MEDISEC ON CALL

Winter 2014

Around the clock support for the Irish GP community

MEDISEC IRELAND

MEDISEC ON CALL

winter issue 2014

It is my pleasure to welcome you to the Winter edition of our bi-annual newsletter.

We appreciate the many challenges you, our members, are facing on a daily basis with increased regulation, stress from rising claims and complaints, not to mind the financial pressures due to cutbacks. Against this background, we are continually impressed and reassured by the commitment shown by GPs to provide optimum care and empathy to patients in difficult and often trying circumstances. We would like to reassure you that our team is available on a 24/7 basis to provide support and advice to you and to try to alleviate some of your pressures. No query is too small, so please do feel free to contact us on any matter over the coming year.

I would like to remind you that Medisec is wholly owned by each one of you, our GP members. As CEO, I can assure you that as a not for profit company, our primary focus is to protect your interests and to provide you with the most competitively sourced medical indemnity insurance, proactive claims, complaints and disciplinary assistance and support, round-the-clock advice along with risk and best practice guidelines.

I would like to end by taking this opportunity to wish you all a very happy and peaceful Christmas on behalf of everyone at Medisec.

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RETENTION OF MEDICAL RECORDS

As medical practices store medical records in computer case management systems which do not give rise to storage implications, it is recommended such medical records are kept indefinitely. In the case of physical records, e.g. kardex or other manual records, we suggest to follow the recommendation of the Medical Council that the retention and eventual disposal of medical records should be in accordance with the guidelines provided in the National Hospitals Office (NHO) Code of Practice for Healthcare Records Management published in 2007 – as outlined in the table opposite.

Medical records should be kept in a secure, physically safe environment protected from fire, flood or pests. Appropriate security measures should be in place to prevent access by unauthorised personnel, especially if notes are stored off site.

TYPE OF PATIENT RECORD	RETENTION PERIOD
Adult/General	8 years after last contact.
Deceased patients	8 years after date of death.
Children and young people	Retain until the patient's 25th birthday or 26th if young person was 17 at the conclusion of treatment, or eight years after death. If the illness or death had potential relevance to adult conditions or genetic implications, specific advice should be sought as to whether to retain the records for a longer period.
Maternity (all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child.
Mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001)	20 years after the date of last contact between the patient and the doctor, or eight years after the death of the patient if sooner.
Patients included in clinical trials	20 years.
Suicide - notes of patients having committed suicide	10 years.
Cause of Death Certificate Counterfoils	2 years.
Records/documents related to any litigation	NHO recommend that the records are reviewed 10 years after the file is closed. Note however, if the litigation is related to a child, this should not be used to lessen the retention period set out above.

Medisec is delighted to announce its sponsorship of an exciting project in partnership with UL hospitals. The project forms an important part of our ongoing support of General Practitioners in getting to grips with the management of risk in the practice of medicine. It is widely recognised that one of the biggest risks to patient safety occurs when the patient passes across the "boundaries" of care, for instance, when they move between primary and secondary care. The Report of the Commission on Patient Safety and Quality Assurance attributed failures in patient safety of this kind to:

"Failures in communication, lack of protocols for care handover, differing systems of care provision between providers, and lack of clarity about where responsibility and accountability for patient care lies in such situations"

Patients and families have high expectations of GPs. It is important that GPs are 'on high alert' in relation to these boundaries of care particularly in light of the constant and relentless pressure on practices. Good systems and processes need to be in place to provide assurance to patients. We are aware of course that this is not simple and that there are many people who have a role to play, including the patient. This project aims to have clinicians from primary and secondary care working together to identify risk and in turn, seek to reduce it.

Prior to embarking on the project, Medisec consulted widely with relevant stakeholders, including the SCA, the Medical Council, ICGP, HIQA, the Quality and Patient Safety Unit at the HSE, The Institute of Pharmacy, the Graduate School of Medicine at UL and patients groups, to identify what actions might be useful to help reduce risk at these patient interchanges. We have representatives of all the aforementioned bodies on our Steering Group and are most grateful to them for giving us their time and very considerable expertise.

"The main aim of this project is to determine the key areas of risk to patients at the points of a patient's admission to and discharge from hospital"

The main aim of this project is to determine the key areas of risk to patients at the points of a patient's admission to and discharge from hospital. In addition we have the following objectives:

- To investigate the experiences of clinical incidents in the healthcare settings from the perspectives of both healthcare professionals and patients, and determine key strategies for improving healthcare services and transitions.
- To explore feasible options through a collaboration with Primary Care and the Acute Hospital.
- To provide information for GPs and their insurers that will faciltiate improvements in the quality of care in addition to reducing the number of clinical incident claims.
- To identify the main contributory factors associated with non-reconciliation of medication.
- To inform future education programmes / interventions / CPD modules that are aimed at instructing GPs and other healthcare professionals on risk management strategies when patients pass across the 'boundaries' of care.

In order to ensure we are hearing the real issues our study will involve those healthcare professionals closest to the point of care of the patient. Healthcare professionals from secondary care will include hospital consultants, registrars, interns, nursing staff and administration staff. In the community we will concentrate on Pharmacists and GP Practices. The leadership shown to date by GPs, Hospital Consultants and Pharmacists consulted augurs well for the success of the project.

