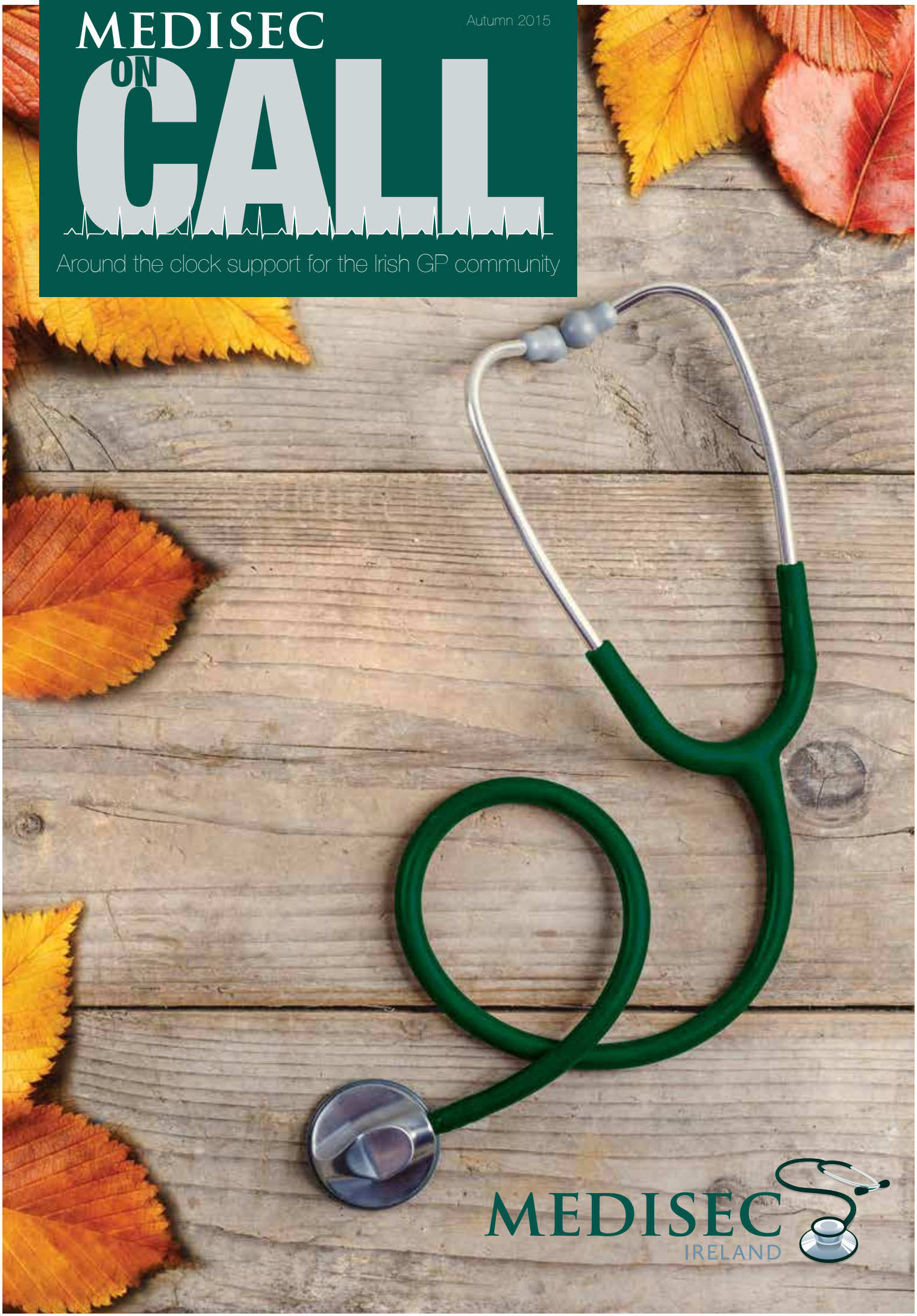
MEDISEC ON CALL

Autumn 2015

Around the clock support for the Irish GP community



MEDISEC IRELAND

MEDISEC ON CALL
autumn issue 2015

Welcome to the autumn edition of Medisec On Call.

A lot of the articles you'll read are based on actual queries we receive on a daily basis, and highlight the advice given and lessons learnt along the way. We hope you find them useful. And as usual we welcome all feedback, so please get in touch if you'd like further information on what's been covered, or have suggestions on topics you'd like to see covered in future.

I'm delighted to report that we continue to see a significant growth in membership, which now stands at over 1,500 GPs in Ireland. This is an increase of 25% over the last three years!

As you know, we actively encourage members to contact us with any medico-legal queries. We have seen a 100% increase in advisory support required from our members. This service is available 24/7 from our team here in Ireland and no query is too small so please feel free to contact us on any matter.

To continue giving you high quality service and fast response times, we have recently appointed an in-house legal counsel, Deirdre McCarthy and a GP Risk Advisor, Dr Mary Davin-Power to our team. Deirdre joins us from Hayes solicitors where she was a partner on their healthcare team, acting for doctors in medico-legal matters for over 15 years. Mary will be well-known to many of you and has a wealth of experience as a practising GP and in Medico-Legal Medicine. I have no doubt that they will make a very real and valuable contribution to our member services.

I hope you enjoy reading this edition.

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CEO Medisec

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OUR TEAM IS GROWING

WE'D LIKE TO WELCOME SOME NEW FACES WHO HAVE RECENTLY JOINED THE MEDISEC TEAM. IN-HOUSE LEGAL COUNSEL DEIRDRE MCCARTHY AND GP RISK ADVISOR DR MARY DAVIN-POWER, ARE HERE TO MAKE A REAL AND VALUABLE CONTRIBUTION TO THE SERVICES WE OFFER OUR MEMBERS.

DEIRDRE MCCARTHY

Deirdre McCarthy joins us from Hayes solicitors where she was a partner on their healthcare team, acting for doctors in medico-legal matters.

Deirdre qualified as a solicitor in 1999, having studied at Trinity College, Dublin (LLB) and the Law Society of Ireland. Since then she has built up a wealth of experience representing clinicians and hospitals at inquests, Medical Council and Dental Council inquiries and in the defence of healthcare professionals and hospitals in medical negligence cases.

Deirdre has significant experience in high-value medical claims, advising on complex issues relating to causation, liability and investigating and valuing quantum. She also has a particular interest in the area of informed consent and has presented to clients on risk management issues and data protection obligations.

She also lectures and gives tutorials to students of the Law Society of Ireland on a range of topics in the area of medical negligence.

DR MARY DAVIN-POWER MB BCH BAO LRCP&SI MICGP MRCGP MMEDSC

Mary will be well known to many of you and has a wealth of experience as a practising GP and in Medico-Legal Medicine.

She qualified in medicine from the Royal College of Surgeons in Ireland in 1982 and spent several years specialising in Primary Care in the UK, before returning to live in Ennis, Co. Clare, where she spent 15 years in General Practice. It was here she developed an interest in Medico-Legal Medicine, having a significant amount of professional interaction with the Gardaí, Social Services and the Legal Profession. She moved to Dublin in 2005 and became involved in medical education as both Clinical Skills Tutor in the RCSI Graduate Entry Programme and CME Tutor in North Dublin.

In 2013 she attained a MMed.Sc in Medical Education from Queens University Belfast. She now lives in Dublin where she practices both in the Trinity College Student Health Service and in North Dublin. She is Continuing Medical Education tutor for GPs in North Dublin, is closely involved with the Irish College of General Practitioners and also acts as Faculty Liaison Officer, helping develop ICGP faculties countrywide.

