Challenges facing Rural GPs in 2010

Key Legal Issues

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Overview

1. Practising in a resource constrained environment
2. Your obligations when referring patients to secondary and tertiary providers
3. Acting within your scope of practice/competencies – what if there is only you?
4. Maintaining professional boundaries in rural communities

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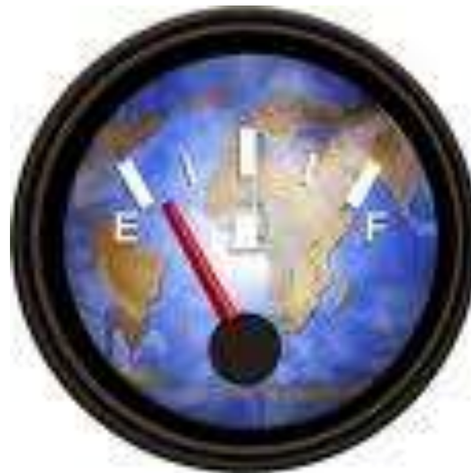
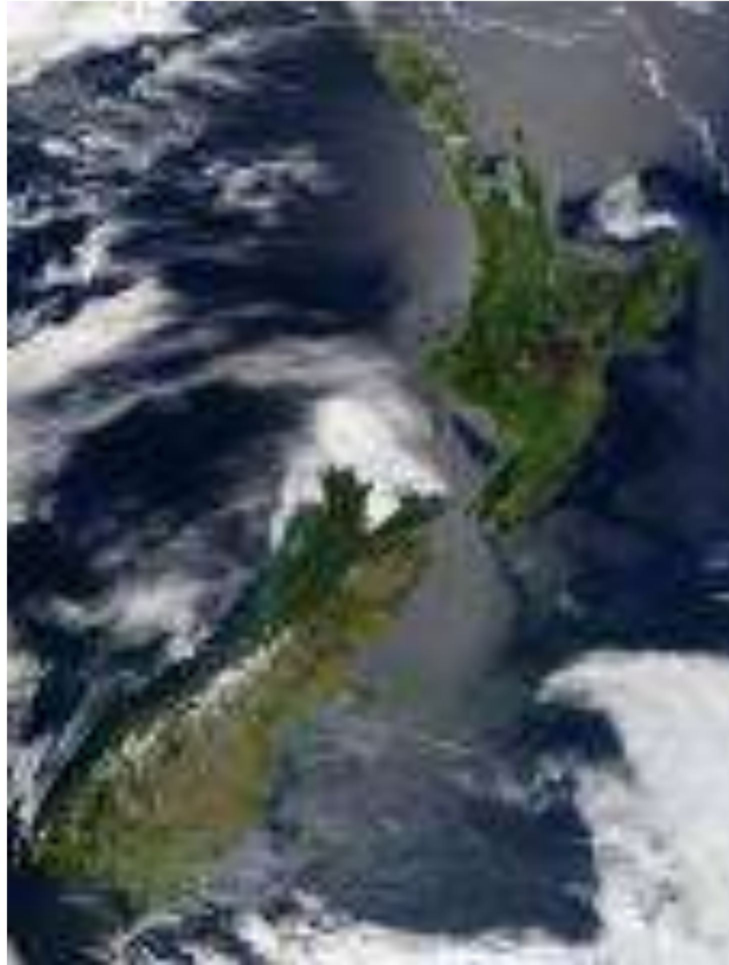
Practising in a resource constrained environment



New Zealand's healthcare system



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New Zealand's healthcare system

- A centrally funded, tax-based system
- Publicly funded health care is funded by Vote Health and by ACC
- Most funding is devolved via Crown Funding Agreements between the MoH and DHBs
- Hospital care, community health care and public health services provided to "eligible people" free of charge

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Objectives of the Public Health System

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Objectives of the Public Health System

- Section 3(1) of the New Zealand Public Health and Disability Act 2000 (“the NZPHDA”):
  - Improve, promote and protect the health of New Zealanders
  - Reduce health disparities by improving health outcomes of Maori and other population groups
  - Ensure community voice in matters relating to provision of health and disability services
  - Provide appropriate, effective and timely services

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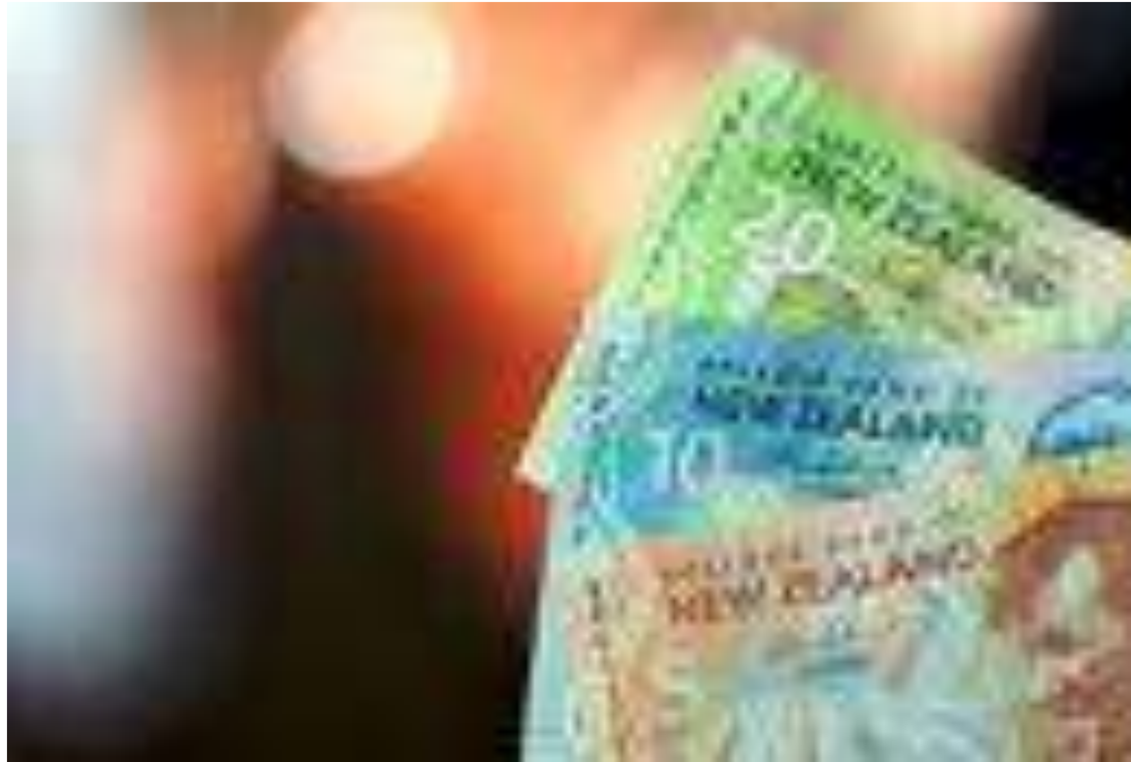
Recognition of resource constraints



