



Practice MATTERS

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CRSA SPECIAL

A look at what a Medical Protection
Clinical Risk Self Assessment can do for
your practice

INSIDE...

HANDLING A MEDICAL COUNCIL COMPLAINT

A step-by-step guide on
managing your response

CHALLENGES OF RURAL GENERAL PRACTICE

How to avoid potential pitfalls

HOW TO MANAGE A DISRUPTIVE PATIENT

Advice on the best way to
manage such a situation



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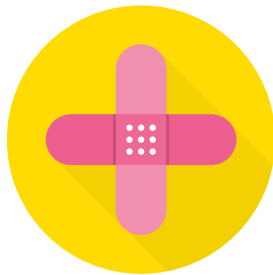
MEET YOUR REGIONAL MEMBERSHIP CO-ORDINATOR: RACHEL LYNCH

Rachel has worked at Medical Protection for more than ten years:

"I regularly visit medical schools and hospitals to talk to members and arrange medicolegal events for some of the professional organisations in Ireland, including the Royal Colleges.

"If you would like a visit to talk about your membership, or you are organising a teaching event, training day or conference, then you can contact me to help arrange sponsorship or a speaker."

Contact her on 087 2867491
Rachel.lynch@medicalprotection.org



We welcome contributions to *Practice Matters Ireland*, so if you want to get involved, please contact us on **+44 113 241 0221** or email: kirsty.plowman@medicalprotection.org

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WELCOME

Welcome to this edition of *Practice Matters*, a publication that aims to support you and your practice.

In this edition, on page 6, we focus on what a Medical Protection Clinical Risk Self Assessment (CRSA) can do for you in helping to highlight areas of risk in your practice. Creating a safe environment for your patients and staff is of great importance in achieving good patient care and practices need to improve risk management systems to achieve that.

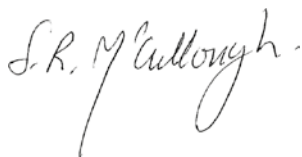
We also recognise the challenges you may face as a rural GP and offer advice on how to avoid potential difficulties. Meanwhile, on page 18, we discuss how to manage a disruptive patient which can be one of the most challenging aspects of general practice.

Dealing with a complaint from the Medical Council can be very stressful. On page 10 I seek to reassure you on how to handle the process. It is important to remember that if you are faced with a complaint that you are not alone and Medical Protection can offer support and advice.

We are delighted to have a contribution from Dr Ide Delargy who specialises in addiction and well-being of doctors. She discusses the increasing concerns surrounding doctors' mental health and the help that is available to GPs.

Many of you will know Rachel Lynch your Regional Membership Co-ordinator who, in this edition, shares with you a typical day in the role. Rachel, along with colleagues in our wider team, is dedicated to supporting members in Ireland.

I hope you enjoy this edition. We welcome all feedback, so please contact us or if you have any ideas for topics you would like us to cover.



Dr Sonya McCullough
– Editor-in-Chief



REGISTER FOR THE 2016 GP CONFERENCE

Medical Protection's 2016 GP Conference will be taking place on 1 October at the Convention Centre Dublin.

General practice continues to pose its challenges to GPs and their teams – but advice and support is on hand at this year's GP Conference.

Our knowledge experts will put the spotlight on risk, covering all the basics from practical problems and tips on running a practice.

You can also attend our series of interactive workshops, including medicolegal dilemmas from the Medical Protection caseload.

Running from 9am – 4.30pm, the conference admission costs are:

- €75 for Medical Protection GP members
- FREE for GP trainees
- €40 practice managers, practice nurses and practice staff
- €150 for non-members

To register your interest in the conference please email

vicky.colthart@medicalprotection.org

or visit

medicalprotection.org/ireland/gpconference



Follow us on Twitter



Good news for those who like to be kept up-to-date whilst on-the-go – Medical Protection is now on Twitter! If you use Twitter in a professional capacity, why not follow [@MPsdoctorsIRE](https://twitter.com/MPsdoctorsIRE)?

A DAY IN THE LIFE...



Medical Protection's Business Development Manager for Ireland and your Regional Membership Co-ordinator, Rachel Lynch, shares a typical day

Rachel began working for Medical Protection in August 2003 with an initial remit to run a student scheme that involved membership recruitment and renewals. She still manages this aspect, but her role now encompasses a marketing and business development perspective.

She works closely with post-graduate institutions such as RCSI, ICGP, RCGP (ROI), ICO, College of Anaesthetics, RCPI – specifically Institute of Obstetrics and gynaecology. She attends their events to endorse Medical Protection and the importance of membership.

A lot of her day to day work involves handling your queries and speaking to potential members.



Two thoughts sprung immediately to my mind when asked to write a 'day in the life' piece for *Practice Matters* – firstly: "Who is going to want to read that?" – Well, if you are, then I guess that's that question answered! My second was "what does an average day even look like for me?"

I am usually out at various events hosted by Irish College of General Practitioners (ICGP), Royal College of Surgeons in Ireland (RCSI), Royal College of Physicians of Ireland (RCPI), or student committees. You will also find me at various hospitals attending grand rounds and intern lunches or I'm attending meetings in Dublin. On my busiest days I'm in my office at home in County Louth.

I wake at 5.45am – if my one-year-old hasn't got me up already then my alarm certainly has!

I log on quickly to see where I am with emails and make sure all is in order for the day ahead. Today is an 'event day' for me – Charter Day at RCSI. Charter Day marks the foundation of RCSI over 200 years ago and is a three-day series of training meetings for consultants and non-consultant hospital doctors (NCHDs). Medical Protection has supported this event for over four years – supporting surgeons and surgical trainee's education and training.

Following registration, the meeting commences and I chat to a number of doctors about a variety of things including their membership and our educational events – I always try to endorse our workshops to consultants and NCHDs whenever I have the opportunity.

Whilst delegates are in lectures, I use the time to catch up on emails, schedule events and organise my diary. I liaise with the membership department to follow up on member queries and applications.

I also use the opportunity to drop into the faculty office in RCSI to chat to the staff about RCSI results day in May – Medical Protection supports this exciting day which marks the start of the 'real world' for over 250 new doctors. Before returning to the conference, we discuss the Intern Induction day in July.

