

**General Practitioner, Dr D**

**A Report by the  
Health and Disability Commissioner**

**(Case 01HDC03196)**



Health and Disability Commissioner  
Te Tōhau Hauora, Hānaitanga



**Parties involved**

Dr A	General Practitioner / Complainant
Mrs B	Registered Nurse / Complainant
Mrs C	Consumer (deceased)
Dr D	General Practitioner / Provider
Ms E	Consumer's daughter

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**Complaint**

On 20 March 2001 the Commissioner received a complaint from general practitioner Dr A and registered nurse Mrs B about services provided to Mrs C by general practitioner Dr D. The complaint is summarised as follows:

- *On 2 September 1999 Mrs C consulted her general practitioner, Dr D, as she had chest pain and discomfort, and her Nitrolingual spray had been minimally effective for her angina. Dr D took an ECG test that showed signs of cardiac ischaemia, but he took no further action to follow this up or treat Mrs C, and he did not request advice from a colleague or a cardiologist.*
- *Dr D ordered blood tests, which showed Mrs C had elevated cardiac enzymes. The results were returned to Dr D that same afternoon but he failed to check for them or act upon them.*

An investigation was commenced on 16 May 2001.

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**Information reviewed**

- Medlab test results
- Records from the public hospital

Independent expert advice was obtained from general practitioner Dr Chris Wright.

## Information gathered during investigation

Seventy-five-year-old Mrs C consulted her general practitioner, Dr D, on the morning of 2 September 1999 as she was suffering from chest pain. Mrs C had a history of ischaemic heart disease (which causes an inadequate supply of blood to the heart muscle) and gastric symptoms.

Practice nurse Mrs B was on duty when Mrs C arrived at the practice. Mrs B advised me:

“At approx 10am on the 2<sup>nd</sup> September 1999, one of the receptionists at the medical centre came to me to say that [Mrs C] arrived complaining of chest pain and discomfort since early that morning. She also had to take her Nitrolingual spray for angina twice with very little effect. The last being at 6am that morning. I immediately took her to our treatment room where I layed her on the bed. Her blood pressure was 124/76 and her pulse 58 per min and I did an ECG [electrocardiogram – a tracing of the heart’s electrical activity]. I then notified [Dr D] about [Mrs C’s] chest pain. She stated she felt unwell. Approx 10 minutes later she was seen by [Dr D] in his consulting room. I spoke to her afterwards and she stated he thought it was indigestion, but was going to get some blood tests done.”

Dr D recalled Mrs C’s consultation:

“As can be seen from the appointment books of all three doctors practising at the centre at that time, I was fully booked on the morning of 2 September 1999. At approximately 10h15 I was informed by the nurse about the patient after she had done an ECG and checked the blood pressure. I immediately excused myself from the consultation I was busy with and popped in to see the patient briefly in our treatment room.

Her history was not consistent with myocardial infarction and her clinical condition did not cause any alarm. She was therefore requested to wait until I had finished with the patient I was consulting and was seen in my consulting room about 10 minutes later.

The patient had driven herself to the surgery and walked in as usual. She stated that she had developed mild chest pain on sitting up in bed after waking at around 6am that morning. She had no discomfort at that stage. She had had a large meal the previous evening. There was no history of chest pain on exertion or of persistent chest pain. There was no history, signs or symptoms of shortness of breath or fatigue. There was no restlessness or history of sweating or clammy skin. She was not in heart failure. Jugular venous pressure was normal. There were no basal crepitations [dry crackling sounds in the lung] or oedema [fluid retention] and she was obviously not in shock. There were no cardiac murmurs. The patient had been a heavy smoker for many years and her chest was always a bit noisy. She was certainly not in distress.

