General Practitioner, Dr B

General Practitioner, Dr C

An Accident and Medical Centre

A Report by the

Health and Disability Commissioner

(Case 03HDC03134)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer (dec)
Dr B	Provider/General practitioner
Dr C	Provider/General practitioner
Ms D	Complainant/consumer's sister
Ms E	Consumer's niece
Dr F	Specialist gynaecologist
Mr G	Consultant general surgeon
Dr H	Director at the Accident and Medical Centre
Dr I	Director at the Accident and Medical Centre
Dr J	ACC's expert advisor/General practitioner
An Accident and Medical Centre	Provider/Medical Centre

Complaint

On 28 February 2003 the Commissioner received a complaint from Ms D about the care provided to her sister, Ms A, by Dr B and Dr C at an accident and Medical Centre in 2002. The following issues were identified for investigation:

Between 25 January 2002 and 31 July 2002, Dr B and Dr C did not provide services of an appropriate standard to Ms A. In particular, Dr B and Dr C did not:

- *diagnose Ms A's cancer and foot conditions accurately and in a timely manner*
- *urgently refer Ms A to appropriate specialists once the seriousness of her conditions became apparent.*

In July 2002 Dr B did not provide Ms A with the information that a reasonable consumer in her circumstances would expect to receive. In particular, Dr B did not advise Ms A about her ultrasound results in July 2002.

An investigation was commenced on 29 July 2003 when Dr B and Dr C were notified of the complaint made against them. On 22 July 2004, Dr H and Dr I, the directors of the accident and medical centre, were notified of the complaint.

Information reviewed

- Information was obtained from the following sources:
  - Ms D
  - Ms E
  - Dr B
  - Dr C
  - Dr F, obstetric and gynaecological consultant, Women's Health, a District Health Board
  - Dr H, director, the Accident and Medical Centre
  - Dr I, director, the Accident and Medical Centre
  - Clinical Director, Women's Health, a District Health Board
  - Chief Medical Officer, a District Health Board

- Ms A's medical records from Dr B and the Accident and Medical Centre
- Ms A's medical misadventure file from ACC
- Independent expert advice obtained from Dr Jim Vause, general practitioner

Information gathered during investigation

Background

Ms A
Ms A, aged 62 years, had multiple pre-existing conditions, including obesity, long-term smoking, diverticulitis, hypertension, chronic obstructive respiratory disease and peripheral vascular disease. Ms A had consulted Dr B as her general practitioner for over 20 years.

On 12 July 2002 Ms A was found to have endometrial carcinoma (cancer of the uterus). On 16 July, before treatment could be arranged for this condition, Ms A developed ischaemia of her right foot. Ms A saw Dr C at the first medical practice, one of two adjoining medical practices that form part of the Accident and Medical Centre (the Centre), as Dr B was unavailable. Dr C ordered an X-ray and adjusted her hypertension medication. However, between 29 and 31 July Ms A's condition deteriorated and Dr B advised her to present to the Emergency Department at the public hospital. Ms A was admitted to the public hospital on 31 July. She was found to have suffered a recent severe heart attack and the ischaemia of her right leg was so severe that the only option was amputation. The surgery was performed on 2 August. On 24 August Ms A suffered a stroke. On 4 September her family were advised that her cancer was advanced and there were no treatment options. Ms A was discharged home to her family on 18 September and died a few weeks later.

Dr B
Dr B graduated in 1954 and worked as a general practitioner. In 2002 Dr B was working three half days a week in a semi-retirement role at the first medical practice as an independent contractor paid a 'fee for service' basis. Dr B saw his own patients, some of whom had consulted him for nearly 50 years. When Dr B was not on duty, one of the other doctors would see his patients who were not able to wait to see Dr B at his next duty.

Dr C
Dr C graduated in 1994 and obtained Fellowships of the Royal Australian and Royal New Zealand Colleges of General Practitioners in 2000. He has been practising at the Centre at the first medical practice since November 2000.

The Accident and Medical Centre
The Centre comprises six healthcare businesses operated from three buildings on one site. There are two separate medical practices on the site: the first medical practice and the second medical practice. Dr B and Dr C worked (as two of four medical practitioners working as independent contractors at the practice) at the first medical practice. Dr I also worked at the first medical practice, and is a director of the accident and medical company and, via a family trust, is co-owner of the first medical practice.

Record-keeping at the Accident and Medical Centre
The accident and medical centre use both manual (handwritten) records, and an electronic record system. Practitioners at the Centre may record their consultation notes manually or electronically, depending on their preferences. Laboratory results, hospital discharge summaries and specialist reports are filed according to the form in which they are sent and received (electronically, or by post).

Manual records are filed next to the reception for easy access and all doctors have computer terminals in their consultation rooms to access the electronic records. Dr B manually recorded his consultations.

Dr I explained the record-keeping system as follows:

> "Computer system – The fileserver at [the first medical practice] provides information for both practice businesses at [the first and second medical practice] and they are electronically linked on the same network. Each business has its own manual filing system and otherwise operates entirely independently. There is very little 'crossover' of patients between the practices. The electronic record of all patients is available to all doctors at all times and the paper record is kept in the filing rooms at the appropriate practice.
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> …
>
> [T]he electronic record provides a full record of all the lab tests for every patient attending the centre regardless of whether the request is electronically generated or manual and regardless of whether their lab results are also provided in paper form. A full

> and complete record of all lab tests is available to all doctors at all times on the office computer system.
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> …
>
> All of our new records are currently fully electronic and all incoming mail is now also scanned and provided digitally. New patients to the practice do not have a paper record except where there are some old notes and even these are usually selectively scanned before being referenced and stored. All doctors and nurses contribute to a single electronic record."

Dr I, a co-director of the accident and medical company, informed me:

> "[A]ll doctors [at the Centre] have access to a computer at the time of consultation and it is their preference to use this or to record clinical notes manually.
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> …
>
> Investigations are ordered through the computer system so electronic request forms are generated and remain attached to the patient's clinical record. With manual systems, investigations which are ordered are noted on the manual record at the time of consultation by the doctor.
>
> An audit trail is achieved electronically as per The Royal New Zealand College of General Practitioners Discussion Paper (Interim Advice on Minimising Error in Patient Test Results). It is the responsibility of the individual doctor who orders a test to follow this up. Manual generated requests are noted by the doctor on the consultation record or card and are accessible at the next visit to ensure that they have been done.
>
> … [M]anual notes are filed adjacent to the receptionist's working area for access on request by any doctor. [Dr B] prefers manual notes and if his patient is being seen by another doctor then reception routinely arranges for the handwritten notes to be given to the doctor seeing the patient prior to the consultation."

Medical assessments, January to June 2002

On 25 January 2002 Ms A attended Dr B complaining of dysuria (difficulty in passing urine) and tenderness high in her abdomen, front and back, and in the kidney area.

Dr B stated:

> "[Ms A's] lower abdomen and pelvis were normal. A urine specimen was sent to the laboratory and she was given a six day course of Noroxin [antibiotic] in case an infection was detected. No bacteria were found in the specimen. These pains on urinating had been occurring since [Ms A] had started a sexual relationship. I considered that they were as a result of a urethral irritation, and [Ms A] consistently responded well to either Noroxin or co-trimoxazole."

Dr B's handwritten record noted:

> "Dysuria and renal area tenderness.
> Spec to lab & Rx Noroxin 6/7 [6 days] & Zopiclone [hypnosedative] 7.5mg 30."

There is no indication in Dr B's records which laboratory the specimen was sent to, the results of the test or when they were received.

On 1 February Ms A returned to see Dr B as her symptoms were ongoing. Dr B noted, "Still pelvic discomfort & dysuria etc". Dr B informed me that Ms A was reporting tenderness over the bladder and pain on passing urine. Her abdomen and pelvis were again found to be normal on examination. Dr B considered that Ms A's symptoms were the result of sexual activity and prescribed an alternative antibiotic, 30 tablets of cotrimoxizole two tablets to be taken twice daily. No record of the examination is noted in the clinical records.

On 13 February Ms A returned for a routine blood pressure assessment. Dr B recorded her blood pressure as within normal limits for her age at 145/85 and provided her with a repeat prescription for three months of the hypertension treatment atenolol. He noted that she continued to have dsyuria and gave her a prescription for a further 30 tablets of co-trimoxazole, continued her zopiclone, and added Diazepam 2mg to be taken twice daily. Dr B informed me:

> "Her urinary symptoms were almost gone, but a few more co-trimoxazole tablets were prescribed at her request."

Ms A's next visit to Dr B was on 27 March for her long-standing diverticulitis, which was causing her upper abdominal discomfort. Dr B informed me that "co-trimoxazole usually settled the inflammation for her". His clinical record for that visit notes that Ms A was 86.3kg, and he gave her a prescription for a further 40 tablets of co-trimoxazole.

Ms A reported feeling much improved when she called to see Dr B on 3 April for a medical note to excuse her from attending jury duty.

Abdominal symptoms – June 2002

On 5 June Ms A visited Dr B for her routine blood pressure check and a renewal of her hypertension medication. Ms A's blood pressure was unchanged, but she reported bowel spasm. Dr B informed me that he performed a "full examination of her upper and lower abdomen". He stated that he did not detect any abnormalities and there was "no pelvic cystic swelling". Dr B does not recall whether he examined Ms A, but he did record the prescriptions for atenolol and the antispasmodic Merbentyl, to be taken three times daily "as required".

On 14 June the notes record that Ms A telephoned the surgery saying she had "cystitis". Dr B prescribed 12 Noroxin tablets.

On 19 June Dr B recorded that he prescribed a further 40 tablets of co-trimoxazole for Ms A. Dr B recalled that Ms A had telephoned the surgery on that occasion to request the prescription.

Ms A returned to the surgery on 28 June complaining of dysuria and increasing incontinence. Dr B recalled that he performed a pelvic examination and found a large cystic swelling in her pelvis. He told Ms A what he had found and advised her to have an ultrasound scan of her pelvis and lower abdomen. Following the ultrasound he intended to refer her to an outpatient clinic for specialist review.

Dr B recalled:

> "She knew I was worried about the cyst and could not give an accurate diagnosis without ultrasound and specialist help. She … could not afford a private ultrasound and opted to go to the X-ray Dept. at [the public hospital]. I gave her the ultrasound request form to take directly to the X-ray Dept. that day with urgency on the form. There was no complaint of leg swelling that day, and no abdominal or pelvic cystic swelling had been detectable before 28/6/02."

Dr B received the result of Ms A's ultrasound scan (performed on 12 July) on 15 July. The report noted an "enlarged, grossly abnormal uterus, the features of which favour endometrial pathology and in particular endometrial carcinoma. The presence of the ascites is suspicious of peritoneal spread of malignant disease." Dr B sent a fax to the outpatient clinic requesting an urgent gynaecological appointment for Ms A.

Leg ischaemia – July 2002

Ms A returned to the first medical practice on 16 July. Dr B was not on duty and so Ms A was seen by Dr C. Dr C informed me that this was the first occasion he saw Ms A, who reported right foot and leg pain, which had become worse over preceding weeks. The pain increased when she walked and the foot had looked pale at times. Ms A also reported that the leg was painful at night.

