MEDISEC ON CALL

Spring 2016

Around the clock support for the Irish GP community

MEDISEC IRELAND

MEDISEC ON CALL

spring issue 2016

Welcome to the Spring 2016 edition of Medisec On Call.

I hope you enjoy reading this edition, which covers some of the medico-legal challenges our members encounter on a daily basis. By reporting on these issues that you may face, we hope to assist you in your quest to provide better, safer healthcare for your patients.

In this newsletter, we are grateful to our contributors Dr Jim McShane for tackling the topical issue of sports injuries and how GPs should deal with concussion; Angela Tysall from the HSE who writes about the HSE embracing open disclosure, and Dr Mary Gray who deals with the difficult task of a patient who is not fit to drive. Contributions from our legal panel cover topics ranging from guardianship and children, mental health issues and preparing occupational health reports.

We also report on the findings of a collaborative study between Medisec and the University of Limerick Hospitals Group, to uncover risks and initiate improvements in communication between primary and secondary care in regards to patient referral and discharge.

These are exciting times for Medisec. We have come a long way since we began in 1994. However, having arranged insurance cover for thousands of GPs over the last 22 years, helped several hundred face negligence claims or Medical Council complaints and provided advice to hundreds more each year, our simple business objective remains unchanged; to make sure that while you look after your patients, our dedicated team look after you. We are here to give you peace of mind every hour of every day, all year round.

After nine years in Fitzwilliam Place, we are pleased to announce we are moving to a new location over the summer, in order to house our expanding team: 7 Hatch Street, Dublin 2. We look forward to settling into our new space and welcoming you there.

In the meantime, I hope you enjoy your summer.

Ruth Shipsey
CEO Medisec

Email:
ruthshipsey@medisec.ie

Mobile:
087 264 8245

Phone:
1800 460 400 /
+353 1 661 0504

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To contact Medisec you can email us at info@medisec.ie, telephone +353 1 661 0504 or FreeFone 1800 460 400

Medisec Ireland Limited, 11 Fitzwilliam Place, Dublin 2.

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DEIRDRE MCCARTHY

We are delighted to announce that the new editor of Medisec On Call is Deirdre McCarthy, our in-house legal counsel. If there is anything you would like to see included in our newsletter, you can email Deirdre at deirdremccarthy@medisec.ie

THE PITCH SIDE DOCTOR

Dr Jim McShane is a General Practitioner in Dun Laoghaire and a member of the Faculty of Sports & Exercise Medicine. He is the Deputy Coroner for County Dublin and is also the Programme Director for the TCD/HSE Specialist Training Programme in General Practice. Jim has extensive experience in sports medicine, having worked with Leinster Rugby and the Irish National Rugby team for the past 13 years.

Many of us GPs and hospital doctors are lucky enough to have children involved in sport. We therefore spend many hours on sidelines around the country. It is natural then that some of us provide medical expertise when called upon. Often this medical expertise is given on an informal and as-needed basis, and that is fine. It is, in my opinion however, preferable if there is some formality put around this. This can simply be letting the coach know before the game you are there and happy to be called on if required. This will focus your mind and prepare you mentally if you are called upon.

Medical cover on a more formal basis can also be given to our children's teams and other local sports teams. This is more demanding and can involve more than just pitch side work; planning the season's rota, pre-season talks on injury management to parents and coaches, as well as injury follow-up in the days or weeks following games are just some of the duties that will befall us in this role.

If we are undertaking any such roles, we should be prepared! To me, part of being prepared is being appropriately attired and the most important piece of attire is a pair of football boots. Wearing boots will prevent you slipping or falling, and will save your shoes from being destroyed.

We should carry a medical bag and this should match our capabilities. In other words, we should only carry equipment that we are able to use. We should not attempt to do things pitch side that are beyond our abilities and our training. Therefore, if your training allows you to suture, manage soft tissue injuries and stabilise fractures, by all means do so. If you don't have the training, players should be referred, or the emergency services called if necessary.

CONCUSSION

Concussion is the injury of most concern to parents, coaches and doctors. It is now being taken very seriously by most sporting bodies and in this regard, the IRFU has led the way with its 'Safe Rugby Programme', a useful pocket guide to concussion in Rugby Union, which has been distributed nationwide. You can see a copy on the IRFU website.

Concussion is a complex injury and while there is much we don't know and understand about it, we do know that it is an injury that must be taken extremely seriously. We now know that a player with a suspected concussion should be removed immediately from the playing field or training and they should not return. The player should be medically assessed, not left alone and should not drive a vehicle.

The visible clues of a suspected concussion are:

- Lying motionless on the ground
- Slow to get up
- Unsteadiness
- Balance problems or falling over
- Grabbing/holding head
- Dazed or blank look
- Confusion
- Loss of consciousness
- Seizure

Concussed players may complain of the following symptoms:

- Nausea or vomiting
- Drowsiness
- Irritability
- Emotional liability
- Sadness
- Anxious
- Confusion
- “Don’t feel right”
- Headache
- Dizziness
- Feeling slowed down
- Feeling like “in a fog”
- Blurred vision
- “Pressure in head”
- Sensitivity to light
- Sensitivity to sound
- Amnesia
- Concentration difficulties
- Neck pain
- Blurred/double vision

A player’s memory can be tested in order to confirm the diagnosis by asking the Maddock’s questions. These simple questions are:

- Which ground are we at?
- Which half of the game is it?
- Who scored last?
- Who did you play last week?
- Who won that game?

Getting these questions correct is not a reason to allow a player to return to play or train if there are signs or symptoms of a suspected concussion. Getting any of the questions wrong confirms the diagnosis of concussion.

The most important role we have in this area is recognising the signs and symptoms of suspected concussion and ensuring permanent removal from the playing field. Handing the player over to a responsible adult or parent follows this, with the advice that they should not be left alone or drive.

We may subsequently be consulted about when it is safe for a player to return to play. In rugby there are very clear guidelines:

- From U-6’s to U-20’s the player must not return for 23 days.
- Adults must not return for 21 days.

These periods include a minimum period of 14 days rest after the injury. If all symptoms have subsided, this is followed by a period of graduated return to play, which involves a graduated build in the intensity of exercise before returning to contact training or playing.

Coaches, parents and especially players themselves may not always agree with our diagnosis of concussion or suspected concussion. We have a duty to protect these players and by following these guidelines rigidly, in recognising the signs and symptoms, removing the player permanently, resting the player and only allowing a return to play in the appropriate time frame gives them the best protection.

The IRFU run weekend courses in ‘Safe Rugby’ for doctors, physiotherapists and coaches. These are really valuable and should be done annually in order to feel comfortable working at any level of rugby.

No extra medical indemnity is required to work as a team doctor, but I would encourage any doctor engaging in same to inform their insurers.

Being a team doctor is a most rewarding role. I would encourage anyone with an interest to get involved, especially if you are going to be pitch side anyway watching your son or daughter. It brings with it some responsibilities and we need to prepare and train ourselves appropriately.

Good luck and see you pitch side.

Jim

We have had many enquiries about GPs providing services as Medical Officers during sports events. As a GP, you should give due consideration to the possible implications of your role before you agree to provide services at such events and we advise you to ascertain exact duties and responsibilities before agreeing to provide such services. The Medisec Master Policy covers members for these events provided the work undertaken is that of a GP and not as an event doctor, who is responsible for crowd control, ambulance cover, provision of appropriate medical equipment etc. For further clarification on our Best Practices for General Practitioners, please visit our website: http://www.medisec.ie/a-z/sports-events

WALKING THE TIGHTROPE

BALANCING THE PATIENT'S BEST INTERESTS WITH THEIR RIGHT TO LIBERTY

Section 10 of the Mental Health Act 2001 came into force in November 2006. It sets out the legal basis for the role and responsibilities of the GP in the involuntary committal of a patient to a psychiatric hospital.

The Act was enacted to bring Irish law, in respect of mental health issues, into line with international human rights standards.

The underlying cardinal principle of the Act is to safeguard the liberty of patients.

There are very limited circumstances in which an individual's right to liberty can be interfered with, save by judicial process.

The involuntary committal of a patient is one of the very limited exceptions. That being the case, the Courts will always strictly interpret the procedures to be followed under the Act. Any deviation from the prescribed procedures will render any subsequent admission order to a psychiatric hospital (or "approved centre" as defined by the Act) invalid and, consequently, will expose a general practitioner to a potential claim in medical negligence.

The first step in the involuntary admission procedure is that the GP (or any registered medical practitioner) must receive an application from a third party to commit the patient.

The applicant can be a spouse or relative of the patient, an authorised officer of the Health Service Executive, a member of An Garda Síochána or any other member of the public.

