practicematters

Professional support and expert advice for GPs and practice staff

MPS

Putting members **first**

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THIS ISSUE...

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THE MEDICAL PROTECTION SOCIETY

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In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

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MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 290,000 members around the world. Our benefits include access to indemnity, expert advice and peace of mind. Highly qualified advisers are on hand to talk through a question or concern at any time.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

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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We welcome contributions to ***Practice Matters***, so if you want to get involved, please contact us on **0113 241 0377** or email: **sara.dawson@mps.org.uk**.

Welcome

Dr Richard Stacey
Editor-in-chief and MPS medicolegal adviser

For people with sight loss, visiting a GP surgery can be a difficult experience. Patients hear their name being called but then quite often don't know which consulting room the doctor has disappeared back into.

In this issue of *Practice Matters*, Victoria Armitage from the Royal National Institute of Blind People, tells us her experience of general practice as someone with visual loss, and shares some tips for healthcare professionals to help make services more accessible for people with visual loss. A few simple changes in practice could make a world of difference, as well as helping to ensure you are complying with equality legislation.

As summer approaches GPs will experience increasing requests for declarations that patients are "fit to fly". Patients may have special reasons for wanting to travel and GPs may feel pressured to complete forms and declarations of fit to fly. Patients may not always consider that air travel is risky, and it is important that GPs act in their patients' best interests and only make statements that are truthful and honest. On pages 6-8, Dr Rachel Birch presents three case scenarios advising what you can do to support patients while minimising your risks.

A common question on the MPS helpline is "how do I deal with a father's requests to access his child's medical records?" On pages 14 and 15, we provide some FAQs and an algorithm giving a structured approach for dealing with this scenario.

Another dilemma we receive queries about is whether practice staff can be registered as a patient at their practice. This can be a tricky situation as you obviously want to maintain a good working relationship with the member of staff, but, as the GMC states: "Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship." Read page 22 for medicolegal advice on this dilemma.

A round-up of the most interesting news, guidance and innovations

MPS opposes new criminal sanctions and urges government rethink

The Medical Protection Society is calling on the government to rethink plans to introduce a new criminal offence for healthcare professionals for wilful neglect or ill-treatment.

In a response to the government's consultation, MPS argues strongly that there is no justification for new legislation and believes that it will only add to the climate of fear.

Dr Nick Clements, Head of Medical Services at MPS, said: "MPS opposes the introduction of new criminal sanctions against healthcare professionals for wilful neglect or ill-treatment. We believe the proposed legislation is ill-considered, unnecessary and will undermine the drive for more openness with patients.

"The current regulatory, disciplinary and criminal framework when applied properly is effective at ensuring doctors face the consequences of their actions and additional penalties are not needed.

"With these proposals, the government has focused too much on penalising doctors and not enough on providing the support that can bring about genuine change. We believe that these sanctions will obstruct the much-needed open and transparent learning culture and will add to the current climate of fear amongst doctors. MPS urges the government to rethink."

Read MPS's full response here: **www.medicalprotection.org/uk/response-document/MPS-response-to-governments-consultation-on-new-offence-of-ill-treatment-or-wilful-neglect**

MPS Alert

Please call the MPS helpline if you've made any changes to your professional status. Whether you're a GP or a non-clinical person, please call the helpline to make sure you have the appropriate indemnity in place, either supplied by your employer or arranged by you through MPS.

Do not wait for your membership subscription renewal, call MPS on **0845 718 7187** (Monday-Friday: 8am to 6:30pm) as soon as you take on new responsibility or a new role.

NEWS IN BRIEF

Guidance
The latest version of *Safeguarding Children and Young People: Roles and Competences for Health Care Staff* has been jointly published by the Royal Colleges and professional bodies. This revised version emphasises the role of executive teams and board members, while also taking into account the structural changes which have occurred across the NHS. The framework is applicable across all four countries of the UK and sets the standards and requirements expected of all health staff.

Legal update
The NHS Revalidation Support Team has issued a briefing note on *Responsible officer conflict of interest or appearance of bias. Request to appoint an alternative responsible officer.* The briefing explains the process to be used by designated bodies where a conflict of interest or appearance of bias exists between a responsible officer and a doctor. *Source: NHS*

Controlled drugs
According to the BMA GPs Committee some CCGs are informing GPs they cannot put Controlled Drugs on repeat prescriptions – this is incorrect. There appears to be some confusion by only reading the first sentence of the NPC's guide. CCGs are confusing repeat prescribing within a clinical context (ie, as every GP would understand it) with a "repeatable prescription", which is defined in the Pharmaceutical Services Regulations. *Source: BMA GPs Committee*

Scottish guidance
The Scottish Government has published a report on the results of its consultation on recommendations for no-fault compensation in Scotland for injuries resulting from clinical treatment. The report provides an analysis of the responses received and also sets out the Scottish Government's proposed way forward. *Source: Scottish Government*

Events

Pulse Live
This year's agenda provides a stimulating mix of plenary and keynote sessions and three conference streams tailored to the learning needs of GPs and practice managers.

When: 12-13 June 2014
Where: Manchester
More: www.pulse-live.co.uk

MPS GP Conference: GPs at the Heart of Patient Safety
At this time of great change and challenge, MPS's annual conference offers delegates the opportunity to pause and reflect on their pivotal role in providing high quality and safe care.

When: 12 June 2014 and 19 June 2014
Where: London and Manchester
More: www.mps.org.uk/gp-conference

RCGP Annual Primary Care Conference
The theme is 'Futureproof: resilience in practice', how can we or how are we working towards strong, resilient general practice for the future, providing the best possible practice and outcomes for patients?

When: 2-4 October 2014
Where: Liverpool
More: www.rcgp.org.uk/annualconference

Management in Practice
This event covers all the issues that impact on the management of primary care practices, including: commissioning, legislation, IT, HR, finance and more.

When: 7 October and 16 October 2014
Where: Birmingham and London
More: www.managementinpractice.com/events

MPS HR and Employment Law Seminars
These half day seminars are aimed at practice managers and will give you the tools you need to tackle HR and Employment Law more effectively.

When: 17 September 2014, 22 October 2014 and 19 November 2014
Where: Glasgow, Manchester, London
More: www.medicalprotection.org/uk/gps/croner-seminar

MPS Practice Management Seminars
These seminars have been developed to help guide you through the minefield of patient safety and complaints. The day will be very practical and interactive, giving you the tools to take back to your practice.

When: Throughout the year
Where: Gloucester, Surrey, London, Milton Keynes, Edinburgh, and Nottingham
More: www.mps.org.uk/PMSeminars

FIT TO FLY

As summer approaches GPs will experience increasing requests for declarations that patients are "fit to fly". Sessional GP and medicolegal consultant *Dr Rachel Birch* presents three case scenarios advising what you can do to support patients while minimising your risks

Case 1 – Can I fly after surgery?

