



MDU wardround

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PATIENTS
IN THE PUBLIC EYE

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Introduction from the medical editor

Since 1983, doctors have topped the yearly Ipsos/Mori¹ poll of professions most trusted by the public, fighting off competition from teachers, scientists, judges and the police.

This annual endorsement reflects the effort that doctors invest in justifying the trust that patients place in them.

Respecting confidentiality is central to this. Patients who fear that their personal information will be the subject of gossip or routinely disclosed to third parties without their consent are unlikely to disclose their concerns in the consulting room. Such reticence will make it impossible for clinicians to make the correct diagnosis or provide appropriate care and treatment.

And yet doctors regularly need to respond to requests for details about their patients. It may be from a colleague, someone in authority such as the police or a coroner, or perhaps a journalist. In some cases, there will be a legal obligation to provide information but in others, the patient's consent is required. We regularly receive calls from members who are struggling to balance their ethical duty of patient confidentiality with their other legal and ethical obligations. This issue of *wardround*, which focuses on different aspects of confidentiality, provides some of the answers.

Whether you are caring for a celebrity patient or someone in the public eye, or you receive a request from social services or the police, decisions to disclose confidential information can be challenging. If you need specific advice from the MDU's team of medico-legal experts, you can call our 24-hour medico-legal helpline on 0800 716 646.

Dr Sally Old
Medical editor

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¹ Politicians trusted less than estate agents, bankers and journalists, Ipsos/Mori, 15 February 2013 <http://bit.ly/wardround99>



Patients in the **public eye**

Confidentiality can easily be breached if your patient is a celebrity and the media are hungry for juicy details. Dr Sally Old, MDU medico-legal adviser, reveals all.

Imagine you are on duty with the trauma team at your hospital in the early hours of the morning when a well-known television personality is brought in to A&E with major injuries following a car accident. His identity has been spotted by bystanders at the scene who have already uploaded videos of the aftermath of the crash on to the internet. Within an hour of the patient reaching your department the media are camped outside the hospital, greedy for any news.

If you were faced with this situation what would you do? If journalists were to ask you for a comment on your way out of the hospital at the end of your shift, would you be tempted to say anything? Would you say anything about the case to your friends and family when you get home?

During your career as a doctor you may be involved in treating well-known people who become your patients for one reason or another. It goes without saying that such high profile patients deserve the same level of confidentiality as anyone else, but it can be more difficult to ensure that level of protection of their personal and medical information when the media are clamouring for a story.

Speaking to journalists

The GMC advises doctors that "You must not put information you have learned in confidence about a patient in the public domain without that patient's express consent."¹ Journalists know that doctors have a duty of confidentiality to their patients and, if you stand firmly by the line

that you cannot comment for this reason, then generally journalists will not continue to question you. If you realise that a particular case is likely to generate a lot of media interest, speak to your trust press office or seek advice from the MDU press office.

Enquiries about patients

Be aware of the possibility that people trying to get information about a patient might pose as legitimate enquirers such as a family member. An extreme example of this was the prank call made to the private hospital where the Duchess of Cambridge was hospitalised early in her pregnancy. The Australian DJs involved posed as the Queen and Prince Charles² and were given an update on the Duchess' condition.

If you are passed a call from someone who says they are a close relative of a patient, what steps can you take to assure yourself that the caller is the person they claim to be? Your trust may well have a policy about this which you should follow. Such a policy might suggest that you ask the caller some questions to reassure you that they are who they say they are. For example you could ask them to tell you the patient's full name (including middle names) address, date of birth and postcode. Similar enquiries can be made when professionals call asking for information, for example when taking a call from a GP you might check that they know the patient's NHS number.

A further safeguard would be to take the caller's number and ring them back. For instance if a GP surgery or police officer is asking you for information, you can check that the telephone number is valid by returning the call, before disclosing any details about your patient.

None of these systems are completely secure however, and if you are ever in doubt, or if you are being asked to disclose particularly sensitive information, you may prefer to do that via a more secure medium than over the telephone, such as in writing or email.

Once you have established the identity of any third party seeking information about your patient then you will need to take account of the patient's wishes. If possible, find out from your patient who information can be shared with and in what circumstances. The GMC reminds us that "early discussion of this nature can help to avoid disclosures that patients would object to. They can also help to avoid

misunderstandings with, or causing offence to, anyone the patient would want information to be shared with."³

If you are asked to disclose information without a patient's consent then you will need to consider this request carefully. Although there are situations where information may be provided in the public interest, these are rare and such disclosures need to be considered carefully, taking into account all the circumstances. Seek advice from a senior colleague, your Caldicott Guardian or the MDU.

Security of medical records

There is also the risk that third parties might try and obtain medical information without even asking first. We all know that medical records, whether in paper form or electronic, need to be kept securely. However, it has been said that the biggest threat to NHS security is its staff⁴.

