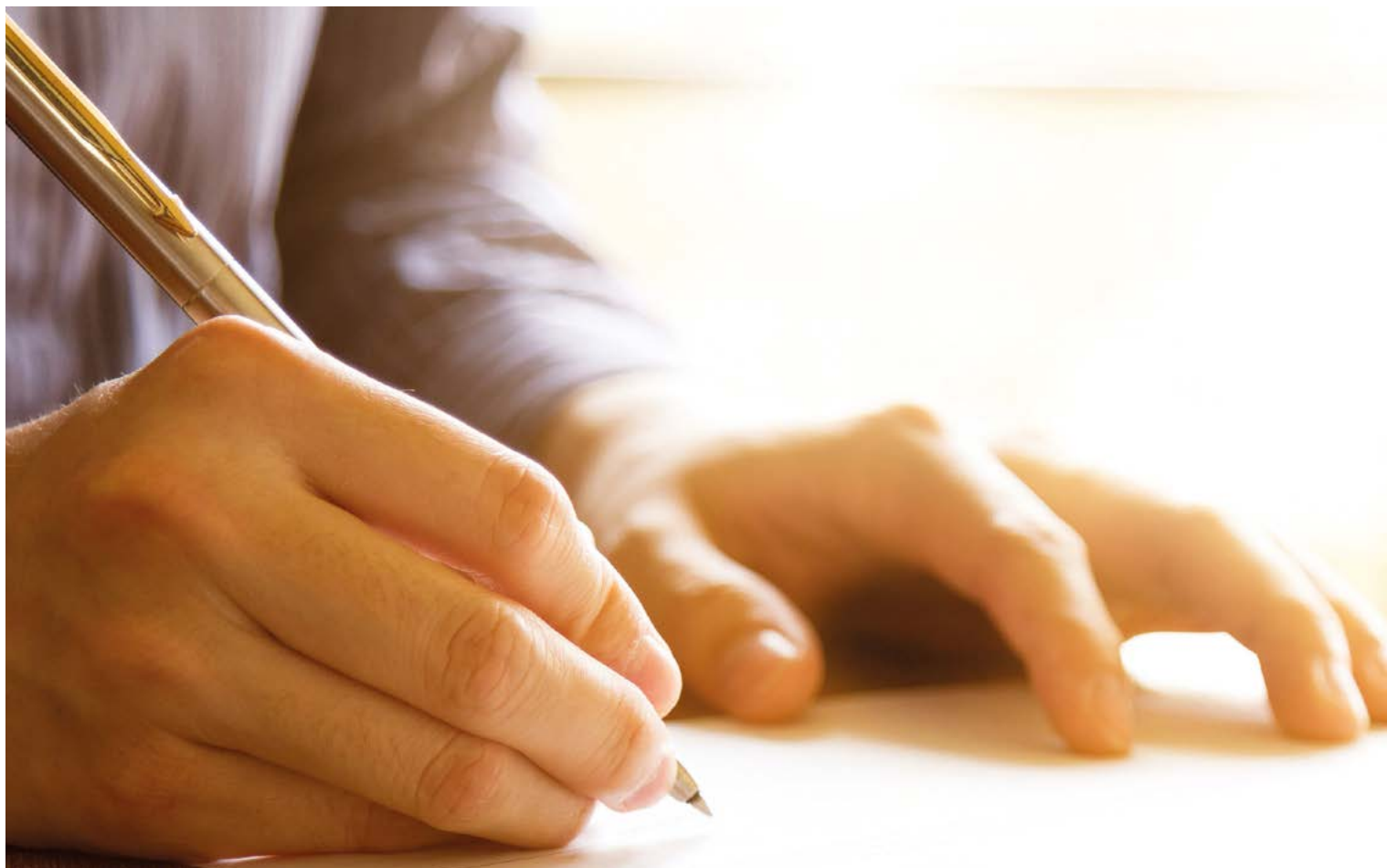




Practice MATTERS

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EDITORIAL TEAM

Dr James Lucas
EDITOR-IN-CHIEF



Anna Francis
EDITOR



CONTRIBUTORS

Dr James Lucas, Suzanne Creed, Anna Francis, Katy Meade and Louise O'Rourke.

PRODUCTION

Allison Forbes

Please direct all comments, questions or suggestions about Medical Protection service, policy and operations to:

Victoria House
2-3 Victoria Place
Leeds LS11 5AE
United Kingdom

chief.executive@medicalprotection.org

In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

Medicolegal advice

Tel +44 113 241 0200

querydoc@medicalprotection.org

Membership enquiries

Tel 1800 509 441

member.help@medicalprotection.org

medicalprotection.org

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Practice Matters (Print) ISSN 2052-1022
Practice Matters (Online) ISSN 2052-1030

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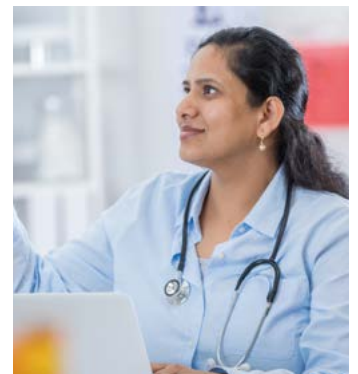
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WELCOME

It is my pleasure as always to welcome you to this edition of *Practice Matters*. There is a lot to report since my last editorial. Developments on the policy front are clearly like buses!

It will not have escaped the attention of readers that following the referendum in 2018, the Government moved quickly to introduce legislation to regulate the termination of pregnancy. This is a subject that tends to divide opinion and there is no reason to believe that the views of healthcare practitioners will be any less diverse than those of the population that they serve. Medical Protection's role is clear. We are here to offer guidance to members with regards to the interpretation of the law and its application to clinical practice. Our position in relation to indemnity for those GPs who decide to participate in the new service is set out on page 14. We also touch on the issue in the context of our regular 'Ask the expert' feature on page 18. As the termination of pregnancy service matures, we expect medicolegal dilemmas to arise in practice and we will keep you updated in future editions of *Practice Matters*.

Healthcare is inherently risky. Despite everybody's best efforts, things will occasionally go wrong. Medical Protection has long championed the importance of open and honest conversations with patients when treatment does not go to plan. On pages 10-11 Louise O'Rourke and Katy Meade of Hayes solicitors examine the legal protection for apologies on the back of some recent provisions in the Civil Liability (Amendment) Act 2017. At the time of writing, open disclosure is not required by the law (it is, of course, a professional obligation). However, the Government is introducing legislation that will mandate the disclosure of certain adverse events. Medical Protection is concerned about the potential for unintended consequences arising from this important legislation and our Chief Executive, Simon Kayll, is raising these issues at the highest level, on your behalf.

Before leaving the policy front, I should mention the new 'meet the team' feature. On page 5, *Practice Matters* puts some questions to our policy & public affairs manager, Tom Reynolds. We hope that you will enjoy hearing about Medical Protection colleagues who work behind the scenes.

Influencing the debate about healthcare policy is one area where Medical Protection aims to deliver our 'more than defence' approach. Another is our risk management advice to members. On pages 12-13, Suzanne Creed, clinical risk and education manager, examines some of the key prescribing risks identified through visiting practices, and outlines strategies for mitigating them. Suzanne brings a wealth of experience from working at the coalface in primary care in Ireland and her article is full of pragmatic advice, perhaps best summed up by the dictum "systems, systems, systems". Suzanne also looks at the issue of team communication, which is vital in underpinning safe clinical care, on pages 16-17.

