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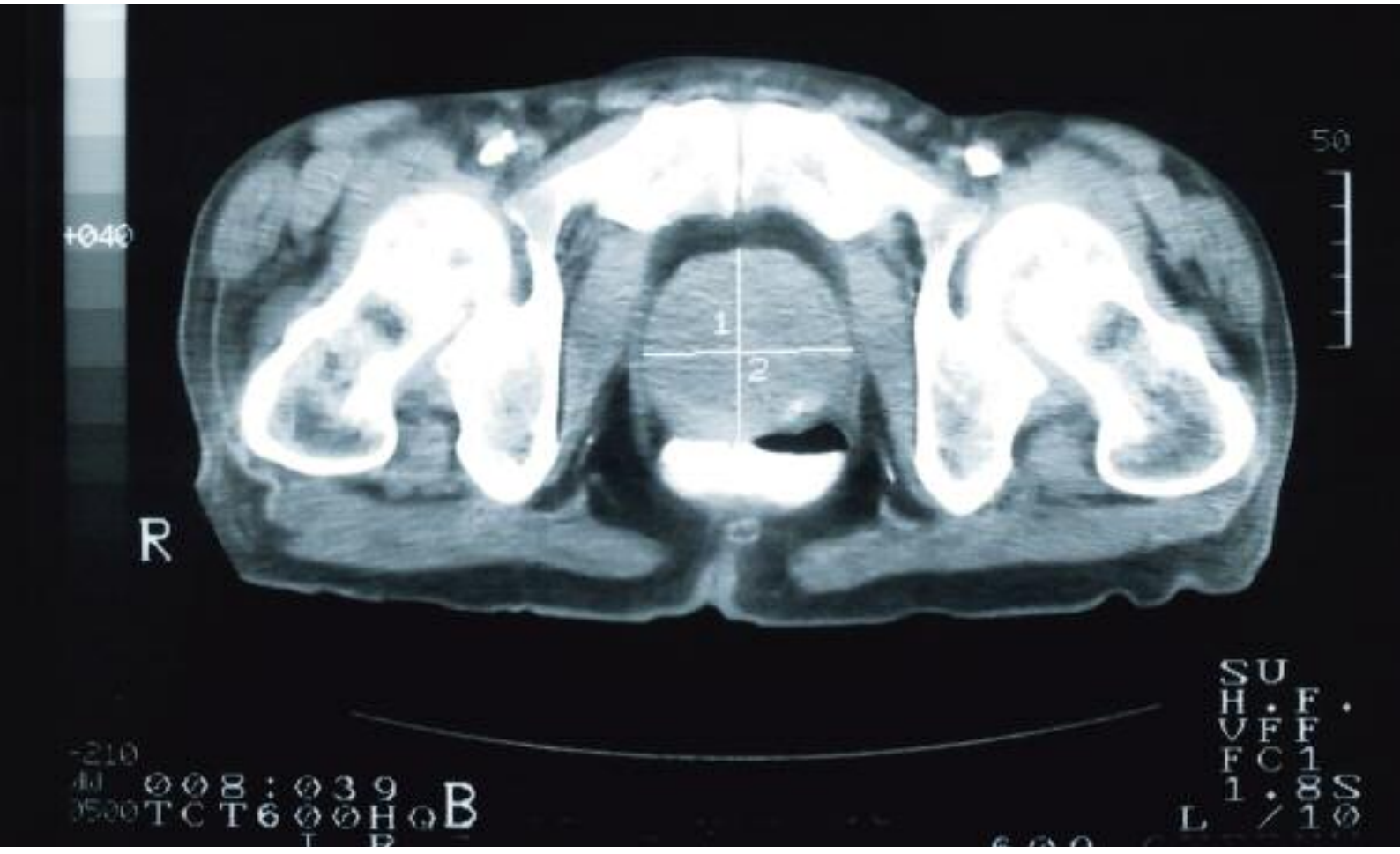
THE MDU

GoodPractice

The MDU journal for GPs and GPSTs



Prostate cancer:

an enigmatic disease

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Protecting your business

CORPORATE INDEMNITY SOLUTION

EDITORIAL

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Welcome

As the British summer draws to a close it is a pleasure to announce the publication of the fourth issue of *Good Practice*, the journal for MDU GP and GPST members.

Prostate cancer is the most common cancer in men and with a rising incidence it is perhaps unsurprising that the MDU has seen an increase in the number of files opened to assist members with prostate cancer complaints and claims over the last ten years. The majority of the complaints concerned alleged failed or missed diagnosis of the condition. In this edition Dr Sally Old, MDU medico-legal adviser, examines this trend in more detail and provides advice to assist GPs in avoiding some of the potential pitfalls of diagnosing and managing this enigmatic disease.

This summer has unfortunately seen unrest and violence on the streets of some of our larger cities. In situations where a crime has been committed it is not unusual for a GP to receive a police request for the disclosure of confidential information about a patient, who may be either the victim or the alleged perpetrator. Dr Kathryn Leask's article on reporting criminal offences provides advice about the confidentiality dilemmas such requests may pose. Further helpful guidance is also available on the MDU's website.

Also in this edition are articles on Lasting Powers of Attorney and safeguarding vulnerable adults, as well as some reassuring advice about the position of the GP when a patient wishes to deliver her baby at home. And as patients return from their beach holidays, the IN FOCUS section includes advice for doctors on managing malignant melanomas.

Please do not hesitate to contact the MDU advisory helpline if you would like to learn more about any of the issues raised in this publication, or would like to discuss a particular scenario in more detail.

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Medical editor and MDU medico-legal adviser

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GoodPractice
The MDU journal for GPs and GPSTs

Feedback

We welcome your feedback. If you have any queries or comments, or would like to request more information on a particular topic, please write to:

Marketing Department
MDUSL
230 Blackfriars Road
London SE1 8PJ
or via the web at the-mdu.com/feedback

NEWS IN BRIEF

IN BRIEF

Recording consultations

A patient's consent or valid authority must be obtained before a consultation can be recorded, either on video or audio, new GMC guidance states. *Making and using audio and visual recordings of patients* (2011) clarifies the ethical principles of making recordings, including secondary uses for which the patient may not have initially given consent.

The guidance also covers recording of telephone calls, which many practices do routinely. Calls may be recorded for legitimate reasons such as medico-legal purposes, staff training or audit, providing all reasonable steps have been taken to inform the caller that their call may be recorded. Doctors must not make secret recordings of conversations with patients.

Fast track claims

The Ministry of Justice has proposed a new scheme[1], modelled on the road traffic accident scheme, to 'fast track' low value clinical negligence claims through the county courts. The MDU has questioned the validity of the approach, since clinical negligence claims are significantly more complex than road traffic accidents and the outcome of a claim can have serious professional and personal repercussions for the doctors involved.

Dr Matthew Lee, director of professional services at the MDU, commented: 'While it is in our members' interests that claims are settled as early as possible in cases where patients have been negligently harmed, it makes no sense to settle them unless there are good grounds to do so. In the interests of fairness to doctors, any scheme for low value claims would need to incorporate safeguards. The MDU is doubtful that a scheme for road traffic accidents can be modified sufficiently to make it acceptable to all parties in the highly complex world of clinical negligence.'

1 *Solving disputes in the county courts: creating a simpler, quicker and more proportionate system, a consultation on reforming civil justice in England and Wales*, Ministry of Justice, March 2011. www.justice.gov.uk/downloads/consultations/solving-disputes-county-courts.pdf

The Bribery Act 2010

The Bribery Act 2010 came into force in July 2011, bringing with it a new offence of 'failure of commercial organisations to prevent bribery'. Commercial organisations include partnerships.

A commercial organisation will be liable if a person associated with it (which may include employees and third party suppliers) bribes another person intending to gain or retain business or an advantage in the conduct of business of the organisation.

