Sharing primary care records
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Concern about patient confidentiality is one of the common reasons for members to contact us for advice and assistance. In this issue, we look at confidentiality from several different perspectives.

Knowing how to store patient information correctly is essential and doctors must also have a thorough understanding of how and when it may be appropriate to share or disclose that information. Technology and systems development underpin and assist with this but can also bring their own difficulties.

Medico-legal adviser Dr Carol Chu examines these issues – first, in relation to the care.data project and what GPs should know about sharing primary care records, and second, the implications of using smartphones and other portable devices for collecting and storing patient data.

Also in this issue, Dr Philip Zack considers what happens when the GP is the subject of the recording. Would you and should you feel threatened if a patient recorded your consultations?

Elsewhere in the issue, medico-legal adviser Dr Sanjeewa Sumathipala reflects on his previous role as a forensic practitioner. We have also included some interesting case studies, one of which emphasises the need to adhere to recognised guidelines in the clinical setting.

I hope you enjoy reading this issue and please do, as always, contact us if you would like to feed back about these articles or if you have any questions or dilemmas you would like us to consider in future editions.

Dr Christine Bradford
Interim medical editor
Setting the pace in advisory services

New head of advisory services and former GP, Dr Caroline Fryar, talks to Good Practice about the challenges of her new role.
Monday morning is a traditionally busy time for GP practices when anxious patients and their families are most likely to call for advice or to make emergency appointments. It’s a similar story on the MDU advice line as former GP, Dr Caroline Fryar reveals: “Members who are involved in a case are invariably under great strain and without the distraction of work they can easily spend the whole weekend worrying about their situation. Many are audibly relieved to be put through to an adviser who understands the process they are going through and can reassure them.”

Sadly, the number of members in this predicament is on the increase. During 2013, the MDU took more than 33,400 calls from members on its advice line, an increase of 3% from the previous year and up 17% on five years ago. A quarter want general medico-legal advice about areas such as confidentiality and mental capacity but 40% of calls relate to a complaint or some form of investigation, including scrutiny from the GMC and employers’ disciplinary processes.

Complaints to the GMC have been growing since 2007 while according to the Health and Social Care Information Centre (HSCIC), the NHS attracted the equivalent of 3,000 written complaints each week in 2012-13. In that context, it’s little wonder that the MDU advisory team opened over 13,000 new case files in 2013 to assist members.

As the new head of advisory services, it is now Caroline’s job to manage the response to the unprecedented level of demand for our services, ensuring medico-legal advisers are on hand to offer expert guidance and support to members from the outset. She explains: “The way an adverse incident or complaint is managed initially can make a difference to the way the situation develops so it’s important our advisers are as accessible as possible and can get things on the right track from the start. It’s why we offer a 24-hour advice line service and why we have appointed ten more doctors to our team, bringing the number of medico-legal advisers to 40.”

Caroline succeeds Dr Michael Devlin, who has taken on a new MDU role as Head of Professional Standards and Liaison, representing the MDU in dealings with the Department of Health, the GMC and other national organisations.

Caroline agrees it is a challenging time to take on the role but doesn’t feel the advisory team’s growing caseload represents a decline in standards, “There are increasing public expectations of medical practice and a culture which seeks to apportion blame if something goes wrong. There is also greater awareness of problems which emerge in practices and hospitals and these tend to be handled in more formal ways.”

A medico-legal adviser since 2006, Caroline qualified in 2000 and worked in general practice in Cheshire before joining the MDU. She is typical of most advisers in having a long-standing interest in the law and completed a postgraduate law degree in 2011. She is also a member of the Faculty of Forensic and Legal Medicine (FFLM) where she is an examiner and recently helped develop the new Diploma in Legal Medicine so that professionals with an interest in legal medicine can develop their knowledge.

Outside the office, she is an enthusiastic runner, pounding the streets around her home in Cheshire and competing in 10k races and half-marathons where her best time is under two hours although since having had children, she jokes that she is now delighted to make it around the course.

Back at the MDU, Caroline oversees a team from a wide range of medical specialties, from general practice to neurosurgery. “It’s important that medico-legal advisers have experience of clinical practice at a senior level,” she says. “We want members who call our advice line to speak to an adviser who has ‘been there’. We’ve all had our own ‘heartsink’ moments in practice but the level of scrutiny is becoming more intense.

“While medico-legal advisers are no longer in clinical practice, the relationship we have with members is similar in many ways to the one we had with our patients. We need to support them and we become very close as months, and sometimes years, go by.”

“It’s shocking to think that a number of the members’ files I took on in 2007 have closed in 2012 after several different investigations into the same incident.”

Reflecting on the personal qualities needed, Caroline observes: “Advisers must be able to empathise but equally importantly they need excellent communication skills to speak with, and on behalf of, members. And they must quickly get to the heart of the matter and ensure the doctor receives a realistic assessment of the possible consequences and how best to respond. This sometimes involves seeking advice from the MDU’s in-house legal team and flagging cases to colleagues in the claims team.

