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Dr Beverley Ward
Introduction from the medical editor

Progress in modern technology and changing lifestyles in the 21st century mean that practices need to keep up with the expectations and demands of patients who use their services. This can be a challenge for all staff, but we hope this edition of *inpractice* will provide some useful guidance.

Our main feature article deals with practice appointment systems, which have become more and more complex. While there is a need to improve access for patients, this must be balanced against the patients’ safety, which of course, is the priority at all times. This article provides some tips for maximising the efficiency and safety of your systems.

The days of paper records and practice message books are long gone. Instead, electronic devices are being used more and more by primary care teams. Nicola Mullineux from Peninsula Business Services highlights the health and safety issues related to use of these devices.

It is an unfortunate reality for any practice that occasionally patients complain about the care provided. The NHS complaints procedure, updated in 2009, may have resulted in some confusion regarding timescales allowed for response. Medico-legal adviser Dr Peter Connell clarifies your obligations when responding to complaints.

Similarly, members of staff may have concerns that they wish to raise about their working environment, sometimes in form of a grievance. The enclosed guidance from Peninsula will be helpful to managers who deal with staff grievances.

I hope you find this issue of *inpractice* useful. Of course, we welcome any feedback you may have.

Dr Beverley Ward
Medical editor
By appointment
As demand for GP appointments increases, patient access has become one of the most contentious aspects of primary care. Practice managers may find themselves caught in the crossfire between anxious patients and overworked clinical staff. Medico-legal adviser, Dr Beverley Ward, assesses the medico-legal challenges involved in managing practice appointments systems.

Today’s practice managers face a considerable challenge – to find innovative ways of meeting patient demand for appointments, without compromising patient safety or overloading the system.

The average GP practice dealt with 4,384 more consultations per year in 2011/12, compared with 2004/5 according to a recent estimate by the Royal College of General Practitioners (RCGP). Such was the pressure on resources that 10% of patients who sought a consultation with a GP or practice nurse in 2012/13 failed to get one.

In an effort to ease the pressure and improve access, the government and doctor leaders agreed to end the contractual requirement for 10-minute appointments from April 2014, giving practices greater flexibility. Surgeries are also now expected to offer and promote online appointment booking and repeat prescription services.

Many practices have already been exploring alternatives to face-to-face consultations in a bid to alleviate pressure on the system and meet patient needs. For example, telephone consultations increased from an estimated 12.5 million to 18.9 million between 2004 and 2012, a rise of over 50%.

While such initiatives can improve operational efficiency, particularly for routine matters, practice managers must still ensure patient safety isn’t compromised. More broadly, it’s important to consider the medico-legal implications of all practice policies and procedures which concern patient access, from appointment booking to reducing Do Not Attends (DNAs).

**Standard local rate**

Patients should be able to call the practice on a number that charges the standard local rate. Since April 2010 there has been a veto on practices entering contracts which involve the more expensive 084 telephone number and practices were expected to amend or end contracts that didn’t comply. But according to NHS England a minority of practices (around 8%) continue to use them. It has asked Local Area Teams to remind practices that they will be in breach of contract if they do not make this a priority. There are also plans to audit telephone services this year to check what progress has been made. If you are affected, speak to your telephone provider or seek advice from your Local Area Team.

**Telephone skills**

Poor communication and perceived rudeness during telephone calls are a common cause of complaint. But a patient who has been kept waiting a long time or wrestled with a convoluted automated system is just as likely to be annoyed and anxious when they are connected. The receptionist who picks up the call may find him or herself having to manage the patient’s irritation.

With this in mind, it’s worth considering regular training for reception staff to ensure their telephone skills are up to scratch, including checking the identity of the caller, actively listening without interruption, being courteous and staying calm in the face of aggression. It’s also important to ensure that calls are answered within a reasonable timeframe (it’s a good idea to have a target) and that there are enough staff available to answer the telephone at peak times.
It's a good idea to have a practice telephone policy which covers points such as:

- patient confidentiality
- staffing levels
- documenting calls and emergency contact numbers (which should be included in your out-of-hours answering machine message).

The policy should be regularly reviewed and updated.

**Triage and telephone consultations**

Telephone triage is a useful way of determining urgent and not so urgent cases so that appointments can be allocated according to patient need. However, the process must be properly thought through.

