Reforming the MEDICAL COUNCIL supporting DOCTORS, improving PATIENT CARE

Environment of 'innocent until proven guilty' must be created for doctors

We all know the apprehension when correspondence from the Medical Council arrives in the door – and the reasonable relief when it is just a request for payment.

Leaving aside the actual outcome of any proceedings, we also know of colleagues whose health has suffered during or after fitness to practice proceedings even if we have not received notice of a complaint ourselves.

The GMC in the UK has recently completed a study of suicide in doctors subject to GMC proceedings following a report of 94 deaths arising in concert with such investigations.

Our system in Ireland is similar - and the aim of this national audit of doctors is to confirm a similar effect on doctors practising in Ireland since the introduction of the Medical Practitioners Act in 2007 by the then Minister for Health, Mary Harney.

Indeed it may well be that that physician mortality and morbidity associated with our Council's proceedings will be higher than that in the UK, not least because of the statutory preference within the Act for public proceedings.

In fact the first recommendation of the GMC suicide review among doctors was to create "an environment where doctors undergoing a fitness to practise investigation feel they are treated as 'innocent until proven guilty' – highly unlikely if your complaint is being broadcast on Irish national print, radio and/or television.

As doctors, we understand the importance of audit in assessing medical/practice interventions - this is simply another audit except this time focusing on physician rather than patient mortality/morbidity.

We need your assistance. If you and your colleagues can return the questionnaire by post or email, it will create an evidence base on which future reform of the current toxic culture of medical regulation can begin in ernest.

We need your feedback regarding how many colleagues you know who have been before the Council - and whether their health was affected either during or after fitness to practice enquiries. We do not wish names but simply whether death or morbidity accompanied those subject to proceedings.

We will be presenting the data at our joint Irish Medical News/Medical Advocates Conference on October 6th.

This information will then provide an impetus for regulatory reform in concert with the upcoming elections to the Medical Council and the essential fundamental changes to the Medical Practitioners Act 2007.

Regulation should assist doctors in improving patient care – we greatly appreciate your input to this essential change for doctors and their patients.

Dr David Walsh

Dr David Walsh, Consultant, and Sylvia Green, Consultant, Medical Advocates announcing the Focus on Medical Regulation Conference in Dublin next October

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MEDICAL ADVOCATES
Protecting Your Reputation

The problem is there is no adverse outcome for those individuals or bodies who drives these groundless complaints - and that is not right

Why doctors must lobby more to get fair play against complaints

Liam Twomey is a medical doctor practising in Rosslare, Co Wexford. He was Fine Gael Dail Deputy for the Wexford constituency until last year when he announced his retirement. Dr. Twomey is a native of Bealad, Clonakilty, County Cork. He will address the conference on the political path towards amending the Medical Practitioners Act 2007.

Dr Liam Twomey

One of the key points about complaints from the Irish Medical Council is the different personalities of doctors receiving them.

Doctors by nature work on empathy and on helping and accommodating their patients. They don't think in the same way as say a solicitor who looks at getting the legal end right and is used to following the letter of the law. They're tuned in for adversity where GPs are not.

That is why it hits doctors so hard when they are served with a letter of complaint by the Medical Council.

It says in very formal language that a complaint has been received and it wants the individual to furnish the council with a number of things.

Doctors get upset; it throws them. It's like they get a punch in the solar plexus. It drags on for six months and they are never quite sure where it is going. They are told letters are going to preliminary hearings and may go to a full hearing.

Female GPs are harder hit by such complaints. They take it personally. There is a need for the professional organisations to engage in this issue because it is having a huge impact.

There are about 500 complaints each year of which sanctions might be brought against six or seven doctors. That means about one percent has an adverse outcome. So what we must do is protect the 99 per cent who are complained against when it is found there is no case to answer.

I don't mind saying I had a vexatious complaint that was dismissed but I've been in public life and was the sort of character that met the complaint head on. However, a lot of doctors aren't like me and in fact see such an accusation as something of a stigma. Many bottle it up which is not good for them.

The problem is there is no adverse outcome for those individuals or bodies who drives these groundless complaints - and that is not right.

For instance, I have seen nothing coming from Irish Medical Council which says it has learned lessons from the likes of the Martin Corbally case.

As the people who pay for all this, doctors should get a report explaining the Martin Corbally case to them. There may be other similar cases which we don't know about.

