



Healthcare Update

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Mandatory professional competence requirements for doctors

The Medical Practitioner Act 2007 (the Act) aims to enhance and reform the regulation of the medical profession and replaces the Medical Practitioners Acts 1978 to 2002. On 1 May 2010 all remaining provisions of the Act came into force. These provisions relate to the maintenance of professional competence or ongoing education/training of registered medical practitioners. As a result there is now a statutory obligation for the first time on all registered medical practitioners to maintain their own professional competence on an ongoing basis “pursuant to a professional competence scheme applicable to that practitioner” and to co-operate with any related rules made by the Medical Council (the Council). These provisions were central recommendations in the 2006 Lourdes Hospital inquiry report.

The Council may recognise medical education and training bodies for the purposes of assisting the Council in performing its functions. There is also an obligation on the Health Service Executive and other employers of registered medical practitioners to facilitate the maintenance of professional competence of medical practitioners. Every registered medical practitioner is now required to register with a relevant professional competence scheme within the next 12 months as they will be legally obliged to demonstrate they are maintaining professional competence from 1 May 2011. They will have to complete 50 hours of continuing professional development (CPD) and clinical audits a year or 250 hours over a five year period. Generally speaking one hour of CPD training will generally generate one CPD credit.

Medical negligence working group

The President of the High Court, Kearns P recently established a working group on medical negligence litigation. It will examine the present system of managing medical negligence claims and make recommendations for improvement as well as draft legislation to give effect to its recommendations. It is to look at all aspects of the process from pre-action procedures, pleadings, discovery or disclosure, video link evidence from experts / witnesses to other forms of resolution such as mediation. It will consult with the Law Society, solicitors, barristers, insurance representative bodies, indemnifiers and insurers and is due to report by the end of November 2010.

In particular the group is to consider how case management and other streamlining measures may improve the progression of medical negligence claims. Case management by judges would represent a fundamental change in the conduct of litigation. For example, a trial judge could call a pre-trial case management conference to narrow down the issues, and/or specify dates for the mutual exchange of documents, set a trial date and timetable which would then be controlled by the court.

Another issue to be considered by the group is the question of introducing optional or mandatory ‘periodic payment orders’ instead of the current ‘lump sum’ payments. There are two types of damages in personal injury actions: general damages and special damages. All parties involved in handling and managing these claims eagerly await the group’s findings.



Nurses and Midwives Bill 2010

On 22 April 2010 the long awaited Nurses and Midwives Bill 2010 (the Bill) was published and it is currently progressing through the Dail. The Bill repeals the Nurses Act 1985 and provides for a modern statutory framework for the regulation of the nursing and midwifery professions. The Bill will establish a new Board, An Bord Altranais agus Cnámheaschais na hÉireann (the Nursing and Midwifery Board of Ireland) to protect the public. It will have 23 members, both elected and appointed, representing nursing and midwifery, educational bodies, members of the public and stakeholders. The National Council for the Professional Development of Nurses and Midwives will be dissolved and its staff will transfer to the new Board.

The Bill also:

1. Recognises midwifery as a separate and distinct profession. It provides for clinical supervision of midwives who must have adequate indemnity insurance and the establishment of a Midwives Committee to advise the Board in relation to midwifery practice issues.
2. Provides for a non-nursing/midwifery majority on the Board and on the Fitness to Practise Committee and the new Preliminary Proceedings Committee unlike An Bord Altranais.
3. Provides for the registration of nurses and midwives and the registration of candidates and advanced nurse/midwife practitioner posts. It also prohibits unregistered nurses and midwives engaging in the practice of nursing or midwifery.
4. Provides that the new Board will be able to approve education programmes and to specify standards of practice for registered nurses and midwives and give guidance on professional conduct and ethics.
5. Sets out a new statutory framework for the maintenance of professional competence of registered nurses and midwives.
6. Places an obligation on employers to facilitate the maintenance of professional competence of nurses and midwives, in particular, by providing learning opportunities in the workplace.

HealthCast report findings

PricewaterhouseCoopers' (PwC's) April 2010 report "HealthCast: The Customisation of diagnosis, care and cure" is the culmination of a year-long study of 25 health systems including research amongst almost 600 global health industry leaders including Ireland. In response to the global recession and pressure to reduce rising national health costs associated with chronic diseases, government and health leaders recognise that individuals must play a bigger role in managing their health and overall health spending. Key findings in the survey include:

1. An overwhelming 84% of global health leaders agreed that reimbursement to hospitals, physicians and other providers should be based on quality health outcomes and not the number of procedures, for example, in order to create incentives for health providers to encourage behavioural changes in their patients.
2. There is a big job to be done in patient education through proper communication of health information and risks.
3. A radical shift in health funding will emerge. For example, nearly three-quarters of health leaders expect that health funding and financing in their countries will be redistributed from treating sickness in acute care settings to keeping people well and out of hospitals, nursing homes and doctors' offices.
4. Nearly half of global health leaders expect medical tourism to increase by 2015, as health systems compete for consumers by offering personalised care that is cheaper and incorporates access to the latest medical innovations.