The electrocardiographic diagnosis of an acute myocardial infarction [heart attack] depends upon serial ECG tracings since it is not uncommon in the first few hours of an infarction to have absent or indeterminate ECG findings. Pain of myocardial infarction can be similar to angina pain but is usually more severe and/or longer lasting and

relieved little or only temporarily by nitro-glycerine spray. The decision to admit a patient should be based upon the patient's history and physical findings. Because of the atypical history, lack of supportive physical findings and perhaps a lowered index of suspicion because of previous similar episodes the patient was not admitted.

The patient said that she was expecting a friend over that afternoon and she was sure it was just indigestion. There was no characteristic history and I did not have enough reason to suspect another diagnosis other than indigestion. I let her go home and hence the warning at the end of my notes 'to return to surgery if pain persists or phone 111 if two nitro lingual sprays do not help'.

Because I had not seen the patient since 6.4.1998 (17 months) I referred her for a blood test at Medlab Community Laboratory which was in the same building as the surgery. I requested liver functions, Glucose and HbA1c [haemoglobin], electrolytes and cardiac enzymes."

Ms E, Mrs C's daughter, disputed Dr D's comments about her mother's lifestyle. Ms E informed me that her mother had a driver's licence, but did not own a car and had not driven for about ten years. She said her mother normally walked every day, but was driven to the surgery on 2 September by a neighbour, which was an indication of how unwell she was. Ms E said that Dr D's statement that her mother was a heavy smoker was incorrect as her mother smoked only two to four cigarettes a day. Ms E also stated that it was unlikely that her mother would have had a heavy meal on the evening of 1 September. However, this information is unable to be verified, as Mrs C's dinner companion that night has not been located.

Dr D's hand-written records of the consultation read:

"Chest pain this [morning]. 2x NL [Nitrolingual] spray did help somewhat. Atenolol 50mg ½ daily, Frusemide 1 [daily], Solprin ½ daily, Lorazepam 1 mg tds."

In a different coloured pen is recorded:

"Woke up this morning and on sitting up got chest pain. Had a large meal of chips and steak as well as a doughnut. Tender epigastrium. ECG plus/minus normal except for clear angina. BP 120/70. Impression: Hiatus hernia as well as angina. Add Losec 1 bd (60). Advised on diet and raising bed. To return to surgery if pain persists or phone 111 if two nitro lingual sprays do not help."

Regarding the blood tests that Dr D had ordered, Medlab advised me:

"1. Original request forms are kept for only 1 year so it is not possible to state exactly what tests [Dr D] requested but from the computer record of the reported test results, I believe he would have requested:

Myocardial enzymes  
Serum sodium

Serum potassium  
 Serum glucose  
 Blood HbA1c

2. Any clinical information supplied would have been on the original request form and so is not available.
3. Test results (see attached – Appendix A).
4. From a biochemistry point of view the results are suggestive of myocardial infarction. The patient may also be diabetic but this is not definite from the results available.

It is our normal policy to phone or fax test results of this nature and to record that fact on the request form. As that record has now been destroyed, I cannot confirm this but the fact that a CK-MB was performed, and this test is not normally performed with myocardial enzymes unless the total CK is elevated (as it was in this case), the evidence is that the elevated CK of 792 was recognised by the staff as a significant result and the CK-MB test added. This elevated result of 109.4 (13.8%), would also have been recognised as significantly abnormal and so the results would have been either phoned or faxed through to [Dr D], immediately after validation.

5. [Dr D] has his laboratory results sent by both hard copy and electronic media. He would receive copies of results in both forms at least once a day. As mentioned above, it is our policy to phone or fax urgent results (as requested by the Doctor), or significantly abnormal results (as interpreted by the laboratory), immediately they are available.”

Mrs C’s test results were:

“Myocardial Enzymes

Test	Result	Normal Range
S. AST [serum aspartate transaminase]	40 U/L	(5 – 35)
S. CK [serum creatine kinase]	792 U/L	(< 200)
S. CK-MB	109.4 U/L	(< 25)
% CK-MB	13.8 %	(< 6)
<u>Renal</u>		
S. Sodium (Na)	139 mmol/L	(138 – 145)
S. Potassium (K)	3.8 mmol/L	(3.6 – 5.2)
<u>Glycaemic Control</u>		
S. Glucose	9.6 mmol/L	(3.0 – 6.0)
HbA1c	6.2 %	(3.5 – 6.0).”