I continue my conversations with delegates dealing with a number of membership queries and talking two GPs through our Clinical Risk Self Assessments (CRSA) process. Throughout the day I keep an eye on the media for articles of interest on health and similar topics to send to our team. We do this to ensure we as an organisation are up to speed on the issues affecting all doctors in Ireland.

The lunch break at the conference provides me with more conversation opportunities; I relish my chance to meet and interact with members. I speak with a number of NCHDs and hand out membership application forms.

Following this my time frees up to make a few calls and handle more emails. I then pop over to the dotMED annual medical conference in Temple Bar.

Later on I meet with members of the student committee at RCSI. We discuss sponsorship opportunities, which Medical Protection can provide, for a variety of college activities and charity events.

At around 4.30pm my involvement with the conference ends and I pack up my things. I arrive home just in time to start my daughter's night-time routine. After dinner and an hour or so of putting my feet up it's time for leaba - I'm exhausted!

To contact Rachel, call **087 2867491** or email rachel.lynch@medicalprotection.org

WHAT CAN A CRSA DO FOR YOUR PRACTICE?

Medical Protection's Clinical Risk Self Assessments (CRSAs) offer an opportunity for all members of the practice team to work together, talk openly and develop practical solutions that promote safer practice

All healthcare providers have a responsibility to improve patient care, ensure patient safety and reduce medical error. Creating a safe environment for your patients and staff is of paramount importance and practices need to implement or improve risk management systems to achieve that.

WHAT IS A CRSA?

A Clinical Risk Self Assessment (CRSA) for general practice is a unique consultancy programme provided by Medical Protection designed to identify potential risks within a practice and develop practical solutions to mitigate these risks. Using a systematic approach specifically developed for general practice, a CRSA aims to improve the quality of patient care and reduce a practice's exposure to unnecessary risk.

THIS RISK ASSESSMENT WILL:

- Improve a practice's systems, the quality of care provided and help manage clinical risks
- Reduce the risk of harm to patients
- Reduce the likelihood of complaints and claims
- Help meet national standards
- Improve communication within the team
- Provide useful evidence for appraisal.

The full-day assessment, which is delivered in-house, involves the whole practice team – GPs, managers, nurses, administrative staff and other healthcare professionals.

In 2014 Medical Protection undertook 107 CRSAs across Ireland and the UK. From this we have been able to determine the most common risk areas within general practices.

KEY RISKS DURING 2014:

- Confidentiality – 94.4%
- Prescribing – 88.8%
- Communication – 86%
- Health and safety – 83.2%
- Record keeping – 74.8%
- Test results – 72%
- Infection control – 71%
- Staff training – 64.5%

Risks are not always related to clinical practice but can be due to deficiencies in systems, communication, equipment or training. With this in mind we work with practices to identify specific risks and to formulate practical solutions to assist practices in delivering a consistent, patient-centred service.

PRACTICE PROFILE – CENTRIC HEALTH, IRELAND

Medical Protection has delivered its CRSA programme to five of Centric Health's general practices.

Centric Health, founded in 2003, is an international healthcare services company which provides medical recruitment, primary care and diagnostic imaging services in Ireland, the UK and Australia. The group operates 16 GP practices in Ireland.

Dr Ray Power, Centric Health's Group Medical Director, approached Medical Protection to book a series of CRSA programmes.

"As a group of colleagues we were motivated to develop an emphasis on quality risk and patient safety as part of our culture and felt a CRSA was an opportunity for us to establish an initial baseline and adjunct to helping five of our GP practices."

The practices which underwent the CRSA process were:

- Barrow Medical
- Boroimhe Medical
- Churchtown Medical
- Raheny Medical
- Ranelagh Medical



BEFORE THE VISIT

CRSAs are facilitated by a team of Clinical Risk Assessment Facilitators, who are experienced primary care healthcare professionals, and have undergone formal training and accreditation with Medical Protection.

The facilitators who were appointed to conduct the CRSAs for Centric Health were Dr Diarmuid Quinlin, Diane Baylis and Julie Price. Diarmuid has over 20 years' experience as a GP and currently works at Woodview Family Doctors in Glanmire, County Cork.

Diarmuid believes that a CRSA is a great tool to review systems within a practice to ensure they are as safe and robust as possible:



“Research has shown that the CRSA is a catalyst for substantial positive change within practices¹”, he said. “The assessment helps a practice develop more robust patient safety systems – an important consideration especially with the looming prospect of HIQA inspecting GP practices.

“The assessment integrates seamlessly into the normal day in the practice and is an enjoyable occasion for all the practice staff, and everyone is involved – administration and clinical.”

Prior to the visit, the practices were required to fill out an online questionnaire. This allowed the facilitators to obtain some information about the staff, their roles and responsibilities and the services offered to patients at the five general practices. In addition to this, all practice teams were asked to complete a staff survey relating to the culture of the practices.

The facilitators examined the information gathered from the pre visit questionnaire and results of the staff survey in advance of the visit to tailor the CRSAs to the needs of the individual practices. From here they developed unique schedules for the full-day visits.

ON THE DAY

A CRSA assessment day starts with the facilitator conducting in-depth interviews with key members of staff. The aim of the interviews is to examine the systems and protocols within the practice to identify any potential risks.

The facilitators began the assessment days by meeting with practice managers who gave detailed insight into the practices and how they operate. Topics discussed included practice services and protocols, patient involvement, engagement and confidentiality, teamwork and communication, communication with other agencies, administration, IT, confidentiality and information governance.

Adopting a similar framework to the first interview, the facilitators then met with a GP to discuss topics such as record keeping, equality and diversity, prescribing, management of test results, chaperones, safeguarding of adults and children, chronic disease management and minor surgery.

Following on from the doctors, the facilitators met with nurse practitioners. This discussion looked at areas such as child immunisations, travel vaccinations, minor illness, chronic disease management, contraceptive services, infection control, staff immunisation and equipment.

