Canaries in the coalmine

I recall a law professor annotating one of my essays — with reference to my having cited a single case to back up a sweeping generalisation — that "one swallow does not make a summer". Doubtless the same is true of complaints. But when HDC receives two complaints about a GP (Dr X) from unconnected patients in short succession, and the second is forwarded by another doctor in the practice with the comment, "Neither I nor [the second practice] partner believe we can achieve anything more than further discord by discussing the problem with Dr X", one starts to suspect problems in the practice — and possibly with the practitioner. The recent saga of Dr X and her two unhappy patients merits recounting to a broader audience.

A suburban practice

Drs X, Y and Z are vocationally registered GPs in a suburban medical practice. Dr X joined the practice a few years ago. They are independent practitioners who share expenses and cover for each other. The practice is a busy one, employing several nurses and receptionists. Things proceeded reasonably happily until there was a breakdown in the relationship between Dr X and Drs Y and Z. This was reflected in the fact a meeting of the three doctors had not occurred during the five months prior to HDC's involvement, and had been "professionally mediated with an additional support person for Dr X". This only came to light when HDC sought further information from the practice, during assessment of the following complaints.

Complaint A — missed MI

The first complaint arose out of a missed diagnosis of MI in a fit, 40-year-old woman, A. She had presented to her regular GP, Dr X, complaining of chest pains of a nature and severity she had never before experienced, described (and documented) as "incredible while walking". Dr X did not document any enquiry about the cardiovascular risk factors of smoking, hypertension, hyperlipidaemia, diabetes or family history, nor did she detail any examination of the heart, lungs and peripheral pulses. The only documented examination was of the chest wall for tenderness, blood pressure (146/95) and the skin of the back (for a mole).

Dr X (and the peers with whom she later discussed the case) did not include MI in the differential diagnosis. Dr X did ask A, "Do you think you are having a heart attack?" (a question vividly recalled by A, but initially denied by Dr X, who later admitted she had indeed asked it, but had overlooked the error in her response to HDC!). Dr X sensibly explained she had asked A this "because often that is what patients may be worrying about [but] I was not thinking she had a cardiac cause of chest pain and wanted to reassure her".

Dr X told A she thought it likely she had gastro-oesophageal reflux or musculoskeletal chest wall ligament strain, and prescribed Losec and Brufen. She asked A to return for review in two weeks.

A's chest pain continued intermittently, and she returned to see Dr Z (having felt "fobbed off as a hypochondriac" by Dr X) eight days later. Dr Z arranged an ECG, which showed abnormalities, and A was promptly admitted to hospital, where the diagnosis was confirmed as MI, with underlying atherosclerotic coronary disease later revealed by coronary angiography.

A's letter to HDC indicated one of the reasons she chose to complain was a curious phonecall from Dr X later in the day after she had seen Dr Z for the results of the ECG. (A believes Dr X saw her in the waiting room, but Dr X said she noticed A's name on Dr Z's appointment list, and was "concerned that there might be unresolved medical issues"). According to A, Dr X told her over the phone that the cervical smear test she had had some months earlier showed some abnormalities — even though the previous notes stated "Smear Norm Rcl 2yrs". Dr X explained that she was

concerned about a possible polyp noted when taking the smear, and that A needed to make another appointment to discuss it. Patient A naturally found it strange that Dr X rang her about this issue some months later, and wondered whether there was some other motive. To Dr X's credit, she did phone A in hospital the next day, to apologise for missing the cardiac problem.

HDC decision

Many GPs may have missed an IHD diagnosis at some time. What was of concern was that, having noted "incredible" chest pain "while walking", Dr X did not exercise reasonable care and skill in exploring the chest pain history and did not undertake a sufficient examination to exclude a cardiac cause for the chest pain. As my advisor, Dr Stuart Tiller, commented, "Cardiac chest pain must always be considered because the known adverse sequelae from such a missed diagnosis can be fatal for the patient. A missed diagnosis of gastro-oesophageal reflux or musculoskeletal pain does not carry the same risk from missed or delayed diagnosis." Dr X had failed to take an ECG, which due care required given the patient's presentation.

