General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 03HDC04996)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Dr B	General Practitioner
Dr C	General Practitioner (overseas)
Dr D	Consultant in Medical Oncology
Dr E	Obstetrician and gynaecologist
Dr F	General Practitioner
Dr G	Radiologist
Ms H	Practice Nurse
Ms I	Practice Manager
Ms J	Masseuse
Dr K	General Practitioner
Dr L	General and gastrointestinal surgeon
Dr M	Partner at the general practice

Complaint

On 7 April 2003 the Commissioner received a complaint from Mr A about the standard of medical care provided to his wife, Mrs A, by general practitioner Dr B. The complaint was summarised as follows:

Dr B, general practitioner, did not provide services of an appropriate standard to Mrs A. In particular, Dr B:

- *did not refer Mrs A for further tests when she reported ongoing lower pelvic pain and abdominal bloating between 10 January and 3 July 2002*
- *did not refer Mrs A for a specialist assessment when she specifically asked for a referral in relation to her ongoing lower pelvic pain and abdominal bloating*
- *did not diagnose that Mrs A was suffering from ovarian cancer.*

An investigation was commenced on 14 May 2003.

Information reviewed

- Mrs A's affidavit sworn 23 June 2003
- Mrs A's clinical records from Dr B and Dr C
- Report from Dr D, consultant in medical oncology
- Report from Dr E, obstetrician and gynaecologist
- Information from:
  - Dr F, general practitioner

- Dr C, overseas general practitioner
- Dr G, radiologist
- Ms H, practice nurse
- Ms I, Practice Manager
- Ms J, masseuse

Independent expert advice was obtained from general practitioners Dr Jim Vause and Dr Helen Moriarty.

Information gathered during investigation

Background
Mrs A, who was aged 52 in 2002, enjoyed good health for most of her life. Dr B was her and her family's general practitioner at a medical centre for about 26 years.

Mrs A was part of the medical centre's cervical screening recall programme. In 1992 Dr B discovered that she had a cervical polyp when he performed a routine cervical smear, and he referred her to a gynaecologist, who performed a total hysterectomy. After the hysterectomy Mrs A was advised that she no longer required cervical smears.

Mrs A continued to consult Dr B for general health matters between 1992 and 2000. On 19 June 2000 Dr B recorded:

> "Chat about stress & anxiety with son. He likes to upset her. She wants 'happy pills' but not Prozac. In Nov 1996 when she tried Prozac she reacted badly."

Dr B prescribed clonazepam 0.5mg ¼–½ a tablet three to four times a day to control her anxiety, and the sedative Zo Tab 7.5mg 1–2 tablets at night.

Mrs A was regularly seen at the medical centre throughout 2001 for a number of matters including indigestion, a painful left wrist, vaginitis, oral thrush and prescription renewals.

Health consultations – early 2002
Mrs A consulted Ms J on 4 January 2002 for a therapeutic massage because of persistent pain in her lower back, general muscle weakness and malaise. Ms J is an overseas qualified doctor but is not practising medicine in New Zealand.

On 10 January 2002 Mrs A saw Dr B because she had discovered that she had a small lipoma (a common benign tumour comprised of fat cells) in the region between her left shoulder blade and spine. Dr B reassured Mrs A that she could have massage over the lipoma. He noted that they discussed the benefit of upper body exercises.

At her third visit to Ms J on 22 January, Mrs A reported that she had received no benefit from the massage treatments. Ms J discussed the need to lose weight. They also discussed Mrs A's abdominal pain and "tummy" bloating. Mrs A asked Ms J if there was any

possibility that the pain could be related to cancer. Ms J indicated that cancer was one possibility and "strongly recommended" that she see her doctor urgently, and ask for his opinion and possible referral to a gynaecologist. Ms J stated that her advice was based on information provided by Mrs A, including her age (50+), and the fact that she had not seen a gynaecologist for a number of years and had not had any medical tests performed recently.

On 8 February Mrs A had an episode of vaginitis, which Dr B treated with Micreme, an antifungal/antibacterial vaginal cream. Mrs A returned to see Dr B on 14 February for treatment of residual thrush. There is no record in the clinical notes for these visits that Mrs A was experiencing pelvic pain or abdominal bloating, or that she asked to see a gynaecologist.

On 21 February Mrs A consulted Dr B suffering from hot flushes and painful breasts, "tremendous indigestion", burping and stomach pains, and a sore throat. Dr B does not recall Mrs A mentioning abdominal pain at the consultation. He did not prescribe any treatment for her throat as he considered that the cause was viral. Dr B referred Mrs A for blood tests, which included an assessment of hormone levels. The results were consistent with menopause.

Dr B's notes for that visit record:

> "Thinks her symptoms are due to menopause. Check hormones again. Very congested breasts. Generally unwell. Very non specific & very sore throat."

(Ms I, Practice Manager at the medical centre, informed me that Dr B always dictates his clinical records. His dictation from consultations concluded before 5pm are always typed the same day, but his notes dictated after 5pm are held over for typing the following day.)

Dr B stated that Mrs A did not ask to be referred to a gynaecologist. He said, "I would happily refer her if she had asked. I would not refuse or be negative about such a request. I readily refer patients to specialists for second opinions and further management." Dr B also stated:

> "Most women would not, on these symptoms, ask to be referred to a gynaecologist. I did not raise this as a recommendation in light of the symptoms and the findings."

On 26 February Mrs A was seen by Dr K at an after-hours service complaining of indigestion and vomiting. Dr K noted that Mrs A had no diarrhoea. He palpated her abdomen and found it to be soft. He made a provisional diagnosis of gastritis and prescribed ranitidine to control her gastric irritation.

On 27 February Mrs A telephoned Dr B's surgery and spoke with Ms H, practice nurse, about her ongoing problems. Ms H suggested to Mrs A that she might need hormone replacement therapy (HRT) and made an appointment for her to see Dr B.

On 4 March Mrs A had a further discussion about HRT with Dr B, as there had been recent publicity about the adverse effects of the treatment. She had no symptoms of abdominal

pain, diarrhoea or weight loss at the time. Dr B started Mrs A on the hormone replacement Premarin 0.625 mg, and told her that if she felt that she was not receiving any benefit she could double the dose. Dr B also prescribed the hypnosedative Zo Tabs, to help her to sleep.

Mrs A recalled:

> "On the next two consecutive appointments (which I believe to have been the ones on 21 February and 4 March 2002) I said directly to [Dr B], 'I want a referral to a gynaecologist.' However, on both occasions he said words to the effect of 'No, it is not necessary', but did not appear to do any further tests or press for further information himself. On the second occasion I asked [Ms H] his nurse why he would not refer me, and she said that it was because he could do as well for me himself."

Ms H has no recollection of this conversation.

On 11 March Dr B recorded that Mrs A had been seen by another doctor at the after-hours service on 9 March complaining of a "burning sensation in the epigastric area 2-3/52 [2 to 3 weeks] not helped by meds". Dr B's notes record that he considered the possibility that Mrs A was suffering from a peptic ulcer or reflux disease. Dr B noted that she reported that her bowels were functioning normally, with no bleeding or changes to normal patterns. He recorded that Mrs A was prescribed Maxolon three times daily for two weeks to relieve the burning sensation. (However, it is not clear from the records whether it was the other doctor or Dr B who prescribed the Maxolon.)

Dr B decided to assess Mrs A's liver function and test her for pancreatitis and *Helicobacter pylori* antibodies (which if present would indicate a possible gastric ulcer). He ordered a series of blood tests and prescribed Losec HP7 (a combination package containing Losec, and antibiotics amoxicillin and clarithromycin, to kill the *Helicobacter pylori* bacteria and allow a peptic ulcer to heal).

On 26 March, Mrs A called in at the surgery for the results of her blood tests. Ms H informed Mrs A that the blood tests were normal. Mrs A informed Ms H that she had developed oral and vaginal thrush while taking Losec HP7 and requested treatment. Ms H explained the treatment to Mrs A but told her that she would need to see Dr B for review. Ms H documented the consultation and that Mrs A was travelling overseas over Easter. On 28 March Mrs A was given Sporanox (antifungal agent).

Mrs A spoke with Dr B about the thrush treatment on 2 April prior to going overseas and told him that she was also suffering from an itchy throat.

On 9 April when Mrs A was overseas she suffered intermittent epigastric pain and consulted Dr C, general practitioner, who noted:

> "Gets relief from belching – on Losec. [relieves bloating and reflux]
> O/E [on examination] BP 160/90. Epigastric discomfort.

> Needs gastroscopy. ↑Losec i bd. [increase to one Losec twice daily] R/V prn. [review as needed]"

Dr C recorded that he made a further house call to Mrs A at 7.30pm on 11 April. He noted that she had experienced a further episode of nausea and epigastric pain and recorded that he attempted to talk to Dr B, who was unavailable. Dr C noted:

> "O/E: BP142/90  tenderness, soft abdomen – Stemetil [anti-nausea]. Try Somac."

Dr C advised Mrs A that she needed to see a specialist about her epigastric problems. On 12 April Dr C followed up on Mrs A's condition and noted that Mr and Mrs A were travelling on to another city that day. Mrs A said she felt much better.

Mrs A stated:

> "On the first day after my return from [overseas], 16 April 2002, I visited [Dr B] and specifically put the question to him 'Do I have cancer?' He made only a cursory external examination of my pelvic area by hand, feeling for lumps or painful areas, and then declared that there was no cancer present. No ultrasound or more technological tests were carried out.
>
> [Dr B] carried out various blood tests during this period … [that] came back negative. On occasions when my stomach was distended, he commented that I had a lot of air in there. However his prescriptions all seemed to relate to the heartburn/indigestion aspect of my symptoms, such as Losec, Famotidene, Mylanta and Sporonox, together with Clonazepam for stress, but did not appear to be addressing my pelvic pains and bloating."

Dr B recorded on 16 April that Mrs A had been "really sick with reflux while [overseas]", and had sought medical advice for the management of the symptoms while on holiday. Dr B informed me:

> "I am saddened that [Mrs A] feels that no ultrasound or more technological tests were carried out. This is incorrect."

Referral for further investigations – 2002

The records show that on 16 April Dr B ordered a barium meal and ultrasound scan for Mrs A and referred her to Dr L, general and gastrointestinal surgeon, for endoscopy and assessment of her problems.

Mrs A had the abdominal ultrasound and barium meal at a radiology centre on 18 April. Dr G, radiologist, reported that the ultrasound showed that the liver, gallbladder, pancreas, spleen and kidneys were all normal, and that there was no free abdominal fluid or mass lesions. He reported that the barium swallow was unremarkable apart from some minor tertiary contractions in the distal oesophagus.

Dr G informed me that the abdominal ultrasound performed on Mrs A on 18 April did not include the pelvic or ovarian area. The request from Dr B made no reference to pelvic pain;

it referred to pain in the right upper quadrant of the abdomen, epigastric pain and gastro-oesophageal reflux. Dr G said that if the sonographer had seen something unusual on ultrasound, for example ascites (fluid in the abdomen, often associated with secondary cancer), this would have been reported and a wider view taken. In Mrs A's case, no abnormality was seen.

On 24 April Mrs A returned to see Dr B. Dr B noted:

> "Been very tense, tearful irritable, tension headache, neck. Given Clonazepam ½ TDS [three times daily] to QID [four times daily]. Advised to increase the Premarin to 1.25. Form given for blood test in 1/12 [one month's] time."

Mrs A saw Dr B again on 2 May. Dr B noted:

> "Feeling a lot better. Lot calmer. Discussed her X-ray results with her. Waiting to see [Dr L]."

Dr L performed an endoscopy on Mrs A on 7 May and took a tissue biopsy specimen for histological examination. Dr L noted that she gave a history of "just over two months of belching initially, then burning epigastric pain radiating up the retrosternal area" which was initially well relieved by a course of treatment for *Helicobacter pylori*.

Dr L recalled:

> "At the time of initial assessment, she did not mention lower abdominal pain or any other abdominal/digestive tract symptoms, other than those directly referable to the upper gastrointestinal tract. It is my customary practice to make general enquiries about lower digestive tract and symptoms at the time of this initial assessment, although I have no specific records to that effect in [Mrs A's] file. Nonetheless, in my experience, patients will mention other digestive tract or abdominal symptoms, if these are present and interfere with their lifestyle, or if the patients felt that the initial (GP's) referral reasons or symptoms were erroneous."

Dr L recorded in his letter to Dr B of 7 May that his opinion was that Mrs A's problem was "oesophagagogastric dysmotility/oesophageal spasm" and recommended ongoing treatment with a trial of reflux suppressants until she found one that suited her. He did not arrange to see her again.

The histology specimen reported:

> "A small number of *Helicobacter pylori* organisms are identified. There is no evidence of intestinal metaplasia, dysplasia or malignancy. The features are of Helicobacter gastritis."

Management of gastric symptoms – 2002

On 29 May Mrs A telephoned the medical centre and spoke to Ms H to report that she had finished the Losec and was about to commence the alternative anti-reflux treatment

famotidine. Mrs A informed Ms H that she would return to see Dr B, as recommended by Dr L, if she had no symptom relief from the medication.

Mrs A saw Dr B on 7 June and told him that she was still getting reflux and throat discomfort. He advised her to take the famotidine twice daily and started her on a course of Flagyl, an antibacterial, and Merbentyl, an antispasmodic, before meals. Dr B noted: "I still think it is all related to bloating and GI [gastrointestinal] rather than a sore throat."

On 3 July Mrs A saw Dr B because she had been experiencing frequent bowel motions since commencing the Flagyl. Dr B advised Mrs A to take acidophilus tablets to counteract the effects of the Flagyl on her bowel. He prescribed Dicap antidiarrhoeal capsules and told her to take one every morning "to slow things down". Dr B advised Mrs A to take the Merbentyl only when she needed to.

On 24 July Mrs A returned to the surgery and was seen by Dr M, a general practice partner at the medical centre. She asked Dr M whether she should continue to take HRT. Dr M noted that there was no history of breast cancer in Mrs A's family and that she was happy to continue on the low dose of HRT Dr B had prescribed. He emphasised the need for breast examination and regular checks. There is no mention in the notes that Mrs A reported abdominal discomfort, or that Dr M performed a physical examination.

Over the next six months Mrs A was seen at the medical centre or telephoned on a number of occasions, for problems such as breast screening, sinusitis, an inflamed eye, neck stiffness and bone density testing. There was no further report of epigastric pain. Mrs A recalled that Dr B frequently suggested that she could be suffering from stress. She said that although she had at one time taken Prozac, an antidepressant, she never suffered from serious depression.

Medical consultations – 2003
On 19 January 2003 Mrs A consulted Dr F at the after-hours service, because she was concerned about stomach bloating and related pain. Dr F recorded:

> "c/o [complaining of] quite sudden over 2/7 [2 day] distension of abdo [abdomen]
> no pain except mild low
> O/E no masses
> L^{o} ↑ [increased] resonance
> 'doughy' feel all over
> some areas of ↑ resonance mildly tender
> no guarding
> ? cause
> ? bowel distension
> for trial of Domperidone 10mg (20) [for relief of nausea and flatulence]
> → USS [ultrasound] if no better."

Ms H recalled that Mrs A telephoned on Monday 20 January. Mrs A said that she had attended the after-hours service the previous day because of abdominal distension and been

told to consider having an ultrasound examination. She said she was feeling better and was unsure if the ultrasound scan was still necessary. Ms H advised Mrs A to have the scan.

On 23 January Mrs A had the ultrasound scan. She went to Dr B's surgery later that day to receive the results. Dr B had not received the results and asked Ms H to telephone the radiology centre. Mrs A recalled that while he was waiting for the results, Dr B re-examined her pelvic area and commented that there was "a lot of air". She said that when Dr B became aware of the results he told her that "it could be cancer", and immediately telephoned Dr E, gynaecologist, to arrange an appointment. However, as it was late in the afternoon there was no appointment available until midday the following day, 24 January.