One of Medical Protection's key strengths lies in our local knowledge. On page 15, I share a recent case where a member sought advice about a cross-border referral, with a focus on the HSE's guidance. Our work across many jurisdictions, including New Zealand, South East Asia and South Africa, also provides us with a broad lens with which to share learning.

In the last edition of *Practice Matters*, I described the implications of a recent Irish High Court judgment relating to patient confidentiality. We are sharing the lessons of that case with our colleagues in the UK. To return the favour, on pages 8-9 I have highlighted a negligence claim involving non-clinical staff (in this case, hospital receptionists), which was recently considered by the UK Supreme Court.

Our *Practice Matters*' editor, Anna Francis, examines the issue of complaints on pages 6-7, with a focus on the interesting findings from a study of the North Dublin GP Out of Hours service, NorthDoc. Complaint handling is a subject that we return to often in our publications and we make no apologies for that. It is such an important matter to get right first time and essential for learning and service improvement.

I hope that you enjoy this issue. If you have ideas or comments on our articles, we would be delighted to hear from you.

Dr James Lucas
Editor-in-Chief and Medicolegal Consultant



MEET THE TEAM

In this issue of *Practice Matters*, we want to introduce you to Tom Reynolds, our policy & public affairs manager



Practice Matters (PM): Hi Tom! So how long have you worked for Medical Protection and what were you doing beforehand?

Tom Reynolds (TR): I joined Medical Protection in 2014. Prior to that, I worked as a parliamentary aide to a number of MPs in the United Kingdom Parliament.

PM: Can you describe a ‘typical day’ at work?

TR: The first thing I do is go through all the key news websites and the day’s papers from around the world – seeing what stories could impact members. Then it’s a case of monitoring parliamentary business in the Oireachtas and the UK Parliament, and making sure Medical Protection engages with legislation that could have a medicolegal impact on healthcare professionals. Often, the rest of my day then involves meeting with representatives from medical colleges, regulators and other healthcare bodies to ensure we are all working together as best as we can to support the profession.

PM: What has been your proudest achievement while working at Medical Protection?

TR: My proudest moment was giving evidence to the Williams Review – a UK Government review into gross negligence manslaughter and its application in healthcare, following a professional outcry. Standing up for members is what my job is all about, and as a result of our submission to that review, the UK Government agreed to our call for the doctor’s regulator (the General Medical Council) to be stripped of its power to appeal fitness to practise decisions. Making sure doctors face a proportionate and fair regulatory regime is a personal priority for me.

PM: Ireland is very active in relation to policy matters. What do you see as the main opportunities and challenges over the next 12 – 18 months?

TR: I think the main opportunity society needs to seize is lasting and significant legal reform to bring down the cost of clinical negligence in Ireland. One challenge, as well as an opportunity, is making sure healthcare professional regulation remains fair and proportionate. The Government is currently legislating considerably in this area, and Medical Protection is engaging with them closely and standing up for members.

PM: What position is Medical Protection adopting in relation to ‘open disclosure’ in Ireland?

TR: At Medical Protection, we have long advised members that an apology is not an admission of liability. An apology should be seen for what it is – an acknowledgement that something has gone wrong and a means of showing empathy. We do, however, have concerns about the current drive towards creating a mandatory open disclosure duty for doctors. Changing healthcare professionals reactions to incidents from one of fear into an eagerness to report, explain and learn from the incident can only happen through cultural change. There is a real danger that punitive legislation aimed at creating openness will have the opposite effect. That’s why we are engaging closely with the Government on this.

PM: What can members do if they are concerned about a particular government policy proposal?

TR: Get in touch! My team and I are always eager to hear from members about any emanating policy proposals. As a not-for-profit membership organisation, the policy & public affairs team at Medical Protection is here to be a champion for your medicolegal interests. So if you have views, concerns or comments about any live legislative or regulatory debates in Ireland, we want to hear from you.

PM: Tell us something that people might be surprised to know about you?

TR: Away from my role at Medical Protection, I am also a Justice of the Peace for Central London – more commonly known as a magistrate. It’s a fascinating role; hearing criminal trials, determining bail applications, and sentencing convicted offenders.

PM: How do you unwind after a day at work?

TR: The honest answer is having a good meal, with either a few pints or a nice glass of wine. However, if I’m being good then the answer will be a nice run. I am a keen distance runner and take part in a number of running events to raise money for the charity Guide Dogs.

MITIGATING COMPLAINTS IN AN OUT OF HOURS GENERAL PRACTICE SETTING

Less than 1 in 1,000 patients complain about out of hours general practice according to new research from the Health Research Board Centre for Primary Care Research at the Royal College of Surgeons in Ireland

A new study from the Health Research Board Centre for Primary Care Research at the Royal College of Surgeons in Ireland on Northdoc – the North Dublin GP out of hours service – has discovered that from over 300,000 face-to-face consultations, only 234 patients made complaints. This works out at a rate of 0.61 complaints per 1,000 GP consultations.

The study looked at nearly half a million telephone contacts between patients and NorthDoc Medical Services CLG between 2011 and 2016. Of the complaints made, it found that unmet patient expectations and parental concerns over antibiotic treatment of children were amongst the most common. While research on patients' complaints in out of hours general practice is limited, the new research has presented some interesting and positive findings.¹

COMMON COMPLAINTS

Common themes seen as a reason to complain in an out of hours practice setting included dissatisfaction with clinical examination and unmet expectations regarding management. An example of this is a parent being unhappy that oral antibiotics were not prescribed to their child who was diagnosed with a viral infection.

Other complaints included:

- clinical problems – including misdiagnosis, prescription errors and inadequate clinical examination
- communication problems – including the perception of being dismissed or ignored
- concerns about confidentiality breaches
- management problems – including waiting times, staffing levels, problems with facilities provided and issues with fees.

MITIGATING COMPLAINTS

Communication

One of the hardest things for GPs working in an out of hours setting is that they do not always know the patient they are seeing or have access to their medical records. This means that good communication with the patient, and GP colleagues, is key.

Poor communication is well recognised as a contributing factor in complaints² – which is why it's equally as important that when communicating with patients, doctors listen as much as they talk; thereby leading to a more accurate diagnosis and a reduced risk when it comes to medical errors.

Team communication is also important, and out of hours staff need to work closely together to ensure the service runs smoothly. There also needs to be an efficient system for passing information between healthcare professionals, including the patient's GP.



The NorthDoc complaints procedure is based largely on a fast verbal response to the patient. It encourages patients to make their complaint in any format that they wish – ranging from formal contact with the HSE’s complaint procedure online to direct contact with NorthDoc via an email account. Dr Desmond MacDonell, director of medical governance at NorthDoc, also encourages all personnel within the service to accept verbal feedback and to communicate it quickly to ensure a quick response to patients.

“Staff can notify me by email following a complaint, advising the patient that I will respond verbally. A relatively small percentage of our complaints are received in writing, and in turn, only a very small percentage receive a written response. All complaints are nonetheless closed with a comprehensive written report to the board of NorthDoc.