The study will involve semi-structured interviews and focus groups. Interviews will be conducted by co-investigators Mary Culliton, an experienced healthcare professional, and Dorothy Leahy, an experienced researcher from the Department of General Practice at the Post Graduate Medical School at UL. The semi-structured interviews will include 5 broad areas (e.g. demographic and descriptive data, current risk management practices, experiences of previous complaints / clinical incidents, perceived challenges in their current position and attitudes towards risk reducing initiatives.

A focus group will also be conducted with patients from primary and secondary care to investigate their previous experiences with the healthcare services.

The outputs from the project will hopefully include:

- A comprehensive account of the current understanding of safety priorities among healthcare professionals in addition to the identification of the key risk areas at the points of admission to and discharge from hospital.
- Policy development: by making an important contribution to health policy and increasing knowledge with regard to risk management at the interface between primary and secondary care.

We are most grateful to all our collaborators on this project and to the members of the Steering Group who have already contributed to its development. The leadership already shown by GPs, hospital doctors and pharmacists to inform the project augers well for its success. We look forward with great interest to sharing the outcomes in 2015 as part of our drive to assist our members provide safe healthcare to their patients.

DIFFICULT DECISIONS
INVOLVING MINORS AND YOUNG ADULTS

Patrice O'Keeffe ,
Partner, Comyn Kelleher Tobin , Panel Solicitor

Doctors can often be faced with dilemmas when called upon to treat minors in challenging circumstances. The purpose of this article is to set out some broad basic principles. In addition, by way of a case study, we have focused on one such example – a 15 year old girl who seeks contraception without parental consent.

AGE OF CONSENT (16 YEARS +)

A person over the age of 16 years can give consent to surgical, medical or dental treatment and it is not necessary to seek consent from the parents. This also covers any procedure undertaken for the purposes of diagnosis and any procedure ancillary to treatment such as anaesthesia. A 16 or 17 year old can give their own consent to surgical, medical and dental treatment as if they were an adult.

No different to adult consent, a doctor should establish that the 16 or 17 year old person understands the healthcare decision and its consequences.

AGE OF CONSENT (15 YEAR OLD)

In general, parental consent is required to assess and treat a 15 year old. In effect, the presumption is that anyone under the age of 16 will not be competent to consent.

In exceptional circumstances, a 15 year old patient may be able to give their consent or refusal, based on an assessment of their maturity. The critical consideration is whether the treatment is in the child's best interests. The HSE's National Consent Policy states:

"Firstly, you should try to encourage and advise the young person to involve their parent. In exceptional circumstances, where you consider that the service is in the best interests of the minor, you may provide the service if you are satisfied that the minor has sufficient maturity to make an informed decision; the minor's views are stable and a true reflection of their beliefs taking into account their physical and mental health; the nature, purpose and usefulness of the intervention is in keeping with the minor's best interests; the benefits outweigh the risks of the proposed treatment; or you have met any legal requirements under child welfare and protection law or guidelines."

The obligation placed on a doctor under the Medical Council Guidelines provides similar guidelines:

"In exceptional circumstances, a patient under 16 might seek to make a healthcare decision on their own without the knowledge or consent of the parents. In such cases, you should encourage the patient to involve their parents in the decision, bearing in mind your paramount responsibility to act in the patient's best interests".

The Courts in Ireland have not yet shown any clear intention to follow the English "Gillick competence" position, which says a child could consent if he or she fully understood the medical treatment that is proposed:

"As a matter of Law the parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed."

PARENTS RIGHT TO KNOW?

In general, the duty of confidentiality to a patient also applies to children.

For patients age 16 to 18, in general, the duty of confidentiality should be respected but cannot be guaranteed. In exceptional limited circumstances, it might be necessary to breach confidentiality where the patient's health or life is seriously endangered.

For patients under 16, doctors are often faced with the dilemma of whether the child will be deterred from seeking healthcare services by a fear of disclosure to their parents. However, in medical ethics and law there are circumstances in which a breach of confidentiality may be justifiable where, for example, you reach the conclusion that disclosure to the parents is necessary to prevent harm to your patient or someone else. In those circumstances it is best practice to warn the patient that you intend to make such a disclosure.

CASE STUDY: SEXUALLY ACTIVE 15 YEAR OLD GIRL

When a doctor is asked to prescribe contraception to a 15 year old girl, who does not wish to inform her parents, best practice is to insert a detailed note on the patient's file following the consultation.

The Criminal Law (Sexual Offences) Act 2006 and the HSE Children First Guidelines, place an obligation on the heath care professional to rule out any possibility or suspicion that any aspect of sexual intercourse was abusive, exploitative, or non-consensual. Accordingly, doctors should be mindful of the risks involved in providing medical treatment to this age group and should therefore:

1. Document the result of an assessment:
   a. Is the doctor satisfied that the patient has a mature understanding?
   b. Is the doctor satisfied that the patient is at risk in the absence of the treatment?
   c. Is there any suspicion or evidence of abuse?
   d. Is there any suspicion or evidence of neglect?
   e. Any actions taken?

