General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 01HDC01078)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A (deceased)	Consumer
Dr B	Provider / General Practitioner
Ms C	Complainant / Consumer's sister
Ms D	Consumer's partner
Dr E	General Practitioner
A Public Hospital	Provider

Independent expert advice was obtained from an independent rural general practitioner, Dr Janne Bills.

Overview

Mr A was a 57-year-old Maori man who consulted his general practitioner, Dr B, for many years about his back pain. However, from about June 1999 Mr A's back pain levels increased significantly. Dr B prescribed various combinations of painkillers, but Mr A continued to have pain. In December 1999, Mr A was found to have terminal cancer of the lung. Following radiation treatment he became very ill and his family took him to see Dr B. Dr B diagnosed a chest infection, prescribed antibiotics and arranged home care. He did not admit Mr A to hospital.

Mr A's family sought a second opinion from another general practitioner a few hours later. This general practitioner diagnosed pneumonia and arranged for Mr A's urgent admission into hospital. Mr A was actively treated for his pneumonia over a six-day period. He was due to be discharged home when he suddenly died.

Complaint

On 25 January 2001 the Commissioner received a complaint from Ms C on behalf of her late brother, Mr A, about services provided to him by general practitioner Dr B. The complaint was that:

- *Mr A frequently consulted Dr B about his back pain in the two years preceding his death. The cause of his pain was not fully investigated, and his symptoms were not adequately treated.*
- *Ms D, Mr A's partner, raised the possibility of Mr A having cancer on a number of occasions with Dr B. He told her that it was "nothing as serious as that" and did not investigate her concerns.*
- *On 4 February 2000 Mr A's condition deteriorated. He was taken to Dr B's surgery. Dr B did not fully examine Mr A and did not arrange for his admission to hospital. Mr*

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> *A consulted another doctor, later that morning, who immediately arranged his admission into a public hospital.*

An investigation was commenced on 19 April 2001.

Information reviewed

- Mr A's medical records supplied by general practitioner Dr B
- Mr A's medical records from general practitioner Dr E
- Mr A's medical records from the public hospital
- Information supplied by Ms C
- Information supplied by Ms D

Information gathered during investigation

Medical background
Mr A had a medical history of renal cell carcinoma (cancer), treated with left nephrectomy (removal of the kidney) in the 1970s and a prostatectomy (removal of his prostate) in 1988. He was a lifelong non-smoker. Mr A's medical records show that from about 1987 he began to complain of lower back pain, requiring some time off work due to his back pain in 1988.

In 1992 Mr A transferred his care to Dr B, general practitioner. Dr B received Mr A's medical notes dating from 12 March 1987. However, although Dr B was therefore aware of Mr A's previous operations for cancer, there was no information about the type of tumour, when the surgery took place, follow-up arrangements, or histology reports (describing the malignancy of the cancer).

During the years that Mr A consulted Dr B, he frequently renewed his sickness benefit, which he claimed on account of his previous operations and osteoarthritis. Mr A also sustained a number of injuries to his back. Dr B recalled Mr A's consultations as follows:

> "…
>
> Mr A had been a patient at […] Medical Centre since 2/6/92. He always presented either for a renewal of his Community Wage certificate or for ACC related complaints. He was not keen on any medications and just wanted his certificate to be renewed. He never made appointments and just popped in whenever it suited him or when the Community Wage certificate was due for renewal. We always did our best to fit him for consultations. In addition, he hardly paid for the consultations and on numerous occasions, he was not charged any fee as he never paid. On a very few occasions, he

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was charged a very minimal fee which he never paid, and subsequently these had to be written off as bad debts. He appeared to consider health matters of low priority. He did not want to spend money on medications or further investigations. He always came alone, except on a very few occasions, when he was accompanied by his partner [Ms D]. He was a very short tempered person, and would not accommodate anything else, apart from what he wanted, for example, just filling his medical certificate etc. All his referrals were to [the public hospital] for x-rays and Specialist's clinics, which were free, as he did not want to pay for any part charges etc.

…"

On 26 March 1996 Mr A had x-rays which showed degenerative changes (deterioration) in his lumbar spine (lower back):

"26/3/96 LUMBAR SPINE – Examination 1:
Moderate degenerative lipping [bony overgrowth] at the L3/4 level. No localised loss of disc space seen. Only minimal degenerative changes elsewhere."

