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 regularly. 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.

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Successful leadership

Leadership skills
Time management
Supervision of staff
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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 Model\(^1\). 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

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<td>2.</td>
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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 Goleman describes a series of leadership styles shown in table 2.

Table 2 Six leadership styles at a glance

<table>
<thead>
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<th>Style</th>
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<td>Coercive</td>
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<td>Authoritative</td>
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<td>Democratic</td>
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<td>Coaching</td>
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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 cardiopulmonary 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 decisions.

Table 3 The five leadership proprieties

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<th>Propriety</th>
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<td>Fiduciary propriety</td>
<td>Patients first</td>
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<tr>
<td>Collegial propriety</td>
<td>Colleagues first</td>
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<tr>
<td>Bureaucratic propriety</td>
<td>Organisation first</td>
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<tr>
<td>Inquisitorial propriety</td>
<td>Knowing why things went wrong</td>
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<tr>
<td>Restorative propriety</td>
<td>Acting to make amends</td>
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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 Shale.

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

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

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.

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.

Reference

In her book *Isn't it about time?* 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

1. *Isn't it about time? How to stop putting things off and get on with your life*, A Perry. Worth Publishing 2002
The proportion of a consultant’s time spent managing others and managing physical and intellectual resources continues to increase.

What skills does a consultant need to become an effective manager? This section provides some useful information on supervisory skills for consultants.

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 guide\(^1\) and the GMC’s guidance on appraisal\(^2\) 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

People skills

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. This section looks at people skills.

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.

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 18-23.

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During your career as a doctor, you may already have acquired many of the management skills you need as a consultant. In this section, 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 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 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 bleeps. 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.

**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.**

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Managing your team

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

This section aims to help you ensure safe and effective patient 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.

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

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.

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.
appropriate 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 managers1.

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-speciality 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&As

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 Consent: Patients and doctors making decisions together (2008) elaborates on this and indicates that it is the responsibility of the doctor undertaking the investigation or providing the treatment to discuss it with the patient (paragraph 26).

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

The delegating doctor will remain responsible for ensuring that the patient has been given sufficient time and information to make an informed decision.

The delegating doctor also has a duty to ensure that the patient has given their consent before the investigation or treatment begins (paragraph 27).

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
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 framework\(^1\) 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 a 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

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. Evidence\(^2\) shows 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.

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. You might say something like ‘I can imagine you’re feeling pretty exhausted with all of that; when you’re in pain it’s not easy to be looking after someone else too’. It lets the patient know that you are attempting to ‘put yourself in their shoes’ and aim to understand their perspective. By acknowledging their emotion, even if we get it wrong when we guess what they are feeling, the patient will appreciate our effort.

It also helps avoid that repetitive-story scenario where the patient repeats themselves; by empathising and summarising, the patient knows you have heard and they don’t need to tell you all over again.

### References

Effective questioning

As doctors, we are often like detectives; looking for clues to solve the problem. Sometimes our consultations can sound like a series of rapid-fire questions though, with the patient giving yes-no answers and little else in the way of valuable information.

It is more helpful to start with open questions (beginning with what, where, when, who, how?) as this tends to elicit a fuller response. 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. Aim to keep an open mind as long as possible, rather than prematurely jumping to conclusions.

Sometimes we use leading questions, such as “You don’t have chest pain, do you?”. 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 shown 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 needs.

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 Sarah Coope

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We run a one day communication skills workshop which has been developed to meet the needs of busy doctors. For more information and to book go to themdu.com/learn

References

3 Patients’ memory for medical information, Roy P C Kessels, PhD, J R Soc Med. 2003 May; 96(5): 219–222. PMID: PMCS39473

GMC, Consent: patients and doctors, making decisions together (2008)
Effective communication with patients and colleagues alike is vital for patient safety and can improve patients’ experience of hospital. This section looks at the elements of effective communication with patients and their relatives.

**Privacy**
In a hospital setting, 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 turn off your mobile phone.

**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.

People with visual or hearing problems need particularly special consideration. 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.

- 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. The basic principle in most cases, is 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.

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### Q&As

**Q** My 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 16 of Consent: patients and doctors making decisions together (2008), the GMC says you should not withhold information from patients because a friend or carer 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.

