



MDU

Consultant guide

We have developed this guide to support you in some of the common challenges you may face as a consultant.

The content will be added to and updated when needed. The latest version can be found at themdu.com

I hope you find it useful. If you have any medico-legal questions or concerns please seek our advice on freephone [0800 716 646](tel:0800716646).



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Successful leadership

Leadership skills

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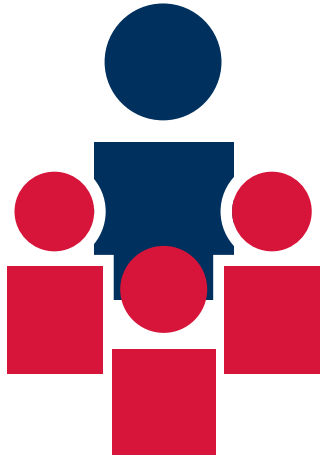
People skills

Organisational skills

Managing meetings

Managing your team

Leadership skills



The importance of medical leadership is now widely acknowledged. Leadership encompasses a range of skills including people management and service design and delivery, which can be developed and improved.

Why develop leadership skills?

The GMC's guidance *Good medical practice* (2013) and *Leadership and management for all doctors* (2012) both recognise leadership as a key part of doctors' professional work, regardless of specialty and setting.

Leadership forms a natural part of medical practice, so your skills in the clinical arena can be transferred into the area of leadership when working with others to provide care. You will already have been developing leadership skills during your training, but there are a number of specific skills associated with leadership that you can work on and improve.

There are three general approaches to developing your leadership skills. You can consider leadership from the point of view of:

- what leaders do - a competency-based approach
- how leaders lead - an engagement approach
- why leaders lead - a moral leadership approach.

Competency leadership frameworks

This approach is typified by the NHS Leadership Academy's Healthcare Leadership Model¹. By concentrating on nine leadership dimensions you can direct your development to acquire specific competencies to help you lead. Developing your skills will allow you to develop your career as a consultant adding value to the work you do and allowing you to develop interests in new areas.

Table 1 The Leadership Dimensions

1. Inspiring shared purpose	6. Engaging the team
2. Leading with care	7. Holding to account
3. Evaluating performance	8. Developing capability
4. Connecting service	9. Influencing for results
5. Sharing vision	

Reference

¹ *Healthcare Leadership Model*, NHS Leadership Academy, 2013.

Engaging leadership

It is arguable that leaders can only be successful if others want to follow their lead. This is more than merely acquiring competencies. It requires the development of a leadership style, which engages and motivates others so that they will follow your lead. It also means developing your emotional intelligence. Dr Daniel Goleman² describes a series of leadership styles shown in table 2.

Table 2 Six leadership styles at a glance

Coercive
Authoritative
Affiliative
Democratic
Coaching
Pacesetter

Goleman further argues that successful leaders do more than identify their preferred style. They are adaptable, selecting the style appropriate to the circumstances in order to be effective. For example, a coercive or authoritative style will help achieve results when leading a team undertaking cardio-pulmonary resuscitation. It will be less effective when leading a team working on clinical pathway development. Here a coaching or democratic style might give better results.

Learning to grow your emotional intelligence isn't easy but it can be done. Many leaders find that leadership coaching helps them to develop a portfolio of styles and to use them to adapt their approach.

Moral leadership

The final thing to consider if you want to develop as a successful leader, is why leadership is important. This requires a moral approach to leadership. The moral leadership approach requires you to consider the ethical conflicts, which arise in leading health services when making leadership decisions³.

Table 3 The five leadership proprieties

Fiduciary propriety	Patients first
Collegial propriety	Colleagues first
Bureaucratic propriety	Organisation first
Inquisitorial propriety	Knowing why things went wrong
Restorative propriety	Acting to make amends

Balancing the needs of your patients against those of your colleagues or the organisation you work for is critical for successful leadership, and failure to get the balance right may lead to problems not just for you and your team, but for

patients and more widely. For instance, placing colleagues' needs above the organisation may lead to conflict, whereas placing the organisation above colleagues and patients may lead to poor motivation and poor care. Placing colleagues and the hospital above patients' needs when things go wrong may lead to defensiveness or even the temptation to cover up errors.

To develop a better understanding of the issues of conflicting ethical proprieties in medical leadership you may wish to read *Moral Leadership in Medicine* by Dr Suzanne Shale⁴.

As a consultant others will expect you to act as a leader. Thinking about the competency framework described here will allow you to reflect and identify specific skills you may wish to acquire or develop. However, to be an effective leader it is more important to understand your leadership style, learning to adapt it to the circumstances of the situation where your leadership is needed. An understanding of the ethical conflicts which arise in healthcare will also allow you to ensure you work within a framework of moral leadership.

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References

- ² *Leadership That Gets Results*, D Goleman, Harvard Business Review, March-April 2000.
- ³ *How to fix the NHS's crisis of moral leadership*, M Roddis, Health Service Journal, 25 July 2013.
- ⁴ *Moral Leadership in Medicine: Building Ethical Healthcare Organizations*, S Shale, Cambridge University Press, (2012).

Understanding the culture you work in



It is important to understand the culture in which you work. In this section we look at some of the key subcultures that may help guide you.

Effective leadership means having insight into the culture of the team and its place in the organisation. The GMC has published research by Suzanne Shale into medical subcultures and the effect they have on performance¹, which described subcultures:

Diva subcultures: these arise when powerful and successful professionals are not called to account for inappropriate behaviour, and colleagues modify their working practices to accommodate them.

Factional subcultures: these arise when disagreement within a team becomes endemic and the group starts to organise itself around continuing conflict.

Patronage subcultures: these emerge when colleagues perceive strong bonds of loyalty, dependence and/or respect towards a benevolent leader possessed of social capital. The clinical group becomes reluctant to question or challenge the patron.

Embattled subcultures: these may arise when resource has long been inadequate and is perennially unequal to demand. The group feels besieged by the unmet need they see in patients, and may exhibit burnout, learned helplessness, and resentment.

Insular subcultures: groups that have become geographically or psychologically isolated from the cultural mainstream of the larger organisation, with the result that behaviours, professional practice, or standards of care deviate from accepted norms.

Medical leaders have a responsibility to build positive cultures in their teams.

These cultures can inhibit patient care and stifle the functioning of the teams you work in, so how can you affect the culture of your team? Shale argues that this can be achieved through 'cultural housekeeping'.

You might want to ask yourself the following questions.

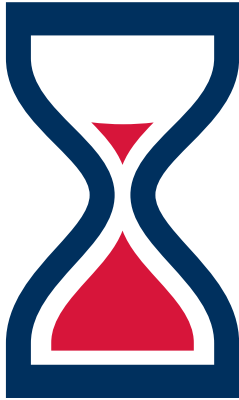
- What aspects of your own behaviour may be contributing to a negative culture?
- How can you act as a positive role model?
- Do you need to attend to your own behaviour in routine interactions such as building relationships through everyday conversations?
- How can you promote collaborative problem solving?
- Do you assign responsibility for outcomes?
- Do you provide supportive coaching?

The following sections provide advice on how this can be achieved.

Reference

¹ *How doctors in senior leadership roles establish and maintain a positive patient-centred culture. Research Report for the General Medical Council Dr Suzanne Shale March 2019*

Time management



Using your time more effectively can have beneficial effects at work and at home. This section offers some time management tools to help you make time work for you.

At times of stress and increased workload such as during pandemics and other critical health events, it is vitally important that we use our time effectively both for patient care and to maintain our resilience in the face of workload pressure. Although time management can't increase the hours in the day or reduce your workload, it can help you feel more in control.

Some people seem able to manage their time much better than others. They tend to see time as a resource they can control. On the other hand, many of us are so immersed in the issues we have to deal with on a day-to-day, or even hour-by-hour basis, that we find it hard to see time as a resource, but rather a problem that constrains us.

How can we learn to use time as a resource?

One way is to spend time prioritising the tasks ahead and allocating time to perform them. This will give you some sense of control. The figure below shows how tasks can be prioritised, giving you a much clearer idea of what to focus on first.

Rather than plunging into the day, spend a few moments considering the grid and prioritising tasks for the day. Allocate time for the firefighting tasks first and start to fit the others around them. If you don't have time for time wasting and distracting issues, that will not be such a problem, but if you start your day with these issues as they arise, you will find that you don't have time for the really important things.

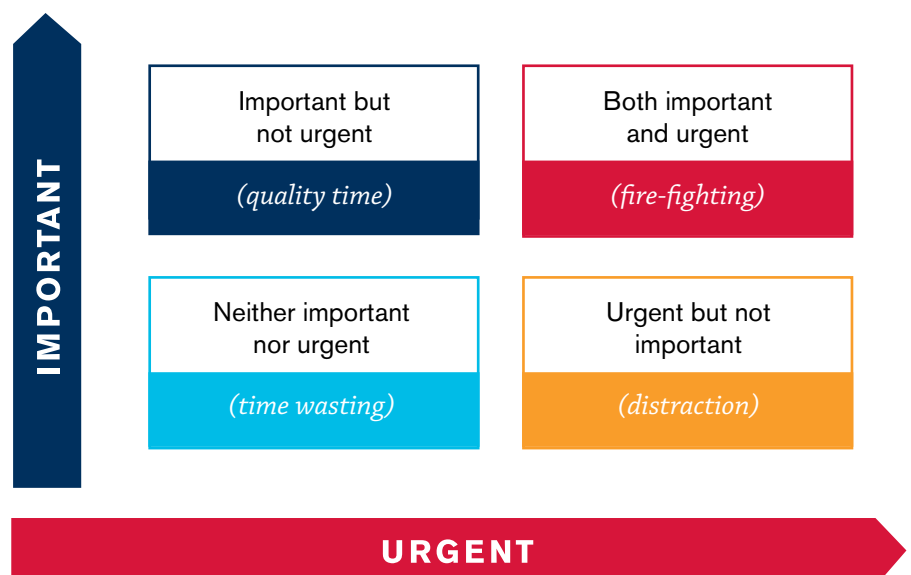
At times of increased workload pressure, it is important to ensure you schedule regular breaks into the day to allow for comfort and refreshment stops.

Procrastination is the thief of time

Another way to better manage your time is to learn to avoid procrastination. We all procrastinate on occasions, often because the task in hand does not interest us or it overwhelms us with its complexity.

Managing your time effectively can be critical in helping reduce the impact of stress on your life.

Figure 1: Time management grid¹



Reference

¹ *7 Habits of Highly Effective People*, SR Covey. Published by Simon & Schuster 1989.

In her book *Isn't it about time?*² psychotherapist Andrea Perry suggests that procrastination occurs because we delay or put off:

- becoming aware of a task
- exploring and experimenting with the task
- choosing and getting involved
- completion of the task once started.

If you are putting off starting a task and behaving as though you are unaware that you need to undertake it or, when you think about it, you consider putting it off until later, then you need to build

reminders into your schedule to ensure you prioritise effectively. Try putting the completion deadline into your diary with reminders beforehand to force you to think about the task.

If you put off exploring the task – perhaps because you believe it isn't interesting or might be a waste of your time – try suspending judgement about whether the task is good, bad or worthwhile. Schedule some time to start thinking through the task. You may find, once you have started, that it is more interesting than you previously considered.

If you put off choosing you need to concentrate on your ability to make decisions. Give yourself permission to make your own choices. Consider why the task has fallen to you, is it because you have the necessary skills to do the work? You have choices here, are you the right person for the task? If not, how could you manage it differently?

If completing a project is an issue for you, perhaps it seems overwhelming, or of an unmanageable complexity, break the task down into smaller more manageable steps and take each one at a time.

Some practical tips for time management

- Work out what you want to achieve.
- Make a list.
- Set priorities based on the importance and urgency of each task.
- Build breaks into your schedule.
- Break down big tasks into smaller more manageable chunks.
- Avoid distractions (don't answer phones or emails until you have scheduled time for these tasks).
- Don't allow others to draw you in to their tasks.
- Consider if the task could be better done by someone else and delegate.
- Recognise and acknowledge if you procrastinate. You are not alone and others may be able to offer help and support.



Developing techniques to manage your time and avoid procrastination will help you work smarter not harder by letting you think of time as your friend not your enemy.

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Reference

² *Isn't it about time? How to stop putting things off and get on with your life*, A Perry. Worth Publishing 2002

Supervision of staff



The proportion of a consultant's time spent managing others and managing physical and intellectual resources continues to increase.