The security of any medical records system relies on staff abiding by their duty of confidentiality and in the integrity of the

“If possible, find out from your patient who information can be shared with and in what circumstances.”

systems used to restrict access to information. Do not share your computer passwords or smartcards with anyone.

If you are logged in at a computer terminal and have to leave it for any reason then remember to log out. If you leave a patient's notes up on the screen they could be read by anyone. ►

- ✦ All patients deserve the same degree of confidentiality for their medical records.
- ✦ If the media enquire about a patient under your care, explain that you cannot comment because of your duty of confidentiality.
- ✦ Ask patients who they would be happy for you to share information with.
- ✦ Don't release information to third parties unless you have consent or you can justify doing so, for example in the public interest. You will need to assure yourself they are bona fide.
- ✦ Take steps to prevent unauthorised access to patient records.
- ✦ Beware of inadvertent confidentiality breaches, e.g. from discussing patients in a place where you can be overheard.
- ✦ Tempting though it may be, do not share confidential information about patients with your friends or family, either in person or via social networking.



Learning points

And anyone walking past could use the computer to look up the records of other patients, such as any well-known individual being treated at your hospital. Bear in mind that if anyone inappropriately looks up a patient's medical records on the computer while you are logged in, it is going to be traced back to you via the audit trail rather than the person who has obtained the information illicitly.

The GMC advises "You should not share passwords or leave patients' records, either on paper or on screen, unattended or where they can be seen by other patients, unauthorised healthcare staff, or the public."⁵

Speaking to your colleagues, friends and family

The GMC reminds us that "many improper disclosures are unintentional".⁶ If you need to discuss a case with your colleagues then make sure you do that in a place where you cannot be overheard. The patient's bedside, the nurses' station, in the corridor, lift or staff canteen may all be places where unauthorised healthcare staff or the public might be able to hear.

When you leave work you should not discuss confidential information with your friends or family. It might be tempting to share some juicy details with your close friends, but this itself is a breach of the patient's trust in you. Can you trust your friends not to pass that information on further, given that you have already been tempted to discuss it yourself despite your professional duty?

Also be wary of commenting on identifiable cases via social media such as internet chat forums. Once information is online it can be difficult to remove as others may distribute or comment on it. Even seemingly superficial details about patients could be identifiable. For example, researchers looking at 84 threads detailing clinical incidents posted on the doctors.net.uk anaesthetic forum could identify the hospital involved in 38 cases after a Google search on the poster's name. Five descriptions of cases included the hospital, date, age, sex and further identifying details of the patient.

With the rapid increase in doctors using social media, the GMC has now included advice about this in its guidance. Essentially

the same standards are expected of doctors when communicating through social media as when face to face with patients. *Good Medical Practice* (2013) advises "When communicating publicly, including speaking to or writing in the media, you must maintain patient confidentiality. You should remember when using social media that communications intended for friends or family may become more widely available."

References

- ¹ GMC, *Confidentiality* (2009) – supplementary guidance on Responding to criticism in the press, paragraph 3
- ² <http://bit.ly/wardround15>
- ³ GMC, *Confidentiality* (2009) paragraph 64.
- ⁴ *The Guardian* 4 May 2011 The biggest threat to NHS security: its staff
- ⁵ GMC, *Confidentiality*, paragraph 13
- ⁶ GMC, *Confidentiality*, paragraph 13
- ⁷ *Anaesthesia Special Issue: Abstracts of the AAGBI Annual Congress*, 19-21 September 2012, Bournemouth, UK Volume 67, Issue Supplement s2, pages 9–23, October 2012
- ⁸ GMC, *Good Medical Practice* (2013) paragraph 69

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Who wants to know?

Picture the scene. In the middle of a busy ward round, you are asked to speak to a social worker who has contacted the ward by telephone. The social worker tells you that concerns have been raised by a relative of Mrs Smith, an elderly patient admitted from home with dehydration and widespread bruising. You are asked to disclose information about the patient's medical history.

On your way back to the ward, you are stopped by the daughter of another patient, Mr Jones, who wishes to discuss her father's recent diagnosis of disseminated colonic carcinoma.

Relatives will often ask you for information about a patient, but what if the request comes from the police, social services or another third party? Dr James Lucas, medico-legal adviser, explains when it may or may not be justifiable to disclose confidential information.

Confidentiality is central to the bond of trust between doctor and patient. Respecting patients' rights to confidentiality is one of the duties of a doctor registered with the General Medical Council.

All information about a patient should be considered confidential, including their personal details, records of admission to hospital or attendances at clinics, and the very fact that a person is or was your patient.

Consent is the foundation stone of disclosure, although there may be certain circumstances in which it is appropriate to disclose confidential information in the absence of consent (or even against the patient's wishes).

The GMC makes clear in *Confidentiality* (2009) that asking a patient for their consent to disclose confidential information demonstrates respect and is part of effective communication with a patient.