“I find that verbal responses are very effective in that the matter can be fully discussed with the patient. A 15-minute telephone conversation enables a thorough discussion of the complaint, whereas a written reply tends to be short and somewhat prescriptive, and in my opinion, less likely to result in a complete resolution of the matter.”

Quality standards

High standards and a consistent approach to patient care are key. Employees should all meet agreed criteria and a detailed induction programme should ensure all staff have a thorough understanding of the relevant out of hours systems and processes.

The Royal College of General Practitioners (RCGP) has an Out of Hours Clinical Audit tool that can be used across all staff groups to cover the main aspects of an out of hours service. It’s designed to promote consistency and provide a framework to examine and develop the quality of calls and consultations.³

Risk management within the out of hours team should be an integral part of any meeting, giving staff the opportunity to report and review any complaints or incidents. It is important to ensure action plans are developed, as this will ensure the practice is accountable for implementing the changes.

It is also good practice to ensure that any changes to the function or running of the practice are communicated effectively to patients.

HOW TO MANAGE COMPLAINTS

The research states that 85% of patient complaints were managed effectively to the satisfaction of the patient by the out of hours service. This highlights the value of local complaints resolution structures in general practice settings.

The benefits of having a local complaints procedure include:

- obtaining patient feedback, both negative and positive
- highlighting areas of concern
- addressing issues early
- reducing the chance of a medical negligence claim by dealing with the complaint effectively
- diverting the complaint from the Medical Council.

It is important to have a written complaints policy within the practice that details your practice’s approach to managing and handling complaints.

You also need to identify who is the responsible person within the resolution structure for managing/handling complaints – this could be a senior GP.

Some practices find it helpful to have a complaint management checklist which can be retained within the file as a useful aide-memoire, to ensure that none of the steps in the complaints handling process are inadvertently overlooked.

On receiving a complaint, it is important to acknowledge this with the patient – we suggest that you acknowledge receipt of the complaint within three working days.

It is also important to advise the complainant that they will receive a full response and to give an indication as to when they can expect this. Some jurisdictions have introduced timeframes for responses in primary care (for example, in Northern Ireland, where the substantive response is expected within ten working days). However, whilst it is important to deal with complaints promptly, the quality of the response must not be sacrificed in favour of meeting a deadline. It might be the case, for example, that a key individual is unavailable for comment (eg due to leave or illness) and it would be more appropriate to await their return. Complainants should be kept advised of any such delays.

In the event that a patient complains verbally to the practice, it is important to establish at this stage if they wish to write formally to particularise their concerns. Where a complainant raises a significant clinical governance issue but declines to submit their concerns in writing, it can be helpful to summarise the issues in the acknowledgement letter, to afford the complainant the opportunity to correct any misunderstandings and/or to expand upon their complaint.

Any acknowledgement with the patient should include a commitment to investigating what has gone wrong.

When responding to a complaint, an apology can go a long way, acknowledging with the patient any distress that the situation has caused. In many cases, patients just want to understand the clinical issues. Even in cases where the practice concludes that the service provided was appropriate, empathy with the complainant’s perceptions can be helpful in bringing the matter to a conclusion.

In the letter of response, it is important to provide a chronology of the events in question so that the complainant has a full understanding of what has happened, and to respond to each issue raised in the complaint. Where indicated, the practice should outline the action that it plans to take and an estimate of the timescales for introducing any service improvements – giving clear responses to each issue raised will provide the patient with a full understanding of what has happened. It can also be helpful to offer to write to the complainant with an update in relation to any changes that have or will be introduced.

You may feel it appropriate to invite the complainant to meet with the practice to discuss any unresolved concerns or to explain the response in further detail.

It is also good practice to ensure that all complaints are recorded. Confidentiality must be maintained, as with clinical records. Complaints should be recorded separately from the patient’s medical record. Documentation should be clear and accurate.

REFERENCES

1. Wallace E, Cronin S, Murphy N et al. Characterising patient complaints in out-of-hours general practice: a retrospective cohort study in Ireland. *British Journal of General Practice* 2018;68:e860-e868. doi:10.3399/bjgp18x699965
2. Price et al (2007). Emerging risks in out-of-hours primary care services. *Clinical Governance: an International Journal* 11(4) 289-298
3. Urgent and emergency care clinical audit toolkit. London: RCGP 2010

LITIGATION UPDATE

It is very unusual for a clinical negligence claim to get to the highest reaches of the court system. Rarer still are cases involving non-clinical staff such as receptionists. *Dr James Lucas*, medicolegal consultant, discusses such a case which was recently considered by the Supreme Court in the UK and extracts potential learning points for practices in Ireland¹



THE FACTS

Mr Darnley, aged 26, sustained a blow to the back of the head during an assault late one afternoon. He telephoned his friend, Mr Tubman, to explain what had happened, adding that he had a headache which was getting worse. Mr Tubman drove his friend to an Accident & Emergency (A&E) department at an NHS Trust. Mr Darnley was noted to have attended A&E at 20.26 hours.

Mr Tubman was a witness to the conversation between Mr Darnley and the A&E receptionist, and became involved in the discussion. On Mr Tubman's account, the background to Mr Darnley's attendance was explained to the receptionist. She was informed by both men that they were worried that Mr Darnley had sustained a head injury and needed urgent attention. According to Mr Tubman, the receptionist told Mr Darnley that he would have to sit in the waiting room for up to four-to-five hours, before somebody would be available to look at him. Mr Tubman said that Mr Darnley explained to the receptionist that he could not wait that long as he felt that he was about to collapse, and that the receptionist replied that if the appellant did collapse, he would be treated as an emergency.

The two receptionists on duty that evening gave evidence in court as to their usual practice, as they were unable to recollect the conversation with Mr Darnley. One receptionist indicated that she would have mentioned an assessment by a triage nurse within 30

minutes of arrival; and the other said that she would inform a patient that they would be seen by a triage nurse as soon as possible.

Mr Darnley sat down with Mr Tubman in the A&E waiting area, but he left shortly afterwards because he felt too unwell to remain and wanted to go home to take some analgesia. Neither Mr Darnley nor Mr Tubman informed the receptionist or anyone else about their intention to leave the A&E department, however both of the receptionists on duty noticed that the men had left and notified the receptionist taking over on the next shift to look out for Mr Darnley.

Mr Darnley was driven to his mother's house and went to bed. He became distressed a short time later and an ambulance was called. He was taken to hospital where a CT scan demonstrated a large left temporal/inferior parietal extra-dural haematoma with marked midline shift. Despite neurosurgical intervention to remove the extradural blood clot, Mr Darnley suffered permanent neurological impairment in the form of a severe and very disabling left hemiplegia.

LITIGATION

In the context of his claim against the NHS Trust, Mr Darnley included an allegation of breach of duty by the reception staff. This related to the information provided about the time that he would

have to wait before being seen by a clinician, and also alleging a failure to assess him for priority triage.

The High Court judge concluded that the harm suffered by Mr Darnley was outside the scope of any duty or obligation owed by the Trust or its reception staff. The judge said that the connection between the alleged inadequacies of the information provided and the harm suffered was broken because the decision to leave was ultimately down to Mr Darnley.

