First impressions count

Do you have a triage protocol, or do you rely on common sense?

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Rachel has worked in the Marketing Department at MPS for more than ten years: “I regularly visit medical schools and hospitals to talk to members and arrange medicolegal events for some of the professionals organisations in Ireland, including the Royal Colleges. “If you would like a visit to talk about your membership, or you are organising a teaching event, training day or conference, then you can contact me to help arrange sponsorship or a speaker.” Contact her on 087 2867491 or at rachel.lynch@mps.org.uk

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PRACTICE MATTERS IRELAND | VOLUME 2 – ISSUE 1 | 2014 | www.medicalprotection.org
Welcome
Welcome to the latest edition of Practice Matters Ireland, and my first as Editor-in-Chief.

Working as a medical adviser, I experience first-hand the pressure on Irish GPs at the moment. Each day brings new requests for medical advice, and new claims and complaints to be dealt with.

MPS wants to help you reduce your risk, and this edition is full of practical risk management tips you can use in your practice. On page 6, we look at risk hotspots identified in Clinical Risk Assessment data from our visits to practices across the UK and Ireland – from confidentiality at the reception desk to repeat prescribing protocols.

Sometimes, it is not poor clinical or communication skills but poor protocols and procedures which make the difference between a successful clinical outcome and a claim. We look at those on page 11, sharing how you can make sure no test results slip through the net, and on page 14.

Finally, our Careers section takes a look at professionalism: how to encourage it in your team (page 10), and putting into practice (page 12) your awareness of a lack of it amongst your colleagues (page 12). Sometimes, seemingly small events can have serious professional consequences.

We hope you enjoy this edition – as ever, do get in touch with your feedback and suggestions for future content.

Dr Sonya McCullough | Editor-in-Chief, MPS Medical Adviser

Update
Practice nurse membership

If you (or your practice) employ practice nurses, they can apply to become members of MPS in their own right. On 1 March 2014, the Irish Nurses and Midwives Organisation (INMO) withdrew its indemnity arrangements for practice nurses. The benefits of MPS membership are provided on an occurrence basis. This means that members can apply for assistance with complaints and claims arising from incidents that occur during their membership – even if it is brought years after they have left MPS or cease to practice for any reason.

Out of hours – Nurses working in urgent or out of hours care should contact the Membership Service Centre to discuss their application.

Why is indemnity for nurses important?

If you are a GP employing a practice nurse you must ensure the nurse has appropriate and adequate indemnity for their own acts and omissions. The benefits of GP membership of MPS do not include indemnity for your vicarious liability for the nurse.

If you have any questions regarding practice nurse membership please feel free to contact Rachel Lynch on rachel.lynn@mps.org.uk, 01 289 2169, or visit www.medicalprotection.org/Ireland/practice-nurses for more information.

REVISED GUIDANCE ON GOOD PROFESSIONAL PRACTICE

The latest Medical Council's term, the Guide to Professional Conduct and the Code of Practice for Registered Medical Professionals (2013) will be reviewed and revised. In the meantime, paragraph 21 of the Guide has been updated to reflect recent developments in Life During Pregnancy Act, commenced from January 2014.

The up-to-date guide can be viewed on the Medical Council’s website: www.medicalcouncil.ie/News-and-Publications.

A date for your diary...

This year’s MPS GP Conference will be held on Saturday 13 September at The Convention Centre Ireland, in Dublin. For further details see the advert on the back-cover of this edition, or visit www.medicalprotection.org/ireland/GP-conference-spotlight-on-risk.

Scenario 1

Mrs B is a 75-year-old patient at Dr M’s practice. Mrs B has a history of Type 2 diabetes and hypertension and Dr M has known her for many years. Mrs B’s daughter has voiced some concern about her being rather forgetful lately. Until last year, Mrs B lived alone and managed well but is currently living with her daughter. Mrs B makes an appointment to see Dr M in relation to her testimonial capacity as she is in the process of making a will. What should Dr M consider covering with her?

The law in Ireland in relation to testamentary capacity is very similar to English law on the subject. Under the Succession Act (1965) “the person making the will must be of sound disposing mind”.

It is important to remember that testamentary capacity is not the same as ordinary capacity, and a person requires a high level of mental function to be in a position to make a will. Testamentary capacity is not easy to define but it must be capable and it must be individually, by the GP, to be assessed, and contemporaneous notes kept.

