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Medical Protection Society

Saturday, August 10, 2019

(Room 9)

16:30 - 18:30 WS #126: MPS Medicolegal Forum - Risks and Outcomes: How to Protect Yourself (120mins, rot repeated)

Medical Protection

TEN PITFALLS TO AVOID IN GENERAL PRACTICE.

GP CME CHRISTCHURCH 2019.

Dr Lucy Gibberd & Dr Samantha King,
Medical Protection Medical Advisers.

Today’s aims

1. Discuss common issues using actual cases.
2. To answer your questions .
3. Reassure you!

Top 10

1. Good communication.
2. Results management.
3. Good clinical notes.
4. Responding to complaints.
5. Privacy.
6. Medication errors.
7. Setting good boundaries.
8. Rest homes.
9. MCNZ update.
10. HPDT.

1. Good Communication

Do you agree?

Your patient will not become a complainant if they continue to value the relationship more than the right to complain.

Thus the paradox

Most errors do not lead to complaint; most complaints do not arise from errors.

Communication is paramount

70% of litigation is related to poor communication

Beckman, 1994

The scenario

- Patient attends with her social worker for renewal of her sickness benefit. Has not seen this particular doctor before but has attended clinic previously. Doctor decides needs to look for part-time work or training.
- Social worker expresses concern at this in view of history.
- Doctor supports his approach saying ‘there are many severely crippled people working full-time including many of my patients who are mentally retarded. Also crippled people managing farms and people without limbs lecturing around the world.

The scenario

- After insistence from the patient & social worker they were told ‘only people who are under the ground – ie dead – cannot work.’

What do they do?

Initial HDC response – no MPS input

Includes phrases such as:

“The social worker filled her letter with lies. I am now worried that she has done such a dirty job before many times and has put false information about children she is dealing with.”

“Her first letter to us was also full of lies.”

“She also lied in her letter to you.”

“I feel I have done my job very well & dealt with her care in a professional manner. However, it has happened many times before that these type of people, if you do not do what they want, complain against doctors with many lies.”

What does the HDC decide?

Case 1

- Jan 2015 woman in mid-30's presented with scalp infection.
- Advised would be given antibiotics for 3 months and shampoo.
- Prescription for tablets but no shampoo.
- Initial improvement then gradual onset of new onset acne, tired & lethargic, poor concentration, feelings of paranoia especially while driving, rapid heart beat and feelings of anxiety at night.
- Got 2nd month's repeat & noticed name on box different – Anten. Researched on internet = doxepin.
- Should have been doxycycline.

Case 1

- 17 Feb, talks with nurse early morning & says I think I have been prescribed anti-depressants instead of antibiotics.
- Nurse is ‘surprised’ and says someone will ring back.
- Patient rings practice on afternoon of 19 Feb as has not been rung, and nurse tells patient wrong drug had been prescribed at original consult.
- Nurse gives instructions on how to wean off Doxepin and arranges prescription for Doxycycline – further $25 pharmacy fee.
- One week later still no word from GP so complaint to practice via HDC advocate.

Case 1

- Next day Dr rings Medical Protection, is advised this is a matter HDC likely to take very seriously and given advice on what to do.

What did Medical Protection advise?

Case 1

- Apology letter ‘for the errors I have made’ both in initial prescription and not contacting patient once error apparent.
- Offer to meet (at no cost of course).
- Refund of consultation and extra prescription cost.
- ‘Hope that I can win your trust once again.’

How does the patient respond?

Outcome: cordial meeting & relationship apparently restored

Hi Dr N

Thank you for your email. I appreciate your response.

I am glad this hasn't made things awkward between us and I hope for you to still be my doctor in the future.

An update on me, I stopped taking the anten on Sunday and things are starting to look better for me. Well I think they are. Hope so.

Have a good day and I'll see you on Thursday.

Cheers

Continuing to value the relationship

People forgive mistakes if doctors sit down and tell the patient what happened and help them through it.

Wendy Brandon; Previous Chair, MPDT

Good communication

1. Be personable.
2. Eye contact.
3. Make a human connection.
4. Don’t interrupt unless necessary.
5. Summarising what you have heard.
6. Closed loop communication.
7. Body language.
8. Beware of humour.

2. Managing results

Case 2

- Patient, Mr A, a 74yr old man who saw a locum Dr D who performed DRE and PSA as part of screening for the prostate.

