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Professional support and expert advice for GPs and practice staff

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Are you social media savvy?

How to maintain professionalism online

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THIS ISSUE...

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Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

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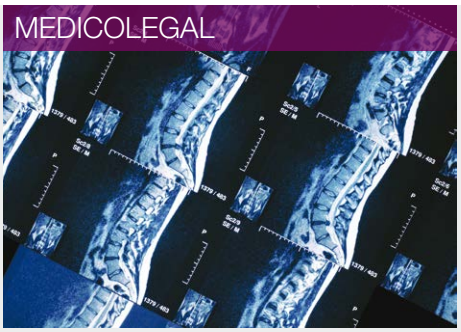

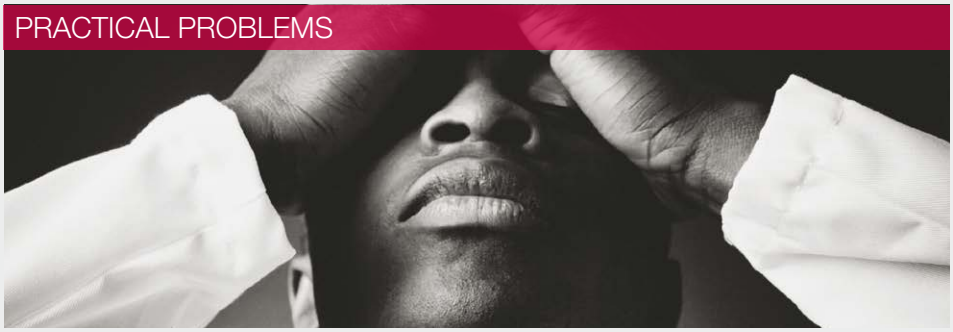

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We welcome contributions to ***Practice Matters***, so if you want to get involved, please contact us on **+44 113 241 0683** or email: **sarah.whitehouse@mps.org.uk**.

Welcome

Dr Graham Howarth
Editor-in-chief, MPS Head of Medical Services (Africa)

Welcome to the second edition of *Practice Matters*, a magazine for the whole general practice team.

We know that the whole team matters when it comes to improving patient safety. High-quality urgent care begins with the first impression, and the key player here is often the receptionist on the front desk. GP Dr Carmen Gerber looks at how your practice can run a safe and effective non-clinical triage system on page 14.

When dealing with increasing patient demands, administrative matters can often add to the pressure for general practitioners. In a busy working week, it can be tempting to push letters to one side to deal with at a later date. However, if you receive a subpoena, you have a legal and professional obligation to respond immediately. Katherine Greig, MPS Panel Lawyer and Director at MacRobert Attorneys, offers some practical advice on what to do to ensure you stay on the right side of the law on page 6.

This issue, we take a closer look at the potential pitfalls of using social media, blogs, and Skype to share information with colleagues and patients, which are often blurred by the many advantages of staying connected. Find out more on page 10.

Finally, Dr Mohamed Bhikhoo, from the MPS Education Faculty, explains how to get the best clinical outcome from even the most challenging of consultations on page 12. It makes for interesting reading – our own behaviour can often make a situation challenging from the outset.

Remember, once you have read this issue, you can gain your CPD points by completing our questionnaire on page 15.

We hope you enjoy this edition and would be interested to hear your comments, as well as any topics you would like us to feature in the future.

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From the case files...

Each issue the team that bring you *Casebook* share interesting general practice cases

When treating patients who attend frequently, especially within a short space of time, it can be all too easy to be blinded by a familiar diagnosis based on pattern recognition. This is particularly true if it is a commonplace, and seemingly innocuous, condition.

The safest approach when treating frequent attenders is to go back to basics: document a thorough history and be prepared to re-examine the patient if their symptoms change.

Back with back pain

Mrs S was a 35-year-old shopkeeper with an established history of recurrent UTIs, which had responded well to antibiotics. An ultrasound in the past had confirmed kidney stones.

