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NATIONAL RURAL HEALTH CONFERENCE

6/4/18

RURAL PRACTICE AND THE HDC - ARE RURAL GPS TREATED DIFFERENTLY?

Dr Tim Cookson, MPS Medical Consultant

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NO

- Questions?

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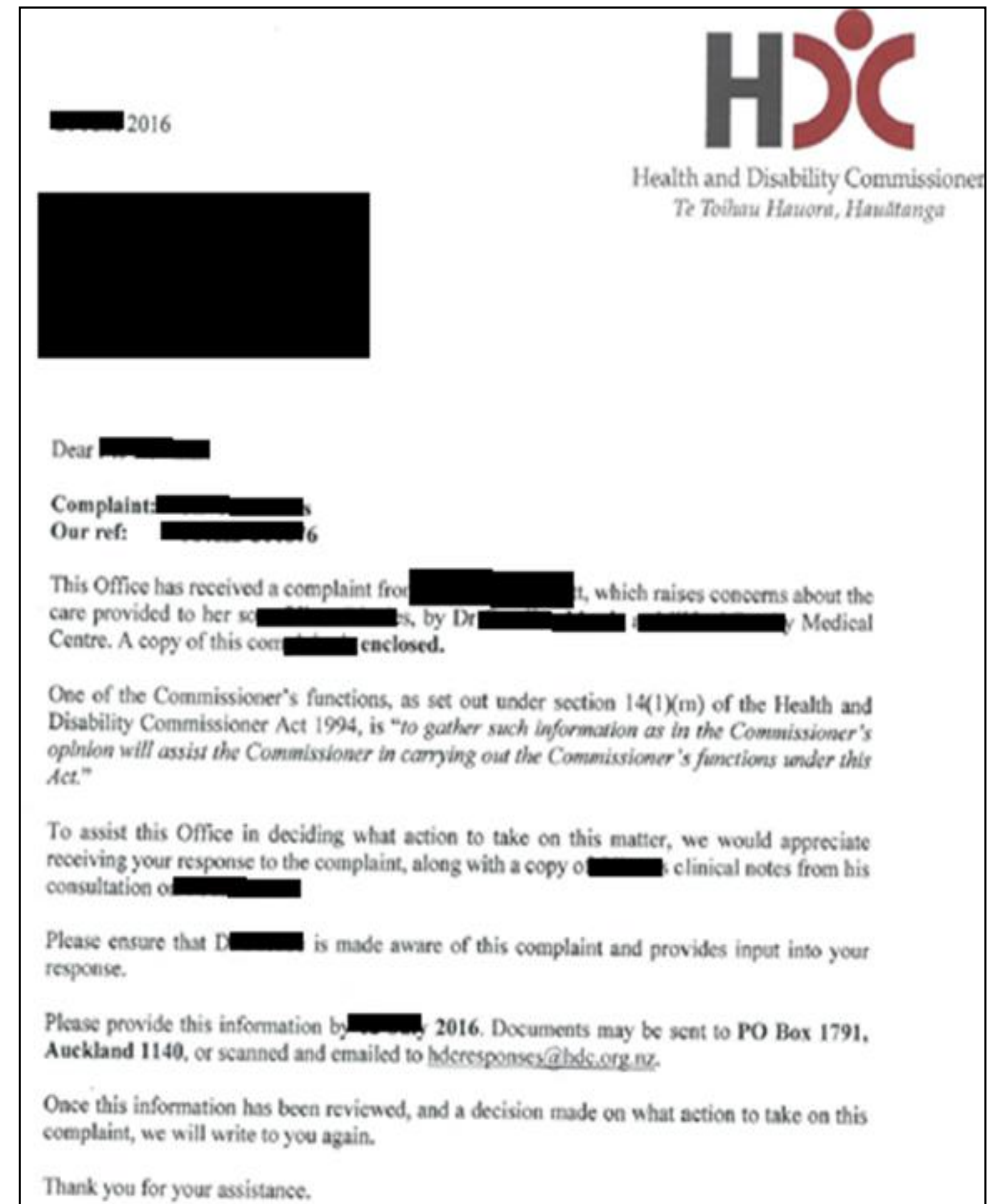
Who gets complained about?