- 15 October 2014 the PSA was 7.2ug/L (0.0-6.5).

- Dr C checked the result and documented a repeat PSA in 6/12, probably BPH. No recall was set and the patient wasn't informed of the result.

Was it necessary to inform the patient ?

Case 2

- 21 April 2015 Mr A was recalled for CVD bloods by the nurse. Included was a PSA test. This test was never done.

How important is it to chase these bloods?

- 1 May saw Dr B for unrelated matters. Dr B ordered a test for PSA but did not inform Mr A due to time constraints. No notes documenting the blood test.

Was it necessary to inform the patient about the PSA in light of the recent recall?

Case 2

- 4 May Mr A's PSA result was 10.5ug/L. Dr B felt this was a borderline result. Mr A wasn't informed of the result. A repeat test was planned for 3/12.
- On the recall date the nurse sent a request form to Mr A for CVD bloods, PSA was not requested.
- 5 November 2015 Mr A saw Dr C with urinary symptoms. His prostate was enlarged and nodular, PSA was 15.3ug/L. Prostate Cancer was diagnosed.

Case 2

Outcome

- Dr C was found in breach of Right 6 The right to be fully informed. Dr C failed to inform Mr. A of the prostate result, its implications and the plan to retest in 6/12.

- Dr B breached Right 4 The right to services of an appropriate standard. Failure to rule out other causes of the raised PSA , failure to document relevant clinical information including the reasons for ordering a PSA, his assessment of the result and plan to retest.

Case 2

Outcome

- Dr B also breached Right 6 by failing to provide information regarding the PSA test, the results, implications and management.

- The Medical Centre was breached for mismanagement of the recalls. Adverse comment was made about the Test Result Policy.

Learning points

Communicate with your patients:

- Informed consent for blood tests.
- How the results will be given to them.
- What you plan to do.
- Right under the Code
- Shares responsibility with the patient as a safety measure.

Learning points

Setting tasks:

- Decrease cognitive load.
- Ensure instructions are clear for the staff.
- Coordinating tasks (2 recalls in short space).
- When and how often do you chase?

Case 3

- An elderly man fell off the ladder from the roof and suffered multiple fractures, including the pelvis.
- The verbal report from the CT only noted the fractures, missing the enlarged mesenteric lymph nodes.
- The formal report included comment about the lymph nodes but this report was not seen by any clinician at the DHB.
- A copy of the report was sent to the GP practice. This was seen and filed without action by a locum, who then returned overseas.
- The diagnosis was not made for 6/12

Was the locum at fault?

Case 3

The HDC

- No criticism was made of the GP locum. The primary responsibility fell to the DHB.
- The patient was still in hospital at the time the result was seen by the locum, who possibly assumed the result would have been acted on in hospital.
- However, as nothing was annotated in the clinical notes, the regular GP was unaware of the report and this contributed to further delay in diagnosis of the rectal carcinoma.

Case 4

- 18 February patient is seen in ED with left chest pain with exertion, SOB and chronic cough.
- ED Dr diagnosed pneumonia. Patient declined admission. ED Dr advised GP review, but no timeframe was given.
- Patient did not see the GP.
- Radiologist advised repeat CXR in 2 weeks. Neither ED Dr or GP acted on this.
- Lung cancer was finally diagnosed one year later.

Whose responsibility is it to act here?

Principles

If you order a test it is your responsibility:

- To review, interpret and act on the results in a timely manner.
- To ensure that responsibility for the patient is passed on appropriately.
- Ensure the patient is informed and any necessary action is taken.

Principles

Unless communication has been received about who is responsible, clinicians who have been copied into test results should double check that the result has been actioned and the patient has received appropriate follow up.

In this case, comment made by the GP expert.

Principles

I think it unreasonable to expect primary care providers to have to check with their secondary care colleague as to who is taking responsibility for management of every significantly abnormal result… that they are copied in to.

In this case, comment made by the GP expert.

Case 4

The HDC

- GP received an adverse comment for not being more proactive in confirming his assumption that the ED Dr would order the repeat CXR.
- The Commissioner recommended that the DHB review its process of handover of care to the GP.
- The Commissioner recommended the National CMO Group work to put clear guidelines in place.

And still we wait...

Principles

RNZCGP:

Some situations – where the duty of care to the patient has been **clearly** transferred to the GP (including clinical details) – or where the result indicates a life-threatening situation, **call for the GP to act**.