Kate McMahon
Kate McMahon & Associates
Medisec Panel Solicitors

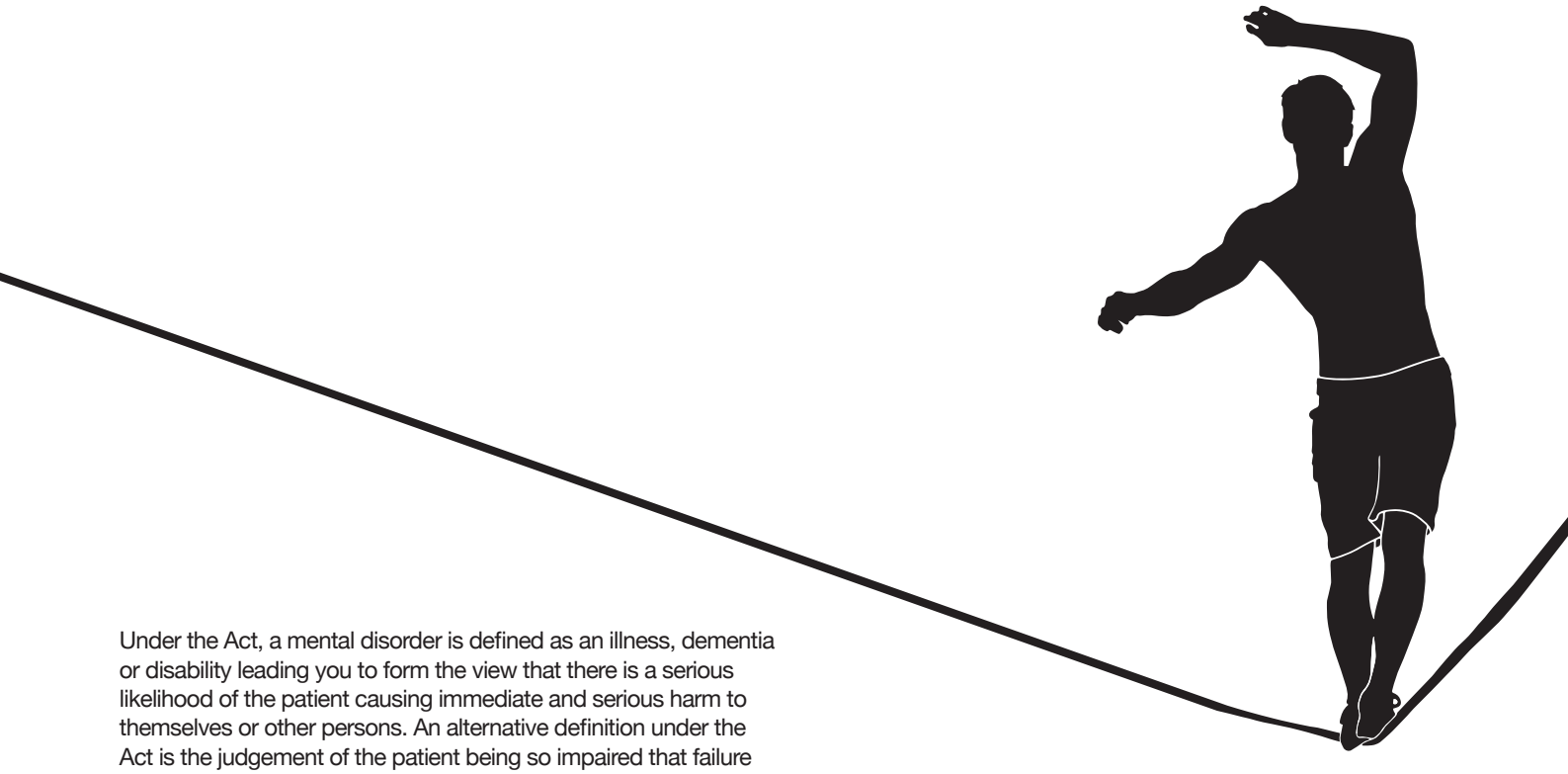
The Act specifically disqualifies the following persons from making an application to a registered medical practitioner:

1. Anyone under the age of 18 years.
2. An authorised officer of the HSE or a member of the Garda Síochána who is a relative or spouse of the patient.
3. A member of the governing body, or the staff, or the person in charge of the approved centre concerned.
4. Any person with an interest in the payments (if any) to be made in respect of the care of the patient concerned in the approved centre.
5. Any registered medical practitioner who provides a regular medical service at the approved centre concerned.
6. The spouse, parent, grandparent, brother, sister, uncle or aunt of any of the persons mentioned in points 2-5.

The applicant to the GP must have formed the view that the patient has a mental disorder and the applicant must complete a statutory form within 48 hours of observing the patient demonstrating symptoms of mental disorder.

There are four individual forms for the four categories of persons making an application to a GP and it is very important that as the GP, you ensure the correct form has been presented.

You must then examine the patient within 24 hours of receipt of the application form. There have been a number of authorities before the Courts, both before and after the enactment of the 2001 Act, which make it abundantly clear that there must be a personal examination of the patient concerned which must be documented and which must demonstrate that you have formed an individual opinion that the patient is suffering from a mental disorder.



Under the Act, a mental disorder is defined as an illness, dementia or disability leading you to form the view that there is a serious likelihood of the patient causing immediate and serious harm to themselves or other persons. An alternative definition under the Act is the judgement of the patient being so impaired that failure to admit the person to an approved centre could lead to a serious deterioration of their condition or prevent the administration of appropriate treatment that could be given only by such admission, and the reception, detention and treatment of the person concerned would be likely to benefit or alleviate the condition of that person to a material extent.

Personality disorder, social deviance or drug or other addictions are specifically excluded as criterion for involuntary admission.

The critical part of your role in involuntary admission is the carrying out of the examination. The patient must firstly be informed of the purpose of the examination, unless you form the opinion that advising the patient as to the purpose of the examination would be prejudicial to the patient's mental health, wellbeing or emotional condition. If you do hold this opinion, it should be documented in the clinical records.

In a case of O'Reilly – v – Mid Western Health Board (a case taken by a patient under the old Mental Treatment Act 1945), a GP signed an application form on foot of accounts of the Plaintiff's history from both her husband and father, and from a visual examination of her from 12 to 15 yards away, whilst she was having a dispute with her husband.

The Plaintiff was hysterical and violent towards her husband but was not aware of the GP's presence.

A second doctor signed the form after physical examination of the Plaintiff and consultation with the first GP and a Consultant Psychiatrist.

Both the High Court and Supreme Court (in 1993) found that the first GP's actions were sufficient "examination" for the purpose of the Act and hence the Plaintiff failed to win leave to take proceedings against the GP or the Mid Western Health Board.

The Plaintiff, however, appealed her case to the European Commission of Human Rights in Strasbourg, which ruled in her favour.

A consideration of Section 10 of the 2001 Act was held in a recent case of S.O. – v – The Clinical Director of Tallaght Hospital by Mr Justice Gerard Hogan.

The GP in this case signed a Section 10 form but did not actually see or examine the patient.

As in the O'Reilly case, the GP relied on what the patient's mother and brother told him in respect of their observations and he also heard a tape recorder conversation between the brother and the patient.

The patient was removed to Tallaght Hospital and a Consultant Psychiatrist examined and signed an involuntary admission order.

The Judge, however, held there was complete failure on the part of the GP to carry out a personal examination of the patient, which was required by Section 2 of the Act, and hence the requirement of Section 10 that there be a prior examination by a registered medical practitioner before a patient is brought to an approved centre had not been met. Accordingly, the subsequent detention was held to be invalid and illegal.

Accordingly, it is fair to say that the Irish Courts take a very strict approach to the provisions of the 2001 Act. If there is any failure to observe, to the letter of the law, the procedures as laid down by the Act, then any subsequent detention in an approved unit is an invalid detention.

It doesn't matter whether a consultant psychiatrist in the approved unit fully agrees with the general practitioner's view that the patient is suffering from a mental disorder. The GP's view can only be formed after a physical examination of the patient and no amount of collateral evidence such as accounts from family members, recordings, etc, can make good the failure of a GP to actually examine the patient.

To sum up, if you fail to follow the procedures laid down in Section 10 of the Act, or fail to actually examine the patient, then you expose yourself not only to a potential claim in medical negligence, but also to the possibility that such a patient may seek a declaration before the Court in Strasberg that their committal represented an arbitrary detention in violation of Article 5 of the Convention on Human Rights.

If you require any further guidance in relation to the procedures to be followed in any individual case, then do not hesitate to seek the assistance of Medisec.

INFORMATION TRANSFER BETWEEN PRIMARY AND SECONDARY CARE

BEST PRACTICE AND RECOMMENDATIONS TO INITIATE IMPROVEMENTS IN COMMUNICATION

The transfer of information between primary and secondary care in regards to patient referral and discharge, and solutions, strategies and training initiatives surrounding this were among the important themes emerging from an interesting study we recently sponsored which has just been published.

The main aim of the project was to investigate experiences of clinical incidents in healthcare settings from the perspectives of both healthcare professionals and patients, and determine key strategies for improving healthcare services and transitions in care.

In a 2014 report, Medisec, in collaboration with Healthcare Consultant Mary Culliton, identified the key risks for GPs and were keen to further explore the main risks arising from the interaction between hospitals, GPs and pharmacists at the points of a patient's admission to, and discharge from, hospital.

The study, a collaboration between Medisec and the University of Limerick Hospitals Group, was based in the Mid-West, with healthcare professionals from primary care sites (GP practices and pharmacies) and secondary care hospitals. The steering group included representatives from the State Claims Agency (SCA), Health Information and Quality Authority (HIQA), Irish College of General Practitioners (ICGP), School of Pharmacy Trinity College Dublin, Schools of Medicine: University of Limerick (UL) and University College Dublin (UCD), Medical Council, World Health Organisation (WHO) Patients For Patients' Safety, Health Service Executive (HSE), UL Hospitals. The project was managed by Ms Culliton and UL Researcher Dr Dorothy Leahy PhD.

The lead investigator was Clinical Director at UL Hospitals Dr John Kennedy. Academic support was provided by Professor Walter Cullen UCD, Professor Paul Finucane and Dr Dorothy Leahy, UL Hospitals.

Semi-structured interviews were conducted with healthcare professionals including GPs, pharmacists, consultants, hospital doctors, nurses and administration staff and a focus group with patients from primary and secondary care.

The analysis of participant data illustrated the following:

- Medication error was the most predominant risk highlighted among healthcare professionals. The report recommends that to decrease the risk of medication error, electronic information sharing practices be synchronised across primary and secondary care.

- Current referral pathways to hospital are complex and conflicting views among healthcare professionals on appropriate referral routes were apparent. The report recommends clearer referral pathways and support for healthcare professionals from primary and secondary care, in terms of providing more resources in units such as the MAU, AMAU and the LIU.

- While most GPs use IT based systems in their practices, paper based systems are still creating barriers in communication between primary and secondary care. Healthcare professionals in both sectors are receiving handwritten referral and discharge letters, with limited and in some cases illegible patient information. The report recommends a long-term solution - syncing IT systems across primary and secondary care and greater use of electronic communication, including the usage of 'healthmail' an email system that allows all hospitals to communicate clinical information securely to GPs.

- Healthcare professionals requested, and the report recommends, the expansion of the role of the hospital pharmacist. Increasing the number of hospital pharmacists at ward level and encouraging more collaboration with other healthcare professionals from primary and secondary care could reduce the risk of medication error.

- Patients want to be empowered. The report recommends, where possible, patients can access their own medical notes, to promote patient inclusion in their own healthcare and to facilitate better patient communication, education and awareness.

