# MEDISEC ON CALL

Summer 2017

Around the clock support for the Irish GP community

MEDISEC IRELAND

MEDISEC ON CALL
summer issue 2017

*Deirdre McCarthy, In-house Legal Counsel, is Editor of Medisec On Call.* ***Should there be any topic you would like to see included in our newsletter, or if you no longer wish to receive it, you can email Deirdre at deirdremccarthy@medisec.ie***



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Medisec Ireland CLG,

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## WELCOME TO OUR SUMMER NEWSLETTER

Our vision is to be recognised as the indemnity body of choice for GPs in Ireland and to be respected as the pre-eminent GP advisory and risk authority, while arranging exemplary indemnity cover for you our GP members. We hope we are achieving this and delivering an exceptional, personalised and professional support service to you and your team, at what can be a difficult and challenging time in your career.

We believe that the best advice on how to continually improve our services comes from the people who use them. Therefore, we will shortly email all our members. If you have sought our support over the last year, we would ask you to respond to the email and complete a survey on your experience. Please be honest! Your feedback will help us raise our standards, resulting in a better quality of service for everyone. All responses will be treated in the strictest confidence. As a mark of our appreciation, we will donate €20.00 to Crumlin Children's Hospital Research Fund for every completed questionnaire we receive.

I am delighted to report that we continue to see a significant growth in membership. Our membership now stands at over 1,700 GPs, which we understand represents approximately half of GPs practising in Ireland. With increases in membership, we have seen a resulting increase in advisory activity answering over 1,200 queries last year. This service is available on a 24/7 basis and over 96% of queries are answered on the same day. No query is too small, so please do feel free to contact us on any matter.

To ensure the same high quality of service and response times to members, I am pleased to inform you that we have appointed another solicitor to our team. Aisling Malone joins us from Hayes solicitors, having previously worked in-house in the Medical Council and having trained in Matheson. Aisling has a wealth of experience in medico legal complaints and advisory work and will make an excellent addition to our team.

Finally, I am very grateful to our guest contributors in this edition of On Call; Dr Myra Cullinane for her words of wisdom to GPs on attending the Coroner's court; David Bell, HR specialist for his advice to GP practices dealing with sick employees; Dr Claire Collins, Prof. Andrew Murphy and Edel Murphy for their insight into primary care clinical trials and Dr John Brennan with his top tips in patient safety for trainee GPs. I am also grateful to our legal panel solicitors for contributing a range of interesting articles on important topics such as confidentiality, capacity and release of records.

I hope you have a lovely summer.

Ruth Shipsey
CEO Medisec

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# THE CORONER'S INQUEST

Dr Myra Cullinane FRCPI BL
Dublin City Coroner

*The coroner's inquest is changing, and awareness of the coroner's role is increasing amongst the public, their legal representatives and medical practitioners.*

*Increasingly general practitioners (GPs) are drawn into the information gathering process that the coroner will undertake prior to holding an inquest and they may ultimately be called to give evidence at the inquest.*

*There are currently 39 coroners in the State and each of these will have their own specific procedures. The following reflects the current general legal principles applying to any death that becomes the subject of a coroner's inquiry.*

## THE ROLE OF THE GP

A GP may report a death directly to the coroner, or may be contacted by the coroner when the death of their patient has been reported either by the Gardaí or a hospital doctor. If the cause of death is unknown or unnatural, the coroner will direct an autopsy to be carried out. If the autopsy report reveals an unnatural cause of death or if significant issues in relation to management prior to death arise, then an inquest will be held.

Prior to the holding of an inquest, the coroner gathers relevant evidence from those witnesses who may be of assistance to the coroner's enquiry. In general, in the preparation for inquest, members of An Garda Síochána act as officers for the coroner and gather evidence by way of deposition directly from the witnesses.

## GATHERING EVIDENCE

The method by which medical evidence is gathered varies according to coroner's district, there are no specific legal provisions in this regard. Currently some coroners will write directly to the GP seeking a medical report in relation to the deceased to be forwarded to the coroner's office.

In other districts however, it may be the case that the Garda will call to the surgery, acting as a coroner's officer, in order to take a statement in relation to the deceased from the GP. It is important to understand that the Gardaí are not acting in the investigation of crime in these circumstances. Such Gardaí are acting at the direction of the Coroner and are legally entitled to take the statement for the purpose of the inquest hearing. Any disclosure made by the GP in these circumstances is at the direction of the Coroner and is a legal obligation in the same manner as disclosure under any other Court Order. Issues in relation to confidentiality are a matter for the Coroner. Sensitive information in relation to the deceased may not be included in the inquest file but may be of assistance to the coroner in understanding the totality of the circumstances. It may be that the entire record is requested by the coroner if it is considered to be relevant, this is a matter for the individual coroner. Each case turns on its own facts and the same principles apply.



## THE MEDICAL REPORT

It is not likely that a GP will be called to give direct evidence an inquest unless such evidence is central to the issues being enquired into, however their medical report may be read into the record in its entirety or referred to at inquest, and will form part of the public record after redaction of sensitive information. In those circumstances expressions of condolence in the report are usually well received by those family members that are in attendance at inquest. It should be borne in mind that there is no legal privilege when supplying such a report to the coroner and it may be shared with interested parties, such as the family or their legal representatives, prior to or subsequent to the inquest.

## THE AUTOPSY REPORT

In relation to the autopsy report of a deceased patient, this becomes a matter of public record after inquest and is available from the coroner's office to the GP on request. It is generally not the practice to supply a copy of the autopsy report prior to the receipt of the GP's report or deposition but it is available on request if the GP is attending the inquest to give evidence once their draft evidence has been received.

## THE INQUISITORIAL PROCESS

It must be remembered that inquests are inquisitorial in nature. The coroner is attempting to make certain findings of fact in relation to the deceased, namely their identity, the date and place of death, the medical cause of death and, with reference to the circumstances of the death, to record a verdict that reflects the manner in which the death occurred. The coroner will ask questions of the witnesses to assist in these findings and will allow other interested parties such as the family to ask further questions within the scope of the enquiry. There are no 'sides' at an inquest unlike in adversarial civil or criminal proceedings. Nobody is blamed or exonerated at an inquest and no adverse findings are made against any individual practitioner.

If the GP is called to give evidence at inquest, notice will be given of the date and location of the inquest hearing. There is no obligation to be legally represented at an inquest - this is a matter for the individual practitioner. It is advisable for GPs to consult with their medico-legal advisor to outline the facts of the case and their involvement, seeking their advice in relation to representation.

## ATTENDING AN INQUEST

The GP should attend court with a copy of their medical report. It is also permissible to have a copy of the deceased's medical notes in court. These may be of assistance to the witness and can be referred to while giving evidence.

The coroner's inquest is held in public. Members of the press may be present. The format of the inquest hearing may vary depending on the coroner's district, but in general the coroner will open proceedings with some introductory remarks outlining the nature of proceedings and will then formally open the inquest of the named deceased. The coroner will call the witnesses, usually following the chronology of events leading up to death concluding with the pathologist. Each witness is called by name to the witness box and can either swear on a holy text according to their religion or may choose to 'affirm' if they are of no religious belief.

The GP is often called early in the proceedings. The practitioner will read their report into the record and subsequently the coroner will ask questions aimed at clarifying the facts. The coroner will then allow questions from interested parties either directly or from their legal representatives, if present. The witness may amend or add to their evidence while at inquest. At the conclusion of their evidence, the witness may wish to extend their condolences personally and this is permissible. There is usually no obligation to remain in the court having given evidence and the witness may ask the coroner if they are excused at that point.

## THE JURY

A minority of inquests are held in the presence of a jury. There is an obligation on the coroner to sit with a jury in cases such as death in custody, road traffic collisions, and unlawful killing. If matters of public interest are to be raised the coroner has discretion to hold the inquest before a jury. Deaths occurring in the context of medical treatment are seldom held before a jury unless there are significant issues raised that might lead to future similar deaths.

## THE VERDICT

At the conclusion of an inquest, the coroner summarises the evidence heard and records the findings, as outlined above, followed by the verdict. A verdict represents the means by which, or the manner in which, the death occurred. The verdict is separate from the medical cause of death. There are a limited number of verdicts open to the coroner. Those that are more common include Accidental Death, which is a death arising out of entirely unforeseen circumstances; Suicide, where the deceased has taken his or her own life and intended to do so. Misadventure, the unintended result of the intended action. This verdict can be extended to Medical Misadventure when the death has occurred in the context of medical treatment. Occupational Disease, such as death related to mesothelioma as a result of occupational exposure to asbestos. The *Open Verdict*, is when the evidence heard does not go to fully explain the manner in which death occurred. In complex circumstances such as multifactorial causation, the coroner may record what is known as a Narrative Verdict. This will be a short neutral recounting of the evidence heard.

The most important point in relation to any verdict is that it should carry no imputation of blame or adverse finding against any party.

If requested to provide evidence and the practitioner is unsure as to what specific points in the patient's history should be addressed, the coroner will always be happy to be contacted to give guidance in that regard. In addition to evidence in relation to the specifics of the management of a given case, coroners are dependent on the assistance of GPs in giving their evidence in relation to the medical and social background of their deceased patient in many of their enquiries. Such evidence will often lead to a more thorough and meaningful inquiry for the family.

On behalf of coroners in Ireland, I would like to express our gratitude for the ongoing support of those of you working in general practice.

# PATIENT CONFIDENTIALITY

## WHEN CAN IT BE BREACHED?

by Alison Kelleher,
Partner,
Comyn Kelleher Tobin,
Medisec Panel Solicitors

### GENERAL PRINCIPLES OF CONFIDENTIALITY

Confidentiality is a fundamental principle of medical ethics and is central to the trust between patients and doctors. Patients are entitled to expect that information about them will be held in confidence, even after death.

Paragraph 29.3 of the Medical Council Guidelines states:

*"29.3 Before sharing or disclosing any identifiable information about patients, you must take into account the Freedom of Information (FOI) principles.*

*You must be clear about the purpose of the disclosure and that you have the patient's consent or other legal basis for disclosing information. You must also be satisfied that:*

- *you have considered using anonymised information (information that does not identify the patient), and you are certain that it is necessary to use identifiable information;*
- *you are disclosing the minimum information to the minimum number of people necessary;*
- *the person or people to whom you are disclosing the information know that it is confidential and that they have their own duty of confidentiality."*

### DISCLOSURE WITH A PATIENT'S CONSENT

Where a patient is capable of making their own healthcare decisions, GPs must obtain the patient's consent before giving medical information to a third party.