Consider how to get the best from your team.

Delegation

Effective delegation can, for some, be the hardest management skill to attain. Delegation does not mean instructing junior staff to do the work and leaving them to get on with it.

To delegate, you need a good understanding of the skills and capabilities of the person to whom you delegate responsibility and their limits. Even when you delegate responsibility for a task to someone else, accountability for their work will remain with you, so you have a responsibility to ensure they are doing the work to your satisfaction.

You will need to arrange for them to report progress to you, and you may need to direct their work periodically. If you find they have problems with the work, not only will you need to make other arrangements, but you will also have a responsibility to work with the person to improve their skills.

Many people would accept that good managers delegate effectively, so this is an essential skill to develop, despite any temptation to avoid it by doing the work yourself or removing responsibility from your staff.

Performance management

Improving the performance of those staff accountable to you is the lynchpin of management. This involves meeting with your staff regularly to review their work, assigning them new tasks and checking on the quality of their work.

You should seek to meet with each of your staff regularly on a one-to-one basis, as often as weekly for direct reports. It is not advisable to manage the performance of individual staff in group settings as this can undermine their confidence and may lead to tensions within your team.

Regular one-to-one meetings can be used to review each individual's work in a setting away from the bedside, thus allowing you to reinforce messages on performance. In addition, this forum gives you the opportunity to correct staff and also where improvements in performance do not occur with time, allows you to discuss with them what needs to be done next.

One of the most common criticisms of managers embarking on formal or disciplinary action with under-performing staff is that the manager had not told the staff member that their performance was sub-standard or given them a chance to improve. Regular meetings give you the opportunity to tackle these issues. You should keep notes of the content of these meetings.

Personal and professional development of staff

Delegation and performance management, if done effectively, will allow you and your staff to develop a clear picture of their development, teaching and training needs.

As a manager, you have a responsibility to address these needs with your staff. This may mean actively teaching and training some staff yourself on the job. You will also need to help them create a personal and professional development plan. This should be done at least once a year, at their appraisal.

Improving the performance of those staff accountable to you is the lynchpin of management.

One very important point is to make sure you do not use appraisal meetings as opportunities for performance management. These two things should always be kept separate and performance issues should be tackled when they occur and not left for an annual appraisal.

It is beyond the scope of this section to detail all the skills needed as an appraiser. You should look at NHS England's medical appraisal guide¹ and the GMC's guidance on appraisal² for more details.

Pastoral care

Managing staff also requires you to have some skills in pastoral care, especially for staff whose performance is not up to the required standard, or where it is apparent they have problems in the workplace.

Managers need to be alive to their staff's problems in keeping a work-life balance and in dealing with the stress of a high-pressure job. The warning signs may include poor time management, lateness and frequent absence, failure to take regular annual leave or working excessive hours not warranted by the scope of their duties.

Deteriorating relationships with colleagues may also indicate either failing competence, inability to cope with stress or some undisclosed health problem.

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Reference

¹ *Medical Appraisal Guide: A guide to medical appraisal for revalidation in England*, NHS Revalidation Support Team, 2013.

² *The Good Medical Practice Framework for Appraisal and Revalidation*, GMC (2013).



Consultants need to manage their teams effectively. Although you can use personal development time to acquire specific skills, most management acumen is developed on the job.

Negotiation

The scope and accountability of a task should be settled by negotiation before the work is started. This applies to authority delegated to you from your manager and work you delegate to others. In either case, negotiation is important to ensure the work is done effectively and safely.

It is important to have a clear understanding of what you want to achieve and how it is to be done before you start to discuss the work with others. In addition, be alive to the concerns of the other person you are dealing with, and their limitations. Coming to an agreement where the other person is working beyond their competence is not successful negotiation, even if it gives you what you want in the short term. The other person in the negotiation is more likely to cooperate if they feel they have gained something positive from the encounter. Indeed, both parties should feel they have 'won' something. A good negotiator will make sure the other person feels this way.

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Constructive confrontation

A good manager is prepared to confront awkward situations. This is particularly pertinent in the area of personal conduct. It is natural for many to avoid conflict. Consequently, poor personal conduct in the workplace is often not corrected and managers find ways to work around difficult people rather than correct their behaviour.

Managers should always be prepared to 'manage the little moments'. Mention poor behaviour at the time it occurs, calmly and without anger. This is easy to do if mentioning poor conduct becomes a habit. The other person, when challenged, will nearly always immediately apologise when told quietly 'this is not the way we do things', or their conduct has offended or concerned you. Once they have been calmly reminded a few times, in most cases the poor behaviour will stop.

Where you need to have a detailed one-to-one conversation with someone whose behaviour concerns you, you should spend a little time in advance preparing what you are going to say, and how you are going to say it. For example:

- consider a brief statement of the problem from your point of view and select a specific example to illustrate it
- describe your feelings around it
- clarify why it is important for you, the team, or the organisation
- identify your contribution(s) to it and wish to resolve it
- get the other person to respond

- enquire into their views using active listening techniques, ensure full understanding, and acknowledge their position and interests
- ascertain what was learned:
 - where are you both now?
 - what is still needed for resolution?
 - what was left unsaid that needs saying?
- how can you move forward?
- make an agreement and have a method to hold the person accountable for it
- record your conversation and agreement and plan a time to review.

Communication

We understand the need for highly developed communication skills in dealing with patients. These are also needed when managing staff. A good manager is an effective active listener, able to understand what staff are really saying and take appropriate action based on it. More detail on the types of communications skills required can be found on pages 21-26.

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Organisational skills



During your career as a doctor, you may already have acquired many of the management skills you need as a consultant. Here we examine a vital area of management – organisational skills.

Managing upwards

It is widely believed that the real art of management is in managing relationships with those who manage you. In order to do this well, you need to understand the role and function of the senior managers in your workplace as well as their pressures and constraints. It will be to your advantage to demonstrate you are willing to talk their language and engage in their concerns. By and large, staff who do this find it much easier to get what they want from their managers.

Strategy

As a consultant, you will be required to become involved in the strategic development of your workplace. You are an expert in the area of your specialist interest and should be the first port of call for the board when they need to consider development of services. In order to ensure your advice is listened to, it is important to engage in the process of strategic development.

In essence, strategic development means having a clear idea of where your trust is placed in terms of the work it does; its scope, quality, shortfalls and how it is perceived by its stakeholders (patients, commissioners of service, other healthcare providers, etc). The next stage is to discover where the trust needs to be in future: what new clinical and technological developments will arise over the next strategic period (usually five years), how demand for services will change, what will happen to the demography of your population, and how the availability of resources, both physical and human, will change.

The development strategy needs to define in detail what needs to be done over the strategic period to move from the present state to the new position. This will involve developing individual plans, such as business cases and workforce plans for change to support the strategic direction.

Business case development

A business case should be explicitly linked to an agreed strategy for change and should follow the same principles (where are we now, where do we need to be, and how are we going to achieve it). If the case is to be approved it must demonstrate convincingly the need for change, and provide secure evidence to back up any assertions. There will also need to be a cost benefit or other economic analysis to demonstrate that the benefits of change outweigh the cost of development and provision.

Finally, the business case must enumerate the benefits and show how they will be realised once the change is in place. You will find expertise in the general management of the trust to help you develop business cases, but you will need to convince the trust of the need for the change before general management support will be made available to help you.

As a consultant, you will be required to become involved in the strategic development of your workplace.

Workforce planning

The same strategic principles apply to a workforce plan. Here, you will need to give details of the numbers and types of staff currently involved in service provision, then undertake a skills audit to show what skills are lacking. Not only will you need to demonstrate, with evidence, what extra numbers of staff will be required to fill the skills gap you have identified, you will also need to show that the proposed skills mix is the most economically viable. This will mean considering new techniques and types of service delivery.

For example, will new techniques in your field require more nurses or other clinicians in future to do work currently done by doctors? Should the emphasis move away from provision by trainees to provision by independent practitioners, such as consultants or associate specialist (SAS) doctors?

Alternatively, could this work be done more effectively in primary care or in the community in future rather than in hospital, and if so, what support will you need to provide to make the transition effective?

You should demonstrate the current levels of efficiency and effectiveness in service provision, and factor in ways in which this can be improved alongside your plans for expansion, in order to demonstrate optimal efficiency. General managers in the trust can help you develop workforce plans. Analysis of existing job plans may help by providing a baseline and demonstrating where there are shortfalls in staff numbers and availability.

Financial skills

Analysing and managing a departmental budget is no different in principle from managing a household budget.

Staffing costs make up about three-quarters of total departmental expenditure. The staff budget for individuals will include hidden costs, such as NI contributions, in addition to salaries, which should be factored in when estimating the cost of new staff.

Analysing and managing a departmental budget is no different in principle from managing a household budget.

Budget statements will normally account for staffing costs first. Each cost item will have several columns in a budget statement to indicate the agreed annual cost, the actual cost to date, and the variation between the two, so you can see at a glance where expenditure is well-controlled and where to consider changes to bring costs back into line. Management accountants in the trust are available to go through budget statements with you and advise as to how you can manage them.

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Managing meetings



Managing meetings well, as a chair or as a participant, can make them productive and useful for getting things done. What simple rules might make meetings more effective?

Meeting types

The meetings consultants attend may be divided into two basic types: clinical (such as case conferences, multidisciplinary team meetings, mortality and morbidity, audit and other clinical governance meetings) and managerial. This section concentrates on the latter.

There are two types of management meetings.

1. Informal meetings, which are part of the everyday routine of the workplace.
2. Formal meetings, run as part of the trust management.

Of course meetings may also be one-to-one or group meetings.

Informal meetings

Informal and one-to-one meetings form an important part of the day-to-day life of a hospital. They may also be part of the way you manage the performance of your trainees or other staff for whom you are responsible. They may also form part of the way your own performance is managed.

In addition, you will be meeting with general and department managers, clinical governance staff and so on. Despite being informal, it is good to stay focused when discussing any form of business, and not to indulge in chatter or gossip. Remember that rules of courtesy and professionalism apply at all times, even in informal one-to-one meetings and especially if conflict arises.

It is important to keep some form of record of these types of meetings, especially if you have been tackling important matters or confronting issues with other participants. It is perhaps

worth keeping a short file note in which the date and time of the meeting, those present, the basic topics covered and things that were agreed can be recorded.

Many managers send this in an email to the other person after the meeting. This is useful as you can all have a common understanding of what was said and agreed. We all understand the importance of making a record of clinical interventions, but we have a tendency to forget that noting meetings can also be very helpful, so the agreed actions are documented, and subsequent misunderstandings are avoided.

Informal meetings within the directorate, or across the organisation also play an important role in the day-to-day life of the hospital. The same guidance applies here as with one-to-one meetings.

Formal meetings

Formal meetings in the NHS, such as board meetings and statutory committee meetings, usually have fixed agendas and members are selected according to their roles, or as representatives of work groups. These meetings may be long and discuss subjects in which you have little direct interest. As a consultant, your behaviour in these meetings will be observed and may help form your reputation in the trust. Remain professional and businesslike and make contributions based on your knowledge and skills.

Informal meetings within the directorate, or across the organisation also play an important role in the day-to-day life of the hospital.

Often the chairs of these meetings are looking for people to take on other tasks, for example running sub-groups or projects. If you take on such responsibilities, be prepared to give them your time and attention.

Chairing meetings

Whether you are chairing formal or informal meetings, good chairing skills will help ensure the meetings are effective and productive.

Ensure your meeting has a well-defined purpose, with clear objectives. In a formal meeting, these things should be stated in written terms of reference. The period over which the meetings will occur and their frequency should be planned in advance. Once the meeting has served its purpose it should be ended.

Make sure you invite the most appropriate people to the meeting. Only have those whose contributions are needed and keep numbers to a minimum. For example, a committee with more than 10 members is likely to be unwieldy, hard to control and ineffective. Always provide a written agenda in advance so members know what to expect and are reminded to report back their actions.

State the end time for the meeting on the agenda and keep to time. This may mean prioritising your agenda, so you ensure the most important issues are covered first. Typically, if your meeting is scheduled to last more than an hour, you are trying to squeeze too much in to the agenda, so change it.