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.

Unfortunately, you cannot discount the possibility that you may face a complaint – either from your patient's son if you do disclose the diagnosis to the patient, or from the patient herself, if she feels information was wrongly withheld from her. 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.

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.
**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.

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Q&A

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 guidance 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.

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Reference
Records management

Good record keeping
Confidentiality of electronic records
We all make records on a day-to-day basis, from telephone messages to a detailed personal diary. No one’s memory is wholly reliable. Records, whatever form they take, are a useful reminder of a course of events, required actions, steps taken, outcomes and further action. In medicine, good record keeping and management are of paramount importance.

**GMC guidance**

In a clinical context, records are essential and *Good medical practice* (2013) outlines your responsibilities. The GMC explains that in providing care, you must keep clear, accurate, and legible records which report 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.

Records should be made straight away or as soon as possible after patient care. Records are primarily intended to support patient care and should authentically represent each and every consultation (including by telephone). 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.

**Clarity and accuracy of records**

Records of patient consultations are now often held electronically. While entering the notes of a consultation on a computer may ensure they are legible, it also requires care. For example, it is clearly essential that the information must be attributed to the right patient’s medical records.

Along with clarity and accuracy, details are also important to remind you, or another member of your team, of your care and management plan. The notes may become important later on, if there is a complaint or claim, which will typically be made months or years after a consultation.

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

**Storing records**

Records should be stored securely and protected against accidental loss, including corruption, damage or destruction.

Records include:
- hand-written notes
- computer-generated notes
- blood test results
- x-rays
- copies of correspondence
- photos or slides
- theatre records.

All records need to be kept secure and confidential at all times. Technology is not foolproof and regular back-ups should be made. It is advisable to consider keeping these securely at a different site.

Patients have the right to request access to their records. Make sure that patients know what will happen to the data held about them and that they agree to its processing or disclosure. Under the Data Protection Act 2018, organisations or independent practitioners no longer have to register with the ICO but will need to pay a data protection fee. The fee is calculated on members of staff and turnover for independent practitioners. The ICO has guidance on this.

Clinical records must be kept confidential at all times, including during transfer between sites. It would be important to ensure that anyone who takes records out of the practice - say, to work from home - is aware of confidentiality obligations, for example, the need to avoid inadvertent disclosure of patient’s information to family members or visitors. This would include locking paper records away in a suitable filing cabinet, and ensuring any computer systems are appropriately confidential and secure.
The General Data Protection Regulation (GDPR) introduces a duty to report personal data breaches, for example, loss or data or confidentiality breach within 72 hours. There are stiff penalties for personal data breaches.

**Retaining records**

There is no longer a specific statutory provision covering the retention of private medical records. The Records Management Code of Practice for Health and Social Care (Information Governance Alliance, 2016), Records Management: NHS Code of Practice (Scotland) (Scottish Government, 2012), Welsh Health Circular (2000) 71: For The Record (National Assembly for Wales) and Good Management, Good Records (Department of Health, Social Services and Public Safety, last updated March 2015) all include schedules of minimum retention periods for different types of records. Claims do sometimes arise after these timescales, so ideally all records should be reviewed before they are destroyed, and it would be prudent to keep any patient records where there has been an adverse incident or complaint, until you know it is concluded.

Disposal should be carried out in such a way that protects patient confidentiality, for example, by shredding paper records. Computer-held records may be difficult to delete entirely from a hard drive and appropriate IT advice should be sought.

**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 handwriting records, 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.

**Avoid abbreviations**

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

**Do not alter an entry or disguise an addition**

Tampering with records has led to GMC investigations. Clinical notes should be made at the time of treatment or as soon as possible afterwards. 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, 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. Never try to insert new notes. It might appear easy to alter computer records, but computerised record systems have an audit trail that will allow alterations to be discovered.

**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 come through electronically now, so care should be taken to record abnormal findings in the clinical records and document any appropriate action.

**Be familiar with the Data Protection Act**

All patients have the right to access their medical records and this right is defined in the the General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 2018), which allows patients to receive a copy of their records, subject to exceptions.
We regularly receive enquiries from members relating to the storage, transmission and security of electronic patient records. All doctors must protect confidential patient information held or transmitted electronically.