2. Document efforts to encourage the minor to involve his/her parent(s)/legal guardian(s).

3. Seriously consider the legal requirement to report sexual activity of a minor under 17 years to either the Gardaí or to the HSE under the Children First Guidelines. In relation to child sexual abuse, it should be noted that, for the purposes of the criminal law, the age of consent to sexual intercourse is 17 years for both boys and girls.

The HSE Children First Guidelines imposes obligations where a doctor might suspect a risk of neglect or abuse.

Neglect is defined "in terms of an omission, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, and/or medical care".

"4.9.3 While GPs have responsibilities to all their patients, their primary consideration should be the best interests of the child. Whenever a GP becomes concerned that a child may be at risk of, or the subject of, abuse of any kind, it is essential that these concerns are discussed with the HSE Children and Family Services without delay.

4.9.4 Where clinical uncertainty exists, GPs may need to discuss their concerns with other professionals who are experienced in working with child abuse cases. GPs should therefore be aware of how to contact the relevant personnel for expert medical advice. Where, following such discussion, a GP is satisfied that there are reasonable grounds for suspecting that a child is being, or has been, abused or neglected, he or she should immediately inform the HSE Children and Family Services in accordance with the standard reporting procedure …"

It is also instructive to look at the position for such contraception cases in England where what are known as the Fraser Guidelines were laid down by Lord Fraser in a House of Lords' case, and require the professional to be satisfied that:

- the young person will understand the professional's advice;
- the young person cannot be persuaded to inform their parents;
- the young person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment;
- unless the young person receives contraceptive treatment, their physical or mental health, or both, are likely to suffer;
- the young person's best interests require them to receive contraceptive advice or treatment with or without parental consent.

THE CHILDREN FIRST BILL 2014

Practitioners should be aware of the Children First Bill 2014, which will put elements of the Children First: National Guidance for the Protection and Welfare of Children (2011), on a statutory footing.

When implemented into law, the Bill will place a statutory obligation on certain professionals to, including Medical Practitioners, to report child protection concerns to the Child and Family Agency (Tusla).

Another proposed change is that a mandated person (such as a Medical Practitioner) shall not be required to make a report to the Child and Family Agency where 'a child aged 15 years or more but less than 17 years is engaged in sexual activity with a person who is not more than 2 years older than the child and where the mandated person knows or believes that there is no material difference in capacity or maturity between the two parties, and where the child has made known his or her view that a report should not be made to the Child and Family Agency and where the Medical Practitioner relies upon that view'.

The HSE Children First Guidelines are available on the website of the Department of Children and Youth Affairs website http://www.dcya.gov.ie/documents/Publications/ChildrenFirst.pdf

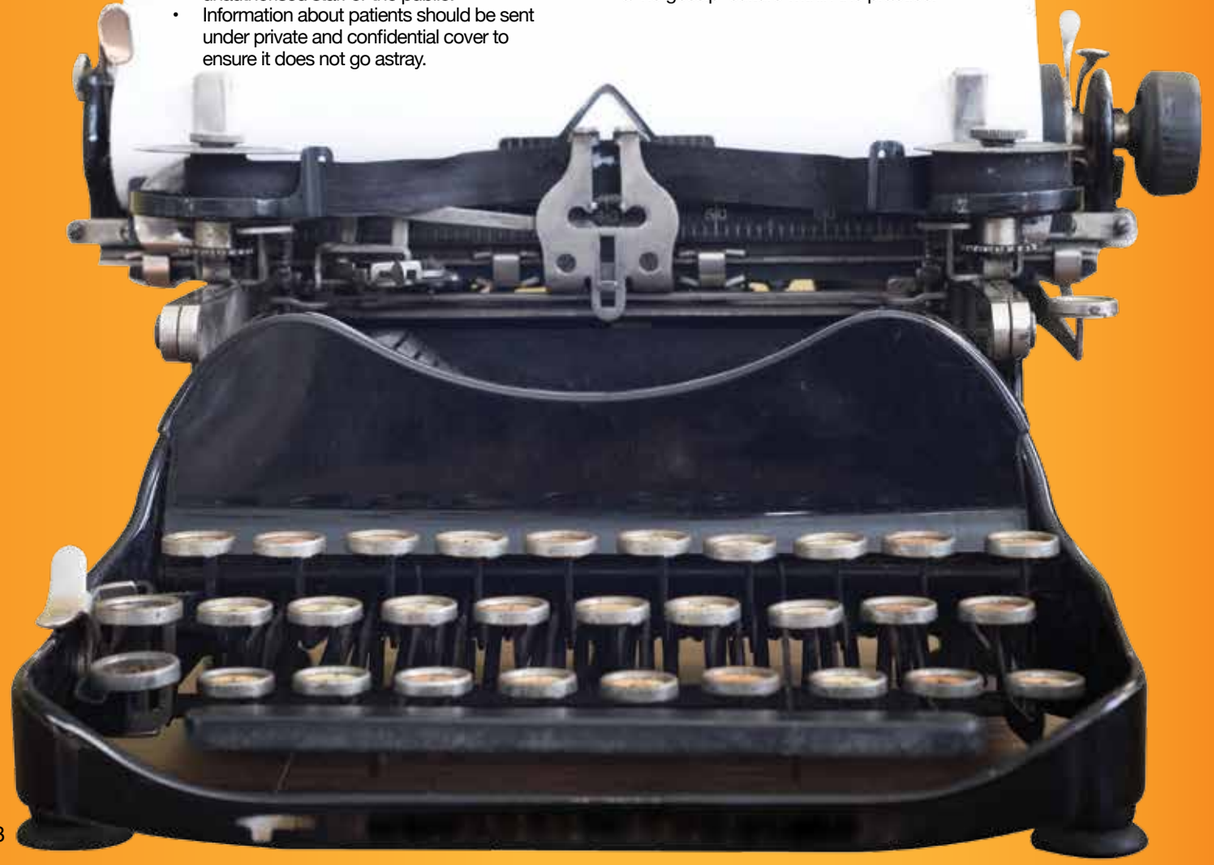
The HSE National Consent Policy Part Two Children and Minors is available on the HSE website http://www.hse.ie/eng/about/Who/qualityandpatientsafety/National_Consent_Policy/NationalConsentPolicyPart2.pdf