- Males more often complained about than females
- Urban doctors more complained about than rural.
- Women patients complain more often than men
- Majority ethnic groups complain more often
- Proceduralists more often complained about
- A&M complaints > other general practices

HDC Complaints

The dreaded letter:

- Who should reply?
- Do you need consent?
- Contact your indemnifier.



2016

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Dear

Complaint:
Our ref: 6

This Office has received a complaint fro t, which raises concerns about the care provided to her s s, by Dr Medical Centre. A copy of this co **enclosed.**

One of the Commissioner's functions, as set out under section 14(1)(m) of the Health and Disability Commissioner Act 1994, is "*to gather such information as in the Commissioner's opinion will assist the Commissioner in carrying out the Commissioner's functions under this Act.*"

To assist this Office in deciding what action to take on this matter, we would appreciate receiving your response to the complaint, along with a copy o clinical notes from his consultation o

Please ensure that D is made aware of this complaint and provides input into your response.

Please provide this information by **2016**. Documents may be sent to **PO Box 1791, Auckland 1140**, or scanned and emailed to hdcresponses@hdc.org.nz.

Once this information has been reviewed, and a decision made on what action to take on this complaint, we will write to you again.

Thank you for your assistance.

Medical Protection

What can HDC chose to do

- Gather information (commonest).
- Dismiss the complaint.
- Refer back to provider to respond.
- Refer to advocacy service.
- Refer to another forum (e.g. Privacy Commissioner/ MCNZ).
- Investigate.
- Refer for mediation.

The next letter

- HDC now investigating.
- Will normally have expert opinions by now.
- Doctor or practice could be found in breach of Patient Code of Rights.
- Consider providing a further response/ more information.

HDC
Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Attn:

Complaint:
Our ref:

As you may be aware, the Commissioner has received a complaint from concerning the care provided to her at The Commissioner has now completed his preliminary assessment of this complaint and has decided to commence a formal investigation. He has asked Legal Investigator to assist him.

Scope of investigation
The issue arising from the complaint that the Commissioner intends to investigate, as it relates to C :

- *Whether, in 2 provided with an appropriate standard of care.*

A copy of the complaint letter was sent to C . For ease of reference, a further copy is **enclosed**.

Investigation process
The investigation is impartial. The Commissioner will consider all relevant information received from M , as well as relevant information from other parties. Once the Commissioner has gathered all the relevant information, he will consider it and decide what further action is appropriate. If he considers that there has been a breach of the Code of Health and Disability Services Consumers' Rights (the Code), the Health and Disability Commissioner Act 1994 (the Act) allows him to do a number of things. For example, he may make recommendations and serious cases may be referred to the Director of Proceedings for disciplinary or civil proceedings.

Where next?

If found in breach

- May be required to:

  1 - Apologise.

  2 - Run audits/update procedures.

  3 - Undergo training/education.
- May be referred to MCNZ re competency or conduct concerns.
- May be referred to Director of Proceedings who may take case to Health Practitioner's Disciplinary Tribunal.
- Cannot impose fines

MOU between HDC and the Medical Council

- HDC will notify the Council whenever they commence an investigation into a doctor.
- HDC will notify Council if a clinician is involved in 3 or more similar low level matters within a 5 year period.
- Good reason to try to have a good in-house complaints procedure.

Recent HDC complaint

17HDC00490

- Rural group practice
- Senior experienced GP from overseas
- Started work in NZ in 2013, event occurred in 2016.
- No previous complaints to practice or to HDC
- Proper induction process into practice & had required period of supervision with no significant concerns raised.
- Up to date with CME and all requirements for APC

The patient

- 42 YO female enrolled in the practice in 2014
- History of ongoing alcohol dependency under the care of the DHB A&D Service admitted to 1 L cider per day.
- Anxiety with depression not on medication - regular counselling, recurrent breast abscesses, cigarette smoker,
- Multiple social problems – separated from abusive partner, brother murdered 1 yr prior, not working, financial difficulties.
- Supportive family but not living locally.

