Issue 2 • May 2016

Challenge Medical Indemnity

Inside this issue:

Mr David Walsh, MD

Dear Consultant,

Welcome to our Challenge Medical Indemnity newsletter.

I am pleased to report our consultant indemnity scheme with CNA Insurance Company Ltd is running very well since its inception in November 2014. We currently supply comprehensive indemnity to over 30% of the full time private consultant market and we expect this figure to rise to 50% by the end of 2016. Extending our automatic run-off cover period to 21 years has given consultants additional peace of mind when moving. Our underwriters are confident with their existing rate, we have consultants who are renewing their indemnity with us for the 3rd time this year and they continue to be underwritten on the same rates.

In this edition, we are excited to announce the recent appointment of Ms Ann O'Driscoll as lead Medico-Legal and Clinical Risk Advisor at Challenge. We are also pleased to have a significant contribution from Asim A. Sheikh BL who has provided us with an incisive and relevant piece on 'The Practice of Medicine and Open Disclosure', which I would advise you to take the time to read.

Challenge are committed to delivering comprehensive indemnity at competitive rates, we are also committed to delivering service levels which integrate with the busy schedule of a practicing consultant in Ireland. We would encourage consultants to obtain a quotation from us prior to renewing your current membership subscription. We will provide you with all the information you need so that you can make an informed decision on what indemnity solution will work best for you and your practice.

Regards

David Walsh
Managing Director
Challenge.ie

Challenge appoint in-house Medico-Legal Advisor

Challenge are pleased to announce the appointment of Ms Ann O'Driscoll, Solicitor, as lead Medico-Legal and Clinical Risk Advisor. This appointment is significant as it provides ease of access to medico-legal and clinical risk expertise to all of our consultant clients. For the past 20 years, Ann has specialised in defending medical malpractice claims and representing doctors and nurses at inquests and Fitness to Practice enquiries. She advises healthcare organisations on clinical risk, clinical governance and medico-legal matters. She is highly regarded in both legal and healthcare circles. Ann is also a lecturer and examiner on the UCD Graduate Diploma in Health Care (Risk Management and Quality) course. Prior to joining Challenge, Ann was the partner in charge of healthcare at DAC Beachcroft Solicitors, Dublin.

21 Year Run-Off Cover

We are delighted to confirm a significant extension to our indemnity cover offering for Private Consultants with CNA Insurance Company Ltd. The existing automatic Run-Off Cover period has been extended from 10 to 21 Years, for permanent retirement, disability or death. A consultant must be on our scheme for a minimum of 1 year to qualify for this cover. It is something which we have been promising to our existing clients from the time they moved their indemnity cover through Challenge. This additional cover is good news for our consultants who will gain greater peace of mind in the knowledge that their private work will remain automatically covered well into retirement. We are the only medical indemnity insurance provider offering 21 years run-off cover and a €0 policy excess to private consultants in Ireland.

The Practice of Medicine and Open Disclosure

– by Asim A. Sheikh B.L.

Asim A. Sheikh is a practising barrister specialising in clinical negligence and medical law.

He is also a Lecturer in Legal Medicine, at Forensic and Legal Medicine, School of Medicine, UCD.

He lectures and has published widely on aspects of medical law. He also lectures in the RCSI and occasionally in TCD and the Law Society.

He is a member of the National Advisory Council on Bioethics, and is Editor of the Medico-Legal Journal of Ireland.

It is appropriate to very briefly and generally discuss why the concept of "open disclosure" and "apology" is of any importance in a general and social setting. In this respect, the following has been observed:

> "Despite its importance, apologizing is antithetical to the ever-pervasive values of winning, success, and perfection. The successful apology requires empathy and the security and strength to admit fault, failure, and weakness. But we are so busy winning that we can't concede our own mistakes.
>
> The botched apology - the apology intended but not delivered, or delivered but not accepted - has serious social consequences. Failed apologies can strain relationships beyond repair or, worse, create life-long grudges and bitter vengeance."[1]

The author goes on to state that:

> "Far and away the biggest stumbling block to apologizing is our belief that apologizing is a sign of weakness and an admission of guilt. We have the misguided notion we are better off ignoring or denying our offenses and hope that no one notices."[2]

