General Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 00HDC02718)

Complaint

The Commissioner received a complaint from the complainant, Mrs A, and the consumer, Mr B, concerning the provider, Dr C. The complaint is summarised as:

- *On 17 December 1999 Mr B consulted Dr C at his Medical Centre because he was concerned that the symptoms he was experiencing were the same as those when he had a brain haemorrhage in 1991.*
- *Dr C arranged for Mr B to have blood tests and advised that a scan would be performed if the blood test results were negative. Mr B had one lot of blood tests that day and another lot on 29 December 1999.*
- *On or about 12 January 2000 Mr B and Mrs A had not heard back from Dr C about Mr B's blood test results. Mrs A rang the medical centre and was put through to a nurse who advised her that Mr B had glandular fever and to take Disprin, Vitamin B and get plenty of rest.*
- *A week later, dissatisfied with the diagnosis of glandular fever, Mr B sought a second opinion from Dr D in his home town. Dr D arranged a scan that day at a public hospital, which revealed that Mr B had a brain tumour.*
- *Mr B and Mrs A are concerned about the "unprofessional manner" in which Dr C handled Mr B's symptoms, in light of the specific information that was provided, and query whether Dr C even considered the blood test results at all.*

Investigation process

The complaint was received on 13 March 2000 and an investigation was commenced on 10 May 2000. Information was obtained from:

Mrs A	Complainant
Mr B	Consumer
Dr C	Provider / General Practitioner
Dr D	Provider / General Practitioner
Mrs E	Provider / Practice Nurse
Mrs F	Provider / Practice Manager

Expert advice was obtained from Dr G, an independent general practitioner.

Information gathered during investigation

Background
On 17 December 1999 Mr B went to see Dr C, general practitioner, at his Medical Centre (the Centre). Mr B's wife, Mrs A, accompanied him. Mr B complained to Dr C that he felt very weak and tired, and had a lot of pressure inside his head (headaches). Mr B told Dr C that he was very concerned about his job as a share milker and his ability to continue working. Mr B reported a past history of brain haemorrhage in 1991, which was treated conservatively (without surgery) and from which he made a full recovery. Mr B was concerned that when he experienced the same symptoms in 1991, the doctor whom he consulted then advised him that he had sinusitis. Mr B insisted it was more than sinusitis. A CT scan at that time showed that he had suffered a brain haemorrhage. Surgery was not required.

Mrs A asked Dr C if he could arrange a CT scan to check her husband's condition, as he did not want a repeat of what had happened to him in 1991. Mr B wanted a clinical check from Dr C to see what was happening to him. Mrs A advised me that she felt Dr C questioned her husband on irrelevant issues, asking whether he was depressed, or had financial or marital problems.

Mr B and Mrs A recalled Dr C advising them that he would do some blood tests first to check on Mr B's condition, and if the blood tests did not show up anything, Dr C would get back to them to decide what to do next.

Clinical examination
Dr C examined Mr B and noted that apart from a general "flat affect", the clinical examination was normal. Clinical examination included blood pressure, heart sounds and a full neurological examination of power, tone, co-ordination, reflexes and optic fundi (that part of the retina/the layer at the back of the eyeball that is sensitive to light, where the blood vessels and nerves exit the eye).

Management plan
Dr C advised that as part of Mr B's management plan, it was agreed that Mr B would return to Dr C as necessary, if he continued to feel unwell, or if the situation changed, with a view to possibly referring him to neurology in view of his previous history.

Neither Mr B nor Mrs A recalled Dr C advising them that Mr B should return and see him if he continued to feel unwell. Mr B advised that Dr C might well have told him to come back if he did not feel well, but he does not remember Dr C giving him this advice.

Mr B and Mrs A said that they discussed the possibility of a scan with Dr C, without any firm commitment from him. However, they thought that Dr C alluded to the possibility of Mr B having a scan if his blood test results were negative. Dr C refuted this and maintained that he did not state that a scan would be performed if Mr B's blood test results were negative.

Blood tests
Dr C arranged blood tests for Mr B to check whether there was any reason for his symptoms of tiredness, malaise and headaches. Mr B had blood tests on 17 and 29 December 1999.

Dr C advised that he had told Mr B that someone would telephone him with the results of the blood tests if they were "positive". Dr C's clinical notes for Mr B's consultation on 17 December state:

> "Bloods and phone. See prn [as required]. ? Refer neurology."