Mrs B recalled the sequence of events as follows:

“The next morning I received the hard copy of the laboratory tests on my desk as was the normal routine. I noted the elevated cardiac enzymes. I immediately showed them to [Dr D] who told me [Mrs C] had died the previous evening and that the police had called him. He asked me why he wasn't made aware of the results which had been faxed to him by MedLab the previous afternoon.

I had not seen the faxed results. The standard procedure was for the receptionists to clip all the faxes to the 'emergency clipboard' outside each of the three doctors' offices from where they could attend to it asap. This had indeed happened. I told him I had not seen the results, but that he did need to attend to his faxes, which very often piled up without being checked by him.

He then stated why didn't MedLab contact him by phone to let him know? 'They phone me about other results, why didn't they phone me about this?' I reiterated that MedLab had faxed the results to him the previous afternoon and he obviously hadn't seen it. Since that incident, faxes that came through for [Dr D] with 'stars' after the results, were given to me by the reception for actioning. I do not know if he had contacted MedLab about the results.”

Dr D explained that although Medlab faxed these abnormal results to him that afternoon he was unaware of this. Although Medlab would frequently telephone him with results that had serious implications, that did not happen on this occasion. He explained:

“The system of bringing the abnormal laboratory result to my notice failed in that I did not receive a phone call from the laboratory as I had become accustomed to. The nurse who was normally very good with interpreting laboratory results also did not see the faxed result. It must have been put in my box by either one of the three receptionists or the Medlab phlebotomy nurse who usually came into our surgery to talk to and assist the receptionists when she was quiet in the afternoon.

There was no such entity as an emergency clipboard in our surgery. Every doctor has a Perspex box for the placing of patient files as they arrive as well as any other forms, documents, letters etc. All letters and documents are normally turned 'face down' to prevent the public from reading them. The fax could have been amongst other papers in this box but I obviously did not see it. If I had, I would have arranged for immediate admission.

Since this tragic experience I have changed the system in my surgery in that all laboratory results go immediately to the practice nurse who scans them and has the authority to interrupt me immediately she becomes aware of any serious abnormality. Since this incident I make a point of instructing the patient to contact me or the practice nurse whenever I request cardiac enzymes in a patient who is not admitted. I am obviously more aware of silent myocardial infarctions and have re-read the relevant chapters in my 'Cardiology for the House Officer' textbook.”

The Police telephoned Dr D on the evening of 2 September 1999, as Mrs C had died at her home. Dr D described what happened next:

“Living quite close to her I arrived at the patient’s home at approximately 20h00. There was a police officer at home as well as a good friend of the patient. The friend told me that they had had a normal day and that she had prepared dinner for them. After dinner he did the dishes while she took a hot shower. Prior to the hot shower she was perfectly normal and apparently did not have any symptoms.

Immediately after the hot shower she complained of tiredness and a heaviness in her chest and said she was going to bed for a while to rest. She did not phone our surgery which would have automatically transferred the call to [...] Clinic. She also did not phone 111 as instructed. The patient’s friend finished tidying up the kitchen and when she didn’t respond to him talking in the kitchen he went to her bed and found her dead. I am not sure whether her friend phoned the police directly or whether the police was phoned by [...] Clinic.

I found her in bed lying on her right side with her back towards the chest of drawers as if she was asleep. I inspected the body and certified her dead. Her medicines were close to her on a chest of drawers beside her bed.”

Dr D explained that Mrs C had presented with a silent myocardial infarction some four hours after experiencing symptoms interpreted as indigestion. He believes that she had suffered a sub-endocrinal infarction and then a second, catastrophic infarction later that day after a large meal and a hot shower.