3. Good Clinical Notes

Case 5

- Jane was a shift worker in her 40’s.
- Was seen 16 times by 6 different doctors over an 18 month period.

What are the risks with this setting?

Continuity of care

- Right 4(5) of The Code : mandates co-operation among providers to ensure quality and continuity of services.
- Part time GP's, registrars, acute / overflow doctors, locums.
- What are your policies?
- Are patients encouraged to see the same GP?
- The responsibility of the enrolled GP.

Case 5

- Jane's symptoms were varied and inconsistent.
- One of the GP's requested a pelvic US very early on to investigate LIF pain. Jane's symptoms improved but did not fully resolve. The GP confirmed the need for the US.
- Jane never had this done.

How much responsibility do doctors have? How much do patient's have?

Case 5

- As time went on Jane's symptoms became more consistent, with lower abdominal pain and change in bowel habit.
- One of the GP's (Dr L) noted that Jane had not returned to her for follow up appointment and discussed the case with two of her senior colleagues. They decided to get an overview of the history.
- Dr L took the time to read through the relevant file notes as many different GPs were involved.

Case 5

- As a result, Jane was referred again for US which showed free fluid in the pelvis and enlarged left ovary.
- Jane was referred to the gynaecology service who diagnosed ruptured ovarian cyst.
- Dr L was concerned that the Gynae team had missed something. She requested Ca 125, which was markedly elevated.
- A diagnosis of ovarian cancer was made.
- Sadly the patient died a few months later.
- Jane’s mother complained to the HDC.

The HDC complaint

None of the doctors were found to have breached The Code because they could demonstrate good care.

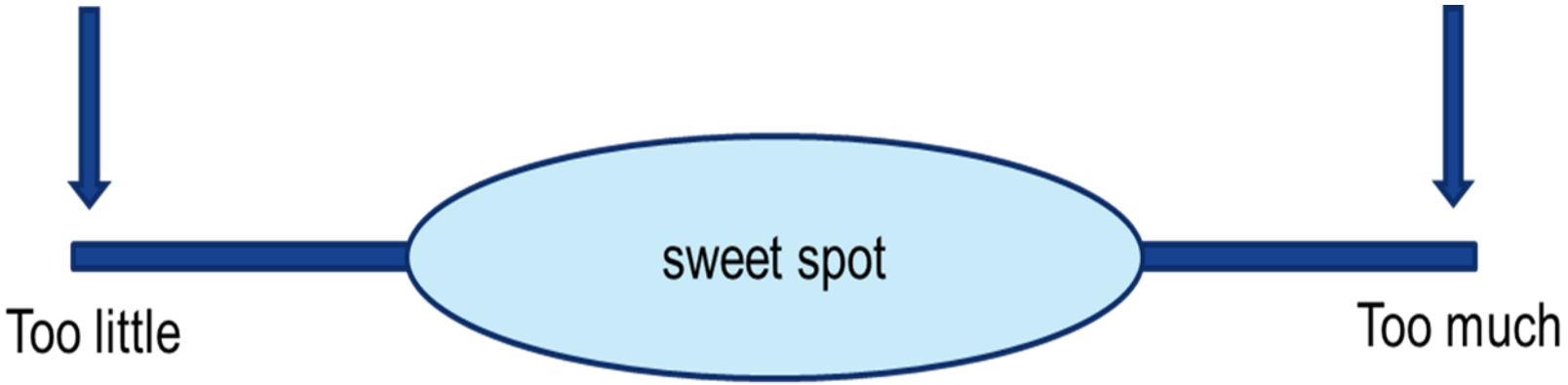
Learning points

- Helicopter view.
- Document the corridor conversations.
- Discussion of difficult cases – peer review within the practice.
- Good documentation.

Clinical notes

- Good documentation can save your patient's life. It can also save you when a complaint is made.
- Good notes save you time and emotional energy.
- Enable continuity of care, particularly if you lay out the plan moving forward.
- Read the problem list, medications, the last consultation.
- Document every encounter: phone, corridor consultations.

Getting the balance right



- When should you write more?
- When should you write less?

Relationship with the DHB

- It may not feel like it some times, but we are on the same side.
- Dr L questioned the diagnosis made by the DHB.
- Push if you need to, don’t accept that a referral that is knocked back is right.
- Consider, have I given the DHB enough information to make a good decision?

