General Practitioner

Report on Opinion - Case 98HDC16797

Complaint

On 17 June 1998 the Medical Council of New Zealand received a complaint from members of the consumer's family about services provided to their mother, the consumer, by the general practitioner. The Medical Council referred the complaint to the Health and Disability Commissioner. The complaint is summarised as follows:

- *The consumer consulted with the general practitioner over an eighteen month period prior to June 1997, regarding her concerns about increasing body weight, particularly in the stomach and abdominal area. The general practitioner's assessment was that this was not in any way remarkable and was due to post menopause. During this eighteen month period the general practitioner did not conduct any physical examinations, blood tests or refer the consumer for ultra sound scans.*
- *In mid-June 1997 the consumer consulted with the general practitioner, still concerned about her weight gain and abdominal pain. The general practitioner did an abdominal and internal examination and assured the consumer that nothing was abnormal and prescribed mild medication for irritable bowel. The consumer insisted on an ultra sound scan and the general practitioner referred her for a scan the next day.*
- *The next day the consumer learned she had ovarian cancer through the radiologist who assumed that the consumer already knew she had cancer. The x-rays showed the consumer's ovaries were obliterated. She had probably had had the cancer for eighteen months to two years.*
- *The consumer had total hysterectomy, approximately a week after that diagnosis. Despite receiving reports from all those involved with the consumer's surgery and care after surgery, the general practitioner never contacted the consumer. The consumer transferred her care to a new practitioner in February 1998.*
- *The consumer's family are concerned about how very brief the general practitioner's medical notes are, that some consultations have not been recorded in the consumer's notes and if they have there is not enough information to them.*

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Investigation Process

The complaint was received by the Commissioner via the Medical Council of New Zealand on 30 July 1998. An investigation was commenced on 13 November 1998 and information was obtained from:

The Complainant / The Consumer's First Daughter
The Complainant / The Consumer's Second Daughter
The Complainant / The Consumer's Third Daughter
The General Practitioner / Provider
The Consumer's First Friend
The Consumer's Second Friend

Copies of the consumer's medical records were obtained and the general practitioner's appointment diaries were viewed. The Commissioner obtained independent advice from a general practitioner.

Information Gathered During Investigation

The consumer's first recorded consultation with the general practitioner was in mid-January 1989 and the consumer saw him intermittently during the following years. Her last three consultations with the general practitioner were in early February 1996, late November 1996 and mid-June 1997.

At the consultation on early February 1996 the consumer's weight was recorded as 61.5kg. Her blood pressure and breasts were checked. A cervical smear was taken and the result of this was normal. A repeat prescription was provided for *prempak-C* hormone replacement therapy. A Hepatitis A vaccination was given because the consumer was about to leave on an overseas trip.

During the consultation in late November 1996 the consumer's blood pressure and breasts were checked again. Her weight was recorded as 61kg. Poor asthma control was noted and the consumer advised she was using *ventolin* only as required. A further prescription for *prempak-C* was provided along with a trial of *pulmacort*. This was to be reviewed in three months.

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Information Gathered During Investigation, *continued*

In mid-June 1997 the consumer's weight was recorded as 63kg and a *prempak-C* prescription was provided. The notes recorded a one week history of abdominal distension (enlargement). The possibility of irritable bowel syndrome was noted by the general practitioner. Next to the word "*bowels*" there is a tick, which the general practitioner explains means "*bowels ok*." An abdominal examination was carried out and tenderness was noted on both sides of the stomach. A vaginal examination was performed. The general practitioner noted that the consumer had a retroverted uterus (an abnormally positioned uterus that occurs in approximately twenty percent of women) but nothing abnormal was felt during the physical examination. Under the "*plan and treatment*" sub heading in the consumer's notes the general practitioner recorded, "*try Normacol, ultrasound pelvis*."