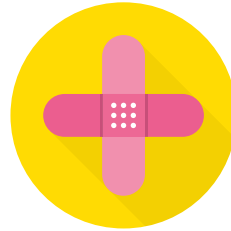
After the interviews the facilitators had the opportunity to inspect a consultation room at each practice where they examined equipment and asked questions about waste removal, safety and hazards, fridges and waiting areas. Depending on the schedule for the day this time is flexible for the facilitator to explore more areas of the practice.

During the afternoon a risk assessment workshop is held for all the practice staff, raising awareness and providing staff with an understanding of the principles of risk management.

In the workshop staff are asked to:

- Identify potential and existing risks that could/have had an impact on either patient or staff safety.
- Discuss in groups a selection of the risks identified, agreeing what measures /strategies could be adopted to reduce these risks occurring or recurring. Agree the actions the practice needs to take and what the key priorities are.

The interactive workshop, which can last for up to two hours, is designed to analyse risk management – why it is important, what staff are doing about it, what staff need to know and what they need to do – with the overall aim to reduce harm to patients, staff and visitors.



WHAT HAPPENS AFTERWARDS?

Once the full-day assessments were complete, Medical Protection compiled a comprehensive report for Centric Health detailing the findings of each assessment. This included the risks identified, recommendations (actions to mitigate these risks) and useful guidance.

The confidential report was made available to the group through a secure online system. This became a working tool from which Centric Health could take steps to mitigate risks in the practice.

Diarmuid said: “The resulting report is detailed – identifying both strengths and areas where improvement is possible.

“My practice underwent a CRSA several years ago and we gradually implemented many of the suggestions and recommendations.

“These changes are virtually invisible to the outside world, but have greatly enhanced our ability to deliver a safe, effective service to our patients.”

Across the five sites, Medical Protection determined that practice staff at Centric Health were dedicated, professional and caring. They also offered a range of appointments and used computers extensively.

Key risk areas that were identified across the five practices included:

- Repeat prescribing protocol
- Compliance with controlled drug legislation
- Policies and procedures for test results
- Child protection and safeguarding of at-risk adults
- Approach to infection control
- Health and safety
- Staff training
- Procedures for resuscitation

The recommendations, relating to risks identified during the CRSA visit, are detailed in the practice report and on a ‘follow-on action’ screen. To assist a practice with prioritisation, each risk has been ‘risk rated’ into a category, i.e. short term (red), medium term (orange) and longer term (yellow).

Space is provided for the practice to enter actions that are completed. This tool helps a practice manage their risks and provides an important log of the progress made in tackling the risks identified.

Dr Power, Centric Health’s Group Medical Director, said: “The report gave us a roadmap and empowered each of our practices to take responsibility in prioritising their highest risk area. Since the CRSA, we have consistently put in place the appropriate intervention.

“We have been able to get a significant number of initiatives going that are aligned with the key recommendations.

“From a qualitative point of view the assessment helped us to nurture a quality and no-blame culture. The new approach we have adopted has encouraged openness and transparency within the practices.

“Additionally, as part of the assessment considerations, we appointed a quality and risk manager across our network of GP practices.

“I would highly recommend a CRSA to other practices, it’s very valuable.”

Practices with four or more Medical Protection members can receive a CRSA free of charge as part of the membership package while practices with one to three Medical Protection members can access the programme at a cost of €1,000. Practices with no Medical Protection members can still book a CRSA for €2,000. A CRSA also goes towards health professionals CPD.

To find out more, visit medicalprotection.org/ireland/crsa or to make a booking, email crsa@medicalprotection.org or call +44 (0)113 241 0359

REFERENCES

1. Bowie P, Price J, Hepworth N, et al. System hazards in managing laboratory test requests and results in primary care: medical protection database analysis and conceptual model. *BMJ Open* 2015;5: e008968

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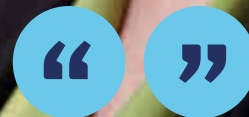
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THE CRSA DAY IS AN
EXCELLENT EVENT
THAT INVOLVES ALL
PRACTICE MEMBERS.
IT HIGHLIGHTS AREAS
THAT ARE WORKING
WELL AND THOSE THAT
COULD BE IMPROVED.
I WOULD HIGHLY
RECOMMEND IT.

FEEDBACK FROM A
PRACTICE MANAGER

HANDLING A MEDICAL COUNCIL COMPLAINT

Dealing with a Medical Council complaint can be very stressful. Dr Sonya McCullough talks you through the process and shares advice on how best to handle it



Dr Sonya McCullough has been a Medicolegal Adviser at Medical Protection since 2009. Prior to joining, Sonya led a varied clinical career – after qualifying at Queen’s University Belfast in 1991, she worked in obstetrics and gynaecology for a number of years, including a short time in South Africa. She was a consultant in genitourinary medicine and also worked in the field of forensic medicine.

Sonya supports Irish members through her dedicated work which incorporates:

- Representing members’ interests
- Advising members about a wide variety of medicolegal and ethical issues
- Handling individual cases
- Supporting and counselling members

Many doctors, at some stage in their career, will receive a complaint from the Medical Council. At Medical Protection, we understand how upsetting this can be and we support and advise members with these complaints on a daily basis.

Whatever the complaint, these practical tips explain what you should do next.

RECEIVING A COMPLAINT LETTER

The initial letter will be from a case officer at the Medical Council appointed to assist the Preliminary Proceedings Committee (PPC) with your case. On behalf of the PPC the case officer will carry out investigations which can include a request for your comments on the complaint, statements from other individuals involved or, if the case is particularly complex, the instruction of an expert. The case officer, if necessary, will also obtain a copy of the medical records in the matter.

The PPC generally meet once a month and will consider the complaint. From the first letter you receive from the Medical Council, you will note that there is no obligation on you to reply or submit a response at that time – it will not be detrimental to your case if you do not respond to the initial invitation to submit a response; a holding letter will suffice on receipt of the initial letter.

In our experience, submitting a response immediately will not necessarily speed up the process, particularly in circumstances where a number of doctors have received a complaint from an individual or where an expert requires to be instructed. You will also note from the first letter that you will need to confirm to the PPC that you are registered in a Professional Competence Scheme and provide evidence of your participation in CPD activity. We strongly advise you to submit this CPD information to the Medical Council without delay.

