Spring 2019

MEDISEC ON CALL

Around the clock support for the Irish GP community

ANNIVERSARY

27/4/1994 - 27/4/2019

Looking after you while you look after your patients since 1994

MEDISEC ON CALL

Aisling Timoney, Legal Counsel, is Editor of Medisec On Call. If you would like to suggest a topic to feature in a future edition or if you no longer wish to receive On Call, please email Aisling at **aislingtimoney@medisec.ie**.

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THE MISSION OF MEDISEC IS

- Supporting members with round-the-clock focused advice on the medico-legal and ethical challenges of general practice
- Assisting members with complaints, investigations and disciplinary issues
- Educating members on best practice and risk mitigation to promote optimum care for patients
- Arranging the best and most competitive professional indemnity insurance for members in Ireland.

THE VISION OF MEDISEC IS

- Recognition as the membership organisation of choice for General Medical Practitioners in Ireland by achieving excellence in providing support, advisory and risk management education services and arranging professional indemnity insurance.

THROUGH THIS VISION

- Medisec undertakes to promote excellent patient care by our members throughout Ireland.

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WELCOME TO OUR SPRING NEWSLETTER

I am delighted to welcome you to the latest edition of our On Call newsletter, which celebrates our 25th year in business.

As always, I am most grateful to our guest contributors in this edition of On Call: Yvonne Joyce, Partner of CKT Solicitors shares an update on the Coroner's Court; Eileen Grace, Partner of Eugene F Collins Solicitors deals with legal structures for GP practices; and David Nutley from the Office of the Ombudsman, provides insight into the role of the Ombudsman, Peter Tyndall and how his office can examine issues involving GPs.

I would highlight the feature in this edition of On Call on the recent judgment by Judge Barr, dismissing a High Court case against a GP. The GP's contemporaneous medical records were a crucial piece of evidence in the case and this feature is important reading for all members. I am also very pleased to introduce a new regular feature to On Call, dealing with the Life Cycle of a Patient. In this and subsequent editions, we will track a patient's journey under your care from early childhood to end of life, addressing the medico-legal queries which typically arise at each stage of life.

As you know, we are constantly trying to innovate, and January saw the launch and roll-out of MedZine, our monthly online update. MedZine comprises a number of different sections of interest, for example, MedTalks, a video series in which staff members provide quick overviews on topics of interest, a case studies section, a Clinical Corner, factsheets and articles. This initiative is part of our continued commitment to supporting members with best practice guidance and we have received extremely positive feedback to date. Don't hesitate to contact us at info@medisec.ie if there is a particular topic that you would like us to address in On Call or MedZine.

I am pleased to inform you that as part of our commitment to helping you and your practice staff provide the highest standards of patient care, we are continuing our in-house workshop series for practice managers, practice nurses and administration staff. Full details are set out on page 21. There is no charge to attend the workshops and I would recommend all members encourage their practice staff to register and attend. Capacity at each workshop is limited but subject to demand, we will arrange additional dates as required.

Working closely with our members for 25 years has given Medisec unique insight into the complexities, challenges and nuances of general medical practice in Ireland. We recognise that our members seek to achieve excellence in primary care for the benefit of patients nationwide and are proud to support them in so doing. Our priority is always looking after our members while they look after their patients.

We have commenced a 360° review of our business and are developing a three-year strategic plan. We will focus on ensuring that Medisec capitalises on its success and growth to date and maximises future business opportunities to the optimum benefit of its members. Our unrivalled responsiveness and support and focus on risk management education will continue to be the hallmarks of our service as we look forward to the next 25 years of standing as partners to Irish GPs and as we count down towards our Golden Jubilee!

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PATIENTS' REQUESTS FOR RECORDS?
LET'S SET THE RECORD STRAIGHT…

One of the most common queries that we deal with in Medisec is requests for records. We receive hundreds of calls annually from members, wondering how they should respond to such requests from patients. Members typically want to know under what circumstances they can release patient records and they want to know how to do so safely. This has become even more relevant following the introduction of GDPR and patients' increasing awareness of their rights.

In this article, we explore how such requests can arise in practice and the steps GPs that should take to protect themselves when releasing records.

1. HOW DO REQUESTS ARISE?

It is well-established that patients have a right to access and obtain copies of their own medical records (subject to some limited exceptions set out below). This right is expressly set out in three different domains:

(i) The Medical Council's Guide to Professional Conduct and Ethics (8th Edition, 2016) (the **"Ethical Guide"**)

(ii) Data Protection Legislation including the General Data Protection Regulation 2016/679 (**"GDPR"**)

(iii) Freedom of Information (**"FOI"**) Legislation

The request for records may come directly from the patient themselves or it could come from a third party acting on behalf of the patient (for example a solicitor). Other third parties, for example employers, family members, insurance companies and/or financial institutions may occasionally contact GPs seeking patient records for their own purposes. When faced with such a request from a third party, it is vital that the GP has fully informed patient consent before releasing such notes (see below).

(i) The Ethical Guide
Paragraph 33.5 of the Guide states that:

"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…"

(ii) GDPR
Article 15 of GDPR allows a patient to request a copy of any personal data, including medical records that a GP/GP practice holds in relation to them. Under GDPR, patients are entitled to copies of their records free of charge.The records (or a reason for refusing to release same) should be provided to the patient/requester within 30 days. Under GDPR, the GP can refuse to disclose the records if they are of the opinion that doing so would cause the patient harm.

(iii) FOI
Under FOI principles, medical card/GMS patients have a right of access to their medical records. The HSE is considered to hold the records of GMS patients and the GP in turn holds them as custodian on behalf of the HSE. Notwithstanding the above, when requests for GMS records are received, GPs should ideally deal with the request themselves, unless the records in question are very complex and the requester has expressly opted to go the FOI route. The rationale here is that such patients have a right to request their records under ethical/data protection principles in any event and so the GP should not be seen to be impeding their access to their records. A decision to refuse to disclose the records to a patient can also be made under FOI, if disclosing them would cause the patient harm.

FOI does not apply to private patient records.

2. CHECKLIST/STEPS GPS SHOULD TAKE TO PROTECT THEMSELVES WHEN RELEASING RECORDS

There are a number of steps that a GP should take when a request for records is received. The first step is to ascertain whether the patient is private or GMS, as this may be a determinative factor in deciding who manages the request. As noted above, if the request if very complex and if the GMS patient has expressly requested their records under FOI principles, the patient may be directed to the HSE.

In all other circumstances, GPs will need to consider requests for records themselves and there are a number of factors to bear in mind in this regard. The primary considerations are always the patient's best interests, confidentiality and consent.

Consent
If it is not the patient themselves who is requesting the records, the GP should obtain consent from the patient before releasing any information. The patient should be made aware of the nature and extent of the request (for example whether an entire chart, or limited records have been requested) and the GP should satisfy themselves that the patient has given informed consent to the release of the actual records sought. It is best practice to obtain written consent and keep a copy of this on the patient's file.

GPs should respect the patient's consent or refusal unless the refusal to release the records could result in harm to the patient or another person. (For specific advice on disclosing medical records without consent, you should contact Medisec).

Capacity
If a GP has any cause to doubt the patient's capacity, they should insist that the patient attend the practice for a brief consultation before releasing the records. This will give the GP an opportunity to assess whether the patient has capacity and whether or not it is in the patient's best interests to have their records released to them.

Review
Before releasing any patient records, GPs should carefully review the records and ensure that there is no cross-contamination between patient files and that no information is included in error. GPs should be particularly careful with older records where the details of all family members may have been kept together on one file.

The records may contain information about third parties and this may require removal/redaction. Similarly, information that is likely to cause the patient harm will need to be removed/redacted.

The need to redact part of the records has to be considered on a case-by-case basis and a GP will need to consider whether the redaction would defeat the purpose of the request for disclosure. For example, if a patient was requesting their notes for family law proceedings, certain third party information contained in the notes may be relevant to the proceedings. A 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.

Inform
If the records contain consultant's letters or documents, we would suggest that GPs inform the consultant(s), as a matter of courtesy, before the records are actually released.

If the patient's records contain sensitive reports on mental health, the relevant medical practitioner who authored those reports should be contacted and the GP should seek confirmation whether the release would be likely to cause harm to the patient or not prior to the release of such copy records.

Release
It is important for GPs to remember that they should always keep the original version of the records. Complete and legible photocopies should be released to the patient and these should be clearly marked as "Patient Copy"; the reason being that if the patient loses or accidentally discloses the records it will be clear that the breach did not emanate from your practice.

You should also ask the patient to sign an acknowledgement confirming that they have received a copy of their records.
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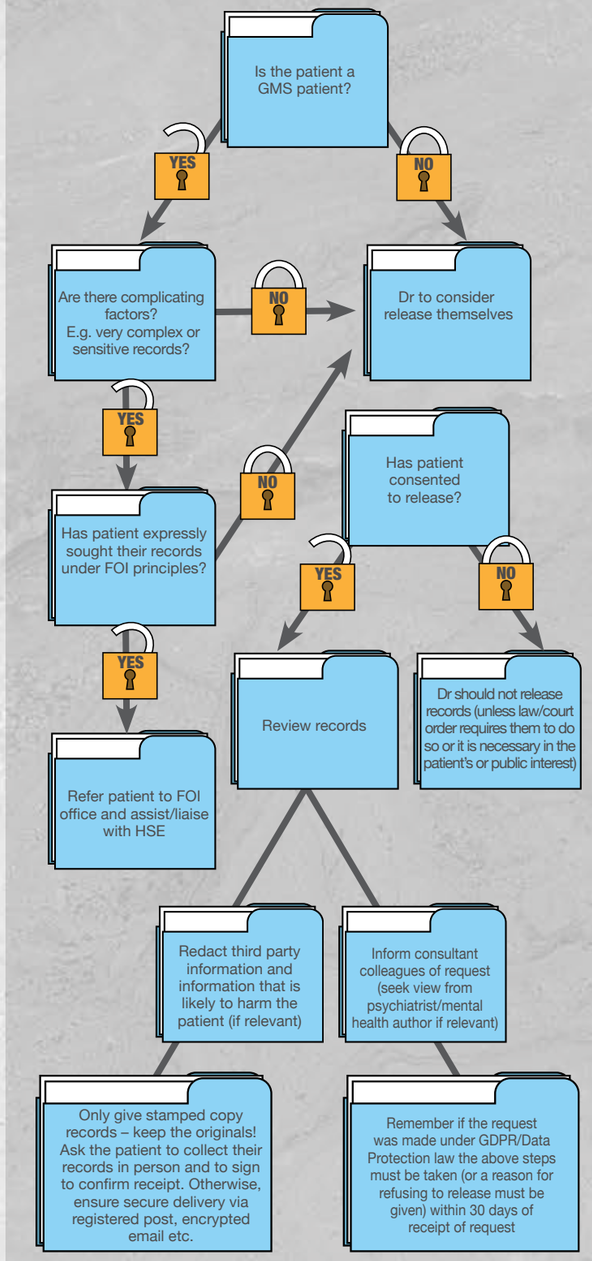


OPTIMAL STRUCTURE IN WHICH TO OPERATE YOUR GP PRACTICE

By Eileen Grace
Eugene F. Collins Solicitors

Medical practices had tended for years to be sole practitioners or partnerships. More recently, GPs have been willing to explore the idea of incorporating a company to avail of potential tax and pension planning benefits that can arise from running a practice through a company.