The objective of the steering group is to use the findings of the report to initiate improvements in the communication between primary and secondary healthcare sectors. There is continued collaboration of the agencies involved to action the recommendations identified and we, in Medisec, are committed to supporting the process.

MEDICAL FITNESS TO DRIVE GUIDELINES

The principal source of guidance for GPs in relation to fitness to drive assessments is 'Sláinte & Tiomáint - Medical Fitness to Drive Guidelines'. It provides guidance on medical fitness to drive under the broad headings of neurological disorders, cardiovascular disorders, diabetes mellitus, psychiatric disorders, drug and alcohol misuse, visual disorders, renal disorders, respiratory and sleep disorders.[1]

At Medisec, we frequently receive queries on the obligations and requirements of a GP for reporting on a patient's fitness to drive.

A driver should inform the NDLS and their insurance provider of any long-term or permanent injury or illness that could cause or increase the risk of impairment while driving. They will require a medical report to support their application for, or renewal of, a licence. In the case of NDLS medical examinations, drivers have a duty to declare their health status to the examining health professional. Drivers are also required to report to the NDLS when they become aware of a health condition that may affect their ability to drive safely. A driver should not drive while medically unfit to do so and can be convicted of an offence for doing so. Drivers must adhere to prescribed medical treatment and monitoring/management plans for their condition.

You have a duty to advise patients on the impact of medical conditions and treatments on their ability to drive, and to recommend restrictions and ongoing monitoring as required. Such restrictions/monitoring requirements should be recorded in patient records and noted on the NDLS medical report as per the guidelines.

You are also expected to advise the patient of their responsibility to report their condition to the NDLS if indicated (who may amend or revoke the licence). In Ireland, there is no medical condition that routinely requires reporting by a health professional directly to the NDLS. A positive duty is imposed on health professionals to notify the relevant authority in writing of a belief that a driver is physically or mentally unfit to drive, poses a risk to public safety and is not compliant with professional advice to stop driving. In urgent situations outside of normal working hours you can make a report to the Gardaí rather than the NDLS. It is preferable that such action should be taken with the driver's consent when possible and with the driver's knowledge of the planned action. In exceptional circumstances e.g. risk of violence to the health professional, a decision not to inform the driver of a planned report may need to be considered. See Sláinte & Tiomáint for useful guidance on this.

Case study: a middle-aged male first presented to his GP with a recent history of heavy binge drinking. There were stressful life changes at the time and he presented as highly motivated to reverse his alcohol pattern and as having good insight into the risks of ongoing drinking. Biomarkers were elevated in this case. His occupation involved commercial driving for his employer under a Group 2 licence category. His occupational health doctor agreed with his GP that he did not present as alcohol dependent. Issues relating to driving were discussed with the patient including the risk of having his licence revoked in the case of 'persistent alcohol misuse'. The patient undertook to attend support services to cease drinking.

Following further reviews it became clear that he was continuing to engage in 'persistent alcohol misuse'. On foot of Medisec's advice, his GP advised him verbally and by letter (which included a copy of the relevant extracts from Sláinte & Tiomáint) that he should cease driving under his Group 2 licence for a minimum of one year of abstinence, or controlled drinking pending reviews, and advised of his obligation to notify the NDLS and his insurers. The GP informed the patient he would not be able to drive for a minimum of three months of abstinence or controlled drinking, pending review under his Group 1 licence. The GP also informed the patient that should he learn that the patient had not complied with this advice, a written report would have to be forwarded to the NDLS. The GP documented his advice to the patient clearly in the medical notes.

This case study indicates the clear shared responsibility of a GP and a patient in relation to the certification of a patient's fitness to drive. If you have any doubts about a patients fitness to drive or the impact of a particular condition on fitness to drive you can refer the patient to an appropriate specialist.

If you have any queries about certifying a patient's fitness to drive, contact Medisec for advice.

1.The 2016 Edition of Sláinte & Tiomáint was published in April and is available on www.ndls.ie.

Dr Mary Gray
GP Limerick,
Medisec GP advisory
panel member

COMMUNICATION WITH PATIENTS BY TEXT

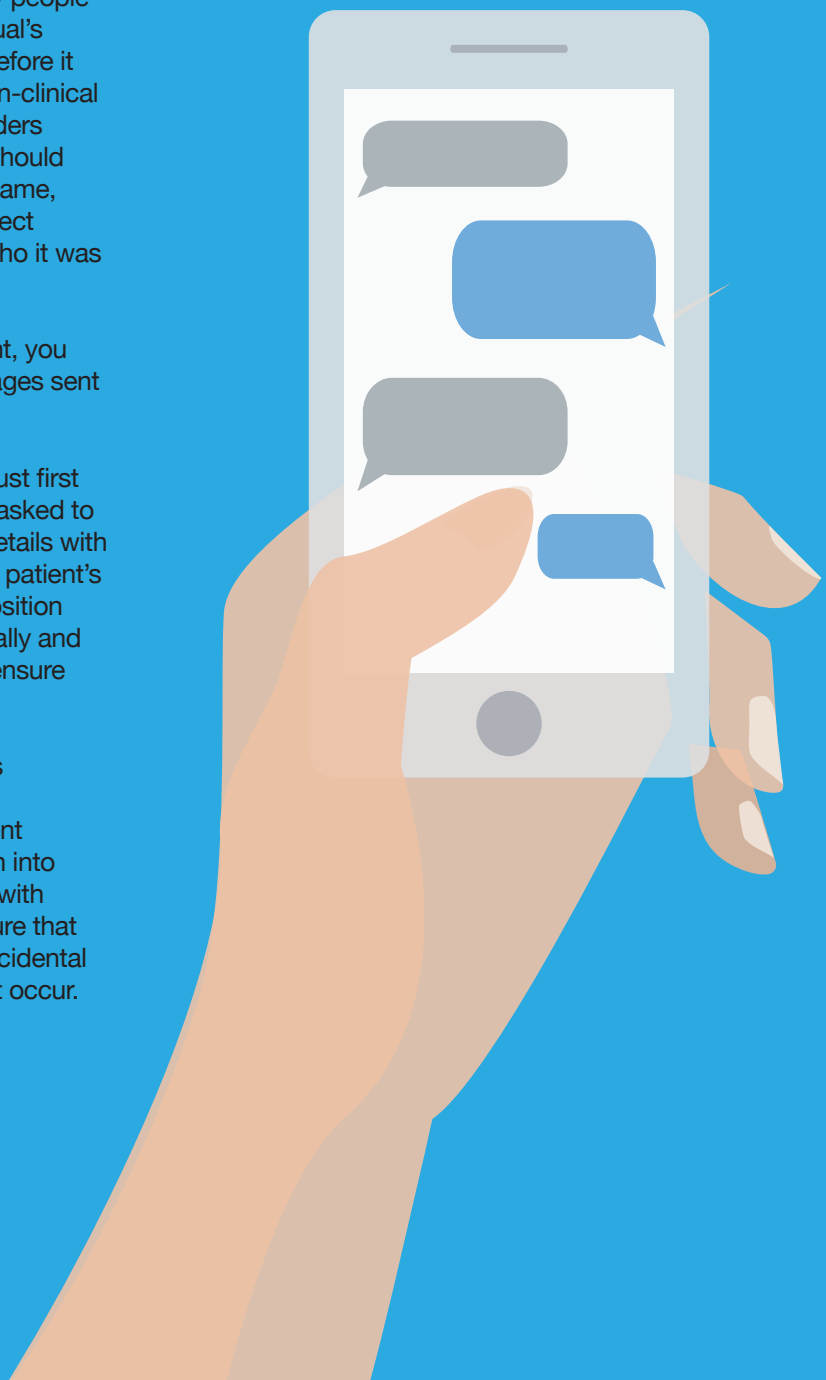
HOW AND WHEN TO USE TEXT MESSAGING TO CONTACT PATIENTS

Contacting patients by text seems like an efficient and appealing method of communication. However, difficulties may arise when sending confidential information by text; messages may be read by people other than the intended recipient or an individual's phone number may have been changed. Therefore it is advisable to restrict messages by text to non-clinical matters only, for example, appointment reminders or notification that test results are ready. You should exclude any identifiers, such as the patient's name, so that if the message is delivered to an incorrect phone, the person reading it does not know who it was intended for.

As applies to all communications with a patient, you should make sure that details of all text messages sent are noted in a patient's file.

To communicate with a patient by text, you must first seek their consent. Ideally patients should be asked to give formal consent when they register their details with your practice. This should then be kept on the patient's chart. The Data Protection Commissioner's position is that such consent should be renewed annually and a reminder system put on the patient's file to ensure follow up.

The Guide to Professional Conduct and Ethics for Registered Medical Practitioners provides clear guidelines in relation to maintaining patient confidentiality and this should always be taken into consideration with respect to communication with patients. As their doctor, it is up to you to ensure that the patient's privacy is maintained and that accidental disclosure of confidential information does not occur.



TROUBLESOME.....

MANY COMPLAINTS WE RECEIVE IN MEDISEC RELATE TO THE MISDIAGNOSIS OF TESTICULAR SWELLING, PAIN AND DISCOMFORT. HERE ARE A FEW POINTERS TO AVOID THESE OCCURRENCES.

TESTICULAR TORSION

The young adult who presents with an acutely painful testicle with severe symptoms of short duration presents little clinical difficulty – he should be referred directly to secondary care for urgent scrotal exploration.

Why is it missed?
Testicular pain and tenderness may be absent in up to a third of the patients. Swelling of the testis or scrotum, oedema or erythema of scrotal skin, and abdominal pain may be the presenting symptom in these cases. Pain may be intermittent (with episodes of torsion and detorsion) or a dull ache of gradual onset; it may also be referred to abdominal or inguinoscrotal regions.

TESTICULAR PAIN IN CHILDREN

Acute testicular pain in a young child should be treated as a testicular torsion until proven otherwise. Nausea or vomiting associated with scrotal pain indicates that urgent referral for emergency exploratory surgery is necessary. In a screaming male infant, the scrotum may not always be carefully examined to exclude torsion, and this diagnosis may be overlooked as a cause for infant distress.[1]

Beware of the embarrassed ten year old who may complain of lower abdominal pain, because he is too terrified of a scrotal examination!

