General Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 04HDC14223)

Parties involved

Mrs A (dec)	Consumer
Mrs B	Complainant/Mrs A's daughter
Dr C	General Practitioner/Provider

Complaint

The Commissioner received a complaint from Mrs B about the care provided by Dr C to her mother, Mrs A. The following issues were identified for investigation:

- *The appropriateness of Dr C's assessment, investigation and treatment of Mrs A's leg pain between 15 July and 28 July.*

An investigation was commenced on 30 November.

Information reviewed

- Mrs A's medical records from Dr C and a public hospital
- Independent expert advice obtained from Dr Philip Jacobs, general practitioner

Information gathered during investigation

Dr C had been Mrs A's general practitioner since 22 December the previous year. She had a medical history of high blood pressure, anxiety/depression and panic attacks. The records show that she consulted Dr C infrequently and mostly for repeat prescriptions.

On 5 July Mrs A consulted Dr C with pain in the back of her right upper leg. Following his examination Dr C diagnosed sciatic nerve pain and prescribed pain relief and an anti-inflammatory agent. He asked Mrs A to return if her symptoms did not settle. Dr C recorded the following in Mrs A's medical records:

> "Examination Notes: Weight 68kg
> c/o pain radiating down lateral aspect of right upper leg knee level. No history of injury. No lumbar pain. Has full painless flexion. SLR [straight leg raising] 90 degrees L&R. Left side causes the right sided pain. Some pain with full extension. [Prescribe] synflex/paracetamol See again SOS T."

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

Contrary to Mrs B's complaint that Dr C did not adequately examine her mother, Dr C reported that he did thoroughly examine Mrs A. He asked her to lie on her back on the examination couch and examined each leg for tone and strength and performed the "straight leg raising test". This test caused pain in her upper right leg consistent with sciatic nerve pain. He noted that she did not have any ankle swelling and, in the absence of any other signs or symptoms, he diagnosed that Mrs A was suffering with right-sided sciatica.

Mrs A's pain did not improve and she saw Dr C again on 15 July. Dr C re-assessed her and reported that he could find no change in her clinical picture. He recommended X-rays of the lumbar spine and right hip, and discussed whether she should have them privately. She decided to have them at a public hospital, even though this could take some weeks. In the meantime, Dr C prescribed Tramal, a stronger analgesic. Dr C recorded the following:

> "Examination Notes: Pain ISQ. Is intermittent. No relief at all from synflex and has digesic also without help. For X-ray LS spine and right hip at [the public hospital] [prescribed] tramal.
> Actions: Tramadol cap 50mg 1prn [when necessary] Qty 20 – rep 0
>
> Visit date 21 July
> Examination notes: REFERRAL SENT TO [the public hospital] RADIOLOGY – RE: XRAY OF L/S SPINE AND R HIP"

On 28 July Mrs A returned to Dr C, accompanied by her daughter, Mrs B. Mrs B advised me:

> "A week later my mother returned, and I went with her on this occasion. The pain was worse, and the pain relief was not giving her any relief. She could only walk a few metres by now. My mother explained to the GP that she remembered lifting a heavy pot from the ground up to her deck a day or two before the pain started. [Dr C] reluctantly filled out an ACC form, and we got the xray that day."

Dr C stated that Mrs A was still in a lot of pain but she was able to walk. She still had not received an appointment for her X-rays. Mrs B thought the X-ray was urgent and should be done the same day. Mrs A asked if it could be covered by ACC. After further questioning from Dr C, Mrs A told him that some days prior to the onset of the pain she had lifted some heavy flower pots, which may have been the cause. Dr C said that, as he had recorded at the first visit that Mrs A's pain was not related to injury he was at first reluctant to complete the ACC form. However, on further questioning Dr C completed the form.

The following day Dr C received the X-ray report, which did not show spinal or hip abnormalities. Dr C did not see Mrs A again.

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

The public hospital
On 31 July Mrs B took her mother to the public hospital with a swollen leg. On her arrival the triage nurse recorded the following:

> "4/52 [four-week] history of problems with pain R) leg – GP thought it was sciatica. Anti-inflammatories and pain relief – noticed swelling to R) leg yesterday PM – decreased strength R) leg nil pins/needles."

The doctor who assessed Mrs A thought she may have a deep vein thrombosis, although she had no history of blood clotting problems or abnormality. The ultrasound revealed a large abdominal tumour (lymphatic cancer) and a clot extending from the mid femoral artery up into her abdomen.