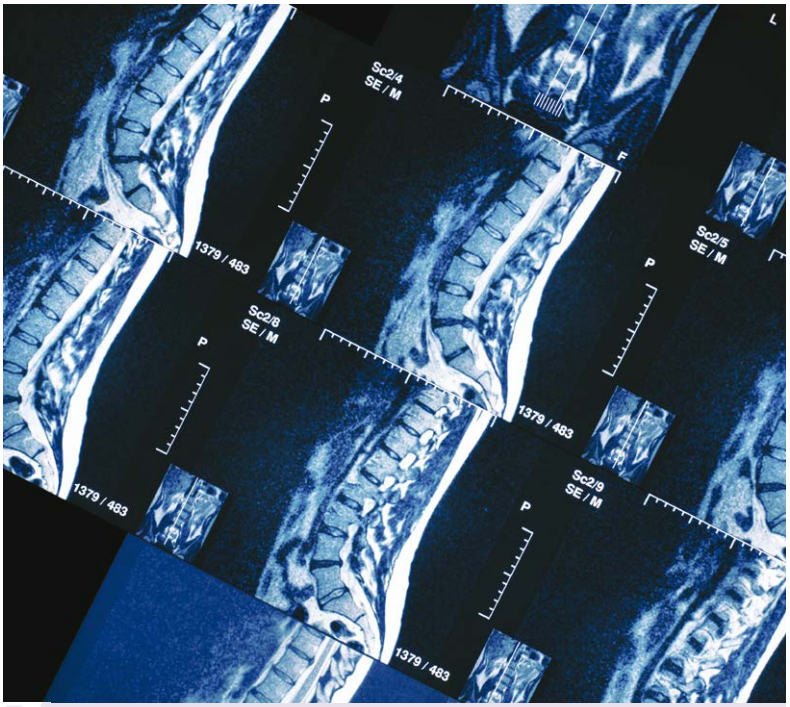
She presented to her GP, Dr F, complaining of back pain for the past six weeks and tingling in her right leg, which was relieved by lying down. Dr F took a full history and examined her back, including a neurological examination. Dr F diagnosed Mrs S as having sciatica, exacerbated by lifting heavy boxes in the shop. Dr F prescribed regular analgesia and advised her about careful lifting and gentle exercises. However, the pain continued to worsen.

Dr F saw her again four weeks later and this time was concerned as Mrs S was having difficulty walking. She was referred for physiotherapy. Whilst waiting for the physiotherapy appointment Dr F saw Mrs S again, this time with symptoms of a urinary tract infection including frequency and urge incontinence. Again a urine sample was sent to the lab and confirmed a urinary tract infection, which was treated successfully with antibiotics.

Mrs S's back pain and right leg sciatica continued to deteriorate to the extent that she could not sit and she returned to the surgery again. Dr F was concerned about the repeated urine infections in association with back pain and the recent onset of incontinence, and informed Mrs S that she felt an ultrasound scan of her urinary tract system would be prudent. A urology referral was made and a CT scan confirmed a renal stone and a retroperitoneal mass.

Mrs S had further investigations for the mass and was eventually diagnosed with non-Hodgkins lymphoma. Mrs S was very upset when she was diagnosed, as she felt the back pain had always been due to the mass, and she made a claim against Dr F for failing to refer her earlier. Experts who looked into the case agreed that the management had been appropriate and Dr F had acted like any other reasonable GP would have at the time.

The experts also found that although some of the examinations weren't examples of best practice, they were not unacceptable. At no time was an urgent or emergency referral warranted. The case was discontinued once the patient became aware of MPS's supportive expert evidence.



Learning points

- Back pain is one of the commonest complaints seen in general practice. Doctors may easily disregard back pain but it is important to keep in mind that a small proportion of them mean serious or life-threatening pathologies.
- Taking a good history and examining the patient regularly when they attend without a firm diagnosis with back pain is important, even if they come with a recurrent complaint. Re-examine if there is any change in symptoms. Good documentation of history and examination is safe practice. This helps other clinicians to understand the history of a complaint better. It can be the basis of a good defence if a case ever becomes a claim.
- When patients attend with different symptoms and illnesses at the same consultation, differential diagnosis can be more complex and therefore greater awareness is necessary.
- Keep up-to-date with guidelines on best practice for back pain. Remember these alternative differential diagnoses when assessing a person with back pain.
- Failure to diagnose is not inevitably negligent. There was a careful, well-documented assessment of the patient on every occasion.

This case originally appeared in Casebook *(Vol. 21 No.1 January 2013).*

You've received a subpoena…

Katherine Greig, MPS Panel Lawyer and Director at MacRobert Attorneys, offers some practical advice on what to do if you receive a subpoena

Medical practitioners are occasionally called upon to provide factual evidence in court relating to their involvement in the treatment and management of one of their patients. Generally speaking, this is sought by means of a subpoena issued by the court concerned and served on the witness by the Sheriff of the Court.