While the concern of the patient's relatives and close friends is understandable, information must not be disclosed to them without the patient's consent. If the patient does not consent, GPs should respect their decision, except in very exceptional circumstances where failure to disclose information would put the patient or others at risk of very serious harm.

### DISCLOSURE WHERE THERE IS NO CAPACITY

If the patient lacks capacity to give consent and is unlikely to regain capacity, a GP may only consider breaching patient confidentiality if it is in the patient's best interests to do so. The views of family members are relevant in weighing up the best interests test to be applied, but without any formal legal authority such as an Enduring Power of Attorney, a family does not have any right to confidential information unless it is felt by the GP that it is in accordance with the patient's best interests.

### DISCLOSURE REQUIRED BY LAW

#### DISCLOSURE REQUIRED BY COURT ORDER

Confidentiality will be overridden when ordered by a judge in a court of law, or by a tribunal or body established by an Act of the Oireachtas. For example, a Fitness to Practice Committee of the Medical Council has the power to issue a "Production Order", which is akin to a Court Order directing that copy records of a patient be provided to the Medical Council.

#### DISCLOSURE REQUIRED BY STATUTE

Infectious Disease Regulations oblige all medical practitioners to notify the Medical Officer of Health or Director of Public Health of certain infectious diseases, including most recently, Zika Virus. The patient should be advised of the GP's statutory obligation to report the patient's details to the relevant authority, and that the report will be treated in a confidential manner.

### DISCLOSURE IN RELATION TO A VULNERABLE PERSON

Where a GP knows or has reasonable grounds for believing that a crime, abuse or neglect has been perpetrated against a vulnerable person, special considerations apply where it is appropriate and necessary to protect that vulnerable person. The Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 came into force on 1st August 2012 and provides that it is an offence to withhold information on certain offences against children and vulnerable persons from An Garda Síochána.

### DISCLOSURE IN RELATION TO CHILD PROTECTION CONCERNS

Under the Protections for Persons Reporting Child Abuse Act 1998, disclosures are protected by law if they in good faith report suspected child abuse to a designated officer.

GPs have an obligation to follow the Children First Guidelines and promptly report any reasonable concerns to Tusla. Paragraph 26 of the Medical Council Guidelines states:

*"You must be aware of and comply with the national guidelines and legislation for the protection of children, which state that the welfare of the child is of paramount importance. If you believe or have reasonable grounds for suspecting that a child is being harmed, has been harmed, or is at risk of harm through sexual, physical, emotional abuse or neglect, you must report this to the appropriate authorities and/or the relevant agency without delay. You should inform the child's parents or guardians of your intention to report your concerns taking into account that this may endanger you or the patient…."*

So long as the report is made in good faith in a child's best interests, the provision of information to the appropriate statutory agencies for the protection of a child is not a breach of confidentiality or data protection.

### DISCLOSURE IN THE PUBLIC INTEREST

Paragraph 31.3 of the Medical Council Guidelines provides guidance in relation for disclosure in the public interest to protect a patient or another identifiable person, or the community more widely. Before making a disclosure in the public interest, a GP must be satisfied that the possible harm the disclosure may cause the patient is outweighed by the benefits that are likely to arise for the patient or for others. Again, the information should only be disclosed to an appropriate person or authority, and include only the information needed to meet the purpose of the disclosure.

As a general rule, in balancing the duty of confidentiality against the duty to protect a patient or a third party at risk of serious harm, GPs should consider:

- the likely impact on the patient or third party, should confidentiality not be breached;
- the profound and irreversible consequences of making a disclosure;
- whether there are any appropriate alternatives to breaching confidentiality, such as counselling a patient to make the disclosure themselves.

### EXCEPTIONS TO DISCLOSURE UNDER DATA PROTECTION AND FREEDOM OF INFORMATION LEGISLATION

Section 8 of the Data Protection Act lists a number of exceptions to the rules applying to data processing. This includes information held in a personal record that is *"required for the purpose of preventing, detecting or investigating offences or prosecuting offenders" or "to prevent injury or other damage to the health of a person or serious loss of or damage to property".*

The legislation does not elaborate on the seriousness of the offences or threats concerned. However, for GPs who have a professional duty to protect the confidentiality of their patients, it is generally accepted that it would not be ethical to comply with any request for disclosure of sensitive personal information unless withholding the information would potentially have **profound adverse consequences**.

### RISK OF SERIOUS HARM IF INFORMATION DISCLOSED

There are occasions, such as a request by a patient for release of their own psychiatric records where there could be a risk to the patient's safety if the records are released.

Section 28 of the Freedom of Information Act states that access to records can be denied in circumstances where the disclosure of the information concerned might be prejudicial to the individual's physical or mental health, well-being or emotional condition.

Guidance published by the Information Commissioner sets out the considerations that public bodies, including the HSE should take into account when deciding whether to disclose or withhold sensitive medical information under the Freedom of Information Act. The Guidance states that particular procedures must be followed where disclosure may be prejudicial to a patient's health or emotional well-being. In these circumstances, if a vulnerable patient requests information, consideration should be given to releasing information to an appropriate health professional nominated by the patient, rather than the patient themselves.

The Guidance confirms that release of personal information to a third party should **only be made in exceptional circumstances where, on balance, the public interest in disclosure outweighs the right to privacy of the individual**

**concerned, or where release of the information would benefit the individual.**

Section 4(1) - Data Protection (Access Modification) (Health) Regulations, 1989 provides for such instances and states –

*"Information constituting health data shall not be supplied by or on behalf of a data controller to the data subject concerned in response to a request under section 4(1)(a) of the Act if it would be likely to cause* ***serious harm to the physical or mental health of the data subject"***.

In the case of Mr X and the Health Board, 12 December 2000, the Data Commissioner took the view that it was appropriate to withhold information from a patient where there was **evidence of a real and tangible possibility of harm** being caused to the general health, welfare and good of the patient as a result of release of medical information to the patient.

The Data Commissioner has clarified that this is a variation in the right of access that should only be applied in **rare circumstances**.

## SUMMARY

Unfortunately, a GP should never and can never give 100% assurance to a patient that all medical information will be kept confidential.

Where a GP has concerns in relation to breaching confidentiality and making a disclosure of information or records without consent, consideration should be given to:

- General Freedom of Information and Data Protection principles.
- The purpose of the disclosure.
- Whether the use of anonymised information would suffice.
- Disclosing the minimum information to the minimum amount of people necessary.
- Ensuring the intended recipient is aware the information is confidential and that they have their own duty of confidentiality.

The advice for all doctors is to proceed with caution and if in any doubt, contact Medisec for assistance.

## CASE STUDY

A Medisec member recently sought advice in a situation where a HIV positive male patient was in a known sexual relationship with another female patient of the practice. The GP knew that the female patient was not aware of her partner's HIV status. The GP was aware that the couple were not using appropriate practices to avoid transmission and the female patient had a serious risk of contracting HIV from her partner.

Medisec advised the GP:

- To invite the male patient to the practice to discuss the GP's concerns.
- At that consultation, to reiterate the seriousness of the GP's concern for the patient's partner, to explain that there is a chance that the partner may already be infected with HIV and explain the risks of any further unprotected intercourse. The GP should, at that consultation, offer to meet with both partners together and explain the diagnosis of HIV.
- If, following the consultation with the male patient, a concern remained that the patient may not tell his partner, the GP should advise the patient that patient confidentiality is not absolute. Where there is a serious risk to the health of an identifiable member of the public, such as potential infection with HIV, then this may justify a breach of confidentiality. The GP should advise the patient that, as there is a serious risk of profound adverse consequences if the female patient is not informed of the HIV status, the GP may have no option but to notify his partner.
- If the patient refuses to inform his partner, the GP should advise the patient that unless he tells his partner of his HIV status, the GP is left with no option but to contact his partner herself to inform her of her partner's HIV status.
- As a last resort, the GP should arrange to meet with the female patient and inform her of the risk of contracting HIV from her partner. The HIV patient should be advised that this step is being taken by the GP and he should be given a further opportunity to either consent to the disclosure or to inform his partner.
- The GP must be prepared and able to justify this decision to disclose confidential information without permission.
- If the GP does take the step of informing the patient's partner, the GP should advise her that this information is given in strict confidence, on a confidential basis for her own safety only and the GP should advise the patient that her partner's confidentiality should be respected and maintained.
- Finally, the GP should carefully note the discussions with both partners and the reasons for the refusal by the patient to inform his partner and carefully document any steps taken before and at the time of informing the patient's partner.

# PATIENT CONFIDENTIALITY

## WHEN CAN IT BE BREACHED?





# Top Tips in Patient Safety for GP Trainees

Quality Improvement is the combined and unceasing efforts of everyone; healthcare professionals, patients and their families, researchers, payers, planners and educators, to make the changes that will lead to better patient outcomes, better system performance and better professional development[1]. High quality care is care that is safe, effective, efficent, timely, equitable and person-centred[2].

Despite an increasing drive for improved quality in healthcare, much of the care provided to patients is unsafe. In the United States alone, it is estimated that over 250,000 people die each year as a result of medical error, making this the third leading cause of death[3]. In an Irish context, approximately 12.2% of patients experienced an adverse event during hospital treatment in 2009[4].

Unfortunately, in Ireland to date, there has been no large scale epidmiological study to reliably quantify error and harm rates in General Practice. A recent study of GPs in France found a Patient Safety Incident rate of 26 per 1,000 patient encounters[5]. In the UK, self reporting has revealed an error rate of 75.6 per 1,000 patient consultations[6], while use of a Global Trigger tool in Scotland demonstrated patient harm occuring at a rate of 1 event per 48 consultations[7]. Regardless of methodology, these figures demonstrate the need to treat patient safety as a major global healthcare concern. In this context, it is paramount that measures are taken by all members of the healthcare community to try to reduce this burden of healthcare associated harm for our patients.

Sadly, in many instances in General Practice, patient safety and it's improvement have traditionally been approached from the perspective of risk, fear and patient harm. However, at a human level, it is crucial to recognise that the science of patient safety can be constructive, pragmatic and enjoyable. This poster aims to demonstrate 10 straightforward, positive and practical ways to improve patient safety. It was originally conceived as a tool for GPs in training, however, most of the tips included may be relevant to all working in General Practice.

Enjoy!

Dr. John Brennan is currently a 4th Year GP Registrar on the HSE Dublin/Mid-Leinster GP Training Programme and RCPI/ISQua Healthcare Quality Improvement Scholar in Residence

This poster was awarded Best Poster at the European Society for Quality and Safety in Family Practice (EQuiP) Conference held at the Royal Marine Hotel, Dun Laoghaire on March 3rd and 4th 2017.