Mrs A was admitted to the public hospital on 1 August under the care of the Haematology Department. She was diagnosed with mantle cell lymphoma and a DVT in her right leg. She received two cycles of chemotherapy. Initially Mrs A appeared to respond to the treatment but suddenly the tumour increased in size and she was referred to the palliative care team on 2 September. She was planning her discharge from hospital when she deteriorated and subsequently died on 12 September.

Independent advice to Commissioner

The following expert advice was obtained from Dr Philip Jacobs, general practitioner:

"**Purpose** To provide independent expert advice on whether [Dr C] provided an appropriate standard of care to [Mrs A] (dec).

Background [Mrs A] consulted [Dr C] on 5 July with pain in the back of her right upper leg. Following his examination [Dr C] diagnosed sciatic nerve pain and prescribed pain relief and an anti-inflammatory agent. He asked [Mrs A] to return if her symptoms did not settle.

[Mrs A] saw [Dr C] again on 15 July as she had no relief from her medications. [Dr C] assessed her again and as there were no changes in her symptoms recommended X-rays of the lumbar spine and right hip. After discussing whether she should have the radiology privately [Mrs A] decided to have the X-rays at the hospital even though this could take some weeks. In the meantime [Dr C] prescribed stronger analgesia and wrote the request for X-rays at [a public hospital].

[Mrs A] returned to [Dr C] on 28 July accompanied by her daughter, [Mrs B]. [Mrs A] remained in a lot of pain. There is disagreement between [Dr C's] and [Mrs B's] comments about [Mrs A's] mobility

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

when they attended this consultation.

[Mrs A] still had not received an appointment for her X-rays. [Mrs B] thought the X-ray was urgent and should be done the same day. [Mrs A] asked if it could be covered by ACC. After further questioning from [Dr C], [Mrs A] told him that she had lifted some heavy flower pots some days prior to the on-set of the pain which may have been the cause of it. [Dr C] completed the ACC claim form.

The following day [Dr C] received the X-rays report indicating no spinal or hip abnormalities demonstrated. [Dr C] did not see [Mrs A] again.

On 31 July [Mrs B] took her mother to [a public hospital] with a swollen leg. Ultrasound revealed a large abdominal tumour (lymphatic cancer) and a clot extending from the mid femoral right up into her abdomen.

[Mrs A] was admitted to [a public hospital] on 31 July. She was diagnosed with mantle cell lymphoma and DVT in her right leg, and died [a few weeks later].

Complaint

[Mrs B's] complaint is outlined in her letter to the Commissioner but the issue arising from her complaint that the Commissioner investigated was identified as followed:

- *The appropriateness of [Dr C's] assessment, investigation and treatment of [Mrs A's] leg pain between 15 July and 28 July.*

Supporting Information

- The complaint letter to the Commissioner dated 25 August, marked 'A' (Pages 1-2)
- Notification letter to [Dr C] dated 30 November, marked 'B' (Pages 3-5)
- [Dr C's] response to the Commissioner dated 29 December, marked 'C' (Pages 6-11)
- First four days of [Mrs A's] medical records from [a public hospital], marked 'D' (Pages 12-35).

Expert Advice Required

To advise the Commissioner whether, in your opinion, [Dr C] provided services of an appropriate standard and in addition provide the following information:

1. What particular standards apply in this case?
2. Given [Mrs A's] symptoms, did [Dr C's] examination and treatment reach an appropriate standard and, if not, how was his care inappropriate?
3. Should [Dr C] have examined [Mrs C's] abdomen?

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

4. Did [Dr C] refer [Mrs A] for further investigation in a timely manner?
5. Should Dr C have considered any other investigations?

If, in answering any of the above questions, you believe that [Dr C] did not provide an appropriate standard of care, please indicate the severity of his departure from that standard. To assist you on this last point, I note that some experts approach the question by considering whether the providers' peers would view the conduct with mild, moderate, or severe disapproval.

Are there any aspects of the care provided by [Dr C] that you consider warrant additional comment?

My name is Philip Jacobs and I have been asked by the Health and Disability Commissioner to provide independent advice concerning the above complaint.

I have read the Guidelines for Independent Advisors and agree to follow these guidelines.