Altering clinical notes

- GP Student Health. An 18 year old patient was seen with longstanding constipation and haemorrhoids. She had tried many creams and laxatives without success. On examination a small haemorrhoid was seen. The GP referred the patient to a private surgeon.
- The patient had joined Southern Cross within the last few months. Southern Cross would not accept the claim as this was pre-existing condition. Father sent an angry email wanting the notes amended as the patient's history was less than a year. Also wants a letter to Southern Cross.
- There were no previous notes on file.

What should the GP do?

When is it OK to alter notes?

4. Responding to complaints

Complaints are…

- Common.
- Stressful:
  - Discuss with peers.
  - MAS/MPS counselling.

Guiding principles of good complaint handling

- Follow a good process.
- Be patient focused - try to put things right.
- Be open and accountable.
- Act fairly and proportionately.
- Seek continuous improvement.

Pitfalls of poor complaints handling

- More work and stress.
- Damage to reputation.
- Escalation to HDC, MCNZ.
- Failure to learn…more complaints!

Reasons why complaints may be escalated

- Unnecessary delay in responding.
- Response incomplete/poor explanations.
- Factual errors in response.
- No acknowledgement of mistakes.
- Inadequate apology.
- Inadequate system changes.

When a complaint occurs

- Early resolution is in everyone's interest.
- Be the first to discuss with patient.
- Be transparent (open disclosure).
- Seek advice and assistance (MPS).
- Seek support: colleagues, counselling?
- Let your family know.

Obligations under the Code of Rights

- Right 10 – right for consumer to complain and duties providers have in assisting with complaints.
- Providers must have a complaints procedure and follow this.
- Providers must facilitate the fair, simple, speedy, and efficient resolution of complaints.

Obligations under the Code of Rights

To have a complaints procedure where:

- Acknowledgment within 5 days.
- Response within 10 days or consider how much more time required.
- If 20 days or more, then notify complainant why.
- Monthly updates.
- Provide information about your complaints procedure and give details of HDC/Health Advocates.
- Document complaint and actions taken. NOT in the clinical notes.
- Complainant given all information relevant to complaint.

5. Privacy

Privacy


© Mike Baldwin / Cornered
BALDWIN
"Somehow your medical records got faxed to a complete stranger. He has no idea what's wrong with you either."

Brain teaser

- Demented female patient, daughter concerned the husband (not her father) is violent to her mother.
- Geriatric assessment - no evidence of this but admitted to rest home.
- Husband attentive, community carer spreads rumours that patient admitted because husband assaulted her.
- Police involved, trespass order for husband not to approach care.
- Husband has EPA, unaware daughter has made allegations against him.
- Daughter gone to court to get EPA in her favour.
- Court likely to request opinion from GP whether husband still fit to be EPA.
- GP thinks daughter is very believable, genuine, and likes her.
- GP has all 3 as patients.

Questions

- Does he have a conflict?
- Can he provide a report for the court that is honest and will keep everyone happy?
- If not, which way does he lean?
- If there is a conflict of interest, can he keep all 3 as patients?
- If there is a conflict of interest, who does he keep as patients?
    - Female patient?
    - Husband?
    - Daughter?
    - Combination?

Privacy and lawyers

- Client requests access to his file.
- Large file – nearly 96,000 pages!
- Firm delayed responding then informed him it would cost –
    - $500; $1000; $5,000; $10,000; $20,000 – which do you think?
- Complaint to OPC - decision breach as failed to provide information within 20 days.
- Client would be happy with information digitally on USB stick - $7.99. OPC set charge at $7.99
- Lawyers refused to back down, client filed complaint with HRRT.
- When informed of this, lawyers delivered 2 boxes of files, client had them copied, returned originals.

Privacy & GPs

- 18 March 2019 media release – Wellington GP.
- 133 patients sent ‘group’ email that revealed identities of patients by their email addresses (visible to all recipients).
- Receptionist had used the ‘to’ section for the addresses rather than the ‘bcc’ section.
- What action should the GP take?
- 2 days later email apologising for breach.
- Ironically – the original email was to inform patients the practice would stop using ‘ordinary email’ as it was not ‘secure enough for private health communication between GPs and patients.’

Releasing notes

- Parents requesting children’s notes.
- Relatives requesting notes after a patient has died.
- Patient’s requesting their own notes.
- Police requesting notes.