As Mrs C had experienced similar episodes previously, and “because the ECG was less striking than usual, indeterminate and difficult to interpret given her previous history”, Dr D sent Mrs C home from the surgery with a warning to return or call 111 for emergency assistance if her symptoms returned and were not abated by two Nitrolingual sprays.

Dr D explained that Mrs C had previously suffered similar episodes of upper abdominal pain. In August 1997 she had abdominal pain after taking the antibiotic Rulide, while already taking Gaviscon (a gastric reflux suppressant). In early March 1998 Mrs C had consulted Dr D about upper abdominal pain and bloating. An ECG showed angina and abnormal premature contractions. Dr D wanted to admit Mrs C to hospital on that occasion. As she declined admission, he advised her to seek medical assistance if the pain persisted or worsened. Although blood tests showed impaired glucose tolerance she did not meet the criteria for diabetes mellitus. In late March 1998 Mrs C complained of vomiting after a fatty meal. The cause of the vomiting was deemed to have been a large rich meal.

Mrs C also presented to another GP at the practice on 28 July 1999 complaining of chest discomfort. She was given some Disprin and referred to a public hospital where she stayed until 30 July. She was treated with aspirin and atenolol for unstable angina and referred back to her GP to have anticholesterol treatment followed up, urea and electrolytes checked, and an instruction that if her chest pain recurred she might require further investigation.



Unfortunately, a full copy of Mrs C's general practitioner records was not provided to me during this investigation. Dr D advised me that he has been unable to locate them. At the time these events occurred, Dr A (the complainant) and Dr D worked at the same practice. Later that year they parted company and Dr A set up a new practice with Mrs B as his practice nurse. Mrs B explained that she had borrowed Mrs C's medical records from Dr D's practice, photocopied extracts to accompany this complaint, and then returned the full record to the closed filing system at Dr D's practice.

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## **Independent advice to Commissioner**

The following expert advice was obtained from an independent general practitioner, Dr Chris Wright:

“Re: medical services provided for [Mrs C] by [Dr D].

### **Information Provided**

- Letter of complaint from [Dr A]
- Letter with information from [Mrs B]
- Notes from telephone conversation between Investigation Officer and [Mrs B]
- Notes from telephone conversation between Investigation Officer and [Dr A]
- Letter of reply from [Dr D]
- [Mrs C's] medical notes
- Letter from [the pathologist] and Medlab results
- Notes from telephone conversation between Investigation Officer and [Dr D]
- [The public hospital's] ECG copies from [Mrs C's] hospital admission 28-30 July 1999

[Mrs C] attended [Dr D] with recent chest pain on 2 September 1999. She had a history of ischaemic heart disease and gastritic symptoms over preceding years and as well as her heart medication of Frusemide, Atenolol and Aspirin, she seems to have taken both antacids and Zantac at various times in the past (medical notes). She had used her Nitrolingual spray twice that morning with some effect.

There are discrepancies between [Dr D's] and [Mrs B's] recollections. [Mrs B] states that [Mrs C] was feeling unwell and had ongoing chest discomfort from early that morning. [Dr D] writes that [Mrs C] was undistressed and had no chest discomfort at the time of consultation, but that she had had chest pain for an unspecified time that morning.

[Dr D's] taken history did not appear to be a classical one for cardiac pain. He notes the consumption of a large fatty meal the evening before and the development of pain on getting out of bed. He took her blood pressure and found her upper stomach to be

tender then presumably took into account her past history of dyspepsia. An ECG was performed.

The ECG given to me from [Dr D's] notes show two ECGs, mounted one above the other on the same page. They look similar. [Dr D] is unable to remember if the two ECGs were done on the same day or whether the upper ECG was performed at an earlier time. The only difference between the two ECGs appears to be due to ECG machine speed, which appears doubled in the lower ECG, suggesting they were probably performed at the same time. Whatever the case, the lower ECG of 2 September 1999 has been read electronically by the ECG computer and notes several abnormalities. Assuming the upper ECG has been run on the same morning, I then don't have previous ECGs from the surgery to compare them against. [Dr D] writes that this ECG on 2 September 1999 was '*less striking than usual* indeterminate and difficult to interpret given her previous history'. This suggests he had access to a previous ECG.