“They also need the strength and skill to have difficult conversations. We often see correspondence relating to a member’s case before they do. As a result, we might have to break the bad news of a GMC investigation or that a journalist is looking into the case. Unfortunately, the media has a seemingly inexhaustible appetite for medical stories. Advisers can call on the MDU’s press office for help in managing the media, which members tell us they find very reassuring.”

While much of her time is spent helping doctors in difficulties, Caroline is also focused on representing the interests of members and helping doctors adapt to changes in the regulatory landscape, such as revalidation and CQC. She concludes: “As a GP, I was drawn to the MDU because I felt it always had the profession’s interests at heart and represented them. Now it’s rewarding to be able to contribute to that work.”

### Reference

Dr Carol Chu, MDU medico-legal adviser, looks at the medico-legal implications of sharing records through care.data and other secondary purposes.

The care.data programme has focused public attention on how GPs share data within the healthcare team, social care organisations, and for wider NHS purposes.

GPs are faced with increasing requests to share patient records with various bodies and many GPs have contacted us for information and advice. This is an evolving area and some of the governance procedures associated with such sharing are not entirely clear at this time. However, there are some basic principles that apply when sharing any patient information and doctors should bear these in mind when deciding whether to share patient records with other healthcare practitioners or organisations.

Before you share information
We advise that before agreeing to share patient information for either clinical or secondary uses you should do the following.

1. Ensure there are robust information governance processes in place.
2. Ensure you have patients’ consent for specific data sharing (where their consent is required), or record their opt out.
3. Establish who is responsible, and the extent of that responsibility, for each party that contributes to and has access to shared patient records.
4. When sharing patient data agree processes between organisations to ensure that data is accurate and up to date and that procedures are in place to correct data if it is found to be inaccurate or out of date.
5. When sharing patient data within the team, ensure processes are in place to flag up actions which one part of the team may wish another part of the team to take, e.g. if district nurses wish the GP to review a patient.
6. Inform patients of all the different uses for which you are seeking consent for their information to be used. The Information Commissioner’s Office (ICO) expects GPs to make proactive efforts to inform patients of each data sharing initiative.
7. Ensure the practice has robust policies to document patients’ wishes and consent regarding each and every sharing of their patient records for which their consent is required.

Data sharing for secondary uses
Sharing data may be for the primary purpose of patient care or for secondary purposes. In this article we answer some of the common questions we have received about sharing data for secondary purposes. We have also published separate guidance (http://bit.ly/goodpractice55) on sharing data within the healthcare team.

Secondary uses of patient information include research, public health monitoring, health services planning and epidemiology. The GMC’s Confidentiality guidance recognises the importance of such secondary uses but states that non-identifiable information should, in most cases, be sufficient.

What is care.data and what effect does it have on how the practice shares data?
Care.data is a programme to extract data about patient care from different parts of the health service, including GP practices and hospitals, with the aim of supporting commissioning, planning and research. The system is being managed by the Health and Social Care Information Centre (HSCIC) and NHS England, on behalf of the NHS.

Many practices have had arrangements in place where a third party has been processing patient records and other data on behalf of the practice. Patient consent is required for their data to be processed by a third party in this way.

The care.data programme is a different and specific project covered by legislation which gives HSCIC a legal right to data under the Health and Social Care Act 2012 (H&SCA) and Directions to the Health and Social Care Information Centre for the collection of primary care data, 2013.

Can patients opt out of the care.data programme?
The Secretary of State for Health has said that patients can ask to opt out of having their data forwarded to the care.
data programme and this will normally be respected. Even if patients agree that their personal confidential data can be shared with HSCIC, they can still object to it being sent by HSCIC to an accredited third party, e.g. researchers or commissioners who have Section 251 (H&SCA) approval. There are specific ‘read codes’ that can be placed on patient records which are intended to prevent data being extracted if patients have opted out of the care.data project.

If a patient has already opted out of the summary care record programme, should I opt them out of the care.data programme?

If a patient has opted out of a separate programme to share data, such as the summary care record programme, this is entirely separate and does not mean that they will also opt out of the care.data programme. Patients are able to opt out of either programme (or both), but need to make their views known separately about each programme.

Can I opt out all of my patient records from the care.data project?

Where patients have not objected to having their data extracted for the care data project, GP practices cannot opt out of sending those patient records to HSCIC as this is a legal requirement. Full details of what data will be extracted and how often it will be refreshed are available on the HSCIC website.

What information should I give to patients about care.data?