Until recently, Dr. Davin-Power was Primary Care Representative on the Quality Assurance Committee of the CervicalCheck Programme and serves on both the Clinical Ethics Forum in Beaumont Hospital and the GP Liaison Committee in The National Maternity Hospital, Holles St.

She is immediate past President of the Medico-Legal Society of Ireland and current President of the Association of Graduates RCSI. Dr. Davin-Power is very much involved in the maintenance of standards in General Practice and assists the Irish Medical Council in this area.

THE DOCTOR AS WITNESS

Kate McMahon,
Kate McMahon & Associates,
Panel Solictor

PREPARING MEDICO-LEGAL REPORTS AND GIVING EVIDENCE IN COURT.

HOW TO PREPARE MEDICO-LEGAL REPORTS

From time to time, you may be asked by a patient's solicitor to prepare a medico-legal report for the purpose of litigation. A fundamental rule of evidence is that a witness in a Court case may only give factual evidence, however as a doctor you may be asked to give your professional opinion.

When preparing a medico-legal report, bear in mind that although the report is prepared on behalf of a patient with whom you may have a close professional relationship, you're acting as an independent medical expert to assist the Court. When writing the report therefore, you must not be drawn into the trap of regarding yourself as 'one of the team' and endeavouring to do the best for your patient. The professional views expressed in your report and the evidence given to the Court should be impartial and objective, and should be to assist the judge.

Writing a medical report to a high standard will make it less likely that you will be called to attend Court. As a practice, it is only where there is an ambiguity or other concern that the doctor is asked to attend in person.

And while there is no set formula for a medico-legal report, the format suggested here is broadly approved by most litigation solicitors. See www.injuriesboard.ie for the template medical report used in claims submitted to the Injuries Board.

SECTION ONE – INTRODUCTION

In this section you should introduce yourself by speciality (General Practitioner), give a short summary of your qualifications and a short outline of the case E.g. 'Mary Byrne has been a patient of this practice since 2002. In July 2015 she suffered injuries in a road traffic accident and I have been asked by John Doe and Company Solicitors to prepare a medico-legal report dealing with her injuries, treatment to date and prognosis.'

It's useful to include a paragraph entitled "Conclusions" in this section, summarising your findings, which will be detailed later in the report:

E.g. 'Mary Byrne suffered a mild whiplash injury in the accident, the subject matter of this report. She has been treated to date with analgesics and anti-inflammatories and I would expect a full resolution of her symptoms within six months.'

SECTION 2 – THE FACTS OF THE CASE

In the next section you should relate the facts of the incident as told to you by the patient:

E.g. 'Mary tells me that she was involved in a road traffic accident whereby her car was hit from behind by another car.'

You should then give details (referencing your clinical notes) of all examinations conducted by you with the dates thereof and observations and diagnosis made by you.

You should include details of all medication prescribed by you or referrals to other healthcare professionals E.g. Physiotherapists, Orthopaedic Surgeons, etc.

SECTION 3 – YOUR OPINION

This section, the most important part of your report, should contain your professional opinion on the injury sustained by your patient, and your reasoned thinking as to how you have arrived at that professional opinion.

You should detail any relevant medical history, e.g. a previous injury to the same area of the body. An example of this would be:

'Mary had been attending me for many years for treatment for osteoarthritis and consequently, she was a particularly poor candidate for an accident of this type and has suffered significant pain as a result of this accident. It is my professional opinion that her reported symptoms are in keeping with what I would expect from a patient with this profile.'

Unlike the UK, there is no specific requirement in the Republic of Ireland for expert witnesses to include a 'Declaration of Truth and Impartiality'. However, I believe that it is in the interest of the expert General Practitioner that they include a statement in the following terms in their report:

"I confirm that my duty to the Court as an expert witness overrides any duty to those instructing or paying me, that I have understood this duty and have complied with it in giving my evidence impartially and objectively; and that I will continue to comply with that duty as required."

It's very important you review the report before it is signed and forwarded to your patient's solicitor. This report may well form the basis of your attendance and cross-examination in Court and any shortcuts taken at this stage would prove difficult and potentially embarrassing for the General Practitioner in appearing in Court.

It is also essential to have the patient's full consent before submitting the report to a solicitor and that the patient understands the extent of the report concerning their own medical condition, therefore consider allowing the patient to see the report before submission.

GIVING EVIDENCE IN COURT

You may be requested to give evidence in Court, and the key to this is preparation.

It's essential you study your medical records (and re-read your medical report) carefully so your memory is absolutely accurate as to what your records and report contain. You should bring the patient's medical records to Court with you and refer to them, rather than simply reading them out.

You should always remember that in giving evidence, you are an expert witness with a duty to give an independent and honestly held opinion to assist the Trial Judge.

When giving evidence it's essential that you confine yourself to the area of your expertise (i.e. General Practice).

If you don't feel competent when asked a question (particularly in cross examination), then you should state that and defer to the expertise of other medical professionals.

As you are attending Court in your role as an expert witness, you should dress appropriately, as you would for a formal business meeting.

Judges of the Court are addressed as 'Judge' - the term 'My Lord' was thankfully abandoned some time ago!

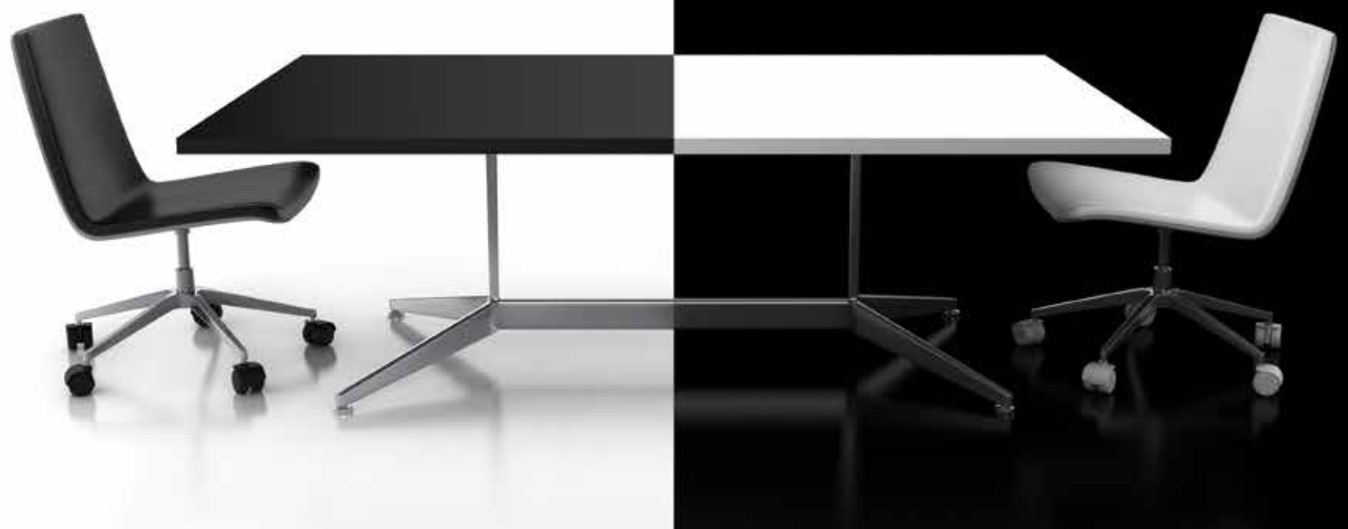
Address your answers to the Judge and not to the counsel asking the questions. This allows the Judge to hear your answers with the added advantage of avoiding an intimidating barrister's stern glare during cross examination!