A duty of confidentiality

Confidentiality is central to the trust between doctors and patients. The duty of confidentiality is defined and protected by common law and an increasingly complex body of statute law. The GDPR and DPA 2018 impose a legal duty on those responsible for processing personal data to ensure it is processed (which includes storage) securely. Article 5(1)(f) of GDPR says that personal data shall be: ‘Processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical and organisational methods’.

Doctors are also accountable to the GMC if patient confidentiality is breached. The GMC provides detailed guidance on the ethical aspects of confidentiality and information sharing in its guidance Confidentiality: good practice in handling patient information (2017).

The Health and Social Care Information Centre has also published good practice guidelines for NHS organisations on the transfer of electronic data. The guidance, which includes links to other relevant guidance and templates, states the following:

- ensure that all staff involved in data transfer are appropriately trained and have access to clear policies and guidelines
- establish authorisation procedures for extraction of batched data from organisational systems
- encryption of data and management of removable media
- do not hold person-identifiable data on portable storage devices unless it is encrypted
- ensure that secure courier arrangements are understood and adhered to
- ensure that the data transferred is effectively deleted from the portable device used for transfer.

If you take photographs or videos as part of the clinical care of patients, you should follow GMC guidance on Making and using video and audio recordings of patients (2013). You should ensure that such photographs and videos are downloaded onto a secure computer as soon as possible and delete the images from the camera afterwards. You should avoid using your mobile phone to take patient photographs.

All NHS organisations should have a Caldicott Guardian. This is a senior person responsible for protecting the confidentiality of patient and service user information and enabling appropriate information sharing. You may find it helpful to seek the local Caldicott Guardian’s advice about data security within the NHS environment. If you work in the NHS, you should also familiarise yourself with your employer’s own data security policy and procedures.

Security of computer-held data

The GMC also expects doctors to protect the confidentiality of patient information. The GMC states in its guidance Confidentiality (2017), paragraph 8, ‘Make sure any personal information you hold or control is effectively protected at all times against improper access, disclosure or loss.’

Article 32 (1) of the GDPR states:

‘Taking into account the state of the art, the costs of implementation and the nature, scope, context and purposes of processing as well as the risk of varying likelihood and severity for the rights and freedoms of natural persons, the controller and the processor shall implement appropriate technical and organisational measures to ensure a level of security appropriate to the risk.’

Reference

No manual or electronic system will ever be 100% secure, but should an unauthorised disclosure occur you will need to be able to justify the steps that you have taken to prevent breaches in patient confidentiality.

Under the GDPR and DPA 2018 the Information Commissioner has the power to impose penalties of up to 10 million Euros for serious data breaches.

Mixing personal and private use
As normal working hours are incredibly busy, it might seem more convenient to catch up on work on your home computer, or just take your work laptop home with you. But this can present a host of medico-legal problems, as information held on hard drives is notoriously difficult to erase permanently. We advise members not to mix personal and patient data on any computer.

Doctors using home computers or personal laptops to store patient information may also be in breach of the Data Protection Act 2018, as the Act lays down strict guidelines for the processing of sensitive personal data. In addition, a complaint could be made to the GMC about a breach of confidentiality.

Thieves
Doctors are expected to take appropriate steps to prevent theft of computer equipment. While paper records are unlikely targets for random theft, computer equipment may be a different matter. Laptops and portable devices are perhaps the most vulnerable to theft and you may wish to consider whether sensitive data should be kept on them at all.

Under legislation introduced in 2018, the Information Commissioner’s Office can order organisations to pay up to 10 million Euros for serious breaches of the DPA.

Unauthorised access
This could happen either in the workplace, or following theft. You should consider installing suitable security on to your computer equipment to prevent unauthorised access.

Hardware or software failure
You should take appropriate measures to safeguard data against accidental loss. Over time, errors may develop in storage media and for this reason backing up of data is recommended. You may choose to keep back-up data off site to keep it secure in the event of a fire or theft.

Cloud storage
Some doctors are considering using cloud computing services to store their electronic data. This is when data is stored on a virtual, off-site server run by a third party. The internet provides the connection between your computer and the database, which means you can access the data from any computer with an internet connection. While this may be convenient, there are significant security and confidentiality considerations to take into account.