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Recognition of resource constraints

- The system's objectives are to be pursued "to the extent that they are reasonably achievable within the funding provided" (section 3(2) of the NZPHDA)
- A provider is not in breach of the Code of Rights if the provider has taken reasonable actions in the circumstances (Clause 3 of the Code of Rights)
- Personal injury that is solely attributable to a resource allocation decision is not covered by ACC (section 32(2)(b) of the Injury, Prevention, Rehabilitation and Compensation Act 2001)

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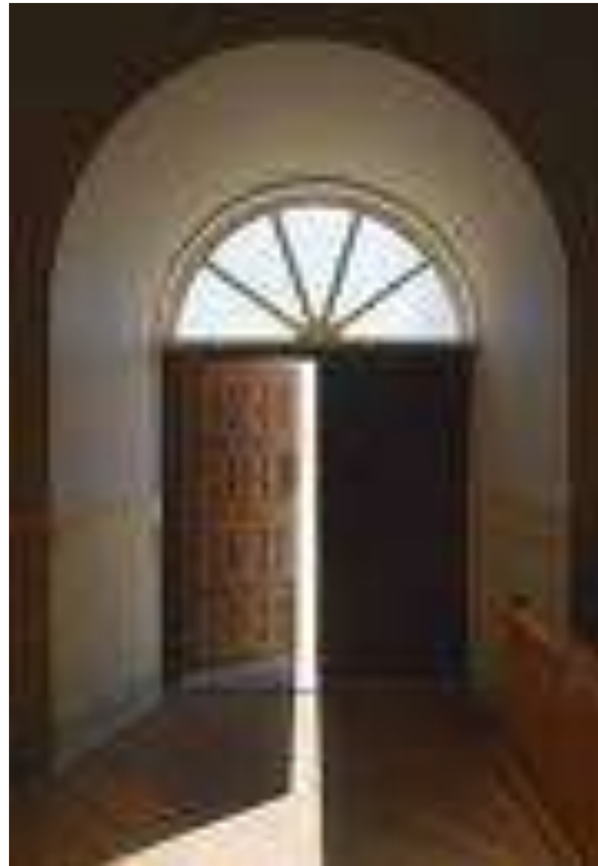
Right to Access Health Services



Right to Access Health Services

- Right to access health services in an emergency
- But – no general right of access to health services in New Zealand
- Human Rights Commission = the Code of Rights should include a right to access health services
- HDC recently consulted on whether the HDCA/Code of Rights should include a right to access health services

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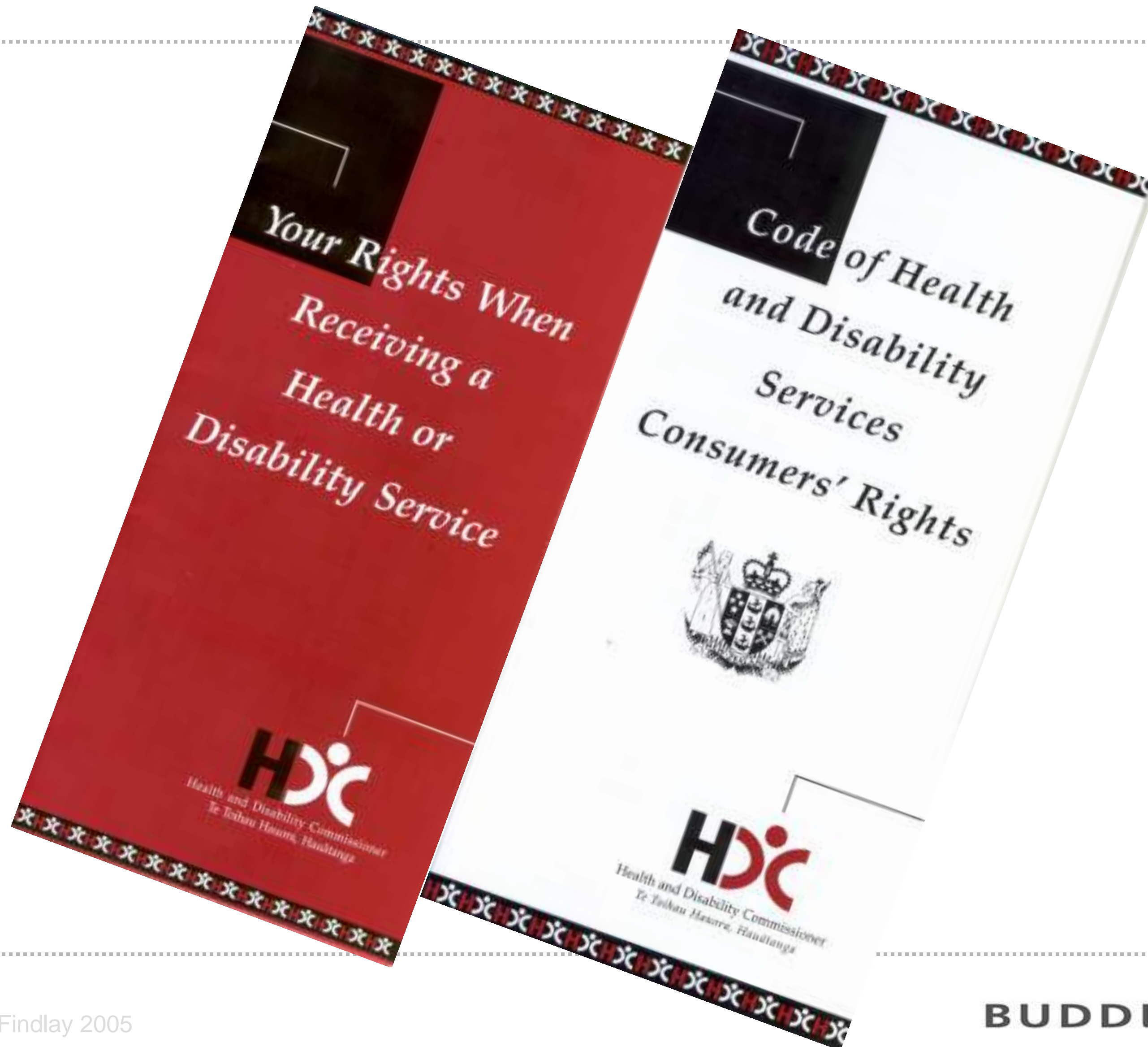
Provision of Health and Disability Services



