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Important – please note
Due to the dynamic nature of medical law we suggest that you access our website at www.medicalprotection.org/ireland for the most up-to-date information. May 2012.

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The production team were Dr Stephanie Bown (Editorial Consultant), Philip Walker (project management and production) and Neil Benton (design and typesetting).

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This booklet was produced with doctors in the early years of hospital practice in mind. It is intended to offer general guidance to help them circumvent the commonest pitfalls encountered in everyday practice. MPS members are always welcome to telephone our medicolegal advice line for more specific practical advice and support.

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

We are a mutual, not-for-profit organisation offering more than 250,000 members help with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Fairness is at the heart of how we conduct our business. We actively protect and promote the interests of members and the wider profession. Equally, we believe that patients who have suffered harm from negligent treatment should receive fair compensation.

We promote safer practice by running risk management and education programmes to reduce avoidable harm.

MPS is not an insurance company. The benefits of membership are discretionary – this allows us the flexibility to provide help and support even in unusual circumstances.
Introduction

At MPS, we have a wealth of experience and expertise in helping doctors and other healthcare professionals with ethical and legal problems, and in reducing the risks that arise from their practice. This gives us a unique insight into the reasons why things go wrong and why complaints and litigation occur, and into what can be done to reduce this.

In our experience, most incidents leading to medicolegal problems fall into one of the following categories:

- Failure to appreciate legal and professional responsibilities
- Problems in clinical management
- Medication errors
- Administrative errors
- Failure of communication, including inadequate medical records.
Understanding your legal responsibilities

Each year we see numerous cases where doctors have unwittingly fallen foul of the law. This is often because they are unaware of the relevant statutes regulating their area of practice or because they have not fully understood the principles underlying considerations such as consent or confidentiality.

The best way to avoid running into similar problems yourself is to develop a good working knowledge of (and comply with) the legal framework that governs the practice of medicine. There are three main sources:

- **Statutes** – These are Acts of the Oireachtas and associated regulations (statutory instruments) laying down clear requirements that must be adhered to. Some, such as the Mental Health Act, cover particular aspects of practice, but there are many others which, although not specific to medicine, nevertheless have a considerable impact on medical practice (for example, the Data Protection Acts of 1988 and 2003).

- **Case law** – Principles derived from the interpretation of individual court cases on relevant areas such as consent, confidentiality and clinical negligence. These principles apply to all areas of clinical practice and represent a constantly evolving area of law (what we call “common law”).

- **Codes of conduct and statements of professional responsibility issued by the Medical Council** – All practitioners must comply with the standards of practice and responsibilities that are a condition of their continued registration.

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**Box 1: Examples of important statutes affecting medical practice**

- Child Care Act 1991
- Children Act 1997
- Constitution of Ireland
- Control of Clinical Trials Act 1987
- Freedom of Information Act 1997
- Lunacy Regulations (Ireland) Act 1871
- Medical Practitioners Act 2007
- Mental Health Act 2001
- Non-Fatal Offences Against the Person Act 1997
- Sexual Offences Act 2006
- Status of Children Act 1987
Consent to treatment

To treat patients without their consent is a violation of their constitutional rights and transgresses a fundamental principle of medical law. The basic rule is simple: no-one has the right to touch anyone else without lawful excuse and if doctors do so it may well undermine patients’ trust. Such behaviour may lead to a clinical negligence claim, a complaint to the Medical Council or even civil or criminal proceedings for assault.

There are three components to valid consent:

- Capacity
- Information
- Voluntariness.

A patient may give express or implied consent to a procedure. In many circumstances, implied consent is sufficient – eg, if the patient undresses for an examination – but in cases where the proposed procedure or treatment is complex, invasive or may have significant consequences for the patient it is important to obtain express written consent. You are also obliged by law (Control of Clinical Trials Act 1987) to obtain the written consent of participants before including them in clinical trials or research.

Be sure to allow the patient enough time to consider your advice and to reach a decision. If a patient feels that the consent has been “rushed”, a negligence claim may ensue, regardless of whether the procedure is carried out competently or not.
Box 2: Points to remember about consent

- To be valid, consent must be freely given by a patient with capacity making an informed decision.
- Consent is much more than a signature on a form.
- Patients have a right to information about their illnesses and the investigations and treatments proposed. You have a corresponding duty to provide adequate information and warnings, and to answer questions truthfully.
- The amount of detail you provide about risks, alternatives and possible adverse outcomes will depend on the circumstances – eg, degree of urgency – and on the patient’s individual requirements.
- Communicate information in terms that the patient can understand.
- If you are proposing an invasive procedure, you should inform the patient about risks associated with the anaesthetic and risks associated with the procedure itself, especially if they might affect the patient’s decision to proceed.
- Discuss a procedure with a patient only if you are sufficiently knowledgeable to answer their questions.
- The person who will be undertaking a procedure is ultimately responsible for obtaining valid consent. He or she may delegate the consent process to a suitably qualified colleague, but the delegate must be familiar enough with the procedure to explain it fully and to answer all the patient’s questions.
- Never coerce a patient into a decision – a competent patient has the right to refuse consent.
- As a matter of good practice, note in the patient’s records the nature of the discussions that have taken place.
- The consent form, signed and dated by the patient and doctor, is part of the clinical notes and should be filed with them.
- If you are in any doubt about obtaining valid consent, discuss your concerns with a senior colleague or an MPS medicolegal adviser.

Capacity

Doctors should presume that adults have the capacity to consent to or refuse a proposed treatment unless it can be established that they lack that capacity. Each assessment of an individual’s capacity should relate to a specific decision – a patient may, for example, be incapable of understanding the complex implications of a major procedure like a liver transplant, but still be able to comprehend the risks and benefits of diathermy to remove a wart.
The test of capacity currently applied in the Irish courts is the “C test”, which derives from the English case of Re C. The test is in three parts, all of which have to be fulfilled for a patient to be deemed competent to make the decision they are being asked to consider:

1. Does the patient comprehend and retain treatment information?
2. Does the patient believe that information?
3. Does the patient weigh that information, balancing risks and needs, to arrive at a choice?

Only the courts (or an official empowered by a court) can consent to treatment on behalf of an incapacitated adult. This does not mean, however, that incapacitated adults should be denied necessary medical treatment. Treatment can – and should – be given if the patient’s doctors, in consultation with the patient’s relatives and carers, conclude that it is in the patient’s best interests (see Box 3). The focus should be on what the patient would consider to be in his/her best interests, not what the doctor would want done if he were in the same position. Any intervention should be the minimum necessary to safeguard the patient’s wellbeing.

**Box 3: When a patient is incapacitated**

“Where an adult patient is deemed to lack capacity to make a healthcare decision, you should take reasonable steps to find out whether any other person has legal authority to make decisions on the patient’s behalf [see editor’s note below]. If so, you should seek that person’s consent to the proposed treatment.

“If no other person has legal authority to make decisions on the patient’s behalf, you will have to decide what action to take. In doing so, you should consider:

- which treatment option would provide the best clinical benefit for the patient,
- the patient’s past and present wishes if they are known,
- whether the patient’s capacity is likely to increase,
- the views of other people close to the patient who may be familiar with the patient’s preferences, beliefs and values, and
- the views of other health professionals involved in the patient’s care.


**Editor’s note:** This would only be if the patient has been made a Ward of Court, in which case you must obtain written consent from the case officer assigned to the Ward. If the proposed treatment is particularly intrusive or carries significant risks, the case officer may refer the matter to the court.
Children and young people

“When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account.”