Dr C informed me:

> "On examination (according to my computer notes and referral note) she was found to have poor peripheral pulses; in particular, the dorsalis pedis was not palpable but her posterior tibial pulse was present. Her toes were pale, and her calves were supple. At this stage my impression (diagnosis) recorded in the computer notes was 'Peripheral Vascular Disease'."

Dr C referred Ms A for an outpatient assessment by a General Surgery Clinic Vascular Service. He wrote and faxed the referral that day and received a confirmation of receipt by email. Dr C recorded the consultation on the card that Dr B used to record his clinical note noting, "Will see [Dr B] tomorrow for 'enlarged uterus'". Dr C also entered the consultation into the Centre's computerised record.

Dr B saw Ms A on 17 July. He recalled that it was at this time that he told her of the ultrasound results and of the need for specialist intervention. Dr B checked Ms A's heart and blood pressure and she told him about her leg problem. Dr B examined Ms A's legs and found that her right lower leg was cool and dusky in colour. He could feel a pulse, although it was not strong. Dr B advised:

> "At that stage the diagnosis was unclear but I felt that it could have been brought on by pelvic pressure from the cyst that could be compressing the right iliac artery in her pelvis. I considered that the Gynaecologists needed to remove the cyst urgently."

Dr B recalled that Ms A informed him that she had an appointment with a gynaecologist at the outpatient clinic on 18 July, and he told her to let them know about her leg problems, as well as show them her abdomen and pelvic cyst (Ms A's gynaecologist appointment actually took place on 22 July 2002).

Ms A returned two days later because her ankles had started to swell, and was again seen by Dr C. Dr C noted the results of Ms A's ultrasound scan and that she had been referred for gynaecological assessment. He considered the association between pelvic malignancy and thrombosis, and ordered an ultrasound scan to exclude deep vein thrombosis. The scan was normal.

Gynaecology assessment – 22 July

On 22 July Ms A was seen by Dr F, gynaecologist, at the gynaecology outpatient clinic. (Dr F had previously seen Ms A in May 2001 when she treated her for low-grade cervical dysplasia.) On examination Dr F found that Ms A had an asymtomatic large pelvic mass, the size of a 24-week pregnancy, but her cervix was normal. Dr F made a provisional diagnosis of uterine sarcoma, as Ms A had no history of postmenopausal bleeding. Dr F arranged for further investigations and placed Ms A on the urgent waiting list with a provisional date for a laparotomy on 26 August 2002.

Ms D and Ms E recalled that Dr F "insisted that [Ms A] go back to the Medical Centre and immediately be put back on the Atenolol, as [Ms A's] blood pressure was sky high". Ms A returned the same day (22 July) to Dr C, who noted that she was hypertensive and resumed her on atenolol. Dr C did not take any further action concerning her foot at this consultation, although he noted that Ms A had an "enlarged uterus and fluid in her abdomen", and that she had received a provisional booking for a hysterectomy. Dr F's letter to Dr C detailing her assessment of Ms A on 22 July does not mention her blood pressure or that she should resume taking atenolol.

Deterioration of leg problem

On 29 July Ms A returned to see Dr B. She showed Dr B her right lower leg, which was swollen and cool. Dr B reaffirmed his earlier conclusion that the condition of Ms A's leg was caused by pressure from the pelvic cyst. He prescribed pethidine 50mg three times daily for pain.

Two days later, on 31 July, Ms D telephoned Dr B to inform him that Ms A had developed a lump in her groin. Dr B advised Ms D to take her sister to the public hospital Emergency Department. He recalled that he told Ms D to "demand [Ms A] be admitted and treated as we have been waiting too long for the specialists to do something".

Ms D and Ms E do not accept that Dr B said that they should demand that Ms A be admitted to the public hospital. They recalled:

> "[Ms D] rang [Dr B] to say that [Ms A] had found a lump on her groin and [Ms D] was going to take her to [the public hospital]. [Dr B] said that was a good idea. [Ms D] asked if a referral was needed and he said no."

Ms D said that the conversation ended there.

The public hospital
Ms A was admitted to the public hospital on 31 July with an ischaemic right lower limb. A CT scan confirmed the diagnosis of uterine sarcoma. Ms A was informed by surgeon Dr G, on 2 August, that she had cancer of the uterus. Dr F informed me:

> "I was contacted by the surgical team and informed of her situation. I had discussed her case with the on-call gynaecology team and plans were made for her to have a laparotomy along with the amputation. However, laparotomy was deferred and, amputation carried out under regional anaesthesia due to anaesthetic concerns regarding her cardiac status. Anaesthetists also recommended that elective laparotomy be deferred for six weeks.
>
> I reviewed [Ms A] on the surgical ward and discussed further management plans with her."

Follow-up August/September 2002
Ms A recovered well from the amputation on 3 August and was sent to a rehabilitation unit, but on 24 August she suffered a stroke. She was admitted to a city hospital, and on 28 August was transferred back to the public hospital for ongoing treatment.

On 4 September a meeting was arranged between medical staff and Ms A's family to inform them that the cancer had spread to the point where there were no treatment options. Ms A was discharged to Ms D's home on 18 September and died several weeks later.

Subsequent events

Advocacy support
On 24 June 2004 an advocate from the Health and Disability Consumer Advocacy Service informed me that they had supported Ms D in obtaining resolution in the matters relating to the treatment and care Ms A received from the public hospital. Ms D waived her option to meet with the public hospital staff in favour of a written report responding to her concerns.

When Ms D reviewed the information provided by the public hospital she notified a advocate from the Health and Disability Consumer Advocacy Service that she was satisfied with the response, except for one aspect, which was that she felt that the hysterectomy and amputation should have been performed simultaneously. However, Ms D advised that she did not wish to pursue this matter further.

ACC

ACC received a claim from Ms A for medical misadventure on 13 September 2002. General practitioners Dr Ian St George, Dr J, and Dr Niall Holland provided expert advice to ACC. Dr Holland advised ACC:

> "This cancer appears to be of an aggressive rapidly growing form and it is also likely that the outcome would have been no different even with an earlier diagnosis.
>
> …
>
> The management by [Dr B] has been appropriate and timely for the symptoms and findings as they presented."

Dr J advised ACC:

> "[Dr B and Dr C] each had different note systems, [Dr B's] being hand written, [Dr C's] being on the computer, suggesting they were in separate practices and saw [Ms A] when the other was unavailable.
>
> …
>
> I consider that there has not been a failure of [Dr B] or [Dr C] to observe a standard of care and skill reasonably to be expected in the circumstances.
>
> …
>
> While repeat antibiotic prescribing without further investigations is not recommended practice, such prescribing, in some resistant cases, is required and I do not consider constitute a failure in the standard of care and would not have made a difference to the course of subsequent events. I consider that the management of this aspect by [Dr B], while not ideal, does not constitute medical error."

Dr St George advised ACC:

> "[Ms A] presented to [Dr B] with recurrent urinary and pelvic symptoms for five months before he suspected a possible 'complicated' urinary infection and found a pelvic mass. It is very likely her urinary symptoms were caused by pressure of the mass on her bladder from the start. The repeated prescription of antibiotics without proper examination is inappropriate, and the consequent delay in diagnosis is a result of his failure to examine her.

…

I have concerns about [Dr B's] competence: his clinical notes are far from adequate, and I am not sure from his letter that he appreciates the importance of physical examination and investigation of recurrent urinary symptoms."

The claim was declined by ACC on 12 December 2002 on the basis that there was no evidence that Ms A's personal injury was directly caused by the actions of a health professional.

Additional information

Dr C
Dr C provided a copy of his computerised record of Ms A's consultations with him and informed me:

"It is clear that our practice, like many other medical centres, has certain doctors who prefer handwritten records and others who prefer computerised clinical records. It is also clear that each doctor may choose to make use of the computer system to differing degrees. This may, for example, reflect the doctor's typing ability and beliefs that the presence of a computer may interfere in some way with the consultation.

… I made entries in both the written and computer notes on every occasion that I saw [Ms A]. This was because I knew that [Dr B] was [Ms A's] usual doctor and I was aware that [Dr B] uses primarily handwritten notes. I also made a computerised record because I felt that a computer record was important should [Ms A] consult other doctors. Other computerised information such as test results and discharge summaries are made available to [Dr B] as printed copies provided by the staff or the laboratory."

Ms E
Ms E informed me that when she and her mother, Ms D, requested Ms A's medical records, they were sent only the handwritten records. When they asked for all of Ms A's test and laboratory results, they were told that there were none.

Independent advice to Commissioner

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

"Thank you for your request for an Independent Advisors report on the case of [Ms A], your reference 03/03134/WS

I have read and agree to follow the H&DC Appendix H: Guidelines for Independent Advisors.

I am a vocationally registered general practitioner, having graduated MBChB from Otago University in 1976. I have practiced as a GP since 1979 and gained Membership of the Royal New Zealand College of General Practitioners in 1989. In 2001 I gained a Diploma of General Practice from Otago University. Currently I work 6/10ths as a GP in a 4 doctor provincial practice.

Concerning possible conflicts of interest, I do not know any of the doctors involved in the care of Ms A. However I personally know Dr St George and Dr Holland who have provided advice to ACC, which is contained within the documentation.

I have perused the following supporting information supplied by you in relation to this enquiry.

- Letter from [Ms D] dated 24 February 2003 to the Commissioner, marked 'A'.
- Letter from [Ms D] with further medical notes received on 20 March 2003, marked 'B'.
- Copy of [Ms A's] medical misadventure file from ACC received on 11 April 2003, marked 'C'.
- Investigation letter to [Dr B] dated 29 July 2003, marked 'D'.
- Investigation letter to [Dr C] dated 29 July 2003, marked 'E'.
- Letter from [Dr C] to the Commissioner dated 19 August 2003, marked 'F'.
- Letter from [Dr B] to the Commissioner dated 21 August 2003, marked 'G'.
- Copy of [Ms D's] letter dated 15 September 2003 to ACC requesting a review of the ACC decision not to grant compensation, marked 'H'.
- Transcript of the interview with [Ms D] and [Ms E] on 23 October 2003 marked 'I'.
- Letter from [Dr C] to the Commissioner dated 9 December 2003, marked 'J'.
- Letter from [Dr B] to the Commissioner dated 11 December 2003 with enclosures, marked 'K'.

Background comments:

I have some concern as to the presentation of the evidence, namely the doctors' clinical records. [Dr B's] notes are contained as part of [Ms D's] letter marked 'B'. [Dr B's] reply to the Commissioner contained summaries of his records in addition to

further information which appears to be sourced from personal recall. [Dr C's] notes were presented in two sections, firstly sourced from the ACC enquiry, pages 131-135 of 'C' and then in [Dr C's] and [Dr B's] letters F and G.