Certainly and importantly, the perception that an apology may equate legally to "an admission of guilt" is of relevance in the medico-legal sphere where there is an anticipation and/or fear of litigation. By way of an example in practice, in the US case of ***Estate of Johnson v. Randall Smith, Inc. (23/4/13, Supreme Court of Ohio)***[3], the defendant performed surgery to remove the patient's gallbladder. The procedure was converted from laparoscopic to open surgery after the common bile duct was injured. This was a known risk of the procedure and the defendant explained the full situation after the surgery. The patient returned as a result of complications arising from that injury and required transfer to another hospital. However, prior to the transfer, the patient became upset and emotional and the defendant in an attempt to console the patient took her hand to calm her and stated, "I take full responsibility for this. Everything will be okay." The patient and her husband took a negligence action alleging medical negligence, and the husband alleging a loss of consortium. Prior to the commencement of the trial, the defendant issued a motion seeking to exclude the evidence and statement of apology which he had made to the patient on the basis that it was statutorily excluded under what was colloquially known as the "apology statute."[4] The plaintiffs included an argument that the defendant's statement was not an apology or expression of sympathy, but rather an admission of the doctor's negligence. At first instance, however, the court found in favour of the defendant in excluding the statement finding that, "… The statements and gestures and actions…" of the defendant were covered under the code and therefore were inadmissible. The Court of Appeals held that the words of the of doctor that he would "take full responsibility" within the particular context could be taken to mean that he was admitting fault and therefore, the statement was admissible because its probative value was not substantially outweighed by the danger of unfair prejudice. On appeal to the Supreme Court, the relevant provision of the code was examined and it stated that:

> "In any civil action brought by an alleged victim of an unanticipated outcome of medical care or in any arbitration proceeding related to such a civil action, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence that are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim, and that relate to the discomfort,

1 Lazare, A. "Go Ahead, Say You're Sorry." Psychology Today, January/February, 1995, 40-43.

2 See fn1.

3 135 Ohio St.3d 440, 2013-Ohio-1507.

4 Ohio Revised Code (RC) 2317.43.

> pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care are inadmissible as evidence of an admission of liability or as evidence of an admission against interest."

The Supreme Court reversed the decision of the Court of Appeals and stated that the statement made by the defendant was exactly the type of evidence designed to be excluded by the code as evidence of liability in a medical negligence action. However, it seems that the courts, certainly in the US, will still admit "statements of fault" and/or "mistake language", therefore making a distinction between the exclusion of statements of apology and sympathy, and the inclusion of statements and language utilising words such as mistake, error and fault.[5] The issue of apologies and fault will be examined further and later in this article.

The United Kingdom

February 2013 saw the publication of the U.K.'s *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry*.[6] The inquiry was charged with examining serious failings at the Mid-Staffordshire NHS Foundation Trust. This inquiry built on the findings of the previous 2009 independent inquiry in which concerns were raised about the Trust's mortality rate as compared with other similar trusts. In the course of the first inquiry, examples of extremely poor standards of care administered to patients were revealed, such as and amongst others:

- Patients left in excrement in soiled bed clothes for lengthy periods;
- Assistance not provided with feeding for patients who could not eat without help;
- Water left out of reach of patients;
- Wards and toilet facilities left in filthy conditions;

The inquiry made 290 recommendations. Part of the recommendations were in relation to openness, transparency and candour, the report stating that:

> "For a common culture to be shared throughout the system, these three characteristics are required: Openness... Transparency… Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it."

Recommendation 174 stated that:

> "Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information."

The report concluded that a statutory obligation should be imposed on health care providers and registered medical and nursing practitioners to observe the duty of candour and importantly, Recommendation 181 made it clear that the provision of information in the exercise of candour, "… should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy."

As a result of these issues, a statutory duty of candour upon health service bodies (as opposed to upon individual practitioners) was introduced under the provisions of **Health and Social Care Act 2008 (Regulated Activities), Regulations 2014, Regulation 20**. The significance of the introduction of a statutory duty of candour in the UK is that a breach of any of the fundamental standards is a strict liability offence with the potential of criminal prosecution.

Along with the statutory obligations placed on health service bodies in the UK, guidance in relation to ethical and professional obligations upon practitioners have also been updated to reflect current practice. In this respect, the joint guidelines of the General Medical Council (GMC) and the Nursing & Midwifery Council (NMC), *Openness and Honesty when things go wrong: the professional duty of candour*[7], work upon the central tenet that practitioners must, "be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place."[8]

Ireland

In this jurisdiction, recent catastrophic damage medical negligence cases have once again brought to the fore some of the difficult and complex issues which arise in such cases, including apparent criticism for delays in admitting liability along with calls for a legal 'duty of candour'.[9]

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5 see further: "Supreme Court of Ohio protects physician's statement of comfort under Apology Statute", accessed at: http://www.lexology.com/library/detail.aspx?g=892bd123-fe3f-45c0-8292-4403adb30053

6 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry HC 947, Chaired by Robert Francis QC (2013, London: The Stationery Office).