INTERMITTENT TESTICULAR TORSION

It is important to remember that some patients may present with intermittent symptoms due to spontaneous de-torsion. Short periods of acute groin pain, which may or may not be accompanied by vomiting and subsequent spontaneous relief, should alert you to this condition.

TESTICULAR CANCER

Non-resolving testicular pain
While most testicular tumours present as a painless mass, recurring testicular pain and/or discomfort in any male should be investigated promptly with ultrasound to rule out a malignant lesion or subacute recurring torsion.

Patients presenting with a swelling in the scrotum should be examined carefully and an attempt made to distinguish between lumps arising from the body of the testis and other intrascrotal swellings. An ultrasound should be performed to make a distinction. Those patients suspected of harbouring a testicular malignancy, i.e. a lump in the testis, doubtful epididymo-orchitis or orchitis not resolving within two to three weeks, should be referred urgently for urological assessment.[2]

TESTES

RARE OCCURRENCE

On average, 132 cases of testicular cancer were diagnosed each year in Ireland between 1994 and 2010. Testicular cancer is relatively rare and makes up less than 2% of all invasive cancers diagnosed in men. However in young patients, it is one of the most common cancers, representing 30% of all cancers in 25-39 year olds. Very few men aged over 50 are diagnosed with testicular cancer (less than 10 per year). Most GPs see a patient with a testicular malignancy only once or twice in their careers.[3]

PRESENTATION

Patients will usually present with a painless scrotal mass or an enlarged testicle. Some patients will describe a 'dragging sensation' in the scrotum, and rarely can present with gynaecomastia or hydrocele.[2]

BEWARE DISTRACTING HISTORY

Occasionally a patient will present following local trauma to the testes, however, it is not thought that the trauma causes the cancer, but rather that it brings an existing mass to the attention of the patient. Beware therefore of confusing a small mass as post trauma 'bruising'.[3]

EPIDIDYMO-ORCHITIS

A diagnosis of Epidiymo-orchitis, which does not resolve in two - three weeks should be referred urgently for urological assessment.[2]

IN SUMMARY

- If there is any testicular mass, refer promptly for ultrasound, even if it feels benign.
- Testicular torsion may be difficult to diagnose if symptoms are intermittent or atypical, but it must be considered in all cases of scrotal pain, with careful history and examination.
- If there is unresolving or recurrent scrotal pain, refer promptly for ultrasound and consider urgent urology opinion.
- Do not be distracted by a history of recent trauma. Investigate any persisting discomfort or swelling.

References:
1. BMJ 2010;341:c3213 BMJ Practice Easily Missed? Testicular torsion BMJ 2010; 341
2. SIGN Guideline No. 124 Management of adult testicular germ cell tumours : A national clinical guideline. 2011
3. National Cancer Registry Ireland 'Cancer Trends' 2012.

21st CENTURY FAMILIES

RECENT CHANGES TO THE RULES RELATING TO THE APPOINTMENT OF GUARDIANS AND WHAT TO WATCH OUT FOR IN YOUR PRACTICE.

Alison Kelleher, Comyn Kelleher Tobin
Medisec Panel Solicitors

The Children and Family Relationships Act 2015 radically overhauled previous legislation providing for the guardianship of minors. These changes became operational in January 2016 and were introduced to recognise the increasing diversity of modern blended family units.

WHAT IS GUARDIANSHIP?

Guardianship is the collection of rights and duties that a parent or non-parent may have in respect of a child. For example a right to make decisions, including, in some limited cases, consent to medical treatment.

WHO IS A GUARDIAN?

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, 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. In the absence of a statutory declaration, 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.

However, in the future, guardianship will 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, including months after the child's birth.

It should be emphasised that the naming of an unmarried father on a birth certificate is often misunderstood as an automatic right to guardianship, when in fact this is not the case.

Foster parents are not guardians. However, some foster parents may be given enhanced rights by a court in special circumstances where they have fostered the child for at least five years. In all other cases, foster parents do not have the same rights as guardians.

WHO ELSE CAN BE APPOINTED UNDER THE NEW RULES?

With these new legislative changes, for the first time express provision has been made for the appointment of multiple guardians for a child. Previously, multiple guardians could only be appointed under very limited circumstances where a parent died without appointing a testamentary guardian.

Now, a parent's spouse, civil partner or cohabitant of no less than three years will be able to apply for custody or guardianship where he or she has shared parenting of the child for the past two years.

Any person can now also apply to court for guardianship or custody of a child where he or she has undertaken the child's day-to-day care for more than 12 months and the child has no parent or guardian willing or able to act as guardian.

Temporary guardians can also be appointed by the court for the first time. This can happen when a guardian nominates a replacement guardian in writing and can set out in that document any limitations they would like to impose on that person's right of guardianship. The nominated person can apply to the court to activate their rights of guardianship. It is at the court's discretion whether to appoint the temporary guardian, and the court can limit the extent of the temporary guardian's rights whilst appointed, for example whether the temporary guardian can consent to medical treatment.

RECORDING GUARDIANSHIP IN YOUR PRACTICE

Frequently, there are misunderstandings as to whether an unmarried father is a guardian.

Unfortunately, where statutory declarations are signed by the parents, there is no central register for these declarations and the parents simply keep copies of the declarations themselves.

When registering a new child patient, you should make appropriate enquiries of the child's parent or guardian. To avoid confusion, if you are told that a guardian has been appointed to a minor patient then it is good practice to ask for a copy of the court order or declaration and keep it on the child's records for future reference.

MULTIPLE GUARDIANS. POTENTIAL FOR CONFLICT?

As already mentioned, the Act recognises the potential for the appointment of multiple guardians, for example new spouses of parents. An appointment of non-parents as guardians will only be made with the consent of each guardian of the child. However, where it is felt that the appointment of an additional guardian is in the best interests of the child, a court can use its discretion to dispense with a guardian's consent if it is found to be unreasonably withheld. In practice, it is not anticipated that multiple guardians will be a very common occurrence but you should be aware of this possibility.

If a court appoints a guardian to a child where one or both parents are alive, the additional guardian will not have the right to make certain important decisions about the child unless that right is expressly granted by the court. Instead, the additional guardian's rights may be limited to making day-to-day decisions on behalf of the child.

As the additional guardian's right to make important decisions is discretionary, a court may or may not extend the guardian's right to be able to consent to medical, dental and other health-related treatment for the child. Therefore, it is essential that you are aware of the extent of a guardian's right to provide consent to treatment on a child's behalf and this should be easily clarified by having a copy of the court order on file.

CONSENT TO TREATMENT OF A MINOR BY A GUARDIAN

The consent of a parent or guardian is required to treat a patient under the age of 16.

In practice however, it is appropriate to seek consent from a minor where the child has the capacity to understand the nature and implications of the proposed treatment or procedure. Even when children lack the capacity to give consent, they should still be involved in the decision-making process.

If a parent or guardian and a child are in agreement about a medical decision then this should not present a problem. However, if parents, guardians, a child or a GP are in disagreement then care should be taken.

CHILDREN IN CARE

As already set out, a foster carer does not have the same rights as a guardian unless the foster parent has enhanced rights appointed by a court in very specific circumstances. When treating a child who is subject to a statutory care order, the child's parents or guardians should be consulted where possible.

However, the Child and Family Agency is authorised to consent to any necessary assessment, examination, medical or psychiatric treatment on behalf of a child in care. In practice, the child's social worker is usually the appropriate person to provide the consent.

BEST INTERESTS OF THE CHILD

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.

The rule of thumb is that the more complex the decision, or the more serious the situation, the greater the need to include all parents and guardians in your discussions. Where there is reason to believe that the parents or guardians may not be in agreement with one another, you should always seek the consent of all parents or guardians.

In all cases, **the best interests of the child must be the paramount consideration.**

If you are concerned that a parent or guardian may make a decision on behalf of a child that is likely to adversely affect the interests of a child, the best course is to contact Medisec for specific advice on individual cases.

ACCESSING RECORDS

As a general rule, parents and guardians who have been appointed the appropriate rights have a right to request access to a child's records. If it is felt that the minor is sufficiently mature to understand the implications of the release of his or her records, then his or her consent should be obtained before allowing access. If the patient is too young and/or lacks capacity to consent to the release of the records, then the records should only be released when you are satisfied that it would be in the patient's interests to do so. In situations where it may not be in the child's best interest to release the information, then you are advised to err on the side of caution and consult Medisec for further advice.

SUMMARY

The changes described above have modernised the law in this area by extending parental rights and responsibilities to non-traditional families. If you are faced with a potential involvement of a guardian in a child's treatment decision, it is important to firstly clarify the precise role of the guardian and whether they have the necessary rights to consent on behalf of the child. Above all else, it should be remembered that your paramount responsibility is to act in the minor patient's best interests.

STANDALONE TELEMEDICINE CONSULTATIONS

WHAT IT MEANS AND HOW IT AFFECTS YOUR COVER.

Firstly, when we talk about standalone telemedicine, we mean a service where a GP, employed by a third party provider who manages the service, provides consultations with non-patients. This is separate from telemedicine services you might routinely provide to your own patients or through a locum service to which you are attached. This is already part of what is considered 'normal' GP practice.

We sought the views of Medisec's GP Advisory Panel ("Panel") and underwriters Allianz plc in relation to standalone telemedicine services and we are pleased to confirm that it will come within the realm of 'normal' GP work where:

- The telemedicine service provider has the endorsement of a relevant professional body.
- Or where the Panel is satisfied with the standards of a particular standalone telemedicine service and satisfied that it is delivered by appropriately trained GPs.

In light of this, our underwriters Allianz plc will provide cover for members, as per policy terms and conditions, on foot of an individual application if the telemedicine service provider has the endorsement of a relevant professional body.

If the telemedicine service provider does not have the endorsement of a relevant professional body, we will require information to enable our GP Advisory Panel to consider the proposed service and inter alia its quality assurance processes, clinical guidelines, training, data protection systems, policies on safeguarding patients including vulnerable patients; for example minors and patients with mental health difficulties.

Your Medisec membership is personal to you and the benefits of membership should therefore not be taken to include assistance with any claim or other legal action against an employee, contractor, agent or legal entity such as a website or company in relation to the provisions of telemedicine. In all applications, we will therefore require details of the insurance/indemnity arrangements of the telemedicine employer.