There is an argument that GPs cannot attempt to limit their personal liability in providing care to their patients and consequently, if a GP practice was operating through a company, it should be an unlimited company, rather than a limited company.

There is a growing trend of medical practices operating through a tiered structure, with individual GPs being a partner in a medical practice partnership, through their respective, individually-owned company. Each GP provides their services to the practice partnership through their own company. One advantage of this approach is that the GP's company can be structured to maximise tax and pension benefits for that particular GP.

However, there are potential risks and problems to consider and obtaining tax advice is crucial in order to weigh up the tax consequences. Importantly, GPs should ensure that any activities that cannot lawfully be operated in a company are conducted personally or through a partnership. It should be noted that GMS patients cannot be dealt with through a company structure because the doctor/patient relationship/ contract is with the GP personally.

Understanding the different opportunities and protections offered by the choice of trading entity requires careful consideration. There are advantages and disadvantages to each approach which are explained below. The tiered structure approach described above leads to the GP being both a partner in the practice partnership and a shareholder/director of his/her own company and this heightens the need to ensure that the different obligations arising from each structure are fully understood.

The main advantage in setting up a private company is that the company has a separate legal personality, allowing it to hold property and enter contracts in its own name. Companies are owned by the shareholders and run by the directors - often one and the same. They are subject to statutory responsibilities, which are primarily set out in the Companies Act 2014. Perhaps the most onerous and least attractive statutory obligation for a limited company is that financial accounts must be prepared in a legal format, audited and filed in the Companies Registration Office ("CRO"), although exemptions are available for smaller operations. Unlimited companies, save for certain exceptions, do not have to file accounts.

All documents filed in the CRO are publicly available. As well as loss of privacy, practical difficulties arise such as increased costs and administration work, both at the time of incorporation and on an on-going basis afterwards.

In contrast, a general partnership is not a separate legal entity from its members. This means its partners can be held liable for any debts incurred by the partnership and it also means partners can be sued personally. Partnerships are not required to publicly file or disclose financial or other information. No set up formalities are required. The Partnership 1890 Act sets out certain rules for determining the existence of a partnership, which include the following:

- Joint or common ownership of property 'does not of itself create a partnership' even where the profits from the property are shared;
- The sharing of gross returns does not of itself create a partnership; and
- The receipt of shares of profits is prima facie evidence of a partnership, but it does not of itself make the recipient a partner.

In practice, partnerships are established pursuant to a Partnership Agreement which states clearly the purpose and intent of the partnership being created.

The below table compares the main differences between partnerships and companies, distinguishing for completeness between limited and unlimited companies.

FEATURE/REQUIREMENT	GENERAL PARTNERSHIP	LIMITED COMPANY	UNLIMITED COMPANY
Legal Documentation/ Legislation	Partnership Agreement or in absence of such, Partnership Act 1890.	Constitution of Company Companies Act 2014 and other company related legislation.	Constitution of Company comprising a Memorandum of Association and Articles of Association. Companies Act 2014 and other company related legislation.
Registration Process	No requirement to register with CRO; if using a business name, then need to register that.	Must register with CRO. Must have at least one director and separate secretary. More expensive to form than a partnership.	Must register with CRO. Must have at least two directors and a secretary. More expensive to form than a partnership.
Filing/Disclosure requirement	Few, if any, filing obligations, so greater privacy.	Ongoing filing obligations Audited accounts required to be filed, subject to statutory exemptions.	Ongoing filing obligations but less onerous than for limited companies. No obligation to file accounts save for certain companies with all corporate shareholders
Liability	Partners liable for all partnership debts subject to limited exception.	Shareholders are not liable for losses save to the extent of capital invested by them in the company, which can be minimal.	Shareholders do not have limited liability and are liable for debts and losses of the company.
Legal Status	Partnership is not a separate legal entity. Partners can be sued in own name. Partnership interests usually cannot be sold or transferred.	Company is separate legal entity from owners. Shares in a company can be sold/ transferred subject to the rules of the Constitution of the company.	Company is separate legal entity from owners. Shares in a company can be sold/ transferred subject to the rules of the Constitution of the company.
Management	Usually all partners involved in management as set out in Partnership Agreement.	Board of directors manage company which may or may not be all or some of the shareholders.	Board of directors manage company which may or may not be all or some of the shareholders.
Profits/Return of Capital	Partners withdraw capital and profits as per their partnership status and rights.	Profits and capital distributed pro rata to shareholding and subject to provision of Companies Act which can be restrictive regarding payment of dividends and repayment of capital.	There are less restrictions on payments to shareholders than in limited companies.
Holding Assets	Partnership can't own property/ assets in own name – must be held by parties.	Company holds its own assets separate to shareholders.	Company holds its own assets separate to shareholders.
Succession	Partnership continues only so long as it has partners as per its Partnership Agreement or pursuant to the Partnership Act.	A company has perpetual succession until wound up or struck off. Existence is separate from shareholders which can change from time to time.	A company has perpetual succession until wound up or struck off. Existence is separate for shareholders which can change from time to time
Taxation*	Partner are treated as individually carrying on a separate trade and pay income tax on profits at rates up to 55%.	Irish companies pay tax at 12.5% on trading profits. If retain profits, there may be an additional surcharge. GP practices may be liable to additional close company surcharge, effectively increasing the corporation tax rate to c.20%. Dividends received by shareholders are separately charged to tax in the hands of the shareholder.	Irish companies pay tax at 12.5% on trading profits. If retains profits, there may be an additional surcharge. GP practices may be liable to additional close company surcharge, effectively increasing the corporation tax rate to c.20%. Dividends received by shareholders are separately charged to tax in the hands of the shareholder.

*Subject to tax advice.

The above article is not intended to be and does not constitute legal advice. We recommend that Medisec members should take specific tax and legal advice regarding their particular circumstances.

SUSPICIOUS MINDS

FORGED/ALTERED PRESCRIPTIONS OR SICK CERTIFICATES

LEGAL CONSIDERATIONS

It is an offence for a person to forge a document purporting to be a prescription issued by a registered medical practitioner. It is also an offence for a person to be in possession of a forged prescription or a duly issued prescription which has been altered with intent to deceive.

Forgery is a criminal offence and a person is guilty of forgery if he or she makes a false instrument (any document) with the intention that it shall be used to induce another person to accept it as genuine and, by reason of so accepting it, to do some act, or to make some omission, to the prejudice of that person or any other person.

MEDICAL COUNCIL'S GUIDE TO PROFESSIONAL CONDUCT AND ETHICS, 8TH EDITION, 2016 (THE "GUIDE")

Below are some of the relevant points set out at paragraphs 41 and 42 of the Guide:

- In issuing certificates, reports, prescriptions and other formal documents, you must be accurate and make sure the document is legible. You must also include your Medical Council registration number.
- You should only sign a certificate, prescription, report or document for a patient following a review of the patient's condition.
- You must make sure that prescription pads and prescription-generating software are kept securely and are only accessible to those authorised to prescribe.
- You should safeguard patients with drug dependencies by taking reasonable steps to make sure that they are not inappropriately obtaining drugs from multiple sources. You can do this, for example, by liaising with drug treatment services, other doctors and pharmacists.
- When prescribing medications, you must comply with the Misuse of Drugs legislation and other relevant regulations and/or guidelines.

We have set out a few familiar scenarios below but all cases are different and the following are guidelines only. We suggest members contact Medisec for specific advice on a case-by-case basis.

SCENARIO 1

During a busy afternoon surgery, you are contacted by a local pharmacist who informs you that a patient has presented at the pharmacy with a suspected forged/altered prescription.

PRACTICAL ADVICE AND TIPS

Firstly, you should ask the pharmacist to provide you with a copy of the prescription. You should check the medical records in the practice to ascertain the date of the patient's attendance and any medicines prescribed on that date. If there is any doubt, you should not confirm that the prescription has been forged or altered. In addition, you should not disclose or discuss confidential patient information with the pharmacy.

Following your review of the prescription, if you are satisfied that the prescription is forged or has been altered to include additional medication, you should advise the patient in writing; or in person, that it has come to your attention and you are satisfied that the prescription has been forged or altered. It is important to avoid making any accusations but you can ask the patient if he/she knows anything or can offer an explanation. Remember to ascertain whether the patient requires any referral in terms of addiction services etc. to see if he/she needs any assistance in that regard. You should also make it clear to the patient that it is unsafe to take medication that is not prescribed by a doctor. We advise taking careful notes of any conversation with the patient and keep a copy of the forged/altered prescription on the patient's file. You should also advise the patient that any alteration to a prescription is a most serious offence which is generally reported to the authorities.