(UNICEF, A summary of the Convention on the Rights of the Child, Article 12)

Although the age of majority is 18, the law recognises 16 and 17 year olds as having the capacity to consent to medical and dental treatment on their own behalf.

It is not clear, however, whether someone of this age also has a right to refuse treatment as this has not yet been tested in the courts. Theoretically, a parent or legal guardian can consent to treatment that a 16 or 17 year old is refusing, but this is not an ideal situation (see Box 4) and in such circumstances it is probably better to refer the matter to the courts to decide.

If a minor of 16 or over is incapable of giving consent, it may be obtained from the young person’s parent/guardian or, if necessary, a court of law.

Box 4: When a minor refuses treatment

“The child has rights protected under the Constitution — to autonomy, to bodily integrity and to dignity — and these rights are not dependent on the child having legal capacity to consent. On this basis, ... the imposition of treatment on a resistant child is something which should be approached with great care and ... matters such as the child’s best interests and the least invasive alternative should be taken into account.”

In law, the consent of the parent or legal guardian is required if a child is under the age of 16. In practice, however, it is reasonable to seek the consent of a minor with the capacity to understand the nature and implications of the proposed treatment or procedure. This should not present a problem if the child and parents are in accord about a decision to consent to treatment. Difficulties can arise, however, if the parents of a minor are in disagreement with clinicians or the patient about what is in the child’s best interests.

If there are two people with parental responsibility, it is usually sufficient for one of them to give consent, but where decisions may have profound, irreversible consequences, both of them should be consulted. The more complex the care and the greater the level of intervention required, the greater the need to include both parents in discussions and secure the consent of both. You should also seek the consent of both parents when you have reason to believe that they may not be in agreement with one another (e.g., if they are no longer living together, are in conflict, and have joint custody of the child).

Even when children lack the capacity to give consent, they should still be involved as far as possible in the decision-making process (see Box 5 on page 9).

**Who can consent on behalf of a minor**

**The minor him/herself**
Under The Non-Fatal Offences Against the Persons Act 1997, minors aged 16 or 17 may consent to surgical, medical or dental treatment. Parental consent is generally needed for all other minors, and for 16 and 17 year olds who lack capacity.

**Parents**
A child’s mother, whether married or unmarried, has automatic legal guardianship of the child.

The child’s father also has guardianship if he is married to the child’s mother, either before or after the birth of the child. A father who is not married to the mother can be appointed as a joint guardian of the child if he and the child’s mother have made a statutory declaration to that effect. Alternatively, he can apply to the courts to be appointed a joint guardian.

**Legal guardians**
Testamentary (i.e., named in a deceased parent’s will) and court-appointed guardians can make healthcare decisions on a child’s behalf.

**Foster carers**
Foster carers can consent to urgent medical treatment for a child. They can also consent to ancillary treatment, such as a general anaesthetic. For non-urgent treatment, consent should be sought from the child’s natural parents.
Foster carers or relatives who have been caring for a child for five years or more may be granted a court order that authorises them to consent to “any necessary medical or psychiatric examination, treatment or assessment with respect to the child”.2

HSE
If a care order has been made for a child under the age of 16, the HSE can consent to elective treatment in the best interests of the child. It is good practice, however, to also consult the child’s parents if possible.

The courts
If a child has been made a Ward of Court, the consent of the case officer appointed by the court is needed before medical treatment can be carried out, except in an emergency.

The District Court can make an emergency care order placing a child in the care of the HSE if there is uncertainty or dispute about the validity of a refusal of treatment on the part of a parent or a minor aged 16 or more.

Consent to disclosure of personal health information3
“The minimum age at which a person can give consent to having their personal data processed is not specified in the Data Protection Acts.

“Section 2A(1) of the Acts provides that, where a person by reason of his or her physical or mental incapacity or age, is or is likely to be unable to appreciate the nature and effect of giving consent, such consent may be given by a parent or guardian or a grandparent, uncle, aunt, brother or sister of the person provided that the giving of such consent is not prohibited by law.

“Where a person is under the age of majority (18), the Acts require the data controller to make a judgement on whether the young person can appreciate the implications of giving consent.

“The ... Non-Fatal Offences Against the Person Act, 1997 (Section 23) provides that a minor who has reached the age of 16 can give consent to medical treatment. It would therefore be reasonable to conclude that a young person of 16 or above could give consent to the processing of their medical data. For a person under that age, Managing and Protecting the Privacy of Personal Health Information in Irish General Practice4 provides useful guidance. It suggests that, where the individual is under 16, consent may still be given, but that this requires that the medical practitioner involved assess whether the young person has the maturity to understand and make their own decisions about the handling of their personal health information. In relation to the right of access to health data, it recommends that the general practitioner use professional judgement on a case by case basis, on whether the entitlement to access should be exercisable by (i) the individual alone, (ii) a parent or guardian alone, or (iii) both jointly. In making a decision, it suggests that particular regard should be had to the maturity of the young person concerned and his or her best interests. This guidance on the exercise of the right of access could also usefully be applied in other contexts.”
Box 5: Best practice for involving children in healthcare decisions

“... best practice in this area may be summarised as follows:

- the child must be involved in treatment decisions as far as possible
- the patient’s parents or carers must be involved in treatment decisions
- the views of children must be obtained and respected
- the relationship between healthcare professional and child should be based on truthfulness, clarity and awareness of the child’s age
- children must be listened to and their questions responded to, clearly and truthfully
- communication with children is not a once-off occurrence, but must be an ongoing process
- training in communication skills with children is an essential component of appropriate professional training.”

Advance directives

An advance directive is a statement made by a competent adult in anticipation of a time in the future when he or she may lack the capacity to make healthcare decisions. Such statements usually take the form of advance refusal of specified treatments, but may also contain information about the patient’s values and beliefs.

At present there is no legislation covering advance directives in Ireland and there is very little relevant Irish case law to clarify their legal status, but the Medical Council provides the following guidance on the ethical position:

“An advance treatment plan has the same ethical status as a decision by a patient at the actual time of an illness and should be respected on condition that:

■ the decision was an informed choice, according to the principles of informed consent,...,
■ the decision covers the situation that has arisen, and
■ the patient has not changed their mind.”

If there is any doubt about the validity or applicability of an advance decision, “you should make treatment decisions based on the patient’s best interests. In making such a decision, you should consult with any person with legal authority to make decisions on behalf of the patient and the patient’s family if possible.”

End of life decisions

When patients are seriously ill and lack the capacity to make medical decisions on their own behalf, clinicians may be obliged to make treatment decisions in the patient’s best interests. This might include choosing not to intervene if a treatment or procedure would be burdensome and with little benefit to the patient. The Medical Council advises:

“There is no obligation on you to start or continue a treatment, or artificial nutrition and hydration, that is futile or disproportionately burdensome, even if such treatment may prolong life. You should carefully consider when to start and when to stop attempts to prolong life, while ensuring that patients receive appropriate pain management and relief from distress.”

However, decisions to discontinue a life-prolonging treatment or intervention (such as artificial nutrition and hydration) should be carefully discussed within the healthcare team and with the patient’s family. The substance of your deliberations should be documented in the patient’s notes, and if there is any doubt about the right course of action, the decision should be referred to the law courts (see Box 6).
Box 6: End of life decisions

In 1996, the Supreme Court heard the case of a 45-year-old woman who had been in a near persistent vegetative state for 23 years and was being fed via a gastrostomy tube. Her mother, with the support of the rest of her family, applied to the High Court for permission to have the feeding tube removed and to allow life-threatening infections to take their course without antibiotic intervention. The High Court judge consented to this on behalf of the Ward, but the institution in which the Ward was living and the Attorney General appealed against the decision.

