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THE MEDICAL PROTECTION SOCIETY
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Alternatively you will find an electronic feedback form on our website at: www.medicalprotection.org/feedback.
In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.
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Follow us on Twitter
Good news for those who like to be kept up-to-date whilst on-the-go – MPS is now on Twitter! If you use Twitter in a professional capacity, why not follow @MPSdoctorsIRE

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Guiding you through the claims process

Following member feedback, MPS has launched a new way of supporting members when they receive a clinical negligence claim. Designed to provide members with an efficient and informative service, the new process will streamline the experience for members who find themselves on the receiving end of a claim. A new Claims Guide provides clear information about how MPS can help, and explains the legal process step by step. 

Look out for more details in the September edition of Casebook.

New Health Minister, Leo Varadkar

A new Minister for Health, Leo Varadkar, was appointed on 11 July. Dr Varadkar is a qualified GP, having studied Medicine at Trinity College Dublin. MPS has written to him to ask for a meeting to discuss the claims environment in Ireland.

Review of medical training and career structure

The Department of Health has published the Final Report of the Strategic Review of Medical Training and Career Structure. The report focuses on issues relating to strategic medical workforce planning, career planning and mentoring support for trainee doctors. It also addresses specific issues in relation to the specialties of public health medicine, general practice and the community-based aspects of psychiatry. 


‘Exodus’ of trainees is a complex issue – study

Over 80% of doctors entering basic specialist training aspire to work as consultants in Ireland, according to a new study. However, the study, which was recently published in the Irish Journal of Medical Science, found that 92.5% intend to spend some time working abroad, adding that trainees leave the Irish healthcare system for lifestyle reasons, but also due to failure to be appointed to higher specialist training programmes.

Meet your Regional Membership Co-ordinator: Rachel Lynch

Rachel has worked in the Marketing Department at MPS for 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 are organising a teaching event, training day or conference, then you can contact me to help arrange sponsorship or a speaker.”

Contact her on 017 2867491 or at rachel.lynch@mps.org.uk

Medical Council recognises new specialties

The Medical Council has announced that it now recognises three new specialties: intensive care medicine, neonatology, and pain medicine.

Source: Medical Council

ICGP news

Dr Peter Sloane, ICGP NERG’s Director, has been elected to the role of Chairperson of the Vasco da Gama Movement (VdGM). The VdGM is the WONCA Europe working group for new and future GPs. It has members from 37 European countries and undertakes a range of activities, including research and education. Dr Sloane will hold the Chairpersonship on behalf of Ireland for the next three years.

In addition, the ICGP has been awarded the Second Vasco da Gama Movement Forum. This was a two day European conference for new GPs and family doctors in training which took place in Dublin on 20 and 21 February 2015. The theme is “Family Medicine 2.0: Innovation and Awareness”. A number of speakers have already been invited and it is planned to use the Forum as an opportunity to showcase the very best of Ireland and Irish general practice.

Source: Dr Peter Sloane

MPS wants legal reform in Ireland

MPS is lobbying the government to introduce a pre-action protocol to make the claims process more efficient. We believe that significant legal reform is the most effective way of reducing the cost of clinical negligence and the cost burden on doctors; however, in the short-term, the introduction of a pre-action protocol is an important element of this and should offer a relatively simple-to-implement solution.

A pre-action protocol outlines what actions should be taken and information given at what stage and within what timeline. This should introduce predictability, discipline and transparency to the claims process, benefiting both healthcare professionals and patients. It can also help the patient/clinician relationship by encouraging a climate of greater openness. Further benefits include:

- Resolution of more clinical negligence claims without recourse to the courts, helping to reduce legal costs.
- Timely disclosure of medical records, which help to speed up the resolution of a claim.
- Narrowing the issues in dispute before proceedings are issued, putting both the plaintiff and defendant in a better position to make fully reasoned pleadings. This helps to cut down on cost and delay as court pleadings are less likely to require future amendment.
- Early disclosure of information on claimed financial loss and offers to settle, helping to resolve claims quicker.

Such a protocol – as long as it has effective incentives to ensure compliance – may go some way to control the legal costs associated with clinical negligence claims.
MPS membership vs state indemnity

When it comes to professional protection, most doctors recognise the value in having arrangements in place in case something goes wrong. However, some of those who are members of MPS in addition to having state indemnity do not use the many resources offered by MPS to help in everyday situations, even before a complaint or claim is made.