7 Published June 2015, General Medical Council and Nursing and Midwifery Council. Accessed on 14/4/16 at: http://www.gmc-uk.org/static/documents/content/DoC_guidance_english.pdf

8 Fn7, p9..

9 "Girl (12) awarded €2.6m over birth injuries" Irish Times, Tuesday, 26th November, 2013: accessed on 30/11/13 at: http://www.irishtimes.com/news/crime-and-law/girl-12-awarded-2-6m-over-birth-injuries-1.1608173 and, "HSE criticised for five-year delay as boy awarded €8.5m" Irish Times, Friday, 29th November, 2013, accessed on 30/11/13 at: http://www.irishtimes.com/news/crime-and-law/courts/hse-criticised-for-five-year-delay-as-boy-awarded-8-5m-1.1611865, and see: "Adversarial cases make a mockery of the HSE's open-disclosure policy" Irish Examiner, 4th January, 2016, accessed on 15/4/16 at: http://www.irishexaminer.com/viewpoints/analysis/adversarial-cases-make-a-mockery-of-the-hses-open-disclosure-policy-374227.html

The Practice of Medicine and open disclosure (Continued)

The uncomfortable place an apology occupies within the mechanism of litigation was recognised by Peart J in ***O'Connor v Lenihan***[10] (a case which dealt with the issue of organ retention). The Court made the following pertinent observation in relation to the issue:

> "I have little doubt that no award of damages would be even half as useful in easing their feelings of anger and distress as a forthright and sincere and appropriately tendered apology for the anger, hurt and distress caused, however unintentionally at the time, by the retention of their babies' organs, and perhaps an acknowledgement to the plaintiffs that the failure to explain that organs and tissue might be retained was not these days an acceptable way of dealing with such a situation. But the problem is that our legal system is not conducive to such steps being taken by defendants exposed to a claim for damages once fault might be seen to be acknowledged by such an apology, and are inhibited from taking a step which perhaps in other circumstances they would wish to take in order to assist those who have suffered distress and hurt. Perhaps the meeting of the 6th June 2000 in this case was an effort being made in this respect, but if the plaintiffs' evidence is true, and I am conscious of the fact that the defendants have not been called upon to give their evidence at this point in the proceedings, it singularly failed for whatever reason to achieve its worthy objective. That is a pity."

Noting this case, in 2008, the Law Reform Commission in its consultation paper dealing with alternative dispute resolution recommended that, "…a statutory provision be considered which would allow medical practitioners to make an apology and explanation without these being construed as an admission of liability in a medical negligence claim."[11]

Whilst currently, there is no legal duty of candour in Ireland, from a conduct and professional ethics perspective, a duty to inform patients and their families with regard to an adverse event was stipulated in 2009 by virtue of the seventh edition of the Medical Council's Guide to Professional Conduct and Ethics. This states that:

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

- acknowledge that the event happened,
- explain how it happened,
- apologise, if appropriate, and
- give an assurance as to how lessons have been learned to minimise the chance of this event happening again in the future."

Therefore, a failure to follow the above guidelines has potentially been a ground for professional regulatory / fitness to practice proceedings since these guidelines came into place in 2009.

"Open Disclosure"

November 2013 saw the introduction of a national policy of "Open Disclosure"[12].

What does such duty entail?

The Health Service Executive (HSE) in conjunction with the State Claims Agency (SCA) in its National Guidelines, *Open Disclosure: National Guidelines - Communicating with service users and their families following adverse events in healthcare*[13], describes open disclosure as:

> "An open, consistent approach to communicating with service users when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the service user informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event."

The guidelines indicate that the following matters should be disclosed to 'service users' (patients and clients of the HSE and of services funded by the HSE):

- Incident/adverse event (An incident which results in harm to a person that may or may not be the result of an error);
- Suspected adverse event (an adverse event suspected but not yet confirmed);
- No harm event (An incident occurs which reaches the service user but results in no injury to the service user. Harm is avoided by chance or because of mitigating circumstances);
- Near miss events (incidents which could have resulted in harm but did not either by chance or timely intervention) are to be assessed on a case-by-case basis and where there is a risk/potential for future harm, the event should be discussed with the patient/service user.