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Royal College of Physicians of Ireland

HSE Feidhmeannacht na Seirbhíse Sláinte Health Service Executive

## Patient Safety: Top Tips for GPs in Training

**Brennan J**
**GP Registrar and RCPI/ISQua Quality Improvement Scholar in Residence**
**HSE Dublin/Mid-Leinster GP Training Programme**

TOP TIPS

### 360 Degree Vision
Put yourself in the patient's shoes and advocate for safety from there

### Handover
Good handovers protect patients from harm and doctors from risk

360°

### Human Factors
HALT when you are Hungry, Angry, Late or Tired

### Your Own Mother Test
Be aware of and guard against depersonalising patients at times of stress

### Protocols and Guidelines
Checklists are an effective tool to help you as a doctor

### Significant Events
Recognise and learn from the analysis of positive and negative events

***Stage 4 – Analysis of the significant event***
The analysis of a significant event can be guided by answering four questions:
1. What happened?
2. Why did it happen?
3. What has been learned?
4. What has been changed or actioned?

The possible outcomes may include:
- no action required;
- a celebration of excellent care;
- identification of a learning need;
- a conventional audit is required;
- immediate action is required;
- a further investigation is needed;
- sharing the learning.


### Apologise
This reinforces recognition of an event and human sensitivity

### Respect, Revere and Relish the Team
Quality and safety are shared goals

### Work Within Scope
If you're not 100% comfortable doing something seek help or support

### Safety 2
Focus on the positives and the things that work well


**References** Significant Event Audit; Guidance for Primary Care Teams, NHS National Patient Safety Agency, National Reporting and Learning Service, Published October 2008.
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# PATIENTS' ACCESS REQUESTS FOR *MEDICAL RECORDS*

by Antonia Melvin,
O'Connor Solicitors,
Medisec Panel Solicitors

A patient's right of access to a copy of their own records is provided for in three forums:

- The Medical Council Guidelines[i]
- The Data Protection Acts and[ii]
- The Freedom of Information Act (FOI ACT).[iii]

## QUALIFICATION: POTENTIAL SERIOUS HARM TO PATIENT

The Medical Council Guide to Professional Conduct and Ethics 8th Edition provides at paragraph 33.5:

***"33.5 Patients have a right to get copies of their medical records except where this is likely to cause serious harm to their physical or mental health. Before giving copies of the records to the patient, you must remove information relating to other people, unless those people have given consent to the disclosure."***

Both the Data Protection and Freedom of Information (FOI) Acts are subject to provisos regarding the potential harm that access to the records may have on the patient. The Data Protection (Access Modification) (Health) Regulations 1989 set out that access can be refused if the disclosure of medical records to the patient "would be likely to cause serious harm to the physical or mental health of the patient". Similar regulations apply to Social Work records. Likewise section 73(3) of the FOI Act provides that access to medical, psychiatric and social work records may be refused where "it might be prejudicial to the requester's physical or mental health, well-being or emotional condition."

## REQUESTS IN RELATION TO GMS PATIENT RECORDS:

Upon receiving a request for a patient's records the first thing to ascertain is whether or not the patient is a GMS patient.

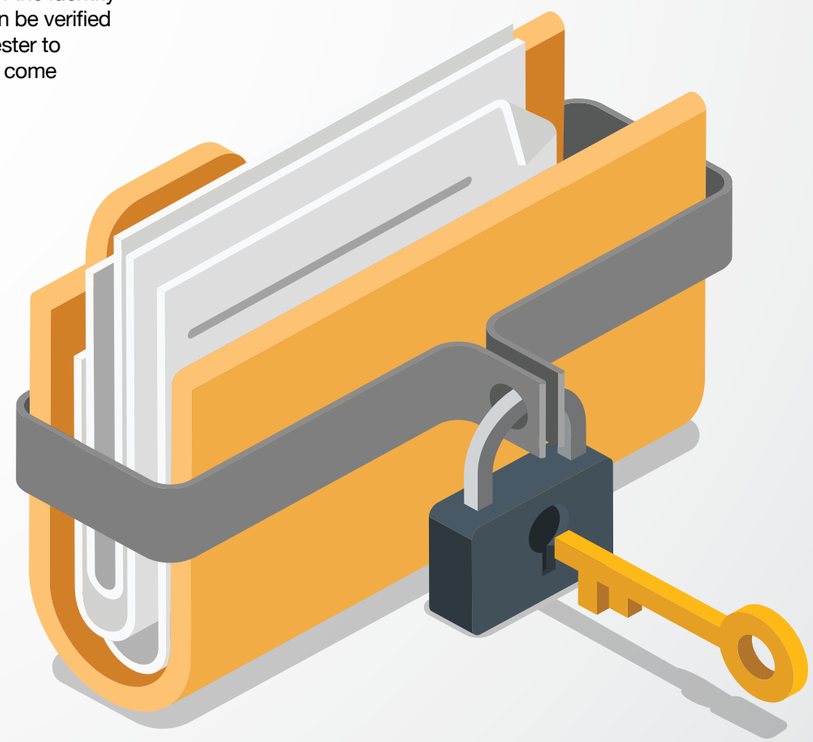
The FOI Acts 1997-2014 grant individuals a right of access to personal records concerning the individual, which are held by public bodies. Although a GP practice is not a public body, the HSE is and so the FOI Acts apply to records held by GPs in relation to patients who are medical cardholders, i.e. GMS patients. It does not apply to the records of private patients.

- Where GPs receive requests for GMS patients' records that specifically refer to the FOI Act, **unless** the request is extremely straightforward without any complicating factors, the requests must be referred to the relevant HSE body for processing.
- The HSE has resources and processes in place to comply with the requirements, timeframes and, internal appeal processes set out in the FOI legislation and are the appropriate body to deal with FOI applications.
- Where the application is very straight forward and contains no matters of issue either in relation to the content of the records requested or as to who is making the request (i.e. requests for a deceased patient's records, or requests by third parties), the GP can inform the individual that while an FOI request must be forwarded to the HSE, the GP can facilitate the request for records under Data Protection or routine access if the patient so wishes.
- Even if the requester does not specifically refer to the FOI in their request for access to a GMS patient's records, **unless** the request is extremely straightforward without any complicating factors, the GP should refer the requester to the HSE FOI process as described above.
- The GP should refer the requester to the relevant HSE body and application form, which can be found here, and inform the requester that the GP will cooperate fully and promptly with the request from the FOI when received; http://www.hse.ie/eng/services/yourhealthservice/info/FOI/Making_a_Request/foiform.doc
- The HSE will then examine the file taking on board the relevant considerations to determine if the records should be released.
- The HSE FOI Officer allocated to the request will contact the GP to request the records and any relevant information.
- The GP should deal promptly with the request from the FOI Officer to deliver a **copy** of the records, and fully set out to them in writing any relevant information or concerns which the GP may have with regard to release or redaction of such records. If the GP believes that disclosure of some or all of the records, under FOI, is not justified because it would be prejudicial to the patient's 'health or emotional well-being' the GP should notify the HSE of this fact, advising the FOI Officer of their reasons for this decision, as they are required to refuse the application in such circumstances.

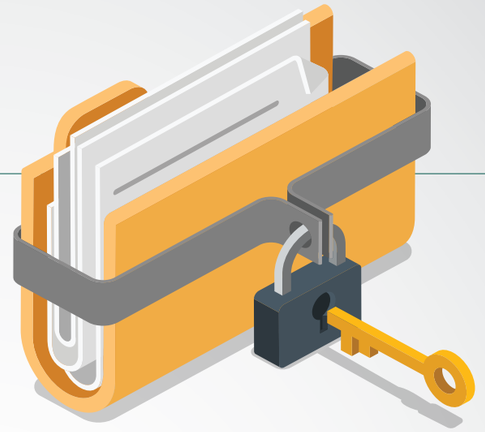
## ROUTINE/ADMINISTRATIVE ACCESS AND DATA PROTECTION REQUESTS:

If the request does not relate to a GMS patient (or, if having considered the factors set out above, the GP believes the GMS patient request can appropriately be dealt with under routine/administrative access (Medical Council Guidelines) or the Data Protection Acts) the following steps should be taken:

- Under the Data Protection Acts, each GP practice should have a designated person assigned to deal with Data Protection requests.
- Also if being dealt with under Data Protection, a fee of no greater than €6.35 can be charged and the records must be provided to the patient within 40 days from the receipt of the valid request and fee.
- Requests should be received in writing. This is required for Data Protection requests but advised as good practice in all instances.
- The GP should satisfy himself of the identity of the requester patient; this can be verified by a telephone call to the requester to confirm the request has indeed come from them.
- The GP should satisfy himself of the capacity of the patient to make the request. If for any reason the GP doubts the patient's capacity, the GP should insist that the patient attend the practice for a consultation before release.
- As referred to above, the GP must satisfy himself that release of the records would not be likely to cause serious harm to the physical or mental health of the patient. Where a GP is unsure as to whether it is in the patient's best medical interests to receive the records, it may be appropriate to have the patient attend the practice for a brief consultation before deciding to release.
- Under Data Protection, if, on review, the GP decides access to the records should be denied, the patient must be provided with the reason for the decision and only the part of the records likely to cause harm should be removed with the rest of the records released in the usual way. Patients should also be informed of their right to complain to the Data Protection Commissioner.[iv]



# PATIENTS' ACCESS REQUESTS FOR *MEDICAL RECORDS*



- Records must be reviewed carefully and consideration given on a case by case basis to the requirement to redact information in relation to **third parties**, unless their consent is sought before delivery.[v]

- The consideration of third party identity does not generally include references which relate to other health professional colleagues in the context of carrying out their professional duty.

- Expressions of opinion by third parties may be disclosed without seeking the individuals' consent, unless the opinion was provided in confidence or on the understanding that it would be treated in confidence. In that instance access to the opinion can be refused if the person who submitted it refuses consent.[vi]

- Consideration of redactions concerning third party information may need to take into account whether the redaction would defeat the purpose of the request, i.e. third party information may be relevant in a family law dispute where allegations of domestic abuse were reported to and documented by a GP. The GP needs to consider the best interests of their patient in each case and make a clinical decision as to whether the information should be redacted. Medisec advice can be sought in such a situation.

- In light of the above requirements relating to the likely effect on mental health and appropriate redactions to protect third parties, it is absolutely necessary for decisions, relating to access to records, to be performed and signed off by a suitably qualified medical professional, ideally the patient's treating GP and this should not be delegated to an administrative staff member.

- In terms of best practice it is recommended that as a matter of professional courtesy, and insofar as disclosure may involve disclosing a consultant's letters or documents, the consultant should be informed of the pending disclosure before the records are actually released in copy form.