GENERAL PRACTITIONERS & CONFIDENTIALITY

Confidentiality is a legal and ethical principle and is central to trust between a general practitioner and patients. Without assurances about confidentiality, patients may be reluctant to seek medical advice or treatment or give their GP the information needed to provide appropriate, effective care. Complaints or legal actions against GPs on the basis of an alleged breach of confidentiality are extremely rare. However, everyone working in general practice must understand the rules of confidentiality. All patient information is confidential from the most sensitive diagnosis to the fact of having visited the surgery to being registered in the practice. Standards of confidentiality apply to all health professionals, students, administrative and ancillary staff including receptionists, secretaries, practice managers and cleaners.

Most breaches of confidentiality within general practice are often inadvertent overheard disclosures. Confidentiality breaches may be contributed to by to the physical environment of the practice such as room design, computer location, telephone position or seating. In order to avoid problems:

- Make sure all practice staff are aware of their obligations under the Data Protection Acts to keep personal data, including medical records, secure.
- Do not discuss patients where you can be overheard, for example at practice reception or waiting areas.
- Do not share passwords or leave patient's records on paper or screen unattended or where they can be seen by other patients, unauthorised staff or the public.
- Information about patients should be sent under private and confidential cover to ensure it does not go astray.
- When sending patient referrals to a third party via e-mail, use encryption software and inform the patient that you are sending the information this way.
- If you are sending or receiving patient information by fax make sure the fax machine is in a secure location. Have a practice protocol for managing information sent and received by fax.
- Restrict the use of devices such as USB keys within the practice.
- Patient's test results should only be accessible to appropriate members of the practice team.
- Have in place a practice protocol for checking the identity of a patient before giving test results over the telephone. A common error is to speak to the wrong family member with the same name. Do not leave messages regarding results on an answer phone.
- Do not telephone a patient's place of work without their express consent.
- All staff members receiving personal information regarding patients must understand that it is given to them in confidence and that they are bound by a legal duty of confidence, whether or not they have contractual or professional obligations to protect confidentiality.
- Have all practice staff and students sign a confidentiality agreement which includes the use of social media sites.
- Encourage all practice staff to work together to ensure that standards of confidentiality are upheld and improper disclosures avoided. Promote and insist on a 'no gossip' culture within the practice.



ASSESSING
A PATIENT'S CAPACITY TO MAKE DECISIONS

As a doctor, you must presume that every adult patient has the mental capacity to give or withhold consent to any examination, investigation or treatment, unless the contrary is proven.

In general practice assessing a patient's capacity to make decisions is part of every encounter and the process is generally spontaneous and straightforward. During a consultation, the doctor confirms the ability of their adult patients to understand their medical condition and options for care. For some patients however, the assessment may not be straightforward and you may have to assess a patient's decision-making capacity more carefully than usual.

There are a number of clinical scenarios where this may occur in general practice including:

1. The patient has an abrupt change in mental status. This change may be due to infection, medication, an acute neurologic or psychiatric episode or other medical problem;
2. The patient has a known history of impaired decision-making such as a chronic neurological or psychiatric condition or intellectual disability concerns.

The ability of a patient to make a decision may depend on the nature and severity of their condition, or the difficulty or complexity of the decision. Some patients may be able to make simple decisions but may have difficulty if the decision is complex or involves a number of treatment options. Other patients may be able to make decisions at certain times but not others because of fluctuations in their condition. Assessment of mental capacity, therefore, should always be a 'decision-specific' test ie whether a person lacks capacity to take a particular decision at a particular time. You must not assume that because a patient lacks capacity to make a decision on a particular occasion, they lack the capacity to make decisions at all, or will not be able to make similar decisions in the future.

These patients may require careful assessment but may still be able to make their own decisions.

There is, at present, no statutory definition of capacity in Irish law but if the proposed Mental Capacity Bill 2008 is enacted a definition will be introduced. This draft defines capacity as 'the ability to understand the nature and consequences of a decision in the context of available choices at the time the decision is made'.