Four out of the five justices hearing the case upheld the High Court ruling. In their deliberations, they considered whether artificial nutrition and hydration constitutes medical intervention and whether its withdrawal would be in the Ward’s best interests. The four justices who upheld the decision concluded that tube feeding does amount to medical intervention because it is intrusive, and that it would be in the Ward’s best interests to withdraw such intervention. They took the view that withdrawing artificial means of sustenance would not be tantamount to terminating her life; it would be allowing nature to take its course.

Emergencies

Legal action against doctors providing treatment without consent in an emergency is extremely rare. In genuine emergencies, do not hesitate to provide immediately necessary treatment unless there are clear indications that the patient would object to the treatment.
Confidentiality

Confidentiality is central to the trust patients place in their doctors. It is an important legal and ethical principle – doctors must abide by the principles of the 1988 and 2003 Data Protection Acts and by the Medical Council’s guidance.

Sharing confidential information

At face value, confidentiality may seem a very straightforward principle, but there are all sorts of situations where it is difficult to know if patient information should be shared or not – with the gardaí, for example, or social workers.

Confidentiality is usually referred to as an ethical issue. It is, but it is also a legal principle.

- Healthcare workers employed by hospitals and clinics are bound by confidentiality clauses in their contracts.
- There is a common-law duty to preserve professional confidence.
- There are requirements under the Data Protection Act to keep personal data, including medical records, secure.
- It is a condition of your registration to abide by Medical Council guidance, which includes a requirement to respect patient confidentiality.

The duty of confidentiality goes beyond undertaking not to divulge confidential information; it includes a responsibility to make sure that written patient information is kept securely. Confidential records should not be left where other people may have casual access to them and information about patients should be sent under private and confidential cover, with appropriate measures to ensure that it does not go astray.
Patients should be informed about the kind of information being held about them, how and why it might be shared, and with whom it might be shared. It is especially important to inform patients – and to let them know that they have the right to withhold consent – if you intend to use their personal information for purposes other than their immediate care, or to share it with non-medical agents such as social workers.

Confidentiality is not an absolute principle, and there are exceptions to the rule. The circumstances in which it is permissible to disclose information about a patient to a third party are:

- **Disclosure with the patient’s consent.** This includes fulfilling requests for information made by insurance companies, employers, solicitors and other organisations.

- **Sharing information with members of the clinical team.** This should be on a need-to-know basis, and patients should be informed that they can withhold consent for certain information to be shared as long as it doesn’t endanger members of staff or others.

- **To comply with a court order.** Compliance with a request for information from a court is mandatory.

- **To comply with a statutory reporting requirement.** Some reporting of confidential patient information is permissible or required by law – eg, reporting a notifiable infectious disease (see Box 7) or reports to the national cancer registry.

- **To protect a child from abuse or neglect.** The welfare of the child is paramount, so an appropriate breach of confidence (to a social worker, for example) is justified if you have reason to believe the child is at risk.

- **In the public interest.** It is usually considered justifiable to disclose confidential patient information in order to prevent serious harm befalling a third party. This includes disclosures to the guardai to help them in the prevention, detection or investigation of serious crimes.

**Data protection advice from the Commissioner**

The following information has been extracted from *The Medical and Health Sector: The Data Protection Rules in Practice*, [www.dataprotection.ie](http://www.dataprotection.ie) (as of 9 May 2012).

**Can I pass patient details on to another health professional for clinical purposes?**

“If you are passing patient data on to a person or body acting in an agency capacity for you – such as a clinical laboratory – then this is not a ‘disclosure’ under the Data Protection Act, and the Commissioner does not insist on specific patient consent in such cases. However, you should inform the patient in advance that their data will be used in this way.”
“If you are passing the patient data to another health professional for guidance and advice on clinical issues, the patient data should be kept anonymous. If you wish to pass on the full patient data, including identifying details, you will need the consent of the patient in advance, except in cases of urgent need.”

**What if I need to disclose patient data, and I don’t have the time to obtain consent?**

“If patient details are urgently needed to prevent injury or other damage to the health of a person, then you may disclose the details. Section 8(d) of the Acts makes special provision for such disclosures. However, if the reason for the disclosure is not urgent, then you will need to obtain consent in advance.”

**Can I use patient data for research or statistical purposes?**

“Ideally you should make patients aware in advance if you intend to use their data for your own research purposes. However, the Acts provide that such uses of personal data are permitted, even where the patient was not informed in advance, provided that no damage or distress is likely to be caused to the individual.”

**Can I disclose patient data to others for research or statistical purposes?**

“You may pass on anonymised or aggregate data, from which individual patients cannot be identified. Ideally, you should inform patients in advance of such uses of their personal data. If you wish to pass on personal data, including identifying details, you will need to obtain patient consent in advance.

“Cancer research and screening is an exception to this rule. Under the Health (Provision of Information) Act, 1997, any person may provide any personal information to the National Cancer Registry Board for the purpose of any of its functions; or to the Minister for Health or any body or agency for the purpose of compiling a list of people who may be invited to participate in a cancer screening programme which is authorised by the Minister.”

**Box 7: Notifiable infectious diseases**

“As soon as a medical practitioner becomes aware of or suspects that a person on whom he/she is in professional attendance is suffering from or is the carrier of an infectious disease, or a clinical director of a diagnostic laboratory as soon as an infectious disease is identified in that laboratory, he/she is required to transmit a written or electronic notification to a Medical Officer of Health.”

Health Protection Surveillance Centre

[www.hpsc.ie](http://www.hpsc.ie)
Tips to avoid confidentiality breaches

- Do not leave case notes lying around in publicly accessible areas.
- Resist the temptation to look up patients’ records out of idle interest (e.g., because you know the patient personally, or the patient is a celebrity). If you are not involved in the patient’s care you have no more right than any other member of the public to access their records.
- Do not use information contained in the medical records for purposes other than patient care, unless consent has been obtained or the data anonymised.
- For research or audit, anonymise information about patients in such a way that they cannot be identified. If this isn’t possible, obtain the patient’s consent.
- If you write identifiable information about patients on scraps of paper, post-it notes or in a notepad, keep track of them – don’t leave them lying around in your car or in your pockets, etc. When you’ve finished with them, dispose of them securely.
- Follow the hospital’s policies on safe storage of records and their removal from the premises.
- If you download patient information onto a memory stick or flash drive, make sure it’s encrypted and that the files are password protected. Keep the memory stick in a secure place.
- Change your computer password regularly, keep it secret, never let anyone log onto the system in your name, and never borrow someone else’s ID to log on.
- If you are faxing confidential patient information, call the recipient first to check that you have the right number and to tell them the fax is on the way. Ask them to notify you if it doesn’t arrive. You might also consider using a cover sheet warning the recipient that the contents of the fax are confidential.
- Be aware that emails are not secure, so take care not to include identifiable information about patients in emails unless you are confident that the emails are being adequately encrypted.
- Even letters can go astray, so they should be marked “Confidential” on the envelope and care must be taken to ensure that the correct address is used (see Box 8). Consider using registered post for highly confidential letters.

Box 8: The wrong number

In 2009, the Data Protection Commissioner reported the case of a company that carries out DNA tests sending the results of a paternity test to a client’s next-door neighbour. By the time the mistake was discovered, the next-door-neighbour had already opened the envelope and read the contents.

www.dataprotection.ie
Problems in clinical management

Negligence is a legal concept. It does not mean neglect or wilful misconduct, but a failure to attain a reasonable standard of care. Any doctor can make an error of judgment. Some are legally defensible, others are not; what is important is whether the management can be defended by a responsible body of professional opinion.