Mrs B came to see Dr A in the middle of a busy on-call surgery. She said she wouldn't take up much of his time, but that she needed him to complete a form. She had undergone an elective laparoscopic cholecystectomy five days ago in the local private hospital. She had booked a flight to France for the following day as she wanted to visit her sister and recuperate there.

Since she had undergone recent surgery, the airline insisted that she produce a medical travel clearance form. She asked Dr A to complete the form there and then as she had lots to organise before her flight tomorrow.

Dr A explained to her that he didn't feel he had the expertise to comment on her fitness to fly. Mrs B became quite distressed and started to cry. Dr A arranged to see Mrs B at the start of his afternoon surgery, as he felt that he couldn't fully address this issue within a busy on call morning.

Dr A didn't feel he had the competency or experience to be able to assess Mrs B's fitness to fly and was reluctant to complete a form to state that she was "fit to fly".

When Mrs B returned, Dr A took a full history of the date and type of surgery and how she had been in the postoperative period. He noted the absence of any symptoms of complications. He examined her abdomen and was satisfied that she appeared to be making a good recovery after her procedure.

He discussed with her whether or not she should actually be flying so soon after surgery, and whether or not she should ask for assistance at the airport with the walking distances involved. He advised her to discuss her recent surgery with her travel insurance company.

Dr A offered to write a factual letter for the airline, stating the date and type of surgery. However, she was adamant that she required a medical travel clearance form.

Dr A contacted her surgeon, Mr C, at the private hospital. He agreed to review the patient that evening and advise her on her travel arrangements.

Mr C was not happy with the patient travelling the following day. He advised her to wait a full ten days until after her abdominal surgery prior to flying. However he issued her with a medical travel clearance form for ten days post op and she changed her flight and travel plans accordingly.

Learning points

- The General Medical Council advises in paragraph 14 of *Good Medical Practice* that doctors "must recognise and work within the limits of your competence".[1] Dr A was correct not to provide a certificate for Mrs B when he felt this was outwith his expertise as a GP.
- It is appropriate to ask consultant surgeons for advice on travel after surgical procedures and they are likely to wish to be involved in such discussions.
- Patients should be advised to check with their travel insurance companies if there are any doubts about their fitness to travel.
- The Aviation Health Unit (AHU) of the Civil Aviation Authority (CAA) has a statutory responsibility to safeguard the health of persons on board aircraft. They have provided guidance for health professionals on fitness to fly.[2] This is a useful resource for doctors.

Case 2 – A trip of a lifetime

Mrs H had insulin dependent diabetes mellitus and came to see Dr K in a routine diabetic clinic appointment. She was delighted as her husband had organised to take her to Australia for their ruby wedding anniversary. She had read that people with diabetes may require medical travel clearance from their doctors before being allowed to board an aircraft. She had downloaded information from the airline's website to show Dr K and she asked him to provide her with a letter stating that she was "fit to fly".

Dr K undertook a routine diabetic review with Mrs H. They discussed her medication regime, and she denied any hypoglycaemia symptoms. He looked at her recent blood results and conducted a physical examination. It appeared that her diabetic control was good and her condition was stable.

They discussed what she would need to carry with her on the flight. She would require needles, insulin, a blood sugar testing kit and medications for diabetic emergencies.

Dr K arranged for her to see the diabetic specialist nurse at the local hospital to discuss the insulin regime she would require for the flight, and agreed to provide a typed letter outlining her diagnosis and the fact that her condition appeared to be stable with no recent deterioration. On this basis he felt able to state that there appeared to be "no reason why this patient should not be fit to travel".

Dr K also planned to outline in the same letter the equipment and medication that Mrs H would be carrying in her hand luggage and the reason why she needed to carry it.

He advised Mrs H to contact the airline in advance to discuss the fact that she would be carrying equipment and medication and to discuss her dietary requirements for the flight.

Learning points

- Airlines may ask patients to provide letters or medical certificates confirming that a person's medical condition is currently stable and the patient is "fit to fly".
- GPs should consider the wording of statements for airlines carefully, and where possible offer factual information about a patient's condition, the stability of it and presence or absence of recent deterioration.
- If asked to comment on fitness to fly, avoid stating a patient is "fit to fly" as the latter could be perceived as a guarantee of a patient's fitness.
- Try to word statements carefully, using phrases such as "this patient's condition appears to be stable" or "I know of no reason why this patient shouldn't be fit to fly".
- The British Diabetic Association offers advice on diabetes and travel. It is advised that for flights over eight hours a specialist doctor or nurse should be consulted regarding an insulin regime.[3] Passengers should be able to administer their own medication without difficulty. It is important that they are aware of problems caused by time zone changes and follow the specialist advice.

REFERENCES

1. GMC, *Good Medical Practice* (2013) www.gmc-uk.org/guidance/good_medical_practice.asp
2. Aviation Health Unit of Civil Aviation Authority, *Guidance for Health Professionals: information on assessing fitness to fly* www.caa.co.uk/default.aspx?catid=2497&version=low
3. British Diabetic Association www.diabetes.org.uk
4. Royal College of Obstetricians and Gynaecologists, *Air travel and pregnancy: information for you* www.rcog.org.uk/air-travel-and-pregnancy-information-for-you

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Case 3 – Last holiday before the baby comes along

Dr B received a form in her pigeon hole regarding Mrs F, a new patient to the practice who was 30 weeks pregnant. She had never met this patient before. In fact, her only medical record entry was when she became pregnant. She saw Dr B's partner and was referred to the midwife.

The form was for medical confirmation of fitness to fly. It asked the doctor or midwife completing the form to state that the pregnancy was uncomplicated, providing the estimated delivery date and confirming that the patient was "fit to fly".

The following day, Mrs F had a telephone consultation with Dr B. She told her that she had booked a long weekend in Prague with her husband, as they felt it was important to have a holiday before the baby arrived. She would be 32 weeks pregnant at the time of the trip.

Dr B took a history from Mrs F. It appeared she was fit and well and had had no problems during her pregnancy at all. This was her first pregnancy and she had been seeing the midwife regularly.

Dr B felt that before she could complete the form, she would like to see Mrs F for a face-to-face appointment and review her maternity notes. Mrs F was not keen to do this, as she was still working full-time and had already taken time off work to see the midwife the following day.

Dr B discussed her concern about signing a form to state that Mrs F was "fit to fly" without seeing her. Mrs F fully appreciated her dilemma.

After a discussion, they decided that it would be most appropriate for the midwife to complete the form for Mrs F, as she had been regularly seeing her throughout her pregnancy.

The following week Dr B received a message from Mrs F to let her know that her midwife had completed the form and she was off to Prague.

Learning points

- The General Medical Council states in paragraph 71 of *Good Medical Practice* that "you must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading… you must take reasonable steps to check the information is correct."
- Dr B was correct to wish to review Mrs F in person and review her maternity record to ensure that the information was correct.
- Most airlines ask for a medical confirmation of fitness to fly once a pregnancy has reached 28 weeks' gestation. They ask for this to be completed by either a doctor or a midwife. In the above situation it was appropriate for the midwife to complete the form, as Dr B had never met Mrs F.
- Airlines have rules about how late in a pregnancy a patient may travel and it is important that patients check the rules with the individual airlines.
- The Royal College of Obstetricians and Gynaecologists have published guidance for patients considering flying during their pregnancy.[4]

Summary

Air travel is so accessible and it is increasingly common for people to go abroad for holidays. Patients may not always consider that air travel is risky and consider that it is a routine matter for a GP to sign a fitness to fly statement.