Releasing notes quiz

1. Mother has custody of 5yr old girl. Father who has access one weekend a month requests copy of her notes – no reason given. Doctor has no other background information.

Releasing notes quiz

Answer

- Ask why he wants the notes (he doesn’t have to tell you).
- What specifically is in the notes (narrow it down if possible).
- Is there anything contentious in the notes?
- What is in the child’s best interest?
- Must release to a parent (regardless of custody) unless you have a good reason to withhold.

Releasing notes quiz

2. Parent requests notes of 13 year old daughter who was brought into practice by school nurse 2 weeks ago.

- Does the child get a say?

- Do the rights of the child outweigh the parents right to the notes?

Releasing notes quiz

Answer

- Ask the patient.
- Assess Gillick competence.
- What is in the child’s best interest?
- The decision is best made by the clinician (rather than the practice manager) because they know more about the circumstances.
- The competent child’s consent or refusal outweighs the parent’s right.

Releasing notes quiz

3. Wife requests notes of husband who died of natural causes 2 months ago.

Releasing notes quiz

Answer

- Ask who the executor of the will is.
- Ask why she wants the notes (she doesn't have to tell you).
- Specify what information (narrow it down).
- Read through and redact information as needed: third party information, information you know the patient would not want released.

Releasing notes quiz

4. Wife requests notes of husband who died of natural causes to check if any inheritable disease which may affect child. Husband had no will.

Releasing notes quiz

Answer

- What information and why?
- Is the wife NOK?
- Limited release.
- Who is going to complain?

Releasing notes quiz

5. Mother requests notes of adult son who committed suicide 5 years ago. Son had no will.

Releasing notes quiz

Answer

- Who is NOK?
- What is in the notes.
- Consider the family dynamic: would the son have wanted his mother to have his health information?

Releasing notes quiz

6. Daughter, who holds EPA, requests notes of mother who is in dementia unit.

Releasing notes quiz

Answer

- The EPOA is enacted.
- The daughter’s consent is as though the patient consents.
- Again consider what needs to be redacted.
- Must release unless there is good reason to withhold.

Releasing notes quiz

7. Daughter, who is nominated as EPOA, requests notes of mother who is living independently at home.

Releasing notes quiz

Answer

- Is the EPOA enacted?
- If not seek consent of the mother.

Releasing notes quiz

8. Acrimonious divorce. Mother has full custody of their 11 year old son. The son has disclosed to the GP that the father has threatened him whilst on a day's outing. The son felt very unsafe. The father requests the child's notes. He asks that this be kept confidential.

Releasing notes quiz

Answer

- Non-custodial parents retain their right to their child's HI. However this his has limits.
- The mother cannot veto this. The views of the mother to be taken into account, however the father has asked for this to be kept confidential.
- Is the child Gillick competent?
- What is in the child's best interest? This is paramount.

Releasing notes quiz

9. Police request notes of anyone who has presented with burns in last 48 hours (investigating a murder).

Releasing notes quiz

Answer

- Under legislation we have a discretion to co-operate with the police.
- Safest to get consent from the patient if possible.
- This request is very broad, ask the police to narrow the request to a specific person.
- How urgent is the request. If not urgent ask for a Production Order
- What is in the patient's best interest? Consider the seriousness of the crime being investigated, what would the patient want.

Releasing notes quiz

10. Police request notes of a patient who is missing, there are concerns for their safety.

Releasing notes quiz

Answer

- Assess urgency, is there time for a production order?
- Are you more likely to get a complaint about releasing or not releasing?
- Consider if the patient would want this information released.
- What is in the patient’s best interests.
- Discretionary.

Releasing notes quiz

11. CYFs request parents' and child's notes under section 66 1 (a) and (b) of the Children, Young Persons and Their Families Act, 1989.

Releasing notes quiz

Answer

- Child’s notes can be released if in their best interests, this is discretionary.
- Parents health information: best to obtain consent. Consider trust in the therapeutic relationship. If the notes are supportive of the parent they will likely give consent.

Releasing notes

- Parents requesting children's notes – the child's best interests are paramount, can be complex, ask if not sure.
- Relatives requesting notes after a patient has died – ask who is executor/administrator of estate. Beware of warring siblings.
- Patient's requesting their own notes – must be released unless you have a good reason to withhold. What can reasonably be redacted?
- Police requesting notes – consent/Production Order/discretion.