The Clinical Indemnity Scheme (CIS) handles medical negligence claims in the public sector, and its focus is on ensuring patients have access to compensation. However, the results of an adverse incident can carry other risks for health professionals. CIS indemnity is limited in that it does not necessarily extend to assistance for disciplinary processes, inquiries or Garda or Medical Council investigations. Therefore, those state doctors who do not make alternative arrangements may find themselves vulnerable in any forum other than a claim.

The benefits of membership

MPS membership goes beyond state protection provided by the CIS. In 2013, 400 doctors were referred to the Medical Council. Those doctors who did not have MPS membership faced the potential of having to deal with these situations without specialist medicolegal representation or assistance. It is also important to know that if you are working as a private practitioner, the CIS won’t cover you for the financial consequences of a claim for clinical negligence.

CIS indemnity is limited in that it does not necessarily extend to assistance for disciplinary processes, inquiries or Garda or Medical Council investigations. Therefore, those state doctors who do not make alternative arrangements may find themselves vulnerable in any forum other than a claim.

The following case shows how MPS indemnity goes above the support offered by the state:

Dr K was working in the A&E department of a busy hospital on a particularly demanding Saturday night when a patient, Mr O, arrived in a semi-conscious state. Mr O was well-known to the department; his medical notes revealed a history of alcohol abuse following years of hardship. This was not the first time Mr O had arrived at A&E following a binge and he was usually kept in to sleep it off. It was a busy evening and Dr K was pushed for time. History-taking was difficult as Mr O seemed very sleepy and incoherent, but the sweet smell of imbibed alcohol was enough for Dr K to dismiss his symptoms as simply the effects of excessive alcohol consumption.

An examination did nothing to change Dr K’s mind. Bloods were taken and sent to the lab and an entry was made in the nursing notes for the results to be followed up later. Dr K then took Mr O to a quiet corner to sleep it off and continued to attend to other patients. Unfortunately, the next morning Mr O was found dead.

Everyone in the department was shocked to hear of the regular attendant’s death but worse was to come when his bloods were reviewed and it was noted that his blood glucose had been 33mmol/L with a high potassium level. When Dr K had assumed Mr O was drunk, he was actually in ketoacidosis, meaning his death that night was probably preventable.

Contact us to find out how you can make the most of your membership with MPS: www.medicalprotection.org, call us on 1800 509 441 or email us at Member.help@mps.org.uk.

ADDITIONAL READING

MPS factsheet: www.medicalprotection.org/guidance/mediacenter/professional-guidance/what-to-do-when-you-face-media-attention/A-guide-for-docors-on-handing-the-media

MPS risk management workshops: www.medicalprotection.org/ireland/membership/what-we-offer/risk-management-workshops

REFERENCES

Working abroad

A staggering 60% of the current cohort of interns have left, or are in the process of leaving, Ireland, says Dr Alan Corbett, one of the organisers of the National Intern Conference and Social (NICS) held in Cork in June. Here he provides a round-up of the conference.

For too long the vast untapped potential of new doctors as agents for change within our health service has been unrejected by both clinical and executive management. This is a mistake. As the very front line of hospital–patients’ interaction with the medical service you have a unique insight and a valuable contribution to make.

Dr Anthony O’Connor, The Medical Independent, columnist, Letter to NICS

The core concept behind the National Intern Conference and Social (NICS) is brilliantly captured in this quote taken from a message Dr O’Connor sent to NICS, which took place on 28 June in the Brookfield Centre, UCC, Cork. The conference attracted a fantastic line-up of guest speakers who gave talks on medical technology and innovation, and the humanities in medicine, and provided wonderful insights into careers in expedition and sports medicine. The primary aim of NICS 2014, however, was to provide a national forum to discuss pertinent issues affecting interns, NCHDs and the healthcare system. The main focus was emigration. A staggering 60% of the 2013/2014 cohort of interns have left, or are in the process of leaving, Ireland. The emigration of Irish NCHDs is not a new phenomenon, and the reasons for our departures are vast.

Visiting and taking a “gap year” are high on the agenda of some of my colleagues, but for many more including myself, emigration is a last resort. Understandably we are affected by the significantly better work–life balance available overseas. However, we are being actively encouraged to leave by the ongoing failure of many hospitals to implement the European Working Time Directive, non-application of contractual entitlements and falling income levels.