See www.justice.gov.uk/guidance for more information and guidance on the Act.

National bowel cancer symptom awareness campaign

to launch in January 2012

As part of plans to tackle England's relatively poor cancer survival rates (compared with Western European countries) Health Minister Paul Burstow recently announced a series of campaigns to raise awareness of the symptoms of cancer and encourage earlier diagnosis, where the cancer is at a more treatable stage.

Following successful regional pilots of a bowel cancer awareness campaign, the Department of Health (DH) is rolling out a national campaign to raise awareness of loose stools and blood in stools for more than three weeks as symptoms of bowel cancer and to encourage people with symptoms to go to their GP early. The campaign will launch at the end of January 2012 and will run for eight weeks.

In addition to a national campaign on bowel cancer the Department is running a regional pilot for a campaign to raise awareness of the symptoms of lung cancer, and encourage people who have had a cough for more than three weeks to visit their GP. This will run from 10 October 2011 for five weeks, in the Midlands and some adjacent areas.

Over 60 PCTs have also received funding to run local campaigns to raise awareness, and encourage early diagnosis, of oesophago-gastric cancers, the symptom of blood in urine (an indicator of kidney and bladder cancers) and breast cancer in older women.

Spotting **the sick** child

Speed of deterioration and difficulties in communicating with younger children can hinder diagnosis of a sick child. An online support tool, commissioned by the Department of Health, helps healthcare professionals make timely and accurate diagnoses.

Spotting the Sick Child (www.spottingthesickchild.com) is aimed at frontline doctors, nurses and paramedics who look after young children. It is evidence-based and teaches the basic facts and relevant examination for the most common complaints in acutely ill children and young people.

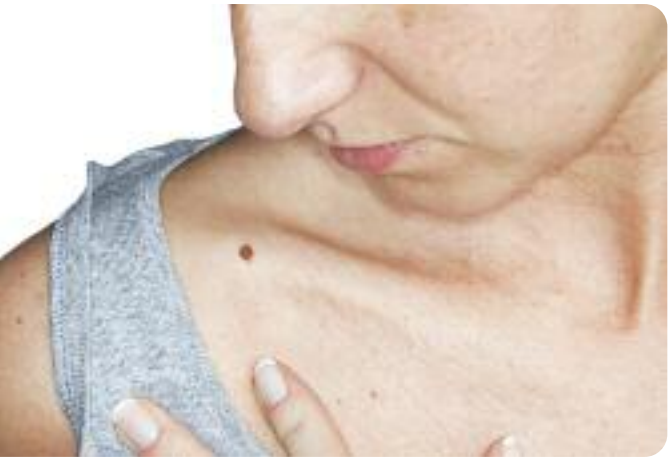
The e-learning tool was commissioned by the Department of Health (DH) and produced by OCB Media, in conjunction with experts from the University of Leicester and the University Hospitals of Leicester NHS Trust. The resource also won the Patient Safety in Diagnosis category at the Patient Safety Awards 2011.

Spotting the Sick Child provides examination and diagnosis information about the seven most common acute problems that children present with: rash, breathing difficulties, dehydration, fever, fits, abdominal pain and head injury. The interactive material includes video guides, assessments of real life patient cases and relevant medical information. Participants can assess and track their own progress in a variety of simulated situations.

There are currently 11,000 active user accounts and the numbers are still growing. The resource is now used as the primary diagnostic training tool for sick children within the NHS and is shortly to be adopted in New Zealand and Hong Kong. Other countries are also looking to deploy localised versions.

IN FOCUS

Managing malignant melanomas



With the holiday season coming to an end, the MDU has published advice to GP members on avoiding the pitfalls of treating skin lesions. In the last five years, we have been notified of 123 cases arising in primary care which involved patients with malignant melanoma. The majority (89%) involved allegations of delayed or failed diagnosis.

Other allegations included inadequate excision of a mole, inappropriate referral or poor management of patients after a malignant melanoma diagnosis had been made. Over 50 of the cases led to a claim for clinical negligence. Of those which have been settled, the average compensation paid to the claimants by the MDU was £47,000 and the largest single amount paid was £180,000.

The MDU has published the following advice to doctors:

- Ensure practice protocols and staff training relating to dermatology are fully up-to-date and in line with national and locally agreed guidelines.
- Patient consultations should be clearly documented, including the history taken, the examination performed, the differential diagnosis and management plan.
- Check patients understand plans for follow-up and make sure that these are clearly documented.
- Have a system to ensure that test results are appropriately followed up including a process for dealing with abnormal results and ensuring these are communicated to patients.
- Have a robust system for analysing adverse incidents to see what lessons can be learned and what changes should be put in place to prevent a similar occurrence in the future.
- Give patients an explanation and an apology if something does go wrong, particularly if the outcome is poor or unexpected. Ensure that you take steps to deal with the consequences and that you arrange appropriate treatment and follow-up.

Terrorism and confidentiality

The government's *Prevent* strategy[1], an anti-radicalisation policy to prevent people being drawn into terrorism, includes a section on the role of healthcare professionals as 'critical partners' in helping to identify those vulnerable to radicalisation.

Under the Terrorism Act 2000[2], it is already a criminal offence to fail to disclose to the police information that may be of 'material assistance in preventing the commission by another person of an act of terrorism'. Guidance from the GMC also recognises that doctors may be justified in disclosing information about patients in the public interest to assist in the prevention, detection or prosecution of serious crime. It may, for example, be neither safe nor practical to seek consent to such disclosure from the patient, or to inform them beforehand that you intend to disclose information.

The *Prevent* strategy compares preventing someone from becoming 'radicalised' with safeguarding vulnerable patients who are at risk of abuse. The document states: 'The key challenge is to ensure that healthcare workers can identify the signs that someone is vulnerable to radicalisation, interpret those signs correctly and access the relevant support'.

It is too early to say whether the *Prevent* strategy changes doctors' obligations regarding confidentiality and disclosure, although it does emphasise the importance of early intervention, when the individual might not pose a threat to others.

The MDU will keep members informed of developments regarding this extremely complex issue. If you have specific concerns about disclosing patient information, please call our 24-hour freephone advisory helpline on **0800 716 646**.

References

1 *Prevent Strategy*, HM Government, June 2011. www.homeoffice.gov.uk/publications/counter-terrorism/prevent/prevent-strategy/prevent-strategy-review?view=Binary

2 Terrorism Act 2000, section 38b. www.legislation.gov.uk/ukpga/2000/11/section/38B

For a fuller report on reporting criminal offences and confidentiality, see page 21.

MDU rings of confidence for members at London 2012

The medical Games Makers will be responsible for providing medical services such as first aid at the Olympic venues during the London 2012 Olympic and Paralympic Games. This may involve treating spectators, staff or even participants (although athletes are likely to consult their own team doctors, unless it is an emergency).

Dr Richard Budgett, chief medical officer of the London Organising Committee of the Olympic and Paralympic Games (LOCOG) has confirmed that all primary and emergency care at venues (for spectators and athletes), in the Olympic villages and at the official hotels, will be provided outside of the NHS and so will not benefit from NHS indemnity. It is therefore important that volunteers ensure they have adequate individual indemnity arrangements in place for this work.

As an MDU member, the professional indemnity policy of insurance provided by the MDU[1] will cover you for this work, without payment of any additional subscription, and without having to notify the membership department that you will be volunteering, provided you meet each of the following criteria:

- You are an official LOCOG volunteer (or Games Maker).
- You are in active MDU membership and have paid a subscription for clinical work.
- You have a current GMC Licence to Practise (or other relevant professional registration, such as with the GDC or NMC).
- You are not restricted to working in an Approved Practice Setting (unless you have received confirmation that the Games environment is to be given Approved Practice Setting status).
- You are not entering into any formal arrangement to provide care for individual athletes/teams (although you may be required to treat athletes on an ad hoc basis in the course of your volunteer duties).
- You will be working within the limits of your competence in line with your professional obligations.