On foot of recent press reports, as noted, it is important for health care providers to understand not only what open disclosure entails, but also, to ensure there is no confusion about the concept. It should be noted, importantly, that disclosure of an adverse event to a patient, with an expression of regret, does not equate to an admission of liability in a legal sense, even though the perception from a patient's perspective may indicate that "saying sorry" or expressing regret that something has "gone wrong" indicates an admission of fault from the health care providers. The Guidelines state that, "Expressing regret for a service user's experience or emotions is not an admission of liability e.g. 'I am very sorry that the procedure was not as straightforward

[10] "Unrep, HC, 9/5/05.

[11] Alternative Dispute Resolution (LRC CP 50 - 2008), Law Reform Commission, July 2008.

[12] see further: http://www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/Open_Disclosure/

[13] http://www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/Open_Disclosure/opendiscFiles/opdiscnationalguidelines2013.pdf

as we had hoped and that you have experienced some of the complications we discussed."[14]

The National Guidelines in Chapter 6 provides a "Stages of Open Disclosure Algorithm" for staff, which notes that, "when it is established that an error has occurred, apologise to the service user. Note: an expression of regret or apology should not include any admission of fault until the facts are known."[15]

It is important to note that, from a legal perspective, an admission of legal liability can only occur once liability is established after the basic elements of the tort of negligence are satisfied, that is: a legal duty of care between health care provider and health care receiver is established, there is a breach of the required standard of care by the health care provider, there is loss/damage to the healthcare receiver and, the loss/damage has been caused by the action/omission of the health care provider.

There are many examples of medical outcomes which are not satisfactory but do not equate to negligence. Medicine, generally, is not in law regarded as an exact science.[16] Such unsatisfactory outcomes may well require a full and open disclosure to a healthcare receiver, but would not result in any admission of liability, as all of the evidence would not indicate negligence. It should also be borne in mind that any party, against whom an allegation of professional negligence is made, is properly and fully entitled to answer any such allegation and have their good name and integrity protected by the means of due process. Therefore, the guidelines make it clear that, "Liability or blame should not be projected or accepted unless this has been investigated and agreed to"[17]. Further, the guidelines wisely urge prudence in relation to the recording of an apology stating at section 6.4.2.7 that:

> "An apology/expression of regret can sometimes be inferred by the service user as an admission of liability therefore the exact words used and the context in which the apology is provided should be documented in the minutes of the disclosure meeting and in the clinical record."

Once the process of litigation commences, if after the process of full and proper investigation, the evidence of the defendant party is clear and unambiguous that the matter cannot be defended from a liability perspective, a full defence denying liability may not be sustainable without good reason, and a decision to accept liability may have to be considered.

Further Reforms

The draft ***Civil Liability (Amendment) Bill 2015*** intends to support "Open Disclosure". The proposed ***Open Disclosure Provisions*** (Draft November 2015) included a definition of "apology", which was defined as, "an expression of regret in respect of a patient safety incident." Also, a "disclosure" was defined as "any statement, verbal or otherwise, which may include an apology, made by or on behalf of a health services provider to the service user or to a connected person in relation to a patient safety incident."

A *"health services provider"* provided for reference to a range of health professionals and is either: "(a) a body corporate, or an unincorporated body of persons, through which or in connection with which (whether by reason of employment or otherwise) a health practitioner provides a health service, or; (b) a health practitioner where the practitioner is not providing a health service through or in connection with (whether by reason of employment or otherwise) a body referred to in paragraph (a)".

Head 4 sets out that relevant Standards will be set by the relevant authority (HIQA) in relation to disclosure which may include standards on the manner in which a disclosure is made, arrangements to assist a service user to understand what is being disclosed, the persons who will make the disclosure on behalf of a service provider, information to be given to a service user, actions to be taken by a provider to prevent recurrence of an incident and records to be kept by a provider in relation to a disclosure.

Further, and importantly, if disclosure is made in accordance with the above section, Head 6 states that:

> "In any civil proceedings in respect of personal injury to or death of a service user, a disclosure, made in accordance with standards set under head 4-
>
> (a) does not constitute an express or implied admission of liability by the relevant health services provider or by an employee of the provider in connection with that death or injury, and
>
> (b) is not relevant to the determination of liability in connection with that death or injury.
>
> (2) A disclosure by a health services provider, made in accordance with standards set under head 4, does not constitute an express or implied admission of unprofessional conduct, carelessness, incompetence or unsatisfactory professional performance, for the purposes of any enactment regulating the practice or conduct of an employee.

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[14] fn 13 at pages 47-49.