Brain drain

In recent years this mass exodus has begun to have a great impact on the efficiency and stability of the healthcare service. The IMO’s industrial relations officer Eric Young, who participated in the NICS panel discussion, described this year’s situation as a “staffing crisis”, as more than 200 NCHD posts were left vacant this July. Falling levels of NCHDs are detrimental to the health service and patient care is affected at all levels with increases in the already long hospital waiting lists, and the possibility of a reduction in emergency department opening hours. This also leads to increased stress for the doctors who remain. NICS 2014 sought solutions from both a panel and audience members.

Keynote speaker Senator Colm Burke is acutely aware of the issues. NCHDs face and has written extensively of the need to “stop talent haemorrhage from the medical system” and the fact that “the treatment of young doctors by the HSE is causing an escalating crisis”. Patients are best cared for by doctors that are secure and happy in their work, trained to the absolute highest standard, healthy of mind and body, adequately rested, mentored and fulfilled in their vocation.

One brave GEM (graduate entry medicine) in the audience spoke openly of the financial pressures they had faced during the year. Trying to fund their ACLS course or pay the re-registration for the IMO added huge strain to their budget and stress to their personal life. GEMs are spending an average of €1,300 on monthly loan repayments and still need to fund rent and all other living expenses while earning approximately €2,000/month after tax. Senator Burke is presently engaging with GEMs from all over Ireland to seek solutions to this problem and encourage anyone interested in sharing their experiences to email him at: colm.burke@oir.ie.

It is wonderful to see that NCHDs are becoming more vocal about problems. It is noteworthy from the discussions at NICS and follow-up discussions on the “Enough is Enough…” group on Facebook that all NCHDs actually find the current process of finding postgraduate exams and awaiting a refund troublesome. The existing process is one of many minor issues we face. Others raised at NICS include the mountain of paperwork which must be regularly tackled when changing rotations and moving between hospitals. When all of these minor issues are stacked up we have a leaking tower pointing more and more NCHDs to vote with their feet and book one-way flights.

NICS highlighted for me that finding solutions is easy but implementing change is difficult. Why? Basically it is not anyone’s responsibility. This is what really needs to be worked on. Implementing solutions to administrative and human resources issues, for example, should not be the responsibility of doctors. We certainly need to be involved and vociferous in discussions, but the accepted solutions need to become someone else’s responsibility. Filling hospitals is not the answer, firing individuals who fail to deliver is.

Looking forward

There is some good news, however. Dr Anthony O’Connor’s article “Going forward, looking back” was published in the Medical Independent in January 2013. It is clear to see from this inspiring piece that great strides have been made by committed groups of NCHDs and consultants over the past 18 months, and despite the negatives highlighted above there has been great progress, which new doctors in particular should benefit from. I think the words of Dr O’Connor best conclude why it is so important we all contribute and continue this great work.

If you are interested in applying for a position on the National Intern Conference Committee for NICS 2015 please email: nationalinternconf@gmail.com and visit www.nationalinternconf.com. I wish you all the best for a challenging, insightful and exciting first year as a doctor.

Dr Anthony O’Connor, The Medical Independent, columnist, Letter to NICS
**MPS protection: What you need to know before you work abroad**

At MPS we are acutely aware of all the time and money that has been invested in training doctors and do not wish to be seen to be encouraging doctors to leave Ireland. Doctors who have trained in Ireland are uniquely placed to understand the Irish healthcare system. It can also be beneficial for those who have not trained in Ireland to work here too.

Having said that, we are aware that many young doctors do indeed leave the country, often only temporarily to gain knowledge and work here too.

**What protection is needed?**

Before practising it is vital to protect yourself: new countries mean new risks. The best intentions will not always protect a doctor from human error and professional scrutiny. This is why having access to protection and access to medicolegal advice is vital. MPS has over 296,000 members in more than 40 countries, so it is possible that membership could be arranged.

Doctors traveling abroad should be alert to the current legal, cultural and ethical climate within a particular country, in addition to knowledge of the health system. MPS’s role is to protect the interests of members when concerns are raised about their practice, in any form – claim, complaint, medical council investigation.

**Arranging your protection**

You should contact Membership Services well in advance of your intended travel date, providing exact details and dates of any work you are intending to undertake overseas, to see if you are eligible for protection.

This is particularly important because some countries have made it a requirement that all healthcare practitioners have insurance-based indemnity. MPS is not an insurance company and discretionary indemnity is not recognised in these areas. Call Membership Services on 1800 509 441 or email international@mpps.org.uk for more information.