Provided you can answer 'yes' to all of the above, you do not need to contact us and you can rest easy in the knowledge that you are covered by an insurance contract with an indemnity limit of up to £10 million[1], combined with the traditional discretionary benefits of MDU membership. However, should you have any doubts or questions about your indemnity requirements please email **membership@the-mdu.com** or call the freephone membership helpline on **0800 716 376** (lines are open Monday to Friday, 8am to 6pm).

MDU members who are entering into a formal arrangement to provide care or support for one or more Olympic athletes or teams, whether paid or unpaid, may seek indemnity from the MDU in the usual way. However, you will need to notify us of this work in advance and, where indemnity is agreed, you will be required to pay a subscription that is appropriate for your specialty and for the volume of work you will be undertaking. We may also need to add an endorsement to the professional indemnity policy of insurance.

Other MDU members may find themselves providing care for Olympic Games spectators or participants as part of their normal duties, for example, in a local designated NHS facility. If this will form part of your usual work you do not need to notify us and no additional subscription will be due.

Attending a sporting event in a professional capacity – whether paid or not – is a planned activity and quite different from acting as a Good Samaritan. If you are just a spectator at a sporting event and a member of the crowd collapses you could nevertheless be called on to help as a Good Samaritan. Doctors have an ethical duty, set out by the GMC, to help in an emergency. (*Good Medical Practice*, 2006, paragraph 11). The MDU provides members with an insurance policy covering Good Samaritan acts anywhere in the world[1]. In this context, a Good Samaritan act is defined as the provision of clinical services related to a clinical emergency, accident or disaster when you are not present in your professional capacity but as a bystander.

1 Subject to the terms and conditions of the policy underwritten by SCOR UK Company Limited and by International Insurance Company of Hannover Limited.

MEMBERSHIP

The GP Enterprise Awards – organised by *GP* newspaper together with the RCGP, and sponsored by the MDU – have once again unearthed some exciting innovations from the heart of general practice.

ENTERPRISE AWARDS 2011

Royal College of General Practitioners

GP

The Category Winners

A common thread of this year's category winners is that all have improved care for patients while making savings for the NHS at a time when high quality and cost-effectiveness have never been more valued.

The category winners were chosen by a judging panel of GPs and lay representatives who freely gave their time and expertise to the judging process. The judging was a challenging but rewarding experience. The only disappointment was that strict judging criteria meant that a number of categories could not be awarded.

Voting was then opened to readers of *GP* newspaper to select the overall winner of the £4,000 MDU Enterprise Award.

The winner of the MDU Enterprise Award will be announced at the RCGP Annual General Meeting on 18 November 2011.

Practice Team

Dr Fitzsimons and team, South Holderness Medical Practice, Withernsea, East Yorkshire.

One-stop review of multiple long-term conditions

In April 2010 this practice launched an innovative scheme for reviewing patients with more than one long-term condition. The approach brings together GPs, nurses, pharmacists and the patients to improve quality and efficiency of care.

Before a patient's annual review with the nurse, a GP reviews the current management of the patient's conditions and the pharmacist checks the record for missing or inappropriate prescribing. The patient also completes a health needs assessment questionnaire.

During a single, 25-minute nurse appointment all the patient's long-term conditions are reviewed and any suggestions from the GP or pharmacist are discussed. This information is then recorded on the computer system using surgery-designed templates, and an agreed personalised care plan for each condition is printed out for the patient to keep in a special folder with all of their health-related information. Appropriate referrals are made to community services.

Over the past year the practice has completed combined health checks on more than 1,000 patients. When surveyed, 89% said they now understand their long-term conditions better.

The practice also analysed 50 patient records following the review, which found a potential saving of £76.40 per patient per year from reductions in inappropriate medication and more cost-effective prescribing.

Dr Fitzsimons said: 'We feel that this is an excellent example of how a multidisciplinary team, plus the patient, can be involved as equal partners in the management of long-term conditions.'

MEMBERSHIP

Innovative Clinical Care (Specific)

Dr Mike D'Souza and team, Kingston, Surrey.

Innovative Clinical Care (General)

Dr Malav Bhimpuria and team, Huntingdon, Cambridgeshire.

Credits for drug misusers

The Canbury Medical Centre in Kingston, Surrey, took on the care of more than 30 Class A drug misusers who had been rejected by the local specialist services for lack of compliance, and developed a scheme that resulted in 83% becoming 'street clean' and allowed them to be cared for in general practice.

First, Dr D'Souza and his team stabilised patients by switching them to weekly methadone. The patients could then move on to the CareCreds scheme that allowed them to earn up to £14 per month in Boots vouchers and certificates for improving their behaviour.

By the end of the six-month study period the following results were achieved:

	Before	After
Number injecting	17%	3%
Number 'street clean'	36%	83%
Number off Class A drugs	0%	25%

Moving the patients on to weekly methadone reduced the stigma around daily attendance, and fear of withdrawing the 'privilege' helped with compliance. The CareCreds scheme builds on the concept of patients earning credits for looking after themselves. 'It was designed as a social intervention, with medical pretensions, to see if we could turn people's lives around by giving them the chance to earn and repair their own stress,' said Dr D'Souza.

Boots was chosen as a place where they could buy food, health products and other rewards, and in fact many of the patients bought gifts for their children and families.

Rapid sleep apnoea diagnosis

Dr Bhimpuria and his team have transformed the way they manage obstructive sleep apnoea syndrome (OSAS) with a quick new service that reduces hospital referrals but ensures appropriate referral where necessary.

The practice uses a 'triple lock' of clinical assessment, Epworth sleepiness score and overnight pulse oximetry, to diagnose OSAS promptly and refer suspected cases to the sleep clinic for treatment.

The GPs secured funding to buy an oximeter (about £430) and the software for interpretation (about £400). When they suspect a patient has OSAS, they assess them, give them an Epworth scale and loan out the oximeter. The patient returns the next day to have the data uploaded to the surgery computer system to create a report. The whole process takes only about a minute.

'Since the service was introduced, our referrals have fallen,' said Dr Bhimpuria, 'and those we are referring are more appropriate.'

Dr Bhimpuria said all patients had received the oximeter within one working day of seeing the GP and the feedback had been excellent.

Come and see us at one of the following events

The MDU will have a stand at the following events. Come and visit us for any membership enquiries or just to say hello. We would be pleased to see you.

RCGP Medical Educators' Group

19 October 2011
ACC, Liverpool

RCGP Annual Primary Care Conference

20-22 October 2011
ACC, Liverpool
Stand 63/65

NAPC Annual Conference

1-2 November 2011
The ICC, Birmingham
Stand 45

MIMS Paediatrics

24 November 2011
Cavendish Conference Centre, London
Stand 1

NEW

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THE MDU

FEATURE

Home deliveries

The number of home deliveries has decreased dramatically over the last 50 years and today just 2.7% of all births take place outside hospital[1]. The MDU receives calls and requests for advice from GPs who are asked in an emergency, and in some other circumstances, to be involved in intrapartum care. Dr Sally Barnard, MDU medico-legal adviser, reports on some of the queries members have asked.

FEATURE

Unassisted home births

A GP member contacted the MDU advisory helpline about a 33-year old patient who was nearing the end of her first pregnancy. The patient had declined all antenatal testing during the pregnancy and told the GP that she intended to give birth at home without a midwife in attendance. The patient's close friend was going to be present and would act as a doula and help with the delivery if necessary.

The member had spoken to his patient at some length about her plans for the delivery and was satisfied that she understood the risks involved in declining a hospital delivery and had capacity to make this decision. However, the doctor was concerned about the legality of a woman giving birth attended only by her friend as he understood that a midwife had to be present at the delivery.