We can provide specific support for your individual complaint and recommend that you do not respond until we have had an opportunity to consider the matter with you and assist you in drafting a robust response.

FORMING YOUR RESPONSE

If you are the subject of a complaint, take a moment to stop and think before responding. A well-thought-out letter of response is far more likely to be successful than an intemperate one. In the event that you do not submit an initial response to the Medical Council, you will be invited to respond. If you have still not responded, a subsequent letter will direct you to respond and you are obliged to respond at this stage.

In general the PPC will order that a copy of your response is shared with the complainant for their further comments, if any. You will generally be provided with a copy of the complainant’s additional comments and will have an opportunity to respond further. We normally advise that you only provide additional comments where the complainant has raised a new issue or where you have not responded to a particular matter in your initial letter of response. It is therefore essential that the initial response deals with all the aspects of the complaint and responds in some detail to all the issues raised.



At Medical Protection, we understand how upsetting this can be and we support and advise members with these complaints on a daily basis.

In responding to the complaint it is useful to set out the following:

- A short paragraph or two detailing your background, experience and qualifications to date.
- If relevant, a paragraph or two providing detail on the system in place in the unit in which you work.
- What you understand the complainant's concerns to be and each of the issues of concern should be identified and responded to in turn.
- The chronology of your involvement in the case and your justification for treatment offered.

HOW WE CAN SUPPORT YOU

Handling a complaint requires time and commitment during a period when you might be feeling at your most vulnerable. We strongly advise you to contact us immediately and not respond to the Medical Council until you have had an opportunity to discuss the case.

It is important that we are in receipt of a full copy of the correspondence that you have received, including the initial letter from the case officer and the full letter of complaint.

The adviser who will assist and support you with the response will require the following information:

- Details of your period of involvement in the case i.e. the date on which you first saw the patient and the date on which you last saw the patient.
- A complete copy of the full bundle of documentation that you will have received from the Medical Council so that we have sufficient information on all aspects of the case with which to provide comment.

You will be allocated a unique reference number which should be quoted in all future correspondence with us and directed to the expert dealing with your case.

We provide individual membership, so if you and your colleagues all receive a complaint from the Medical Council you should all seek assistance separately from us.

WHAT HAPPENS NEXT?

The PPC will decide if there is prima facie case to answer and whether or not the matter should be referred to the Fitness to Practice (FTP) Committee for a Public Inquiry. In our experience only a very small number of cases are sent forward to a FTP Inquiry and the vast majority are resolved at the initial PPC stage.

We would also advise that in circumstances where the matter is particularly complex or the allegation is serious in nature, Medical Protection may instruct one of our local panel firm solicitors in Dublin to assist with the matter. Where it is unlikely that the case will go forward to a FTP Committee and the complaint is limited, it is less likely that there will be any requirements to instruct a panel firm solicitor or to have a meeting regarding the case and the adviser will work with you to assist in drafting a robust response to the Medical Council.

We hope this information will provide some reassurance in dealing with matters at the Medical Council.

If you receive a letter from the Medical Council contact Medical Protection for advice at **+44 113 241 0200** or **Medical.Edinburgh@medicalprotection.org**

Medical Protection also provides an independent and confidential counselling service and accessing the service is easy. Contact **info@medicalprotection.org**

If you find yourself and your practice in the media spotlight seek early advice from Medical Protection. To read our Guide to handling the media, visit **medicalprotection.org/ireland/about/media-centre/a-guide-for-doctors-on-handling-the-media**

CHALLENGES OF RURAL GENERAL PRACTICE

Although a rewarding career, being a rural GP is not without its challenges. Dr Rachel Birch, a Medical Protection Medicolegal Adviser, provides advice on how to avoid potential pitfalls



For some GPs, rural general practice epitomises all that they hoped for in a career in medicine. It is a chance to be a true generalist, living and providing care in a close remote community. The work can be diverse, encompassing emergency medicine, out-of-hours (OOH) work, clinical procedures and community hospital work as well as the more traditional GP work. GPs may enjoy professional autonomy and the chance to be involved in developing improved services for patients.

However, as the following case studies demonstrate, doctors should be aware of possible risks and take steps to reduce them, where possible.

CASE 1 – PATIENTS AS FRIENDS

Dr F works in a close rural community in Tipperary as one of two GPs and is friends with many of his patients. He saw Miss B at the weekend at a school social event. She is a local teacher and told him that she was not sleeping. She said that she didn't have the time to visit Dr F and asked him to give her a prescription for sleeping tablets. She was also reluctant for anything to be documented in her records as her sister works as Dr F's receptionist and she was worried she would find out. She said that people have been talking about how tired she looks in the local post office.

Medical Protection advice:

- Dr F should explain to Miss B that he needs to review her in the appropriate setting and avoid undertaking an assessment at a social event.
- He should arrange a suitable time for Miss B to consult with him at the practice, perhaps when her sister is off duty.
- The consultation should be documented contemporaneously within her medical record.
- He should reassure Miss B that her medical record is confidential and will not be seen by her sister. He may wish to consider password protecting her record, so that only clinicians may access the consultation details.

- Although situations such as these may occur, patients in rural communities are often very aware of the importance of doctors maintaining boundaries between personal and professional life.

CASE 2 – CONCERN ABOUT A COLLEAGUE

Dr A and Dr D work as GP partners in a remote part of rural Kerry. On Monday morning Dr D arrived looking tired and dishevelled and Dr A could smell alcohol on his breath. Dr A spoke to Dr D and he stated that he overdid things the night before. Dr A suggested Dr D went home and covered Dr D's workload as well as his own. After two further episodes the following week, Dr D eventually confided in Dr A that he felt very down and was using the alcohol to help him sleep. Dr D is registered as a patient at the practice.