Enjoy the trip and we look forward to welcoming you back into Irish MPS membership when you return home with your horizons broadened. Please remember that when you return to Ireland it is crucial that you contact us to let us know that you are back in the country.

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**Your digital footprint**

Medical students worldwide are well versed in the use of social media as a supplementary learning tool and as a means of socialising. The ease with which social media moves between socialisation and education regularly blurs the line between the two. This can lead to future problems in maintaining professional boundaries online, so it’s important to be mindful of how you will use social media as a medical professional.

According to a recent survey by Pennsylvania State College of Medicine, the social media savvy of many incoming medical students may lead to unintended medical privacy and confidentiality breaches. The survey found that overall students seemed to be conscious of the potential dangers of social media use and had a good understanding of how it could be used or misused in a professional context. However, when faced with a professional dilemma, there was a dichotomy between what the students said they would do versus what they thought they should do. Through 39% of students said that they should tell a hypothetical peer to remove drunken pictures and foul language from Facebook, 41% said they would actually do nothing.

The Irish Medical Organisation’s position paper on social media reminds doctors and students of their digital footprint: “Anything that has once been typed or posted and immortalised on the internet can always resurface.” Be aware that images or personal views posted on the internet create a lasting digital footprint with potentially serious implications for your professional career. The growing trend is for employers to screen potential employees online and while you may not associate the content you currently post online with your future career placements, it has been reported that online activity can affect placements in residency programmes.

Aside from career implications, social media misconduct may also compromise the public’s perception of the medical profession. Relationships between doctors and patients that are not based around clinical care can raise a number of significant ethical issues. Take care never to breach patient confidentiality. Patient privacy breaches can cause much greater harm when occurring online given the potential wide reach of social media and the permanency of digital information. Most improper disclosures of patient information are unintentional. Although individual pieces of information may not alone breach patient confidentiality, the sum of published information online could be sufficient to identify a patient or someone close to them. Avoid posting content regarding patients. Even if they, their case, or symptoms have been anonymised, there is still the chance of identification. No content on social networking sites should ever reference patients or their specific case.

To maintain appropriate professional boundaries, consider separating personal and professional content. Adjust your privacy settings on Facebook so that only friends and family can see your content; however, be aware that the content you generate online can still reach a public domain regardless of your intention for the information to be public or private. This also applies to content others may post on your behalf. On Facebook your friends can “tag” you in a photo that you may not wish to have in the public domain. Change your privacy settings so that you cannot be tagged in this way by others. Should you receive a friend request from a patient, politely re-establish professional boundaries by directing them to your Facebook practice page (you can also ignore the request without the person knowing).

Professionalism is a longstanding foundation of the medical profession, and as the healthcare conversations increasingly move online the challenge is how to redefine professionalism for a digital age. Increasingly doctors will be called on to contribute their expertise and experience as the internet becomes the medium of choice for patients researching health information. This is an opportunity to expand the reach of healthcare information and deepen the practice of medicine. The professional standards expected of doctors do not change because they are communicating through social media. Rather social media presents new circumstances to which the established principles still apply.

‘The way you use social media today is laying the foundation for your professional future tomorrow. If you are looking for some guidance, take note of the 12 word social media policy created by the Mayo Clinic Center for Social Media;’

- Don’t Lie, Don’t Pray
- Don’t Steal, Can’t Delete
- Don’t Cheat, Can’t Delete
- Don’t Steal, Don’t Reveal

Following these simple rules can prevent most social media missteps, and help you maintain your professionalism in a dynamic and constantly evolving digital age.

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1. Published online. Medical Student Views on the Use of Facebook: A Pilot Survey by Residency Admissions Committees. accessed 27 August 2014; www.ncbi.nlm.nih.gov/pubmed/22763589

2. Irish Medical Organisation. MD Froster Paper on Social Media (April 2013); http://tinyurl.com/pv65fnw


**Marie Ennis-O’Connor** is a digital health strategist, social media consultant and keynote health media speaker. A founding member of Health 2.0 Dublin, part of the Health 2.0 International movement, she is a regular contributor to health publications on the effective use of social media in healthcare.


**A 35-year-old man was admitted to the emergency department by ambulance, having been found collapsed on a footpath in the local town centre. I have examined him and found a facial laceration which I intend to suture. However, the patient is intoxicated. Is it medicolegally appropriate to proceed with treatment in circumstances where the patient is intoxicated?**

**Advice**

The Medical Council makes clear that there is a legal and ethical obligation to respect patient autonomy, by ensuring that informed consent has been given by a patient before any medical treatment is carried out.