If you have a suspicion that forged or stolen prescriptions are in circulation, we advise immediately alerting the community pharmacist. The role of the community pharmacist is to alert the local pharmacists if such prescriptions are in circulation to ensure they will not be dispensed. There is no strict obligation on you to notify the Gardaí; however, you may wish to do so if you have concerns for your own safety or for the safety of your patient or others.

You may also wish to take steps to remove the patient from your practice. The team in Medisec are happy to provide assistance to you in this regard.

SCENARIO 2

It has come to your attention that your practice nurse has forged or stolen prescriptions from the practice. You have concerns for your nurse and also for patient safety.
What should you do?

PRACTICAL ADVICE AND TIPS

Please refer to scenario 1 above for the appropriate approach in terms of approaching this matter with the practice nurse. It would be appropriate to follow the same approach here however, this scenario raises additional considerations. Subject to the nurse's agreement and consent, you should seek help for the nurse through her own GP. It is vital that your nurse gets adequate support and engages with the appropriate programme to address any underlying health issues that he/she may be experiencing. We suggest that you might also advise your nurse to seek immediate assistance and advice from their Union and/or Representative body.

With regard to your concerns in respect of patient safety, you must seek to remove any threat to the public and; with this in mind, due to the seriousness of the matter, it is important that you do not allow the nurse to continue to work, whether supervised or not, until she is certified fit to do so.We recommend ensuring, insofar as possible, that your nurse does not have access to any prescription pads or medication. It is also important that you check the medical records within the practice so that you are aware of the full extent of the forgery of the prescriptions. You may wish to contact your practice solicitor to discuss any employment law issues, for example, possible suspension/dismissal on foot of his/her employment contract.

It is unlikely that the forged or stolen prescriptions are in circulation; however, as with scenario 1 above, If you have a suspicion that the prescriptions are in circulation, our advice is to immediately alert the community pharmacist and give consideration to contacting the Gardaí.

If the forgery and/or theft of prescriptions is/was extensive you may have no option but to report your nurse to the Nursing and Midwifery Board of Ireland. Should this situation arise, please contact Medisec and we can provide specific advice.

SCENARIO 3

You are contacted by a local employer who confirms to you that an employee has presented a number of sick certificates to the HR department which appear on your practice headed paper and contain your signature. The HR manager expressed some concerns as to the authenticity of the sick certificates and asked you to confirm whether you issued the sick certificates to the employee. What should you do?

PRACTICAL ADVICE AND TIPS

Start by asking the HR department to provide you with copies. You should check the records in your practice to ascertain whether the employee is a patient of your practice and if you issued any sick certificates to them relating to the period in question.

- In circumstances where you ascertain that the employee is not a patient, we recommend that you write to the HR department confirming that you did not write the sick certificates in question and they did not originate from your practice (subject to confirming with your partners/ employees that this is in fact the case). Your letter to the HR department should be factual and limited to this confirmation and should not stray into any allegations, such as categorically stating that the sick certificates were falsified or by whom. As stated above, forgery is a criminal offence and it is open to you to report the matter to the Gardaí if you wish to do so.
- Where the employee is a patient of your practice, we advise that you send the company a holding response in the first instance. In your response, you should state that you are not currently in a position to discuss the matter due to doctor/patient confidentiality. You can advise the HR department that you will make contact with your patient and, if their consent is forthcoming, you will revert in due course. If; however, consent is not forthcoming from your patient, you cannot discuss the matter with the HR department and you can suggest that they discuss the issue with the patient directly.

Contact your patient and ask them to attend at the practice for a discussion; face to face is preferable but if necessary a telephone conversation will suffice. You should advise the patient that you have received copies of sick certificates from their employer and you are satisfied that you did not write the sick certificates and they did not originate from your practice. Avoid making any accusations and ask the patient if he/she knows anything or can provide an explanation. Ascertain whether your patient consents to you discussing the matter with their employer. You should explain to your patient that forgery is a criminal offence and you may have to report the matter to the Gardaí. Remember to keep careful and detailed notes careful and detailed notes of all discussions with your patient.

Based on your discussion, you may wish to consider your continued relationship with your patient. If, for example, your patient makes disclosures that make it clear that your relationship of trust has broken down; for example, if they admit to forging the sick certificates, you may wish to take steps to remove the patient from your practice.
If this situation arises, please call the team in Medisec for assistance.

THE CORONER'S COURT – *GUIDANCE FOR STATEMENTS AND GIVING EVIDENCE*

By Yvonne Joyce
CKT Solicitors

"The Coroner's core function is to investigate sudden and unexplained deaths so that a death certificate can be issued. This is an important public service to the living and in particular to the next-of-kin and friends of the deceased.

The coroner service not only provides closure for those bereaved suddenly but also performs a wider public service by identifying matters of public interest that can have life/death consequences."

WHAT IS THE CORONER'S ROLE

The Coroner, who is a barrister, solicitor or registered medical practitioner, is appointed to inquire into all deaths reported to them. They will seek to establish the identity of the deceased person and the medical cause of death. If the cause of death remains in doubt after a post mortem, an Inquest will be held.

WHAT DEATHS MUST BE REPORTED TO THE CORONER

The general rule is that any death which is thought to be due directly or indirectly to any unnatural cause must be reported to the Coroner. Deaths reportable to the Coroner include the following:

(a) Deaths occurring at home or other place of residence:

- where the deceased was not attended by a doctor during the last illness;
- where the deceased was not seen and treated by a doctor within one month prior to date of death;
- where death was sudden or unexpected;
- where death may have resulted from an accident, suicide or homicide;
- where the cause of death is unknown or uncertain.

(b) Deaths occurring in hospital:

- where a patient dies before a diagnosis is made and the general practitioner is also unable to certify the cause;
- when death occurred whilst a patient was undergoing an operation or under anaesthesia;
- where death occurred during or as a result of any procedure;
- where any question of negligence or misadventure arises;
- where death may have resulted from an accident, suicide or homicide;
- where the death occurred within 24 hours of admission to hospital.

(c) A death is reported by a member of the Garda Siochana or the Governor of a prison:

- where death may have resulted from an accident, suicide or homicide;
- where death occurred in suspicious, unexpected or unexplained circumstances;
- where a dead body is found;
- where there is no doctor who can certify the cause of death;
- immediately following the death of a prisoner.

(d) Other categories of reportable death include:

- sudden infant deaths;
- certain still-births;
- death of a child in care;
- where human bones are found;
- where a body is to be removed out of Ireland.

WHEN IS AN INQUEST NECESSARY?

If the initial medical examination shows the unexpected or sudden death to have been a natural one and there is a doctor who is in a position to certify the cause of death, there may be no need for an Inquest. The Coroner will allow the doctor to complete the Medical Certificate of the Cause of Death and the form will be sent to the Registrar of deaths so that the death can be registered by the relatives.

If a doctor is not in a position to certify the cause of death, the Coroner may then ask a pathologist to carry out a post-mortem examination (autopsy). If this occurs, the examination must be done as soon as possible. The Coroner cannot register the death until the pathologist's report is received.

An Inquest must be held if the post-mortem examination shows that the death was due to unnatural causes.

WHAT IS THE PURPOSE OF AN INQUEST?

The Inquest is a limited fact-finding inquiry to establish the answers to:

- **who** has died,
- **when** and **where** the death occurred, and
- **how** the cause of death arose
- any further particulars as the Coroner deems fit.

It is not the job of the Coroner to blame anyone for the death. Civil or criminal liability will not be considered. However, the Coroner has the power to investigate not just the main cause of death, but also "any acts or omissions which directly led to the cause of death".

The Coroner can decide to hear the Inquest with or without a jury. The Coroner or jury can make a verdict including accidental death, misadventure, suicide, open verdict, natural causes (if so found at Inquest) and in certain circumstances, unlawful killing.

PREPARING STATEMENTS

The Coroner can request depositions (statements) from any person if he/she considers this will assist his/her preparation for the Inquest.

While the statement may be taken by the Gardai in their capacity as agent for the Coroner, in the case of patient deaths, the Coroner normally seeks the statement directly from the witness. The Coroner generally makes a decision following receipt of the deposition as to whether the person is required to attend as a witness.

When preparing a deposition, you should be mindful that the statement will be read aloud in the Coroner's Court, potentially in the presence of bereaved family members and you should carefully consider its tone and contents.

Every week, Medisec assists members with preparing reports for the Coroner's Court and the following is a helpful guide :-

- Review the deceased's medical records carefully.
- The statement should be a typed, detailed, factual and impartial account, written in the first person and based on the records and your knowledge of the patient.
- The statement should set out your full name, employment status, medical qualifications and period of employment.
- It should not contain your views or comments on the treatment provided by others or the believed cause of death.
- It should specify the nature of your contact with the patient and outline anything unusual.
- It should give a factual chronology of events, referring to the notes whenever you can and specify which details are based on your memory, the notes or your normal practice.
- The report should be capable of standing on its own – do not assume the reader has any knowledge of the case.
- Consider questions which may be asked at the Inquest and try to answer them in the statement.
- Avoid using jargon or medical abbreviations such as "SOB" for shortness of breath. If you give the name of a drug, explain what type it is e.g. antidepressant. Use plain English.
- Avoid statements that are speculative.
- Date and sign the statement.

GIVING EVIDENCE

The Coroner decides who should be called as a witness. Witnesses may agree to attend voluntarily or may be served with a summons.

If you are requested to give evidence at an Inquest, you are required to attend. A witness who does not attend when they are summonsed may be held in contempt of court. In certain limited circumstances, a signed statement or other document may be given in evidence in lieu of attendance and this is entirely at the discretion of the Coroner.