- If the patient's records contain consultants' reports on the patient's mental health, it is recommended that the relevant consultant who authored those reports provide prior consent to the release of such copy records. A note to the effect that records will be released to the patient after a certain date, unless the consultant has returned with specific objections to their release or advice re appropriate redactions may be helpful. This allows the GP to move forward with the request and at the same time involve the relevant consultant in the decision.[vii]

- Original records must always be retained within the practice and complete and legible photocopies of the records should be provided to the patient.

- A GP should record their decision-making process regarding the release of records, the date when information sent, what was sent and to whom. It is recommended the decision-making process is documented separate to the consultation records but still in the patient's file.

- If a patient is unhappy with a GP's response to a Data Protection request, they can refer the matter to the Data Protection Commissioner for review.

- It is recommended that medical records sent to a patient in response to a "routine access" or Data Protection request, are sent by registered post, or are collected by the patient (who may be asked to provide photographic I.D. when attending to collect records).

If you have any queries in relation to a request for a copy of a patient's medical records contact the advisory team at Medisec.

## REQUESTS IN RELATION TO DECEASED PATIENT'S RECORDS

Such requests require additional considerations. For further detail on this issue see Medisec Advices webpage http://www.medisec.ie/a-z/deceased-patients-notes.

[i] Guide to Professional Conduct and Ethics for registered Medical Practitioners, 8th Edition par33.5
[ii] Sec. 4 of the Data Protection Acts 1988 and 2003
[iii] Sec. 12 of the Freedom of Information Act 2014
[iv] Sec. 4(7) of the Data Protection Acts 1988 and 2003
[v] Guide to Professional Conduct and Ethics for registered Medical Practitioners, 8th Edition par33.5 and Section 4(4) of the Data Protection Acts 1988 and 2003
[vi] Section 4(4a) of the Data Protection Acts 1988 and 2003
[vii] The Data Protection (Access Modification) (Health) Regulations 1989 prohibit release of health data without first consulting with the individuals doctor or a suitably qualified health professional.



# DO NOT RESUSCITATE (DNR) ORDERS

A Do Not Resuscitate (DNR) order refers to a decision not to proceed with cardiopulmonary resuscitation in the event of a cardiac or respiratory arrest. This order indicates to healthcare professionals not to perform cardiopulmonary resuscitation (CPR) on a patient in these circumstances.

As a GP you may often be requested to complete a DNR directive form, usually in the context of a nursing home or hospital. Decisions about attempting cardiopulmonary resuscitation (CPR) raise very sensitive and potentially distressing issues for patients and their families. CPR may not work, or may only partially work, leaving the patient brain damaged, or in a worse medical state than before the cardiac arrest. In these circumstances where CPR offers more burdens than benefits to patients, a DNR order may be medically and ethically appropriate.

There is no single specific national policy for DNR and it is addressed within the context of the National Consent Policy[i] and Advance HealthCare Directives[ii].

## KEY POINTS TO REMEMBER

The issue of a DNR order should primarily be discussed with the patient and their wishes should be taken into account and recorded. The patient's family should also be consulted (with patient consent) and the decision should not be made in isolation. Ideally the patient, family and healthcare team should be involved.

If the patient lacks capacity then the family, next of kin and or the Designated Healthcare Representative should be consulted. The GP must make an objective assessment of what is in the best interests of the patient, taking account of all relevant factors, particularly the patient's own views if known.

Under no circumstances should a DNR order be made without consultation with the patient or their representatives.

It may happen that the GP is presented with a form to sign with no forewarning or preparation, and the GP should not feel pressurised to sign without going through the various necessary steps. A simple 'DNR' form, while necessary, will not provide adequate detail of any conversations or discussions with the patient and/or their relatives regarding the clinical and ethical aspects of the DNR directive. It is therefore imperative that the GP records the details of discussions with the patient and others leading to the decision and to include reference to the clinical condition and decision-making capacity of the particular patient.

If a DNR order is made, this should be clearly documented in the patient's notes, together with the reasons for the decision and the process of decision-making.

The Irish Medical Council in its 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 2016, does not specifically deal with DNR orders but states that an "Advance healthcare plan or directive has the same status as a decision by a patient at the actual time of an illness and should be followed provided that;

- the request or refusal was an informed choice, in line with the principles (of consent) in paragraph 9;
- the decision covers the situation that has arisen; and
- there is nothing to indicate that the patient has changed their mind."

Please do contact Medisec if you have any queries surrounding a particular DNR form you have been asked to complete.

[i] http://www.hse.ie/eng/about/Who/qualityandpatientsafety/National_Consent_Policy/NationalConsentPolicyPart4.pdf
[ii] www.medicalcouncil.ie/News-and-Publications/Reports/Guide-to-Professional-Conduct-and-Ethics-8th-Edition-2016-.pdf

# SICK LEAVE
## THE IMPLICATIONS FOR PRACTICE STAFF

*As a profession that deals with the sick on a daily basis, you could be forgiven for thinking that GPs are better equipped to deal with the issue of sick leave. In my experience though, the uncertainty and difficulty they experience is just as apparent as in any other business. In fact, if anything, it is perhaps more prevalent.*

When it comes to sick leave, having a clear policy and sticking to it, is important. If you don't already have a policy in place, now is the time to do it. The possible financial and non-financial losses to your business caused by employee absence can be wide and varied and include:

- Payment of employee while absent, dependent on your policy.
- Payment of staff, perhaps at overtime rate, to cover absent employee.
- Lost income due to cancellation or disruption to appointments.
- Increased workloads on other staff.
- Reduced quality of service to your patients.

Generally, the most effective ways of managing absences are inexpensive and easy to administer (no pun intended). In this article the following questions will be answered:

1. Are there any circumstances where an employee has a right to sick pay?
2. Should a sick leave policy be written down?
3. What should the policy contain?

**1. ARE THERE ANY CIRCUMSTANCES WHERE AN EMPLOYEE HAS A RIGHT TO SICK PAY?**

In general there is no statutory right to sick pay in Ireland. Some employees are covered by registered agreements outlined by a Joint Labour Committee (JLC) that may have a right to sick pay, for example the Hairdressing JLC issued in 2002 includes a sick pay scheme.

If an employer breaches an order of the JLC it is an offence and they may be subject to a fine.

**2. SHOULD A SICK LEAVE POLICY BE WRITTEN DOWN?**

Some employers do not have a formal sick pay policy but routinely pay employees who are out sick. This system works well except where one or more employees take advantage of the employer's generosity, giving rise to difficulties with both the employer and other employees. If the policy is informal it could in fact become a contractual right of the employee on the basis of 'custom and practice' and an employer could find himself or herself bound to paying sick leave without any right to withdraw it, unless it is clearly stated in a policy.

It is always preferable, and good human resource practice, for an employer to have the policy, whether they pay sick pay or not, written down and this policy should be implemented across the board.

**3. WHAT SHOULD THE POLICY CONTAIN?**

It is important that an employee is fully aware of the manner in which the employer deals with absence and the procedures for reporting absence. This may be stated in the employment contract, in the employee handbook or in a separate practice policy document. The absence policy should include the following:

**A STATEMENT ON THE EMPLOYER'S APPROACH TO ABSENCE**

The policy should state that good attendance is expected; the effect of absenteeism and that absence is measured and tracked by the company or practice. Moreover, the policy should specify that the employer will take any measures it deems appropriate to address unacceptable absenteeism, up to and including amendments to existing benefits.

**EMPLOYEE NOTIFICATION REQUIREMENTS**

The policy should clearly outline for the employee (1) who they should contact if they are unable to attend for work and (2) when they should contact, e.g. must they contact in advance of normal working time to allow the employer time to make alternative arrangements or within a number of hours of normal starting time?

The expected frequency of employee contact with the employer during continued periods of absence should also be clearly outlined.

**PROVISION OF MEDICAL CERTIFICATES**

The policy should state when the employee is required to provide a medical certificate, what must be stated on that certificate and the frequency with which those certificates must be submitted. It is important to note that the provision of a medical certificate does not excuse absence; it merely provides an explanation or reason for it.

By David Bell
Managing Director of The HR Department, outsourced human resources specialists for Irish SMEs.

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Website: www.thehrdepartment.ie

**PAYMENT WHILE ABSENT**

The Terms of Employment Information Act, 1994-2001 places a legal obligation on the employer to advise employees of the terms and conditions (if any) relating to incapacity for work due to sickness or injury. Thus the policy must outline whether or not the employee will be paid during the absence and the conditions relating to payment. For example, payment of sick pay should be conditional on compliance with notification requirements, provision of certificates, submission of state disability cheque or acceptable levels of absence. It is important that the employer clearly specifies the grounds on which an employee may be disqualified from payment.

**MEDICAL EXAMINATIONS**

The policy should state that the employer reserves the right to refer the employee to an employer-nominated doctor at any time, at the absolute discretion of the employer and that it is a condition of the employee's employment that they attend the doctor and consent to the employer receiving a copy of the doctor's medical report.

In conclusion, whilst most employers are happy to pay an employee for the time they are off sick there may come a time where this is not possible due to frequent or prolonged absences. Employers should have a clear policy as to how much and for how long sick pay will be paid to avoid any confusion.

MEDISEC
IRELAND

# BEST PRACTICE

## CONFERENCE 2017

SAVE THE DATE
**SATURDAY 14TH OCTOBER**
CONRAD HOTEL, DUBLIN
**MORE INFORMATION COMING SOON**

# Consent and Capacity

By Janet Keane,
Kate McMahon & Associates,
Medisec Panel Solicitors.

All adults are presumed to have sufficient capacity to decide on their own medical treatment, unless there is significant evidence to suggest otherwise.

There is a presumption that an adult patient has capacity, that is to say the cognitive ability to make a decision to refuse medical treatment, but that presumption can be rebutted.

From a legal perspective, when determining if a patient is deprived of the capacity to make the decision to refuse medical treatment by either:

a. By reason of permanent cognitive impairment, or
b. Temporary or transient factors,

the test relates to whether the patient's cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the preferred treatment. The consequences of accepting or rejecting is in the context of the choices available (including any alternative treatment) at the time the decision is made.

The veracity of the tests in relation to a patient's cognitive ability and whether or not it has been impaired to such an extent that he or she is incapable of making a decision to refuse the proffered treatment is guided by the following principles:

a. That the patient has not comprehended and retained the treatment information and, in particular, has not assimilated the information as to the consequences likely to ensue from not accepting the treatment;
b. The patient does not believe the treatment information and, in particular, if it is the case that not accepting the treatment is likely to result in the patient's death, does not believe the outcome is likely; and
c. The patient has not weighed the treatment information, in particular the alternative choices and the likely outcomes in the balance in arriving at their decision.