The starting point is always to presume that a patient will have capacity to make decisions about their own healthcare.

If a patient is unable to understand, retain, use or weigh up the relevant information, or use it to make a decision about treatment, they may be regarded as lacking the capacity to give consent to the proposed investigation or treatment.

In your opinion, the patient’s degree of intoxication is such that he cannot understand an appropriate explanation of the procedure. Furthermore, it is your view that the patient cannot retain the relevant information, or use it to make a decision about treatment.

The patient is therefore considered to lack capacity to consent to suturing of his facial wound.

In circumstances where a patient lacks capacity to make a decision, it is a matter for the doctor to decide what action to take. You should consider a number of factors, including which treatment option would provide the best clinical benefit for the patient; whether the patient’s capacity is likely to increase; the views of other people close to the patient (such as family members), who may be familiar with the patient’s preferences, beliefs and values; and the views of other healthcare professionals involved in the patient’s care.

**Outcome**

Staff at the department had already attempted to contact the patient’s family, without success. Following a discussion with the patient’s consultant and in view of the very minor degree of blood loss from the wound, the doctor decided to postpone the decision to suture the wound on the assumption that the patient’s capacity would increase as the intoxication diminished. The decision to postpone suturing and the plan to reassess the patient in the emergency department at regular intervals were carefully documented in the clinical records.

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**I was asked by nursing staff to prescribe additional analgesia for a post-operative patient complaining of pain. I undertook a brief assessment of the patient and prescribed a non-steroidal anti-inflammatory drug (NSAID).**

**Advice**

Due to an emergency on another ward, I was unable to document my clinical management in the patient’s records. At the end of my shift, I was told that the patient suffered from an acute exacerbation of asthma following administration of the NSAID. I am concerned because I failed to elicit the history of asthma and furthermore, I didn’t have an opportunity to document my assessment. What should I do?

**Advice**

Whilst records should be made at the same time as the events that are being recorded, it is clear in this instance that there were extenuating circumstances due to an emergency on another ward.

You should make a retrospective entry in the records, making clear the time and date on which the additional information has been added, and an explanation as to why a contemporaneous note had not been made.

The Medical Council’s guidance on adverse events indicates that patients are entitled to honest, open and prompt communication with them about adverse events that may have caused them harm.

In circumstances where it is necessary in the public interest, the Medical Council advises that disclosure of patient information may be required by law, for example in accordance with a court order.

There is also a public interest in having a confidential medical service and, before making a disclosure in circumstances where a patient has refused consent, the doctor should consider the possible harm that may result to the patient, as well as the benefits that are likely to arise.

In any case where a disclosure has been made in the interests of other people, you are advised to inform the patient of the disclosure unless this would cause them serious harm.

You would have to be able to justify any disclosure of information without consent and should discuss the matter with senior colleagues, and carefully document any decision made.

**Outcome**

The doctor contacted the officer and asked for a copy of the patient’s signed consent to disclose the information, in the first instance. The Medical Council advises that disclosure of information without consent may be justifiable in exceptional circumstances where it is necessary in the public interest.

The doctor explained what had happened, offered an apology for the distress that had resulted from the prescription of the NSAID, and the lessons that had been learned from the incident. The patient, who had made a full recovery from the episode, was very appreciative of the doctor’s open and honest approach to the adverse incident.

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**I assessed an 18-year-old woman in hospital for a fractured metacarpal and several fractured ribs. I later received a telephone call from the Gardaí, requesting a statement in relation to the clinical findings. The officer alleged that the patient was involved in an altercation with another woman at a nightclub, and explained that the patient has been charged with an assault.** I was encouraged to provide information to assist with the prosecution of the patient. What should I do?

**Advice**

There are certain limited circumstances in which disclosure of patient information may be required by law, for example in accordance with a court order.

In the absence of such a requirement, you are advised not to disclose information about the patient without the patient’s express consent, unless it could be justified in the public interest.

Therefore, you should ask the officer for a copy of the patient’s signed consent to disclose the information, in the first instance.

The Medical Council advises that disclosure of patient information without consent may be justifiable in exceptional circumstances where it is necessary in the public interest.

There is also a public interest in having a confidential medical service and, before making a disclosure in circumstances where a patient has refused consent, the doctor should consider the possible harm that may result to the patient, as well as the benefits that are likely to arise.