The information was not consistent between these sections, for [Dr B's] handwritten notes in 'B' were not the same as his letter to the Commissioner 'G' while I found the results of [Dr C's] requested leg vein ultrasound results in [Dr B's] letter and [Dr B's] urine results in [Dr C's] notes. It is probable that this reflects problems in the record system of the ... Medical Centre, an issue I have further commented upon in my summary, but there may be other reasons for this.

In reply to your questions:

Re [Dr B's] care for [Ms A]

A brief summary of the consultations with this problem, mainly from [Dr B's] notes (handwritten in documentation section B)

Date	*Clinical features*	*Prescriptions*
25-1-02	*Dysuria, (pain on passing urine) renal (loin) area tenderness. No examination findings recorded otherwise no other problems*	*Noroxin 6 days supply*
1-02-02	*Pelvic discomfort and dysuria. No examination findings, no other problems*	*Cotrimoxazole 30 tabs*
13-02-02	*Dysuria. No examination findings. Blood pressure checked*	*Cotrimoxazole 30 tabs*
27-03-02	*Diagnosis made of diverticulitis*	*Cotrimoxazole 40 tabs*
3-4-02	*[Dr B] completes a medical certificate excusing [Ms A] of jury duty*	
20-05-02	*Repeat prescription*	*Diazepam, zotabs*
5-6-02	*Repeat prescription for atenolol (blood pressure medication) and merbentyl for bowel spasm. No examination recorded in notes ([Dr B's] letter G states 'full examination of upper and lower abdomen' was carried out)*	*Atenolol, merbentyl*
14-6-02	*? Phone call cystitis*	*Noroxin 12 tabs*
19-06-02	*? Phone call*	*Cotrimoxazole 60 tabs*
28-06-02	*Dysuria and increasing incontinence. Examination findings recorded of 'o/e' (on examination) 'large pelvic mass'. [Dr B's] letter G is a lot more comprehensive and indicated that he is recalling from memory*	

	rather than notes taken at the time. [Ms A] is referred for ultrasound examination to be followed by a gynaecological opinion	
12 July	*Ultrasound performed*	
15 July	*Referral to gynaecologist received by hospital*	
22 July	*Seen by [Dr F], gynaecologist*	

Was [Dr B's] management of [Ms A's] urinary symptoms appropriate?

No (see next question answers).

Did [Dr B] appropriately consider the cause of [Ms A's] symptoms?

No.

Taking the information provided in [Dr B's] records:

- The first presentation appears to have been managed appropriately, although his lack of recording of clinical signs is inadequate.
- On 1-02-02 [Ms A] has presented with pelvic discomfort and more urinary symptoms. [Dr B] has not carried out an appropriate clinical examination and does not appear to have identified that the previous urine specimen sent to the laboratory for culture was clear. While this test result does not exclude urinary infection it should have flagged to [Dr B] a need to exclude other diseases or conditions.
- Similarly on 13-02-02 there is no indication in [Dr B's] notes of any consideration of further investigation.
- The diagnosis of diverticulitis on 27-03-02 is also of concern as there is no recording of the symptoms or examination signs that [Dr B] used to reach this diagnosis. It is likely in retrospect that [Ms A's] symptoms were due to her pelvic problems.
- The same would apply to the 5-06-02 consultation.

[Dr B's] letter 'G' contains information in addition to that recorded in the clinical notes. This letter was written 13 months after the events above. This additional information is that [Dr B] performed abdominal examinations on 1-2-02 and 5-6-02, information presumably recalled from his memory, not the clinical records. No pelvic examinations were performed in these times.

Thus [Dr B] had some 4 occasions in which he should have considered further investigation. It is entirely possible that he did examine [Ms A] but he has failed to record any significant examination findings until the 28-06-02 consultation. I would suspect that he did not adequately examine [Ms A] on the four occasions prior to this.

In 'G', [Dr B] indicates that his diagnosis on the 25-01-02 consultation was of 'urethral irritation' due to sexual activity, a diagnosis he repeated on the 1-2-02. His prescribing

of noroxin for the first presentation is consistent with a diagnosis of urinary tract infection, not of 'urethral irritation'. His repeat prescribing of cotrimoxazole is also inconsistent with this diagnosis.

On 16-6-02 [Dr B] prescribed more noroxin for [Ms A] after she rang with a diagnosis of cystitis (i.e. a urinary tract infection) and then changes this to cotrimoxazole on the 19-06-02 because of the cost of the noroxin.

This management is inconsistent with his diagnosis of urethral irritation.

There are other factors in [Ms A's] history, which should have caused [Dr B] to consider a need for further exploration of diagnosis.

1. [Dr B] had noted (although not in his clinical records) that [Ms A] was in a new sexual relationship at the time. This would be a likely cause of recurrent urinary tract infection or dysuria (painful passing of urine) due to irritation in the vaginal/urethral area, but [Dr B] had no proof of the former as a cause and could not presume the latter with any certainty. Sexual relationships also indicates a need to consider and exclude a sexually transmitted cause of [Ms A's] symptoms such as chlamydia. There is no indication anywhere that [Dr B] did this.

2. If diverticular disease was [Dr B's] working diagnosis, I would have expected some other clinical examination findings, vital signs (especially temperature) and some further investigation such as an abnormal blood screen in the notes to support this diagnosis, more so given the number of prescriptions he issued for cotrimoxazole for this problem. There is no recording in [Dr B's] notes of such data.

3. [Ms A] had a past history of abnormality of her cervix (Cervical dysplasia). In conjunction with her negative urine culture results and persistent dysuria, [Dr B] should have considered a possible connection between the two, even though [Ms A] had a recent negative smear result and negative colposcopy, for neither cervical smears nor colposcopies can 100% exclude significant gynaecological causes for [Ms A's] proven recurrent symptoms. Mitigating in [Dr B's] favour is that [Ms A] did not have any cervical abnormality but [Dr B] has no record in his notes that he had considered this.

Was the medication that [Dr B] prescribed for [Ms A's] symptoms appropriate?

As per his clinical records on page 007 the medication prescribed on her first presentation, noroxin is scripted at a dosage and time span appropriate for urinary tract infection (not for urethral irritation). While noroxin would not be considered best practice especially in a first presentation with a urinary tract infection, it is effective and appropriate.

Subsequently, [Dr B] prescribed cotrimoxazole, which also is effective in urinary tract infections in general practice, however the scripting is for longer courses (between 30

and 60 tablets), which suggests either [Dr B] was thinking of diverticular disease, or possible prevention of recurrent urinary tract infections. In total [Dr B] prescribed 160 tablets of cotrimoxazole, which might possibly be considered acceptable management of a recurrent urinary tract infection, but certainly not of urethral irritation. His clinical records are poor on this matter and his letter 'G' does not clarify his thinking. This lack of clarity should have alerted him to a need to investigate [Ms A] further in order to establish more clearly a diagnosis.

Was it appropriate for [Dr B] to issue repeat prescriptions for her symptoms without further examination?

No.

Should an ultrasound for [Ms A] have been ordered earlier? If so, when?

A pelvic ultrasound should normally be performed after a clinical examination reveals abnormality. As such an examination was first carried out on 28-06-02 then [Dr B's] requesting of this investigation was entirely appropriate.

Were [Dr B's] referrals timely?

[Dr B's] actions following the visit and diagnosis on 28-06-02 are entirely appropriate and any perceived delay in action on the part of the secondary services cannot be due to any of [Dr B's] inactions on the matter of the abnormal pelvic scan result.

Was the quality of [Dr B's] records appropriate?

No. His notes are inadequate in content with [Ms A's] symptoms poorly recorded, examination findings lacking and management plans deficient.

In structure, his records lack a problem list; show poor organisation of test results, a lack of recording of test requests and no indication of a follow-up/recall system.

Some of this problem is also due to the dichotomy of the [Accident and Medical Centre] having two clinical record systems, one handwritten, and the other computer based.

For example the result of the urine cultures performed on 25-01-02 were not in [Dr B's] notes but rather I found this in [Dr C's] letter. There is no recording in [Dr B's] notes of his performing [Ms A's] follow up cervical smear on 21st November 2001. However there was a cervical smear result in [Dr B's] letter 'G' on page 399. It is possible that some of this distribution of information as presented to myself was a result of the method by which the clinical notes were collected.

In your opinion, did [Dr B] adequately inform [Ms A] about her ultrasound results?

The ultrasound of 12 July 2002 indicated a high likelihood of cancer of the uterus with the addition of 'suspicious of peritoneal spread of malignant disease'.

[Dr B] thus knew that cancer was the most likely diagnosis. However, as every doctor knows, a diagnosis of cancer cannot be accurately made until a definitive test such as histology from a biopsy specimen is available. This is usually the most accurate (but never 100% so) test. There were other tests such as blood tests and a CT scan result available to the hospital doctors, however [Dr B] did not have these results at this early stage. As an indication of the uncertainty, there is a chest x-ray result in the hospital records (page 026) with the indication for the procedure being performed on 31 July as

> '? uterine carcinoma' (cancer)

[Dr B] mentions in his letter 'G' that he

> 'told [Ms A] of the ultrasound and the need for specialist intervention'

He also indicates that when he saw [Ms A] on the 17 July even with the ultrasound result he referred to her problem as being due to a cyst. (Page 391)

There were investigations performed by [Dr F] on the 22 July, which are further suggestive of cancer (page 021 and 022). However only one of these results is contained in the ... Medical Centre notes (computer generated) appearing page 134 of 'B' and that result in only very marginally abnormal.

Given this uncertainty, a doctor would have to evaluate other factors likely to influence a patient's understanding of the results. [Dr B] had known [Ms A] for a long period of time and was aware of her personal circumstances (e.g. personality, social circumstances) which would influence her perception of test results and subsequent referral. This is indicated in his letter 'G' referring to [Ms A's] concern about the [outpatient clinic] and also the transcript of the family interview 'I' page 430 that refers to [Ms A's] anxiety.

The family first knew of the cancer diagnosis on 3rd August (page 419). They indicate [Ms A] had been told of the cancer diagnosis by [Dr G] a few days prior to this. I would suspect that this was on the 1st August which was when a CT scan (page 030) which was strongly indicative of pelvic cancer was reported. Thus [Dr G] had some 4 test results indicating cancer, unlike [Dr B] who only had one.

The final factor to consider in this section is that patients may not tell their family of significantly abnormal test results. If it is presumed that [Ms A] knew at least on the 1st August of the cancer diagnosis and it took until the 3rd for the family to learn, there can be no certainty that the full contents of the [17th] July discussion between [Dr B] and [Ms A] on the ultrasound test results was passed on to the family.

I therefore come to the opinion that [Dr B] did discuss with [Ms A] as to some of the significance of the ultrasound test result. As to whether the diagnostic likelihood of

cancer was mentioned, I cannot prove. Given the uncertainty of this diagnosis for [Dr B], this uncertainty can be accepted as he made a prompt referral which he knew would lead to clarification of the diagnosis.

That he did not discuss this with the rest of the family I could not describe as being a failure on [Dr B's] part.

What are the relevant standards relating to this complaint and did [Dr B] comply with those? If you consider that relevant standards were not met, was the departure minor, moderate, or major?