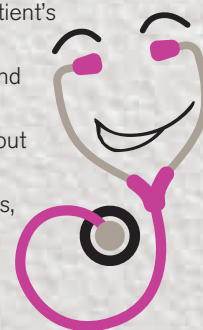
Disclosures to family members

You should not assume that a patient will agree to disclosure simply because they have a close personal relationship with the person seeking information. The patient's express consent should be obtained. Difficulties may arise when a patient lacks capacity to consent to disclosure, for example, when a patient is admitted in an unconscious state, or suffers from cognitive impairment secondary to a neuro-degenerative illness. Paragraphs 59 and 60 of *Confidentiality* (2009) contain guidance relevant to this scenario (see box on right), emphasising that you must respect the patient's dignity and privacy.

In order to assess a patient's best interests, it may be necessary to share confidential information with someone close to them but that does not equate to a general right of access to the patient's clinical records. And in these circumstances, you should only share relevant information. ▶

Considerations in cases where the patient lacks capacity to consent:

- ★ Is the patient's lack of capacity permanent or temporary? If temporary, can the decision to disclose reasonably wait until they have recovered capacity?
- ★ Has the patient previously expressed any preferences?
- ★ Has the patient asked you to consult anyone or is there someone with legal authority to make decisions on their behalf?
- ★ Have you considered the views of people who are close to the patient? For example, do they consider the proposed disclosure to be in the patient's best interests?
- ★ What do you and the healthcare team know about the patient's wishes, feelings, beliefs and values?



Examples of disclosures that are required by law

1. Following an order made by a judge or presiding officer of a court.
2. In certain cases of communicable disease, when you must inform the proper officer of your local authority.
3. Preventing the commission of an act of terrorism.
4. To comply with a statutory request made by a regulatory body such as the GMC.

Disclosures to social workers, police and others

From time to time you may have to share confidential information with an agency providing social care. It is important that the patient is aware of this and consents. You should only disclose the minimum information necessary and take care not to breach another person's confidentiality.

If you believe that a patient is being neglected, or physically, sexually or emotionally abused, and the patient lacks the capacity to consent to disclosure, you must inform an appropriate responsible person or statutory agency.

“... there are circumstances in which you are legally obliged to provide confidential information...”

Confidentiality (2009) makes clear that you must not disclose personal information to a third party, such as solicitor or police officer, without the patient's express consent, unless it is required by law or can be justified in the public interest.¹



However, there are circumstances in which you are legally obliged to provide confidential information to the authorities. Patient consent is not necessary in these circumstances, but it is good practice to notify the patient, where practicable, unless to do so would undermine the purpose of the disclosure.

Gunshot wounds and wounds caused by a blade or sharp instrument are considered to represent a special category of injury, and doctors working in emergency settings are advised to be familiar with the GMC's supplementary guidance on disclosure in these circumstances.²

“The decision to disclose confidential information in the public interest can sometimes be finely balanced.”

There may also be cases where the public interest overrides doctor/patient confidentiality, for example if failure to make the disclosure could expose others to a risk of serious harm or death. But doctors should remember that there is also a public interest in the provision of a confidential medical service. You must balance the potential harm to the patient's interests and the overall trust between the profession and the public, against the benefits to be gained from releasing the information. You should still ordinarily seek your patient's consent unless to do so would be impracticable, would put you or others at risk of harm, or would prejudice the purpose of the disclosure.

The decision to disclose confidential information in the public interest can sometimes be finely balanced. A detailed note should be made in the patient's clinical

record and doctors should always be prepared to justify their decisions. We encourage doctors in training grades to discuss these cases with a senior colleague, preferably the consultant in charge of the patient's care, if they are available. Occasionally, it may be necessary to seek input from your trust's Caldicott Guardian or legal department. If you do have concerns, don't hesitate to seek guidance from one of our medico-legal advisers via the MDU's 24-hour advisory helpline.

Outcome

At the conclusion of the ward round, you discuss the social worker's request for information about Mrs Smith with your consultant and the rest of the clinical team. You establish from a GP referral letter that Mrs Smith is on warfarin. The district nurses have had difficulty obtaining blood from her due to the condition of her peripheral veins, and this had led to the development of bruising on her upper limbs. Mrs Smith is drowsy and unable to participate in any meaningful discussion, however, your consultant expects her to recover with fluid replacement within 24 hours. The team agrees that the decision to disclose information to social services could reasonably wait for Mrs Smith to regain capacity. The social worker is informed of the decision.

You then speak with Mr Jones, who is very keen for information to be shared with his daughter. However, he would like to participate in the discussion and you arrange for a private room, out of earshot of the ward, to be made available for a meeting.



References

¹ GMC, *Confidentiality* (2009)

² GMC, *Confidentiality: supplementary guidance* (2009)

Serious assault

POLICE LINE DO NOT CROSS

The scene

An ST1 doctor was treating a female patient who had been admitted to ITU with a serious head injury. The police arrived on ITU and claimed that the patient, a gang member, had been involved in a violent incident and had seriously assaulted another female.