If non-clinical staff take down patient details for a GP call back, they must have appropriate training and there should be a full written protocol which includes red flag symptoms such as weight loss or a persistent cough. There should be no need to go into detail about patients' medical history and those who only want to discuss their concerns with a health professional should not be penalised. To protect patient confidentiality, calls should be taken where they can't be overheard, rather than at a reception desk in the waiting room.

Many practices provide a call-back service so that patients can talk to a health professional or be allocated an emergency appointment. Even if the telephone calls are recorded (and if they are, this should be made clear to patients), the clinician or practice nurse assigned this duty should have access to the patient’s records and make the same detailed clinical notes that would be expected in a face-to-face consultation. In the event of a problem, the practice should be able to document the reason for the call and the advice offered. It’s also advisable to document the call-back process used in case it is questioned during a CQC inspection or in the event of a complaint.

**Home visits**

Home visits can be a sensitive area because the person making the request is often anxious about their own health, or that of a close relative, and their expectations may be unrealistic.

To help pre-empt any problems, it is a good idea to publicise your policy on home visits on your website and in practice literature, making clear that the service is usually for the housebound or seriously unwell and encouraging patients to use the system appropriately. The policy should set out how people can request a home visit (for example, if they need to call the surgery before a particular time), explain that a doctor or nurse may contact them to assess the urgency and make it clear that their preferred doctor may not be available. As with all consultations there should be a full note of such conversations in the patient’s record.

If an appointment is made for a home visit, there should be a clear protocol in place to confirm the patient’s address details and ensure the visit is documented in the records.

**Online appointment booking**

Practices are now contractually obliged to provide secure online access to services such as booking and cancelling appointments.

More than half of practices already offer patients this option but if your practice does not yet have this facility, we advise you to contact your Local Area Team. According to guidance from NHS Employers, NHS England and the General Practitioner’s Committee* (GPC) all practices will have approved national software made available to them this year so that they can meet this requirement. The guidance also says that practices should ensure “that an appropriate number of appointment slots are able to be booked online”. It suggests reserving 20% of appointments for online booking, although that will depend on the characteristics of your local population.
Appointments policy

Your appointments policy should be available on the practice website and in the waiting area. It’s also a good idea to communicate the policy to new patients when they register. The policy could include the following.

- Surgery times and extended hours sessions.
- Types of appointment available e.g. urgent, advance, ‘arrive and wait’, practice nurse, travel clinic etc.
- Appointment booking methods (telephone and online).
- The practice’s commitment to answering telephone calls within a certain time and whether calls are recorded.
- Requesting home visits and the circumstances when they are provided.
- Whether patients can request a particular GP.
- When patients can request a double appointment.
- How to cancel an appointment.
- Practice statement on DNAs.
- How to summon medical help outside practice hours.

If the nurses in your practice triage patient phone calls, ensure they get in contact with our membership team to let us know.

Text reminders

NHS England reports that more than 12 million GP appointments are missed each year in the UK, at a cost of over £162 million to the NHS and considerable disruption and delay to practices. As a cost-effective way of tackling the problem, some GP practices now provide a text reminder service to the patient’s mobile phone.

Text messaging can work well in this context, though we advise practices to seek patients’ specific consent and opt-in before texting. Ensure you explain clearly what information will be texted and the security arrangements in place. If the information is serious or important, such as requests for urgent follow-up, consider alternative or additional methods of communication.

Details of text messages sent to or received from patients should be noted in their medical record, including the date and time of transmission, the content of any message and the details of any reply.

Responding to DNAs

A competent adult patient is responsible for ensuring their own attendance at an appointment, but this is not to say that practices have no responsibility in cases of non-attendance. Ensure your practice has a clear and consistent protocol for prioritising and responding to missed appointments and that a record is kept of any steps taken to follow up with the patient. For example, if a patient who may be acutely unwell fails to attend an emergency appointment, it is important the practice can demonstrate that all reasonable and timely steps were taken to investigate the circumstances and need for care.

Even if a patient persists in missing or is late for appointments, it would be difficult to justify their removal from the list unless the practice has spoken to them about this and determined whether there are any underlying causes such as confusion about the appointments system or anxiety. In the majority of circumstances, removal should be an option of last resort and GPs are contractually obliged to have given the patient a warning in the previous 12 months. Keep a clear and detailed note of any incidents that have led to the removal, any steps that have been taken to resolve the situation, the specific reasons for the removal and the process of removal that was followed.

