Regional practitioner reprimanded over personal relationships, conflict of interest, poor communication and record-keeping

Key messages from the case

Boundary breaches do not necessarily involve sexual relationships. Professional boundaries may become blurred where doctors and patients also have a close personal or commercial relationship, as a case involving a doctor in regional Australia illustrates.

Details of the decision

Dr S was practising as a GP in regional Australia, and also worked part time as a VMO at the regional hospital. He then began working fulltime at the hospital as a generalist medical officer. His care was subject of a number of complaints.

Boundaries – personal relationships, treating family and friends

Ms A and her children were Dr S's neighbours. Ms A had migrated from Indonesia, had limited formal education and was improving her English language skills. Ms A and her children visited Dr S and his then wife at home, and Dr S and his wife sometimes looked after Ms A's children.

Ms A also attended Dr S as her GP. When Ms A became pregnant, Dr S advised her she should seriously consider a termination given her age and the resulting risk that the baby may have Down Syndrome. He told her she was being irresponsible when she refused to consider an abortion. Ms A stopped consulting Dr S and he wrote to her urging her to consult another practitioner for her antenatal care.

Dr S conceded it was inappropriate for him to treat Ms A, given the close personal relationship, and that he should have referred her to another practitioner.

Patient confidentiality

Dr S conceded he had discussed Ms A's pregnancy with his former wife and that this was a breach of confidentiality.

After the personal and professional relationship had ended, Dr S wrote an affidavit in support of Ms A's ex-partner in contested Family Court proceedings.

The tribunal found that it was highly inappropriate for him to write the affidavit, which disclosed confidential information. There was no legal requirement for him to do so and if there had been information that was relevant to the children's welfare it could have been obtained by subpoena.

Boundaries – conflict of interest

81-year-old Mr B was a patient of Dr S in hospital. He was in the process of moving from his home into an aged care facility.

Dr S provided a gate pass for Mr B to leave hospital and drove Mr B from the hospital to Dr S's home so Dr S's daughter could test drive the car Mr B was planning to sell.

Dr S was aware that Mr B may have capacity issues – he had recorded a provisional diagnosis of anxiety and frontal lobe dementia and had prescribed antipsychotic medication.

The tribunal was satisfied that Mr B was a vulnerable aged patient. Whether or not Dr S was aware of it, there was a power imbalance and Dr S was in a potential conflict of interest situation in facilitating the sale of Mr B's car to his daughter. Arrangements for the sale had been carefully planned and Dr S had ample opportunity to consider his situation. His actions were in clear breach of the Medical Board's Code of Conduct in relation to conflicts of interest.

Standard of care and communication

Complaints were also raised about Dr S's standard of care in treating multiple patients at the regional hospital.

One elderly patient, Mr C, suffered severe chest pain while on the ward after being admitted with a head injury. An ECG conducted 55 minutes later, revealed a myocardial infarction. The consultant cardiologist was not contacted for some hours. Mr C was not transferred to the nearest tertiary hospital with cardiac facilities, but two days later he was transferred to a larger regional hospital where he died on arrival.

In several cases, Dr S was criticised for not ordering appropriate tests and medications. Hospital staff complained that he had failed to review patients, and failed to provide instructions, prescribe appropriate medications or communicate treatment plans. They claimed he had failed to consult or unreasonably delayed consulting on-call specialists. In one case he had prescribed medication contra-indicated for a patient who was on warfarin.

The tribunal accepted expert evidence that application of policies and treatment decisions were nuanced in some cases. It also accepted that Dr S had not been advised of relevant transfer protocols, and may have been given incorrect advice about transfers.

However, the tribunal was critical of Dr S's delays in consulting on-call specialists, delays in reviewing patients, and prescribing errors.

The tribunal found Dr S's care was significantly below that expected of a practitioner of his expertise and experience.

Medical record-keeping

Where concerns were raised about Dr S's care, there was often no record in the patient's notes that Dr S had conducted examinations, discussed treatment options with patients or their treating GPs, or developed a treatment plan. He had not recorded unsuccessful attempts to consult on-call specialists.

Evidence from colleagues at the hospital noted the difficulties Dr S's poor record-keeping caused them. They were often unable to take over care, and needed to start again to evaluate a patient.

In some cases, Dr S assumed the IMG he was supervising had made a record.

The tribunal accepted that notes were not always available at the bedside or nursing station. However failure to document important clinical information was in breach of legal and professional record-keeping obligations.

Failure to ensure that junior doctors under his supervision completed records was also unsatisfactory.

In the case of Mr B, Dr S claimed he had recorded the dementia diagnosis to remind nursing staff of their duty to care for a difficult and demanding patient. The tribunal considered this explanation 'extraordinary'.

Dr S conceded his record-keeping was below standard and that this constituted unsatisfactory professional conduct.

Outcome

Cumulatively, Dr S's conduct constituted professional misconduct.

The tribunal accepted Dr S had undertaken professional development and gained some insight into the shortcomings of his treatment and communication. However it agreed with medical experts that Dr S was not suited to work in the care of acute medical patients and should not be permitted to work in a hospital environment.

At the time of the hearing, Dr S was working as a GP in a shared practice and the tribunal accepted evidence from his colleagues that his skills were suited to his current role.

The tribunal reprimanded Dr S and imposed conditions that he not work in a hospital environment. Dr S was also required to undertake mentoring on boundary and ethical issues arising in general practice, and ordered to pay the regulator's legal costs.

Key lessons

Boundary issues – Your professional obligations require you to act in the best interests of your patients and to ensure that your personal views do not adversely affect the care of the patient.

Confidentiality – Ensure that you understand your obligations to maintain patient confidentiality. A patient's spouse or partner is not entitled to access information about a patient without the patient's authority, unless the patient lacks capacity or access is otherwise legally permitted or required.

You may be required to disclose patient information in response to a valid legal request, or to avoid danger or serious harm to individuals or the public. In such situations always seek advice. Contact Avant or your college or professional association.

Treating family and friends – Avoid treating anyone with whom you have a close personal relationship, except in an emergency or where there is no other help available, because the close personal relationship may mean you lack appropriate objectivity and may affect continuity of care for the patient.

Conflicts of interest – Be aware of situations where your financial, personal or professional interests may conflict with those of a patient. You must be able to recognise and resolve any potential conflict in the best interests of the patient.

Document all decisions carefully to assist with handover and continuity of care. This also helps clarify and provide evidence of your clinical decision-making processes.

Records need to contain enough information to allow another practitioner to identify the patient and continue their care.

Document all inputs to patient care including discussion with patients and professional colleagues such as specialists or treating practitioners.

If you delegate record-keeping to a junior colleague, you are still responsible for checking and confirming accuracy of the record prepared by that junior colleague.

References and further reading

Avant factsheet – Boundary issues

Avant factsheet – Treating family members, friends or staff

Avant factsheet – Privacy basics and data breaches

Avant factsheet – Providing medical records to a third party

Avant factsheet – Medical records: the essentials

Medical Council of NSW – Guideline for self-treatment and treating family members

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