Mr Darnley appealed the High Court's decision. The appeal was dismissed by a majority of the Court of Appeal. Lord Justice Jackson's judgment included a comment that imposing a duty on the receptionist would add a new layer of responsibility to clerical staff. Moreover, the judge said that Mr Darnley should accept responsibility for his own actions with regards to his having walked out of the department without telling staff that he was about to leave.

THE CASE WAS APPEALED FURTHER AND WENT TO THE SUPREME COURT

Mr Darnley further appealed and went to the Supreme Court, where the Justices considered that the case fell within an established category in which the law imposes a duty of care. They also accepted that as soon as Mr Darnley had attended the A&E department and had been booked in, he was accepted into the system and entered into a relationship with the NHS Trust. They ruled that it was not appropriate to distinguish between medical and non-medical staff with regards to the duty of care, and that in this instance, the NHS Trust had charged its non-medically qualified staff with the role of being the first point of contact with persons seeking medical assistance. As a result, they had an assumed responsibility for providing accurate information.

Having established this, the Justices went on to say that, whilst acknowledging the enormous pressure on staff, it is not unreasonable to require receptionists to take adequate care not to provide misleading information as to the likely availability of medical assistance.

The standard required is that of an averagely competent and well-informed person performing the function of a receptionist at a department providing emergency care.

The Justices held that Mr Darnley had been misinformed by the receptionist as to the true position with regards to triaging, and was, as a result, misled as to the availability of medical assistance. The Justices referred to the critical finding of the trial judge – namely that it was reasonably foreseeable that a person who believes that it may be four or five hours before he will be seen by a doctor may decide to leave. The provision of misleading information by the receptionist was therefore found to be negligent. Causation was also established on a number of grounds. Importantly, the Justices referred to the trial judge's findings that if Mr Darnley had collapsed whilst at the NHS Trust, he would have been transferred earlier for neurosurgery, with the result that he would have made a very near full recovery.

Mr Darnley's appeal was allowed by the Supreme Court.

REFERENCE

1. Darnley (Appellant) v Croydon Health Services NHS Trust (Respondent) [2018] UKSC 50

LEARNING POINTS

The judgment is not binding in Ireland. However, it is entirely possible that the courts in Ireland would adopt a similar approach when considering the duty of care of non-clinical staff such as receptionists. Whilst the case in question related to care in an emergency department, there is nothing to indicate that a different approach would be taken by the courts when considering out-of-hospital settings. This is particularly relevant in the context of 'open surgeries' or 'walk-in centres' providing primary care, where patients may have to wait to be assessed. Practices might therefore consider the following guidance on foot of the judgment:

- The development of a protocol is critical in terms of defining the roles and responsibilities of non-clinical staff on the 'frontline' of a clinical service. Protocols should encompass issues such as:
 - Dealing with special patient groups, eg children and those with special needs.
 - Clearly understood thresholds for alerting clinical staff to the presence of patients who may require prompt attention, eg patients presenting with time-sensitive complaints such as chest pain.
 - Expectations with regards to documenting patient encounters.
 - Communicating with patients when the waiting time significantly increases, eg because of a medical emergency or staff illness.
- Appropriate training of non-clinical staff with patient-facing roles is essential. The training needs of temporary/agency staff should be considered as part of induction processes at the practice. In the case of established administrative staff, refresher training should be considered. It is important to retain training materials and logs.
- The present case could be used as an illustration of the role of administrative staff in providing clear information to patients when they present for clinical assessment and the risks of patient harm, and costly litigation, when the duty of care is breached.
- Consideration could be given to an agreed 'script' or form of words to be used when explaining the system in operation at the practice. Patients should understand what they should do if they believe that their condition is deteriorating whilst waiting for clinical assessment.
- Written information relating to triage procedures/waiting times, including patient information leaflets and signage within the practice, might be helpful in supplementing verbal explanations and demonstrating that clear guidance has been provided to patients.

In conclusion, it is important to reassure non-clinical staff that the judgment does not impose highly unrealistic expectations in relation to the standards of communication with patients. Neither does it impose responsibility on receptionists with regards to the design of the system in operation at the practice or the fact that some patients will have to wait to be assessed due to the resource-constraints within healthcare. In Medical Protection's experience, it is extremely rare for allegations of breach of duty to be directed towards practice receptionists or other administrative staff and we expect this to remain the case.

LEGAL PROTECTION FOR APOLOGIES

There was no legal protection for apologies given to patients in Ireland until last year. *Louise O'Rourke* and *Katy Meade* of Hayes solicitors look at legal protection for apologies in light of new emphasis on open disclosure and legislative change



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Until recently, an apology given to a patient could be used as evidence in legal proceedings or referred to in a complaint to the Medical Council.

However, since September 2018 there has been legal protection for the making of an apology, provided that it is made in the context of an open disclosure process and in accordance with detailed guidance which has been set out in legislation.¹ Although there has been a long standing commitment to the provision of apologies and the process of open disclosure by Medical Protection, the professional bodies, the HSE and Medical Council, it is only in the aftermath of recent issues with Cervical Check and the publication of the Scally Report² that wider public scrutiny has been focused on how open disclosure is carried out in Ireland.

Under existing legislation and Medical Council guidelines,³ the decision whether to engage in open disclosure has been left to the judgment of the individual clinician or healthcare provider. However, the new Patient Safety Bill⁴ – which is expected to be enacted later this year – contains provisions which direct mandatory open disclosure of certain adverse events, and will impose sanctions on healthcare providers for any failure to comply.

With that in mind, clinicians are keen to understand whether an apology made within the context of open disclosure might later be taken as evidence of admission of fault, and as to how far an apology should go.

Before considering the legal protections that are now in place for apologies, it is helpful to briefly outline the role of an apology in the open disclosure process.

THE ROLE OF AN APOLOGY IN THE OPEN DISCLOSURE PROCESS

An apology in the context of open disclosure is an expression of sympathy or regret and is an integral part of the open disclosure process. Although it is at the clinician's discretion as to whether an apology is made, a genuine statement of regret can assist in the overall success of the process, and should always be considered.

The aim of open disclosure is to foster trust between patients and their treating clinicians, and there can be no doubt that all parties benefit from a sincere expression of regret when things go wrong. Simply saying sorry that an event occurred can avoid legal proceedings or a Medical Council or other complaint being issued down the line.

TIPS FOR CLINICIANS

- Further guidance on the open disclosure process and the legal protections for apologies can be found in Section 10 of the Civil Liability (Amendment) Act 2017.
- Open disclosure is currently voluntary but the Patient Safety Bill, expected to be enacted later in 2019, will introduce mandatory open disclosure for serious adverse events.
- Clinicians should be reassured that an apology given within the context of an open disclosure meeting is legally protected and is not admissible as evidence of fault in civil or regulatory proceedings.
- However, there will be situations where reference may nonetheless be made in subsequent proceedings to the provision of an apology, and care should therefore be taken to ensure the apology is made in the manner prescribed by the legislation.
- Where the cause of an injury has yet to be determined, best practice is to acknowledge that the adverse event occurred and apologise for what happened. It is helpful to provide reassurance to a patient and their family that they will be kept informed as investigations progress.



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WHAT IS A STATEMENT OF REGRET AND HOW FAR SHOULD AN APOLOGY GO?