Dr B stated:

> "I have a very clear recollection of this consultation. … When I read the report I was very sad on [Mrs A's] behalf. I had concerning news to share, I needed to get her to a gynaecologist urgently and I needed to convey this reassuringly with compassion. This I tried to do for her. Having read the faxed result I returned to my consultation room with the faxed report in my hand. I did not say, 'Here are the scans and I think it could be cancer.'
>
> I remember very clearly that I did not say it could be cancer. I did not wish to frighten [Mrs A], and said that we would need to refer her to a gynaecologist urgently to sort out the 'growth' that was shown.
>
> I was unable to contact [Dr E] at that time and did ring him the next morning to make an urgent appointment for [Mrs A]."

Dr E saw Mrs A at midday on 24 January. Dr E recorded that Mrs A reported a three-week history of abdominal discomfort and loose bowel motions, and abdominal distension for one week. He noted that she reported experiencing stomach pains, reflux and some bloating during 2002 but these symptoms had settled with the treatment (famotidine) prescribed by Dr L. Dr E examined Mrs A and found that she had soft distension of the abdomen with no real tenderness and a large soft mobile mass high in the pelvis.

Dr E referred Mrs A for a chest X-ray and abdominal/pelvic ultrasound examination. The examinations were performed on 27 January. The chest X-ray showed pulmonary effusion (a collection of fluid) of the right lung. The ultrasound identified a large volume of ascites in the abdomen and a large mass in the centre of the pelvis that was "most likely a serous cystadeno carcinoma".

On 4 February Dr E performed a bilateral oopherectomy and omentectomy on Mrs A. At the conclusion of the surgery Mrs A was diagnosed as suffering from a Stage 3 well debulked mixed Mullerian tumour (ovarian cancer). A week later she was referred to Dr D, oncologist, for follow-up treatment.

Mrs A died on 5 November 2003.

Additional information

Dr B
Dr B provided the following additional information:

> "[Mrs A] is a gentle and sensitive person. … She has suffered from stress with regard to her work, her two sons. ... I know that in light of her diagnosis it is understandable that [Mrs A] would feel that her stress was not as bad as I recorded it or perhaps diverted me from diagnosing her ovarian cancer. … In all respects I wanted to help her be relieved of the problem she brought to each consultation. I regret that the diagnosis of ovarian cancer was not made earlier but as I review the notes and reflect on the consultations there were none of the symptoms reported that pointed myself or the other doctors to the diagnosis.
>
> I wish to reiterate that [Mrs A's] visits prior to January 2003 were not related to lower abdominal pain. Even when she was very unwell [overseas], she relayed symptoms of reflux, which was when I referred her for an ultrasound, barium meal, and to [Dr L], for further investigation. This is also reflected in what she told [Dr L], and did not include mention of lower abdominal pain.
>
> …
>
> At no time did [Mr A] accompany his wife to any of these consultations.
>
> I do not recall at any consultation refusing to refer [Mrs A] to a gynaecologist, and must state most emphatically that it would be most out of character for this to have occurred."

Mrs A
In a sworn affidavit dated 23 June 2003, Mrs A stated:

> "My husband and I both questioned [Dr E] and [Dr D] very closely about the cancer and in particular how long it might have been present, [Dr E] on Wednesday 12 February 2003 on receiving the results of the biopsies, and [Dr D] on the following Monday 17 February 2003 in the course of our initial meeting. Both were, for obvious professional reasons, very guarded in their replies, but both indicated that the tumour had very probably been present for twelve months or more, and both, in particular [Dr D], was very apologetic for the failure to diagnose it much earlier."

Dr E and Dr D were asked for their recollections of these conversations.

Dr E's response

> "Firstly there is the issue of whether I indicated some concern at the lack of an earlier diagnosis. At all times I have indicated to both [Mrs & Mr A] that it is always preferable to discover a cancer of the ovary as early as possible in its clinical course. However in [Mrs A's] case her more specific symptoms were only present for several weeks prior to seeing me. She had some upper abdominal symptoms that her General

Practitioner had recognised and had referred her to a general surgeon for thorough investigation and consideration. At least from the information I have available I do not feel the length of time before a referral was made to me was unreasonably long.

The second issue you asked for comment on, related to comment as to whether the cancer was likely to have been present for at least 12 months. It does seem that from studies of the natural history for malignancies that the tumours can be present for some months or even years before the presentation. Of course in many of these situations there are no symptoms present and no reason to suspect a diagnosis. Cancer of the ovary is notorious for late presentation.

In summary then I do think it likely that [Mrs A's] cancer may have been present for some months prior to her presentation. However this in no way implies that it should or could have been diagnosed at a significantly earlier point in time."

Dr D's response

"It is always disappointing when a cancer is diagnosed at an advanced stage and I would have expressed empathy and regret to [Mrs A] that hers had been diagnosed with the extent of disease reported to be present at surgery. Ovarian cancer, however, typically presents at an advanced stage, as it only produces symptoms when there is significant disease present. Typically 70-80% of patients with ovarian cancer of any histological type are diagnosed when the cancer has already spread beyond the pelvis (known as Stage III as in [Mrs A's] case). Ovarian cancer is thus difficult to diagnose because of the late onset of symptoms that are often non-specific and I note that in [Mrs A's] affidavit she describes seeing a number of different medical practitioners before she was ultimately diagnosed. My comments do not therefore necessarily reflect direct criticism of her GP."

ACC

A medical misadventure claim was lodged with ACC in relation to the misdiagnosis of Mrs A's ovarian cancer. On 13 April 2004 ACC declined Mr A's claim because it did not meet the criteria for medical misadventure. ACC found no evidence that Mrs A's cancer should have been diagnosed at an earlier stage. ACC held: "It would appear from the clinical records that [Dr B's] investigations in respect of [Mrs A's] presenting symptoms was entirely appropriate."

Independent advice to Commissioner

The following expert advice was obtained from Dr Jim Vause, an independent general practitioner:

> "Thank you for your request for an Independent Advisor's report on the case of [Mrs A] and [Dr B], your reference 03/04996/…
>
> I have no connection, either personal financial or professional, with [Mrs A] or [Dr B], nor with any other persons mentioned in the files.
>
> I have read and agree to follow the H&DC Appendix H: Guidelines for Independent Advisors.
>
> I am a vocational registered general practitioner, having graduated MBChB from Otago University in 1976. I have practised as a GP since 1979 and gained Membership of the Royal New Zealand College of General Practitioners in 1989. In 2001 I gained a Diploma of General Practice from Otago University.
>
> I have perused the following supporting information supplied by you in relation to this enquiry.
>
> - Letter of complaint to the Commissioner and accompanying documentation from [Mr A], dated 3 Apri1 2003, marked with an 'A' (11 pages)
> - Notes taken during an interview with [Mr A] on 9 May 2003, marked with a 'B' (1 page)
> - Notes taken during an interview with [Mrs A] on 12 May 2003, marked with a 'C' (1 page)
> - Response to the Commissioner from [Dr E], gynaecologist, dated 3 June 2003, marked with a 'D' (11 pages)
> - Response to the Commissioner from [Dr F], dated 9 June 2003, marked with an 'E' (3 pages)
> - Response to the Commissioner from [Dr B], dated 10 June 2003, marked with an 'F' (47 pages)
> - Response from [Ms H] practice nurse, to questions from the Commissioner, received on 3 July 2003, marked with a 'G' (2 pages)
> - Affidavit provided by [Mrs A], dated 24 June 2003, marked with an 'H' (11 pages)
> - Clinical records for [Mrs A] received from [Dr C], [overseas] general practitioner, 15 July 2003, marked with an 'I' (2 pages)
> - Letter of response to the Commissioner from [Dr D], oncologist, received on 22 July 2003, marked with a 'J' (2 pages)
> - Letter of response to the Commissioner from [Dr E], gynaecologist, received 24 July 2003, marked with a 'K' (2 pages)
> - Letter of response to the Commissioner from [Ms H], received 25 July 2003, marked with an 'L' (2 pages)

- Telephone call from [Dr G], radiologist, on 23 July 2003 in response to request for information, marked with an 'M' (2 pages)
- Reply letter from [Dr B] dated 24 September (7 pages)
- Accompanying copies of [Dr B's] clinical notes (written and computer) (38 pages)

I have been asked to provide the Health and Disability Commissioner with a professional opinion on whether [Dr B] provided [Mrs A] with services of an appropriate standard. In particular:

- Was [Dr B's] assessment of [Mrs A's] symptoms between 10 January and 3 July 2003 appropriate?
- What is the accepted practice for the management of epigastric discomfort, reflux and belching?
- Did [Dr B] follow accepted practice in relation to [Mrs A's] reported alimentary tract symptoms in 2002?
- Is there any evidence that [Mrs A] was suffering from lower pelvic pain and abdominal bloating prior to January 2003?
- Should [Dr B] have performed a pelvic examination while managing [Mrs A's] menopausal problems?
- Given [Dr B's] belief that [Mrs A's] symptoms were related to menopause, did he undertake appropriate investigations and/or treat her appropriately?
- What is the incidence of ovarian cancer? What are the recommended investigations for a general practitioner to undertake to detect this condition?
- Was [Dr B's] overall management of [Mrs A] appropriate? Should a specialist referral have been initiated? If so, when?

In addition:

- Are there any other professional, ethical and other relevant standards that apply and, in my opinion, were they complied with?
- Are there any other comments I may consider relevant that may be of assistance?

TIMELINE

Below is a brief timeline of the significant events in the case.

September 2001
Presentation to [Dr B] with wrist problems, vaginal symptoms, oral thrush after antibiotics, mild high blood pressure and a scapula lipoma.

January 2002 to July 2002
Presentations to [Dr B], [Dr K], [Dr C] with various abdominal symptoms.
Presentations to [Dr B] with oral thrush.
Presentations to [Dr B] with menopausal symptoms.

May 2002
Seen by (after referral) [Dr L], Surgeon, with gastroscopy and abdominal ultrasound

July 2003-January 2003
Presentations to [Dr B] with diarrhoea, menopausal review, nasal problems, neck strain

January 2003
Presentation to [Dr F] with sudden onset of bloating after hours leading to ultrasound scan and diagnosis of ovarian cancer.

Quality of the evidence

In appraising the information provided, the discrepancy between [Mrs A's] description of abdominal and pelvic pain and [Dr B's] and other doctors recording of epigastric problems (the epigastric region is the central upper part of a person's abdomen immediately under the rib cage) creates difficulties.

I have closely compared the information and note an inaccuracy in [Mrs A] affidavit 'H' number 9 stating that on 16-04-02

'*No ultrasound or more technological tests were carried out*'

[Dr B] clearly requested an abdominal ultrasound on this day, the test being completed on the 18th April as indicated in the received test results in his clinical notes.

Such inaccuracy is not unreasonable when a patient is recalling events a year and two months later, and I use this merely to highlight a need to appraise the quality of the provided evidence.

The discrepancy between the accounts places an emphasis on the reliability of [Dr B's] clinical notes. In assessing this, there is an obvious sparseness in his recording of [Mrs A's] symptoms and of his examination findings.

On a number of occasions (at least 14) the clinical note entry has been made a day or two later than the actual consultation. I have presumed, from an entry on 24-07-02 '*dict.*' that clinical notes were dictated (presumably into a tape recorder) and then typed by a practice staff member. This should be confirmed, as recording clinical details from memory a day later is likely to result in a significant filtering of clinical information.

In reply to specific questions raised:

1. Was [Dr B's] assessment of [Mrs A's] symptoms between 10 January and 3 July 2003 appropriate?

The discrepancy indicated above between [Mrs A's] affidavit and [Dr B's] records needs to be considered in answering this question.

[Mrs A] affidavit of 23-06-03 'H'

Her symptoms began in early 2002 and varyingly were:
Bloated stomach, indigestion, reflux, lower pelvic pain, diarrhoea. (reflux in this case appears to refer to the passage of stomach acid up into the lower gullet, commonly called reflux oesophagitis)

1. She describes asking [Dr B] for a referral to a gynaecologist on 21-2-02 and 4-3-02.

2. On 16-04-02 she asked [Dr B] 'Do I have cancer' and records his 'cursory examination of my pelvic area by hand'. She also states 'No ultrasound or more technological tests were carried out'.

[Dr B's] Clinical Records 'F'

As presented, with respect to [Mrs A's] statements summarised above:

1. There is no recording in the notes of a request to see a gynaecologist on 21-2-02 or 4-3-02 although clearly menopausal symptoms were a reason for consultation.

2. On the 16-04-02 consultation, [Dr B] referred [Mrs A] onto [Dr L], for barium meal and for abdominal ultrasound examination. There is record of these investigations being carried out on 18-04-02 and a referral letter dated 16-04-02 from [Dr B] to [Dr L].

Perusing [Dr B's] notes for presentations by [Mrs A] which could be indicative of other abdominal problems, she presented with reflux symptoms and bloating symptoms on

18-03-02 A follow-up after seeing the [after-hours service]. Investigation with blood tests.

16-04-02 (after her [overseas] trip). She was referred for ultrasound and to gastroenterologist [Dr L] and given Famotidine and Mylanta (acid suppression medication) for reflux.

10-06-02 Reflux and throat problems

Symptom recording:

Unfortunately the clinical notes are brief in recording patient symptoms. I can only find one occasion where the symptoms recorded refer to abdominal problems consistent with [Mrs A's] account, other than reflux. On 10-06-02 there is an entry by [Dr B]

'*I still think it is all related to bloating and GI (gastrointestinal) rather than sore throat.*'

Yet there is no reference in the notes prior to this of bloating. This gives some hint that [Dr B] was aware of significantly more than he recorded and points to the reliability issue for the clinical notes in recording the doctor's thinking and the patient complaints.

Examination recording:

Equally the records are brief as to clinical examination carried out. I cannot find any entry which records abdominal or pelvic examination by palpation. Either [Dr B] did not perform any such examination or he failed to record an examination.

[Dr B], in his reply letter of 24 September 2003 states under point 4

'*I have reviewed [Mrs A's] notes for the early part of 2002. The notes of 26 February record upper abdominal symptoms. An abdominal examination was carried out at that time and the findings were recorded as "soft".*'

Alas I cannot find, in [Dr B's] notes, any entry for 24 February 2002, nor any entry thereabouts which indicates an abdominal examination was carried out.

However, [Mrs A], in her affidavit 'H' states that on the 16-04-02

'*he made only a cursory examination of my pelvic area by hand, feeling for lumps or painful areas and then declared there was no cancer present*'.

This clearly indicates that [Dr B] did examine [Mrs A's] pelvic area and presumably the rest of her abdomen. This supports my opinion that [Dr B] failed to accurately record his examinations.

There are a few other occasions recorded in the notes where any reasonable GP would have carried out at least an abdominal examination in a woman presenting with the symptoms [Mrs A] describes. Unfortunately there is no recording of examination findings on any of these occasions.

Table one

Date	Reason for consultation
3-07-02	Diarrhoea
10-06-02	Reflux and bloating
18-03-02	Fol1ow-up from [the after-hours service] epigastric pain presentation

There are other presentations of some possible relevance to [Mrs A's] subsequent ovarian cancer where I would have expected some recording of clinical examination carried out and the findings of those examinations.

They are

Table two

Date	Presentation Problem	My observation on recording of examination
17-04-01	Weight Loss ...	There is no recording of [Mrs A's] weight
31-08-01	Vulvovaginitis:	No recording of whether there was a vaginal examination and although swabs were taken, there is no record of the test results or the test orders
11-02-02	Vaginitis.	No recording of examination, although swab results are present supporting a diagnosis of vaginal thrush
21-02-03	Menopause:	Poor examination finding. Does 'congested breasts' refer to a patient's description or a clinical examination? No mention of discussion of pros and con of HRT usage

Some comparison on symptoms and examination recording can be elicited from the other doctors seen by [Mrs A] during this time:

Table three

Date	Doctor visited	Symptom and examination recorded
25-08-01	[Dr …], [the after-hours service]	Urinary symptoms. Abdomen soft
26-02-02	[Dr K], [the after-hours service]	Indigestion and vomiting Abdomen soft
9-03-02	[the after-hours service]	Epigastric pain and burning sensation
9-04-02	[Dr C], [overseas]	Epigastric discomfort, no mass on examination
7-05-02	[Dr L], Surgeon, …	Belching, epigastric pain
19-01-03	[Dr F], …	Sudden bloating, No masses on examination

Of greatest relevance in [Mrs A's] case is that the first entry describing a lower abdominal mass is that of [Dr E], Obstetrician and Gynaecologist on 24-01-2003, after the ultrasound scan requested by [Dr B] had been performed.