Don't take a robust cross-examination personally. The whole purpose of the barrister conducting this is to test your expertise and credibility.

The overriding obligation is to give your evidence in an objective, reasoned, fair-minded and non-partisan manner, and to concede any points that need to be conceded.

Under the Defamation Act 2009, a witness giving evidence in Court enjoys absolute privilege and immunity from prosecution unless the false evidence is given maliciously and for the witnesses' own purpose.

WHEN THE RELATIONSHIP OF TRUST BETWEEN YOU AND YOUR PATIENT BREAKS DOWN



Good medical practice is based on a relationship of trust between a patient and doctor and involves a partnership based on mutual respect, confidentiality, honesty, responsibility and accountability. Unfortunately, as in all walks of life, the relationship of trust can and does breakdown for a number of reasons.

We regularly hear from GPs faced with difficult and challenging patients: from patients refusing to comply with advice and make the necessary lifestyle changes required to make treatment effective; to patients who are threatening, aggressive and present a risk of violence to the GP and the practice staff; From patients who may have developed an inappropriate fixation on a GP, to patients who have moved outside the catchment area, thus posing a difficulty to provide safe treatment. The list is endless and no two situations are ever the same.

When the relationship of mutual trust and respect has broken down, our members frequently seek our advice and assistance with regard to removing a patient from their list; advice on whether a removal is justified, and assistance with the steps involved in removing a patient and the drafting of supporting letters. Members are also often concerned that patients may complain about them to the Medical Council or the HSE as a result of removing them from their list.

There is no standard reply to the queries received and each situation must be looked at on a case by case basis. We advise members that they should only end a professional relationship with a patient when the breakdown of trust means that they can no longer provide good clinical care or treatment that a patient may require. When alternative medical care is in place, you should transfer the patient's medical records without delay.

ONCE A GP RAISES CONCERNS, IT IS IMPORTANT THAT FAIR PROCEDURES ARE ADOPTED AND WE ADVISE YOU TAKE THE FOLLOWING STEPS BEFORE ENDING A DOCTOR-PATIENT RELATIONSHIP:

- Firstly communicate with your patient, letting them know you are considering ending the relationship. Give them the reasons why you believe the normal partnership between a patient and doctor, based on trust and mutual respect, has broken down, and why in these circumstances you believe it would be in their best interests to seek an alternative General Practitioner.
- You should make a note in their medical records and include the reasons for the warning as explained to the patient.
- If the patient is amenable, you must do what you can to restore the relationship if possible. For example if there has there been a misunderstanding, can it be rectified?
- Under no circumstances should a patient be removed on the basis of race, gender, social class, age, religion, sexual orientation, appearance, disability, medical condition or need for specific treatments.
- If you hold a conscientious objection to a treatment you must give the patient sufficient information to enable them to obtain the treatment they seek from another doctor or to transfer to that doctor.

REMOVING A PATIENT

Following a discussion with your patient, if you decide to end the relationship you must write to the patient and explain the reasons, unless you feel that doing so would be harmful to their physical or mental health. You must also record the decision in your medical records. If patient is a medical card holder you must write to the HSE and ask that they nominate an alternative GP to deal with the patient.

Please note that until care has been taken over by another doctor or service, you retain responsibility for your patient. This means that you must provide emergency services and any care or treatment that your patient may require. When alternative medical care is in place, you should transfer the patient's medical records without delay.

Transferring a difficult patient is to be distinguished from the case where a patient elects to sign up with a new GP. In that instance a patient will sign a "change of doctor" form supplied by the new GP. The HSE will then re-allocate the medical card to the new doctor.

HELPING YOU DEAL WITH COMPLAINTS

HOW THE MEDISEC COMPLAINTS AND DISCIPLINARY SERVICE WORKS

We understand how the stress of a complaint can affect the already busy life of a GP. The Medisec Complaints and Disciplinary Service is here to give support to our members who receive patient complaints, either directly from the patient, or, through the Medical Council or HSE.

The service assists with matters related to professional conduct and ethics, including professional conduct and poor professional performance, responsibilities to patients, medical records and confidentiality, consent to medical treatment and professional practice.

It's a service we provide on a discretionary basis, and in determining whether it's given, the Medisec Board will consider, among other things, whether the member:

- Contacts Medisec as soon as a complaint is notified and before any action is taken in each instance
- Agrees to follow the advice of Medisec and its Solicitors, and doesn't do anything contrary to that advice
- Advises Medisec of any relevant issues immediately

This support is reviewed at each stage of the complaints procedure, and the complaints and disciplinary service applies to General Practitioner activities only, within the terms of cover.

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BEHIND CLOSED DOORS

EVERY PATIENT AND DIAGNOSIS IS DIFFERENT. AND SOMETIMES THIS MEANS LONGER WAITING TIMES.

When a patient books an appointment, you don't know how much time they will need. Every patient is different, and some need more time than others. A 20-year old can get undressed, examined and dressed again a lot quicker than a 90-year old can.

And a routine cold diagnosis will never take as long as sensitively delivering bad news will. On top of this there's the urgent phone calls to be made and the accurate filling out of reports and forms to be done.

And while all this is going on, the waiting room can fill up fast. Nobody likes to keep patients waiting, and the key to a happier waiting room is better communication. Which is why we've made a poster you can hang in your waiting room, succinctly explaining why occasionally there may be longer waiting times.

To order a free poster for your surgery, please call us on 1800 460 400 or drop us an email at info@medisec.ie

PREPARING THIRD PARTY MEDICAL REPORTS, RECORDS AND CERTIFICATES

WHAT TO INCLUDE, WHICH PROCEDURES TO FOLLOW AND WHO CAN SEE WHAT

Deirdre Malone,
Comyn Kelleher Tobin

As a doctor, sometimes you'll be asked to prepare reports on your patients (or any patient) for third parties including employers, solicitors and insurance companies. Examples of these situations include:

- When acting on behalf of an employer: pre-employment assessments or fitness to return to work following any extended absence
- When acting on behalf of an Insurance Company: E.g. to produce a PMA or assess a patient for the defence of litigation
- Reviewing patients for the purpose of a report to an Insurer: E.g. a travel insurance claim made by the patient

A patient may seek a copy of the records, report or certificate you have provided and the question of whether the patient is entitled to a copy is often asked.

CONFIDENTIALITY

A patient is generally entitled to expect that the information they give to you during a consultation will be kept confidential, but there are limited circumstances when you are permitted to breach your duty of confidentiality to a patient. When a patient attends for assessment on the instructions or direction of a third party, such as an employer, solicitor or insurer, the patient must understand that the confidential information provided by them during the consultation will be given to that third party and may well include past medical history.

CONSENT

While a patient may understand that by carrying out the assessment you will be reporting to a third party, you should also have a written consent from the patient, generally provided by the instructing party when the assessment is requested. You should also outline the reason for reviewing the patient, which will be relevant in the event of a request for a copy of the records or report at a later stage by the patient. It can be as simple as reviewing the written form of consent with the patient, for example, saying:

"Company X has asked me to review you today to see if you are fit to return to your role as XX within the Company. I will send a report of my findings to the HR Manager/Director of the Company at the end of this consultation. I will only include information that is relevant to this assessment. I will discuss my findings with you, so that you know what I will say in the report and you can ask me any questions that you may have about my diagnosis."

And you should seek clarification that the patient understands your role before starting the formal assessment.