As a result of this consultation [Dr D] felt that [Mrs C's] main problem was either a gastric one (or indigestion), or acid reflux. He prescribed Losec to reduce stomach acid production and gave general advice on diet and raising the head of the bed. He also advised her to return to the surgery if pains persisted or phone 111 if the use of Nitrolingual spray failed to help pain.

[Dr D] states that the most recent ECG otherwise done at his surgery was on 28 July 1999. From the notes he did not see [Mrs C] on that day and I presume another doctor in the practice conducted the consultation and referred her to hospital (it is noted in the [the public hospital's] Emergency Department notes that she was given aspirin at the 'GP surgery' on this day). Serial ECGs over the ensuing days at [the public hospital] were available to me and are different in the frontal and lateral leads to the ECG taken on 2 September 1999.

As stated, I have no other ECGs from the surgery to compare with the ECG of 2 September, but note that [Dr D] wrote that a previous ECG from March 1998 showed '?angina'. ECGs done in July 1999 in hospital demonstrate abnormality, but in a different area of the heart than the later ECG.

The ECG of 2 September, in my opinion, shows possible old injury to the underside of the heart and definite ischaemic ('anginal') changes in the front part of the heart, but this is not necessarily diagnostic of an acute heart attack. It shows, nevertheless, significant abnormalities, which should make a practitioner suspicious of a cardiac problem, possibly an acute one. It is reasonable to assume that the most recent ECG done in the surgery previously on 28 July 1999, ([Dr D's] charging/accounts records), looked like the ECG from [the public hospital] that I have available (done also on the 28 July), and that the changes in surgery ECG recordings from 28 July to 2 September should have caused suspicion that the latter ECG's new changes may be of recent origin.

Despite his diagnosis of non-cardiac pain, [Dr D] referred [Mrs C] to the medical laboratory for blood tests, including cardiac enzymes.

These were performed on the same day at the local medical laboratory. There were significant abnormalities in [Mrs C's] cardiac enzymes, which indicated heart damage. [The] pathologist at Medlab [...], is sure that these results 'would have been either phoned or faxed through to [Dr D]'.

The laboratory appears to have faxed [Dr D's] surgery with the abnormal result during the day. This is [Dr D's] belief as well as [Mrs B's]. [Dr D] believes it was the responsibility of [Mrs B] to show him the fax (notes from telephone conversation with Investigation Officer) and [Mrs B] states that she had not seen the results. [Dr A] states that [Dr D] did not attend to his 'urgent clipboard' (his emphasis), but [Dr D] denies the presence at the time of such a clipboard. He does however say that each doctor had a box for such correspondence.

[Mrs C] died that evening at home and [Dr D] attended to certify death. The subsequent death certificate states the cause of death as being 'Acute Myocardial Infarction' or heart attack.

### **Opinion**

[Mrs C] was admitted to [the public hospital] just over one month previously with ischaemic heart disease and unstable angina. A hand-written discharge letter was sent out on 30 July 1999. [Dr D] was aware of her angina as he had recognised anginal pain in March 1998 and had placed her on Atenolol for one month for this. There is not any mention of whether she continued the medication after that month. She had been on Atenolol from [the public hospital] for over a month at the time of death.

In the presence of chest pain, medical practitioners need to have a high level of suspicion of a cardiac cause and have good clinical/ECG/biochemical reasons to feel happy about a different diagnosis. I think there has been increasingly defensive medicine practised in this type of case, even in the last three years since these events, but also believe that in 1999 a high degree of wariness in this type of presentation would have been the norm.