As data controllers of the GP records, practices need to comply with the Data Protection Act (DPA) 1998 principles, one of which requires that sensitive personal data is processed lawfully and fairly. The Information
Commissioner has explained6 that fairness in processing data about individuals means that you must be transparent – be clear and open with them about how their information will be used. HSCIC has provided an information pack to practices to help them tell patients about how care.data will affect them. There was also a campaign to raise patient awareness about the new system, which included delivery of a leaflet to every household in England beginning in January 2014. In line with recent advice from the Information Commissioner, we advise that you start providing information for your patients about the care.data programme and be ready to answer their questions as soon as you can, even though the first data extracts, which were due to take place in Spring 2014 were on hold at the time of publication5. There is further information on the ICO website6.

What measures do I need to take to protect the data being processed?

The seventh Data Protection Act principle says “Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data”. Even where your patients’ data is processed by a third party, you must satisfy yourself that the third party has adequate and appropriate measures in place to ensure the principle is not breached. We suggest you contact the HSCIC for guidance on what technical measures third parties must have in place and on the wording of a standard agreement between the practice and the third party acting as a data processor.

Do I need to check the accuracy of the data being shared?

There is a provision for GPs to view the data extracts to check for accuracy but you do not have to check each and every extract. The practice’s responsibility as data controller for the patient records you hold in the practice continues as before. Once the extracted records for care.data have been received by HSCIC, HSCIC will then become the data controller for that information.

What about getting patient consent to share data for other secondary uses, such as CPRD?

The Clinical Practice Research Datalink (CPRD) is the observational and interventional research service jointly funded by the National Institute for Health Research and the Medicines and Healthcare products Regulatory Agency (MHRA). CPRD extracts anonymised information from GP systems. Patients have a right to opt out of taking part in CPRD activity. Your practice will be asked if you wish to take part.

GP practices may also be asked to contribute anonymised patient record data to other research
programmes organised by universities or suppliers of GP systems. You need to be sure that the DPA principles are complied with and robust information governance arrangements are in place to prevent data about patients being released without their consent.

Specific research projects which seek access to identifiable patient data must have approval from the local Research Ethics Committee and documentation should be available. If the researchers contact you for information you should ask to see patient consent.

Duty of confidentiality
Confidentiality is central to the trust between doctor and patient. Patients may be reluctant to seek medical attention if they do not feel that their doctors will keep personal information confidential. As well as an ethical duty of confidentiality, there is a legal duty enshrined in both case law7 and through the Human Rights Act 19988. However, this duty of confidentiality is not an absolute duty. In its guidance on confidentiality9 the GMC states that a doctor can disclose personal information if it is required by law, if the patient consents or if it is justified in the public interest.

Data Protection Act 1998
GPs are data controllers for patient records that they hold. When considering sharing records you need to be aware of DPA principles. Those relevant for sharing data are principle 2 which says that "personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or these purposes". Principle 4 states that "personal data shall be accurate and, where necessary, kept up to date". The ICO website has useful guidance on DPA9 and also on sharing records10.

Revised Caldicott principles
In the recent review of Information Governance11, a revised list of Caldicott principles that apply to the use or transfer of personal confidential data within or from an organisation was suggested and accepted by the government12.

I. Justify the purpose(s). The proposed use should be defined, scrutinised and documented and continued use should be regularly reviewed.

II. Don’t use personal confidential information unless it is absolutely necessary.

III. Use the minimum necessary personal confidential data.

IV. Access to personal confidential data should be on a strict need to know basis.

V. Everyone with access to personal confidential data should be aware of their responsibilities.

VI. Comply with the law.

VII. The duty to share information can be as important as the duty to protect patient confidentiality.

References
A 55-year old man attended his doctor about a skin lesion on his right shoulder. The skin lesion was catching on clothes and bleeding. The general practitioner, an MDU member, carefully examined the lesion and concluded that it was a seborrhoeic keratosis. She was experienced in minor surgery and so offered the patient cryotherapy, which was performed the same day.

Ten weeks later, the patient returned to his GP about an unrelated matter. The GP noted that the cryotherapy site had healed in an irregular fashion. She arranged for the patient to return to the minor surgery clinic in a fortnight, by which time the lesion was red and inflamed. The GP therefore referred him to the fast-track dermatology clinic.

The dermatologist was not able to make a definitive diagnosis based solely on the clinical appearance of the lesion. However, the scar was excised and sent for histology. Unfortunately, this revealed a malignant melanoma. The specialist performed a wide local excision procedure, but shortly afterwards the patient developed lymphadenopathy. A short time later, it became apparent that the patient had developed metastatic disease.

The patient quickly approached a firm of solicitors and brought a claim for compensation against his GP. He alleged that she had failed to recognise that the lesion was suspicious and had failed to urgently refer him to hospital for further investigation. The patient also alleged that it had been inappropriate to perform cryotherapy and that the GP’s overall management had resulted in an unnecessary period of pain and suffering.