ASSESSMENT

The assessment should be specific to the incident or illness for which you have been asked to report but there are occasions when, acting on the instructions of a third party, you may find yourself in a situation where the patient presents with a more sinister possible diagnosis. As a GP, you are responsible for the overall management of your patients, but not necessarily for patients for whom you have been asked to carry out a particular assessment, after which there will be no ongoing relationship. Care for any such possible diagnosis should be transferred back to the patient's primary GP and this information should be transmitted promptly.

In these situations you should notify the patient of any potential concerns and possible adverse findings in a sensitive manner. You should advise the patient that if they consent, you may contact their own doctor for follow-up, and you should also advise the patient to make contact with their doctor too.

TO WHOM IS THE DUTY OF CARE OWED?

Any information you provide in a report or certificate must be factually accurate. You must make sure you are not influenced by any inducements or pressures you may receive from those instructing you.

Fundamentally, you owe a duty of care to the person instructing you, such as the company/employer. However, you must also afford the patient the same standard of professionalism as applies to the care and treatment of any other patient.

CASE STUDY

A doctor is asked to review a patient and certify the patient as fit for a particular role to a prospective employer. The role involves heavy lifting and manual handling. The patient has a history of significant back pain. The doctor certifies the patient as fit for the new job. The patient subsequently sustained an injury in the new job.

1. The doctor here has a duty of care to their patient. To refer to a relevant court decision, Hedley Byrne & Co Ltd –v- Heller & Partners [1964] AC 465:

   '[If] a doctor negligently advises a patient that he can safely pursue his occupation and he cannot and the patient's health suffers and he loses his livelihood, the patient has a remedy.'

2. The doctor owes a duty of care to the prospective employer (even though there is no contractual relationship between the employer and the doctor).

It is a generally accepted principle that a medical doctor owes a duty of care to the person to whom the statement is made and who relies upon it (Kapfunde –v- Abbey National plc [1998] IRLR 583). In this case study, the doctor was fully aware that the certificate would be provided to the employer for the purpose of certifying that the patient was fit for the specific role.

EXCEPTIONS - THE DATA PROTECTION ACTS

The Data Protection Acts 1988-2003 (and Freedom of Information Act 1997-2014) permit a patient to take up copies of their medical records, which will include medical reports and certificates held about that patient upon the patient's written request.

There are exceptions set out in the legislation permitting a doctor to refuse to release the medical information sought to the patient. These include:

1. The Data Protection (Access Modification) (Health) Regulations, 1989. It states that 'health data' shall not be provided to a patient 'in response to a request for access, if that would cause serious harm to his or her physical or mental health.'

2. If the report was prepared specifically on behalf of the opposing side in relation to existing (and not simply contemplated) litigation, the report and the correspondence with the instructing solicitor will be privileged and does not have to be disclosed to the patient.

In recognising that doctors are regularly presented with requests for reports from third parties, you should also remain cognisant of the fact that the patient is likely (save as outlined above) to be entitled to take up a copy of that report. Only in the event of the two limited exceptions outlined above, can you refuse to release the records/notes/report and/or certificate to the patient.

At all times you should be mindful not to release reports or notes that mention a third party.

For example, if the letter of instruction requests a Certificate of Fitness to return to work following an extended absence of an employee, it is likely that the employee will be entitled to take up a copy of the notes taken at the time of assessment, together with the report/certificate furnished to the employer.

In contrast, if you're asked to prepare a report by the employer's solicitors in relation to the condition and prognosis of a patient in respect of a Personal Injury action, such records and reports will attract litigation privilege and the patient will have no entitlement to receive a copy.

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

THE IMPLICATIONS OF CORBALLY V THE MEDICAL COUNCIL AND ORS

CORBALLY V THE MEDICAL COUNCIL AND ORS [2015] IS ONE OF THE MOST SIGNIFICANT CASES IN THE AREA OF PROFESSIONAL REGULATORY LAW TO BE CONSIDERED BY THE SUPREME COURT IN RECENT YEARS

Brendan Curran
Associate, O'Connor Solicitors

The facts are well known at this stage but it is worth briefly summarising them. In early 2010, patient X (aged 2½) was referred to Professor Corbally's private clinic in Our Lady's Children's Hospital in Crumlin with a history that the frenulum under her top lip was catching, causing an ulcer under that lip and contributing to a gap in her front teeth.

Professor Corbally made a single error in writing up the patient's notes by describing the required procedure as an excision of the "upper lingual frenulum". There is no upper lingual frenulum and it is more accurately described as an 'upper labial frenulum'.

Professor Corbally booked the patient in for her procedure and correctly completed an admissions form for the patient, listing her for a 'tongue tie (upper frenulum)'.
The admissions form was sent to the admissions department but unfortunately the reference to 'upper frenulum', through no fault of Professor Corbally, was not inputted into the hospital system. The reason for this was that the system as it then operated in Crumlin had one code only for all frenula dissection, all three types being described as 'tongue tied'. That being so, the operation was inputted in the system as a 'tongue tie release' without the addition of the words 'upper frenulum'. However, it should be noted that on the day of admission, the patient's parents provided and furnished a consent to the procedure for a 'tongue tie – upper frenulum release'.

Professor Corbally had intended to perform the surgery himself, however he was called away and his Specialist Registrar was delegated to perform the procedure. Unfortunately, the Specialist Registrar carried out a lingual frenulectomy, which was an unnecessary procedure and one which, having been carried out, left the patient still requiring the upper frenulum release, which was undertaken when the child was brought back to theatre that same day.

An Inquiry was held before the Fitness to Practise Committee of the Medical Council, which made three findings of Poor Professional Performance against Professor Corbally. The Committee recommended to the Council that it impose the sanction of admonishment or censure on Professor Corbally and the Council thereafter decided to admonish Professor Corbally. It is important to note that no evidence was given before the Fitness to Practise Committee that, prior to the surgery being carried out, anyone ever looked at Professor Corbally's original incorrect notes.

Professor Corbally instituted judicial review proceedings in the High Court and Mr Justice Kearns took the view that in the case of a finding of Poor Professional Performance (for which a lesser sanction of advice, admonishment or censure could not be appealed, but would still have serious consequences for the doctor) one had to imply a requirement for single lapses or offences that the lapse or offence should be 'serious'.

Justice Kearns was therefore of the view that none of the allegations proven against Professor Corbally could amount to Poor Professional Performance as any errors were not very serious and made no real contribution to the eventual procedure carried out by the Specialist Registrar.

The Medical Council appealed the decision of the High Court to the Supreme Court and the central issue for determination was essentially the extent to which once-off errors can be the subject of a finding of Poor Professional Performance within the meaning of the Medical Practitioners Act 2007. For his part, Professor Corbally sought clarification as to the extent to which a once-off error, which was not serious in its nature or effect, could be the subject of a finding of Poor Professional Performance within the meaning of the Medical Practitioners Act 2007.

Justice Hardiman delivered the majority decision of the Supreme Court in which he stated that:

"I would apply a 'seriousness' threshold to a finding of Poor Professional Performance, as well as to professional misconduct… only conduct which represents a serious falling short of the expected standards of the profession could justify a finding by the professional colleagues of a doctor of Poor Professional Performance on his part, having regard, in particular to the gravity of the mere ventilation of such an allegation and the potential gravity of the consequences of the upholding of such an allegation."

Justice Hardiman also had regard to the public nature of such Inquiries and was of the view that before a medical practitioner can be subjected to the 'extremely threatening ordeal of a public hearing' before the Medical Council, either for Professional Misconduct or for Poor Professional Performance, there must be reason to believe that what can be proved against him is something of a serious nature.