Medical Protection advice:

- It is likely that Dr D's health and drinking could affect his clinical judgement. Dr A should discuss this with Dr D and suggest he takes some time off work to address his health issues.
- The Medical Council states: "If you are concerned about a colleague's health or professional competence due to misuse of alcohol or drugs, a physical or psychological disorder or other factors, you have an overriding duty to make sure that patients are protected. The best way to support a colleague in such circumstances is to advise them to seek expert professional help or to consider referral to the Medical Council's Health Sub-Committee. However, if there is a risk to patient safety, you must inform the Medical Council of your concerns without delay¹⁷". Therefore Dr A should advise Dr D to consult his own GP.
- The Medical Council advises: "You should have a plan in place to ensure continuity of care for your patients if you become unexpectedly ill¹⁸". If Dr A is unable to find a locum GP to cover Dr D, he may wish to consider seeking advice from the HSE.

There was an obvious conflict here, in that Dr D is both Dr A's colleague and patient. Having discussed this concern, Dr D



preferred to go and stay with his sister in Cork and seek advice from her GP. He made a successful return to work four weeks later.

CASE 3 – NO SIGNAL

Dr S works in a remote area in Galway. The nearest hospital is 1 ½ hours away. Late one snowy winter evening he undertook a home visit to Mr B who lived on his own on a farm. He was complaining of abdominal pain and Dr S diagnosed probable early appendicitis. He advised hospital admission, but Mr B had no relatives or friends with transport, so Dr S planned to arrange an ambulance to take him. On attempting to make the call, he realised he had no signal on his mobile phone. The patient did not have a home telephone either. Dr S told the patient he would go to a neighbouring farm to call for the ambulance.

Due to the poor weather and an ambulance service resource issue, it took two hours for the ambulance to arrive at Mr B's farm. He started developing worsening pain in the ambulance and was found to have a perforated appendix when surgery was undertaken later that night.

Although Mr B made a full recovery, he made a complaint to the practice. He was unhappy about the delay in admission to hospital and believed that Dr S had not called the ambulance quickly enough.

Medical Protection advice:

- Dr S should respond to the patient, offering an apology for the distress that the patient experienced, and outlining the steps he took to ensure that the ambulance was arranged.
- The practice may wish to consider undertaking a Significant Event Analysis regarding this incident to consider what changes could be implemented to prevent a similar incident in the future.
- Issues to explore include the limitation of the environment and whether telecommunications in the area could be

improved, perhaps by use of a radio, or using two mobile phone providers, if the coverage is patchy.

- Consider the use of alerts on the medical record, if a patient doesn't have a house telephone, so that this is known in advance. Take the name and number of the caller, when house visits are requested for these patients.
- If the practice looks after GMS patients, they should consider raising their concerns with the HSE as funding may be available.

These case studies illustrate some common themes within rural general practice in Ireland. However, as well as shared challenges that may occur in the non-rural general practice setting, there are other things for the rural GP to consider².

IT ISSUES

Due to their wide spectrum of work, rural GPs may find themselves routinely using several different clinical systems that vary from their own GP computer system. Examples include OOH systems, hospital and emergency department records, forensic forms and test result and request systems. Each system requires separate usernames and passwords which can present a challenge in itself.

In a remote environment, the benefits of being able to access clinical information from other healthcare systems are clear. However, extensive IT work and strategic planning would be required to enable integration of health systems. In addition careful consideration would need to be paid to issues of confidentiality and patient consent if such a system were to be proposed.

Email communication is likely to be used more than in non-rural settings and doctors should ensure that these any emails are saved within the patient's medical record.

In some areas there is poor broadband connectivity, especially in the branch surgeries that extremely remote GPs are required to staff. Doctors can find themselves, at short notice, not being able to get into the OOH records system or the hospital

results system. This has obvious implications for clinical safety and workload, as clinicians may find themselves duplicating records in case of the internet not being unavailable. Most rural GPs would welcome supported access to Wi-Fi in all clinical locations, making the recording of CPD and the accessing of clinical decision making software accessible. Doctors may wish to discuss these requirements with the HSE.

PRIMARY/SECONDARY CARE INTERFACE

Generally rural practices have good links with secondary care colleagues. Many rural practices provide medical cover for local community hospitals and, as such, discuss cases more frequently with consultants than perhaps their non-rural colleagues. Outreach clinics for hospital specialties also see GPs and consultants taking the opportunity to meet at the community hospital, to discuss cases or catch up on local developments.

Good communication with secondary care colleagues works to both doctors' advantage. Consultants are likely to appreciate the clear benefits of having knowledge of the community and relationship with GPs when they are discharging patients. The community hospital can be a good step-down or step-up for patients too unwell to be at home but not severe enough for the main hospital.

In addition to providing cover for community hospitals, rural GPs tend to do their own OOH work. This provides for continuity of care for the patient, in that doctors continue to care for them when admitted to the community hospital and are responsible for following up results after community hospital discharge. This overlap between community and hospital care may also mean that traditional barriers between GPs and community staff do not exist. GPs may encounter midwives, community nurses and health visitors on a daily basis, which can lead to good communication and cooperative working.

RECRUITMENT

Some rural practices may find difficulty in recruiting permanent staff, especially doctors. Despite the many advantages and temptations of working in a rural setting, it is not for everyone, and it can take a leap of faith for a non-rural GP to move out of their comfort zone.

In recent years there have been financial pressures on rural GPs too, although current steps are being taken to support rural GPs³.

This may lead to understaffing, which can present risks to both patients and practice staff.

GPs may find that even taking a simple week's holiday can seem like climbing a mountain, in terms of effort. However, they should not forego holidays for this reason, as it is important to have time off from this very challenging role. When recruiting a locum to cover, it is not enough to find someone who is willing to cover the work. They should be suitable in terms of experience and skills to be able to perform the challenging job of a rural GP.

The Medical Council advises: "If you delegate tasks to doctors in training, you are still responsible for making sure the task is

carried out safely and competently". Although this guidance applies to delegation to doctors in training, the same principles would apply to delegating work to a locum GP.

The Medical Council guidance goes on to say: "You should ensure that the safety and welfare of your patients is protected during your absence. If you arrange replacement cover, you must ensure that the locum doctor is appropriately qualified, registered and in good standing with the Medical Council. As far as possible, patients should be told in advance about the temporary arrangements that will be in place during your absence".

