

Health Practitioners Disciplinary Tribunal
***The Director of Proceedings v Dr Martin* — 31 August 2006**

Ms C became a patient of Dr Martin in 1999. Between 6 September 2001 and 11 October 2002 Ms C consulted Dr Martin on a number of occasions. Ms C had a history of constipation, but during 2002 this was accompanied by extreme pain and discomfort in her lower abdomen. She used laxatives such as Fleet and Normacol, prescribed by her GP. During the latter half of 2002, she was frequently constipated, sometimes for up to five days at a time.

On 27 June 2002 Ms C went to the GP practice seeking a prescription for a Fleet enema. Dr Martin was not available and so another GP, Dr L, saw Ms C. Dr L was not comfortable issuing the Fleet prescription for a patient she didn't know, and questioned Ms C about her symptoms and history. Dr L established that Ms C dated the onset of the problems to the beginning of 2002, that Ms C had taken four Dulcolax tablets to treat the most recent episode of constipation, and that Ms C's grandfather had died of bowel cancer at the age of 43.

Dr L was concerned that Ms C needed to be carefully monitored, that a definite diagnosis had not been established, and that serious conditions had not been excluded. Dr L made full notes of the consultation. She gave Ms C a form to test for faecal occult blood, and also discussed the case with Dr Martin.

The expert called on behalf of the prosecution was critical of the care provided to Ms C from 6 September 2001, when Ms C complained of constipation lasting one week. He said Dr Martin should have undertaken a rectal examination or scheduled a time for one to be performed. He also considered that at subsequent consultations Dr Martin should have referred Ms C for a colonoscopy or barium enema to exclude bowel cancer, and/or performed a rectal examination.

The Tribunal found no adverse finding in relation to these matters. However, it found that Dr Martin's conduct from 19 July 2002 onwards warranted findings of professional misconduct.

After her consultation with Dr L, Ms C saw Dr Martin again on 19 July 2002. In light of the concerns raised by Dr L, and the fact that this was the sixth occasion Ms C had presented at the clinic complaining of constipation, Dr Martin should have encouraged Ms C to have occult faecal blood tests and arranged an appointment for a thorough examination. The possibility of a

colonoscopy and/or barium enema should also have been discussed at this time.

On 11 October 2002 Ms C had her last in-person consultation with Dr Martin. She had abdominal pain, had taken Normal Plus, and was still constipated. On this occasion Dr Martin performed an abdominal examination. She palpated soft masses, which she said were easily indented on the left side of Ms C's abdomen. Dr Martin concluded that these were faeces in the descending colon, and that Ms C was constipated.

On 2 December 2002 Ms C telephoned Dr Martin to seek further laxatives because she had been constipated for two to three weeks. She had been to an accident and medical clinic the previous day, and a rectal examination revealed that her bowel was empty.

Having heard all the evidence, the Tribunal found that, on both occasions, Dr Martin did not encourage blood tests, colonoscopy or barium enema to exclude bowel cancer.

The Tribunal also made other findings of professional misconduct in relation to additions made to the clinical notes without recording the date the additions were made, and in relation to Dr Martin intentionally misleading the Commissioner about that fact during the course of the HDC investigation. This last part of the charge was seen as the most serious.

Dr Martin was censured and fined \$15,000, of which \$10,000 relates to the last part of the charge, and costs of \$10,000 were awarded to the Tribunal and also to the Director of Proceedings. Permanent name suppression was declined.