In cases of negligence, the only remedy available in law is financial compensation: damages are paid to restore claimants to the position they would have been in had the negligent act not occurred. Before damages are payable, however, the claimant must prove all three of the following:

- They were owed a duty of care.
- There was a breach of that duty of care.
- Damage was suffered as a result.

Clinical practice

The test for establishing negligence in a patient’s diagnosis or treatment derives from the Dunne case, in which Finlay CJ set out the principles that courts have since applied when assessing the standard of care the patient received. The first of his principles provides the basis for all the rest; in essence, it states that a doctor should not be considered guilty of medical negligence if other doctors of equal experience in the same specialty would have followed the same practice; such a practice must, however, be rational and reasonable.

Adopt accepted practice

Accepted practice is easy to define in some areas – prescribing in accordance with the recommendations of the Irish Medicines Formulary is an obvious example. Increasingly, proper practice has to be based on evidence (ie, determined by systematic methods based on literature review, critical appraisal, multidisciplinary consultation and grading of recommendations by strength of evidence). See Appendix 1 for links to evidence-based websites.
Accepted methods of investigation and treatment are often described by clinical guidelines. Such evidence-based guidelines improve the quality of clinical decisions, help replace outdated practices, and provide benchmarks for clinical audit.

Guidelines are supposed to be an aid to clinical judgment, not a substitute for them. In theory, then, you may choose to exercise your discretion by deciding not to follow a particular guideline. In reality, however, you should only deviate from the accepted practice embodied in the guidelines if you have very good reasons for doing so. If your judgment is called into question, you will have to demonstrate why you were justified in not complying with the guidelines.

Conversely, if you follow respectable clinical guidelines and base your decisions on evidence, you will be in a very strong position if a complaint is made against you.

**Act within your limitations**

Although you are not expected to be infallible, the law expects that, as a doctor, you exercise a reasonable standard of skill and care at all times.

Never undertake a task that is beyond your competence – when in doubt, seek help from a more experienced colleague.

Ensure you have sufficient help and equipment available for any procedure you undertake, and for the management of all foreseeable complications.

**Keep up to date**

Make Continuing Professional Development (CPD) an integral part of your working life. This not only means keeping up to date with new treatments and technologies, but also requires self-reflection and the expansion and honing of your skills, understanding and knowledge-base.

CPD is a mandatory requirement of registration. All registered medical practitioners are required by the Medical Council to be registered with a Competence Assurance Scheme and to acquire at least 50 CPD credits each year.

**Box 9: Defining poor performance**

“Poor professional performance, in relation to a medical practitioner, means a failure by the practitioner to meet the standards of competence (whether in knowledge and skill or the application of knowledge and skill or both) that can reasonably be expected of medical practitioners practising medicine of the kind practised by the practitioner.”

**Take responsibility for your health**

If you have an illness, disability or infection that may put patients at risk, you must seek medical advice and, if necessary, stop or reduce your practice. The safety of your patients should be your prime concern.

**Check equipment**

Be fully conversant with any equipment you use – ensure that it has been properly serviced and is in working order before beginning any procedure.

**Delegate appropriately**

In the context of multidisciplinary and cross-agency teamwork, it can be difficult to distinguish between delegation and shared responsibility. The question is really one of accountability, and working in a team doesn’t relieve you of your personal accountability for your professional conduct and standard of care.

As a member of a clinical team, you will have responsibilities for the care of patients, some of which you might delegate to staff who do not belong to a registered professional organisation. In these circumstances you would be held accountable for the actions of those staff members, so you must satisfy yourself that they are competent to take on the duties you are delegating to them and supervise them if necessary.

The matter is a little different when you delegate to a professional colleague. You would not be held accountable for the actions of another registered professional, but you would still be expected to delegate appropriately (ie, to a colleague with relevant training and skills) and to have provided them with sufficient information to carry out the task assigned to them.

**Keep comprehensive up-to-date records**

The medical record is an essential component of patient care. A good medical record will contain all the information one clinician needs to take over where another left off – or, to put it another way, to allow a clinician to reconstruct a consultation or patient contact without relying on memory. It should, therefore, provide all the information a newcomer to the care team would need to know about a patient and their treatment plan.

If you ever need to alter the notes at a later date, make it clear that you are introducing a retrospective correction. Any alteration to paper records should be clearly dated and signed. Do not obliterate the original entry – just run a line through it. Never try to rewrite notes at a later date. Do not delete entries in computer records, but add annotations to them if necessary (and date and initial them if the software doesn’t do it automatically).

Do not write derogatory statements or criticisms about patients, colleagues or others; be as objective and factual as you can in making your notes. If you record
any history provided by someone other than the patient, make sure you include the source – eg, “Has been ‘confused lately’ (daughter)”. Remember, patients have a legal right of access to their records, which can also be scrutinised by the courts.

The Academy of Royal Medical Colleges has adopted a national standard for note-keeping in the UK (see Box 10). Many of the standards are concerned with the structure of case files, and aimed at hospital medical records administration, but the standards concerned with content provide valuable guidance for doctors. Part 2 – A Clinician’s Guide to Record Standards, contains detailed advice about what to document when clerking, handing over care and writing discharge summaries. The information can be downloaded from the Royal College of Physicians website – www.rcplondon.ac.uk.

Box 10: Selected Generic Record Keeping Standards

- Every page in the medical record should include the patient’s name, identification number ... and location in the hospital.

- Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed.

- Entries to the medical record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded.

- Every entry in the medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made.

- An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why.

- The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital.

- Advance Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified.

Academy of Medical Royal Colleges, A Clinician’s Guide to Record Standards Part 2: Standards for the Structure and Content of Medical Records and Communications when Patients are Admitted to Hospital (2008)
Medication errors

Although, strictly speaking, medication errors should come under the heading of clinical management, they account for such a high level of complaints, claims and adverse incidents that they deserve separate mention. The three most common errors reported in a recent study\textsuperscript{11} are:

- Wrong dose (21.9%)
- Omitted medication (20.2%)
- Wrong medicine given (10.1%)

Underlying these are myriad causes, such as those listed below. Most of the errors can be avoided by simple checking procedures and clear, open communication.

- Badly transcribed instructions
- Illegible prescriptions
- Miscalculation of dosage
- Confusion between similar-sounding drug names or similar-looking packages
- Clicking on the wrong drug in a drop-down menu
- Prescribing contraindicated drugs
- Not checking for potential drug interactions
- Not reviewing repeat prescriptions
- Failure to follow up/monitor
- Failure to act on laboratory results

**Box 11: Medical Council guidance**

“You must ensure as far as possible that any treatment, medication or therapy prescribed for a patient is safe, evidence-based and in the patient’s best interests. You should be particularly careful when prescribing multiple medications in case the combination might cause side effects. You should also take particular care when prescribing for patients who may have an impaired ability to metabolise the medication prescribed. You should weigh up the potential benefits with the risks of drug adverse effects and interactions when deciding what to prescribe. This also applies to the exercise of the prescribing of generic drugs. A patient’s treatment regime should be reviewed periodically.”