The treatment information, by reference to which the patient's capacity is to be assessed, is the information which the clinician is under a duty to impart - information as to what is the appropriate treatment, that is to say what treatment is medically indicated at the time of the decision, and the risks and consequences likely to flow from the choices available to the patient in making the decision. In assessing capacity, it is necessary to distinguish between misunderstanding or misperception of the treatment information in the decision-making process on the one hand, and an irrational decision or a decision made for irrational reasons on the other hand.The former may be evidence of lack of capacity; the latter is relevant to the legal assessment. In assessing capacity, whether at the bedside in a high-dependency unit or in court, the assessment must have regard to the gravity of the decision, in terms of the consequences which are likely to ensue from the acceptance or rejection of the preferred treatment.

## Consent and Minors

There are two broad categories of minors - those over 16 who are conferred with a right to consent to 'medical, dental and surgical treatment, by Section 23 of the Non-Fatal Offences against a Person Act 1997' – and those under 16, which raises the question of what is referred to as 'Gillick competence'. In relation to over 16 minors, there is nothing in the legislation to say that 16 and 17-year-olds have the right to refuse treatment. Section 23 confers only the right to consent to surgical, medical or dental treatment. For the purposes of psychiatric treatment, a person is only considered an adult from the age of 18, in accordance with Section 2 of the Mental Health Act 2001. Gillick competence is the shorthand term for the capacity of the mature under 16 to consent to medical treatment. Gillick v West Norfolk and Wisbech AHA concerned a mother's attempts to seek a declaration that her children (who were younger than 16) would not be prescribed the oral contraceptive pill without her knowledge or consent. The Court decided that children had a right to consent to medical treatment. In this jurisdiction, in the case of North Western Health Board v WH, the Supreme Court found that in most circumstances and, in keeping with the family's rights under the constitution, the welfare of a child is best served by deferring healthcare decisions to a child's parents. The Court held that there would be circumstances where, in the face of a grave threat to the welfare, health or life of the child, a Court would displace the decision-making authority of the parents, but that the facts in WH did not warrant such a step. In Temple Street v D - The High Court ordered the carrying out of a blood transfusion to a child whose parents objected on religious grounds. The test, which appeared to be adopted, was if there is an immediate and real danger to the life of the child or an acute medical or surgical issue, then the Court is more likely to intervene.



## Medical Council Guidelines

The Medical Council, within their Guide to Professional Conduct and Ethics for Registered Medical Practitioners, provides general guiding principles in relation to capacity to consent. They state that "every adult patient is presumed to have the capacity to make decisions about their own healthcare. As their doctor, you have a duty to help your patients to make decisions for themselves by giving them information in a clear and comprehensible manner and by ensuring that they have appropriate help and support. The patient is also entitled to be accompanied during any such discussion by an advocate of their own choice." There are instances where obviously a person's consent can be affected by infirmity. In this regard, the Medical Council advises that a functional approach should be taken when considering the capacity requirements in such an instance. The criterion in assessing the relevant choice depends on the following:

- The patient's level of understanding and retention of the information they have been given.
- Their ability to apply the information to their own personal circumstances and come to a decision.

The considerations for a clinician to take if the patient has no other person with legal authority to make decisions on their behalf are the following, as per Medical Council Guidelines:

- Which treatment option would provide the best clinical benefit for the patient?
- The patient's past and previous wishes if they are known.
- Whether the patient's capacity is likely to increase.
- The views of other people close to the patient who may be familiar with the patient's preferences, beliefs and values.
- The views of other health professionals involved in the patient's care.

## Informed Consent to Medical Treatment

One of the key issues which often arises in medical negligence actions is the detail of the prior informed consent obtained from a patient. If it can be established that the complications that arose were foreseeable complications which could arise without any negligence and that such risks had been outlined to the patient and accepted, then it is safe to say that no negligence should arise on a strictly informed consent basis.

In Geoghan v Harris, the judgement of Kearns, J in the High Court sets out the principles to be followed and considered:

(i) The Defendant is obliged to give a warning to the Plaintiff of any material risk which is a known or foreseeable complication of the operation. Materiality includes consideration of both
   a. The severity of the consequences; and
   b. The statistical frequency of the risk.
(ii) That the test to be adopted by the Court, as to what risks ought to be disclosed to a patient before an operation, is the test of the reasonable patient. By adopting that test, it was the patient, when fully informed, rather than the doctor, who made the real choice as to whether or not the treatment was to be carried out.
(iii) That when deciding whether or not a warning would cause a patient to forgo an operation, the Court must first adopt an objective test. The test is to yield to a subjective test where there is clear evidence in existence from which the Court could reasonably infer that what a particular patient will in fact have decided in the circumstances.
(iv) There is in fact no category of 'inquisitive patient' in existence in Irish law because of the onerous obligations, as referred to above, imposed on the medical profession to warn patients of all risks with severe consequences, regardless of their infrequency. In accordance with Medical Council Guidelines, obtaining informed consent cannot be an isolated event. It involves a continuing process of keeping patients up to date with any changes in their condition and the treatments or investigations proposed. Whenever possible, you should discuss treatments and options at a time when the patient is best able to understand and retain the information.

Every adult with capacity is entitled to refuse medical treatment. Even in circumstances where a clinician vociferously disagrees with their decision, that decision must be respected, with a clear explanation to the patient as to the possible consequences of refusing treatment and offer the patient the opportunity to receive a second medical opinion if possible.

One word of forewarning and caution relates to the Criminal Law (Sexual Offences) Act 2017. Although yet to be commenced, it is likely that The Act will be by the end of this year. Minister Fitzgerald has confirmed that the age of consent will remain at 17 years of age. However, a proximity of age defence will be introduced which can be relied on where the sexual act is a non-exploitative, consensual act and the parties are aged within two years of each other. In terms of a GP's analysis as to the capacity of such a minor to consent as referred to above, we will need to wait and see if specific guidelines are issued in relation to this legislation and the Children First Act 2015* once the relevant sections of both legislations are commenced. Medisec's advice is that a GP would require a thorough consultation with the minor sexually active patient, to allow a GP to make an honest clinical assessment on the patient's capacity and to try and ascertain the age of the patient's sexual partner. Medisec will update members in relation to any changes that are implemented in this area of the law which will impact on GPs in their daily practice.

* This is in line with section 14(3) of the Children First Act 2015 which provides for exceptions to reporting requirements of mandated persons in relation to sexual activity of older teenagers, reporting is not required where the child is sexually active between the ages of 15 and 17 and the other party is not more than 2 years older than them and where the mandatory person believes there is no material difference in capacity or maturity between the parties and that the sexual activity is not intimidatory or exploitative of either party. This section of the Act has not yet been enacted and guidelines are awaited.

# PRIMARY CARE CLINICAL TRIALS

## BUILDING THE IRISH GENERAL PRACTICE EVIDENCE BASE

by Edel Murphy, Andrew Murphy and Claire Collins
HRB Primary Care CTNI NUI Galway
ICGP

Primary healthcare is the essential first point of contact in our efforts to keep people well and improve their quality of life. It is the point where many crucial decisions are made. With enhanced expectations now of primary care, GPs are involved every day in the management of increasingly complex, frail and multi-morbid patients. It is important that GPs can draw on firm evidence to make treatment decisions for each patient - evidence that should, at least in part, be obtained from research conducted in primary care. A vibrant Irish primary care research environment generating high-quality evidence is a key foundation stone to the delivery of quality primary healthcare. Building research capacity in health services has been internationally recognised as important in order to produce a sound evidence base for decision-making in policy and practice[1] and having GPs involved in research has been shown to increase the quality of service[2].

Funded by the Health Research Board (HRB), the HRB Primary Care Clinical Trials Network Ireland (CTNI) is currently contributing significantly to this evidence base. It aims to improve individual patient health and healthcare by conducting high quality, internationally recognised, randomised trials in Irish primary care, addressing important and common problems. The ICGP is a main partner in the CTNI, collaborating with the National University of Ireland Galway, the Royal College of Surgeons in Ireland (RCSI), and Queen's University Belfast (QUB) (www.primarycaretrials.ie).

Patients are currently being recruited into an EU-wide trial on the efficacy of antiviral medication for influenza. Recruitment is ongoing in an EU-wide study on the management of lower respiratory tract infections, while a feasibility trial of patient safety in primary care is close to completion. The CTNI is about to launch a number of new trials, including:

- **SATIN** – a trial evaluating whether patients with suspected simple urinary tract infections can be managed equally well with either ibuprofen or nitrofurantoin. This trial aims to recruit 20 practices and 440 patients and the principal investigators (PIs) are Prof Andrew W Murphy and Dr Akke Vellinga, NUI Galway. Recruitment to this trial will be from practices within the catchment area of Galway University Hospital.

- **SPPiRE** – a trial optimising prescribing in older adults using online supports for GPs. The target for this trial is to recruit 30 practices and 450 patients. The PI is Prof Susan Smith, RCSI and practice recruitment will be nationwide.

Practices will also have the opportunity to participate in smaller trials in the areas of diabetes, mental health and dementia. Planning has just commenced for a large trial on the management of patients with atrial fibrillation, funded by the HRB, with the aim of significantly reducing the risk of stroke.

**DR. CLAIRE COLLINS**

is the Director of Research and Innovation at the Irish College of General Practitioners.

**PROFESSOR ANDREW MURPHY**

is Professor of General Practice, NUI Galway, the Director of the HRB Primary Care CTNI and a GP in Turloughmore, Co. Galway.

**EDEL MURPHY**

is the Development Officer for the HRB Primary Care CTNI.

### WHAT DOES PARTICIPATION REQUIRE OF THE GP PRACTICE?

All trials have been developed with the close involvement of GPs and patients. The impact on the practice is minimised as much as possible and trial sponsors try to ensure that specific financial support to practices for trial participation covers practice participation and a little more. Therefore, while some additional time is required depending on the actual trial, the aim is that this time is balanced by the enhanced diversity of work and financial support.

All trials conducted through the CTNI are approved by a recognised Research Ethics Committee, and, where required, by the Health Products Regulatory Authority (HPRA).

### WHY PARTICIPATE?

By participating in CTNI research, primary care staff have the opportunity to contribute to the primary care evidence base and to collaborate with leading academics and clinicians to bring about change. CTNI research also provides patients with the opportunity to take part in clinical trials, support the development of new treatments and approaches to care delivery. Involvement in some trials may help practice staff fulfil Irish Medical Council annual audit requirements, while in others, staff accumulate CPD points, through research-related meetings and trial-specific training.

Increasingly, taking part in clinical trials generates a new revenue stream for practices, while enabling staff to keep up-to-date with the latest leading-edge therapeutics and emerging behavioural interventions.