The Presentation

- Seen once previously by dr 3/12 previously for breast abscess, review of coccyx contusion & renewal of WINZ certificate
- Rang practice & spoke with practice nurse – unwell for 3 days, difficulty breathing and difficulty sleeping.
- Nurse’s call not recorded in daily record.
- Seen same day, dry cough, no pain or fever, no other URTI sx such as sore throat or runny nose.
- No other history obtained.
- No exploration of breathing or sleep difficulties.

Examination

- Talking in normal sentences
- Felt cool to touch but temperature not recorded.
- Respiratory rate not recorded but estimated to be around 18 per min.
- Pulse 168 (as recorded on O2 sat meter), BP 90/60, sats 94 (cold fingers).
- Throat normal, no enlarged nodes, chest clear with no wheeze or crepitations,
- ECG done – no ischaemic changes, sinus tachycardia 158.

- Your differential diagnoses?
- Your plan of management?

Management

- Diagnosis – tachycardia secondary to alcohol abuse and anxiety.
- Rx Bisoprolol to slow heart rate & improve cardiac output.
- Consulted with colleague who did not disagree with plan of management.
- Advised to return if no improvement or getting worse
- Practice nurse who had done the ECG was concerned that more had not been done but did not discuss with doctor or nurse colleague until the next morning.

Possible Outcomes

- 1 – gradually improved but complaint that management incorrect
- 2 – no improvement overnight, seen next day and commenced on antibiotics, complaint that pneumonia not diagnosed.
- 3 – deteriorated and subsequently admitted to hospital
- 4 – died overnight.

How did this happen?

- Where were the gaps?
- 1 – history taking?
- 2 – examination?
- 3 – investigations?
- 4 – processing of information?
- 5 – was the distance to hospital a factor?
- 6 – what responsibility did the colleague and the nurse have?
- Outcome for the doctor- worked for further 3/12 under supervision then retired.
- Referred to Director of Proceedings.

Treating family and those close to you – MCNZ statement 2016 – where rural GPs are treated differently

The man who is his own lawyer has a fool for a client

- Does this apply to doctors and other health professionals?
- What about treating family and those close to you?
- Does MCNZ have the balance right?

History

- Percival’s Medical Ethics published 1803 argued for the separation of professional and personal identities in the care of family members.
- The first code of ethics drafted by the AMA in 1847 recommended against physicians treating family members –

‘the natural anxiety and solicitude which the physician experiences at the sickness of a wife, a child … tend to obscure his judgement, and produce timidity and irresolution in his practice.’

Theoretical concern about treating family and friends

- Emotional involvement may reduce clinical objectivity, producing bias which we may not be aware of.
- Overtreatment and under-treatment are both possible outcomes.
- It may be less likely that the full relevant history is obtained, assumptions may be made about depth of knowledge of patient, and some potentially relevant questions and examinations may not be done.
- Family or friends may place you under specific pressures regarding management that would not apply with usual patients.

There is a substantial gap between what professional organisations recommend and what doctors actually do

- Confirmed both by surveys and our own experience.
- MCNZ says it is getting regular and frequent notifications from ACC and the MOH.
- Significant variation in the positions of regulatory authorities around the world.
- If this is such an important principle, why is there such variation?

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Earlier statements in 2001 and 2007

2013 statement

- 2013 MCNZ ceased to issue APC to retired doctors which would allow them to treat themselves and family – only 5 years ago.
- Changes - The following are specific situations when you **must not** treat yourself, family, friends etc –
- Prescribing drugs of dependence and psychotropics.
- Performing invasive procedures (unless an appropriate referral process has been followed)
- Removed section allowing doctors to prescribe for themselves etc. for continuing condition, with GP monitoring.

2016 Statement – much more detailed, new definitions

- Family member – anyone with both a familial connection & personal or close relationship which could reasonably be expected to affect professional and objective judgement.

- Includes but is not limited to - spouse or partner, parent, child, sibling, members of extended family, members of partner's extended family.

