Issue 3 • January 2017

Challenge Medical Indemnity

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Mr David Walsh, MD

Dear Consultant,

Welcome to our Challenge Medical Indemnity newsletter – January 2017 edition.

I'd like to wish all of our consultant and healthcare clients a happy, healthy and prosperous New Year. At Challenge, our commitment for 2017 is the continued provision of comprehensive healthcare indemnity at competitive rates.

Our private consultant indemnity scheme with CNA Insurance Company continues to grow at a significant pace and we are aiming to achieve 50% of the full time private consultant market by the end of 2017.

In this edition we are pleased to be providing you with a comprehensive update on the latest edition of the Medical Council Guidelines from Barrister at Law, Asim A. Sheikh BL. We are also pleased to announce the appointment of Daniel Spring & Co Solicitors, who are experienced Healthcare Law practitioners, to the CNA panel. Our underwriters also wanted to remind us of their long term commitment to indemnifying private healthcare practices in Ireland and have included a note to that effect.

I will be meeting with Minister for Health, Mr Simon Harris in the coming weeks to update him on our progress over the past 5 years and to inform him of our client's wishes going forward. We will also discuss the Oireachtas committee report on the Cost of Medical Indemnity Insurance and the pending law reforms for medical negligence cases. Similar reforms have been implemented in other countries and have had a positive impact over the longer term.

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 private healthcare practice in Ireland.
Thank you for your continued support,

Regards

David Walsh
Managing Director
Challenge.ie

CNA appoint Daniel Spring & Co

Donal Spring

Fiona Brassil

Challenge are pleased to announce the appointment of Daniel Spring & Co Solicitors to the CNA panel of law firms. Donal, Fiona and their Healthcare Law team are widely recognised within the healthcare industry. They are also a nominated firm on the State Claims Agency panel and have extensive experience in dealing with catastrophic injuries claims, fatal injuries claims and representing practitioners at inquests and Tribunals of Inquiry. We are looking forward to working with them in 2017.

For further details see **www.danielspring.ie**

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 Medical Council Guidelines 2016: A welcome evolution for medical practitioners

– 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.

The Guide to Professional Conduct and Ethics for Registered Medical Practitioners was published in May 2016 and is now the 8th Edition of the guide. The last edition dated back to 2009. This article looks briefly at some of the newer additions included in this version of the guide.

From a purely legal perspective, the purpose of the Guide at all was stated by Judge McGovern in M.R. v. T.R. *(Frozen embryos)*[1], when he stated that, *"These ethical guidelines do not have the force of law and offer only such limited protection as derives from the fear on the part of a doctor that he might be found guilty of professional misconduct with all the professional consequences that might follow."*

This was of course not in any way to belittle the status of the Guidelines, but rather to explain their application in a legal setting when contrasted to their application in a professional setting. Therefore, from the perspective of a medical practitioner, the guidelines represent an extremely important perspective in relation to professional practice for which practitioners can be held accountable before the Medical Council in relation to a potential complaint, 'with all the professional consequences that might follow'. In this respect, as most medical practitioners will know, those consequences are always of significance. A breach of the guidelines, which if leading to a complaint, will lead to an investigation by the Preliminary Proceedings Committee and if the case is warranted to be passed on to the Fitness to Practice Committee, can lead to a full public oral hearing with the resulting consequences from censure to striking off, all of which are serious in nature.

NEW ADDITIONS?

Addressing the doctor-patient imbalance: the Doctor as Advocate

The guidelines introduce the "Three pillars of professionalism" which are: Partnership, Practice and Performance. The main principles discussed within the guide are now discussed within these pillars, and some new and important aspects of "best practice" are now emphasised and re-discussed.

It is arguable that the doctor-patient relationship is not one of equal standing and therefore, not in fact a "partnership" of equality.[2] It is probably the case that most professional relationships are of unequal nature: the patient/client is reliant on the practitioner/professional for advice and assistance which if administered with any want of care may lead to serious detriment. It is therefore completely understandable that high standards are expected. There is no controversy in such expectation.