The MDU advised that the Nursing and Midwifery Order 2001 made it an offence for a person to attend a woman in childbirth unless that person is a registered midwife or doctor. It is acceptable for a student midwife or medical student to attend a woman in childbirth if their course of study has been approved by the Nursing and Midwifery Council (NMC) or General Medical Council (GMC).

The NMC's 2004 document *Midwives rules and standards*[2] sets out what is meant by 'attendance upon' – namely 'providing care or advice to a woman or care to a baby whether or not the midwife is physically present'. There is an exception to the 2001 Order when the case is of sudden or urgent necessity.

The GP was advised that there is no legal obligation for a midwife to be present at a delivery. However, except in an emergency situation, it would be unlawful for a non-midwife or doctor to 'attend' a woman in labour. The adviser added that the member might wish to speak to his patient again to explain that, in the absence of an emergency, her plans to allow her friend to deliver the baby without a midwife present would be unlawful.

Prescribing opiates

A GP had been approached by a private midwife who asked her to prescribe some pethidine, metoclopramide and naloxone for a patient planning a home delivery. The GP had not met the midwife before and was concerned about writing a prescription in these circumstances.

The adviser explained that midwives have their own limited prescribing rights[3] which allow a midwife to prescribe pethidine and naloxone, so it was not clear why the midwife had asked the GP to do this. It may have been that the midwife was unhappy to carry the controlled drugs around with her, and therefore preferred the patient to keep a supply at home. Alternatively, it may have been in order to give the patient a free supply, as she would have been exempt from NHS prescription charges.

When a GP issues a prescription, he or she remains responsible for it even if the drugs are administered by someone else, in this case the midwife. The GP also retains responsibility if the drugs are misused or passed to another person.

GMC guidance, *Good Medical Practice* (2006), states in paragraph 3(b) that:

'In providing care you must prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs'.

It goes further in its advice, *Good Practice in Prescribing Medicines* (2008), paragraphs 3 and 7 of which state:

These are fictional cases compiled from actual cases in the MDU files.

FEATURE

'You should only prescribe drugs to meet identified needs of patients and never for your own convenience or simply because patients demand them.

'If you prescribe at the recommendation of a nurse or other healthcare professional who does not have prescribing rights, you must be satisfied that the prescription is appropriate for the patient concerned and that the professional is competent to have recommended the treatment'.

The member was advised that midwives, even in private practice, have a statutory requirement for supervision by a local 'supervisor of midwives'. It was suggested that the GP might wish to discuss the situation with her, so that a practice policy could be formulated in case there were future requests of a similar nature.

Providing intrapartum care

A GP member rang the MDU advisory helpline to discuss his responsibility to attend a home delivery if something were to go wrong with either the woman or the baby during the confinement. It had been a number of years since the doctor had had any obstetric experience and the practice's obstetric bag had fallen into disuse.

The member was advised that the GMC's guidance in *Good Medical Practice* (2006)[4] states that:

'In an emergency, wherever it arises, you must offer assistance, taking account of your own safety, your competence, and the availability of other options for care'.

The adviser added that if the GP was required to provide assistance in an emergency, the care provided would be judged against the standards of a reasonably competent GP and not an obstetrician or neonatologist.

The adviser recommended that the GP might wish to explain to the woman the limitations of his experience in obstetrics while offering reassurance regarding his willingness to provide care if needed in an emergency until such time as specialist assistance could be secured.

The adviser also recommended that the GP speak to the patient, and her partner if the patient consented to this, to discuss the pros and cons of home versus hospital delivery, as the GP needed to be confident that the patient had capacity to make this decision, and that her ability to choose was not impaired by illness or undue pressure from another person. Finally, the adviser suggested that the GP should make careful notes of all discussions in the patient's records.

In the MDU's experience, it is rare for a GP to receive a claim for medical negligence in relation to intrapartum care. Where it does happen, the allegations are usually that the home delivery had resulted in either a baby with a disability, a stillbirth or neonatal death. The MDU recommends GPs take the following steps to minimise the chances of medico-legal repercussions:

- Be aware of the limits of your own competencies and act within them.
- Keep detailed records of any discussions with patients and relatives.
- The patient's decision does not always have to appear rational or be understandable to others providing that it was made when the patient had capacity to do so.
- Don't be wary of assisting in an emergency.
- Call the MDU to discuss cases if you have concerns.

Am I indemnified to provide obstetric care?

The MDU recognises that GP members may on occasion be required to provide emergency and unplanned obstetric care for a patient where specialist care is not immediately available. In the unlikely event of a claim arising in such circumstances MDU members may be reassured to know they are covered under the professional indemnity policy of insurance up to a limit of £10 million[5].

However, the benefits of MDU GP membership would not ordinarily extend to a member's involvement in elective or planned obstetric care, nor to the routine provision of emergency obstetric cover for home deliveries. GP members who wish to offer any form of obstetric service are therefore advised to contact the freephone membership helpline on **0800 716 376** to discuss their individual indemnity requirements.

References

1 Office for National Statistics 2010.

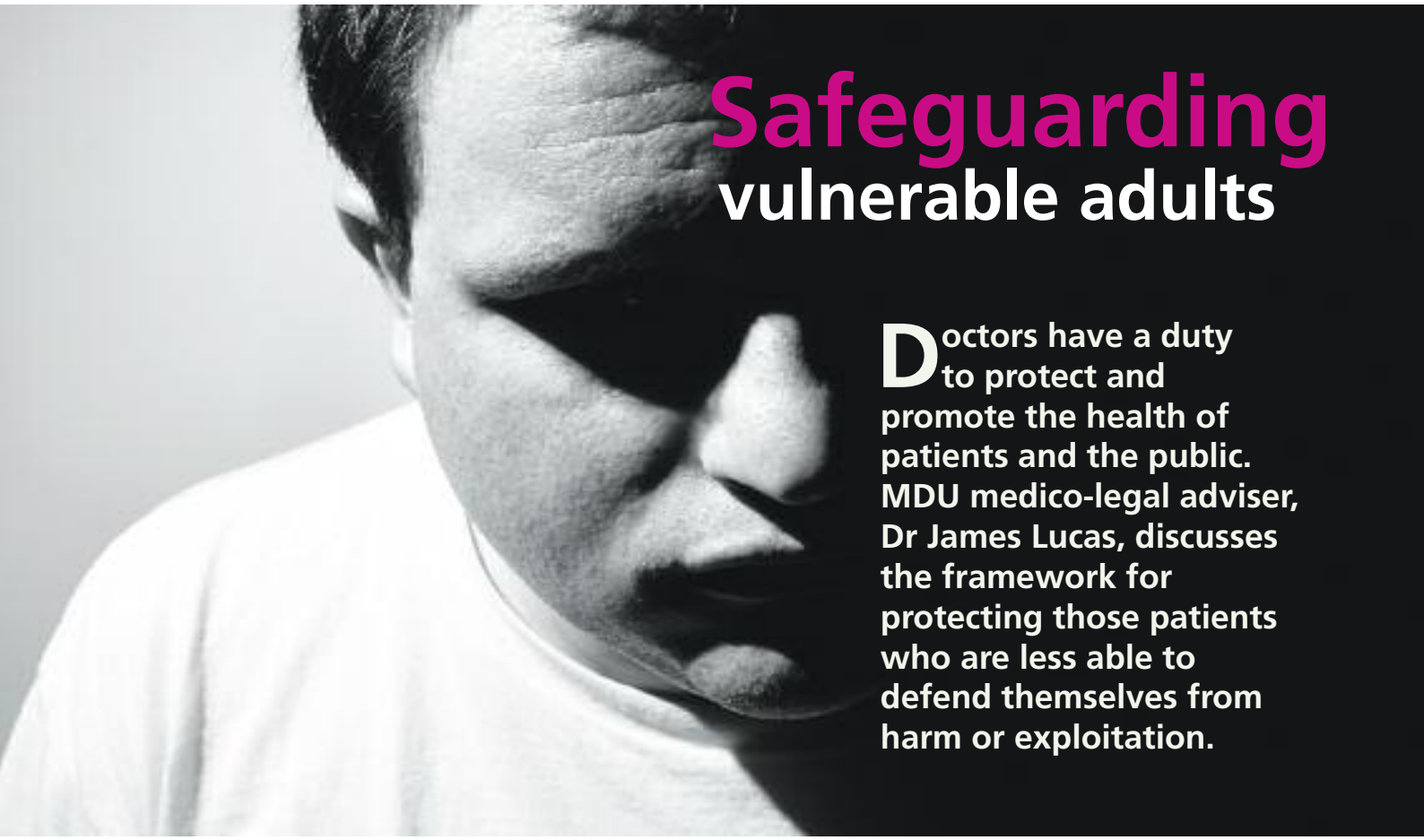
2 *Midwives rules and standards*, the Nursing and Midwifery Council, 2004. www.nmc-uk.org/Documents/Standards/nmcMidwivesRulesandStandards.pdf