Doctors may wish to consider discussing with the patient whether air travel could adversely affect a pre-existing medical condition. The guidance outlined by the Aviation Health Unit of the CAA is a useful resource as it outlines factors to consider including the effect of decreased air pressure in the cabin, immobility, timings of medication, the mental and physical effect of navigating through airports and the need for health insurance.

Doctors may wish to contact individual airlines' medical advisors or the Aviation Health Unit at the CAA if they have specific queries.

Fitness to fly can be an emotive area. Patients may have special reasons for wanting to travel and doctors may feel pressure to complete forms and declarations of fitness to fly. However, it is important that GPs act in their patients' best interests and only make statements that are truthful and honest and not misleading.

Rather than signing a statement of "fitness to fly" doctors may wish to consider providing a factual letter outlining the recent course and stability, or not, of the patient's medical condition. The final decision as to whether a patient may fly rests with the airlines and information provided from the GP will assist them in this decision.

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HOT TOPIC

care.data

The care.data programme has been subject to intense media coverage and scrutiny. GMC Chairman *Professor Sir Peter Rubin* looks at what doctors can disclose and in what circumstances

Trust is a fundamental part of the doctor–patient relationship. Patients share personal details with doctors and give us an insight into their lives. They believe, and rightly so, that within clear boundaries, what is discussed and noted within the four walls of the surgery or consulting room remains private. But, in an era where we are increasingly using technology to store and share information and to connect with patients through telemedicine and smartphone apps, issues around confidentiality have been put firmly under the microscope.

If patients don't feel informed or reassured about what happens to the information they are giving their doctors, then they may be reluctant to seek medical attention or to provide the information necessary in order for doctors to provide good care.

On the other hand, doctors know as well as anyone that there are huge benefits for patients in making best use of new technology; it is surprising that the NHS has been slow to innovate, but with resources now at a premium we have to respond.

I firmly believe that as a profession we need to be making more use of apps, email, text and videoconferencing, and promoting the benefits of doing so – in a secure way of course – to patients.

So far as data is concerned, the NHS is uniquely placed to bring together population level, anonymised data about healthcare quality and outcomes. Doctors have responsibilities to improve the health of the public, as well as to treat the patient in front of them. This is not always an easy circle to square.

So, exactly what information can doctors legitimately disclose and under what circumstances?

GMC guidance on this is clear: generally, patients should be asked for their consent before confidential information about them is disclosed. There are times, however, when this will not apply.

If there is a legal obligation for doctors to pass on information then they must do so. The transfer of information in the care.data programme is a legal requirement and, unless a patient opts out, their information will be shared.

However, the law also says that this must be done fairly and doctors have an important role in supporting patients to make informed decisions about their healthcare, including the use of their confidential information.

The GMC expects doctors to provide information on the programme and what it means and also give information to patients on how they can opt out.

Doctors can also disclose confidential information about patients if they consider disclosure to be in the public interest. This may be justified to protect individuals or society from harm such as serious crime or communicable diseases. Information can be disclosed without consent (and in exceptional cases where consent has been withheld) if it is in the public interest to do so.

There is no denying that this is tricky and it is up to us as doctors to make a judgment and weigh up the harm that is likely to arise from not disclosing the information against the possible harm to the patient. Doctors also need to consider the implications of their actions for the overall relationship of trust between doctors and patients.

In the unfortunate event of a medical emergency, the GMC would also expect doctors to pass on information relevant to the patient's care and, when they are able, to tell the patient what they have done.

Confidentiality is an area of practice which presents many challenges and is central to the relationship we have with our patients. We want to provide the best care to patients and we can only do so if they are open and honest with us and us with them.

Read the GMC's full guidance here: www.gmc-uk.org

Technology in general practice

Kate Taylor, MPS Clinical Risk Manager, explores the implications for nurses of technology in general practice

Life in the 21st century is dominated by technology – mobile phones, pagers and high-tech devices – we can be interrupted anywhere, at any time. Technology allows us to order shopping online, communicate with friends and family via social networking sites, book holidays, download music, read books and so much more.

So, has technology impacted on general practice? Many practices send patients text messages, offer patients the opportunity to book appointments online, order repeat prescriptions electronically, learn about services provided by the practice via a website, as well as inviting patients to comment on their experience of the services provided via websites, such as NHS Choices. Clinicians use electronic medical records, receive test results electronically and have electronic messaging systems for internal practice communication.

Potential risks

The use of technology comes at a price and there are potential risks in a healthcare setting. Through the Clinical Risk Self Assessment (CRSA) programme, MPS has identified emerging risks that general practice teams need to be mindful of and proactively address.[1]

Nurses working within general practice need to be aware of the implications that some of these key risk areas can have on their role and level of responsibility within the practice:

1. Communication

Nurses are increasingly encountering the patients who have done their own research into diseases they have, or think they have, and used the internet to access medical advice.

The web contains a vast spectrum of information: at one end there is controlled and reputable medical information, while at the other end we have uncontrolled websites of a commercial, personal or ideological disposition. Balancing these opposing sources presents medicolegal issues for nurses. This can prove challenging for practice nursing teams as patients are becoming better informed and have raised expectations.

The Nursing and Midwifery Council (NMC) state in *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*: "You must listen to the people in your care and respond to their concerns and preferences." [2]

Risk management advice:

- Ensure that you have effective communication skills, including listening and empathy, to assist the consultation.
- Warn about the reliability of material from the internet.
- Be receptive about information from the internet.
- Be open to new means of communication, but manage them effectively.
- Remind patients that there are constraints on your time and you can't read all the printouts that they bring you.
- Work within your competence.
- Keep a record of the consultation in the patient's record.

2. Email

The use of email has proven to be revolutionary in terms of improving communication; however, although email is an attractive way for patients to communicate with the practice, safeguards are required in order to preserve patient confidentiality. Unless messages are encrypted, patients should be aware that their messages could potentially be read by someone else.

Risk management advice:

- Seek the patient's consent before communicating by way of email.
- Only appropriate matters should be dealt with via email exchanges, for example, appointment scheduling, ordering repeat prescriptions and obtaining test results.
- A standard protocol for email exchanges could prevent emails from patients asking for more complex information about medical symptoms or their proposed treatment, which would be difficult for the practice to respond to quickly and appropriately.
- It is important to ensure that all emails to and from the patient are included as part of the patient's medical record.
- Ensure that there is a protocol for regularly monitoring incoming emails (including during periods of leave).
- Be wary about the workload implications of dealing with incoming emails.
- Take all reasonable steps to ensure that the email is being sent to the correct address.
- Be aware of the limitations of email correspondence (for example, examination findings, body language may be important parts of a clinical assessment).