Standards applying are those of

1. Adequate clinical examination. [Dr B] appears not to have adequately examined [Ms A] on the 1-02-02, 13-02-02, 27-03-02 and probably 5-06-02. Standards applicable are those of the Medical Council of New Zealand Good Medical Practice.[1]

2. Diagnostic standards: a failure to adequately exclude other possible causes of [Ms A's] symptoms or to substantiate a working diagnosis in a patient presenting with recurrent symptoms. Standards applicable are as above in the Medical Council's Good Medical Practice.

3. Clinical records: He has failed to record significant clinical information. The standards applicable are those of the Medical Council of New Zealand[2] and the Royal New Zealand College of General Practitioners Aiming for Excellence, Section D.[3]

4. There are no explicit standards or well-developed evidence based guidelines available to GP's in New Zealand on criteria for investigation of urinary and lower abdominal/pelvic symptoms. The New Zealand Guidelines Group Heavy Menstrual Bleeding Guideline and Uterine Fibroid Guideline do not cover Ms A's presentation to [Dr B]. The medical literature in Medline, Cochrane Collaboration and Primary Care guidelines generally indicates the need to exclude sexually transmitted causes in

[1] Good Medical Practice: A Guide for Doctors. Medical Council of New Zealand, P O Box 11 649 Wellington Available on line at http://www.mcnz.org.nz/about/forms/goodMedicalPracticeHdbk2003.pdf

[2] Guidelines for the maintenance and retention of patient records. Medical Council of New Zealand, P O Box 11 649 Wellington Available on line at http://www.mcnz.org.nz/about/forms/recordsguide.pdf

[3] Aiming for Excellence, (2nd Edition 2002) Published by Royal New Zealand College of General Practitioners, PO Box 10440, Wellington

a woman presenting with dysuria (especially chlamydia). This is best exemplified by the American Academy of Family Physicians article.[4]

In evaluating [Dr B's] performance, I have appraised the comments made by Dr Holland and Dr St George in their judgements for ACC on this case, for they are both practising general practitioners of considerable experience and expertise.

I note that Dr Holland refers to [Dr B's] presumption that [Ms A's] recurrent urinary tract infections were due to her sexual activity (page 140). This is presumptive on the proof of urinary infection in [Ms A's] case, but the only urine result available from 25-01-02 (not in [Dr B's] notes however) was negative for a urine infection. (page 134).

I believe that a reasonable GP when faced with the recurrent dysuria, pelvic pain and a urine result showing no infection, would have carried out further examination either a pelvic bimanual palpation or visualising of the vaginal lining with a speculum. Alternatively further efforts to prove or disprove a urinary tract infection should have been undertaken.

I agree with Dr St George's opinion that [Dr B's] poor standard of care for [Ms A] resulted in a delay of the diagnosis of her uterine cancer.

[Dr C]

Was the treatment provided to [Ms A] by [Dr C] reasonable under the circumstances?

Date seen	*By*	*Clinical features and actions taken*
16 July	*[Dr C]*	*Sore blue foot. Referred for radiology ultrasound. (Recordings of this consultation appear to be both in [Dr C's] computer notes and also in [Dr B's] handwritten notes but in a different handwriting which I suspect is [Dr C's.])* *Stopped atenolol*
17 July	*[Dr B]*	*Same problems. No action taken*
18 July	*[Dr C]*	*Given pain relief, x-ray performed. Ultrasound results showed no abnormality detected according to hospital notes*
22 July	*[Dr C] (after seeing [Dr F], the gynaecologist)*	*For pain relief (tramadol) and blood pressure check. He restarted atenolol*
29 July	*[Dr B]*	*Leg 'swollen and cool'*

[4] The Woman with Dysuria. American Academy of Family Physicians. Available online at http://www.aafp.org/afp/980501ap/kurowski.html

31 July	*Via A&E [the public hospital]*	*Urgent admission with lump in groin. Found to have had a heart attack (myocardial infarct)*
2 August	*[Dr G]*	*Tells [Ms D] of [Ms A's] cancer*
3 August		*Right Below Knee amputation*
24 August	*[Rehab Unit]*	*Stroke and admitted to [a city hospital]*

Were [Dr C's] referrals to specialists for her foot condition timely?

The treatment provided by [Dr C] seems entirely appropriate. Given the timing of events, [Ms A's] risks factors for peripheral vascular disease and her known pelvic and uterine problems, I believe [Dr C's] management of her poor blood supply to her leg is appropriate and in accordance with the National Referral Guidelines[5]. Although these guidelines are not evidence based and have not been acknowledged by the RNZCGP or NZMA, they are a reasonable indicator of expected urgency for care.

On [Ms A's] first presentation to [Dr C], he has correctly detected a problem with the blood supply to her foot. She presented sore toes of a blue, pale colour but without any skin damage. She also had, at times, calf pain when walking. Such a presentation of a patient with peripheral vascular disease is not uncommon in general practice although usually in patients a lot older than [Ms A].

In evaluating the care, the main issue is the degree of urgency and the type of referral, either semi urgent referral or urgent admission.

At the first visit [Dr C] felt that [Ms A's] problem was possibly due to peripheral vascular disease, that is narrowing of the arteries in [Ms A's] legs causing a compromised blood supply. He had also considered blockage of her leg veins as a possible cause along with compression of her veins/arteries in her pelvis from the 'cyst'.

In retrospect, after further investigation and surgery, it was thought that Ms A did not have peripheral vascular disease, but that, according to [the vascular surgeon] at [the public hospital]

> 'it was more likely that she had had an embolus'

i.e. that a section of blood clot caused by [Ms A's] heart attack had broken off and travelled from her heart to her leg and there blocking the blood supply. The exact location of the lodgement of this emboli I cannot determine, as the hospital records do not reveal any investigation locating such a clot. The relevance of such an investigation for her actual care is debatable and establishing whether or not she actually had

[5] National Referral Guidelines, Ministry of Health, Available on line at
httpp://www.electiveservices.govt.nz/
index.cfm

peripheral vascular disease is similarly of little help in her clinical care, for the obstruction to the blood supply to her leg was the overwhelming problem which needed action.

Neither [Dr C] nor [Dr B] could have been reasonably expected to have diagnosed or suspected [Ms A] had suffered a heart attack, for this seems only to have been discovered by the hospital at ECG, the indications for which are not recorded but appear to have been routine.

The National Referral Guidelines (appendix 1) indicates that at this initial presentation, [Ms A] would be prioritised as being semi-urgent, that is to be seen within 1 month. I note that [Dr C's] referral to the vascular surgeon was given a 5 week wait by the hospital in line with this.

The question to be asked is whether on her presentation on the 22nd July to [Dr C] or 29th July to [Dr B], was there indication for urgent referral or hospital admission.

'Acute limb-threatening ischaemia' is the criteria for urgent referral/admission and it is difficult to ascertain at what point [Ms A's] leg problem moved from its previously semi-urgent to an urgent status.

Consideration needs to be made of the likely role [Ms A's] pelvic problem in compromising the blood supply to her leg. I suspect [Dr C] considered that the issue of urgency for operation would be evaluated at her gynaecological outpatient visit to [Dr F] on 22nd July 2002. I do not have records of this visit, except for blood test results taken that day, thus I do not know [Dr F's] evaluation of [Ms A's] leg. Given that [Dr F] took no further action with respect to her leg problem, I would appraise that [Ms A's] leg was not 'acute limb-threatening ischaemia' at this time.

On the 29th July she saw [Dr B] with her leg problem. He changed her previously prescribed pain relief of tramadol to pethidine. Ischaemic leg pain tends to be severe and sometimes requires narcotic pain relief. The lack of response to tramadol would indicate deterioration in her condition. [Dr B] does not record the state of [Ms A's] leg very well, describing

> 'Still oedema (swelling) legs from pelvic'

without any indication of an assessment of her blood supply. [Ms D], in her letter 'A' indicates that [Ms A's] leg had deteriorated

> '… as by now her foot had now turned a horrible shade of blue and had spread halfway up her right calf … she was having to use her cane, as she could not fully put pressure on the foot.'

The discharge letter of 29 August reports that on admission [Ms A] was found to have a femoral hernia and

> 'no pulses were felt from the groin down'.

[Dr B] in his letter 'G' does not mention any examination of [Ms A's] leg other than it was

> 'Swollen and cool'.

In this letter he states that when he saw [Ms A] on 29-07-02

> 'she reported that she had not been seen as yet by either the gynaecologist or vascular specialist'.

He does state that he believed she was to be seen the next day at the [outpatient clinic] and therefore his suggestion that she draws the specialist attention to her leg problem seems satisfactory. Alas there is dissonance between this letter of [Dr B's] and the events as reported in his notes, in [Dr C's] notes and in [Ms D's] letters, the latter indicating she saw [Dr F] on the 22nd July.

I believe that the actions of [Dr C] in this circumstance were appropriate. [Dr B's] actions were also appropriate except for the 29 July consultation where there is some uncertainty of [Dr B's] examination and thinking, especially the apparent confusion in his letter 'G' re [Ms A's] seeing the specialist.

What are the relevant standards relating to this complaint and did [Dr C] comply with those? If you consider that relevant standards were not met, was the departure minor, moderate, or major?

The relevant standards I have used on the assessment of urgency are those contained in the Ministry of Health National Referral Guidelines (appendix 1). Please note that these standards are not uniformly applicable due to significant resource variation around the country and the lack of widespread professional involvement in their development. However they provide a suitable outline on the assessment of urgency in this case.

In your opinion, does the administration system for patient notes and test results at the practice appear to be appropriate?

The presence of two sets of clinical notes, one the handwritten notes of [Dr B's] … and the other the computerised records used by [Dr C] is a source of concern. This results in a splitting of important clinical information and increases the difficulty in understanding the time line of events and the decision reached by the doctors. Given the importance of clinical records in treating patients, I suspect that some of the problems in this case may have been aggravated by this dichotomy of clinical records. It is probably a reason for some of date/time discrepancies in [Dr B's] letter 'G'.

Concerning the test results, [Dr C] in his letter 'J' states:

> 'investigations are ordered either electronically or in written form to pathology laboratories and radiology providers'.

The computer printouts forwarded in the documentation indicate where investigations have been ordered. However there is no actual presentation of the investigation requests. [Dr C] may simply have not forwarded these.

However, if the ... Medical Centre does not keep records of their requests there will be difficulty in maintaining an audit trail of test results in accordance with the RNZCGP advice on patient test results.[6]

Of note is that in [Dr C's] records there is acknowledgement from the DHB as to receipt of the GP referral. This is a pleasing development that should be flagged to other DHB's in New Zealand as it allows general practitioners and their patients some assurance as to the processing of referrals.

By contrast [Dr B's] notes lack the recording of hand written investigation requests and the separation of his notes from the PMS system at the [accident and medical centre] will make it difficult to implement an effective test results audit trail.

Certainly the benefits of computerised records are exemplified by the ease of reading from [Dr C's] notes, the ease of tracking test result and requests and medication prescription, a contrast with [Dr B's] records.

I would advise the ... Medical Centre to address this important professional issue.