Locum GPs should have a good induction process before they start work and a handover from the GP who they are covering, being clear on the expectations of the role as well as providing an insight into the geography of the area and how to arrange certain care. Before a Locum starts you should also check they have adequate indemnity arrangements in place as well as appropriate registration.

The ICGP are considering the delivery of specific training in rural medicine, for both medical students and GP trainees⁴. Providing more support for rural GPs to attend CME events is also proposed. These would be great steps to improving safety and recruitment of locum GPs in rural medicine.

EDUCATION AND PEER SUPPORT

In a remote setting, it may be challenging to keep up to date and attend courses and training. Even the act of organising an appraisal may take some organising.

Rural GPs tend to be creative in the methods they use to keep up to date, using online CPD and learning modules as well as attending training sessions.

Within practices and the wider primary care team it is important to discuss any significant events and ensure that appropriate learning is taken from events, both with adverse but also good outcomes. There will be situations where this learning could be extended to the community team and secondary care.

GPs may wish to arrange peer support relationships with other rural GPs, so that they can share learning and discuss cases. The use of telephone or videoconferencing may be useful in such circumstances.

OWN HEALTH

Rural GPs need to be aware of their own health and consult colleagues when appropriate.

The Medical Council states: "If you become ill, you should seek advice and help from another doctor rather than treat yourself. Even as a doctor, you should have your own general practitioner".

There is the potential for both social and professional isolation and it is important to take steps to ensure that this doesn't happen. In addition, in a busy all-encompassing job, with challenges, such as 24-hour on-call sessions, there is always the potential for burnout.

Doctors should ensure that they maintain a good work-life balance and it is important that when they are not working, they are truly away from work. That said being in some of the country's most beautiful locations can present wonderful opportunities for enjoying that time off.

DISTANCE FROM THE HOSPITAL

Rural GPs are only too aware that they may be a long way from secondary care. They need to be able to cope with many different types of emergency situations and may need to spend several hours with the patient prior to transfer. The decision on how to get the patient off an island, for example, balances clinical need with resource implications. In remote areas, the weather and road conditions come in to play, at certain times of the year, when roads may simply be unpassable.

Although midwives are accessible locally, GPs may be involved in obstetric emergencies. Having protocols, training and advance planning, for example transferring at risk patients to the mainland, is essential.

Rural GPs need specific training, often funded by themselves, and this should be updated on a regular basis. Necessary training includes advanced life support and pre-hospital care. Such training is an essential part of being able to deal with any emergency situation.



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The cases mentioned in this article are fictional and are used purely for illustrative purposes.

With GPs providing care for patients on the numerous inhabited offshore islands, even seemingly simple tasks like organising blood tests may be dependant on boat timetables. Regular treatment such as dialysis needs careful planning and coordination.

PRIMARY CARE WORKLOAD

Since GPs cover consultations, OOH sessions and also any local community hospital, it is important to ensure a balanced and well-managed appointment system. This may incorporate telephone appointments as well as in person, if the practice area is large and patients have difficulties with travel. Good liaison with the community nursing team may help in ensuring that patients receive good appropriate care and a multidisciplinary approach is essential, as all members of the team will be reliant on each other.

The practice should have a chaperone policy and consider how to ensure availability of chaperones for examinations. This may present challenges for small practice teams.

On average, the population is two years older in rural areas than in urban areas and there may be higher levels of unemployment and relative poverty⁴. As such, the patterns of disease may be different to that encountered in urban areas. When coupled with a reduction in services in some rural areas, such as schools, access to A&E, ambulance provision and transport, rural general practice can feel like a totally different job to that in its urban counterparts.

Despite the many challenges that rural GPs may face, it presents an exciting and rewarding career and the chance to make a real difference to their patients.

As a busy clinician we know it is a challenge to fit in training and development. Prism, our online programme of interactive modules, can be accessed at a time and place to suit you ensuring you keep your knowledge up to date. To find out more, visit prism.medicalprotection.org



PHYSICIAN, HEAL THYSELF

Dr Ide Delargy is a GP at Blackrock Family Practice in County Dublin who specialises in addiction and is the Clinical Lead for the Practitioner Health Matters Programme. Here she discusses the increasing concerns surrounding doctors' mental health and well-being

Dr Delargy has over 20 years' experience at both practice and policy level in the area of substance misuse in Ireland and the UK. She is currently Director of the Substance Misuse Programme at the Irish College of General Practitioners as well as National GP Co-ordinator for the HSE Addiction Service and Chairperson of the Sick Doctor Scheme.

The subject of doctors' health and well-being is attracting growing interest around the world. There is an evolving body of research looking at the impact of poor doctor health on patient care and, in parallel, evidence showing that those who enjoy good mental health and are 'engaged' achieve better patient outcomes.

Doctors are not immune to illness and mental distress with studies¹ even suggesting that doctors are more prone to mental health problems and higher rates of suicide than the general population. Although Irish studies addressing issues relating to doctor health problems are limited, there is sufficient concern about the high prevalence of stress, burnout and mental health disorders in the profession. Increasing patient demands, perfectionist personality traits and the challenging working conditions may be contributing to these problems. Another difference is a higher prevalence of abuse of prescription medicines which the practitioner may be prescribing for him or herself.

The rates of substance misuse and mental health problems among healthcare professionals are at a minimum similar to those among the general population. However many international studies suggest higher rates in doctors.

One in four doctors, dentists and pharmacists – just like everyone else – will have mental health problems at some stage. About 10 to 15% will have a problem related to alcohol or drugs, which is again similar to the general population, according to figures from the new Practitioner Health Matters Programme (PHMP) which is dedicated to providing confidential advice and support for doctors.

GPs and work-related stress

A Medical Protection survey of over 450 Irish GPs revealed that a staggering 95% of respondents had experienced work-related stress in 2014. Furthermore:

- **The leading causes of stress were increased patient expectations (90%), an increasing risk of litigation (77%) and heavy workloads (75%)**
- **Stress had a big impact on respondents' personal lives (80%), health and well-being (79%), empathy towards patients (60%) and concentration (56%)**
- **Nearly half (49%) enjoy their jobs but recognised that changes need to be made, while stress had caused almost a third (30%) of respondents to question their careers.**

STIGMA, AWARENESS AND WARNING SIGNS

Admitting to having a mental health or a substance misuse problem continues to carry a stigma and a sense of shame. For doctors it can be even more difficult to acknowledge a problem. In addition to the sense of shame and stigma associated with such problems, the fear of reputational damage and concerns around confidentiality contribute to delays in presentation. Unfortunately many delay coming forward to seek help and many therefore present very late and usually in crisis.