Dr C advised me that his intention was to possibly refer Mr B to neurology if Mr B failed to improve and returned for further consultation.

Dr C advised the Centre's policy: he reviews all results he orders; if blood test results are positive, he asks his practice nurse, Mrs E, to ring the patient and pass on the results and to make follow-up arrangements if appropriate.

Both Mr B and Mrs A thought that Dr C advised them that someone would telephone them with the results of the blood tests no matter what the results were. They would then take it from there as to what should be done next, in terms of further checks for Mr B. Mr B and Mrs A recalled Dr C advising them that he would perhaps arrange a CT scan if the blood test results came back negative, but Dr C advised that he did not state this to Mr B and Mrs A.

Blood test results
Mr B had blood tests on 17 December which included CBC, LFTs, U&Es, TSH, ferritin and EBV (glandular fever screen). The results were all normal, the EBV screen showing past exposure only. On 29 December Mr B had a follow-up EBV screen (a repeat glandular fever screen) which, as is usual, was initiated by the Laboratory. The results of this test confirmed that Mr B had had glandular fever in the past.

On or about 12 January 2000 Mr B and Mrs A were becoming increasingly concerned as Mr B's general condition was deteriorating and they had not been advised of the results of the blood tests or what the next steps should be. Mr B continued to feel unwell and his symptoms of tiredness, malaise and headaches had increased over this period. However, Mr B did not return to see Dr C. He thought that since he had not been advised of any blood test results, "no news was good news". Nonetheless Mrs A felt concerned when they had not been contacted by the surgery about the blood test results.

Dr C advised that at the time that Mr B consulted him on 17 December there were no clinical signs to indicate a serious neurological problem, and Mr B chose not to return to him for follow-up. In Dr C's opinion, patients have a responsibility for their own health and if they have ongoing symptoms or concerns, they are encouraged to seek a review.

On or about 12 January 2000 Mrs A telephoned Dr C's surgery to find out the results of the blood tests, as they had not heard anything from the surgery. Mrs A spoke to one of the practice nurses. Mrs A does not know the name of the nurse. Mrs A recalled that the nurse informed her that her husband's second blood test results (ie, the repeat glandular fever screen) indicated that he had had glandular fever in the past. Mrs A recalled that the nurse advised her that her husband should take Disprin and Vitamin B, and get plenty of rest, presumably in case he was still suffering from the effects of the glandular fever. Mrs A was not impressed with the nurse's advice as she thought Dr C should arrange a scan to find out what was wrong with her husband, although she did not tell the nurse this.

Mrs E is Dr C's practice nurse. Mrs E did not recall conveying any blood test results to patients named Mr B or Mrs A. Mrs E also noted that she had been on holiday from 24 December 1999 to 5 January 2000. At the time that Mrs A telephoned the surgery to ask about her husband's blood test results, Mrs E was job sharing with another nurse.

Mrs E advised that the surgery receives a lot of telephone calls in one day and that a number of nurses work at the surgery. Mrs E advised that it could have been any one of the practice nurses who spoke to Mrs A.

Advice from Dr C about notifying patients of blood test results
Dr C advised that the nurses at the surgery make several calls every working day to advise patients of blood test results. In Dr C's opinion, for a nurse not to remember a specific phone call after a gap of six months is understandable; but that is not to say that the telephone call did not happen.

Neither Dr C nor his nurse record every follow-up action or telephone call to patients as this, in their view, is not practical. There are 8500 registered patients at the Centre and many more casual patients. Each general practitioner at the Centre sees between 30 to 40 patients a day. In Dr C's view, extra resources would be required if such a system were to be adopted. Dr C believes that the practice could not afford this.

Dr C was on holiday from 1–16 January 2000. Dr C was unaware that Mr B and Mrs A were concerned that they had not been informed about Mr B's blood test results or that Mr B's condition was deteriorating.

Dr C did not specifically advise his locum, Dr H, of Mr B's consultation before going on holiday. He stated that the initial blood test results from 17 December 1999 had already been received and dealt with appropriately before he went on holiday. The second blood test results arrived while Dr C was away, and he thought that they would have been seen and dealt with by Dr H.

Dr C stated that it is usual practice for the practice nurses to deal with telephone call enquiries from patients and follow up with the doctor concerned, as appropriate.