The police asked for the patient's name and address as well as information about her current condition. When the ST1 hesitated, they told her that she had a statutory duty to disclose these details under s29(3) of the Data Protection Act, which allows information to be disclosed for the 'prevention or detection of a crime'. Due to her injuries, the patient was unable to consent to disclosure. The doctor still felt uncomfortable about providing this information and called the MDU for advice.

MDU advice

The doctor asked the MDU adviser whether she was required, or even allowed, to disclose this information to the police. The adviser referred her to the GMC guidance on confidentiality¹ and explained that confidentiality is central to the trust between doctors and patients and should normally be respected. The adviser emphasised that the doctor's first priority was to discuss the request for disclosure with the treating consultant with overall responsibility for the patient. The adviser

also suggested that the trust Caldicott Guardian should be made aware of this situation and be involved in the decision-making process.

In general, the adviser explained, no personal information should be disclosed to a third party such as a solicitor, police officer or officer of a court without the

"... confidentiality is central to the trust between doctors and patients..."

patient's express consent, unless it is required by law or can be justified in the public interest².

The adviser stated that there were other issues to consider in this case.

- Currently the patient could not consent to disclosure as she lacked capacity; this may be temporary so the doctor could advise the police that consent would be sought once the patient had regained consciousness and capacity³ if possible.
- If this was not possible and the police wanted to investigate a serious crime, then disclosure may be justified in the public interest to protect others^{4,5}.
- If seeking consent puts the doctor or anyone else at risk of harm, disclosure

without consent might be possible but the doctor would have to be prepared to justify her decision⁶.

- The member was advised that although s29(3) allows you to disclose information in certain circumstances without fear of prosecution under the Data Protection Act, it does not displace the professional and ethical obligations imposed upon you as a doctor by the GMC, i.e. it is permissive rather than mandatory.

The member was advised of the importance of documenting in the notes all discussions and decisions regarding this disclosure and to inform the patient of their decision, if it was safe to do so.

The doctor later contacted the MDU again and said that the consultant had decided to disclose the information to the police in the public interest. They had documented that, although the patient was currently not a risk to others, she could be when discharged and they could not rule out that she might abscond.

References

- ¹ GMC, *Confidentiality* (2009) paragraph 6
- ² GMC, *Confidentiality* (2009) paragraph 22
- ³ GMC, *Confidentiality* (2009) paragraph 60
- ⁴ GMC, *Confidentiality* (2009) paragraph 36-37
- ⁵ GMC, *Confidentiality* (2009) paragraph 53
- ⁶ GMC, *Confidentiality* (2009) paragraph 39

Develop your ethical shadow

Dr Louise Dale, MDU medico-legal adviser, asserts that medical ethics drive every professional decision a doctor makes and advises doctors in training to start to develop their ethical shadow.

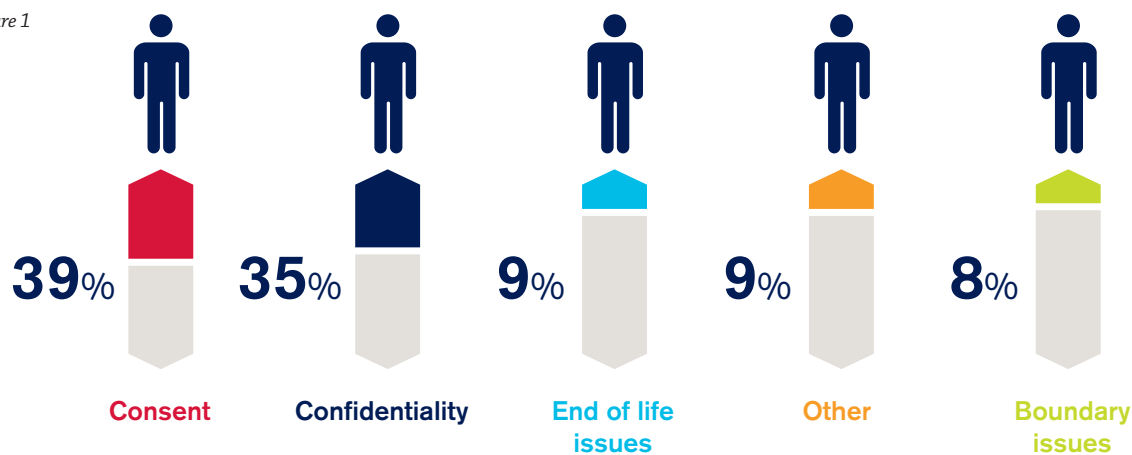
Have you ever felt that uncomfortable uncertainty that sneaks up when you have to make a decision with obvious ethical conflict? Some common examples that doctors of all grades and specialties may identify with are:

- deciding how to resolve a patient's lack of capacity to consent to life-saving treatment
- whether to disclose confidential patient data to third parties, such as insurers or the DVLA
- the validity of an apparent advance decision.