Raising awareness about the health issues doctors experience as well as signposting how they might access help is of paramount importance. Very often there are early warning signals that someone may be getting into difficulty but unfortunately these signals are frequently ignored or missed. It is acknowledged that the person with the problem is often the last person to realise that they need help.

Initial warning signs can be very subtle and may develop over time – examples include:

- Changes in work patterns in someone who had previously been careful and attentive to their work.
- Behaviours such as appearing distracted, lack of attention to detail, poor punctuality, not answering their bleep or irritability with colleagues.
- A change in appearance such as neglecting dress or personal hygiene might also indicate a problem.

As problems escalate, the signs become more obvious, ranging from a person on duty who may smell of alcohol to requiring frequent breaks to access and use certain substances. Someone behaving in this manner is clearly at a very advanced stage of illness.

The predominant demographic associated with these problems are males in their middle years. However in recent times there is increasing evidence that younger female practitioners are starting to present more frequently to practitioner health programmes.² This may be linked to the fact that there are a lot of additional pressures on women in terms of trying to manage their family life and all of the career pressures that exist. Additional factors particularly for women with children may be the requirement to move location for the purposes of ongoing training. Many people find these transitions difficult and may result in loss of support networks and disconnection from family and friends.

SEEKING HELP

While most people find this difficult to do, reaching out to a colleague who may be experiencing difficulties and encouraging them to seek medical advice may be the kindest thing you could ever do for that colleague. In many cases simple advice, reassurance and rest may be all that is required but too often however more serious problems are covered up or ignored. This can have devastating consequences for the impaired doctor, for their families and their patients.

Guidance for GPs who are concerned about colleagues is set out in the Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners (2009). It states: "If you have concerns about a colleague's conduct or competence, you should talk through your concerns initially with the doctor in question. In such a situation, or where you have a concern in relation to potentially unsafe systems, you must act to prevent any immediate risk to patient safety by taking appropriate steps to notify the relevant authority about your concern as soon as possible. If you are not sure who you should report your concern to, ask a senior colleague for advice."

"If you are concerned about a colleague's health or professional competence due to misuse of alcohol or drugs, a physical or psychological disorder or other factors, you have an overriding duty to make sure that patients are protected. The best way to support a colleague in such circumstances is to advise them to seek expert professional help or to consider referral to the Medical Council's Health Sub-Committee. However, if there is a risk to patient safety, you must inform the Medical Council of your concerns without delay."

It has been well-documented that doctors do not access medical help in the normal ways. This can mean that they self-manage and self-medicate their medical or mental health problems without seeking an objective medical opinion. Despite the fact that Medical Council guidelines recommend that all doctors should have their own personal GP it is a fact that many health professionals do not.

Based on the available evidence the expectation would be that of the 19,000 registered doctors in Ireland an estimated 1,900 may have a problem and need help. Currently the numbers presenting would fall significantly short of that so clearly there is an unmet need out there. Making that first contact will often be the most difficult step but once a person is treated in a dignified, confidential manner and is offered the help they need it becomes easier.

Practitioners who are unwell may often be in financial difficulty as a result of neglecting their practice or being unable to attend to it effectively. It can be a chicken and egg scenario with the financial constraints contributing to their stress and mental health issues and making things worse for them. Seeking help is free of charge so financial difficulties need not be a barrier to accessing the appropriate support and advice.

If you have concerns about yourself or about a colleague the PHMP is there to help.

Visit practitionerhealth.ie for further information.

Medical Protection also provides an independent and confidential counselling service and accessing the service is easy. Contact info@medicalprotection.org

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HOW TO MANAGE A DISRUPTIVE PATIENT

Dealing with a disruptive patient can be one of the most challenging aspects of general practice. Senior Medicolegal Adviser Dr Richard Stacey provides advice on the best way to manage such a situation

At the end of a busy Monday morning surgery at the Lakeview Practice, Dr Durcan was asked by the practice manager if she would mind speaking with one of the receptionists (Sarah) who was upset as a consequence of an altercation with a patient at the reception desk.

The patient had brought a repeat prescription request and had insisted that it should be processed immediately. Sarah had explained that all the GPs were currently in surgery and that the practice policy was that 24 hours' notice was required for all repeat prescription requests. The patient was unhappy with this explanation, raised his voice and (in front of a busy waiting room) said, "the policy is useless, the practice is useless and you are completely useless!" The patient then stormed out of the practice leaving Sarah in tears.



WHAT ARE THE IMMEDIATE ISSUES?

The immediate priority is to speak with Sarah in a protected setting in order to provide her with support and to seek an understanding as to what happened.

In order to investigate and corroborate the events, it would be helpful to seek a written statement from Sarah, together with any of her colleagues that witnessed the incident.

In light of the undoubted upset this has caused to Sarah, it is important to offer her the requisite support.

Irrespective of the fact that the patient's behaviour has been unacceptable, the following matters should be taken into consideration:

- The repeat prescription request will require processing.
- There may be an underlying reason why the patient requested the repeat prescription as a matter of urgency.
- The patient's behaviour may have been a manifestation of an underlying mental health problem and/or there may be mitigating personal/social circumstances.

In light of these matters, it is important to make contact with the patient in order to highlight the distress that their behaviour has caused, to clarify the position in relation to the provision of the prescription and to seek an understanding of any underlying issues.

Please refer to Box A for tips in relation to approaching the patient.