In addition, we will require you to:

- Satisfy us as to your training and plans for continuous ongoing training in the area of telemedicine.
- Let us know the number of hours/sessions per week you will be working in telemedicine;
- Provide us with details of your practice's protocols and policies on data protection, privacy, and confidentiality.
- Provide written confirmation that you will comply with the current edition of the Medical Council's 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners' and, in particular but without limitation, the Medical Council guidelines on telemedicine.
- Confirm awareness of the limitation of your training and expertise and confine your practice to those areas in which you have the appropriate expertise.
- Confirm that the service will be provided by you from a base in Ireland to patients in Ireland.
- Inform Medisec at the time of your annual renewal whether you intend to continue providing such a standalone telemedicine service.

As this is a new and evolving area of general practice, we will need to monitor the risks involved. Our agreement to cover members working in Telemedicine will be subject to annual review and may be withdrawn at any time on foot of reasonable notice.

Medisec and in turn Allianz appreciate the evolving nature of general practice and wish to be progressive in promoting the best use of technology for the provision of optimal healthcare services for patients. We hope you understand the need to be prudent and cautious, to ensure that while we are protecting patients, we are at the same time protecting our members' interests. Exposing you to a higher level of risk than necessary would result in increased premiums. It is for this reason we will view such requests for cover on a case-to-case basis.

DECEASED PATIENT'S NOTES

WHAT TO CONSIDER AND PROCEDURES TO FOLLOW WHEN RESPONDING TO REQUESTS

Members regularly contact us in relation to requests for a copy of a deceased patient's notes. Requests for notes can come in from various places, for example, a spouse looking for the notes, a concerned family member, Gardaí or a Life Insurance Company. Depending on the circumstances of the case, there are many different factors to consider.

[1]According to Medical Council guidance, your duty of confidentiality continues after a patient has died. This is an ethical requirement and not a legal one, as the right to sue for a breach of confidentiality dies with the patient. If a patient has requested that any information remain confidential you should respect their wishes. If the deceased patient has not given you any instructions regarding his personal information, you must take into account why the information is required and whether or not the information would be of benefit or detrimental to the family.

Section 24.2 of the Medical Council Guidelines is most helpful and states:

24.2 *'Patient information remains confidential even after death. If it is unclear whether the patient consented to disclosure of information after their death, you should consider how disclosure of the information might benefit or cause distress to the deceased's family or carers. You should also consider the effect of disclosure on the reputation of the deceased and the purpose of the disclosure. Individual discretion in this area might be limited by law.'*

With this in mind, when you make your assessment you should consider:

- The reason for the request.
- The confidentiality of personal information.
- Would the disclosure cause distress to the deceased's family or carers?
- Would the disclosure effect the reputation of the deceased?
- Would the deceased have consented to the release of the records to the requester when living?
- The nature of the records to be released. If the record is inherently private, and of a very sensitive nature, then it is likely not to be released unless there are compelling reasons for doing so.

Always remember that in the absence of prior consent of the deceased during their lifetime to release the information, you should seek written consent from the personal representative or executor of the deceased patient's will. If that consent is not forthcoming, you must protect the confidentiality of the records.

When preparing the records for release, it is necessary to redact all information in the copy records in relation to third parties before you release the copy records, especially in light of the pending new Medical Council Guidelines. In terms of best practice, we recommend that as a matter of professional courtesy, and insofar as disclosure may involve disclosing a consultant's letters or documents, you should inform the consultant of the pending disclosure before you release the records in copy form. If there are psychiatrist's reports on file, we advise you to seek the permission of the psychiatrist in advance of disclosure.

Requests from Life Insurance Companies

In some cases, consent from the personal representative is not required. However it is appropriate to inform the personal representative in advance of disclosure. For example there is a standard clause in most life insurance policies which the patient / policyholder would have signed when they took out the policy consenting to the insurance company seeking medical information from any medical doctor, at any time and the authority remains in force even after death. It is important that GPs have sight of the consent signed by the patient in advance of any such disclosure.

[1] Guide to Professional Conduct and Ethics for Registered Medical Practitioners 7th Edition

QUICK TIPS

UNACCOMPANIED MINORS

As a GP, you should exercise caution if an unaccompanied minor is 'sent' to your surgery without an accompanying parent. Often a kindly GP will attempt to accommodate the busy working parents by agreeing to see little Johnny with his cough or verruca without a parent present. Even with telephone consent, and the parent on the end of the phone, Johnny may not give an accurate history or even realise the primary reason why he was 'sent' to the GP.

The issues that arise are myriad. There are concerns regarding capacity, consent, chaperoning, accurate diagnostics and examination. The minor may not understand any explanations given and it may prove difficult to contact a parent by phone. The minor may give a different report of proceedings when he returns home than what you understood to have taken place.

Consulting with an unaccompanied minor should take place only in an emergency and where the best interest of the minor is concerned.

But what if a minor self-refers for independent medical advice? This is a very different scenario and must be handled with care. (See Medisec Newsletter Winter 2014 'Difficult Decisions involving Minors and Young Adults' accessible through Medisec website).

RECORD KEEPING

Members should abide by the Medical Council guidelines in relation to record keeping:

23 Medical records
23.1 You have a duty to maintain accurate and up-to-date patient records either in manual or electronic form. You are expected to be aware of your obligations under the Data Protection Acts in relation to secure storage and eventual disposal of such records as well as relevant published Codes of Practice.

You should also remember that accurate and complete notes are essential in the event of a complaint or a claim.

HOME BIRTHS

The new Maternity Care Strategy launched in January has indicated more input from Primary Care with regard to maternity services. We would like to remind you that your Medisec policy does NOT cover the provision of antenatal/postnatal care for patients who intend to have or have had a planned home delivery. These patients should be referred to the local maternity hospital for routine ante and postnatal care.

Similarly, the provision of an ultrasound service in maternity care, for assessment of gestational age and/or the assessment of health or otherwise of the foetus, is not covered by the Medisec Policy.

Cover is in place for GP involvement in Combined Care Schemes provided that:

(i) The antenatal and postnatal care provided is under 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.

COMPLAINTS POLICY

We appreciate that practices are committed to providing high quality care to patients and endeavour to ensure that these services are delivered with dignity and respect. However, as with any service, and as we see on a daily basis, you will not always get things right. We are all human and will make mistakes. Misunderstandings arise, or we may fail to provide what was promised by us.

By introducing a complaints policy we believe that in the majority of cases, complaints can be resolved swiftly and efficiently to everyone's satisfaction and a simple apology or explanation will usually suffice. Failure to listen or deal with dissatisfaction can lead to an escalation of the complaint to regulatory bodies such as the Medical Council and cause considerably more stress for those involved.

A Practice Complaints Policy template can be obtained from Medisec.

TEST RESULTS PROTOCOL

The risk of your practice's exposure to a complaint or claim in relation to systems errors can be reduced by implementing or reviewing your protocols surrounding ordering, receiving and informing a patient of their test results and, where appropriate, arranging follow-up tests or referrals.

WHAT TO DO IF A PARENT REFUSES A VACCINATION FOR A CHILD

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 (if available from the local immunisation office). 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.

You should enter a warning note on the front of the relevant patient's chart to alert your practice colleagues, who may treat the patient in the future, that they have not been immunised. This is to ensure proper continuity of care going forward, as a childhood illness might be more serious in a non-vaccinated child and it could be argued that there is a duty of care on you to highlight this fact.

THE CHILDREN FIRST ACT 2015

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

HOW THE IMPENDING CHILDREN FIRST ACT 2015 WILL IMPACT GENERAL PRACTICE, AND WHAT YOU CAN DO TO PREPARE FOR THESE CHANGES.

The Children First Act 2015 was introduced by the Minister for Children and Youth Affairs as part of a programme for change which involved a suite of child protection legislation to include the **National Vetting Bureau (Children and Vulnerable Persons) Act, 2012** and the Criminal Justice (Withholding of Information on **Offences against Children and Vulnerable Persons) Act 2012**. Together this legislation is intended to copper fasten the State's commitment to the protection of children.

The purpose of the bill was to put parts of the **Children First: National Guidance for the Protection and Welfare of Children (2011)** on a legislative footing and the new legislation will operate in tandem with those guidelines. Importantly, the existing 2011 Guidelines are being revised and updated to reflect the new legislative obligations and processes and to provide clarity and ensure consistency between them.

At present, only a small number of the Act's sections have been commenced, including section 28 which deals with the abolition of the Defence of Reasonable Chastisement detailed below. However, the parts of the act most relevant to GPs are unlikely to commence until the guidelines are fully updated and we at Medisec will inform you as soon as this happens.

The key child protection measures in the Act are:

- A requirement for mandated persons (including GPs) to report child protection concerns to the Child and Family Agency/Tusla.
- A requirement for mandated persons to assist Tusla with their investigations, if requested.
- A requirement for organisations providing services to children (including GP practices) to carry out a risk assessment and to formulate a Child Safeguarding Statement (see below).
- Children First Interdepartmental Group put on a statutory footing.
- The abolition of the Defence of Reasonable Chastisement.

ABOLITION OF THE DEFENCE OF REASONABLE CHASTISEMENT

The Act amends the Non-Fatal Offences Against the Person Act 1997 by abolishing the Common law defence of reasonable chastisement, which was the last remaining defence to slapping a child. This was previously abolished with regard to schools but had not been extended to parents until now. It raises children's rights to equal protection under the law as adults.

MANDATORY REPORTING

The Act provides for mandatory reporting of child protection concerns to Tusla for 28 designated categories of persons who are deemed to be Mandated Persons. This includes medical practitioners, nurses, physiotherapists, social workers and teachers. The focus is on individuals who routinely deal with children, and where their training, qualifications and professional experience make them well equipped to recognise risks to children, resulting in improved quality and consistency of reports received by Tusla.

Reporting:

- A mandated person (MP) must report past harm, present harm or risk of harm to children as soon as possible to Tusla.
- Harm means assault, ill-treatment, sexual abuse or neglect of a child in a manner that seriously affects or is likely to seriously affect the child's health, development or welfare.
- A report may be based on knowledge, belief or reasonable grounds for suspicion.
- Applies only to information received by a MP in the course of their employment.
- The information may have been received as a result of disclosure by a child.
- The Act is retrospective as to harm but prospective as to when the information was received.