I am currently a General Practitioner working as a partner in a group practice in an urban area. I have been in General Practice for 19 years, 12 years as a rural GP and 7 years in my current position. I am an accredited teacher in the GP Training Programme and act as a small group tutor for the day release seminars. I also work as a Palliative Care Liaison for Pegasus IPA, and provide advice and assistance to GPs caring for their terminally ill patients at home. I have served on the RNZCGP Council and been a member of the Executive. I am a member of the Faculty Board of the Canterbury division of the RNZCGPs. I am a Fellow of the Royal New Zealand College of General Practitioners, have Diplomas in Obstetrics and Gynaecology and Palliative Medicine. I hold a medal for teaching and a Distinguished Service Medal for work for the College.

This is a case where a 71 year old woman with a previous medical history of hypertension and anxiety/depression presented on the [5 July] with a history of new onset of pain in her right leg. There was no history of injury, no lumbar pain and no other symptoms as recorded. The examination revealed the presence of full painless flexion with some pain on extension. Straight leg raising was normal apart from a paradoxical pain on the right side when the left leg was raised. The pain was assessed by the attending GP and thought to be consistent with nerve root irritation arising from the lumbar spine. He prescribed an anti inflammatory drug and an analgesic and advised her to return if required.

She returned ten days later on the [15 July] stating that the pain was the same although intermittent. She had not found pain relief from those drugs supplied and had tried another analgesic, digesic (from another source), which had also failed to relieve the pain. The General Practitioner decided to further investigate the problem and requested an X-Ray. After discussion with the General Practitioner, the patient decided to have the

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

X-Ray at the public hospital rather than pay for a private examination. She was advised by the GP that this could take some time, perhaps some weeks. The General Practitioner supplied the patient with some Tramadol, a stronger analgesic. According to the notes a request for an X-Ray was not sent until [21 July], some 6 days after the consultation.

On the [28 July], nearly two weeks after the last consultation, the patient returned to the General Practitioner. She was clearly frustrated with the lack of progress in symptoms and lack of X-ray appointment. Her daughter states in her letter that her mother was only able to walk a few metres whereas the General Practitioner states she was able to walk freely. She wished to register an Accident Compensation Claim, stating that she had been lifting heavy plant pots in the week prior to the commencement of her pain. The General Practitioner agreed to do this and the X-Ray was taken the same day at a Private Clinic under Accident Compensation. He noted that she was still in marked pain. He also arranged acupuncture and doubled the dose of the Tramadol.

The General Practitioner states that he reviewed the X-Ray result the next day and as there was only mild degenerative disease present in the lumbar spine and hips and no evidence of sinister pathology, no immediate action was taken.

The patient subsequently developed, on the [31 July], a swollen painful right leg. Her daughter took her to [an accident and medical clinic] where she saw [a doctor who] examined her and felt that she probably had a right sided Deep Vein Thrombosis. He did examine her abdomen and found what he/she thought was a palpable bladder. [The doctor] referred her on for immediate assessment at the Public Hospital. There she was assessed, a Deep Vein Thrombosis thought likely, commenced on Clexane to thin the blood and sent home to return the next morning for an ultrasound scan.

It appears that the Radiology Registrar performing the ultrasound scan noted the abdominal mass and rather than just doing a scan of the leg and the veins looking for a Deep Vein Thrombosis, did an abdominal ultrasound. This revealed a large mass 14.5cm x 8.7cm in the right side of the pelvis displacing the bladder and preventing the kidneys from fully draining into it. Subsequent investigations revealed a mantle cell lymphoma and unfortunately after a turbulent course, the patient died.

What particular standards apply in this case?

Back pain and nerve root irritation are extremely common presentations in General Practice. The vast majority is due to straightforward mechanical low back pain that responds to anti inflammatory drugs, simple analgesics and encouragement of ongoing activity. Sometimes physical therapy may be used as an adjunct to care. The Accident Compensation Corporation receives many claims for low back pain and has generated guidelines, which are well researched and have been widely distributed to General Practitioners.

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

The guidelines state (1)
'At the initial assessment the critical role for the health providers is to screen for Red Flags. These may indicate serious disease (not always confined to the back) that can cause back pain. If Red Flags are present, referral for specialist management should be considered.'

'The health provider must take a careful and thorough history to identify:

1. The history of the acute episode
2. Activities that may be associated with pain
3. Any Red Flags – the risk factors for serious disease
4. How limiting the symptoms are
5. If there have been similar episodes before
6. Any factors that might limit recovery and an early return to usual activities including paid work (this includes assessing possible yellow flags)
7. The level of activity required to resume usual activities – this includes taking a history of the patient's work, recreation and daily living activities.