3. Recording of consultations

It is becoming increasingly common for patients to ask to record a consultation on their phone, to share with a third party. Whilst the nurse may feel that the presence of a recording device may hinder the nurse-patient relationship, the nurse has a duty to assess their condition and advise on any necessary treatment.

Risk management advice:

- Explore the patient's reasons for recording the consultation; in most cases it will be to ensure that they do not forget important information and/or that they may wish to share it with a friend or relative. There may be other ways of communicating this information (for example, by writing down the relevant information or recording a summary of the relevant points at the end).
- Any concerns about the recording, including managing the security of their confidential information, should be discussed with the patient beforehand.
- Consider a copy of the recording being placed in the patient's medical record.

4. Text messaging

Many practices are signing up to using a text messaging service to inform patients of appointments, flu vaccinations, etc. Text messaging allows practices to target and contact hundreds of patients within minutes. Patients can respond by text with replies automatically forwarded to a specified email address.

Risk management advice:

- Ensure that text messages are as secure as possible and compliant with the relevant legislation and professional guidance.
- Ensure explicit consent is obtained from patients prior to using text messaging as a form of communication.
- Remember that text messaging in this context is a professional communication; hence 'text speak' should be avoided.
- Ensure that the patient's number is correct (and bear in mind that some patients may frequently change their number).
- Do not communicate sensitive information by way of text.

5. Social networking sites

Many practices have embraced some of the social networking sites as an innovative way of communicating with patients; with this growing phenomenon the Nursing and Midwifery Council have developed clear guidance recommending that nurses ensure they use privacy settings when visiting such sites.[3]

Risk management advice:

- Do not post anything you would not want others to see.
- Do not discuss work-related issues online, including conversations about patients or complaints about colleagues.
- Never post pictures of patients or service users, even if they ask you to do this.
- Social networking sites should not be used for raising and escalating concerns.
- Protect your own privacy.

6. Record keeping and visits

Most nurses recall the days when handwritten clinical notes were the norm; now this is the exception, perhaps only in the context of a home visit or when issuing a handwritten prescription. Particularly within general practice, most nurses will be working with clinical computerised systems.

Risk management advice:

- Ensure that you have received appropriate computer training, including the use of the practice clinical system.
- It is easy to overlook making an entry in the records after a home visit; try and ensure that they are written up at the earliest opportunity and if possible create a reminder before you undertake the visit.

Conclusion

Technological advances will undoubtedly bring further changes and risks will never be eliminated entirely; however, identifying and managing the risks early on will go a long way to provide a safer environment for patients.

Technological advances will undoubtedly bring further changes and the risks will never be eliminated entirely; however, identifying and managing the risks early on will go a long way to provide a safer environment for patients

The web contains a vast spectrum of information: at one end there is controlled and reputable medical information, while at the other end we have uncontrolled websites of a commercial, personal or ideological disposition

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1. MPS Clinical Risk Assessment – **www.medicalprotection.org/uk/education-and-events/clinical-risk-self-assessments-for-GPss**
2. Nursing and Midwifery Council (NMC), *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives* (2008) London
3. Nursing and Midwifery Council (NMC), *The Code: Social Networking Advice* (2012) – **www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Social-networking-sites**

ADDITIONAL READING

1. *Your Practice* (2012) Dilemma: Recording Consultations. A Patient Asks to Record My Consultation – What should I do? Vol 6 No 3 – **www.medicalprotection.org/uk/your-practice-september-2012/dilemma-recording-consultations**
2. MPS factsheet: *Communicating with Patients Via Fax and Email* – **www.medicalprotection.org/uk/england-factsheets/communicating-with-patients-by-fax-and-email**
3. MPS factsheet: *Making Audio and Visual Recordings of Patients* – **www.medicalprotection.org/uk/england-factsheets/making-audio-and-visual-recordings-of-patients**
4. MPS factsheet: *Communicating with Patients by Text Message* – **www.medicalprotection.org/uk/england-factsheets/communicating-with-patients-by-text-message**

Case scenario

Practice nurse Kerry had an extremely bad day at the practice. On returning home she logged onto Facebook and commented on her day; a colleague responded and subsequent exchanges of messages uncovered the identity of a patient who had attended the practice that day. Nurse Kerry had suggested to her colleague that patient X was his usual moaning self.

On returning to work the following day, nurse Kerry was asked to see the practice manager. On arriving at the practice manager's office it became apparent to Kerry that something serious was going on as one of the senior GP partners was also present. Kerry was questioned by both the practice manager and the GP about the practice policy on confidentiality and was asked to reflect on any activity that she may have been involved in that may have compromised confidentiality.

Another staff member had seen the exchange of messages and had alerted the practice manager. Kerry was subsequently managed through the practice's local disciplinary procedures.

Advice

- Ensure you are familiar with the practice IT policy.
- Ensure you are familiar with the practice confidentiality policy.
- Sign and agree a confidentiality statement that includes the use of social networking sites.

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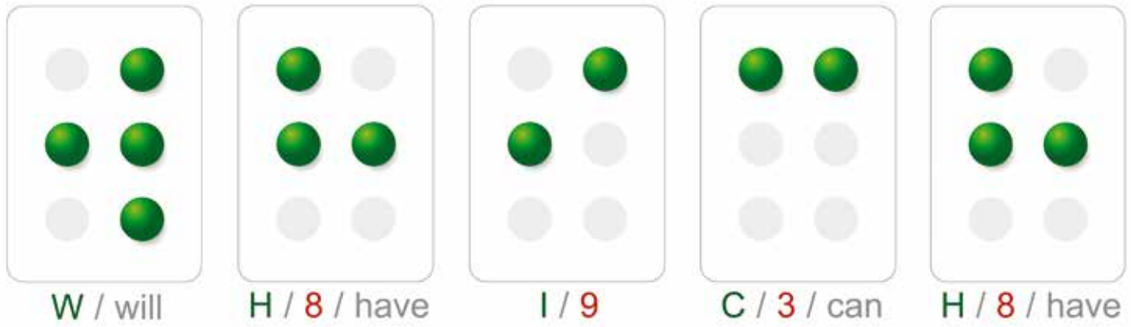

Which room?

Victoria Armitage, from the Royal National Institute of Blind People, shares her experience of general practice as someone with sight loss

In my work for the RNIB, I've met many people with sight loss who regularly tell me about the difficulties they experience when visiting a GP or a hospital. As someone with sight loss myself, I have experienced first-hand the frustration of, for example, being sat in a waiting room and hearing my name called only to discover the ghost to have already disappeared back into their consulting room – which room?

Sometimes these difficulties are frustrating and embarrassing, but some can be much more serious, with many patients not being given information in a format that they can read, or more vulnerable patients being left without knowing where their food and drink is, or even that it has arrived.