Open disclosure should be made as soon as practicable after an adverse event, and may need to occur before a full investigation has been carried out. If a clinician decides that an apology is appropriate, it is advisable to consider in advance what the apology will cover. For example, is the apology to be simply a statement of regret regarding what happened, or an apology based on the findings of a full internal/external investigation?

When the cause of an event has not yet been determined, it is always advisable to avoid going so far as to accept responsibility or to stray beyond one's area of expertise. It is also preferable not to speculate or blame others for the outcome. Best practice, if further investigation is required, is to acknowledge the occurrence of the adverse event and to genuinely apologise for what happened.

CAN AN APOLOGY BE USED AS AN ADMISSION OF LIABILITY OR EVIDENCE OF FAULT?

Historically, the lack of legal protection for apologies may have created reluctance for some practitioners to apologise, fearing such apology could prejudice them in subsequent civil or regulatory proceedings.

The legal protections now contained in the 2017 legislation should serve to allay any such fears.⁵

The 2017 legislation provides that an apology made at an open disclosure meeting shall not constitute an express or implied admission of fault or liability, and shall not be admissible as evidence of fault or liability in proceedings which determine the issue of negligence or fitness to practise. The law also directs that to provide an apology shall not invalidate a contract of indemnity or insurance.

Notwithstanding these provisions, it is likely that some patients will try to use the fact that an apology was given as evidence in subsequent legal proceedings. It is important to be aware that the protective provisions expressly apply to apologies made in an open disclosure meeting. It is also important that where an apology is given, it is appropriately phrased and clinicians should always keep to the forefront of their minds what it is they are apologising for.

PRACTICAL ADVICE FOR MAKING AND DELIVERING APOLOGIES

The timing of open disclosure and giving an apology are important, and clinicians should take time out to prepare for the meeting. It is advisable, particularly when the cause of the event has yet to be determined, for clinicians

to seek support from a senior colleague where possible. Ideally, a clinician from the practice should be present at the open disclosure meeting. In order to avail of the legal protection for an apology, it is essential that clinicians correctly follow the procedures set out in the legislation. If the procedures are not followed, legal protection for an apology given is not guaranteed.

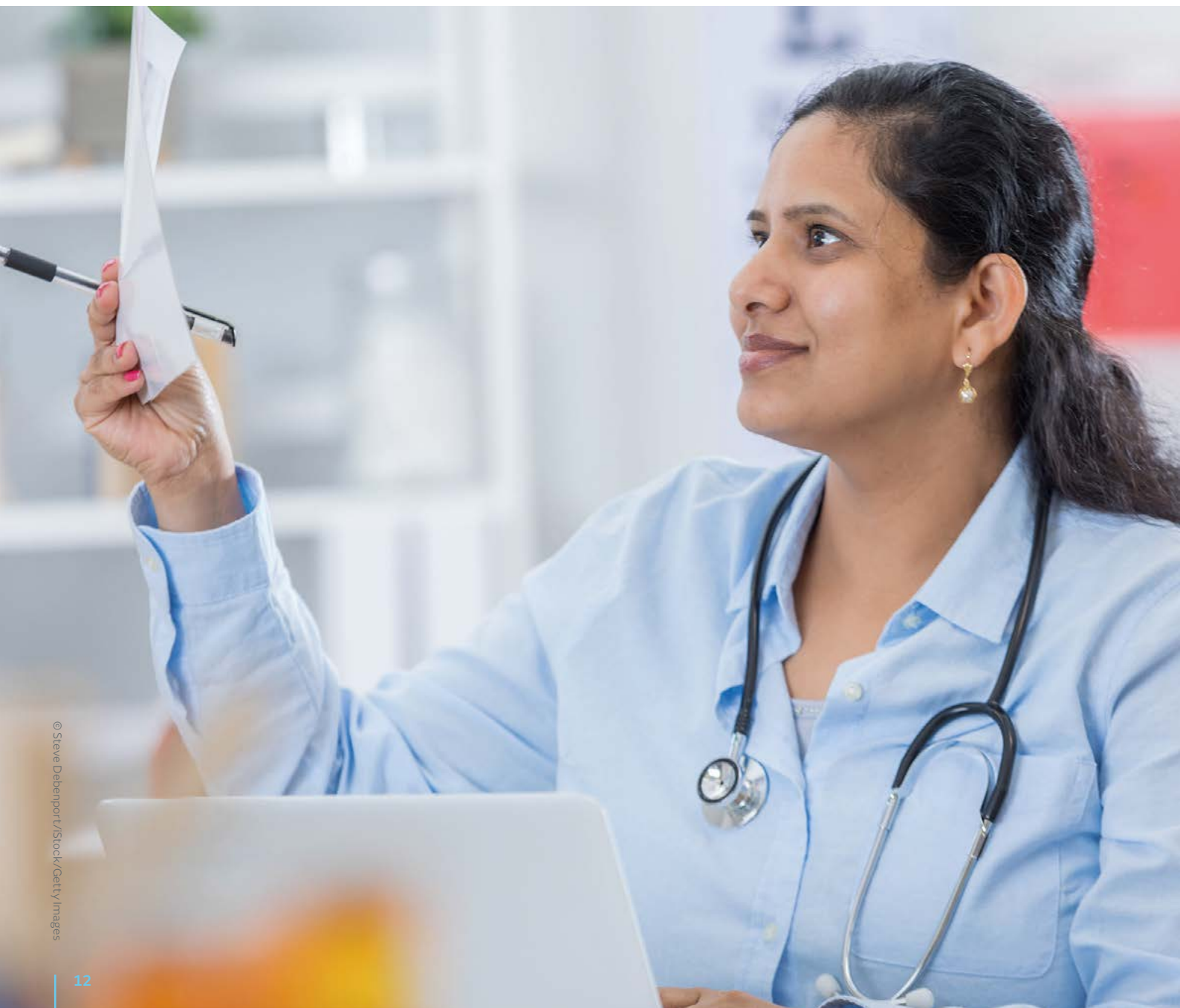
Saying sorry is never easy and finding the right words can be difficult. When preparing for a meeting where an apology is to be made, it can be helpful to discuss your approach with your professional advisers. The 9th edition of the *Medical Council's Ethical Guide and Code of Conduct* – due later this year – is expected to provide further clarity on the provision of apologies and on open disclosure.

REFERENCE

1. S.I. 10 No. 237/2018 – Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018
2. *Scoping Inquiry into the Cervical Check Screening Programme*
3. Section 67.2 of the Guide to Professional Conduct and Ethics for Registered Practitioners 8th Edition 2006
4. Patient Safety Bill 2018
5. Sect 10. Civil Liability (Amendment) Act 2017

RISKY BUSINESS – EXAMINING YOUR REPEAT PRESCRIBING PROCESS

Healthcare providers have a statutory obligation to improve the quality of patient care, ensure patient safety and reduce medical error. *Suzanne Creed*, clinical risk and education manager, examines the repeat prescribing process; one of the key risks identified as part of the CRSA programme in Ireland, and outlines some strategies to mitigate this risk



By developing and implementing simple risk management principles, practices can address the risks and may prevent avoidable harm to patients.

Medical Protection has been undertaking clinical risk self assessments (CRSAs) in general practice across the UK and Ireland since 2000. A CRSA is a unique systematic approach used to identify potential risks within a practice and develop practical solutions to mitigate these risks; ultimately improving the quality of patient care and reduce a practice's exposure to unnecessary risk.