Are there any other matters which you believe to be relevant to this complaint?

A minor matter, but perhaps reflecting [Dr B's] clinical competence is evident on [Ms A's] 8-8-01 presentation with a nipple excoriation. Nipple change can be an indication for further investigation to exclude breast cancer especially in a woman of this age[7]. Breast examination should have been performed and a plan of action should have been undertaken to assure that the problem had resolved after treatment. Further investigation such as mammography should also have been considered. None of these three steps have been performed according to [Dr B's] notes.

Summary

This is an unfortunate case of a lady with a number of events producing a complex clinical picture. I believe [Dr C's] care for Ms A was appropriate but [Dr B's] was deficient due to his failure to adequately examine and investigate Ms A's urinary and

[6] Patient test results, RNZCGP, 88 The Terrace, Wellington. Available on line at http://www.rnzcgp.org.nz/PDF/ManagingPatientTestResults.pdf

[7] Guidelines for the early detection of Breast Cancer. New Zealand Guidelines Group. Available on line at http://www.rnzcgp.org.nz/standard_guidelines.php

abdominal symptoms. Unfortunately, given the nature of her cancer, it is unlikely that the outcome would have been different with earlier detection in 2002."

Responses to first provisional opinion

Medical Centre
In response to my first provisional opinion, Dr I and Dr H submitted on behalf of the Accident and Medical Centre:

"Every general practice in New Zealand has a mix of digital, faxed, mailed, emailed and handwritten material that constitutes the full patient record.

The very few who have tried to 'go paperless' by scanning paper records still keep backups of the paper record and I know of none who have managed to convert the full past record for all patients into a paperless system.

Thus like all other practices we have a combination of electronic and paper records.

The attached will give you an idea of the crossover between these systems. Our practice would be similar to our peers although leaning toward an electronic record.

In terms of documents received from outside the practice, or referrals from the practice, these are dealt with as follows:

- All lab results are returned by computer and become part of the electronic record.
- All of [the public hospital] discharge summaries are delivered electronically.
- Almost all of the specialists' reports are posted and arrive by mail and are checked manually. (A very few by electronic document system 'EDS'.)
- All of our hospital referrals are faxed to the department concerned.
- All of our specialist letters are prepared in typed format and given to the patient and or sent to the specialist (a few soon by EDS.)

None of our lab requests are electronic – they are all printed forms, which are provided to the lab. (The lab does not accept electronic referral.)

Every patient at [[the accident and medical centre] has a patient number corresponding with his or her manual record and every patient has the same number corresponding with his or her electronic record.

[Dr B] and [another doctor at the Centre] vary to the extent that consultation notes are recorded in the manual, not the electronic file. However, the system is such that both files are available to all doctors at all times. Indeed every doctor's room has a computer, which can access the entire electronic record for every patient, and every doctor has immediate access to the entire manual record on request.

We do not compel doctors to communicate with their peers or keep their records in a particular format. It might seem 'obvious' that everyone should record their notes in either an electronic or manual format but all doctors have different skills in writing or typing and we accommodate this variety.

The key issue here is that both the electronic record and the written record are immediately available to the doctor at the time of the consultation.

Dr Vause comments in his summary that the '*two sets of clinical notes result in a splitting of important clinical information and increases the difficulty in understanding the time line of events'*.

Critical clinical information is received from specialist reports, after-hours clinics, hospital admissions, imaging reports and other investigation results. This information is generally part of the manual record and doctors at any practice must be proficient in assimilating this information into a timeline. Some doctors find that they have a greater facility at extracting information from a manual than an electronic record. To form a complete picture of a patient's history a doctor at any general practice or hospital in New Zealand will need to review elements from both the electronic and manual record.

The provisional opinion records … that '*it is not clear how a doctor who primarily uses the computer based system would know to check the manual clinical record for test requests and results.'*

As above, all test reports are received electronically and are checked by the doctor who requested the test. Lab test results are all on the electronic record so there is no confusion. If the results are required – they are all in the one place. It is the responsibility of the ordering doctor to ensure that the test is completed and returned for review. Other results are split between the manual and electronic record. X-ray reports for instance may be received and filed in either the manual or electronic record depending on the source of the information.

The provisional opinion further records that 'conversely – a doctor who normally uses manual notes may not check the computer records for consultations and information record by other doctors'. While this might be possible, it is not what occurs in practice. We are all aware where the individual doctors record clinical notes and we are all readily able to access those notes.

It is a doctor's responsibility to check notes where he/she feels this may be relevant. There is no impediment to this checking – the information is always available and it is

no more difficult to look into a file for a clinical note than to look on the computer for it.

It is no fault of the medical centre, its owners, or its systems that we have both electronic and manual records. It is commonplace and inevitable.

I would respectfully suggest that this is not a '*system set up to fail'* as the Commissioner suggests. To the contrary, it is a system set up by well-qualified doctors with due consideration to the potential pitfalls of electronic systems

[Dr B] joined the practice several years ago with his set of 3x5 index cards, a system that served doctors of his generation well. He had no prior experience with computers and although he learned to navigate the records, the input of notes into the computer ultimately requires typing which on a part time basis he felt was not worth learning.

It is not possible overnight to change a medical records system from manual to an electronic record. All of the hospitals and all of the GPs I know have both systems in place. At present we have a system in evolution and while we may be moving to a full electronic record – we are not there and nor are the other GPs, hospitals, labs or specialists.

I do not accept that our systems are at all deficient and I believe we exceed the standards of most of our peers in respect of our record systems.

We would welcome the Commissioner to visit our site and review the above before a final decision is rendered.

The provisional opinion also records the *'pleasing'* development of GP referral receipts from [the public hospital] and a desire to highlight this to other DHBs. It is a pleasing progression, certainly, but there are other areas where the hospital records systems remain deficient. GPs have struggled for years to obtain timely reports regarding our patients' specialist clinic reviews and imaging requests. Many hospital clinics do not forward clinic notes and the radiology department does not forward investigation results when the GP has not requested them. This leaves our clinical record incomplete and makes it difficult for us to manage our patients."

Dr B

In response to my first provisional opinion, Dr B's barrister submitted:

"At the outset I can confirm that [Dr B] has reviewed his practice and will further do so in light of the report. I also **enclose** a written apology from [Dr B] to [Ms D] and others in [Ms A's] family. I would be grateful if you could forward the letter of apology to [Ms D].

My main concern is to address the provisional decision to forward this matter to the Director of Proceedings ... [in light of] the supportive opinions from independent practitioners; [Dr B's] own reasonable explanations of his care of [Ms A]; the difficulty

of the diagnosis and complex presentation, as well as [Dr B's] age, reputation and health.

I do not intend to again traverse the facts of this case. Matters that are not of concern are the timeliness of [Dr B's] referral on finding a pelvic mass, and actions in relation to [Ms A's] foot ischaemia. I do consider greater recognition should be given to [Dr B] in this respect.

The provisional opinion focuses on the period from January to 28 June 2002 and [Dr B's] treatment over this period with noroxin and cotrimoxazole. Having been provided with the Medical Misadventure Unit file, you are aware that Dr Holland and Dr J take no issue with [Dr B's] care. The differing views held by Dr Holland and Dr J on the one hand, and Dr Vause and Dr St George on the other exemplify the complex nature of this case.

I cannot find any basis in the provisional opinion for preferring the view of Dr Vause. On the evidence as a whole Dr Vause's opinion is harsh.

Physical examinations

Dr Vause states that if [Dr B] performed physical examinations these were inadequate. There is nothing on which to base this assumption. [Dr B] has consistently maintained that physical examinations were performed in the months prior to June 28 – refer [Dr B's] report to ACC. The absence of a record does not mean a physical examination was not carried out. [Dr B] also gave oral evidence at the ACC review hearing in this respect. No issues as to his credibility were raised (the reviewer accepted his evidence). You are not bound by that, but it is certainly a relevant consideration.

There is no evidence that the pelvic tumour was detectable at an earlier stage. There were no signs of a pelvic growth until 28 June. The tumour was asymptomatic (as confirmed by [Dr F]). The pain described by [Ms A] prior to this time as in the left side of the lower abdomen (refer notes: *'renal area tenderness'*). The tumour when found was in the right iliac fossa.

Medical records

My instructions are that [Dr B] was implored by [Ms A] not to record the details of her relationship, and the 'unsatisfactory' sexual relationship that led to her presentation with dysuria. [Dr B] was placed in a difficult position in that regard. With hindsight he acknowledges it would have been wiser to make more full records and reassure [Ms A] of the confidentiality of those. However he felt bound by the confidence requested of him by a patient of very long standing. Whatever the wisdom of that, the situation did not contribute to a delay in diagnosis.

Dr Vause refers to the absence of a reference in the notes to a 'new relationship'. This matter was alluded to at the ACC review hearing (at which I was present). [Ms D]

acknowledged that [Ms A] had been involved in a relationship, and I do not believe that has been disputed in correspondence to your office.

The provisional opinion also comments on some apparent confusion by [Dr B] in recording dates of events. This is not material and is to be expected given the notes were taken without provision for copies to be made.

Reasons for Medication

[Dr B] did not prescribe noroxin and cotrimoxazole to treat cystitis. He prescribed ten day course of cotrimoxazole for diverticular disease and three day courses of noroxin as a preventative measure to avoid the sequelae of intercourse related injuries causing dysuria. I am advised that neither acute cystitis nor recurrent urinary tract infections are treated with ten day courses of cotrimoxazole and were not in this case.

It is clear that neither Dr J nor Dr Holland in writing reports for the ACC considered [Dr B's] prescribing to be inappropriate. This is not referred to in the provisional opinion. It is a significant omission, particularly where Dr St George's advice is referred to and where no reasons are given for preferring one view over the other.

The diagnosis of diverticular disease was made several years prior to the events in question by […]. [Dr B] was familiar with how the disease manifested in [Ms A], and the treatment that provided relief. It is a reasonable assumption that [Ms A] also was familiar with the symptoms of diverticular disease, having lived with it for a number of years. This is borne out by her telephone requests for cotrimoxazole.

[Dr B] prescribed cotrimoxazole as it was proven to be effective treatment. As above, noroxin was prescribed on the occasions that an infection was suspected. This was entirely appropriate.

Other relevant facts

Greater weight needs also to be given to the absence of evidence of any uterine symptoms: no post-coital or post menopausal bleeding, and recent normal smears, for example. [Dr F's] reports confirm that [Ms A's] uterine cancer was '*asymptomatic*'.

I am advised that gynecological tumours are notoriously difficult to diagnose, and this is borne out by the evidence. In addition to the complicating factors of pre-existing disease and the symptoms related to sexual behaviour, obesity also can confound diagnosis on physical examination. ([Ms A] was obese). This is not to say, however, that [Dr B] accepts the tumour was missed at an earlier stage. You will also be cognizant of the fact that even after referral to specialist services had been made a diagnosis was not available for a further month.

[Ms A] presented a challenge in that she was very anxious and wary of medical examinations and procedures. It is not criticism of [Ms A] to record also that she at

times did not wish to have a consultation, but requested repeat prescriptions. In the circumstances of a well known patient and known diagnosis (diverticulitis) [Dr B] should not be criticized for allowing this on occasion.