If you are called to give evidence at an Inquest:-

- It is advisable to read your report again carefully beforehand and take a copy with you to the hearing. It is also helpful to review the records.
- Evidence is given on oath or affirmation. Most Coroners will then ask you to read your deposition and will then ask a series of questions based upon it.
- At the conclusion of the Coroner's questions, a member of the deceased's family or a legal representative may question you. When answering questions, the following advice may be helpful:
  - Listen to the question carefully, rather than answering the question you want or expect to hear.
  - If the question is unclear, do not hesitate to ask for clarification.
  - It is usually better to keep your answers short. Further questions can be put if more detail is required.
  - Answer as clearly, honestly and succinctly as you can.
  - Do not be afraid to say based on your memory, the records or your normal practice that you do not know the answer, to refer to a more appropriate witness, or to ask to refer to the records if you need to.
  - Try to avoid speaking too fast.
  - Avoid medical jargon if at all possible.
  - Sometimes the questioning may seem to be repetitive or based on a misunderstanding of clinical practice, but you are expected to respond to each question and to retain a professional composure.

Please do not hesitate to contact Medisec if you are called to make a statement or attend an Inquest or if you have any concerns whatsoever. Medisec will be happy to provide you with advice and support.

OPEN DISCLOSURE

The Civil Liability (Amendment Act) 2017 (the "Act") was commenced on 22 September 2018. The Act sets out a statutory process for voluntary open disclosure on a protected basis. It is important to be aware of the new legislation and how it could apply to your GP practice.

This guidance note aims to familiarise you with the open disclosure process and set out the steps that you must take in order to ensure that the legal protections set out in the Act attach to any disclosure you may make.

BACKGROUND

The Medical Council's Guide to Professional Conduct and Ethics, 2016 imposes an ethical obligation, described as "Open disclosure and the duty of candour" on healthcare practitioners. The previous version of the Guide in 2009 contained similar provisions under the heading "Adverse events".

The HSE National Disclosure Guidelines offered this simple definition of open disclosure in 2013: "an open consistent approach to communicating with service users when things go wrong in healthcare".

In reality, despite these ethical provisions and national guidelines, there has not been a consistent approach to open disclosure, largely due to the lack of legal protections around disclosures. An obvious concern for healthcare practitioners was that information or apologies offered in open disclosure would be used against them in subsequent civil or regulatory proceedings and this may have had a chilling effect.

The Act includes statutory provisions about open disclosure, periodic payment orders and pre-action protocols. All of these measures will significantly improve the medico-legal claims process in Ireland. The open disclosure provisions are likely to have the greatest impact because legal protection now applies to information and apologies offered in open disclosure, when the statutory process is followed.

The Act allows you to disclose to a patient or a "relevant person" (a close family member, spouse, civil partner, cohabitant or nominee) that a **patient safety incident** (a "**PSI**") has occurred and apologise, if appropriate.

An example of a PSI in a GP setting might be a concerning PSA test result, which was inadvertently overlooked for a significant period of time and the patient has been diagnosed with prostate cancer.

When done correctly, the Act states that your disclosure and apology made during an **open disclosure meeting** ("**ODM**"), will not amount to an admission of fault or liability and it cannot invalidate any insurance or indemnity. The Act also states that the disclosure/apology will not amount to evidence of fault or poor professional misconduct/performance in any regulatory proceedings.

WHAT TO DO TO ENSURE THAT YOU MAKE OPEN DISCLOSURES CORRECTLY – PROCEDURAL REQUIREMENTS

- ***What** may be disclosed?*

1. incidents that cause injury or harm to a patient which was unintentional or not anticipated;
2. an incident where no actual injury or harm resulted but the healthcare service provider has reasonable grounds to believe the patient was at risk of unintentional or unanticipated injury or harm;
3. an incident where a patient was saved from unintentional or unanticipated injury or harm and the healthcare service provider has reasonable grounds to believe that but for the intervention / prevention, the patient would have suffered injury or harm.

If disclosing, you should disclose all relevant information in connection with the PSI (for example, the date the PSI occurred and a description of same, along with an account of the effects and consequences of the PSI).

- ***Who** may disclose the information?*

The patient's principal healthcare practitioner shall make the disclosure (so for our purposes this would mean the patient's regular GP) unless the circumstances require another GP to make the disclosure.

- ***When** should the disclosure be made?*

The Act says the disclosure shall be made at a point in time that the healthcare service provider considers appropriate, having weighed up the desirability of doing it as soon as practicable and taking into account whether all of the likely consequences have developed and whether all relevant information may not yet be available. Generally, you should make the disclosure as soon as practicable after a PSI occurs. Some delay may be acceptable if all the consequences of the PSI are not yet known or if you are awaiting further information. However, delaying disclosure can sometimes compound the issue and upset patients. The Act makes clear that additional meetings may be held if further information comes to light and further clarification meetings can also be held if the patient so requests.

- ***How** should the disclosure be managed?*

You must make the disclosure at an ODM in order for legal protection to attach to it. The preferred form of meeting is a face-to-face one, but if this is not possible a telephone meeting will suffice.

Before the ODM, you should ensure that you are adequately prepared and the following matters should be considered:

- preparing notes for consultation in advance of the ODM
- the complexity of the information that needs to be discussed and how to simplify that information for the patient's / relevant person's benefit
- who will attend the ODM (we recommend asking a colleague to join you for support and as a witness)
- who will be the main point of liaison between the patient or relevant person and the health practitioner/ health service provider
- whether an apology will be offered and if so, in what terms

You should ensure that the ODM is conducted in a manner that is as open and honest as possible. The Act states that you should provide the patient (or relevant person, as the case may be) with the following information at the ODM:

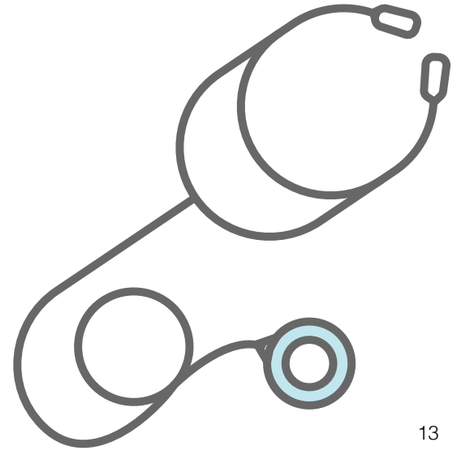
- a list of attendees present at the ODM
- the date the PSI occurred and how/when it came to your attention
- a description of the PSI and the consequences of same
- steps taken to address the PSI and ensure it happen again i.e. lessons learned and corrective / preventative measures adopted
- an apology (if appropriate)
- a written statement (in the prescribed form) including the information above and the date of the meeting. You should sign this statement.

Patients are not under any obligation to engage with an open disclosure process and may decline to do so. Certain procedural requirements then apply in terms of providing them with a written statement recording that fact. If the patient / relevant person declines to accept the written statement from you, further obligations in terms of note keeping arise. Members can contact Medisec for assistance if this situation arises.

Members can find copies of the standardised, mandatory forms which must be completed at various stages of the open disclosure process at www.opendisclosure.ie.

Medisec encourages open disclosure where PSIs occur. Our advice to members has always been to treat complaints and adverse incidents as opportunities to "reflect, correct and communicate". We hope that fostering a culture of open disclosure will promote transparency and improve public confidence in health services generally and we note that international experience suggests that open disclosure also leads to reduced litigation and fewer formal complaints.

We would strongly encourage that members liaise with Medisec before engaging in any open disclosure process, as strict procedural requirements must be followed to ensure that the disclosure is protected.



THIRD PARTY REQUESTS FOR REPORTS *A TRIPLE THREAT?*

Every day of the week, GPs are requested to disclose their patients' confidential information to third parties. The expected response is usually to complete some category of a report, whether that involves filling out a form, completing a certificate or preparing a medico-legal report. These reports are often very difficult and time consuming to prepare and in our experience very easy to get wrong. In this article, we identify the legal and ethical issues that arise for GPs when asked to disclose confidential patient information to third parties and look at three problem scenarios.

CONFIDENTIALITY

Confidentiality is a fundamental principle of medical ethics and is central to the trust between patients and doctors. Put simply, a patient can reasonably expect that anything they tell a GP during a consultation will be kept confidential. There are some exceptions to this general principle. The most common exception is where the patient consents to the disclosure of the confidential information. The other exceptions include where the disclosure is required by law (for example, pursuant to a court order); or where the disclosure is in the public interest (for example, to protect a third party from a significant risk of death or very serious harm).

INFORMED CONSENT

In the context of reports for third parties, GPs will almost always require the consent of the patient before disclosing their confidential information to the third party. That consent must be fully informed, so that the patient understands and agrees to the purpose and scope of the disclosure.

The fact that a patient completed an application form or the fact that they showed up for an appointment, can give the GP false reassurance. Before issuing any report on the request of a third party, it is best practice to obtain written consent directly from the patient so that the GP can be certain the patient fully comprehends:

i. that their confidential information will be disclosed to a third party,

ii. the extent of the information that will be disclosed, and

iii. to whom the disclosure will be made.

Showing the patient a copy of the final report before sending it is ultimately the best way to ensure you have the patient's informed consent. It is also an opportunity to identify and correct any inaccuracies or omissions. Without the patient's informed consent, the GP cannot proceed to disclose the report to the third party.

DUTIES

In addition to the duties owed to the patient, it is well-accepted that GPs owe a duty of care to third parties to whom reports are sent and who rely upon them.

When looking at the extent of that duty, the Medical Council's Guide to Professional Conduct and Ethics (the **"Guide"**) is an invaluable resource on the topic. Paragraph 40 of the Guide deals with medical reports and sets out the key duties and obligations placed on doctors.

Paragraph 40.2 of the Guide states:

"Reports must be relevant, factual, accurate and not misleading. Their content must not be influenced by financial or other inducements or pressures."

Dealing specifically with reports for third parties, paragraph 40.5 of the Guide states:

"…you should explain to the patient that you have a duty to the third party as well as to the patient, and that you cannot keep relevant information out of the report..."

CONTENT

There is rarely any difficulty ensuring the content is factual, accurate and not misleading. However, the question of what is relevant can often present a difficulty when determining the appropriate content to include in a report for a third party. The reason for the report is key in determining what is relevant to include in that report. Different types of reports will involve different levels of disclosure. We find it helpful to distinguish between reports based on the category of third party to whom they are to be provided – the most common being reports for employers; reports pprepared for solicitors for litigation and private medical attendant reports (**"PMA reports"**) for insurers.

