Patient disenrolment — proceed with care

For all the talk about every complaint being a treasure, it's hard not to feel personally aggrieved when you or your staff are complained about — especially when you think you've provided good service. The unworthy thought, "ungrateful wretch", sometimes comes to mind. But in my experience it is better to let one's initial annoyance abate, and to focus on responding to the substantive issue in a calm and reasoned manner.

Telling a complainant to "go elsewhere" is not really an option for HDC, though after exhaustive efforts we sometimes send people to the good offices of the Ombudsmen. But for doctors, especially for GPs whose books are full in communities where there is a waiting list of patients wanting to enrol, it may be tempting to treat a complaint as evidence of irretrievable breakdown in the doctor–patient relationship and disenrol the patient. A recent case highlights the pitfalls of this approach.

An unhappy Mum

Mrs A's two daughters (aged 2 and 7) and husband were patients of Dr X at a medical centre in a rural community. The centre is owned by Dr Y, who employs Dr X, two other part-time doctors, and nursing and admin staff. Mrs A was very happy with the care her daughters received from Dr X.

The trouble all began when the older daughter had a sore throat in late July 2008, and an early morning consultation with one of the part-time doctors, Dr X being unavailable. A swab was taken and a provisional diagnosis of viral infection made. Mrs A was asked to phone back for the results later in the week. The child's condition deteriorated, with vomiting and a high temperature, but a late afternoon call to the practice left Mrs A with unanswered questions. Since the local practice was now closed, she ended up taking her daughter to another medical centre, where tonsillitis was diagnosed and antibiotics prescribed.

Later the same day, Mrs A wrote a letter of complaint to Dr Y, noting that the second doctor had said "it's not really reliable to do a swab on a child of that age". The complaint also mentioned the late afternoon call to the practice ("not very informative") and an incident 8 months earlier when Mrs A felt the care provided by the part-time doctor for the younger child had not been up to scratch. Clearly on a roll, Mrs A noted that she would refuse to see that doctor in future, and that she wanted a refund of the $20 fee. She stated, "If I receive top service or … feel completely happy with the result … then I would be more than happy to pay the $20."

Dr Y's response

One could not blame Dr Y for wanting to draw breath after receiving this complaint. Twelve days later (in the meantime there had been a lengthy phone call from a practice nurse to Mrs A, trying to resolve the complaint without success), Dr Y responded. He said he had reviewed both episodes of care and found it "completely appropriate", and noted that "no practice can run" on the basis that the customer only pays if she thinks she has received "top service". He refunded the $20 and advised that he had removed the family from the patient register, "as I do not believe we can meet your expectations". He wished Mrs A well with her future care.

Unsurprisingly, Mrs A was shocked to be summarily dismissed in this way. She wrote to Dr Y saying that she was "very disappointed" by his response, pointing out that she had "a right to express" how she felt about the two consultations, and inviting him to put things right, "instead of going through HDC". Two months later, after no response, Mrs A made a formal complaint to HDC. She noted the difficulties in finding alternative medical care for her daughters without travelling a long way. Mrs A concluded: "I did not expect in raising this complaint that my children would be stopped from seeing Dr [X], had I known this would happen, I may never have complained, although one should be able to complain."

HDC involvement

We wrote to Dr Y for an explanation. After some prodding, he responded with the real reason for his reaction — that Mrs A had read her letter of complaint to a local young mother's group to garner support, and that five mothers had "expressed dismay to practice staff about this slandering of a doctor". Dr Y had not replied to her second letter because he could see "an endless exchange of communications … without resolution". The relationship between the medical centre and the family had ceased, and there was "no possibility that this family could return to the register". Dr Y insisted he was acting within NZMA ethical guidelines, and did not need to help the family find another doctor.

I decided to telephone Mrs A. She adamantly denied badmouthing the practice in the community, and said her main goal was to have her daughters and husband reinstated as patients of Dr X. Mrs A struck me as genuine, so I decided to involve the local PHO to see if the situation could be resolved. The PHO went to great lengths, meeting separately with Mrs A and Dr Y in an attempt to broker a solution. The PHO proposed a six-month trial of Dr X taking back the family (something he was happy to do) and the PHO paying for care from another practice any time Dr X was unavailable (to avoid "clawback" payments). But Dr Y was adamant, willing to be a test case if necessary. He said the therapeutic relationship with Mrs A had been so damaged that "his staff could not provide safe care to the family". The PHO advised that it appeared to be "an irreconcilable situation".

It was time for another phone call, this time to Dr Y. I told him that he did *appear* to have breached Mrs A's rights, both by effectively denying Mrs A her right to complain, and by failing to comply with relevant standards (both the PHO's disenrolment rules, and the NZMA Code of Ethics requirement to give a patient "reasonable notice" of withdrawal of care and to facilitate "an orderly transfer of care". I invited Dr Y to reflect on whether he really wanted all the hassle of an HDC investigation, with the possibility of adverse findings, publicity, and even referral to the Director of Proceedings (given the public interest issues raised by the case).

A week later, Dr Y phoned me to say the practice was willing to take the family back on a six-month trial basis, though he feared that the arrangement was "potentially flawed" and that Mrs A would make fresh complaints. I commended him and his staff on being willing to give it a go. I also called Mrs A with the news — and told her that it was important she enter the arrangement in good faith. She was delighted, and assured me she would co-operate. I contacted the PHO to formalise the arrangement.

Calling it quits

It may be tempting to do what Dr Y did, and treat a complaint perceived to be unjustified as sufficient reason to terminate the doctor–patient relationship. Doctors do have the right to withdraw care in a non-emergency situation, but there are two important caveats: patients are legally entitled to complain, under right 10 of the Code of Rights, and to receive a prompt, fair and reasoned response; and patients need to be given reasonable notice of withdrawal, and help to find another doctor.[1] *Cole's Medical Practice in New Zealand* states that "a doctor may only decide to discontinue seeing a patient when there is a breakdown in the patient–doctor relationship such that the doctor is rendered incompetent to treat the patient".[2]

Dr Y's response in effect negated Mrs A's right to complain, and left her stranded in finding alternative care for her family. Advocates and HDC staff report an increasing number of cases where medical centres have summarily dismissed patients seen to be "difficult" or "complaining", or who have unpaid bills (more common as the recession bites). Sometimes insult is added to injury by including information about the reason for termination when transferring the patient's file to a new practice. (In my view this is unfair — administrative information should be kept separate from clinical records.)

Maintaining a relationship in the face of a complaint can be a challenge — but also an opportunity to resolve misunderstandings and improve communication and care for the future. Calling it quits should be an option of last resort.[3]

Ron Paterson
Health and Disability Commissioner
New Zealand Doctor, 3 June 2009

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[1] Refer NZMA Code of Ethics, Responsibilities to the Patient, para 6 (2008) and Medical Council of New Zealand guideline, "Ending a doctor–patient relationship", para 4 (2004).

[2] St George, I (ed), *Cole's Medical Practice in New Zealand* (Wellington: Medical Council of New Zealand, 2009), p 60.

[3] See also Paterson, R, "Calling it quits — ending a doctor–patient relationship", *New Zealand Doctor*, 15 June 2005, p 14.