3 1. Prescription Only Medicine (Human Use) Order 1997 SI No. 1830.
2. The Medicines (Pharmacy and General Sale-Exemption) Order 1980 SI No. 1924.
3. Medicines (Sale or Supply) (Miscellaneous Provisions) Regulations 1980 SI No 1923.

4 *Good Medical Practice* (2006), GMC, 13 November 2006 (paragraph 11). www.gmc-uk.org/guidance/good_medical_practice.asp

5 Subject to the terms and conditions of the policy underwritten by SCOR UK Company Limited and by International Insurance Company of Hannover Limited.

FEATURE



Safeguarding vulnerable adults

Doctors have a duty to protect and promote the health of patients and the public. MDU medico-legal adviser, Dr James Lucas, discusses the framework for protecting those patients who are less able to defend themselves from harm or exploitation.

The opportunity to assess patients in their home or residential care environment, often over a prolonged period of time, provides general practitioners with a particularly well placed perspective on safeguarding concerns. The ability to assess the physical, psychological and social needs of patients is a fundamental tenet of general practice and such skills are important in the identification and management of abuse and neglect.

Data published by the Office for National Statistics (ONS) shows that the fastest growing demographic in the UK is the 85 years and over group[1]. Given the burden of degenerative disease in this age group, it seems probable that the proportion of adults classified as vulnerable is set to increase, with concomitant challenges to doctors.

The recent Department of Health (DH) publication *Safeguarding Adults: The role of health service practitioners*[2] sets out, with case examples, how doctors and other health professionals should respond when they have concerns.

How is a vulnerable adult defined in the guidance?

A vulnerable adult is defined as a person 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'[3].

Identifying concerns

Doctors are encouraged to look beyond first impressions and be receptive to signs of neglect and abuse. Recognising a pattern of concerns might be of more relevance than an isolated finding.

The MDU advises members to seek a second opinion from an experienced colleague when they are uncertain of the significance of a particular finding, for example, when they are unsure whether an injury to a vulnerable adult is consistent with the account provided by the patient's carer.

FEATURE

The safeguarding principles

The guidance stresses the need to get the patient's consent before taking action on their behalf and to maximise the patient's involvement in all decisions about their care, safety and protection. In practice, this means that patients should be encouraged to describe what is happening to them and then assisted in making decisions about the management of any concerns. It is important to protect and support the vulnerable in the least intrusive way possible; and to work effectively with other services. Decisions made must respect the person's age, culture, beliefs and lifestyle.

Can a health practitioner act in the absence of patient consent?

The guidance acknowledges that it may be appropriate to act without patient consent if there is a competing risk to children or other vulnerable adults. In these circumstances, the guidance says doctors should record the following criteria for defensible decision making:

- show that the alternatives were explored and disregarded
- the reasons why this is the least restrictive option
- the views of those consulted
- legal authority, where any enforcing measures are used.

Patients who lack capacity

Where a patient is found not to have capacity, doctors can lawfully act in his or her best interests, as set out in the Mental Capacity Act 2005 (MCA), taking into account relevant factors such as the views of the patient, their values, lifestyle and beliefs and the views of others involved in their care. Paragraph 63 of the GMC's *Confidentiality* (2009) guidance offers advice on what to do if you believe that a patient may be a victim of neglect or physical, sexual or emotional abuse, and the patient is unable to give consent for you to disclose it.

It states: '…you must give information promptly to an appropriate responsible person or authority, if you believe that the disclosure is in the patient's best interests or necessary to protect others from a risk of serious harm. If, for any reason, you believe that disclosure of information is not in the best interests of a neglected or abused patient, you should discuss the issues with an experienced colleague. If you decide not to disclose information, you should document in the patient's record your discussions and the reasons for deciding not to disclose. You should be prepared to justify your decision'.

What is the role of a Safeguarding Adults Board?

The guidance advocates a partnership approach to responding to concerns about vulnerable adults through a Safeguarding Adults Board led by the local authority. There will be local procedures and protocols for responding to concerns, which members are advised to be familiar with. It is particularly important to remember that a safeguarding referral does not necessarily lead to an investigation under formal procedures. It is a process by which additional information can be obtained, finding out if there are genuine concerns and acting to put matters right.

The MDU advises doctors to familiarise themselves with the DH guidance which sets out a general step-by-step approach to safeguarding concerns. Above all, members are reminded of their legal and ethical duty to act if they believe a vulnerable adult patient is being subjected to exploitation, abuse or neglect.

Members who have a specific query relating to vulnerable adult patients can contact the 24-hour freephone advisory helpline on **0800 716 646.**

References

1 *Mid-year population estimates*, Office for National Statistics; The National Register Office for Scotland; Northern Ireland Statistics and Research Agency, 30 June 2011. www.ons.gov.uk/ons/media-centre/index.html

2 *Safeguarding Adults: The role of health service practitioners*, Department of Health, March 2011. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125233.pdf

3 *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, Department of Health, 20 March 2000, (paragraph 2.3). www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4074540.pdf

FEATURE

Requests for assistance to make a Lasting Power of Attorney

Since the introduction of the Lasting Power of Attorney (LPA), patients have increasingly turned to their GP to act as witness or 'certificate provider'. Dr Rachel Sutcliffe, MDU medico-legal adviser, explains the ins and outs of LPAs.

In 2007, The Mental Capacity Act 2005[1] replaced the previous scheme for Enduring Powers of Attorney (EPA) with a new legal authority – the Lasting Power of Attorney (LPA).

The LPA is a legal document which allows a patient (the 'donor') to appoint an 'attorney' to make decisions on their behalf for matters relating to their welfare, property or financial affairs. The LPA is not legally recognised until it is registered with the Office of the Public Guardian (OPG).

In the last three years, the MDU has seen an increase in the number of GP members requesting advice regarding LPAs. In 2008, there were just four cases. This increased to 12 in 2009 and 25 in 2010. This may reflect the increase in the number of LPAs being made by patients.

The annual report provided by the OPG records that in the year ending March 2011, 190,000 applications to register an LPA or EPA were received, in comparison to 127,000 in 2009/10[2].

Types of LPA

It is important to appreciate that there are two types of LPA. The first is modelled on the previous EPA and covers property and affairs; but since 2007, it has also been possible to create a LPA which covers personal welfare, which includes decisions about medical treatment.

With this in mind, the MDU advises doctors to find out which type of LPA their patient is planning to make. Separate forms are provided for the two types of LPA. The property and affairs LPA is more common. However, the application process for both types of LPA follows the same principles.

The form consists of three parts; GPs are usually asked to assist patients with Parts A and B. Part C is signed by each attorney or replacement attorney.

