Managing medico-legal risk – a closer look at some key issues

PMAANZ/AAPM Education Symposium
Objective
What we will cover

• A whistle stop tour highlighting the importance of good systems, policies and procedures relating to:
  – Regular medical review
  – Appropriate follow up, notification of results and referrals to other healthcare providers
  – Your responsibilities for others
  – Managing competence and fitness to practise concerns about health practitioners
  – Documentation
So that you......
Regular Medical Review
Case study (11HDC00440)

- A woman was overweight, a smoker, over 35 years of age, and had a family history of thromboembolism
- She therefore had a risk of developing a deep vein thrombosis
- She had taken a combined oral contraceptive (Estelle) in the past, but her GP at the time deemed Estelle to be unsuitable because of the woman’s risk factors for DVT
- The woman transferred her care to a Medical Centre, where she saw a GP, who prescribed Estelle
Case study (11HDC00440)

- There was no documentation of the prescription, discussion of risks, or alternative options.
- Over the next three and a half years, the first GP and the two other GPs provided repeat prescriptions for Estelle for the woman.
- Over that time, the woman’s risk factors increased.
- No medical review was undertaken to determine whether Estelle was suitable.
- The woman’s blood pressure was not recorded for two years.
- Woman underwent cholecystectomy, developed a pulmonary embolism and died.
HDC findings - breach

• First GP:
  – breach of right 4(1) by reinstituting Estelle for the woman without a proper assessment of her suitability or recording her blood pressure
  – Breach of right 6(1)(b) by failing to inform the woman of her risk factors or suitable alternatives to Estelle
  – Breach of right 4(2) by failing to comply with professional standards in respect of her documentation.

• Medical Centre
  – breach of right 4(1) by failing to ensure that the woman’s ongoing use of Estelle was adequately monitored through regular, specific medical reviews and counselling on risk factors

• Other GPs
  – Fell below appropriate standards but no breach
Learnings?
Health Check

• Does your practice have good policies and procedures around:
  – First consultations with new patients
  – Obtaining patients’ previous clinical records
  – Informed Consent
  – A reminder system which trigger regular medical reviews where indicated
  – Good documentation
A+? Or room for improvement?

“The key to success is constant and never ending self-improvement. Like my new sideburns?”
Appropriate follow-up, notification of test results and referrals
Case Study (12HDC00555)

- Woman was living in a serviced apartment in a retirement village
- A GP held weekly clinics at the retirement village
- The woman presented to the GP numerous times over 20 months
- The GP repeatedly ordered blood tests for the woman, the results of which indicated a high risk of diabetes or glucose intolerance
- The GP failed to appropriately follow up the results or inform the woman of the results
- The woman deteriorated until hospitalised, when a diagnosis of diabetes was made
HDC findings - breach

- GP’s repeated failure to manage the woman’s elevated glucose levels appropriately, and to ensure that the abnormal tests were appropriately followed up was extremely poor care and a breach of right 4(1).
- His failure to inform the woman of the results of the tests was a breach of right 6(1)(f).
- His record keeping fell below the expected standard and was a breach of right 4(2).
- The GP was referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.
Case study (12HDC00203)

• Woman consulted a locum GP at a medical centre complaining of tiredness
• She had had a right hemicolecctomy for bowel cancer in the 1990s
• Blood tests showed the woman had anaemia and the locum GP prescribed oral iron and referred her to the Surgical Outpatient Clinic for a colonoscopy
• The locum did not set a reminder on his computer for the results of the colonoscopy
Case study (12HDC00203)

- A few days later the woman’s whānau requested that she be referred privately for a CT colonography
- The locum wasn’t working that day, so the woman’s usual doctor initiated the referral
- He noted the referral in the clinical records, but did not communicate this to the locum
- He did not set a reminder on his computer for the results of the CT colonography
- The CT colonography identified a tumour in the woman’s colon
- She was not told of this until 4 months later
Contributing factors to the delay

• Neither GP followed up their referrals
• The radiology service sent the result electronically to the GP at his old address at another medical centre
• That medical centre advised that the result was forwarded to the GP at his current medical centre but this does not appear to have been received
• Despite the woman and her whānau asking for the result, staff did not follow up the result
• The woman recalls being told by a staff member that “everything was fine”
HDC finding - breach

- GPs who refer patients to a specialist have a responsibility to take reasonable steps to follow up the referral
- The GP and the medical centre did not take reasonable steps to follow up the referral
- The woman did not receive services with reasonable care and skill
- Both the GP and the medical centre were held to have breached right 4(1)
Learnings?
Things to note – providing info to patients

- Patients have a right to be told why the test is recommended and when and how they will be informed of the results.
- Knowing when and how test results will be notified is reassuring for patients and also acts as an important safeguard.
- Patients are entitled to be notified of all test results if they wish.
Things to note - referrals

• Any test ordered where there is concern about an adverse finding requires pro-active follow up
• There is a need for efficient systems for handling test results and referrals, particularly in cases where the diagnosis may be serious
• GPs have a key role to play in following up referrals to check that they are actioned properly. The referring GP has a duty of care to the patient for their ongoing clinical management pending specialist assessment
Things to note - referrals

- A specific aspect of the duty of care is to co-operate with other providers to ensure continuity of care under right 4(5)
- Practices must have robust systems for managing referrals, so that referred patients do not fall through the cracks
Health Check