A subpoena can be issued out of the following:

- An Inquest Court (for example, where a practitioner treated a patient who subsequently died and is called upon to give factual evidence to assist the court in making a finding regarding the cause of death)
- The Criminal Court (for example, in a case of rape or assault where a practitioner may have been involved in treating the victim)
- The Civil Court (for example, where a practitioner may have treated a patient after a motor vehicle accident and the injury is the basis of a subsequent claim for damages)
- Professional conduct hearings before the HPCSA, CCMA hearings, Children's Court matters, and Family Court matters.

Consider the following scenario. Dr A, a specialist neurosurgeon, takes service of a subpoena issued out of the High Court requiring him to present on a particular date to give evidence for the plaintiff in a civil trial. The plaintiff is Mrs B, who sought treatment from Dr A for her painful back following failed back surgery performed previously by Dr C. She has instituted a civil action for damages against Dr C, and needs Dr A to testify as to what he observed when he assessed and treated her to establish proof of what damages she suffered.

In this case, Dr A is being called to give a

What next?

factual account of his involvement in the patient's treatment and management, as well as in regard to his personal observations of the patient's condition. He is not an expert witness and will therefore not be paid "expert fees" by the party calling him. He will only be required to speak to the facts of his involvement, and not to provide his opinions regarding the treatment and management of the patient by Dr C.

The first step: contact MPS

When a witness receives a valid, issued and served subpoena, they are obliged to comply with its provisions. If they fail to do so, they can run the risk of being held in contempt of court, with an accompanying fine or even a warrant being issued for their arrest.

If you receive a subpoena, contact MPS as soon as possible, as they may be able to provide assistance assessing whether the subpoena is valid, has been correctly issued and served in good time, and then enter into communications with the lawyer for the party who issued the summons. In some situations, this can lead to negotiations to ensure that the practitioner is inconvenienced as little as possible. For instance, it might be arranged that the practitioner is only required to ensure they are available for specific days rather than the whole trial.

Consent

The practitioner may not provide information relating to the treatment and management of their patient to anyone or any party without the patient's express consent. Similarly, in court, a practitioner may not give evidence regarding the treatment and management details of their patient without express consent – unless they are ordered to do so. This means that when consent is withheld, the practitioner must advise the presiding officer in court of their obligation of confidentiality and of the lack of patient consent, whereupon the presiding officer may order them to proceed to give the evidence.

Consulting with parties

If a patient subpoenas a practitioner to give evidence as a factual witness, the practitioner is allowed – but not obliged – to consult with him/her in preparation for the trial. Practitioners should therefore be wary of being misled into thinking that they must consult with the party subpoenaing him before and/or during the trial.

If the practitioner refuses to liaise with the party who subpoenaed them, it may discourage the party from actually calling the practitioner to give evidence in court as they are unlikely to risk unfavourable evidence being elicited.

Medical records

A practitioner may receive a subpoena "duces tecum", which means that they are not only required to present themselves at court to give evidence, but also bring certain specifically identified documents when they testify. Usually this refers to original clinical records. If the practitioner does not have the patient's consent to disclose the records, then they should only do so under protest when ordered to by the presiding officer.

In some civil proceedings before the High Court, a subpoena may also specify that the witness hand the requested documents to the Registrar of the Court "as soon as possible". Rather than lodging the original documents in the court file, the practitioner may choose to enter into an agreement with the party subpoenaing him to provide copies of the original documents directly to each of the parties, with the originals to be taken to the trial if necessary. In this situation, it is always advisable to obtain the patient's consent first (where possible).

Whatever the reason for a subpoena being issued, the onus on you remains the same: to provide the court with a factual account, free from bias or embellishment

Should consent to provide the documents remain withheld, then professional opinions are divided with regards to whether the practitioner would nevertheless be obliged to hand the records to the Registrar before the trial date. MPS will be able to advise you on the right option in your particular case.

Reimbursements

Being called upon to give evidence invariably means that a practitioner will have to spend time (and sometimes a considerable amount) away from their practice, and they may also be required to travel.

Unfortunately, recompense for practitioners doing civic duty, as provided for in the relevant legislation and the Rules of Court, is generally minimal. Reimbursements can be sought for reasonable travel expenses, accommodation and meal costs, as well as for lost income; however, it is capped at a modest nominal amount per day.

Whatever the reason for a subpoena being issued, the onus on you remains the same: to provide the court with a factual account, free from bias or embellishment. If you have any questions about your role and responsibilities, contact MPS to talk through your concerns.

Are you social media savvy?

The advantages of using social media to share information with colleagues and patients are obvious; the pitfalls are less so, says MPS Head of Medical Services (Africa), *Dr Graham Howarth*

It's an obvious but important point: if you are going to use social media, make sure that you use the most secure privacy settings on social networking sites. Though remember, privacy settings are not foolproof, and not all information can be protected on the internet. Identities can be traced, so be careful you don't inadvertently post comments about your work, patients, or your practice.