On 16 October 1997 Mr A presented to Dr B with a sore back after lifting a heavy table a few days earlier.

1998
On 12 May 1998, Mr A saw a locum at Dr B's surgery following a further injury to his back, and was put on ACC.

1999
Mr A re-injured his back on 2 June 1999 and complained of lower backache and right shoulder pain. He saw Dr B, who prescribed slow-release diclofenac (an anti-inflammatory painkiller) 100mg daily for a month and referred him to a physiotherapist. The physiotherapist who treated Mr A wrote back to Dr B suggesting that an x-ray would be appropriate, as Mr A had night pain which had not responded to treatment.

Her letter to Dr B advised the following:

"RE [Mr A]
[Mr A] has a thoracic dysfunction [centre of his back] that so far is not responsive to therapy. Pain is worse sleeping and on couch at night while sitting. I believe a significant contribution to his pain was due to postural factors and I have discussed this with [Mr A]. However could you please investigate the possibility of thoracic pain being referred from other structures or causes. If no cause apart from thoracic spine can be found I would be happy to see him again."

Mr A had the x-ray on 1 July, which stated the following:

"#3 CERVICAL AND LUMBAR SPINE:
Technical difficulties with this patient.

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The cervical spine shows quite marked loss of disc space and osteophylitic lipping most marked at the C3/4, C5/6 and C6/7 levels. Minor degenerative changes in the interlaminar joint. Only minor encroachment on the intervertebral foraminae.
LUMBAR SPINE:
Increased sclerosis [hardening] of the body of T12. Prostatic secondaries which have to be excluded, although the appearance could also represent Paget's Disease despite non-expansion of the vertebrae.
A bone scan may be of assistance. Moderate degenerative lipping at L3/4."

The results were faxed through to Dr B on 13 July, and he faxed a referral letter for Mr A to have a bone scan at the public hospital that same day. Dr B's referral letter stated the following:

"Xray L/S spine on 1/7/99 → increased Sclerosis T12 Lower backache
?Osteoarthritis
?Pagets
Prostatic secondaries."

The bone scan result (on 5 August 1999) revealed bony abnormalities which the radiologist advised he thought was probably Paget's disease (deformity of the bones). However, he did not rule out skeletal metastases (cancer secondaries). He advised the following:

"# WHOLE BODY BONE SCAN 05/08/99:

Absent left renal activity is noted and on discussion with the patient [Mr A] explains this is a nephrectomy in the 1970s on the basis of renal cancer. This is not documented in the referral.

There is however, significantly increased radio tracer uptake at T12 and to a lesser extent involving the entire sacroiliac joint. These findings are entirely consistent with Paget's Disease. However, skeletal secondary at T12 can not be fully excluded scintigraphically. Radio tracer distribution otherwise throughout the axial and appendicular skeleton is within normal limits."

On 2 September 1999 Mr A once again complained of back pain to Dr B. Dr B prescribed codeine phosphate (a painkiller) 30mg twice daily in conjunction with diclofenac and referred Mr A to the Orthopaedic Department at the public hospital for further investigation into the cause of his pain. Dr B's referral letter queried Paget's disease or metastases:

"1) Lower backache
2) Pains behind R scapula
Recurrent lower backache pain
Cervical spine and R shoulder lately worse
… please find copy of bone scan results. ?Pagets Disease ?metastatic disease
Grateful for further investigations and management please. No relief with physiotherapy.
Diclofenac

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Losec 20 mgs daily Codeine PO 30 BD."

The referral was not actioned by the public hospital. The referral is recorded in Dr B's notes and there is a copy in Mr A's file; however, there is not a copy in Mr A's public hospital notes. The public hospital stated that it did not receive this referral.

On 23 September Dr B recommended an osteopath to Mr A (to treat his back pain), but Mr A did not pursue this.

On 13 October Mr A returned to Dr B's surgery complaining of a sore right shoulder and difficulty with sleeping. Dr B ordered some blood tests and prescribed the following medications: Panadeine (painkiller) 2 tablets three times a day, Brufen Retard (painkiller) 800mg two daily, Imovane (sleeping tablets) 7.5mg nocte and an injection of morphine (painkiller) 10mg IV. Mr A's blood test results showed that his ESR levels (which indicate whether infection is present) were normal. However, the test for Paget's disease was slightly elevated.