Justice Hardiman also identified that "There are, both in the 2007 Act, and elsewhere, various private non-accusatorial, non-adversarial, strategies available to ensure high professional standards". This may ultimately mean that a greater number of complaints should result in a Performance Assessment being carried out in respect of a medical practitioner rather than a full Inquiry being held.

It is now clear that the Supreme Court has recognised that medical practitioners are not infallible and while there may be a number of matters which, though not serious, may legitimately aggrieve patients or their relatives, statutory regulators must be capable of saying that a complaint, although legitimate, will not proceed to the point of a Fitness to Practise Inquiry unless it involves a serious act or omission.

As a result of the Supreme Court decision, the distinction between Poor Professional Performance and Professional Misconduct is perhaps unclear. However, the ultimate effect in practice is that matters of a minor or trivial nature should not proceed past the Preliminary Proceedings Committee or investigation stage.

The statement of Justice Hardiman in relation to the "extremely threatening ordeal of a public hearing" has led some to suggest that the Supreme Court decision may significantly reduce public Inquiries before the Fitness to Practise Committee. However, while there has been a fall-off in the referral of complaints to the Fitness to Practise Committee for public Inquiry, I believe it may be going too far to suggest that public Fitness to Practise Committee Inquiries are a thing of the past. Of course, it is important to remember that whilst the default position is that Inquiries be held in public, doctors (and indeed witnesses) can request that an Inquiry be held in private providing sufficient reason(s) can be shown.

SUPPLEMENTAL MEMBERSHIP FOR GP TRAINEES

BECAUSE SOMETIMES THE CLINICAL INDEMNITY SCHEME COVER ISN'T ENOUGH

If you're a GP Trainee on an ICGP approved training scheme, then the Clinical Indemnity Scheme covers you in relation to the provision of professional medical services in the course of your training. But it doesn't cover you for Good Samaritan work, medico-legal advisory queries you may have, or for legal advice in the event you are complained about to the HSE or Medical Council. And that's why we've decided to help.

For just €150 per annum, you get unrivalled complaints and disciplinary assistance, 24/7 advice and cover for Good Samaritan Acts, so that while you're training, you'll have the peace of mind to give the best patient care possible, even during stressful times in your career.

And when you join Medisec, you're joining a not-for-profit company, founded and owned by over 1,500 GPs in Ireland, for GPs in Ireland. An Irish company that really will be with you, at every step of your career.

Please note: this doesn't cover you for locum work as a GP, or for the provision of medical services in the course of training in your GP practice, or scheme hospital as this is covered by the CIS.

Interested? Either fill out the application form sent to each ICGP CIP Training Scheme or:

Call us on 1800 460 400 or visit medisec.ie

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IN BRIEF

USING SOCIAL MEDIA

It's important to remember that as well as offering opportunities, social media can present some challenges. If you have an online presence you must ensure your online activities don't contravene The Medical Council Guide to Professional Conduct & Ethics for registered Medical Practitioners. In addition, you should maintain strict privacy settings, being careful not to inadvertently post comments about your patients. You must also maintain a professional boundary between you and your patient. This means you should not accept patients as 'friends'. If a patient contacts you about their care/treatment through your private profile, you should indicate that you cannot mix social and professional relationships and, where appropriate, ask them to make an appointment to see you at your surgery.

HAVING A BABY?

We offer Maternity Leave policy extension for up to 52 weeks. We must be notified in writing before you take your maternity leave. Good Samaritan cover will be provided during this period. Contact us on 1800 460 400.

BEST PRACTICE PROTOCOLS FOR VACCINATIONS

Providing immunisation is an important part of every day practice and many tasks relating to immunisation can be delegated to the practice nurse, with firm practice protocols making the job easier and minimising risk for all involved. We regularly receive notification of an adverse event following administration of vaccines, for example incorrect or out of date vaccine given or repeat vaccine administered inadvertently, due to notes not being updated accordingly.

To reduce the risk of these occurrences, it's important to ensure appropriate protocols of storage, record-keeping and stock-taking are in place:

- Vaccines should be stored in a pharmaceutical fridge with a max/min thermometer and an alarm if possible
- The refrigerator plug should be well marked DO NOT UNPLUG for the advice of cleaning staff
- A regular stock-take should be carried out and expiry dates checked
- New stock should be put to the back of the fridge and shorter dated stock at the front
- Always remember to obtain informed consent for immunisation and update the medical records accordingly

DEALING WITH GARDAÍ REQUESTS FOR RECORDS

When Gardaí request copies of records on an arrested patient, or a patient who is the subject of an assault, there are three points to remember. Pending prosecution, the patient is still an innocent party and you can't release notes, unless:

- You have written consent from the patient (or solicitor acting on the patient's authority) to disclose the records
- You are subject to a Court Order or Subpoena
- If the patient is at large and posing a danger to himself or others, where access to his medical records would be in his best interest or the best interest of others

THE KEY ISSUES AND PITFALLS OF DOCTORS' PARTNERSHIPS

By Eamon Harrington,
Comyn Kelleher Tobin

PARTNERSHIP DISPUTES ARE OFTEN STRESSFUL, BITTER AND COSTLY, AND IN OUR EXPERIENCE THE MOST COMMON DISPUTES ORIGINATE FROM POOR PLANNING AND POOR OR NON-EXISTENT PARTNERSHIP AGREEMENTS. AT COMYN KELLEHER TOBIN, WE HAVE REPRESENTED DOCTORS IN DISPUTE, AS WELL AS MEDIATED DISPUTES BETWEEN DOCTORS, AND HAVE SEEN FIRST-HAND HOW DOCTORS HAVE BEEN AFFECTED: INCLUDING SLEEPLESS NIGHTS, BROKEN FRIENDSHIPS AND DISASTROUS FINANCIAL OUTCOMES.

A common recurring theme is that problems could have been avoided by taking two critical steps:

1. Investing in specialist legal and accountancy advice when preparing a signed partnership agreement.
2. Practising only when the partnership agreement has been signed.

There are many issues partnerships need to regulate; management rights, bankruptcy, mental incapacity, criminal convictions, liability of partners, financial rights, partnership property, goodwill and death, and I've outlined some of these issues here.

GMS Payments
One of the biggest mistakes made by doctors is not properly addressing the issue of superannuation. A Partnership Agreement needs to address how superannuation/withholding tax is applied under the GMS Contract.

If it is agreed that profits are to be shared equally, is this arrangement also applied to superannuation/withholding tax and is it enshrined in the Partnership Agreement and notified to the pension trustees?

In selling the practice, what is agreed in respect of superannuation payments? Typically, it's advised that the doctor keeps the superannuation date until the date of retirement. And typically, a vendor would structure the sale of a practice to protect the vendor so that superannuation rights remain with the vendor until the vendor's retirement.

When a practice is being sold, it's not uncommon to defer consideration to be paid over time. Again, care must be taken in drafting the Agreement to ensure the schedule places withholding tax and superannuation in separate schedules.

Sessions
Another cause for disagreement is unequal responsibility for sessions. Frequently, when a doctor joins an existing practice, lack of clarity can lead to an unequal workload and disharmony. Therefore it should be dealt with in the Partnership Agreement.

Drawings/Tax Liability
The Agreement should specify a drawings policy. In particular, it should specify the need for partners to be tax compliant in all matters including activities independent of the partnership.

Entry and Exit Provisions
The introduction and exit of partners can cause disagreement so it's advisable to have clear principles from the outset.

When two partners are introducing a third partner, the Agreement should set out a process/structure. The basis of entry should be agreed – how is the practice going to be valued? If there is disagreement on whether to admit a new partner, should there be a special majority required or weighted voting for decision-making? Should there be a veto arrangement or other deadlock provision? Should there be an expulsion provision and what protections exist to prevent wrongful expulsion?

