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Case Study

Aged care physician reprimanded for poor clinical decision-making, record-keeping, and communication in end-of-life care

Key messages from the case

Complaints against a specialist geriatrician relating to her treatment of 12 patients in end-of-life care highlight the importance of clear communication and collaborative decision-making with patients and families.

The case also reinforces the importance of careful record-keeping to document discussions, capacity assessments, and treatment decisions at this stage of care.

Details of the decision

Dr T's employer notified Ahpra of concerns about Dr T's practice of medicine in respect of 12 geriatric patients with complex clinical histories and care needs. The concerns related to her:

- clinical decision-making, diagnoses and treatment decisions
- capacity assessments
- record-keeping
- communication.

Clinical decision making

The tribunal concluded that in some cases Dr T had moved too quickly to a decision to cease all active treatment without conducting appropriate physical examinations, considering all available information, or investigating treatable causes for the patient's symptoms.

In other cases, Dr T had moved too quickly to use syringe drivers and increase doses of opioid medications sometimes without appropriate pain assessment. Some experts felt that her medication decisions were inappropriately hastening death.

They considered that Dr T appeared inflexible in her treatment approach and unable to explore differential diagnoses or options to provide the best outcome in terms of clinical care, quality of life, comfort, psychological and social wellbeing.

At the hearing she appeared to lack insight into the concerns and seemed unable to consider changing her approach.

The tribunal concluded she had breached her professional obligations under the Medical Board of Australia's Good medical practice: a code of conduct for doctors in Australia to provide professional and patient-centred care.

Capacity assessment

The tribunal also concluded Dr T had moved too quickly to assess patients as lacking capacity. There was no evidence of capacity assessment, or attempts to locate a substitute decision maker.

Medical records

Dr T's notes did not meet the appropriate standard and were insufficient to ensure continuity of care. She had failed to record many relevant issues including:

- relevant details of clinical history
- investigations or clinical findings
- details of treatment or patient management decisions
- patient reviews at multidisciplinary team meetings
- capacity assessments
- discussions with or information given to patients and their families.

As the senior member of the care team, the tribunal felt Dr T could be expected to set an example for the rest of the team in her medical record keeping. They were critical that Dr T delegated note-taking on her rounds to the least knowledgeable member of the team (e.g. an intern) and did not check them for completeness or accuracy.

Communication

Dr T's peers and employer felt that she had failed to communicate or consult with patients and / or family members about treatment decisions. They also alleged that she was inflexible in her approach, failed to consult or take advice from colleagues who were involved in the patient's care – including GPs and specialists – and became 'enraged' when her care plans or treatment decisions were questioned.

The ultimate decision to move to palliative care may have been correct — the issue was with the manner and speed of decision-making and lack of consultation.

The inadequate medical records made it difficult to know how the family were informed or guided in coming to treatment decisions. The tribunal found that relevant investigations had not been carried out, and that diagnoses or treatment options had not been considered. Therefore, families had not been provided with adequate information.

The tribunal also found that families had not been given sufficient time to process information or options and reach a decision on appropriate care.

Outcome

The tribunal found that Dr T's conduct amounted to unsatisfactory professional performance.

Dr T was reprimanded and required to undertake:

- education on record keeping, end-of-life care, capacity assessments, medication in palliative care, diagnostic processes in aged care, ethics and professional boundaries and communication
- a 12-month mentoring program with an approved mentor.

Key lessons

Good patient care involves being open to consider all options and to make clinical decisions based on patient's overall best interests – including their social, psychological wellbeing as well as clinical outcomes.

It also requires careful documentation of all decisions to assist with handover and continuity of care. This helps to clarify and provide evidence of your clinical decision-making processes.

Documentation should include all information relating to patient care including details of discussions at multi-disciplinary team meetings and discussions with patients, carers, and family members.

Be careful to record assessments undertaken – such as capacity assessments.

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

You are expected to communicate with patients, colleagues and all persons who are involved in the patient's care, including, where appropriate, family members and substitute decision-makers . This includes being willing to explain your clinical decisions and the basis for these decisions, to discuss alternatives, listen to different views, answer questions and give decision-makers time to absorb and consider information and come to a decision.

References and further reading

- Avant factsheet – Medical records: the essentials
- Atul Gawande – Humanising your practice
- Avant factsheet – Capacity: the essentials
- Avant factsheet – Substitute decision-makers

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