The Information Commissioner’s Office (ICO) has published Guidance on the use of cloud computing which has a useful checklist. For example: is data encrypted when in transit, what are the deletion and retention timescales and will the data be deleted securely if you withdraw from the cloud? Additional questions to ask include: what audit trails are in place so you can monitor who is accessing the data, which countries does the provider process the data in and is a written contract in place including confidentiality clauses? Data can only be sent to a third country when that country has an adequate level of protection for that data.

For further information, please visit themdu.com/guidance-and-advice/latest-updates-and-advice/storing-information-using-a-data-cloud

Maintenance of computer equipment
If you work in an environment where you are able to influence computer maintenance, such as private practice or GP, you may want to consult IT experts to ensure that the equipment is appropriately maintained and serviced. In these circumstances, we’d recommend that you use a reputable company and have a written contract. The contract will need to make it clear that the computer contains sensitive personal data and should ensure the confidentiality of such data. You may wish to seek a specific undertaking from the repairer not to attempt to access any of the data on the machine.

Disposing of old computers
Information held on hard drives is notoriously difficult to erase completely and confidentiality could be breached if patient information is not entirely destroyed. For example, even reformatting a hard drive might not make all the data previously held on it irretrievable to a determined person. We advise that you seek specialist advice.

There are companies that specialise in recycling old computers. If you decide to use such a company, you would need to ensure there was a guarantee that they would securely wipe the hard drive before destroying or recycling the computer.

Using email
The convenience afforded by email may be attractive but where it contains patient information, you must consider the risk of the email being intercepted. You must make sure that patient information you hold is effectively protected against improper disclosure at all times.

Under the the GDPR and DPA 2018 you are expected to inform patients of how their confidential information is being handled, allowing them the opportunity to object if they wish. Any email exchange
Minimising accidental confidentiality breaches from electronic records

Our advice to members to reduce the risk of accidental confidentiality breaches from electronic records is as follows.

- Be aware of relevant guidance, such as that provided by the GMC and the NHS, as well as your legal requirements.
- Don’t mix personal and professional data on your computer — it could lead to breaches of confidentiality and it is notoriously difficult to erase some information permanently from a hard drive. This can be a particular danger when doctors use laptop computers for professional and personal use.
- Nominate a person to be responsible for procedures for handling confidential data.
- Train all staff to keep information confidential and include a confidentiality clause in all employment contracts.
- Prevent unauthorised access to confidential information by using password protection and other security measures.
- Take professional advice before connecting your computer to a network and keep a record of the advice.
- Ensure you have a written contract, outlining confidentiality requirements, with the company that repairs and maintains your computers.
- Ensure that hard drives are properly erased, removed or destroyed before disposing of any computer equipment.
- Ensure electronic means of communication such as fax and email are secure before sending the information.
- Contact the MDU if you have any specific concerns about electronic records or you need advice about a breach of confidentiality.

You should not forward emails from your NHSmail account to your home email.

- Most patients understand and expect that relevant information must be shared within the direct care team to provide their care. You should share relevant information with those who provide or support direct care to a patient, unless the patient has objected.²
- As a general rule, you should seek a patient’s express consent before disclosing identifiable information for purposes other than the provision of their care or local clinical audit, ‘such as financial audit and insurance or benefits claims.’³

This list is not exhaustive and you may wish to consult IT specialists for advice on ensuring the security of any patient information, which is held electronically, and this extends to sharing that data and disposing of it securely when it is no longer needed.

References

² GMC, Confidentiality (revised May 2018), paragraph 27.
³ GMC, Confidentiality (revised May 2018), paragraph 78-79.
Expertise

- Writing a report
- Acting as a medical expert witness
- Giving evidence as a witness of fact
Writing a report

Doctors 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 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.

Guidance for expert witnesses is provided on page 33 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.

You need any advice about whether it is appropriate to provide a report, please contact us.

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, remember 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 requested your report and for what purpose, and to list the documentation you have used in preparing your report.

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.

References


* 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.
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.

Remember to sign and date your report when you are ready.

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.