- Reports are made to 'authorised persons' within Tusla; who are designated officers within the meaning of the Protection for Persons Reporting Child Abuse Act 1998.
- Reports should be made on the prescribed form – (These are being updated at present).
- In cases of emergency, reports can be made without a form but a form must be completed within three days of making the report.
- Reports can be made jointly with another person.
- While we await the specific guidelines, it is anticipated that best practice continues to be that a GP informs parents of the intended reporting in advance, unless this could result in further harm to the child.

Exceptions:

- **Section 14(3) of The Children First Act 2015** provides for exceptions relating to sexual activity of older teenagers. Reporting is not required where a child is sexually active between the ages of 15 and 17 and the other party is no more than 2 years older than them and where the mandatory person believes that there is no material difference in capacity or maturity between the parties and the sexual activity is not intimidatory or exploitative of either party. To allow you to make an honest clinical assessment, this will necessitate a thorough consultation with the minor patient. We will need to await the guidelines but it would appear from the Act if you are faced with a sexually active 14 year old seeking contraception, you have an obligation to report. This provides a helpful legislative position in what is a difficult yet common scenario in general practice involving minors seeking contraceptive advice and treatment. A motivating factor for this section is to ensure that children are not deterred from going to GPs and pregnancy services for advice because of a fear of being reported.
- Reporting is not required regarding second-hand information received from another MP who has already made a report. It remains to be seen if the guidelines will address whether a verbal confirmation or otherwise from another MP (such as from another GP in a practice) that a report has been made will suffice.

Sanctions:

- There are no sanctions for MPs who fail to report, however, **medical practitioners should be aware that a failure to report could give rise to employment disciplinary sanctions or complaints to and initiation of Fitness to Practice procedures by the Medical Council**. It is therefore imperative that you act in full compliance with the Act and Guidelines when introduced. If uncertain, you can seek guidance from Medisec.
- Any MP making a report will receive an acknowledgement from Tusla noting the date of the report. You shoud retain this as proof of a report made.

Post Report Obligations:

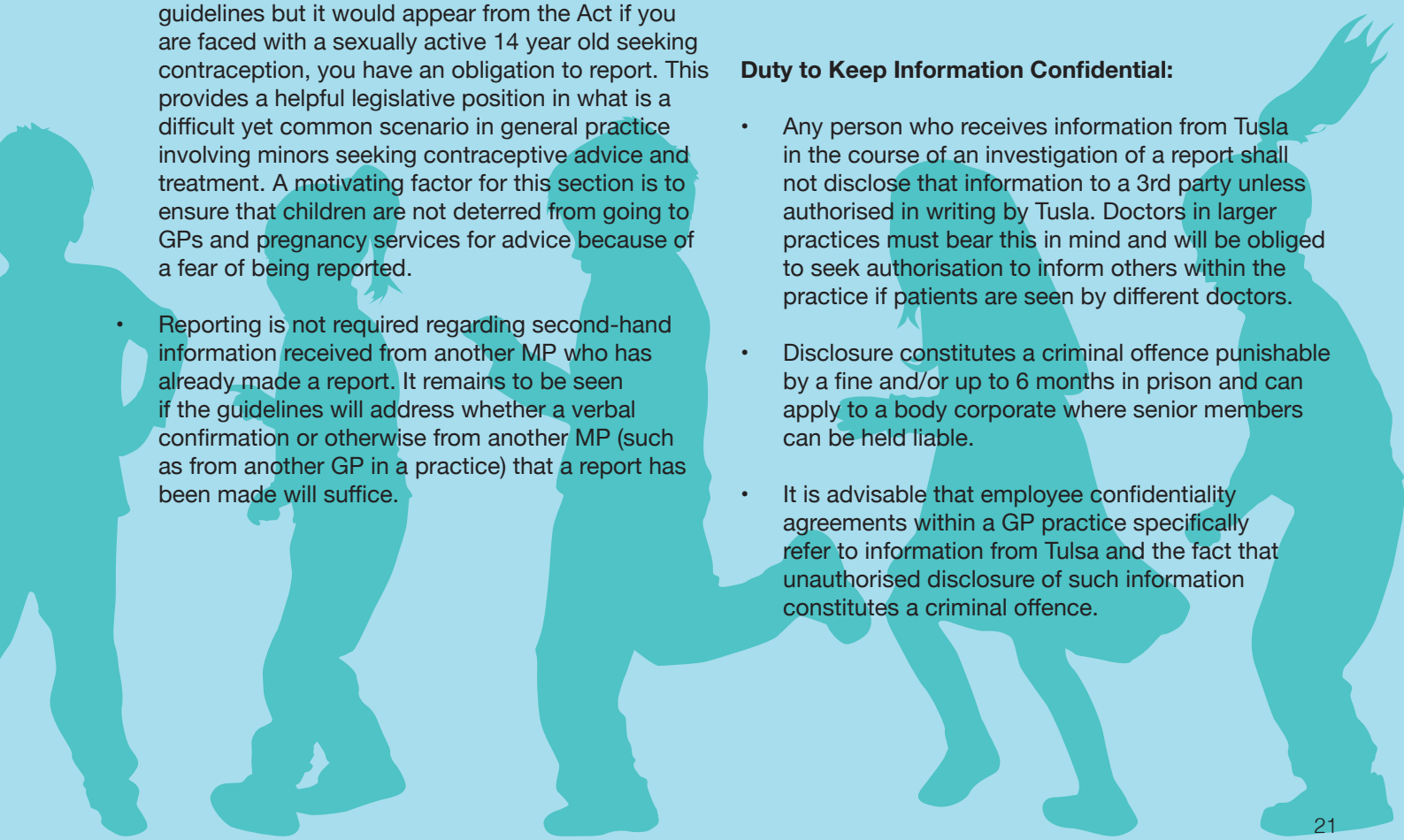
- MPs must assist Tusla promptly with investigations, if requested. This may involve providing information, reports, documents or attendance at meetings. This may give rise to legitimate concerns about further demands on your limited time and resources and it will be important to monitor the manner in which this part of the Act is operated.

Protection to MPs

- MPs cannot be sued on the basis of information given to Tusla upon request and it cannot be used in evidence against them in civil or criminal proceedings.

Duty to Keep Information Confidential:

- Any person who receives information from Tusla in the course of an investigation of a report shall not disclose that information to a 3rd party unless authorised in writing by Tusla. Doctors in larger practices must bear this in mind and will be obliged to seek authorisation to inform others within the practice if patients are seen by different doctors.
- Disclosure constitutes a criminal offence punishable by a fine and/or up to 6 months in prison and can apply to a body corporate where senior members can be held liable.
- It is advisable that employee confidentiality agreements within a GP practice specifically refer to information from Tulsa and the fact that unauthorised disclosure of such information constitutes a criminal offence.



OBLIGATIONS ON ORGANISATIONS:

A **GP practice, as a designated "organisation" providing "relevant health services"** to children and young people will be required to:

- Undertake an **assessment of any risks** to a child while the child is availing of its services.
- Use this as the basis for developing a Child Safeguarding Statement (CSS) which will outline the policies and procedures in place to manage the risk of harm to children whilst they are availing of the organisation's services.
- Appoint a relevant person to be the first point of contact in respect of the organisation's CSS.
- Review the CSS every 24 months, or after any material change in what it relates to.

Other existing statutory obligations relevant to the protection of children, such as the requirement to obtain Garda vetting of staff engaged in activities related to children, will continue in parallel.

Organisations will have three months after the relevant sections of the Act are commenced to comply with the obligations. The Act provides that the Child Safeguarding Statements (CSS) must be in accordance with guidelines issued by the Minister and Tusla. As already mentioned, these guidelines are being updated and will likely include guidance regarding the form and content of Child Safeguarding Statements (CSS). Once the relevant guidelines are implemented, Medisec will give you more advice around drafting child safety statements and other practical steps to help you comply with the legislation. If you have any queries about the impact of the legislation on your practice, please contact Medisec.

At the moment, we know that Child Safeguarding Statements (CSS) must assess the risk and specify the procedures in place for:

- Managing identified risks
- Dealing with allegations against staff
- Recruitment of suitable staff
- Reporting welfare and abuse concerns to Tusla
- Providing child protection information, instruction and training to staff
- Listing mandated persons within the practice
- Appointment of a relevant person