REPEAT PRESCRIPTIONS

Medication errors are the source of about 20% of all litigation occurring in general practice and many of these are preventable.¹

Common specific examples include:

- wrong dose
- inappropriate medication
- failure to monitor for toxicity and side effects.

Repeat prescribing is a deceptively complex process; involving over 20 steps – from the initial decision to prescribe, to the patient finally swallowing the medication.² Errors can and do arise at any of these steps. It is important, therefore, that practices have robust repeat prescribing systems in place to minimise this potential for harm to patients. This system should be outlined in a repeat prescribing policy, thus ensuring consistency throughout the practice. All relevant staff should be appropriately trained in the use of the policy and it should be regularly reviewed.

Patients, practice staff and pharmacists all have a role to play in reducing error. Hospital prescriptions and alterations to medications on hospital discharge letters add a further layer of complexity and an enormous potential for error. Safe repeat prescribing is everyone's responsibility; however, the legal responsibility lies with the doctor who signs the prescription.

HOW AND WHEN DO YOUR PATIENTS REQUEST THEIR REPEAT PRESCRIPTIONS?

Written requests are preferable to verbal requests, as the opportunity for error is reduced. They should be encouraged and can be facilitated by developing a 'repeat prescription request form' that can be posted, emailed or delivered in person to the surgery.

Some practices still accept prescriptions by phone. In such instances, the practice should have a designated receptionist to deal with such requests and they should be given protected time in a quiet location to manage these requests.

"Can't I just wait for the doctor to sign it?" Sound familiar?

Patients need to know how your repeat prescribing system works. Many practices allow a turnaround time of between 48 and 72 hours for repeat prescriptions. This will allow colleagues who work part time or have days off to prepare prescriptions on their return to work without increasing the workload of their colleagues. Practices should use every available opportunity to educate patients about why it takes time to safely prepare and rigorously check the prescription. The receptionists, pharmacists, GPs, practice website and leaflets should all reinforce your process.

GPs should also discuss and agree with local pharmacists that they will dispense an emergency seven day supply. This is

particularly helpful when a patient presents on a Friday evening requesting that their hospital script be transferred to a GMS one. The GP then has adequate time to write and sign the script. It's really important for others in your team not to undermine this timeframe by suggesting it will be ready 'later today'.

ENSURING APPROPRIATE CLINICAL REVIEW

How does a clinical review happen at your practice? Is it systematic or on an 'ad hoc' opportunistic basis? Synchronising the clinical review and quantity of medication issued is highly convenient for patients and the practice.

A useful strategy is to issue sufficient medications until the next clinical review is due. This will also cut down on the overall number of repeat prescription requests at the practice. Patients requesting medication in advance or after their review date may signify overuse or under use of medication and should be brought to the attention of their own GP.

SIGNING PRESCRIPTIONS

Ideally, the doctor who is signing the prescription should know the patient and check the patient file when performing this task. They must ensure that the medication is appropriate and that all necessary monitoring has been undertaken and results are satisfactory. Consider what happens at your practice when you are absent or on holiday? What process is in place? Although another doctor (including the GP registrar) can sign the prescription, even if they are unfamiliar with a patient, it is not ideal for them to do so.

Primary and secondary care interface – high risk!

What happens to a medication change on a hospital discharge letter? How do you manage prescriptions from hospital consultants – eg the transfer of a private prescription to a GMS? Only the GP should add, delete or amend the patient's medication record. Doctors should never ask, expect, or allow the secretary to do this.

Medication changes should be made upon receipt of the hospital letter and ideally done by the patient's own GP. You should consider informing the pharmacists of any alterations to a prescription – eg explicitly writing "Atenolol discontinued" or "Ramipril dose increased" on the script. This may avoid unnecessary phone calls from an astute pharmacist, while enhancing clinical governance.

Uncollected prescriptions

Uncollected prescriptions should be brought to the attention of the prescribing GP, where a relevant note should be entered in the patient's file. Destruction of uncollected prescriptions should only be undertaken on the advice of the prescribing GP.

LEARNING POINTS

Managing risk in general practice is everyone's responsibility. It should become part of the everyday activity within the practice and involve both clinical and administrative staff. The whole practice has a part to play in recognising potential risks and mitigating them. Looking closely at existing systems will always bring into view new ways of working, and most importantly, improving patient safety.

REFERENCES

1. Silk N, What Went Wrong in 1,000 Negligence Claims, Health Care Risk Report (2000).
2. NHS National Prescribing Centre (UK). Saving time, helping patients: A good practice guide to quality repeat prescribing (2004).



TERMINATION OF PREGNANCY – INDEMNITY UPDATE

Following the referendum and constitutional amendment in 2018, legislation to regulate the termination of pregnancy was signed into law on 20 December 2018. The relevant legislation is the Health (Regulation of Termination of Pregnancy) Act 2018¹

Following the enactment, termination of pregnancy is now lawful in Ireland under the following circumstances:

- without restriction up to 12 weeks of pregnancy
- where there is a risk to the life, or of serious harm to the health, of the pregnant woman; the foetus has not reached viability; and it is appropriate to terminate the foetus to alleviate the risk to the woman
- in an emergency situation where such a risk is immediate
- where there is a condition present that is likely to lead to the death of the foetus either before or within 28 days of birth.

It is thought that most terminations up to nine weeks of pregnancy will take place in the community setting – with the expectation that 80% of terminations will be carried out in such a way, although a small number may need to take place in maternity hospitals for medical reasons. All terminations after nine weeks of pregnancy will take place in maternity hospitals.

To date, 200 GPs have agreed to provide abortion services, and the HSE has set up an information and counselling helpline for those individuals experiencing an unplanned pregnancy. This free service, called ‘My

Options’, launched on 1 January 2019 and is available to everyone who needs it. The freephone advice line – available on 1800 828 010 – has professional and experienced counsellors on hand to talk to people about their options, including continued pregnancy support and how to access termination of pregnancy services in Ireland. Further information about the service is available online.²

Under the Act, no medical practitioner, nurse or midwife is obliged to carry out or participate in carrying out a termination to which they have a conscientious objection, except in an emergency situation. However, a person who has a conscientious objection must make alternative arrangements for the transfer of care, to enable the woman to access termination services as necessary.

Following the enactment, the Medical Council has deleted various paragraphs of the *Guide to Professional Conduct & Ethics*, removing any conflict between the guide and the legislation. The amends include the removal of paragraphs 48.1 to 48.4 and the amendment of paragraph 48.5 as follows:

“You have a duty to provide care, support and follow up for women who have had a termination of pregnancy.”

The Medical Council is also working through a detailed process to update the guide following the enactment, reviewing a number of paragraphs to ensure that the

guidance is relevant and appropriate for doctors and patients in light of the new legislation.³

The Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland has published *Interim Clinical Guidance: Termination of pregnancy under 12 weeks*,⁴ and we understand that the ICGP has also issued interim guidelines to its members.⁵

Medical Protection considers that medical termination of pregnancy falls within the scope of general medical practice. Provided the doctor is appropriately trained and complies with the law and clinical and Medical Council guidance, Medical Protection is willing to offer indemnity to those GPs who choose to provide this service, and presently does not expect the price of GP subscriptions to be affected by this development.