Difficulties can often be compounded because many people are often reluctant to identify themselves as needing additional help and will try to hide the fact that they have sight loss. Sometimes people will carry around a visible sign of sight loss, such as a small white stick called a symbol cane, but many people with severe sight loss do not think of themselves as someone who is "blind" or even "partially sighted". Sometimes people may simply identify with "having bad vision".

Of course, health professionals and clerical staff are usually rushed off their feet – so it's no wonder that the needs of people with sight loss do get overlooked. However, a few simple changes in practice could make a world of difference to patients with sight loss – as well as helping to ensure that you are complying with equality legislation.

Under the Equality Act (2010) people with sight loss are entitled to be treated fairly. The Act expects reasonable adjustments to be made to services so that persons with sight loss use them independently.

As well as the Equality Act, NHS England is currently developing an Accessible Information Standard to ensure that all NHS and social care providers have a method of recording and providing the reading format preference of people with disabilities, such as sight loss. The Standard could be enforceable as early as 2016.

Many of our supporters are keen to pass on recommendations to NHS providers about how they could improve their care for people with sight loss, and we also know that NHS providers are increasingly using patient experience to improve their services. That's why we've recently taken all the feedback we have received over the years and compiled some tops tips for healthcare professionals on treating people with sight loss.

Much of our advice is common sense, but in a busy care environment it's easy to overlook some of these issues. However, with one in five people aged 75 and over living with sight loss, making these small changes could make a massive difference to the experiences of your patients.

I have experienced first-hand the frustration of being sat in a waiting room and hearing my name called only to discover the ghost to have already disappeared back into their consulting room – which room?

To access the RNIB's top tips and help make services more accessible to people with sight loss, visit **www.rnib.org.uk/toptips**. If you would like more information contact the RNIB campaigns team on 020 7391 2123.

From the case files…

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

"From the case files" features unusual cases and cases with strong learning points. Here we deal with a common question on the MPS helpline – how to deal with a father's requests to access his child's records

HOME

Algorithm for responding to father's requests for access to his child's records

Father makes a request for access to his child's records

Is the child Gillick competent?

Yes

Explain to the father that you will need to seek the child's consent

Seek the child's consent

Disclose/withhold the records in accordance with the child's instructions

No

Does the father have parental responsibility?*

Yes

Disclose the records with the following caveats:
1. The child's best interests should be considered as paramount
2. The records should be screened and any information that relates to identifiable third parties** or any information that would cause serious harm (to any party) should be redacted***

No

The father does not appear to have a right of access to the child's records

Consider whether or not it is in the child's best interests to disclose information to the father

*Refer to the Parental Responsibility quick-guide
**This would not include healthcare professionals who have been involved in the patient's care
***If the records are redacted then they should be supplied to the father under the cover of a letter explaining that the records have been redacted to remove third party and/or harmful information

MPS frequently receives calls about access to a child's records. The most frequent scenario is an estranged father making a request to have access to information or copies of his child's records.

These requests can place practices in a difficult position for the following reasons:

- There is commonly a background of a parental dispute
- Both parents may be patients at the practice
- The motivation behind the request may not be clear
- The potential to get drawn into the parental dispute.

The algorithm on the previous page provides a structured approach for dealing with a father requesting access to his child's records.

In relation to non Gillick competent children it is important to establish whether or not the father has parental responsibility. Box A sets out in what circumstances a father would have parental responsibility.

In practical terms, upon receipt of a request from a father to access the records of a non Gillick competent child, you should explain that in order to deal with his request you would require sight of a relevant document that confirms that he retains parental responsibility.

This may include a copy of the relevant court document, a copy of a marriage and/or birth certificate, or a letter from the father's solicitor, confirming that he retains parental responsibility.

BOX A.

Parental responsibility – A Quick Guide

The Children Act sets out who has parental responsibility. A father would have parental responsibility in the following circumstances:

- If he holds a custody or residence order for the child
- If he holds an emergency protection order for the child
- If he has adopted the child
- If he is the child's father and was married to the child's mother when the child was born
- If he is the child's father and was not married to the child's mother when the child was born but:
  - now has a residence order
  - now has a Parental Responsibility Order
  - has made a Parental Responsibility Agreement with the child's mother
  - has since married the child's mother
  - (since 1 December 2003) is registered as the father under paragraphs (a), (b) or (c) of sections 10(1) or 10A(1) of the Birth and Deaths Registration Act (1953) or the corresponding law in Scotland or Northern Ireland.

USEFUL LINKS

- MPS factsheet, *Parental Responsibility* – **www.medicalprotection.org/uk/england-factsheets/parentalresponsibility**
- MPS factsheet, *Confidentiality – General Principles* – **www.medicalprotection.org/uk/england-factsheets/confidentiality-general-principles**
- GMC, *0-18 Years: Guidance for All Doctors* – **www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp**
- GMC, *Confidentiality* – **www.gmc-uk.org/guidance/ethical_guidance/confidentility.asp**

Frequently asked questions

The father requests that he is updated every time his child attends; do I have to comply with this request?

If the father does have a right of access to his child's records then he would be able to request access at reasonable intervals. However, the practice is not obliged to agree to update the father every time his child attends and this may present the following difficulties:

- There may be a significant administrative burden associated with this request
- The practice may be criticised for not informing the father if the child attends and the father is not informed as a result of an oversight
- There may be legitimate reasons why it would be inappropriate to inform the father of a child's attendance
- If a child becomes Gillick competent then they may object to the father being informed of their attendance.

If a father makes such a request, you might wish to encourage him to liaise with the child's mother in relation to their child's health (appreciating that their personal relationship may be strained).

Can a charge be made for providing copy records?

If the father has legitimate right of access to his child's records, then his request can be considered as a Data Subject Access request under the provisions of the Data Protection Act (1998).

The Act makes the provision to charge a fee of up to £10 for the provision of hard copies of computer records, or up to £50 for the provision of a combination of hard copy computer and/or hand written records.

The charges should be commensurate with the costs incurred in relation to the provision of copy records and should not exceed the specified ceiling charges.

The practice has received a Court Order requesting disclosure of a child's records – should they be provided?

The practice would be obliged to disclose the records in accordance with the instructions on the Court Order.

Should the mother be informed that the father has requested access to their child's records?

There is no absolute obligation to inform the mother that the father has requested access to their child's records, although there may be circumstances in which you would consider doing so, for example, if you felt that it was in the child's best interests to inform their mother that the request had been made.

The key issue is to seek confirmation that the father has a legitimate right of access to the records, in which case disclosure could reasonably be justified with the caveats set out in Box A.

The guidance should assist in relation to addressing most requests from fathers to access their child's records, but if you have a particular concern about the circumstances of a particular request, then please contact MPS for further advice.

HOME

Practice nurse training

Nurse and CQC inspection adviser *Elaine Biscoe* says that more training is needed for nurses as their responsibilities expand at a rapid rate

During the 20 years I have been working as a practice nurse, the boundary between the role of the nurse and GP has become increasingly blurred with nurses taking on expanded responsibilities. Like GPs, nurses in primary care work in a demanding, complex environment that no other role in their nursing careers can have prepared them for.