Dr C advised:

> "All the doctors at [the Centre] have several different ways of communicating test results. In some cases it is decided with the patient that we will contact them (as in this case). Sometimes we will contact them only if there are abnormal results. Sometimes the patient will be advised to contact us for results. Sometimes we will mail out results to patients. There is no one way of doing this as there needs to be flexibility depending on the type of result or problem, the patient's availability by phone, the patient's wishes, etc. etc. Laboratory and x-ray results are received each day both electronically and by paper copy; i.e. there is a dual system to avoid results being overlooked. Each day, I access the Observations file in our PMS [Patient Management System] and review the results. The results remain in this file until actioned and transferred to individual patient files. In addition, the paper copies are sorted by my nurse and given to me along with the patient file. The results are reviewed by me and the notes to see what action was arranged. If the patient is to be contacted, I will do this myself but the nurse makes the vast majority of calls. I will tick paper copies seen by me and/or write down what action has been taken. I go over each file needing action with my nurse. If we are to contact the patient with results I will record this in the notes at the time of consultation as 'bloods and phone', as in this case."

Dr C went on to explain that the doctor who orders the blood tests is the person who reviews the results. After direction by the doctor, the doctor's practice nurse then contacts patients by phone to advise of blood test results. If patients telephone the Centre requesting blood test results, they are put through to the nurse, who will then advise them of their blood test results.

Second opinion

Mr B and Mrs A were dissatisfied with the service and care they received at Dr C's surgery. Hence, on 21 January 2000 Mr B sought another opinion from Dr D.

Mr B advised Dr D of his concerns regarding the tiredness and headaches he had been experiencing over the past six weeks. Mr B told Dr D that he had already seen another doctor about the matter and that he wanted a second opinion.

Dr D performed a clinical examination on Mr B but could find nothing amiss. Dr D stated that he did not suspect "brain haemorrhage" when he saw Mr B:

> "I would like to make a point that I did not arrange for [Mr B] to have a scan for a specific suspected brain tumour. I was as surprised as anyone that that was the diagnosis. When I saw him it was for a second opinion about his lassitude and I was aware that he had already seen another doctor … I could find nothing in this on my examination, but decided to ask the Medical Registrar to see him in the Emergency Department because:

a. His symptoms were becoming rather disabling over a prolonged period
b. Because of the history of an atypical cerebral bleed … several years previously."

Dr D asked the medical registrar in the Emergency Department at the public hospital to see Mr B that day, 21 January. Dr D did not advise the name of the medical registrar to whom he spoke.

Mr B went to the public hospital as arranged by Dr D. The medical registrar was able to arrange a CT scan that afternoon. The CT scan revealed a brain tumour. On 24 January the public hospital advised Dr D that a tumour had been found. Dr D was surprised at the diagnosis, given that his clinical examination of Mr B found nothing amiss, so he telephoned the medical registrar and told him of this. The medical registrar told Dr D that he had been equally surprised at the outcome of the CT scan as he also had found no clinical signs of a brain tumour when he examined Mr B.

Complaint
On 28 January 2000 Mrs A went to Dr C's surgery and spoke to the practice manager, Mrs F, in the reception area. Mrs A was angry and very upset. As there were other people in the reception area, Mrs F took Mrs A into another room and asked her what the problem was. Mrs A told Mrs F that her husband had a brain tumour and that Dr C did not detect this when her husband consulted him on 17 December 1999. Mrs A told Mrs F that her husband was in hospital and very sick. Mrs F suggested that Mrs A speak to Dr C there and then, but Mrs A refused and left.

Mrs F immediately informed Dr C about the incident and Dr C tried to contact Mrs A at her home by telephone that day to discuss the matter, but there was no answer. On 1 February 2000 Dr C finally managed to contact Mrs A by telephone. Dr C offered to see Mrs A and discuss any concerns. Dr C understood from his conversation with Mrs A that her husband was to have surgery and was expected to fully recover.

Aftermath
Mr B underwent surgery on 9 February 2000 to have the tumor removed. Laboratory results revealed that the tumor was benign.

Dr C stated that he and his staff behaved at all times in a competent, reasonable and professional manner. Dr C has offered to meet and attempt to answer and resolve any questions that Mr B and Mrs A may have, but Mr B and Mrs A have refused all offers.

Dr C advised that the Royal New Zealand College of General Practitioners and First Health Independent Practice Association have assessed the Centre, and Dr C as an individual general practitioner, as keeping good records and having good systems in place.