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Provision of Health and Disability Services

- The Code of Rights:
  - Confers a number of rights on all consumers of health and disability services in New Zealand
  - Places corresponding obligations on providers of those services
  - Has a wide application and extends to any person or organisation providing, or holding themselves out as providing, a health service to the public or a section of the public
  - With regard to disability services, it extends to goods, services and facilities provided to people with disabilities for their care or support or to promote their independence, or for related or incidental purposes

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A brief review of key provisions

- Rights 1-3 - consumers have the right to:
  - Be treated with respect
  - Freedom from discrimination, coercion and exploitation
  - Dignity and independence
- Right 4 - providers have a duty to:
  - Provide services with reasonable care and skill
  - Comply with legal, ethical, professional and other standards
  - Co-operate with other providers to ensure quality of care

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A brief review of key provisions cont.

- Rights 5-7 – consumers have the right to:
  - Right to effective communication
  - Right to the information that a reasonable consumer in that consumer's circumstances would expect to receive
  - Right to make an informed choice and give informed consent
- Rights 8-10 - consumers have the right to:
  - Have a support person present
  - Decide about participation in teaching and research
  - Complain to the provider, an advocate or the Health and Disability Commissioner

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In an ideal world….

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In an ideal world….

- In the commentary to the Proposed Draft of the Code of Rights, the Commissioner said:

> *“In an ideal world providers would give full effect to all the rights of all consumers. However, in reality no provider is able to do this and unless some reasonable limits are in place, providers will constantly be in breach of the Code”*

- The Commissioner also said:

> *“Because providers do not have unlimited funding, a limit will be justified where resource constraints apply…. [W]here there are any consumers competing for the available time, space and funding, giving effect to the rights of one consumer may mean that full effect cannot be given to the rights of another consumer. In such circumstances it will be unreasonable to hold a provider liable for breach of the Code”*

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Clause 3

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Clause 3

- A provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances
- The onus is on the provider to prove that it took reasonable actions
- “Action” includes failure to act
- “The circumstances” means all the relevant circumstances, including the consumer’s clinical circumstances and the provider’s resource constraints

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Relevant HDC cases

- Canterbury Health Inquiry – April 1998
- Southland DHB Inquiry – October 2002
- Missed diagnosis (02HDC09734) – September 2003
- Failure to respond to deteriorating mental health (01HDC13687) – July 2004
- Missed diagnosis in ED (04HDC12081) – December 2005
- Urology First Specialist Appointments (04HDC13909) – April 2006
- North Shore Hospital Inquiry (07HDC21742) – April 2009

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Canterbury Health – April 1998

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Canterbury Health – April 1998

- Canterbury Health did not provide its Emergency Department in 1996 with sufficient resources in terms of space or equipment to enable services to be provided with reasonable care and skill
- More significant were the shortages of medical and nursing staff to ensure the safety of patients
- Because of inadequate staffing the Emergency Department operated in an unsafe fashion, despite the efforts of the medical, nursing and other staff
- Were the actions of Canterbury Health reasonable in the circumstances, owing to resource constraints?

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Canterbury Health – April 1998

- Canterbury Health submitted that the circumstances indicated resources constraints and complying with the Code would have necessitated capital expenditure to remodel buildings. The Directors were obliged to take a conservative approach to expenditure
- To claim this defence, Canterbury Health would have to show it took steps to bring the necessary expenditure to the Shareholder's attention
- Canterbury Health did not advise the Crown Company Monitoring Advisory Unit that the efficiency drive and the time-frames of the workout programme might threaten standards of patient care, nor did it advise Southern Regional Health Authority that revenue was inadequate to meet its obligations
- Canterbury Health did not recognise that it was providing inappropriate services and was paid the price it requested in 1996/1997 from Southern Regional Health Authority for the Emergency Department services