2016 Statement – much more detailed

New definitions –

- Care – anything that is done for a diagnostic, preventative, palliative, cosmetic, therapeutic or other health-related purpose.
- Those close to you: Any other individuals who have a personal or close relationship with you, whether familial or not, where the relationship is of such a nature that it could reasonably be expected to affect your professional and objective judgement.

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Must not provide care to self, family or those close to you in the following circumstances

- Prescribing medication with risk of addiction
- Prescribing psychotropics
- Prescribing controlled drugs
- Undertaking psychotherapy
- Issuing certificates including ACC, fitness to drive, off work etc
- Performing invasive procedures

Exceptional circumstances when care may be provided

- If you are working in a particular community where there are people close to you who are patients because it is difficult for them to access other practitioners. However, in this situation there are additional pressures and you must be aware that objectivity may be compromised.
- You must have a low threshold for referring these patients to an independent doctor for consultation, and for seeking advice from a colleague and utilising your peer networks.
- Confusingly also states that '. The care is monitored by another doctor.'
- Challenging with manpower scarcity

Other jurisdictions

- The UK, Australia, Canada and the US have similar philosophies, but none is so proscriptive.
- ‘Must not’ is now used in NZ where ‘should not’ was the term previously used and the one used in many of these – semantics?
- AMA – physicians generally should not treat themselves or immediate family members
- Australia states *‘Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship.’*
- Singapore – S*elf-prescribing is discouraged but it is acknowledged that doctors often do treat themselves’. If you choose to provide significant care to those close to you, such as major surgery, you have an obligation to make sure your objectivity etc is not compromised.*

Other jurisdictions

Other NZ Organisations

- Germany – *Physicians may dispense with all or part of the fee in the case of family members, colleagues, their family members and destitute patients.*
- Dentists – *'should not prescribe medicines and controlled drugs for themselves and should not prescribe for family members or friends, unless they are patients and the medicine relates to dental treatment requirements.'*
- Psychologists – *'Psychologists seek to avoid dual relationships where that might present a conflict of interest. A dual relationship is where the psychologist has a personal and professional relationship with a patient'.* Compare with MCNZ – *'must not provide psychotherapy'* to family and *those close to you.'*

The evidence

- Coles states – *‘Be committed to autonomous maintenance and improvement in your clinical standards in line with best evidence-based practice.’*
- Do the same standards apply to MCNZ??
- What is the evidence of harm when treating self, family or those close to you?
- I could find no study that showed that outcomes were significantly different when comparing treating someone close to you compared with a patient who was not close.
- In the absence of evidence of harm, what limitations are justifiable?

The consequences

- Review of MPS files shows that most transgressors get an educational letter
- Disciplinary action is generally reserved for prescribing narcotics to family, particularly if it is intended for personal use, and treating close family with mental health issues and no external overview.
- One case though of prescribing antidepressants for 3 years to a spouse who then attempted suicide resulted in a 6 month recertification program.
- Is the MCNZ bark worse than its bite? HPDT case

Is it fair?

- MCNZ gets reports from ACC & MOH. Only relates to prescribing and certificates.
- Otherwise MCNZ relies on notifications from HDC or direct complaints to MCNZ
- Care – anything that is done for a diagnostic, preventative, palliative, cosmetic, therapeutic or other health-related purpose.
- Is this any less significant than prescribing? Much less likely to be reported to MCNZ.
- What if your family member has a different surname?
- Are doctors treated equitably by our regulator?

Where to from here?

- There is also an assumption that we don’t get close to our patients, whereas the reality is that we do and this could affect our judgement.
- What about cultural expectations?
- Is there a better way that MCNZ could manage this issue?
- Does this ‘must not’ approach reflect a broader philosophy that MCNZ has towards doctors in NZ?
- Do we in the medical profession accept this ideology from our regulator if it is clearly different from what many of us do and lack of evidence of harm?

Summary

- No evidence that rural GPs are treated differently by the HDC
- Rural GPs less likely to be complained about
- Most complaints to the HDC result in no further action, but this does not make them less stressful for the doctor concerned
- MCNZ does recognise that rural GPs are different allowing greater flexibility for treating those close to you

Further support and information is offered on our website, in addition to our publications, booklets, factsheets and case studies.

medicalprotection.org

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