I was in the Dail when the Medical Practitioners Act 2007 came before it. It was passed with indecent haste a few weeks before the general election that year. There was very little debate for that reason. In essence, no debate and little or no follow up on it.

We should now be pushing for changes to that 2007 Act.

Our professional unions should be initiating debate on the issues that are affecting doctors so that they can be highlighted in public. There is a need to properly inform the Oireachtas on how this is affecting our people. We need to look at how we might bring about change for the better.

There is a serious case for doctors to get more involved, not necessarily in the Irish Medical Council, but to see what's happening in and around the Council.

If we have a problem with the Medical Council, we need those representative bodies to row in behind us. We need representatives

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raising red flags for our profession in the Oireachtas or with the Department or other agencies.

The system is currently very bureaucratic and maybe we should put the focus on where the complaints are coming from. Then we could evaluate those complaints and assess the doctors who are under the microscope.

Even at this remove, I think the doctors sitting on the medical council would do well to write a report over what happened in the Professor Martin Corbally case. The reputational damage to people like him can be immense and should never be allowed to happen the way it did.

If we approach our problems with open minds and properly discuss the issues, there is a chance that real change can come about.

There will always be underperforming and careless members of the profession but we are quite good ourselves at weeding them out.

We must also realise that sometimes complaints can come because doctors are burning out and not because they are bad doctors. They have layer upon layer of stress in their job. Some can't even plan holidays because they have heard stories about having to come back from the airport because a locum didn't turn up to cover for them.

We've very adversarial in our legal system and all medics need a say in this - young doctors, GPs and consultants. Young doctors are leaving because this adds further stress in an already busy life.

We don't treat our young doctors well. We need proper conversations to take place on this issue. It will reach a point where we are worse than America. Soon we won't deal with anyone with back pain without an MRI. We're just going to be so ridiculous and there is no sense that authorities are taking this on board.

I've heard people blame the media for the bad publicity doctors get when there are complaints.

The media historically sensationalises anything that makes a good story. There is no point in blaming bad journalism for our problems.

If the Medical Council, the Department of Health, HSE and Oireachtas do their own jobs properly, the media becomes by and large an irrelevance. As I said before we must protect the 99 percent who are complained against without any foundation for those complaints.

Martin Corbally

A QUESTION FOR DOCTORS COMPLAINED AGAINST

Between now and our conference, it would be apposite to ask doctors who were the subject of complaints: "Did you feel you were let down by those who were supposed to support you?"

The doctors I speak worry most about the reputational damage both locally and among their own patient population.

At present there is no redress for those doctors who are cleared and this area must be looked at.

There might be a role for some group like Medical Advocates to not just represent doctors but also to lobby on their behalf by rewriting legislation to protect the profession.

Nothing will change unless we look for it. We need to actively go out and say where we need this change. The IMO, NAGP and ICGP are good organisations who do a good job. They make a difference.

The key officers should be full-time instead of trying to run a practice and fulfil the role at the head of their organisation.

It's almost impossible to run a stressful business for 50-60 hours a week and also do a good job in the IMO or other organisations. I believe we need to professionalise how these organisation run themselves.

Medicine on the defensive

Dr Christoph Lees, MD MRCOG, is Reader in Obstetrics and Fetal Medicine at Imperial College London; Honorary Consultant in Obstetrics and Head of Fetal Medicine at Imperial College Healthcare NHS Trust, Centre for Fetal Care, Queen Charlotte's and Chelsea Hospital; Visiting Professor at the Department of Development and Regeneration, KU Leuven, Belgium; Founder, Doctors Policy Research Group, Civitas. His non-clinical interests are in the field of medical regulation and here he answers questions on the present and future development of this broad subject. Among his most recent non-clinical publications is a report on the general medical council, GMC - Fit to practise?

Dr Christoph Lees

Are we in an era of defensive medicine?

Ever since I was a medical student in the 1980s, junior doctor in the 1990s and consultant in the 2000s we have talked about 'defensive medicine'. The truth is that medicine is only really as defensive as we want to make it as the public typically understand that good doctors should sometimes take risks on behalf of a patient. But since the millennium the practice of medicine has begun to change tangibly- and defensively.

The three aspects of process that make medicine defensive is the civil law (medical negligence), increasingly the use of criminal law and regulatory processes. In many ways, we are crying out for a new compact between the medical profession and our patients: though medical negligence cases offer a fair route for redress, the criminal law is being used inappropriately and regulatory processes are an extremely blunt way of dealing with performance, and almost always act too late and end with an unrecoverable outcome.