CASE STUDY 1: PRE-EMPLOYMENT ASSESSMENT

John is offered a position as an accountant and attends for a pre-employment medical assessment. The GP conducts her assessment and finds that John is fit to work. Should the GP disclose that John has well-controlled diabetes and / or that he suffers from occasional lower back pain?

Employer requested reports usually require the least amount of disclosure of confidential patient information. These reports most often arise in relation to a patient's fitness to work (pre-employment assessment) or to return to work (following a prolonged absence). The purpose of this type of report is to confirm whether the patient is fit for work / or to return to work and in particular, to ensure the patient can perform the role safely without undue risk to their health or the health/welfare of others. This may include setting out whether any adjustments or adaptations should be made to make recruitment / return to work possible.

Only the result of the assessment should be disclosed to the employer. Any medical history or information including the results of any physical examination remain confidential and should not ordinarily be disclosed to the employer. In exceptional circumstances, more detailed insights on the impact of a particular condition may be necessary and appropriate to enable the employer to come to a decision but such disclosures would only be appropriate with the patient's consent.

It is of course up to the GP to determine whether a particular illness or condition affects a patient's suitability for a particular job. In John's case his diabetes is well-controlled and the GP has decided that he is fit to work as an accountant. Having formed that view, there is no basis for her to disclose that he has Type II diabetes unless he requires adaptations or accommodation in order to carry out the role.

Similarly, the GP's assessment is that John's occasional lower back pain is not a barrier to employment. However, if he requires certain adaptations or accommodations (such as an ergonomic assessment of his workstation, a particular seat or desk etc) in order to manage his condition and safely carry out his role, this should be disclosed to the employer.

CASE STUDY 2: REPORT FOR LITIGATION

Martha was involved in a low impact car accident 18 months ago. She suffered minor soft tissue injuries to her neck and spine and attended her GP once immediately after the accident. Martha has not returned since. She has a previous history of back pain and she suffered from post-natal depression after the birth of her first child 11 years ago. Her mother and aunt both had breast cancer. Martha's solicitor has now written to the GP for a medico-legal report in order to pursue a claim for personal injuries.

Reports prepared for litigation will necessarily involve disclosing considerably more detail, given the purpose for which the report is prepared. In a personal injuries claim such as this, the report should address the patient's injuries arising from the accident, as well as any other relevant injuries or symptoms and also the patient's current condition and prognosis, if appropriate.

Paragraph 40.1 of the Guide states that

"…Reports should be specific to the episode for which the report has been requested. If the report relates to the patient's current state of health, you should carry out an up-to-date examination where appropriate."

As it has been 18 months since the GP last saw Martha, the GP should carry out an up-to-date examination before completing the report. In terms of the content of the report, Martha's previous back pain should be disclosed as it is relevant to her current claim for injuries to her neck and spine.

It is a matter for the GP to determine whether the history of post-natal depression is relevant and should be included. On balance, our view is that it should not be disclosed where it appears her accident-related injuries are not ongoing and given the nature of the psychiatric illness and how long ago she suffered from it. The position may be different if her psychiatric illness was more recent, if her physical injuries were slow to recover or if she was also claiming for a psychiatric injury as a result of the car accident.

In our view, the family history of breast cancer is not relevant to the claim and should not be disclosed even if the relevant family members consented to the disclosure.

CASE STUDY 3: PMA REPORT

Laura is a 45 year old engineer who has had a diagnosis of breast cancer. She had a mastectomy and has been in remission for 6 years. He also has a family history of heart disease. Laura requires life insurance in the context of an application for a mortgage. Her GP has been asked for a PMA report.

PMA reports for insurance companies or other financial institutions tend to involve the greatest level of disclosure of confidential patient information. The reason for the report is essentially to present a full picture of the patient's health to facilitate a decision on whether the patient is eligible for the particular product and if so, to determine the loading/price. Given the extensive disclosure required with PMA reports, it is particularly important that the GP obtain the patient's informed consent. Failure to make full disclosure of a relevant medical condition will invariably result in a denial of any later claim under the policy. Best practice is to call the patient in so that they fully understand the nature and extent of the disclosure to be made.

However Part 4 of the Disability Act 2005 imposes an important limitation in relation to the disclosure of the results of genetic screening (positive or negative) to an insurer. Where there is such disclosure the insurer cannot take into account or process the results. This exception does not apply where there is a diagnosis of a genetic illness.

In this case, Laura's previous diagnosis with breast cancer is relevant and should be disclosed. However, the patient's family history of heart disease should not be disclosed as this would involve disclosure of third party information. The GP could not rely on Laura's consent to release confidential information about her brother or uncle. Our advice is to put a line through this section of the form with the words, 'third party information' or 'refer to patient'. It is for Laura to disclose this information about her own family history.

If you have any queries about preparing reports for third parties, contact Medisec for further advice.

Cycle of Life

Our new Cycle of Life feature will highlight the most commonly arising medico-legal issues in each stage of a patient's life. In this edition, we start by focusing on infants and young children. This feature is a high-level overview only and Medisec members with specific queries should not hesitate to get in touch with us for advice at any stage.

1. HOMEBIRTHS

- NB - If a patient has opted for a home delivery, the Medisec policy does NOT cover any aspect of antenatal, intra-partum or postnatal care up to and including the postnatal two and six week check for both mother and baby. Where a home birth has taken place the postnatal care of the mother and baby must be referred back to the care of the local Obstetric and Neonatal service. If a GP undertakes to provide these services they are not covered under their Medisec policy.

2. GUARDIANSHIP OF MINORS

- Guardianship is the collection of rights and duties that a parent or non-parent may have in respect of a child, for example, the right to make decisions, including the right to consent to medical treatment.
- Mother - historically, a child's mother, whether married or unmarried, has automatic legal guardianship of the child.
- Married father - a child's father also has automatic guardianship if he is married to the child's mother, either before or after the birth of the child. Following a separation or divorce, both parents remain the child's legal guardian (unless removed by the court), regardless of whether one or both parents have custody of the child.
- Unmarried father - a father who is not married to the child's mother can be appointed as a joint guardian of the child if he and the child's mother have made a statutory declaration to that effect.
- Guardianship will also be acquired automatically by an unmarried father where he has lived with the child's mother for at least 12 consecutive months after 18th January 2016, and at least 3 of these months are after the birth of the child.
- In the absence of a statutory declaration or proof of guardianship under the new legislation, it is currently for a court to decide what, if any, guardianship rights it will grant to an unmarried father, regardless of whether or not his name is recorded on a birth certificate.
- Proof of Guardianship - it is good practice to protect the confidentiality of patients by insisting on proof of guardianship and formal identification before discussing any patient information with a patient's parents.

  Proof of guardianship includes:

  (i) A marriage certificate showing that the father was married to the child's mother

  (ii) A Statutory Declaration by the child's mother

  (iii) A Court Order
- Where there are two or more parents or guardians with appropriate rights who share parental responsibility, it is usually sufficient for one parent or guardian to give consent to day to day treatment. However, where decisions may have profound and or irreversible consequences, both or all parents or guardians should be consulted. It is important to deal with requests from legal guardians professionally, to afford equal treatment to all legal guardians and not to show any bias.

3. BABY'S RECORDS

- Always keep in mind that the records can be seen by both guardians (and possibly by the child when they turn 18).
- Avoid inappropriate comments in records (e.g. over-anxious mum or strange kid).

4. VACCINATIONS

- Ensure written consent of parent / guardian. The form supplied by HSE should suffice. If you are on notice that both parents do not consent, it is best practice that the parent(s)/legal guardian(s) sign a refusal form (available online from the National Immunisation Office)." (so deleting the reference to if available from the local office.
- If the parents refuse vaccination and all avenues of communication have been explored, it is best practice that the parent/legal guardian sign a refusal form (if available from the local immunisation office).
- As regards children in the care of the HSE – you may need to see the care order (statutory or voluntary) and ensure the social worker can give consent to vaccines. If the child is in voluntary care, the parent's consent is likely required.
- Report any adverse events to HPRA.
- Tidy the fridge! Make sure you carry out regular stock takes and check expiry dates.
- What to do if incorrect vaccine given:
- Open disclosure – iinform the parent(s)/legal guardian(s) as soon as possible and invite them to meet.
- Contact HSE / Vaccination Board / National immunisation office and arm yourself with information about any potential adverse effects.
- Keep careful notes of all discussions with patients and HSE etc.
- Review practices to ensure it doesn't happen again and communicate this to the parent.
- Don't charge for follow – up!

5. MEDICATIONS

- Beware paediatric doses!!

6. ABUSE – MANDATORY REPORTING AND TUSLA

- The commencement of the Children First Act 2015 on 11 December 2017 means that GPs are classed as "mandated persons" and must report suspected harm to Tusla.
- GPs have two obligations:
  - To report the past, ongoing and/or potential harm of children above a defined threshold to Tusla; and
  - To assist Tusla, if requested, in assessing a concern which has been the subject of a mandated report.
- Harm is defined as assault, ill-treatment, neglect or sexual abuse. A GP must inform Tusla when they have reasonable grounds for concern.
- If a child is in immediate danger and you cannot contact Tusla, you should notify the Gardaí.
- If you have doubts as to whether your concerns meet the threshold, contact Tusla on a "no-names" basis for guidance.
- The standard report form is available on Tusla's website. As mandated persons, GPs cannot make anonymous reports to Tusla. Legislation protects mandated persons acting in good faith from civil liability / data protection obligations etc.
- You are not required to inform a family that you are making a report but it is best practice to do so (to include explaining your reasons) unless informing the family may:
  - place the child at further risk; or
  - impair Tusla's ability to investigate the concern and carry out a risk assessment.

- If you don't report in circumstances where you should, it's open to Tusla to make a complaint about you to the Medical Council and / or to report you to the National Vetting Bureau of An Garda Síochána.
- Record-keeping. You should always keep notes of your conversations with Tusla and record your decision making carefully even if you decide not to report in case you are ever asked to stand over it.

