



NEWDOCTOR



PROFESSIONAL SUPPORT AND EXPERT ADVICE FOR NEW DOCTORS

PHYSICIAN, HEAL THYSELF

A LOOK AT THE INCREASING
CONCERNS SURROUNDING
DOCTORS' MENTAL HEALTH
AND WELL-BEING

INSIDE...

TOP 10 TIPS FOR CONSENT SUCCESS

Tips to assist trainee doctors when seeking a patient's consent for a procedure

A GUIDE TO WORKING IN ANAESTHESIA

All you need to know about the speciality

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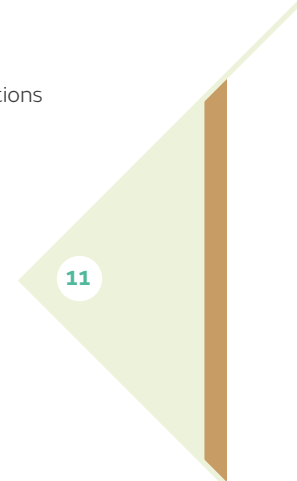
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Rachel has worked in the Marketing Department at Medical Protection for over ten years:

"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 087 2867491 or email Rachel.Lynch@medicalprotection.org

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NOTICEBOARD

Welcome to the 2016 edition of *New Doctor*.

Designed specifically for junior doctors in Ireland, this magazine aims to provide you with medicolegal advice and practical tips to help bridge the gap between life as a medical student and life as a junior doctor.

One of the key areas we are eager to highlight at this stage in your career is the importance of keeping good medical records. Responsibility for writing in the medical notes often falls to junior doctors, and while it may seem a simple administrative task it is actually one of the most important things you will do in

your day-to-day life as a doctor. Legible, thorough, contemporaneous records of every interaction you have with a patient are not only key to continuity of care, they are also your best defence should a patient make a complaint or a negligence claim against you. You can read more on keeping good clinical records on page 12.

It is vitally important to keep an eye on your own health, particularly when starting a new job. Doctors are not immune to illness and mental distress, with one in four likely to suffer from mental-health problems at some stage. On page 6 Dr Íde Delargy of the Practitioner Health Matters Programme discusses the importance of taking care of yourself, and the support that is available.

I hope you enjoy this edition and you find it interesting and useful. As always, if there's something you'd like us to focus on in the next edition or you have any feedback, please send us your ideas and comments.

Dr Gordon McDavid
Editor-in-Chief and Medicolegal Adviser



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HOT TOPIC



MENTAL CAPACITY

Dr James Lucas, Medicolegal Adviser

Day-to-day clinical practice is underpinned by the recognition that patients have a fundamental right to participate in decisions about their care. But doctors sometimes face situations where a patient is unable to understand, retain or weigh up the information provided, or unable to communicate their decision. In these cases, patients are regarded as lacking capacity to make a decision about a proposed healthcare intervention.

It has long been recognised that the law relating to those who lack capacity, enshrined in the Lunacy Regulations (Ireland) Act 1871, has not kept pace with advances in ethics and the need to ensure a human rights based approach to healthcare.

The Assisted Decision Making (Capacity) Act 2015, which was signed into law by the President on 30 December 2015, replaces the archaic 'wards of court' system and represents a paradigm shift with respect to those who lack capacity. When the legislation comes into force, there will be far-reaching implications for decision-making in cases where a patient lacks

capacity. Some of the key features of the Act are as follows:

- The functional approach to the assessment of capacity and the requirement to consider capacity in relation to a specific decision, at a specific time, is placed on a statutory footing for the first time.
- Provision for written agreements which permit a person to appoint someone else to assist with, or jointly make, decisions about their care, when his or her capacity is in question or may shortly be in question.
- Provision for the Circuit Court to appoint "decision-making representatives" who can then make decisions about a patient's welfare.
- A new regime for "enduring power of attorney" which will mean that a person appointed by the patient can assume legal authority to make decisions on the patient's behalf when they lack capacity.
- Provision for written "advance healthcare directives" which seek to provide healthcare professionals with information about a patient's will and preferences concerning treatment

decisions, including life sustaining treatment, in the event that they lose capacity.

Broadly speaking, the Act will significantly expand the categories of individuals who will have legal authority to make decisions on a patient's behalf and who should be consulted by doctors dealing with patients who lack capacity to make healthcare decisions. Doctors will also need to consider how to deal with ethically challenging situations such as when a substitute decision maker is deemed to be acting in a way which is not in the patient's best interests.

