In addition, you must consider her psychological needs and consider whether it is necessary to consult her GP to inform your discussion about risks and benefits. If the patient is determined not to involve her GP, you must record this in her notes and consider how it affects the balance of risk and benefit and whether you should go ahead with the operation. If, after discussion you believe that the operation will not be of benefit to the patient, you must not provide it.

If asked, you should forward the patient's medical records to any surgeon the patient subsequently goes to see.

Given the patient's behaviour, you may feel that there has been a breakdown in the patient-doctor relationship, in which case you should explain this to the patient, ideally in writing.

*'...you should end a professional relationship with a patient only when the breakdown of trust between you and the patient means you cannot provide good clinical care to the patient.'*

Remember paragraph 62 of *Good medical practice* (2013), which states that you should end a professional relationship with a patient only when the breakdown of trust between you and the patient means you cannot provide good clinical care to the patient.

The GMC has provided explanatory guidance on ending your professional relationship with a patient, which explains that 'you should not end a professional relationship with a patient solely because of a complaint the patient has made about you or your team.' The guidance goes on to say that you must be satisfied that your reason for wanting to end the relationship is fair and does not discriminate against the patient.

## Treating children

**Q** A 15 year-old girl was admitted to A&E with an ectopic pregnancy. She says that she has had a sexual relationship with her boyfriend for the last year and had been on the pill.

**When her parents arrive she says she does not want them to know about her condition. What should I do?**

**A** Sharing information with relatives is normally done only with the patient's express consent. You need to consider if the patient is competent to refuse consent for her parents to be informed in this case. Children under 16 can consent on their own behalf if they have the intelligence and maturity to understand the implications of their decision. For example, to consent to treatment, the patient would need to understand the nature, purpose, benefits and risks of any procedure, as well as the risk of going untreated and any alternatives. She would also need to be able to retain, use and weigh up this information, and to communicate her decision. If the patient has capacity to consent to treatment, then she may also have the capacity to withhold consent to disclosure of confidential information.

In paragraph 21 of the GMC's guidance *0-18 years: guidance for all doctors* (2007) it says 'You have the same duty of confidentiality to children

*'You have the same duty of confidentiality to children and young people as you have to adults.'*

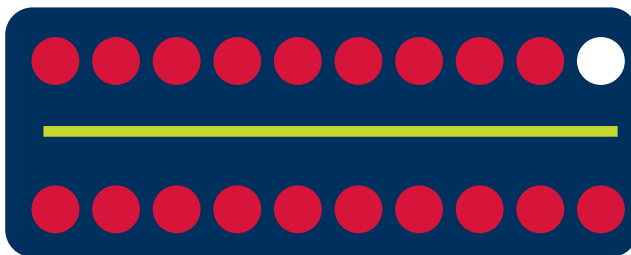
and young people as you have to adults.' In paragraph 53 of the guidance, it says in Scotland anyone aged 12 or over is legally presumed to have capacity to control access to their health records. The capacity to consent may vary according to the question being considered, that is, consent to the treatment or to disclosure of her condition, as well as the individual's state of maturity and the effects of their illness or treatment.

Every reasonable effort should be made to persuade the patient to involve her parents, explaining why it may help to have their support. If she has capacity but refuses, then you may only disclose if there is an overriding public interest, or if disclosure is required by law. Disclosure in the public interest may be necessary to protect the patient or others from risk of death or serious harm, for example, if she is at risk of sexual, physical or emotional abuse.

You may not be able to judge whether a relationship is abusive without knowing the identity and age of her boyfriend. You should carefully balance the benefits of knowing her partner's identity against the potential loss of trust in asking for or sharing such information. If you are considering a disclosure in the public interest it would be wise to first discuss the case with your local named or designated doctor for child protection, as stated in paragraph 60 of the GMC's guidance *0-18 years: guidance for all doctors* (2007).

Whether or not you decide to disclose information to the girl's parents, record your decision and the reasons for it in the patient's notes. If you decide to disclose against your patient's wishes, you should tell her your intentions, unless you feel that this would undermine the purpose of the disclosure or put her at increased risk of harm.

***If you are considering a disclosure in the public interest it would be wise to first discuss the case with your local named or designated doctor for child protection.***



## Writing claims and insurance reports

**Q** I am sometimes asked to complete reports for patients making an insurance claim or seeking state benefits, what should I do if I feel that the claim has no merit?

**A** When completing such reports, ensure that the information you provide is a factual and balanced account of the patient's condition, regardless of your own view of the merit or otherwise of the claim. It is important to remember that unless you are specifically instructed to do so, you are not being asked to make a decision as to the merit of the claim or application, but rather to provide information to allow others to make a decision.