References

1. RCGP, 34m patients will fail to get appointment with a GP in 2014 (February 2014). http://bit.ly/inpractice37
2. The University of York Centre for Health Economics, Consultations by type (Table 10), Productivity of the English National Health Service from 2004/5: Updated to 2011/12 (January 2014). http://bit.ly/inpractice38
Dealing with staff grievances

A distressed receptionist asks to see you privately as she has an urgent issue to discuss. She has scheduled in a meeting later in the day in a private room. During the meeting, you find out that the employee feels like she is being taunted by her colleagues, who leave her out on purpose. She works part-time and no longer feels part of the team. She becomes visibly upset and starts crying, claiming that she dreads coming to work every day. The employee wants to raise a formal grievance and is considering leaving the practice if the situation does not improve.
Peninsula advice

Familiarise yourself with your practice procedures

The first step when facing a scenario such as this would be to familiarise yourself with your practice's grievance procedure, including the time limits for addressing grievances and your practice's anti-bullying procedures.

Act promptly

Allegations of this nature should be taken seriously and dealt with promptly so you should not delay in starting the formal grievance procedure, as requested by the complainant. Sometimes an informal method of dealing with grievances can bring about a resolution but, in this circumstance, the complainant has opted for a formal procedure. Other immediate considerations include whether to transfer the complainant to another part of the practice while the procedure is under way, but this action should only be taken if the complainant asks for it as otherwise it may be seen as a punishment.

Gather information

You should get as much detail as possible about the incidents that the complainant has mentioned, including:

- when the incident(s) happened
- where the incident(s) took place
- who was present
- what was said.

This exercise will allow you to carry out full investigation. You may ask the complainant to set out her grievance fully in writing.

Formal grievance hearing

A formal grievance hearing should be held to clarify the allegations. It is the responsibility of the employer to arrange this meeting, which should be in line with the grievance procedure. The meeting should be held at a time and place notified to the complainant in advance.

The complainant has the right to be accompanied by a colleague or a trade union representative at the hearing. This is a statutory entitlement and failure to offer this, or to refuse a selected companion, could raise further issues. It is best to invite the complainant to the meeting in writing, setting out clearly their right to be accompanied. As with all workplace procedures of this sort, a paper trail is important in case questions are raised in the future.

The hearing will allow for the clarification of the issues that need to be addressed, and the employee's desired outcome. In this scenario, this may be:

- relocation of staff
- reorganisation of the team
- disciplinary action against those who are alleged to be behaving in this way towards the complainant.

Investigation

The investigation is a significant part of a grievance procedure and the following should be considered and recorded.

- Speak to those who the complainant alleges have been taunting her.
- Speak to anyone who witnessed the alleged events.
- Take statements from everyone you speak to.

Throughout, it is crucial that the investigator remains impartial and maintains confidentiality in order to protect the rights of everyone involved. The investigation conversations should not be treated as a disciplinary hearing.

Reaching a conclusion

After the investigation stage, you may uphold the grievance and agree to take action. Alternatively, where there are multiple parts to the grievance you may uphold some but not others, or decide that all of the complaints are unfounded. You should write to the complainant informing her of your decision, allowing the right of appeal if the grievance is partly or wholly unsubstantiated.

In this scenario, offering mediation to the individuals involved may help them rebuild their working relationships. This can be offered whether the grievance has been upheld or not. Mediation looks to achieve a resolution through open and honest conversation where the individuals can explain how they are impacted by each other's behaviour.

Learning points

- Do not delay unreasonably in any part of the procedure.
- Ensure your investigation is thorough by speaking to all of those who were involved or who witnessed the events, and taking all of their comments into consideration.
- Remain impartial when considering evidence, do not allow yourself to be influenced by personal prejudice.
- It is not necessary to prove beyond all reasonable doubt that the alleged events occurred – you just need reasonable belief formed after a thorough investigation.
- Adhere to your contractual procedures and policies.

This is a fictional case compiled from actual cases from Peninsula’s files.

groupcare

GROUPCARE members receive access to a free 24-hour employment law advice line. For more information on how to set up a GROUPCARE scheme, visit

themdu.com/groupcare
Health and safety when using portable devices

Tablets and mobile phones are used more and more in primary care. From accessing patient information during home visits to catching up on CPD credits, it’s never been easier to stay updated and in touch. Nicola Mullineux, research co-ordinator from Peninsula Business Services, outlines the health and safety risks that can occur when using portable devices.