In any case where a disclosure has been made in the interests of other people, you are advised to inform the patient of the disclosure unless this would cause them serious harm.

You would have to be able to justify any disclosure of information without consent and should discuss the matter with senior colleagues, and carefully document any decision made.
O of the greatest dilemmas in medicine is choosing where you’ll be happiest developing your considerable talents for the next four decades. For many, the demographic variability of general practice strikes a chord, while the lure of creating a resilient therapeutic alliance attracts others to fields like psychiatry, and the rapid pace and acute presentations of emergency medicine appeals to the dopamine chasers amongst us.

Occasionally, you find a colleague who thrives on the compulsion perfection of drama, which might have included any number of local lesions. Depending on the geography of your institution, the on-call commitments will vary from one to three times a week, depending on the ward inpatients, offer specialty advice to colleagues to practise the core clinical competencies of independent operating by manipulating anatomy or physiology in the latest book, as well as in a whole host of other local lesions.

“General”: adjective

Affecting or concerning all or most people or things; widespread.

Clinical tutor Dr Michael Daly provides some top tips on why you should choose general surgery as a specialty

“Generalists are not simply technicians; they continue to review patients who have been with the team for up to five years after their initial operation. Discharging a patient in yesterday’s hemi-colectomy patient, out-ruling a potential anastomotic leak after they developed a syndrome in a ventilated patient in ICU, providing support, especially in secondary centres, as is the ability to work with a varied and knowledgeable team which includes physiotherapists, occupational and social workers, specialist nurses, anaesthetists, intensivists and the theatre staff. Surgery is not for everyone, but those who appreciate providing compassionate, appropriate, and ultimately effective treatments in an intensely personal sense will gravitate towards it. Students who are passionate about applying the theoretical to the practical and enjoy practice-based learning in a dynamic and professional environment thrive in this specialty. Surgery is a significant life event for the majority of patients and therefore interpersonal skills and empathy are highly valued commodities in trainees, as is the ability to self-reflect. It is a highly competitive field, and you should try and get as many operating and inpatient attachments as you can, whether it’s by way of a formal rotation, voluntary elective or signing up for team audits with your local general surgeon. History is written by those who show up, so angle your internship go a long way, and a safe, professional and knowledgeable intern will be much sought after for entry into core surgical training whether in Ireland or abroad. Operating is but one aspect of the job, and while it can be incredibly rewarding, the role of the surgeon itself is one with many different facets, all of which must be mastered to provide comprehensive care. General surgical disease affects all people and is always concerning. To be in a position to allocate it is a lifelong privilege.

I would like to see the day when somebody who had no hands, for the operative part is as much aetiology of classical anatomy to the latest developments in pharmacology, before a surgical team breaks off for theatre or outpatients.

Outpatients can be incredibly rewarding as it’s here that you see the tangible effects of your work; whether it is a routine follow up of a perforated appendix or pre-assessing a patient’s global fitness for a proposed and potentially challenging bariatric surgery. General surgeons are not simply technicians; they continue to review patients who have been with the team for up to five years after their initial operation. Discharging a patient in this situation is very rewarding, and it’s definitely a highlight of the job. From time to time outpatients will consist of purely surgical work with a minor operations list. This is an excellent opportunity for junior colleagues to practise the core clinical competencies of independent operating by tackling sebaceous cysts, squamous and basal cell carcinomas and a whole host of other local lesions.

Every patient should be offered a chaperone for an intimate examination to protect their dignity and privacy. In this case, having a chaperone present protected the doctor from unfounded allegations.

Learning points

Here, the Medical Council was not concerned about the medical care provided, since Dr V had kept a comprehensive and contemporaneous clinical record, but by Dr V’s conduct. The allegations made, if proven, would be serious and might demonstrate impairment of Dr V’s fitness to practise.

In this situation the importance of a chaperone was paramount. Every patient must be afforded dignity and privacy, and this typically means offering a chaperone for an intimate examination. However, this is not the only time when a chaperone should, or can, be offered. It should be remembered that a chaperone also protects the doctor from unfounded allegations, as demonstrated in this case, and that the patient refuses the presence of a chaperone then you may wish to defer the examination or refer the patient on to a colleague who would be willing to conduct the examination so long as there is not unreasonable delay and the clinical situation does not demand urgent assessment.

The case report detailed is based on MPS experience from around the world and is anonymised to preserve the confidentiality of those involved.
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