It is anticipated that the Act will come into force in late 2016. A Code of Practice is being developed by a steering group appointed by the Health Service Executive and an 'assisted decision-making' education and training implementation plan will be rolled out in due course.

Medical Protection will be monitoring the roll out of the legislation and keeping our members apprised of developments.

STAYING SAFE ON SOCIAL MEDIA: PERSONAL VS PROFESSIONAL

Social media in healthcare has many benefits. However, as with any novel way of working, *New Doctor* Editor-in-Chief **Dr Gordon McDavid** says it is essential to consider the potential consequences that may accompany the advantages



Social media has enabled any individual to publish comments online to a potentially national or global audience; accordingly it also carries risks that doctors should keep in mind.

Inappropriate posts online could invite a complaint, disciplinary action or even a referral to the Medical Council. Medical Protection has seen an increase in doctors seeking advice relating to the use of social media in recent years. The Medical Council's latest edition of their *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* has just been published and devotes a whole paragraph to guiding on doctor's use of social media. Based on our experience we have long advocated the following, which we are pleased to see echoes the ethos of the Medical Council's guidance:

Ensure you are stringent with your security settings

Social media has, in effect, blurred the boundary between personal and professional life. Doctors should ensure appropriate security settings are in place on their online profiles, as patients may be able to access information about their private lives and/or make contact on a personal level if settings are insufficient. This may leave patients feeling as though they have struck up an inappropriately close relationship with their doctor. In such circumstances, doctors should discuss online contact with their patient to ensure this is entirely professional. Alternatively it may be worth considering arranging to transfer that patient to another doctor to ensure the patient receives care that is not affected by a close connection.

Patient confidentiality is paramount

It is all too easy to make a comment online about a difficult or unusual patient interaction. Such action could constitute a breach of confidentiality by releasing identifiable information about a patient, even if their name has not been used. It is important for doctors to ensure they remember their duty of confidentiality and be aware that any comments they make may reach a far wider than intended audience.

Understand the guidelines and regulations

Guidance on using social media is developing as its use in healthcare increases. It features prominently in the updated IMC ethical guide and the Irish Medical Organisation published a position paper on it in 2013. Although some of the guidance may appear obvious or common-sense, its aim is to ensure appropriate and consistent conduct and should be read by all doctors that use social media.

It is important to remember that anything posted online has the potential to be widely distributed and held indefinitely, so before commenting and pressing 'enter', doctors should think about whether they would be satisfied with their patients or employer reading it.

Enforce boundaries

Whilst social interaction with patients (particularly in rural practices) is unavoidable, it is of the utmost importance that doctors remember their professional duties and responsibilities when communicating online.

When interacting face-to-face with patients, even outside the consultation room, it is often obvious if a professional doctor-patient relationship diverts from the norm and early correction can occur. However, this is not always clear when using social media as seemingly innocent online discussions with patients can be misinterpreted. It is therefore important for doctors to keep their online relationships with patients strictly professional and to not accept 'friend' requests from patients on personal accounts.

Be wary of relationships that could be interpreted as 'something more'

A patient could, potentially, allege that their doctor used their position to pursue an improper relationship and demonstrate this with examples of online interactions. Developing a close social relationship with a patient online is inappropriate, and the Medical Council's ethical guidance clearly states that: "Your professional position must never be used to form a relationship of an emotional, sexual or exploitative nature

with a patient or their spouse or with a close relative of a patient."

Whilst such criticism may seem unlikely, it could be very difficult for a doctor to justify an online personal relationship with a patient as being entirely professional and appropriate.

Remain professional

If doctors decide to use social media to interact with patients, it is important to remember that this could constitute the provision of care and they are expected to act as they would in a traditional consultation. This means that records should be kept, all conduct should be in line with acceptable practice and the patient's care should not be compromised.

The way forward

There is no intention to suggest that doctors should not use social media, as it can offer many benefits including access to international expertise and allowing doctors to engage with patients in innovative and convenient ways. Medical education can also be enhanced as information from around the globe can be easily and flexibly accessed and shared.

However, Medical Protection recommends that doctors hold separate social media accounts to keep their professional activity distinct from their personal activity. This is reiterated in the Medical Council's new ethical guidance at paragraph 20.3. It is important that caution is exercised so that doctors can ensure they use social media responsibly to minimise the risk of inadvertently finding themselves in difficulty.