The clinical examination should identify any relevant abnormal neurological signs and assess the degree of functional limitation caused by the pain. The history may indicate the need for a more extensive general clinical examination, particularly if Red Flags for serious or systemic disease (such as cancer) are suspected.

Back pain with radiating leg pain should be managed in the same way recommended for acute low back pain. Manipulation may not be advisable if there are neurological signs – caution is required.'

'Red Flags help identify potentially serious conditions

1. Features of Cauda Equina Syndrome viz some or all of urinary retention, faecal incontinence, widespread neurological symptoms, and signs in the lower limb, including gait abnormality, saddle area numbness, and a lax anal sphincter.
2. Significant trauma
3. Weight loss
4. History of Cancer
5. Fever
6. Intravenous drug use
7. Steroid use
8. Patient over 50 years
9. Severe, unremitting night-time pain
10. Pain that gets worse when lying down

Investigations in the first 4-6 weeks do not provide clinical benefit unless there are Red Flags present. Radiological investigations (X-Rays and CT scans) carry the risk of potential harm from radiation-related effects and should be avoided if not required for

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

diagnosis or management. Red Flag pathology may lie outside the lumbar region and so may not be detected with radiology.

The history and assessment should be reviewed at appropriate intervals (usually weekly) until the symptoms have mostly resolved and the patient has returned to their usual activities. The aim of the clinical assessment is to exclude Red Flags, identify any neurological deficit requiring urgent specialist management, assess functional limitations caused by the pain and determine clinical management options.'

One of the key issues in this case is whether there were Red Flags present that should have alerted the General Practitioner towards further or different action. The brevity of the notes makes it difficult to fully ascertain this issue and this is aggravated by some disparity between the complainant and the General Practitioner about events. Indeed the complainant included an extra consultation that either has not been recorded or does not exist. The most obvious Red Flag was the patient's age; at 71 she was well over the age of 50. There was some evidence of weight loss as recorded in the General Practitioner's own notes. On the [19 March] the patient weighed 72 kg and on [5 July] she weighed 68kg. Although this is not a large weight loss, it is still significant in the overall context of the presentation. There is no record of temperature being taken and recorded. The nature of the pain was such that it was severe despite the relative freedom of movement. An additional factor was the atypical presentation; there was no history of injury (initially anyway), no significant lumbar pain, and relatively full range of motion despite significant nerve root pain.

Given [Mrs A's] symptoms, did [Dr C's] examination and treatment reach an appropriate standard and, if not, how was his care inappropriate?

I believe that in the first instance [Dr C's] examination and treatment were appropriate. He clearly took a reasonable history and undertook an examination that, in his own mind, was able to confirm a probable diagnosis of nerve root compression arising from the lumbar spine. As already stated this is a very common presentation and in most instances this management would have been appropriate. The patient's age and weight loss could have been considered significant, but should have been a trigger for further investigation if she failed to improve.

At the second consultation it is unclear from the notes whether [Dr C] re examined the patient. In his letter to the H and D Commissioner he states he did and there was no change either in her symptoms or her examination findings. He did remark however that her pain was not responding to the analgesics. This clearly triggered off an intention to investigate further and he ordered an X-Ray. I believe in the presence of the now three Red Flags (age, weight loss [Dr Jacobs noted that [Mrs A's] weight was recorded in her medical records at 72kg on 19 March and 68kg on 5 July] and severe pain) further investigations were appropriate and an X-Ray was appropriate. However it should have been arranged as an urgent case at the Public Hospital through direct discussion with an Orthopaedic Surgeon, Neurosurgeon, or Radiologist. In some instances, it would not be unreasonable for a patient to wait three weeks for an X-Ray, but that was not the case

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

here. If the patient cannot afford private radiology, then the role of the General Practitioner is to liaise with the Public system to achieve timely investigation. It also appears that the request for the X-Ray was not made for a week after the second consultation further delaying access.

The other problem here is that X-Ray itself was not sufficient. The absence of back pain or restriction of back movement should have suggested that the net needed to be spread wider. It would have been appropriate to order a blood test, the minimum requests being CBC, ESR or CRP, Cr and LFTs. The urine should have been dip-sticked looking for blood, protein or white blood cells.