How does this manifest itself typically?

The classic situation is performing a cardiac operation on a severely sick patient: with open-heart surgery they may have a 50 per cent survival chance, without surgery less than 10 per cent. But which cardiac surgeon now wants to fall the wrong side of the mortality statistics? There is strong anecdotal evidence that there is a reluctance to treat in many (mainly surgical) fields and high risk but necessary operations are avoided. But it isn't just surgery: in primary care there is never a penalty for inappropriately frequent referral, but there is for a failure to refer. In obstetrics, an unnecessary Caesarean is very rarely a reason to go to court.

The effect of this is twofold: (1) inappropriate referral and investigation-which is both expensive and time consuming and (2) A 'stifling' of a doctor's first duty, which is to act on behalf of the patient rather than to 'watch their back'.

Have you been able to quantify the effect of erasure and suspension in terms of figures?

The UK's GMC publishes an annual report so these figures are publicly accessible (http://www.gmc-uk.org/SOMEP_2016_Full_Report_Lo_Res.pdf_68139324.pdf). The number of suspensions and erasures has increased ten-fold in 25 years and a doctor has a four per cent risk of a GMC complaint per year, as seen in the table below. The cumulative likelihood of a GMC complaint in a 35-year working career is over 50 per cent. (See chart Below)

Doctors are good copy and make sensational headlines; journalists now do more work and check facts less than ever - is there a co-relation in these two facts that is deleterious for the medical profession?

On the one hand, a free press is essential for the proper functioning of a mature civilized democracy, on the other an unfettered and irresponsible press can destroy careers, lives and families. It is certainly the case now that cases are poorly reported with 'identikit' stories emerging through different media outlets. A major problem is that although a doctor may be named and their practice commented on, the doctor has no ability to speak about the particular case under the spotlight, so is 'sitting prey'. There should be some method of redressing this unjust balance, perhaps by preventing a doctor being named until an investigation is complete for fear of punitive damages. As I suggest later, the use of libel laws may be appropriate.

Where does social media figure in terms of doctors, complaints and the dissemination of half-truths, accusations and downright less about how doctors perform?

This is widespread. You only have to look at well-known blog websites

Year	Number of registered medical practitioners (RMP)	Enquiries/Complaints to GMC (% of RMP)	Suspension or erasure
1992	143,224	1,300 (0.9%)	17
2006	240,328	5,085 (2.1%)	153
2012	252,566	10,347 (4.1%)	126
2015	234,740	8,269 (3.5%)	191

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to see thinly veiled references to doctors and often disparaging remarks. Once again, the playing field is hopelessly biased against doctors and whilst a balance should be struck allowing free speech, there must be some redress for doctors whose reputations are unfairly traduced. I would favour the use of libel laws in this context. This is something that medical defence organisations are very un-keen to pursue - presumably on the basis that this would count against a doctor at a disciplinary hearing, and might be very costly to prosecute. But something must be done-this problem is only going to get worse.

Investigations - should there be a time-limit as this often affects the lives of doctors and their families?

This has been a major problem with the GMC, and continues to be. Doctors contacting me often have cases on-going for several years. Despite the GMC apparently trying to tackle this, I don't see much evidence of this improving. A particularly pernicious characteristic of investigations is the apparent 'trawling' exercises undertaken in order to bolster a case. There must be limits to the length of investigation: if a case cannot be brought within 12 months of the original complaint, then it should surely be dropped unless there are exceptional circumstances.

How can the GMC push on with current format when 25 per cent of their complaints are thrown out?

This is a really interesting question. Of 8,269 complaints in 2015, 5,419 (66 per cent) were closed immediately. One hundred and ninety one-or 2.3 per cent- ended with suspension or erasure. These figures suggest that the system is grossly disproportionate: most complaints shouldn't have been made, and of those that were investigated the 'conviction' rate (if I can put it like that) was incredibly low. Does this represent value for money - or an efficient use of resources? Almost certainly not. Some devolved method of local first line complaint investigation would at least allow only appropriate referrals to be made to the GMC.

If you had a magic wand, what reforms do you think could be implemented both from the GMC and doctors viewpoints which would bring about immediate improvement?