It is important to read the agenda and minutes beforehand, ensuring you have done your allotted tasks from the last meeting. Clarify some house rules for behaviour at the start, such as no interruptions, only one person to speak

Ensure your meeting has a well-defined purpose, with clear objectives. In a formal meeting, these things should be stated in written terms of reference.

at a time, and only talking when you, as chair, permit. Don't allow disruptions or distractions and discourage people from taking calls or answering beeps. Encourage people to stick to the point under discussion. Sum up the actions to be followed up, and by whom, at the end of each item.

At the end of the meeting recap and remind people of the agreed schedule of meetings. If people start to leave before the end, consider if the agenda is too long. By agreeing a finish time in advance and always keeping to it, they are less likely to do so.

Circulate minutes containing actions points to members as soon as possible after the meeting. These need to state the name of the person delegated to perform each action, and the meeting to which they will report back. Remember to give people time to do the actions agreed, and to get the notes out early as a timely reminder.

Virtual meetings

Virtual meetings have become the norm recently and if run well can be as effective as face to face meetings. However, you should bear some simple rules in mind to ensure they work well.

Arrange your surroundings so they are professional and do not distract others. View yourself through the camera before you join the meeting to check you can be seen.

Keep the camera level with your face, by adjusting the height of the computer if necessary - no-one wants to spend the meeting looking up your nose.

Dress appropriately. You may be at home, but you are still in a professional meeting. Avoid eating at your computer.

It may be tempting to catch up on other things during the meeting, but the sound of your keyboard is likely to irritate and distract others and your lack of attention will become obvious. If you need to make notes, do so using paper and pen, and don't attempt to catch up with emails during the meeting.

Mute your microphone when you're not talking. This will avoid feedback. If you raise your hand electronically to speak, remember to cancel it afterwards. Also, remember to unmute before you speak and mute again after you have finished.

Maintain the discipline of raising your hand so the chair can invite your contribution. Overspeaking is distracting in any meeting, but in remote meetings it may well lead to contributions being missed.

Stay seated and present throughout the meeting. Don't be tempted to switch off your camera in order to cover for absence or any other reason. Your colleagues are likely to view this as rude or unprofessional.

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Managing your team



Healthcare in hospitals is increasingly delivered by multidisciplinary teams and this can present communication challenges.

Take care when working with other clinicians, especially in the handover of care, training and supervision.

Trainees

As a consultant, it is likely you will be required to supervise and teach trainee medical staff. It is common for trainees and students to accompany consultants in clinics, on ward rounds and in theatre as part of their training. You should bear in mind that you must obtain informed consent from patients to disclose identifiable confidential information (including the results of investigations, such as x-rays) for teaching purposes, and prior to any examination or intervention conducted for training purposes.

During ward rounds, trainees are often asked to record your decisions in your capacity as consultant. While it would seem unreasonable for you to check every entry they make, it is your responsibility to ensure their accuracy. You should make sure that trainees keeping notes on your ward rounds understand what has been discussed and decided for each patient and the importance of ensuring the notes accurately reflect this.

When reminding trainees of the need to work effectively, try to remember not to undermine their confidence by correcting them in front of others. The best performance management comes when you have one-to-one discussions with those you are supervising. You should ensure you have regular meetings with your trainees where you can guide them into the right way of working. It is also good practice not to use regular teaching sessions or appraisal meetings to manage their day-to-day performance.

Referral and transfer of patient care

The management of patients in hospital usually involves a wide range of clinical teams and your patients may need to be referred to other teams or services.

The GMC says in paragraph 44 of *Good medical practice* (2013) that doctors 'must contribute to the safe transfer of patients between healthcare providers and between health and social care providers'. This means that, when referring or transferring a

patient to the care of another specialist or provider, you should provide all relevant information about the patient and check, where practical, that a named clinician or team has taken over responsibility when your role in providing a patient's care has ended.

Delegation of aspects of care

Sometimes it is appropriate to delegate by asking a colleague or junior member of the team to undertake a particular aspect of care or treatment on your behalf. Paragraph 45 of *Good medical practice* (2013) states that, 'when you delegate, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care'.

When you delegate a task to another, the responsibility remains with you. Assuming the other person will do the task well and leaving them to do it is regarded as a derogation of your responsibility and is not effective delegation of the task. As an example, if you order an investigation on your patient and then leave it to a trainee to review the result in your absence, the responsibility for acting appropriately on the result will remain with you.

Handover and cover when you are off duty

Effective handover is essential. You should ensure that appropriate handover arrangements are in place for your patients. Adequate time should be set aside to hand over the care of your patients to your colleagues. Try not to allow the pressures of clinical work to encroach upon this aspect of communication, which is essential to patient safety.

When you are off duty you should be satisfied that suitable arrangements have been made for your patients to be cared for by colleagues with the appropriate

Footnote

On 1 June 2012 the key functions and expertise for patient safety developed by the NPSA transferred to the NHS Commissioning Board Special Health Authority.

qualifications, skills and experience to provide safe care for the patient.

To highlight the importance of proper care handover, the Junior Doctors Committee of the BMA produced a best practice guide *Safe Handover Safe Patients: Guidance on clinical handover for clinicians and managers*¹.

The guidance identifies common problems which occur during handover. For example, failing to make roles and responsibilities clear, which can lead to different members of the team assuming one of their colleagues has updated the team taking over when in fact this has not happened. It states that every hospital needs to develop its own handover policy and provides examples of successful schemes from hospitals around the country.

The advice given to ensure safe handover includes the following points.

- Involve all key members of the multidisciplinary team. Each trust should identify the key people who need to attend handover meetings.

The ideal model includes all grades of staff from each included specialty, sub-specialty or ward as appropriate.

- Be aware of any new locums on the team and make sure suitable arrangements are in place to familiarise them with local systems and the hospital.
- Ensure handover is at a fixed time, of a sufficient length, and in a room that is large enough for all to attend and will be suitably free from distractions.
- Ideally handovers should be 'bleep free', except for immediately life-threatening emergencies.
- Make all staff aware of the handover period and arrange shifts for all staff involved to allow them to attend in working time.
- Ensure handovers are supervised by the most senior clinician present and have clear leadership. Avoid too much jargon and explain any abbreviations.

Information which might be included in written handover includes in-patients, accepted and referred patients due to be assessed, accurate location of all patients and operational matters relevant to clinical care, such as ITU bed availability. Discuss patients with potential problems so management plans can be clarified to ensure appropriate review. It is also worth discussing other outstanding tasks and when they should be completed.

The issue of effective handovers is of widespread concern to the profession. Other bodies, such as the Royal College of Surgeons of England², have also provided guidance on handovers, which you might find of use.

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References

¹ *Safe Handover Safe Patients: Guidance on clinical handover for clinicians and managers*, BMA.

² *Safe Handover: Guidance from the working time directive working party*, the Royal College of Surgeons of England, 2007.

Q&A

Q It's my usual practice to ask the junior doctors to obtain pre-operative consent from patients admitted for elective surgical procedures. However, the most recent F1s have suggested that they consider this delegation may be inappropriate. What should I do?

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 suggest following the GMC's guidance in *Good medical practice* (2013), paragraph 45, which states that the delegating doctor must 'be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.'

The GMC's guidance 'decision making and consent' (2020) elaborates on this and says that you may decide to delegate part of the decision-making process but should consider whether that is appropriate in terms of the nature of the intervention and the complexity of the information about it, the level of uncertainty about the outcome, whether the patient already has a trusting relationship with you or the person you would delegate to, and anything unusual or concerns you anticipate the patient may have (paragraph 43). You must make sure that the person you delegate to is suitably trained and competent, has sufficient knowledge and skills to have an appropriate dialogue with the patient, and that the person feels competent to carry out the task and agrees to refer to you (or

another appropriate colleague) if they need information, advice or support (paragraph 44).

Some 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 it is delegated to another sufficiently experienced junior member of your team.

This example is fictional but based on cases from the MDU's files.



Communication skills

Staying patient focused

Communicating with patients and their relatives

Communicating with the patient's GP

Staying patient focused



*It is often said
“communication is the key”
and this is especially true of
interactions between doctor
and patient.*

*Developing core
communication skills can
make a significant difference
to doctor-patient interactions.
The Calgary-Cambridge
framework¹ is a valuable
comprehensive consultation
model and the core skills are
highlighted here.*

Building rapport

At the heart of many patient complaints lies poor communication, often because as doctors we are over-pressured, tired, trying to meet competing demands and therefore we may not feel, or perhaps give the impression that we don't have the time to truly listen or explain. But does it really take longer to communicate well?

Building rapport is about creating a positive impression and connection with the patient. Sometimes this is easy to do; conversation flows and the patient opens up readily and seems to like and trust you. Other times, it just feels as if things are hard work, as if you've started off on the back foot.

It's really important to spend a few seconds before calling the patient into the room reading the notes and ensuring you have 'let go' of any emotional discomfort from the previous consultation. Sometimes this requires a quick pace around the room, or if necessary a cup of tea. It's just as important that you take care of yourself in order to be as effective and present for the next patient.

Always introduce yourself if you haven't met the patient before. "Hello, my name is ...". If the rapport doesn't come naturally as you're talking with the patient, it can help to demonstrate a positive sense of connection through noticing the patient's tone of voice, their speed of speech and the words they use and subtly match your responses to fit, not mimicking, just mirroring in order to give them the sense of familiarity. The same goes for gestures and body language in a subtle way – if they are sitting in a certain position, perhaps move yourself into a similar posture.

Appropriate smiling and eye contact also go a long way to build a positive, friendly, interested impression which then encourages the patient to relax and builds trust with them.

Active listening

How often do we find ourselves planning what we want to say next while the other person is talking or even letting our mind wander? At times of increased work pressure, it becomes harder to stay focused on the task in hand. Patients will soon notice if we are not actively listening to them.

You can demonstrate that you are concentrating on what the patient is saying by giving them time to finish their sentences and not interrupting early on. There is evidence² to show that there is a 'golden minute' at the start of the consultation that, if we allow it to unfold, will elicit a lot of useful information from the patient and also give them the sense of being respected and listened to. This can be hard to do if we fear we may lose control of the discussion by allowing the patient to talk unchecked but, in fact, it will save us time further into the consultation as the patient is less likely to feel the need to interrupt.

It also means listening not just to the content of what they are saying and by using recaps and short summaries show the patient that we have understood, but also listening to the feelings and meaning behind what they are saying. By reflecting this back to the patient, we demonstrate empathy. For example, the patient talks about their elderly relative who they are caring for, whilst at the same time trying to cope with worsening sciatica. An empathic statement about the strain of caring while trying to cope with pain lets the patient know that you are attempting to understand their perspective. By acknowledging their emotion the patient will appreciate our effort.

By empathising and summarising, the patient knows you have heard and they don't need to tell you all over again.

References

¹ Calgary-Cambridge framework, JD Silverman, S Kurtz, J Draper, J Benson, 2003.

² *The effect of physician behavior on the collection of data*, Beckman HB, Frankel RM, Ann Intern Med. 1984 Nov;101(5):692-6.

Effective questioning

At the start of a consultation it's important to give the patient the opportunity to tell their story. Open questions (beginning with what, where, when, who, how?) offer an invitation for them to do so.

Once you have uncovered the presenting complaint and the background, you can then funnel down to more disease-specific closed questions in order to rule out certain conditions or red flags.

Sometimes, leading questions, such as "You don't have chest pain, do you?" can be helpful to draw out information as the patient may find it hard to disagree with you.

Exploring the patient's perspective on their illness by asking them about their thoughts, "What have you put your back pain down to?" may provide some useful background and possibly their health beliefs relating to their symptoms.

At the back of a patient's mind may be some concerns or worries, which when elicited, may mean that you can provide more effective reassurance. You can ask them "When you've been thinking about your headaches, is there anything in particular that concerns you?" or "Are there any other questions I can answer for you today in order for you to leave feeling reassured?".

Efficient explaining

Studies have shown³ that most patients forget between 40%-80% of medical information provided immediately. We can improve this by tailoring our explanations more carefully to what the patient wants to know, by asking them what questions they have and possibly writing these down.

It is also important to give bite-size pieces of information at a time, rather than a long speech, and to pause at regular intervals to see how it has been received and whether the patient has any questions.

Some doctors regularly ask their patients to feed back a summary of what they have understood. This could work well if you have written down their questions at the start of explaining things and then ask them if you have answered those questions adequately.

It is often useful to provide additional written information in the form of leaflets, or signpost them to available resources.

Most patients want to be more involved in decisions about their care than they are. Many would like more information than we give them, therefore this part of the consultation is vitally important in terms of encouraging responsibility and imparting information, as well as decision-making.