In the late 1990s, I wrote a dissertation for an MA in Medical Ethics and Law outlining my belief in an ethical dimension, or ethical shadow, that co-exists in every medical decision. This belief remains as firm as ever.

The 'ethical shadow' influences a doctor's reasoning, whether consciously or subconsciously - for example, when deciding if, when and how to treat a patient.

Figure 1



“The ‘ethical shadow’ influences a doctor’s reasoning, whether consciously or subconsciously”

In the last 10 years, the MDU has opened over 8,700 advice files which involved some aspect of ethics or ethical decision-making, mainly regarding consent, confidentiality, end of life care and boundary issues. See figure 1 above.

I believe it is vital to good medical practice that all doctors develop a specific sensitivity to the ethical dimensions of every situation they encounter. This should start as a student in medical school, and continue to be honed throughout a medical career. Fortunately, teaching of medical ethics - once considered trivial, redundant or impossible (Hope, 1998)¹ - has come a long way and is now an integral part of medical training.

Ethical strategies

What strategies are available to help doctors reconcile the ethical component of their decision making?

Medical ethicists have traditionally based their teaching on two moral philosophical theories: consequentialism and deontology.

Consequentialism is self-explanatory: it is a way of making your decision, or guiding your action, by deciding on the outcome with the best consequences, for one person, or for a group. Deontological reasoning has no concern for consequences, just for duty. For example, choosing to tell a patient the full extent of their terminal condition, on the basis that it is always right to be honest. Deontological decision-making models are often based on the four principles of professional ethical duty - autonomy, beneficence (doing good), non-maleficence

(not doing harm) and justice.

Other ethical theories are very different from the impartial, apparently universal doctrines of deontology and consequentialism. They include virtue ethics, where a doctor makes a decision because that is what the virtuous, conscientious or person of integrity might do. Sometimes, you may also act in ways that favour the particular specifics of a discrete section of the community (communitarian ethics). You may sometimes act through communication with all relevant parties taking into account the particular details of individuals and their relationships with the people around them, encompassing some of the reasoning of feminist ethics. You will appreciate that these theories are situation-specific. Some contemporary medical ethicists would argue that they are more appropriate for medical decision-making.

In practice, you will be juggling many philosophical models to reach a decision about a patient's care, and often without realising it. Whenever there is choice, a decision must be made. So often in medicine the ethics involved in each of the options collide, and there is no absolute right answer. When you document and justify your reasoning in the records, you will be consciously or unconsciously giving voice to an ethical theory of some sort.

My work with MDU members has shown me how difficult we, as doctors, find some of the ethical dimensions of our decision-making. But personal reflection and learning help build confidence in making difficult decisions, especially those which appear only in shades of grey.

For me, medical ethics forms the very frontier of our profession's development. Whichever approach you choose, strong awareness of your ethical 'shadow' and sensitivity to the ethical aspects of your decision can only enrich your personal career development, as well as promoting good practice to the benefit of patients.

Further reading

- GMC guidance: *Good Medical Practice* (2013)²
- *Confidentiality* (2009)
- *Consent: patients and doctors making decisions together* (2008)
- *0-18 years: guidance for all doctors* (2007)
- *Treatment and Care towards the End of life: good practice in decision making* (2010), (which has excellent, simple models for making the many decisions often needed, both when patients have capacity and when they do not.)
- *Philosophical Medical Ethics* (1985) by Professor Ranaan Gillon of Kings College, London (a compact introduction and my personal favourite)
- *Medical Ethics and Law, the core curriculum* (2008) by Hope, Savulescu and Hendrick
- *The worried student's guide to medical ethics and law* (2011) by Bowman.
- Standard texts by Beauchamp and Childress, Mason and McCall Smith, Brazier and Cave, and Herring.
- *The BMA's Medical ethics today*, (is an up-to-date reference manual on the subject.)

Training courses

The MDU offers training courses on Medical Ethics and Law. Details can be found at themdu.com/learn

For personal medico-legal advice on your individual needs, please call the MDU advisory helpline on 0800 716 646.

References

- ¹ Hope T (1998) Ethics and law for medical students: the core curriculum, *Journal of Medical Ethics*, 24, pp147-148
- ² www.gmc-uk.org

Keeping it confidential

Would you know what to say if you were asked to disclose details of patient care by the police? What if a journalist asks for your side of the story following a complaint? Try this quiz to find out how well you understand your duty to protect patient confidentiality.

Q A 15-year-old amateur footballer has injured his ankle during a Sunday football match and is brought into the emergency department by his father. His father steps out to take a call on his mobile phone. You continue to assess the boy, who you believe is Gillick competent. When you ask if he is taking any other medication, he confides he is taking human growth hormone to help build up his muscle. He asks you not to tell his father. What do you do?