The third consultation seems to have been side tracked by a request for ACC coverage. I suspect this was a desperate move by the patient and her family to receive further investigation and hopefully relief from the pain. It was certainly stated in the General Practitioner's notes that she was 'still in marked pain'. A realisation that there was a major problem should have triggered off blood tests or admission for further investigations. It does not appear that there was any formal follow up after the X-Ray and this is of concern, as a negative X-Ray was just as serious as a positive one in this clinical context.

Should [Dr C] have examined [Mrs A's] abdomen?

I believe that at the second or third consultation [Dr C] should have examined [Mrs A's] abdomen. In order to explore this it is important to look at the differential diagnoses. The possibilities that could have been entertained were

1. Compression fracture (osteoporotic) in the lumbar spine causing nerve root impingement
2. Malignancy in the lumbar spine causing collapse and compression of a nerve root (eg metastatic disease or multiple myeloma)
3. Extra dural spread to a nerve root from malignancy such as metastatic melanoma.
4. Lumbar disc degeneration with prolapse and nerve root involvement
5. Pelvic tumour compressing lumbosacral plexus (ovarian, rectal most common but also bladder or uterine)
6. Abdominal Aortic Aneurysm, bulging posteriorly and irritating lumbosacral plexus

Whilst this list is not exhaustive, only some of these problems can be ruled out by an X-Ray. An abdominal examination and a rectal or pelvic examination would have revealed the major pathology. I believe the Deep Vein Thrombosis was a separate acute event, linked to the malignancy and obstruction of pelvic veins but was probably not clinically evident at [Dr C's] last consultation.

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

Did [Dr C] refer [Mrs A] for further investigation in a timely manner?

I believe that [Dr C] had intentions to investigate [Mrs A] in a timely manner but felt disabled by a system that allows those with back pain or nerve root pain with a history of injury to receive an ACC funded X-Ray straight away, but those with no history of injury and low funds to wait for some weeks on a hospital waiting list. The General Practitioner has an important role to act as a patient advocate when dealing with the Public Health system and [Dr C] did not do this. It left the patient little choice but to act as her own advocate in achieving a service, hence the ACC claim. Blood tests and an ultrasound were not carried out until admission to hospital was achieved so clearly this was 3 weeks after initial presentation.

Should [Dr C] have considered any other investigations?

I believe this has been answered above.

Other Issues

This case is a very sad one. [Mrs A] went from being relatively healthy to seriously ill within 3-4 weeks and has subsequently died. The tumour was advanced at presentation and was seriously life threatening from an early stage, as evidenced by bilateral hydronephrosis. Pelvic tumours are notoriously difficult to detect and will frequently present late. This is because there is capacity within the pelvis for tumour tissue to grow to a large size before it compresses or damages other tissue. It is very unusual for a pelvic tumour to present with symptoms of nerve root compression without other symptoms. It is very common for nerve root compression to be caused by lumbar disc disease.

[Dr C] is clearly a very experienced General Practitioner, and as such will have seen many cases of nerve root compression without serious disease. The Red Flags and the variation from the normal clinical course seem obvious in retrospect but I believe are not nearly as obvious in prospect. He could have, and indeed should have, behaved in a different manner especially when he realized that further investigations were required. He should have examined [Mrs A's] abdomen and pelvis. He should have ordered an urgent X-Ray and blood tests with a view to seeking further investigations in the secondary sector. I believe the majority of my peers would view this with mild disapproval given the atypical mode of presentation and the clear acknowledgement by [Dr C] that further investigation was necessary.

Unfortunately the outcome for [Mrs A] would not have been different even if the tumour was detected at presentation and I believe this needs to be taken into consideration."

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

Response to provisional opinion

Dr C provided the following response to my provisional opinion:

> "I have received your provisional report and appreciate the opportunity to make a few comments, in particular with regard to the breach finding. Dr Jacobs comments that this is a sad case which is certainly true and it is one that has weighed heavily on me as it must have with the family of [Mrs A]. I have reviewed my practice as a consequence of what has occurred. I have also **enclosed** a letter of apology, and would be grateful if you could forward that to the family of [Mrs A].
>
> I ask that you reconsider your finding that I have breached the Code on the basis of the following matters.
>
> Dr Jacobs notes the presence of '*red flags*' that were present when [Mrs A] initially consulted me, namely [Mrs A's] age, weight loss and pain. I was aware of these and initiated my request for X-ray examination, which I considered to be the most important initial test, on her second visit to me. I would not normally have requested an X-ray for sciatic-like [pain] in isolation, until there had been a proper opportunity to assess the patient's response to treatment. It was these other symptoms that prompted me to request an X-ray. I was not aware at the time that there was a significant delay in the request for X-ray being sent to [a public hospital]. I have taken steps to prevent such a delay occurring again. However at the time I considered that the request would be sent immediately and at the most a waiting period of about two weeks would follow. In the circumstances I did not consider that length of time to be an inordinate delay.
>
> The X-ray requests were specific tests aimed at a specific symptom. There were absolutely no urinary symptoms at presentation to indicate that urine tests were indicated. The blood tests suggested by Dr Jacobs are again non-specific; had they been taken they may only have suggested that there was an abnormality but not anything specific. Having said that, at a follow-up examination after the negative X-ray report my investigation would have included a repeat physical examination, ultrasound scans, and in-depth blood tests. My recordings of [Mrs A's] weight were part of my initial work up as she had not mentioned any weight loss.
>
> I believe that, at an early stage, I had recognised that this was not a typical case of sciatic pain and had initiated a logical and considered plan of investigation that was overtaken by the rapidity of events.
>
> The provisional opinion also comments on the rapid progress of [Mrs A's] condition and the lack of follow up after the X-ray report was received. I consider this is an unreasonable criticism. The examination was performed on Thursday afternoon and I received the report on the Friday afternoon. The thrombosis developed over the weekend before [Mrs A] was able to be recalled for follow up.

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

[Mrs A] was examined by doctors at the emergency clinic and at [a public hospital] after the development of the thrombosis. The diagnosis of a pelvic tumour was not made by those practitioners but was made by the radiologist the next day. In my view this indicates that even when [Mrs A's] condition had developed it was not able to be readily diagnosed, at least not on the basis of physical examination.

The provisional opinion also refers to the request for ACC to cover the cost of the X-ray rather taking a central role during the third consultation. This was indeed the case and I too wanted the X-ray done that day. The request was made and, after discussion between [Mrs A] and her daughter, the scenario of lifting garden pots was put forward. I felt most uncomfortable about this as my original notes recorded no history of any such event, so much time was spent with this and attention diverted away from what, certainly with the benefit of hindsight, were more important issues. This is something that I have considered at length since then.

As stated above, I have reviewed my practice in light of this case. I have discussed it with other practitioners with whom I work. I have also discussed the delay with regard to the X-ray request with the practice manager and procedures to remedy this have been initiated."

Further independent advice

Dr Jacobs provided the following comments on the issues raised by Dr C above:

"I accept [Dr C's] explanation that he was aware of the unusual or atypical nature of this presentation. Indeed in my initial report I stated 'this clearly initiated an intention to investigate further'. I believe that this intention should have triggered him to perform a more extensive examination including palpation of the abdomen and rectal or pelvic examination.

I agree an X-Ray examination was also important as it would, mostly, detect bony pathology such as collapse or metastatic infiltration. However a normal X-Ray would not exclude non-bony causes of nerve root pain. Indeed, at this point [Dr C] did not know whether he was dealing with a simple but severe case of nerve root compression from lumbar disc pathology, or a potentially serious other cause. The addition of the blood tests as described, very clearly provides further clues as to the likelihood of serious pathology. The testing of the urine similarly collects more evidence about her underlying physical state (eg urine full of protein may prompt a search for Bence-Jones protein as seen in myeloma, an infected urine may prompt a search for infection elsewhere such as that seen in discitis, a large amount of blood in the urine may suggest a renal carcinoma causing spinal secondaries or retro peritoneal spread). The collection

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

of this evidence at an earlier stage may have prompted a realisation that there was indeed sinister pathology and led to an earlier diagnosis.

With respect to [Dr C's] comments about lack of follow up, it was not recorded in his notes what follow up was arranged after the X-Ray. I accept that he may well have intended to follow the patient up the following week and I am uncertain about what was said to the patient at the time. I would emphasise that in circumstances such as this, where serious pathology is suspected, there needs to be in place a clear and mutually negotiated plan of action.