GMC guidance

Effective communication with your patients and colleagues is vital for patient safety. The GMC says in paragraph 1 of *Good medical practice* (2013) that good doctors 'establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity.'

The GMC devotes a section of *Good medical practice* (2013) to communication, partnership and teamwork. Paragraphs 31 to 34 state, 'To communicate effectively:

a) You must listen to patients, take account of their views, and respond honestly to their questions.

b) You must give patients (patients here include those people with the legal authority to make healthcare decisions on a patient's behalf) the information they want or need to know in a way they can understand.

You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs⁴.

c) You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.

d) When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.'



Dr Mike Roddis

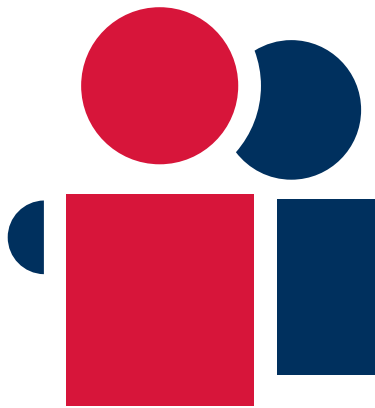
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References

³ *Patients' memory for medical information*, Roy P C Kessels, PhD, J R Soc Med. 2003 May; 96(5): 219-222. PMCID: PMC539473

⁴ *Decision making and consent*, GMC (2020)

Communicating with patients and their relatives



Effective communication with patients and colleagues alike is vital for patient safety and can improve patients' experience of hospital. Consider the elements of effective communication with patients and their relatives.

Privacy

In a hospital setting, particularly at times of high workload, the issue of privacy is one that needs special consideration. Ensuring privacy in open wards can be very difficult, especially where visitors are present and curtains are the only barrier to a conversation being overheard by people in neighbouring beds. Where you need to discuss a sensitive issue, consider finding a private area or office.

Where you are discussing sensitive issues or communicating bad news, try to avoid interruptions. You could, for instance, hand your bleep to a colleague for a few minutes and silence your mobile phone.

Remote and virtual consultations

The Covid-19 pandemic has understandably seen a rise in the use of remote consultations to replace face to face outpatient consultations and follow ups. The GMC offers comprehensive guidance on how to conduct these safely¹.

Using your trust's system for these consultations provides the most effective security and allows you to have access to the patient's records during the consultation.

It is important to remember that some of your patients may be unfamiliar with the technology, so you should be prepared to help them deal with technical issues.

It is also important to ensure you are satisfied that you are talking to the right patient, that you are aware of any other people who may be listening to or watching the consultation, and that your patient is happy for them to be there.

A remote consultation is appropriate where:

- The clinical need is straightforward.
- You have access to all the information you need including their patient record and for prescribing.

- You don't need to examine the patient.
- You are satisfied that the patient has capacity to consent to treatment decisions.

Special needs

Special consideration also needs to be given to patients with specific communication problems. They may require special arrangements to be able to communicate effectively and you may need to set aside more time.

Patients who normally speak another language may require an interpreter, and you should consider that understanding medical terminology for these patients may be particularly difficult. While family members may offer to act as translators this is not always appropriate.

For understandable reasons, a family member might be reluctant to pass on more complex aspects of a patient's illness to them. You should consider using a professional independent translator for key discussions, such as when discussing the risks and benefits of treatment or giving information about the prognosis of a serious illness.

The hearing impaired can sometimes struggle to understand in a noisy ward. Using a quieter office or private area can be very helpful.

People who have impaired capacity should be given all practicable assistance to understand and contribute to decisions about their care. This might require time and input from a trained advocate or a family member. Make sure you explain things in an appropriate way to children. Older children with sufficient maturity will be able to take decisions about some aspects of their medical care.

Communicating with relatives

Consultants may be required to speak to relatives of patients to update them on their family member's progress or prognosis. This is a vital task, but there are important considerations. For example, you should do the following.

Reference

¹ <https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations>

- Remember that your primary duty of confidentiality is to the patient. Often patients will appreciate you speaking to their relatives and updating them of events, but don't assume that this is always the case.
- Seek permission from the patient to speak to their relatives, either in person or by telephone. The patient will need to know what you intend to discuss with their family before they can give informed consent.
- Make sure they are aware if this includes aspects of their medical history that are relevant to the current illness but which may be sensitive, such as, certain infectious diseases or termination of pregnancy. You should only disclose confidential details about a competent adult patient with their consent.
- Try to have discussions with family members in the presence of the patient. This will avoid confusion arising from different interpretations of what you have said. Some patients may feel angry if they believe their family has been given a different account from the one they received.

Where you are discussing sensitive issues or communicating bad news, try to avoid interruptions.

It is almost inevitable that at some time you will be asked to keep a diagnosis away from a patient by his or her relatives, where there is concern that a serious or untreatable condition might be diagnosed. Often, you can address their worries by explaining that the

patient needs to understand their illness to engage appropriately with treatment. You should be clear to relatives of your obligation to interact honestly with all your patients, although it may be justified to withhold information from patients that might cause serious harm to their mental or physical health.

If dealing with a large number of relatives, it can sometimes be helpful to agree one or two points of contact between the medical staff and the family members. This can save time and also avoid confusion where some family members may draw a different understanding from your comments.

Q&As

Q An elderly female patient's son has approached me saying he is worried that his mother has cancer. He has asked me not to tell her if this is the case because, he claims, she 'would not cope' with the information. I have now got the biopsy results back and they confirm that the patient has indeed got cancer. What should I do?

A Although the patient's son may have the best of intentions, he cannot decide what information his mother receives. In paragraph 15 of *Decision making and consent* (2020), the GMC says you should not withhold information from patients because someone close to the patient asks you to, unless you believe that giving it would cause the patient serious harm. It goes on to explain that 'serious harm' means more than that the patient might become upset or decide to refuse treatment, this is a limited exception and you should seek legal advice if you are considering withholding information from a patient.

You should speak to the son and ask for the reasons behind his comment, being mindful of the patient's confidentiality. It may also be helpful to seek the opinion of other health professionals involved in the patient's care, such as the nursing staff.

You need to be prepared to justify any decision you make and you should carefully document all your discussions on this matter and record the reasons for your decision.

Q I was explaining a diagnosis of motor neurone disease to my patient, who had her family present for support. As I finished the discussion, the patient's daughter took me aside and asked me how long her mother had to live. What should I do?

A As a competent adult patient's right to confidentiality should be respected, you should not disclose this information to the daughter without her mother's consent. You should explain to the daughter that you will need to ask the patient if

she is happy for you to talk to her daughter about her illness. To give truly informed consent, the patient will need to know what information the daughter is seeking. You should consider that this delicate question may be something that the patient also wants to know the answer to and has been afraid to ask, but it may also be something she does not want spelled out to her. One option would be to ask the patient if she would prefer you to talk to her daughter alone, or to see them together.

The examples contained in this section are fictional but based on cases from the MDU's files.



Communicating with the patient's GP



Good communication between consultants and general practitioners is essential to good medical practice, and particularly important in ensuring continuity of care when patients are transferred from hospital to primary care.

Continuity of care

The GMC highlights the importance of continuity and coordination of care in its guidance *Good medical practice* (2013). Paragraph 44 states that 'you must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers.'

The transfer of information between the hospital and GP setting is particularly important, especially when changes are made to treatment plans. The GMC advises in *Good practice in prescribing and managing medicines and devices* (2013) paragraph 32 that 'when prescribing for a patient you should check the completeness and accuracy of the information accompanying a referral.

When an episode of care is completed, you must tell the patient's GP about changes to the patient's medicines (existing medicines changed or stopped and new medicines started, with reasons); length of intended treatment; monitoring requirements and any new allergies or adverse reactions identified, unless the patient objects or if privacy concerns override the duty, for example in sexual health clinics'.

When patients move between hospital and primary care, there may be some confusion over who has overall responsibility for the patient and ongoing monitoring of their condition. Paragraph 35 of the GMC prescribing guidance states that 'decisions about who should take responsibility for continuing care or treatment after initial diagnosis or assessment should be based on the patient's best interests, rather than on your convenience or the cost of the medicine and associated monitoring or follow-up'.

If you ask the GP to prescribe a drug for the patient, agree with the GP how the treatment will be monitored and reviewed. You should satisfy yourself that the prescriber has sufficient information to prescribe. Doctors are legally responsible for any prescription they sign, so if you ask a GP to prescribe, it is important to familiarise them with the drug and its likely side effects.

You have a responsibility to ensure that letters to GPs contain all the necessary information about the patient, their condition, and the required dose frequency of the drug prescribed as well as the monitoring required. A GP who is unclear about any aspect of the prescription may refuse to prescribe the drug or may wish to clarify this with the consultant before issuing a prescription, which may delay the treatment.

To avoid some of these problems, you may wish to consider agreeing a shared care protocol with GPs, which should include responsibilities and details of follow-up arrangements. The Department of Health and National Prescribing Centre have both published guidance on the responsibility for prescribing between hospitals and GPs¹. Both documents stress the seamless transfer of care for the patient from hospital to general practice.

Reference

¹ NHS Executive, Responsibility for prescribing between hospitals and GPs: EL (91) 127, London, Department of Health, 1991 and GP Prescribing Support, National Prescribing Centre/NHS Executive, September 1998.



Q&A

Q I recently started a patient on an unlicensed drug and requested the patient's GP provide repeat prescriptions. The GP is concerned because he had never heard of the drug before and does not want to issue repeat prescriptions. What should I do?

A In the UK, no medicine can be marketed for human use without a product licence granted by the Medicines and Healthcare products Regulatory Agency. You should usually prescribe licensed medications within the terms of their licence; however, the licensing arrangements permit doctors to prescribe unlicensed drugs, and to use drugs for unlicensed indications in specific circumstances. Legal responsibility for the decision to prescribe falls to the clinician who signs the prescription. Doctors have a 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. The decision to prescribe an unlicensed drug must be one capable of support from an informed, reasonable body of clinicians of similar training and experience.

The GMC provides specific guidance² on prescribing unlicensed medications and the prescription of medications outside their licence. You should first be satisfied that a licensed medication would not meet the patient's needs. If you believe it is necessary to prescribe an

unlicensed medicine for a particular patient, you should be satisfied that there is sufficient experience of using the medicine to demonstrate its safety and efficacy (paragraph 70).

Informed consent is a crucial aspect of off-licence prescribing. You must make it very clear to the patient that the medication is unlicensed, and why that is. You will need to explain why you are prescribing it and what alternatives exist. 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 accepts them.

Paragraph 70 of the prescribing guidance states that you should take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring, and any follow-up treatment, or make sure that arrangements are made for another suitable doctor to do so. Make a clear record of all medicines prescribed and your reasons for prescribing an unlicensed medicine.

It will be important to establish with the patient's GP who will be responsible for this before the medication is prescribed. If the patient's GP is to be responsible for monitoring the patient, they must be satisfied doing so would not fall outside the limits of their individual knowledge and competence. The doctor signing and issuing the prescription personally bears the responsibility for that treatment.

Any GP who is to provide ongoing management must understand the patient's condition and the treatment prescribed, and must be able to recognise any adverse effects of the medication. You may wish to have a discussion with the patient's GP about the drug's safety and value in this particular condition. If satisfied, the GP may then be happy to prescribe the drug, but the decision is ultimately theirs. They will be responsible if they agree to continue the prescription.

It may be helpful to set up a formal shared care agreement with the GP. It may also be necessary to draw up a protocol for the use of the drug and approval should be sought from the GP's Clinical Commissioning Group to ensure compliance with any local guidelines on prescribing.

The example above is fictional but based on cases in the MDU's files.

Reference

² GMC, *Good practice in prescribing and managing medicines and devices* (2013), paragraphs 67-70.

Records management

Good record keeping

Data protection - in brief

Good record keeping



Good quality records can make all the difference to clinical care of your patients. Records can include electronic notes, referrals, written handovers, phone notes etc. As well as their primary clinical purpose, records also fulfill important secondary functions such as helping the practitioner demonstrate the quality of the care they provided.

GMC guidance

In a clinical context, records are essential, and the GMC's *Good medical practice* (2013) outlines your responsibilities. It explains that in providing care, you must keep clear, accurate, and legible records made at the time of the events or as soon as possible afterwards. Your clinical records should include the relevant clinical findings, the decisions made, the information given to patients, any drugs or other treatment prescribed, and who is making the record and when.