The United Kingdom define a person lacking in mental capacity as 'if at a material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary'.[1]

The test of capacity currently applied in Ireland is from the English case of Re: C [1994] 1 All ER where the court provided a three-part test that has to be fulfilled when assessing a patient's capacity to consent (or refuse consent) to medical treatment.
Can the patient:

1. Understand and retain the information relevant to the decision in question;
2. Believe that information, and;
3. Weigh that information in the balance to arrive at a choice.

Assessments of mental capacity should only be carried out where there is a legitimate doubt about a patient's capacity and not because the doctor disagrees with the patient or thinks their particular decision irrational.

In making decisions regarding a patient's capacity you must make the care of the patient your first concern and always have his or her best interests foremost. Ensure that the patient is given every assistance to make decisions. Discuss treatment options in a place and at a time when the patient is able to understand and retain the information. Seek advice from family or friends of the patient around the best way of communicating with your patient if necessary, taking account of confidentiality issues, and use communications aids if necessary. If a patient has difficulty retaining information, give him or her a written record of your discussions, detailing what decision was made and why.

If your assessment leaves you in doubt about a patient's capacity to make a decision, you should seek advice from others involved in the patients care or those close to the patient who may be aware of the patient's usual ability to make decisions. You may also need to seek advice from colleagues with relevant specialist experience such as psychiatrists or neurologists. If you are in any doubt about a patient's capacity please contact Medisec immediately.

[1]The Mental Capacity Act 2005 Part 1 section 2

DISPELLING THE MYTH

PAYING FOR TAIL INSURANCE MAY NOT BE AS PAINFUL AS YOU THINK

The two types of Professional Indemnity cover currently available for GPs in Ireland are either a claims-made contract or discretionary occurrence based cover.

Medisec, through our underwriters Allianz plc, offer a claims-made insurance policy which covers those events and claims that occur and are reported while the policy is in effect or where the company agrees to apply a retroactive period of cover. All coverage ceases on the date the policy is terminated and hence a GP must ensure they have tail or run off cover to deal with claims that may arise once they retire or discontinue availaing of the Medisec scheme for whatever reason.

Discretionary occurrence based cover indemnifies events that occur during the period the policy is in effect regardless of when a claim is filed, even if you are no longer covered by that indemnifier. This does provide certainty (subject to the discretionary element) and no need for tail cover, however as many GPs are telling us some such cover is becoming prohibitively expensive.

Claims-made contract policies are substantially cheaper than discretionary occurrence policies. For instance the Medisec Master Policy, underwritten by Allianz plc offers full cover including out of hours sessions at €4,984*. Occurrence coverage tends to be very expensive because the GP is pre paying for tail costs whether the tail gets used or not. International figures highlight that discretionary occurrence coverage is on average 40-50% more expensive than a claims made contract. The savings over time are likely to be substantially more than the cost of tail coverage at the end of claims made coverage.

Medisec rewards loyalty and offers free tail coverage if a GP has been a member with us for 10 years prior to their 65th birthday.

GPs worry about the uncertainty of tail cover and there are certain myths about the costs involved. To dispel such myths it is worth looking at the figures involved. For members with 10 years loyalty up to their 65th birthday, there is no tail cover cost at retirement as it is paid by Medisec. For those who have not been with us for such a time, decide to retire early or discontinue availaing of the Medisec scheme, for instance if they decide to emigrate, tail cover currently stands at circa €15,000*. This is paid in instalments over an 8 year period and covers any claim/event at any time after their retirement or leaving our scheme.

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

We've talked about the cost and myths surrounding tail cover, which is the number one fear GPs have when changing indemnity provider. Any Medisec members will say that the most important aspect of our offerings is not the cost, but the support they receive from our experienced, Irish based team, who understand the challenges faced by GPs.

* Current quoted rates as at Sept 2014 which are subject to annual change.

EMERGING TRENDS IN MEDICAL NEGLIGENCE LITIGATION

As Panel Solicitors to Medisec, our practice continuously monitors trends in claims against Doctors with a view to advising members as to how they might avoid being involved in medical negligence litigation.

Over the past 12 months, we have noticed the following three areas as being an emerging source of potential liability to General Practitioners:

HSE INFANT AND MATERNITY SCHEME
Under the above scheme General Practitioners are expected to participate in developmental checks of babies in the neonatal period.

In the past 20 years, there have been a large number of claims brought on behalf of infants with hip dysplasia which went undiagnosed until the infant was weight bearing.

As you will appreciate, this can have very severe consequences for children where there is not an early diagnosis, resulting in treatment such as osteotomy which can have long term sequelae for the patient.

Prior to the current HSE Infant and Maternity Scheme, the clinical screening for hip dysplasia was carried out by consultants at the six week check-up. This was complimented by the on-going checks by the Public Health Nurses.

The aim of the scheme is to have developmental checks conducted outside the secondary care system and General Practitioners are now routinely carrying out the 6-7 week neonatal developmental examination, including the clinical assessment of hip dysplasia, with on-going checks by the Public Health Nurses.