BOX A

APPROACHING THE PATIENT

- The thought of approaching a patient in such circumstances is undoubtedly anxiety-provoking.
- It is important that the approach is made at the earliest opportunity (but not before a full understanding of the incident has been reached).
- The approach should be made by the most appropriate person (for example; one of the GPs or the practice manager).
- Protected time should be set aside.
- A contemporaneous note should be made of the conversation with the patient.
- Sometimes, the conversation with the patient can be cathartic and the patient may accept that their behaviour was inappropriate and offer an apology.
- Conversely, the patient may dispute the allegations and take a confrontational approach.

Our Managing Conflict and Aggression in General Practice workshop will assist your practice in recognising and managing different aspects of conflict that they may encounter at work. It provides practical tools and tips that can be used to help resolve a difficult situation. For more information and to book, contact education@medicalprotection.org or +44 (0)113 241 0624

CAN THE PRACTICE REMOVE THE PATIENT FROM THE LIST?

It is entirely understandable that, for a variety of reasons, one of the first considerations is as to whether or not to remove the patient from the list.

The Medical Council's Guide to *Professional Conduct and Ethics* (2009) states at paragraph 14.1: "If you are asked to examine or treat a patient who presents a risk of violence, you should make reasonable efforts to assess any possible underlying clinical causes of the violent behaviour. However, you are not obliged to put yourself or other healthcare staff at risk of undue harm in the course of such assessment or treatment¹."

If patients have been violent to any members of the practice staff or have been threatening to the point where there have been fears for personal safety, Medical Protection would recommend that the incident should be reported to the Gardaí straightaway.

If you wish to discontinue treating a public patient, you should advise the HSE of this fact and the reasons why. The HSE is then responsible for ensuring continuity of care and will refer the patient to the panel of local doctors available for them to register with. It's a good idea to notify the patient in writing that the HSE will make these alternative arrangements for their care, as a matter of courtesy and good practice, and to avoid the patient making a complaint relating to poor communication. You should transfer any medical records promptly and provide care as appropriate in emergency circumstances.

According to the Medical Council, if you wish to discontinue providing care for a patient you are not released from your ethical responsibilities to patients. Therefore you must continue to provide any care that might be needed until alternative arrangements are in place. The guide states: "Once you undertake the care of patients you should usually provide continuity of care for the duration of the illness. If you decide to withdraw your services, either as an individual practitioner or as part of a team or group that has decided to withdraw care, it does not release you from your ethical responsibilities to patients. This means that you must provide emergency services and any care that may be required by those for whom you hold clinical responsibility. When alternative medical care is in place, you should transfer the patient's medical records without delay."

"You should provide medical information, normally with the patient's knowledge and agreement, to another member of the profession when requested²."

If you face a situation like this and require advice or support then contact one of our medicolegal advisers on +44 (0)113 241 0200 or email querydoc@medicalprotection.org

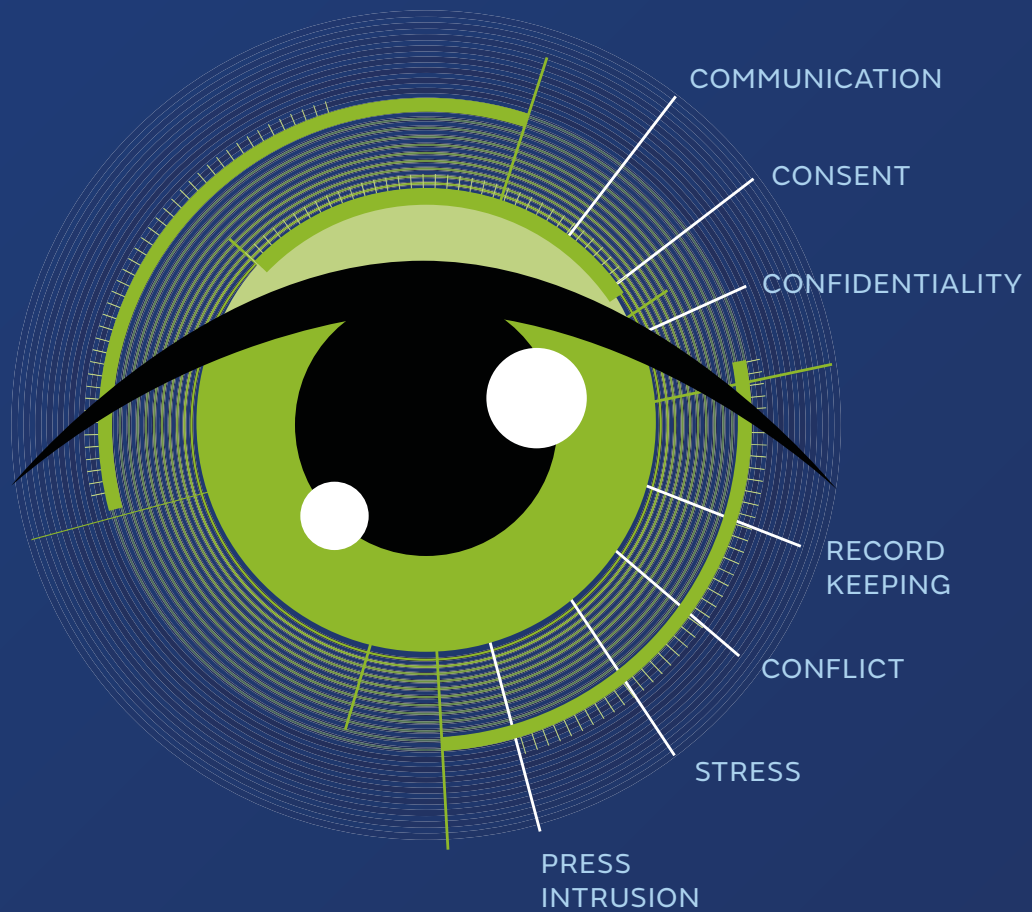
For more information on this topic see the Medical Protection factsheet 'Removing patients from the practice list' on our website: medicalprotection.org/ireland/resources/factsheets

The cases mentioned in this article are fictional and are used purely for illustrative purposes.

References

1. Medical Council, Guide to Professional Conduct and Ethics, (2009) www.medicalcouncil.ie/News-and-Publications/Publications/Information-for-Doctors/Guide-to-Professional-Conduct-and-Ethics-for-Registered-Medical-Practitioners.pdf
2. Ibid

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