Examples

A.
- GP's male patient informed him about episodes of domestic violence and drug and alcohol abuse on the part of his partner, the mother of his young children.
- The GP considered that the children were at potential risk of abuse and neglect and he had an obligation to ensure the concerns were reported to Tusla without delay.
- In an effort to maintain the relationship with the patient, the Dr informed the patient of his obligation.
- The patient was very upset and threatened legal action and a complaint to the Medical Council and then said that he had fabricated the stories.
- The GP was concerned about the children's living situation and had to remain firm and proceed with the report.
- The report was made and the patient left the GP's practice.

B.
- A mother brought her three year old daughter to a GP on a Friday and said the child had complained of painful bruising and said that her much older, teenage brother was hurting her.
- The GP referred the child to A&E with a detailed letter including the suspicious history.
- The GP later spoke to a nurse in A&E and was assured a paediatrician was reviewing the child and liaising with Tusla.
- The GP submitted her own report to Tusla the following Monday and subsequently received a letter from Tusla stating that the child was exposed to risk over the weekend because the GP had not made a report immediately.
- While the Dr should have been entitled to rely on the reassurance from A&E, the safer course of action would be to report to Tusla on the Friday even if this would have resulted in two reports being made.

7. REQUESTS FROM SCHOOLS REGARDING ASTHMA AND EPI PEN INSTRUCTIONS

- Chronic health conditions such as asthma, diabetes, epilepsy and allergies are common and it is likely that GPs will have many patients with such conditions.
- Schools and crèches have increasingly been in contact with GP practices about training for staff on devices and edications e.g. inhalers, insulin, buccal midazolam (for seizures) or Epi-pens.
- It is the responsibility of the school or crèche to arrange for appropriate training for staff. GPs are not under any obligation to provide this training but may do so if they wish.
- Manufacturers provide clear instructions on how to use the devices.
- GP should ensure that the parents / guardians are advised about training those associated with the care of the children on how to use the relevant devices.

Examples

A.
- GP asked to do a demonstation in her child's school on the use of Epi-pens and Volumatic spacers / inhalers.
- GP was happy to give the training as her child had a severe allergy and she was confident with her abilities to provide training.
- Some GPs would not be confident in the use of these devices and have understandable concerns about the potential exposure to liability. The decision is for the GP to make.
- GPs can refer the school or crèche to the manufacturers who may be in a position to provide training.

B.
- GP received a request from the mother of a 4 year old patient for a letter about the patient needing salbutamol to accompany a letter to Board of Management of School.
- There is no issue with the GP providing this information to the school but he / she should check for consent of the father as well.
- If child was older, Dr could assess the child's maturity and discuss it with them.
- There is no need to seek any form of indemnity from the school but the GP should ensure information given is accurate.

8. DOCTORS ASKED TO PROVIDE COVER FOR CHILDREN'S SPORTING EVENTS

Pitchside assistance.

- This refers to young children involved in sport, where a GP may be on the sideline as a spectator. A GP can consider putting some formality in place i.e. let the coach or teacher know that you are happy to be called upon if required.

Medical assistance on a more formal basis to local sports team or for an event.

- You should know the duties and responsibilities and specific requirements.The duty of care can vary greatly depending on the level of responsibility, as can the exposure to risk and the GP's indemnification requirements.
- Consider whether you have the appropriate competency to carry out the role and prepare by carrying a medical bag with equipment that you are able to use. Do not attempt to provide care that goes beyond your ability and training.

- Be cognisant of recognising and reacting appropriately to serious conditions such as suspected concussion at sporting events.

Medisec cover.

- GP Members are not covered under the Medisec policy to act as an Event Doctor, i.e. the medic with responsibility for ensuring that appropriate procedures and controls are in place for the whole event eg. crowd control, ambulance cover, provision of appropriate medical equipment etc.

9. SCREENING FOR COMPETITIVE SPORTS

There is no obligation on a GP to become involved if it would be outside the GP's area of competency.
It depends on level of screening required. The GAA has issued good advice, see also guidance from the IRFU, especially regarding concussion management etc.

TOP TIPS

CHANGES TO ETHICAL GUIDE (TOP)

The Medical Council is working through a detailed process to update the Ethical Guidance following the enactment of the Health (Regulation of Termination of Pregnancy) Act 2018. The Ethics Working Group is reviewing a number of paragraphs of the Guide to ensure that the guidance is relevant and appropriate for doctors and for patients in light of the new legislation.

The Medical Council has decided to delete paragraphs 48.1 to 48.4 of the Ethical Guide, thus removing any conflict between the Ethical Guide and the new termination of pregnancy legislation. Paragraph 48.5 of the Guide, slightly edited, "You have a duty to provide care, support and follow up for women who have had a termination of pregnancy" will remain in place. It is clear that doctors have an ethical duty to provide care, support and follow up for a patient who has had a termination of pregnancy, as outlined in paragraph 48.5.

It is understood that the Medical Council will consult again with doctors and relevant stakeholders in relation to proposed amendments to other sections of the Ethical Guide in due course.

We confirm that the provision of termination of pregnancy services will be covered as per Medisec's Policy terms and conditions, subject to:

1. The GP having the necessary training and working within and maintaining their competence
2. The GP providing the services in accordance with clinical guidelines issued by the ICGP
3. The GP following all legal, contractual and ethical obligations, and
4. Appropriate referral pathways and clinical support services being in place.

We refer members to the ICGP consent form in addition to the HSE consent form.

PHYSICAL AND INTIMATE EXAMINATIONS IN GENERAL PRACTICE

Medisec members are reminded of the provisions of paragraph 35 of the Medical Council's Guide to Professional Conduct and Ethics, which state:

35.1 Clinical assessments of patients often involve a physical examination as well as relevant history-taking. Before undertaking any physical examination, including an intimate examination, you should explain to patients why it is needed and what will be involved, and get their consent.

35.2 You should respect patients' dignity by giving them privacy to undress and dress, and keeping them covered as much as possible. You should not help the patient to remove clothing unless they have asked you to do so, or you have checked with them that they want your help.

35.3 Where an intimate examination is necessary, you must explain to the patient why it is needed and what it will entail. You must ask the patient if they would like a chaperone to be present – for example, a nurse or family member - and note in the patient's record that a chaperone was offered. You should also record if a chaperone was present, had been refused, or was not available but the patient was happy to proceed.

35.4 You must not carry out intimate examinations on anaesthetised patients unless the patient has given written consent to this in advance.

It is important to note that it is mandatory to offer a chaperone and to document that one was offered. Medisec members may wish to display our practice posters regarding a chaperone policy in their waiting room and can contact us at any time to request copies of the poster.

PARENTS REFUSING VACCINATIONS

The HSE guidelines on vaccinations for GPs state:

"In those instances where a parent/legal guardian/ client refuse vaccination and all avenues of communication have been explored, it is best practice that the parent / legal guardian / client sign a refusal form. In the instance where combination vaccines or multiple vaccines are recommended, the name of each vaccine and the disease/diseases that they protect against should be clearly outlined in the refusal form. If a refusal form is unavailable, these details should be recorded in the patient notes".

Accordingly, it is important that you explore all lines of communication, outlining the benefits of vaccination and the corollary risks of not vaccinating to a child's legal guardians. All the legal guardians should sign the refusal form.

INVITE QUERIES FOR THE GP PANEL

For many years, Medisec has had the assistance of a GP Advisory Panel which reviews procedures and developments taking place in general practice. The Panel meets formally on a quarterly basis and considers a wide range of issues which concern General Practitioners. The Panel advises both Medisec and its insurer, Allianz, as to what it considers normal GP practice for inclusion under the professional indemnity insurance policy. However, the final decision on Policy cover rests with Allianz.

In addition, Medisec are in ongoing contact with the Panel on day-to-day issues arising from an advisory, claim or indemnity perspective. Any Medisec member can raise a query with the Panel by contacting our Clinical Risk Advisor, Dr Mary Davin-Power.

CALLED TO GIVE EVIDENCE IN COURT?

Medisec regularly provides assistance to members who are called to give evidence in a variety of situations, including Coroner's Inquests and criminal cases. GPs are 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. Medisec is available to provide assistance to members in drafting witness statements and where necessary or requested, will accompany members to Court.

GP TRAINERS' OBLIGATIONS: A REMINDER REGARDING OUT OF HOURS

Members who are GP Trainers are referred to the ICGP's detailed policy on the Out of Hours Experience for GP Registrars and reminded, in particular, of the following principles:

1. A GP trainer must always know when the GP trainee is doing an out of hours session

2. There must be appropriate clinical supervision in place (the GP trainer or a nominated substitute must be physically present with the GP Registrar or available by telephone)

3. A debriefing has to happen after every shift and should routinely happen on the next working day or soon thereafter

4. The GP trainer may arrange a deputy e.g. for annual leave etc. It is acceptable for an experienced GP Principal in the GP Registrar's practice or in another practice within the same OOH arrangement to provide the clinical supervision but the GP trainer must be satisfied that suitable arrangements are in place.

MEDISEC RISK WORKSHOP

We are pleased to announce that we will be running our popular Medisec Risk Workshop for practice managers, nurses and administration staff in our office on 23 May 2019 and we will announce further dates for additional workshops in Autumn 2019. The workshops will be half-day events (from 10am - 2pm) in our office here at Medisec, on 7 Hatch St Lower, in Dublin 2. Attendance is free of charge and tea, coffee and refreshments will be available on arrival. We will address many of the medico legal challenges that routinely arise in general practice. By tackling these issues with practical guidance, we hope that those who attend will be more aware of risk and promote a safety culture within your team. We strongly recommend that all members encourage their staff to register and attend. We would advise that you contact us to secure a place as soon as possible, as availability will be limited. If a member of your team is interested in joining us at the session please contact us by email at info@medisec.ie at your earliest convenience. We look forward to welcoming your staff to our offices.

THE OMBUDSMAN AND THE HEALTH SECTOR

By David Nutley,
Head of Quality, Stakeholder Engagements and Communications,
Office of the Ombudsman.

WHAT DOES THE OMBUDSMAN DO?