In paragraph 71 of *Good medical practice* (2013) the GMC advises that 'You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.' It goes on 'You must make sure that any documents you write or sign are not false or misleading. You must take reasonable steps to check the information is correct, and you must not deliberately leave out relevant information.'

The GMC requires that doctors asked to provide information to a third party should be satisfied that patients have sufficient information about the scope, purpose and likely consequences of the disclosure and understand that relevant information cannot be withheld.

Additionally the doctor should have seen written consent to the disclosure from the patient or someone authorised to act on his or her behalf. Patients have a statutory right to view certain reports, such as those for insurance or employment purposes, before they



## ***‘You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.’***

are sent. Even where no statutory right exists, the GMC advises in paragraph 115 of *Confidentiality: good practice in handling patient information (2017)* that a doctor should offer to share a copy of any report written for employment or insurance purposes before it is sent unless the patient has ‘already indicated that they do not wish to see it, disclosure would be likely to cause serious harm to the patient or anyone else, or disclosure would be likely to reveal information about another person who does not consent’.

Occasionally when patients have seen a report, they ask doctors to withhold certain information or to amend it before they submit it. You should only do this if you feel it can be done without compromising the accuracy of the report. If you cannot reach an agreement about the content of a report, a patient may add a dissenting statement detailing why he or she disagrees with the doctor’s account and, he or she may of course refuse to allow the report to be disclosed.

If the patient refuses to allow a report to be disclosed once the assessment has been done, make it clear to the patient that, if the report is not disclosed,



adverse inferences may be drawn. If the patient in that situation still does not consent, this must be respected and the report cannot be disclosed.

In situations where a report is being provided to fulfil a doctor’s contractual obligation to a third party, the doctor must obtain the patient’s consent before undertaking any examination or writing a report for that organisation. When seeking consent, explain the purpose of the examination or report and the scope of the disclosure.

## Reported concerns not addressed

**Q** I have a concern about a fellow colleague's surgical outcomes. I have worked with this colleague for a number of years. More recently, I have observed a number of post-operative problems and have been called in to the hospital, when on call, to deal with post-operative emergencies arising out of his cases.

**I have tried discussing the concerns with my colleague but this proved to be difficult as we have never really got on very well. I also feel that at directorate meetings previously, he was reluctant to accept advice and guidance.**

**Because my colleague would not take any notice of my concerns, I raised them with the clinical director but he did not appear to be interested. I then spoke in person to the medical director but he has not taken any action either. I am still seriously concerned that patients may be at risk. What should I do?**

**A** First and foremost, you have a duty to protect patients from harm. It was appropriate to voice concerns to the clinical and medical directors because the colleague in question would not discuss the matter with you. Although you may be anxious to avoid further disharmony in your department, you should consider setting out your concerns in writing to the medical



director. Doctors are required to comply with GMC guidance, which requires doctors to take steps promptly if they have concerns about a colleague which could impact on the safety of patients, so that concerns are investigated and patients are protected if necessary. The GMC has published advice for all doctors in *Raising and acting on concerns about patient safety* (2012). Doctors who are managers have additional responsibilities set out in the GMC guidance *Leadership and management for all doctors* (2012).

Keep a record of all correspondence on this matter. In the unlikely event that the medical director refused to investigate the concerns; or that a thorough investigation did not address the matter and you still believed patients were at risk, you might need to consider approaching the GMC yourself. But hopefully setting out your concerns in writing to the medical director should be enough for the matter to be properly investigated and, if it is necessary, for action to be taken to protect patients.



## Loss of USB memory stick

**Q** I was working late last week and decided to finish a report I was writing at home. Later on I wanted to save my work and realised that I couldn't find my USB memory stick anywhere. I am really worried because there was some statistical and patient identifiable data on it. What should I do now?

**A** Any loss of data should be reported to the nominated senior person within your organisation straight away. This is so that appropriate action can be taken, which may include informing the patients involved and the Information Commissioner's Office, depending on both the volume and sensitivity of the personal data involved.

It is possible that a breach of patient confidentiality could result in you receiving complaints from the patients involved, a disciplinary or potentially a GMC investigation and any negative media attention that could attract.

If you do need to work on confidential documents at home, you should discuss how to do this safely with your local IT manager. You may need to take physical precautions such as ensuring your device is password protected, encrypted and stored under lock and key.

You will need to be aware of, and adhere to, the relevant legislation, including the Data Protection Act 1998, and guidance produced by the GMC, for example *Confidentiality: good practice in handling patient information* (2017).