A month later, on 15 November, Mr A consulted Dr B about his ongoing pain. Dr B referred Mr A to the Rheumatology Clinic and also prescribed more Imovane tablets to assist with sleeping. His referral letter advised the following:

> "Severe osteoarthritis
>
> Osteoarthritis Cervical Spine and lower back. Pain worst over last 3-4/52 radiating to back of R scapula. Tendermost C/Spine (on NSAID [anti inflammatory medication])
> PH [patient history] 1) L nephrectomy for CA kidney
> Grateful for your opinion and further management please
>
> …"

This referral did not result in any further tests. A copy of the referral letter is recorded in Mr A's medical notes, but is not recorded in Mr A's public hospital notes.

On 4 December 1999 Mr A consulted Dr B again about his back pain. The Orthopaedic Department at the public hospital had still not seen him. Dr B recorded in Mr A's notes that he was making another referral to the Orthopaedic Clinic. A copy of this referral letter is not in Mr A's medical record; however, it is in his public hospital notes. The referral letter states:

> "…
> Severe osteoarthritis c/spine. Persistent pains. Pain not controlled on Brufen R + Codeine PO4. Xray c/spine → marked loss of disc space and osteophylitic lipping most marked at C3/4 C5/6 + C6/7.
> Grateful for your assessment and further management please. Night sweats +
> Needs further investigation
> …"

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Dr B changed Mr A's pain relief once again in an attempt to manage his pain, prescribing two 60mg tablets of dihydrocodeine tartrate (a strong analgesic) twice daily and 10mg amitriptyline (for muscle spasm) at night.

On 21 December Mr A presented again, complaining of back pain. He was accompanied by his partner, Ms D, and a family friend. This time Dr B telephoned the orthopaedic registrar at the Emergency Department of the public hospital and discussed whether Mr A could be seen the same day. Apparently the registrar was reluctant. Dr B said that it was only because he was so firm that he was able to persuade the Emergency Department to see Mr A. Mr A's sister, Ms C, disputes this. She said Dr B organised an urgent referral to the Emergency Department only at the insistence of Ms D and the family friend.

Mr A was seen at the Emergency Department that day. Ms C stated that the duty doctor was "reluctant to investigate" and again it was only at the insistence of Ms D and the family friend that Mr A was x-rayed. Mr A's chest x-ray showed he had advanced cancer in his lungs. The histology was unclear but, given his medical history, the provisional diagnosis was metastatic renal carcinoma (secondaries from his previous kidney cancer). The x-ray report stated the following:

> "#6 CHEST:
>
> There is a large mass in the posterior segment of the right upper lobe together with at least two smaller masses in the right lower lobe and further smaller mass in the left upper lobe. Appearances are consistent with lung metastases. Slightly enlarged heart, cardiothoracic ratio 16/32, but no signs of cardiac failure. Some minor consolidation in the right lower lobe could indicate active infection as well."

Mr A was admitted to hospital and charted morphine elixir (fast-acting morphine syrup for pain). A bronchoscopy (examination of the bronchi) was undertaken and a tissue sample removed from his upper lung. He was discharged the next day, at his request, so he could spend Christmas with his family. The public hospital wrote to Dr B on 23 December and advised him that lesions had been found on Mr A's chest x-ray in the "right upper and lower zones". Treatment was to await the histology results.

2000

On 18 January 2000, Mr A's biopsy results confirmed his diagnosis:

> "MICROSCOPIC DESCRIPTION
>
> …
>
> I gather that the patient has a history of previous renal cell carcinoma. The original histology of the renal cell carcinoma was not reported at this laboratory. The differential diagnosis includes metastatic renal cell carcinoma and hepatocellular carcinoma. Given the history of previous renal cell carcinoma, the histologic features favour metastatic renal cell carcinoma.

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DIAGNOSIS
LUNG: TUMOUR CONSISTENT WITH METASTATIC RENAL CELL CARCINOMA AS SUGGESTED CLINICALLY."

Mr A was readmitted to the public hospital for radiotherapy treatment on 20 January 2000. On 1 February 2000 Dr B wrote a medical certificate for Mr A, stating that his incapacity was the result of metastatic disease. On 3 February Mr A was discharged back home to the care of his partner, Ms D.