Under a leading English case, a law which has been approved in the Irish courts, the judge set out the following principles in relation to testamentary capacity:

1. The testator must understand that she is executing a will.
2. She must know the nature and the extent of her property and the persons and others who are to be benefited by it.
3. She must be able to decide whether or not to benefit such a person.
4. In 1995 the British Medical Association and the Law Society published a report entitled Assessment of Mental Capacity: an advisory note for doctors and lawyers, which contains a useful checklist, although this is neither authoritative nor exhaustive. It should be able to understand the following:
   a. That she will die.
   b. That the will should come into operation on her death and not before.
   c. That she can change or revoke the will at any time before her death, provided that she has the capacity to do so.
   d. Who the executors are and why they should be appointed as executors.
   e. Who gets what under the will.
   f. Whether a beneficiary’s gift is outright or conditional.
   g. That she spends her money or gives away her property during her lifetime the beneficiaries might lose out.
   h. That a beneficiary might die before her.
   i. Whether she has already made a will, and if so, how and why the new will differs from the old one.
   j. The extent of the property owned solely by her.
   k. The fact that certain types of jointly owned property might automatically pass to the other joint owner, regardless of anything that is said in the will.
   l. Whether there are benefits payable on her death which might be unaffected by the terms of her will.
   m. The extent of the property could change in her lifetime.

It is possible that Mrs B’s solicitor has some doubt as to her capacity to make a will and has therefore sought Dr M’s opinion. Dr M should make a specific appointment to assess her capacity to make a will – the principles and checklists would be of some assistance. Mrs B has been forgetful and is living independently. It may be prudent for Dr M to check her capacity in general terms before moving to consider her testamentary capacity. If Dr M feels this is outside her area of competence, she could consider referring the patient to a psychogeriatrician in the first instance.

Scenario 2

Mr M was a patient at Dr A’s practice for many years. However, he died in 2013. Dr A only saw him on one or two occasions in 2008. Mr M’s son has made an application to take out a Grant of Probate and requires confirmation that he was a testator in mind when he made his will in 2009. Dr A was aware from a review of the medical records that Mr M was diagnosed with Alzheimer’s disease in 2010.

Here, the testator cannot be assessed with regards to testamentary capacity. Under Irish law, there is a general presumption that a will is valid, but this presumption can be reversed where, for example, the deceased died in a mental institution or one of the causes of death on the death certificate is Alzheimer’s disease. In these circumstances, the probate office will usually seek an affidavit from testamentary capacity from the deceased’s doctor and it is possible Dr A may feel some pressure to provide such an affidavit stating that at the date of the will his deceased patient had testamentary capacity. The affidavit of mental capacity by a doctor will state that a doctor attended the testator in his professional capacity for a certain period, preferably around the time the will was executed. It will confirm that the doctor is satisfied that the testator was of sound disposing mind when he made his will. It was fully capable of doing so. Great care should be exercised by Dr A in these circumstances. It is important that he has no reason to believe that the patient did not have testamentary capacity.

In circumstances where the deceased could not be assessed on the issue of testamentary capacity, the family’s legal representative may have to make an application to the court to have the issue of the validity decided upon by a judge.

In this scenario, Dr A was not particularly well acquainted with the patient and had not seen him since 2008, one year before he made his will. Mr M was subsequently diagnosed with Alzheimer’s disease. It would be difficult for Dr A to be clear that Mr M had testamentary capacity in and around the time that he made the will. Therefore it may be prudent for him simply to confirm that he cannot assess on the issue of testamentary capacity.

REFERENCE

1. Banks v Goodfellow

Follow us on Twitter
Good news for those who like to keep up-to-date whilst on the go – MPS is now on Twitter. If you use Twitter in a professional capacity, why not follow @MPSdoctorsRE?

MPS on tour...