It seems that the guidelines do not suggest that it is an equal partnership. For this reason, the language and scope of these guidelines seem to work towards perhaps redressing that imbalance. To this end, there is an increased emphasis in relation to the medical practitioner as an advocate. The issue of the practitioner as advocate was first introduced into the 7th edition of the guide. Then, it was stated that *"subject to duty to act in the best interests of patients, you have a responsibility to engage and advocate…"*. The Guidelines state at section 4.5 that, "you should act as an advocate for your patients…"[3] and go on to now state that:

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1 see [2006] IEHC 359.

2 see further: "Patient Autonomy and Responsibilities within the Patient-Doctor Partnership: Two Sides of the Same Unequal Coin?" Chapter 6 in: Donnelly, M. and Murray, C (eds). *Ethical and Legal Debates in Irish Healthcare: Confronting Complexities* (Manchester University Press, January 2016) pp 84-100.

3 In the 'guide to the guide' it is stated that where the words 'you should' are used (as opposed to 'you must' which signifies an absolute duty to comply), this describes *"...best practice in most circumstances, accepting that it may not always be practical to follow the principle or that another approach may be appropriate in particular circumstances. You should use your judgement in such cases."*

The Medical Council Guidelines 2016: A welcome evolution for medical practitioners (Continued)

> "Your duty is to act in the best interests of patients and you have a responsibility to engage and advocate with the relevant authorities to promote the provision of suitable healthcare resources and facilities. If you work in a facility that is not suitable for patients or for the treatment provided, you have a responsibility to advocate on behalf of your patients for better facilities."

Further, at section 63.1, entitled "Patient safety and advocacy", it is stated that:

> "As a doctor in a management role, you have a responsibility to advocate for appropriate healthcare resources and facilities if insufficient resources are affecting or may affect patient safety and quality of care."

The Irish Medical Organisation (IMO) addressed this issue in 2013. The role of the doctor in this respect was comprehensively described and it was stated that:

> *"Doctors are charged to be altruistic and trusted to act in the best interests of their patients without political, economic, commercial or organisational influence. Doctors not only have a duty to advocate on behalf of their patients but patients must be able to trust that their physicians are looking after their best interests."*[4]

It should be noted that both the IMO and the current edition of the Medical Council guidelines recognise the potential barriers in relation to practitioners being advocates. Resources are the usual culprit and, therefore, organisations will also have to look carefully towards the evolution of standards and expectations of practitioners and, accordingly, change the environment in which such practitioners work in order to ensure that the standards can be met appropriately. It will be interesting to see how practitioners do and will act as 'advocates' for patients as a matter of best practice. The next time the Medical Council survey patient attitudes of the profession[5], perhaps they should ask if they feel doctors acted as their advocates. It will be even more interesting when a plaintiff in the future might decide to make a complaint that a doctor failed in his/her duty to act as an advocate to see how this will be dealt with. Allied to these views, it is important that practitioners also express their opinions as to how they can be facilitated vis-à-vis their expected responsibilities as advocates to patients.

One important issue and, perhaps, an issue that is one of the most obvious, is in relation to the resource of "time". This is something that clearly needs to be addressed from both an organisational and personal perspective as it feeds into a number of issues of professional importance including the essential issue of consent. Practitioners must decide how their time and resources are to be allocated within their workplace.

Put simply: practitioners are either deprived of time from an organisational perspective or deprived of their own time which they can spend with patients if they take on an increased and, perhaps, at times unmanageable workload. If this is the case, it results in practitioners being stretched too thinly thereby depriving them of the essential contact time they require with patients. Such a situation is not compatible with the expectations of best practice and law, and good practice is, therefore, compromised in areas such as advocacy and consent.

Under the three pillars, there is a clear emphasis on attempting to balance the inequality between the relationship. In addition to advocacy, the concept of partnership emphasises the importance of trust, patient centred care, working together and good communication involving listening to patients and colleagues.