Independent advice to Commissioner

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

"**Re: complaint 00/00662/[…]**
With regard to the information forwarded to me by the office of the Health & Disability Commissioner, and in my own personal and professional opinion as a medical practitioner given the above information is correct, in confidence, I would make the following points:

1. What are the standards and were they applied?
A reasonable general practice standard, for a man with these presenting symptoms, and his past history, would be a thorough examination of the neurological system and cardiovascular system. Investigations and management would then be dependent on the findings. In this case, it is my opinion that a satisfactory examination of the neurological and cardiovascular system occurred. A reasonable set of blood tests investigating primarily the malaise and tiredness was undertaken although debatably thyroid function tests might also have been ordered. [In his response to my provisional opinion, Dr C advised that he had included thyroid function tests as part of the blood tests ordered for Mr B. I accept that this information was not initially noted by my advisor.] From the presenting symptoms and examination findings, a reasonable diagnosis was made, and a reasonable management plan was instituted involving follow-up as required, and possible referral to neurology.

2. Telephone advice and laboratory interpretation
There appears to be some uncertainty as to whether a diagnosis of glandular fever was delivered as the definitive working diagnosis, and if so by whom, and did appropriate glandular fever advice follow etc. etc. Or was it just that glandular fever needed further investigation.

The symptoms given could be accounted for with a diagnosis of glandular fever, and deterioration warranted further review as it would seem was arranged.

3. Patient expectations and Doctor's advice
There is a dilemma here between a patient's self diagnosis and expectations, and the doctor's clinical impressions, in as much as the patient appears to be indicating that all of the symptoms were similar to the previous brain haemorrhage, and that a scan was required, and yet the doctor's findings did not support this. It is accepted general practice to negotiate management plans with the patient, in the context of their level of understanding, family, financial and cultural context, and their expectations from the consultation. It is also expected that a competent GP will apply their learning and experience to offer sound and honest advice. In this instance, the recorded suggestion of a referral to neurology could have been a reasonable negotiated middle ground, of the type '… I understand your concerns regarding a further brain haemorrhage, and

you may be correct, but thankfully all of the findings at this point suggest something else. How would it be if we investigate this first of all, with a view to if the symptoms are no better or get worse, or if the blood tests are unhelpful, that we take advice from the neurology team ….' The notes appear to reflect such an approach, but it is uncertain whether this was communicated to the patient.

> In summary, it is my opinion that Dr C performed a consultation to a standard that was reasonable for a competent general practitioner."

On 12 June 2001 Dr G was asked to provide further advice and comment upon:

- the usual practice for a general practitioner regarding advising or communicating blood test results to a patient;
- the external measurement standard on which he relied to form his opinion about Dr C performing a consultation to "a standard that was reasonable for a competent general practitioner".

Dr G's advice and comments are stated in full below:

"With regard to the information forwarded to me by the office of the Health & Disability Commissioner, and in my own personal and professional opinion as a medical practitioner given the attendant information is correct, I would make the following points:

1. What is the usual practice for a GP regarding follow up of blood test results to a patient?

This is a difficult question as no definitive guidelines address this question. I have been concerned in the past regarding this issue, and enclose advice I received [appendices] from the medical defense organisation in 1999. When I put this in context with the realities of everyday general practice, and the very definite requirement for patients to share both autonomy and self responsibility (both in an informed, non threatening context), I believe that a basic minimum requirement is for some follow-up arrangement to be discussed and understood.

I would suggest that a reasonable default would be for the patient to make contact with the practice for all results, and that any abnormal results are also followed up by the practice as a matter of course.

2. How would a GP usually communicate blood results to a patient?

The usual communication of blood results is via a practice nurse, and occasionally via the doctor themselves. A practice nurse is very capable of communicating results, although the interpretation and management plan for those results does rest with the doctor. The issue of whether responsibility is with the ordering doctor or the doctor to whom a copy is sent, or the family doctor is another difficult question not requiring attention in this case.

3. Defining 'a reasonable general practice standard …'
This is my personal interpretation of what I consider to be a reasonable standard. This arises from my own personal experience, and from medical journal readings, general practice meetings and peer reviews, examiners meetings and observations for the RNZCGP, postgraduate ethical meetings and discussions, and as a member of the […] Hospital ethical, clinical board, and quality and risk management committees. Accordingly, I tend to preface my advice as an amalgam balancing the most acceptable path from all of these sources."