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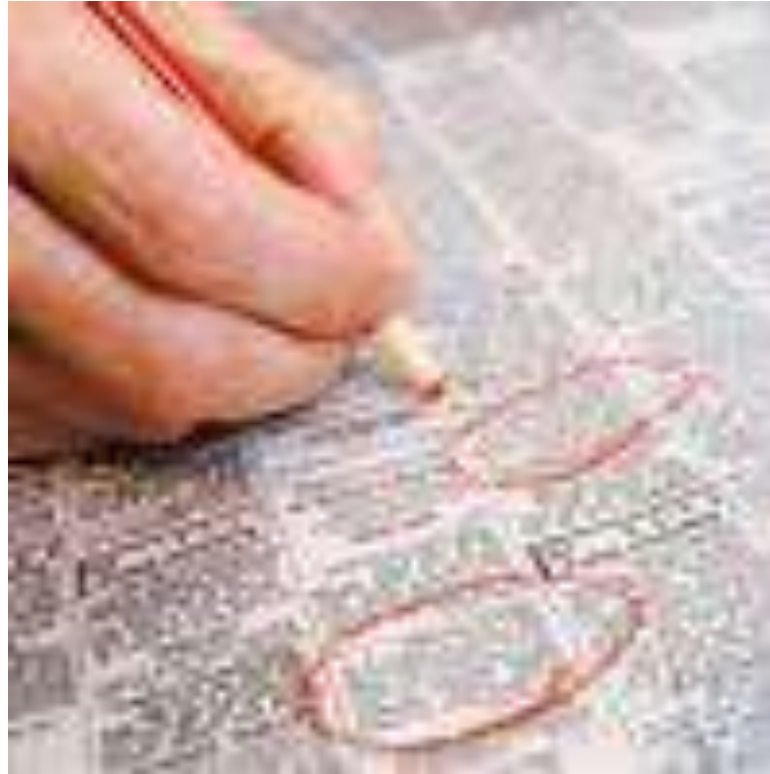
Southland DHB Mental Health Services – October 2002



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Southland DHB Mental Health Services – October 2002

- Like other mental health services in provincial New Zealand, Southland DHB's mental health service suffered from a shortage of qualified staff. There was a chronic shortage of psychiatrists, which resulted in the MOSS in effect practising as a psychiatrist without adequate supervision
- However, there was little evidence that options to increase the availability of psychiatric expertise were pursued as rigorously or comprehensively as might have been expected in the circumstances

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Southland DHB Mental Health Services – October 2002

- In response to the HDC's provisional opinion, Southland DHB criticised the application of "idealised standards" and submitted that financial constraints, staffing constraints and the unsuitable design of its inpatient mental health unit restricted its ability to provide the ideal standard of service to mental health consumers
- It was left with only two choices – providing a service which does not meet the ideal standard set by the HDC or not providing the service at all

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Southland DHB Mental Health Services – October 2002

- The HDC acknowledged that consumers receiving services of an appropriate standard when faced with the sort of constraints experienced by Southland DHB represented significant challenges
- However, he did not accept that Southland only had two options open to it
- The HDC encouraged regional collaboration and the formation of alliances to improve service quality and access for consumers

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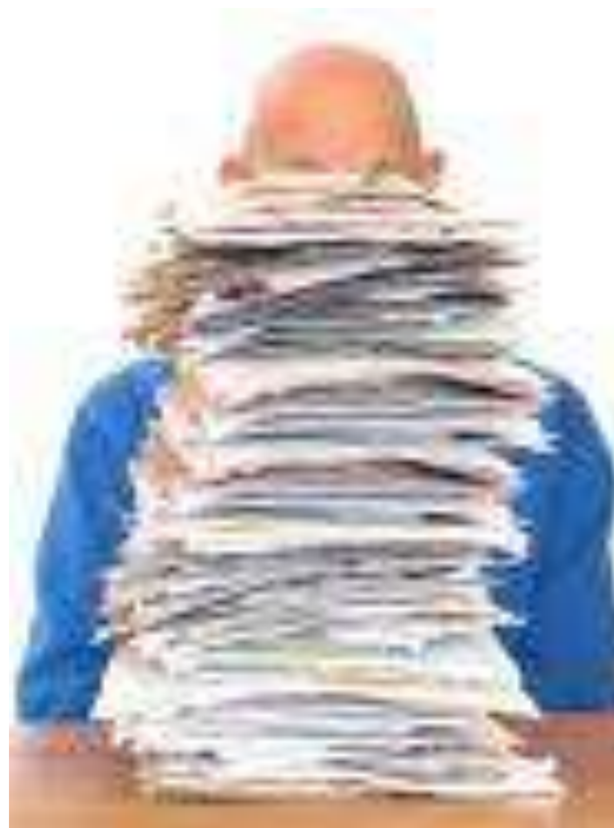
Missed diagnosis (02HDC08734) – September 2003



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Missed diagnosis (02HDC08734) – September 2003

- Missed diagnosis of testicular torsion in a 12 year old boy
- Held that resource constraints are highly relevant circumstances in a small provincial hospital
- The surgeon did not breach Right 4(1) because it would be unduly harsh to single him out as responsible for the misdiagnosis of the patient's condition
- There were extenuating circumstances in this case including:
  - He was affected by resource constraints
  - His own heavy workload and in particular the large amount of information from a variety of disciplines that he was required to assess each day, no doubt significantly increased the risk of error

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Deteriorating mental health (01HDC13687) – July 2004

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Deteriorating mental health (01HDC13687) – July 2004

- Dr D and Dr E expressed concerns about lack of resources for the provision of mental health services
- The resource constraints by mental health services at the DHB that year were significant and clearly impacted on Mrs B's care
- The question was whether the DHB responded reasonably given the lack of resources

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Deteriorating mental health (01HDC13687) – July 2004

- There were serious systemic failures arising from the changeover of responsibility for provision of mental health services in the area to the new DHB:
  - A key Mental Health Team staff member was inadequately trained in his role and responsibilities
  - There was lack of clarity around the processes
  - The full time psychiatrist felt overworked and unsupported in terms of access and resources
  - CATT was not always able to respond to request for crisis assistance for patients in the area

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Deteriorating mental health (01HDC13687) – July 2004

- The DHB failed to ensure that:
  - the roles and responsibilities of staff were clear
  - Processes were clearly understood by those involved
  - There was a clear system for ensuring co-operation among providers to ensure continuity of care
- The DHB was therefore in breach of Rights 4(1) and 4(5) of the Code

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Deteriorating mental health (01HDC13687) – July 2004