As these other doctors could not detect [Mrs A's] cancer prior to 24-01-03, then it is entirely consistent that [Dr B] would not have detected [Mrs A's] cancer, unless he had carried out a pelvic bimanual examination, for which the indication is debatable.

2. What is the accepted practice for the management of epigastric discomfort, reflux and belching?

Accepted practice is establishing a clear symptom history, examination to exclude other significant pathology (specifically abdominal examination), consideration of any need to perform investigation such as blood tests, abdominal ultrasound and referral for gastroscopy, (that is passing a fiberoptic tube into a patient's stomach via their mouth

and oesophagus). The decision to carry out these further investigations would depend on the patient's symptoms, clinical findings on examination and assessment of their risks of significant disease (chiefly age).

In addition, if reflux oesophagitis (the most likely diagnosis in a patient presenting with the above) is suspected, a patient response to antacids (e.g. Mylanta) or acid suppression medication (e.g. Famotidine and Omeprazole) is also supportive of a diagnosis of reflux oesophagitis, and thus is appropriate management, both short and long term.

3. Did [Dr B] follow accepted practice in relation to [Mrs A's] reported alimentary tract symptoms in 2002?

Yes, with the proviso on the matter of poor recording of symptoms and examination.

4. Is there any evidence that [Mrs A] was suffering from lower pelvic pain and abdominal bloating prior to January 2003?

Lower pelvic pain is not recorded as a symptom in [Dr B's] notes, nor in the specialist records or those of the other doctors [Mrs A] saw during this period (refer Table three).

However there is recording of abdominal bloating on 10-06-02 but this would also have been consistent in [Mrs A's] case, with the swallowing air which commonly occurs with indigestion and reflux oesophagitis.

5. Should [Dr B] have performed a pelvic examination while managing [Mrs A's] menopausal problems?

It is important to differentiate an external pelvic examination from a bimanual or internal pelvic examination. The former is simply palpating a patient's abdomen from the outside, while the latter involves palpating internal pelvic structures by gloved finger via a woman's vagina. Bimanual examination would offer a greater chance of detecting a pelvic mass such as in ovarian cancer.

A decision to perform a bimanual examination would depend on the nature of [Mrs A's] menopausal symptoms. Those common to menopause, namely hot flushing, tiredness and emotional disturbance would not indicate a need for pelvic examination, whereas if [Mrs A] had problems more indicative of pelvic/uterine/ovarian problems (which are not common in menopause) then an examination would be indicated.

Reflecting the manner of [Dr B's] recording of patient symptoms, there is no description in [Dr B's] notes of [Mrs A's] particular menopausal symptoms.

[Mrs A's] affidavit 'H' suggests [Dr B] carried out an external pelvic examination on 16-04-02 in response to her concerns about 'cancer', but not a bimanual examination, although this is not 100% explicit. Using the affidavit, particularly [Mrs A's] declared concern about cancer, I would judge that a reasonable GP would have performed a pelvic examination. However there is at least one provable inaccuracy in the affidavit and that relates to this consultation. [Dr B's] notes do not record any examination or

discussion about cancer. There is too much uncertainty for me to reach a reliable judgement on this issue.

6. Given [Dr B's] belief that [Mrs A's] symptoms were related to menopause, did he undertake appropriate investigations and/or treat her appropriately?

Yes

7. What is the incidence of ovarian cancer?

In 1999, there were 308 new cases of ovarian cancer recorded in New Zealand giving a rate of 12 per 100,000 women. This compares with a rate of 17 per 100,000 women in the UK and a rate of breast cancer of 87 per 100,000. While ovarian cancer is the fifth most common cancer in New Zealand women,[i] it only accounts for 4% of cancers in women.

8. What are the recommended investigations for a general practitioner to undertake to detect this condition?

Bimanual pelvic examination would be recommended should a GP need to exclude ovarian cancer as a diagnosis in a woman. If a pelvic mass was discovered or suspected, ultrasound imaging is the recommended investigation.[ii] This requires referral to a radiologist and is frequently not funded publicly for a GP request. If a patient cannot afford to have the procedure performed privately, a GP would have to refer the woman to a gynaecologist.

However, the problem with this disease is that it is very difficult to detect at an early enough stage to have a high chance of success from surgery.

The problem is the vagueness of the symptoms of ovarian cancer. In 2000 Goff and Mandel completed a survey of 1725 Canadian women with ovarian cancer.[iii]

From the study:

'*When asked about symptoms before the diagnosis of ovarian carcinoma, 95% reported symptoms, which were categorized as abdominal (77%), gastrointestinal (70%), pain (58%), constitutional (50%), urinary (34%), and pelvic (26%). Only 11% of women with Stage I/II and 3% with Stage III/IV reported no symptoms before their diagnosis.*'

'*The time required for a health care provider to make the diagnosis was reported as less than 3 months by 55%, but greater than 6 months by 26% and greater than 1 year by 11 %. Factors significantly associated with delay in diagnosis were omission of a pelvic exam at first visit; having a multitude of symptoms; being diagnosed initially with no problem, depression, stress, irritable bowel, or gastritis ...*'

From a survey of 160 Swedish women with ovarian cancer in 1993:

'*Diagnosis of ovarian cancer is difficult due to the multitude of symptoms often appearing late in the disease.*'[iv]

Thus delay in diagnosis is unfortunately common in ovarian cancer and GPs need to have a high index of suspicion to detect this cancer early.

9. Was [Dr B's] overall management of [Mrs A] appropriate? Should a specialist referral have been initiated? If so, when?

[Dr B] appropriately referred [Mrs A] to a specialist for investigation of her upper abdominal symptoms in April 2002. It is important to note that the specialist did not elicit any lower abdominal symptoms or abnormal findings in his examination, other than the inconclusive gastroscopy results.

Summary

This is an unfortunate case which highlights again the difficulty in detection of ovarian cancer.

[Dr B] appears to have cared appropriately for [Mrs A] judging by the information in his clinical notes but for his failure to record [Mrs A's] symptoms and his clinical examination findings with sufficient accuracy, especially his abdominal and pelvic examination.

The issue of whether [Dr B] should have examined [Mrs A's] pelvis by vaginal bimanual examination, is difficult to ascertain as the clinical records give little indication for this. Equally [Mrs A's] early symptoms are similarly non-indicative of pelvic disease, supported by the recordings of her symptoms by other doctors she saw in this time (table three).

According to the information contained in [Mrs A's] affidavit, particularly her declared concern about cancer, a reasonable GP would have performed a pelvic examination. However there is at least one provable inaccuracy in the affidavit which relates to the consultation when, according to her affidavit she put the question *'Do I have cancer?'* to [Dr B]. [Dr B's] notes do not record any examination or discussion about cancer. There is too much uncertainty for me to reach a reliable judgement on this matter.

In judging [Dr B's] clinical records, a suitable standard for clinical notes in general practice is defined in the RNZCGP clinical note review module. The note review module has been in existence for a number of years and the criteria for judging clinical notes in '*Aiming for Excellence: An Assessment Tool for General Practice*'[v] is derived from this. While not applicable for all consultations, it is a general standard and [Dr B's] clinical records fail to meet an appropriate standard to be expected of a GP in these circumstances.

I trust this opinion is of help to the Commissioner and I am available for further consultation on this case.

REFERENCES:

[i] New Zealand Health Information Services. On line at http://www.nzhis.govt.nz/stats/cancerstats.html

[ii] National Radiology Referral Guidelines. On line at http://www.electiveservices.govt.nz/index.cfm under Guideline index, Referral Guidelines, Radiology

[iii] Goff BA, Mandel L, Muntz HG, et al: *Ovarian carcinoma diagnosis.* Cancer 9:2068-2075, 2000

[iv] Wikborn C, Pettersson F, Silfversward C, Moberg PJ Symptoms and diagnostic difficulties in ovarian epithelial cancer. *Int J Gynaecol Obstet.* 1993 Sep;42(3):261-4.

[v] Aiming for Excellence: An Assessment Tool for General Practice. 1st Edition January 2000: 31-32. RZNCGP, PO Box 10440, Wellington."

Responses to first Provisional Opinion

Dr B

In response to my first provisional opinion Dr B stated that he noted the independent expert's comment that he could not find reference to his performing an abdominal examination on Mrs A around 24/26 February 2002. Dr B clarified that Dr K (at the after-hours service) saw Mrs A on that date and that it was Dr K who performed the abdominal examination (see page 3 above).

Dr B stated that he has reviewed his practice in relation to record-keeping and now endeavours to expand his clinical records for all patient consultations.

Mr A

Mr A forwarded a response to my first provisional opinion from his lawyer. Mr A's lawyer raised the following issues:

1. Mr A's "complaint is that [Dr B] did not address [Mrs A's] concerns (or suspicions) that she had cancer and that he did not act on [her] request for a referral to a specialist gynaecologist. It is not a complaint *simpliciter* that [Dr B] failed to diagnose [Mrs A's] ovarian cancer. Neither Dr Vause or the Commissioner have, in my view, adequately addressed that distinction …"

2. There is evidence of gender bias in Dr B's account of his management of Mrs A's symptoms, Dr Vause's advice, and the first provisional opinion:

   - The conclusion that Mrs A "was a middle-aged woman who was making frequent visits to doctors with persistent but relatively vague or ill-defined symptoms … and kept asking if she had cancer".

   - The number of references to Mrs A's memory of the consultation of 16 April 2002 being incorrect.

   - The reference to the "discrepancies between [Mrs A's] account of her symptoms and what is recorded in [Dr B's] 'poor' records and the records of other doctors whom she consulted only intermittently".

   - "[W]hen an abdominal ultrasound and barium meal revealed nothing, [Dr B] suggested the symptoms were either 'stress-related' or menopausal, and ceased serious inquiry."

   - Dr B came to this conclusion despite Mrs A's evidence about the symptoms, including the recurrent abdominal pain and lower back pain (and the possibility of cancer) that she raised with her masseuse Ms J.

   - "Dr Vause and the Commissioner accept [Dr B's] assertions (on the basis of his 'poor' records) that [Mrs A] did not report the same symptoms to him."

   - "The finding that none of the other doctors whom [Mrs A] consulted diagnosed her cancer either so it was reasonable for [Dr B] also to fail to diagnose her cancer, or to refer her to a gynaecologist …"

   - "Dr Vause and the Commissioner's findings that, in effect, [Mrs A] is mistaken, or lying, in the account she has provided on oath, i.e. their preference for [Dr B's] word (especially when unsupported by his records) over [Mrs A's]."

3. The Commissioner and Dr Vause failed to adequately address Mr A's complaint about the standard of care Dr B provided to Mrs A between January 2002 and January 2003, in that:

   i) There is no evidence that Dr B actively managed Mrs A's symptoms.

   ii) The fact that other doctors did not diagnose Mrs A's condition is irrelevant. The other doctors saw Mrs A intermittently and "it would have been reasonable for them to have relied upon the fact that she had a GP who was primarily responsible for her care, and to have not been aware of, or even particularly interested in, her clinical history over any length of time".

iii) Mrs A had no routine care such as 'Well-Woman' checks during the relevant period and that Dr B appeared to believe that because Mrs A did not have a cervix she did not require a gynaecological check.

iv) Because of the rarity and difficulty in diagnosing ovarian cancer, general practitioners should have a "high index of suspicion" in relation to this disease. Given Mrs A's persistent symptoms, and taking into account that ovarian cancer can present in the early stages as gastritis, this should have been one of the differential diagnoses that Dr B considered, investigated and eliminated as early as possible.

v) It is not accepted that Mrs A did not ask for a referral to a gynaecologist.

vi) Dr B has been given the benefit of the doubt because his "sparse" and "poor" clinical records are insufficient to corroborate the complaint.

vii) "Keeping accurate, contemporaneous record of every patient's care is an essential obligation. … On that basis alone, if the doctor keeps poor records, that should be taken as indicating his or her general standards of care and the patient or complainant should be given the benefit of the doubt; not the other way round."

Mr A's lawyer concluded that "the Commissioner must consider whether there might have been a better outcome for [Mrs A] if she had been cared for by a woman practitioner", and submitted that:

- the complaint should be referred to a female general practitioner for further advice
- Dr Vause should be asked to review his assessment taking into account the possibility of gender bias
- the Commissioner should reconsider his findings and include a recommendation that the Medical Council review Dr B's competence, particularly in relation to his care of female patients.

Additional advice to Commissioner

In light of Mr A's response to the provisional opinion, the Commissioner sought advice from an independent female general practitioner, Dr Helen Moriarty:

"***Expert Advisor Report:***

Preamble:

I have received instructions from the Commissioner and Guidelines for Independent Advisors. I have read and followed these guidelines in preparation of this report.

I am a New Zealand Registered Medical Practitioner with the following qualifications obtained at University of Otago: MB,ChB, MGP, DPH, P/G cert. Hlth Sci.

I am a Fellow of the Royal New Zealand College of General Practitioners, and also Fellow of the Chapter of Addiction Medicine of the Royal Australasian College of Physicians. I have built my medical career over 27 years, working at the primary care-hospital interface.

I have had a special interest in women's health. At my own general practice surgery in Cambridge (during the early 1990s) we ran a Well Women's clinic, which was always well attended. I later worked (and trained) in Venereology and Sexual Health Medicine in Wellington.

I am currently a Senior Lecturer in General Practice at the Wellington School of Medicine and Health Sciences. I also work at the Specialist Rehabilitation Service of Hutt Valley District Health Board.

Instructions from the Commissioner were to prepare an expert medical advisor's report. The purpose of this report is to provide independent advice about whether [Mrs A] received an appropriate standard of treatment from [Dr B], general practitioner.

[Mrs A] stated that during February and March 2002, she consulted [Dr B], who had been the [A] family's general practitioner for 25 years, with continuing lower pelvic pain and abdominal bloating. She asked to be referred to a specialist, but [Dr B] informed her that her problems were menopausal, ([Mrs A] had a hysterectomy in 1992) and that he could treat her symptoms.

The clinical records show that [Mrs A] was seen by [Dr B] once in February 2002 complaining of gastritis and twice in March 2002 with a 'burning sensation in the epigastric area' and reflux. She was treated with pylori antibiotics. Following a prolonged acute episode while on holiday [overseas] in April 2002, [Dr B] referred [Mrs A] for a barium swallow and an abdominal ultrasound, which were performed on 18 April and reported as 'unremarkable'. [Dr B] then referred [Mrs A] to [Dr L], who performed an upper endoscopy with biopsies. The results were normal. [Dr L] prescribed Losec to control [Mrs A's] reflux and belching. [Mrs A] was seen regularly by [Dr B] over the following nine months for a variety of complaints most of which were associated with menopause.

I received the following background information:

On 19 January 2003 [Mrs A] experienced a sudden severe bloating of her abdomen and saw [Dr F] at the after-hours medical centre. [Dr F] reassured [Mrs A] but referred her for an ultrasound scan.

On 23 January [Mrs A] returned to see [Dr B], who telephoned through for the results of the scan taken that morning. He told [Mrs A] that she had cancer, and referred her to [Dr E], gynaecologist. [Dr E] immediately ordered a CT scan, which confirmed that

[Mrs A] had advanced ovarian cancer. [Dr E] performed a bilateral oophorectomy and omentectomy on 4 February and referred [Mrs A] for follow-up chemotherapy and radiotherapy.

[Mrs A] was told on 9 May 2003 that she has three to fifteen months to live.