Ombudsman Peter Tyndall is the State's independent complaint handler. His office investigates complaints from the public about the administrative actions of most providers of public services such as government departments, local authorities, publicly-funded third-level education bodies and the HSE.

CAN THE OMBUDSMAN INVESTIGATE COMPLAINTS ABOUT THE HEALTH SECTOR?

Yes. In the health and social care sector the Ombudsman can examine complaints about bodies such as:

- the HSE
- GPs if carrying out services on behalf of the HSE (for example to medical card or GP card holders)
- bodies acting on behalf of the HSE (such as providers under section 38/39 of the Health Act 2004)
- public hospitals
- nursing homes (public and private)
- the Department of Health
- TUSLA
- HIQA
- the Medical Council (in relation to registration of medical practitioners)
- CORU (in relation to the registration of members)

It is important to note that the Ombudsman cannot examine complaints about the 'clinical judgement' of GPs or the HSE, that is, diagnosis or decisions about treatment. Neither can he examine complaints about recruitment, pay and conditions of employment, or private healthcare. Two case studies from the healthcare sector are set out below.

WHAT TYPE OF COMPLAINTS DOES THE OMBUDSMAN RECEIVE ABOUT THE HEALTH SECTOR?

In 2017 the Ombudsman received 608 complaints about the health sector. The highest numbers of complaints were about hospitals (246), the medical and GP card (59), primary/community care (55) and the Nursing Home Support Scheme (29).

IS THE OMBUDSMAN INDEPENDENT?

Yes. The Ombudsman is independent and impartial when examining complaints.

IS THERE A FEE?

No. It is free to make a complaint to the Ombudsman.

HOW MANY COMPLAINTS DOES THE OMBUDSMAN RECEIVE?

The Ombudsman receives over 3,000 complaints every year from the public. Before bringing a complaint to the Ombudsman the complainant must have first tried to resolve their complaint with the provider of the public service.

THE OMBUDSMAN'S CASEBOOK

Every quarter the Ombudsman publishes summaries of cases his Office dealt with over the previous months in 'The Ombudsman's Casebook'. It describes complaints across all the areas the Office deals with, such as Health, Social Care, Education and Local Government
It is circulated in digital format to over 2,500 officials in public service providers, members of the Oireachtas and other public representatives. It is also available on the website: www.ombudsman.ie.

If you wish to receive The Casebook electronically then please e-mail: casebook@ombudsman.ie with 'SUBSCRIBE' in the Subject line.

MORE INFORMATION ON THE OMBUDSMAN:

Visit www.ombudsman.ie for more information and you can follow the Ombudsman on Twitter: @OfficeOmbudsman

CASE STUDIES FROM THE HEALTH SECTOR: WOMAN REFUSED FULL COST OF SECOND CROSS BORDER TREATMENT DESPITE INITIAL APPROVAL.

Background

A woman who was suffering from pancreatic cancer complained to the Ombudsman when the HSE refunded her a lesser amount for a second similar treatment under the Cross Border Directive than it had for her first treatment.

The Cross Border Directive (CBD) allows patients to be reimbursed for the cost of treatment abroad based on the cost of public care for the treatment in Ireland or the cost abroad, whichever is the lesser.

In this instance, the woman's first application for surgery had been approved and she had received full reimbursement based on the information provided by her UK consultant. She sought similar reimbursement a second time for further similar surgery. The HSE approved her second application in advance of the surgery but then refused to reimburse her the full amount. The HSE said that the information supplied by her consultant was incorrect and referred her clinical records to the Health Pricing Office (HPO) in Ireland for an independent review. The HPO said a lesser payment should be made as, on average, the treatment she required did not require the length of stay in hospital that the consultant's information indicated.

As a result, when processing the second payment to the woman, the HSE deducted the "overpayment" from the first application and applied the lesser rate to her second application. This left the woman significantly out of pocket (€8,821) as she had to pay for her full treatment costs in advance. She was told by the HSE to take the matter up with her consultant in the UK.

Examination

The woman was expected to undergo identical treatment on both occasions. When she received approval and reimbursement on the first occasion, she had every reason to believe that the reimbursement rate would be the same on the second occasion. Her second application had been approved in advance of her treatment and details of the proposed surgical care were available to the HSE.
It was not until she had undergone surgery a second time, and applied for reimbursement, that the HSE challenged her clinical care and sought advice from the HPO.
The Ombudsman considered that the HSE had acted unfairly in applying the lesser payment to both applications, having already approved the higher payment.

Outcome

The HSE decided to reimburse the woman for both procedures based on the higher amount. This meant that she received €8,821 to make up the financial shortfall with regard to her two applications. The HSE also agreed to review its procedures around coding to ensure that applicants have knowledge of likely reimbursement levels prior to acquiring financial liabilities for treatment abroad.

DELAYS IN TRANSFER OF ELDERLY MAN AND HIS FAMILY NOT INFORMED OF FALLS

Background

A man complained about a 12 day delay in arranging a transfer for his late brother from Letterkenny University Hospital to University Hospital Galway, the regional centre, for a urology review. His brother's condition deteriorated before a transfer occurred and he later passed away.
The man felt that not enough was done to ensure the transfer happened. In addition, his brother suffered a number of falls while he was in hospital. The family complained that they were not told about all the falls.

Examination

The man suffered four falls while in hospital. He received treatment after each fall and an orange band was placed on his wrist to indicate he was at risk of falling.
However, no particular actions were taken to prevent him falling again, documentation was incomplete and the family was not notified of all the falls.

The urology team in the regional centre accepted the man for transfer but his name was not added to the bed management list in the regional centre until 13 days later. The local hospital rang most days to see if a bed was available and wrote in the bed management log book 'no bed' or 'not on list'. They were not aware, until the Ombudsman's examination, that the man's name had not been put on the list.

At one stage the team in the regional centre said the man was not suitable for transfer until more tests were done. The family was not aware of this.

It was clear that there was no agreed protocol covering the procedure for the transfer of patients between the two hospitals. The consultant had little involvement in the transfer and all dealings were by telephone which resulted in serious communication issues.

After waiting 12 days for a transfer, the family complained. The consultant rang the regional centre and the man's name was then added to the transfer list. Sadly, the man soon become too unwell for a transfer to take place.

Outcome

The Hospital Group committed to finalising a Bi-Directional Patient Flow policy to streamline the process for transferring patients within the hospital group. The importance of clear documentation and communication in arranging transfers was to be included in induction training for hospital doctors.

The local hospital formalised a new falls management policy and specialist 'Frailty' training, which includes a module on falls prevention and management. This was rolled out to all nursing staff in the local hospital.

The General Managers of both hospitals wrote to the family and apologised.

Peter Tyndall, Ombudsman

RECENT JUDGMENT OF INTEREST

Mr Justice Barr delivered judgment in a High Court case brought against a number of named defendants, including a GP, on 28 February 2019. This is a significant judgment because the GP's medical records were an important piece of evidence in Judge Barr's findings on the key question of liability. We set out below some extracts from the judgment regarding the GP's involvement. The judgment addressed other matters including the technical issue of the probable size of the breast tumour in 2014, which was the subject of detailed expert evidence, which is not summarised below. The full judgment is available online at www.courts.ie.

The plaintiff contended that the defendant GP was negligent in the care and advice she gave the plaintiff in consultation on 24th September, 2014. The plaintiff gave evidence that in the three months prior to that visit, she had developed a lump in her left armpit, which she had discovered in the shower. After researching her symptoms online, she became concerned and made an appointment to see a female GP, as she stated that she expected that a breast examination would be done.

The plaintiff alleged that the defendant negligently performed an inadequate examination of her left axilla and reassured her that she could not find anything of concern. She also alleged that the defendant negligently failed to offer and to carry out a breast examination and failed to advise the plaintiff to return for a review within two/six weeks. The plaintiff alleged that the defendant acted negligently and in breach of the National Breast Cancer GP Referral Guidelines, issued by the HSE in April 2009.

The defendant accepted that she saw the plaintiff on 24th September, 2014, when she had a concern about a lump in her left armpit. The defendant gave evidence that with the exception of two things, she could not recall the details of that consultation. The two things she did recall, were that the plaintiff said that she did not have any family history of breast cancer and that she had declined a breast examination when offered one. Other than that, the defendant had to rely on her contemporaneous medical notes, which read:-

"Concerned re? Axillary lump x 3 months

Non tender

o/e no lump palpable in axillae, declined breast exam –

no relevant FHX breast disease.

note long standing eczema o [sic] arms

imp - ? resolved LN secondary to excema [sic]

reassure

TCI if recurs."

The plaintiff gave evidence that the lump in her left armpit persisted after September 2014 but that based on the defendant's reassurance, she did nothing about it. In August 2016, the plaintiff attended a different GP with a concern about a lump on her breast, which she had noticed approximately three weeks previously. A breast examination and axillary examination were completed and the plaintiff was referred urgently to the breast clinic. In the following weeks, scans revealed a tumour measuring 5cm in the left breast. An ultrasound scan of the left axilla revealed mild cortical thickening.

Due to this finding, a biopsy was carried out of the lymph node, which revealed malignancy in the node of the same type as that found in the breast. The original treatment plan was a mastectomy and nodal clearance, to be followed by adjuvant chemotherapy and radiotherapy for her chest. However, subsequent scans revealed that the disease had spread to other parts of her body. For that reason, the surgery was not done. Instead, the cancer was treated with a variety of chemotherapy and hormone therapy drugs. In order to reach a conclusion on the question of liability, it was necessary to resolve the conflicts in evidence in relation to what did or did not happen at the consultation on 24th September, 2014.

AXILLA EXAMINATION

One area of conflict was whether the plaintiff was examined while lying on the examination bed in the consultation room, with her left arm raised and her hand behind her head, as she alleged, or whether she was examined sitting on the bed with her left arm slightly abducted from her body and her elbow supported, as alleged by the defendant.