- It was accepted that Dr D was acting under resource constraints
- However, the HDC did not consider that the lack of resources excused his failure to assess Mrs B's condition adequately, respond appropriately to a number of crisis contacts or to prescribe appropriate medication
- The HDC referred to the case *Perera v MDT*, in which Hubble J stated:

> *"There can be no doubt that the test [for a doctor's duty of care] is harsh on medical practitioners who are working under-resourced and under-staffed and often extreme hours. The expected standard in relation to medical practitioners must be high, because unlike with lawyers and psychologists, errors can be life threatening or fatal. Only the practitioner himself or herself can assess their personal capacity when confronted with a problem, it is right therefore that they alone can decide whether it is desirable to call on further assistance or advice, or at least invite greater participation from those assisting who might otherwise be reluctant to intervene"*

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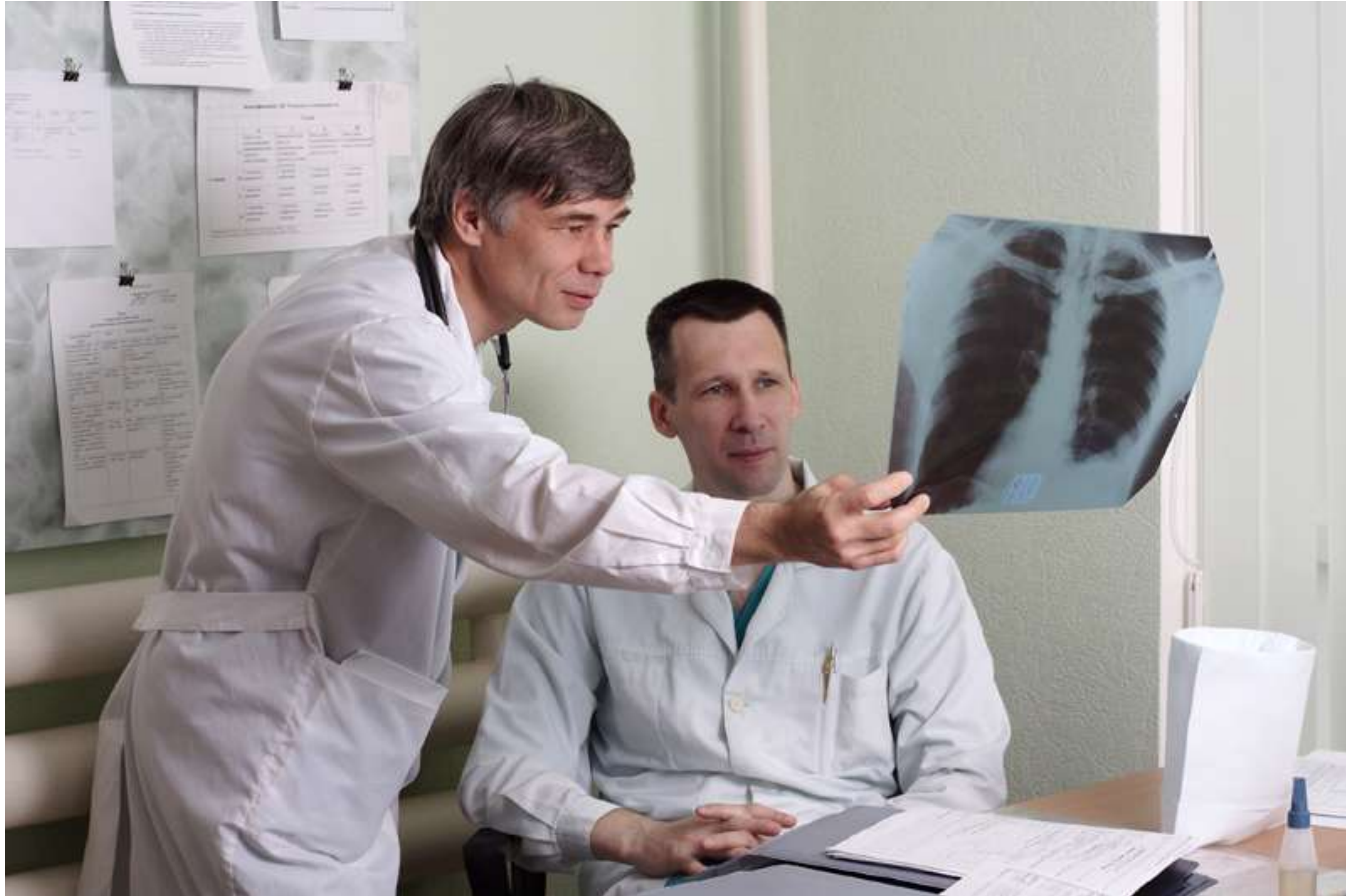
Missed diagnosis in ED (04HDC12081) – December 2005



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Missed diagnosis in ED (04HDC12081) – December 2005

- Mr A was the eighth patient seen by Dr C in the first two and a half hours of his duty
- Dr C misdiagnosed Mr A's condition and discharged him. Mr A subsequently collapsed at home and died
- Held that the responsibility for the missed diagnosis should be shared between Dr C and the DHB
- The HDC did not accept that a busy and tired registrar can be excused from all responsibility because of a systems failure
- Particularly because of the pressure on registrars in an ED overnight, they should pay particular attention to any relevant guidelines, not hesitate to contact the on-call consultant and delay the patient's discharge until appropriate investigations have been undertaken

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Missed diagnosis in ED (04HDC12081) – December 2005

- Employers are responsible for ensuring its employees comply with the Code. They have a defence if they can prove they took steps as were reasonably practicable to prevent the employee from doing or omitting to do the things that breached the Code
- The HDC concluded:

> *"I am not convinced that the Board had "the necessary staffing, radiological support and discharge processes to ensure patients received appropriate and safe treatment…The Dunedin Hospital Emergency Department needs to aim to have sufficient specialist staff to staff night shifts – although I recognise that this will be a challenge for Dunedin Hospital, as is it for many public hospitals in New Zealand. The bottom line is that care should not be compromised because a patient presents at an emergency department at night or on the weekend. If specialist staff are not on duty in the department, they must be readily accessible on call"*

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Urology FSAs (04HDC13909) – April 2006

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Urology FSAs (04HDC13909) – April 2006

- The HDC stated:

  "It is well recognised within the health sector that there is insufficient funding to meet the immediate health needs of all New Zealanders. It is inevitable that not all patients who require treatment will be able to be seen, and some patients may spend a significant time period waiting to be assessed and treated in the public sector. In this environment, it is essential that patients waiting for assessment and treatment in the public sector receive appropriate care and management until such time as they are able to be seen"

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Urology FSAs (04HDC13909) – April 2006

- The HDC found that the specialist was responsible for:
  - Appropriately assessing and prioritising Mr C given the clinical information available at the time
  - Ensuring that Mr C was actually seen in accordance with the prioritisation and that he was given priority over less urgent patients

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Urology FSAs (04HDC13909) – April 2006

- The HDC found that the DHB was responsible for:
  - Ensuring patients and their GPs are given clarity about whether they will be seen, and if so, when treatment will be provided
  - If the number of patients seeking to be seen exceeds the resources available, it is the DHB's responsibility to advise the patient and the referring GP that the patient may not be seen within six months, if at all, in the public system
  - The patient and the GP should be given clear and specific advice about the option of seeking private assessment and treatment
  - The GP should be told to re-refer the patient if his or her condition deteriorates, or there is further relevant information that would affect the patient's priority that was not included in the original referral letter

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Urology FSAs (04HDC13909) – April 2006

- The HDC concluded that:

  "District Health Boards have an obligation to put systems and procedures in place to ensure an adequate and effective system for managing waiting lists for first specialist appointments, under which patients are kept informed of their status and options. Individual clinicians have an obligation to work with the DHB to appropriately prioritise and offer appointments on the basis of priority"

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North Shore Hospital Inquiry – April 2009

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North Shore Hospital Inquiry – April 2009

- The HDC initiated an inquiry into the care provided to five patients treated at North Shore Hospital between April and October 2007
- Although four of the five patients died, there was no evidence that treatment injuries or lapses in care caused their death
- However, the care provided to all five patients breached the Code of Rights in significant ways
- The failings were not the fault of individual staff but rather the result of systemic issues, overcrowding and pressures on staff

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North Shore Hospital Inquiry – April 2009

- The Board and its senior management must accept accountability for the failings identified in the report
- The Commissioner concluded that the DHB "*failed to fulfill its duty to provide sufficient staff and robust systems to withstand fluctuating demands and to ensure good communication between staff and with patients and their families*"
- It is not enough for a Board simply to "*toll the bell of scarce resources*" to excuse itself from liability under the Code

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North Shore Hospital Inquiry – April 2009

- The Commissioner noted his "*considerable sympathy for the difficulties Waitemata DHB has faced in trying to meet the needs of a rapidly growing population. DHB staff and senior managers have tried valiantly to anticipate and resolve problems, and have continued to try to provide the best care possible in difficult circumstances*"
- However, *"not enough attention was paid, soon enough, by the Board to the concerns of the staff and the solutions they proposed. Not was enough action taken to plan and provide good systems for patient care in the short term or to plan ahead for predicted population growth"*

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Your responsibilities

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Medical Council Statement

MEDICAL COUNCIL OF NEW ZEALAND

AUGUST 08 www.mcnz.org.nz

Statement on safe practice in an environment of resource limitation

If the state, an agency of the state, or an institution limits the services made available to the public, the responsibility for the consequences of these decisions must largely rest with the state or the institution. Such institutions are encouraged to make such decisions with the help and advice of doctors[1]. Doctors who are unable to provide the preferred treatment because of resource limitation must inform the patient of the preferred treatment and must furthermore advocate for its provision.

Background

The rationing of health services is becoming more explicit. Doctors, through their training and experience, bring particular expertise to decisions on resource allocation and should be

04 Doctors have a responsibility to the community at large to foster the proper use of resources and must balance their duty of care to each patient with their duty of care to the population. In particular this involves making efforts to use resources efficiently, consistent with good patient care.

05 Doctors working as managers, medical administrators or public health physicians must endeavour to allocate resources in the way that best serves the interests of a community or population of patients.

06 In all roles, doctors should use evidence from research and audit to endeavour to make the best use of the resources available.

07 Acting on these ethical principles in an environment of

Operating in a resource constrained environment as an individual

- As a GP:
  - Be familiar with the Medical Council's Statement on safe practice in an environment of resource limitation
  - Appropriately assess and prioritise in accordance with relevant guidelines
  - Raise concerns about delays/inefficiencies
  - The expected standard in relation to a doctor's duty of care is high
  - Working in a resource constrained environment does not excuse all actions (or failures to act)
  - Comply with relevant guidelines, policies and procedures
  - Recognise your limits
  - Seek supervision where appropriate
  - Call for further assistance and advice

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Operating in a resource constrained environment as a provider

- As a provider:
  - Ensure an effective system is in place for managing referrals and adequately informing patients
  - Ensure the roles and responsibilities of your staff are clear
  - Put in place clear guidelines, policies and processes
  - Ensure that there is a clear system for ensuring co-operation among providers to ensure continuity of care
  - Identify and act quickly where the effects of resource limitations may risk the standard of patient care
  - Listen and respond to concerns raised by your staff

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Operating in a resource constrained environment as a DHB

- As a DHB:
  - Pursue options to address these concerns comprehensively and rigorously (and ensure this is documented)
  - Consider regional collaboration and the formation of alliances to improve service quality and access for consumers (particularly in provincial centres)
  - If all reasonable possibilities to fund its acute services and pay for any related capital development (to redevelop or expand its facilities) from its existing budget have been exhausted, and the Board itself cannot produce a solution, it must put a detailed case to central government for additional funding