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Part A – declaration by the patient

Part A should be completed by the patient and requests details about the person(s) giving the LPA and what authority for decision making is being granted. The patient's signature or mark at Part A must be witnessed and the GP is often asked to fulfil this role. The patient should sign in the GP's presence. The date of the signature at Part A must be before or the same as the date of the signature at Part B.

Part B – declaration by the certificate provider

The certificate provider can be a 'lay person' who has known the patient for at least two years, or someone who has the appropriate skills and knowledge to be able to form a professional judgment about the patient's understanding. This can be their GP, but it could also be a solicitor, barrister, advocate, registered social worker or independent mental capacity advocate. There is no requirement for a professional certificate provider to have known the patient for two years.

The MDU advises members to read the certificate provider and witness guidance produced by the OPG before completing Part B. This guidance forms part of the LPA application form a GP would be given by the patient or their representative and is also available on the Justice website[3].

The certificate provider is required to discuss the content of the LPA with the patient in private without the proposed attorney present and certify that the patient understands the purpose of the LPA and the scope of authority; and that no undue pressure or fraud has been used to induce the patient to create the LPA.

The form makes it clear that if someone were to challenge the LPA, you might be required to explain how you formed your opinion. As a professional certificate provider, GPs are expected to make an assessment of the patient's mental capacity at the time of signing the LPA. The MDU advises its members to document this assessment in the medical records.

Assessment of mental capacity

The Mental Capacity Act 2005 provides a statutory two-stage test for capacity which GPs should apply when acting as a certificate provider.

1. Does the patient have an impairment of the mind or brain, or is there some sort of disturbance affecting the way it works, whether temporary or permanent? If so,
2. Does that impairment or disturbance mean the patient is unable to make the LPA at this time? The patient would be unable to make the LPA if they are unable to:
    - understand the information relevant to making the LPA
    - retain that information
    - use or weigh that information as part of the process of making the decision about the LPA, or
    - communicate their decision to the GP.

If any one of these criteria is not met, the patient will lack the mental capacity to make the LPA and you should decline to complete Part B, explaining your reasons for doing so to the patient and their proposed attorney(s). In this situation the matter may be referred to the Court of Protection which has the power to appoint deputies to make decisions for patients who lack capacity.

Charging a fee

GPs are not contractually obliged to agree to act as the certificate provider but many wish to assist their patients in this regard. If you are planning to charge a fee for completing the paperwork then you should be mindful of the GMC's guidance relating to financial agreements with patients and be transparent about the charge to be invoiced prior to agreeing to complete the LPA form[4].

Being asked to act as a certificate provider can initially seem somewhat daunting but most GPs find that once they have familiarised themselves with the relevant forms they are able to complete the task efficiently.

For specific advice on LPAs, please call the MDU's 24-hour freephone advisory helpline on 0800 716 646.

References

1 The Mental Capacity Act 2005. www.legislation.gov.uk

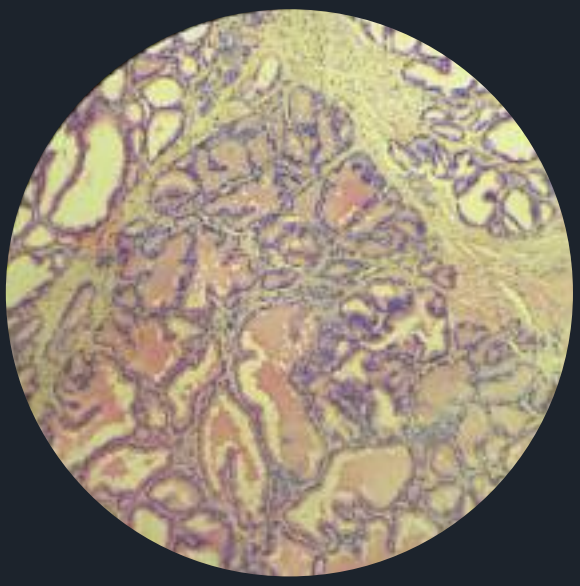
2 *Office of the Public Guardian Annual Report and Accounts 2010/11*. www.justice.gov.uk/downloads/publications/corporate-reports/OPG/opg-annual-report.pdf

3 www.justice.gov.uk/global/forms/opg/lasting-power-of-attorney/index.htm

4 *Good Medical Practice* (2006), GMC, (paragraph 72). www.gmc-uk.org/guidance/good_medical_practice.asp

FEATURE

Prostate cancer: an enigmatic disease



Prostate cancer is the most common cancer in men and the incidence is rising. MDU medico-legal adviser Dr Sally Old examines the pitfalls of diagnosing this widespread disease.

With 37,000 cases reported annually in the UK, prostate cancer accounts for almost one in every four malignancies in males[1]. Despite its prevalence, NICE has described it as 'probably the most enigmatic malignancy in men'[2].

This enigma arises from the disparity between the high incidence of histological evidence of prostatic malignancy found post mortem in elderly males when compared to the number of men who develop problems related to prostate cancer during their lifetime.

The diagnostic and management strategies for prostate cancer are evolving and controversies rage over various aspects, most notably in relation to the question of screening. GPs are often placed in a difficult position when deciding whether to investigate for prostate cancer by testing prostate specific antigen (PSA) and deciding subsequently how to handle the results.

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Over time there has perhaps been a move to more active intervention but this is not without risks and treatment can adversely impact the quality of a man's life. This can complicate discussions with men about the various options available.

In the last ten years, the MDU received a total of 178 complaints about doctors in relation to patients with prostate cancer. Of these cases 70% (124) concerned alleged failed or missed diagnosis of the condition. Other complaints centred on management of patients after diagnosis, including allegations of failure to provide or refer for what the patient considered the most appropriate treatment.

In addition, the MDU has also seen an increase in the number of files opened to assist members with prostate cancer complaints and claims. This is perhaps no surprise given the trend towards more active investigation into the symptoms and intervention in this condition – a patient may be less likely to complain about a delay in diagnosis by their GP if the consultant advises a 'watch and wait' strategy, but if treatment is recommended a perception of a delay might be of more significance to the patient.

For prostate cancer, as with any other illness, patients rightly expect a timely and accurate diagnosis, as well as appropriate advice from their GP about management. It is important for GPs to ensure that their practice has a system in place to follow up results of investigations such as PSA tests and that the implications of an abnormal finding are appropriately communicated to the patient, with referrals made when necessary.

The following fictional case examples derived from our experience may help to illustrate these points.