When writing prescriptions

- Be sure that the treatment is indicated.
- Check that the intended drug is not contraindicated and that the patient does not have a history of adverse reactions to it. Ensure that it will not interact with the patient’s other medication and warn the patient about any potential interactions with over-the-counter remedies.
- If issuing a hand-written prescription, write legibly, taking special care if the drug name could easily be confused with another – use capital letters and give the generic rather than trade name.
- If you use a computer for your prescribing, be aware of the risk of selecting the wrong drug from a drop-down menu (eg, penicillamine instead of penicillin).
- Write clear and unambiguous instructions for dosage, frequency and route of administration.
- Note the prescription and any other relevant information (eg, warnings given to the patient) in the medical record.
- Ensure that the patient is aware of what is being prescribed, and why. Use patient information leaflets to augment your verbal instructions, and be particularly careful to warn patients about possible side-effects, adverse drug interactions (including herbal medicines), or potentially dangerous activities, such as driving while taking drugs that induce drowsiness.
Checking procedures

- Be particularly careful when choosing the dose for a drug you are not familiar with.
- If a pharmacist or nurse questions a drug order or prescription, check it carefully – many problems are prevented by helpful interaction between colleagues.
- Always read the label on the bottle or vial before administering a drug or other substance, such as water for injection.
- Establish the identity of the patient and double-check the prescription before administering medication.

Communication

- If you are prescribing medication to be administered by other members of the healthcare team, issue clear and unambiguous instructions – answer fully any queries they may have.
- Make sure that your outpatients understand how to take the medication you prescribe, and that you warn them of any possible serious side-effects or effects that would make driving or operating machinery dangerous.
- Document the administration of drugs and infusions (name, time, dose) in the appropriate place in the medical records.

Box 12: Mis-heard verbal prescription leads to patient's death

A patient, in the course of treatment in an acute hospital, was given parenteral morphine. The patient was sensitive to the drug and developed respiratory depression. The patient’s doctor called in an order for an ampoule of naloxone to be administered. A dose was prepared from ward stock and given but there was no response. A repeat order for a second ampoule of naloxone was also given and again the patient showed no improvement.

The nurse then questioned the doctor; “How much of this Lanoxin do you want me to give?”

Instead of NaLoxone, the nurse heard LaNoxin. The patient subsequently died. Contributing to the error, the nurse had not repeated back the verbal order to the doctor, and the doctor had prescribed an ampoule of the drug rather than a metric weight dose. The nurse had accepted the incomplete order and administered an ampoule of LANOXIN® (digoxin) both times.

Box 13: SALADs (Sound Alike Look Alike Drugs)

Examples of sound-alike and look-alike drug pairs that have been involved in errors and near misses in Irish hospitals:

- Actimel® / Actonel®
- Amiodarone / Amlodipine
- Anexate® / Anectine®
- Carbamazepine / Carbimazole
- Casodex® / Codalax®
- Dipyriramole / Disopyramide
- Lanoxin® / Naloxone
- Losec® / Lasix®

- Actin® / Actonel®
- Amiodarone / Amlodipine
- Anexate® / Anectine®
- Carbamazepine / Carbimazole
- Casodex® / Codalax®
- Dipyriramole / Disopyramide
- Lanoxin® / Naloxone
- Losec® / Lasix®

Advice for prescribers to minimise the risk of SALAD mix-ups

- Write the full drug name when prescribing – never abbreviate.
- Specify the exact dose on the prescription – never use ‘as directed’.
- Consider ‘tall man’ lettering eg, OxyCONTIN®, OxyNORM® on prescriptions or labels etc. to identify key differences in high-alert SALAD pair names.

Prescribing for children

While all the foregoing advice on avoiding medication errors applies to both children and adults, special care is needed when prescribing, preparing and administering drugs to children. Drugs that are relatively innocuous in adults may have adverse effects in children. Variations in height, weight and body mass can make them more susceptible; or they may quickly accumulate toxic levels as a result of slower metabolism and excretion. At MPS we see many examples of errors occurring because a doctor failed to check the appropriateness of a drug and its route of administration for children or infants, or to prescribe the correct dose. We have also seen tragic cases (such as the one recounted in the case report below) in which infants have died or been seriously and permanently impaired because doses of drugs were miscalculated or a decimal point misplaced.

Case report

An overworked doctor who had been on duty for 11 hours overnight while deputising for a colleague on leave, was asked to see a premature infant with congestive heart failure. He was not normally responsible for the care of premature infants, but he prescribed digoxin to be given intramuscularly and calculated (by mental arithmetic) that the dose should be 0.6 mg.

Just as he was settling down for a well-earned rest, the ward nurse phoned to ask whether the dose shouldn’t be 0.06 mg as she had had to open two ampoules. Without thinking, he told her to “Give it as I ordered”. An hour later he was called to the ward because the baby had suffered a cardiac arrest.
Advice for safer paediatric prescribing

- Refer to a paediatric formulary when appropriate and always seek advice from colleagues if you are not sure.
- When writing a prescription, include the child’s age and write the exact dose in weight and (if liquid) volume required for administration.
- Always calculate doses on paper and get a competent colleague to check your arithmetic.
- When writing dosage, take special care in placing the decimal point and putting a zero in front of it.
- If you are prescribing in very small amounts of less than 1 milligram, prescribe in micrograms (written out – not abbreviated) to avoid confusion over the placing of decimal points.
- When prescribing for a child, it is particularly important to give the parents all relevant information such as:
  - the name of the drug
  - the reason for the prescription
  - how to store and administer the drug safely (if appropriate)
  - common side-effects
  - how to recognise adverse reactions.

Parents must always be warned about side-effects, particularly those that will be distressing to the child (eg, alopecia with cytotoxic drugs). It is also helpful to remind them of the importance of storing drugs in their labelled containers, and well out of children’s sight and reach.
Administrative procedures

Errors have a tendency to compound themselves, so it is worth taking the time to ensure that essential tasks are carried out carefully. Many complaints arise from simple mistakes that could have been easily avoided. The most common administrative failures are:

- failure to pass on important information
- failure to arrange appointments, investigations or referrals with the appropriate degree of urgency
- failure to review the results of investigations
- failure to arrange follow-up and monitoring
- mislabelling, misfiling and failure to check labels

Follow appropriate systems

Every hospital should have policies and procedures in place for checking medications, identifying the site of an operation, counting swabs and instruments, and so on. Even so, there are numerous incidents, complaints and negligence claims to show that these checks are far from foolproof; if you place too much trust in them, you may easily become complacent and assume that they have been carried out competently.

- Before carrying out a procedure, always check the patient’s identity and look at the case notes and relevant images to establish the nature and site of the procedure, even if someone else has already prepared or marked the site.
- Familiarise yourself with your hospital’s policy on ordering and administering blood products.
- Make sure that any specimens and accompanying forms or reports are accurately and fully labelled.
- See that all hazardous substances and waste are labelled with appropriate warnings.
- Be aware of health and safety legislation as it applies to your day-to-day work, eg, disposal of sharps, etc.

No-one is perfect, so clinicians will occasionally overlook, forget, or not be aware of crucial information that has an important bearing on a patient’s wellbeing. Patients therefore have an important role to play in the information system. If they are kept well informed and are encouraged to voice their concerns, they can act as a vital failsafe in the information system. Patients usually know what they’re in hospital for; they know their medical history, they’re usually familiar with their medication, they have their own welfare high on their agendas, and they rarely mistake themselves for another patient. It therefore makes good sense to stop and listen to them if they express concern about an intended procedure or treatment.
Case report: Wrong kidney removed

The following text is an extract from a serious incident report carried out after a healthy kidney was removed from a young girl in a Dublin hospital in 2008. The child, XY, had a poorly performing right kidney, but had been listed for a left nephrectomy. She was admitted to hospital the day before the operation and consent was taken for a left nephrectomy, as listed. The parents apparently queried the site of the operation, but, despite this, the operation proceeded as planned on the left side.