However, unlike for new GPs, there is very little training for this other than, at good practices, some shadowing of a more experienced colleague, and then courses or study days (when available) for specific responsibilities.

New primary care landscape

Formal consultation skills training and education about how the new and mystifying world of primary care actually works ranges from rare to unheard of. To some extent all practice nurses will have felt pressure to fulfil the expectations of everyone from the patients to their new employer. I have worked in several "training" practices and by this I mean practices that train new GPs, and the difference between the training provided for new GPs is stark and inexplicable in today's world of primary care.

Training for practice nurses is piecemeal and varies enormously from single study days to six month diplomas. Crucially no additional training, apart from initial training to qualify as an RGN, is mandatory for much of the day-to-day work. In my experience, what is lacking is day-to-day mentoring for the nurse back in the surgery as she struggles to put theory into practice with real patients.

This is never truer than in the areas of spirometry and diagnosis of patients with asthma and COPD, a role often left to nurses. Another example is travel health, the complexity of which, like wound care, merits a specialty in its own right.

Delegation

To add to the minefield that is now the working environment for our new practice nurse, for some areas of her work she will realise that the GP who is delegating care of the patients at the practice to her does not have appropriate knowledge either. According to the GMC's *Good Medical Practice* (2013): "When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate, qualifications, skills and experience to provide safe care for the patient."

She is expected to be the expert, and crucially to always be vigilant for what she doesn't know – often from day one. At larger practices, this is less likely as hopefully more experienced practice nurses can advise. However, let's not forget the enormous pressure a new member of the team will feel to avoid repeatedly interrupting her colleagues and "get behind".

Wound care

Complex wound care is another area that the new practice nurse will quickly realise occupies much of her time. At least for tasks such as cervical smears, and vaccinations, there is usually an acknowledgement that they must not be undertaken until some sort of training has been attended. Not so for wound care, regardless of the complexity. It must be remembered that there is potential for serious complications for patients with chronic wounds. However, there is a widespread, unspoken belief that if you're a nurse, you can deal with "dressings".

Extended responsibilities

I acknowledge that some practices do their best to arrange an induction and training programme for their new nurses and don't, intentionally, pressure them with responsibilities they are not ready for. However, I'm not sure there is sufficient understanding of the nature of what practice nurses do, and the training and support that is needed to ensure safe practice. Many practice nurses will be familiar with the experience of attending a training day, and then being expected to see relevant patients immediately.

When practice nurses take on extended responsibilities, such as seeing patients with minor illness, it should be borne in mind that she will be judged by the professional standard of the post she is performing at the time; ie, if a nurse takes on a doctor's role, she will be judged by the standards of a reasonable doctor. In other words, being a novice will be no defence. Although nurses are personally accountable for their practice, in an extended role their risk increases, so they may well have their own liability if practising autonomously.

Shared training

GPs need to take an increased interest and responsibility for the work they are effectively delegating to nurses. Most importantly they need to recognise the exposed, vulnerable nature of the role. One way of improving this understanding would be for a GP at the practice to attend some of the training days jointly with the nurses.

Practice nurse mentors

In this new world of CCGs, perhaps consideration could be given to general practice nurse mentors who could work between practices supporting new nurses as they establish themselves and become confident. There also needs to be a proper pathway into the role, as already exists with GPs. Litigation against health professionals is increasing generally, and it is also acknowledged that there will be a need to employ new practice nurses in the next five years as current practice nurses retire. It is therefore high time there was appropriate training and support for this rewarding and challenging role.

Elaine Biscoe is a practice nurse with nearly 20 years' experience. She has worked as a lecturer for practice nurses and acts as an expert witness for cases where there is alleged breach of duty by practice nurses. She is also a Specialist Adviser for the CQC inspections of GP surgeries.

How to encourage professionalism in your trainees

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Professionalism can be hard to define and even harder to teach. *Dr Mark Dinwoodie*, Head of Member Education at MPS, highlights some practical tips to encourage professionalism in trainees

In the UK, doctors are good at reporting incidences of incompetence or unprofessionalism. A recent study showed that 73% of UK doctors who had knowledge of such incompetence reported it, compared to only 41% in Ireland.[1]

All doctors have a duty to act when they believe patients' safety is at risk, or that patients' care or dignity are being compromised. *Raising and Acting on Concerns About Patient Safety* (2012) sets out the expectation that all doctors will, whatever their role, take appropriate action to raise and act on concerns about patient care, dignity and safety.[2]

You may assume that it is patients who complain about you, but in reality it could be your colleagues who are disgruntled. There has been a year-on-year increase in the number and proportion (now 10%) of complaints received by the GMC about doctors from other doctors.[3]

What is professionalism?

The Royal College of Physicians defined professionalism in 2005 as a set of values, behaviours, and relationships that underpins the trust the public has in doctors.[4]

The concept of professionalism is the basis of medicine's contract with society. It's what society and patients expect of their healthcare professionals. Professionalism is the way that healthcare professionals fulfil their part of this contract and in return they are rewarded by the trust of patients.

How do you personify professionalism? Some people would see professionalism as being predominantly about observable behaviours. Others believe it is a much broader concept encompassing competences in terms of knowledge, clinical and non-clinical skills, which together with appropriate attitudes and values result in expected professional behaviours and relationships.

When it comes to day-to-day practice, professionalism is about adherence to a defined set of standards. You should work with your trainee to try and incorporate these standards and codes of practice into everyday behaviour and performance, by following the GMC's guidance, *Good Medical Practice*.[5]

A patient's trust in a doctor is no longer assumed; it is reached and earned through a display of appropriate professional qualities and behaviours, for example, expertise, probity and concern or caring, and these act as markers of professionalism.

Communication issues and poor doctor-patient relationships are major causes of medicolegal action and complaints.[6] Many of these communication behaviours would be viewed as unprofessional: poor communication (not being listened to, lack of empathy, lack of information), disempowerment (feeling devalued, not being understood or taken seriously), desertion (feeling abandoned, family excluded, staff arrogance).[7]

Teaching professionalism

Trainers need to actively encourage professionalism and not just assume that trainees will automatically acquire it, or simply wait until they transgress.

It's relatively easy to teach someone a specific skill like injecting a shoulder and assessing whether the trainee has acquired the skill. The same can't be said for professionalism.

Teaching aspects of professionalism can be achieved through delivering a formal curriculum, teaching the knowledge and skills to develop capability, helping to establish necessary attitudes, and enabling our trainees to display appropriate professional behaviour.

Knowledge

Knowing the professional standards as identified by the GMC is a good starting point. Topic discussions with trainees are a useful way of teaching them about key issues such as confidentiality, consent, use of chaperones, etc. Ask them 'how would you respond to a request for information from a patient's relative?' as a way to help them apply this knowledge.

Skills necessary to display professional behaviours

In order to be able to exhibit professional behaviour, we need to ensure trainees have the necessary skills which include clinical skills, a range of communication skills and record keeping.