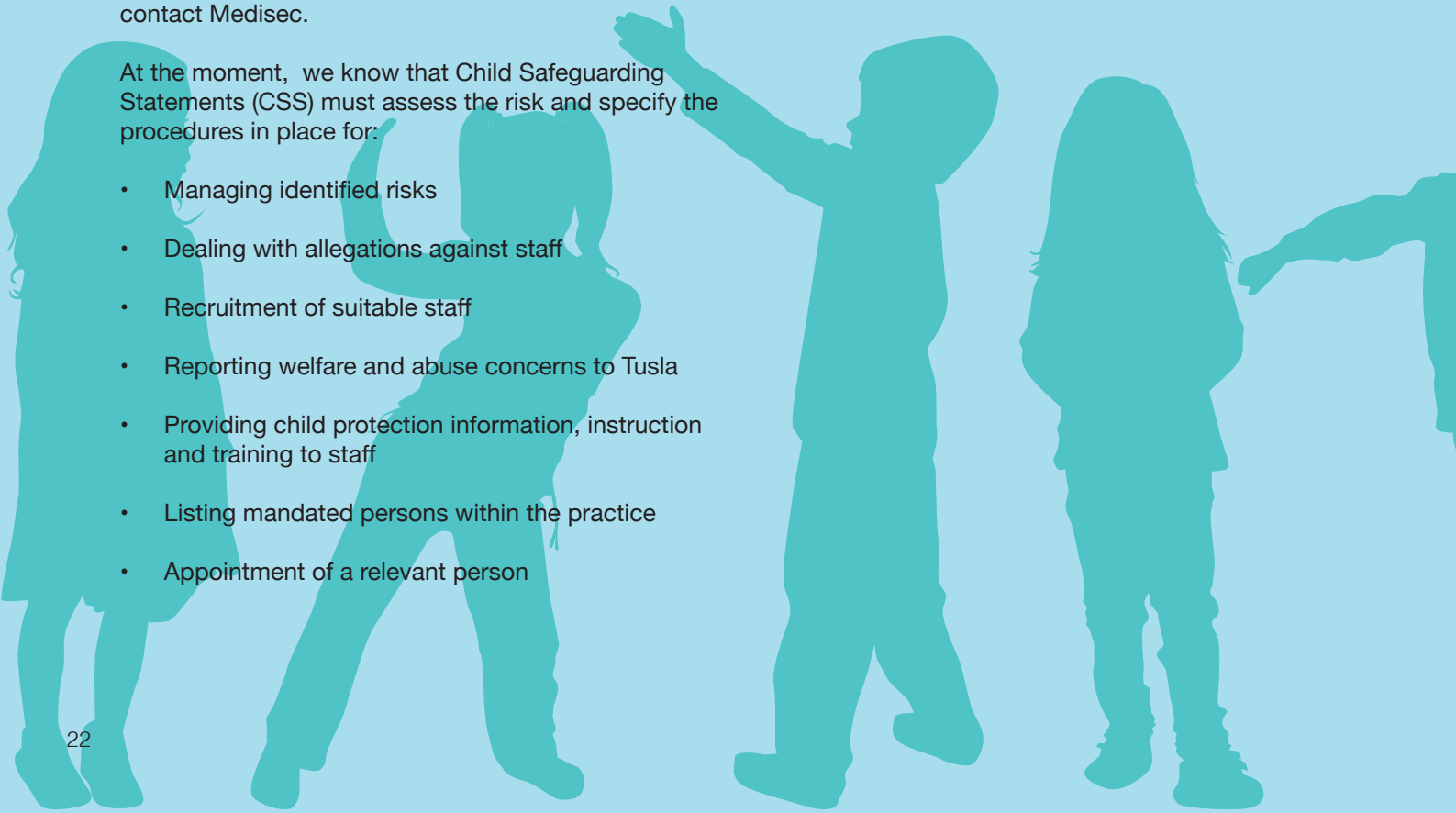
The CSS must be provided to staff and must be given to parents, members of the public and Tusla if requested. The Act establishes a Register of Non Compliance for organisations which fail to provide Tusla with a Child Safeguarding Statement (CSS) when requested and this register will be open for public inspection.

TO CONCLUDE:

While the true impact of this Act will, to a large extent, depend on the quality of resources provided in response to reports made to Tusla, the provisions of the Act provide a clear and public statement; that child abuse is something that society will no longer tolerate, and that people who work with children know they have a voice.

In the words of Kofi Anan:
"There is no trust more sacred than the one the world holds with children. There is no duty more important than ensuring that their rights are respected, that their welfare is protected, that their lives are free from fear and want and that they can grow up in peace."

For now, medical practitioners should be aware that The Children First Act 2015 is being implemented, all be it on a piecemeal basis, and that as a result there will be fundamental changes in the law concerning the protection and welfare of children. This will impact on General Practice, and Medisec will work with you to prepare for these changes.



MATERNITY LEAVE AND YOUR COVER

HOW TO SUSPEND YOUR POLICY AND WHEN TO RESUME IT.

As you may be aware, one of the benefits of being a Medisec member is your entitlement to suspend your policy during your maternity leave. The Period of Insurance can be extended, free of charge, for up to 52 weeks. All you have to do is request an extension in writing before using this benefit and again inform us in writing before you intend to return to practice.

During the period of maternity leave, you are not allowed to practice medicine and so you will not be insured for claims and/or incidents occurring during the Maternity Leave. You will, however, have Good Samaritan coverage for bona fide medical emergencies.

We have received a number of calls from members asking if it is possible to return to work for one day only, for example to cover a locum or a colleague who needs last minute cover. Allianz plc, our Underwriters, have confirmed that if you decide to return to work, even for one day, then cover must be re-instated and they are not in a position to make any exceptions.

If a claim is made against you while you are on maternity leave, for an event that took place before you went on maternity leave, you will of course be covered.

If you have any more queries about maternity leave and your cover, please get in touch with on one of our Membership Team, Antonella or Barbara or email us at info@medisec.ie

SPONSORSHIP

IRISH MEDICAL FOOTBALL TEAM

Medisec is pleased to be a sponsor of the **Irish Medical football team.** The team was founded in 2014 and first competed at the 21st annual World Medical Football Championships. Taking place in LA last year, the team finished a very respectable 7th, out of 18. Two of the team also presented at the Global Congress on Health and Medicine in Sport, which runs alongside the tournament.

The team is made up of 25 doctors from various specialties and grades and some of our Medisec members are star players! The team's mission off the pitch is to promote the benefits of physical activity on both physical and mental health, in conjunction with our charity partner Pieta House. Last year the team helped to promote the Darkness Into Light run, holding fundraisers throughout various hospitals to raise some much-needed funds for Pieta House.

WE WISH THE TEAM SUCCESS IN THE 22ND ANNUAL WORLD MEDICAL FOOTBALL CHAMPIONSHIPS, IN BARCELONA THIS JULY.

MUSIC IN MEDCICINE

We are also proud to have sponsored a **'Music in Medicine'** concert held in St Ann's Church on Dawson Street on April 14.

It was a charity event held in aid of the Irish Stroke Foundation,to highlight the benefits of music in medicine for both doctors and patients. A large number of medics took part and also performing was the 'Music Matters' choir, who run community inclusive choir groups, including people with memory problems and intellectual disabilities.

At Medisec, we welcome and support the principles of Open Disclosure, and encourage our members to engage with patients in an open, honest and transparent manner when things go wrong. So we are delighted to have Angela Tysall, Lead for Open Disclosure: HSE Quality Improvement Division, sharing her experience with us.

OPEN DISCLOSURE IN GENERAL PRACTICE

COMMUNICATING OPENLY AND TRANSPARENTLY WITH PATIENTS FOLLOWING ADVERSE EVENTS

Angela Tysall

WHAT IS OPEN DISCLOSURE?

"An open, consistent approach to communicating with patients when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event."

Open disclosure is also referred to as "open communication".

(Australian Commission on Safety and Quality in Health Care)

THE BACKGROUND

On the 12th November 2013, Dr James Reilly, Minister for Health at that time, launched a national policy, national guidelines and associated documents on Open Disclosure. The policy and guidelines were developed by the HSE and the State Claims Agency, based on best practice globally and also on learnings from a two-year pilot programme in two acute hospitals here in Ireland: the Mater Misericordiae University Hospital, Dublin and Cork University Hospital.

Medical Council standards in the 2009 Guide To Professional Conduct And Ethics state that:

"Patients and their families are entitled to honest, open and prompt communication about adverse events that may have caused them harm. You (the medical professional) should acknowledge that an event happened, explain how it happened, apologise if appropriate, and give an assurance as to how lessons have been learned to minimise the chance of this event happening again in the future."

Disclosure of harmful medical errors to patients has emerged as a professional and regulatory standard across medical specialties. The HIQA Standards for Safer Better Healthcare 2012 require that:

"Service providers should fully and openly inform and support service users as soon as possible after an adverse event affecting them has occurred or becomes known and continue to provide information and support as needed".

THE PRINCIPLES OF OPEN DISCLOSURE

The principles of open disclosure include:

- A timely acknowledgement to the patient/support person about what happened and what impact it had on the patient, physically, emotionally and socially.
- An apology or expression of regret, which includes the phrase 'I am sorry' or 'we are sorry'.
- A factual explanation of what happened – without speculation or conjecture.
- Providing an opportunity for the patient and their support persons to relate their experience/story.
- A discussion of the potential consequences of the adverse event.
- An explanation of the steps being taken to manage the adverse event and to minimise the likelihood of a recurrence of such an event.

- Keeping the patient and their nominated support person(s) informed and involved in the review, learning and quality improvement process.

- Providing ongoing practical support for patients to manage the effects of harm and agreeing on matters regarding their ongoing care and treatment.

The Open Disclosure Programme in Ireland also emphasises the principle of staff support. Modern health care is complex, delivered in high-pressure environments and often involves multiple practitioners working in teams and across organisations. Excellent outcomes are most often the result but sometimes, despite our best efforts, things can go wrong and staff may experience varying levels of traumatic stress following an adverse event. It is important that, while the care of the patient involved is paramount, organisations provide ongoing support for the staff involved in the event and also for staff not involved but who are also affected by the event.

Think about your GP Practice
How do you support and monitor colleagues involved in and affected by an adverse event?

The importance of Open Disclosure for patients and their families has been regularly highlighted by both the media here in Ireland and internationally over the past 3-4 years. In particular the impact of non-disclosure, often referred to as "the second harm" inflicted on our patients by our failure to communicate with them in an open, honest and transparent manner following an adverse event.

Open Disclosure is reasonably expected by patients and their families. Positive benefits include the maintenance of the patient's confidence in the health care provider, prevention of misconceptions about what caused their adverse event, facilitation and partnership in decision making about future care, and assisting in the emotional recovery of the patient.

Aside from the fact that you have a professional and regulatory obligation to engage in Open Disclosure, it is important to emphasise that Open Disclosure should be motivated by an ethical, humane and patient-centred response which addresses the fundamental human needs and rights of patients to be treated with dignity and respect.

Professor Lucian Leape of Harvard University talks about the "Golden Rule" explaining that we should not deliver any less to our patients than we would expect for ourselves or for a loved one. It is as simple as that.

OPEN DISCLOSURE AND COMPLAINTS

Open Disclosure is a key component in the management of complaints and in bringing the complaint to a satisfactory resolution.

An early expression of regret or apology can minimise the possibility of a verbal complaint becoming a formal written complaint or the further escalation of a formal written complaint to independent review, the Ombudsman or the litigation process. If, following the investigation of the complaint, the service is found to be at fault, it is important to openly acknowledge this to the complainant, provide a factual explanation, apologise for the identified failure(s) in care/error and for the harm, distress and disappointment caused to the complainant as a result of this. It is also important to provide reassurance in relation to ongoing care and treatment and also in relation to the steps being taken by the service to manage the issues raised and to try to prevent a recurrence of these issues.