The team investigating the underlying causes of the error reported the following findings:

Consent

"Patient XY, who was having a major procedure, was clerked and consented by an SHO who was not competent to perform the operation, and who obtained consent on the basis of what was written in the notes. This would be normal practice within the department, although the majority of surgeons indicated that the formal radiology report should also be reviewed at this point.

continued over
Case report: Wrong kidney removed continued

Reviewing images

"... In patient XY’s case the imaging was not reviewed at any stage:

"In clinic at the point of listing for surgery; At the point of clerking and taking consent; On the pre-operative morning ward round; In response to the parents’ queries about the operation side.

"In addition the imaging was not reviewed in theatre prior to positioning XY for the procedure or making the incision, and intra-operatively when the kidney was noted to have a healthy appearance.

"... the way in which the hospital’s consent process is structured makes it unlikely that the person obtaining formal consent will be competent to review x-rays, and neither are the films readily available on the ward. Discussions in clinic are not universally treated as part of the formal consent process and it is not stipulated that radiology should be examined at that point.

"... The investigation revealed that it not uncommon practice to rely on radiology reports as a substitute for the images."

Marking the operation site

"Patient XY was marked in the theatres reception by the SpR, in the presence of the parents, on the basis of a review of the medical records (but not imaging).

"At the time of the incident, [the hospital] had no formal or universal process to confirm the pre-operative checks that should be made to confirm that the correct patient was having the correct procedure, and on the correct side. It was essentially at the discretion of the general surgeons to formulate their own practice, based on internationally accepted standards.

"... It was noted by more than one consultant that they would expect site marking to be done when the patient was clerked and consented, ie on admission to the ward, normally by an SHO. This would mean that site marking could not be done with reference to radiological imaging, as SHOs are not felt to have the experience and competence to review imaging, and it would not usually be present on the ward.

"... Ward and theatre staff commented that in their experience patients may not be marked until arrival in theatre. It would not be unheard-of for a patient to be marked after they have been anaesthetised and positioned for the procedure.”

Independent Review Report published by the Clinical Indemnity Scheme at www.stateclaims.ie
Adverse incident reporting system

What do you do if something goes wrong, or you have a close call? Do you think about reporting the incident? If not, you should do. All healthcare facilities covered by the Clinical Indemnity Scheme (CIS) are required to report all adverse incidents to the State Claims Agency. You should, therefore, notify the hospital’s Quality and Risk Department or its equivalent as soon as possible after an adverse event. The CIS defines a reportable incident as “any patient safety incident directly related to service user treatment or care which did or could have resulted in an adverse outcome”.

The CIS uses the information for two purposes: (1) to improve patient safety by identifying high risk areas of practice; (2) to prepare for any claims that may arise from the incident. It publishes annual statistics showing the types of incidents reported (see Box 14) and also produces occasional alerts to particular risks (eg, the management of nasogastric feeding tubes) with best practice advice to minimise the risk.

Box 14: Top five clinical incidents reported in 2009

- Slips/Trips/Falls (27,607)
- Violence/Harrassment/ Aggression (9,445)
- Medication incident (8,251)
- Records/ Documentation incident (5,654)
- Treatment incident (5,559)

Clinical Indemnity Scheme STARSWeb Statistics 2009. www.stateclaims.ie
Failures of communication

Underpinning good patient care is good communication, and this goes beyond establishing good relations with patients. In today’s team approach to delivering healthcare, communication has to extend to more people and there are therefore more opportunities for it to fail.

Box 15: Communicating with colleagues

“Doctors working in multidisciplinary teams should ensure that there are clear lines of communication and systems of accountability in place among team members to protect patients.”

Medical Council, Guide to Professional Conduct and Ethics for Registered Medical Practitioners (2009)

Communication between primary care, secondary care and social and voluntary services should be seen not as a chain, but as a communication net, within which any one member may need to communicate with any other (see Figure 1). Good management requires all members of the communication net to be conscious of who is doing what – an adequate standard of continuing medical care can be achieved only if all participants – both medical and non-medical – understand their roles.

Figure 1: The communication net

Keeping people informed in the interests of continuity of care must be balanced against the need to maintain confidentiality, and both these issues should be borne in mind when sharing relevant information about patients. Unless the patient asks you not to, it is entirely appropriate to share information about patients with people involved in their care.
The transition to electronic records is taking place in a piecemeal manner, a situation that has the potential to compromise the safety of patients, as illustrated in the case report below. Even if there are no such lags within your hospital’s IT infrastructure, there may be disconnects across sites. Many community-based clinics, for example, are still using paper records, and the information contained in them is not always transferred to the electronic record. Do not assume, therefore, that you have access to a patient’s complete history via the hospital’s electronic record; there may be paper records held off-site containing crucial information.

**Case report: Dual system causes communication breakdown**

Mr A, a 67-year-old publican, was referred to A&E with a suspected transient ischaemic attack. He was seen by Dr K, the junior doctor on duty, who arranged a CT scan for the following morning.

Mr A was transferred to a medical ward for observation overnight and the scan was performed later the next day by Dr E, the radiologist on-call. Dr E was not able to report the scan straight away, but Mr A was told that he could go home and that his GP would be contacted in due course with the result of his tests.

Two weeks later, Mr A was found collapsed in the basement of his pub. He was readmitted to A&E where an emergency CT scan showed a large cerebellar tumour with evidence of recent haemorrhage. There were signs of ventricular dilatation and raised intracranial pressure. Unfortunately, Mr A died before he could be transferred to a neurosurgical centre for specialist treatment.

It later came to light that no-one on the ward had followed up Mr A’s first CT scan, which showed a mass in the cerebellum that the radiologist reported as “consistent with a primary or secondary neoplasm”. At the time, the hospital had been operating a mix of electronic and paper records. The radiologist had lodged his report in the electronic system, but this had not been transferred to the patient’s case notes, which had been filed away after the patient’s discharge.
Recording essential information

Inadequate medical records are the underlying cause of many failures of communication – the records are the essential tool of communication between members of the multidisciplinary team. Subtle but significant changes may be missed when several different doctors see a patient over many days, unless adequate information is available from previous examinations.

What you include or leave out of the record is a matter of professional judgment, but you should take care to include all information that other members of the team will need to continue care of the patient safely. As months or years may elapse between treatments or illnesses and staff may have changed in the meantime, the records should also serve to reconstruct events at a later date without recourse to memory. Advice on what to include in the medical record can be found on page 19. For hints on keeping good records, and advice on access to and disclosure of medical records, phone or email MPS’s communications department (publications@mps.org.uk) and ask them to send you a copy of the MPS booklet, Medical Records – An MPS Guide, or download it from the MPS website.

Handover

Responsibility for the average patient’s care passes between numerous healthcare teams during the course of one episode of hospitalisation. And to shift changes and transfers between departments and specialty units must be added the transfer of the patient from primary to secondary care and back again. Each transition from one setting to another, or from one team to another, represents a heightened risk for the patient. One of the most common root causes of medical mishaps is communication failure during the transfer of care.
Given the potential for communication breakdown at each transfer, it’s little wonder that poor handover has been identified as a root cause of so many medical mishaps (see Box 16). The World Health Organization recommends that handovers between shifts and between units should:13

- “Use a standardized approach to minimize confusion.
- Allocate sufficient time for staff to ask and respond to questions.
- Incorporate repeat-back and read-back steps as part of the hand-over process.
- Limit the exchange to information that is necessary to providing safe care to the patient.”