The HRB Primary Care CTNI are interested in hearing from GPs who would like to participate in or find out more about some of these trials. You can register with the CTNI on www.primarycaretrials.ie or contact the CTNI on info@primarycaretrials.ie

[1]UK Department of Health. R&D in Primary Care - National Working Group Report. UK Department of Health, Leeds, November 1997. Catalogue no. 97CC0138.
[2]Vogel, I. Research Capacity Building: Learning from Experience. UK Collaborative on Development Sciences, 2011.

Medisec and its underwriters Allianz support members' involvement in primary care clinical trials and recognise the benefits of such learning. Medisec members should seek prior approval from Medisec before participating in any such trial. If the trial is under the auspices of a recognised and relevant Research Ethics Committee and the work envisaged under the trial is considered 'normal' GP work then such trial would generally be covered by Medisec's professional indemnity policy subject to Allianz's terms and conditions. GPs partaking in a trial would be asked to confirm that they will follow all guidelines issued by the supervising Research Ethics Committee.

# WHAT TO DO WHEN THE GARDAÍ CALL SEEKING PATIENT RECORDS

By Hilda O'Keeffe
Partner
Comyn Kelleher Tobin Solicitors
Medisec Panel Solicitors

**THIS ARTICLE IS PART OF OUR SERIES ON PATIENT ACCESS TO MEDICAL RECORDS, IN THIS CASE OUTLINING THE DIFFERENCE WHEN THE REQUEST COMES FROM THE GARDAÍ**

**CONFIDENTIAL INFORMATION**

As a GP you have a duty not to disclose confidential or personal information, unless you have your patient's consent or the disclosure is permitted by law.

In general, a patient's consent is required to release confidential medical information to the Gardaí.

There are, however, certain limited circumstances where the public interest in disclosing information outweighs the patient's interest in preserving confidentiality, or the disclosure is required by law.

**LEGAL CONSIDERATIONS**

1. **Medical Council Guidelines**
   In summary, paragraph 29 and paragraph 31 provide that:

   - Confidentiality is central to the relationship of trust between a patient and doctor.
   - Sharing of patient information is sometimes appropriate in limited circumstances.
   - Before deciding to disclose information, be clear about the purpose of the disclosure and have either the patient's consent or another legal basis which permits disclosure.
   - When disclosing information as required by law or in the public interest, inform patients of the disclosure, unless this would cause them serious harm, or would undermine the purpose of the disclosure.

2. **Data Protection and Freedom of Information Legislation**

   The basic principles of Data Protection/Freedom of Information legislation require you to protect the medical records of your patient securely and to only release sensitive personal data with the explicit consent of the patient or in certain other limited circumstances.

   The exemptions which permit disclosure are set out in Alison Kelleher's article on Confidentiality on page 6.

   It is very important to be aware that these exemptions do not place an obligation on you to make the disclosure, but rather permit the disclosure to the Gardaí.

   The Information Commissioner guidance provides that you have "discretion to release personal information to a third party only in exceptional circumstances where, on balance, he or she is of the opinion that the public interest in disclosure outweighs the right to privacy of the individual concerned."

3. **Memorandum of Understanding (MOU) between HSE and DPP**

   This is an arrangement which only applies to GMS patients, where the HSE is the Data Controller of the patient's records and the disclosure relates to the provision of records to An Garda Síochana to assist in the prosecution and investigation of potential offences. The Memorandum is "intended to assist the HSE and the DPP to balance the duty of the HSE to protect confidentiality of the information it holds with the duty of the DPP to access material relevant to criminal proceedings". Consent of the patient is required to release any medical records under the MOU.

   Because of the additional safeguards the MOU affords, if appropriate, the MOU should be the preferred method of release to the Gardaí.

   Any request for release of information to the Gardaí under the MOU should be notified to the HSE Office of Legal Services.

**SCENARIO**

During a busy afternoon surgery, you are informed that a member of An Garda Síochána is at reception and wants to speak to you. The Garda is seeking a copy of the clinical records of your patient, who is being held in custody. The Garda explains that the patient has allegedly committed a serious crime, which has resulted in harm to another person.

**WHAT SHOULD YOU DO?**

If the Garda does not have a Court Order and there is no immediate threat to anyone, it would be reasonable to refuse the request and inform the Gardaí accordingly. The refusal should be documented in the notes. If the patient's consent is not forthcoming, the notes should not be released, unless the Gardaí produce a Court Order directing release of the notes.

**PRACTICAL ADVICE AND TIPS**

- Request official identification.
- Consider your duty of confidentiality to your patient and the balance between the individual's right to privacy and the need to investigate offences.
- Seek a copy of the original Court Order. If a Court Order has been issued, you are obliged to release the records specified in the Order.
- If no Court Order is available, seek an official letter of request for the specific records signed by a Garda Sergeant on the Garda Síochána's headed notepaper prior to seeking your patient's consent.
- Retain a copy of the request and the response on the patient file.
- Establish whether the patient is a GMS patient. If so, inform the Garda that you intend to refer the request to the HSE Freedom of Information Officer.
- Where the patient is a not GMS patient, the GP is the data controller and the consent of the patient should always be sought by the GP.
- If the GP is unable to obtain consent, the GP should:
  - clarify if the information can be obtained in an alternative manner;
  - establish the purpose of the request;
  - document the patient's reason to refuse consent;
  - carefully consider whether on balance there is a valid reason to release the records without the patient's consent, e.g. Court Order, incapacitated patients and required in their best interests, legislative exceptions such as notifiable diseases, investigation of an offence or the public at risk of serious harm;
  - keep in mind that pending prosecution, the patient is still presumed to be innocent and you should not release notes or records unless consent from the patient or their solicitor is received in writing.
- If on balance, in the rare circumstances that you determine that the records should be released without a Court Order and you have taken legal advice before doing so, the patient must be informed of the decision to release the records.
- If in doubt, seek advice from Medisec.

# QUICK TIPS

**ANTENATAL CARE**
Medisec, via their underwriters Allianz plc, will cover the GP and his/her practice nurse (if a trained midwife) to provide routine antenatal care under the supervision of a consultant obstetrician for a planned hospital delivery on condition that the GP provides supervision of the antenatal care given and signs off on each antenatal visit. The Maternity and Infant care contract is with the GP and therefore it is the GP who carries the responsibility for providing safe antenatal care according to best practice. Medisec does not recommend the practice nurse midwife providing independent antenatal care without the recorded clinical input of the GP.

Medisec will not provide cover for antenatal, intranatal or postnatal care to a patient who is planning a home delivery.

**MEDICAL COUNCIL REGISTRATION**
The Irish Medical Council Guide to Professional Conduct and Ethics 8th Ed. paragraph 54.1 insists that 'You must practise in the name(s) under which you are registered and always use your registration number when representing yourself as a registered medical practitioner.'

It can become a problem if a doctor is practising under a different name, and where a patient cannot identify a doctor on the register, it could lead to an allegation that the doctor is 'not registered'. Medisec would like to remind GPs who might have some different variations of their name to check online to ensure that they are practising under their registered name.

**'NO SIGNATURE' INSURANCE POLICIES**
Some members have been contacted by an insurance company to provide a PMA report on a patient who has apparently agreed to an application for an insurance policy which is marketed as a 'no signature' policy – where all agreements including consent to disclose medical information, have been made by phone. Medisec does not recommend that these are completed or returned by a GP without the GP first making contact with the patient and obtaining and documenting up to date informed consent from the patient for disclosure, including ensuring that the patient understands the extent of the disclosure involved.

**CALLED TO GIVE EVIDENCE IN COURT?**
Medisec often provides assistance to members who are called to give evidence in a variety of situations, including coroners' inquests and criminal cases. GPs are also occasionally asked to attend Medical Council inquiries to give evidence in the case of another doctor being subject to an inquiry. While some of these cases are straightforward, some may not be so clear cut. Where there may be difficulties for the GP, Medisec is happy to provide assistance in drafting witness statements, and, where necessary, accompanying members to court.

**RETROSPECTIVE DISCLOSURE OF HISTORIC ABUSE BY ADULTS**
The HSE 'Children First' document states: 'While GPs have responsibilities to all their patients, their primary consideration should be the best interests of the child. Whenever a GP becomes concerned that a child may be at risk of, or the subject of, abuse of any kind, it is essential that these concerns are discussed with the HSE Children and Family Services without delay'. 4.9.3

Sometimes a patient may reveal to the GP that they suffered abuse in the past, and may request absolute confidentiality about the matter from the GP. The GP must establish whether any other person is at current risk of similar abuse, and if that is the case the GP cannot guarantee confidentiality and is obliged to report the issue to the Child and Family agency without delay.

Children First further states… 'The provision of information to the statutory agencies for the protection of a child is not a breach of confidentiality or data protection'. 3.9.4

## RED ALERT

**PROFESSIONAL COMPETENCE REGISTRATION AND COMPLETION**
Medisec would like to remind members that maintenance of professional competence is an absolute obligation on all doctors registered with the Medical Council. This includes compliance according to the framework laid down.

Since May 2011, all doctors on the Irish Medical Council register are **legally obliged** to maintain their professional competence by enrolling on a professional competence scheme and following the requirements set by the Medical Council.

Each professional competence year runs from 1 May – 30 April.

The framework for professional competence is in brief:
- 50 CPD credits per annum (which includes activities in particular categories, maintenance of knowledge and skills, practice evaluation and development, personal learning and research or training.)
- 1 clinical audit (a minimum of 12 hours per annum)

Some GPs are still unaware that maintaining professional competence is a condition of remaining on the Medical Council register and being allowed to practise as doctors in Ireland.



# COMPLAINTS
## *AND DEALING WITH DIFFICULT PATIENTS,*


Managing difficult patients is part of the spectrum of issues dealt with in general practice. As we all know many patients can be angry or demanding because they are ill, they may be concerned that they might have a life threatening or life limiting illness, or they may have certain sensitivities due to a past experience, not necessarily with the GP, or in that GP's practice. When faced with an angry or accusatory patient it can be difficult to restrain one's own emotions. Responding to a patient's anger with further anger, having an overly defensive manner or using a raised voice will serve only to increase upset and disagreement all around, as well as being extremely unpleasant for all involved. Some small hints to assist in managing such patients might include:

1. Allow the patient time to air their accusation or concern, using empathic active listening skills. Allow the patient talk for as long as they want until there is no more for them to say. Often by that time they will have calmed to a degree.

2. The GP can enquire at that point if there is anything else they would like to add.

3. The GP can respond with a low calm voice and assure them that their concerns will be taken very seriously, investigated if necessary by the practice and that the GP will revert to them when the full process is completed.