An ultrasound examination was arranged. The ultrasound was carried out the following day and a large ovarian mass was identified. On the following day the consumer had a consultation with gynaecological oncologist. The gynaecological consultant confirmed the presence of a mass on the left side of the pelvis and abdominal ascites (fluid in the abdominal cavity). In his written report to the general practitioner the gynaecological consultant stated that the consumer had noticed abdominal distension for ten days prior to the examination. Six days after the ultrasound scan was carried out a hysterectomy was performed. Two days later the consumer was diagnosed with stage three, grade three ovarian cancer. The consumer underwent chemotherapy and *taxol* (anticancer drug) treatment during the following months. Throughout this period the general practitioner received a number of reports from the specialists treating the consumer. The general practitioner advises that he telephoned the consumer once, after her operation, when the diagnosis was certain and with the intention of offering support. However, he had an uncomfortable conversation with her and found her to be angry and resentful about the diagnosis. The general practitioner advises that he felt any further attempt to contact the consumer was inappropriate, for fear of inflaming her grief process. The general practitioner felt that the consumer's anger and resentment were about the diagnosis itself and were not personally directed at him at that time. He did not attempt to contact the consumer again and she did not approach him for medical treatment.

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Information Gathered During Investigation, *continued*

In December 1997 the consumer consulted another general practitioner ("the second general practitioner"). In February 1998 the consumer began dual care between a public hospital's oncology unit and the second general practitioner. She arranged for her medical records to be transferred to the second general practitioner's clinic.

The consumer passed away at her home in mid-May 1998. Shortly before her death the consumer dictated a letter to the general practitioner. The consumer advised that over an eighteen month period she had expressed concern to him about increasing body weight, particularly in the stomach and abdominal area. The consumer questioned why blood tests and an ultrasound had not been recommended earlier. She expressed concern that the general practitioner had not identified the ovarian abnormality during the consultation in June 1997 and she stated that she had needed to insist on an ultrasound scan being performed. The consumer's health deteriorated and she was unable to sign the letter. Family members have confirmed that the contents of the letter accurately reflected the consumer's views about the treatment provided to her by the general practitioner. The consumer's family forwarded the letter to the general practitioner and the Medical Council after the consumer's death.

The general practitioner informed the Commissioner that he did not assure the consumer that *"nothing was abnormal"* during the consultation in mid-June 1997. He advises that his assessment of her abdominal distention and pain was that it was probably bowel related, possibly in the nature of irritable bowel, and that her tenderness on abdominal examination reflected this. The general practitioner advises that he proceeded to discuss a differential diagnosis which included gynaecological pathology and how he could test for this. He stated:

> *"It was at this time that I, and not* [the consumer], *raised the possibility of having an ultrasound scan. After this discussion she chose to have a scan. It is incorrect to state that "*[the consumer] *insisted" on an ultrasound scan.*

The general practitioner advised the Commissioner that in his experience it is not unusual for something that shows up on an ultrasound scan not to have been felt during an earlier examination. He also advised that it is still possible to have irritable bowel syndrome, with gas, wind and tenderness yet still have normal bowel movements.

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Information Gathered During Investigation, *continued*

The general practitioner advised that prior to the consultation in June 1997 he had no memory of, or file entry about, any serious concern expressed by the consumer regarding weight gain. He has advised that this does not exclude the consumer mentioning the matter, just that it would not have appeared to be of serious concern worthy of recording or noting at the time. He had no recollection of the consumer ever discussing urinary incontinence with him and advised that anything of significant concern to the patient would normally be noted in their records. He also advised that the notes recorded that the consumer had advised that she had been aware of abdominal symptoms for only about one week prior to the consultation in June 1997. The general practitioner does not recall making any comments about weight gain and does not recall remarking, *"that this was not in any way remarkable and was due to post menopause".*

In regard to his note taking, the general practitioner stated that the notes in the consumer's records were no longer or shorter than they had ever been during his nineteen years of practice and that he found them perfectly adequate for his clinical use. He advised that there were no unrecorded consultations and that the only reason a date may appear without any corresponding notes is because the patient failed to keep an appointment.