Dr X protested that this criticism was based on hindsight bias, missing the point she was not being criticised for a failure to make the diagnosis of IHD, but rather for her failure to take a baseline ECG or document an adequate clinical history and examination for the proper assessment of chest pain of uncertain origin.

In relation to the phone call to A about the polyp, I wrote to Dr X: "In my view, if it was important enough for you to telephone A to check that everything was alright, you needed to set aside sufficient time to have a proper conversation. Otherwise, there was a risk your call would be misinterpreted, as indeed occurred." As regards Dr X's denial then admission of asking A whether she thought she was having a heart attack, I noted that it was "very surprising that when dealing with a complaint to this Office (a fairly rare event in your and most GPs' practice career) you would fail to check a basic and important point" and recommended that Dr X pay more attention to crucial details when responding to any future complaints.

I was left with some concerns about Dr X's communication skills, and a sense that her handling of the complaint had been a little odd. Even though this was only a single complaint, from the viewpoint of HDC it is not simply "a numbers game" (contrary to the view of Wellington barrister Gaeline Phipps, *New Zealand Doctor*, 28 January 2009) and I decided to bring the matter to the attention of the Medical Council.

Complaint B — rude to Mum

B's complaint involved an unhappy consultation with Dr X three months after the consultation with patient A. B was a new patient (her regular GP at another local practice was away) who booked a double consultation with Dr X about her seven-year-old daughter (concerning her asthma) and her three-year-old son (about bowel problems). B complained to Dr Y (who forwarded the complaint to HDC to resolve) that she had felt bullied by Dr X to join her practice, and that Dr X was "very grumpy" and "rushed" and said that she didn't have time to sort the problems out on a Friday afternoon, without the children's medical records and with other patients waiting.

Dr X told HDC that practice staff had been instructed *not* to book new patients on a Friday afternoon when she was the sole doctor on duty. This, and her rationale of needing to see the prior records to explore complex conditions, seemed a plausible explanation for her frustration — though no reason to upset B, the mother. But further enquiry of the practice elicited the fact that "a number of [Dr X's] patient case notes allude to discussions on enrolment", which suggested it might be assuming unnecessary prominence in Dr X's consultations. It also turned out that no other patients had arrived by the time Dr X finished seeing B's children; that Dr X spent only eight minutes each

with the two children (indicated by time of invoice); and that it was over half an hour before Dr X started making any notes on her next patient. These facts were difficult to square with Dr X's claim "a number of patients were waiting in the waiting room…patients who had been coming to the practice for a number of years and obviously needed [her] attention", with the implication she was rushing to see her next patient.

Significantly, Dr X's response to HDC described "considerable tension" in the practice and accused Drs Y and Z of "quite unfairly" complaining to the Medical Council about her, and even queried "their connection or involvement" with A's and B's complaints (something for which HDC saw no evidence). Dr X also admitted her personal circumstances , had "had a marked effect upon [her] ability to respond to [the complaints to HDC] as quickly as [she] would have liked".

HDC decision

In my view, the second complaint did not warrant further investigation. I wrote Dr X a succinct letter, recounting the key facts and stating:

"1. I think you owe B an apology for what happened during the consultation — something more fulsome than the 'I do very much regret that B was unhappy with the consultation' and 'I am sorry that B is upset' [Dr X's letter to HDC].
2. I have decided to bring this complaint and the relevant correspondence to the attention of the Medical Council. This makes sense given my recent referral of A's complaint and the concerns expressed to the council by Drs Y and Z about you.
3. I intend to notify [the local PHO] of my concerns about the apparent dysfunction within the practice."

A happy ending?

Four months later, Dr X has apologised to A and B, who are both pleased to put the experience behind them and happy with their current medical care; the PHO has become actively involved and concluded there is little likelihood of the issues between Dr X and Drs Y and Z being resolved — but has offered to pay for a mediation to help dissolve the practice; and the Medical Council is assessing Dr X.

To use another metaphor, it seems these two complaints were "canaries in the coalmine" and that there were problems in Dr X's own practice, and in her practice setting. As I wrote to Dr X, "I trust that your current difficulties can be resolved for the benefit of you, the Medical Centre, and the community you serve."

Ron Paterson
Health and Disability Commissioner

New Zealand Doctor, 25 February 2009