 Damian Smyth, Editor-in-Chief, MPS Medical Adviser

- Come and say hello at the ICGP Summer GP events – first quarter 2014
- ICGP’s Clinical Risk Programme Manager Julie Price ran a session on the importance of keeping good medical notes at the ICGP education day on 31 January at the IMR in Sandyford.
- The ICGP Trainers gathered together on 27-28 February in the Radisson blu in Galway for two days of training. MPS Dr Mark Dimwood ran a session on ‘How to teach professionalism to your Trainee’ – this session was very well received and there has been a request for follow-up sessions. (Find out more in his feature on page 10).
- MPS sponsored the RCPI/IRFU (Irish Faculty) Spring Meeting on 29 March in the Burlington Hotel, Dublin. The day focused on ‘The GP and the Law’ and all the practical elements involved, such as report writing. The day was very well-attended and enjoyed by all delegates.
- We are in our second year of free GP Practice Risk Management workshops.
- We have facilitated more than seven so far this year. For further information please contact rachel.lynn@mps.org.uk.
The risks of being a locum

I met a senior casualty nurse lately who told me about the difficulty of doctors in training changing every six months; they had to fit into established routines and practices. The same applies to locum GPs starting at a new practice. Established members of staff, including receptionists, might see themselves as the unacknowledged captain, running the ship. They want no challenge to established practice, especially from a locum GP. There will be occasions when they can be heard perpetuating the lowly status that locums are held in... "Your doctor is away, I am afraid. We only have a locum if you want to see him." This is where the relationship starts between the new locum GP and the patient. The secondary or nurse is often permanent and established, protected by employment law as well as by established relationships in the practice. The GP locum is temporary and vulnerable; their reputation is entirely dependent on the answer to the question that the GP principal asks his receptionist on his return. "How did the locum get on?" The GP locum needs a reference, this time not from his consultant in hospital, but from the receptionist, patients, and the locum agency. It is rare indeed for the principal to ask the GP locum how things went with the receptionist and patients. And the relationship is not strong enough for the principal to get the truth. "Grand" is an easy answer. Doctors are therefore sometimes more vulnerable than nurses and secretarial staff. And yet the buck stops there. GP locums may find themselves challenged successfully by established staff around issues that the doctor feels affect clinical practice: "sign this, this, and this," in rapid and blinding speed. It is understandable, if unhelpful, that the GP who is away, and who has never met the locum, will take the version of history as narrated by his secretary: "the locum would not sign some of the forms." The principal may be understandability shy and reluctant to discuss an awkward issue with the locum, now gone. It is easier to nudge the GP to get both sides and it is easier not to hire the awkward locum again rather than upset the applicant. Gone is the search for the truth and best practice. We are all human and we all have bad days, but human upset will cause human error. Medical error is far more expensive and time-consuming than working on all relationships, especially the vulnerable ones. Strange as it may seem, the most vulnerable person is often the doctor.

Dr Paul Heaslip is a GP based in Dublin

In practice

Communications

1. Overhearing receptionist (phone/face-to-face) 77.8%
2. Failing issues 68%
3. Issues re staff confidentiality agreement 51.6%

It is important that staff are trained around issues of confidentiality and the message is regularly reinforced. Overhearing conversations at the reception desk is a common concern. Strategies such as avoiding identifying patients by name on the telephone (which can be overheard by other patients in the reception area) and offering patients the availability of a private room in order to speak more confidentially would help to mitigate this risk.

Confidentiality

1. Overhearing receptionist (phone/face-to-face) 77.8%
2. Security and personal safety (including extended hours/none working) 58.8%
3. Premises, fixtures, furniture, etc 48.4%

The Safety, Health and Welfare at Work Act 2005 requires "every employer and every self-employed person so far as is practical, to identify the hazards and assess the risks at their place of work, and to prepare a written safety statement." This would include ensuring that staff know what to do in the event of a fire, staff have been trained in health and safety, workstation assessments are undertaken for staff who use a VDU, and staff are protected from violence at work.

Health and Safety

1. Training 66%
2. No/inadequate practice leaflet/practice website 52.9%

Many medication errors are preventable. Common examples include wrong dose, inappropriate medication, and failure to monitor for toxicity and side effects. Having a robust repeat prescribing protocol is a good way of improving effectiveness and safety of medication.

Prescribing

1. Issues re uncollected scripts 52.9%
2. No/Inadequate repeat prescribing policy 49.7%
3. Issues re anticoagulant management 33.3%

Complete and contemporaneous records are essential to maintain good quality patient care and are needed if a complaint or claim is made. Courts sometimes take the quality of the record as an indication of the care provided to the patient. It is important from a continuity of care aspect, and also medically, that a record is made after every encounter with the patient. Ensure that home visits are fully recorded as soon as possible in the medical record, and medication prescribed should be added in the normal way to the prescribing screen.