On this matter, Judge Barr preferred the defendant's evidence. Her evidence was that having taken the relevant history, while sitting at a chair beside her desk, she asked the plaintiff to move over and sit on the examination bed. The defendant stated that it would not be appropriate to examine the axilla with the patient lying on the bed and with their arm lifted back over her head, because this would render the muscles and tissues in the underarm area taut. She stated that they had been taught to have the patient sitting on a chair or on an examination bed with their arm slightly abducted away from the body.

The doctor would support the arm at the elbow, so as to render the muscles of the axilla and upper arm lax. This was necessary to enable an adequate examination of the axilla by palpation.

Another issue was whether the defendant carried out an adequate examination of the plaintiff's axilla. In her evidence, the plaintiff stated that she thought that the defendant had been slightly dismissive of her complaint that she had a lump under her arm and had carried out a somewhat cursory examination of her left axilla. The defendant gave evidence that she had palpated the left axilla on two occasions. She stated that she had also palpated the right axilla for completeness and for comparison purposes. The clinical examinations had been negative. The defendant stated that she had examined both axillae, because she had recorded this in the plural in her notes. Judge Barr preferred the defendant's evidence on this issue.

BREAST EXAMINATION

The central conflict between the parties, was whether the defendant offered the plaintiff a breast examination and whether she refused it. The plaintiff's account was straightforward. She said that she was not offered a breast examination and therefore did not refuse one. The defendant's account was that having palpated the two axillae, she said to the plaintiff in a conversational tone, "I would like to perform a breast examination", or words to that effect. She said that she made this request in a conversational tone, so as not to alarm the plaintiff, because in light of the negative axilla examination, she did not believe that there was any indication that the plaintiff had breast cancer. The fact that the plaintiff was a young woman with no family history of breast cancer, meant that the index of suspicion of breast cancer was low.

The defendant stated that when the plaintiff declined to have a breast examination, she did not feel that she could push the matter further.

RECENT JUDGMENT OF INTEREST

The index of suspicion for breast cancer was low and this was the first occasion on which she had treated the plaintiff as a patient, although they had met previously when the plaintiff brought in one of her children who was sick. Given the low index of suspicion for breast cancer, the defendant did not push the matter further.

THE MEDICAL RECORDS

Judge Barr found that the defendant's notes were satisfactory, insofar as they gave sufficient detail of the relevant matters discussed at the consultation. The critical part of the notes read "declined breast exam".
Judge Barr stated that he was satisfied that the defendant would not have deliberately written in her notes that the plaintiff had declined a breast examination, if that was not the case. He preferred her evidence that the plaintiff declined a breast examination after the negative axillary examination, as supported by her contemporaneous notes.

CONCLUSIONS

Having considered the technical evidence, Judge Barr found that the defendant was not negligent in failing to make a second or more vigorous request to examine the plaintiff's breasts at the consultation on 24th September, 2014. Judge Barr said that even if he was wrong to have concluded that there was no negligence by the defendant and if she had negligently failed to carry out a breast examination on 24th September, 2014, that did not lead to any loss or injury.

Judge Barr was satisfied that having regard to the probable size of the breast tumour in 2014, it would not have been palpable on clinical examination at that time. In other words, had the defendant examined the plaintiff's breasts on 24th September, 2014, she would not, on the balance of probabilities, have found any lump in the breast. Consequently, she would have simply reassured the plaintiff that all was well and no further investigation would have been carried out. Judge Barr found that the defendant did not act negligently in her care of the plaintiff and dismissed the case against the defendant.

OUT & ABOUT

- In January, we were delighted to announce our sponsorship of the Trinity College Dublin GP Society for 2019
- Medisec were pleased to support an event on Pancake Tuesday in House, Leeson Street in aid of Focus Ireland
- Claire Cregan and Dr Mary Davin-Power attended the Medico-Legal Society Academic Day in the Honourable Society of the King's Inns on 16 February 2019
- Aisling Timoney gave a presentation on Open Disclosure and Patient Safety Legislation to the Women In Medicine in Ireland Network Annual Conference on 23 March 2019, coordinated and organised by Dr Sarah Fitzgibbon
- Eimear Bourke gave a Medico-Legal Updates lecture to a CPD event organised by Astellas in the Crowne Plaza Hotel, Blanchardstown on 30 March 2019
- Niall Rooney and Suzanne Browne attended the 3rd annual Teddy Bear Hospital organised by the Paediatric Society of Trinity College Dublin, supported by Medisec
- Ruth Shipsey presented on Medico-Legal Challenges in Daily Practice to the Wexford ICGP Faculty on 02 April 2019

Dr Mary Davin-Power, Mr Justice Peter Kelly, President of the High Court and Claire Cregan at the Medico Legal Society's Academic Day, February 2019.

Aisling Timoney speaking at the WIMIN Conference 2019.

Pic. Mel Maclaine of The Photo Project

Dr Sarah Fitzgibbon, GP, organiser of the WIMIN Conference 2019.

Pic. Mel Maclaine of The Photo Project

Niall Rooney and Sophia Rooney with volunteers from the TCD Teddybear Hospital at its 3rd annual event, supported by Medisec.

Dr Ciara Kelly, Newstalk, Eimear Bourke, Aoife O'Higgins and Barbara Doyle of Medisec supporting a Pancake Tuesday charity event in aid of Focus Ireland.

Suzanne Browne, Calvin Browne and Asia Aru at the 2019 TCD Teddybear Hospital event.

RED ALERT

HOME BIRTHS

We wish to bring your attention to the issue of cover under the Medisec Master Policy (underwritten by Allianz plc) in relation to the provision of ante-natal care under the Mother and Infant Scheme. Please note that cover is in place under your policy for GP involvement in Combined Care Schemes provided that:

(i) The antenatal and post-natal care provided is under the supervision of an obstetrician attached to a recognised Maternity Hospital.
(ii) The GP does not provide intrapartum care i.e. assistance at the birth. This is specifically excluded under their policy cover.
(iii) patient opts for a maternity hospital birth, care of which would be under the supervision of an obstetrician as at (i) above.

GPs are not covered under the Medisec Master Policy to sign up to the scheme if a patient is opting for a home birth. If a patient opts for a home birth during the scheme we advise that arrangements are made by your patient for alternative ante natal care immediately.

- NB - If a patient has opted for a home delivery, the Medisec policy does NOT cover any aspect of antenatal or postnatal care up to and including the postnatal two and six week check for both mother and baby. Where a home birth has taken place the postnatal care of the mother and baby must be referred back to the care of the local Obstetric and Neonatal service. If a GP undertakes to provide these services they are not covered under their Medisec policy.
- Members are covered to provide medical advice and/or treatment in circumstances of a bona fide medical emergency.

Please note for avoidance of any doubt that cover is not in place for members to provide ante-natal care for any patients, including private patients, opting for a home birth.

NEO-NATAL CARE FOLLOWING HOMEBIRTHS

Cover is not provided for GPs to carry out the 2 and 6 week check for babies and the 6 week check for mothers in respect of delivery of care to babies or mothers in the neonatal period following a home birth, unless the mother or baby have been first checked by an obstetrician or paediatrician as appropriate and the GP is provided with evidence of such visit. Essentially, once mother or baby have been screened by the relevant expert, in the same way they would in the context of a hospital birth, here is no barrier to the GP then providing care to mother or baby as normal. Cover has always been provided to GPs to see a mother or baby with any acute illnes. Cover has always been provided to GPs to see a mother or baby if they are sick. If you have any queries in relation to the above please do not hesitate to contact one of our team.

NEEDLE STICK INJURIES

The GP has a responsibility to protect themselves, their patients and their staff from harm. One potential hazard is that of a needle stick Injury. All clinical and cleaning staff are particularly vulnerable. Medisec have some tips to ensure this risk is kept to a minimum:

1. Have an up to date Sharps Policy – this ensures all staff are aware of what action to take in the event of a needle stick or sharps injury.
2. Ensure ALL sharps boxes are kept out of reach of children but close enough to the clinician for easy access.
3. Whoever uses the needle should be the one to dispose of it.
4. Remind staff of the dangers of overfilling sharps boxes – the safe line is clearly demarcated on each bin.
5. Remind clinical staff NEVER to recap needles.
6. Keep clinical surfaces clean and free from clutter.
7. Wearing gloves reduces the risk of a needlestick injury.
8. Ensure that all appropriate staff are immunised against Hepatitis B. Consider your cleaning staff.

RECORDING HOUSE CALLS

In the course of defending a GP against a claim or complaint, it can become apparent that a house call which took place has not been documented. Of course it is just as important to record your House Call consultation as it is your routine clinic consultations. On a busy day, when house calls are fitted in between clinics and the GP is under pressure, it can be easy to forget to record the clinical details of the house call.

Medisec has some suggestions:

1. Use the GP Software to remind you to enter the details – eg do not remove the house call request (and ensure admin staff do not either!) from the appointments bar until the clinical details have been entered.
2. Task a member of administration staff to remind you, and to ensure that you do enter the details on your return.
3. Take a handwritten record in the patient's home and scan it into the patient file on your return.

Whatever method you use, try to find a method that works easily and efficiently for you and your colleagues.

POSTERS FOR YOUR SURGERY

As part of our commitment to supporting members with best practice and risk mitigation advice, we have developed a range of eye-catching practice posters.

We believe our posters are an effective way to communicate important messages to your patients and to let them know about your practice policies. Member feedback has been very positive and we always welcome any suggestions for developing the series.

Our posters are available in hard copy or in digital format for display on television screens within your practice.

Please contact us at info@medisec.ie to request copies or to suggest a new idea.

Call **1800 460 400** please email **info@medisec.ie**

We're always on call

While you're busy caring for your patients, Medisec is doing the same for you.

Medisec provides advice on best practice, legal and ethical issues and Medical Council complaints, as well as arranging professional indemnity insurance. We provide 24/7 support whatever the issue, however big or small.

We are owned by and run for GPs in Ireland so you can be sure we always have the best interests of you and your patients in mind.

Call **1800 460 400** or visit **medisec.ie**

Medisec Ireland CLG is a single agency intermediary with Allianz plc and is regulated by the Central Bank of Ireland.

MEDISEC IRELAND