It can be difficult to manage one's own emotions in situations as described above, but doing so is certainly in the best interest of the patient and definitely in the best interest of the GP.

The GP can give an expression of regret that the patient is upset, until the situation is clarified. There can be a temptation to try to resolve the issue immediately due to the patient's insistence, but taking the time to follow the procedures of the practice complaints policy can be easier and more thorough in the long term.

In this article we have highlighted some tips for dealing with a difficult patient who presents with a complaint. If you require more information on complaint procedures, Medisec are happy to provide templates for a practice complaints policy and an attractive poster for the waiting room.

**TO ORDER A FREE POSTER FOR YOUR SURGERY, PLEASE CALL US AT 01 661 0504 OR EMAIL INFO@MEDISEC.IE**

# PRIVATE MEDICAL ATTENDANCE FORMS
# CASE STUDIES

**By Kate McMahon,
Kate McMahon & Associates,
Medisec Panel Solicitors**

In the last edition of Medisec On Call, we considered some of the difficulties that can be caused for GPs in completing private medical attendance (PMA) reports.

Specifically the article considered the issue of consent and disclosure.

In this article, we look at some case studies that have arisen over recent years and where we have encountered issues with PMAs, and discuss what lessons GPs can learn from these scenarios.

At the outset, GPs need to recognise that PMA reports form part of a patient's clinical records. If there is a request for disclosure of a patient's records (either under Freedom of Information Act, Data Protection Acts or through the discovery process through the Courts) the reports will be disclosed as part of the patient's records. There will be no distinction between the clinical notes and the PMA reports. Both will be regarded as an accurate and contemporaneous record of the patient's health, diagnosis and treatment plan.

**CASE A**
A patient of a rural GP called to have a PMA form completed in connection with a short-term loan which he intended taking out from a financial institution.

The GP was aware that, many years beforehand, the Plaintiff had been diagnosed with a form of cancer for which he had been in full remission in the intervening years.

The patient was concerned that, if the GP disclosed this condition in the PMA report, he would either be refused life cover or, alternatively, would be heavily penalised.

The GP therefore did not include his knowledge as to the patient's relevant medical history.

He was confident that, during the short term of life cover required (three years) over the repayment of the loan, the underlying condition was most unlikely to recur.

Tragically, the patient died very suddenly from a completely unrelated medical condition (myocardial infarct).

The insurance company sought a copy of the Deceased's GP records and immediately saw that the diagnosis of cancer many years beforehand had not been disclosed to them.

Notwithstanding the fact that the cause of death was completely unrelated to the information not disclosed, the non-disclosure allowed the insurance company to declare the policy null and void and refused to pay out benefit under the policy to the Deceased's widow and children.

The Next of Kin brought an action against the GP for his failure to disclose the relevant medical history leading to a failure for them to collect a payment under the policy.

Whilst there was a legal argument that, even if there had been full disclosure, the policy would have been declined, and hence no payment would have been made, the fact that there was a non-disclosure of a previous medical condition caused a difficulty for the GP.

Provided the facts not disclosed to the insurer are highly material to the insurer (and a previous diagnosis of cancer would fall within this category) then it is irrelevant that the non-disclosed facts are unconnected with the event triggering cover under the policy (the heart attack).

This case illustrates a particular difficulty for GPs practising in a close community. If they disclose material facts to an insurer against the wishes of a patient, they are at risk of not only jeopardising the goodwill of their practice but also breaching the duty of confidentiality to the patient.

As outlined in the previous article, it is essential that a full consultation take place with the patient before any PMA be completed, and that the patient is aware of what information is being disclosed.

If a patient is resistant to material facts being disclosed, then the GP should not complete the PMA form and should simply indicate that they do not have the patient's consent to complete the form.

**CASE B**
A patient attended her GP with a complaint of eczema on her arms.

The doctor carried out an appropriate clinical examination and wrote up very comprehensive notes of the examination, the diagnosis and treatment.

Almost one year later the patient was diagnosed with malignant melanoma.

The patient attended the doctor for the purpose of completing a PMA report in respect of a critical illness policy which she held.

At this stage, there was no criticism being made of the GP by the patient.

However, some 12 months later, the patient claimed that, at the first visit when the diagnosis of eczema was made, she drew the attention of the doctor to a mole on the back of her neck which was asymmetrical, bleeding and had a large diameter.

The doctor was adamant that there was no such complaint made by the patient, nor any suggestion that the patient had shown him the mole one year previously.

The patient had herself completed the Critical Illness questionnaire and, when asked "When were symptoms of the disease (in respect of which a claim was being made under the policy) first seen by a medical attendant?" the patient had written "Almost one year ago" and named the GP as the medical attendant who had first seen the mole.

The GP was concerned for his patient and anxious that he do everything possible within his power to ensure that she would be paid under the terms of the policy and so he signed off the form on what was essentially inaccurate information at variance with his notes.

Subsequently, a claim was brought against the GP on the basis that he had failed to either diagnose the mole as a malignant growth one year earlier and therefore denied the patient an opportunity to have treatment initiated at an earlier date.

Alternatively, the criticism that was made of the doctor is that if he had any concerns about the nature of the mole (as one would have expected of him to have if the mole was as described by the patient) then he should have taken a sample for biopsy.

The doctor in question was a very careful note-taker and readily volunteered that he only signed-off on the patient's version of the first consultation to assist her in her claim for critical illness benefit.

He did not consider the claim form to be part of the patient's clinical records. Effectively, he was now exposed to a finding of negligence against him simply due to goodwill on his part - without realising that he was completing a clinical record in respect of his patient.

**CONCLUSION**
The PMA form, whether it is an application for insurance or an application for benefit under an insurance policy, should be treated by GPs as requiring as much accuracy in its completion as the patient's clinical notes. A failure to do so, or treating the forms as separate and distinct from the clinical records, exposes the GP to a potential finding of negligence.

As always, please seek the advice of Medisec in the event that you have any issues in relation to completion of PMAs.

# TRIAGE AT RECEPTION

## I WANT AN APPOINTMENT NOW!

*Everyone who has ever worked behind a GP's reception desk hears this demand every day. Everyone wants to be seen NOW!*

In general practice, many complaints to the Irish Medical Council result from a patient's experience of their initial interaction with a practice and especially being denied an appointment when they require immediate attention. While systems to ensure the efficient running of a practice, including how to manage requests for urgent appointments, are important, they should not compromise patient safety. This article examines issues which practices should consider in how they manage, and respond to, such requests.

### THE ACUTELY ILL PATIENT

For several reasons, it is important to remember that limited information might be obtained from a patient at the reception desk. Sometimes the patient has difficulty describing their symptoms adequately. Reception Staff should be aware of this - and, if a patient appears significantly unwell, they should notify the GP/practice nurse immediately, either by phone or instant message – and ensure that the message is received. Practices should agree how reception staff will contact GP/practice nurse in the event of an emergency and all members of staff should be aware of this.

While acutely life threatening situations are rare in general practice, they are an important event when they occur. All staff must remain vigilant and be aware that general practice attracts a self-selecting group of patients who may already be suffering significant illness, which can deteriorate rapidly.



Where there is an acute presentation to the practice and the patient is advised to attend elsewhere e.g. another practice/hospital, details of the episode/actions taken should be recorded, and the GPs in the practice notified so they can follow up with a call if necessary.

### PRACTICE SUPPORT AND TRAINING

Practices should be supportive of reception staff and all members of the practice team should remain aware of how difficult it is to 'always get it right' at reception. In particular, reception staff should be advised to immediately alert the GP or practice nurse if a patient presents to reception about whom they have concerns.

Ongoing training for reception staff is useful. New members of staff should have an opportunity to learn about practice procedures in caring for people who present to the practice acutely unwell and how to respond if a person requests an urgent appointment. Feedback should be formative and constructive and staff should be given positive feedback in situations where they have responded appropriately. As well as being upsetting to a colleague, harsh words or criticism by the GP may prevent a receptionist from flagging the presence of an unwell patient in the waiting room in the future.

New staff may not understand the meaning of words like 'acute' or 'chronic' in a healthcare environment and may need assistance in learning the terminology with which we may all be familiar. Furthermore, it might be assumed that all reception staff are aware of the very serious categories of presentations which warrant urgent assessment (e.g. dyspnoea, chest pain, acute severe pain, facial or limb weakness of sudden onset, etc).

A member of the frontline staff, when faced with a significantly ill patient, may panic and inappropriately respond when a patient presents with an acute or life threatening problem. Ongoing training helps remove uncertainty and helps equip staff members with the skills to analyse the level of urgency presented.

### PRACTICE CONSIDERATIONS

Has your receptionist had some form of training in how to triage patients, within or outside the practice? If so, how long ago and do they need to refresh their knowledge? Can you ensure that all staff have had comparable training and have similar ability in recognising patients with acute illness? Have all practice staff been trained in providing First Aid/CPR?

Some patient groups require special consideration due to their particular vulnerability and all reception staff should be aware of these:

- Women who are pregnant
- Children and especially young infants
- Elderly
- Patients with chronic conditions: e.g. Diabetes, COPD, mental health disorders
- Patients with intellectual disability
- Patients who are unable to speak English

### IF IN DOUBT

In any practice the default position for any member of staff must be 'If in doubt, ask the GP or practice nurse'. An open, supportive and friendly ethos in the practice goes a long way to support patient safety, where communication levels between clinical and non-clinical staff are easy and relaxed.

### SPARE APPOINTMENTS

A number of spare slots can be kept every day where possible for on the spot appointments, lowering the stress levels of the GP - and the entire practice team.

### COMMUNICABLE DISEASE

Triage training should include a management system of separating those with communicable illness, whether a child with chicken pox or an adult with the flu, and where space allows they should be directed to a separate waiting area – or perhaps encouraged to sit out in the car until the GP is ready to see them. They pose a significant and unseen danger to other patients who may be immunocompromised – small babies, the elderly and those on immunosuppressant therapy to mention a few. Most receptionists can recognise that a child with a rash is potentially infective and the signs of influenza are self-evident. If there is no policy or training, a new member of staff may not see infectivity as an issue, so firm leadership and good communication are key to a good system of triage in any practice.

### NO GP ON SITE

Every practice needs to have an action plan for what the receptionist should do when a patient arrives at the practice, and appears extremely ill. Ensure that the reception staff feel they have the authority to call an ambulance if the situation demands it.

### DOCUMENTATION

Any requests for urgent attention should be recorded. Where an urgent appointment is requested, and a 'soon' appointment offered, it should be recorded in the records by the reception staff. Records can indicate that a soon appointment was offered when an urgent or immediate appointment was demanded, and where the staff member felt that course of action was appropriate.