OPEN DISCLOSURE AND LITIGATION

Several studies in the United States have demonstrated a reduction in litigation following the adoption of an Open Disclosure policy. In 2002, the University of Michigan Healthcare System adopted an Open Disclosure policy and found on an examination of their incidents between 2001 and 2007 that the ratio of litigated cases reduced from 65% to 27% during that time and that their average litigation costs more than halved. A more recent study in Chicago, Illinois revealed comparable data. The impact of Open Disclosure on litigation here in Ireland has not yet been assessed.

OPEN DISCLOSURE LEGISLATION

The principal obstacle to Open Disclosure in Ireland is the absence of legal protection for participants. The Government gave its approval on 3rd November, 2015 to the drafting of provisions to support Open Disclosure of patient safety incidents.
Provisions to support voluntary Open Disclosure had originally been included in the planned Health Information and Patient Safety Bill, but will now be included in the Department of Justice and Equality's draft Bill on Periodic Payment Orders to facilitate earlier enactment. The legislation is part of a broader package of reforms aimed at improving the experience of those who are affected by adverse events.

MAKING OPEN DISCLOSURE WORK

Evidence from other countries has demonstrated that there are many essential components required to implement an Open Disclosure policy effectively within healthcare settings. In his review of international success stories in 2013, key conclusions drawn by Professor John Wakefield, Chair of the Australian National Open Disclosure Pilot Committee**,** are as follows:

- Frontline clinicians must have an understanding of those clinical adverse events that require reporting and Open Disclosure.
- There must be a general awareness and understanding among clinicians of the approach required in relation to Open Disclosure discussions and the importance of providing information on any significant matters relating to the event, the consideration of risk management and the need to provide an apology.
- Clinicians must feel safe to report and at the same time have a willingness to seek advice and to be advised.
- Clinicians need appropriate resources to tap into, by way of support.
- An apology is wasted if a clinician has no sense that there is a problem or that an adverse event has occurred.
- Training and support for staff is required and should be ongoing.
- The impact of adverse events on clinicians should be recognised, with adequate support provided and an awareness that not all clinicians may be able to engage in Open Disclosure discussions as a result of personal trauma following the event.
- Open Disclosure must be considered as a responsibility of the organisation and not just the staff involved. A multidisciplinary response to adverse events is a more supported approach and should include engagement from management, clinicians and quality and risk management staff.
- Adequate preparation for Open Disclosure discussions with service users and their families is critical.

IN CONCLUSION

Open Disclosure is now recognised as a practice that benefits patients, their families, staff and organisations. The Open Disclosure process is an integral part of incident management, patient safety and quality improvement programmes.

The established therapeutic relationship between you and your patients provides an advantage for communicating openly and transparently when things go wrong or do not go to plan and an apology or expression of regret from you to your patient can assist with their acceptance of the event and bring great comfort and healing.

HAVE YOU BEEN AFFECTED BY AN ADVERSE EVENT?

Medisec's team of medico-legal advisers are available 24/7 to guide, direct and support you in relation to any adverse event that may occur in your practice. Support is also available from the ICGP. Visit www.icgp.ie/DoctorsHealth for more details.

Further resources are available on: www.hse.ie/opendisclosure

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RED ALERT
BEWARE PSA!

A patient noted during a hospital admission to have an elevated or abnormal blood result is a common difficulty. This may be indicated on the hospital discharge summary with instructions for the GP to 'follow up'.

When initiated by the hospital, this information can be easily missed or not highlighted, and the discharge summary with the relevant information inadvertently scanned into the patient's file without further action.

Even if the patient has been informed, they may not fully comprehend the relevance or importance of such follow up. Consider tasking your administration staff or practice nurse to come up with a good protocol or management plan for these cases. If your software system won't allow it, or is too complicated, do not underestimate the power of a diary or notebook to alert the practice nurse of an overdue test or recall.

Marginally elevated PSA levels are a common bugbear, but nevertheless must be followed up in a timely manner to avoid missing a significant prostate cancer. Sadly this has come to our attention on more than one occasion.

EMPLOYER REQUESTED **REPORTS**

BEST PRACTICE, PROCEDURE AND FREQUENTLY ASKED QUESTIONS

Deirdre Malone,
Comyn Kelleher Tobin
Medisec Panel Solicitors

With a high duty of care owed by employers to their employees, employer companies regularly engage doctors to assess and report on their employees. The employer pays the doctor for the assessment and report, but questions often arise surrounding the employee patient's entitlement to review the prepared report. We regularly encounter doctors who are also privately employed as the patient's own GP.

To assist you, here are some of the most frequently asked questions about employer requested reports. The following underlying basic principles will also apply:

CONSENT

Before carrying out an assessment on a patient for any purpose whatsoever at the request of a third party, it is imperative that a doctor obtains consent, both to the assessment, and to treatment, if applicable. Furthermore, it must be made clear to the patient that the information obtained by the doctor during the consultation will be provided to a third party. It is not a confidential consultation.

Best practice is to obtain a written consent from the individual attending. A consent form can take the following form:

"Your employer has asked me to review you today to see if you are fit to return to work or I have been asked by the solicitors acting on behalf of X company to prepare a report as part of their defence to your case against X.

I will send a report of my findings to (the HR Manager or the solicitors) at the end of this consultation. I will only include information that is relevant to the assessment. I will discuss my findings with you so that you will know what I will say in my report and you can ask me any questions that you may have about my diagnosis."

THE RULE OF THUMB

Any private patient is entitled to write a letter to a doctor to seek a copy of personal information held about them. Personal information includes all records, blood tests, or letters received from hospitals or consultants specifically identifying the patient.

Once a request (generally called a data access request) is received, a doctor is required to:

1. Give the patient a copy of every document (manual or electronic) held by the practice.
2. Provide the documents within 40 days.
3. Charge no more than €6.35 to prepare a copy of the documents.
4. Redact any information relating to identifiable third parties.
5. If any psychiatric reports are held, the consent of the relevant Consultant Psychiatrist should be sought before releasing them.
6. If any other consultant reports (non-psychiatric) are held on the patient's file, out of courtesy and as a matter of best practice, the GP should advise the relevant consultant that the reports are being released.

When a doctor agrees to carry out an assessment of a patient on behalf of an employer client, as a matter of best practice, the doctor should inform the employer in advance that they may have to provide copy of the report to the patient, pursuant to Data Protection legislation requirements.

WHAT TO INCLUDE IN THE REPORT?

The Guidance on Ethical Practice for Occupational Physicians - a report from the Faculty of Occupational Medicine at the RCPI - reminds doctors of the requirement to confine the report and advice to the purpose of the report.

If a doctor obtains consent to provide a third party with a report regarding a patient, such consent is limited to the scope of the assessment and review.

FREQUENTLY ASKED QUESTIONS

All the queries that we have received relate to company nominated doctors and requests for reports received from companies and employers looking for information on situations including:

- Fitness to work assessment (following absence due to illness/injury).
- Workplace adjustments (shorter hours and different roles).
- Injuries sustained at work.

Q. If a doctor is asked by an employer client to review an employee who has been injured at work, is the patient entitled to a copy of the report under any circumstances?

At the time of an accident/incident:

A-1. If the examination and assessment takes place on the day (or days) following the accident, the employee is likely to be entitled to see a copy of the report. In the normal course of events, the doctor should explain to the patient:

- The purpose of the assessment.
- The diagnosis.
- What will be included in the report.
- What follow up or further treatment is required.

Court proceedings are expected (contemplation of litigation):

A-2. If the employer is aware that the employee intends to issue proceedings specifically arising from a work-related injury, it is arguable that the employer may claim legal professional privilege over that report. To satisfy the requirement of "contemplation of litigation", it is likely that the employer will need to be in receipt of an initiating letter from the employee's solicitors. In this scenario, the employee is not entitled to a copy of the report.

For completeness, if the case is a High Court case, it is highly likely that the report will be provided to the employee or their representatives at some stage, as part of the rules of disclosure. Every report should be prepared on the basis that the employee patient will see the report at some point in the future.

Q. If the employee is also a patient of the practice, are they automatically entitled to a copy of the report?

A. No, the employee is not automatically entitled to a copy of the report simply because they are also a patient of the doctor. Different circumstances give rise to different answers.

- If the employee is a patient and the purpose of the report was to assess fitness to return to the workplace following a period of absence, they are entitled to a copy of the report. In the first instance, the employee should be advised to request a copy of the report from their employer.
- If the employee has sued their employer and proceedings are in existence, and the report is prepared at the request of solicitors or the employer for the purpose of defending the litigation, the employee/patient is not entitled to a copy of the report.
- In the usual course of events, a patient is entitled to a copy of a report if they request a copy under the data protection legislation (this is for private patients only). The Freedom of Information Act applies for public/GMS patients.

There are exceptions to the rule permitting a patient to have access to a copy of the medical records/reports. This includes where it may cause undue harm, to the physical or mental health of the patient.

Note: It is not necessary to obtain the employer's consent to the release of the record pursuant to a data access request if litigation is not in existence against the employer.

Q. What instructions should a doctor seek before carrying out an examination on a patient for a third party?

A. Before agreeing to assess any patient, a doctor should ensure that they are not conflicted. Basic information to be sought includes:

- The patient's name and address.
- The patient's date of birth.
- The purpose of the visit.
- Any other relevant information.

Any other relevant information includes whether the doctor is required to assess the patient as fit to work or, whether a report is required on liability and causation, or condition and prognosis for the defence of litigation. In general this information will come from the employer's solicitors if it relates to litigation.

Q. What happens if a doctor is preparing a report for the purpose of defending litigation and, in the assessment of the patient, identifies a health problem?

A. At all times, a doctor is obliged to act in the best interest of the patient, irrespective of who has engaged the doctor to carry out the review and assessment.

It is imperative that if a doctor identifies a problem requiring further assessment, the patient is notified of any follow up treatment required, and a referral to their own doctor or another specialist (if appropriate) is given.

CONCLUSION

As a general rule, any report prepared by a doctor is likely to eventually be seen by the patient. Reports should always be prepared carefully and accurately to ensure that they comply with the doctor's duty to act in the best interest of their patient.

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.

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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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