FIND OUT MORE

For more advice on using social media see the factsheet on our website. Please visit:

medicalprotection.org/ireland/resources/factsheets

PHYSICIAN, HEAL THYSELF

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

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

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

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

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

Stigma, awareness and warning signs

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

Raising awareness about the health issues doctors experience as well as signposting how they might access help is of paramount

importance. Very often there are early warning signals that someone may be getting into difficulty but unfortunately these signals are frequently ignored or missed. It is acknowledged that the person with the problem is often the last person to realise that they need help.

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

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

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

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

Seeking Help

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

Guidance for doctors who are concerned about colleagues is set out in the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (2016). It states: "If you have concerns about a colleague's conduct or competence, you should first talk through your concerns with the doctor in question in a sensitive and discreet way. If you have any concerns about patient safety, you must act to prevent any immediate risk to patient safety by notifying the relevant authorities (including the Medical Council) about your concern as soon as possible. If you are not sure who you should report your concern to, ask a senior colleague, the Medical Council or your medical indemnity company for advice."

It also states: "If you are concerned about a colleague's health or professional competence due to the misuse of alcohol or drugs, a physical or psychological disorder or other factors, your primary duty is to protect patients. If there is a risk to patient safety, you must inform the relevant authority of your concerns without delay. If there is no current risk, you should support your colleague by advising them to seek expert professional help or to consider referral to the Medical Council's Health Committee."

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

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

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

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



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2. Gerada C, Jones R and Wesley A, Young female doctors, mental health, and the NHS working environment, *BMJ Careers* (2014)

If you have concerns about yourself or about a colleague the PHMP is there to help. Visit practitionerhealth.ie for further information.



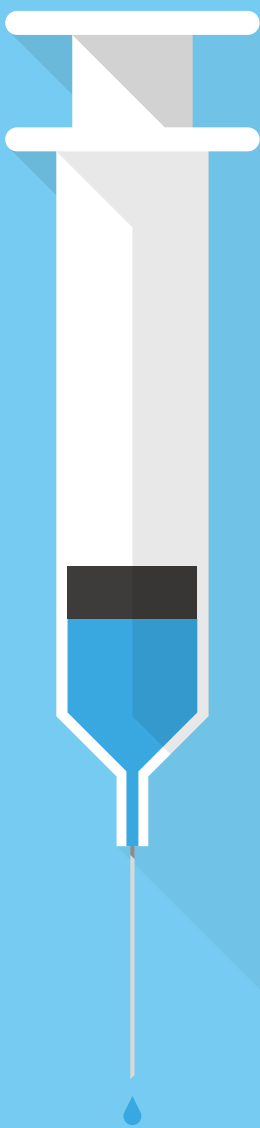
Medical Protection also provides an independent and confidential counselling service for those experiencing medicolegal difficulty and accessing the service is easy.

Contact querydoc@medicalprotection.org



A GUIDE TO WORKING IN ANAESTHESIA

Final year trainee **Dr David Moore** provides some top tips on why you should choose anaesthesia as a specialty



In 2009, I joined the anaesthetic scheme following basic specialist training in medicine. Like many of my colleagues, I had limited exposure to anaesthesia during my undergraduate and intern years. It was during my medical training years that I encountered anaesthetists in emergency scenarios and observed their skill and leadership in the most adverse conditions – I wanted to feel that level of confidence and control in managing the sickest patients in the hospital.

Interestingly, when I surveyed my colleagues, they all reported similar reasons for pursuing an anaesthetic career – positive previous experience with an anaesthetist, an ability to handle any clinical situation, a “jack of all trades”, a practical hands on specialty, and a unique skill set. So how does the Specialist Anaesthetic Training (SAT) scheme facilitate this professional development?

The SAT scheme

The SAT scheme is a six year run-through training programme. The first two years of training require the trainee to master basic skills (airway management, vascular access, intrathecal and epidural interventions, ultrasonography) and core knowledge (anatomy, physiology, physics, pharmacology and clinical medicine). Progress during the two years is assessed in the membership exam.

The subsequent three years involve rotations through different sub-specialty areas (obstetrics, paediatrics, cardiothoracics, vascular, intensive care, pain medicine, etc.); the goal is to become a skilled “perioperative physician”. We learn how to assess and prepare patients with different morbidities for a wide variety of surgical procedures. We learn about intraoperative monitoring, ventilatory and haemodynamic supports, and we develop more advanced skills (bronchoscopy, transoesophageal echocardiography, advanced airway skills, interventional pain management techniques).