The purpose of clinical records

Clinical records are primarily intended to support patient care and need to provide an accurate representation of each and every consultation (including by phone). Any other function for clinical records is secondary. Examples include protecting the practitioner against future claims or complaints, demonstrating CQC compliance, helping the police or supporting or denying a patient's claim.

In a medico-legal context, clinical records are extremely valuable as evidence of what happened. It is much easier to write a statement of events when your clinical record is thorough. Nobody can write down every detail and it is not true to say that 'if it's not written down it didn't happen'. It is reasonable to give evidence based on what you remember. But memories fade, complaints and claims can be made years after the events and a written record is powerful.

Clarity and accuracy of records

Records of patient consultations are now usually held electronically. Electronic notes are good for legibility but require care. For example, it is clearly essential that it's the right patient's medical records and it must be clear who is making the record.

Whether you are writing on a screen or by hand, make sure your records are unambiguous. If you use abbreviations that are uncommon, explain them.

If you are making handwritten notes - phone notes, for example, or written handovers - remember that these are also part of the records. As with formal entries into clinical records, make sure that these are legible and accurate. Make sure that all records are dated, timed and where appropriate, signed.

Records should be made straight away or as soon as possible after patient care.

Recording your work

Ward rounds. It may be that in order to make your ward rounds run more smoothly, you ask a colleague to act as 'scribe' to add details to the clinical records. Although this can be time efficient, it is important to remember that the notes need to include all the details you want to record about your assessment and your plans for the patient's care. Some clinicians choose to check over the record made by the 'scribe' and others choose to enter their own notes; it is for you to ensure that the notes of your assessment, however they are made, are fit for purpose and fulfill the GMC's expectations of what should be included.

Clinic notes. You might make notes in clinic (onto an electronic record, or handwritten) and also dictate a letter to the GP. Keep in mind that even the most robust administrative services can go wrong on occasion so, rather than rely entirely on the letter you dictate as a record of the consultation, do make sure that your clinical record includes enough information to stand alone as the record of the consultation in the event that the letter becomes unavailable.

Phone advice. You might be asked for advice over the phone, particularly when you are on call. Even if you are confident that the person who you're giving advice to is keeping a note, you will not know exactly what they write about your advice unless you check. You may wish to consider keeping your own note of advice calls. We recommend you keep a record of what information you were told as well as the advice you provided so that, if called upon to do so, you can explain why you gave your advice as you did.

Advice to GPs and other departments. As with providing advice by phone to your own team, you should keep a record of what you have been told and what advice you provided, in case you are later called upon to explain your advice.

What to do if the records are inaccurate or incomplete

Do not go back and amend clinical records. Even when you want to make changes to improve the completeness or accuracy of the record, amending records after the event can give an impression of dishonesty and can lead to criticism.

If a new finding demonstrates that a previous entry in the notes is factually incorrect, for example, an entry has been made in the wrong patient's records, then the amendment must make this clear. As a rule of thumb for handwritten

notes, errors should be scored out with a single line so the original text is still legible and the corrected entry written alongside with the date, time and your signature. Any new additions should be separately dated, timed and signed by the doctor who made them and at the time they made them. Never try to insert new notes. It might appear easy to alter computer records, but this should not be done.

When you are making a new note to correct a previous one, make a new entry clearly dated with the date on which it is made. Marking your new entry as 'note made in retrospect' will make it explicitly clear to any reader that you are making this new record at a later date. If possible, cross-reference the notes for ease of reading. For example if you discover on 12 January that the note you made on 1 January was incorrect (or missed out something important) you could write "This note written on 12 January, in retrospect, about consultation 1 January" And you could add a marginal note to the 1 January record (if possible on your system) to say "This note was later found to be incorrect (or incomplete) – please see retrospective note of 12 January".

Good record keeping tips

Write legibly

You may be able to read your own handwriting but can anyone else? Will you always be available to translate that indecipherable squiggle? Most records will now be computerised but there may still be occasions when you will need to handwrite patient records and if so, take a little extra time and care to write legibly.

Include the date and time

The delay between an incident and notification of a claim could potentially be several years. If writing records by hand, your dated and timed notes will be invaluable in clarifying the sequence of events during your treatment of the patient, as by that time it is unlikely you will be able to remember clearly what happened. With electronic records, the time and date is automatically stored on the computer's hard drive.

Make sure your identity is clear, for example by handwriting your name in upper case letters and including your GMC reference number. This will help anyone who needs to identify you later on.

Avoid abbreviations

What does PID mean? Prolapsed intervertebral disc or pelvic inflammatory disease? It may be clear to you but could be ambiguous to others. If you must use abbreviations, limit them to those approved in your workplace.

Avoid unnecessary comments

Offensive, personal or humorous comments are unprofessional, often misunderstood and could damage your credibility. Remember, patients have a right to access their records and a flippant remark in a patient's notes might be difficult to explain to a judge or Medical Practitioners Tribunal Service (MPTS) fitness to practise panel.

Check dictated letters and notes

Typed letters and notes have the advantage of legibility, but do have problems of their own. Letters dictated and then typed up later by a secretary may contain errors due to problems with the quality of recording or simple misunderstandings of medical terminology. They should be checked, corrected and signed by the doctor who dictated them.



If you are using typewritten records, you may wish to make a contemporaneous handwritten note as well – these can be invaluable if the patient needs to be seen again before the notes are typed up or if the record of your dictation is accidentally lost.

Check reports

You will need to see, evaluate and initial every report or letter before it is filed in the patient's records. Most results now come through electronically, so care should be taken to record abnormal findings in the clinical records and document any appropriate action.

Be familiar with the data protection legislation

All patients have rights as data subjects, including the right to access their medical records (subject to some exceptions). Make sure you are familiar with data protection legislation (see our separate guidance) and also with your contractual obligations relating to data security.

Data Protection – in brief



You have responsibilities under data protection legislation whether your work is NHS, private, or both. In the private sector you have additional obligations as a data controller. This sheet provides a brief introduction and signposts to the detailed guidance you will need.

Data protection legislation

The General Data Protection Regulation (GDPR) came into law in Europe in 2018. The Data Protection Act (2018) is the UK's implementation of GDPR. Everyone using personal data has to follow 'data protection principles'. They must make sure information is:

- used fairly, lawfully and transparently
- used for specified, explicit purposes
- used in a way that is adequate, relevant and limited to only what is necessary
- accurate and, where necessary, kept up to date
- kept for no longer than is necessary
- handled in a way that ensures appropriate security, including protection against unlawful or unauthorised processing, access, loss, destruction or damage

The Information Commissioner's Office (ICO) is the UK's independent authority set up to uphold information rights and has the power to take action when breaches occur.

Your obligations

The GMC expects all doctors to be familiar with and follow confidentiality, data protection and record management policies where you work and know where to get advice on these issues (<https://bit.ly/395bcGu>).

Everyone using personal data (for example, data about patients) must follow data protection principles in line with data protection legislation.

Your obligations under GDPR will vary depending on whether you are a data controller or data processor. As a general rule, you will be the data controller for data about private patients and a data processor when you are working for the NHS. There is more information about the roles of data controller and data processor on the ICO website (<https://bit.ly/2M9ez69>).

If you are in private/independent practice, please see our 'introduction to the GDPR for independent practitioners' (<https://bit.ly/2Y6TBHT>).

If you are employed by the NHS, your contract will set out your data protection obligations and you must follow the information management policies where you work. Any data controller who processes 'special category' data at scale - for example an NHS hospital using patient data - is obliged to appoint a data protection officer (DPO). The DPO can inform and advise employees on data matters so it is important to know who your DPO is.

Loss or misuse of data could lead the ICO to take action against a data controller or data processor. There are several examples of NHS trusts facing enforcement notices and fines. NHS trusts might take disciplinary action against staff who do not fulfil their data protection obligations. And a GMC investigation could result in action on your registration if there has been a serious or persistent failure to follow GMC guidance.

Data breaches

The GMC expects you to follow data protection policies where you work including policies on the use of laptops and mobile devices (<https://bit.ly/3oauU7X>).

We get many calls from members facing difficult decisions about whether or not to disclose patient information without consent in the public interest, but it is much more common for breaches of confidentiality or losses of patient data to happen by accident. Sometimes policies have not been followed and sometimes human error has led to a breach.

As a consultant you will already have a lot of experience in dealing with confidential information and you know how careful you need to be to avoid inadvertently disclosing confidential information by being overheard, leaving

a computer on, leaving notes where they should not be left, etc. If you are aware of practices in your workplace that could jeopardise confidentiality, it is your responsibility to raise and act on your concerns (<https://bit.ly/3610cr0>).

A common source of data breach is, in our experience, emails being sent out to a group of recipients whose email addresses are visible to each other in the 'CC' box. Occasionally a data breach can happen if paper notes are taken away from the hospital and then lost, or if a device with patient data on it is stolen. Or you might find that your clinical letter has been sent to the wrong address.

If you are involved in a data breach, you need to deal with it promptly because reporting to the ICO must be done without undue delay and not later than 72 hours after you become aware of the breach. Your health service organisation (such as your employing trust) should have a protocol in place and your DPO will usually be in a position to advise and support you. Please see our separate guidance on data breaches for more information (<https://bit.ly/2KGrkVu>).

Holding and retaining of records in independent practice.

If you hold records of patients in your independent practice, you need to pay a fee to the ICO and will be added to the register of data controllers (<https://bit.ly/3620a0Z>).

As a data controller you need to be aware of your obligations. Our 'Introduction to data protection for independent practitioners' provides some guidance (<https://bit.ly/2Zm3dz0>) and the ICO website (<https://bit.ly/2ODJDFu>) provides in-depth information and guidance that you will need to follow. This includes self assessment tools to help you work through the measures you need to take to make sure data is held, transferred and disposed of securely (<https://bit.ly/2KDZ2eh>).

In terms of retaining records, you should follow guidance published by the UK health departments on how long records should be retained and how they should be disposed of, even if you work outside the NHS.

In England, retention periods are set out in Appendix 3 of the 'Records management code of practice for health and social care 2016' but a new draft document is undergoing consultation as we go to press (November 2020 <https://bit.ly/3sP860I>).

In Scotland, retention periods are set out in Scottish Government Records Management Code of Practice for Health and Social Care (Scotland) 2020 (<https://bit.ly/39XIW8P>) (<https://bit.ly/39451IT>).

If your private practice is based in Northern Ireland or Wales, please contact us for the latest position.

Expertise

Acting as a medical expert witness

Giving evidence as a witness of fact

Setting up in private practice: medico-legal considerations.

Writing a report



Consultants may be required to prepare reports for a number of purposes, for example for the coroner or when a patient brings a claim for clinical negligence.

Background

You may be required to write a factual report if you are involved in a case that is investigated, for example by your employer, the coroner, or as a claim for clinical negligence.

Here we provide some general guidelines for writing a factual report but please ask us for personalised advice whenever you need it.

If you are writing a report to be used as part of a response to a complaint, you are likely to need to write a different style of document (please see our guidance on complaints handling and seek advice if you are not sure).

Guidance for expert witnesses is provided on page 36 *Acting as a medical expert witness*.

General principles

You must be familiar with the GMC's publications *Good medical practice* (2013) and *Acting as a witness in legal proceedings* (2013).

Paragraph 72 of *Good medical practice* (2013) says:

- You must be honest and trustworthy when giving evidence to courts or tribunals. You must make sure that any evidence you give or documents you write or sign are not false or misleading.
- You must take reasonable steps to check the information.
- You must not deliberately leave out relevant information.

In paragraph 4 of *Acting as a witness in legal proceedings* (2013), the GMC states:

- 'Whether you are acting as a witness of fact or an expert witness, you have a duty to the court and this overrides any obligation to the person who is instructing or paying you.[‡]
- This means you have a duty to act independently and to be honest, trustworthy, objective and impartial. You must not allow your views* about

a person to affect the evidence or advice you give.'

Doctors have a duty to cooperate with formal inquiries. But it is also important to remember your duty of confidentiality, which extends beyond death. If you need any advice about whether it is appropriate to provide a report, please contact us.

Doctors have a duty to cooperate with formal inquiries. But it is also important to remember your duty of confidentiality, which extends beyond death.

When you have agreed to provide a report it is important to do so in a timely way so, if you foresee a delay, keep in touch with the person who has requested the report. It is best to write reports as soon after the events as possible, while your memory is fresh.