Global studies have confirmed that community screening for hip dysplasia has generally yielded disappointing results. In the UK, the Medical Research Council Working Party on Congenital Dislocation of the Hip in 1998 (Godward & Dezateux, 1998) found that the incidence of an operative intervention for congenital dislocation of the hip was similar to that reported prior to the introduction of screening and the majority of children requiring surgery for congenital dislocation of the hip were not identified by screening.

However, the experiences from the South Australian neonatal hip screening programme reported radically different outcomes (Chan et al, 1999). A similar approach to hip examination was undertaken with all infants being examined after birth, at six weeks of age and staff at well baby clinics run in the community (with high attendance rates) are also trained to examine hips at between 1 to 4 weeks of age. Routine ultrasound scanning was not used. This approach showed a significantly lower incidence of late presenting cases of developmental hip dysplasia and the conclusion drawn was that the training of staff carrying out the hip examinations was the critical factor in the effectiveness of screening.

Thus it appears that the success of neonatal screening based on clinical examination is largely dependent on the experience and training of the staff carrying out the examination.

The research data appears to suggest that a positive outcome from the screening programme will only be obtained if both the Clinicians and Nurses involved in the programme are specially trained in the detection of hip dysplasia.

The difficulty in the current arrangement from a General Practitioners perspective, is that responsibility for the six week developmental check-up, which is the optimal time both for detection of and for correction of dysplasia with conservative treatment, is being laid at the door of the General Practitioner, who is not specially trained in detection of this condition.

We have seen a number of recent cases in which an argument is being advanced on behalf of the HSE (as co-defendant with the GP in these cases) that even if there is a failure on the part of the Non Consultant Hospital Doctors in carrying out the neonatal examination in hospital, or on the part of the Public Health Nurses employed by the HSE to detect the condition subsequent to the examination by the General Practitioner, the "window of opportunity" has passed, and therefore liability for any delay of detection will lie with the General Practitioner.

We very much appreciate that this potential liability on the part of GPs cannot be addressed individually by Practitioners. The need for resources to be put in place to improve training in the techniques of neonatal hip examination for Doctors may be a matter that has to be addressed to the HSE by General Practitioners representative bodies.

DRUG ALLERGIES OR ERRORS
Despite the move from handwritten clinical records to computerised records we continue to see a lack of consensus as to the appropriate method of "red flagging" to indicate drug allergies or contra indications for patients on long term drug therapy.

It is absolutely imperative that every general practice can demonstrate that they have a robust system of flagging either drug allergies or systems which alert all practitioners within the practice that the particular patient is on long term therapy which contraindicates certain prescription drugs for the patient. It is particularly important that any locums working within the practice are made fully aware of the system for identifying such issues.

In one particular case a patient who was on long term Warfarin was prescribed a Macrolide antibiotic on two occasions by two different General Practitioners within a practice. The patient subsequently collapsed and died from bilateral subdural haemorrhages caused, it was believed, by an interaction between the two drugs which adversely impaired the deceased patient's ability to clot.

We are aware that some software systems now carry an interactive facility and would strongly encourage its use on a routine basis.

Whilst we appreciate that General Practitioners have a very good and close working relationships with Pharmacists, it is no defence in law to say that a General Practitioner expects the Pharmacist to pick up the potential of prescription interaction.

DELAY IN ACCESS TO DERMATOLOGY SERVICES
We have seen a significant increase in claims against General Practitioners for an alleged failure to diagnose malignant melanomas and an allegation that there was a delay in referral to the dermatology services.

We are acutely aware that in certain areas of the Country there is a very long delay between a referral from the general practice to a dermatologist for assessment of a suspicious lesion.

If General Practitioners are prepared to deal with suspicious lesions without reference to the dermatology services, or pending receipt of appointments, then they need to have protocols within the practice describing which lesions are to be dealt with by way of biopsy, which lesions the practice are prepared to deal with without special services, and the indicators for which lesions need to be referred for urgent analysis.

Arising from a number of recent cases, our strong advice is that cryotherapy should only be used where there is a definite diagnosis of a benign skin condition (e.g.viral wart or solar keratosis) and that diagnosis is supported by the history and clinical findings. Needless to say these factors should be clearly documented in the clinical notes.

Whilst it may be reasonable to initially treat such apparent benign conditions with cryotherapy, if the expected clinical outcome does not result, further investigation or referral as appropriate should be undertaken in a timely manner.

Cryotherapy and cautery are both essentially destructive processes. The aim of cryotherapy is to destroy the lesion in its entirety. Therefore, unless the practitioner can demonstrate by reference to his notes that he is confident that the diagnosis is that of a benign lesion, the use of this treatment method, which removes the possibility of biopsy of the lesion, will render the practitioner vulnerable to litigation. Histological examination of excised lesions should be carried out both for current confirmation of diagnosis and to avoid confusion over future new lesions that may arise nearby, and in accordance with best practise advisories.

http://www.hse.ie/eng/services/list/5/nccp/profinfo/melanomagpreferralguidelines.pdf

Kate McMahon,
Kate McMahon & Associates,
Panel Solictor

REPORTING PROCEDURE

IF CHILD ABUSE IS SUSPECTED

While GPs have responsibilities to all their patients, if child abuse is suspected, their primary consideration should be the best interests of the child. Whenever a GP becomes concerned that a child may be at risk of, or the subject of, abuse of any kind, it is essential that these concerns are discussed with the Child Protection Agency TUSLA.