Code of Health and Disability Services Consumers' Rights

The following Rights from the Code 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.

RIGHT 6

Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

...

(f) The results of tests ….

Opinion: No breach

In my opinion Dr C did not breach Right 4(1) of the Code.

Right 4(1)

Alleged failure to diagnose
In relation to Mr B's consultation with Dr C on 17 December 1999, my advisor's opinion is that a satisfactory examination of the neurological and cardiovascular system occurred. A reasonable set of blood tests investigating primarily Mr B's malaise and tiredness was undertaken. From Mr B's presenting symptoms and Dr C's examination findings, my advisor's opinion is that a reasonable diagnosis was made by Dr C and a reasonable management plan was instituted involving follow-up as required, and possible referral to neurology.

There is no evidence to suggest that Dr C handled Mr B's symptoms in an "unprofessional manner" in light of the specific background information (prior brain haemorrhage) provided by Mr B and Mrs A at this consultation. It is of note that Dr D advised me that he had not suspected a "brain haemorrhage" when he saw Mr B and referred him for a scan.

Scan
There is disputed evidence as to whether or not Mr B was advised that a scan would be performed if the blood test results were negative. Dr C advised me that as part of Mr B's management plan it was agreed that Mr B would return to Dr C as necessary, if he continued to feel unwell or if the situation changed, with a view to possibly referring him to neurology in view of his previous history.

Mr B and Mrs A said they had asked Dr C if he could arrange a CT scan to see if he could check Mr B's condition, as he did not want a repeat of what had happened to him in 1991. They said they discussed the possibility of a scan with Dr C, but he made no commitment. However, they thought that Dr C alluded to the possibility of Mr B having a scan if his blood test results were negative. Mr B thought that this was the next step.

Dr C disputed this and maintained that he did not state that a scan would be performed if Mr B's blood test results were negative. His medical notes record:

> "Bloods and phone. See prn [as required]. ? Refer neurology."

Dr C advised me that his intention was to possibly refer Mr B to neurology if Mr B failed to improve and returned for further consultation.

However, I am unable to conclude whether or not Dr C indicated that a CT scan would be arranged if Mr B's blood test results returned as normal. Nevertheless, it is clear that Mr B and Mrs A thought that a CT scan was appropriate and, whilst they accepted that blood tests needed to be taken in the first instance, they expected that Dr C would arrange a CT

scan to exclude the possibility of a haemorrhage or other sinister pathology if the blood test results were negative.

Dr C's manner
There is no evidence to suggest that Dr C handled Mr B's symptoms in an "unprofessional manner" in light of the specific background information (prior brain haemorrhage) provided by Mr B and Mrs A at the consultation. It is of note that Dr D, who provided Mr B and Mrs A with a second opinion, advised me that he did not suspect "brain haemorrhage" when he saw Mr B:

> "I would like to make a point that I did not arrange for [Mr B] to have a scan for a specific suspected brain tumour. I was as surprised as anyone that that was the diagnosis. When I saw him it was for a second opinion about his lassitude and I was aware that he had already seen another doctor … I could find nothing in this on my examination, but decided to ask the Medical Registrar to see him in the Emergency Department because:
> a. His symptoms were becoming rather disabling over a prolonged period
> b. Because of the history of an atypical cerebral bleed … several years previously."

I am guided by all the information I have gathered and by my expert advice. I am satisfied that Dr C performed the consultation to a standard that was reasonable for a competent general practitioner and did not handle Mr B's symptoms in an "unprofessional manner". Accordingly, in my opinion Dr C did not breach Right 4(1) of the Code.

Opinion: Breach

In my opinion Dr C breached Right 6(1)(f) of the Code in failing to advise Mr B of his blood test results.

Communication of blood test results
There is a conflict of evidence as to whether Dr C personally, or through his practice nursing staff, made contact with Mr B and Mrs A to advise them of the results of his blood tests. Mr B and Mrs A maintain that they were never contacted by Dr C or his practice nurses with the results of Mr B's blood tests. They had to initiate contact on or about 12 January 2000 as they were becoming increasingly concerned as Mr B's general condition deteriorated. They felt that once the results of the blood tests were known the next steps in Dr C's management plan could be initiated. Mrs A advised that when she telephoned Dr C's surgery to find out the results of the blood tests she was told that her husband's second blood test results (ie, the repeat glandular fever screen) indicated that he had had glandular fever in the past. Mrs A recalled that the nurse advised her that her husband should take Disprin, Vitamin B and get plenty of rest, but no further

management was discussed. Mrs A was not impressed with the nurse's advice as she thought that Dr C should arrange a scan to find out what was wrong with her husband, although she did not tell the nurse this.