Prior to early February 1996 the most recent date marked in the consumer's medical records is early June 1995. No notes are entered next to this date. Copies of the general practitioner's appointment diaries for the 1995 and 1996 periods were obtained. These show that the consumer had booked an appointment with the general practitioner for 2.00pm on the afternoon of early June 1995. The letters DNTU are marked beside the consumer's name. The general practitioner advises that this stands for, *"did not turn up."* Notes in the appointment diaries show that the consumer ordered repeat prescriptions from the general practitioner in mid-January 1995 and late June 1996. The type of prescription is not specified and there is no entry of these prescriptions in the consumer's medical records. In late August 1996 the words "[consumer's name] *a/c 13"* appear. The consumer's family advise that a cheque for thirteen dollars was written out to the general practitioner "*for flu*" on this date. There is no record in the consumer's notes of a visit to the general practitioner on or about this date and no record of an influenza injection being administered.

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Information Gathered During Investigation, *continued*

The consumer's daughters advise that prior to June 1997 their mother frequently discussed concerns about weight gain in her abdominal area with them. The consumer's first daughter advised that her mother often commented that she had put on weight. She had gone through menopause, was aware of the weight gain and was concerned about it. The consumer often commented to her friends about the matter and had started walking every day in an effort to reduce her weight. The consumer's first daughter believes that an appointment made by her mother in late 1996 was due to concern about weight gain. The first daughter advises that after the cancer diagnosis her mother stated more than once that she was annoyed at the general practitioner because she had mentioned the weight gain to him a number of times. The first daughter also advised that after the consultation in June 1997, but before the ultrasound had been carried out, her mother telephoned her and said that she had insisted on a scan being carried out. She says her mother told her that the general practitioner had said to her, *"it's your money, if you want a scan it's up to you."* The first daughter recalled that on a number of later occasions her mother again stated that it was she who had insisted on the scan. The consumer's first daughter also advised that she thought that her mother may have had several incidents of incontinence during 1996, however she is not positive about this.

Another daughter, the consumer's second daughter, recalled to the Commissioner that her mother had noticed a weight gain around her abdominal area. This increased over time and was particularly noticeable with regard to clothing. Her mother discussed the matter with her a number of times. The consumer started swimming and walking and bought a treadmill and an abdominal exerciser in an effort to lose weight. Whenever her mother commented about weight gain the second daughter would say, *"have you checked it out with* [the general practitioner]*?"* She recalled her mother saying that the general practitioner told her it was nothing to worry about, she was a post menopausal woman and had to expect this.

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Information Gathered During Investigation, *continued*

The second daughter also advised that she thought her mother had suffered from incontinence during a trip to Malaysia in September 1995. She recalls that after the cancer diagnosis, her mother told her that she had discussed the incontinence with the general practitioner previously. The second daughter did not know how many incontinent episodes her mother had discussed with the general practitioner. The second daughter advised that her mother informed her that during the consultation with the general practitioner in June 1997 she had insisted on a referral for an ultrasound scan. The second daughter remembered a message that was left on her mother's answer phone machine by the general practitioner. This was after her mother had a hysterectomy in June. The second daughter does not think her mother returned the call to the general practitioner nor that she had any further contact with him.

Another daughter, the consumer's third daughter, advised the Commissioner that on one occasion, around the end of 1996, her mother informed her that she was having some *"leaking."* The third daughter had asked her mother what she meant and the consumer replied that she was leaking urine. The third daughter asked her mother whether she had spoken to the general practitioner about this matter. She said that the consumer replied "*yes*", and that the general practitioner had said that it was hormonal. The third daughter suggested that her mother try pelvic floor exercises.

The third daughter advised that she did not know what happened during the consultation that lead to the ultrasound referral but she advised that the evening of the day that the ultrasound was done, her mother told her, *"I bloody well had to insist on one."* The impression the third daughter got from this was that her mother had to actively pursue the option of an ultrasound scan.