The MDU claims handler obtained detailed instructions from the member outlining her extensive past experience in dermatology and cryotherapy. She had made her assessment and management plan in full consideration of NICE Clinical Guideline number 27, Referral for Suspected Cancer. On the basis of this, the MDU claims team served a detailed Letter of Response to the patient’s solicitors, emphasising that the GP’s management had been in line with the seven point checklist for pigmented skin lesions contained in the guideline and liability was denied.

The patient discontinued his claim against the GP and formal legal proceedings were not issued.

Dr Thom Petty
Deputy head of underwriting
A delay in diagnosis

A 12-year old girl saw her GP complaining of right knee pain after slipping during a netball game the previous day. No abnormality was detected on examination and the GP suggested painkillers and rest.

Six months later the girl was seen by another GP with a new complaint of knee joint pain. Some joint line tenderness was found on examination but a knee x-ray showed nothing abnormal. The GP referred the girl for physiotherapy.

Two months later she saw another GP who noted that the patient was now suffering from hip and knee pain and wrote to ask that her physiotherapy appointment be expedited.

Two weeks later she consulted a fourth GP who conducted a careful examination of her hip and knee joints. The doctor found a full range of movement but some lateral hip tenderness. She arranged for the patient to be seen by the physiotherapist in three days’ time.

After several weeks of physiotherapy, the physiotherapist telephoned the GP and suggested that the girl have an x-ray of her hip. This showed a widening of the growth plate on the right femoral head. While the epiphysis appeared normal, the radiologist suggested that the patient undergo further evaluation.

She was referred to an orthopaedic surgeon who performed an open reduction and fixation of a right slipped upper femoral epiphysis. The patient later underwent fixation of the left upper femoral epiphysis.

A claim was subsequently received alleging negligent delay in diagnosis and referral. Allegations were made against all the GPs involved in the patient’s care. Expert reports were obtained on behalf of the MDU members from an independent GP expert. He was not critical of their management as he felt that a careful evaluation had been performed each time the patient had been seen. When the physiotherapist had alerted the GP to the possibility of a hip problem, he felt that appropriate action had been taken.

A further expert report was obtained from an orthopaedic surgeon. He considered that the epiphyseal slip had occurred shortly before the girl had been seen for the first time. He considered that the surgical treatment would have been the same whenever she had been referred for surgery and any delay had not altered the management or outcome.

A letter of response was served, denying liability on behalf of the MDU GPs. Shortly afterwards, the claim was withdrawn.

Dr Frances Szekely
Senior medical claims handler
News in brief

FFLM diploma in legal medicine

The Faculty of Forensic and Legal Medicine (FFLM) has introduced a new qualification for people with an interest in legal medicine, but who don’t meet the strict entry criteria for the Faculty of Forensic and Legal Medicine’s MFFLM qualification.

The Diploma in Legal Medicine is open to all candidates, and is aimed at those interested in gaining the qualification which might include medical and nursing examiners, clinical risk managers, expert witnesses, forensic nurses, paramedics and psychiatrists, coroners, responsible officers and many others with an interest in legal medicine.

Successful candidates will gain the post-nominals DLM, although the qualification will not entitle them to undertake specific forensic or legal medicine work. Registered doctors who gain a distinction will be exempt from the first part of the MFFLM.

The qualification was developed by the FFLM, with input from the MDU and other medical defence organisations.

Dr Caroline Fryar, MDU head of advisory services and lead examiner for the diploma, says, “The examination broadly reflects the first part of the MFFLM in terms of detail but will be marked at a lower level than the membership exam. It is designed to allow candidates to demonstrate an excellent grounding in the principles of legal medicine.”

For details on applying, fees and an optional online training package, visit ffilm.ac.uk

Mental health crisis care concordat

The Department of Health and the Home Office have published a mental health crisis care concordat, a joint statement about how public services should work together to respond to people who are in mental health crisis. The document sets out the principles and good practice that should be followed by health staff, police officers and approved mental health professionals when working together to help people in a mental health crisis. It follows the refreshed Mandate for NHS England, which includes a new requirement for the NHS that “every community has plans to ensure no one in mental health crisis will be turned away from health services”. It was signed by 22 national organisations including the RCGP, CQC, NHS England, social services and the police.

The concordat considers:

- access to support before crisis point
- urgent and emergency access to crisis care
- the right quality of treatment and care when in crisis
- recovery and staying well, and preventing future crises.

The concordat is intended to serve as a joint statement of intent and common purpose, and of agreement and understanding about the roles and responsibilities of each service. It aims to help to make sure people who need immediate mental health support at a time of crisis get the right services when they need them, and get the help they need to move on and stay well.

The concordat draws attention to the fact that CQC monitors and inspects the quality of care, and this is likely to be piloted over the spring and summer and rolled out from October. CQC will put a greater emphasis on inspecting and monitoring the care that people with mental health problems receive in the community, including during a crisis. It will develop tools and methods to ensure that consideration is given to the key issues for people experiencing a mental health crisis in the future as part of the new regulatory approach.