Holistic approach to practice

Apart from the expected requirement that practitioners remain up-to-date and within their competence when treating patients, the guide has expanded its scope in terms of the values and principles expected from doctors. The guide expects doctors to reflect values and principles of a more holistic nature and expects them to involve themselves in reflective practice (formal review through audit and informal reflection), act as role models to medical students, trainees and other colleagues and be involved in teaching and training medical students and doctors to new practice. These are welcome additions and a recognition of the influence that medical practitioners have on the profession as a whole.

Update on 'Poor Professional Performance'

As a result of the judgment in the *Corbally* case[6], the guidelines have been updated to add to the statutory definition of poor professional performance by stating that a "failure" under the definition of professional performance means a "serious failure".

Consent

This edition of the guide has clearly benefited from the HSE National Consent Policy (2013), aspects of which are incorporated into the new edition e.g. section 11.4 which deals with giving information to patients and which states that practitioners should:

> "consider the patient's individual needs and priorities. For example, patients' beliefs, culture, occupation or other factors… You should try to meet patients' communication needs – for example – if patients have a visual or hearing impairment, a learning disability or if English is not their first language.

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4 at section 24. See further: IMO Role of the Doctor Series: *The Doctor as Advocate* (Position Paper, April 2013).

5 The last review was: *Listening to Complaints: Learning for Good Professional Practice* (Medical Council, 2015).

6 *Corbally v. the Medical Council* [2015] IESC 9, per Hardiman J at para. 96.

The Medical Council Guidelines 2016: A welcome evolution for medical practitioners (Continued)

The section dealing with consent and children has been expanded. The guide effectively accepts and applies the concept of "Gillick competence"[7], in relation to situations where young people do not wish to have their parents informed of medical treatment, after careful consideration of a young person's rights and best interests, and goes on to state definitively that having considered these issues, *"you should provide treatment for young people without informing the parent(s)… If you consider that it is in the patient's best interest to do so and the patient has sufficient maturity and understanding to make the decision."*

However, as stated above, if practitioners feel that their time is limited as a result of personal or organisational reasons, this will lead to problems in relation to essential issues such as the taking of consent. Whilst the issue of consent may be dealt with in a fuller discussion at another time, recent and important case law from the UK has emphasised the most important mechanism of communication between doctor and patient.

In relation to bringing patients to the centre of care, the UK Supreme Court in the case of *Montgomery v Lanarkshire Health Board*[8] (which concerned a diabetic patient who during labour encountered a shoulder dystocia) the issue of informed consent arose for consideration. UK law has now also embraced a patient-centred test in relation to disclosure of risks. However, in describing and explaining what this actually means, Lords Reed and Kerr stated the issue which healthcare needs to recognise – a basic tenet of the doctor-patient relationship, achieved by … dialogue with the patient:

> "…the doctor's advisory role **involves dialogue**, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form."

This statement will hardly come as a surprise to practitioners who know better than others that the best mechanism of communication with patients is one which involves dialogue. However, the necessity of this dialogue will undoubtedly increase, especially in circumstances where the patient demographic will also change in the future (as we deal with an increasing elderly population), and in circumstances where the doctor-patient relationship is no longer seen as a paternalistic one in which the practitioner does not engage with the larger circle of individuals in dealing with the care of patients.

This obviously includes time in multidisciplinary conferences and, also, with the coming into place of the Assisted Decision-Making (Capacity) Act 2015, it will involve the necessity to deal with people other than also the patient when capacity is in any way compromised. All of this will require the resource of time. Practitioners should therefore prioritise this issue as an essential part of their practice planning.

Any compromise, in this respect, will have a direct impact on the ethical administration of their duties towards the patient. As part of the expectation that practitioners now indulge in "reflective practice", it is advisable that time management is looked at. A simple question becomes of major importance: "am I spending enough time with my patients?" If the answer is "no", this will undoubtedly have an effect on basic aspects of the doctor-patient relationship: the time to take a detailed history, the time to be involved in the overall consent process, the time to have discussions with patients, the time to develop a rapport with patients, the time to be involved in advocacy, and the time to be involved in training and updating of skills – all issues which are now expected of practitioners, especially in accordance with the new edition of the Medical Council guidelines.