Most requests for a factual report will not include a request for opinion so stick to the facts. If you are asked for your opinion there is a danger that your role as a factual witness will become blurred. If pressed to give an opinion, remember to do so only if comfortable and to comment only within your knowledge and expertise.

Format of your report

Your report may be written on headed paper. If you do not have headed paper, do include your personal details (including GMC number).

Start with an introduction of yourself, for example: "My name is...my qualifications are..." Include your qualifications as abbreviations and full text. Then describe your status at the time of the incident you are describing, for example, "At the time I cared for the patient, I had been working as a (your role or position at the time) at (name of trust/practice) for 15 years". Specify the nature of your contact with the patient, for example if you saw the patient on the NHS or privately, for clinical or forensic purposes.

It may be helpful to indicate who has

References

[‡] Civil Procedure Rules, rule 35.3, Criminal Procedure Rules, rule 33.2, Family Procedure Rules, rule 25.3, Children's Hearings (Scotland) Rules 1996, Act of Adjournment (Criminal Procedure Rules) 1996, Criminal Justice (Evidence) (Northern Ireland) Order 2004.

* This includes your views about a patient's lifestyle, culture or their social or economic status, as well as the characteristics protected by legislation: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation.

requested your report and for what purpose, and to list the documentation you have used in preparing your report. It is important to note whether you are including information from memory. You should ensure you reviewed all relevant records before writing your report. If you are asked to produce a report but do not have the material you need, please ask us for advice.

Describe the events chronologically, basing your description on the clinical records. It is also reasonable to include details from your memory or usual practice (please see *Report writing tips* for more detail).

Describe each relevant consultation or contact in a separate paragraph. Include dates and times. For each encounter, include details of history,

examination, your working diagnosis (and/or differential diagnoses) and plan. Where possible, mention whether you saw the patient alone or with another person. Describe any referrals you made, identifying the name of the person to whom you referred the patient.

Where possible, include significant negatives as well as positive findings, and describe what information you gave and what follow-up arrangements you made.

Make sure you do not leave out anything relevant.

If you need to include details of care provided by other people (for example, to explain the context of your own involvement), make it very clear who did what and confine yourself to details

from the clinical records. It is not usually appropriate to comment on the adequacy of what other people did.

Make clear when your involvement with the patient ended.

Double check your report against the notes once you have finished it, to make sure it is completely consistent and does not leave out anything significant.

If you are submitting your report electronically, transfer the final wording into a new 'clean' document and check carefully before you sign and date the document, to make sure old edits cannot reappear.

Go to **themdu.com** to watch our video on writing a medico-legal report.

Report writing tips

- Each report should be capable of standing alone. Do not assume that the reader will know anything about the case.
- Write in full sentences.
- Use straightforward language, avoiding or explaining medical jargon, technical terms or abbreviations. Remember that your report may need to be read by people who are not medically trained, including the patient or their relatives.
- Separate your report into paragraphs and consider numbering the paragraphs for ease of reference.
- Remember to use the patient's name. Repeated uses of 'the patient' can sound very impersonal in a document that might be read by the patient or their family.
- Identify colleagues who were present, by name and job title.
- The reader may not know anything about how you work or what your job title means, for example 'ST7 on call' may need explanation.

- Make sure your report is unambiguous. It is much clearer to the reader who did what if you write in the first person - for example, "I fetched the cardiac arrest trolley while Dr X undertook cardiopulmonary resuscitation" is clearer than 'He was resuscitated while the trolley was fetched'
- When you are including details from memory, make this clear. For example "My notes state that...and in addition I remember that..."
- You should also make it clear when you are describing something about your usual practice that you did not record. For example, "I did not record the detail of how I did the procedure but my usual practice is..."
- If you are describing having 'safety netted', it is helpful to explain what you believe you warned the patient to look out for and what advice you would have given them about seeking urgent care.
- If you are including test results make sure you include the units and reference ranges, and a brief explanation of what the test result meant. For example 'the eGFR

(estimated Glomerular Filtration Rate) was 50ml/min where a value of over 90ml/min would be normal. This indicated a significant reduction in kidney function since the test had last been performed...etc.

- If you are referring to drugs, provide the generic name and include a brief description of what the drug was for as well as the dose and route of administration. If you use the tradename of a drug, it should start with a capital letter.
- Type your report and check carefully for punctuation and errors.
- Finally, keep a copy of your signed report as submitted (and a note of when and to whom you submitted it) in case you need it later. Likewise keep copies of any documents appended to the report which should also be specifically referred to in the body of the report.



Acting as a medical expert witness



Medical expert witness reports are used to help a court or tribunal to come to a decision. The reports can range from an assessment of current clinical condition and prognosis following injury in a road traffic or industrial accident, to an opinion on the apportionment of responsibility when more than one party has contributed to clinical negligence, and/or the amount of compensation a victim of negligence should receive. Occasionally, an expert witness report is required in criminal proceedings.

The role

A court, tribunal or committee may require the opinion of an impartial expert witness experienced in the relevant specialty to assist them in making a decision about a case. As a consultant, you may feel that you have sufficient skills to become an expert witness and here, we outline the expert's role and duties.

Who is an expert witness?

Expert witnesses are practitioners with sufficient experience in their field to be able to give a reliable and informed independent opinion about specific issues in a case.

An expert witness differs from a witness of fact (also known as a professional witness) in several important respects.

- The witness of fact has usually already seen the patient for clinical purposes, whereas an expert witness is normally first approached by a solicitor or claims handler when a patient initiates legal proceedings.
- A witness of fact is normally not in a position to decline to provide a report for the court because they have first-hand knowledge of events. On the other hand, an expert witness may decline to act at the outset.
- Witnesses of fact are normally paid a fixed fee, whereas expert witnesses may be able to negotiate a fee. (A solicitor will normally agree with the expert in advance what the general scale of the fee might be).
- The expert witness may well be in regular communication with the legal team engaging with them during the preparatory stages of the case. Expert witnesses will likely be expected to attend a trial or hearing and listen to evidence given by other witnesses before giving evidence themselves. The witness of fact will almost always be precluded by the court or tribunal from listening to evidence given by others in advance of giving their own evidence.

This list of differences is not exhaustive and sometimes the roles of the expert witness and witness of fact overlap.

How does a doctor become an expert witness?

A good expert witness combines training, skill and experience. Whilst there are no hard and fast rules, if you have at least 10-15 years' experience in your specialty, you may have the necessary background knowledge and could reasonably propose yourself as a potential expert witness. You would need to compile a CV detailing your general and specific medical experience, including any teaching posts, publications and lectureships.

A number of bodies, such as the Expert Witness Institute¹, produce directories of experts in the UK. These provide the details of the expert and how they can be contacted and may list, with the appropriate consent, any high-profile cases in which they have been involved.

Many doctors who intend to become expert witnesses attend courses run by companies that specialise in training experts in report writing, the legal process generally and court appearances in particular. Expert witnesses can also draw on the advice and experience of colleagues and those whom instruct them as to general evidential and stylistic principles. Once an expert is known and respected in their field, they may expect to receive regular instructions from solicitors and others.

The duties of an expert witness

GMC guidance on acting as an expert witness

The GMC publication *Acting as a witness in legal proceedings* (2013) sets out guidance for witnesses, expanding on the core principles set out in *Good medical practice* (2013). All expert medical witnesses must be familiar with these publications.

Reference

¹ ewi.org.uk

The GMC makes clear that doctors who act as an expert witness must ensure that the instructions they are given are clear and unambiguous and that they restrict any statements to areas where they have relevant knowledge or direct experience and which fall within the limits of their professional competence.

The expert witness is expected to include all relevant information and give a balanced opinion. However, if there is not enough information to reach a conclusion on a particular point, this must be made clear.

Other key points of the GMC guidance are as follows.

- Both the expert witness and the witness of fact, owe a duty to the court and this overrides any obligation to the person who instructs them or pays their fee.
- If the expert witness's views change on a material matter, he or she has a duty to ensure that appropriate people are made aware of this without delay.
- The expert witness should not disclose confidential information without patient consent, other than to parties to the proceedings. The exceptions are where you are obliged to do so by law, or ordered by the court or tribunal or the administration of justice demands it.
- The appropriate people must be made aware of any potential conflicts of interest you may have without delay.

The GMC makes clear that doctors who act as an expert witness must ensure that they restrict any statements to areas where they have relevant knowledge.

Academy of Medical Royal Colleges Guidance²

This document, aimed at clinical professionals, sets out the standards and conduct expected of a clinician acting in the role of a witness (expert or professional) and is endorsed by professional bodies including the GMC.

The document makes the point that acting as an expert witness is extremely important for the administration of justice as well as providing an interesting and valuable experience. The performance and behaviour of an expert witness reflects not just the individual but also their wider specialty and profession. Clinicians undertaking this role should reflect this in their professional development plan and undertake relevant training. Failure to properly understand their duties to the court could result in sanctions against the clinician.

Other points from the Academy of Medical Royal Colleges Guidance include:

- In order to demonstrate legitimacy, healthcare professionals providing expert evidence must hold the appropriate licence to practise/ registration and be in, or sufficiently recently in, practice. This is essential if producing a report from direct assessment and/or examination of the patient.
- If this is not the case, the healthcare professional must be able to demonstrate why it is appropriate for them still to act as a witness and that they have maintained the appropriate expertise.
- If the case refers to historical events the healthcare professional should ideally have been in practice at the time of the events or be able to demonstrate understanding of the standards applicable at the time and the context of the incident.
- The document also sets out expectations regarding training for the role of expert witness, CPD activity and that the expert role should be reflected at annual appraisal. The healthcare professional should only give evidence within their scope of competence in their area of expertise and should not pass judgement on other disciplines. The witness must have a full understanding of the

wider context of the care and should be able to explain the spectrum of opinion and indicate, with sufficient reasoning, where their own opinion fits into the spectrum.

- The Academy of Medical Royal Colleges Guidance also sets out the personal responsibilities on healthcare professionals in terms of probity, impartiality, declaration of interests and acting within their sphere of competence.

Civil litigation

In order for a clinical negligence claim to be successful, the claimant must prove that there was breach of duty by a medical practitioner, and that this breach caused injury to the claimant. Expert witnesses are required to provide an opinion and assist the court in establishing whether there is validity in the claim.

An expert witness must be familiar with Part 35 of the Civil Procedure Rules³. These rules stipulate that experts must be independent and that they must write their report for the benefit of the court, not for the party requesting it.

Failure to observe the spirit of the rules may leave an expert vulnerable to criticism, and may reduce the credibility of their evidence.

Once instructed to advise in a civil case, an expert's duties can include the following:

- clinically examining the patient
- writing reports with reference to the available evidence, which may be drawn from the medical records, witness statements and medical literature. Documentation that has been relied upon in the formation of an opinion should be specifically listed in your report.

Reference

² *Acting as an expert or professional witness - Guidance for healthcare professionals (2019)*

³ <https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part35>

- meeting with other experts to identify areas of agreement and disagreement
- attending court, tribunal or a regulatory hearing to give oral testimony about their chosen field in the context of the case.

Report writing

Report writing is the key starting point of an expert's involvement in any case. Once the expert witness has considered the documents made available and/or examined the patient, they will draft a report, which must express an independent opinion about the medical issues. The expert should take into account other possible views and provide a range of opinions, where relevant.

At the end of the report the expert is required to sign a declaration confirming that they understand their duty to the court and that they have complied with that duty. An expert who makes a false statement within the body of a report without an honest belief in its truth is liable for proceedings for contempt of court.

Literature search

This is an integral part of writing a robust and comprehensive report. The expert witness will cite references from guidelines, peer-reviewed journals or textbooks in support of their opinion.

Where there are no publications to support their opinion, the expert should declare this. In order to provide a balanced report, it is often helpful to refer to literature that would support a different opinion, and the expert should explain why their interpretation leads them to advance their particular opinion.

Case conferences

Discussing reports, and the case generally, with lawyers and others involved provides an opportunity for identifying any weaknesses in a case and uncovering other medical issues. Therefore, the expert witness plays an important role, as the lawyers will base their decision on how to proceed largely on the expert's advice.

Attending court

The overwhelming majority of civil claims do not proceed all the way to trial. However, should an expert be required to give evidence in court, they must be familiar with all the evidence relied upon by the judge, which not only includes their own report, but also reports from the other expert witnesses. The expert must be able to answer, competently and credibly, the other party's questions during cross-examination.