The Department of Health has said that 'the movement of unencrypted person identifiable data held in electronic format should not be allowed in the NHS' and 'wherever possible, person identifiable data should always be stored on a secure server.'<sup>1</sup> You should familiarise yourself with and follow your trust information security policy.

***'...the movement of unencrypted person identifiable data held in electronic format should not be allowed in the NHS...'***



### References

<sup>1</sup> Letter to all Information Officers at Strategic Health Authorities from Matthew Swindells, Director General, Information and Programme Integration, Department of Health, 20 January 2008. <http://bit.ly/shaletter>

## Co-prescribing unlicensed medicines with a GP

**Q** I recently started a patient on an unlicensed drug and requested the patient's GP provide repeat prescriptions.

**The GP was concerned because she had never heard of the drug before and furthermore, she thought that it was unethical and possibly illegal to prescribe a drug outside of its product licence. What should I do?**

**A** Legal responsibility for the decision to prescribe falls to the clinician who signs the prescription so before the GP can provide repeat prescriptions she will need to satisfy herself that she can do so. Of course, it is not for you to give the GP legal and ethical advice, but hopefully the following helps you to understand the position.



In the UK, no medicine can be marketed for human use without a product licence granted by the Medicines and Healthcare products Regulatory Agency. However, the licensing arrangements permit doctors to prescribe unlicensed drugs, and to use drugs for unlicensed indications in specific circumstances.

Doctors have a legal duty to take reasonable care and to act in a way that is consistent with the practice of a responsible body of their professional peers. If a decision to prescribe an unlicensed drug was ever tested, the clinician's decision would have to be capable of support from an informed, reasonable body of clinicians of similar training and experience.

Informed consent is a crucial aspect of off-licence prescribing. Doctors must make it very clear to the patient that the medication is unlicensed, and why that is. Patients must be told why the drug is being prescribed, what alternatives exist, and have all their questions answered fully. You must make a clear record that the indications for the drug and the risks have been explained and that the patient both understands the risks and is willing to accept them. The GMC provides specific guidance on the prescription of unlicensed medications and the prescription of medications outside the terms of their licence.

## ***...it may be helpful for you to provide the GP with information about the drug's safety and value in this particular condition.***

Paragraphs 67-74 of *Good practice in prescribing and managing medicines and devices* (2013) guidance for doctors states that the prescribing doctor should be satisfied that an alternative, licensed medication would not meet the patient's needs and that there is a sufficient evidence base and/or experience of using the medicine. Additionally paragraph 70 (b) states that the doctor signing and issuing the prescription personally bears the responsibility for that treatment. It is imperative that any GP who is to provide ongoing management understands the patient's condition, the treatment prescribed and can recognise any adverse effects of the medication and should take responsibility for monitoring and any follow up treatment. If the GP agrees to provide repeat prescriptions, it will be important to agree with her when she will take over responsibility for prescribing the drug.

The GMC also specifically addresses the issue of prescribing medicines to hospital outpatients. Paragraph 41 indicates that where a patient's care is shared between clinicians, doctors with responsibility for the continuing management of the patient must

be fully competent to exercise their share of this clinical responsibility. If the patient's GP is to be responsible for monitoring the patient, she must be satisfied that she understands enough about the drug to do so.

As you are familiar with the drug, it may be helpful for you to provide the GP with information about the drug's safety and value in this particular condition. Paragraph 40 makes clear that you should be willing to answer the questions posed by a colleague and assist in caring for the patient as required. If the GP is satisfied, she may then be happy to prescribe the drug, but the decision is ultimately hers. She will be responsible if she agrees to continue the prescription.

If the GP agrees, you could set up a formal shared care agreement and consider drawing up a protocol for the GP to follow, making clear the monitoring requirements and indications for dose adjustments. It may also be necessary for the GP to seek approval from the CCG to ensure prescribing the drug in this way complies with any local guidelines on prescribing.

## Disclosure to the DVLA

**Q** A 30 year-old patient has been recently diagnosed with epilepsy manifesting with grand mal seizures. I previously advised the young woman that she should not drive a car in line with the Driving and Vehicle Licensing Agency (DVLA) guidance *Assessing Fitness to Drive: A Guide for Medical Professionals*. At the subsequent review, it was apparent that she had continued to drive in order to take her children to and from school. I am concerned about the safety of her and her children, as well as other road users and pedestrians. What should I do?

**A**

While you have a duty of confidentiality to your patient, there are circumstances where it may be necessary to breach confidentiality to protect patients or others from harm. However, before you do so, the GMC advises that every effort should be made to persuade the patient to stop driving voluntarily. (See GMC's guidance on reporting concerns about patients to the DVLA or to the Driver and Vehicle Agency (DVA) (Northern Ireland) found in the supplementary guidance accompanying *Confidentiality* (2017).