Patient Portal –
the Good , the Bad and the Ugly

The Good:

- Patient ease of access.
- Reduce work load in notifying results.
- Allows patients to correct their health information.

The Bad:

- Patients may question what is written in notes.
- Patients may be concerned re abnormal bloods which are not significant.
- Providers may feel limited in what they write in the notes.

The Ugly:

- Patients aware of diagnosis before told in person.
- Generate complaint after seeing adverse comment in notes.
- Other health providers unaware that patient will see their letters.

Sharing information with colleagues

- Need systems to ensure patients know how information is shared between clinicians. Beware of cut and paste of clinical notes. Does the entire problem list need to be sent?
- Seek patient's permission to share information and then provide information to colleagues without delay.
- Most situations don't share information if patient does not agree.

Testsafe

- Doctor sees patient in the afterhours clinic for a sore ankle. The patient has given the nurse her regular medication list. The patient denied needing more analgesia. The doctor accessed Testsafe and found her last prescription for a variety of medications, including medications the patient has not disclosed.

- The patient complains that the doctor has breached her privacy. Is this true?

Can we access Testsafe:

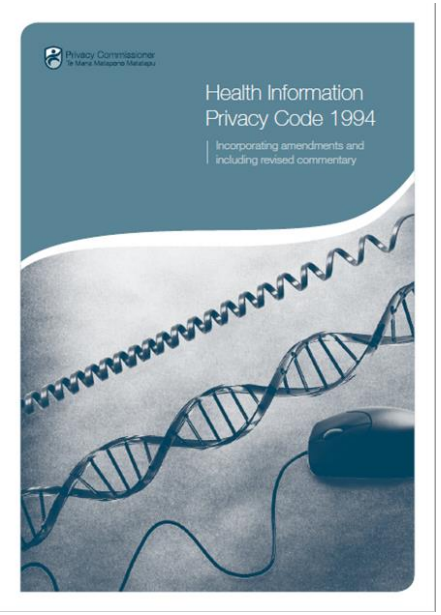
- For our enrolled patients.
- A&M setting.
- If they've made a complaint about us.

The messages

- Privacy issues are complex.
- Even with best intentions, it is easy to slip up.
- If in doubt about either keeping or releasing information contact your indemnifier.

Resources

- privacy.org.nz for further information on the Health Information Privacy Code and online tutorials regarding privacy.
- Webinar on Privacy in Prism at medicalprotection.org/nz.



6. Medication errors

Case 6

- Experienced, competent GP. A petite elderly patient with pain issues, on multiple analgesics. The GP wanted to rationalise the patient's medications in order to ensure her safety. The patient is asked to come for a consultation.
- During the consultation the GP decides to stop other medications and prescribe fentanyl patches.
- Accidentally prescribes 100ug patches instead of 12.5ug patches. (a click of the button on the computer). The prescription is generated on ordinary paper, not on CD form.
- The pharmacist calls and asks for the prescription on a CD. The GP prescribes the correct size patch on a CD form.

Case 6

- The pharmacist however has already dispensed the medication…..
- The error is not picked up until the next morning when the prescriptions are being reconciled by the pharmacy.
- They call the GP. The patient isn't answering the phone.
- They race over to the house and the patient doesn't answer the door.
- The police are called and break into the house.
- The patient is unarousable but alive and is taken to hospital.
- An HDC complaint is lodged.

Errors in general practice

- Occur in <1/1000 consultations

  (Sanders et al 2003)

- Prescription errors are the largest single cause

  (Rubin et al 2003)

- 30-40% cause patient harm

  (Rosser et al 2005)

Beware

- Medication alerts:
  - Alert fatigue.
  - Generic v trade names.
- Interactions.
- Unfamiliar medications.

7. Setting Boundaries

Demanding patients

- Male patient repeatedly arrives without notice and demands an appointment with the doctor. On one occasion the patient came around behind the receptionist and stood directly behind her whilst demanding an appointment.
- On the phone shouts and at times swears at the receptionist.
- Demands repeat prescription without seeing the doctor.
- Refuses to pay his account despite many letters from the practice manager.
- In a 5 doctor practice only 2 have not seen this patient.

What do you do?

Demanding patients

Can you safely disenrol the patient?

What are the grounds for instant disenrollment?

Do the other doctors need to take the patient?