Attitudes and values

Examples of attitudes and values associated with being a medical professional are: integrity, being open, compassion and accountability. To assess attitudes and values, you could ask attitudinal questions, for example:

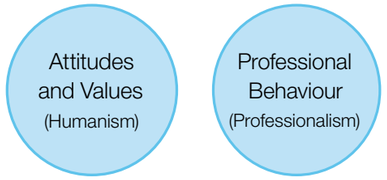
How much do you agree with the following statements (on a scale of 1-7):

"It is important to apologise to patients when mistakes have occurred."

"It's OK to take shortcuts if pressed for time."

Is the behaviour attitude consistent?

Aligning attitudes and values with professional behaviours authenticates professionalism.



What we see externally are behaviours and capability. It is what lies internally such as values, beliefs and attitudes that drive this behaviour. Professional behaviour without consistent underlying values lacks authenticity and integrity and is more likely to deteriorate when under pressure.

Informal and hidden curricula

Most of the teaching of professionalism is likely to occur through informal and hidden curricula. Role modelling can be very powerful especially if accompanied by reflection.

INFORMAL CURRICULUM	HIDDEN CURRICULUM
Stories and anecdotes: "I had a case a few years ago where..."	Developing an appropriate practice culture regarding attitudes and behaviours
"Chats" over coffee	Raising the profile of professionalism
Peer learning	Role modelling: ■ The way they see you act with patients ■ The way you act towards them ■ The way you act to other team members ■ The attitudes and values you express
Medical and lay media "stories"	
Placements to help challenge attitudes	
Reflecting on and discussing everyday situations	
Documenting examples of professionalism to discuss	

Feedback on professional behaviour

You can assess the professional behaviour of trainees by role-play, case-based discussion, rating scales and observation of a consultation. You can use formative assessment techniques to assess and enhance trainees' capability.

Feedback from a variety of sources, for example, staff, patients or colleagues, can be very useful.

We should be encouraging reflection, self-assessment and self-correction about the impact of errant professional behaviour.

Patient-centred v doctor-centred

Being patient-centred is an important part of professionalism. Sometimes we can become very "me" focused and lose sight of the fact that the patient is our main priority.

Hearing these types of phrases may give an indication that this is happening:

"I don't see why I should…"

"I had the usual time-wasters in this morning…"

"Patients need to realise that I can't…"

Hot buttons

Certain patient behaviours or comments can trigger an automatic inappropriate response which could be perceived as unprofessional, before our cognitive control has had a chance to prevent it. Identifying what these hot buttons are and early recognition that they are being pressed is important. Reframing patient behaviour that can stimulate these responses may help prevent automatic potentially unprofessional responses.

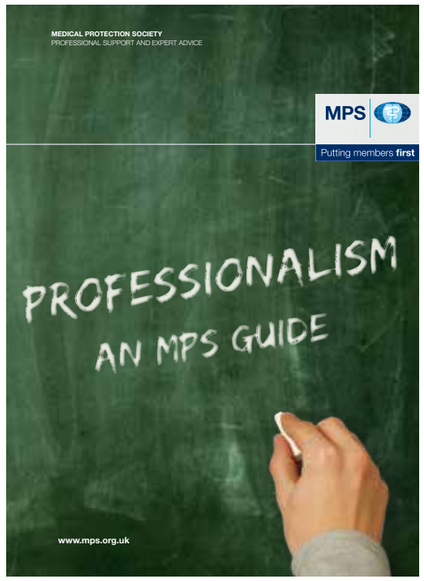
Summary:

- Ensure trainees know and understands what acceptable professional behaviour is
- Encourage appropriate values and attitudes to authenticate professionalism
- Encourage patient-centred care
- Role modelling and facilitating reflection on observed behaviour is likely to be effective
- Enabling insight into attitudinal or behavioural deficiencies will help many trainees improve
- Reflective practice is vital to enable trainees to develop professionalism
- Reframing and managing hot buttons can be useful tools.

Conclusion

Professionalism matters. It's what society and patients expect and helps avoid complaints and claims, particularly at a time when patient expectations are growing. In such times your professional attributes can really come to the fore and make all the difference when under pressure.

Useful link: Read our MPS handbook on *Professionalism – An MPS Guide*: **www.medicalprotection.org/uk/booklets/professionalism-an-mps-guide**



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Top ten tips for professionalism

1. **Probity:** Honesty and integrity are central to probity and define how any professional person should act. This is vital in healthcare as the doctor-patient relationship is balanced on trust.
2. **Expertise:** Doctors are expected to have a particular set of skills in their chosen field, at a level that can be considered expert. The validity of this expertise is maintained by ongoing training throughout the course of a medical career.
3. **Respect:** You should aim to be courteous and should respect the rights, dignity and autonomy of those who consult you in a professional capacity.
4. **Responsibility and reliability:** A professional person should honour commitments and ensure that tasks and duties are completed and addressed, by taking the initiative and leading by example. In medicine, a lack of immediate attention to your duties can be the difference between life and death.
5. **Respectability:** There are expectations that a professional will work and behave in a manner that is appropriate to the nature of their particular profession. In medicine, these expectations are unique: good standards of personal appearance and dress, appropriate standards of speech and personal conduct – such attributes will confirm to a patient an acceptable standard of respectability.
6. **Standards:** A professional person is expected to have the ability and dedication to achieving a set of standards in their duties that their peers find acceptable.
7. **Conduct:** The GMC has clear expectations of the correct behaviour and conduct of a medical professional. You should ensure that your actions are appropriate and proper: www.gmc-uk.org/guidance/good_medical_practice.asp
8. **Social responsibility:** The caring nature of the profession means that a healthcare professional must possess a strong sense of empathy; a desire to do good – and this can be broadly described as having a social responsibility.
9. **Ethics:** Professionals such as doctors must adhere to a strict code of ethics. It is necessary to first separate the law on the one hand, and ethics on the other, in order to grasp the essential nature of professional ethics. www.medicalprotection.org/uk/booklets/MPS-guide-to-ethics-a-map-for-the-moral-maze
10. **Openness when things go wrong:** Doctors have a professional and ethical obligation to be open and honest when things go wrong.

Through the eyes of a locum

The Great Escape

Dr Euan Lawson, a locum GP from Cumbria, explains why every GP, including locums, should have an open door when consulting

Many GPs are contemplating their future and hatching their plan for their own great escape. We've been battling hard but GPs are now more like beleaguered prisoners of war than enthusiastic combatants. It can be a lonely business and the worry is that a few will go stir crazy.

One sweltering summer I did a locum for several weeks in a practice that tested my resolve. Sat in my hot box it was more *Bridge on the River Kwai* than *Colditz*. Sometimes general practice leaves me feeling like Alec Guinness's confused colonel, dazed by the heat, trying to do the best for my men while we all build a bridge for the enemy. That film finishes on the medical officer and his sweaty, anguished face. "Madness. Madness!" indeed. He could have been gazing on the modern NHS.