In [Mrs C's] case, there were reasons to be suspicious that this might be cardiac pain, despite the not totally typical description. These reasons would include:

- Recent admission with unstable angina
- Abnormal ECG
- Partial relief with Nitrolingual spray.
- Known glucose intolerance
- Smoker
- Elevated fasting cholesterol
- Possible atypical presentation in an elderly patient

The history in such a case is usually the most important indicator of the type of pain and gives vital clues as to future management. There is a divergence of opinion between [Mrs B] and [Dr D] as to the length of time of pain and whether it was still present at

the time of consultation. [Dr D's] contemporaneous notes give minimal information. He writes:

- Chest pain this morning
- Partial help with Nitrolingual spray
- Pain occurred on sitting up
- The presence of a fatty meal the previous evening

He expands however on the history in [Mrs C's] case in his written letter of reply of 26 April 2001. I am not sure where the extra information came from as when I examined the original medical file photocopy there is no evidence that questions about exertional chest pain, shortness of breath or sweating were asked, as [Dr D] states. Such questions as pain duration, radiation, site and quality do also not appear to have been put to [Mrs C] but may have given more accurate information as to cause of pain.

[Dr D's] examination was also brief and although examination can often be normal in the presence of acute heart attack, it is nevertheless important to examine the cardiovascular system when chest pain is a presenting symptom. Taking the blood pressure and palpating the abdomen is not an adequate examination in these circumstances. Again in the letter of 26 April 2001 [Dr D] provides extra information, viz. no breathlessness, no restlessness, no evidence of heart failure, no oedema, no murmurs, not in cardiac shock and no crackles audible in the chest. The above would be an excellent example of a cardiac examination, but these details are again not evident in the original file.

It is to be noted that [Dr D] correctly decided to order an ECG and cardiac enzymes on [Mrs C].

The issue of duration of chest pain needs to be addressed. There is variance in the description of this. If the chest pain was brief and occurred several hours previously, then it might tend to make the General Practitioner consider that alternative diagnoses were possible. If ongoing, then more urgency and care should be shown. [Dr D] has not stated how long the pain lasted and [Mrs B's] performing an ECG before being asked by [Dr D] would go along with her belief that the pain was significant and possibly still present. I am unable to determine the duration of pain issue but at the point of consultation, [Dr D] was faced with an abnormal ECG and a patient who had had chest pain of an undetermined length that morning.

It is possible that [Dr D] did not have the available previous surgery ECG of 28 July 1999 but that he did have the previous ECG of March 1998 which he has stated showed 'Angina'. If the March 1998 and September 1999 ECGs were very similar and if [Mrs C] had had a very short period of time with chest pain that morning, it is possibly reasonable to believe that a heart attack or significant anginal attack had not occurred. Even then however, her chest pain plus risk factors makes it important to rule out cardiac ischaemia as a diagnosis. Any deviation from this scenario however invites criticism.

[Dr D] failed to appreciate the importance of an abnormal ECG in the presence of an unspecified period of chest pain and appears to have had a low level of suspicion for heart disease, despite several reasons in [Mrs C's] history that suggest he should have retained a high level of suspicion.

There is disputed evidence over the duration of [Mrs C's] chest pain.

The practice systems error, despite the outcome, is a relatively minor departure from the normal standard of care.

If the information in the original hand-written medical notes is to be preferred over the subsequent information in [Dr D's] letter of 26 April 2001, the history taking and examination demonstrate a more serious departure from normal standard of care.

[Dr D's] overall clinical handling of this case also demonstrates a more serious departure from the normal standard of care.

I am unable to reach a decision as to the exact duration of chest pain.

If a previous ECG could be shown to be very similar to that of 2 September 1999 and it is believed that [Mrs C] had only a brief episode of chest pain earlier in the day, it may have been reasonable to assume this pain to be non-cardiac or a minor anginal episode. With this scenario, there still remain criticisms of practice systems and of history taking and examination.”