A Ignore the patient's wishes as he is not yet 18 and clearly irresponsible. You have a quiet word with his father who is in the waiting area.

B Explain to the patient the risks he is running and encourage him to talk to his parents. You also give him the number of a drugs support group for further advice.

Q You and the other doctors from your year at medical school have set up a Facebook group. You use it to:

A Tell them about the amusing patients you see while on your placements. After all this is a closed group so no one else can read what you write.

B Arrange nights out with your friends and keep in touch.

Q A journalist calls you at the GP surgery where you are on a rotation. A patient has alleged that you failed to diagnose her broken wrist, leaving her in pain for three days. The journalist wants your side of the story. Do you:

A Tell him that a scaphoid fracture is always difficult to diagnose, particularly when the patient fidgets and won't allow you to examine them properly.

B Explain you cannot comment because of your duty of patient confidentiality and call the MDU straight away.

Q During a ward round you see a patient with painful keloid scarring following breast reconstruction surgery. You have a particular interest in dermatology and with her consent you take a picture on your smartphone. A colleague who is also interested in the specialty later asks you to forward the image. What do you do?

A Send the image to your colleague with a few relevant details about the patient's age and treatment.

B Explain that you cannot do this without the patient's informed consent.

Q As you are passing through reception you overhear a receptionist joking with a colleague about an obese patient who has broken a chair in the consulting room within earshot of other patients. Do you:

- A** Join in with a joke of your own about fat patients. After all, a sense of humour is important in medicine.
- B** Tell your supervisor what you have seen. He later arranges for all reception staff to attend refresher training on patient confidentiality.

Q You are an ST1 in obstetrics and gynaecology. One evening you are in the supermarket when you see a patient who was discharged a couple of weeks ago following a caesarean section. Do you:

- A** Introduce yourself to the patient, congratulate her and wish her a speedy recovery. You later remember she was desperately disappointed that the baby was a boy.
- B** Leave her alone. You don't want to risk embarrassing her and breaching her confidentiality by discussing her treatment in public.

Q You have treated a patient who sustained minor facial injuries. Shortly after he is discharged, you are approached by a policewoman wanting to know his name and address as he is suspected of leaving the scene of a robbery. What do you do?

- A** Pass on the patient's details straight away. You thought there was something untrustworthy about him.
- B** You don't believe you would be justified in disclosing this information in the public interest in these circumstances and explain that you need the patient's consent to pass on his details.

Q There never seems to be enough time to complete an audit for your portfolio and you consider working on the project while you are away for a weekend. Do you:

- A** Save all the data on a memory stick so you can work on the project from the comfort of your own laptop.
- B** First seek advice from your trust's data controller about your trust's procedures for encrypting and transferring information.

Mostly **A**s

You may be too easily tempted to reveal confidential information about a patient and the care they are receiving when this cannot be justified. Even if you are acting with the best of intentions, disclosing such details without the patient's consent can easily result in a complaint and get you into difficulties with your employer, deanery and with the GMC. We recommend you check out the MDU's medical ethics and law online learning module at themdu.com/learn

which should enhance your understanding of confidentiality and how this important principle relates to your daily practice.



Mostly **B**s

Congratulations. You clearly understand your central role in safeguarding patient confidentiality and are unlikely to undermine the trust placed in you by your patients.





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Appropriate consent

A doctor who had recently discharged a patient following a brief admission was contacted by the patient's insurance company for information about his illness and treatment. The doctor, an ST1 based on a general medical ward, contacted the MDU advisory helpline because she wasn't sure how to proceed.

MDU advice

The medico-legal adviser suggested that the doctor's first step would usually be to check whether the insurance company had provided written consent from the patient to disclose this information to them. In most cases, reports to insurance companies should not be disclosed without explicit consent from the patient.

“The doctor could then provide a factual account of the patient's diagnosis...”

The GMC's confidentiality guidance¹ makes clear that doctors should ensure that the patient's consent has been obtained, that the patient understood what information would be disclosed and the consequences of this disclosure.

The doctor revealed that the insurance company had not provided written consent and so the medico-legal adviser suggested that she contact them to explain that she could only send them the information that they wanted once the company provided the appropriate consent from the patient.

With appropriate patient consent, the doctor could provide an insurance report. The medico-legal adviser suggested this should be typed on headed paper, clearly

identifying the doctor's name, qualifications and position within the trust, as well as the purpose of the report and the name of the person who requested it. The doctor could then provide a factual account of the patient's diagnosis and the treatment given during the patient's recent admission. However, the GMC guidance states that she only needed to disclose relevant information². For example, details of previous admissions for unrelated medical conditions did not need to be included in the doctor's report.