That summer, the computer told me there were half a dozen GPs in the building – but it was the only clue to their existence. All I saw were the closed doors. I don't know if they regarded locums as the enemy but they certainly weren't fraternising. It was the kind of practice that scheduled patients for the locum while the regular GPs had a coffee break. There are times when working as a GP can feel like doing time in solitary. In the cooler, Steve McQueen style. Only it's worse as you don't even get the peace and quiet of actually being on your own.

Yet just two things are needed to dispel the loneliness of general practice: door wedges and a NAAFI break. Forget the escape plan. There is no need to smash up the common room table to shore up the tunnels. No walking around on visits shaking your legs to disperse the freshly dug soil.

Every GP should prop open their door when not consulting – it may result in the occasional request to sign a script but the actual human contact that results is worth it. The NAAFI break is observed with near religious conviction in the forces. And for good reason – tea breaks are a chance to share stories and experiences. Careless talk may cost lives, but, in this case, gossip will save us. And don't forget to invite the locum.

Dr Lawson is also the deputy editor of the *British Journal of General Practice*

Sample AKT questions on prescribing

With *Dr Mahibur Rahman* from Emedica

1. What value of gifts from patients or relatives must be recorded in a register of gifts under the General Medical Services (GMS) contract regulations?

A. All gifts regardless of value
B. £10 or more
C. £25 or more
D. £50 or more
E. £100 or more

The correct answer is E: £100 or more. The gift does not have to be monetary to be recorded – it is the value of the gift that is important. The register of gifts should include the donor's name and nature of the gift.

2. A 60-year-old caucasian patient has a diagnosis of hypertension confirmed on ambulatory blood pressure measurement (ABPM). His average BP on ABPM was 160/98 mmHg. He is not on any medication. Which of the following is the most suitable management option?

A. Suggest lifestyle modification only at this stage and repeat BP in six months
B. Treat with Amlodipine 5mg od
C. Treat with Lisinopril 10mg od
D. Treat with Indapamide 2.5mg od
E. Treat with Doxazosin 10mg od

The correct answer is B: Treat with Amlodipine 5mg od. This patient has Stage 2 hypertension as his ABPM is over 150/95 mmHg. The current NICE guidelines recommend starting treatment for patients in this group. Patients aged 55 or over should be started on a calcium channel blocker 1st line.

3. A 68-year-old lady has a risk assessment for osteoporosis and as a result is sent for a DEXA scan. What T-score for hip bone mineral density from the DEXA scan would indicate osteoporosis?

A. -2.5 or more
B. -2.0 or more
C. -1.5 or more
D. -1.0 or more
E. -0.5 or more

The correct answer is A: -2.5 or more. The T-score gives the bone mineral density compared to the BMD of a healthy young adult. It is expressed as standard deviations (SD) from the mean. A T-score from +1.0 to -1.0 is considered within the normal range. -1.0 to less than -2.5 is considered osteopenia. A T-score of -2.5 or more below the mean is considered osteoporosis.

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Dr Mahibur Rahman is the medical director of Emedica, and works as a portfolio GP in the West Midlands. He is the course director for the Emedica AKT and CSA Preparation courses, and has helped several thousand GP trainees achieve success in their GP training examinations since 2005.

MPS members can get a £20 discount off the Emedica MRCGP courses. Details of the courses are available at **www.emedica.co.uk**

Dilemma – Staff as patients

It has come to the attention of our practice that a long-standing member of our reception staff team is registered as a patient at our practice. We had a management meeting about this and the partners feel uncomfortable about the arrangement. Please can you advise on how we should manage this situation – should we remove her from the practice list?

Practice Manager, Huntington

Medicolegal advice

By *Dr Marika Davies*, MPS Medicolegal Adviser

Providing care to anyone you know can be problematic. The GMC recognises this in its guidance *Good Medical Practice*, which states that you should avoid providing medical care to anyone with whom you have a close personal relationship.

Even if GPs and members of staff do not consider themselves to have a 'close personal relationship', in general, it is considered best practice for members of staff to register as patients at different practices to the one in which they work.

It is in the best interests of all patients to have access to independent and objective medical care.

Withholding information

Difficulties will likely arise when providing care to patients who are also members of staff. For example, the patient may not disclose information that is crucial to a diagnosis or management of a condition because they are embarrassed to share that information with someone with whom they have a working relationship.

Likewise, doctors may fail to ask sensitive questions or carry out intimate examinations, which ultimately is not in the best interests of the patient.

Informal chats

There is a risk that staff will consider that an 'informal' chat with their GP about a medical issue counts as having consulted their GP. However, the GP may not have explored their concerns as fully as they would have if they had had a formal consultation and it is unlikely that they would have conducted an examination or documented the relevant information in the medical records.

Another element is that all patients are entitled to confidential medical care. The fact that their medical records are kept at their place of work introduces a risk that a colleague will accidentally or purposefully access confidential information that is held about them.

Employment issues

A patient whose doctor is also their employer may feel unable to refuse treatment, question a decision or seek a second opinion.

If a member of staff requests a sick certificate, the doctor will be aware of the effect their absence will have on the smooth running of the practice and the pressure on other colleagues, which may impact on their ability to be entirely objective. It may be particularly difficult if the cause of the absence from work is stress in the workplace.

> "Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship" GMC, *Good Medical Practice* (2013)

Managing the situation

The simplest solution is for staff to be registered somewhere other than where they are also employed, but the situation needs to be handled sensitively. Often patients will have been members of a practice for many years and will be very resistant to the suggestion they should register elsewhere.

Explaining the reasons for your request carefully and helping them to understand why it is in their best interests not to be a patient of the practice is important. Provide them with information about other practices or GPs in the local area, and consider having a reciprocal agreement with another practice.

A decision to remove a patient from your list would be a last resort, and should only be considered if there is an irretrievable breakdown in the doctor-patient relationship. Given you will clearly wish to maintain a good working relationship with the member of staff it is unlikely to reach this stage, and the partners will need to come to an agreement about how best to handle each individual case.

Contact MPS to discuss any concerns and consider putting a practice policy in place to address the issue moving forward.

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Royal College of General Practitioners

The route to membership for established GPs

Membership by Assessment of Performance

The route to RCGP membership for established GPs

HOME

Membership by Assessment of Performance (MAP) has been designed for established GPs in the United Kingdom who wish to attain MRCGP, whether through a desire to strengthen their CVs, become GP trainers, or purely for the personal satisfaction and professional validation it offers. Previously called iMAP, the programme has been redesigned to cover all the areas required for revalidation.

> "I underestimated how much difference it would make towards my practice, and my enthusiasm for my work"
>
> *(Dr Bearn, Southwest London)*

> "I was relieved to find that a lot of the work was very relevant to what I was doing day-to-day"
>
> *(Dr Haridas, Cambridgeshire)*

> "When one has been in practice for a little while it is easy to stagnate; I feel invigorated by the iMAP process and ready to take on new challenges"
>
> *(Dr Pruden, East Sussex)*

Visit our website for more information, call us on 020 3188 7661 or email map@rcgp.org.uk

www.rcgp.org.uk/map