The real change must be a political mind-set one. The NHS is a cash limited organisation and the GMC and its progressively harsher regulation regime that now insinuates itself into every aspect of a doctor's personal and private life may be regarded as a useful means of controlling a notoriously independent minded workforce. In the junior doctor strikes in 2016, the GMC intervened in an unprecedented way warning doctors about the effect of their actions-despite the fact that (whatever ones views on this may be), industrial action is entirely legal.

The time is right now for a 'medical reformation,' where the Victorian GMC is completely reformed and slimmed down to undertake its core function of maintaining a list of medical practitioners (and perhaps investigating the most serious transgressions), with region based medical tribunals taking its place. I wrote of the need for such a change in the BMJ in 2011 (http://www.bmj.com/content/342/bmj.d2895): "To move towards such a world would require, as happened in the late Middle Ages in Europe (then in a religious context), nothing less than a Reformation. It would require that the royal colleges regain their primacy in determining standards and directing postgraduate education; it would require that doctors renounce their corporate allegiances as de facto civil servants. And it would require the General Medical Council to tear itself away from its comfortable position as a Department of Health quasi-quango."

Is revalidation a costly waste or a necessary step forward?

Revalidation was introduced in 2012 following Dame Janet Smith's recommendations in respect of the Shipman inquiry. Suggested by some as a method of improving healthcare by reflective practice, continuing medical education and appraisal and others as a method of catching bad or dangerous doctors, it has not demonstrably fulfilled either goal and with it has failed to win the support of doctors. Revalidation is regarded by most doctors on the shop floor as a costly misuse of time and resource. Tellingly, the GMC's interim survey on revalidation found that about one third of doctors had a negative impression of revalidation, one third neutral and one third positive (http://www.gmc-uk.org/UMbRELLA_interim_report_FINAL.pdf_65723741.pdf). Over one half of those surveyed said that it made no difference to their practice. Furthermore, in this era of evidence based medicine, there is no evidence at all that it improves patient safety, improves the quality of medicine or that it picks up underperforming or dangerous doctors. This may be why few other countries undertake such a system. The immense bureaucracy associated with its introduction has undoubtedly created a burden for employing organisations. A perhaps unintended consequence is that several doctors nearing retirement simply cannot be bothered to undertake the process; this is a terrible shame-and waste of senior doctors whom we really should be doing everything we can to maintain in practice. In 2014, the GMC withdrew a licence from 24 doctors following a non-engagement recommendation and in 2015, this number increased to 62.

Dr Lees is speaking in a personal capacity and his views are his own

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Who benefits from Fitness to Practise hearings being conducted in public?

It is claimed that it is in the interest of transparency. But is it?

John Quinn is a Senior Associate in Noble Law Solicitors Medical Regulatory Law Group and a qualified Attorney-at-Law in New York. He advises clients in relation to regulatory complaints, fitness to practise hearings, disciplinary hearings, commercial disputes, injunctions, judicial review, insolvency, tortious claims, defamation and employment matters. His aim is to start a conversation among doctors about the shortcomings of the current regulatory regime, so that positive changes for the profession and the public can be achieved.

John Quinn

Under the Medical Practitioners Act, 2007, Fitness to Practise hearings are, for the most part, heard in public, in an apparent effort to be in the interest of transparency. But is it? I think, although public hearings add to the perception of transparency, the current statutory regime, swings the balance grossly against the doctor's constitutional right to earn a livelihood.

The Medical Council's purpose is to protect the public. Arguably there are times when they stray more into punishing the doctor rather than protecting the public, which are not necessarily the same thing.

This has perhaps been brought sharply into focus by the recently publicised case of Doctor Salah Aziz Ahmed, in Cavan General Hospital. This involved the longest running (and arguably most costly) Fitness to Practise hearing, since the Medical Practitioner's Act 2017 came into force. The Fitness to Practise Committee investigated 18 complaints against Dr Aziz, only one of which upheld a finding of poor professional performance.

This begs the question; who benefitted from this public process? Certainly not the doctor, who, regardless of the vast majority of the complaints not being upheld, has spent three years suspended from duty, awaiting the outcome of this unnecessarily protracted hearing. It must be remembered that there is quite often, a catastrophic and sometimes tragic human story behind the regulatory hearings. The patients, and their families, have also endured a three year long process in this case, the result of which has the potential to destroy the reputation and career of a doctor who has been successful in defending 17 of the 18 complaints made. Is this a fair outcome and does it serve to protect the public?