Declaring that you are a medical professional adds weight and credibility to your views, but this privilege brings a responsibility not to undermine public confidence in the profession. If you are providing medical opinion and are happy for it to be professionally held to account, then you must identify yourself as a doctor.

A social network is not an appropriate place to raise a concern. Even 'doctors only' forums have risks as they may be accessed by members of the public, employers, or friends of friends may pass on information attributable to you.

Keep information confidential

Doctors have a privileged position owing to their access to patients and information divulged in communication with them. To abuse this is to erode trust and confidence in the doctor–patient relationship.

The National Health Act 2003 makes it an offence to disclose patients' information without their consent and the HPCSA's official guidance, *Confidentiality: Protecting and Providing Information* (2008) views confidentiality as central to the doctor–patient relationship. It states that:

"Patients have a right to expect that

information about them will be held in confidence by health care practitioners. Confidentiality is central to trust between practitioners and patients. Without assurances about confidentiality, patients may be reluctant to give practitioners the information they need in order to provide good care."[1]

Your duty of confidentiality applies online as well as offline. Posting inappropriate comments or photographs or describing a patient's care on a social media website could damage your reputation, leading to disciplinary action and unwanted media attention.

Even if you do not mention a patient's name they may be identifiable from information written about them, especially if the case is reported in the local press.

Be professional at all times

As doctors, you are not only representing yourself and your practice but also the profession. You have a responsibility to act professionally at all times and not bring the profession into disrepute.

Consider who may be able to access photographs of you on your personal accounts and whether there is information you would not want your employer to see. Derogatory or flippant comments about patients can be damaging to the public perception of doctors and their trust in the profession.

Keep boundaries

It may be flattering to receive online contact or a "friend" request from a patient with whom you have a good rapport, but conversing with patients online is inadvisable. Relationships should be kept strictly professional and the doctor–patient boundary should not be blurred.

Be cautious about online contact with colleagues too, to maintain the distinction between your personal and professional lives.

Think before you type

Once you post a comment or photograph online you relinquish control of that information, so think carefully before hitting 'send' or 'upload'.

Although critical comments patients make about your care online may be upsetting, potentially damaging to your reputation, or even defamatory, avoid giving a knee-jerk reaction when responding. It is important to keep a cool head and look at the issues objectively.

Consider treating the comment as a formal complaint. Using the appropriate formal complaint channels will allow you to explore and investigate patients' concerns and provide an explanation and apology where appropriate.

Doctor–patient confidentiality can prevent you from directly challenging negative feedback; however, such comments can be defused creatively with a positive response. For instance, if a patient comments "my appointment was late and my doctor seemed in a hurry to get me out the door", you could reply by stating: "We are sorry that you are unhappy with the service on this occasion. As the only practice offering this service in the area, we pride ourselves on serving as many patients as possible."

Should a user's feedback reveal a genuine deficiency, use it as an opportunity to improve your practice. Invite the patient to discuss their concerns and provide a point of contact, demonstrate that you have listened to their concerns and are addressing them – the patient may even reply with a positive comment online.

If in doubt…

If you are still unsure about how to tackle a tricky situation online, talk to your employer or contact MPS to discuss the best way forward.

Taking care to avoid these potential pitfalls will help you make the most of social media, which offers exciting new ways to communicate in the ever-changing world of medicine, and has become an integral part of our lives.

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Consultations via Skype

Skype is currently a popular method of conducting video calls, both for personal and business needs, but is it an effective way for patients to consult their doctors? A recent MPS case concerned a patient who relocated and asked his doctor to continue their consultations via Skype.