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## **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: Breach – Dr D**

### *ECG results*

My advisor noted that in the presence of chest pain, practitioners need to have a high level of suspicion of a cardiac cause of that pain, and good clinical reasons to substantiate a different diagnosis. I accept my advisor's statement that, notwithstanding the incomplete medical record, the ECG taken on 2 September 1999 of Mrs C showed significant abnormalities that should have made Dr D suspicious of a cardiac abnormality, possibly an acute one.

Dr D should also have been suspicious that Mrs C's pain had a cardiac origin for the following reasons: her recent hospital admission with unstable angina; an abnormal ECG; partial relief with Nitrolingual spray; glucose intolerance; history of smoking; elevated fasting cholesterol; and a possibly atypical presentation in an elderly patient.

Given Mrs C's history, atypical presentation and abnormal ECG, Dr D should have taken additional steps to determine the cause of her pain and, in particular, to exclude a cardiac cause.

### *Blood tests*

Despite a diagnosis of non-cardiac pain, Dr D ordered blood tests that included cardiac enzymes. These tests were performed that day and revealed significant abnormalities, which indicated heart damage. These test results required urgent follow-up, especially in light of Mrs C's history and the abnormal ECG.

The reason why Dr D was not aware of these results is not clear. They were faxed to his surgery that afternoon. He stated that the laboratory or the practice nurse would normally have brought such results to his attention. Mrs B stated that the results were placed in Dr D's in-tray in the normal manner but he failed to clear it in time.

The tests Dr D ordered were undertaken and results were available that same day. These results warranted urgent follow-up, which did not occur as Dr D was not aware of them. General practitioners are responsible for following up in a timely fashion potentially abnormal or significant test results. A general practice should have a system in place that ensures urgent results are promptly brought to the attention of the general practitioner who ordered the tests. On balance I am satisfied that although there was a system in place for reviewing test results, Dr D failed to use reasonable endeavours to follow up Mrs C's results in a timely fashion.

Whatever the reason for Dr D not becoming aware of Mrs C's blood test results the same day, in my opinion it was his responsibility to ensure that he was aware of such urgent results, especially given her abnormal ECG. Mrs C needed the cause of her chest pain to be established quickly and treated. Had Dr D been aware of and followed up these abnormal results, appropriate treatment could have been commenced.

### *Examination and record keeping*

I also note my advisor's opinion that Dr D's examination, as recorded in his contemporaneous record of Mrs C's consultation, was brief and inadequate in the circumstances. His letter of reply to this investigation, written in April 2001 some 19 months after Mrs C's death, contains detailed information about her presentation and symptoms. This information was not contained in the contemporaneous record of the consultation. It follows that either Dr D's examination and history taking was substandard, or that his record keeping did not comply with professional standards.

### *Conclusion*

I consider that Dr D did not treat Mrs C with reasonable care and skill and failed to comply with professional standards. Given her history, atypical presentation, and abnormal ECG, Dr D should have taken steps to further investigate the cause of Mrs C's chest pain and exclude cardiac ischaemia as a diagnosis. He should also have ensured that he was made aware of the blood test results he had ordered. I accept my expert advice that Dr D's "overall clinical handling of this case ... demonstrates a more serious departure from the normal standard of care". In these circumstances, Dr D breached Rights 4(1) and 4(2) of the Code.

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## **Action**

I recommend that Dr D take the following action:

- Apologise to Ms E, Mrs C's daughter, in writing. The apology is to be sent to the Commissioner and will be forwarded to Ms E.
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## **Further actions**

- A copy of this report will be sent to the Medical Council of New Zealand and to the Royal New Zealand College of General Practitioners.
- This matter will be referred to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- Copies of this report, with details identifying the parties removed, will be sent to the Royal New Zealand College of General Practitioners and will be placed on the Health and Disability Commissioner website, [www.hdc.org.nz](http://www.hdc.org.nz), for educational purposes.