Maternity Provisions
There should be a clear agreement on what happens in the event of a partner wishing to take maternity leave. In our experience, practices work well when the approach is that the doctor going on maternity leave maintains her profit share, she arranges locum cover and pays the cost of the Locum from her share of the partnership profits, but can apply for that purpose the locum subsidy from the GMS. It should also be possible for the doctor to set against her tax liability any additional cost incurred in engaging the locum.

Sick Leave
Again, there should be a clear agreement on what happens in the event of partner needing to take sick leave. In addition to the subsidy available from the GMS, the agreement should define:

i. The period for which sick leave is paid – typically it is 26 weeks to be paid after a period of time on sick leave.
ii. The period for which a partner's profits are maintained as of right (often 12 months) and at the discretion of the remaining partners.

Life Cover
A partnership agreement should contain a requirement to have joint life cover, to protect the practice from a cash-flow crisis that might be caused following the untimely death of a partner. Otherwise, there will not be cash available to buy out the partner's survivors and it may not be possible to raise finance from the bank.

Income Protection
The GMS Contract provides income protection for GMS income only. Therefore protection is needed for private fees.

Profit Sharing
There are many permutations on profit sharing arrangement. They need to be clearly defined. For instance, will profits of the practice be divided equally? Or in other instances will they be paid proportionately to how many sessions are carried out?
In respect of new partners, it is very common to build up equity over time, particularly where an initial 'buy in' payment is not made.

What is Partnership Income?
Disputes can arise as to what is partnership income.
Again, such income should be clearly defined in the partnership agreement, so there is no doubt as to whether say payments for an out-of-hours service rota is to be regarded as private income and not partnership income.

Expenses
Whether expenses such as car and phone are regarded as expenses of the practice needs to be considered – frequently, because such expenses are not incurred equally.

Warranties
When joining a practice, warranties should be sought in respect of any personal/partnership tax obligations and any clinical indemnity issues that arise in relation to treatment provided prior to the introduction of the new partner.

Premises
Arrangements are frequently too loose. The better advice is to ignore the partnership relationship and treat it as a landlord and tenant relationship. Put in place a standard lease agreement addressing matters such as insurance, repair and maintenance obligations. In respect of furnishing and equipment, document what items constitute partnership assets and so forth.

There are many draft boilerplate partnership agreements, but if medical practice is your career, then the partnership agreement is one instance where you ought to take advice. There are specialist legal and accountancy advisors who fully understand the nuances of GP practice and the pitfalls that need to be avoided. The benefit of putting in place a good partnership agreement in our experience outweighs the emotional and financial stress you may suffer if you don't.

@healthmail.ie

HEALTHMAIL:
SECURE CLINICAL EMAIL

AN AGING POPULATION AND CO-MORBIDITY MEANS HANDLING COMPLEX PROBLEMS IS BECOMING THE NORM IN IRISH HEALTHCARE. SOMETIMES WHAT'S NEEDED TO SUPPORT PATIENT CARE IN THE COMMUNITY IS AN ANSWER TO A CLINICAL QUERY RATHER THAN A PHYSICAL REFERRAL TO AN OVERSTRETCHED OUTPATIENTS' DEPARTMENT. HEALTHMAIL IS A NEW HSE SERVICE THAT ALLOWS GPs TO SECURELY AND CONFIDENTIALLY COMMUNICATE PATIENT IDENTIFIABLE CLINICAL INFORMATION WITH CLINICIANS IN PRIMARY AND SECONDARY CARE.

Healthmail is securely connected to all HSE clinicians and to a wide range of voluntary hospitals and health agencies. More agencies are connecting each week. The Healthmail service went live on November 10th 2014 and close to 1,000 GPs signed up in the first six months.

THE KEY BENEFITS OF HEALTHMAIL ARE:

- Improved access to clinical information at the point of care
- Supports a team-based approach to patient care
- Easy to use and free to GPs
- Reduces time spent on the phone
- More secure and reliable than faxes
- Can attach documents or images
- Useful for transferring patient records between practices

Healthmail is bounded. Emails can only flow between the secure clinical email service and identified white-listed domains, such as @hse.ie, @stjames.ie and @mater.ie. All Primary Care Team clinicians with @hse.ie addresses are securely connected to Healthmail. This opens up a secure communications pathway between practice nurses and community nurses.

It is important that GPs and practices with Healthmail accounts check their inboxes regularly. Once a GP registers with Healthmail their inbox is created and their new email address e.g. joe.bloggs@healthmail.ie is available to be viewed and searched. So even if you are not sending many emails initially it is possible that other clinicians are sending patient identifiable clinical information to your inbox. If you find it difficult to get into the routine of checking your Healthmail account regularly then organise for your practice support staff to check the account daily. This can be done for multiple Healthmail and normal email accounts using the full version of Microsoft Outlook software.

Healthmail is a project of the HSE Primary Care Directorate. It is a cooperative venture involving the Health Service Executive, Irish College of General Practitioners and Department of Health.

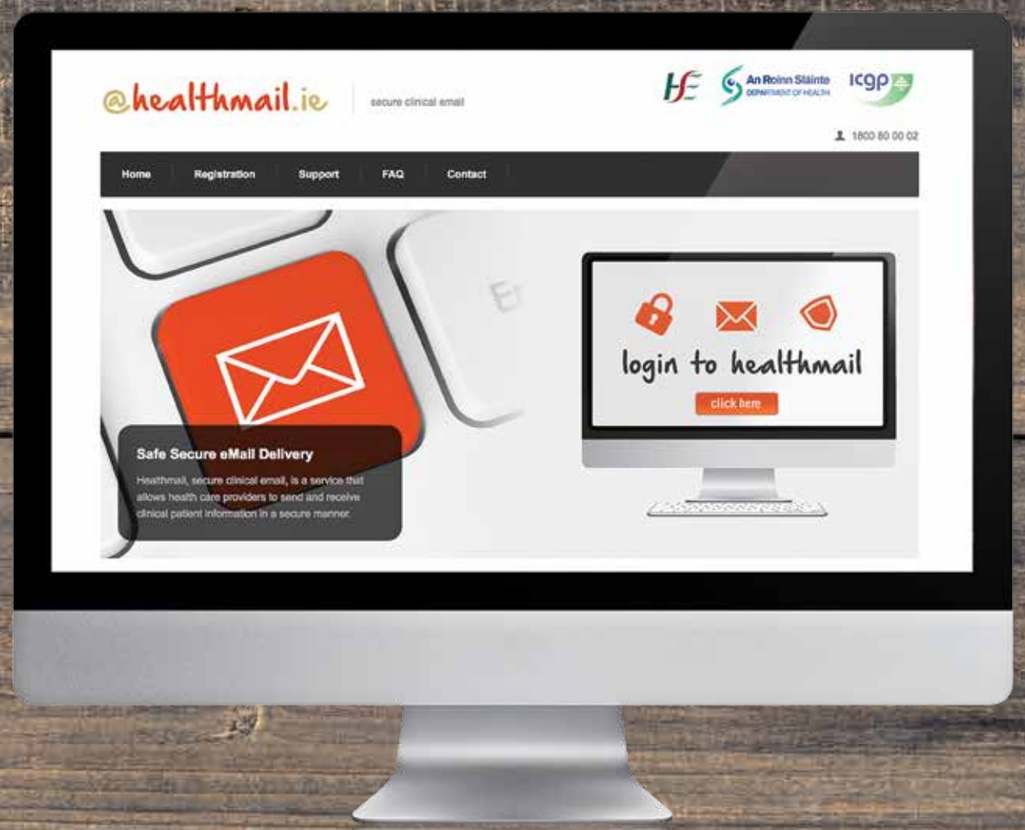
Find more information at:
https://www.healthmail.ie or
http://www.icgp.ie/healthmail

HOW TO REGISTER FOR A HEALTHMAIL ACCOUNT
GPs can register for a Healthmail account at https://www.healthmail.ie. Their application is authenticated by the ICGP and they receive a user name to their normal email address and a password by SMS text message. A GP with an @healthmail.ie account can communicate patient identifiable clinical information with clinicians who use @hse.ie and @voluntaryhospital.ie email addresses. HSE staff do not need an @healthmail.ie account. They can communicate securely from their existing @hse.ie account to all GPs who have an @healthmail.ie account.