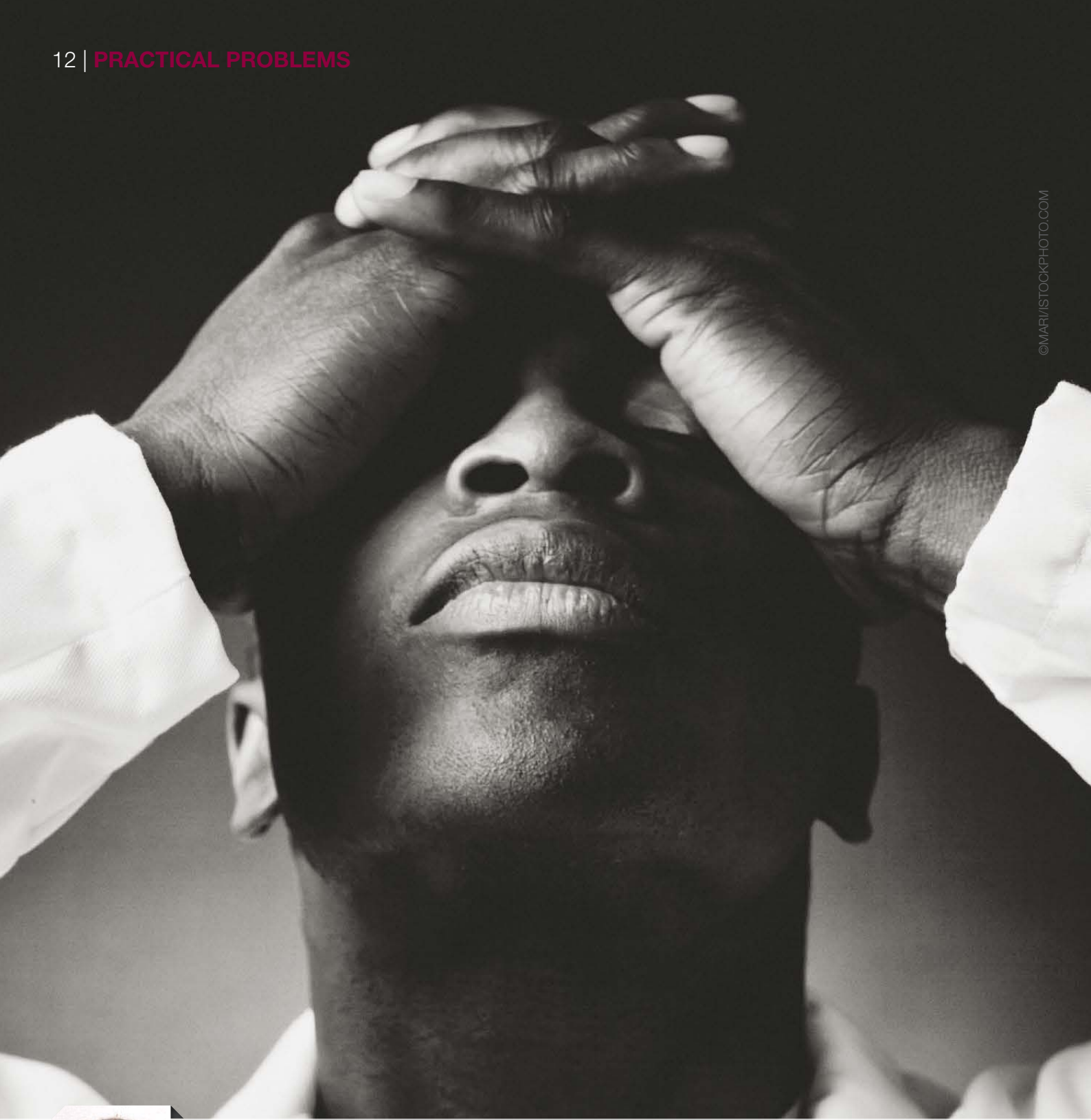
The advantages of Skype consultations are, like telephone consultations, improved access, speed, convenience and cost – although, like telephone consultations, there are disadvantages. Warning signs about a patient's condition that are missed through a lack of face-to-face interaction will leave a doctor vulnerable if an adverse outcome follows.

The HPCSA has no specific guidance on Skype consultations but the general flavour of their guidelines on telephone consultations is applicable. A full clinical assessment is not possible by either telephone or Skype, despite the disadvantages being slightly reduced in the latter. The guidelines do not permit charging for conveying test results by telephone, nor a first assessment conducted by telephone – and the same applies to Skype.

In addition, the HPCSA does not condone the initiation of prescription medicine on the basis of anything other than physical examination of the patient. The HPCSA specifically prohibits the prescription of schedule V, VI or VII substances in the absence of a personal examination or report from another clinician, except in the case of repeat prescriptions for chronic conditions.

Any perceived shortcomings with Skype itself – or with equipment associated with the consultation, such as a webcam or laptop computer – will not be a defence in the event of an error in diagnosis or treatment occurring. The HPCSA states that a practitioner will remain personally responsible for their diagnosis, irrespective of what facilities were relied upon to provide aid in that regard.

Ultimately, a first consultation should always be held in person, when a full examination and detailed history can be taken. Although subsequent consultations could possibly be carried out via Skype or telephone, MPS does not encourage it – particularly because subtle changes in a patient's condition could be missed. Additionally, doctors will not be able to alter previous prescriptions or prescribe for new medication in the absence of a personal consultation.