A friend of the consumer ("the first friend"), advised the Commisisoner that she recalled the consumer coming around to visit her after the consultation with the general practitioner, but before the scan was performed. The first friend remembered that the consumer was very angry and she told her friend that the Doctor had said to her, when discussing the scan, *"if she wanted to waste her money that was fine."* The first friend had interpreted these comments to mean that the Doctor thought that there was no necessity for a scan to be carried out.

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Information Gathered During Investigation, *continued*

Another friend of the consumer, the second friend, recalled that the consumer often discussed concerns about her weight with her and that she dieted and exercised frequently. The consumer was upset that she could not maintain her tummy area as she would have liked. Her weight concerns related only the abdominal area. Shortly after being diagnosed with cancer the consumer told the second friend that she had to, *"push for a scan."* She told her that she had to insist that her general practitioner investigate the matter further and provide a more definitive explanation of her symptoms.

Independent Advice to Commissioner

The Commissioner obtained independent advice from a general practitioner. The advisor stated that prior to mid-June 1997 there were no significant grounds for the general practitioner to refer the consumer for an ultrasound scan. Likewise, the advisor believed that there were no grounds for referring the consumer for a blood test to determine CA125 levels at any stage while the consumer was receiving care from the general practitioner. This is because the CA125 tests are a marker for ovarian cancer and are used only after ovarian cancer is suspected or diagnosed on an ultrasound scan.

The advisor stated that if the consumer had expressed serious concern to the general practitioner about weight gain in her abdominal area and if these concerns were expressed in a serious manner then they should have been included in her medical notes. Likewise, if significant concerns had been raised with the general practitioner about urinary incontinence then this information should have been recorded in her notes as well.

The advisor noted that it is not part of the contract between patient and general practitioner that the general practitioner maintain contact with a patient who is receiving care from an oncologist. As a matter of professional courtesy most general practitioners will in fact do so but it is not the standard requirement that this be done.

Despite this, the advisor felt that if the general practitioner had maintained reasonable contact with the consumer after the diagnosis a lot of the anger that the consumer and her family felt towards the general practitioner may have been diffused.

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Independent Advice to Commissioner *continued*

The advisor noted that physicians can make errors when conducting vaginal and abdominal examinations. He noted that the important thing is that the general practitioner attempted to make the examination, and the fact that he failed to detect the abnormalities is not to say that he breached professional standards.

In the advisor's view the content of the general practitioner's clinical notes probably does comply with the required professional standards, but only just. The advisor noted that this was a *"marginal call".*

In the advisor's opinion it is not acceptable for repeat prescription requests to be recorded in appointment diaries rather than in a patients individual records. He stated that prescriptions should be recorded in the notes as they are issued. The advisor also stated:

> *"This is an unfortunate situation where a woman has succumbed to ovarian cancer. Ovarian cancer is notorious that by the time it is diagnosed it is frequently too late for anything to be done. It is known as "the silent cancer" and sadly it has no classical early warning signs. Too often by the time it presents, it is simply too late for anything effective to be done, as was the case with* [the consumer]. *Weight gain* per se *is not a sign of ovarian cancer and generally most doctors would be alarmed at weight loss rather that weight gain. Plus there were no clear cut signs for* [the general practitioner] *to seriously consider an abdominal pelvic malignancy".*

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

...

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

...

General Practitioner

Report on Opinion – Case 98HDC16797, continued

Opinion: No Breach

In my opinion the general practitioner did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights

Failure to Refer for Blood Tests or Ultrasound Prior to mid- June 1997
In my opinion the general practitioner's failure to refer the consumer for blood tests or an ultrasound examination prior to mid-June 1997 did not breach the Code of Rights. Prior to June 1997 the consumer's last visit to the general practitioner was in late November 1996. I agree with the independent advisor that in November 1996 there appeared to be no significant grounds for the general practitioner to refer the consumer for an ultrasound scan or to carry out investigative blood tests.