Perhaps there should have been a more stringent process at the start to distil through all of these complaints and assess whether they were worthy of further investigation. Moreover, I think it is fair to question the benefit of holding such hearings in public, by default, when the net result is a pyrrhic victory for the doctor, where he has been substantially vindicated, but is unable to reclaim the reputational damage (or the financial loss) he has suffered in the meantime.

Under the previous statutory regime (most recently governed by the Medical Practitioner's Act 1978), hearings were heard in private. The argument can be made, that they were perhaps shrouded in secrecy or kept "in house". Under the 2007 Act, the dynamic switched to hearings being held in public unless an application (by either the doctor or the complainant) is made to have the hearing heard 'otherwise than in public'.

Following the initial investigation of the complaint, the Medical Council has the power to seek suspension of the doctor's registration pending the hearing, if the Medical Council is of the opinion that such suspension is necessary to protect the public (s60 of the Act). Generally the doctor can avoid this suspension by voluntarily undertaking (pursuant to section 67 of the Act), not to practise pending the outcome of the hearing.

This means that, under the current legislation and regulatory regime a doctor can't practise during a process that could last up to three years, even though the doctor has not been found guilty of professional misconduct or poor professional performance. If the doctor operates under a public contract, they may be suspended on pay but if a doctor has a private practice then they will lose that, and the patients lose out also. Given the reputational damage a doctor may suffer in the meantime, the reality is that they quite often, never regain the confidence of the public and their career in Ireland is at an end.

An obvious example of this is the esteemed Professor Martin Corbally; who was successful in appealing Medical Council sanctions to the High Court. The Medical Council appealed the High Court ruling to the Supreme Court where Professor Corbally was once again successful, in what was a scathing judgement of the Medical Council. Although he was ultimately vindicated, Professor Corbally endured a 7 year public ordeal to clear his professional name.

Sadly, Professor Corbally now practises in Bahrain and the Irish public, whom the Medical Council were established to protect, have lost his talent and experience.

Pursuant to s65 of the 2007 Act, the Fitness to Practise Committee has the power to hold the hearing "otherwise than in public", if it is satisfied that it is appropriate to do so in the circumstances. The Sunday Times have recently (and repeatedly) pursued a campaign

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> Mistakes can happen but the question is whether they should end a career, particularly when those mistakes are deemed to have not fallen short of the expected standard.

against a former high profile obstetrician/gynaecologist. Strikingly however, this particular case was deemed by the Fitness to Practise Committee to be an appropriate case for a private hearing. The Sunday Times, ran an article about that decision with the headline "Patient denied public hearing". The article then proceeded (as did articles in subsequent editions) to discuss the minutia of that private hearing, thereby rendering the decision to hold the hearing otherwise than in public (along with the carefully considered and valid reasons for doing so) irrelevant. Unlike the High Court, who can hold parties in breach of its "in camera" rulings, in contempt of court, the Medical Council hold no such powers under the Act to enforce their own decisions regarding the conduct of the hearing. This flaw under the Act, leaves a doctor with little recourse other than a complaint to the Press Council, unless they wish to embark on costly and ill-advised High Court Defamation proceedings. Further, the repeated publishing of information, that was, for the most part, originally published over four years ago, can hardly be said to be in the best interests of the public, but instead feels more like a witch hunt designed to maintain a culture of fear and mistrust in doctors, who dedicate themselves, ironically, to the service and protection of the public.

While I absolutely agree that protecting the public is of the utmost importance, I do wonder whether the current approach is an appropriate way to do so. The balance is skewed; I think it arguably interferes with a doctor's constitutional right to earn a livelihood and that a better balance could be struck with a private hearing and but a publicly published finding. Certainly, if someone's conduct warrants a serious sanction then the public should be aware of it, but only after the doctor has been afforded the opportunity for fair procedures and the investigation and hearing has been completed. The Medical Council rarely now issue their full ruling, but instead simply issue the final decision. I believe the public would be better protected by the publication of the full decision, whether the complaint is upheld or not, following a private hearing, which save in exceptional circumstances, would allow the doctor to continue working and maintain their professional integrity and reputation pending the outcome.

The current statutory regime lends itself to criticism that, while it may be intended to protect the public, it is instead, more often than not, seen by doctors as a vehicle for naming and shaming the complained against doctor, before the doctor has had the benefit of fair procedures, thereby punishing the doctor rather than protecting the public.

Doctors are people too; they have personal lives, neighbours, families and friends, which can be forgotten. Mistakes can happen but the question is whether they should end a career, particularly when those mistakes are deemed to have not fallen short of the expected standard.