Other matters

[Dr B] will shortly attain 77 years of age. He has been in practice for 51 years. Over the course of his long career [Dr B] has conducted himself in such a manner as to earn an OBE for services to the community. It is remarkable that after such a lengthy period of time he recalls that he has had no other ACC medical misadventure claims against him. He has also had no formal complaints lodged with the Medical Council or your office that have resulted in an adverse finding. [Dr B] advises of a complaint to your office some years ago (by a fellow practitioner) which did not lead to an adverse finding.

[Dr B] has earned an excellent reputation. I cannot overstate how great the impact of this and the ACC investigation has been on him, particularly coming as it does at this stage of his career.

This matter has also had ramifications for [Dr B's] health. I have no doubt that should a referral be made to the Director of Proceedings, [Dr B] will suffer further set backs in his health. Advanced age, and health, is matters which the courts take into account and are proper matters for you to consider.

Following your referral to the Medical Council, it will separately assess the case and in particular whether a competency review is warranted. Whatever the Council's decision, that referral itself will be serious for [Dr B]. It will also be the third time he has to answer for his actions in relation to this matter.

In light of the above, and with the greatest respect, I consider that a referral to the Director of Proceedings would be a wholly inappropriate exercise of your powers in all the circumstances. I see no value in disciplinary proceedings to any party; they would be disproportionate punitive to [Dr B]. This is a very tragic case, not least because of the aggressive nature of [Ms A's] cancer. There is no evidence to suggest an earlier diagnosis would have affected the outcome."

Further independent advice

Dr Vause provided the following further advice regarding issues raised by the directors of the Medical Centre in their response (see below) to my first provisional opinion:

> "On the matter of the record system at [the] Medical Centre, the reply by [Dr I] indicates an acceptance of their double note system. While he is accurate in stating that there would be no general practices in this country that are entirely paperless, the large number of practices currently operating clinical records on computer do not have a double system of current clinical notes, for the paper records in most practices are the hand written notes from previous doctors.
>
> From a 2003 survey of NZ general practices:
>
> *'The proportion of practices who reported that their GPs use their PMS to store full clinical notes was 71.8% (670 out of 933). Of these practices, 19.3% (127 out of 659) store full clinical notes on paper as well as electronically.'*
>
> The ... clinic has made significant efforts to make the mixture of manual and computerised recent history medical records operate. If the system functions without problem as [Dr I] describes in his letter, this indicates that in [Ms A's] case, [Dr B's] failure to correctly manage her urinary problems was not affected by any difficulty in his locating [Ms A's] urine test results. This loads the focus for [Ms A's] poor management further onto [Dr B]. However experience with most critical events demonstrates that there is usually a combination of factors, many of which are systems based, as the root cause. Practice systems must therefore be considered as likely factors in this case, should be identified and where possible improved.
>
> In consideration of the clinic's decision not to review its note system, the barriers to improvement appear to be significant. [Ms A] had been a patient at [the Centre] for some time and [Dr B] had *'joined the practice several years ago'*. Thus the practice had ample time to move to a fully computerised clinical records. [Dr B's] reluctance to use the computer is a significant problem in this case if the circumstances are as exemplified by [Dr I's] comment, '*… ultimately requires typing which on a part time basis he felt was not worth learning*'.
>
> This identifies [Dr B's] attitude towards improvement and flags a common governance problems that can occur when general practices are combined. Given that [Dr B] intends to retire, I trust that the clinic addresses its other barriers to improvement and moves to be in line with appropriate standards of general practice.
>
> Below are the standards for Practice Management Systems from Standards NZ.
>
> 'Where practicable this should be achieved by ensuring:
> (a) All records are in a single file/document;

(b) Each member of the team documents health information in a single continuous record for each patient;
(c) All parts of the record, including both electronic and physical components, are clearly linked in order to locate them for retrieval.'

The RNZCGP patient test results paper is also some guidance on the matter of improving practice systems, especially given the increasing identification of test results management as being the source of frequent medico-legal adverse findings against practices."

Response to second provisional opinion

Medical Centre
In response to my second provisional opinion, Dr I submitted:

"[Dr Vause] states that 20% of practices store full clinical notes on paper as well as electronically. I am not familiar with the paper referred to by Dr Vause but I presume the meaning to be taken from his summary is that one in five of all doctors prefer manual clinical notes as well as an electronic component. It should be hardly surprising then that two of seven doctors working at [the accident and medical centre] also prefer manual clinical notes."

…

"Dr Vause suggests that [Dr B's] preference for handwritten notes shows that he has a poor attitude toward professional improvement. Some doctors might find this inference to be insulting. I am sure many of the doctors who continue to prefer to hand write notes do it because they think that this is the best way that they can provide care for their patients not because they are too lazy to learn to type. Many patients complain about doctors 'tapping away on typewriters' rather than actually engaging the patient in discussion. Clearly there is a balance between an immaculate and comprehensive digital record and a doctor fully attentive and focussed on the patient's needs rather than their computer."

…

"[Dr B] is an experienced and respected GP and we certainly never saw him as a 'barrier'. Further Dr Vause suggests that there are other 'barriers' to improvement within our practice and yet he has not identified them. He also suggests that our practice needs to 'move to be in line with appropriate standards of general practice.' Our contention is that we already meet appropriate standards."

…

I have no knowledge of any steps usually taken by medical centres to ensure that locums or doctors are competent other than informal inquiry with their peers and casual overview of their notes at work.

[Dr B] has been in practice for 50 years without a complaint. He is a humble and careful man with a deep concern for his patients. This much was obvious to us. We did not 'audit' his notes. It did not occur to us to take steps to satisfy ourselves that he was competent. I submit that this is the job of the regulatory authorities. I don't think any of us are qualified to determine whether [Dr B] 'remained competent to practise'. I did not know how old he was and wonder whether I might have breached his rights if I were to [tell] him that he was to be 'audited' because he was beyond a certain age."

…

"An audit trail was not available for tests ordered by [Dr B] to ensure that they were indeed carried out by the patient and the results returned to the patient file. In the future at [the accident and medical centre] all tests will be ordered electronically to maintain the audit trail."

…

"This matter perhaps highlights the generational change between the doctor with his mind on his patient's needs and a doctor with an eye for careful documentation and defensive medicine. Both doctors are being careful; it's just the reasons for their caution that differ."

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.

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 –

(a) An explanation of his or her condition; and

…

(g) The results of procedures.

Relevant Standards

The Medical Council guidelines on 'The Maintenance and Retention of Patient Records' (August 2001) state:

"(a) Records must be legible and should contain all information that is relevant to the patient's care.

(b) Information should be accurate and updated at each consultation. Patient records are essential to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory."

The Medical Council publication 'Good Medical Practice – A Guide for Doctors' (2000) states that doctors must:

"keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed."

Section 2.1.4 of Standards New Zealand NZS 8153:2002 New Zealand Standard Health Records (2002) provides:

"All records pertaining to the individual consumer/patient service delivery are integrated. Where practicable, this may be achieved by, but is not limited to ensuring:

(a) All records are in a single file/document. Where multiple volume health records exist (including department records) for a single consumer/patient, the organisation shall have a written policy for the management and creation of these, including guidance on how these files are linked, and which file is used for current information. Where a consumer/patient has more than one physical file in

their health records i.e. multiple volumes, the number of volumes should be clearly identified on the front cover of each file e.g. Vol 2 of 4;

(b) Each member of the team documents health information in a single continuous record for each consumer/patient;

(c) All parts of the record, including both electronic and physical components, are clearly linked in order to locate them for retrieval."

The Royal New Zealand College of General Practitioners publication 'Aiming for Excellence' (2nd ed, 2002) states:

Indicator Group 10 – Human Resource Management

Indicator D.10.2 *All members of the practice team have contracts and current job descriptions*

…

Criterion 5 *Information from annual reviews is used to determine individual and practice team training needs*

Indicator Group 11 – Quality improvement, professional development, quality development and research

Indicator E.11.1 *The practice promotes continuing professional development*

Criterion 1 All practice team members participate in continuing professional development

…

Criterion 3 There is planned professional development including structured peer review

Criterion 4 The practice documents professional development and quality improvement activities

…

Opinion: Breach – Dr B

Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) patients are entitled to services provided with reasonable care and skill. Right 4(2) of the Code affirms the right of patients to receive services that comply with professional and other relevant standards.

Examinations and prescriptions
Ms A's family complained that Dr B failed to diagnose Ms A's condition as early as it could have been. Ms A consulted Dr B on six occasions between January and June 2002. It is not clear exactly how many physical examinations took place between 25 January and 28 June, when Dr B discovered that Ms A had a pelvic cyst. The clinical notes record only one examination, on 28 June, whereas Dr B stated in his response that examinations were also performed on 25 January, 1 February and 5 June. My independent advisor, Dr Vause, commented that if Dr B did perform examinations on these dates, they were not performed adequately.

Dr B said that on 25 January he found Ms A's lower abdomen and pelvis were normal, and his diagnosis was of "urethral irritation" due to sexual activity. He prescribed a six-day supply of Noroxin. When Ms A's symptoms did not resolve he prescribed co-trimoxazole tablets on 1 February, 13 February and 27 March. Ms A also requested repeat prescriptions for Noroxin on 14 June and co-trimoxazole on 19 June by telephone.

Dr Vause commented that Dr B presumed that Ms A's symptoms were due to her sexual activity; however, there is no note of a new relationship in Ms A's records. "This would be a likely cause of recurrent urinary tract infection or dysuria (painful passing of urine) due to irritation in the vaginal/urethral area, but Dr B had no proof of the former as a cause and could not presume the latter with any certainty." Dr B should also have considered excluding sexually transmitted causes of her symptoms, but there is no evidence that he did so.

Dr B stated that Ms A asked him not to record the new relationship. With hindsight he acknowledges that he should have recorded the details and reassured Ms A that the records were confidential. However, he does not believe it contributed to a delay in diagnosis.

Dr Vause advised that the medication regime Dr B prescribed was not consistent with his diagnosis of urethral irritation:

> "While noroxin would not be considered best practice especially in a first presentation with a urinary tract infection, it is effective and appropriate. Subsequently, [Dr B] pescribed cotrimoxazole, which also is effective in urinary tract infections in general practice, however the scripting is for longer courses (between 30 and 60 tablets), which suggests either [Dr B] was thinking of diverticular disease, or possible prevention of recurrent urinary tract infections. In total, [Dr B] prescribed 160 tablets of cotrimoxazole, which might possibly be considered acceptable management of a recurrent urinary tract infection, but certainly not of urethral irritation. His clinical

> records are poor on this matter and his letter … does not clarify his thinking. This lack of clarity should have alerted him to a need to investigate [Ms A] further in order to establish more clearly a diagnosis."

It was not appropriate for [Dr B] to issue repeat prescriptions for her symptoms without performing further examinations. It is unclear from the records what [Dr B's] reasoning was for the prescribing regime he implemented. The only urine test result available from 25 January was clear.