There is evidence that the consumer was concerned about weight gain around her abdominal area for several years prior to 1997. It appears from comments made by the consumer to family members that these concerns were raised with the general practitioner. It is not clear what emphasis was given to these concerns by the consumer in her discussions with the general practitioner. I note that in a report dated mid-June 1997 the consumer's oncologist stated that the consumer had noticed abdominal distention for only ten days prior to seeing him. I also note my advice that weight gain is not a sign of ovarian cancer. I am therefore unable to conclude that the general practitioner breached Right 4(2) in this regard.

Referral for Ultrasound on 16 June 1997
During the consultation on mid-June 1997 an ultrasound examination referral was arranged for the consumer. In her letter to the general practitioner dated early May 1998 the consumer noted, "*you will recall that it was I that insisted on an ultrasound scan on this day, and this omission I consider negligent*." Comments made by the consumer to friends and family members reflect her views about the circumstances surrounding the ultrasound referral. However, the general practitioner advises that it was he who raised the possibility of an ultrasound scan and that the consumer chose to take up this option. The general practitioner disagrees that the consumer insisted on the scan.

In the circumstances it is not possible to determine the exact circumstances surrounding the referral. In my opinion there is insufficient evidence to conclude that the general practitioner's conduct in relation to this particular matter breached the Code of Rights.

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General Practitioner

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Opinion: No Breach, *continued*

Failure to Maintain Contact with the Consumer Following the Diagnosis
In my opinion the general practitioner's failure to maintain contact with the consumer while she was receiving care from the oncologist did not breach the Code of Rights. I note that the general practitioner had been the consumer's general practitioner for a considerable period of time and that he continued to receive updates from the oncologist and other health care providers relating to the consumer's health. There is no evidence that the consumer approached the general practitioner for medical reasons during the period following her diagnosis. Although the general practitioner did not breach professional standards by failing to maintain contact with the consumer, in my view his failure to communicate further with her or to provide ongoing support or resolution of her issues is regrettable.

Adequacy of Notes
I note the independent advice I received on this matter which said that the notes only just comply with professional requirements.

It appears that repeat prescriptions provided to the consumer in January 1995 and June 1996 were not detailed or recorded in the consumer's medical notes. These events occurred prior to the introduction of the Code of Health and Disability Services Consumers' Rights on 1 July 1996. I am not able to form an opinion on these matters.

A cheque for thirteen dollars was written by the consumer in late August 1996. The consumer recorded that this was for "[the general practitioner] *for flu*". The general practitioner's appointment diaries for late August 1996 recorded that there was thirteen dollars owing on the consumer's account. There are no corresponding notes on the consumer's medical records for this date. It is not clear whether a further prescription was provided to the consumer on this date, whether treatment such as an influenza injection was provided by the general practitioner or another member of the clinic, or whether the thirteen dollars was part payment from an account for another consultation. In my opinion there is insufficient evidence to conclude that the general practitioner breached the Code of Rights in relation to this matter, though I note that from early July 1996 the standard of record-keeping is subject to the Code of Rights. The New Zealand Medical Council's Guide to Doctors Entering Practice states that although private clinical records are the personal notes of the individual doctor: *"this does not mean that they can be in a code or very brief and there is a strong ethical duty to maintain adequate records".*

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Opinion: No Breach, *continued*

Although there is evidence to suggest that the consumer discussed weight gain and incontinence with the general practitioner, it is not known what emphasis she placed on these matters or how frequently they were raised. Likewise, it is not known whether her concerns were serious and should have been recorded in her notes or whether they were mentioned only in passing during consultations for other matters.

Actions

I recommend the general practitioner takes the following actions:

- Reviews his record keeping practice and ensures all relevant consumer information, including repeat prescription requests, is fully and accurately recorded in each consumer's individual notes.

- Assesses his policy on maintaining contact with consumers receiving specialist care and consider the appropriateness of continued communication and support on an individual basis.

Other Actions

A copy of this opinion will be forwarded to the Medical Council of New Zealand.