GPs disciplined for lack of care

After a lull in 2004 and 2005, when no general practitioner faced disciplinary charges for shortcomings in clinical care, three recent decisions of the Health Practitioners Disciplinary Tribunal ("the Tribunal") have highlighted the need for GPs to undertake appropriate assessments and referrals so that a diagnosis is not missed. The charges did not allege that the GPs should have diagnosed certain conditions, but rather that the failures to take steps reasonably expected of a GP in his or her position amounted to professional misconduct.

Case 1 — Bowel problems

Ms D became a patient of Dr M in 1999. Between 6 September 2001 and 11 October 2002 Ms D consulted Dr M on a number of occasions. Ms D 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 D went to the GP practice seeking a prescription for a Fleet enema. Dr M was not available and so another GP, Dr L, saw Ms D. Dr L was not comfortable issuing the Fleet prescription for a patient she did not know. She questioned Ms D about her symptoms and history. Dr L established that Ms D dated the onset of the problems to the beginning of 2002, that Ms D had taken four Dulcolax tablets to treat the most recent episode of constipation, and that Ms D's grandfather had died of bowel cancer at the age of 43.

Dr L was concerned that Ms D 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 and gave Ms D a form to test for faecal occult blood. She also discussed the case with Dr M.

On 19 July 2002 Ms D consulted Dr M on an unrelated matter and raised with her the comments made by Dr L and the ongoing constipation. The Tribunal found that in light of the concerns raised by Dr L with Dr M, and the fact that this was the sixth occasion Ms D had presented at the clinic complaining of constipation, Dr M should have encouraged Ms D 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 D had her last in-person consultation with Dr M. She had abdominal pain, had taken Normal Plus and was still constipated. On this occasion Dr M performed an abdominal examination. She palpated soft masses, which she said were easily indented on the left side of Ms D's abdomen. Dr M concluded that these were faeces in the descending colon and that Ms D was constipated. Dr M prescribed Buscopan for spasms and pain.

On 2 December 2002 Ms D telephoned Dr M 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 of the latter occasions Dr M did not encourage blood tests, colonoscopy or barium enema to exclude bowel cancer. It said that her omissions were significant and justified a disciplinary sanction. The Tribunal also upheld a charge of professional misconduct in relation to subsequent additions made to the clinical notes without recording the date on which the additions were made. Dr M was fined $5000 in relation to these two parts of the charge.

The Tribunal viewed Dr M's intentional misleading of the Commissioner (in relation to the altered notes) during the course of the HDC investigation as the most serious aspect of her offending, stating that it "must send a clear message to Dr M and all health practitioners that the Tribunal will punish those who are less than frank and honest with the Commissioner and others investigating complaints". A fine of $10,000 was imposed for this part of the charge. In addition, Dr M was censured and ordered to pay costs totalling $20,000.[1]

Case 2 — Abdominal problems

Ms L had been a patient of Dr S since 1991. Of note in her past medical history was a mini-laparotomy in June 1993 for elective tubal ligation (adhesions were noted), and a history of palpitations, which from March 1994 required medication with atenolol. This was changed to Sotalol in August 1994 after she attended hospital with an episode of supraventricular tachycardia. She also suffered recurrent lower back pain after an injury in September 1993, and had a history of peptic ulcers, which required treatment with ranitidine.

On 11 November 2002, Ms L consulted Dr S complaining of bloating and abdominal discomfort. She was examined and prescribed Motilium.

In February, April and July 2003, Ms L visited for other unrelated matters but also complained of ongoing abdominal symptoms.

On 10 October 2003, Ms L consulted Dr S regarding her bloated stomach. She was weighed (80.5kg) and Dr S prescribed Motilium and Duromine.

On 7 November 2003, Ms L attended the surgery complaining of an upper respiratory tract infection. She had lost 2.5kg. Ms L told Dr S that she was having trouble breathing and that her stomach was no smaller and she still had the same problems. Dr S did not undertake a physical examination, and a repeat prescription of Duromine was provided.