The management of postoperative complications and planning analgesic strategies are important roles of the perioperative physician. There’s a progressive increase in case complexity and level of senior supervision. During these years, you’re expected to pass the Fellowship exam.

The sixth year allows the trainee to pursue more advanced training in a sub-specialty area like intensive care medicine or pain medicine. Anaesthetists are uniquely qualified to deliver care in these seemingly diverse areas of medicine. Our experience in perioperative medicine prepares us to deal with the physiological derangements in the critically ill and the interventional aspects of pain medicine. We also have the largest

number of post-CST fellowships in Ireland (currently 12 posts) for sub-specialisation in paediatric intensive care, obstetric anaesthesia, regional anaesthesia, and so on.

Diversity

It is this diversity in possible career paths that I find so exciting and rewarding about anaesthesia. I am personally interested in regional anaesthesia and chronic pain medicine. Some of my colleagues will be intensive care specialists, others will be paediatric anaesthetists or trauma care specialists. What we all have in common is a range of skills and knowledge that is empowering and invaluable in all clinical environments. This explains why anaesthetists can be found in 70-80% of the hospital departments, and why we’re so busy when we’re on call. During my last on-call shift, I stabilised a patient with a coronary artery dissection and tamponade and transferred him to theatre for an emergency coronary artery bypass graft. This was followed by emergency care of a man with a subdural haemorrhage who required stabilisation and transfer to the neurosurgical centre. We didn’t sleep much that night, but we entered anaesthesia for this clinical challenge and stimulation.

Working hours

Based on information gathered from my colleagues in training, we work on average 60-65 hours per week. This will include one to two on-call shifts per week. Due to the unique skill set of the anaesthetist, you’re in high demand around the hospital at night and on-calls can be very busy. Depending on your level of training you’ll be covering the theatre, the intensive care unit, the labour ward or all of the above. Most anaesthetic departments have well-structured teaching programmes with three to four hours of protected training time per week.

The first steps

For those interested in pursuing an anaesthetic career, the first challenge will be to secure a place on the SAT scheme. It is one of the more competitive schemes, and attracts well prepared candidates. It is advisable to complete an anaesthetic elective, Intern job or standalone SHO job before applying. This will give you experience of the specialty and enhance your CV. The

College of Anaesthetists run an open day and interactive workshops for medical students and Interns every January. Also, the Forum Careers Day in Dublin Castle every September offers an opportunity to speak to anaesthetists and college staff about the scheme and an anaesthetic career.

Applicants to the scheme will be shortlisted for interview if they demonstrate an early interest in the specialty with poster or oral presentations, audits, relevant courses and references (40% of total marks for application form). If shortlisted, the other 60% of marks will be allocated at the interview. Again your knowledge of relevant issues, enthusiasm for the specialty, and evidence that you’ve prepared for interview will all score points. The interviewers will be trying to explore your communication skills, your ability to work in a team and under pressure, and your organisational abilities.

Finally, and most importantly, the future jobs market for Irish consultant anaesthetists is very bright. We are chronically understaffed in Ireland, and there is a need to double the consultant cohort over the next few years to meet international standards. Many posts will offer a diverse working experience with opportunities to pursue sub-specialty interests.



Dr David Moore is a final year trainee in Anaesthesia, and a Pain Medicine Fellow.

He is also Chair of the Committee of Anaesthesia Trainees and a council member in the College of Anaesthetists of Ireland.



FIND OUT MORE

More information may be obtained from the College of Anaesthetists website:

anaesthesia.ie

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Join us this July to discover and debate the medicolegal risks to help you practice safely and ethically. By putting you on the right track early on we could give your career a lifetime of protection.

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CONSENT SUCCESS

Medicolegal Adviser **Dr James Lucas** shares his top ten tips to assist trainee doctors when seeking a patient's consent for a procedure