To read the concordat, visit http://bit.ly/goodpractice68

GP Enterprise awards - still chance to vote

We are proud to continue our support of the GP Enterprise awards, which celebrates innovative new services or ways of working with the ultimate aim of improving patient care. 2014 has brought another successful year, with over 100 entrants from primary care staff who have introduced an innovative service or procedure in their practice. Hosted in conjunction with the RCGP, there are six award categories and each category winner benefits from a £1,000 prize and a commemorative plaque for their practice. Watch out for your chance to vote for the overall favourite category winner on GP magazine and GP online, who will win a further £4,000 and the MDU Enterprise award.

To find out more visit gponline.com/awards

Reference
Download your membership documents

As a member, you can get quick and easy access to your membership documents on our website at a time convenient for you.

Simply log in to the My membership area of the MDU website, choose the document you would like and instantly download and print it. You can even email it to yourself or another recipient or have the document posted to your address.

You can download the following documents from the website:
- proof of membership
- subscription receipt
- tax letter showing the last 7 years subscriptions.

Visit themdu.com/my-membership to find out more.

NEW GROUPCARE seminars

GROUPCARE practices now have access to 16 seminars that help identify areas of potential risk within the practice and minimise complaints from patients. Further to requests from members, two new seminars have been added to the range: Chaperones and Safeguarding adults.

The seminars are accredited for one hour of CPD by the RCGP* and are delivered on the practice premises.

NEW Chaperones

This seminar provides information to all practice staff about the role of a chaperone, including who can be a chaperone and how it works. The presenter will also cover the confidentiality issues you should be aware of when chaperoning, relevant GMC guidance and advice on consent and confidentiality.

NEW Safeguarding adults

This seminar provides information on identifying vulnerable adults, the type of abuse that they may suffer, and the safeguarding principles. The seminar also includes some guidance on handling concerns.

To find out more about GROUPCARE benefits, visit themdu.com/groupcare or contact your local GP liaison manager.

Details of your local GP liaison manager can be found by visiting themdu.com/liaison

*Awaiting RCGP CPD accreditation for some regional versions.

Set up a childcare voucher scheme at exclusive rates

GROUPCARE members can set up a childcare voucher scheme at exclusive, favourable rates.

What is a childcare voucher scheme?

Childcare vouchers, provided by Computershare Voucher Services Ltd, are a tax-free and National Insurance (NI) exempt scheme that enable employers to offer cost effective support to working parents.

The vouchers are an employee benefit which means the value of the vouchers is deducted from the employee’s salary (without any tax or NI contributions). The vouchers are then supplied electronically to the parent to pay their registered childcare provider. There is no net cost to employers to set up a scheme.

Find out more themdu.com/groupcare
Desa Rado

Which areas do you cover?
I cover the south west, north and central London, Croydon, Tonbridge, Redhill, Kingston, Sutton and Brighton.

What is your typical day like?
My typical day is a busy one. It usually starts with preparing for seminars I am giving to GROUPCARE practices, and making sure I have all the paperwork that I need for the day.

I will then drive to my first appointment which may either be a routine practice visit or presenting a seminar that the practice staff have requested.

In between visits, I will catch up on emails and phone calls from existing and new members and ensure that their queries have been answered.

What has been the highlight of your role so far?
I enjoy one to one meetings with our members, as I can focus on addressing their queries and making a difference to the way they use their membership and how they practise.

I also enjoy having the opportunity to showcase the knowledge and experience that the MDU has built up over the 129 years they have supported their members.

If you were a member, which MDU benefit do you think you would regularly use?
The seminars! They are a great opportunity to receive current, informative and relevant medico-legal training, delivered right on your doorstep.

What do you like about working for the MDU?
There are so many reasons why I like working for the MDU. However, the staff stand out as a positive. Being part of a creative and hard working team is great, and the support and friendliness that I receive from my colleagues makes me want to be at my best. It really makes all the difference to me and, I hope, to members too.

Tell us three facts about yourself...
1. I was born and raised in Belgrade, Serbia and have seen my homeland evolve and change over the years.
2. I recently met Camilla, Duchess of Cornwall at a memorial service. She seemed very warm and friendly.
3. During the time of conflict in Serbia, I worked as a journalist and was involved in the production of a story that won a Pulitzer prize.
Jenny Murray

Which areas do you cover?
I am privileged to be the GP liaison manager for Scotland, covering the whole of the country.

What is your typical day like?
As I am new to the role, my typical day consists of lots of communication by phone, email and personal visits with doctors and practice managers in their practices to begin developing the relationships that I hope will become strong and long lasting.

What has been the highlight of your role so far?
In my first month I spent some time with two of my colleagues in Wales and in Newcastle. I witnessed excellent delivery of the training seminars and the overwhelmingly positive feedback from members. It was fascinating to hear how members had applied their learning from the MDU seminars to real life scenarios.