Sometimes experts will have cause to revise their position under cross-examination. Those who provide a

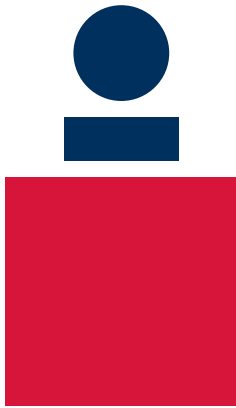
well-reasoned opinion, have considered alternative views and can articulate their analysis will do well in court.

Expert's liability

Experts may be sued in their own right, either for negligence or breach of contract in relation to the production of their report, conduct at an expert's meeting or otherwise during the lifetime of case. Therefore, it is essential that experts are adequately indemnified for their medico-legal work. The MDU advises that all members should keep the membership team updated of their working circumstances.

The expert must be able to answer, competently and credibly, the other party's questions during cross-examination.

Giving evidence as a witness of fact



Doctors can expect to be called to give evidence in court several times during the course of their professional career. They can be called to testify in many different types of judicial proceedings, including criminal cases, coroners' cases and industrial tribunals.

Background

Doctors play an important role in the justice system by contributing evidence both as expert witnesses and as witnesses of fact. All doctors preparing for a witness attendance must be familiar with the GMC guidance *Acting as a witness in legal proceedings* (2013). In addition, we provide information on the role and duties of an expert witness on page 36. Being called as a 'witness of fact' is far more common for a doctor than being asked to provide expert evidence and here we examine the role of a witness of fact.

Witness of fact

A doctor who is a witness of fact (also known as a professional witness) is called to testify to the facts, usually of a consultation or contact with a patient in which they were acting in their normal professional capacity. They may also, on occasion, be required by the court to give a professional interpretation of the facts.

Voluntary and summoned attendance

If you are asked to attend as a witness in circumstances where the patient has provided consent for you to disclose information to the court, you may wish to agree to attend voluntarily. If so, you may be given some choice about the date or time of your attendance.

However, if you do not agree to attend on a voluntary basis (for example, because you do not have consent from the patient - although exceptions apply), you should inform the requesting solicitor accordingly and you may be summoned to attend. For a summons to be valid, it needs to be properly issued and to be accompanied by 'conduct money' (in effect, your travel costs). It can be sent through the post. Sometimes, solicitors will send you a copy of their application to the court for a summons. This is not the same thing and does not mean that a summons has been granted. Distinguishing between the two can be difficult and, if in any doubt, members should contact us for advice.

Failure to attend court in accordance with a valid summons is a criminal offence and you would also be reported to the GMC. If you have any doubts or concerns at all, please call our medico-legal helpline.

Referring to records and reports

While you are giving oral evidence as a witness of fact, the court will probably allow you to refer to the original contemporaneous paper records, or a print-out of the electronic record, in your possession while you are in the witness stand.

It may be helpful to take copies of the records you may want to refer to in a folder, with bookmarks or tabs to help you find the relevant parts quickly while you are on the stand.

The court will probably not allow you to look at any non-contemporaneous records or reports. This applies to anything you may have written at the request of the patient's own solicitors to submit to the court and on which you may be cross-examined. As it may have been some time since writing the report, it is advisable to read your report again carefully before the hearing.

Maintaining patient confidentiality

Even when giving evidence under oath in court, a doctor still has an ethical duty to seek to maintain patient confidentiality. If a question is asked which you fear may have to breach patient or third party confidentiality, you should turn to the coroner, presiding magistrate, judge or chairman of the tribunal and explain your difficulty.

If the presiding officer of the court directs you to breach confidentiality, then, and only then, must you do so, even though you do not have consent from the patient. The solicitor or barrister acting for either side in a case does not have authority to compel you to breach confidentiality – either before or during the hearing.

Giving evidence

The court is most interested in what is called 'first-hand evidence'. This means that it wants you to concentrate on what you personally observed, rather than what you may have been told by someone else.

Your understanding of a case and the interpretation you place on your examination will, however, have been influenced by the history given to you by the patient, so you will need to give the court an account of this where that is relevant.

It is important to bear in mind that your evidence of what you were told is only evidence that you were told something; it is **not** evidence that what you were told was true as a matter of fact.

Being challenged

If your evidence is challenged, it may be on the basis that you failed to put yourself in a position to make an adequate assessment of the patient. You must be prepared to explain not only what you found, but also what you asked, and what you looked for but failed to find.

Your contemporaneous notes may not contain this kind of 'negative' information. No one expects you to make copious clinical notes of every last detail, nor will you be expected to remember every detail of a consultation that at the time appeared to be routine, and which may have been one of several thousand similar cases that you have dealt with in the intervening time.

It is of course appropriate to draw from your memory of events. However, if you cannot recall the details of a particular case, then it is acceptable to state what your 'usual' or 'normal' practice would have been in the circumstances.

The other relatively common area where doctors are challenged is on the level of expertise they claim for themselves. You should not be afraid to say 'I don't know' or to admit that something is beyond your level of experience or outside your area of expertise.

look directly back at the barrister when they are asking the next question. The courts desire an answer that is concise and to the point. On the whole, the more succinct the answer, the better it will be received.

Often a simple 'yes' or 'no' will suffice. If any answer requires further explanation the barrister or advocate will seek such clarification. Sometimes, questioning may seem to be repetitive, but you are expected to respond to each question and to retain a professional composure. The courts expect witnesses to answer only the questions that are put to them. While barristers will often prefer a clear, black-or-white response, very often the reality is a shade of grey.

Answering the questions

You should address your answers primarily to the judge or tribunal (and the jury, if one is present), and then

Q&A

Q I have been called to give evidence in the criminal courts after treating a patient who had allegedly been assaulted and sustained significant head and abdominal injuries. I provided the police with a report, so why am I also required to give evidence and what can I expect to happen in court?

A It would appear in this instance that you are being called to assist the court as a witness of fact. As the patient has given his consent for information to be disclosed to the court, you are advised to cooperate with the court's request and attend voluntarily. The court has the power to summon you if you do not attend and the GMC also expects doctors to cooperate fully with any formal

inquiry into the treatment of a patient. If you treated this patient in the NHS, you are expected to inform your trust's legal department. You will need to review your report again before appearing and take the contemporaneous medical records with you to court. Dress smartly and arrive promptly, but be prepared to wait for some time before you are called into the courtroom.

Bear in mind your duty of confidentiality while giving evidence and, if asked a question which you believe may breach confidentiality, seek direction from the judge.

Paragraph 72 of the GMC's guidance *Good medical practice* (2013) states 'You must be honest and trustworthy when giving evidence to courts or tribunals. You must make sure that any evidence

you give or documents you write or sign are not false or misleading.

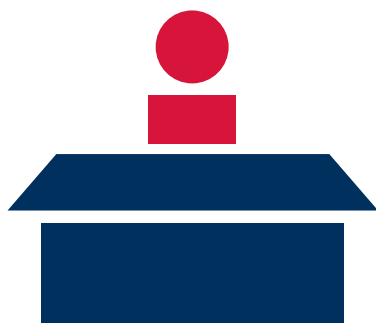
- You must take reasonable steps to check the information.
- You must not deliberately leave out relevant information.'

Ensure your responses are concise and factually accurate and do not be drawn into making statements about matters that you may not be certain of or that are outside your area of expertise.

The example above is fictional but based on cases in the MDU's files.



Setting up in private practice: medico-legal considerations



One of the attractions of setting up as an independent practitioner may be greater freedom to make decisions about the number of patients you see and the treatments you offer.

With this comes responsibility for areas which may have previously been undertaken by other healthcare professionals. Here we examine some of the medico-legal challenges facing consultants who are about to begin independent practice.

Regulation

GMC

In common with other doctors independent practitioners must be registered with the GMC and hold a licence to practise. They also retain all professional obligations regarding ethical standards, revalidation and fitness to practise.

Care Quality Commission (CQC)

All independent health and social care services in England are required to register with the CQC for:

- the type of work they do, and
- at each location in which they carry out that work.

Doctors consulting in a private hospital may not need to register separately if the hospital is appropriately registered, but this exemption will only apply where consultations are carried out under the organisation's management and policies, including those relating to clinical governance, audit and complaints handling.

Doctors who are employed by the NHS alongside their independent practice may also be exempt from registration. However, this exemption will not apply where doctors work in a group if even one member is not employed by the NHS. This exemption will also not apply where certain procedures, such as treatment under sedation or anaesthesia, are carried out. This is a complex area and failure to register with the CQC when this is a requirement can amount to a criminal offence. Members can seek our advice if they have any questions about whether they need to register.

More information can also be found at cqc.org.uk

Indemnity

As NHS indemnity only applies to clinical negligence claims against NHS bodies, it is important to make sure you have appropriate indemnity for your independent practice, including medico-legal work.

The GMC's guidance *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.'

Contact our membership team on freephone **0800 716 376** to discuss your indemnity requirements before doing any independent work.

It is advisable to ensure that the healthcare professionals you employ, such as nurses, are suitably indemnified in their own right where appropriate and that you confirm their registration status.

Marketing your services

It is important to be careful when promoting your services as an independent practitioner. *Good medical practice* (2013), paragraph 69, states 'When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge.'

Any advertisement you make will need to comply with the Advertising Codes enforced by the Advertising Standards Authority. You may also need to consider the Medicines and Healthcare products Regulatory Agency's guidance on the advertising of medicines (The Blue Guide) which can be found online at gov.uk

It is essential to ensure you have written consent from the patients concerned if you intend to use testimonials or patient photographs.

If a third party (such as a clinic) is publishing material on your behalf, it is important you make sure it meets the required standards. As other people's perceptions are important, it may be helpful to consider seeking the views of an impartial colleague or your medical defence organisation beforehand.

Independent practitioners who are registered with the CQC need to apply for permission to use its logo on advertising materials and must abide by its terms and conditions. All these considerations are also relevant if you promote your services via a website.

There is a statutory requirement to take reasonable steps to make it accessible to people with disabilities. The RNIB and the Disability Rights Commission offer advice on this.

If you offer general medical information on your website you should include a statement that it is general advice only and should not be used as a substitute for face-to-face consultations. If you link your website to another, you should inform patients you cannot guarantee that another website is secure and you do not necessarily endorse the contents of the site.

The GMC expects doctors to protect patient information. No electronic system is 100% secure but if you communicate with patients by the internet or email you must warn them that it may not be secure and they need to be told how their data will be used, this information should also be included in your privacy notice.

Independent practitioners considering providing remote consultations should follow the GMC's specific guidance¹.

Medical records

If you hold medical records about your patients, you have an obligation to keep them safe and confidential. You need to consider how long to retain records and who will handle them if you are no longer able to do so. Although there are no guidelines for retention of clinical records in private practice, paragraph 119 of GMC guidance *Confidentiality: good practice in handling patient information* (2017) states 'You must make sure that any personal information about patients that you hold or control is effectively protected at all times against improper disclosure or loss. The UK health departments publish guidance on

how long health records should be kept and how they should be disposed of. You should follow the guidance whether or not you work in the NHS².

If you intend to maintain records relating to private treatment, you are required to register as a data controller under the Data Protection Act 2018 and you will be obliged to comply with that Act. You can find out how to register from the Information Commissioner's Office (ICO) website ico.org.uk

You can read about the implications of the GDPR for independent practice at themdu.com

Fees

The most obvious point of difference with your previous experience is that independent practice is a business operation. It is your responsibility to be honest and open in any financial dealings with patients. Paragraph 4 and 5 of GMC guidance *Financial and commercial arrangements and conflicts of interest* (2013) says:

- 4 If you charge fees you must:
 - a) tell patients about your fees, if possible before seeking their consent to treatment
 - b) tell patients if any part of the fee goes to another healthcare professional.
- 5 You must not exploit patients' vulnerability or lack of medical knowledge when charging fees for treatments and services.¹

You should also take care when offering or providing private treatment to patients you have already seen on the NHS, so that others do not misinterpret your actions. You will need to declare any potential conflicts of interest that may arise. HMRC inspectors may ask to see invoices for your private patients. Tax inspectors have legal powers to obtain documents under Schedule 36, Part 1 of the Finance Act 2008. They can request, in writing, any information or document it is reasonable for them to have to assist in checking a taxpayer's

position. You should satisfy yourself it is reasonable to provide that information. It may be possible to give the necessary information in an anonymised form. The GMC says, 'if you are asked to disclose information about patients for financial or administrative purposes, you should give it in anonymised form, if that is practicable and will serve the purpose. If identifiable information is needed, you must be satisfied that there is a legal basis for breaching confidentiality. You must also be satisfied that the other relevant requirements for disclosing information are met.'