I understand that the complaint was that:

[Dr B], general practitioner, did not provide services of an appropriate standard to [Mrs A]. In particular, [Dr B]:

- *did not refer [Mrs A] for further tests when she reported ongoing lower pelvic pain and abdominal bloating between 10 January and 3 July 2002*
- *did not refer [Mrs A] for a specialist assessment when she specifically asked for a referral in relation to her ongoing lower pelvic pain and abdominal bloating*
- *did not diagnose that [Mrs A] was suffering from ovarian cancer.*

I have sighted the following documentation:

- Letter of complaint to the Commissioner and accompanying documentation from Mr A, dated 3 April 2003, marked with an 'A'. (Pages 1-11)
- Notes taken during an interview with [Mr A] on 9 May 2003, marked with a 'B'. (Page 12)
- Notes taken during an interview with [Mrs A] on 12 May 2003, marked with a 'C'. (Page 13)
- Response to the Commissioner from [Dr E], gynaecologist, dated 3 June 2003, marked with a 'D'. (Pages 14-24)
- Response to the Commissioner from [Dr F], dated 9 June 2003, marked with an 'E'. (Pages 25-27)
- Response to the Commissioner from [Dr B], dated 10 June 2003, marked with an 'F'. (Pages 28-73)
- Response from [Ms H], practice nurse, to questions from the Commissioner, received on 3 July 2003, marked with a 'G'. (Pages 74-75)
- Affidavit provided by [Mrs A], received 7 April 2003, marked with an 'H'. (Pages 76-93)
- Clinical records for [Mrs A] received from [Dr C], [overseas] general practitioner, 15 July 2003, marked with an 'I'. (Pages 94-95)
- Letter of response to the Commissioner from [Dr D], oncologist, received on 22 July 2003, marked with a 'J'. (Pages 96-97)
- Letter of response to the Commissioner from [Dr E], gynaecologist, received 24 July 2003, marked with a 'K'. (Pages 98-101)
- Letter of response to the Commissioner from [Ms H], received 25 July 2003, marked with an 'L'. (Pages 102-103)
- Telephone call from [Dr G], radiologist, on 23 July 2003 in response to request for information, marked with an 'M'

- Letter from [Dr B] (responding to [Mrs A's] affidavit), marked with an 'N'. (pages 104-149)

The Commissioner has requested advice as to whether, in my professional opinion, [Dr B] provided [Mrs A] with services of an appropriate standard.

In particular:

- Was [Dr B's] assessment of [Mrs A's] symptoms between 10 January and 3 July 2002 appropriate?
- What is the accepted practice for the management of epigastric discomfort, reflux and belching?
- Did [Dr B] follow accepted practice in relation to [Mrs A's] reported alimentary tract symptoms in 2002?
- Is there any evidence that [Mrs A] was suffering from lower pelvic pain and abdominal bloating prior to January 2003?
- Should [Dr B] have performed a pelvic examination while managing [Mrs A's] menopausal problems?
- Given [Dr B's] belief that [Mrs A's] symptoms were related to menopause, did he undertake appropriate investigations and/or treat her appropriately?
- What is the incidence of ovarian cancer? What are the recommended investigations for a general practitioner to undertake to detect this condition?
- Was [Dr B's] overall management of [Mrs A] appropriate. Should a specialist referral have been initiated. If so, when?
- Is there any evidence that [Dr B] did not respond appropriately to [Mrs A's] ongoing problems?
- If not, what else should he have done?

In addition:
- Are there any other professional, ethical and other relevant standards that apply and, in my opinion, were they complied with?
- And any other comment I consider relevant that may be of assistance.

I have addressed these bullet points one by one below:

Bullet point 1.
Was [Dr B's] assessment of [Mrs A's] symptoms between 10 January and 3 July 2002 appropriate?

General considerations:

[Mrs A] had considerable contact with medical services between 10 January and 3 July 2002. [Dr B] himself has gone back over these consultations and has provided justification of his approach to some of the consultations (document N pages 104-7). Taking each of these episodes in isolation, the General Practice action was as expected on most occasions. The key consideration here is: was it appropriate for the patient's

regular General Practitioner to have assessed the multiple consultations, with a spectrum of presented symptoms, collectively indicative of failing health, each as isolated episodes.

The patient's General Practitioner is the one place where the personal health history is held and personal circumstances best understood. The GP surgery holds the most complete record of health problems for an individual under their care. When consultations occur at an unusual frequency or there is an unusual collection of health problems or when the health problems do not resolve as expected following appropriate treatment, the GP surgery may be the only health service that knows about this departure from the expected pattern of health care.

In the case of this particular complaint, examples were in evidence of all three types of the departures from the expected pattern of health care:

– consultations were very frequent, especially between 10 January and 3 July 2002,
– there was an unusual collection of symptoms with a number of these unresolved,
– symptoms had not responded to usual treatments.

The overall pattern of presenting health problems was one of deteriorating health.

At [Dr B's] surgery, because many of the consultations by [Mrs A] between 10 January and 3 July 2002 were dealt with incrementally as they occurred, and managed as isolated events, the pattern of presenting health problems had not been considered in a broader context. Consequently the developing picture of deteriorating health was overlooked, and the possibility of cancer as a reason for decline was not investigated. The patient herself had gained the impression that her health concerns not been taken seriously overall (document H page 079).

Specific instances:

The consultations between 10 January and 3 July 2002 illustrate the deconstruction of presenting problems which were in isolation, consistent with incremental decision-making:

Contact 1.

The first contact with [Dr B's] surgery in January 2002 was for a repeat prescription for sleeping pills (document F page 037). This occurred just before the period of interest, 10 January and 3 July 2002, but it is relevant to what happened to [Mrs A] during the period of interest (see contact 4 below).

[Dr B] has said that [Mrs A] had had a sleeping problem for some time and admits that he gave her sleeping pills on occasions (document N page 109). The records supplied confirm that [Dr B] had prescribed sleeping pills to [Mrs A] since at least 1996 (document N page 136), each time in monthly lots of 60 tablets. Records also show that as time went on, [Mrs A] had obtained prescriptions for sleeping pills from [Dr B] with

increasing frequency. Not only does this practice carry the risk of dependency (sleeping pills are addictive) but it also indicates that the sleeping problem experienced by [Mrs A] was not improving, but was getting worse. There is no documentation to indicate that any reasons for deterioration of sleep, other than stress, had been explored. There is no indication that the significance (or hazard) of escalating use of sleeping pills was recognised or discussed with [Mrs A].

Contact 2.

Two days later, on January 10th 2002, [Mrs A] consulted [Dr B] regarding a lump on her back. This was diagnosed as a lipoma. A comment associated with this lipoma diagnosis is unusual: 'it is OK to have a massage on it'. It is uncommon for a patient to request permission to massage a lipoma, especially one that is on the back and therefore out of sight, as a lipoma is a painless and benign lump in the skin. This enquiry implies that [Mrs A] may have been experiencing discomfort in the region of the lipoma (identified as between scapula and spine on the L side). The comment 'discussed upper body exercises' (F 037) also suggests patient concern about the upper body region. [Mrs A] herself has said she had already consulted [Dr B] about severe neck pain in November 2001 (document H page 077).

There is no entry in the records to suggest that this atypical feature of the lipoma consultation had been recognised at the time, or that the nature of the underlying concerns of the patient had been explored, or that the enquiry about massage had been considered in the context of knowledge of her prior health problems.

With the wisdom of hindsight this presentation of shoulder tip discomfort may have been a referred pain from another site (most often it represents an irritation of the diaphragm by fluid lying above or below it).

Contact 3.

The consultation with [the after-hours service] on 24/1/02 for L wrist and arm tenderness was attributed to lifting a heavy box. There are also some unusual aspects of this consultation:

– the trauma event as documented does not explain the severity of the symptoms, sufficient to cause nausea as well as wrist swelling (document F page 061).

– the consultation at [the after-hours service] took place midweek, three days after the identified injury event. This suggests that the symptoms described had taken some time to develop and were not troublesome immediately after lifting the heavy box.

There is no indication that [Dr B's] surgery contacted [Mrs A] to follow up on the improvement of the symptoms or clarify the unusual history aspects of the presentation. An entry in the medical notes about the [after-hours service] consultation was made by 'mc' (document F page 036). It is not clear if either [Dr B] or the practice nurse ever saw this report from [the after-hours service].

If the symptoms of pain and swelling had been reviewed at this stage, the longstanding history of joint and muscle symptoms relating to neck and arms with no specific diagnosis to date should have become apparent (see also contact 6 point B).

Contact 4.

On 29th January 2002 [Dr B] signed another prescription of her regular sleeping pills; zotabs (document F page 036). This repeat requested came only 21 days after the last one. The medical records and insurance claim records supplied both show that for [Mrs A] this was a much shorter interval than for previous repeats. Sleeping pill prescriptions are restricted to a one month supply at a time. The previous month's prescription had been consumed in three weeks. Hence [Mrs A] may have exceeded the prescribed dose of sleeping pills during the previous three weeks. There is no indication in the records if the surgery staff had or had not discussed with [Mrs A] if her sleeping problem was worse, or why the pills were no longer working at the usual dosage, or even that she might have exceeded the maximum prescribed dose (up to two a night). It is unclear if the departure from her usual pattern of repeat requests for sleeping pills had been noted by the surgery staff at all.

Contact 5.

A diagnosis of vaginitis was made on 8th February 2002. It is unclear if this presentation was pelvic pain or discharge or both. The presenting symptoms were not listed. There was no indication why thrush may have developed at this time. [Mrs A] was not taking antibiotics at that particular time.

A speculum exam was indicated to assess extent of the thrush infection (to determine if the infection was internal as well as external) and to inspect the vaginal tissues to exclude treatable causes of thrush such as atrophic vaginitis (associated with menopause). A vaginal swab was taken (document F page 036) to confirm the thrush, but it is not clear by whom. There is no documentation to indicate if the vaginal swab was taken using a speculum and light or merely by swabbing in or near the vaginal orifice.

A bimanual pelvic exam to check the pelvis for underlying causes for the infection, including bladder prolapse, state of ovaries, and to exclude other mass lesions was also appropriate at this presentation because this patient did not have regular internal examinations, since she did not need to have cervical smear tests.

It is not possible to determine from the available documentation whether or not this contact was assessed superficially, as a case of thrush infection. If so, it represented a lost opportunity to review the full history of the symptoms and examine for any underlying causes.

Contact 6, point A.

On 14th February 2002 [Dr B] was consulted about 'residual thrush' (document F page 036). There is no evidence to suggest that any underlying reason as to why the symptoms had not resolved with standard treatment of 6 days of vaginal cream had been explored. There is no record of an examination to assess if the thrush infection had resolved, persisted or deteriorated, or if there was now another infection present rather than thrush again. The patient was given prescription for diflucan tablets, an expensive second line antifungal agent (document H page 083).

There is documentation that patient also had mouth ulcers at the time (document F page 036). Treatment for this problem was also given (flagyl tablets). The level of documentation does not indicate if the mouth ulcers were assessed and treated considering the presence of associated thrush, or regarded as a problem occurring in isolation. The association of mouth ulcers and non-resolving thrush infection is a clinical indication that the immune system of the patient is run down. There is no record to suggest that this possibility was raised with [Mrs A]. There is no entry to indicate if the underlying reasons had been explored as to why this lady might be run down.

Contact 6, point B.

A prescription for celebrex was given at same time as the above consultation (February 14th 2002). This is a medicine prescribed for musculoskeletal pains and arthritis, but the insurance claim records indicate that this was not a regular 3 monthly prescription for [Mrs A]. Any reason why this patient requested this prescription at this time is not identified in the notes. The records from [the after-hours service] (in contact 3) had stated that [Mrs A] was 'already on celebrex', indicating that her use of this medicine had preceded that particular injury event (document N page 127).

The historical insurance claim record confirms this, showing previous prescriptions for celebrex as well as diclofen (A004) and later norflex (A008) on occasions. These prescriptions for non-steroidal analgesia indicate that there was an ongoing painful condition, or conditions, going back at least to November 2001. There are various non-specific descriptions of 'muscle sprain' (document N page 104, 'sore shoulders' (document N page 105), and 'tension in the neck' (document N page 108), but no specific diagnosis appears in the medical records corresponding to these prescription dates. This indicates that although [Mrs A] had presented with musculoskeletal symptoms a number of times and she had been treated for the symptoms each time, a diagnosis had not been made.

The available documentation indicates that these musculoskeletal health complaints had each been managed as if an isolated event. There is no documentation to indicate that the overall pattern, of a patient with ongoing body aches who was also consulting frequently with other health complaints, had been recognised.

Contact 7

On 21st February 2002 the consultation was described as 're menopause'. There is little documentation about the precise nature of the presenting health concerns, and in particular no indication why these concerns were attributed to menopause at the time.

Symptoms of congested breast were noted (document F page 036), without details of the duration of the breast symptoms, severity, laterality, or associated nipple changes or discharge. Although routine mammography had been normal earlier, the development of new breast symptoms warranted a full history of that particular complaint and a breast examination on that day. It is not stated if the breasts were examined on this occasion.

It is stated that the patient also felt 'Generally unwell'. This is not a typical menopause symptom, and it warranted a full history and full medical examination. There is no documentation to indicate whether or not a full medical examination was done at this consultation.

Another symptom was documented at this consultation: 'Very sore throat' (document F page 036). There is no mention of any examination findings relating to the throat, and available records indicate that this particular complaint was not specifically investigated on this occasion.

Blood tests for hormone levels were ordered, to assess menopausal status, along with protein levels, electrolytes, thyroid and diabetes screening tests. These tests excluded some of the possible reasons for the patient feeling unwell. When the blood result results arrived [Dr B] emailed the nurse 'HRT needed'. He was going away, but he asked for [Mrs A] to see him on his return, which she did.

Contact 8.

[Mrs A] had been to [after-hours service] on 26th February, with the first of a series of consultations with gastritis-type symptoms. A report from [after-hours service] of this consultation was received by [Dr B's] surgery next day. A summary of that report was entered into the records by … (perhaps this was … the receptionist?). It is not clear if this report was seen by any of the health professionals at [Dr B's] practice when it arrived.

If the report had been seen by a health professional an expected reaction would have been a phone call to the patient. The surgery had issued prescriptions for nonsteroidal anti-inflammatory medications in the past (see contact 6, point B), and these are known to cause gastritis symptoms. It is expected that the prescriber would wish to clarify her recent intake of these medicines, and advise her to take no more in the meantime.

A call at this time would also have clarified if the symptoms, which had been bad enough to warrant going to the after hours service rather than waiting for [Dr B's] surgery to open the next day, were starting to resolve with the new treatment given. There is no evidence to suggest such a contact with [Mrs A].

This stomach symptom was a new complaint, and part of the emerging picture of a multiplicity of unexplained health concerns occurring within short period for this patient. There is no evidence to suggest that this pattern of failing health was discussed with the patient, or even that the significance of this pattern had been recognised by surgery staff.

Contact 9.

The day following the gastritis presentation to [after-hours service], on 27th February 2002, the practice nurse had a phone consultation with the patient and advised her to see [Dr B] 'to discuss ?HRT'. This was in accordance with emailed instructions from [Dr B]. This was another opportunity for a health practitioner (the nurse in this instance) to undertake an overview of the pattern of ill health, and to follow up on the gastritis consultation to ascertain if ranitidine had helped the symptoms (as mentioned in contact 8). There is no indication that this opportunity was taken at this time.

Contact 10 point A

[Mrs A] saw [Dr B] on March 5th 2002 to discuss HRT (hormone replacement therapy). Premarin, a form of HRT, was prescribed.

The National Guidelines for the Appropriate Prescribing of Hormone Replacement Therapy issued in May 2001 (www.nzgg.org.nz) specifies clearly that HRT is not recommended for symptoms of depression or low mood or for generalised aches and pains, as evidence of effectiveness to date is inconclusive.

Any assumption that menopause could have been the sole cause of the pattern of ill health experienced by [Mrs A] would have been erroneous (had it been made at this time). Any implication to the patient that HRT could remedy her health complaints would have been inappropriate, had it been made at this time.

Contact 10 point B.

Also on March 5th a further prescription was given for zotabs. Once again the rationale for continuing these prescriptions for sleeping pills is not contained in the notes. The interval between prescriptions was just over one month indicating that [Mrs A] had continued to take these pills on a regular basis, two at night. The available documentation indicates that [Mrs A] had been taking them continuously for at least three months at this stage. By March 2002 a review of the need for these sleeping pills, and especially of any underlying causes of ongoing sleep disturbance, would have been most appropriate.

Contact 11.