### TEMPORARY STAFF

Every practice has a time when the reception is under pressure, there may be unscheduled sick leave or a few people on maternity leave at the same time, necessitating temporary staff covering reception. A printed guide can be invaluable. Emergencies do happen at the most inappropriate times.

### TRIAGE

Drawing up a definitive triage protocol is difficult. For example, a patient may calmly say they are experience crushing central chest pain while eating a bag of crisps and smiling, while others will say they 'are grand' and sit quietly in the waiting room while experiencing a life threatening episode. While all practices have different approaches to triage, some suggestions for drawing up a protocol for patients requesting urgent appointments are addressed below. The word 'urgent' has different connotations for different people and this must be borne in mind by reception staff.

*FOR THE PURPOSES OF SCHEDULING APPOINTMENTS, PATIENTS CAN BE CATEGORISED AS FOLLOWS:*

**Routine Appointment:**
Next appropriate available appointment

**Soon appointment (within the week), e.g.**
Patient worried but not in distress
Issue which has been a problem for some time and has no acute features
Repeat of regular medication – running out. (Perhaps a rescue prescription could be supplied until an appointment is available)

**Review today, e.g.**
Severe pain of any kind e.g. acute back spasm/ear infection/ abdominal pain
Eye injury
Acute Discomfort e.g. abscess, severe tonsillitis
Sudden swelling of a limb (DVT)
Already saw GP recently but condition deteriorating
Acute injury/accident/fracture
Pregnant woman concerned (minor bleeding, reduced movements, uti, etc.)
Visual disturbance
Significant Psychological distress
Ill child
Request for Post Coital Contraception

**See immediately (interrupt GP) or ambulance if no GP on the premises, e.g.**
Acute Chest Pain
Acute breathlessness e.g. asthma/pneumonia
Acutely ill child
Floppy baby
Collapsed patient
Acute facial swelling (allergy)
Weakness of facial features or loss of use of a limb (eg CVA)

This of course is not an exhaustive list of urgent presentations.

## *WHAT GOES ON OUT THERE?*

As the GP, do you really know how your reception staff manages patients looking for urgent appointments? How do you know that it is being dealt with appropriately? While it is important to trust your receptionist, it is nonetheless important to remember that the GP is ultimately responsible for how the practice is run.

Do ensure that whatever your protocol, all staff members are aware of it and all manage requests for urgent calls in the same way.

## *SOME TRIAGE RELATED QUESTIONS FOR YOUR PRACTICE TO CONSIDER:*

- Is there a protocol for triage at reception?
- If so, is it written down?
- Is there ongoing triage training for reception staff?
- Can reception staff contact a GP in the practice easily in an emergency?
- Can reception staff reach a GP who may be off the premises in an emergency?
- Do you have a warm, supportive and open relationship with your front of house staff?
- Do your staff think they have a warm supportive and open relationship with the GPs?
- Have you discussed with staff the circumstances in which to call an ambulance without prior GP approval?

If you can't answer yes to all the above maybe it's time for another practice meeting or training session.




# TAIL COVER *explained*

Tail cover is probably the number one fear that GPs have when changing indemnity provider from a claims-occurred provider to a claims-made one. However, when it is explained, it is not as daunting or as expensive as you might think.

Let us examine the types of Professional Indemnity Cover currently available for GPs in Ireland.

### CLAIMS-MADE

A claims-made insurance policy, which is the type we offer, provides cover for those events and claims that occur and are reported while the policy is in effect. All coverage ceases on the date the policy is terminated and hence you must ensure you have tail or run off cover to deal with claims that may arise once you retire or leave practice.

### CLAIMS-OCCURRED

Occurrence-based cover indemnifies events that happen during the period the claims-occurred policy is in effect, regardless of when a claim is filed, even if you are no longer covered by that claims-occurred indemnifier.

### THE COST OF PROFESSIONAL INDEMNITY COVER

Research indicates that claims-made policies are substantially cheaper than occurrence policies.
For instance, the Medisec Master Policy, underwritten by Allianz plc, offers full cover including unlimited out of hours sessions at €5,207.94* per year. We understand that the claims-occurred cover options available in Ireland are substantially more expensive.

However, when comparing both options you must factor in the tail or run off costs of a claims-made policy. At Medisec, we reward loyalty and for members who are 10 years with us prior to their 65th birthday, there is no tail cover cost at retirement as it is paid by Medisec.

For those who have not been with us for 10 years prior to their 65th birthday, or decide to retire early, tail cover currently stands at circa €13,000*. It is paid in instalments over an 8 year period and covers any claim or event at any time after their retirement.

New members inform us that these figures give peace of mind and a realisation that paying for tail cover may not be as painful as they initially think, as, within two or three years, they can recover such cost on the savings they make on their annual subscription if they move from a claims-occurred policy to Medisec.

We've talked about the cost and the myths surrounding tail cover. But if you talk to any of your colleagues who are Medisec members and who have used our services, they will say that the most important aspect of our offerings has not been the cost factor, but the support they receive at a very stressful time, which comes from an experienced team based in Ireland and therefore understands the challenges faced by GPs working in Ireland today.

*Current quoted rates as at July 2016 which are subject to annual change.

# OUT & ABOUT

## EQuiP CONFERENCE - MARCH 2017

Medisec were privileged to support the recent EQuiP International Conference on Patient Safety, hosted by the Irish College of General Practitioners in Dublin and extend our congratulations to Dr Andrée Rochfort, who was responsible for attracting this important and most successful conference to Dublin in her role as Secretary of EQuiP.

At the two day conference 'The Dublin Declaration' was launched, supported by the ICGP, EQuiP and WONCA . The declaration highlighted the following:

1. Acknowledge the unique context of general practice within the greater health system
2. Engage with patients
3. Encourage collaboration between governments, policy-makers and other stakeholders for further development of safety initiatives to protect patients and health professionals from harm
4. Fight for adequate resources in general practice to deliver better safer healthcare
5. Reaffirm the commitment of WONCA Europe to support and advise decision makers in line with WHO Technical Series on Safer Primary Care
6. Address the lack of research and measurement of safety in primary care
7. Emphasise the importance of collaboration on integrating safety in medical education and training curricula and continuous professional development

The Conference included lectures, workshops, posters and oral presentations all aimed at reducing patient risk and improve quality of care. Events included presentations from

*Dr John Gillman, Ruth Shipsey, Dr Ronan Fawsitt and Prof Walter Cullen*

academics and practitioners throughout Europe, including members of our GP Advisory Panel, Dr Mary Davin-Power, who presented on Good Service, Bad Service and Lip Service: Complaints Management in General Practice and Prof. Walter Cullen, Professor of Urban General Practice, UCD, presented a recent Medisec research paper 'Risk Management and Safety Strategies for Patients and Healthcare Professionals in the Primary and Secondary Care Interface – an Irish Perspective', which highlighted the difficulties and risks in transfer of care between primary and secondary care.

Dr Mary Gray, a Board Director of Medisec, moderated a session of oral presentations surrounding issues of Safety Culture and Climate in primary care, and presented a poster on Safer Transitional Care with Geoff McCombe, UCD.

This important international conference addressed issues of relevance to all General Practitioners, and showcased the importance of research in patient safety and improvement of awareness of risk in general practice throughout Europe.

## MEDICINE AND LAW:
### THE CORONER'S INQUIRY AND REFORM

*Dr Mary Davin-Power and Dr Sheila Willis*

Medisec were one of the sponsors for the Medico-Legal Society of Ireland's Annual Academic Day held recently in Dublin Castle. Attorney General Ms Maire Whelan opened proceedings and there were presentations from Professor Denis Cusack, Coroner for North Kildare, Dr Myra Cullinane, Dublin City Coroner, Dr Brendan O Shea, Director of the Postgraduate Resource Centre ICGP, and Mr Stuart Gilhooley, President of the Law Society.

Mr Justice Peter Kelly, President of the High Court, chaired the early sessions followed by Dr Sheila Willis, Director General, Forensic Science Ireland.

A series of real life workshops were held in the afternoon where unsuspecting doctors were interrogated by senior counsel in Coroner's Inquest scenarios with some interesting conclusions by Coroners Isobel O Dea, Brian Farrell, Loretta Nolan and Myra Cullinane. Caroline Conroy from La Touche Training concluded the proceedings with her 'Ten Top Tips for Medical Witnesses'. This event offered a useful forum for both legal and medical professionals who got to see the problems and difficulties from both sides. The Medico - Legal Society of Ireland last year celebrated its 60th Anniversary since its inception in 1956.



*At Medisec we welcome engagement between patients, clinicians and other stakeholders in our healthcare system and encourage all initiatives aimed at improving the healthcare services and patient safety. We have been asked by HIQA to highlight their first nationwide survey of patients' views on hospital care.*

# IRELAND'S FIRST EVER NATIONWIDE SURVEY OF PATIENTS' VIEWS TO GO LIVE THIS MAY

For the first time in Ireland, a new nationwide survey will ask patients for their views on hospital care.

The National Patient Experience Survey will go live nationwide on 1 May 2017. All adult patients who have spent a minimum of one night in an acute public hospital and are discharged during the month of May will be asked to complete the survey. With 40 participating hospitals and an estimated 27,000 patients eligible to participate, this will be the largest single survey of the healthcare system to be conducted in Ireland.

The survey covers all aspects of a patients' stay in hospital, including admission and discharge processes, the ward environment, interaction with staff, and care and treatment. The responses will be combined to produce reports at the national and hospital group level, with the data used to set priorities for the delivery of a better healthcare service for patients and staff alike.

International evidence suggests that the best way to improve the quality of healthcare is to listen to the views of patients and use this feedback to inform the development and delivery of better, more patient-centred care. In order to capture the experiences of patients, the Health Information and Quality Authority (HIQA), HSE and the Department of Health have joined forces to carry out the National Patient Experience Survey.

"The ultimate purpose of conducting surveys of patient experience is to focus on what matters most to patients and in doing so improve the quality and safety of care", says HIQA's Rachel Flynn, who is also heading up the survey. "We are delighted to lead the way on such a large project that will lead to meaningful improvements for patients in Ireland."

The 61 questions in the survey were chosen from the Picker Institute Europe's library of validated questions, which will enable comparison with international best practice. Over 100 people, including patients and patient representatives, policymakers, data analysts and academics were involved in selecting the most important questions for the Irish healthcare context.

Eligible patients will begin to receive a survey pack in the post a few weeks after their discharge. The survey can also be completed online up until 26 July 2017.

Further information about the National Patient Experience Survey can be found at www.patientexperience.ie

National Patient Experience Survey

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*Dr Sinead Beirne* *Dr Niall Macnamara* *Dr Marie Scully* *Dr Padraig McGarry*

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