Demanding patients: writing boundary letters

- The patient has chronic pain, is on morphine for only short term use whilst suffering from Hep C to avoid having to present acutely to ED.
- The patient refuses referral to pain clinic or any secondary care review. He also refuses investigations for Hep C, therefore cannot receive treatment for it.
- The patient has called multiple times, demanding a script for tramadol and triazolam. He has been abusing the reception staff.
- He refuses to come to the practice or pay the script fee. He accuses the practice of playing games with him and wasting his money. He also has a very large account that he refuses to settle. The practice had provided supporting letters for WINZ to assist but the patient has not acted on this.

Have a go

- Spend 10 Minutes to draft a boundary letter.
- We will ask one or two to share their draft.

8. Rest homes

Case

The story

- Elderly patient in rest home has significant peripheral vascular disease with previous leg amputation.
- Patient develops a sacral pressure sore measuring 26cmx18cm.
- The GP only finds this out when he enters the patient’s room and is hit by the odour of necrotic tissue.
- Patient is treated in the rest home as they feel active intervention perhaps futile.
- Son sends patient to hospital. Patient dies.
- Hospital writes risk of harm letter.

Case

The story

- GP had concerns about the care provided
- The rest home had not notified the GP of any concerns about the pressure sore
- 2 GPs were visiting

Rest homes

- 3 way relationship.
- Documentation.
- Tracking tasks.
- Clear policies regarding communication, when to be contacted.
- EPOA.
- DNR.

9. MCNZ updates

MCNZ recent statements – standards for doctors:

1). Providing care to family etc.

- November 2016 release and still tripping up our members.
- Definitions of family member, someone close to you, and care very broad.
- General guide – where the relationship could reasonably be expected to affect your professional judgement.
- Exceptions in urgent situations; small communities etc.
- Must not – prescribe medications with risk of addiction, psychotropic medications, controlled drugs; undertake psychotherapy; issue certificates including ACC; perform invasive procedures.
- Can now treat staff – MPS advice is avoid this.
- Very different rules in different countries & in different cultural groups.

MCNZ recent statements – standards for doctors:

2). Professional Boundaries Nov 2018

- Doctor's responsibility to maintain the boundaries.
- Usually unethical to accept gifts – exceptions.
- Financial dealings with patients generally unacceptable.
- Unwise to hold EPA for a patient.
- All communications especially electronic must be professional.
- Summary – don't accept that Mercedes, don't set up in business with patients & don't be a Facebook troll.

MCNZ recent statements – standards for doctors:

3). Sexual boundaries Nov 2018

- Area of increasing activity and concern for us
- Doctors responsible for maintaining boundaries.
- Never OK to have sexual relationship with patient.
- Only conduct a physical examination when it is clinically indicated & with patient's informed consent – implications.
- Definition – breach of sexual boundaries comprises any words, behaviour or actions designed or intended to arouse or gratify sexual desires. Not limited to physical behaviour – is anything that could be interpreted as sexually inappropriate.
- 3 levels of inappropriate behaviour –
    - Sexual impropriety; transgression; & violation.

MCNZ recent statements – standards for doctors:

3). Sexual boundaries Nov 2018 (cont.)

- Impropriety – includes gestures or expressions that are sexually demeaning e.g. comments on patient's body or clothing, irrelevant comments about sexual orientation, requesting details of sexual history that are not relevant, sex life of doctor.
- Transgression – any touching of a sexual nature short of sexual violation, including propositioning a patient.
- Violation – legal definition – unlawful sexual connection etc.
- Good advice on warning signs, boundaries threatened.
- Obligation to notify – professional obligation to notify MCNZ if patient discloses alleged breach, even if patient does not consent to notification.
- Disclosure by a doctor they have breached sexual boundaries – ring MCNZ. Why the difference?

MCNZ recent statements – standards for doctors:

3). Sexual boundaries Nov 2018 (cont.)

- Former patients – never acceptable if doctor has provided counselling etc. for mental health issues, where patient has impairment likely to confuse their judgement, patient has history of sexual abuse, or where doctor-patient relationship terminated to initiate a sexual relationship.

- Intimate relationships with family members of patients – advise to exercise caution, implications on continuing seeing patient.