Members should also be aware of, and comply with, evolving clinical and IMC guidance, particularly with regard to conscientious objection and working within and maintaining competence.

REFERENCES

1. irishstatutebook.ie
2. hse.ie/unplanned-pregnancy/
3. medicalcouncil.ie/News-and-Publications/Press-Releases/2018/Items/Medical-Council-issues-Update-to-Doctors-in-relation-to-the-Health-Regulation-of-Termination-of-Pregnancy-Act-2018.html
4. rcpi.ie/news/releases/institute-of-obstetricians-and-gynaecologists-issues-interim-clinical-guidance-on-termination-of-pregnancy-under-12-weeks
5. icgp.ie/go/courses/women_s_health/test

FROM THE ADVICE LINE

Dr James Lucas, medicolegal consultant at Medical Protection, shares a recent case where a member sought advice about a cross-border referral



Dr D, a GP, telephoned Medical Protection's medicolegal advice line to discuss an unusual request from a patient. The patient in question required a knee replacement and was considering having the surgery in a hospital in Spain through the (EU/EEA) Cross-Border Directive scheme. Dr D had already referred the patient to a consultant orthopaedic surgeon at a hospital controlled by the HSE. However, due to long waiting lists, Dr D was coming under pressure from the patient to make a referral to the surgeon in Spain. Dr D was worried about the potential medicolegal risks associated with a referral to a medical practitioner outside the Irish jurisdiction.

EXPERT ADVICE

Dr D spoke to Dr P, an expert medicolegal consultant with a specialist interest in the Irish jurisdiction.

Dr P referred to the HSE's guidance on the Cross Border Directive (CBD)¹ which explains that CBD treatment is only available to Irish residents who qualify for public healthcare. The patient must pay for any CBD treatment abroad and then apply to the HSE to claim the cost of the treatment after the patient returns to Ireland. The patient must get a referral by their GP or consultant to get most types of CBD treatment, and they must get prior authorisation if it is required for the particular treatment.

Dr P advised that a GP can refer the patient for healthcare abroad under the CBD in the same way that they would refer the patient for the same treatment in Ireland.

Turning to address Dr D's specific concerns, Dr P emphasised that the HSE itself has indicated that a GP may refuse to refer a patient if they are:

- (i) unfamiliar with the service abroad
- (ii) concerned about the quality of the service abroad
- (iii) concerned as to whether the service will fully meet the patient's medical needs.

Dr P reminded Dr D that the referring GP in Ireland can advise the patient if their healthcare is covered by the CBD, but if the patient is in any doubt, they are advised to contact the National Contact Point. Dr D was advised to check that the patient is well-versed in the details of the CBD scheme and to remind the patient that GPs are not involved in the financial aspects of the scheme (such as pre-approving funding for treatment, which is a matter for the HSE alone).

Dr P also made reference to the Medical Council's guidance in the *Guide to Professional Conduct & Ethics*,² which defines 'referral' as sending a patient to another doctor or healthcare professional to get an opinion or treatment. The Medical Council states that referral usually involves the transfer (in part) of responsibility for the patient's care, usually for a set time and a particular purpose, such as care that is outside the doctor's area of expertise. Dr P read out a paragraph of the Medical Council's guidance that seemed to be particularly relevant in the context of the query:

*"When you delegate or refer you must give sufficient information about the patient and their treatment to the clinicians continuing the care of the patient. You should take **reasonable steps** to make sure that the person to whom you delegate or refer has the **qualifications, experience, knowledge and skills to give the care needed.**"*

Dr P advised that in circumstances where Dr D declined to make such a referral, it would be important to explain the rationale for the refusal to the patient. The discussion should be documented carefully in the patient's medical records.

Dr P also pointed out that the HSE's guidance indicated that where a patient has a 'waiting list letter', a GP referral did not appear to be required under the scheme.

REFERENCES

1. hse.ie/services/cross-border-directive/about-the-cross-border-directive.html
2. Medical Council. Paragraph 22. *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*. 8th edition, 2016.

Footnote: Some of the details of this case have been altered to protect the identities of those involved.

TEAM COMMUNICATION WITHIN GENERAL PRACTICE

Suzanne Creed, clinical risk and education manager at Medical Protection, explores some risk management tips and strategies to improve communication within your team

Effective communication is essential to providing good healthcare and is pivotal to ensuring patients receive safe care. Good communication may also reduce the likelihood of patient complaints and claims. Fundamental to patient safety is effective communication between all members of the practice team, as well as between the practice team members and their patients.

Problems may arise because of a breakdown in communication within the practice. Similarly, the primary – secondary care interface is an area where communication can easily break down, which can also contribute to adverse incidents.

Establishing clear communication within the practice is key to underpinning safe patient care and can help to avoid adverse incidents. The Medical Council also advocates the importance of good communication between healthcare teams.

It states that partnership relies on: “Good communication. This is central to the doctor-patient relationship and essential to the effective functioning of healthcare teams. Good communication

involves listening to patients and colleagues, as well as giving information, explanations or advice.”¹

The general practice team should focus on developing and maintaining robust systems for sharing information.

According to Medical Protection’s Clinical Risk Assessment programme findings, 81% of the practices we visited between 2016 and 2018 had risks associated with internal communication within general practice.

Let’s look at these risks and how you can mitigate them.

INTERNAL MESSAGING

Many practices use sticky notes to pass messages amongst staff. This method is very risky. There is potential for the sticky note to fall off and get lost. Furthermore, conveying messages in this format does not provide an audit trail. The WHO describes how the use of a sticky note contributed to a lethal outcome of a 21-year-old man in 1992.



The use of computer internal messaging and electronic task systems has greatly reduced the use of sticky notes. Practice staff, where possible, should be strongly encouraged to use their clinical messaging software and internal email systems for communication within the practice. These provide a full audit trail of messages transmitted and facilitate the integration of clinical messages into the patient record.

Computerised ‘instant messaging’ systems also have many advantages in general practice. Instant messaging enables urgent messages to be transmitted to clinicians without interrupting a consultation with a phone call or a ‘knock on the door’. However, overuse and inappropriate use of instant messaging is a distraction during a clinical consultation. The practice should agree how instant messaging can be effectively deployed and have clear protocols defining situations when it should be used. Always remember there is a potential breach of patient confidentiality if identifiable data about a patient flashes on the screen during a consultation. Some software systems do not retain instant messages either, so the practice needs to ensure that any patient-specific messages are integrated into the patient’s clinical record.

AVOIDING INTERRUPTIONS DURING CONSULTATIONS

Interruptions during a consultation may inadvertently cause a clinician to lose their train of thought. This may lead to a clinical error. Interruptions may breach patient confidentiality if a patient overhears staff discussing another patient. It is important that guidelines for acceptable interruptions are provided for administrative staff. These should detail reasons when interruptions are acceptable and when they are not, while ensuring that interruptions are kept to a minimum.

PRACTICE TEAM MEETINGS

Practices should aim to have regular full team meetings for all staff. Practice meetings are an ideal opportunity to improve staff engagement. They provide an excellent forum for developing and agreeing on policies and procedures within the practice.