Record keeping

1. Issues re home visit consultations 49%
2. Issues re scanning 43.1%
3. Admin not updating records 35.9%

The number of claims against Irish GPs has more than doubled between 2007 and 2012. The total size of these claims is increasing, too. This is made worse by the courts awarding ever higher settlements and a legal system that lacks a speedy and predictable process for handling clinical negligence claims.

MPS has lobbied both the Health and Justice Ministers on your behalf and we will continue to do so. We have made it clear that the current claims environment is causing severe difficulty.

We place a strong emphasis on risk management and want to help you reduce your risk. Last month, MPS held a number of roadshows across Ireland for members, looking at why patients sue – and what you can do to reduce the risk of it happening to you.

MPS also conducts Clinical Risk Self Assessment (CRSAs) to assess risk levels in practices. Last year, we visited more than 150 practices across the UK and Ireland – below, we reveal our findings of the top five risks in general practice:

1. Communication 100%
2. Confidentiality 100%
3. Health and safety issues (including security) 97.4%
4. Prescribing 95.4%
5. Record keeping and visits 89.5%

- Figures presented as % of total practices visited in 2013.

GPs are experiencing unprecedented levels of claims and complaints. Sarah Whitehouse explains what you can do to reduce your risk – and how MPS can help
Feeling breathless with chest pain
Teenager having a convulsion
Pregnant woman with very frequent contractions
Adult vomiting blood
A baby who is “floppy”?

First impressions count – triage in reception

High-quality urgent care begins with the first impression. The key player here is the receptionist answering the phone. Dr Diarmuid Quinlan asks: do you rely on common sense, or have you robust procedures to manage emergency situations?

The quality of assessment undertaken by the receptionist, who may be a relatively junior member of staff, is crucial to deliver safe and effective urgent care. The challenge is to correctly identify, and rapidly respond to, the tiny number of patients in whom a delay will result in harm, or possibly even death. Have you identified and discussed these emergency situations? Have you a simple procedure for receptionists to follow when these rare situations arise? To rely on the common sense of receptionists to identify rare situations, and hope they respond appropriately, may pose an unacceptable risk to patients, staff and clinicians. Clinically urgent cases are rare, so learning through experience is fraught with danger for all.

Identification and initial management of emergencies by reception staff

This depends on three key components:
1. A framework to identify emergencies
2. Training for receptionists
3. Analysis and feedback

1. A framework to identify emergencies

Some doctors hope that their receptionists can recognise and respond appropriately to such situations, but hope is not a reasonable expectation. The location of your practice can influence how you respond to an emergency situation – the appropriate response for a city centre practice may prove fatal in remote rural Ireland. Clear guidance and appropriate training of staff may help prevent a catastrophe in your practice. Perfect preparation prevents poor performance.

2. Training for receptionists

Many doctors hope that their receptionists can recognise and respond appropriately to such situations, but hope is not a reasonable expectation. The location of your practice can influence how you respond to an emergency situation – the appropriate response for a city centre practice may prove fatal in remote rural Ireland. Clear guidance and appropriate training of staff may help prevent a catastrophe in your practice. Perfect preparation prevents poor performance.

3. Analysis and feedback

Several important lessons can be learned from these rare situations. Consider undertaking a patient-centred, emergency care audit – what more could you want? As clinicians, we should document all clinical decisions and phone calls with patients. We should encourage our administrative staff to do likewise. If the patient has an adverse outcome, every facet of the case may be subject to intense scrutiny. Clerical staff should document their interaction with patients in these high-risk situations. Who said what, and when, may be a key component in your defence should the patient suffer an adverse outcome. Contemporaneous documentation that the patient was offered an appointment, but declined it, may be very helpful to the GP. Electronic record keeping helps administrative staff make important entries in the clinical record, especially in emergency situations. Encourage your reception staff to document conversations with patients in these high-risk situations.

Dr Diarmuid Quinlan is a GP based in Cork and MPS clinical risk assessment facilitator

The objective is to provide the GP with the correct information to take ownership and make the decision in these infrequent situations. Always err on the side of caution – if in doubt, ask the GP. This is our surgery’s personalised triage protocol; your own requirements and location will influence the structure of your protocol. This example will need adapting. We are not endorsing this approach over another.