Once a lead GP in the practice has registered for Healthmail, then a subsidiary account for a practice nurse or a practice generic account can be created. There are two choices for setting up a practice account:

1. Phone the Healthmail help desk, at 1800 800 002 and select option 2, and ask them to change the address of the lead GP's account from joe.bloggs@healthmail.ie to bloggspractice.gp@healthmail.ie
2. Set up a subsidiary account under the lead GP's account as the practice generic account. This can then be used by practice nurses, practice managers and GP locums to send and receive secure emails.

To set up a practice or support staff account go to https://www.healthmail.ie and click on 'Register Support Staff Account'. In order to register a practice or support staff account you need to know the Healthmail address of the lead GP and the security code they were issued in their first Healthmail email and in the 'Account Created' email.



HEALTHCARE ACQUIRED INFECTIONS

HAI RISKS IN PRACTICE... ARE YOU UP TO DATE?

PATIENT TO DOCTOR

- Blood borne virus e.g. Hepatitis B from sharps injury
- Airborne virus eg RSV, Influenza.

Immunise, robust sharps policy, wash hands correctly!

DOCTOR TO PATIENT

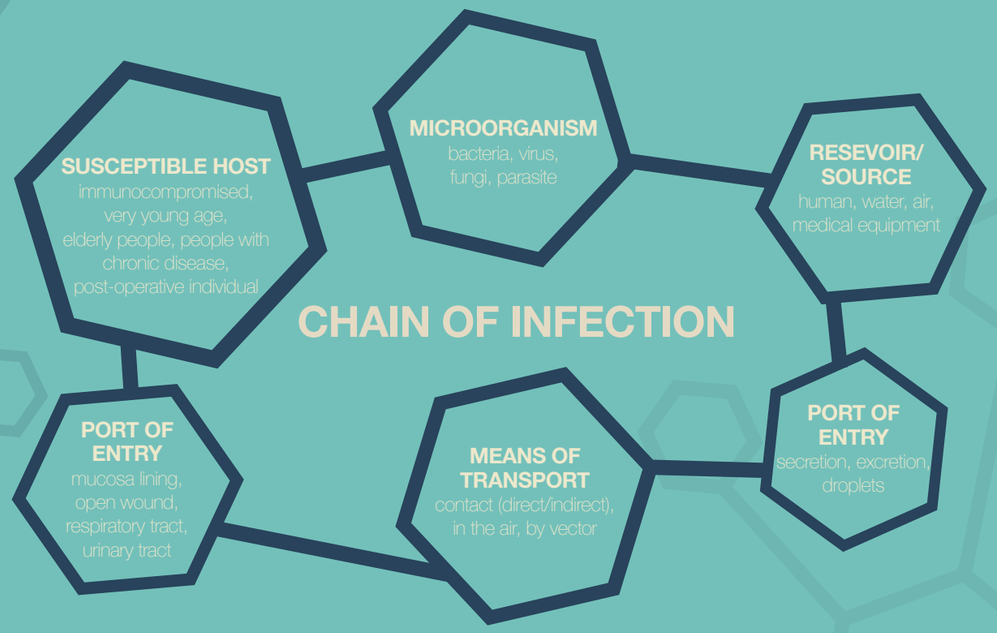
- Contamination of hands e.g. MRSA acting as vector to transmit infection especially in elderly care homes etc.

Decontaminate surfaces, wash hands correctly!

PATIENT TO PATIENT

- Patient with diarrhoea examined on a couch not sufficiently decontaminated before the next patient is examined.
- Patient sitting in a crowded waiting room exposed to airborne viruses e.g. RSV, Influenza, Pertussis.

Adequate decontamination of surfaces, good ventilation, immunisation and wash hands correctly!



CHAIN OF INFECTION

Every attempt at reducing HAI is aimed at blocking the links in the chain of infection.

Every interaction in general practice should include a risk assessment of the potential for infection transmission. Check out 'Infection Prevention and Control for Primary Care in Ireland' guidelines for everything you need to know.

HIQA IS COMING!

Apart from keeping our patients safe we will soon be facing HIQA inspections in primary care.

The Health Information and Quality Authority is the independent statutory body with responsibility for developing and monitoring standards for health and social care services. The authority has identified standards for the prevention and control of HAI's as one of its priority areas in all healthcare settings.

As a GP responsible for the safety of your patients, your staff and yourself, can you answer yes to the following?

1. I am confident my practice Hand Hygiene facilities are adequate to pass a HIQA inspection.
2. All the GPs, nurses and administration staff working in my practice are Hand Hygiene aware and can identify when and how they carry out Hand Hygiene according to the WHO 5 moments for Hand Hygiene during their working day.
3. My staff is appropriately immunised and I have documentary proof of it ready for inspection if needed.
4. It is preferable to move to single use disposable instruments. Have I updated my practice accordingly?
5. Each staff member understands the meaning of and can recognise what single use items are, and how common pieces of equipment should be cleaned.
6. I have a written sharps policy, and 'immediate action for sharps injury' posters are displayed in clinical areas.
7. Each clinical staff member knows how to prevent sharps injuries.
8. Each clinical staff member can demonstrate safe injection procedures.
9. Each clinical staff member is trained in the management of spills of urine, vomit and blood.
10. Should the Health and Safety Authority make an inspection tomorrow, I would have the necessary paperwork available and my staff could demonstrate how they dispose of Healthcare Risk Waste and Healthcare Non-Risk Waste into the appropriate waste stream.
11. We have a documented environmental cleaning policy.

Not confident you can answer yes to the above?
Check out the 'Infection Prevention and Control for Primary Care in Ireland' guidelines for everything you need to know: http://bit.ly/1QcD2xX

You should consider doing your annual audit based on your own standards for HAI prevention - there is a template for this at the end of the guidelines.

THREE EASY PIECES

To instantly improve your practice risk of HAI, do three things today:

1. Check every room in the practice for re-usable towels and throw them out.
2. Check every room in the practice for placement of sharps bins. If they are too accessible to children, move them. If too full, seal and put a sticker on the new bin exaggerating the maximum fill line.
3. Ask your nurse to put a spills kit together if you don't have one.

TEN MINUTE CHALLENGE

Carry out Hand Hygiene audit found in the appendix of the Infection Prevention and Control for Primary Care in Ireland Guidelines.

Dr Nuala O Connor, ICGP Lead Preventing Healthcare Associated Infections and Antibiotic Resistance HCAI AMR.

For more information, visit: www.hse.ie/handhygiene

RED ALERT
HOME BIRTHS

MOTHER AND INFANT SCHEME

Attendance at a home birth is not considered normal GP work and it is therefore excluded under the Terms and Conditions of the Medisec Scheme, which is underwritten by Allianz plc. If a patient ticks yes for a domiciliary delivery, or otherwise expresses her intention to have a home delivery when signing up for the Mother and Infant Scheme you should not under any circumstances sign this form as any involvement in a home birth is expressly excluded from your Policy and you are not covered to provide routine antenatal/postnatal care during that pregnancy.