Top lawyer to question current Medical Regulatory regime

Experienced laywer Felix McTiernan will use the platform provided by the autumn conference to review recent Irish Medical Council (IMC) and Court decisions that raise question marks over the current Medical Regulatory regime.

For instance, he will ask if the Medical Practitioners Act 2007 is fit for purpose? Does the statutory mandate of 'Better Protecting and Informing The Public …' strike a fair balance between the interests of the public and the interests of the medical profession? Is the Preliminary Proceedings Committee fulfilling its intended role?

In a thought-provoking section, Mr McTiernan will also question whether the lay majority on the IMC works well and whether the default position should be that complaints are heard in public, in addition to asking whether the time has come to introduce reporting rules in relation to IMC hearings.

Mr McTiernan is one of Noble's founding partners and Head of Litigation and Commercial Property.

He is a highly experienced lawyer with dual specialities in commercial property and commercial litigation and is a widely recognised leader in these fields. He has acted as consultant to the Law Society's Conveyancing Committee and lectured for many years in property law and conveyancing.

He was appointed by the Minister for Justice to act as an adjudicator in Garda complaint cases. He is also a former member of the Law Society's Litigation Committee and a former vice president of the German-Irish Lawyers Association.

Felix McTiernan

Martin Timmons

JUST CULTURE - EVALUATING OPEN REPORTING AGAINST PROTECTING INDIVIDUALS

Ryanair Deputy Director Safety and Security Safety Manager, Captain Martin Timmons will be addressing October's conference on the topic of 'Just Culture'.

He believes that the subject of just culture cannot be scrutinised without first taking a number of definitions into consideration.

The first of which is safety, for which he cites the definition: "[Safety is] a state in which the possibility of harm to persons or of property damage is reduced to, and maintained at or below, an acceptable level through a continuing process of hazard identification and risk management".

He also alludes to the word culture, as characterised by the beliefs, values, biases and their resulting behaviour that are shared by members of a society, group or organisation, listing the three most influential cultural components as organisational, professional and national cultures.

Finally, he highlights the meaning of just culture itself as: "a culture in which front line operators or others are not punished for actions, omissions or decisions taken by them that are commensurate with their experience and training, but where gross negligence, willful violations and destructive acts are not tolerated".

On his talk this October, Captain Timmons intends to consider the significant differences in modern society between Air Accident Investigation, which investigates the purpose of accident prevention and learning, and Judicial investigations, which investigate the purpose of attributing blame.

With this in mind, one of the questions he intends to pose and explore is whether an organisation should encourage open reporting of near misses from frontline operators while still protecting the individual from litigation.

Is Medical Regulation Fit for Purpose?

Friday, October 06, 2017	
1.30 to 1.55 pm	Registration & Coffee
1.55 to 2.00pm	Moderator: Dr. David Walsh, Consultant, Medical Advocates
2.00 to 2.15 pm	**Is the MPA 2007 Fit for Purpose?** Mr. Felix McTiernan, Noble Law Solicitors
2.15 to 2.30 pm	**Employer & Regulator Legal Co-responsibility in Regulatory Hearings** Mr. John Quinn, Noble Law Solicitors
2.30 to 3.00 pm	**Lessons for Consultants in Ireland**; Professor Martin Corbally
3.00 to 3.30 pm	**Lessons from the UK**: Professor Christoph Lees, octors Policy Health Group (Civitas)
3.30 to 4.00 pm	**Lessons for Irish GPs**: Dr. Marcus De Brun
4.00 to 4.30 pm	**The Transforming Effect of 'Just Culture' in Supporting Pilots While Enhancing Passenger Safety** Capt. Martin Timmons, Deputy Director Safety & Security, Ryanair
4.30 to 5.00 pm	**Effective Medical Regulation is Really about the Patient** Dr. Liam Twomey
5.00 to 5.25 pm	Contributions & Discussion
5.25 to 5.30 pm	Closing Remarks: Dr. Tony Walsh, Consultant, Medical Advocates
5.30 pm	Drinks Reception

To register please email: support@medicaladvocates.ie

Venue: Churchtown House, Weston Park, Dundrum, Dublin 14.

A conference co-hosted by Medical Advocates (www.medicaladvocates.ie) & Noble Law Solicitors (www.noblelawsolicitors.ie). To book your place please email support@medicaladvocates.ie on or before 30th September 2017