To find out more, read MPS’s factsheet. Triage protocol for non-clinical staff www.medicalprotection.org/ireland/factsheets/triage-protocol-for-non-clinical-staff

Q: “Does the patient need urgent medical attention?”

Yes

No

Interrupt the doctor if one of the following:

ADULTS

Very worried patient
Chest pain
Difficulty breathing
Abdominal pain
Ritual
Altered consciousness
Psychological distress
Severe allergy

CHILDREN

Very worried parent
Unwell child and persistent:
Diarrhoea
Vomiting
Fever
Lethargy
New rash

PREGNANCY

Very worried woman
Women with pain/ bleeding/ reduced movement
Ruptured membranes

Dr Diarmuid Quinlan is a GP based in Cork and MPS clinical risk assessment facilitator

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Your practice must:

■ Identify emergency situations
■ Rapidly triage these patients
■ Ensure the patient is seen urgently.

A good place to start is to ask your receptionists:

■ “What would YOU do if a patient phones the surgery reporting…”
Options include telling the patient to:

■ Call 999 or 112
■ Come to surgery immediately
■ Attend the Emergency Department immediately
■ Transfer the call to the GP
■ Offer a call back later by the GP

The next available appointment is... is that OK?

Q: What is the problem?

If the patient does not want to divulge to you, are you not the doctor, explain that you need a very brief explanation of the problem to make a decision whether to interrupt the doctor.

How long has it been happening?

How severe is it?

Previous major health problems?

Ask the patient the following:

Your practice will have a protocol for non-clinical staff. This example will need adapting. We are not endorsing this approach over another.

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How to encourage professionalism in your trainees

Professionalism can be hard to define and even harder to teach. Dr Mark Dinwoodie, Head of Member Education at MPS, highlights some practical tips to encourage professionalism in trainees.

A recent study revealed that Irish doctors are far less likely to report cases of incompetence or unprofessionalism among colleagues. In fact, only 41% of doctors who had knowledge of such incompetence reported it, compared to 72% in the UK.

The report, “Talking About Good Professional Practice,” which includes surveys of both doctors and patients, also suggests some patients’ trust is misplaced. While 77% of patients believe a doctor would tell them if a mistake had been made, only 63% of doctors completely agreed that they would disclose all significant medical errors.

The report underlines the continuing need to focus on defining and embedding appropriate values throughout doctors’ professional lives. It also highlights the need to build a workplace setting which enables doctors to put professional values into action. Collaboration with partners, including the Department of Health, HSE, independent hospitals, and postgraduate medical training bodies will be essential.

When it comes to day-to-day practice, professionalism is about adherence to a defined set of standards. You should work with your trainees to try and incorporate these standards and codes of practice into everyday behaviour and performance by following the Medical Council’s guidance, Guide to Professional Conduct and Ethics for Registered Medical Practitioners.

A patient’s trust in a doctor is no longer assumed; it is reached and earned through a display of appropriate professional qualities and behaviour. For example, expertise, probity and concern or caring, and these act as markers of professionalism. Communication issues and poor doctor-patient relationships are major causes of medicolegal action and complaints.

Many of these communication behaviours would be viewed as unprofessional: poor communication (not being listened to, lack of empathy, lack of information), disrespectful (being devalued, not being understood or taken seriously), desertion (feeling abandoned, family excluded, staff arrogance).

Teaching professionalism

Trainers need to actively encourage professionalism and not just assume that trainees will automatically acquire it or simply wait until they transgress. It’s relatively easy to teach someone a specific skill like injecting a shoulder or simply wait until they transgress. It’s much harder to teach the knowledge and skills to develop capability, helping to establish the necessary attributes, and enabling our trainees to display appropriate professional behaviour.

Knowledge

Knowing the professional standards as identified by the Medical Council is a good starting point. Topic discussions with trainees are a useful way of teaching them about key issues such as confidentiality, consent, use of chaperones, etc. Ask them “how would you respond to a request for information from a patient’s relative?” as a way to help them apply this knowledge.

Skills necessary to display professional behaviours

In order to be able to exhibit professional behaviour, we need to ensure trainees have the necessary skills which include clinical skills, a range of communication skills, and record keeping.

Attitudes and values

Examples of attitudes and values associated with being a medical professional are: integrity, being open, compassion and accountability. To assess attitudes and values, you could ask attitudinal questions, for example: “How much do you agree with the following statement (on a scale of 1-7)?”