If the patient disagrees with the diagnosis and advice to stop driving you may agree with the patient to seek a second opinion, but she should be advised not to drive in the meantime. If she continues to drive, having already ignored your advice about her legal duty



to family and others, you may have no option but to contact the DVLA yourself. You will need to make this clear when you are trying to persuade the patient to stop driving. It may help if you can inform the patient's relatives of your concerns but you would only be able to do this if she agrees.

If the patient continues to drive despite your advice, the GMC recommends that you should contact the DVLA or DVA immediately and disclose any relevant medical information, in confidence to the medical advisor. You will need to try to inform the patient of your decision to disclose before you do so. Inform the patient in writing once you have contacted the DVLA or DVA. Any disclosure made should be the minimum necessary. Make a note in the patient's records setting out your actions and explaining your reasons behind your decision to disclose, as you may be asked to justify your actions if the patient makes a complaint.

## Amending patient records

**Q One of my patients has just died from a heart attack in hospital. I examined him thoroughly three hours ago but only made a brief note of the consultation, as I didn't have time to write up a full note - can I update the record after the event?**

**A** Records are primarily intended to support patient care and should authentically represent each and every consultation (including by telephone). They form the basis of good communication about the patient, between doctor and doctor, or between a doctor and other members of the health care team. However, medical records may sometimes need to be amended.

Any change should be clearly documented either electronically or in writing to show the date of the amendment and the name of the individual making the change – in other words that there is an identifiable audit trail. It must remain possible to retrieve the original entry. Hard copy errors should be scored out with a single line so that the original writing is still visible and the correct entry written alongside with the time, date and your signature.

Medical notes must never be overwritten or inked out and computer forms must never be erased or deleted. Any additions should be

separately dated, timed and signed. Never try to insert new pages of notes. The GMC, in paragraph 19 of *Good medical practice* (2013), states that 'Documents you make to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.' It goes on to say that clinical records should include 'relevant clinical findings, the decision made and actions agreed, the information given to patients, any drugs prescribed or other investigation or treatment, who is making the record and when.' 'Tampering' with records has led to GMC investigations and the MDU has had to settle claims when what might otherwise be quite defensible clinical decisions and actions have not been supported by adequate records.

When adding your more detailed note to the patient's record you should include your name, the date and time of your added note, your findings on examination and an explanation as to why these were not recorded at the time.



## Delegation dilemmas

**Q** It is my usual practice to ask the junior doctors to obtain the pre-operative consent of patients admitted for elective surgical procedures. However, the most recent F1s have suggested that they consider this delegation may be inappropriate.

**A** A junior doctor with limited or no experience of the procedure to be undertaken may lack adequate understanding of the nature of the operation, including the possible risks and complications, to explain the procedure in appropriate detail to the patient.

We would advise consultants to follow paragraph 45 of the GMC's guidance *Good medical practice* (2013) which states that the delegating doctor must be satisfied that the person to whom the task is delegated must not only have the necessary knowledge and experience but also the qualifications and skills to provide the care or treatment. This is expanded in the GMC explanatory guidance *Delegation and referral* (2013).

Paragraph 26 of the GMC's guidance *Consent: patients and doctors making decisions together* (June 2008) elaborates on this duty, and indicates that it is the responsibility of the doctor undertaking the investigation or providing the treatment to discuss it with the patient. The guidance continues by stating that the task may

*The delegating doctor also has a duty to ensure that the patient has given their consent before the investigation or treatment begins.*

be delegated, provided the person to whom you delegate has the necessary training and experience, complies with the GMC guidance and has sufficient knowledge of the investigation or treatment that is proposed, as well as an understanding of the risks involved.

Paragraph 27 of the GMC's guidance *Consent: patients and doctors making decisions together* (June 2008) states that the delegating doctor will however remain responsible for ensuring that the patient has been given sufficient time and information to make an informed decision. The delegating doctor also has a duty to ensure that the patient has given their consent before the investigation or treatment begins.

Consequently F1 doctors, particularly at the start of their rotations, may not have the necessary knowledge and experience to perform the task of obtaining consent. You may therefore consider it appropriate to complete the process of consent yourself or at least ensure that it is delegated to another sufficiently experienced junior member of your team.

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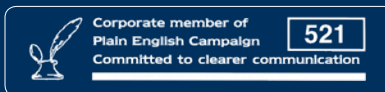
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This information is intended as a guide. For the latest medico-legal advice relating to your own individual circumstances, please contact us directly.

Our medico-legal team is available between 8am-6pm Monday to Friday and provides an on-call service for medico-legal emergencies or urgent queries 24 hours a day, 365 days a year.



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