- 1 Never obtain consent for a procedure that you are not familiar with.** It is the responsibility of the doctor providing treatment or undertaking an investigation to discuss it with the patient, or to delegate the discussion to someone who is suitably qualified. The Medical Council advises that in general, interns are not considered appropriate people to undertake this responsibility unless the procedure is a minor one with which the intern is very familiar and the intern's medical supervisor has clearly explained the relevant information about the procedure to them.
- 2 Record in the notes what a patient has been told.** The presence of a signed consent form does not in itself prove valid consent to treatment – keep contemporaneous notes which record the names of all those present for the discussion; key points discussed and relevant warnings given to the patient; and details of any patient information leaflets or diagrams made to assist the patient's understanding.
- 3 Use your common sense.** Consent is patient-specific and depends on the individual's circumstances, including age, lifestyle, occupation, expectations etc. The information should be provided in a way that the patient can understand. If you are uncomfortable consenting a particular patient, always discuss with a senior colleague.
- 4 Ensure you have documented consent for taking photographs and making recordings.** Your hospital may have specific consent forms that should be used or medical photography departments who can guide you through the process. Do not take photographs on your personal smartphone.
- 5 Remember that patients aged 16 years and over are entitled by law to give their own consent to treatment.** Where the patient is under 16 years, it is usual that the parents will be asked to give consent. The Medical Council makes clear that it is only in exceptional circumstances that a patient under 16 might seek to make a healthcare decision on their own without the knowledge or consent of their parents. If in doubt consult a senior colleague.
- 6 Remember, for consent to be valid, the patient must have capacity.** The starting point in the case of adults is always to presume that the patient has capacity until it is shown otherwise.
- 7 You must respect a competent patient's decision to refuse a particular treatment or investigation, even if you think that the decision is unwise.** The law concerning incompetent adults, who are unable to give valid consent, is more complicated. If you are in doubt consult senior colleagues.
- 8 Allow the patient to give their consent freely.** Pressuring patients into consenting to treatment invalidates the consent. Where possible, patients should be given time to consider their options before deciding to proceed with a proposed treatment.
- 9 Always remember that consent is a process, not a one-off event.** It is important to maintain a continuing discussion to reflect the evolving nature of treatment.
- 10 Ideally consent should be obtained well in advance.** This allows time to respond to a patient's questions and provide adequate information on the procedure that is planned. If you are asked to consent a patient immediately before an intervention and are uncomfortable to do so, you must seek advice from more senior members of the medical team.



For more information on issues relating to consent, read the Medical Protection booklet *Consent to Medical Treatment in Ireland* available at:

medicalprotection.org/ireland/booklets/consent-to-medical-treatment-in-ireland

KEEPING GOOD MEDICAL RECORDS

Responsibility for writing in the medical notes often falls to the most junior members of the hospital medical team. Although this can seem like a simple administrative task, here at Medical Protection we cannot overemphasise the importance of keeping legible, thorough, contemporaneous records of every interaction you have with a patient.

Why keep clinical records?

The main purpose of any clinical record is to provide continuity of care, but medical records are also used for other purposes:

- administrative and managerial decision-making;
- meeting current legal requirements, including enabling patients to access their records;
- assisting in clinical audit;
- supporting improvements in clinical effectiveness through research;
- providing the necessary factual base for responding to complaints and clinical negligence claims.

In general, clinical records that contain sufficient information to secure continuity of care will also contain the information required for all other purposes. In the event of a complaint, clinical negligence claim or disciplinary proceedings, the doctor's defence will primarily depend upon the evidence available in the clinical records. If essential information is missing, found to be inaccurate or indecipherable, cases may be lost when they could otherwise have been won.

What are clinical records?

Clinical records include a wide variety of documents generated on, or on behalf of, all the health professionals involved in patient care. This includes:

- handwritten clinical notes;
- computerised/electronic clinical records;
- all correspondence (including letters, faxes, text messages and emails) relating to clinical matters, including correspondence sent between hospital and practice;

- scanned records;
- laboratory results;
- x-ray films and other imaging records;
- photographs;
- videos and audio recordings;
- printouts from monitoring equipment, particularly in anaesthesia and obstetrics, A&E and ICU;
- consent forms.

What makes good clinical records?

CONTENT

Good clinical records 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. This is particularly important in modern hospital practice when multiple patient handovers is the norm. This will include:

- history – relevant to the condition including any positive and negative answers to direct questions;
- examination of the patient;
- all systems examined;
- all important findings, both positive and negative, with details of any objective measurement such as blood pressure, peak flow, etc;
- differential diagnosis;
- details of any investigations arranged;
- details of any referral made;
- information given to the patient concerning risks and benefits of proposed treatments;
- details of consent given to proposed investigations, treatments or procedures;
- details of the main doses of drugs, total amount prescribed, any other treatment organised with batch number and expiry date of any medications personally administered;
- arrangements for follow-up tests, future appointments and referrals made;
- any further consultations, the patient's

current condition, side effects, complications, etc.

That may seem like a daunting list, but it is all important information that someone would have to remember if it is not recorded – and both doctors' and patients' memories are fallible. Many follow-up consultations will be with different members of the team, who will be totally reliant on the clinical records and therefore will need as much information as possible. The mnemonic "SOAP" is a useful reminder of the essential content you should include.