“It is important to apologise to patients when mistakes have occurred.”

Is the behaviour attitude consistent?

Aligning attitudes and values with professional behaviours authenticates professionalism. What we see externally are behaviours and capability. It is what lies internally such as values, beliefs and attitudes that drive this behaviour. Professional behaviour without consistent underlying values lacks authenticity and integrity and is more likely to deteriorate when under pressure.

Informal and hidden curricula

Most of the teaching of professionalism is likely to occur through informal and hidden curricula. Role modelling can be very powerful especially if accompanied by reflection.

Feedback on professional behaviour

You can assess the professional behaviour of trainees by role-play, case-based discussion, rating scales and observation of a consultation. You can use formative assessment techniques to assess and enhance trainees’ capability.

Feedback from a variety of sources, for example, staff, patients or colleagues, can be very useful. We should be encouraging reflection, self-assessment and self-correction about the impact of smart professional behaviour.

Patient-centred v doctor-centred

Being patient-centred is an important part of professionalism. Sometimes we can become very “me” focused and lose sight of the fact that the patient is our main priority. Hearing these types of phrases may give an indication that this is happening.

“I don’t see why I should…”

“I had the usual time-wasters in this morning…”

“Patients need to realise that I can’t…”

Hot buttons

Certain patient behaviours or comments can trigger an automatic inappropriate response which could be perceived as unprofessional, before our cognitive control has had a chance to prevent it. Identifying what these hot buttons are and early recognition that they are being pressed is important. Reframing patient behaviour that can stimulate these responses may help prevent automatic, potentially unprofessional, responses.

Summary:

Ensure trainees know and understand what acceptable professional behaviour is

Encourage appropriate values and attitudes to authenticate professionalism

Encourage patient-centred care

Role modelling and facilitating reflection on observed behaviour is likely to be effective

Enabling insight into attitudinal or behavioural deficiences will help many trainees improve

Reflective practice is vital to enable trainees to develop professionalism

Reframing and managing hot buttons can be useful tools.

Conclusion

Professionalism matters. It’s what society and patients expect and helps avoid claims and complaints, particularly at a time when patient expectations are growing. In such times your professional attributes can really come to the fore and make all the difference when under pressure.

Useful link: Professionalism – An MPS Guide

www.medicalprotection.org.uk/booklets/professionalism-an-mps-guide

REFERENCES

1. MPS Medical Protection Society, Talking About Good Professional Practice – www.medicalprotection.org

2. The Irish Times, Only half of doctors boy to date to report incompetence 11/7/2017

3. Medical Council, Guide to Professional Conduct and Ethics for Registered Medical Practitioners


www.medicalprotection.org
Writing reports

As a GP, you may be asked to write a report at some point in your career, for a variety of reasons. Find out how to provide a detailed, clear and objective professional report, says Charlotte Hudson

Scenarios: Acting unprofessionally

Seemingly small events can have serious professional consequences, as the following cases illustrate.

A medical student was celebrating the end of exams and set off the fire alarm in a busy pub. He was charged with criminal damage by police.

What happened?
When he finished medical school and applied for registration he had to declare the fact. The Medical Council investigated the case and also required that the doctor see a psychiatrist to ensure he did not have an alcohol problem. They decided all the early stages of the investigation that he should receive a warning that will stay on his registration for five years.

A junior posted comments on Facebook but did not provide any staff or patient ID. However, he referred to “two mad old ladies” and made one or two other inappropriate comments about unspecified patients and staff.

What happened?
The posting was seen by a member of staff and sent to the Medical Director. Disciplinary action was instigated and he was given a written warning by the hospital. This was not referred to the Medical Council. This is due to the doctor’s apologised and deleted all work-related comments on Facebook.

The point here is that although there is no breach of confidentiality, it is a significant issue that would cause an issue if it happened.

A number of issues arise with the increased use of social networking, in particular, patient confidentiality and professionalism. The principle of confidentiality is central to trust between patients and doctors. The Medical Council’s Guide to Professional Conduct and Ethics states that: “Patients are entitled to expect that information about them will be held in confidence. You should not disclose confidential patient information to others except in certain limited circumstances, outlined in paragraphs 28 to 30.”

A junior doctor placed a false work history on her CV. She claimed she had worked in places she did not.