Dr C advised that the first blood test results were received on or about 19 December 1999, prior to his going on holiday. He stated that he would have directed his nurse to advise Mr B and Mrs A of the blood test results, particularly as he had specifically stated in his medical records that this was his management plan, ie "bloods and phone". However, Dr C could provide no evidence that such a phone call took place, nor could Mrs E (his usual practice nurse) recall conveying any blood test results to patients named Mr B and Mrs A. Thus, I can only conclude, based on Mr B's and Mrs A's clear evidence that no contact at all was made to them, that they were not notified.

Dr C did not specifically advise his locum, Dr H (who replaced him while on holiday from 1–16 January 2000), of Mr B's consultation, or any follow-up required, before he left on holiday. Dr C noted that the initial blood test results from 17 December had already been received and dealt with appropriately before he went on holiday, although this could not be proved. The second blood test results arrived whilst he was on holiday, and Dr C thought that they would have been seen and dealt with by Dr H. However, Dr C could not confirm that he had specifically advised the locum to action these results by telephoning Mr B and Mrs A. In the event, it appears that no action was initiated.

On the balance of probabilities, I consider it unlikely that Dr C, his locum or his practice nurses took follow-up action in relation to the second blood test results. Mr B and Mrs A are quite clear that they never received a call or feedback regarding the blood test results and that it was Mrs A who had to initiate contact with the practice, on 12 January 2000.

I accept that it is reasonable for GPs to adopt a practice that they will notify patients of their results only if the results are abnormal/uncertain or indicate the possibility of a problem requiring further investigation. But this is subject to a proviso that patients have the right to be notified of results even if there is no cause for concern. The key point is to ensure that the patient knows what will happen and understands who will initiate the next contact and what further steps, if any, may be taken.

Many patients find it worrying to be left in limbo, wondering if silence means the test results were fine, or if the practice has forgotten to follow up. This is clearly where communication broke down in this case.

There is no evidence that Dr C told Mr B and Mrs A that they would be contacted only if the test results indicated a problem. To the contrary, Dr C's own file note recorded "bloods and phone", where "we are to contact the patient with results". I am satisfied that Dr C failed to ensure that he (or his nursing staff or locum) followed through on the intention that Mr B and Mrs A be telephoned with the blood test results.

Accordingly, in my opinion Dr C breached Right 6(1)(f) of the Code in failing to advise Mr B of his blood test results.

Other comment

- I note that Dr C's practice policy is to telephone patients and inform them of their blood test results only if the nature of the results are uncertain or positive and require follow-up arrangements. I am concerned that Dr C did not clearly describe the practice policy to Mr B. I note Dr C's statement that Mr B's consultation of 12/12/99 "was only the second time he had been to [our] practice, therefore he would have been relatively unfamiliar with our long-established procedure to convey test results to patients". Both Mr B and Mrs A thought that Dr C or one of his staff would contact them by telephone to inform them of Mr B's blood test results regardless of the outcome. In future, Dr C and his colleagues should be mindful of the need to clearly explain the practice policy to his patients, to avoid any confusion.

- I note that Dr C and the practice nurses do not keep a record of every telephone call that they make to patients to advise them of their blood test results. While I note Dr C's concern that extra resources would be required if such a system were adopted at his practice, in my view, it would not cost time or money for the practice nurses to simply place a tick and state the date beside the doctor's notes in the patient's file (ie, "bloods and phone"), when advising patients over the telephone of blood test results. In that way it could clearly be shown what action was initiated, when and by whom. It would also serve as a flag when appropriate action had not yet been taken.

Actions

I recommend that:

- Dr C provide a letter of apology to Mr B and Mrs A for his breach of the Code. This letter should be sent to my Office and will be forwarded to Mr B and Mrs A.

- Dr C review his practice in light of this report.

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

A copy of this opinion with identifying features removed will be sent to the Royal New Zealand College of General Practitioners and the New Zealand Medical Association, for educational purposes.