On 9th March 2002 [Mrs A] was again seen at [the after-hours service] with abdominal symptoms. [Mrs A] saw [Dr B] about this episode nine days later, on March 18th. Although this follow up was quite delayed, given the severity of the urgent symptoms of

9th March, the initial blood tests arranged by [Dr B] were appropriate for the upper gastrointestinal nature of this presentation. The results were all normal.

H Pylori antibody results had also been requested, but as the laboratory routinely sent these away for analysis, these results were not available until a few days after the remainder of the test results had arrived. When the negative H pylori results became available, treatment for H pylori, with Losec7 had already been commenced. This course would have been partially completed by the time it was known that the problem was not H Pylori infection. That negative H pylori test was an indication that the diagnosis of H pylori gastritis should have been reviewed.

There is no documentation to suggest that this negative H pylori test was specifically discussed with the patient, or any plan agreed with the patient as to how to proceed with the investigations in the light of the negative test.

Contact 12 point A.

One week after the consultation with [Dr B], on 26th March 2002 [Mrs A] saw the practice nurse regarding her results. The entry reads '– advised of same'.

There is no indication in the documentation about the type of advice given regarding the normal results, and in particular if the significance of the negative H pylori test was mentioned to [Mrs A] or not.

It is not normally within the role of a practice nurse to act upon negative results without prior instructions from the doctor. On this occasion there had been no email instructions to the nurse from [Dr B], regarding further action intended following the negative H Pylori result.

Contact 12 point B.

Also at the 26th March consultation with the nurse the patient was diagnosed with 'oral thrush' and 'start of vaginal thrush'. Judging from the records, it is possible that this may have been a diagnosis made by the nurse. There is no record of mouth or vagina swabs taken on that day. The assumption that thrush could have been due to antibiotics in the Losec 7 is a reasonable one, on this occasion.

The surgery held information that, for [Mrs A], vaginal thrush infections had taken longer to clear or had required second line preparations to clear it in the past (document H pages 082). In addition, there had been the previous unexplained vaginal thrush infection only a month earlier which also had been slow to resolve (contact 6 point A above). Despite this, standard treatments of lozenges for the mouth and cream for the vaginal thrush were prescribed in the first instance.

These prescriptions would have been signed by [Dr B] acting on the clinical judgement of the nurse. Neither health professional had written any comment justifying the reason

for treating this presumed thrush with standard topical agents, given the past difficulties in treating it with such agents.

Contact 13

[Mrs A] consulted [Dr B] again on 28th March. The entry reads 'still got a bit of an itchy throat. She is worried'. It is not clear from available documentation if [Mrs A] was just worried about leaving for [overseas] at Easter with an itchy throat, or if she had indicated her wider concerns about her state of health at that consultation.

Despite the imminent departure of the patient for an overseas holiday, this presenting problem warranted taking a full history of the throat symptoms, and exploration of the reasons for the patient to be so worried, and an appropriate examination.

There is no documentation of any examination findings. From the evidence provided it appears that assumptions were made that a thrush infection was still present and that this was responsible for the itchy throat. The patient was given a second line antifungal agent (Sporanox) to take for the trip.

The diagnostic possibilities for itchy throat, in addition to unresolved thrush, included a recurrence of mouth ulcers, and non infectious causes such as a postnasal drip from the sinuses. The doctor's surgery had treated [Mrs A] for both mouth ulcers and sinus problems in the past, but it is unclear from the available documentation if those past diagnoses had been recalled, considered or excluded during this presentation with itchy throat.

Contact 14

On her return, [Mrs A] saw [Dr B] on 16th April. She relayed the health problems she had experienced while [overseas]. The diagnosis is documented as 'reflux'. It is possible that this term was supplied by the patient, as reported speech from the doctor [overseas] (although that precise wording did not appear as a diagnosis in the notes from [overseas] (Document I page 095). Alternately it may have been the diagnosis of [Dr B] at that time. Upper GI ultrasound and barium meal were ordered, and these were appropriate, given the clinical presentation.

There was a non-urgent referral to a gastroenterologist at his private rooms (document F page 035), which was also appropriate in the circumstances. The referral was made by telephone (document F page 054). Had the referral included the information that the patient had been generally unwell for some time, this may have relayed to the gastroenterologist the need for a complete history and examination, not just a diagnostic procedure.

Treatment with Famotidine and Mylanta was given, and these are appropriate for relief of upper GI symptoms.

Contact 15.

On 18th April 2002 there was another phone consultation with nurse, reporting 'oral thrush again'. This was discussed with [Dr B]. A further oral thrush prescription was issued and also a repeat prescription of sleeping pills. Both prescriptions would have been signed by [Dr B] following the discussion with the nurse. As indicated earlier, the consequence of unquestioning repeat prescribing of both sleeping pills and of thrush treatments was a delay in the recognition and treatment of any underlying causes of the overall symptom complex.

Contact 16.

On 19th April 2002 [Dr B] saw [Mrs A] regarding her mouth symptoms. From the information available there was no obvious explanation for [Mrs A] to have developed oral thrush again. There is no written comment to this effect.

A mouth swab was taken. The swab result, reported on 22nd April (document F page 046) grew only normal mouth organisms, but this result was unreliable if, at the time the swab had been taken, [Mrs A] was already taking oral thrush medication as prescribed the previous day.

Indigestion medications were prescribed again. This was another opportunity to review the response to treatment so far, and to re-examine the patient. Given that a gastroenterologist had seen the patient for this problem very recently, the health practitioners may have been working under the false assumption that the patient had been fully examined when assessed by the specialist.

Contact 17 point A.

On 24th April 2002 there was a further consultation, this time regarding tension and tearfulness and head and neck aches. This was a new symptom complex; one not consistent with the existing diagnoses of reflux or oesophageal spasm.

There is no documentation of a detailed history of this new symptom complex: the duration, severity, triggers and relieving factors of each symptom, or any indication that possible causes of the symptom complex were explored (other than tension). The blood pressure was recorded, but there is no mention of any other medical examination findings. A diagnosis of 'tension headaches' was made, although the documentation does not indicate what the source of the tension might have been, or if the patient had been assisted to develop a plan to manage this tension.

The dose of hormone replacement therapy was increased, an indication that the symptoms of tension and aches had been assumed to be due to menopause. As mentioned previously, the 2001 Guidelines for Appropriate Prescribing of HRT do not recommend HRT for psychological symptoms such as depression or low mood or for aches and pains.

Contact 17 point B.

Also at this consultation a prescription was given for a sedative to be taken three or four times a day (clonazepam). It is not clear why [Dr B] prescribed these sedatives to [Mrs A] as well, if he believed that an increase in the dose of HRT would treat the symptoms. The doctor has made no mention about discussing the safety of a daytime sedative, considering that his patient was already regularly taking a prescribed night sedative. There is no documentation of a specific diagnosis that might justify use of daytime sedatives. In 1996 the National Health Committee distributed 'Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals' (ISBN 0 478 1054-5) and in 1998 'Guidelines for Assessing and Treating Anxiety Disorders' (ISBN 0 478 10479-0) both documents are available on www.nzgg.org.nz. Both documents caution against the use of sedatives without a diagnosis.

Contact 18.

At the consultation on 2nd May 2002 [Dr B] discussed with his patient the results of her xrays (which were normal). [Dr B] did also check that his patient had a date for her appointment with the Specialist. Both actions were appropriate.

[Dr B] also reviewed the mood symptoms. The comment of 'a lot calmer' (document F page 034) indicates that there was some improvement in the mood symptoms. There is no record of review of the status of any of the other various symptoms experienced by the patient over the preceding five months: muscle aches and pains, headaches, stomach problems, recurrent and resistant vaginal and oral thrush infections.

Contact 19.

On 29th May 2002 [Mrs A] phoned the practice nurse, according to instructions of the specialist. The practice nurse rightly advised her to see GP again if neither of the treatments improved her symptoms. The focus of the phone call was on the stomach symptoms. There is no record of any discussion with [Mrs A] of the other health problems recently managed by the nurse: sleeping problems, thrush and sore mouth.

Contact 20.

On 7th June 2002 [Mrs A] saw the GP, as directed by nurse, because she still had stomach symptoms despite the treatment. The entry (made on the 10th June 2002) indicates that reflux and throat discomfort were considered to be due to 'bloating and GI' (F 033/34). This is not a diagnosis nor is it an explanation for reflux and throat discomfort. There is no documentation to indicate if a full history was taken of the new complaints of bloating and throat discomfort. There is no documentation of any examination to elucidate these two new complaints. Treatment with antibiotics and an antispasmodic was given. It would appear that this treatment was given without a diagnosis. A prescription had been issued the previous day for more sleeping pills (see comments above).

Contact 21

[Mrs A] saw [Dr B] on 7th July 2002 with urinary symptoms. These were attributed to metronidazole. This antibiotic had been prescribed the previous month, for 10 days, such that the course would have been completed at least two weeks earlier. It is unclear if this attribution was made by the patient or by the GP. Urinary frequency is an unusual consequence of such medication, and especially considering the time lapse since last taking it. Investigation, at least with a urine specimen, was indicated. A prescription was given, and advice to take an over-the-counter preparation (acidophilus), although there is no documentation to indicate a diagnosis for the condition that [Dr B] was treating.

The comment 'to take the Merbentyl as needed' (document N page 140) indicates that gastric discomfort symptoms were also still present. A repeat prescription was given for famotidine, but there is no documentation of a review of the progress of the gastric symptoms at this point.

Summary of response to bullet point 1:

In hindsight, these consultations all reflect an incremental approach to clinical decision-making. In no instance was the overarching clinical presentation examined, to reveal the emerging picture of deterioration of health.

Bullet point 2.

What is the accepted practice for the management of epigastric discomfort, reflux and belching?

The term epigastric discomfort represents a complex mixture of symptoms in the upper abdominal region with a number of possible causes. Belching is one such symptom; reflux is one possible cause of epigastric discomfort. The primary care approach to any individual with this problem should be to triage out those patients with symptoms which require urgent specialist referral, and to attempt to elucidate the cause of the discomfort and institute treatment for the less serious cases accordingly.

Evidence-based guidelines for managing these symptoms in General Practice have been under review in New Zealand in recent years. Guidelines on this topic were first issued by the National Health Committee in 1995, but emerging scientific evidence about the indications for investigation and treatment has resulted in some changes to the recommendations since then. Updated guidelines were released in draft in 2003 by the New Zealand Guideline Group but this publication has not yet been finalised.

The draft guidelines are available on the web:
www.nzgg.org.nz/guidelines/0020/Dyspepsia_Guideline_draft.pdf.

The prevailing accepted practice *at the time* is summed up in the 1995 *Medicines Information Bulletin number 95 on Gastro-Oesophageal Reflux Disease (GORD)* from the National Preferred Medicines Centre. Under contract to government authorities, first

the Health Funding Authority and later PHARMAC, the National Preferred Medicines Centre produced these Medicines Information Bulletins which were regularly mailed to all GPs. These are no longer produced, but are available on the web (www.premec.org.nz).

Medicines Information Bulletin number 95 states that 'the characteristic symptom of GORD is heartburn, defined as a burning sensation arising from the epigastrium towards the neck. It occurs in 75% of patients with GORD'.

On investigation of reflux, this bulletin states that 'endoscopic diagnosis is advised in those with persistent or recurrent symptoms, and those with alarm symptoms'. Alarm symptoms are defined as 'dysphagia (swallowing difficulty), bleeding, anaemia, weight loss, initial presentation over 50 years of age, abnormal physical findings'. It also states that 'at least 50% of patients will not show any abnormality at endoscopy'.

This bulletin mentions the spectrum of agents used in the treatment of reflux, and discusses taking either a 'step down' approach to treatment, from the most to least potent or costly agent or the converse 'step up' approach ending with a trial of combinations of agents, to find the level of treatment required to control the symptoms.

Bullet point 3.

Did [Dr B] follow accepted practice in relation to [Mrs A's] reported alimentary tract symptoms in 2002?

a. Accepted practice relating to the history:

This lady had an initial presentation of reflux symptoms at age over 50 years, which is classified as an alarm symptom. The records indicate that [Mrs A] told [Dr B] she had lost weight (document F page 037 entry of 5.1.2001), which is also an alarm symptom. When [Mrs A] told the nurse she had lost 'a lot of weight' (document F page 039) she had attributed this to correct diet and exercise. It is unclear from the level of documentation whether or not these two alarm symptoms were recognised as such.

b. Accepted practice relating to examination:

From available evidence it is not clear if [Dr B] examined [Mrs A's] gastrointestinal system on each occasion when she consulted with gastrointestinal symptoms. A clinical examination is particularly important when new symptoms are presented. Documentation of the actual weight of this patient cannot be located in the available notes.

c. Accepted practice relating to investigation:

[Dr B] did arrange an endoscopic investigation. This was normal.

d. Accepted practice relating to treatment:

At one stage or another, [Mrs A] was tried on almost all of the agents used in the treatment spectrum: antacids, prokinetic agents, H2 receptors, proton pump inhibitors, and also combinations of these agents.

Summary of response to bullet point 3:

The investigation and treatment of her presumed reflux disease did follow accepted practice.

Bullet point 4.

Is there any evidence that [Mrs A] was suffering from lower pelvic pain and abdominal bloating prior to January 2003?

As indicated in the reply to bullet point 1, there were several consultations regarding symptoms of vaginal thrush. It is unclear if the symptoms were of pelvic pain or discharge or both, since the presenting symptoms are not documented.

The first specific mention of 'bloating' appears in the documentation relating to the 7th June 2002 consultation with [Dr B].

Bullet point 5.

Should [Dr B] have performed a pelvic examination while managing [Mrs A's] menopausal problems?

As indicated in the response to bullet point 1, during contact 5 in particular, a speculum vaginal examination was indicated to assess extent of the thrush infection (to determine if the infection was internal as well as external) and to inspect the vaginal tissues to exclude treatable causes of thrush such as atrophic vaginitis (which is associated with menopause). A bimanual pelvic examination was also indicated at that point to check the pelvis for underlying causes for the thrush infection, including bladder prolapse, state of ovaries, and to exclude other mass lesions because this patient did not have regular internal examinations, since she did not need to have cervical smear tests.

It is not possible to determine from the available documentation whether or not a pelvic examination for any underlying causes was performed.

Bullet point 6.

Given [Dr B's] belief that [Mrs A's] symptoms were related to menopause, did he undertake appropriate investigations and/or treat her appropriately?

It is unclear which of [Mrs A's] multiple symptoms [Dr B] believed were due to menopause. Menopause is a normal phase of middle age in the lives of women. Illness is not ordinarily part of this phase. When health problems arise in menopause they should be taken seriously and investigated for possible underlying causes, and treated just as

they would be at any other stage in life, rather than being attributed directly to menopause.

If [Dr B] believed that the vaginal infections were related to menopause, then an internal examination was appropriate to investigate underlying correctable causes such as atrophic vaginitis, as discussed earlier.

If it was her muscle aches and pains that [Dr B] believed were related to menopause, then given the severity and chronicity of these symptoms and associated arm swelling, a review of the complete history and a full physical examination, and possibly even a review by a rheumatologist was indicated to first exclude all other causes of such symptoms.

If it was the sleep problem that [Dr B] believed was a menopausal symptom, it would have been appropriate to recognise that this was a more longstanding problem, not temporally related to the other symptoms, and to first exclude health reasons underlying the more recent change in the chronic sleep pattern, before attributing it to menopause.

If it was 'tension headaches' that [Dr B] believed was a menopausal symptom, then a symptom diary was appropriate to identify manageable triggers, and a full medical examination with special focus on neurological examination to exclude other causes.

If it was low mood that was attributed to menopause then again a full history and neurological examination were especially called for. [Dr B] has indicated that mood problems were an issue in the past, in reaction to family issues. Given the severity of the reported symptoms and the chronicity of this illness and the past history a psychiatrist review was indicated if this illness was thought to be psychological in origin.

General health screening was ordered by [Dr B] to exclude chronic conditions associated with mood change. [Dr B's] tests did show that [Mrs A] had an elevated level of FSH. This is a hormonal change associated with the onset of menopause. It is not in itself an explanation for the above symptoms. As previously mentioned, any assumption that menopause could have been the sole cause of the pattern of ill health, based upon this blood result, would have been erroneous (had it been made at this time).