Managing challenging patient interactions

How can you get the best clinical outcome from even the most challenging of consultations? *Dr Mohamed Bhikhoo*, Family Physician, Honorary Lecturer at the Department of Family Medicine (University of the Witwatersrand) and member of the MPS Education Faculty, explains how.

From time-to-time, we all have challenging interactions with patients. This can happen to any doctor, irrespective of their field of practice or level of experience.

Patients involved in challenging interactions are often referred to as "difficult". When analysed carefully, it is actually the interaction or consultation that has become "difficult" or challenging. These experiences can give rise to a whole range of emotional distress for both parties, which can impact significantly on doctor and patient satisfaction. Doctors have been calling and searching for ways to deal with these distresses. This article examines a range of insights and skills that may assist you to bring about a more favourable outcome for you and your patients.

As doctors, we need to stop and think why the patient may be behaving like this, and consider what the patient has asked or demanded of us that led to us emotively labelling them as challenging. Four broad factors have been identified which can influence challenging interactions.[1]

Patient factors include:

- Unrealistic expectations
- Personality traits
- Cultural and language differences
- Misunderstood feelings or dissatisfaction with treatment
- Inflexibility, seeing no alternatives to their needs.

Clinical factors include:

- Multiple complaints
- Chronic pain
- Substance or drug dependency
- Mental illnesses, especially personality disorders.

System/environmental factors:

- Time pressures
- Limited resources
- Third party pressures.

Clinician factors:

- Personality traits
- Degree of training and skills
- High patient volumes
- Burnout
- Long working hours
- Focusing on the disease and not on the patient.

Whereas patient, clinical, and system factors are easy to understand, it is a bitter pill to swallow when realising that some of the blame has to be pointed at ourselves. In addition, when system factors are at play, doctors tend to be less empathic towards their patients as they feel that they are unfairly to blame for issues that are outside their control.

The greater the overlap of different factors the greater the difficulty in resolving such challenges.

No matter how challenging a patient, it is important to avoid labelling them as such, whether mentally or in writing in the patient's records. Coded language in a patient's notes can lead to stereotyping and preconceived ideas regarding their healthcare needs. For example, reading "complaining of backache and wanting sick certificate" = malingering patient; "vomiting again" = alcohol abuse.

This survival strategy is simply behaviour learnt from seeing similar cases previously, which runs the risk of labelling patients inappropriately and can set up negative behaviour in your approach to the patient, resulting in your patient feeling dissatisfied and neglected. So begins a vicious circle. Furthermore, it can place you at risk of missing serious pathology. For example, the patient with the backache and wanting a sick certificate may in fact have a compressed fracture of the vertebrae.

Strategies for dealing with challenging interactions

Firstly, it is important to recognise and diagnose that you are in a difficult interaction. Establish what the difficulty is and where it lies.

It is also important to establish the patient's view, as they may feel that there is no difficulty. Once this is achieved, develop a plan of action to bring about a favourable outcome.

The key to dealing with a challenging interaction is good communication. Develop a good rapport with your patient and success will follow.

Often, acknowledging the 'difficulty' to the patient is very helpful. "Demanding", "rigid" and "manipulative" patients, when confronted, will realise their game is up and they need to change their behaviour.

Setting boundaries and keeping to them is imperative. When these boundaries are violated it translates into a lack of respect for you, which can result in a strong emotional response. Often, when these boundaries are violated we can feel trapped and the danger is that it can lead to unethical and even illegal behaviour. Examples include prescribing unwarranted narcotic analgesic or writing an inappropriate sick certificate.

Crossing boundaries happens. Patients may be inappropriately seductive with you and make you feel uncomfortable. In these situations, emphasise that this is a professional relationship and request a chaperone be present in the consultation. If necessary, you may want to terminate the relationship and offer the patient to be seen by another doctor. So it is imperative to set and operate within these boundaries. It is beneficial to explain to the patient that you are operating within these boundaries in their best interest. This often disarms the patient and results in behaviour change.

Establishing the patient's expectations and keeping the consultation focused to meet those expectations can help to limit the difficulty, as will establishing your own goals of medical care for the consultation.

At times, patients can become angry and aggressive. Sometimes, they may resort to violence. Your safety is paramount. Do not get into an argument. Do not try to prove that you are right. Do not exert your authority. Call for help, if it is available. If necessary, slowly move to the door and leave the room, rather than asking the patient to leave.