• Does your practice have good policies and procedures around:
  – Record keeping when working off-site
  – Sharing information within the practice
  – Ensuring patients have access to test results
  – Notifying patients of adverse test results
  – Ensuring follow up of test results and referrals
  – The management of test results generally
  – The management of referrals generally
  – Good documentation
Did you pass?
Responsibility for others
Liability for employees, agents and members

HDC Act:

• An employer is vicariously liable for an employee’s action whether or not the action or omission was done with that employing authority’s knowledge or approval

• An employing authority (provider) is liable for the acts or omissions of its agents or members unless the act or omission is done without that employing authority’s express or implied authority
Possible defence

• It is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from acting or omitting to act.
Case study (03HDC03134)

- Dr B, a GP, worked at a medical centre on a semi-retired basis
- He was contracted for 3 days per week and was paid on a fee for service basis
- Dr B was found in breach of the Code for failure to properly investigate the cause of a patient’s symptoms
- Experts raised concerns about Dr B’s competence
- HDC found medical centre vicariously liable for Dr B’s breach
HDC’s findings

• Dr B was an agent of the medical centre
• The medical centre said that “it did not occur to us to take steps to satisfy ourselves” that Dr B was competent and that “this is the job of the regulatory authorities”
What do you think?
HDC’s findings

• HDC rejected this submission and found that it was the medical centre’s responsibility to:

“ensure that all its clinical staff (whether employees or contractors) were practising competently, and were familiar with relevant protocols and guidelines”
HDC’s findings

- It was noted that no formal audit of Dr B’s records/peer review/appraisal was undertaken or required by the centre.
- The HDC concluded:

“It was not acceptable....for a medical practice to absolve itself from responsibility for ensuring that clinical staff are practising competently on the basis that “this is the job of the regulatory authorities”...it is not sufficient to rely on the fact that a doctor is experienced and liked by his patients as evidence of his or her satisfactory performance”
Arranging locum cover

Whether in private or public practice, you must take particular care when arranging locum cover. You must be sure that the locum has the qualifications, experience, knowledge and skills to perform the duties he or she will be responsible for.

Coles Medical Practice In NZ (2013)
So be aware that the practice is responsible for:

- Ensuring employees and agents are qualified, have the requisite experience, and are competent to practise
- Having appropriate and current policies and procedures
- Making sure people who work at the practice comply with policies and procedures and are provided with relevant training
- Dealing with concerns about a health practitioner working for you
Managing competence and fitness to practise concerns about health practitioners
Competency concerns

- **Patient safety is the primary concern** of all involved in providing health services
- Must take **all reasonable steps** to ensure its health practitioners are capable of safely undertaking clinical responsibilities in their contracts
- Expectations of health providers under the Code of Rights
  - Right 4(1): Every consumer has the right to have services provided with reasonable care and skill
  - Right 4 (2): Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards
Managing competence concerns …

- Duty to investigate
- Consider whether external agencies must or should be notified (s34 HPCA Act) BUT duty remains regardless of actions of external agencies
- Documentation is critical
- Action plans are important – must be well documented and followed through

Overriding consideration is the need to protect patients
Managing fitness to practise concerns

If a person…has reason to believe that a health practitioner is unable to perform the functions required for the practice of his or her profession because of some mental or physical condition, you **must** promptly give the Registrar of the RA written notice of all the circumstances.

(Section 45 of the HPCA Act)
What is a mental or physical condition?

- Definition of a mental or physical condition:

  *Mental or physical condition means any mental or physical condition or impairment; and includes, without limitation, a condition or impairment caused by alcohol or drug abuse*”

  (Section 5 of the HPCA Act)
Functions required to practise

- Making safe judgements
- Demonstrating the level of skill and knowledge required for safe practice
- Behaving appropriately
- Not risking infecting patients with whom the health practitioner comes in contact
- Not acting in ways that impact adversely on patient safety
Should you make a notification?

• Making a notification to an RA is a significant step

• When deciding whether it is necessary to make a notification there are a number of factors to consider
  – Is there a risk to patients, the wider public, and/or the practitioner themselves?
  – How big is that risk and how serious are the consequences?
  – Is the behaviour you are concerned about a one-off incident?
  – Is the condition actually impacting on the practitioner's practice – or is it something only influencing their 'outside' life?
  – Is the condition likely to be ongoing and require long-term management?
  – Would mentoring, monitoring supervision or a structured management plan help?
When to notify

- If there is an immediate risk to patients
- If action is required which is outside the bounds of what can be provided in the environment you work in
- If you do not feel you can raise it internally
- If you have raised concerns but are concerned that appropriate action has not been taken
- If the condition is of a long term nature that will require ongoing management
- If the colleague or patient does not wish to self-refer
Patient safety comes first at all times

• You have a responsibility to protect patients from risk of harm posed by a colleague's conduct, competence or health

• If you raise concerns in good faith:
  – Various legislation provides protection from victimisation, dismissal and civil or disciplinary proceedings as a result of raising your concerns
  – You will be able to justify your actions even if your concerns turn out to be groundless – if you have done so honestly, promptly, on the basis of reasonable belief and through appropriate channels

• Failure to act on concerns may be considered by the relevant RA, the HDC or the HPDT
Documentation

- Good clinical records are integral to providing care
- They are vital for enabling continuity of care and ensuring other practitioners know what decisions have been made, why, and what care has been provided
- They can help safeguard practitioners when faced with allegations of inadequate practice
- Notes need to be comprehensive, accurate and contemporaneous
- The starting point is if it isn’t recorded in the notes, it didn’t happen
Questions?
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