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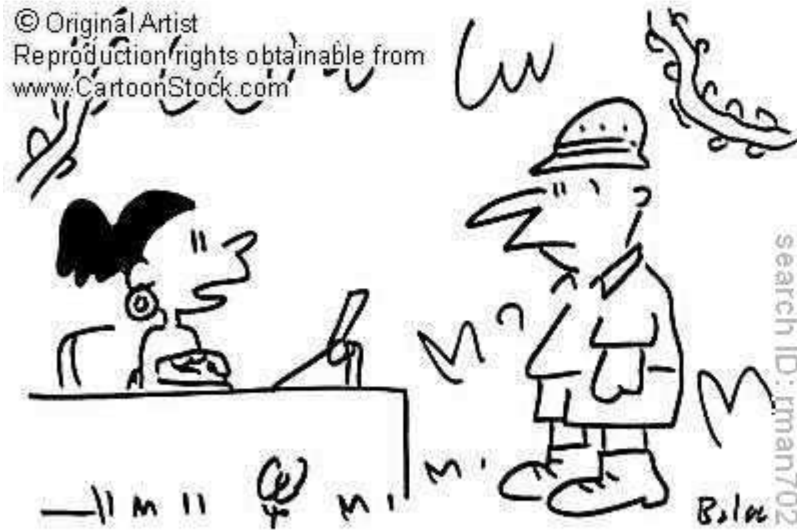
Obligations when referring patients



"You're looking for Dr. Livingstone?
— do you have a referral?"

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Three HDC cases on referrals

- Three HDC cases on referrals - all released on 3 October 2008
- Relate to lost or misplaced referrals
- Set out obligations of referring providers and receiving providers

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Lessons to be learned – providing information to patients

- At the time any test is proposed, 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 tests results will be notified is reassuring for patients and also provides an important safeguard
- Involving patients at all stages of the communication process provides a very reliable check in the system to create errors and ensure communications do not go astray
- Patients are entitled to be notified of all test results if they wish

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Lessons to be learned – information about waiting times

- Right 6(1) of the Code of Rights gives patients the right to receive full information about their condition and treatment options, including advice about the estimated time within which services will be provided

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Lessons to be learned – proactive follow up

- Any test ordered where the practitioner has reason to suspect a cancer diagnosis requires a pro-active follow-up by the referring doctor
- 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 retains a duty of care for the ongoing clinical management of the patient pending specialist assessment

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Lessons to be learned – continuity of care

- A specific aspect of the duty of care is to co-operate with other providers to ensure continuity of care under right 4(5)
- Providers must have robust systems for managing referrals, so that referred patients do not fall through cracks in the system
- Where a (non-GP) provider refers a patient to another provider they should:
  - copy all referrals to the patient and their GP
  - have a system in place to ensure that a referral has been received (and follow it up in the absence of confirmation of receipt) and that care of the patient has been accepted by the receiving provider

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Lessons to be learned – continuity of care

- The (non-GP) receiving provider should:
  - acknowledge receipt of the referral
  - prioritise it
  - arrange for patients to be seen in a timely fashion and their assigned priority
  - keep the patient and his or her GP informed whether, and if so when, the patient will be seen

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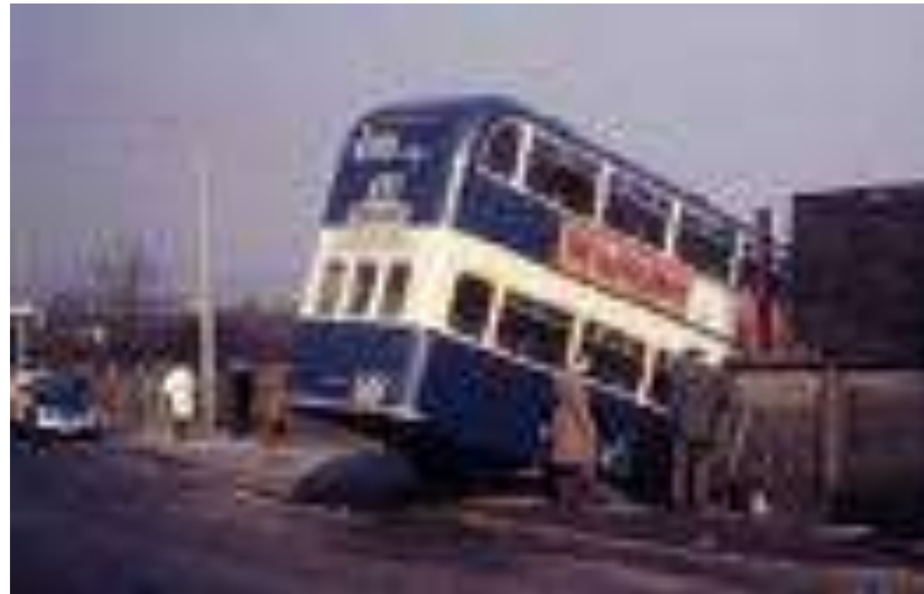
Acting within your scope of practice/competencies



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Scopes of practice

- Defines what a practitioner can do
- Unlawful to practise outside scope

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What about when there is no-one else?