- 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 did this and Dr X did that” rather than “Y was done…” or “the patient was seen”.

- 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…”

- 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.

- 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.

- Type your report and check carefully for punctuation and errors.

- Finally, keep a copy of your report (and a note of when and to whom you submitted it) in case you need it later.
Medical expert witness reports are used to assist 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 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 are a witness of fact. On the other hand, an expert witness may decline to act at the outset.
- An expert witness must provide an entirely independent opinion on the case in question.
- 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 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. 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 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. 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.

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 expert witness must be made aware of any potential conflicts of interest you may have without delay.
- 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.

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 any basis on which to bring a claim.

An expert witness must be familiar with Part 35 of the Civil Procedure Rules. These rules stipulate that experts 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
- 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.

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 revise their position under cross-examination, which can undermine their credibility. Those who provide a well-reasoned opinion, have considered alternative views but nonetheless stand by their opinions 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 or conduct at an expert’s meeting. 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.

Reference

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 33. 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), 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.

### 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 any 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 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.

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.
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 are unlikely to 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 quite acceptable to quote from memory. 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.

Answering the questions

You should address your answers primarily to the judge or tribunal (and the jury, if one is present), and then look directly back at the barrister when they are asking the next question. The courts want an answer that is concise and to the point. On the whole, the more succinct the answer, the better it will be.

Often a simple ‘yes’ or ‘no’ will suffice. It is the job of the barristers or advocates to ask further questions and to gain all the information the court wants from you. 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 truth is a shade of grey.

Q&As

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.

a) You must take reasonable steps to check the information.

b) 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.
Marketing and media

Setting up in independent practice: medico-legal considerations
Dealing with the media
Guide to social media
The ‘Right to be forgotten’ online
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](http://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](http://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.

Independent practitioners considering providing remote consultations should follow the GMC’s specific guidance.

### 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 NHS.”

If you intend to process electronic data relating to private treatment, you are likely to have to register as a data controller under the Data Protection (Charges and Information) Regulations 2018. You can find out how to register from the Information Commissioner’s Office (ICO) website ico.org.uk

Whether you need to register with the ICO or not, you will still be obliged to comply with the the GDPR and DPA 2018, which includes informing patients about what data you are collecting, the reasons for doing so, their rights and the legal basis for processing their data. The ICO has produced guidance regarding privacy notices.

### 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.

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

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.

We run courses for consultants who are considering setting up in private practice. Visit themdu.com/learn for more information and to book.

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

Types of enquiry
The nature of enquiries received by our press office can range from doctors who are the subject of a newspaper campaign, to those facing court or GMC hearings or those involved in high profile public inquiries, all of whom had been contacted by journalists or ‘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 formal complaint, or take legal action against a doctor when things go wrong and increasingly people also go to the media with their story.

While patients, and sometimes their legal advisers, are able to make detailed allegations in the press, 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 assistance, if you are approached by the media for comment about a patient’s case.

- If a journalist calls out of the blue and asks 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.
- Call the journalist back 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 a photographer or broadcaster attempts to photograph or film you, 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.

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 straightforward black and white issues. 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](http://themdu.com) to watch our video about dealing with the media.
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 specialty.

But there are also disadvantages, not least the risk of blurring professional boundaries, disclosing personal information to the public 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 media.

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 any web pages that may be accessed by the public.

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 may result in the patient's identity being recognised – by the patient, their family, your colleagues, or even 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 writing. The only exceptions are images of internal organs, pathology slides, laparoscopic or endoscopic images, recordings of organ function and x-ray or ultrasound images.

Information and images of a personal nature may be accessed by more people than you intended and can cause problems. In 2009 a number of emergency department staff were suspended by their employer for posting images of themselves 'planking'.

This pastime involves taking pictures of yourself or your friends lying down with your arms by your side and feet pointing to the floor. Extra points are awarded for unusual settings, in this case hospital trolleys and the air ambulance helipad.

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

**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
This was really just some fun between friends but serves to demonstrate how important it is to ensure that any posting is professional in nature. It is also essential that you use the privacy settings to ensure your posts cannot be seen by anyone other than your personal or professional contacts.

It may prove detrimental to your professional standing, and possibly your career, if you are tagged in photos other people post to their own page, especially if the image shows you in an unprofessional light.