Examination on 4 February 2000
During the evening of 3 February Mr A's condition deteriorated. When his sister, Ms C, visited him the next morning she was extremely concerned about him. Ms C informed me that her brother was lying in bed, and was clammy and grey. He was having trouble breathing, perspiring heavily, and had coughed up a substantial amount of blood.

Ms D and Ms C drove Mr A to Dr B's surgery. The three-kilometre drive took them nearly half an hour because of Mr A's acute distress and pain. Ms C helped her brother into the surgery and it was only a few minutes before he was seen by Dr B. Neither Ms C nor Dr B can recall what time Mr A was seen, but Ms D estimates that it would have been about 8.30am–8.45am.

Ms C remained present during Dr B's examination of her brother. She was concerned that Dr B only examined Mr A briefly and did not take his temperature. Dr B's notes of his examination of Mr A state:

"Sharp pains Lower chest and abdomen. Coughing up T38°C
phlegm with tinge of blood
Abo soft Tenderness … RIF Amoxil 500mg TDS
1. Constipated Chest clear Microlax enema
2. Gastritis
On leave from hospital."

Dr B diagnosed a chest infection and prescribed Amoxil (antibiotics) and a Microlax enema (medication for constipation). He faxed a referral for home help through to Community Health Services at the public hospital. Ms C recalled that Dr B told Mr A "to go home and rest". She does not recall him discussing a referral for home help.

Dr B recalled this consultation as follows:

"I was aware that the patient was suffering from metastatic disease and was not surprised that he had developed sharp, pleuritic type chest pains and blood in the sputum. I considered he had metastasis in the lung. I was not asked to send a patient into hospital, nor was it hinted at, or suggested. If it had been suggested or admission requested, I would very happily, have sent him to the hospital. My experience with overwhelming majority of Maori patients in particular, is that they wish to stay at home with the whanau when they are terminally ill. He was ill, but I thought at that time, that he could manage at home with the treatment I prescribed. I also organised community

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district nurses during the consultation, to get home help and any other assistance needed.

I am extremely sorry if I misunderstood the wishes of the patient and his whanau during the consultation. I sincerely thought that he was dying, was on appropriate treatment, with no prospect of hospital treatment improving his situation. Unfortunately, I am so far unable to read minds and while admission to hospital was certainly justified under the circumstances, if they desired this, I was not made aware of their desire for admission. If they had not desired admission for him, it was equally justified to keep him at home on antibiotics with district nurse assistance. …"

Ms C was very unhappy on leaving Dr B's surgery. She advised me: "In my opinion I really believed that [Mr A's] condition warranted readmission to hospital." However, she took Mr A to a pharmacy to fill his prescription. The pharmacist confirmed that he dispensed medication for Mr A "sometime in the morning" that day. No record of the exact time was kept.

Ms C had an appointment later that morning to see her own general practitioner, Dr E, at another surgery; however, she was so unhappy with her brother's condition that she decided to give him her appointment instead. The appointment was in the late morning, around 11.00am.

Dr E examined Mr A in the presence of Ms C and diagnosed pneumonia. He told Ms C to take Mr A immediately to the public hospital. He sent a referral letter to Oncology at the public hospital, which stated:

"Pneumonia
Recent had Rx [treatment] for lung lesion. On dexamethasone.
O/e Temp 39
Creps [crackles] R lung espec [especially]. But scatters. Can you assess and Rx [treat]."

Dr E recalled the consultation as follows:

"I saw [Mr A] that day to do an Invalid Benefit Assessment on February 4, 2000. He was febrile [abnormal temperature] and had pneumonia. He was extremely unwell that day, and was having radiotherapy for cancer of the lung. He was sufficiently unwell that urgent hospital care was organised for him."

The public hospital
Ms C drove Mr A immediately to the public hospital where he was admitted with a diagnosis of right-sided pneumonia. The oncology notes state:

"[Mr A] attended clinic today. He was referred in by his general practitioner with problems regarding 24 hour history of increasing of breath, pleuritic chest pain and fevers. He also has a worsening cough productive of brownish, red sputum. When seen in the clinic today, there was decreased movement in the right chest. Left chest has bronchial breath sounds at the left base and chest x-ray has confirmed some abnormality

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> in this area. With this in mind, he has been admitted to the ward today for intravenous antibiotics."