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Responding to an emergency

- Right 4(2) of the Code of Rights – patients have right to care provided in manner complying with legal, professional and other ethical standards
- Medical Council Statement – a doctor's duty to help in a medical emergency
- NZMA Code of Ethics

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Responding to an emergency

- Duty to act within doctor's proper professional competence
- Professional duty to work as a team with other health practitioners and recognise their professional competencies or particular skills
- If do not have necessary skills should present yourself as an individual with some level of medical knowledge/knowledge of emergency first aid
- The fact that instant decisions may have to be taken in an emergency is a factor in deciding whether there has been a failure to meet professional standards

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Failure to attend an emergency

- Risk of being professionally or criminally responsible.
- Must have good reason if do not attend, e.g.:
  - Already attending anther emergency
  - More appropriate for emergency service to attend
  - Another doctor is closer geographically
  - Off duty and has been drinking alcohol or taken substance that may adversely affect competence
  - Attending emergency places personal safety of doctor at risk
  - Other situations where competence may be compromised (e.g. excessive fatigue)
- Keep a written record of reasons for not attending in case decision queried
- Duty to make a reasonable effort to assist in finding alternative care

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Responding to an emergency – a case study

- Rural GP on call during weekend and failed to respond promptly to increasingly urgent emergency calls made to her surgery, as was busy with other patients
- Patient denied access by GP's failure to respond to calls and receptionist's actions as intermediary
- Breach of rights 4(2) and 4(5) of the Code of Rights (ethical duty to attend or arrange immediate assistance in an emergency)
- Illustrates difficulties rural GPs can face in dealing with emergencies when already overworked

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Responding to an emergency – another case study

- Woman treated by doctor in isolated practice after a late night car accident in which she injured her back – the doctor decided against sending her for xrays at the nearest hospital (2 hours drive away) – a week later she consulted another GP and was admitted to hospital and diagnosed with a spinal fracture
- A consideration in favour of conservative management was the undesirability of asking a volunteer ambulance crew to spend the night on icy roads unless reasonably strong suspicion that xray urgently required
- The HDC accepted that this was a relevant factor to take into consideration but thought that arrangements should have been made for her to go to the xray facility by private car

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Responding to an emergency – another case study cont.

- Procedure performed by rural GP (inserting a PICC line)
- Failure to give sufficient information to patient about risks so that she could make an informed choice whether to be treated at a public hospital
- HDC acknowledged the challenges of workload and unique characteristics of rural practice, but said that it is critical that patients be provided with enough information so that they can make an informed choice

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Maintaining professional boundaries in a rural community

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Challenges

- Dealing with people in a dual capacity: GP and friend/acquaintance/neighbour etc
- Maintaining confidentiality
- Loss of objectivity
- Creating boundaries
- Ending doctor/patient relationships

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Medical Council Statement on providing care to yourself and those close to you

- Responsibility of doctor to provide care meeting acceptable clinical and ethical standards
- Treating people close to you is generally a bad idea, especially when:
  - Prescribing drugs of dependence
  - Prescribing psychotropic medicine
  - Undertaking psychotherapy
  - Issuing certificates
  - Performing surgery

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Medical Council Statement on providing care to yourself and those close to you

- Exceptions:
  - In an emergency
  - In a small community due to access issues
- The Medical Council recommends a low threshold for referring patients to an independent doctor for consultation when working in a small community

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Steps that should be taken to avoid problems

- Take extra care to ensure adequate assessment of patient’s condition
- Refer to another doctor if necessary
- Make good records of the consultation:
  - clear, accurate and contemporaneous notes that report relevant clinical findings, decisions made, information given to patient and drugs or other treatment prescribed

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Medical Council Statement on ending a doctor/patient relationship

- Particularly challenging in a rural community
- If initiated by doctor must be prepared to justify decision if called to do so
- Should assist patient in finding a new doctor and give sufficient notice to enable patient to do so
- Where there is possibility of a patient complaint – contact medical indemnity representative before starting to discontinue care
- Unethical to end for sole purpose of starting a sexual relationship with patient

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Process for discontinuation of care

- Tell the patient that professional relationship has ended giving a reason, if possible
- Record the termination in patient's records
- Refer the patient to another doctor of the patient's choice
- Send a letter of referral, with all relevant information (including a full copy of the patient's notes) to the patient's new doctor

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Case Study

- Patient unhappy with her daughter's care when she took her to her GP in a rural practice with a sore throat
- Patient wrote letter of complaint to doctor, asking for a refund, and said she would refuse to see him in future.
- Doctor responded that he had reviewed episodes, found care appropriate, and advised that he had removed the family from the register as he did not believe he could meet their expectations
- Formal complaint made to HDC

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Lessons to be learned

- Tempting in a rural community to treat complaint as evidence of irretrievable breakdown of patient-doctor relationship and disenrol patient
- Patients are legally entitled to complain (Right 10 of Code of Health and Disability Consumers' Rights) and to receive a prompt, fair and reasonable response
- Patients need to be given a reasonable notice of withdrawal and help to find a new doctor, particularly in a rural community
- Not appropriate to summarily dismiss "difficult" patients, or those with unpaid bills

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Sexual boundaries

- Medical Council statement – zero tolerance:
  - Trust;
  - Harm;
  - Power imbalance;
  - Risk of impairing clinical judgment.
- Doctor's responsibility to maintain sexual boundaries

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Sexual relationships with former patients

- Medical Council recognises that in rural areas doctor have to practice and socialise in the same community, including with former patients.
- Sexual relationship never appropriate when:
  - Doctor-patient relationship involved psychotherapy, long-term counselling or emotional support
  - Patient has condition impairing their judgement
  - Patient has been sexually abused in past
  - Doctor-patient relationship ended for sole purpose of initiating sexual relationship
  - When doctor uses power imbalance, knowledge or influence obtained while acting as doctor to initiate relationship

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Things to consider

- Length of doctor-patient relationship
- Interaction since end of relationship
- Context of the relationship with patient (did it include a counselling role, even informally?)
- Will you be caring for other family members still?
- Patient-doctor relationship dynamics, and the patient's understanding of these
- Circumstances surrounding end of patient-doctor relationship
- Patient's degree of vulnerability
- Seek peer advice and advise patient to seek independent advice from e.g. another doctor about risks of being emotionally involved with former doctor

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Case Study – Relationship with former patient

- Had been doctor's occasional patient for 27 years
- Underwent cardiac surgery
- Met doctor at social event and mutual attraction, led to dating and a brief marriage
- Doctor transferred her to another GP before they started dating but continued to prescribe her warfarin and monitor her INR levels
- Breach of Right 4(2) of Code of Rights (duty to comply with professional and ethical standards)

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