If a patient contacts you directly through a personal social media site, then it would be inappropriate to engage in any discussion with them in this forum. You should advise them to contact you through an appropriate confidential and professional route.

Social media sites cannot guarantee confidentiality whatever privacy settings are in use. Therefore engaging in any form of discussion with a patient about their care is to be avoided. You can put in place privacy settings to protect your personal information as fully as possible to minimise some of the risk, but maintaining professional boundaries with patients at all times is of paramount importance.

Be careful who you accept as friends and do not accept requests from patients. Accepting a Facebook request from a patient has led to unwanted amorous advances or, conversely, abuse about the standard of care they (or their loved ones) have received.

Doctors can be vulnerable to criticism of their practice 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 choose to send feedback through sites 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 and Facebook do not permit hate speech, threats, bullying and spam, but Facebook will only remove content that violates its terms. 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 postings of text 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.
Some doctors find to their distress that an online search of their name brings up an unfavourable or unflattering story - a news report about a patient complaint, perhaps, or a past GMC investigation that may have concluded many years ago. When this happens the question often is: can anything be done about it?

**Internet search engine results – legal perspective**

A data protection ruling by the Court of Justice of the European Union (CJEU) in 2014 found that search engine operators are ‘data controllers’ as defined in the Data Protection Act 1998*. Members of the public therefore have the right to ask them to remove search results on privacy grounds if these ‘appear to be inadequate, irrelevant or no longer relevant, or excessive’. The judges said that accurate data that had been lawfully published could ‘in the course of time, become incompatible’ with data protection law.

This is good news, but it is important to understand that decisions will be made on a case-by-case basis. The ruling said ‘a fair balance should be sought’ between the right to privacy and the public interest, which may depend on:

- the nature of the information in question and its sensitivity for the individual’s private life
- public interest in having that information, an interest which may vary according to the individual’s role in public life.

**Having search results removed**

The search engine operator involved in the 2014 CJEU case, Google, has produced a web form for users or their authorised representatives to request the removal of search results and acknowledges that thousands of requests have already been received.

Google explains:

‘When evaluating your request, we will look at whether the results include outdated information about your private life. We’ll also look at whether there’s a public interest in the information remaining in our search results – for example, if it relates to financial scams, professional malpractice, criminal convictions or your public conduct as a government official (elected or unelected). These are difficult judgements and, as a private organisation, we may not be in a good position to decide on your case. Your local data protection authority may be better placed to make this assessment.’

Anyone who wishes to request the removal of search results from Google will need to do the following.

- Submit a valid form of photo ID and contact details.
- Provide proof of authorisation (if appropriate).
- List the URL(s) of the relevant links appearing in the Google search results for their name.
- Explain why each result concerns them (if this is not clear).
- Explain why the result is irrelevant, outdated, or otherwise inappropriate.

**References**

2. Paragraph 94 of the judgement.
3. Paragraph 93 of the judgement.
4. Paragraph 81 of the judgement.
5. Ibid.

* The definition in the DPA 2018 remains the same.
MDU advice

Doctors who submit requests will need to keep in mind that success will depend on the nature of what is being requested as well as why it is causing concern. A request for removal from a search is not automatic.

It is also important to remember that the actual web pages and documents will not be removed from the internet, only the opportunity to access them via a search engine link.

The judgment also only applies to EU countries. Users may still be able to navigate to the particular page by using a completely different search term or the same search term entered into a search engine outside the EU.

Ultimately, the understandable desire to have a website link erased needs to be balanced against recognition that achieving this may not be the end of the matter and may itself attract comment.
When it comes to medical defence

Experience counts

- Free hospital-based seminars
- Setting up in independent practice CPD workshop
- Meetings with your dedicated liaison manager
- 24-hour medico-legal helpline

Visit themdu.com
There’s no pressure quite like the pressure you face as a consultant. The MDU is run by doctors for the purpose of supporting other doctors – something we’ve been doing for longer than any other medical defence organisation.

When you choose the MDU, you’re not only getting guidance, support and defence from the largest medico-legal team in the UK, you’re putting your livelihood in the hands of people who understand just how precious it is.

themdu.com
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.