Non-compliance is an extremely frustrating issue to deal with. Try and educate the patient about their condition, the need for them to take their treatment responsibly, and the dangers of non-compliance, and make detailed notes. Beyond that the situation is out of your control and it is easier to accept that reality rather than forcing the patient to take the treatment.

As with all consultations, it is always good practice to have detailed notes. In the face of a challenging interaction be particularly meticulous with your note keeping, as this is your ultimate line of defence in the event of a complaint or litigation being brought against you.

With special thanks to Dr Lynelle Govender for additional research.

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First impressions count – triage in reception

GP *Dr Carmen Gerber* looks at how high-quality urgent care begins with the first impression – the key player here is often the receptionist answering the phone

Triage, performed correctly by non-clinical staff, can protect patients from suffering catastrophic events due to unnecessary delays. However, if performed incorrectly by inappropriately trained and unsupervised non-clinical staff, the consequences can be harmful and even fatal.[1]

Receptionists are often a patient's first contact with healthcare services and are seen as the gatekeepers to medical practitioners, and so they play an important role in assigning patients to the most appropriate level of care at the right time.

Medical practitioners need to understand that they can be held responsible in the event that a patient suffers harm due to unnecessary delays in accessing or being directed towards the most appropriate level of care in an emergency.[2] For this reason, reception and front-desk triaging is very important.

Training

It is essential that all non-clinical staff are appropriately trained and receive the necessary support and guidance from medical personnel in the practice.[1] Practice staff should be encouraged to immediately alert and consult the medical practitioner or nurse whenever there is any uncertainty about the urgency for medical care.

Several factors need to be considered when planning to implement safe triage strategies at a practice. Medical practitioners should always adhere to the HPCSA's regulations and remain sensitive to patients' rights. Additional factors that need to be considered include the practice's location (rural or urban setting), benefits and risks associated with triaging of patients at the particular practice, access to resources, as well as the level of skills and capabilities of the staff available at the practice.[3] All of these factors can determine the practice's capacity to respond and deal with emergencies.[4]

Rural practices are particularly vulnerable to unnecessary delays due to topographical barriers, scarcity of resources, and limited access to medical staff, specialist services and medical facilities (such as laboratories, radiographic imaging centres etc). Effective triage strategies and protocols in both rural and urban areas play a significant role in ensuring timely access to appropriate emergency care.

Look out for warning signs

It is essential that receptionists are able to identify warning signs and appropriately prioritise patients for appointments. In the initial triage process, patients can be classified as either adult, paediatric, geriatric or pregnant.[4] Patients can then be screened further for the presence of any danger signs.

According to the level of urgency for medical care, patients can be triaged into one of three appointment groups. Emergency appointments should be provided to patients that require immediate treatment. Urgent appointments should take place on the same day, while routine appointments do not need to be on the same day.[2]

If a patient is unsure about the urgency for a consultation, or if a patient indicates that they need urgent care, the receptionist should screen the patient according to the triage protocol for any danger signs. The general practitioner should immediately be alerted and informed if any danger signs are present, or whenever the receptionist is unsure about the level of urgency for care.[2]

Non-clinical staff SHOULD:

- Screen patients for danger signs and symptoms
- Make a record in the notes of the outcome of the enquiry into danger signs and symptoms
- Protect patients' privacy and confidentiality
- Reassure patients where necessary.

Non-clinical staff SHOULD NOT:

- Enquire in detail and/or have a long interview into a patient's reason for visiting
- Provide advice or perform duties outside their roles and capabilities
- Offer medical advice or prescribe treatment.

It is important that appropriate measures are in place to ensure continued protection of a patient's privacy and confidentiality throughout the triaging process. Explaining the practice's triage system to patients in advance will minimise and avoid confusion and conflict, as well as ensure that patients understand why they are questioned by the receptionist about their reason for wanting to see the doctor.[2]

MPS advises members to implement better risk management strategies on triaging of patients at their practices. Medical practitioners are encouraged to implement evidence-based triaging protocols[5] and to train, as well as supervise, non-clinical staff. In addition, keeping good records on all front desk and telephone enquiries can be very important in defending any claim which may later arise.[2]

Dr Carmen Gerber is a Medical Officer in the Eastern Cape.