A GP should inform the child's parents or guardians of their intention to report any concerns, unless informing the parents or guardians might endanger the child. The provision of information to the statutory agencies for the protection of a child is not a breach of confidentiality or data protection, where such a communication is made reasonably and in good faith.

Where clinical uncertainty exists, GPs may need to discuss their concerns with other professionals who are experienced in working with child abuse cases. GPs should therefore be aware of how to contact the relevant personnel for expert medical advice.

Where, following such discussion, a GP is satisfied that there are reasonable grounds for suspecting that a child is being, or has been, abused or neglected, he or she should immediately inform the Child Protection Agency TUSLA in accordance with the standard reporting procedure.

The standard reporting procedure as provided for in the Children First: National Guidance for the Protection and Welfare of Children, published by the Department of Children and Youth Affairs in 2011 is as follows:

- Any person reporting a child abuse or neglect concern should do so without delay to the Child Protection Agency TULSA. Professionals and those involved in organisations working with children who have concerns about a child but are not sure what to do, should discuss these with the Children First Designated Liaison Person in your organisation, or contact your local Child and Family Agency social work department for advice.

- A Standard Report Form can be found at **http://www.tusla.ie/children-first/publications-and-forms.** This should be used by professionals, staff and volunteers in organisations working with or in contact with children, or providing services to children, when reporting child protection and welfare concerns. If a report is made by telephone, this form should be completed and forwarded subsequently to the Child and Family Agency.

- Before deciding whether or not to make a formal report, a GP may wish to discuss their concerns with other professionals experienced in working with child abuse cases. GPs should therefore be aware of how to contact the relevant personnel for expert medical advice.

- Under no circumstances should a child be left in a situation that exposes him or her to harm or to risk of harm pending Child Protection intervention. In the event of an emergency, where a GP thinks a child is in immediate danger and cannot get in contact with their local social work department, they should contact the Gardaí. This may be done through any Garda station.

- The Child Protection Agency TUSLA will follow up on all referrals, even if the Standard Report Form has not been used.

MEDISEC
RED FLAG

Well designed test results systems can trap human errors and help reduce the likelihood of adverse events, thus preventing harm to patients. It is essential that a practice has a robust test result system in place and that all staff are familiar with and fully understand and adhere to the system.

FOLLOW UP OF TEST RESULTS:
GPs should put in place a formal system to review the results of tests they have requested on their own patients. In particular, GPs are reminded of the possibility that the failure to receive the result of a requested test may mean it has not been carried out or it may reflect an error in transmitting the result to the practice. When test results are communicated to the patient this should be recorded in the notes. A simple 4 point tracking system monitoring test requests, results returned, results communicated and acted upon and entered into the chart, will help prevent adverse events and ensure that nothing falls through the cracks. All GPs, practice nurses and administration staff should agree to rigorously follow whatever protocol is adopted by your practice.

CONVEY RESULTS:
It should not be assumed that the patient will telephone the practice for their results. The GP has the responsibility of making every effort to convey test results to patients and the GP should be in a position to produce a paper trail of such efforts if required in the future. A GP should be aware that some test results will arrive later than others and it is often our experience that these are the results not passed on to the patient or followed up adequately, as the patient may have called the surgery before the final results are in or the GP may have reviewed too quickly. An alert system must be in place until all results are in and acted upon. It is not appropriate for non clinical staff to discuss clinical findings. Practices should have appropriate protocols in place in relation to communicating test results.

URGENCY OF REFERRAL LETTERS:
GPs are advised, where possible, to state the level of urgency in referral letters to a hospital or consultant. If appropriate, they should consider contacting a consultant in person. A copy of the referral letter should be retained on the patient's file.

FOLLOW UP OF TEST RESULTS INITIATED IN HOSPITAL SETTING:
GPs should endeavour to use their practice systems to enable them to diary important referral issues and should also consider reverting to the referring consultant/hospital requesting them to organise follow up requirements. GPs should also involve the patient in taking ownership of their medical appointments and make sure all is documented within the patient's chart.

STORAGE OF TEST RESULTS:
Lab reports should be scanned into the patient's computerised file and stored with the rest of their medical records.

LOST OR STOLEN
PRESCRIPTIONS

All doctors within general practice should ensure the security of prescription forms or pads from theft and misuse. Although the incidents of theft may be rare, these forms or pads can be used to obtain drugs illegally, often controlled drugs (CD's) for recreational use or for onward sale. Stolen prescription stationary, forgery and drugs that are fraudulently obtained are likely to be sold for substantial financial gain. Because prescription form pads and single prescription forms are small they are easy to move and to conceal so detecting the theft of these items may be difficult.

There are already a number of security features built into prescription forms to deter theft and fraudulent use including solvent-sensitive ink, ultraviolet marking, coloured backgrounds and serial numbers. However, these are of little use if poor security measures overall allow theft of the forms in the first place. The effective management of prescription forms, for example, how they are stored and accessed by all practice staff, is very important and requires that the practice has appropriate security policies, procedures and systems in place.