Mr A was commenced on IV (intravenous) Augmentin (antibiotic) in addition to his usual medication. The next morning, 5 February 2000, at 5.50am Mr A's oxygen intake was 89% (low) and his temperature was 35° (low). He complained of feeling short of breath after a coughing episode, passing "browny red sputum". He was given an oxygen mask to assist his breathing and improve his oxygen levels. On 6 February his notes record:

> "Still coughing up browny red sputum. Obs Afebrile. BP 102/76 [normal/low] O2 sats 92 air."

On 7 February Mr A was noted as being more independent with his personal cares. By the next day he was described as independent with his cares and mobilising around the ward.

At the ward round on 9 February, a radiation oncologist thought that Mr A's condition had improved sufficiently for discharge to be considered for the next day. IV antibiotics were ceased and Mr A was changed to oral Augmentin.

The possibility of discharge was discussed with Mr A at the ward round the next day, 10 February; however, Mr A did not want to be discharged until the following day as the social worker was assisting him with some financial issues. Later that afternoon, Mr A was reported as being independent with his cares. However, he complained of having difficulty with swallowing and having "a swelling to the left side of his neck". He complained again later that day of difficulty with breathing and was seated upright with the fan, which seemed to give him some relief. He was also coughing up "dirty sputum" which he told staff "was clearing".

At 2.00am on 11 February, Mr A was discovered by nursing staff with his eyes rolled back and slow, laboured breathing. A cardiac arrest call was made but, given Mr A's terminal condition, it was decided that it was more appropriate to keep him comfortable rather than actively resuscitate him. Mr A's family were contacted and he passed away in their presence at 6.45am.

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Independent advice to Commissioner

The following expert advice was obtained from an independent rural general practitioner, Dr Janne Bills:

"I have been asked to advise the Health and Disability Commissioner on the complaint file 01/01078, giving independent advice on whether [Dr B], general practitioner, provided an appropriate standard of care to [Mr A] (deceased). After reading the accompanying information from [Ms C], [Ms D] and [Dr B] provided from the advocacy meetings, the clinical notes from the general practice of [Dr B], notes from [the public hospital], the letter from [Dr E] and the summary from your office, I make the following comments on the issues as outlined.

1. ***[Mr A] frequently consulted [Dr B] about his back pain in the two years preceding his death.***
   a. ***The cause of his pain was not fully investigated.***
   b. ***His symptoms were not adequately treated.***

Perusing the clinical notes even as far back as 1987, [Mr A] had presented with recurring thoracolumbar backache. This had been significant and resulted in him being off work from 1988 (almost as far back as the clinical notes go) and at times required significant analgesia. Xrays on 26/3/96 showed degenerative changes in the lumbar spine. These changes had progressed significantly by 1/7/99 when [Mr A's] back pain began to escalate. He had seen [Dr B] on 2/6/99 because of lower backache and R shoulder pain and he was given a course of anti-inflammatory tablets and referred to a physiotherapist. [Mr A] did not improve and the physio referred him back to the GP suggesting an Xray because of 'night pain', which was unresponsive to treatment. It was at this time that the Xray revealed suspicions of sclerosis of the T12 vertebrae and the possibility of a metastasis or Paget's disease. The radiologist from [the public hospital] suggested that a bone scan would help and [Dr B] sent a request for this on 13/7/99 after the Xray result was received and the patient notified on his mobile phone (from [Dr B's] summarized notes). The bone scan was undertaken on 5/8/99. Unfortunately this result did not help [Dr B] as the radiologist identified the bony abnormalities as being due to Paget's disease, a non malignant disease of bone where the bones soften over a period of years and become deformed. However the radiologist did mention that a skeletal metastasis could not fully be excluded.