Finally, the medico-legal adviser suggested that the ST1 doctor offer to show his report to the patient before it was disclosed to the insurance company, in line with GMC guidance³.

i References

¹ GMC, *Confidentiality* (2009), paragraph 34 (a)

² GMC, *Confidentiality* (2009), paragraph 34 (c)

³ GMC, *Confidentiality* (2009), paragraph 34 (d)

User ID

Password

Login

Laptop theft

An ST1 in anaesthetics emailed the MDU after her laptop was stolen during a break-in at her flat. Her training log, with details of all the cases from the start of her training, was stored on the machine.

She immediately reported the theft to the police, but was very anxious as a friend in another trust had recently received a written warning for breaching the trust's data protection policy.

The doctor wanted advice on whether she had a duty to report this loss to the trust or to any other body and whether she might face disciplinary action.

MDU advice

The adviser asked the doctor to clarify exactly what information she held on the laptop and what security had been in place. The doctor confirmed that any patient cases she had stored were identified only by hospital number and date of birth, and that her laptop was password protected.

The adviser recommended that the doctor check her trust's data protection policy to make sure that she had complied fully with that and inform them what had happened. This should also help pre-empt any difficulties should the media learn of the

incident and publish anything which referred to the trust. As there was no patient identifiable data, there should be no need to report this loss to the Information Commissioner.

After this discussion, the doctor recalled that in her friend's case it was the fact that the lost laptop contained identifiable data which had led to the disciplinary action.

The doctor checked the trust policy and she had complied with this. The trust

thanked her for reporting the loss and confirmed it needed to take no further action. Had this data not been anonymised the anaesthetist might have faced a disciplinary investigation by her trust, and the trust may have faced a heavy fine from the Information Commissioner.

Fortunately, the doctor in this case had an up-to-date back-up copy so she had not lost any information which might have caused difficulties with her training.

- Check that you comply with your trust's data protection policy.
- Keep an up-to-date back-up copy of all important information.
- Password protect your laptop.
- Unless you are registered as a data controller under the Data Protection Act 1998 (for example if you set up in private practice) you should not store identifiable patient information on your own systems.



Learning points



New-look MDU website

We now have a new website so please visit themdu.com to see the transformation. You can also customise your experience to ensure the advice and support you need is at your fingertips. We are already working on further improvements and we would love to hear your thoughts so please email us at feedback@themdu.com

MDU helps make tax less taxing

The MDU has developed an e-learning tutorial to help you with questions about tax. Produced in collaboration with HM Revenue & Customs (HMRC), the programme includes modules on tax allowances, business expenses and National Insurance. As part of the module,

there is a section specifically for those starting out in practice and any potential tax issues they may face.

You can work through the tutorial in your own time and return to it as often as you like. And if you want more information on any particular areas, there are links to other HMRC tips and tools to help. To access the tutorial, visit themdu.com/learn

Good Medical Practice revised

A revised and updated version of the GMC's *Good Medical Practice* (2013) came into effect in April. The GMC also published ten shorter explanatory documents, most of which are updated versions of former supplementary guidance documents. These are available on its website at www.gmc-uk.org

Doctors will need to demonstrate that they work in line with the principles and values in the guidance through the revalidation process. An article on our website¹ highlights the key changes and includes a brief guide to the new explanatory guidance which includes doctors' use of social media and doctors' duty to report sexualised behaviour by colleagues.

The GMC has also updated its prescribing guidance. Among other changes, *Good practice in prescribing and managing medicines and devices* takes a firmer line on self-prescribing, stating that doctors must avoid prescribing for themselves or anyone with whom they have a close personal relationship.

Candour now a contractual matter

Since 1 April, a 'duty of candour' features in all new contracts for the provision of NHS healthcare. It means hospitals must provide patients and their families with information and support if a 'reportable patient safety incident occurs or is suspected to have occurred'.

In practice, this should not mean a significant change as doctors have long had an ethical duty to be open and honest with patients. However, if something goes wrong you will also need to be aware of your own organisation's duty of candour guidance and follow its procedures.

New child protection guidance



In 2011-12 over 600,000 children in England were referred to local children's social care services by people with concerns about their welfare, including doctors. That is according to the new edition of *Working Together to Safeguard Children* which was published by the government in March. The updated national guidance includes a section on the key role of the health service and individual doctors in protecting children and how they should work with other organisations.



References

¹ <http://bit.ly/wardround21>

Quality Improvement - one step at a time

Initiating and participating in quality improvement (QI) projects often allow you to achieve incremental and measurable changes which make a real difference to patients' experience in hospital. It's also a great way to enhance your eportfolio if you have one.

Dr Emma Vaux offers a few tips to get you started.

1. Think differently

Ideas for change can come from a process or policy that you have come across that may affect patient safety or experience or appears to be no longer fit for purpose. Choose something you and others genuinely care about. Keep it simple; you are testing small scale change not trying to do ten things at the same time. You may decide to do a QI project against a known standard e.g. a clinical audit; but this will be a real-time, dynamic audit with the real possibility of making a difference in a short space of time rather than the traditional approach we have become used to.