**Box 16: An international concern**

“Breakdown in communication was the leading root cause of sentinel events reported to the Joint Commission in the United States of America between 1995 and 2006 and one USA malpractice insurance agency’s single most common root cause factor leading to claims resulting from patient transfer. Of the 25 000 to 30 000 preventable adverse events that led to permanent disability in Australia, 11% were due to communication issues, in contrast to 6% due to inadequate skill levels of practitioners.”


One communication technique that seems to be finding wide favour globally is SBAR (Situation – Background – Assessment – Recommendation). SBAR is in many respects an ideal communication model in healthcare because it’s not only simple and easy to remember, but is also flexible, and therefore as applicable for a nurse phoning the on-call doctor with concerns about a patient in the middle of the night as it is for a formal handover between shifts.

Organisations that have adopted SBAR report that it’s played a vital role in overcoming the traditional communication barriers between professionals of different status. This is absolutely crucial. There have been too many instances where nurses and junior doctors have known perfectly well that something is amiss, but haven’t felt able to voice their concerns in unambiguous terms to senior clinicians. Classically, in these situations, they adopt a “hinting and hoping” mode of communication – ie, hinting at what they think needs attention and hoping that the hint will be taken.

To be truly effective, SBAR should be adopted by a whole team (and preferably throughout the hospital) and everyone should be given training in its use. However, there’s nothing to stop individuals using it independently as an efficient means of structuring information. Its advocates have also found it useful for structuring reports, letters and medical notes. The description in Box 17 sets out the essential structure of the model, but further information can easily be found on the internet.
Keeping contact details up-to-date

If you carry a bleep, you have a responsibility to make sure that everyone who needs it knows its number. When you come on duty, you should write it on the handover sheet during handover, and if you’re on call, you should ensure that the ward staff know how to contact you.

You also have a responsibility to keep switchboard informed of your contact details. It is especially important to keep switchboard informed about your whereabouts if you’ll be traveling between sites – to an outlying clinic, for example.

It goes without saying that you should inform the hospital whenever your contact details – mobile or landline number, address and email address – change. It’s surprising how often people forget to do this, but such a seemingly small oversight can lead to big consequences if you can’t be contacted in an emergency. You might, for example, have forgotten to pass on some important information about a patient before you went home, and if you can’t be contacted no-one can ask you about it, which may prove crucial in an emergency.

Box 17: SBAR

S – Situation: What is happening at the present time – ie, who you are, who the patient is, the patient’s location and current condition. Briefly state the problem and/or your concern clearly at this point.

B – Background: The circumstances leading up to this situation, ie, a brief summary of relevant past medical history, the admitting diagnosis, date of admission, prior procedures, current medications, allergies, pertinent laboratory results and other relevant diagnostic results. Include most recent vital signs, important observations outside normal parameters and your clinical impression.

A – Assessment: What you think the problem/diagnosis/appropriate management is – eg, patient is deteriorating/stable, requires monitoring, is at risk of haemorrhage/shock.

R – Recommendation: What should be done to correct the problem/ manage the patient/monitor the situation/maintain continuity of care – eg, awaiting lab results which must be acted upon as soon as they’re available, keep an eye on fluid balance, set up IV if necessary, watch for signs of internal haemorrhage.

The SBAR tool originated in the US Navy SEALS and was adapted and developed for a healthcare setting by Kaiser Permanente.
Referrals

Referrals are another form of transfer of care, so you should ensure that all the essential information about the patient is conveyed to the receiving consultant. A tool like SBAR can be used for structuring the referral letter. Include an indication of the level of urgency of the referral.

Remember to tell the patient (or the patient’s carer) why you are making the referral and let them know what they can expect.

Communication with colleagues in primary care

The divide between primary and secondary care is an area where communication can easily break down, particularly when patients are receiving long-term treatment. If the patient is being given ongoing care as an outpatient it is particularly important to keep the GP informed about his or her progress and treatment, as they may have a bearing on the GP’s own treatment of the patient (see the case report on page 36).

Delays in mailing discharge summaries to GPs are another common cause of adverse incidents. Patients’ GPs should be notified whenever their patients are seen in secondary care, and especially if they’ve referred the patient themselves. As the GP is often familiar both with the patient’s past medical history and with relevant family history, their concerns and suggestions should be taken seriously, as the following case report illustrates.

**Case report: GP’s concerns ignored with fatal consequences**

In a serious incident a few years ago, a GP referred a 9-year-old girl urgently to A&E, sending her and her parents 30 miles in a taxi and telling them to pack an overnight bag for the child.

The girl had recently been discharged home following an appendicectomy and her GP feared that she’d developed a bowel obstruction. He was right, but her symptoms had eased by the time she arrived at the hospital, so the A&E doctor concluded that there was no serious abnormality and sent the girl home.

The GP wasn’t notified, so he didn’t know that the patient was at home. Her symptoms continued and her parents coped as best they could without the benefit of medical advice. Had the GP been aware that the child had been sent home he would probably have contacted the parents or visited the patient, in which case the outcome of this story might have been different. As it was, the child was taken back to A&E by ambulance two days later, having inhaled gastric contents due to a small bowel obstruction. Sadly, attempts to resuscitate her failed and she died shortly after arrival at the hospital.

North Eastern Health Board, *Review of the Circumstances Pertaining to the Death of Frances Sheridan* (nd)
Case report: Poor communication with blinding results

A diabetic clinic in a teaching hospital diagnosed TB in a diabetic patient with a history of weight loss. He was admitted to hospital and, on discharge, was prescribed three months’ supply of ethambutol, rifampicin, pyrazinamide, isoniazid and pyridoxine.

A month later, he was seen in the diabetic clinic but there was no discussion of his TB treatment. He failed to attend his next appointment.

Three months after starting TB treatment, the patient began to complain of deteriorating vision and his GP made an urgent referral to the eye clinic. The GP had not yet received a discharge letter about the patient’s last hospital admission for the treatment of TB, nor had the diabetic clinic informed her of the diagnosis, so her referral letter to the eye clinic made no mention of the fact that the patient was taking ethambutol.

The patient attended the eye clinic several times over a month, but no history of TB or treatment for TB was obtained – his visual loss being attributed to diabetes. However, his vision continued to deteriorate and by the end of this period he was only capable of counting fingers. A week later, the patient attended the diabetic clinic. Only then was the diagnosis of ethambutol eye toxicity raised.

The patient was seen immediately in the eye clinic where the diagnosis was confirmed and the ethambutol stopped, but by then he had sustained a permanent loss of 90% of his vision.
Communicating with patients

Patients who are kept informed about their condition and are involved in deciding on the appropriate treatment are more likely to comply with the treatment you suggest, and less likely to complain if things go wrong.

It is particularly important that you tell patients about the possible side-effects of drugs or treatment you are ordering, and that they know what complications to look out for and what to do if they develop.

Warn patients about the risks before carrying out any procedures or prescribing medication. "Informed" consent is dealt with in more detail in the MPS booklet, Consent to Medical Treatment in Ireland – An MPS Guide, which can be downloaded from our website or ordered through our Communications Department.

When you are discharging patients from your care, tell them about arrangements you have made for follow-up care and given them appropriate advice about what to do if symptoms recur or complications develop. If they are receiving long-term therapy, tell them when to return for review and what symptoms or signs of adverse effects or changes in their condition to report. If possible, give them an indication of when they might expect to see an improvement in their condition, and when to seek medical advice if no progress is made within a certain timescale.

Document any advice you have given the patient. It is useful to document in the record any supporting literature or written information given to the patient.
If things go wrong

Even though we all know that to err is human, few of us can easily accept our own mistakes. This is probably more the case in healthcare than in most other occupations, because errors can have such serious consequences. In a survey of MPS members who had experienced untoward incidents in their practice, almost all of them found that it shook their confidence and eroded their job satisfaction. Complaints from patients tended to be taken as personal attacks, with the doctor feeling angry, hurt and betrayed. Some of these effects lasted for years.