When [Dr B] next saw [Mr A] on 2/9/98, he prescribed codeine phosphate 30mgm twice daily in conjunction with the diclofenac to help manage his pain. This was an entirely appropriate drug regime to use at this time. He also sent off a referral to the Orthopaedic Department of [the public hospital], asking for further investigations to determine a firm diagnosis, querying Paget's or metastatic disease. [Mr A] presented twice in the next 3 weeks for ACC certificates, the latter one for temporary clearance for work. He re-presented on 13/10/00 still complaining of a painful R shoulder and difficulty sleeping. [Dr B] then ordered some blood tests, which could have helped in the diagnosis of metastatic disease. Unfortunately the ESR was normal and the tests for

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Paget's disease were elevated and had been on two previous occasions since 1994. The results of the investigations i.e. the bone scan and bloods did not help [Dr B] distinguish between osteoarthritis, Paget's disease and metastatic cancer. With the patient's increasing pain, [Dr B] then referred him to the Rheumatology clinic on 13/11/99. The patient was still managing to work 2 days per week as a security guard at this time. He added Imovane to his medication regime. With unrelenting pain in his shoulder, the patient presented 3 weeks later to [Dr B] on 4/12/99 and had the analgesia changed to DHC 60mgm 2 bd and amitriptyline 60mgm. Another referral to the orthopaedic clinic was made, although I am unable to find this referral. This referral was made 3 months after the initial referral.

On 21/12/99, the patient re-presented with a lot of pain, and the patient was referred to the orthopaedic registrar to be seen in the Emergency Department despite resistance from the hospital for the patient to be seen.

Summary

a) Set against a long history of chronic back pain, I would state that I believe that [Mr A] was investigated appropriately as he presented. The back pain and shoulder pain appeared to take on an escalating picture as well as the development of night pain during 1999. I think it is most unlikely that any GP would have picked up on the possibility of 'cancer' prior to the appointment on 2/6/99 or before receiving the Xray result of the cervical and lumbosacral spine, ordered on 24/6/1999. The resulting bone scan report and subsequent blood results did not help to support the metastatic diagnosis and therefore made [Dr B's] job much more difficult to confirm a 'cancerous' cause for [Mr A's] pain. However over the next 3 months he sent off three referrals to [the public hospital], and the first one sent on 2/9/1999 clearly stated that he wished to eliminate a metastatic cause. I believe the failure of the hospital to recognise the urgency of this referral also played a significant part in the delay in diagnosis. The comment by the hospital doctor that if they had been able to see [Mr A] 18 months earlier then they may have had a chance to save him (from [Ms D's] letter) may have helped to fuel this complaint against [Dr B]. This is particularly difficult as a GP is unable to access CT scans or MRI scans without a specialist approval. It is possible if [Dr B] had rung one of the orthopaedic surgeons earlier, it may have fast tracked the referral. However it appeared to be a difficult job even in December to get someone to see [Mr A] at [the public hospital] and even when seen, there was some difficulty identifying the cause of his pain as resulting from metastatic cancer. This case was certainly not an easy one to diagnose. I believe that [Dr B] ordered the appropriate investigations at the time and took the advice of the radiologist re ordering a bone scan. Consideration of the chest Xray earlier may have helped him reaching a diagnosis sooner. However it is always easy to say this in hindsight. Also the renal tumour had occurred almost 30 years previously and there is no information in the notes and letters from the urology specialist that mentions a prostatic malignancy, which is unusual. The letter of 1/7/87 from the urology registrar suggests a more benign prostatic hypertrophy rather than a malignancy. Without investigations to back up a diagnosis of a new malignancy, I believe [Dr B] organised the initial investigations for [Mr A] appropriately.

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b) Delay in the diagnosis meant that morphine was not introduced on a regular basis until December [1999] when the final diagnosis was made. This meant that [Mr A] may have been undertreated for 4-6 weeks. [Dr B] appropriately chose agents with increasing analgesic properties, initially Diclofenac, then added in Codeine, Imovane, then changed to dihydrocodeine (DHC) and amitriptyline, which is an acceptable regime for moderately severe musculoskeletal pain and moderately severe pain in malignancy. Most GPs would not be comfortable prescribing regular morphine for purely chronic musculoskeletal complaints, where no definite diagnosis of active malignancy had been made. However it is difficult to know how and when the family expressed their concerns prior to 21/12/1999, the date of admission, as there is no documentation of this i.e. accompanying patient to the consultation or telephone calls direct to the doctor. Some stoical patients are not the easiest people to assess levels of pain. I find it extremely helpful to obtain information from their close relatives regarding the patient's level of functioning as they see them for many hours of the day and the GP only for 15 minutes or so.