If you were a member, which MDU benefit do you think you would regularly use?
I would take advantage of the practice-based medico-legal training seminars. We currently have 16 to choose from, tailored to the needs of our members in Scotland.

What do you like about working for the MDU?
My role means that I am autonomous and can work in the way that best suits the needs of the practices and the area. Since starting out on my journey as a liaison manager in Scotland, I have had amazing support from the liaison team. I am now working hard to spread the word that the MDU is here to help, train and reassure GPs in Scotland.

Tell us three facts about yourself...
1. I was an art school graduate. I studied for a degree in interactive media design and still enjoy producing installation art for exhibition.
2. I have four lovely children between 17 years and 18 months!
3. I enjoy playing traditional Scottish music (the accordion and the Scottish whistle) and I have performed alongside my husband at the Royal Concert Hall in Glasgow as part of the infamous Celtic Connections Festival.
Doctors who share images of patients’ clinical conditions over the internet may be acting outside their ethical obligations. Dr Carol Chu, MDU medico-legal adviser, explains how to stay ‘snap happy’. From a quirky ‘selfie’ to images of a good night out with friends, digital photography has made it easier than ever to share a memorable image with others. According to the photo sharing site Instagram, more than 16 billion photos have been shared by its users and new images are being uploaded at a rate of 55 million every day.

With many GPs now using smartphones and tablets for professional purposes, it may be tempting to make use of file sharing apps and websites to share clinical photographs with colleagues. Although this may seem a useful way to discuss medical conditions with other doctors or to seek another professional opinion, the medico-legal risks could outweigh the benefits. Here’s how to stay on the right side of your ethical obligations.

**Patient consent**
Before you share any clinical image, it is essential to have the patient’s consent, and to have done everything possible to protect their confidentiality.

If an image has been taken as part of a patient’s care, perhaps to trace the progress of their condition over time, you should have already obtained and noted their consent, setting out how it will assist in their care and confirming it will be stored securely.

If practicable, the GMC would usually expect you to explain if the images may be used in anonymised form for a secondary purpose. When patients do not want their image to be used for any other reason, this should be noted in their record.

When a patient presents with an unusual medical condition, you may want to take a picture to share with colleagues or for research. Before you do so, you need the patient’s explicit consent, whether or not you believe they are identifiable. It is your responsibility to do this in a way the patient can understand,
telling them the purpose of taking the picture, how long it will be kept and how it will be stored.

At the same time, reassure them that they can withdraw consent while the picture is being taken or immediately afterwards, without this affecting the quality of care they receive. Again, the patient’s consent should be recorded in their notes.

When the patient is a child who is not Gillick competent, or an adult without capacity, you must obtain permission from someone with authority to act on their behalf. If the image is not required as part of the patient’s care, you and the patient’s representative must be satisfied it is necessary, is in the patient’s best interests and the purpose cannot be achieved another way.

Bear in mind that as young patients mature, you will need to seek their consent to use images taken in previous years.

If you want to share or disclose an image of a patient who has since died, you should follow their known wishes. If the patient is identifiable, you may need to consider obtaining further authority from their executor or family before the picture appears in the public domain.

Storage and security
A digital photograph of a patient must be protected in the same way as other clinical records or recordings. This is likely to be more difficult if you take the photo on a smartphone or tablet that you also use outside work, or which other family members or friends have access to.

Photo sharing apps that automatically upload images to the internet are another potential risk.

We recommend that the issue of use of personal devices by staff is addressed in your practice data protection policies. This reflects recent advice from the Information Commissioner’s Office (ICO) which warned organisations to be clear about which types of personal data may be processed on personal devices.

The ICO guidance Bring your own device², advises using strong passwords, encryption and automatic locks when a password is entered incorrectly too many times.

It also advises registering devices with a remote ‘locate and wipe’ facility to maintain confidentiality of the data should a device be lost or stolen.

We strongly advise doctors not to store identifiable patient images on unencrypted mobile devices. Not only is this against Department of Health guidance, which states that ‘any data to be stored on a portable device such as a laptop, PDA or mobile phone, should be encrypted’⁴, but if your phone was stolen or mislaid, it would be difficult to argue that you had taken all reasonable steps to protect its security.

If the smartphone you use to take a picture is not encrypted, you should download the images to a device that is encrypted and permanently delete the original image.

Sharing images on social media
The GMC states that you must be careful not to share identifiable information about patients online, even if the site is not accessible to the general public⁵.

Even if you think you have removed the identifying details, it may still be possible for the patient or someone close to them to recognise the image from an apparently insignificant detail.

The GMC also warns doctors to exercise caution about the amount of information they reveal, in case multiple posts allow other users to piece the details together and identify the patient.

References
Can I record you, doctor?