[15] fn 13 at page 38.

[16] For example, in the English case of Thake v Maurice [1986] 2 WLR 337 at p354, it was noted by Neil LJ that, "Medicine, though a highly skilled profession, is not, and is not generally regarded as being, an exact science."

[17] fn 13 at para. 6.4.2.4, page 50.

The Practice of Medicine and open disclosure (Continued)

(3) An apology when part of a disclosure made by a health services provider or an employee of a health services provider made in accordance with standards set under head (4) does not despite any wording to the contrary in any contract of insurance or indemnity and despite any other Act or law void, impair or otherwise affect any insurance or indemnity coverage for any person in connection with that matter."

Further, Head 7 provides for an exclusion from admissibility from civil proceedings, of any record created by health services provider solely for the purpose of making a disclosure.

It should be noted that the ***Legal Services Regulation Act 2015*** will, once commenced, amend the Civil Liability and Courts Act 2004 in respect of clinical negligence actions by the insertion of sections, 32(A)-(D): Section 32(D) does not define 'apology'. However, the section in full states:

"(1) An apology made in connection with an allegation of clinical negligence—

(a) shall not constitute an express or implied admission of fault or liability, and

(b) shall not, despite any provision to the contrary in any contract of insurance and despite any other enactment, invalidate or otherwise affect any insurance coverage that is, or but for the apology would be, available in respect of the matter alleged.

(2) Despite any other enactment, evidence of an apology referred to in subsection (1) is not admissible as evidence of fault or liability of any person in any proceedings in a clinical negligence action."

Conclusion

Open disclosure is not an admission of liability. If the above legislation comes into place, this will be solidified, once the disclosure is made in accordance with national policy and in accordance with the relevant legislation.

In this respect, in providing a definition of this nature, a service provider stands in a position where an apology/ disclosure is not an admission of liability, and therefore this will allay the fears of practitioners and service providers and will assist in encouraging open disclosure and ongoing communication with patients who may suffer any type of adverse incident within a clinical setting, without the confusion that such dialogue may be interpreted as an admission of liability with its attached consequences.

This does not guarantee that subsequent litigation will definitely not occur. However, if that possibility transpires, health care providers are fully entitled to defend their good name and reputation vis-à-vis any allegation of negligence.

Candour and open disclosure, is hugely beneficial to patients and families and in potentially reducing medical negligence claims.[18] However, it is also beneficial to health care providers by allowing them to openly communicate with patients without fear or hesitation in relation to the full spectrum of care provided and its outcome. As opposed to fearing the ideal, it should be embraced and utilised as an opportunity to learn, and attempt to further bolster the relationship of trust which is absolutely central to, and essential in, the health care provider - health care receiver relationship, and which can only result in a higher quality of patient care.

However, in order to achieve this end, it will be vitally important that appropriate resources are secured and allocated for healthcare staff, healthcare service providers, trainers and for facilities to ensure that the policies and training are rolled out, tested, validated and are continuously effective, in order that the benefit to all parties is real as opposed to theoretic. Healthcare providers must be in a position to be able to rely on effective training and support for the purpose of disclosure, but also when the litigation process commences.

Otherwise, there is a danger that the national policy and relevant legislation will become open to criticism in terms of any actual shift in professional behavior towards open disclosure and hope of overall benefit to improvement in health care standards and patient safety.[19] This will require a coordinated effort amongst the relevant organisations[20] and, importantly, should involve relevant stakeholders and health practitioners to ensure the operability of the process and its success into the future.

In the meantime, practitioners are advised to embrace the training and materials available and to seek appropriate support when engaging in the open disclosure process. When the appropriate interests of healthcare providers and patients are protected and supported properly, there can then be optimism that a change in cultural attitudes will occur across the spectrum of healthcare and open disclosure and candour will be second nature in practice and to the benefit of all parties.

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[18] See further: Allen Kachalia and David W. Bates. "Disclosing medical errors: The view from the USA", The Surgeon 12 (2014) 64-67 and George G. Youngson. "Medical error and disclosure": A view from the U.K. The Surgeon 12 (2014) 68-72.

[19] As has been stated: "In order to encourage open disclosure more specifically by physicians, a number of countries have enacted disclosure laws mandating disclosure of medical errors under specific circumstances… Several countries have also enacted so-called apology laws, i.e. laws providing that an apology given after an adverse event cannot be used in ulterior legal proceedings… The actual effect of those laws on professional behavior is debatable. Indeed, there seems to be little evidence that such laws have significantly encouraged open disclosure of medical errors. Apology laws have also been criticized as ill-conceived because in virtually all countries, a court of law would never consider a mere apology as evidence of negligent behavior." Olivier Guillod. "Medical error disclosure and patient safety: legal aspects". Journal of Public Health Research 2013; 2:e31, at p184.