I have reviewed the other Doctors' notes concerning their examination findings. It appears that the patient was seen first by [a doctor] at the [accident and emergency clinic]. He suspected a Deep Vein Thrombosis. He did examine her abdomen and found a palpable bladder and a para-umbilical bruit. [A second doctor] in ED recorded 'abdo soft non tender'. The Radiology Registrar on call the following day found a lower abdominal mass. I assume from his notes that this was by examination and that finding prompted him to do an ultrasound. He did not find the mass by ultrasound examination although this investigation confirmed its presence. The O and G SHO [(obstetrics and gynaecology senior house officer)] examined the patient and found a poorly defined firm, non mobile mass suprapubically and to the right. It appears that there was a mass present that was palpable on examination although [the second doctor in ED] failed to detect this. The main issue here, however, is that they did examine her abdomen and [Dr C] did not. He could not detect abdominal pathology if he did not examine her abdomen. In this respect he was deficient.

In summary there remain three areas of concern.

- The lack of physical examination of the abdomen and pelvis in an atypical case of severe nerve root compression.
- The lack of laboratory investigations. These may well have ruled out or ruled in serious pathology.
- The lack of a clear cut management plan in a patient with potentially serious pathology.

I accept [Dr C's] comments that he would have, at the next follow up, included a repeat physical examination, ultrasound scan and in-depth blood tests. Furthermore, if the patient did not develop a deep vein thrombosis, he may well have acted this scenario out in the near future. I do not accept his assertion that the mass was not palpable and recognised only by Ultrasound. It may be that a distended obstructed bladder may have masked the mass but the presence of a distended bladder on examination is in itself abnormal and should have raised major concerns about the pathology. At least three other Doctors found abnormal abdominal signs. I do not accept his assertion that blood tests would be non-specific. It is one of the roles of a GP to try and detect serious

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

> pathology even though the exact diagnosis may be unclear and blood tests would have assisted in this regard.
>
> I accept that [Dr C] has reviewed many aspects of this case in light of the outcome and the complaint, and that as a result he has changed both his attitude and procedures in practice. I feel this needs to be taken into consideration."

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.*

Opinion: No Breach – Dr C

Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) Mrs A had the right to medical services provided with reasonable care and skill.

Examination – 5 July
Mrs A consulted Dr C with pain in her back upper thigh on 5 July. Dr C asked her to lie on the examination couch while he examined the area for tone and strength. The "straight leg raising test" increased Mrs A's pain, which led Dr C to believe Mrs A had sciatica. He prescribed analgesia and an anti-inflammatory agent and asked her to return if the pain persisted.

Dr Jacobs reported:

> "I believe that in the first instance [Dr C's] examination and treatment were appropriate. He clearly took a reasonable history and undertook an examination that, in his own mind, was able to confirm a probable diagnosis of nerve root compression arising from the lumbar spine. As already stated this is a very common presentation and in most instances this management would have been appropriate."

I accept that Dr C's assessment and treatment of Mrs A on 5 July was reasonable and, in my opinion, he did not breach Right 4(1) of the Code.

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

Opinion: Breach – Dr C

Examination – 15 July
Mrs A's pain continued and she returned to Dr C on 15 July. He re-examined Mrs A but could find no new symptoms. However, because she had not responded to previous treatment, her persistent pain required further investigation. He suggested that an X-ray of the lower spine might isolate a cause. Dr C advised Mrs A that she could have the X-ray done privately, which would provide quicker results, or he could refer her to the hospital, which could take some time. Mrs A opted for the hospital referral. However, the referral was not sent to the public hospital until 21 July, resulting in further delays. Dr C prescribed stronger analgesia for Mrs A in the meantime.

According to Dr Jacobs:

> "At the second consultation it is unclear from the notes whether [Dr C] re examined the patient. In his letter to the H and D Commissioner he states he did and there was no change either in her symptoms or her examination findings. He did remark however that her pain was not responding to the analgesics. This clearly triggered off an intention to investigate further and he ordered an X-Ray.
>
> In some instances, it would not be unreasonable for a patient to wait three weeks for an X-Ray, but that was not the case here. If the patient cannot afford private radiology, then the role of the General Practitioner is to liaise with the Public system to achieve timely investigation. It also appears that the request for the X-Ray was not made for a week after the second consultation further delaying access. I believe in the presence of the now three Red Flags (age, weight loss and severe pain) further investigations were appropriate and an X-Ray was appropriate. However it should have been arranged as an urgent case at the Public Hospital through direct discussion with an Orthopaedic Surgeon, Neurosurgeon, or Radiologist.
>
> The other problem here is that X-Ray itself was not sufficient. The absence of back pain or restriction of back movement should have suggested that the net needed to be spread wider. It would have been appropriate to order a blood test, the minimum requests being CBC, ESR or CRP, Cr and LFTs. The urine should have been dip-sticked looking for blood, protein or white blood cells."