[Dr B] commenced hormone replacement therapy. As also mentioned previously, any implication to the patient that HRT could remedy all her health problems would have been inappropriate, had it been made at this time. It is important to note that [Mrs A] did not complain of the hot flushes or night sweats that are classical indications of menopausal hormone fluctuations.

When prescribing hormonal treatment, regular weight and blood pressure monitoring is important. As indicated earlier, documentation of the weight of this patient cannot be located in the available notes. It is also important to regularly review the symptoms, and especially the ongoing indications for treatment with HRT. In this case, the dose of HRT was increased in response to new symptoms of tension and continuing aches (see contact 17 point A) although HRT is not recommended for such symptoms.

Summary of response to bullet point 6:

Given [Dr B's] belief that the symptoms were due to menopause, the available documentation indicates that he did undertake some investigations appropriate for illnesses arising during menopause but that he did not manage the presenting symptoms accordingly.

Bullet point 7.

What is the incidence of ovarian cancer? What are the recommended investigations for a general practitioner to undertake to detect this condition?

Question 1. *What is the incidence of ovarian cancer?*

I am not qualified to answer the question on the incidence of ovarian cancer.

Question 2. *What are the recommended investigations for a general practitioner to undertake to detect this condition?*

Ovarian cancer is one of the conditions not recommended for routine screening in General Practice. Appropriate initial GP investigations would include a bimanual pelvic examination on suspicion of symptoms, and a pelvic and abdominal ultrasound scans if a mass was detected or suspected. When clinical suspicion of an ovary lesion is high, the ovarian cancer marker Ca125 can be requested, as well as liver function tests including protein levels, and alpha foetoprotein, a marker for other cancers.

It is my personal experience that ovarian tumours can be difficult to detect in General Practice as they are often clinically silent in onset, or if associated with symptoms these are such that the true nature of the problem might be readily misinterpreted. Ovarian lesions may be detected through an incidental finding on an examination or investigation into another problem. Often ovarian cancer is detected only at a late or advanced stage.

Bullet point 8.

Was [Dr B's] overall management of [Mrs A] appropriate? Should a specialist referral have been initiated? If so, when?

Question 1. *Was [Dr B's] overall management of [Mrs A] appropriate?*

The incremental manner in which clinical decision-making was undertaken during the period of interest (January 10th to July 3rd 2002) is illustrated in the lengthy response to bullet point 1, above. The consequence of this approach was that the overarching clinical presentation of the patient was not examined in its entirety, to reveal the emerging picture of deterioration in her state of health.

The holistic overview of management of a patient by a General Practitioner is not manifested. [Dr B's] overall management with regard to specific symptoms was appropriate but the clinical process may or may not have been complete:

[Dr B] followed accepted practice in his investigation and treatment of reflux disease, as indicated in the response to bullet points 2 and 3. However, it is not possible, given the available documentation, to determine whether or not the history taking and assessment by clinical examination were completed as appropriate.

[Dr B] did order some appropriate investigations in undertaking the management of symptoms as if they were menopausal but, as outlined in the response to bullet point 6, the available documentation indicates that he did not manage the presenting symptoms as for any similar health condition, since they manifested during menopause.

In regard to management of stress/mood/sleeping problems, the documentation indicates that over-reliance on the use of prescribing of sleeping pills and sedatives, occurred at the expense of investigating and treating any underlying causes for these problems.

Question 2. *Should a specialist referral have been initiated? If so, when?*

Specialist referral was initiated for endoscopy. As mentioned earlier, it is unclear from the level of documentation whether or not the presence of two alarm symptoms was recognised at the time. If alarm symptoms had been recognised it would have been appropriate, on making the referral for endoscopy, to request the specialist review with urgency (as outlined in responses to bullet points 2 and 3 above). An urgent specialist referral was initiated on discovery of an abdominal mass on the pelvic ultrasound scan.

Given [Dr B's] belief that [Mrs A's] symptoms were related to menopause, before attempting to treat these symptoms with HRT a specialist referral would have been indicated for review of the musculoskeletal symptoms and also for the mood symptoms, in view of the severity and chronicity of these symptoms and the lack of evidence that these specific symptoms would respond to HRT (as detailed in response to bullet point 6 above).

Bullet point 9.

Is there any evidence that [Dr B] did not respond appropriately to [Mrs A's] ongoing problems?

The key consideration here is: was it appropriate for the patient's regular General Practitioner to respond to multiple consultations and a spectrum of health problems as if these were isolated episodes. The health professionals had not perceived or considered the clinical presentation of the patient in its entirety. This is especially pertinent during the period of interest, January 10th to July 3rd 2002. This oversight was due to a general pattern of decision-making in which the problems were dealt with incrementally (as detailed in the response to bullet point 1).

Consequently the underlying concerns of the patient went unrecognized; her worry especially about the possibility of cancer as the cause of her decline in health, was not understood and was initially not investigated. The patient herself had also gained the impression that her health concerns had not been taken seriously overall.

Bullet point 10.

If not, what else should he have done?

Records indicate that by end of Feb 2002, and certainly by the end of April 2002, a picture was emerging of:

– consultations occurring very much more frequently than previously,
– multiple ill health complaints with no clear explanation, and
– failure of the symptoms to respond to standard treatments.

This triad, if recognised, should have indicated to health professionals at the General Practice that something of significance was happening to the health of this particular patient.

Had this been recognised, it could have provoked the health professionals caring for the patient to reflect upon the possibility of an underlying problem (other than stress) for this overall clinical scenario. Instead the response was an escalation of the prescribing of remedies for individual symptoms, and a tendency to attribute unexplained complaints on menopause and to an unspecified stressor.

Bullet point 11.

Are there any other professional, ethical and other relevant standards that apply and, in my opinion, were they complied with?

The standards of GP practice are outlined in *'Aiming for Excellence' RNZCGP Standards for General Practice care, 2nd Edition, 2002.* The document is available on: www.rnzcgp.org.nz/PDF/aiming_for_excellence.pdf

In this document, standards are considered in three dimensions using indicators relating to: patients and their outcomes; the professionals and their professional development and practice quality; and continuous quality assurance.

Two standard indicators may be especially relevant in this case. They are (as numbered in RNZCGP document referenced above) indicator D7.1 and D8.2:

Indicator D7.1: Records sufficient to meet legal requirements to describe and support the management of health care provided.

The level of documentation in most of the consultations with [Dr B] did not contain sufficient detail relating to key features of clinical history and examination findings.

Indicator D8.2: Systems to manage patient test results and medical reports.

It is unclear if there was a system in place to ensure that medical reports, especially those from after-hours consultations, were first seen by a health professional before being entered into the medical records. There did not appear to be any system for

prompt follow-up of the patient, on receipt of after-hours medical reports, to ensure that the management initiated at the after-hours clinic had been successful. If there was a system it failed [Mrs A] on multiple occasions.

Bullet point 12.

And any other comment that I consider relevant and which may be of assistance

I understand that one aspect of the complaint was that [Dr B] did not diagnose that [Mrs A] was suffering from ovarian cancer. Ovarian tumours can be difficult to detect in General Practice; they are often clinically silent in onset, or associated with symptoms that might be misinterpreted. However, with hindsight it is apparent that the underlying concerns of the patient about the possibility of cancer went unrecognised, and further investigation into a cause of her decline in health was not pursued, and by the time the cancer was detected, after multiple consultations, it was advanced.

The available documentation has provided examples of the approach of this General Practitioner to the investigation and management of symptoms of stress and/or anxiety and/or depression. There appears to have been a culture of unchallenging acceptance of [Mrs A's] use of 'happy pills' (document N page 136) at the surgery. [Dr B] has explained that [Mrs A] had been treated for anxiety and depression in the past (document N page 108), and the notes confirm that [Mrs A] had been prescribed two sedatives, ativan and clonazepam, on occasions as well as sleeping pills since 1996, and also received prior prescriptions of antidepressants (document N page 136). However, there is no indication of the criteria by which the diagnosis of anxiety or depression had been made, or if any alternate, differential diagnoses had been considered.

The National Health Committee *'Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals'* (ISBN 0 478 1054-5) and *'Guidelines for Assessing and Treating Anxiety Disorders'* (ISBN 0 478 10479-0) both caution against the use of sedatives and antidepressants without a diagnosis.

The above guidelines both recommend the use of non-pharmacological interventions as a first step, especially for the identification and self-management of the causes of psychological distress. Although [Dr B] had referred [Mrs A] to a psychologist in the past (document N page 108) there is no documentation to indicate if the psychologist was or was not consulted or if [Dr B] followed up on the outcome of that referral.

The available documentation has provided an example of the approach of this General Practitioner to the investigation and management of women with symptoms associated with menopause. The Guidelines for Appropriate Prescribing of HRT were released in 2001 with a great deal of publicity directed to health professionals and the general public alike. [Dr B] prescribed HRT for depression or low mood, and for aches and pains, although this is not recommended practice.

The available documentation has provided examples of the approach of this General Practitioner to the investigation and management of sleeping problems. This doctor

repeatedly prescribed sleeping pills to [Mrs A] over many years, and also prescribed daytime sedatives when she was regularly taking sleeping pills at night. Medical notes and insurance claim data (document A page 004) indicate that in most instances the sleeping pill prescriptions were supplied to [Mrs A] without a corresponding consultation with [Dr B] to assess if they were helping her symptoms, or to discuss the timeframe for discontinuation of these pills. ...

A prescribing review may be indicated."

Responses to second Provisional Opinion

In response to my second provisional opinion, Dr B stated:

"I again wish to acknowledge and repeat from the outset my sincere sorrow that a patient I have known for so long had ovarian cancer that I was not able to diagnose.

I wish to reassure you that had [Mrs A] reported to me ongoing lower abdominal pelvic pain and abdominal bloating then I would without hesitation – or the need for request – have referred her to a gynaecologist for review. It is my deep regret that these symptoms were not reported to me or any of the other doctors who treated her. I would like to make some comments on some of the matters of concern about the opinion of Dr Moriarty.

Contact 2

Massage Therapist issue – A lot of my patients who go for massage get their lumps and bumps checked out and they are usually referred back to me by the specialist. I disagree that this is uncommon. This statement shows the difference in the day-to-day practice of a GP compared to the practice of Dr Moriarty.

Contact 7

[Mrs A] had a very sore throat and had been feeling unwell. She had been prone to URTI (upper respiratory tract infection) over the years, not just in the last 2-3 years. I regret not documenting all of [Mrs A's] symptoms. It is my usual practice to go through the 'score sheet' symptoms put out by the Australian Menopause Society and also give the patient pamphlets to keep them informed.

Contact 8

All [the after-hours service] consultation notes do get seen by the general practitioner within 24-36 hours of the visit depending on the date of arrival of the notes at the surgery. If a visit is urgent or significant, the duty doctor telephones the regular GP the morning following the visit. I do contact some patients after receipt of the consultation notes – this is a 'judgement call'. On an average weekend 25-30 patients would visit the

[the after-hours service]. It is not viable to contact every patient who has visited the centre. As both Mr and [Mrs A] worked full time it was not unusual for them to visit [the after-hours service] as a matter of convenience outside of 'normal' working hours. This appears to be the current trend for working people and all current practising GPs acknowledge this. However, academia does not appear to realise this.

Contact 9

This shows that we do contact patients where indicated, contrary to Dr Moriarty's previous assumption. If a woman goes through menopause and needs HRT, I do not feel that she is failing in her health. I do not agree (unless with the benefit of hindsight) that there is a pattern of ill health emerging. Visits to doctors prior to Dr F's visit at [the after-hours service] were for screening tests, URTI, not increasing pain, weight loss, etc. Records show quick, sudden onset over 2/7 (2 days) of abdominal distension. They also show a number of prescriptions for antibiotics by myself and other doctors which is frequently the cause of thrush.

Contact 10

HRT was not given to [Mrs A] just for symptoms of depression or generalised aches. She had other symptoms that, to my regret, I failed to document – night sweats, palpitations and feeling 'waves' of flushing. At no stage was menopause a diagnosis for her epigastric pain.

Contact 11

With regard to the statement that *'The negative H Pylori test was an indication that the diagnosis of H Pylori gastritis should have been reviewed'*, the notes show that [Mrs A] was referred to [Dr L]. The biopsy done by [Dr L] did show mild H pylori, despite treatment. The test results were explained to [Mrs A]. At the time I was using the GP Dat Medical Software, which is not as performance enhanced as the Medtech 32 programme I now use. E-mail was difficult to use in GP Dat. Because of the limitations of GP Dat, our surgery changed to Medtech 32 in November 2003, which has helped with communication and note-keeping.

Contact 14

The referral to [Dr L] was urgent, and not otherwise as claimed by Dr Moriarty. [Dr L] only works part-time so is not available for appointments at all times. He normally arranges an appointment on receipt of a referral letter. The referral was not done by phone. It was documented and dispatched forthwith. The referral was detailed and mentioned severe symptoms (a copy of the referral letter is enclosed). I emphasised that [Mrs A] had been very unwell. I decided to request the barium meal and ultrasound to exclude other causes, with a copy of the results to [Dr L]. [Dr L] makes the decision on what the patient needs with regard to consultation and diagnostic procedure, or diagnostic procedure and short consultation and follow-up.

Contact 17

Clonazepam was given for [Mrs A's] tension + or – neck spasm (please refer to notes) only for a few days. It was not given for depression. She was informed that it was addictive and it was for only a short course. Only 24 tablets were prescribed. It was only for 6-7 days.

Contact 18

My opinion was that [Mrs A] was a lot better in herself. I did discuss her general well being and also checked that she was being followed up in the near further by the specialist.

Contact 20

I examined [Mrs A's] throat and her abdomen.

I did not see [Mrs A] on 7.7.02. I did see her on 3.7.02. She did not have urinary symptoms as claimed by Dr Moriarty. She had loose bowel motions. She was given Dicap. I am disappointed in Dr Moriarty's comments which are incorrect. Please refer to the same section by Dr Jim Vause, bottom of page 6-7, as he did pick it up correctly.

Bullet Point 1

Hindsight – Yes she had epigastric pain that did not settle up till around June. An emerging pattern of health deterioration beyond the epigastric pain is hard to make without hindsight, which Dr Moriarty has had and uses in all her points.

Bullet Point 3

a) I accept that I did not weigh [Mrs A]. She was dieting, but did not look as if she had a dramatic weight loss. I have now changed my practice so that anyone who mentions weight or that they are on a diet is weighed at consultation.

b) I examined [Mrs A's] abdomen on most occasions before and after she saw [Dr L], including when she came back from [overseas] after Easter, and when she had diarrhoea on 3.7.02. On no occasion was there evidence of a mass or lower abdominal pain.

Bullet Point 4

[Mrs A] had never mentioned abdominal pain to me, nor did she to all the other GPs who saw her. Nor did [Dr L] elicit this when taking the history or find anything on examination. He found no pain other than in the epigastrium.

Bullet Point 5

I do not agree that she needed a speculum examination, though with knowledge of her subsequent diagnosis my opinion would differ. There was no indication at that stage. A pelvic-bimanual examination was not indicated, due to lack of symptoms or finding of lower abdominal pain. Examination of her abdomen was done up to May/June 2002.

Dr Jim Vause (page 16-17) also suggests there is no indication for bimanual examination due to lack of symptoms.

Bullet Point 6

Her menopause was not an issue. Her epigastric pain was her main problem.

Bullet Point 8

The referral to [Dr L] was urgent, the time taken for her to be seen was because of his availability and other commitments as he only works part time. He is the only gastric surgeon in town. Dr Moriarty continues to assume that I am using HRT for her musculo-skeletal symptoms and her depression. This is not true.

Bullet Point 10

Between July 2002 – January 2003, I did not see [Mrs A] frequently. This is in contrast to the previous 6 months. I therefore had no reason to suspect that [Mrs A] was not feeling better. I only saw her on 24.7.02 for URTI, 10.8.02 for sinusitis, and on 4.11.02, she saw my nurse for a blood pressure check and said that she was well. My nurse discussed dexascan with her and risks of osteoporosis. Thus, Dr Moriarty's assumption of continuing health deterioration is not true. The Triad she describes was not there by the second part of 2002. Dr Moriarty's suggestion that I attributed her symptoms continually to menopause are not correct.