[20] The need for co-ordination has already been envisaged in some detail: HIQA in its Report, Recommendations on the coordination of patient safety intelligence in Ireland (January 2016), concludes that: "HIQA recognises the many rich sources of patient safety information available and the potential for this information to reduce the risk of harm to patients. However, the lack of coordination of this information, along with the lack of a national incident reporting system, for system wide learning results in the system not reaching its full potential in terms of improving patient safety" (at p45).

Guidance note for notifying claims and circumstances

These guidelines are intended to assist you in identifying what you need to report to us under your Medical Professional Liability, Public & Professional Liability Insurance policy. They are not intended to replace the policy terms and conditions in any way.

Claims Process

Swift resolution of claims is reliant upon the quality of the initial information CNA receives. The more complete the information is, the more quickly CNA can move to resolve a claim.

A Claim/Circumstance Notification Form should be completed in respect of all new notifications and should be sent to: insurance@challenge.ie

What needs to be notified

You are responsible for notifying CNA of Claims and Circumstances which may give rise to a Claim under the policy. Such notice should include:

a. details of what happened and the services and activities that you were performing at the relevant time; and

b. the nature of any, or any possible, bodily injury; and

c. details of how you first became aware of the Claim or Circumstance; and

d. all such further particulars as CNA may require.

Claims

Under the terms of your policy, any Claim must be reported to CNA in writing immediately.

The definition of a "Claim" is any:

" **1.** written or verbal demand made of you; and/or

2. assertion of any right against you, including but not limited to any proceedings, including any counter-claim; and/or

3. invitation to you to enter into alternative dispute resolution, alleging any occurrence, negligent act, error or omission that may give rise to an entitlement to damages."

Examples of a Claim are:

- A letter of claim from solicitors.
- A letter or verbal demand from a patient or third party,alleging wrongdoing and requesting compensation.
- Legal proceedings (e.g. a Summons/Particulars of Claim, etc.).

Circumstances

Under the terms of your policy, any Circumstance must be reported to CNA in writing immediately.

A "**Circumstance**" is defined as:
"any circumstances of which you become aware, or should reasonably have become aware, that may reasonably be expected to give rise to a Claim."

Examples of a Circumstance are:

- Any complaint, written or verbal, in which the patient or patient's representative expresses dissatisfaction regarding the treatment received and alleges that, as a result, the patient suffered bodily injury.
- A request for access to medical records received from a solicitor or third party on the basis that a Claim against you/ your service (to include any of your employees) is being contemplated.
- Any incident in which a Serious Untoward Incident Report is generated.
- Any unexpected or unusual death of which you become aware.
- Any adverse outcome or clinical "near miss" in which you believe there may have been a negligent act, error or omission, irrespective of whether or not the patient is aware of this or whether the patient or patient's representative has made a complaint.

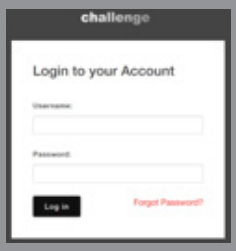
A loss of patient records (which after a relevant search cannot be found).

These examples are for general guidance only and this is not an exhaustive list. If you are in any doubt regarding whether an incident is reportable then you are encouraged to notify the matter to CNA as a precaution.

24 Hour 7 Day Consultant Helpline

In the provision of healthcare, you will encounter unexpected issues which don't always arise during normal business hours and may require a rapid turnaround or even an emergency response. As a Policy Holder with Challenge you have a 24-hour dedicated phone and e-mail helpline service which is provided by our experienced legal partners at DAC Beachcroft Dublin. Consultants should be aware that the helpline is not merely there to assist with medical malpractice claims, inquests and fitness to practice inquiries, it is there to assist you with patient complaints, complaints to the Medical Council, the management of adverse clinical outcomes, risk management and governance issues and any matters which impact on your day to day practice. It is a 24 hour helpline which is manned by people who are there to guide, assist and support you through the ever increasing medico-legal and organisational governance complexities of every day practice.

The number of the Helpline is 01-2319640.



Consultant Online Portal

All Challenge clients also have 24 hour, 7 day communication channel and access to their insurance documents via our online client portal at **www.challenge.ie**

challenge

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