As events unfolded Dr C received the X-ray results on Friday afternoon and Mrs B took her mother to [the public hospital] the following day.

I accept that it would have been prudent for Dr C to do more than order an X-ray for Mrs A, in light of the fact that she was no better and had been in pain for several weeks. Some investigation could have been done during the consultation, ie, a urine test and a more extensive examination. It would also have been prudent for Dr C to arrange the X-Ray referral with some urgency. Accordingly, in my opinion Dr C did not provide Mrs A medical services with reasonable care and skill and breached Right 4(1) of the Code.

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

Examination – 28 July
Mrs A returned to Dr C on 28 July, this time accompanied by her daughter, Mrs B. Mrs A had not received an appointment for the X-ray from the public hospital, and Mrs B considered that, as no treatment to date had been successful and her mother appeared to be worsening, further investigation into the cause of her pain was imperative. Once again the question of public or private radiology was discussed. It was clear that Mrs A considered the financial implication and asked Dr C whether she could claim for the costs through ACC because she had lifted a heavy garden pot the week before her pain started. The fact that the pain could be related to an injury was new information to Dr C, as he had previously recorded on 5 July that Mrs A had not had an injury. After discussion of the potential injury Dr C completed the ACC claim form.

Dr Jacobs reported:

> "I believe that at the second or third consultation [Dr C] should have examined [Mrs A's] abdomen. In order to explore this it is important to look at the differential diagnoses. …
>
> The third consultation seems to have been side tracked by a request for ACC coverage. I suspect this was a desperate move by the patient and her family to receive further investigation and hopefully relief from the pain. It was certainly stated in the General Practitioner's notes that she was 'still in marked pain'. A realisation that there was a major problem should have triggered off blood tests or admission for further investigations. It does not appear that there was any formal follow up after the X-Ray and this is of concern, as a negative X-Ray was just as serious as a positive one in this clinical context."

When asked whether Dr C sought further investigation in a timely manner, Dr Jacobs reported:

> "I believe that [Dr C] had intentions to investigate [Mrs A] in a timely manner but felt disabled by a system that allows those with back pain or nerve root pain with a history of injury to receive an ACC funded X-Ray straight away, but those with no history of injury and low funds to wait for some weeks on a hospital waiting list. The General Practitioner has an important role to act as a patient advocate when dealing with the Public Health system and Dr C did not do this. It left the patient little choice but to act as her own advocate in achieving a service, hence the ACC claim. Blood tests and an ultrasound were not carried out until admission to hospital was achieved so clearly this was 3 weeks after initial presentation."

In mitigation my advisor identified other factors that contributed to the delay in reaching the correct diagnosis. Mrs A deteriorated from being a relatively well woman to being seriously ill in three to four weeks. The tumour was advanced by the time she consulted Dr C; pelvic tumours are notoriously difficult to diagnose and "will frequently present late", the laxity of the abdominal wall allows the tumour to grow large before it impacts on surrounding organs, thus causing symptoms. Furthermore it is unusual for pelvic tumours to present as

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

nerve root compression, symptoms commonly seen by general practitioners and usually caused by lumbar disc disease. Sadly, the outcome for Mrs A would not have been any different if she had been diagnosed sooner.

I accept the advice of my advisor, Dr Jacobs, that Dr C should have referred Mrs A for further investigation sooner. The fact that Mrs A did not respond, and in fact worsened, indicated that the "net needed to be spread wider" for an alternative diagnosis, if not at the second consultation then definitely at the consultation on 28 July. It was by that time three weeks after her original injury and the pain was limiting her mobility. My advisor indicated the need for a more in-depth physical examination, including the abdomen, urine and blood tests and/or referral to a specialist. Dr Jacobs stated: "I believe the majority of my peers would view this with mild disapproval given the atypical mode of presentation and the clear acknowledgement by Dr C that further investigation was necessary."

In my opinion, Dr C did not provide Mrs A services with reasonable care and skill and breached Right 4(1) of the Code.

Actions taken

Dr C provided a written apology to Mrs B for breaching the Code in the care he provided to her late mother, Mrs A. Dr C acknowledged that there was significant delay in sending the referral to the public hospital, which he was not aware of at the time, and has reviewed his practice in light of my advisor's report.

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 details identifying the parties removed, will be 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.