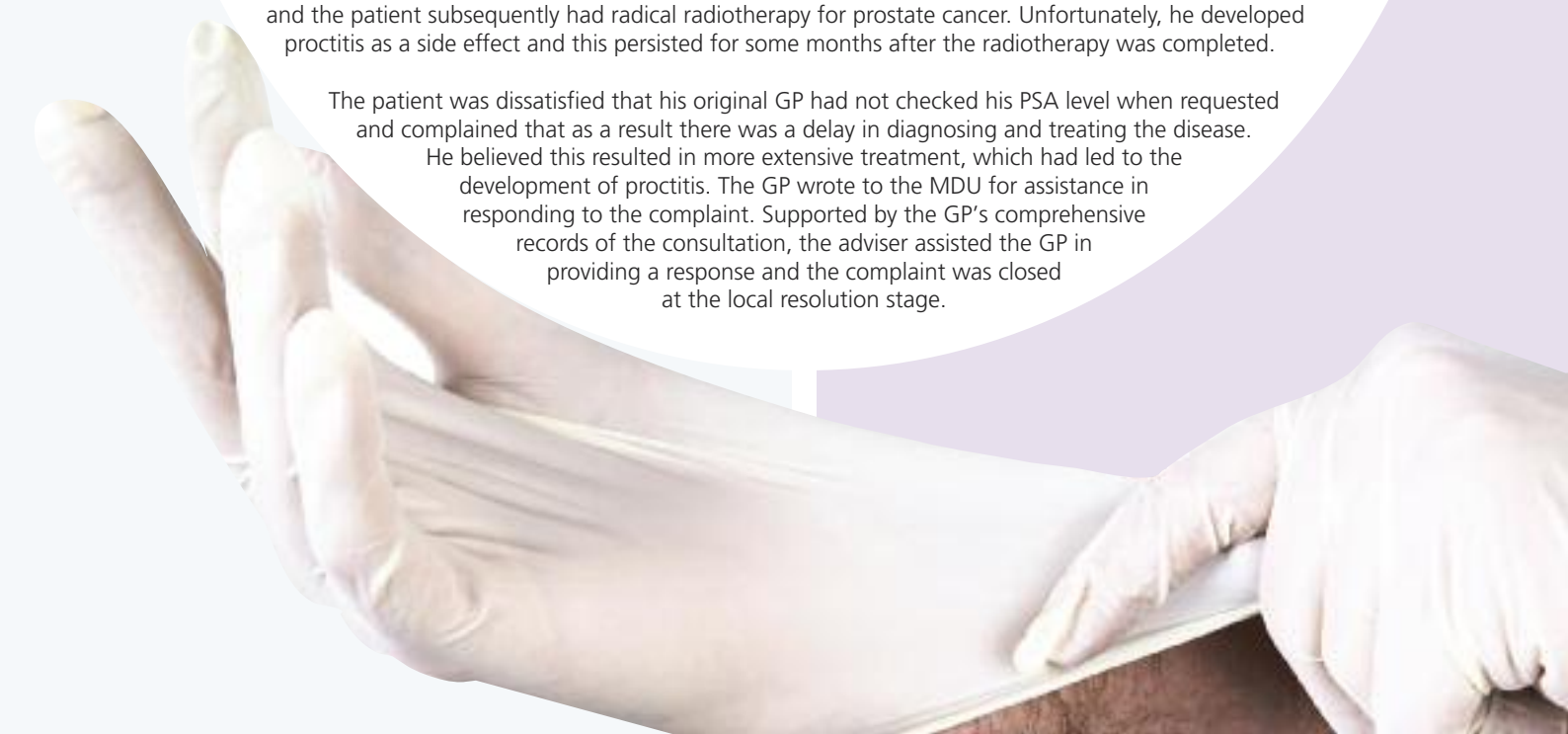
PSA testing at request of patient

A man aged 58 attended his GP, enquiring about PSA testing to 'rule out' prostate cancer. He explained that his father had died of prostate cancer aged 84 and that his younger brother had PSA screening arranged by his employer in the USA.

The GP advised the patient that there was no NHS screening programme for prostate cancer. She asked the patient about his general health and urinary symptoms and there was nothing significant. The GP advised the patient that a PSA test alone could not completely rule out prostate cancer and that, given his family history, there was a small increased risk of prostate cancer so he should come back if any relevant symptoms developed.

Nine months later the patient moved away and registered with a new practice. Experiencing some problems associated with urination, he visited his new GP who ordered a PSA test. The result showed some abnormality and the patient subsequently had radical radiotherapy for prostate cancer. Unfortunately, he developed proctitis as a side effect and this persisted for some months after the radiotherapy was completed.

The patient was dissatisfied that his original GP had not checked his PSA level when requested and complained that as a result there was a delay in diagnosing and treating the disease. He believed this resulted in more extensive treatment, which had led to the development of proctitis. The GP wrote to the MDU for assistance in responding to the complaint. Supported by the GP's comprehensive records of the consultation, the adviser assisted the GP in providing a response and the complaint was closed at the local resolution stage.



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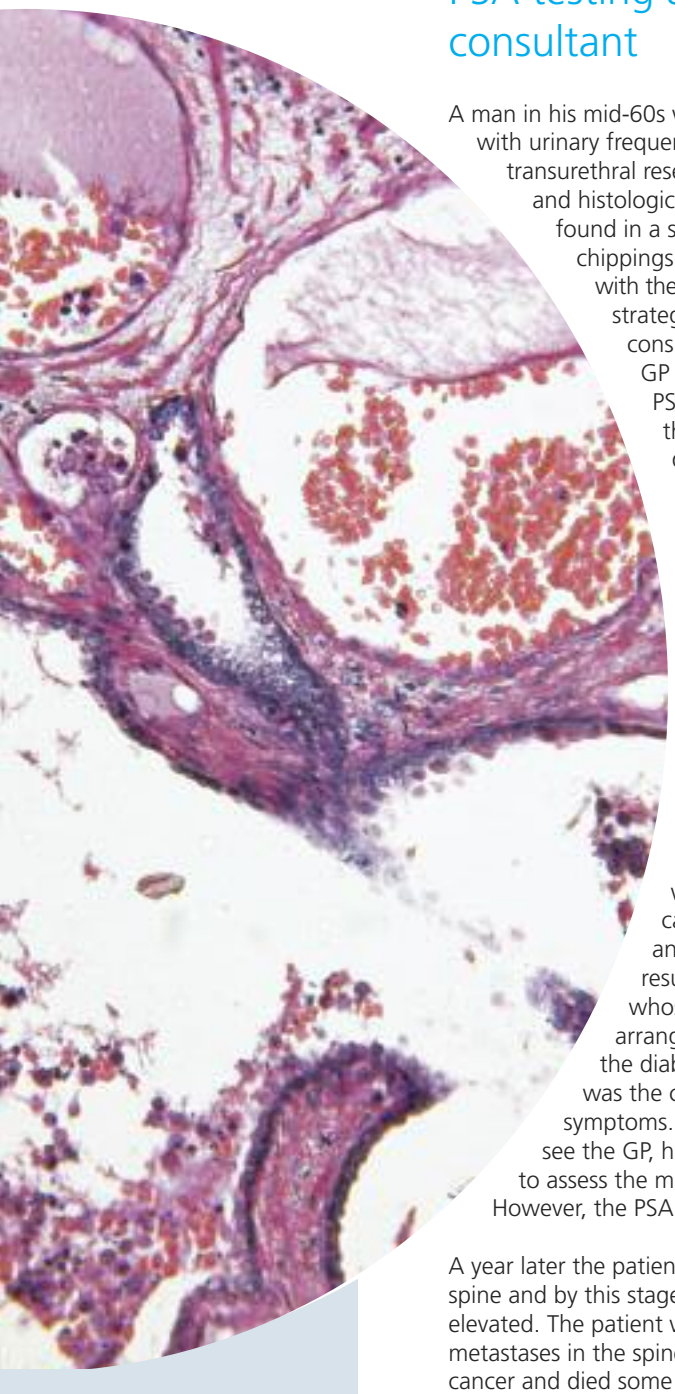


PSA testing at request of consultant

A man in his mid-60s was referred to a urologist with urinary frequency. He underwent transurethral resection of the prostate (TURP) and histological evidence of cancer was found in a small percentage of the chippings. After discussion with the patient a surveillance strategy was agreed. The consultant wrote to the patient's GP asking that she check the PSA level regularly and refer the patient back if he developed significant symptoms or if the PSA level began to rise.

The surveillance strategy was followed for a year, when the patient attended the GP once again complaining of urinary frequency. The GP ordered a number of blood tests, including blood glucose and PSA. The blood glucose test result came back first and was high. The PSA test result came back a few days later and was also raised, but the result was overlooked by the GP whose primary concern was to arrange appropriate treatment for the diabetes, which she assumed was the cause of the patient's symptoms. The patient continued to see the GP, having blood tests at intervals to assess the management of his diabetes. However, the PSA test was not repeated.

A year later the patient developed pain in his spine and by this stage the PSA level was greatly elevated. The patient was shown to have bony metastases in the spine from a primary prostate cancer and died some months later.