The Health and Safety (Display Screens Equipment) Regulations 1992 outline points to consider when using computer equipment, with the aim of minimising the risks of work-related health issues. The regulations were originally written for computers with visual display units, but it also applies to all portable devices such as laptops, mobile phones and tablets. Portable devices such as smart phones, tablets and notepads can be a very useful aid to mobile workers but they should never be supplied as an alternative to a desktop device where that is necessary. Used correctly, smart phones, tablets and notepad devices should not pose any significant risk to the user. However, it is easy to get into bad habits when using a portable device.

It is the employer’s responsibility to ensure all steps have been taken to protect the health of visual display users at work. Workstation assessments should be done at a regular interval (once a year is generally regarded as suitable) and any concerns or observations noted in the employee’s file.

Further information and advice on the use of Display Screen Equipment can be found by visiting hse.gov.uk/pubns/priced/l26.pdf

1 Health and Safety Executive, Display Screen Equipment (Regulations and guidance) (1992).
GROUPCARE Plus and Premium practices can benefit from access to the Peninsula 24-hour health and safety advice line, and the option to purchase the full employment law and health and safety package, at an exclusive MDU discount. To find out more visit themdu.com/groupcare

Before an employee starts to use a new portable device, an introductory session should be scheduled in to cover correct use of the equipment.

After 10-20 minutes’ continuous use, take a short break to stretch your hands, shoulders and neck. You can relax your eyes by looking into the distance and blinking a few times.

Adjust the tablet settings to suit your vision. You can enlarge a webpage or text so it is easier to read.

When reading from (as opposed to interacting with) a portable device, use a stand or tilt the tablet so you don’t need to bend your head.

Keep the screen clean using wipes that are specially formulated for tablet surfaces.

Use a light touch when interacting with the screen.

The ideal position for a tablet is flat on a surface in front of you, or slightly angled towards you to ensure that your wrists are not in an awkward position.

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**News in brief**

**Employment law news bulletin**

April 2014 saw the introduction of a multitude of new employment regulations. *inpractice* rounds up the latest legislation that may be applicable to your practice.

- The weekly rate for statutory sick pay will increase to £87.55. Weekly statutory maternity, adoption and paternity pay will also increase to £138.18.
- Financial penalties will be introduced for employers who are found to have breached employment legislation where there are aggravating features present. The penalty will be payable to the Exchequer (department of government responsible for the management and collection of taxation and other government revenues), in addition to the award and the fee reimbursement to the claimant. A minimum of £100 and a maximum of £5000 will be payable, and these will be applied to tribunal decisions for claims that are brought on or after 6 April 2014.
- The maximum unfair dismissal compensation award has increased to £76,574 (subject to a cap of 52 weeks’ pay).
- The maximum week’s pay for statutory redundancy pay purposes has increased to £464.
- An ‘early conciliation’ process has been implemented by the government to make prospective employee claimants inform Acas of their intention to claim against their employer. This is so that Acas can attempt to conciliate before making a claim. Claims will no longer be sent directly to the tribunal service.
- The statutory discrimination questionnaire will be repealed and replaced with a more informal approach for employees who would like to pose questions to their employer about alleged discrimination.

**CQC announces its proposals for inspections**

CQC is planning to roll out full inspections using the new inspection methodology from October 2014.

The new inspection methodology will be based on fundamental standards that will be common to all sectors, but CQC is adapting the methodology so that inspections are tailored more closely to the sector they are used in. Pilots using the new methodology in primary care started in April 2013. CQC aims to use the experience from the pilots to shape the final inspection methodology that will be developed over the summer.

The first wave of inspections using the new methodology will start in primary care in October to December 2014. A second wave of inspections will then follow in January to March 2015 with the aim of having all primary care practices inspected by 2016. From October 2014, new regulations should also be in place to give CQC powers to require a duty of candour from all the providers it inspects, including in general practice. This means practices will be required to ensure that patients are told when something has gone wrong and to prove to CQC that this has been done. The new statutory duty will be in addition to the ethical duty of candour that already exists for doctors.

CQC is producing handbooks to help each sector understand how it will regulate and inspect them.


To keep up to date with the latest in employment law, visit [peninsulagrouplimited.com](http://peninsulagrouplimited.com)
Know your time limits

MDU medico-legal adviser
Dr Peter Connell looks at the timelines involved when acknowledging and responding to complaints.

A patient who complains to your practice has 12 months from the date on which the matter they are complaining about first happened, or when they first became aware of it, to make their complaint. In responding, practices don’t have this luxury. The NHS complaints procedure sets out timescales for acknowledging, investigating and responding to complaints, and they differ in the four countries of the UK.