Bullet Point 11

I agree my notes are not sufficient. Steps have been taken to address this, including at great cost changing our medical software to Medtech 32 in November 2003.

Bullet Point 12

Clonazepam was prescribed only for a few days – for neck spasm, not anxiety or depression. The referral to a psychologist was a few years ago, related to stress caused by her son. She had several sessions and they did help her, but she continued to have on-going new problems.

…

Page 44 (paragraph 5)

I did examine her whole abdomen to pelvis, but did not do a bimanual examination. I did not feel that this was indicated. Dr Jim Vause also endorses this as her problems did not indicate pelvic/uterine/ovarian problems. She did not at any stage have symptoms indicating pelvic bimanual examination, nor was this suggested by [Dr L]. Dr Moriarty suggests this on the basis of thrush and with hindsight. Moreover, in the second half of 2002, [Mrs A] was relatively well. Dr Moriarty also assumes that I inappropriately used HRT for [Mrs A]. I dispute this whole-heartedly. Dr Jim Vause also believes that I treated [Mrs A] correctly with regard to her menopause (note page 17 of his review).

All that I have said in no way diminishes the sorrow I feel for [Mrs A's] family and the grief I feel as her doctor for so many years. I wish intensely that I had been able to diagnose her ovarian cancer. I feel awful about trawling through her notes after she has died, picking on details and dissecting them in light of the opinions of others. I don't want to appear to show her or her family disrespect and want only the best for them."

In response to my second provisional opinion Dr B's lawyer stated:

"**Dr Moriarty's Opinion**

10. **The Opinion**

10.1 The opinion commences with an incorrect assumption which seems to have coloured the conclusions reached by Dr Moriarty. She states:

'She [Mrs A] consulted [Dr B], [the family's] general practitioner for 25 years, with continuing lower pelvic pain and abdominal bloating.'

10.2 As outlined above, there is no evidence that [Mrs A] attended for these symptoms. There is evidence that contradicts this assumption.

10.3 A further incorrect assumption is made, no doubt highlighting that this opinion is based retrospectively rather than prospectively. Dr Moriarty states that [Mrs A] was seen '*regularly by [Dr B] over the following nine months for a variety of complaints, most of which were associated with menopause'*. As noted by all the other experts who have reviewed this file, most of the symptoms [Mrs A] presented with were for epigastric pain and, on a few occasions, viral upper respiratory tract infections and neck spasms, none of which were associated with menopausal symptoms.

10.4 Part of the provisional opinion contained on page 25 deals with overall management which was not the subject of particular complaint. This aside, the description given fails to recognise that the main issue was upper abdominal pain and reflux, for which referrals were made. The thoroughness of [Dr B's] approach is evidenced by his referring [Mrs A] not just to a gastroenterologist but

also for ultrasound. None of the doctors treating [Mrs A], who did not have the benefit of hindsight available to Dr Moriarty, were pointed in the direction of ovarian causes.

10.5 Comment is not made on the parts of the opinion referring to the prescription of sleeping pills. These prescriptions are not the subject of the complaint and should be removed for the reasons set out at the beginning of this letter.

10.6 At page 26, under the heading 'Contact 2', a long bow is drawn between a patient's questions about massage and a diagnosis of lipoma made by [Dr B]. See the enclosed letter of [Dr B].

10.7 Evidence of the retrospective approach taken by Dr Moriarty is clear in her comments under the heading 'Contact 3'. Unusual prominence is given to a situation where the patient presented with wrist strain given the patient associated this to *'lifting a heavy box'*.

10.8 Contact 5 – Dr Moriarty does not give weight to a reasonably long-standing history of recurrent thrush. Her opinion is not agreed with by Dr Vause, who states: *"As these other doctors could not detect [Mrs A's] cancer prior to 24.01.03, then it is entirely consistent that [Dr B] would not have detected [Mrs A's] cancer, unless he had carried out a pelvic bimanual examination, for which the indication is <u>debatable</u>* [underlining added]." Dr Moriarty does not give any weight to the fact that a high vaginal swab was carried out, with the results showing a heavy growth of candida species.

10.9 Contact 6 – Again, Dr Moriarty is critical of [Dr B] on matters that are not actually the subject of the complaint. This aside, Dr Moriarty does not appear to have given sufficient weight to the heavy growth of candida species reported in the context of a six day vaginal cream being unlikely to resolve such symptoms when the growth was so heavy.

10.10 [Dr B's] management of musculo-skeletal symptoms is not the subject of the complaint. Given the source of pain (knee, especially patella, left wrist varied), it is unclear why Dr Moriarty thinks they should all have been linked, particularly when – in the history given by the patient – they were associated with specific causes.

10.11 It is submitted that it is easy for Dr Moriarty to decide that [Mrs A] had failing health – in hindsight this is however not the test that should be applied.

10.12 Contact 9 – [Dr B] instructs that the fact that Dr Moriarty picked up that his nurse had a telephone conversation with [Mrs A] does indicate that he does contact his patients at times, contrary to Dr Moriarty's previous speculation. See his enclosed letter.

10.13 Contact 10 – Dr Moriarty continues to refer to it as a pattern of ill health, but this is not consistent with the notes. The main documented concern was [Mrs A's] epigastric pain at this stage. Dr Moriarty's recognition, though irrelevant to the complaint that the second prescription for sleeping pills was over one month, is noted.

10.14 Contact 15 – Dr Moriarty has not given sufficient weight to the reality that this appointment was preceded by a recent consultation between [Mrs A] and a competent specialist, [Dr L].

10.15 Contact 16 – [Dr B] advises that as a GP, he would expect Dr L to fully assess [Mrs A]. It was not long before [Dr L] had seen [Mrs A]. He had also given a possible treatment plan and there was no reason not to try it, or adopt a 'wait and see' stance. A swab was done. The patient had been examined. There was no thrush. He had expected that her throat symptoms were due to reflux.

10.16 Contact 19 – It is submitted that the comments made by the expert under this heading again reflect the benefit of hindsight not available to the treating physicians at the time.

10.17 Contact 20 – See [Dr B's] comments in his letter.

10.18 Contact 21 – This is inconsistent with the evidence available in the medical records. I refer you to the opinion of Dr Vause, who more correctly describes the situation where he says:

'On 3 July [Mrs A] saw [Dr B] because she had been experiencing frequent bowel motions since commencing with flagyl. [Dr B] advised [Mrs A] to take acidophilus tablets to counteract the effects of the flagyl on her bowel. He prescribed Decap antidiarrhoeal capsules and advised her to take one every morning "to slow things down". [Dr B] advised [Mrs A] the Merbentyl only when she needed to.'

Dr B's lawyer also criticised Dr Moriarty's expertise:

"9.1 In what are very unusual circumstances, your own chosen expert opinion was not accepted. [Dr B] was advised by letter dated 24 February that this was because the advice was from a male practitioner. It reflects a sad day in our legal system when the gender of a report-writer is seen as grounds justifying an unusual step in your procedures, ie the obtaining of a further opinion.

9.2 Dr Moriarty has a specialist interest from running a women's clinic and later working in venereology and the sexual health field. As stated by Dr Moriarty, she claims (at page 22 of your provisional opinion):

'I have had a special interest in women's health. At my own general practice surgery in Cambridge (during the early 1990s) we ran a Well Women's Clinic …

I later worked (and trained) in Venereology and Sexual Health Medicine in Wellington.'

9.3 Thus, it is not surprising that Dr B, as a general practitioner who does not have the luxury of knowing that symptoms coming through his surgery door will relate to 'women's problems', understandably acts accordingly when gastric/digestive problems are described.

9.4 Dr Moriarty has been an academic for several years, and has not been practising as a general practitioner. This means she works in a different environment from that of a general practitioner and would have difficulty claiming that she has experience of the realities of general practice such that she is as qualified to comment as Dr Vause, who is a practising general practitioner.

9.5 This matter has been reviewed by ACC and its experts, and no finding of medical error was made.

9.6 Dr Vause accepted a commission to provide expert opinion to your office. He made adverse criticism on the quality of the notes, this has been acknowledged by [Dr B] and is being actioned."

Dr B's lawyer concluded, in support of Dr B:

"It is submitted that Dr Moriarty's opinion should not be preferred, and the breach findings changed as a result of her opinion should be removed. The result should be that the first opinion provided by your office stands. Put another way, the new breach findings are not justified on the evidence set out above, and are not justified on the basis of Dr Moriarty's somewhat 'ivory tower/academic' based opinion."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

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

Opinion: No breach – Dr B

Assessment for lower pelvic pain and abdominal bloating
Mrs A complained that during the six month period between 10 January and 3 July 2002 she had numerous appointments when she reported symptoms including bloating, stomach pain, indigestion, reflux, lower pelvic pain, and diarrhoea, but Dr B did not appropriately refer her for further tests.

On 22 January 2002 Mrs A reported to her masseuse that she had abdominal pain and "tummy" bloating. The masseuse advised Mrs A to discuss her symptoms with Dr B, and also the possibility of a referral to a gynaecologist.

Dr B saw Mrs A three times during February 2002. Mrs A recalled that at the last of these visits, on 21 February, she told Dr B that she had indigestion, burping, and stomach pains. Dr B stated that Mrs A saw him with a very sore throat and symptoms of menopause and congested breasts; there was no mention of abdominal pain. Dr B recorded that Mrs A thought her symptoms were due to menopause.

That month Mrs A also saw Dr K at the after-hours service with indigestion and vomiting. On examination, Dr K recorded that the abdomen was soft with normal bowel sounds. He considered a possible diagnosis of gastroenteritis or gastritis and prescribed ranitidine. There is no record of Mrs A reporting pelvic pain or abdominal bloating, or requesting a referral to a gynaecologist at these consultations.

On 9 March Mrs A was again seen at the after-hours service, presenting with a two- to three-week history of a burning sensation in the epigastric region. It was felt that she had reflux or a peptic ulcer. Following this consultation, on 18 March, Dr B organised blood tests, which included checking for pancreatitis and liver function as well as *Helicobacter pylori* antibodies. The results showed normal liver function, no pancreatitis, and a negative result for *Helicobacter pylori* antibodies. Dr B prescribed a course of Losec HP7 followed by Losec to treat the gastric symptoms.

In April while holidaying overseas, Mrs A was seen by Dr C. On 9 April Mrs A had acute epigastric pain and epigastric tenderness on examination and was advised to increase the dosage of Losec; on 11 April Mrs A complained of nausea and epigastric pain and was prescribed Stemetil and Somac.

On 16 April, on her return from overseas, Mrs A consulted Dr B who prescribed Mylanta and famotidine and organised a referral to Dr L, general surgeon, for consideration of a gastroscopy. He also organised an abdominal ultrasound scan and barium meal to exclude other causes. The abdominal ultrasound scan and barium meal were performed on 18 April; the abdominal ultrasound scan was reported as normal and the barium swallow and meal was unremarkable (apart from some minor tertiary contractions in the distal oesophagus).

On 7 May Mrs A saw Dr L and gave a two-month history of belching, followed by a burning epigastric pain radiating up the retrosternal area, which was initially relieved by the course of treatment against *Helicobacter pylori*. An upper endoscopy showed normal

oesophageal, gastric, and duodenal mucosa. Dr L considered that the most likely problem was oesophagogastric dysmotility-oesophageal spasm and changed Mrs A back to Losec. He did not arrange formal follow-up. A biopsy of the stomach later revealed *Helicobacter* gastritis (chronic inflammation of the stomach with a small number of *Helicobacter pylori* organisms) despite previous treatment (Losec HP7) prescribed by Dr B. Dr B explained the results to Mrs A.

On 29 May Mrs A advised Dr B's practice nurse that she had almost finished the Losec prescribed by Dr L and, as recommended by Dr L, was about to commence the alternative anti-reflux treatment (famotidine) that he had prescribed.

On 7 June Mrs A was still suffering from reflux and throat discomfort. Dr B prescribed a course of the antibacterial Flagyl for her sore throat, but was concerned that Mrs A's symptoms had not resolved and added Merbentyl and metronidazole. Dr B stated that he examined Mrs A's throat and abdomen and recorded in his notes that he thought "it is all related to bloating and GI [gastrointestinal] rather than sore throat". There is no reference to bloating in the clinical notes prior to this.

On 3 July Mrs A complained that she had been having frequent bowel motions since she started the course of metronidazole. She was advised to take acidophilus tablets and Dicap antidiarrhoeal capsules to counteract the effects. Dr B stated that this was the only occasion when Mrs A complained of lower pelvic pain, and it followed the course of Flagyl.

On 19 January 2003 Mrs A was seen by Dr F at the after-hours service complaining of a two-day history of quite sudden distension of the abdomen and mild pain in the lower abdomen. On clinical examination, there were no masses felt and Dr F recorded a "doughy" feel all over and mild tenderness in the lower abdomen. He advised a trial of domperidone and recommended an ultrasound scan if she was no better.

Mrs A spoke to Dr B's practice nurse the following day (20 January) and was advised to have an abdominal ultrasound scan. Mrs A had the ultrasound scan on 23 January, and it revealed generalised ascites and a pelvic mass. Dr B obtained the results and informed Mrs A at a consultation on 23 January. Dr B referred Mrs A to Dr E, gynaecologist, who saw her on 24 January. On examination, he found abdominal distension consistent with ascites and a lower abdominal mass. On bimanual examination, there was a suggestion of a large soft mobile mass high in the pelvis. Dr E arranged for a number of further tests, including a CT scan, and scheduled Mrs A for a laparotomy.

Dr B informed me that he examined Mrs A's abdomen on most occasions (while managing Mrs A's menopausal symptoms) up to May/June 2002 and there was no evidence of a mass or lower abdominal pain: "[H]ad [Mrs A] reported to me ongoing lower abdominal pelvic pain and abdominal bloating then I would without hesitation – or the need for request – have referred her to a gynaecologist for review." Dr B stated that prior to January 2003 Mrs A never mentioned lower pelvic pain to him or any other doctor, including Dr L. Dr L recalled that Mrs A did not mention lower abdominal pain or any other abdominal/digestive tract symptoms, other than those directly referable to the upper gastrointestinal tract.

Dr B stated that he did examine Mrs A's whole abdomen to her pelvis but did not perform a bimanual examination as there were no symptoms or finding of lower abdominal pain.

Dr E informed me that Mrs A's more specific symptoms of ovarian cancer were only present for several weeks prior to seeing him. He did not feel the length of time before a referral was made to him was unreasonably long.

My expert advisor, Dr Vause, noted that there was a discrepancy between Mrs A's description of symptoms, describing abdominal and pelvic pain, and Dr B's and other doctors' records of epigastric problems. Dr B's records of Mrs A's symptoms and his examination findings lack detail, and on a number of occasions it appears that the clinical notes were dictated and not made until a day or two after the actual consultation. Dr Vause stated that there are a few occasions recorded in Mrs A's clinical notes where a reasonable doctor, assessing a woman presenting with the symptoms she described, would have carried out at least an abdominal examination, but there is no entry in Dr B's notes to indicate that he physically examined Mrs A on these occasions. Dr Vause commented that lower pelvic pain is not recorded as a symptom in Dr B's notes, nor in the specialist records or those of other doctors who saw Mrs A prior to 2003.

Five other doctors who examined Mrs A between January 2002 and January 2003 recorded that they performed an abdominal examination. These doctors, with the exception of Dr F, who recorded bloating of two days' duration on 19 January 2003, did not identify any abdominal masses or any other lower abdominal abnormalities. Dr Vause considered it significant that the first entry describing a lower abdominal mass is that of Dr E, obstetrician and gynaecologist, after the ultrasound scan requested by Dr B had been performed.

Dr Vause advised me that Dr B followed accepted practice in terms of history, clinical examination, and investigation in relation to Mrs A's reported alimentary tract symptoms in 2002, apart from his poor record-keeping. Dr B appropriately referred Mrs A to a specialist for investigation of her upper abdominal symptoms in April 2002.