After his death the patient's family lodged a complaint against the GP for not following up the raised PSA test result. They alleged that had the prostate cancer been diagnosed a year earlier, the patient would have been able to have radical treatment and would have had a chance of cure. The GP was assisted by the MDU in responding and devised a new practice procedure for following up blood results. The complaint was closed after local resolution.

Prostate cancer: an enigmatic disease

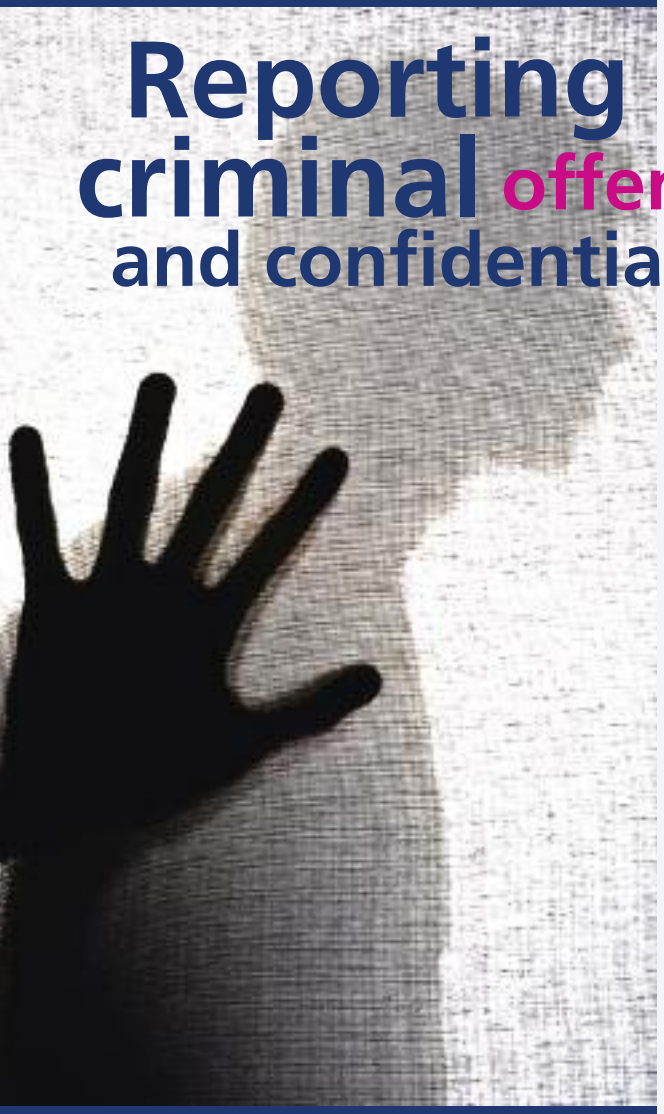
References

1 *Cancer incidence for common cancers – UK statistics*, Cancer Research UK, 2008. http://info.cancerresearchuk.org/cancerstats/incidence/commoncancers/

2 *Prostate cancer: diagnosis and treatment*, NICE, 2008. www.nice.org.uk/nicemedia/live/11924/39687/39687.pdf

FEATURE

Reporting criminal offences and confidentiality



For the doctor-patient relationship to be effective, patients must be able to trust their GP not to disclose confidential information about them. However, there may be rare circumstances in which a doctor may need to breach that confidentiality, says Dr Kathryn Leask, MDU medico-legal adviser.

As a general rule doctors should not disclose confidential information about their patients although patients do usually understand that the sharing of information between healthcare professionals may be necessary in order to provide appropriate care.

But there are prescribed circumstances in which a doctor may justifiably disclose to a third party confidential information about a patient in the public interest, without obtaining the patient's consent or if consent has been withheld.

When considering whether to disclose confidential information about a patient in the public interest, you must balance the potential harm to the patient and your relationship with them, against the benefits to be gained in releasing the information. The GMC, in its detailed guidance on confidentiality[1], states that 'such a situation might arise, for example, when a disclosure would be likely to assist in the prevention, detection or prosecution of serious crime, especially crimes against the person'[2]. The NHS *Confidentiality Code of Practice*[3] gives further specific examples, including murder, manslaughter, rape and child abuse.

You should still ordinarily seek a patient's consent to disclose information in the public interest, unless to do so would be impracticable, put others at risk of harm, or would prejudice the purpose of disclosure. If ultimately you cannot obtain their consent or decide you should not seek it, you should disclose information promptly to the appropriate person or authority and let the patient know you have done so, assuming this would not prejudice the purpose of the disclosure. Any information given should be only that which is necessary for the purposes of the disclosure.

When considering violent crimes against the person it is important to consider whether the risk to the public remains. For example, if a victim of violence refuses police assistance, the GMC states that disclosure may still be justified if others are at risk[4].

If you are concerned about whether to make a disclosure in the public interest without patient consent, it is important to consider the following:

- Speak to colleagues or contact the MDU for specific advice to help you weigh up whether the public interest in disclosing information should override the patient's right to confidentiality.
- Document in the patient's records any steps you took to seek or obtain consent, your reasons for disclosing information without consent, and why you have not informed the patient if that is the case.
- Disclose the information promptly to the appropriate body.
- Disclose only the information necessary to serve the purpose and record what has been disclosed in the patient's records.

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Advice line dilemma

GP members often contact the MDU advisory helpline for assistance in deciding whether or not they should disclose confidential information under specific circumstances. As it may not always be obvious when a disclosure can be justified in the public interest, members find it helpful to discuss the situation with the MDU in order to assist them in reaching a decision.

The scene

A GP was approached during a busy surgery by a detective from the local police asking for information about a person they believed to be a patient at the practice. Mindful of his duty of confidentiality, the GP asked for additional information to enable him to decide whether or not the disclosure was justified.

The detective explained that the person was suspected of mugging, stabbing and murdering a passer-by the night before and was being questioned at the police station. The detective wanted confirmation of the patient's address and to be made aware of any mental health problems the patient may suffer from, or may have suffered from in the past, and any relevant medications. The detective also quoted the Data Protection Act 1998 (DPA) section 29, which allows a person to disclose personal data under certain circumstances, such as the prevention or detection of crime and the apprehension or prosecution of offenders.

The member felt that as a serious crime had been committed and in view of the DPA he would be justified in disclosing the information without consent. However, before doing so he called the MDU for advice.

The advice

The MDU adviser discussed with the member GMC guidance in relation to disclosure without consent and the provisions of the DPA 1998. The member was advised to consider the fact that although a serious crime had been committed the suspect was already detained by the police and therefore not currently a risk to the public.

In view of this it appeared that it might be possible for the police to request consent from the patient to allow the GP to disclose the information they requested. It would be important that any disclosure made by the GP was in accordance with the patient's consent and only that information which was referred to on the signed consent form should be disclosed.

The adviser also explained that section 29 of the DPA was an enabling provision, which allowed the GP to disclose information without being in breach of the Act. However, it did not make disclosure mandatory and the GP still had to consider his ethical obligations to the patient.

Following this discussion the member asked the police to obtain consent from the patient before he was able to agree to a disclosure of the information they required. Had the patient refused it would be open to the police to obtain a court order under which the member would have had no option but to disclose the information, but only that which was referred to in the order.

This is a fictional case compiled from actual cases in the MDU files.

References

1 *Confidentiality*, GMC, 2009. www.gmc-uk.org/static/documents/content/Confidentiality_0910.pdf

2 *Confidentiality*, GMC, 2009, paragraph 54. www.gmc-uk.org/static/documents/content/Confidentiality_0910.pdf

3 *Confidentiality: NHS Code of Practice – supplementary guidance: public interest disclosures*, Department of Health, November 2010. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122031.pdf

4 *Confidentiality*, GMC, 2009, paragraph 54. www.gmc-uk.org/static/documents/content/Confidentiality_0910.pdf

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