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Standard of care & Communication

Milton Lum, Elected Member

Patient X, a 20 year old male, was brought into the Accident and Emergency Department of a private hospital at about midnight with a week's history of increasing lethargy, polyuria, polydipsia and shortness of breath with cough productive of greenish sputum.

He was seen by the Medical Officer and referred to Dr D, a Consultant Physician and Endocrinologist, who made a diagnosis of dehydration, diabetes and pneumonia. X and his father were informed by D of the diagnosis and the need for admission. X was started on insulin, intravenous antibiotic, oxygen by mask and intravenous fluids for rehydration.

X was seen by D the next morning. His blood glucose and hydration had improved. As he had extensive pneumonia and was still symptomatic, he was referred to and seen by Dr E, a Consultant Physician and Respiratory Medicine Specialist, who concurred with the management plan. X was reviewed by D at about noon and noted to have a low grade temperature.

At about 10 p.m. X's father informed the nurse on duty that he wanted to speak to D, who was contacted. X's father informed D that X was still breathless. D explained to him that X needed to be on an oxygen mask to ensure that he received adequate oxygen. D requested the nurse to inform him of X's condition after half an hour if there was no improvement. As the nurse did not call back, D called in and was informed that X was taking the oxygen mask off and putting it over his forehead. D instructed the nurse to ensure that X used the mask properly and to inform him if there was any change in his condition or oxygen saturation.

D reviewed X the following morning and noted that he was alert, oriented but slightly restless. There were still crepitations in the right lung but the diabetic control had improved. The oxygen saturation was 95% on air and 99% on oxygen at 3 litres per minute. X was seen shortly after by E. Both doctors had a discussion and concurred that X was to continue on oxygen and intravenous antibiotics. The need for ventilator support was discussed but as X was clinically stable, it was considered unnecessary at that time.

At about midday, X was found breathless in the toilet. He was put back to bed and given oxygen by mask at 5 litres per minute. As he was tachypnoeic, restless, unresponsive and his blood pressure was unrecordable, he was resuscitated immediately with intubation, insertion of an intravenous neckline and given inotropes, sodium bicarbonate and hydroxyethyl starch solution.

X was transferred to the intensive care unit and attended to by D, E and Dr F, a Consultant Anaesthetist. D informed X's parents and uncles of his critical condition. The chest x-ray showed changes consistent with adult respiratory distress and an enlarged heart which was not seen in the previous x-ray. D contacted Dr G, a Consultant Cardiologist, who suggested an

echocardiogram, which revealed a dilated left ventricle with very poor systolic function. A diagnosis of myocarditis secondary to pneumonia was made.

D informed X's parents of his critical condition twice and the cardiac diagnosis. Despite all efforts, X passed away in the evening. D informed X's parents and relatives of the cause of death about 15 minutes later. A request for a post-mortem was refused.

X's father complained about D and E to the Malaysian Medical Council (MMC). Inquiries were conducted by two different Preliminary Investigation Committees who recommended that the MMC hold disciplinary inquiries.

The charges against D were:
"1. In relation to the above facts wherein the patient complained of shortness of breath and having a reading of high blood pressure you have neglected or disregarded your professional responsibility for the standard of medical care to your patient by not providing thorough professional attention, examination and where necessary doing diagnostic investigation.
2. In relation to the above facts when the nurse informed you of the patient having shortness of breath suggesting the existence of condition requiring appropriate and prompt action you have disregarded your professional responsibility by failing to attend to the patient."

The charge against E was:
"In relation to the above facts and including the severity of the patient's condition you have neglected or disregarded your professional responsibility for the standard of the medical care to your patient by not taking appropriate and prompt action upon evidence suggesting the existence of a condition requiring urgent medical intervention."

Both D and E explained that there was no suggestion of myocarditis prior to X's collapse. There were no additional cardiac sounds or murmurs. The blood pressure was high and not low. The initial chest x-ray which revealed a heart of normal size made myocarditis unlikely.

After hearing the explanations by the doctors and submissions by their legal counsels, two MMC disciplinary panels decided that no case had been made out against both doctors.

Lessons

The MMC has been receiving an increasing number of complaints regarding standards of care in recent years.

The MMC is not concerned about cases which may give rise to action in the courts unless the doctor's conduct has involved a disregard of his professional responsibilities or neglect of his professional duties that it raises a question of serious professional misconduct.

It is pertinent that section 1.1 of the MMC's Code of Professional Conduct states:

"***Responsibility for Standards of Medical Care to Patients***

In pursuance of its primary duty to protect the public, the Council may institute disciplinary proceedings when a practitioner appears seriously to have disregarded or neglected his professional duties to his patients. The public is entitled to expect that a registered medical practitioner will provide and maintain a good standard of medical care.
This includes:-
a. conscientious assessment of the history, symptoms and signs of a patient's condition;
b. sufficiently thorough professional attention, examination and where necessary, diagnostic investigation;
c. competent and considerate professional management;
d. appropriate and prompt action upon evidence suggesting the existence of condition requiring urgent medical intervention; and
e. readiness, where the circumstances so warrant, to consult appropriate professional colleagues.

The MMC's guideline *Good Medical Practice* is also of relevance:

"In this age of super-specialisation, it is good medical practice to refer a patient for definitive management by a colleague who has special training or expertise in dealing with complex clinical problem. A doctor must accept his own limitations in professional competence in these special instances and be prepared to refer a patient to another doctor.

An area of some anxiety is the patient who is referred to multiple specialists. Before initiating such referral, the patient must be informed of the reason for the move. If the second doctor decides to further refer to another specialist, the consent of the principal doctor must be obtained as matter of courtesy.

Fragmentation of treatment must be avoided. Doctors must avoid "overservicing" their patients, In this setting, and the purpose of multiple referrals must be carefully evaluated and strictly for patient's need."

Both MMC disciplinary panels were of the view that shortcomings in the communication between the doctors and the patient's parents and relatives were instrumental in the lodging of the complaints.

The MMC's guideline Good Medical Practice is relevant:

"Unknown to the doctor coming in contact for the first time with a patient, there is a whole retinue of relatives and friends in the background. These people do not normally appear on day-one but descend soon after surgery or other major treatment, or when the patient turns critically ill. They then have a barrage of queries: why did it happen, what went wrong, what is next, will the patient survive, and so on.

It is important for the doctor to appreciate the influence and interest that these relatives and friends have on the patient, and to treat them with courtesy and respect, while taking pains to answer their queries, however irrelevant or exasperating they may be.

In the event of unforeseen eventualities in the course of patient management, it is this pleasant and cordial line of communication and dialogue that will most often see the doctor through the crisis."

There was an issue of the identification of the doctor with primary responsibility for provision of care in this case. This led to the patient's father and ward nurse contacting Dr D for the patient's breathing difficulties and not Dr E.

The identification of the doctor with primary responsibility for provision and co-ordination of care should be made early and made known to the patient, his or her family and relatives, and the nursing staff. Similar identification of the respective roles of other doctors in the team is necessary.