Video-enabled smartphones offer patients the means to record consultations with their doctor. MDU medico-legal adviser Dr Philip Zack looks at the implications.
The prospect of a patient recording their consultation with you may seem quite alarming, but it would be a mistake to assume their actions have an ulterior purpose. In fact, it may even be to your advantage.

Effective communication

Research has repeatedly shown that patients forget much of what they are told by their GP as soon as they leave the surgery – between 40% and 80%, according to one study, which also found almost half of the information they do recall is incorrect. The problem is worse if the patient is not fluent in English, or has hearing difficulties or learning disabilities. Some patients try to take notes during a consultation but even then, they may be so busy writing, they will not have the chance to think of questions or get the reassurance they may need.

By recording a consultation to listen to again later, patients are less likely to miss something important. One consultant urologist had no objection when a patient asked to record a consultation on his smartphone. “I was discussing the ramifications of various surgical options. There were facts, figures and side effects to digest. By filming me, it meant he could do this in the comfort of his own home and weigh up the options at his own pace.”

Patients who understand the risks and benefits of their treatment options are usually able to make an informed decision about the treatment they want, which makes life easier for them, and for their GP when it comes to obtaining consent.

It is also worth bearing in mind that the GMC expects you to ‘give patients 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’.

Covert recording

What if a patient starts recording you without asking permission, or decides to record a consultation covertly, as has happened to a number of MDU members recently?

Are their actions a sign that your professional relationship has broken down?

Although the GMC expects doctors to obtain patients’ consent to make a visual or audio recording, patients do not need their doctor’s permission to record a consultation, because they are only processing their own personal information and are therefore exempt from data protection principles.

Section 36 of the Data Protection Act 1998 states: ‘Personal data processed by an individual only for the purposes of that individual’s personal, family or household affairs are exempt from data protection principles.’

If you suspect a patient is covertly recording you, you may be upset by the intrusion, but your duty of care means you would not be justified in refusing to continue to treat the patient. If you did, it could rebound on you and further damage your relationship with the patient.

Remember that your refusal to continue with the consultation could also be recorded.

A more pragmatic response might be to invite the patient to record the consultation openly and ask them whether you can have a copy of the recording, which can then become part of the patient’s medical records. In seeking their consent, you should reassure them the recording will be stored securely by the practice and only used for this purpose.

It is understandable to assume the worst when a patient tries to record their consultation, but their behaviour should not pose a problem.

It would be a mistake to think they are trying to catch you out or that a complaint or claim will inevitably follow. If you are concerned that the patient’s actions are a sign they do not trust you, you may want to discuss this with them at a later date, but recording a consultation is not itself sufficient reason to end your professional relationship with them.

Admissible evidence

Be aware that recordings (even those made covertly) have been admitted as evidence of wrongdoing by the GMC and in court. However, they can also prove the opposite. If you have acted ethically and professionally, you should have no reason to worry.

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This article first appeared in GP magazine.

References


2. Daily Mail, Why I believe patients should film consultants on their phones, Eden C (9 July 2013).

3. GMC, Good medical practice, paragraph 32 (April 2013).

4. GMC, Making and using visual and audio recordings of patients (2011).

http://1.usa.gov/1hWi8Xp

This article first appeared in GP magazine.
Working as a forensic practitioner

At the end of a morning surgery session, GP Dr San Sumathipala, received a call from the local constabulary. He was asked to come and assess a detainee for fitness for interview.

Issues around confidentiality are complex and the position in the FP-detainee relationship is very different from that in the usual therapeutic doctor-patient relationship.

FPs may have a dual responsibility when assessing a detainee – to the police in collecting forensic evidence and preparing a report for criminal proceedings, and to the detainee as a patient if he or she requires medical treatment. FPs should explain clearly to the detainee at the outset that this is the case, and that no assurance of confidentiality can be given.

However, not all information disclosed to the doctor should necessarily be passed on to the police. Following a parliamentary debate on the Criminal Procedures and Investigations Act 1996, the situation on confidentiality for FPs was clarified for England, Wales and Northern Ireland. It was determined that reports prepared for criminal proceedings may be given to the police, but information obtained for therapeutic purposes would be subject to the usual law and ethical guidance on confidentiality.

Dr Sumathipala explains that if a detainee disclosed in confidence that, for example, they were HIV positive and required medication for this, a separate medical record detailing the patient’s medical history should be kept. This should not be disclosed to the police unless required by law or in the public interest.

Some medical information-sharing with the police may be appropriate, including when the patient consents to the disclosure, or when it is necessary for the protection of the health of the detainee or those around them. Conditions which are not transmissible through ordinary contact (for example HIV) should, however, not be disclosed. If a patient requires transfer to another institution, then the relevant medical information should be sent with the patient in an envelope marked ‘confidential’.

FPs should also provide custody officers with clear details regarding the level and frequency of medical supervision necessary, and specify any medication the detainee requires.