[Dr B] subsequently explained that the co-trimoxazole was prescribed for diverticular disease and the Noroxin was prescribed for the intercourse-related injuries causing dysuria.

I am advised that at the consultation on 1 February, when Ms A reported pelvic discomfort and further urinary symptoms, a pelvic bimanual examination would have been appropriate. Dr Vause stated:

> "I believe that a reasonable GP when faced with the recurrent dysuria, pelvic pain and a urine result showing no infection, would have carried out further examination either a pelvic bimanual palpation or visualising of the vaginal lining with a speculum. Alternatively further efforts to prove or disprove a urinary tract infection should have been undertaken."

This is consistent with Dr St George's advice to ACC:

> "The repeated prescription of antibiotics without proper examination is inappropriate, and the consequent delay in diagnosis is a result of his failure to examine her."

Dr J also advised ACC that repeat antibiotic prescribing without further investigation is not recommended practice. Nothing in the advice to ACC from Dr J or Dr Holland persuades me that Dr B's response to Ms A's repeat presentations was adequate or appropriate.

Dr Vause stated that Dr B's diagnosis of diverticulitis on 27 March is of concern as his records do not show what symptoms or examination he used to come to that diagnosis. He advised:

> "If diverticular disease was [Dr B's] working diagnosis, I would have expected some other clinical examination findings, vital signs (especially temperature) and some further investigation such as an abnormal blood screen in the notes to support his diagnosis, more so given the number of prescriptions he issued for cotrimoxazole for this problem."

Dr B informed me that he was aware that Ms A had suffered from diverticulitis for a long period of time, and this may explain why his notes do not record her symptoms and examination, but there is no evidence that he reconsidered his diagnosis of diverticulitis in light of her ongoing symptoms.

Dr B confirmed that the diagnosis of diverticular disease was made several years earlier by […]. Dr B said he was familiar with the way in which the diverticulitis manifested itself and that co-trimoxazole, which Ms A often requested by telephone, provided her with relief.

A further factor that Dr Vause noted is Ms A's history of abnormality of her cervix, specifically, cervical dysplasia. He stated, "In conjunction with her negative urine culture results and persistent dysuria, Dr B should have considered a possible connection between the two." However, there is no indication that Dr B considered Ms A's 2002 symptoms might be gynaecological in origin. Dr B stated in his response that a colposcopy and a further smear were performed after an abnormal smear result in 2001, and both were clear.

Dr B explained that "[t]here is no evidence that the pelvic tumour was detectable at an earlier stage". The cyst was asymtomatic. The pain Ms A described was in the left side of the lower abdomen, but the tumour was found in the right iliac fossa. He also stated that there is no evidence that the examinations he performed were inadequate.

I agree with Dr Vause and Dr St George that Ms A's ongoing symptoms required further investigations or examinations to accurately determine the cause. Even if Dr B did perform examinations on 1 February and 5 June, as claimed (but not confirmed by any records), there was a four-month period in which Ms A had ongoing symptoms and no examination was performed.

Dr B recorded on 28 June, when he performed an abdominal examination, that Ms A had a "large pelvic cystic mass". When Dr F examined Ms A on 22 July the mass was the size of a 24-week pregnancy. It is reasonable to conclude that if an appropriate pelvic examination had taken place on 5 June, the cyst would have been palpable.

I note Dr B's comments that Ms A was "very anxious and wary of medical examinations and procedures". I appreciate that this does not make a doctor's job easy, but it does not detract from the basic obligation to undertake a proper examination and investigation of the cause of the patient's symptoms unless the patient (having been given full advice about the risks) declines an examination and investigation.

I accept my expert advice that Dr B's care of Ms A was "deficient due to his failure to adequately examine and investigate Ms A's urinary and abdominal symptoms". Accordingly, Dr B breached Right 4(1) of the Code.

Record-keeping

Medical Council of New Zealand guidelines note that "patient records are essential to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory". The Council's guidelines state that records should be "clear, accurate and contemporaneous" and should "report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". The guidelines also state that "records must be legible and should contain all information that is relevant to the patient's care" and that "information should be accurate and updated at each consultation".

Dr Vause commented:

> "[Dr B's] notes are inadequate in content with [Ms A's] symptoms poorly recorded, examination findings lacking and management plans deficient. In structure, his records lack a problem list; show poor organisation of test results, a lack of recording of test requests and no indication of a follow-up/recall system."

Dr B appears to have confused some dates in his response, and the lack of documented information makes it difficult to establish exactly what occurred at the consultations, what tests were ordered and when the results were received. The notes do not record the examinations that Dr B states that he undertook.

Dr B submitted that "[t]he absence of a record does not mean a physical examination was not carried out". However, it is a fundamental requirement that doctors keep accurate patient records. Accurate records assist by confirming the key details of a consultation and follow-up actions. More importantly, as noted in *Coles Medical Practice in New Zealand* (2001),[8] keeping a proper medical record is "a tool for management, for communicating with other doctors and health professionals, and has become the primary tool for continuity of care". The medical record contains vital information relevant to a patient's history, care and treatment, which may be needed if the patient receives subsequent care from other health professionals. This was particularly important in this case, as Dr B worked part-time, and if one of his patients was seen by another doctor, there was a very real risk that the patient's care could be compromised by the notes not being up to date and complete.

It is often stated by medical defence lawyers, "If it isn't documented, it didn't happen." Baragwanath J made comments to similar effect in his recent decision in *Patient A v Nelson-Marlborough District Health Board*.[9] Justice Baragwanath noted that it is through the medical record that doctors have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk). Doctors whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted.

Dr B also states that the inaccurate dates in his response to the complaint were because he was unable to refer to his records of the consultations because the notes had been given to Ms D and Ms E without copies being made. Obviously, Dr B should have retained copies to avoid finding himself in this situation.

Finally, Dr B's barrister submits that Dr B withheld key information from the medical record at his patient's request (Ms A's new sexual relationship, which led him to diagnose 'urethral irritation' in January 2002) because he felt "bound by the confidence requested of him by a patient of long standing". It can hardly be a breach of confidence for the doctor subject to the duty of confidentiality to record information (even highly intimate information) in the

[8] Edited by Dr Ian St George, and published by the Medical Council of New Zealand.
[9] *Patient A v Nelson-Marlborough District Health Board* (HC BLE CIV-2003-204-14, 15 March 2005).

patient's records. Dr B should have explained why he needed to keep a full record of relevant information, but reassured her that the record was confidential.

It is essential that all relevant information, including appointments, examinations, test requests and results, are accurately recorded to guide future management, ensure continuity of care, and enable audit and review. In my view, Dr B's record-keeping was significantly below professional standards and amounted to a breach of Right 4(2) of the Code.

Opinion: No further action – Dr B

Information
Ms A's family raised concerns about the delay in telling Ms A that she had cancer, and alleged that Dr B did not advise her about her ultrasound results in July 2002.

Dr B requested an ultrasound for Ms A after he discovered the pelvic cyst on 28 June. He received the results on 15 July 2002, which noted that Ms A had an "enlarged, grossly abnormal uterus the features of which favour endometrial pathology and in particular endometrial carcinoma". Dr B advised that he told Ms A of the ultrasound result and of the need for specialist intervention on 17 July 2002.

Dr Vause commented:

> "[Dr B's] actions following the visit and diagnosis on 28-06-02 are entirely appropriate and any perceived delay in action on the part of the secondary services cannot be due to any of [Dr B's] inactions on the matter of the abnormal pelvic scan result."

Dr B did not have a definitive diagnosis when he received the ultrasound report on 15 July. Dr Vause noted that although the ultrasound result was highly suggestive of cancer, "a diagnosis of cancer cannot be accurately made until a definitive test such as histology from a biopsy specimen is available".

In accordance with Right 6(1) of the Code, Dr B should have explained the ultrasound result to Ms A on 17 July and gently shared his suspicions of cancer. By that stage his working diagnosis was cancer, even if it needed to be confirmed by histology and gynaecological review. It is not possible to be sure whether Dr B did explain the ultrasound result and share his suspicions with Ms A. Her family believes that she was not told; had she been, she would have told them. However, as noted by Dr Vause:

> "[P]atients may not tell their family of significantly abnormal test results. ... There can be no certainty that the full contents of the [17] July discussion between [Dr B] and [Ms A] on the ultrasound test results was passed on to the family."

Dr B appropriately referred Ms A urgently for gynaecological review.

The results from the gynaecologist's investigations on 22 July were indicative of cancer, but one of the test results was only mildly abnormal. Dr F made a provisional diagnosis of uterine sarcoma, and arranged for Ms A to have a hysterectomy. The hysterectomy did not take place because of Ms A's rapidly deteriorating condition.

Dr G, surgeon, had the advantage of four test results, including a CT scan confirming the diagnosis of uterine sarcoma, when he advised Ms A of the diagnosis of uterine cancer on 2 August.

In the circumstances, when it is not possible to establish exactly what was told to Ms A, or when, no further action is appropriate in relation to this aspect of the complaint.

Ischaemic leg

A further aspect of the complaint is the diagnosis and treatment of Ms A's ischaemic right leg, which needed amputation on 3 August 2002, following an urgent admission to the public hospital on 31 July.

It is clear that Ms A's leg deteriorated, and the question is whether Dr B should have acted sooner in referring her for an urgent vascular appointment or admission to hospital.

Ms A consulted Dr B about her leg condition on 17 and 29 July. On 29 July Dr B changed Ms A's pain relief from tramadol to pethidine. Dr Vause commented that ischaemic leg pain can be severe, requiring narcotic pain relief, and in this case would indicate Ms A's leg was deteriorating.

Dr Vause noted that Dr B did not record the condition of Ms A's leg very well and the records do not indicate that he examined her leg or assessed the blood supply to it. The records from the public hospital state that on admission, Ms A had no pulses in her leg from the groin down.

Dr B informed me that when he saw Ms A on 29 July she said she was going to see a gynaecologist at the outpatient clinic the next day. He recalled advising her to ask the specialist to look at her leg as well. Dr C had also arranged a referral, which the vascular surgeon had categorised as priority 3, based on the information provided by Dr C.

From the information gathered there is no evidence that on 29 July Ms A warranted an urgent referral or admission. Dr Vause commented:

> "[Dr B's] actions were also appropriate except for the 29 July consultation where there is some uncertainty of [Dr B's] examination and thinking, especially the apparent confusion in his letter 'G' re [Ms A's] seeing the specialist."

As it is not possible to establish the exact condition of Ms A's leg on 29 July, I am unable to conclude whether this aspect of Dr B's care was appropriate.

Nipple excoriation
My advisor also noted that on 8 August 2001 Ms A attended Dr B with nipple excoriation. Dr Vause stated that nipple change is one indication of breast cancer, and investigations such as breast examination and mammography should be undertaken to exclude that possibility, particularly given Ms A's age. There is no indication in the records that any follow-up occurred. Dr B's actions in response to Ms A's nipple excoriation did not form part of my investigation into the care he provided to Ms A. However, I draw his attention to my advisor's comments on this matter.