What happened?
This was a serious matter as the doctor had known for a variety of reasons, not least because the doctor denied she had been dishonest, despite the overwhelming evidence, she was struck off the register.

Who is a professional? The simple answer is that a professional is a person. A person like any other, and like any other they are fallible and prone to making mistakes. As with other people, professionals can get sick and can suffer from addiction and mental health problems. As doctors, we are trained to recognise this in our patients and we do so on a daily basis. However, when it comes to our colleagues, these issues seem to be less easily seen and less easily dealt with.

There has always been reluctance amongst the medical profession to report on our colleagues. Having come through such laborious training to become a doctor, we realise what is at stake for our colleagues if they were found unfit to practise. We identify with the stresses they feel and hope that nothing like that would ever happen to us.

Professionalism is a different thing. It is the ability to see the greater good. It is the ability to put aside personal feelings and friendships and do the right thing. Part of our professional responsibility is to ensure that our colleagues are acting correctly.

Part of our professional responsibility is to maintain a high standard across the profession so that patients can feel safe that the person treating them is doing it as well as can be expected. We have a duty to act professionally in all that we do, even if it affects our colleagues.

It’s no surprise that doctors are reluctant to report colleagues. Suspecting that someone has a problem does not make it true. Allegations of improper conduct are taken seriously by the Medical Council and are difficult for the doctor against whom they are made. It makes it worse still when it is a colleague and perhaps friend who makes the allegation. Doctors fear loss of reputation, both among their patients and among their peers. I suspect that until they are able to be professionals, these issues seem to be less easily seen and less easily dealt with.

Here are some practical tips on how to write a report:

- The report should be based on facts and not opinion.
- The report should include dates and, where possible, times.
- The report should not include details that are likely to be sensitive.
- The report should not include details that are likely to be sensitive.
- The report should not include details that are likely to be sensitive.
- The report should not include details that are likely to be sensitive.

REFERENCES

Medical Council’s Guide to Professional Conduct and Ethics (2005), Section 6, paragraph 28, www.medicallaw.org.uk

Who is responsible for the report?

The person who is asked to write the report. This is either the person who has a concern or the authorisation of a person who has a concern.

What can the report do?

- The report can provide facts that are likely to be sensitive.
- The report can provide facts that are likely to be sensitive.
- The report can provide facts that are likely to be sensitive.
- The report can provide facts that are likely to be sensitive.

What should the report include?

- The personal details of the person who has a concern.
- The personal details of the person who has a concern.
- The personal details of the person who has a concern.
- The personal details of the person who has a concern.

What should not be included in the report?

- Personal details, other than the person who has a concern.
- Personal details, other than the person who has a concern.
- Personal details, other than the person who has a concern.
- Personal details, other than the person who has a concern.

What are the potential consequences of writing a report?

- The report could result in a complaint or an investigation.
- The report could result in a complaint or an investigation.
- The report could result in a complaint or an investigation.
- The report could result in a complaint or an investigation.

What is the purpose of writing a report?

- To provide facts that are likely to be sensitive.
- To provide facts that are likely to be sensitive.
- To provide facts that are likely to be sensitive.
- To provide facts that are likely to be sensitive.

What is the role of the medical profession in writing reports?

- To provide facts that are likely to be sensitive.
- To provide facts that are likely to be sensitive.
- To provide facts that are likely to be sensitive.
- To provide facts that are likely to be sensitive.
Avoiding a near hit

Clinical Risk Programme Manager Julie Price shares simple tips for handling test results

Could this happen to you?

Dr Murphy reviewed Miss Y’s computer record, accessing the results of her blood test. Most of the results were normal but there was one showing abnormalities – the thyroid function test (TFT). Dr Murphy knew immediately what had happened. He had brought up the issue of relying on the patient to telephone the practice for their results many times. Miss Y had telephoned after a few days, but the TFT results took longer to be returned.

Dr Murphy explained the oversight to Miss Y, offering an apology. He diagnosed primary hypothyroidism and prescribed thyroid replacement therapy. “Phew,” he thought. “No harm done then, but a near miss, or perhaps more accurately a near hit.”

No tracker system to ensure follow up

The GP might have identified a suspicious symptom, wish to re-examine the patient, or review the patient’s symptoms when test results are available. There might not be a reliable method of checking that the patient has attended his/her follow-up appointment, which may lead to a delay in diagnosis. Introducing either a manual or computerised “tracking system/log” allows the GP to track patients who require monitoring or follow-up.