The intensity and duration of the emotional aftermath does not seem to relate closely to the seriousness of the error or the nature of the complaint; the crucial factor is the ability of the individual doctor to put the experience into perspective and seek out practical and emotional support. Lessons can be drawn from this:

- Assess the circumstances realistically – don’t blow an error or a complaint out of all proportion; remind yourself of all the things you do get right and all the patients who are satisfied with your care.
- Talk the matter through with trusted colleagues and friends who can both empathise with you and give you a realistic assessment of the situation.
- Contact MPS for practical assistance in dealing with a complaint or claim and for advice about handling the emotional repercussions.
- Learn from the situation. If you did make a mistake, acknowledge it. Report it as an adverse incident and engage with your colleagues in developing strategies to prevent similar errors occurring in the future.
- If you have been unjustly accused of substandard care, think what may have brought the accusation about – was it a communication problem, for example? How might you have handled it differently?
- If a patient has complained about you, try not to react defensively by avoiding the issue or making counter-threats. The hospital will handle the complaint, but you should be prepared, if it turns out that you have made a mistake, to give the patient their due – a full face-to-face explanation, a sincere apology and an assurance that you will take steps to avoid a repetition of the problem.
- If, after the complaint has been investigated, it is evident that the complaint has no foundation, you might still consider seeing the patient to explain the outcome of the investigation, give a full account of events and try to ascertain whether the complaint has been caused by a misunderstanding that you can put straight.

The Medical Council gives the following guidance on open disclosure about adverse incidents:14

“Patients and their families are entitled to honest, open and prompt communication with them about adverse events that may have caused them harm. Therefore you should:
acknowledge that the event happened,

- explain how it happened,

- apologise, if appropriate, and

- give an assurance as to how lessons have been learned to minimise the chance of this event happening again in the future.”

Your hospital will probably have a policy that should be applied in cases where avoidable harm has befallen a patient. It will include guidelines about what sort of incidents should be reported to patients (whether they should be told about so-called “near misses” where no harm resulted, for example) and who should be responsible for explaining it all to the patient. This will probably be a senior member of the clinical team, but if the job does fall to you we recommend that you talk to a medicolegal adviser at MPS first. MPS advocates open disclosure and a full and sincere apology to patients when mistakes have been made, but such discussions must be carried out sensitively and without criticising colleagues.

Patients expect a great deal from their doctors, not least of which are superhuman abilities. This means that you are almost certain to disappoint some of your patients some of the time. All you can hope to do in the circumstances is to try and turn negative experiences into positive learning opportunities, thus refining your skills and building, rather than eroding, your confidence.
References


2. Child Care (Amendment) Act 2007, section 43A.


4. ICGP and GPIT, Managing and Protecting the Privacy of Personal Health Information in Irish General Practice (2003).


6. Ibid, para 42.3.

7. Ibid, para 22.2.


10. Academy of Medical Royal Colleges, A Clinician’s Guide to Record Standards – Part 2: Standards for the Structure and Content of Medical Records and Communications When Patients Are Admitted to Hospital (2008). This can be downloaded from the Royal College of Physicians website, www.rcplondon.ac.uk.


Appendix: Sources of guidelines, research and evidence-based care

**Bandolier**
www.ebandolier.com and www.jr2.ox.ac.uk/Bandolier
A monthly journal, based in Oxford but with a global perspective, Bandolier is a trustworthy and well-recognised source of evidence-based healthcare information.

**Centre for Evidence-based Medicine**
www.cebm.net
An Oxford-based centre established with the aim of developing, teaching and promoting evidence-based healthcare and providing support and resources to anyone who wants to make use of them. Its website has useful links to specialty specific EBM sites.

**Clinical Evidence**
www.clinicalevidence.bmj.com
BMJ Clinical Evidence publishes systematic reviews summarising the current state of knowledge and uncertainty about the prevention and treatment of clinical conditions. Athens users and subscribers can access the reviews online via a PC or PDA. There is also a handbook available for purchase.

**Clinical Knowledge Summaries**
www.cks.library.nhs.uk
A reliable source of evidence-based information and practical ‘know how’ about the common conditions managed in primary care. CKS is commissioned and paid for by NHS Evidence, a service provided by the National Institute for Health and Clinical Excellence (contact them before using the website).

**The Cochrane Collaboration**
www.cochrane.org
An international organisation that aims to help people make well-informed decisions about healthcare by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions.

**Health Evidence Bulletins Wales**
www.hebw.cf.ac.uk/index.html
Collection of evidence-based guidance for prevention, diagnosis and treatment of medical conditions.

**Irish Medication Safety Network**
www.imsn.ie/guidelines.html
The IMSN publishes best practice guidelines on the safe prescribing and administration of drugs and solutions.
Lenus
www.lenus.ie/hse
The Irish Health Repository providing access to journals, research reports and HSE publications.

National Guideline Clearinghouse
www.guideline.gov
A comprehensive database hosted by the US government of evidence-based clinical guidelines and related documents from around the world. It has a useful facility for comparing guidelines.

National Institute for Clinical Excellence
www.nice.org.uk
NICE aims to improve the quality of clinical services across the NHS by formulating guidelines on numerous conditions, and advising on methods of audit with relation to these guidelines.

NHS Centre for Reviews and Dissemination (CRD)
www.york.ac.uk/inst/crd
The Centre for Reviews and Dissemination (CRD) is a department of York University, established in 1994. It carries out high-quality systematic reviews that “evaluate the effects of health and social care interventions and the delivery and organisation of healthcare”. It publishes several bulletins which can be downloaded from its website.

Scottish Intercollegiate Guideline Network (SIGN)
www.sign.ac.uk
The Scottish Intercollegiate Guidelines Network (SIGN) was formed in 1993. Its objective is to improve the quality of healthcare for patients in Scotland by reducing variation in practice and outcome, through the development and dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence.

Surgical Clinical Guidelines
www.rcsi.ie
A collection of international guidelines added to each month by the Royal College of Surgeons in Ireland. They select the guidelines that have the most relevance to Irish surgical practice.

The Trip Database
www.tripdatabase.com/index.html
The TRIP Database is a clinical search tool designed to allow health professionals to rapidly identify the highest quality clinical evidence for clinical practice.
Other MPS publications

- *Avoiding Problems: Managing the Risks in General Practice*
- *Consent to Medical Treatment in Ireland – An MPS Guide*
- *MPS Guide to Medical Records in Ireland*
- MPS factsheets (various topics)
- *GP Trainee* magazine

All these publications can be downloaded from [www.medicalprotection.org/ireland](http://www.medicalprotection.org/ireland)

To order hard copies, please write to, telephone or email:

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Medical Protection Society
Granary Wharf House
Leeds, LS11 5PY
United Kingdom

Tel: +44 (0) 113 241 0530
Fax: +44 (0) 113 241 0500
Email: publications@mps.org.uk

Further information

For information, publications, general advice and case reports, visit [www.medicalprotection.org/ireland](http://www.medicalprotection.org/ireland)

For help with your membership, email member.help@mps.org.uk

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General enquiries
T +44 (0) 113 243 6436
F +44 (0) 113 243 0500
E info@mps.org.uk

Medicolegal enquiries
T +44 (0) 113 243 6436
F +44 (0) 113 243 0500
E querydoc@mps.org.uk

Membership enquiries
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