1

Essential content (SOAP)

- **Subjective** – what the patient says.
- **Objective** – what you detect – examination and test results.
- **Assessment** – your conclusions – including the differential diagnosis and rationale for your decision.
- **Problem list & Plan** – management and follow up.

PRESENTATION

Content is important, but so is presentation. If the records are unclear, inaccurate or written in such a way that they're difficult to follow, the content might as well not be there; worse than that, it could cause errors and misunderstandings. Good notes therefore have the following attributes:

- **Clear** – both legible and understandable, especially when handwritten. Each entry should be legibly signed with the date and time.
- **Objective** – clinical records should be factual and free from subjective comments about patients or their relatives. Always assume that patients will read their clinical records at some stage.
- **Contemporaneous** – clinical records should be written up at the time of, or as soon as possible after, an event to ensure accuracy. Retrospective entries should be clearly dated, timed and signed, together with an explanation of

Medicolegal Adviser **Dr James Thorpe** looks at why keeping good clinical records is important, and provides advice on how to do so



why it is being written retrospectively.

- **Attributable** – if information has been given to you by someone other than the patient, then you should record who provided the information as well as what they said.
- **Original** – sometimes it is necessary to amend or alter medical records, for example if a factual error has been made. Any correction must be clearly shown as an alteration, complete with the date the amendment was made and the name of the person who made it so there can be no allegation that the alteration was an attempt to deceive anyone into thinking that it is part of the original record. (See Box 2.)

3

Use of abbreviations in national hospitals

Abbreviations should be avoided if at all possible, but in the event of abbreviations being utilised, only those approved by the National Quality & Patient Safety Directorate and contained within the HSE approved abbreviations document are permitted.

If an abbreviation is used that is not contained within the HSE abbreviations document then the full term, followed by the abbreviation in brackets, should be written on each side of each page where the abbreviation is used. Abbreviations should not be used on:

- a. documentation that is used for transfer or discharge;
- b. communication sent from the healthcare organisation, e.g. external referral letters;
- c. consent forms;
- d. death certificates;
- e. medication sheets.

National Hospitals Office, *Standards and Recommended Practices for Healthcare Records Management* (2011).

Common problems

All of the following can compromise patient safety or lead to medicolegal problems:

- not recording relevant negative findings;
- not recording substance of discussions about the risks and benefits of proposed treatments;
- not recording drug allergies or adverse reactions;
- not recording the results of investigations and tests;
- illegible entries;
- not reading the previous notes when seeing a patient;
- making derogatory comments;
- altering notes after the event (even seemingly simple additions);
- wrong patient/wrong notes.

HSE guidelines on correcting medical records

Deletions or alterations are made by scoring out with a single line followed by:

- a. signature (plus name in capitals) and counter-signature, if appropriate;
- b. date and time of correct entry.
- c. reason for amendment.

Corrections are made as close to the original recording as possible.

National Hospitals Office, *Standards and Recommended Practices for Healthcare Records Management* (2011).

ABBREVIATIONS

Abbreviations are commonly used in clinical records but can be misinterpreted and lead to mistakes in diagnosis or management. So the rule is, when in doubt, write it out – in full. See Box 3 for the rules on abbreviations that apply in national hospitals.

Sarcastic and derogatory abbreviations have no place in clinical records – they are gratuitously offensive and sure to destroy any therapeutic relationship once found out.

LEARN MORE

An e-learning training programme developed to support the Healthcare Records Management Programme and help staff to improve their performance in relation to healthcare records management can be accessed at: hse.ie (HSE Staff only).

MORE RESOURCES

Medical Protection has a series of materials that provide further advice on keeping good clinical records, including articles, advice booklets and factsheets. These can be accessed at: medicalprotection.org

REFERENCES

HSE: *Healthcare Records Management*. Available at: hse.ie/eng/about/Who/qualityandpatientsafety/safepatientcare/healthrecordsmgt/

The case study in this article is fictional and is used purely for illustrative purposes.

Content for this article was taken from the booklet *Medical Records in Ireland: A Medical Protection Guide* written by Sandy Anthony. It can be accessed at: medicalprotection.org/ireland/booklets/medical-records-in-ireland-an-mps-guide

CASE STUDY

Dr A worked as an SHO in paediatrics in 2008. In 2016, he was approached by solicitors acting for the HSE who were defending a claim made by the parents of the child alleging that the treatment of meningitis provided in 2008 had been negligent. The solicitors requested that Dr A provide them with a factual statement detailing his involvement in the case.