2. Use a simple, systematic approach to plan your QI approach

The Model for Improvement¹ (MFI) helps you define:

- what you want to accomplish;
- what change(s) you are planning to make;
- and what you are going to measure to know that any change has led to an improvement.

You may then test changes on a small scale using Plan-Do-Study-Act (PDSA) cycles. Use the resources already available to help guide you in your planning².

3. Be clear and focused

Have a clear vision and objectives so everyone understands what you are doing and why. Using SMART goals (which are specific, measurable, achievable, relevant, time-bound) should help you achieve this.

4. Identify who you will ask to help you

You need supportive senior engagement, usually your supervisor (generally a consultant). It is a good idea to undertake the project as a group, particularly involving the wider multidisciplinary team.

5. Think about how you might involve others

Articulate your vision and try to find the hook that makes them want to get involved as well. For example, what new skills they may acquire and the rewards for participating, such as team recognition, CV boosting and leadership.

6. Organise your time

It is important to complete the project in a specified timeframe (usually over a 12-16 week training post) and maintain momentum. A project template should help chart your progress and keep you on track with regular check-ins with your supervisor². A team approach also helps with the data collection.

7. Make a change and evaluate it to see if it worked

Use a straightforward measuring process so there is no doubting the improvements made. It's important to know the baseline activity before you start so you have a number of points of comparison and keep measuring little and often. Two data points are not enough. Record your results on a run chart so you can see the changes taking place over time.

8. Document your project to show what you have learned

Using the PDSA cycle as the framework for your project, be clear about what was learnt, what worked and what didn't.

9. Sustainability

Think right at the start about how this project will continue when you have moved on. It is important to be clear how your QI project fits with organisational aims and the benefits for staff as well as patients. Identify a successor to take the project forward, working with continued senior support and ensure an established process for continued measurement is in place.

10. Now take that first step and get started

All you need is a SMART aim, PDSA cycles of small scale changes and measure, measure, measure.

Dr Emma Vaux

Clinical Lead, Learning to Make a Difference, Royal College of Physicians & Joint Royal Colleges of Physicians Training Board

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★ Now take that first step and get started

References

¹ <http://www.ichi.org/knowledge/Pages/HowtoImprove/default.aspx> Accessed March 2013

² Learning to Make a Difference: <http://bit.ly/wardround19>

Revalidation

what to expect

Every doctor now has to revalidate in order to continue practising clinical medicine. What does this mean for foundation and ST1 trainees? Caroline Smith from NW Thames Foundation School explains the essentials.

Revalidation is the General Medical Council's (GMC) new system of regulating licensed doctors which was rolled out across the UK at the end of 2012. Licensed doctors, including those in foundation year two and specialty training will have to revalidate, usually every five years and again, after receiving a Certificate of Completion of Training (CCT).

Local Education and Training Boards (LETBs) are committed to helping postgraduate doctors to revalidate by providing as much information and support as possible and they will provide you with regular updates, advice and details of resources available.

What is the purpose of revalidation?

Revalidation is designed to give patients greater confidence in their doctors and support clinicians to maintain and improve their practice.

What do I need to do for this process?

If you are meeting the requirements of your curriculum and have regular meetings with your educational supervisor, there's an excellent chance that you will produce much or all of the evidence you need to revalidate as a matter of course during your training.

Specialty trainees (as well as foundation year two doctors) will need to complete an

enhanced Form R each year which includes a declaration of health and probity. You will also be asked whether you have been involved in any ongoing complaints or serious incidents which have been investigated or significant events over the last year. The GMC defines a significant event (also known as an untoward or critical incident) as any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or events that should have been prevented and are significant enough to be investigated by your employing organisation. Remember that only incomplete and ongoing investigations should be recorded on Form R. If an incident has been fully investigated and the outcome and reflective practice logged fully in your e-portfolio, then there is no need to log this on the Form R as well.

What role does my employer have in my revalidation?

Your trust or employer will send an Exit Report to your LETB to inform the revalidation process through your ARCP (Annual Review of Competence Progression). It will include any unresolved concerns about a trainee's conduct, involvement in serious untoward incidents or complaints. If you have been involved in any such incidents, it's important to discuss it with your educational supervisor and

reflect on the outcome in your e-portfolio as part of the normal educational appraisal process.

If you have engaged with the revalidation process through your annual appraisals and have also provided satisfactory Form Rs over the five year period, it is likely that the Responsible Officer for your LETB will make a positive recommendation to the GMC when the time comes for you to revalidate. You will receive formal notification of your revalidation decision from the GMC.

Time out of training and revalidation.

If you take a break from the training programme with the approval of your LETB (meaning that you do not give up your training number), then your revalidation date and prescribed connection will remain the same, and you do not need to do anything else.

Further information.

GMC's FAQs for doctors in training. <http://bit.ly/wardround20>

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