- All GPs and practice staff should ensure that appropriate procedures are in place for the secure storage of prescription forms and other related stationary.
- Procedures should be in place for the immediate reporting of any loss or theft of prescription stationary and staff should be aware of what actions to take if prescription pads go missing, liaising with pharmacists and the Gardai to minimise any resulting damage.
- A clear record of all prescription stationary stock received should be kept including:
  - what has been received along with serial numbers.
  - to whom prescription forms are issued along with serial numbers.
  - the serial numbers of any unused prescription forms that have been returned.
  - details of any prescription forms destroyed.

It is advisable to hold minimal stocks of prescription stationary.

Patients, temporary staff and visitors should not be left alone with prescription forms or allowed into secure areas where they are stored.

When making home visits take suitable precautions to prevent the loss or theft of forms. Ensure prescription pads are not left on view in a vehicle. GPs on home visits should record the serial numbers of any prescription forms they are carrying and only carry a small number of forms.

To reduce the risk of misuse, blank prescriptions should not be pre-signed.

GP practices should keep a record of the serial numbers of prescription pads issued to locums.

ENGAGING WITH THE MEDIA

SOME RULES OF THUMB

Edelman is the world's largest public relations firm with 67 offices and 5,000 employees worldwide. Edelman Ireland provides media and crisis communications training to GP and other healthcare professional groups. Please see www.edelman.ie

Dealing with the media can be tricky, especially if it is something you are not accustomed to. Below are some important rules of thumb from our media partner, Edelman, that can be taken on board to help you prepare for such situations.

Joe Carmody,
MD, Edelman Ireland

PREPARE, PREPARE, PREPARE….. BY DOING THE FOLLOWING IN THE FIRST INSTANCE

DEFINE THE ISSUE
- What is the basic issue you want to address or you have been asked to address through the media.

IDENTIFY THE PRIORITY AUDIENCE
- Who are the people to whom you want to get your message across through the media channel you are going to be a spokesperson on?

ANALYSE THE PRIORITY AUDIENCE
- How does the issue you are going to address impact on them?
- What is their current position on the issue?

CLARIFY THE OBJECTIVE
- Where do you want the audience to be at the end of the interview?

SELECT THE KEY POINTS/ MESSAGES
- What limited number of key points do you need to achieve this objective?

EXPAND ON THE KEY MESSAGES
- What supporting data/ examples can you use to expand on these points?

DECIDE ON YOUR KEY MESSAGES

Decide on the three/ four key messages that you want to convey and send to your target audience.

If these key points are free standing, they need to be put in logical sequence.

The rule of three is often important here i.e. if you were to finish your interview with three key points for any listeners who are also decision/ policy makers – what would they be?

You will also need to use questions posed by the interviewers as a platform to convey these points. Another rule of thumb when asked a question:

- Answer the question
- Expand on your answer to build a bridge
- Then make a key point/ message and illustrate it with an example (e.g. I had a little girl in the clinic the other day who was xxxxx – people always respond to a real life example!)

You can also keep control of the interview by talking about specific examples and remember the interviewer will never know as much about the topic as you do.

SPECIFIC PREPARATION FOR BROADCAST MEDIA (TV AND RADIO)

- Decide your role in your own mind (e.g. are you representing the ICGP for example, or your practice or the GP profession in general)
- Find out is the interview live or recorded and whether it will be an in-studio or phone interview
- Find out how long the interview will last
- If the interview is live, find out if it is a panel interview or one-to-one interview (and if a panel interview, find out who else will be on the panel and consider what position it is likely that the other panellists will take)

Remember, all interviewers have two standard questions (inevitably using slightly different wording but the sentiment is always the same)
- The first question is usually 'So tell me what is the story here'
- The last question is always 'So what happens now – where do we go from here?'

DRESS CODE FOR MEDIA
- Dress to represent your profession as professional images inspire confidence and communicate and reflect quality
- If you are doing a TV interview do not wear red, yellow or anything stripey

BEFORE THE INTERVIEW STARTS:

- Be clear on the key messages you want to get across
- Do not wear clothes that rustle or jewellery which clanks
- Turn off your mobile phone/pager/beeping digital watch
- Ask the interviewer what the first question is going to be and some guidance on the direction they plan to take; they should tell you all the subjects they plan to cover. But be prepared for things 'out of left field'
- Do not prepare reams of notes (they rustle); but do have key bullet points and facts and figures you might need on one sheet

DURING THE INTERVIEW:

- Keep eye contact with the interviewer, even if they break it
- Do not speak too quickly, or too slowly…
- Keep to the point. Do not allow yourself to ramble
- Pause before each new point
- Answer the question, expand on the answer to build a bridge and then make a point and if possible illustrate it with an example (again people listen to real life examples)
- Focus on moving the audience from Position A to Position B
- Speak clearly and don't use jargon
- Pare the bare essentials – speak to inform, not to impress
- Keep the same distance from the microphone/camera – anchor yourself somehow
- Avoid hand movements (particularly exuberant ones)

AFTER THE INTERVIEW:

- Leave enough silence for the microphone to fade out
- Don't assume you are off air. The microphone may still be live
- Don't get up and try to leave immediately. Wait for their signal – but when you get the signal be ready to move quickly.

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