Acknowledging a complaint
The regulations require primary care practices to acknowledge receipt of a complaint within:
• three working days in England, Scotland and Northern Ireland
• two working days in Wales.

Responding to the complaint
In England, there are no time limits set for responding to a complaint but if a response is not provided within six months from the date of the complaint, the practice must write to the complainant to explain the delay.

In Scotland, you are obliged to confirm that the complaint will be investigated within 20 working days or explain why you won’t be able to do so. If there is a delay you should tell the complainant when they may expect a response.

In Northern Ireland, the investigation should normally be completed within 10 working days but if this is not possible you need to explain why to the complainant and tell them when they will receive a response.

Responses outside the time limits
These time limits may occasionally be impossible to achieve. For example, if the member of staff involved in the complaint goes on leave on the day the complaint is received, it may not be feasible to carry out a full investigation within the expected timeframe.

Whatever timescales apply in the area where your practice is based, it is essential that all complaints are answered within a reasonably prompt period of time, but without compromising the quality of the response. In the MDU’s experience, a complex complaint which involves a number of doctors or healthcare professionals that belong to different defence organisations, Royal Colleges or trades unions could mean inevitable delays. When a delay occurs, it is important that you inform the complainant of the reasons for the delay and when you expect to get in touch with them.

Usually, the complainant is anxious to receive a prompt response and our members are anxious to resolve complaints at the earliest opportunity. However, it is most important that the quality of the response is not compromised by undue haste in carrying out the investigation.

When a patient complains after 12 months
Sometimes, a patient will complain about an incident that happened, or which they became aware of, more than 12 months before the date of their complaint. The regulations state that you should consider a complaint made outside that time limit if the complainant has good reason for complaining, despite the delay, it is still possible to investigate the complaint fairly and effectively.

Since it will probably be impossible to recall the events that gave rise to the complaint accurately after such a long time, you can only rely on the medical records, and what your standard practice was at the time. The staff involved with the complaint may have left the practice, and may be untraceable. In these situations, it is expected that you make reasonable attempts to contact the individuals. If you are unable to do so you can only respond on the basis of the entries in the medical records and what you believe was their standard practice.

Call our medico-legal advice line
Our medico-legal team are on hand to advise you with queries regarding dealing with complaints. Call 0800 716 646 or email us at advisory@themdu.com

Lines are open 9am-5pm Monday to Friday. We provide an on-call service for medico-legal emergencies or urgent queries 24 hours a day, 365 days a year.
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 on 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 seven years’ subscriptions.

Visit themdu.com 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 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
A GP was asked to certify the death of a patient who was registered at the practice, but with whom he had had no previous contact. The patient was an elderly man who, according to paramedics at the scene, had suffered a cardiac arrest after experiencing severe chest pain and had died at home. According to the clinical records the patient had a history of acute angina and a previous myocardial infarction.

Unfortunately, the patient’s usual doctor at the practice was on annual leave for the next two weeks and could not be contacted. The GP was concerned that he was not in a position to sign the death certificate as he had never seen the patient before. The family, however, put the GP under immense pressure to sign the certificate as they needed to take the body away within the next few hours for religious reasons.

The GP rang the MDU advice line to find out whether he was likely to be vulnerable to criticism if he signed the certificate as he was anxious to help the bereaved family.

**Our advice**

The MDU adviser explained that the doctor signing the death certificate should be the one who provided care during the last illness and who had seen the deceased within 14 days of death or after death. The patient’s usual GP was not in a position to do so and another doctor could not do this on their behalf. The doctor signing the certificate should also be confident about the cause of death.

She advised the GP that if there was no other doctor who could fulfil this requirement, the death must be reported to the Coroner as it could not be certified under the current legislation. The GP should provide the Coroner with any information that might help to establish a cause of death.

Although the GP had sympathy for the family’s situation, the adviser also reminded him of his ethical obligations as set out by the GMC. Any report or certificate he signed must not be false or misleading and he must be honest and trustworthy when signing forms and other documents.

**The outcome**

In this case, the GP contacted the Coroner and discussed the patient’s medical history and recent appointments with him as well as the circumstances surrounding his death. The Coroner passed this information on to the registrar of deaths and arranged for a post-mortem to take place. This confirmed that the patient died from a myocardial infarction and an inquest was not necessary. The registrar spoke to the family to explain why this had been necessary. The relatives accepted this and were able to take the deceased’s body once the post-mortem examination had been completed.

Dr Kathryn Leask
Medico-legal adviser

1 References