Opinion: No Breach – Dr C

Ischaemic leg
Dr C first saw Ms A in relation to her leg condition on 16 July 2002. Ms A presented with sore toes, which were pale and blue, with no skin damage. Her calf was sometimes also painful when walking.

Dr Vause commented that Ms A's leg symptoms were not unusual in a patient with peripheral vascular disease, although they are usually seen in patients much older than Ms A.

Dr C identified a problem with the blood supply to Ms A's foot, possibly due to peripheral vascular disease, or as a result of the compression of veins and arteries because of her pelvic cyst. He ordered an ultrasound, which showed no abnormality, and appropriately referred her to a vascular specialist.

Dr Vause advised:

> "The National Referral Guidelines (appendix 1) indicates that at this initial presentation, [Ms A] would be prioritised as being semi-urgent, that is to be seen within 1 month. I note that [Dr C's] referral to the vascular surgeon was given a 5 week wait by the hospital in line with this."

With the benefit of hindsight and the results of the hospital investigations, it appears that the cause of the blood supply being blocked to Ms A's foot may have been a blood clot caused by her heart attack. My advisor stated:

> "Neither [Dr C] nor [Dr B] could have been reasonably expected to have diagnosed or suspected Ms A had suffered a heart attack, for this seems only to have been discovered by the hospital at ECG, the indications for which are not recorded but appear to have been routine."

Dr Vause advised that Dr C's actions in treating Ms A's leg condition were appropriate. I accept my expert advice, and consider that Dr C did not breach the Code.

Opinion: Breach – The Accident and Medical Centre

Vicarious liability
Anything done or omitted by a person as the agent of an employing authority shall in accordance with section 72(3) of the Health and Disability Commissioner Act 1994 be treated as done or omitted by that employing authority, unless it is done or omitted without that employing authority's express or implied authority. Dr B was a contractor at the Medical Centre and as such was an agent of the Centre.

The Medical Centre was required to ensure that all its clinical staff (whether employees or contractors) were practising competently, and familiar with relevant protocols and guidelines. The Centre informed me that "it did not occur to us to take steps to satisfy ourselves" that Dr B was competent, and that "this is the job of the regulatory authorities". I reject this submission for the following reasons.

The Royal New Zealand College of General Practitioners publication 'Aiming for Excellence' (2002) provides guidance to medical practices and states that performance reviews should be carried out on an annual basis for all practice team members. The information from these reviews should be used to address individual and practice training needs. In addition, all practice team members should participate in continuing professional development, which should be planned and documented, and should include structured peer review. Although not specified in the College's indicators in relation to patient information, regular audit of medical records should also be undertaken.

In his advice to ACC, Dr St George noted:

> "I have concerns about [Dr B's] competence: his clinical notes are far from adequate and I am not sure from his letter that he appreciates the importance of physical examination and investigation of recurrent urinary symptoms."

I have been provided with no evidence of steps the Centre took to satisfy itself that Dr B, who was 77 years old and practising on a part-time basis, remained competent to practise, and was keeping clear and accurate patient records. No formal audit of his records or peer review was undertaken or arranged by the Centre. The Centre relied on "informal inquiry with their peers and casual overview of their notes" to be assured of the quality of his medical practice. The Centre apparently does not require that its doctors, including contractors such as Dr B, participate in continuing professional development, peer review, or performance appraisals.

The fact that Dr B was an experienced practitioner did not exempt him from continuing professional development and keeping up-to-date, like any other practising clinician. If the practice managers did not feel confident that they could assess Dr B's competence, they should have sought assistance from colleagues outside the practice who could do so. At the very least, the Centre should have been aware of, and responded to, the unsatisfactory state of Dr B's records.

It was not acceptable in 2002, and certainly is not acceptable in 2005, for a medical practice to absolve itself from responsibility for ensuring that clinical staff are practising competently on the basis that "this is the job of the regulatory authorities". Many doctors are quick to complain about perceived intrusive oversight by the Medical Council. It is far better for problems of individual performance to be detected and addressed by fellow practitioners and managers in the practice setting, rather than wait for an external agency to become involved. As this case illustrates, it is not sufficient to rely on the fact that a doctor is experienced and liked by his patients as evidence of his or her current satisfactory performance.

In these circumstances, the Centre is vicariously liable for Dr B's breach of Rights 4(1) and 4(2) of the Code.

Other comments

Practice record-keeping
In the course of my investigation I requested information from the Centre regarding its system of record-keeping, including the ordering of tests and handling of test results.

The Centre confirmed that some of its doctors prefer to make handwritten consultation records and others prefer to make electronic records. All doctors have access to computer terminals at the time of consultation and it is their choice how they record their clinical notes. Manual records are filed next to the reception area for easy access. If investigations are ordered on the computer, electronic request forms are generated and attached to the physical file. The Centre stated that an audit trail is achieved electronically in accordance with the Royal New Zealand College of General Practitioners discussion papers "Interim Advice on Minimising Error in Patient Test Results" (2003) and "Managing Patient Test Results" (2003).

Dr Vause advised that he had concerns about the record system at the practice. He noted that the "presence of two sets of clinical notes … resulted in a splitting of important clinical information and increases the difficulty in understanding the time line of events and the decision reached by the doctors". He also noted that Dr B's notes do not record handwritten investigation requests, and that the separation of his notes from the PMS system at the medical centre makes it difficult to implement an effective test results audit trail.

I agree with my advisor that the notes in this case are difficult to follow because of the two record systems. It relies on a doctor who primarily uses the computerised system also checking the manual records; and a doctor who normally keeps handwritten notes also checking the computer record. There is clearly greater potential for important information to be overlooked if it is "split" in this way.

The concern that information could be missed when split between the two systems is reflected in Dr C's careful (but laborious) practice, whenever he assessed Ms A, of making entries in both the manual records and the electronic record – he knew that Dr B was Ms A's usual doctor and primarily used handwritten records, but the electronic record was important should Ms A consult other doctors.

The Centre stated that all medical practices in New Zealand contain a mix of physical material as part of the patient record, and that no practice is entirely paperless. While I accept that all medical practices in New Zealand have a mix of physical files and electronic records, it is questionable whether the majority of medical practices in New Zealand simultaneously continue to generate a mix of manual and electronic *consultation* records. Dr Vause commented that most practices do not have a double system of electronic and handwritten notes (less than 20% store full clinical notes on paper as well as electronically).

Standards New Zealand NZS 8153:2002 "New Zealand Standard Health Records" (the Standards) (2002) provide specific guidance to organisations on the integration of medical records, by setting out the standards required for the content and structure of health records. Organisations should have a policy for how health records within that organisation are structured, to allow for rapid access to the relevant parts of the records. The Standards require all records to be integrated, and recommend that integration can be achieved by ensuring:

(a) All records are in a single file/document. Where this is not possible, organisations need to have a written policy for the management and creation of files, including guidance on how the files are linked, and which file is used for current information.

(b) Each member of the team documents health information in a single continuous record for each consumer/patient.

(c) All parts of the record, including both electronic and physical components, are clearly linked in order to locate them for retrieval.

Integrated records and adequate record-keeping are important aspects of a quality health record. The Standards are clear that the optimal way for organisations to integrate records is to keep records within a single file or document, document health information in a single continuous record, and clearly link all records. Where organisations are unable to do all three, they should have a clear written policy in place for the management, creation, and linkage of patient information.

While there is no evidence in this case that Ms A's care was compromised by the record system at the Centre, I remain concerned that having two record systems is not sensible or safe, and potentially puts patients at risk.

Defensive medicine

The Centre suggested that this case "highlights the generational change between the doctor with his mind on his patient's needs and a doctor with an eye for careful documentation and

defensive medicine. Both doctors are being careful; it's just the reasons for their caution differ."

This claim is ill-founded. Being focused on a patient's needs, and proper records, are both important attributes of a careful doctor. If Dr B had taken due care in this case, he would have kept his mind on Ms A's needs, undertaken and documented the examinations and investigations she needed, and prescribed appropriate medication. He failed to do so, and reference to "generational change" cannot disguise that fact. What Ms A deserved was good quality medical care, not poor care *or* defensive medicine.

Actions taken

Dr B
Dr B provided a written apology to Ms D and other members of Ms A's family, in which he stated:

> "I am happy to offer my apology to you in writing and on past occasions I have expressed my sympathy to you and others in [Ms A's] family for your loss.
>
> I was very saddened by [Ms A's] death and as you know she was a patient of mine for a long time. I am sorry for any distress that may have been caused to you. I was at all times doing my best for [Ms A]."

Dr B has reviewed his practice in light of this report. Dr B retired from general practice in May 2005, but wishes to continue to provide occasional sports medicine services in his role as honorary doctor to two sports organisations.

The Accident and Medical Centre
On a visit to the Accident and Medical Centre on 20 June 2005, I confirmed that the Centre has:

- reviewed its record-keeping system in light of the concerns raised in this report
- reviewed its policies and procedures to ensure that medical and nursing staff keep clear and accurate patient records.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand with a recommendation that the Council consider whether a review of Dr B's competence is necessary and whether conditions should be imposed on his occasional sports medicine practice.

- A copy of this report will be sent to 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.

Non-referral to Director of Proceedings

A number of features of this case indicate that a referral to the Director of Proceedings may have been warranted. The fact that Dr B has a long and unblemished record of medical practice, and an excellent reputation, cannot disguise the fact that his care of Ms A was deficient. I note the recent judgment of *Campbell, R (on the application of) v General Medical Council*,[10] in which the English Court of Appeal ruled that evidence of a doctor's previous good record should be taken into account in mitigation when deciding what penalty to impose, but not when deciding whether a doctor has been guilty of professional misconduct. The Court of Appeal noted:

> "Committees should not use personal mitigation to downgrade what would otherwise amount to serious professional misconduct to some lesser form of misconduct … the number and strength of the practitioner's testimonials will almost invariably be irrelevant; they will usually be relevant to the question of appropriate penalty."

Venning J made similar comments in the High Court of New Zealand in the case of *McKenzie v Medical Practitioners Disciplinary Tribunal*,[11] when he rejected the argument that there was a subjective element to the test of whether a disciplinary finding is merited in any given case. The New Zealand Court of Appeal recently endorsed *McKenzie* in *F v Medical Practitioners Disciplinary Tribunal*,[12] noting that the first stage is "to decide if there has been a departure from acceptable standards". Clearly, in this case Dr B's conduct departed from acceptable standards.

[10] *Campbell, R (on the application of) v General Medical Council* [2005] EWCA Civ 250 (11 March 2005).
[11] *McKenzie v Medical Practitioners Disciplinary Tribunal* (HC AK CIV2002-404-153-02, 28 May 2003).
[12] *F v Medical Practitioners Disciplinary Tribunal* (CA213/04, 4 May 2005).

However, I have considered Dr B's response (he has apologised and reviewed his practice), and noted that he has retired from general practice, but wishes to continue very limited sports medicine practice. Given these factors, there is no public interest in further proceedings, and I have not referred Dr B to the Director of Proceedings.

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