Ultimately they advocate that the "healthcare model of the future needs the individual to be at the centre of diagnosis, care and cure"

Link to report: <http://www.pwc.com/us/en/healthcast/index.jhtml>



Patient information and data protection

The Data Protection Commissioner called on the Health Service Executive (HSE) to increase security of patient information in his 2009 annual report which was published on 8 April 2010. This was sparked by the investigation in relation to a HSE report that an unencrypted laptop containing personal data related to HSE clients was stolen from the HSE West PCCC4 offices in Roscommon in June 2009.

Specifically the Commissioner has called for the HSE to:

1. Take organisational responsibility for the encryption of all laptops; it is not sufficient to delegate this responsibility to individual staff members.
2. Introduce policies to prevent similar situations arising in which they do not own or control devices storing HSE patient data.
3. Prioritise the development of secure networks and devices for the transfer of patient data.
4. Develop appropriate controls governing access to patient databases, including directory services.
5. Improve staff training to ensure that all staff, particularly at management level, understand the need to report serious data security breaches.

Link to report: <http://www.dataprotection.ie/documents/annualreports/AR2010.pdf>

Public and service user involvement in health and social care regulation

On 25 January 2010 the Health and Social Care Regulatory Forum published the Framework for Public and Service User Involvement in Health and Social Care Regulation in Ireland. This Forum of chief executives of health and social care regulatory bodies was established in 2008 to explore opportunities to harmonise certain business processes, share best practice and facilitate coordination between member organisations. The Framework was published in response to the 2008 recommendations of the Commission for Patient Safety that 'robust and validated patient and public involvement should be a requirement for all health care oversight, scrutiny, quality control and other accountability mechanisms'.

Under the Framework service users and members of the public should be involved in the work of regulatory bodies:

- To promote openness and transparency by enabling the public to review service quality and be directly involved in the development of rules and standards;
- To act as a safety solution so that health and social services can learn from the experiences of service users, carers and others, particularly as it relates to adverse events;
- To improve the quality of regulated services by ensuring that services are sensitive to the needs and preferences of service users and the public and
- To focus the work of regulatory bodies on service users and encourage public accountability.

The report has been considered by the board/councils of the various regulatory agencies involved in the Forum and a website is being set up for those who wish to engage with the regulatory bodies.

Link to Framework: http://www.hiqa.ie/media/pdfs/Framework_Public_Service_User_Involvement.pdf

Recent appointments

Mr Cathal Magee has agreed to take up the post of chief executive officer (CEO) of the Health Service Executive (HSE) as the contract of the current CEO, Professor Brendan Drumm, expires in August 2010. Under section 17 of the Health Act 2004, the HSE board rather than the Minister for Health and Children is responsible for making the appointment. Dr Susan O' Reilly has also been appointed as the new Director of the Cancer Control Programme and will take over from Professor Tom Keane.



Recent cases

Brachial plexus injury

The Healthcare Department recently defended on behalf of a hospital a brachial plexus injury case which was alleged to have arisen at birth. The consultant obstetrician/gynaecologist was separately represented. Given the strong contemporaneous midwifery notes and other documentary evidence such as the birth register, it was apparent that the plaintiff's birth was managed by the consultant and no issues of negligence fell to be addressed by the midwives. An indemnity was secured from the co-defendant's solicitors.

Travel vaccination injury

In a recent case, a plaintiff alleged she suffered a reaction to a travel vaccination that she received in a clinic. She claimed that the reaction impacted on her enjoyment of her holiday. The Healthcare Department represented the nurse who administered the vaccination. The clinic and treating doctor were separately represented. Further to investigations carried out, it became apparent that while the plaintiff suffered a reaction to the vaccination, all appropriate procedures and protocols were followed, resulting in no negligence by the defendants. The case was settled at an "all-in" level that was agreeable to all.

Finger amputation claim dismissed

In this case the plaintiff sought damages for personal injuries relating to the amputation of the tip of her finger. She alleged that her injury was caused by a faulty door mechanism in a hospital. The Healthcare Department acted on behalf of the hospital. Judge Mathews held that as the plaintiff admitted that she did not look where her hand was, this amounted to an admission of negligence. Therefore he dismissed the plaintiff's claim.

MDU test case

The Healthcare Department is representing the Health Board in one of the two birth injury cases in which the Medical Defence Union have used its "discretion" and withdrawn cover for the consultants involved. The State is challenging the validity of the MDU's decision. When the cases came before the High Court the Health Board paid the sums awarded to the plaintiffs. A 'stay' was placed on the recovery of this money from the doctors involved. The 'stay' on the third party proceedings has now been lifted and it is anticipated that the net legal issues will be addressed in the coming months.

Patient's records decision successfully appealed

The Master of the High Court recently refused a request for discovery from a plaintiff's legal team in a MRSA case. His refusal was on the basis that legislation existed to reverse the burden of proof once the plaintiff could establish that he contracted MRSA. This was appealed successfully before Mr. Justice Lavan and appropriate categories of discovery were then granted.

The Healthcare Unit

If you have any queries on the contents of this update, or if there are other topics you would like to see us address in future editions, please contact any member of the Healthcare Unit listed below.

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