The tracker log allows clinicians to contact patients they are particularly concerned about (a brain scan, for example, or a rising PSA level). Fortnightly or monthly, a nominated receptionist collects the logs and checks that the patient has attended for follow-up; if not, the note is alerted. An alternative is to use your electronic messaging system and send a task to yourself for, two, three, or four weeks’ time.

No system for dealing with multiple tests

The patient should be informed about how many tests will be carried out. Considering providing patients with a list of the samples that they have had taken, along with the usual timescale (see Figure 3).

Patient not informed of abnormal result

Responsibility for acting on results lies with the practice. Practitioners must develop a proactive system for dealing with abnormal results, minimising the risk of a test result being overlooked. It should not be assumed that the patient will phone up the practice to find out if any action is necessary, following tests, as many will not do so for a variety of reasons.

For those who repeatedly do not attend appointments the practice needs to demonstrate that it has tried as hard as any group of competent colleagues in trying to persuade the patient to attend. Record all attempts. It is important to remember that some patients may be less able to take responsibility for their health than others, for example, those with learning difficulties, or mental illness. Do not file a result unless it has been actioned.

Normal results may prompt an action as well as abnormal results. For example, a patient with a normal renal result may be in a position to cease iron therapy. Similarly, if the hospital has asked the GP to follow up results, whether copied or not, the GP should ensure that the results are obtained and actioned properly taken.

No record of tests requested and no way to ensure all tests have been reported on

One of the challenges is ensuring that all samples sent to the laboratory are returned. Practices may consider undertaking an audit of “ins and outs” of patient samples sent to the laboratory, including blood tests and microbiology samples, to ensure that all results are returned. Some computer software programmes now have an electronic pathology testing request system. This is a reliable method of tracking ins and outs, allied to barcode identification of samples and requests.

No clinical staff entering into clinical discussion about the results

Reception staff should not enter into any clinical discussion about the results but simply read out the doctor’s comments, which should be clear and unambiguous so that the receptionist is less likely to be asked further questions by the patient. If further discussion is needed, a telephone appointment should be made with the doctor.

Some results should always be conveyed by the doctor (for example, malignancies, HIV tests). Consider developing a traffic light system:

- Green results are those that can be conveyed by the receptionist, practice nurse or GP
- Amber results are those that can be conveyed by either the practice nurse or GP
- Red results are those that can be conveyed by the GP only.

Finally

Your practice should have a robust and effective test result system and all staff should be fully trained in the procedure. However, no system is ever foolproof. If an adverse event or near hit does occur, the protocol should be reviewed and lessons learnt to prevent a repeat occurrence.

If you are interested in having a CRSA at your practice, please contact MPS Educational Services on +44 (0) 113 241 0624, e-mail crsalmps@mindspring.com, or visit www.medicalprotection.org/ireland/education-and-events-clinical-risk-self-assessments-for-GPs-for-more-information.

Well-designed test result systems can trap human errors and help reduce the likelihood of adverse incidents, thus preventing harm to patients.
Spotlight on Risk

DATE: Saturday 13 September 2014

The Convention Centre Dublin, Spencer Dock, Dublin 1

TIME: Registration from 8.30am for a 9.30am start – 5.00pm close

COST: €75 for GP MPS members | €150 for GP Non-members | €40 for GP Trainees, Practice Managers and Practice Staff

Our third annual conference for GPs and the primary care team will put the focus on the top risks in practice and offer practical advice on how to manage them.

Understanding the medicolegal and ethical problems you face on a day-to-day basis is vitally important, and you need to know how to quickly and efficiently deal with them when they arise.

Topics covered include:
- Working Together as a Team
- Shared Decision Making
- The Importance of Open Communication
- Running a Practice Safely – Pitfalls in Practice
- Prescription for Happiness
- A Fitness to Practise – When Something Goes Wrong

Plus workshops on:
- Medicolegal Dilemmas
- Becoming an Expert
- Top Risk in Practice: Repeat Prescribing
- Top Tips for Practice Managers
- Responding to a Claim
- Mastering Adverse Outcomes
- Incident Reporting – Learning from Significant Events

For further information and to register visit:
www.medicalprotection.org/ireland/gp