MCNZ statement – safe practice in environment of resource limitation

- Doctors have responsibility to support & advocate for patients affected by resource limitation.
- Responsibility to use resources with care – for example Choosing Wisely.
- Where doctors are affected by manpower shortages we have responsibility to attend to our own health needs & be alert to signs of burnout.
- If manpower shortages have potential to have negative impact on patient well-being have responsibility to notify management – preferably in writing.

10. HPDT case

Dr Z:
HPDT, High Court & beyond

- Information in public record, permanent name suppression.
- Rural GP & separate clinic cosmetic work including sclerotherapy.
- Previous issues with medication misuse, Health Committee monitoring.
- MCNZ notification – prescribing of pethidine tablets to single patient.
- PCC detailed and wide examination of practice – staff in tears.
- Other issues found so charges laid before HPDT – 7 charges with total of 68 particulars.
- Charges were around pethidine prescribing, treating family & staff, writing prescription in another person's name, misuse of IV diazepam.

Dr Z:
Example charge

- ‘That Dr Z is guilty of professional misconduct and has committed acts that amount to malpractice or negligence and/or that he has committed an act likely to bring discredit to the profession in relation to prescribing for colleagues.’
- Prescribed to colleagues and/or failed to record any or sufficient consultation notes and/or entered notes retrospectively as follows –
- Patient 1 – prescribed Duromine on 2 occasions; prescribed amitriptyline on one occasion and/or entered notes retrospectively.
- Patient 2 – prescribed Estelle, Duromine, amitriptyline, and diazepam on one occasion each and/or failed to record sufficient consultation notes.
- Other colleagues – prescribed pain relief, contraception, anti-reflux medication, asthma medication & topical creams to colleagues and/or failed to record any or sufficient notes.

Dr Z:
More detail

- Irony – by the time of the Tribunal treating colleagues had been removed from the statement on treating those close to you – Tribunal continued with the charges though.
- Pethidine issue serious – 2,230 tabs of pethidine 100 mg over period of 2 ½ years – 250 mg/day on average.
- Notes poor, prescribing pattern was unusual, chemists were rattled.
- Unusual patient, back injury, not working, returned to part-time work, no evidence of tolerance or side effects.
- Family prescribing mostly minor apart from anti-depressants and benzodiazepines – clearly in breach of statements.

Dr Z:
Diazepam allegations

- Occasionally did sclerotherapy with no clinical support, previous experience with seizure during sclerotherapy, therefore in habit of drawing up diazepam for IV use if needed.

- Poor records, no proper controlled drug book, usually disposed of unused diazepam without witness.

- Charges included that the quantities ordered were excessive and/or that the diazepam was ordered for the purpose of diverting and/or misusing the diazepam.

Dr Z:
HPDT hearing

- Took 6 days, PCC's expert grilled. Found guilty of more serious charges – pethidine & diazepam; more minor charges found not guilty on individual particulars but guilty cumulatively.
- Penalty 6 month's suspension, fines and conditions on practice – devastating outcome for Dr Z and us.
- Many legal holes in Tribunal's decision especially the diazepam. Tribunal essentially admitted it had no evidence the diazepam was being diverted, and agreed that it was not up to Dr Z to prove his innocence, yet found him guilty of diverting!
- After discussion on likelihood of success, and assessment by independent barrister, decision to appeal to High Court.

Dr Z:
High Court hearing

- Judge was very well prepared and did not put up with any rubbish.
- Very direct in his views on many aspects of the PCC's case and their lawyer, also critical that expert gave opinion on areas that they were not expert in and the Tribunal accepted that.
- Very detailed assessment of the roles of Tribunals and what they can and cannot do – for example, over-reliance on their own experience in deciding on a case, finding not guilty on individual particulars but cumulatively guilty.
- Result – 4 charges dismissed, 2 reduced significantly.
- No suspension, fine and costs reduced, conditions imposed.
- MPS claimed costs & awarded >20 k.

Dr Z:
The lessons

- Good notes would have helped immensely.
- Don’t treat family except in emergency.
- If your management regime is unusual keep even better notes including rationale for approach & evidence of patient consent.
- Don’t give up.
- Tribunals now have clearer standards to adhere to.
- Experts need better assistance & training.
- Why did the PCC go to such lengths to find evidence?
- How did the Tribunal get it so wrong?

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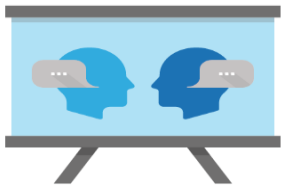

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