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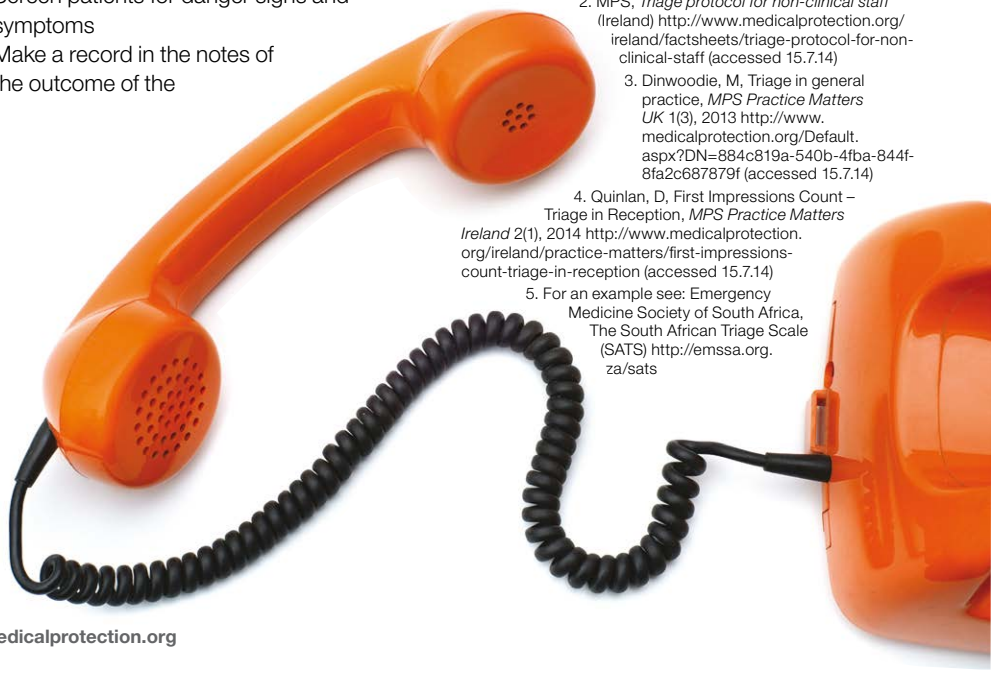
3. Dinwoodie, M, Triage in general practice, *MPS Practice Matters UK* 1(3), 2013 http://www.medicalprotection.org/Default.aspx?DN=884c819a-540b-4fba-844f-8fa2c687879f (accessed 15.7.14)
4. Quinlan, D, First Impressions Count – Triage in Reception, *MPS Practice Matters Ireland* 2(1), 2014 http://www.medicalprotection.org/ireland/practice-matters/first-impressions-count-triage-in-reception (accessed 15.7.14)
5. For an example see: Emergency Medicine Society of South Africa, The South African Triage Scale (SATS) http://emssa.org.za/sats



CPD Questionnaire

CPD questionnaires must be completed online via www.mpconsulting.co.za. After submission you can check the answers and print your certificate.

Instructions:
1. Read *Practice Matters:* all the answers will be found there.
2. Go to **www.mpconsulting.co.za** to answer the questions.
Accreditation number: **MDB001/015/10/2014**

1. Failure to diagnose is not inevitably negligent.
True/False

2. Good documentation helps other clinicians to understand the history of a complaint better.
True/False

3. When treating frequent attenders, document a thorough history and be prepared to re-examine the patient if their symptoms change.
True/False

4. Doctors can ignore a subpoena if they don't think there is anything relevant to share with the Court.
True/False

5. Doctors may not provide information relating to the treatment and management of a patient to anyone or any party without the patient's express consent.
True/False

6. Experts in clinical cases should only comment on matters within their expertise.
True/False

7. Next-of-kin can complete a notice of death and a medical certificate of cause of death.
True/False

8. The admission of guilt statement in form DHA-1663 has to be completed in all circumstances.
True/False

9. Personal information is no longer confidential after a patient has died.
True/False

10. There are only disadvantages when it comes to healthcare professionals using social media.
True/False

11. If you have a grievance, social media is as good a place as any to raise it.
True/False

12. Warning signs about a patient's condition that are missed through a lack of face-to-face interaction will leave a doctor vulnerable if an adverse outcome follows.
True/False

13. A first consultation should always be held in person, when a full examination and detailed history can be taken.
True/False

14. Patients are always responsible for challenging interactions.
True/False

15. Burnout can be a factor in challenging consultations.
True/False

16. Coded language in a patient's notes can lead to stereotyping and preconceived ideas regarding their healthcare needs.
True/False

17. It is imperative to set and operate within clearly-defined boundaries during every consultation.
True/False

18. Non-clinical staff should offer medical advice or prescribe treatment in an emergency.
True/False

19. Healthcare professionals can be held responsible if a patient suffers harm due to unnecessary delays in accessing or being directed towards the most appropriate level of care in an emergency.
True/False

20. Triage protocols can be different in rural and urban practices.
True/False