Members may question this stance. The answer is very clear. If members provide antenatal/postnatal care surrounding a home birth, but are not actually involved in the actual home birth, there would be a risk of being enjoined in legal proceedings should any issue arise with the mother or child. This would have a negative impact on Medisec premiums for all GPs. We believe that this is reasonable given that our top rate of cover is under €5,000, while private obstetricians would be paying hundreds of thousands of euro for cover.

NB: Members should be aware that Medisec does not cover the provision of routine antenatal/postnatal care where a home birth is intended.

COMBINED CARE SCHEMES (MOTHER AND INFANT SCHEME)

Cover is in place for GP involvement in Combined Care Schemes provided that:
(i) The antenatal and postnatal 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) The patient opts for a maternity hospital birth, care of which would be under the supervision of an obstetrician as at (i) above.

IF IN LATER STAGES OF PREGNANCY YOU LEARN THAT YOUR PATIENT IS CONSIDERING A HOME DELIVERY YOU MUST:

- Explain to your patient that you cannot provide maternity care in these circumstances and you should advise them of alternative services available via the HSE.
- Your patient should be referred immediately to the Maternity Hospital where she would have been assessed initially.
- The HSE and the patient should be written to confirming that you are not in a position to provide services under the scheme due to the patient's Home Birth option.
- This should be fully documented on the patient's file.
- If the patient is not in agreement with the above and opts not to engage with alternative antenatal/postnatal care – all risks should be fully advised to the patient and this should be fully documented on their medical file.

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INTRODUCING

THE PRACTITIONER HEALTH MATTERS PROGRAMME (PHMP)

The Practitioner Health Matters Programme (PHMP), which launched September 7th 2015, is a new service providing support to medical practitioners who are concerned about their mental health or who may have a substance misuse or an addiction problem. Dr. Íde Delargy, who previously chaired the Sick Doctor Scheme, is the Medical Director of the programme.

The programme is an independent, strictly confidential service which will help practitioners to seek an early intervention if they have a problem. Referrals will be accepted from an individual practitioner, a concerned colleague/friend/family member or by their employer. The aim of the service is to provide appropriate treatment, advice and support with the intention of getting the practitioner safely back to work as early as possible. The main focus is on providing support to medical practitioners, but there will also be benefits for patient safety by providing an opportunity for medical practitioners to deal with their difficulties. The PHMP is modelled on best international practice in the area of practitioner health and replaces the former Sick Doctors Scheme. Any doctor, at any stage in their career, can avail of the service which is also open to dentists and pharmacists.

The PHMP has access to a range of specialists who have a particular interest and experience in treating doctors. These specialties include psychiatry, psychology, occupational health, career mentoring, life coaching, addiction counselling and financial planning, drug and alcohol testing. Other services will be accessed depending on the individual's needs.

The PHMP operates on a not-for-profit basis and is free of charge at the point of care. It is a registered company that has been awarded charitable status and is registered with the new charity regulator. The PHMP is governed by a board of Directors which include Mr Hugh Kane (Chairman), Mr Fintan Hourihan (Secretary), Mr Kieran Doran from UCC and Ms Frances Nangle Connor, former Nursing Director of the Irish Prison Service. No fees will be payable to directors involved in overseeing the administration of the programme.

There is strong support for the programme with a signed Memorandum of Understandings by the Medical Council, the Dental Council and the Pharmaceutical Society of Ireland. The PHMP have secured start-up funding through contributions from a range of professional and representative bodies, thereby ensuring they avoid reliance on any one source and operate independent of any organisation.

Medisec is delighted to be one of the sponsors of the programme and we are extremely supportive of the work to be undertaken by the PHMP.

More information on the service and how to make a referral is available at www.practitionerhealth.ie

REMOVING FOREIGN BODIES FROM THE EYE

FROM EXAMINATION TO REFERRAL, BEST PRACTICES WHEN DEALING WITH FOREIGN BODIES IN THE EYE

We've had a number of cases over the years around removing foreign bodies from the eye, from advisory queries to claims made against members. Patients often attend the GP surgery with apparently minor issues of discomfort in the eye, or the feeling that something went into the eye.

First of all, a full history should be taken. The patient's description of the circumstances of the injury is the most crucial element in determining the likelihood of globe penetration. A full eye examination should then be performed, including visual acuity, fundoscopy, lid eversion and fluorescein staining.

Corneal abrasions related to conjunctival foreign bodies must be recognised and treated appropriately to prevent corneal infection or scarring. If something on the conjunctiva is not easily removable with a cotton swab, it could be a penetrating foreign body or even a conjunctival pigmented lesion.

WHEN TO REFER THE PATIENT TO THE LOCAL EYE DEPARTMENT

- If there is any suggestion in the history of exposure to a high velocity foreign body, or any possibility of metal shards (e.g. angle grinding) being the cause, due to the risk of globe perforation.
- If the foreign body is identified and firmly embedded in the conjunctiva or cornea, due to risk of conjunctival scarring, or a larger foreign body than was first suspected has perforated the globe.

REMEMBER:

- There may be more than one foreign body in the eye.
- An intra ocular foreign body does not necessarily change visual acuity.
- A firmly embedded foreign body might have penetrated deeper than initially suspected.
- Intraocular penetration can occur with seemingly minor trauma, particularly when foreign bodies result from high-speed machines (e.g. drills, saws, anything with a metal-on-metal mechanism), hammering or explosions.

BEST PRACTICE ADVICE FROM THE MEDISEC GP ADVISORY PANEL:

We advise you to exercise caution when removing a foreign body from the eye. A full history should be taken from the patient. While it may be safe to remove superficial foreign bodies that are not impacted, you should exercise extreme care and caution when removing a foreign body if a history of working with metal products is given. It may be prudent to refer the latter to a specialist centre either to remove it or to ascertain if it has all been removed.

GP CHAPERONE POLICY

WHEN, HOW AND WHY YOU SHOULD OFFER A CHAPERONE WHERE POSSIBLE

Clinical assessment of a patient often involves a physical examination as well as relevant history taking. Before beginning an examination, you should explain what it will entail and seek permission from the patient. Where an intimate examination is necessary, you should explain to the patient why it is needed and what it will entail. You should also let the patient know that they can have a chaperone present if they wish. It is important that all GPs offer a chaperone where possible. The Medical Council's draft 8th edition Guide To Professional Conduct And Ethics is currently under review and likely to be finalised and published in early 2016. It is important to note there is a proposal in the updated draft guide for an explicit obligation on you to offer a chaperone to a patient where an intimate examination is required. There is also a proposed requirement to respect patients' dignity by giving them privacy to undress and dress and keep them covered as much as possible. You should not help the patient to remove clothing unless the patient asks you to do so or you have checked with them that they want your help. All of these measures help to safeguard a patient's dignity and also add protection for you.

Unfortunately we have seen a number of complaints alleging improper examination when a chaperone has not been available to a patient.

It's important to document discussions surrounding chaperones and if one is present a record should be made of this fact. And a note made of the chaperone's identity. If the patient doesn't want a chaperone, or explicitly refuses a chaperone, it should be recorded that the offer was made and declined.

On occasions such as a home visit, or in an out-of-hours setting, a chaperone may not always be possible. In these circumstances you should consider whether the examination is urgent on a clinical basis. If it isn't, you could reschedule for a time when a chaperone is available.

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