Social Media

The issue of social media is dealt with in a new section for the first time. This is obviously a welcome update to the reality of the world we currently live in. However, the obvious danger to the use of social media platforms in the context of professional and confidential relationships is the breach of confidentiality/privacy. The guide states this in the fourth paragraph of this general section stating that, *"you must not publish information about, or images of, individual patients from which those patients might be identified on publicly available platforms."* The section then goes on to state that *"you should avoid discussing or commenting on your patient on social media platforms."* Attempting to balance the potential advantages of social media platforms with its disadvantages is understandable. However, the undeniable importance of confidentiality in the doctor-patient relationship is paramount and, therefore, this should have been made much clearer much earlier in this section as it goes to the very professionalism the guide seeks to endorse and as the guide states later at section 29.1 that, *"Confidentiality is central to the trust between you and your patients and a core element of the doctor/patient relationship."*[9] This is an issue that is axiomatic and known to all practitioners. Therefore, it must be emphasised as a first issue. Practitioners must not compromise patient confidentiality. This rule of first principle does not change as a result of any new technology. Therefore, regardless of what new technology is adopted personally or professionally by a practitioner, the rule of first principle must always be applied and kept in mind.

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7 *Gillick Respondent v West Norfolk and Wisbech Area Health Authority* (HL) [1986] A.C. 112, per Lord Scarman at p 189 and at p 174 per Lord Frasier for what are described as the 'Frasier Guidelines'.

8 [2015] UKSC 11.

9 There is evidence in the literature which demonstrates the issues of problems with patient confidentiality and social media in the context of medical students: see further: Katherine C. Chretien, et al. "Online Posting of Unprofessional Content by Medical Students" *JAMA*. 2009;302(12):1309-1315 (Oct, 2009).

The Medical Council Guidelines 2016: A welcome evolution for medical practitioners (Continued)

Intimate examinations, and patients under anaesthesia

The guideline outlines the absolute duty on practitioners, at section 35.4 who, *"…must not carry out intimate examinations on anaesthetised patients unless the patient has given written consent to this in advance."*

End of Care Life

The section on end of life care has been expanded and now includes specific reference to certain types of treatment. Section 46.3 states:

> "Usually, you will give treatment that is intended to prolong a patient's life. However, there is no obligation on you to start or continue treatment, including resuscitation, or provide nutrition and hydration by medical intervention, if you judge that the treatment:
>
> - is unlikely to work; or
> - might cause the patient more harm than benefit; or
> - is likely to cause the patient pain, discomfort or distress that will outweigh the benefits it may bring."

Abortion

There is a change in wording to the section on abortion. The older guidelines commenced the section stating, *"Abortion is illegal in Ireland except where there is a real and substantial risk to the life."* The phraseology has changed in the new guidelines to take into account the Protection of Life during Pregnancy Act 2013 and now commences at section 48.1 stating that, *"You have an ethical duty to make every reasonable effort to protect the life and health of pregnant women and their unborn babies"* and at section 48.3 that, *"Abortion is legally permissible where there is a real and substantial risk to the life of the woman which cannot be prevented by other means."*

Restraint

For the first time in the guide, the issue of restraint is specifically dealt with and the general principle is laid out at section 52.1 which states that:

> "Managing patients with challenging behaviour requires a multidisciplinary and holistic approach. Physical restraint and the prescription of medication to control behaviour should only be considered when other approaches have failed."

The guide also deals with the issue of the culture of patient safety and referral of problems by raising appropriate concerns. In relation to restraint, the section also states that, *"If you are aware of the use of patient restraint that you consider to be disproportionate, excessive or inappropriate, you should raise your concerns with the senior clinician or with someone in a position to investigate the situation."*

Patient Safety

As part of practitioners' duties regarding their "performance", the guide has significantly increased its discussion on the issue of patient safety at Section 64 and discusses the "culture of patient safety" and states clearly that practitioners, *"should promote a culture of patient safety within the context of the wider healthcare system."* Unambiguously, the guide goes on to state that if practitioners are involved in adverse incident they, *"should report it, learn from it and take part in any review of the incident."* As a part of this culture of safety, practitioners "must inform" appropriate persons or authorities in circumstances where systems or services lead to unsafe practices which may put patients or other colleagues at risk.