If seeking patients' consent or anonymising/coding the information requires unreasonable effort, it may be justifiable to provide relevant information.

Protection of vulnerable groups

A Disclosure and Barring Service (DBS) check may be required at each hospital at which you have practising privileges. Different rules apply in Scotland (Disclosure Scotland) and Northern Ireland (Access Northern Ireland).

If you employ other staff, you are obliged to obtain DBS checks depending on the work they do. The type of check that is done will depend on the work they do. Further advice can be accessed online from the Disclosure and Barring Service section of gov.uk

You should also be aware of employer responsibilities under the Safeguarding Vulnerable Groups Act 2006, which include a duty to refer to the Independent Safeguarding Authority information about employees you consider may pose a risk, or have harmed children or vulnerable adults.

References

- ¹ GMC, *Good Practice in Prescribing Medicines – guidance for doctors* (2013), paras 60-66, gmc-uk.org
- ² GMC, *Confidentiality: good practice in handling patient information* (2017), gmc-uk.org

Complaints procedures

If something has gone wrong during the care of a patient, the MDU advises you to provide an explanation of what has happened, an apology where appropriate, and assurance that steps will be taken to prevent a recurrence. The GMC's guidance in *Good medical practice* (2013), paragraph 55, states 'You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

- a) put matters right (if that is possible)
- b) offer an apology
- c) explain fully and promptly what has happened and the likely short-term and long-term effects'

All complaints, even verbal ones that might have been resolved at the time, should be logged and dated. If you see patients in an independent hospital or clinic, the hospital or clinic is required to have a complaints procedure. If you see patients in other settings, it is important to develop your own in-house complaints procedure that is clearly set out and communicated, and easy for patients and staff to use.

Responding to a complaint in a timely and sympathetic way, including an apology where appropriate, e.g. for any distress caused, may well help to resolve the complaint at an early stage. An apology is not the same as admitting liability and is expected by the GMC where appropriate as part of a 'prompt, open, honest and constructive response'.

It can also be useful to offer the complainant the opportunity to meet to discuss their concerns, perhaps in the presence of a conciliator. On some occasions, a goodwill payment or a refund without any admission of liability may be successful in resolving dissatisfaction but there is no guarantee that this will be effective. This would be

a matter for the individual clinician to decide, but the MDU would be happy to discuss this with members and assist in wording any letters. It may be helpful to model your procedure on the current NHS and social care complaints procedure, addressing complaints using a local resolution procedure.

Unlike complaints related to patients receiving NHS funded care, there is no statutory framework for independent review of complaints from the independent sector. Some independent healthcare organisations are members of the Independent Sector Complaints Adjudication Service, which publishes a Complaints Code of Practice for its members and offers an independent review service for cases where local resolution and complaints review within the organisation fails to resolve the complaint.

The CQC has a remit to monitor private complaints in England, and independent practitioners are required by law to provide an annual summary of complaints to the CQC.

The MDU has published a guide to the NHS complaints procedure which is available to download at [themdu.com](https://www.themdu.com)

Unlike complaints related to patients receiving NHS funded care, there is no statutory framework for independent review of complaints from the independent sector.

Business laws

As a potential employer, it is also important to be aware of any relevant legislation or regulations which may affect your business, for example, the need for employers' liability insurance, the Control of Substances Hazardous to Health (2002) regulations, and various other employment, health and safety, and equality legislation. You may wish to take advice from an appropriately skilled and experienced expert in these fields.

Corporate indemnity for your business

Traditionally, claims for clinical negligence have been made against individual healthcare professionals. Where doctors own, or are employed by a limited company, it is increasingly likely that a claim may be made against the company itself. We offer a comprehensive solution for your business, including indemnity and expert risk management support. For more information, please visit

[themdu.com/corporate](https://www.themdu.com/corporate)

Marketing and media

Dealing with the media

Guide to social media

Dealing with the media



The MDU's press office frequently supports members who have been contacted by the media for comment about their care or treatment of patients. A doctor's ethical duty of confidentiality usually makes it difficult to respond to these enquiries in detail.

Types of enquiry

The nature of enquiries received by our press office can range from doctors facing complaints, court cases or disciplinary hearings to those involved in high profile public inquiries. A journalist may have phoned or emailed asking for a comment, and occasionally members are 'doorstepped' by reporters and photographers.

The duty of confidentiality

Media enquiries are almost always impossible to respond to in detail, because of a doctor's ethical duty of confidentiality. Some patients choose to make a complaint, or take legal action against a doctor when things go wrong and increasingly people also go to the media or take to social media with their story.

While patients, and sometimes their legal advisers, are able to make detailed allegations publicly, doctors are constrained in their ability to respond by both a legal duty of confidentiality and an ethical duty laid down by the GMC. These duties mean that most of the time doctors cannot comment on the details of a case, even if the patient has put the information in the public domain.

Although journalists have a duty to seek both sides of the story, because doctors are often unable to respond, the resulting news story can be very one-sided. This can be both distressing and frustrating if you are the doctor involved, and it is important to have some techniques available to handle media enquiries while protecting confidentiality and presenting yourself in a professional manner.

Planning a response

While doctors are highly trained professionals used to dealing with a range of patients and their concerns, being contacted by a journalist can nonetheless come as a shock. Added to that is the discomfort that many doctors feel about the sensationalist article that could result.

The following guidance may be of help, if you are approached by the media for comment about a patient's case.

- If a journalist contacts you to ask about a patient, stay calm, find out who they are and which paper or media organisation they work for. Tell them you will call back.
- Contact us to ask for help in responding.
- Respond to the journalist as soon as possible, even if it is only to explain that you cannot comment because of your duty of confidentiality. A journalist is unlikely to go away if you ignore them and will usually be on a tight deadline to produce a story.
- It is important to remember that unless they say otherwise, journalists are 'on the record' from the moment they contact you. They will record or take down everything you or your staff say and they can use it in their story. Beware of off-the-cuff remarks and don't confirm any details that could breach patient confidentiality. You cannot even confirm or deny that someone is a patient unless you have their consent to do so.

- If you are approached by a photographer or film crew, don't try to cover your face or hide. Allow them to take a photograph or film you; once they have, they will usually leave you alone.

Ensure patients cannot be identified by any filming or photography and that the film crew are not obstructing patient access.

- Ahead of any hearing or court appearance, review information that exists about you online, including on websites and your social media channels. Consider enhancing your privacy settings and removing or updating outdated images or posts.

It is worth bearing in mind that in the majority of cases where a patient actually carries out the threat of 'going to the media', the media will not be interested. Most journalists understand that medicine and the doctor/patient relationship are not always straightforward. Sometimes journalists will want to make contact just to confirm that there is no story to write, but given a doctor's duty of confidentiality, even that may prove difficult.

MDU members who need advice on dealing with the media should contact our advisory helpline on **0800 716 646**.

Visit **themdu.com** to watch our video about dealing with the media.

Guide to social media



Social media is part of life and used by the majority of people. Ensuring you use social media with care is important for you and your patients.

Social media

Facebook, Twitter, Instagram, discussion forums, content communities, blogs and so on – have many advantages for doctors and patients alike. They allow public discussion on policy changes and the future of medical practice, and provide easy access to healthcare information for patients. They enable medical professionals to discuss developments in their speciality.

But there are also disadvantages, not least the risk of blurring professional boundaries, getting into unprofessional disputes and breaching patient confidentiality.

The GMC has made it clear that the standards expected of doctors do not change because they are communicating through social media¹.

In *Doctors' use of social media* (2013), the GMC also advises doctors:

- not to discuss individual patients or their care via publicly accessible social media
- not to bully, harass or make gratuitous, unsubstantiated or unsustainable comments about individuals online – whether about patients or colleagues
- that it is not appropriate to raise concerns about patient safety through social media
- if you identify yourself as a doctor, you should also identify yourself by name.

Pitfalls and how to avoid them

If you have a public-facing image on any form of social media, then this may be accessed by anyone, including:

- past, current or future patients
- employers
- colleagues
- solicitors
- national media
- regulatory bodies.

Maintaining a profile that projects a professional image, is accurate, based on verifiable information and not misleading is an essential starting point for your public online presence.

You owe a duty of confidentiality to all your patients, whether living or dead. Posting details of a clinical case, however heavily anonymised, for the purpose of education, or for any other reason may result in the patient's identity being recognised – by the patient, their family, your colleagues, or members of the public. In the absence of fully informed patient consent, this would constitute a breach of patient confidentiality.

Images or audio-visual recordings relating to clinical cases can only be used if you have the patient's consent in writing². The only exceptions are images of internal organs, pathology slides, laparoscopic or endoscopic images, recordings of organ function and x-ray or ultrasound images.

Be aware that closed professional groups may have thousands of members, some of which may not be medical professionals. A number of MDU members have found comments made on discussion forums have inadvertently revealed confidential information about patients and been shared more widely.

Maintaining professionalism

It's important to ensure that any posting is professional in nature. Before posting, consider how you would feel if a colleague or patient saw what you had written, or if it was shared to a wider audience.

The GMC has made it clear that the standards expected of doctors do not change because they are communicating through social media¹.

References

¹ GMC, *Doctors' use of social media* (2013), gmc-org.uk

² GMC, *Making and using visual and audio recordings of patients* (2011), gmc-uk.org

Use the privacy settings available however be aware that social media sites cannot guarantee privacy, however secure your settings.

It may prove detrimental to your professional standing, and possibly your career, if you post unprofessional content or if images showing you in an unprofessional light appear on your pages or those of other people.

Maintaining boundaries

For doctors, the boundaries between personal and professional use of social media can blur. Your behaviour and relationships with patients online should be no different from how you would behave towards them in person.

Patients may, for example, try to contact you via a personal social media channel. You should politely and clearly explain to them that this is not appropriate and, if relevant, direct them to your professional profile.

Maintaining professional boundaries with patients at all times is of paramount importance.

Dealing with online criticism

Doctors, particularly those in independent practice, can be vulnerable to criticism through social media sites. For example, NHS Choices, iWantGreatCare and Google reviews are popular among patients wishing to comment on their healthcare experiences. Many patients now choose to give feedback about their care in this way and some comments may be negative, inaccurate or offensive, which many doctors would wish to respond to directly. Most sites set clear guidelines on what can and can't be posted. Readers who consider a post 'offensive or unsuitable' can alert a moderator who will investigate and may remove the posting.

Twitter, Facebook and Instagram do not permit hate speech, threats, bullying and spam, but will only remove content that violates their rules. Dealing with criticism through a site moderator, without breaching patient confidentiality, is probably the safest way to deal with this type of feedback.

Members are advised to contact us on **0800 716 646** in the first instance, before responding to comments posted online about them.

Tips for using social media

- Be professional at all times.
- Maintain appropriate professional boundaries.
- Respect patient confidentiality.
- Take care about any personal post or images on your own site or other sites.
- Optimise the privacy settings on any personal social media site you use.
- Avoid any dialogue with a patient through social media sites.
- Be open about any conflicts of interest, such as financial or commercial interests in healthcare organisations.



For more advice and guidance

Visit themdu.com

Access a wealth of information including:

- Support for a range of issues, such as advice on how best to handle a complaint, or what to do if you find out you're the subject of a GMC investigation.
- Information on our CPD accredited courses, seminars and e-learning modules.
- Guides, case studies, FAQs and journal articles.
- Podcasts and videos.

Download the MDU app

You can also stay up to date with our latest advice and manage your membership online with the MDU app.

- Access your digital membership card.
- View your proof of membership.
- Search our guides, case studies and videos.
- Read journal articles offline.
- Customise your news feed.

If you've not downloaded the MDU app yet, get it free from the App Store or Google Play.



Free group seminars

Take advantage of free training seminars for your team. Between 45 minutes to an hour, delivered by your local liaison manager, either online or face to face. Key topics include remote consultations, avoiding prescribing and medication errors and dealing with challenging consultations, all with an attendance certificate. Book now at themdu.com/groupseminars

For medico-legal queries

24-hour advisory helpline

Call **freephone 0800 716 646**

Email **advisory@themdu.com**

Visit **themdu.com**

This information is intended as a guide. For the latest medico-legal advice relating to your own 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.