All staff should be encouraged to contribute to the meeting agenda. It is important that the minutes of all practice meetings are dated and reviewed for accuracy, agreed and signed. Keeping minutes of practice meetings has several advantages:

- it records the organisation’s response to important events and developments
- decisions can be reviewed at a later date to ensure that action has been taken
- members of staff who did not attend the meeting can be made aware of decisions taken
- good-quality minutes demonstrate that an organisation places appropriate emphasis on careful management. This may be helpful in dealing with serious complaints, litigation or external review by a body such as the HIQA.

BRIEFING SESSIONS

Challenges often arise for part-time staff working within a practice and it can be difficult keeping up to date with the day-to-day running of the practice. Research has shown that face-to-face communication between managers and their teams is vital to the efficient and effective operation of an organisation.³

Many large organisations use team briefings as a way of keeping staff members informed of the latest key organisational decisions and progress. These provide a forum to listen to staff feedback and answer any questions. Practices should consider having a daily quick update or ‘huddle’ – no more than five minutes – to briefly discuss the situation of the day, including any challenges such as staffing arrangements and whether there are new locum clinicians reporting to work on that day.

One practice we visited found the mnemonic ‘**BRIEF**’ helpful:

Brief introductions
Rota and staffing
IT
Emergencies
Forecast (or format of the day)

Briefing sessions should:

- Provide an opportunity for practice managers to meet with their team face-to-face on a regular basis.
- Ensure that staff members are well informed. This reduces the risk of misunderstandings.
- Enable two-way communication: it is not just about giving information, but listening and responding to questions and concerns from the team.

GP PARTNER MEETINGS

“General practitioners often expect partnerships to last until retirement do them part.”⁴

GP partner relations occasionally break down, which can lead to a stressful and potentially expensive outcome. Disputes can arise due to personality clashes, financial disagreements, a power struggle or workload disparity – or commonly a combination of such factors. Such experiences are stressful for all concerned, hence it is vital to address issues early and avoid escalation. Underpinning a successful partnership are regular and effective partners meetings. When things start to go wrong, partners should meet to discuss and try to resolve the issues. They should then explore options and agree a way forward.

The Medical Council states *“When disputes between colleagues arise, they should be settled as quickly as possible. Such disputes should not affect patient care. Denigrating a colleague is not appropriate and should be avoided. You should not deliberately damage the practice of colleagues.”¹*

Good communication is fundamental to good clinical care. Communication is a complex topic. Practices should recognise the importance of regular and effective internal communication and consider how they might further enhance the communication within their own practice.

REFERENCES

1. Medical Council. Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 8th Edition (2016): medicalcouncil.ie/News-and-Publications/Reports/Guide-to-Professional-Conduct-and-Ethics-8th-Edition-2016-.pdf
2. World Health Organisation. Patient advocates use past experiences to change the future (October 2015): who.int/features/2015/ireland-patient-advocates/en/
3. University of Exeter. The benefits of team briefing. exeter.ac.uk/staff/news/teambrief/teambriefing/
4. How to prevent GP partnerships breaking down. *BMJ*. bmj.com/content/346/bmj.f1346

ASK THE EXPERT



Dr James Lucas, medicolegal consultant at Medical Protection, answers some queries from members



A patient attended the practice requesting termination of pregnancy. The GP explained that termination of pregnancy was not a service provided by the practice. The patient was content for the GP to provide some further information to enable her to access such a service. At the time of the consultation, the patient asked the GP not to document her request and the items discussed during the consultation. The GP made some paper based notes in relation to the consultation as a personal aide memoire, but did not add any details to the patient's electronic file pending medicolegal advice. Should the patient's wishes be respected?

In the *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*,¹ the Medical Council advises doctors that “medical records consist of relevant information learned from or about patients”.

The Medical Council goes on to state that doctors “must keep accurate and up-to-date patient records either on paper or in electronic form. Records must be legible and clear and include the author, date and, where appropriate, the time of the entry, using the 24-hour clock”.

In Medical Protection's publication, *Medical Records*², it is emphasised that good clinical records are a prerequisite of delivering high-quality, evidence-based healthcare, particularly where a number of different clinicians are contributing simultaneously to patient care. Medical records are also used for other purposes, such as assisting in clinical audit and providing the necessary factual base for responding to complaints and clinical negligence claims.

The contents of a clinical note relating to a particular consultation are a matter for the professional judgment

of the healthcare provider, bearing in mind the overarching need to keep accurate and up-to-date records containing relevant information.

Assuming that the patient's records are electronic, it would be advisable for the GP to go ahead and transfer whatever information they consider to be relevant from their paper notes to the patient's electronic file. Given that the entry would be added following the consultation, the GP would need to make clear that the note is a retrospective one (and the reason for this).

The GP can refer to the fact that the entry is based upon paper notes made at the time of the consultation. Once the entry is made in the records, the aide-memoire should be confidentially destroyed to prevent any inadvertent data loss/breach of confidentiality.

The GP should reassure the patient that the information will be held securely in the electronic clinical records and will be subject to obligations of doctor – patient confidentiality and GDPR.



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The mother of a four-year-old patient has asked the practice to take a sample from him to facilitate DNA testing. The practice has been informed that the request has arisen in the context of a paternity dispute. The following week, a DNA-testing pack arrives from a private company. The practice is unaware of the boy's father's wishes with regards to the test. Should the practice comply with the mother's request?

The key issues for the practice to consider are as follows:

- Paternity testing is not routine and you cannot be compelled by a parent to carry out the test.
- The healthcare practitioner dealing with the patient would have to consider whether they have the necessary competence in terms of counselling, collecting the sample and potentially interpreting the results.
- In its guidance for doctors,¹ the Medical Council emphasises that patients (or their parents in the case of minors) must have counselling about the possible consequences of genetic testing before consent is sought. Clearly, this information would need to raise the possibility that the results may have a profound effect, with possible lifetime implications for those involved. The discussion would need to be documented in detail in the child's records.
- The overarching duty when treating children is to act in their best interests.

In view of the above considerations and in particular, the question as to whether the healthcare team at the practice has the necessary expertise in relation to the test, the practice should consider carefully whether it is appropriate to proceed. The alternative is to politely ask the child's mother to make arrangements to have the test performed elsewhere.

If, however, the practice decides to proceed with the test, written parental consent should be obtained. The general position is that the consent of one parent/legal guardian will

provide sufficient authority in respect of any health or social care intervention in relation to a child but the HSE's National Consent Policy² makes clear that there are exceptions to this general rule. If the decision will have profound and irreversible consequences for the child, both parents should be consulted if possible. Given the nature of the test in question, it would be prudent to consider this case as exceptional and to seek written consent from both the mother and father (provided that the father has guardianship of the child).

LEARNING POINT

The practice's involvement might be viewed as being of limited compass in circumstances where the test does not relate directly to the diagnosis of a medical disorder. However, in assisting with such a test, a duty of care is likely to be established. In deciding whether to help, the practice would need to carefully consider its responsibilities in terms of counselling and consent, and the possibility that one or both parents might have questions regarding the interpretation of the results.

REFERENCE

1. Medical Council. Guide to Professional Conduct & Ethics for Registered Medical Practitioners. 8th Edition 2016.
2. medicalprotection.org/ireland/booklets/medical-records-in-ireland-an-mps-guide
3. National Consent Advisory Group. National Consent Policy. Health Service Executive. 2017, Version 1.2



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