In this respect, it is important to note that any aspect of practice in any situation or clinical setting which a practitioner is aware is an unsafe practice or may lead to an unsafe practice putting patients or colleagues at risk, gives rise to a duty on the practitioner to inform appropriate persons or authorities.

As member of a Board, if issues of risk arise, practitioners are told they must formally raise these and ask the board that these be recorded. Further, the section on adverse incidents in relation to open disclosure has been amended by being more overt in its language. The guide states that, *"open disclosure is supported within a culture of candour. You have a duty to promote and support this culture and to support colleagues whose actions are investigated following an adverse event."*

CONCLUSION

The latest edition of the Medical Council guidelines are undoubtedly welcome. Certain issues are certainly more overtly stated than before and increased clarity will always be a positive change for practitioners who are seeking to use the guidelines in their everyday practice with their patients. In this respect, more detailed guidelines in relation to specific issues would probably be welcome by practitioners as the gap between editions is significant. Further, this edition of the guidelines seems to elucidate a better reflection of the values which practitioners should aspire to from a holistic perspective. This is helpful: with all the talk of duty and responsibility and at a time where practitioners are always mindful of medico-legal issues, all of which are of obvious importance and practical applicability, it will always be important to remember that medical practitioners are trusted professionals whose influence is felt far and wide amongst patients, the profession and society at large. In this respect, the fact that the guide clearly asks practitioners to be reflective of values is also an important part of how the medical profession progresses in an ever-challenging environment.

Additionally, the exercise of reflection is one which must be engaged by both the practitioner and the organisation in which the practitioner works to ensure that the ultimate goal of patient centred care can be realised. In this respect, the new guidelines in their evolution also expect practitioners to be aware of and to inform organisations, appropriate persons and authorities of situations which may endanger patient safety. In this respect, this hopefully represents not just an evolution of guidelines but also the evolution of the practitioner and the organisation within which they work.

CNA Hardy – Commitment to Ireland

The consultant indemnity scheme was launched in Ireland in November 2014 through Challenge Insurance Brokers and backed through the partner broker in London, Paragon International Insurance Brokers Limited. The scheme is fully underwritten by CNA Hardy (CNA Insurance Company Limited) .

CNA Hardy, along with the brokers, spent many years of investigating and researching Ireland before launching this scheme. CNA Hardy have met with the Director of the State Claims Agency, on a number of occasions and both parties are committed to working together. CNA Hardy have also had excellent and productive meetings with a number of the Chief Executive Officers of the Private Hospitals in Ireland.

CNA Hardy are committed to the longevity of the consultant indemnity scheme in Ireland and have enhanced the scheme on a number of occasions to the benefit of the members of the scheme. The addition of a 21 year extended reporting period is just one example.

For CNA Hardy, the customer comes first. Our winning proposition is the commitment to our customers: We offer more than just a policy – we deliver distinctive insurance solutions and promise a superior customer service through close relationships with our partners. CNA Hardy believe in building enduring relationships and want to focus our energy on partnering with customers who value this approach and seek the same. CNA Hardy's financial strength underpins the contract we have with each of our customers. We receive consistently high ratings from AM Best and Standard & Poor's proving our ability to deliver on our commitment to meeting claim requirements when they arise.

For Further details see **http://www.cnahardy.com/business-capabilities/healthcare**

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.

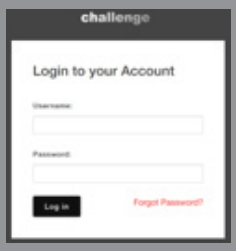
A loss of patient records (which after a relevant search cannot be found).

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 085 8065794



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**

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Email: **insurance@challenge.ie** • Tel: **01 8395942** • Web: **www.challenge.ie**
Challenge House, 28 Willie Nolan Road, Baldoyle, Dublin 13.