A typical evening as an on-call FP might include requests to prescribe medication for a person in custody. Dr Sumathipala describes the Sword of Damocles which can hang over a consultation with a detainee who may be ill but have no medical records.

“You worry about missing a serious illness or injury in a patient about whom you have little or no medical information. Take, for example, when you are assessing a patient who is agitated and aggressive and has been arrested following an alleged assault. It is important to consider whether there may be an underlying mental or physical health condition, a possible head injury, or drug or alcohol misuse that requires treatment.”
“The incidence of mental illness and drug misuse is higher in detainees than in the general population, and their health needs can be complex. At times it can feel that you are treating blind, without the benefit of the records that we would usually depend on.”

For some clinical presentations there is clear guidance for FPs, for example, on the management of head injuries. The Faculty of Forensic and Legal Medicine (FFLM) guidance for this outlines the criteria warranting urgent admission to hospital, and provides advice sheets which can be given to the patient, custody officer or responsible adult.

FPs may also be asked to take samples from detainees or victims of crime or to perform an intimate body search.

While consent is not legally required for an intimate body search for weapons if authorised by a police inspector, the BMA and FFLM both advise that doctors do not perform such examinations without consent.

Dr Sumathipala explains that working at the MDU has increased his awareness of the consequences of what can appear to be an innocuous consultation.

“I can think of times when, although I sought a patient’s informed verbal consent and documented this, I would now seek written consent if practical. It has also brought home the necessity of making clear and careful notes of the advice given to the patient and custody officer as you may need to rely on this later during an investigation or coroner’s inquest.”

During a recent five year period, the MDU opened an average of one case a month to assist members working as forensic practitioners. These range from complaints, to coroner’s inquests and GMC investigations, as well as advice on ethical matters such as consent and confidentiality.

The MDU offers the following advice for doctors working as FPs:

- Ensure that you are working within your competence and area of expertise. The Faculty of Forensic and Legal Medicine has details of courses and qualifications relevant to FPs. There is also helpful joint guidance from the BMA and FFLM.
- Ensure that a detainee has given informed consent to examination, and understands the role of the FP, including that not all information will necessarily be kept confidential.
- Keep careful written records, including written consent where possible. Try to separate out forensic evidence from medical information which relates solely to therapeutic care as you go along and only disclose in accordance with the law and advice.

Despite the obvious challenges, Dr Sumathipala finds working with potentially vulnerable patients, and the complex and varied needs that this can bring, “very rewarding”. He adds: “I also really enjoy the opportunity to experience something so different from my day-to-day work in general practice. It’s good to work alongside the police and to use my skills in what can be a challenging, but ultimately satisfying role.”

Forensic practitioner subscriptions are based on the average number of clinical hours worked per week. When calculating this, as well as including time spent with patients, you should also include time doing patient related administration (such as writing notes, making referrals, arranging transfers, requesting investigations and reviewing results).

References
Challenging patient

A patient presented to a GP practice without an appointment and demanded to be seen immediately by a doctor. The patient was verbally aggressive, visibly upsetting both reception staff and patients in the waiting room.

In order to calm the situation down, the GP arranged to see the patient straight away. He simply wanted a repeat prescription of his anti-hypertensive medication as he had a limited amount left and was going on holiday that day. The consultation passed without further incident.

Two weeks later, the GP rang our advice line following a meeting with the other doctors at the practice and the practice manager. Due to the patient’s unreasonable behaviour they intended to remove him from their practice list. The practice had a zero tolerance policy, but the GP was concerned to know whether the removal was appropriate under the circumstances.

Our advice

The GMC acknowledges that there are rare circumstances when the trust between a patient and their doctor may break down and it becomes necessary to consider whether the breakdown in the relationship is sufficient to warrant the patient’s removal1,2.

The GMC goes on to say that a doctor must be satisfied that the decision is fair3 and must make prompt and appropriate arrangements for the patient’s continuing medical care4.

In addition to this the GP must be mindful of his obligations under the National Health Service (General Medical Services) regulations5, which require the practice to give 12 months written warning of the intention to remove the patient from the practice list unless it is, in the practice’s opinion, not reasonable or practical to do so.

The MDU adviser asked if the patient had behaved in this way before or if there was any reason, such as a mental health problem, which may have led him to behave so aggressively. If so, had he been warned about inappropriate behaviour during the last 12 months?

The adviser suggested that at this point it may be more appropriate to write to the patient warning him that further behaviour of that nature would not be tolerated and could result in him being asked to leave the practice.

The GP was advised to keep a record of the incident and ask the members of staff who had been involved to provide factual statements, and to keep this information in a file separate to the clinical record.

Outcome

In this case, the practice decided to offer a warning to the patient. The patient apologised for his behaviour and explained that there had been personal circumstances which had led him to act in this way. The GP felt that this had restored the doctor-patient relationship and it was no longer necessary to consider removing the patient from the practice list.

Dr Kathryn Leask
Medico-legal adviser

References

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