On 9 December 2003, Dr S further prescribed Sotalol, ranitidine and Duromine following a telephone call from Ms L.

On 24 February 2004, when Ms L visited Dr S, she was in considerable abdominal discomfort. A repeat prescription of Duromine was given without assessment.

On 11 March 2004, when Ms L presented with abdominal pain, Dr S examined Ms L, queried the possibility of a mass on the left side, and arranged an urgent scan.

Ms L went home and spent the next approximately 36 hours in pain. At 3am on 13 March 2004, she called a friend, who took her to an after-hours clinic, and from there she was taken to hospital by ambulance. She was admitted acutely. On 16 March she had a laparotomy, left salpingo-oophorectomy and removal of a 14.7kg ovarian cyst. Her admission weight was approximately 74kg. After the operation she weighed 57kg.

The Tribunal, in making its finding of professional misconduct, found that the following omissions amounted to a significant departure from the standards ordinarily expected of a GP in those circumstances: failure to perform a thorough abdominal examination in October, November and February; prescription of Duromine without measuring and recording Ms L's BMI, pulse and blood pressure; and failure to make adequate enquiries about her health when he prescribed Duromine again in February. By way of penalty, Dr S was censured and ordered to pay costs totalling $22,500. A condition was imposed on the Dr S's practice that he attend an educational programme at the University of Otago Executive Education Department.[2]

Case 3 — Breast lump

On 22 November 2004, Ms W, at that time 40 years old and 21 weeks pregnant, visited her midwife for a routine check-up. The midwife noted that Ms W had a lump in her left breast and she advised Ms W to see her general practitioner.

Ms W had been a patient of Dr J since June 2004. On 24 November 2004, Ms W and her partner, Mr C, attended a consultation with Dr J regarding the lump. Dr J examined Ms W and noted a 3cm diameter lump. He thought it was most likely a blocked duct with infection or a tumour. He (appropriately) prescribed antibiotics and made a follow-up appointment for a week later. He noted that if the lump was not gone, he would refer the patient to a particular general surgeon, who specialised in breast cancer.

On 1 December 2004, Ms W and Mr C attended a second consultation. Ms W advised Dr J that there had been some reduction in the size of the lump and that it was not as sore. There was no discharge. Ms W later said that Dr J did not examine the breast lump or make a follow-up appointment, whereas Dr J says that he did both, but the records are incomplete. No referral to a specialist was made.

In February 2005, Ms W and her partner moved to another town. Ms W told her new midwife that she had a lump in her breast, and Ms W was immediately referred to the breast screening service. Upon examination by a house surgeon, a fixed hard solid lump measuring 6cm by 4cm was recorded. Following a mammography and fine needle cytology a diagnosis of left breast carcinoma was confirmed.

After induction, Ms W gave birth by Caesarean section to a baby girl on 25 March 2005. On 14 April 2005 Ms W underwent a left mastectomy and axillary dissection. A CT scan on 18 April 2005 confirmed likely metastatic disease. Ms W died on 15 November 2005.

It was accepted that Dr J should have recorded whether an examination occurred on 1 December 2004, and that he should have insisted on some review in the next week. He should have alerted Ms W's midwife and made sure that she monitored progress. If there had been an appointment on 6 December 2004 that was not attended, Dr J should have left no stone unturned to be sure that Ms W was seen again and re-examined. The Tribunal upheld the charge and, noting that the conduct fell at the lower end of the scale, Dr J was censured and ordered to pay costs of 30%.[3]

Theo Baker
Director of Proceedings

New Zealand Doctor, 29 November 2006

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1 A full copy of the decision can be found at www.hpdt.org.nz under Tribunal Decisions/Medical practitioners, decision Med/05/15D. Dr M has appealed the findings in relation to the clinical care and the quantum of the overall fine.
2 Decision Med06/28D.
3 Decision Med06/33D.