Fortunately, Dr A had made detailed records of his interaction with the patient and documented the important positive and negative findings on examination. Although he had no recollection of the consultation, with Medical Protection assistance he was able to draft a clear statement based on his contemporaneous notes. This case illustrates that good records can protect a doctor's position, even many years after an event.



WRITING REPORTS OR STATEMENTS

As a doctor, you may be asked to write a report or a statement at some point in your career, for a variety of reasons. **Charlotte Hudson** explains how to provide a detailed, clear and objective professional report

Why might a report be required?

A written report or statement may be the starting point of an investigation into the circumstances leading to or surrounding an adverse incident. This could be an investigation into a complaint, a clinical negligence claim, a criminal case, disciplinary matter by an employer, coroner's inquest or a complaint to the Medical Council.

You may also be required to provide a report for any of the situations below:

- for your employer, possibly after something goes wrong;
- for a solicitor;
- for the Gardaí;
- for a patient's employer or insurance company.

Disclosure of information – are you authorised to disclose this data?

The first point to consider is whether you are authorised to disclose the patient information that is likely to be required as part of the report. You need to make sure you get your patient's consent and check that they are clear about the information you will be providing and why it is necessary.

Disclosing the information may also be in the wider public interest (for example, assisting the Gardaí in preventing or resolving a serious crime), or the disclosure may be required by law (statutory obligation) or to comply with a court order.

The Medical Council states that where the report relates to the patient's current state of health, you are encouraged to carry out an up-to-date examination where appropriate.

Fact vs opinion

Where a report has been requested in relation to a specific incident, it is likely that you will be asked to provide a statement of fact as a professional witness, i.e. giving your account of events leading up to and including

the incident. You should only report the facts as you know them. If, however, you are asked to give an opinion, you must only comment within your area of expertise and make clear any information that represents your opinion.

Writing the report

Your report should be based on:

- the medical records;
- your own recollection of events;
- your usual practice.

Your report should be:

- **Detailed** – it is better to provide too much information than too little.
- **Clear** – avoid ambiguity and explain who did what and when.
- **Objective** – state the facts. Do not use the report to criticise others or make general comments.

What should your report include?

- **Your personal details:** Include your full name, date of birth, address and contact details, your qualifications and relevant clinical experience.
- **Relevant local factors:** If, for example, your surgery is on two sites and this affects the time taken to get to an incident.
- **Details of other healthcare professionals involved:** Where possible, include your colleagues' full names, job title and disciplines.
- **The patient's details:** Name and date of birth.
- **Presentation and history:** You should include dates and, where possible, times
- **Findings on examination and other relevant factors:** If the patient was very difficult to examine because he was agitated and aggressive, provide details of how that behaviour was exhibited.

- **Diagnosis and whether a differential diagnosis was considered:** Include the rationale for any conclusions you reached.
- **Investigations and subsequent management, including dates and the reasons for this plan.**
- **Follow-up arrangements and information given to the patient or relatives.**

The report should be typed, signed and clearly dated by you.

Report writing tips

- Write in the first person singular – "I did this..."
- Avoid jargon and abbreviations.
- Bear in mind that the patient or their relatives are likely to see the report; avoid personal remarks.
- Write your report honestly; don't be influenced by others.
- Check spelling, grammar and punctuation before submitting.
- Ensure that your use of medical terminology is correct and interpretable to the audience i.e. it will be likely that any technical terms need to be accompanied by an explanation.
- If the report is as a result of a complaint or claim, make sure you have seen the complaint or Letter of Claim, or details of any court proceeding before writing.

Making a supplementary report

It may be necessary for you to make a supplementary report to deal with issues that come to light after you have written your original report. Before doing this, review your original report, the medical records and any new documentation.