Dr Vause noted that there is only one occasion, on 10 June 2002, where the symptoms recorded refer to abdominal problems consistent with Mrs A's account, other than reflux. Dr B refers to bloating, but does not make reference to bloating in the notes prior to this consultation. The bloating on 10 June would also have been consistent with the swallowing of air, which commonly occurs with indigestion and reflux oesophagitis.

Dr Vause advised that the need for a bimanual pelvic examination would depend on Mrs A's symptoms; if Mrs A had symptoms of a pelvic/uterine/ovarian problem, then an examination would be indicated. However, no such symptoms were recorded. Mrs A's affidavit suggests that on 16 April an external pelvic examination was carried out in response to her concerns about cancer. A reasonable general practitioner would have performed a pelvic examination in response to such concerns. However, Dr B's notes do not record any examination or discussion about cancer.

Dr Moriarty also considered that overall, Dr B's investigation and treatment of Mrs A's presumed reflux disease followed accepted practice. However, Mrs A had two concerning

symptoms in relation to her gastrointestinal tract problems – reflux symptoms in a patient over the age of 50 and loss of weight. There were several consultations regarding symptoms of vaginal thrush, but it is unclear whether the symptoms were of pelvic pain or discharge, or both, since the presenting symptoms are not documented.

Dr B's records of consultations with Mrs A were sparse and do not provide an accurate record for the period 10 January to 3 July 2002. (This issue is discussed at pages 56-57 below.) However, Mrs A saw a number of other doctors during this time, who did keep accurate records, and they recorded epigastric symptoms only. It is reasonable to assume that Mrs A did not report any problems in her lower abdomen during 2002, since she did not report pelvic and abdominal symptoms to the other doctors.

Overall, I am satisfied that Dr B appropriately referred Mrs A for investigation and assessment of her epigastric problems. In my opinion, there is insufficient evidence to support Mrs A's claim that Dr B failed to refer her for further tests for lower pelvic pain and abdominal bloating in 2002. I do not accept Mr A's lawyer's submission that "if the doctor keeps poor records … the patient should be given the benefit of the doubt". That inference cannot stand in the face of independent evidence from other doctors (who did keep good records), which tends to corroborate Dr B's account, rather than Mrs A's recollection (which I believe to be honest but mistaken). Accordingly, Dr B did not breach Right 4(1) of the Code.

Referral for a gynaecological assessment
Mrs A stated that she specifically asked Dr B on 21 February and 4 March 2002 to be referred to a gynaecologist for assessment of her ongoing lower pelvic pain and abdomen but he did not refer her.

On 21 February Mrs A consulted Dr B and reported that she was suffering from hot flushes, painful breasts, indigestion, stomach pain, and burping. Dr B recorded that Mrs A believed her symptoms to be related to menopause and ordered blood tests to check hormone levels. On 4 March Dr B commenced Mrs A on a low dose of hormone replacement therapy and advised her to double the dose in two weeks if it did not relieve her symptoms. Mrs A stated that when she asked Dr B at these consultations if she could be referred to a gynaecologist, she was told that it was "not necessary". There is no record in the clinical notes that Mrs A asked to be referred to a gynaecologist on either 21 February or 4 March.

Dr B denies that Mrs A asked to see a gynaecologist. Dr B stated that if Mrs A had made such a request, he would have referred her to a gynaecologist for a review and he would not refuse or be negative about such requests. Dr B said: "Most women, would not, on these symptoms, ask to be referred to a gynaecologist." He said that in light of Mrs A's presenting symptoms and his findings, he did not recommend that she see a gynaecologist. He readily makes referrals to specialists for second opinions and further management – as is evident from the specialist referrals he made for Mrs A's gastric symptoms.

Mrs A claimed that on 26 March, she discussed Dr B's refusal to refer her to a specialist with the practice nurse, Ms H, who said that Dr B's decision not to refer her to a gynaecologist was because he could "do as well" himself. Ms H, who has no recollection of

this discussion with Mrs A, made a detailed note of the consultation. She noted the blood test results, discussion of possible treatments for thrush, and that Mrs A was planning to travel and would need to be reviewed by Dr B before she left. She did not record that Mrs A discussed the possibility of a referral to a gynaecologist.

In summary, Mrs A claimed that she specifically asked Dr B for a referral to a gynaecologist for assessment of her lower pelvic pain and abdominal bloating. Dr B denies such a request, and there is no indication in his clinical records that it was made. Mrs A's recollection of reporting of lower pelvic pain and abdominal bloating must be viewed in light of the records of the various health professionals who saw her, none of whom recorded these symptoms or that Mrs A requested a referral to a gynaecologist. Mrs A's claim was made in June 2003 with the knowledge of her diagnosis of ovarian cancer. In my view Mrs A's claim reflects an honest belief, made with the benefit of hindsight, but unsupported by any evidence from the health professionals she consulted.

There is insufficient evidence for me to conclude that Dr B declined to refer Mrs A to a gynaecologist for ongoing lower pelvic pain and abdominal bloating. It follows that Dr B did not breach the Code in relation to this matter.

Diagnosis of ovarian cancer

Dr Vause commented that although ovarian cancer is the fifth most common cancer in New Zealand, it accounts for only 4% of cancers in women. It is very difficult to detect the disease at an early enough stage to have a high chance of success from surgery. The symptoms of ovarian cancer are generally vague, and "GPs need to have a high index of suspicion to detect this cancer early". Diagnosis is difficult because of the multitude of symptoms that appear late in the disease, and delay in diagnosis is unfortunately common in ovarian cancer. Dr Vause stated that a bimanual pelvic examination would be recommended should a general practitioner need to exclude ovarian cancer as a diagnosis, as it offers a greater chance of detecting a pelvic mass such as an ovarian cancer than an external pelvic examination, but the decision to perform such an examination depends on the presenting symptoms.

Dr E noted that it is always preferable to discover cancer of the ovary as early as possible in its clinical course, but in Mrs A's case her more specific symptoms were present only for several weeks. He stated that although he thought that the cancer may have been present for some months, this "in no way implies that it should or could have been diagnosed at a significantly earlier point in time". Dr D commented that ovarian cancer is difficult to diagnose because of the late onset of symptoms that are non-specific. He noted that Mrs A saw a number of different medical practitioners before she was ultimately diagnosed.

Mrs A's symptoms in 2002 were not indicative of pelvic disease. Dr B and the other doctors she saw did not detect her ovarian cancer. Even if Dr B had carried out a pelvic bimanual examination in April 2002 – for which the indication was debatable – it cannot be known whether a pelvic mass would have been detected. As noted by Dr E, "Cancer of the ovary is notorious for late presentation."

Dr Moriarty also advised that ovarian tumours can be difficult to detect in general practice – they are often clinically silent in onset, or associated with symptoms that might be misinterpreted. With hindsight, it appears that Mrs A's underlying concerns about the possibility of cancer went unrecognised, and further investigation of the cause of her declining health was warranted. However, in forming my opinion on whether Dr B acted reasonably, I am conscious of the risk of "hindsight bias". The fact that Mrs A had an underlying cancer that was detected in January 2003 does not mean that Dr B responded inadequately to the information available in 2002.

In summary, Mrs A's symptoms in 2002 were not indicative of pelvic disease. This is supported by the records of her symptoms kept by the other doctors Mrs A consulted. In the circumstances, I agree with the ACC finding that Dr B was not negligent in failing to diagnose that Mrs A was suffering from ovarian cancer. Accordingly, Dr B did not breach Right 4(1) of the Code.

Opinion: Breach – Dr B

Record-keeping
Right 4(2) of the Code affirms the right of all patients to have services provided that comply with professional standards. Good record-keeping is an essential component of good health care.

Both my expert advisors commented on the paucity of information recorded by Dr B in Mrs A's records. Dr Vause noted that Dr B's records of his consultations with Mrs A were sparse and poor; he failed to accurately record his clinical examinations, and appears to have been aware of significantly more than he recorded. Dr B's failure to record accurately the details of his consultations with Mrs A made it difficult to assess Dr B's management of her care. Dr Vause advised that Dr B's clinical records failed to meet the appropriate standard expected of a general practitioner in such circumstances.

Dr Moriarty advised that the standards of general practice are outlined in the Royal New Zealand College of General Practitioners' *Standards for General Practice Care, 'Aiming for Excellence'* (2nd ed, 2002) and that there are two indicators relevant to this case. The level of documentation in most of the consultations with Dr B did not contain sufficient detail relating to key features of clinical history and examination findings and thus did not meet Indicator D7.1, in that the records were not sufficient to meet legal requirements or describe and support the management of health care provided.

Indicator D8.2 relates to systems to manage test results and medical reports. Dr Moriarty commented that it is unclear if there were systems in place to ensure that medical reports, especially those from after-hours consultations, were first seen by a health professional before being entered into the medical records. Additionally there does not appear to have been any system for prompt follow-up of the patient, on receipt of after-hours medical

reports, to ensure that the management initiated at the after-hours clinic had been successful. If there was such a system, it failed Mrs A on multiple occasions.

Dr B responded that he does contact some patients after receipt of consultation notes from after-hours consultations with other practitioners, but it is a "judgement call" whether to do so. Dr B advised me that there were limitations with the GP Dat Medical Software his practice used in 2002, and in November 2003 the surgery changed to Medtech 32, which has helped with communication and note-keeping.

In my opinion, Dr B failed to meet professional standards for record-keeping and did not have appropriate systems in place to ensure prompt follow-up of patient care, and accordingly breached Right 4(2) of the Code.

Other comments

Clinical care
In 2002 Mrs A had a number of contacts with various health professionals including her regular general practitioner Dr B, his practice nurse Ms H, and doctors at the after-hours service after-hours service. I accept the advice of Dr Vause and Dr Moriarty that at each of the consultations Mrs A had with Dr B, his actions appear to have been generally appropriate, although it is difficult to judge because of the poor records. Dr Moriarty advised that the key consideration in this case is whether Dr B's overall management was appropriate given that he was Mrs A's regular general practitioner. It was important for Dr B to take an overview of Mrs A's multiple consultations, particularly when they were with unusual frequency and there was an unusual collection of health problems that did not resolve as expected following appropriate treatment.

On 21 February 2002 Mrs A saw Dr B with non-specific symptoms, general unwellness, congested breasts and a sore throat. He considered that Mrs A's symptoms were consistent with menopause. Mrs A was commenced on Premarin (hormone replacement therapy). Two months later, on 24 April, Mrs A presented with complaints of tension headaches, neck ache, and feeling tense, tearful and irritable. Dr B advised Mrs A to increase the dose of Premarin and prescribed clonazepam.

It is unclear which of Mrs A's symptoms Dr B believed were due to menopause. Dr Moriarty advised that when health problems arise in menopause they should be taken seriously, investigated for possible underlying causes, and treated, rather than being attributed directly to menopause. In Mrs A's circumstances, this included an internal examination for vaginal infections, a complete history and physical examination for muscle aches and pains, exclusion of health reasons that might underlie the change in chronic sleep pattern, and a full history and examination in relation to her tension headaches and low mood. Dr Moriarty commented that a full history and medical examination was warranted on 21 February because "general unwell" is not a typical symptom of menopause and the breast symptoms were new.

Dr Moriarty noted that HRT is not recommended for depression, low mood, and generalised aches and pains, and that the increase in the dose of HRT indicated that Dr B assumed the symptoms of tension and aches were due to menopause. Dr Moriarty advised that "before attempting to treat these symptoms with HRT a specialist referral would have been indicated for review of the musculoskeletal symptoms and also for the mood symptoms, in view of the severity and chronicity of these symptoms and the lack of evidence that these specific symptoms would respond to HRT".

Dr B responded that HRT was not given to Mrs A merely for symptoms of depression and generalised aches; she had other symptoms including night sweats, palpitations and feeling "waves" of flushing which, to his regret, he failed to document. Dr B stated that menopause was not an issue; Mrs A's epigastric pain was her main problem and at no stage was menopause a diagnosis for Mrs A's epigastric pain.

The clinical records indicate that Dr B prescribed sleeping tablets for Mrs A for some time and that she obtained such prescriptions with increasing frequency. Prescribing frequent repeats of sleeping pills carries the risk of dependency and fails to treat the underlying causes of sleep problems. I accept Dr Moriarty's advice that by March 2002 Dr B needed to review the prescription of sleeping pills and any underlying causes of Mrs A's ongoing sleep disturbance.

Dr Moriarty commented that it is unclear why Dr B prescribed clonazepam to Mrs A on 24 April 2002 if he believed the HRT would treat her symptoms. Dr B responded that clonazepam was given for Mrs A's tension and/or neck spasm for a few days; it was not given for depression or anxiety. Mrs A was informed that it was addictive and it was to be taken for only six to seven days.

Dr Moriarty advised that Mrs A's records indicate that by the end of April 2002 there was a picture emerging of:

1. consultations occurring much more frequently than previously;
2. multiple ill-health complaints with no clear explanation; and
3. failure of the symptoms to respond to standard treatment.

Dr Moriarty considered that this triad, had it been recognised by Dr B, should have indicated that something significant was happening to Mrs A's health and *could* have provoked him to reflect upon the possibility of an underlying problem for the overall clinical scenario. Instead, Dr B's response was an escalation of prescribing for individual symptoms and a tendency to attribute unexplained complaints to menopause and to an unspecified stressor. Mrs A's overarching clinical presentation was not considered in its entirety.

There is no record in later consultations of any review in the second half of 2002 of the symptoms Mrs A experienced over the preceding months. Dr B pointed out that he did not see Mrs A as frequently between July 2002 and January 2003 as in the previous six months and therefore had no reason to suspect that Mrs A was not feeling better. I encourage Dr B to reflect on Dr Moriarty's criticism of his care.

I accept that her comments are made with the benefit of hindsight, and may reflect the views of a general practitioner specialising in women's health. However, a patient's regular general practitioner is best placed to maintain the most complete record of the health problems of an individual under his or her care and to understand the individual's personal circumstances. A primary health service such as a medical centre may be the only health service that knows about any departure from a patient's expected pattern of heath care.

Gender bias

Mr A's lawyer requested that I refer the complaint to a female general practitioner or ask Dr Vause to review his assessment taking into account the possibility of gender bias.

Mr A's lawyer submitted that in this case there was gender bias operating insidiously and that there might have been a better outcome for Mrs A if she had been cared for by a female practitioner. She submitted that Dr B displayed gender bias in his management of Mrs A, in that she was a middle-aged woman presenting frequently to doctors with vague and ill-defined symptoms, which he did not actively manage; nor did he refer her to a gynaecologist when she requested him to do so.

There is an emerging body of sociological research that highlights gender disparities in the provision of health care. I note Sandra Coney's comment in her paper "Gender in the health sector" (Women's Heath Summit, 20 & 21 November 2001, Wellington)[1] that a gender approach examines the social, political, and economic dynamics that determine women's heath status and women's access to, and experience of, the health system. Borges and Waitzkin conclude that many social/contextual issues presented during physician visits are, at best, marginalised, frequently negated or ignored, and most often medicalised, with symptoms treated by prescription drugs rather than addressing the underlying problem.[2]

I do not, however, believe that Dr B exhibited gender bias in his care of Mrs A. Dr B did not ignore her various clinical symptoms or her personal circumstances – although he may not adequately have reflected on the unusual frequency of her consultations and her unusual collection of health problems, which did not resolve as expected following appropriate treatment.

I am also satisfied that Dr Vause did not demonstrate gender bias in his report. He appropriately referred to and discussed all the information obtained during my investigation. I accept that his advice reflects the views of a responsible body of general practitioners, whether male or female.

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[1] <http://www.womens-health.org.nz/genderpap.htm> (last accessed 13 April 2004).

[2] S Borges and H Waitzkin, "Women's narratives in primary care medical encounters" *Women and Health* (1995) 23(1) 29.

Actions taken

I note that Dr B has reviewed his practice, in relation to record-keeping, as a result of this case. He informed me that he now expands his clinical records for all patient consultations and uses the Medtech 32 system.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.
- A copy of this report, with identifying details removed, will be sent to Women's Health Action and the Federation of Women's Health Councils Aotearoa, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.