A second opinion

Finally, you should strongly consider contacting Medical Protection before submitting your report to obtain advice on the content. You can send your statements, reports and queries to querydoc@medicalprotection.org

PLEASE NOTE

This article only covers writing a medical report. At later stages in your career, you may be asked to provide a report as an expert witness, in which you will be asked to give an independent opinion on the facts of a case in court. For guidance on writing an expert report, read our factsheet, [A Guide to Writing Expert Reports: medicalprotection.org/ireland/resources/factsheets/factsheets/roi-a-guide-to-writing-expert-reports](https://www.medicalprotection.org/ireland/resources/factsheets/factsheets/roi-a-guide-to-writing-expert-reports)

REFERENCES

¹ Medical Council, Guide to Professional Conduct and Ethics (8th Edition, 2016), Chapter 4, Paragraph 40.1 [medicalcouncil.ie/News-and-Publications/Reports/Guide-to-Professional-Conduct-Ethics-8th-Edition.html](https://www.medicalcouncil.ie/News-and-Publications/Reports/Guide-to-Professional-Conduct-Ethics-8th-Edition.html)



FROM THE CASE FILES

Distractions and human factors such as fatigue are associated with increased risk of errors, as this case demonstrates

L was a healthy four-year-old boy who had accidentally caught his finger in a bicycle wheel, amputating part of the distal phalanx. In the Emergency Department of the local hospital, it was found that the pulp and nail bed of the finger were lost and the bone of the terminal phalanx was exposed. L was admitted under plastic surgery, fasted, and booked for theatre for terminalisation of the finger.

He was assessed for general anaesthesia by consultant anaesthetist Dr B, who noted that L was a fit and well boy weighing 17.5kg, had no medical problems or allergies, and had been appropriately fasted. Dr B conducted an inhalational induction of anaesthesia, with 4% Sevoflurane within a mixture of 70% nitrous oxide/30% oxygen via a modified Ayre's T-piece, using fresh gas flows of 8l/min.

Dr B inserted a laryngeal mask airway (LMA) to maintain the airway, and maintained the anaesthetic with a mixture of nitrous oxide, oxygen and sevoflurane. An intravenous cannula was inserted once L was asleep; 15mcg of fentanyl and 2mg of ondansetron were given during the case and a slow infusion of dextrose saline was administered.

Plastic surgeon Mr U performed the surgery, which proceeded uneventfully. Mr U performed a ring block with 3ml of 0.5% plain bupivacaine for postoperative analgesia. Towards the end of the operation, as Mr U was applying the dressings, the theatre sister, Sr S, noted that L's pulse was very slow at 45 beats per minute. The pulse oximeter showed that the saturations were 52%.

Dr B removed the drapes and L's face was noted to be cyanosed and his pupils widely dilated. Dr B removed the LMA, but the throat was clear. He applied 100% oxygen by facemask and an oropharyngeal airway. No pulse was palpable after 20 seconds of high flow oxygen, so Dr B instructed the surgeon to perform external chest compressions. He gave 0.1mg of adrenaline and a second dose after two minutes. The second dose was effective in restoring a palpable pulse, and the oxygen saturations recovered to normal.

Upon attempting to wake L from the anaesthetic, he manifested severe extensor spasms and epileptiform movements of his limbs. He was intubated, sedated and transferred to intensive care. After a prolonged period of care, he was discharged from intensive care with extensive neurological damage consistent with hypoxic brain injury.

An extensive inquiry was undertaken, which highlighted several areas of very deficient anaesthetic care. Dr B had not spoken to L's parents before the anaesthetic, and had not warned them of the risks of anaesthesia. Dr B said he had finished a 12-hour list with another surgeon and had agreed to help out at short notice. After induction, Dr B had left the reservoir bag concealed under the drapes, where he could not see its movement. He had not used a capnograph to monitor respiration.

He had not recorded a blood pressure or respiratory rate at any time during the case. The monitor alarms had all been switched off earlier in the day and he had not checked or reinstated them. Dr B accepted that there was a protracted period of inadequate vigilance during the case, during which a prolonged episode of severe hypoxia occurred.

This case occurred over a decade ago and L is now a teenager. He has profound impairment of sensation, movement, communication, intellectual function and memory. L's parents made a claim against Dr B, which was settled for a high sum.

LEARNING POINTS

- ✓ A series of human and equipment factors interacted in a catastrophic way to bring about this tragic outcome from a trivial initial injury.
- ✓ Fatigue can be a powerful cause of reduced vigilance, and is associated with increased risk of error. It does not amount to a defence. The mnemonic HALT reminds all healthcare professionals to be extra careful if they are Hungry, Angry, Late or Tired. Ask yourself: am I safe to work?
- ✓ Most anaesthetic machines now incorporate capnography automatically. It is also more difficult to switch off all the alarms on the anaesthetic machine. However, distractions in theatre have become more common, including portable electronic devices that can distract healthcare professionals with text messages and emails.



More support for your
professional development

FACE-TO-FACE LEARNING



The Mastering workshops
should be compulsory. Very informative.

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