Summary
Information received from the family, particularly [Mr A's] partner describes [Mr A's] discomfort and I would agree that [Mr A's] symptoms were probably not adequately treated for the 4-6 week period prior to diagnosis as bone pain is very severe. However, from the evidence that [Dr B] had prior to [Mr A's] admission on 21/12/1999, the analgesia he prescribed was appropriate.

2. ***[Ms D] raised the possibility of cancer on a number of occasions with [Dr B] and felt he did not take her concerns seriously or adequately investigate her concerns.***

It is difficult to get any time line from [Ms D's] letter as to when she approached [Dr B] about her concerns re [Mr A]. There is no mention of any of these conversations in [Mr A's] clinical notes. It is not clear whether she attended some of the consultations with [Mr A] or phoned [Dr B]. However, it is obvious from her letter that she had felt unheard by [Dr B]. If there had been more communication by [Dr B] about what he was planning to do and what investigations he was able to order as a GP, [Ms D] would have been aware that certainly in September he sent a referral to [the public hospital] clearly asking to eliminate metastatic cancer. If a referral could have been accessed quickly, the diagnosis may have been made sooner. I cannot comment on why in the Rheumatology referral he did not mention metastatic disease, but I can only assume that the bone scan and blood tests had not given any suspicion of cancer. Also with the patient's long history of back pain and severe osteoarthritic changes, [Dr B] felt it was more likely that the pain was resultant from severe osteoarthritis and Paget's disease, which some results did confirm. From the information given to me, I do not feel I can comment further on this complaint.

3. ***On 4 February 00, why did [Dr B] not fully examine [Mr A] and arrange for his admission to hospital?***

From reviewing [Dr B's] notes, it is apparent that he became aware of [Mr A's] metastatic renal disease between 19/1/00 and 1/2/00 as the medical certificate reflects a

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new diagnosis on 1/2/00 (compared to 19/1/00). [Dr B] would have known this on 4/2/00 when [Mr A] presented to him for the last time with a fever and a productive cough, tinged with blood, suggesting pneumonia. Having just ceased radiotherapy, he was at risk of infection. [Dr B] did a brief examination that day and diagnosed a chest infection, but documented in the patient's notes that the chest was clear. No temperature was recorded. He prescribed the antibiotics, made the comment that the patient was on leave from hospital. In his letter he makes mention that the patient could go directly to the ward while on leave, but that was not communicated to the patient and family.

I believe that at this appointment, [Dr B] did not ascertain the distress of the patient and his family, who were obviously struggling to come to terms with the diagnosis of cancer and [Mr A's] rapidly deteriorating condition. The family were concerned as to why [Dr B] did not recognise how seriously ill [Mr A] was that day and why [Mr A] was not admitted to hospital. The patient subsequently saw another GP who diagnosed R sided pneumonia the same day. Right sided pneumonia was also noted by the admitting doctor at [the public hospital] later in the day of 4/2/00.

Summary
In this complaint, I believe GP care of the patient and family fell considerably short of 'best practice' …"

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 1
Right to be Treated with Respect

3) *Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.*

RIGHT 4
Right to Services of an Appropriate Standard

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

RIGHT 6
Right to be fully informed

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

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…

(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Opinion: No breach – Dr B

Diagnosis of cancer

Mr A's sister, Ms C, is concerned that despite her brother's frequent consultations with Dr B complaining about pain, and his history of cancer, Dr B did not diagnose the cause of his pain. Mr A was subsequently diagnosed by the public hospital with terminal cancer.

Mr A had received treatment for back pain since about 1987. He transferred his care to Dr B's surgery in 1992. In March 1996, Mr A had x-rays taken which showed degenerative changes in his lumbar spine. His symptoms progressively worsened, and he had a number of back injuries, which he was treated for, as well as osteoarthritis.

When Mr A presented with pain on 2 June 1999, Dr B referred him to a physiotherapist. She recommended an x-ray as his symptoms did not respond to her treatment and he had pain at night. Dr B organised this promptly and Mr A had the x-ray on 1 July 1999. The radiologist suggested Paget's disease could be a possible cause for Mr A's back problems, and recommended a bone scan. Dr B organised this the same day. His referral letter queried "Pagets disease or prostatic secondaries". However, the bone scan results were not conclusive. Paget's disease was identified as a likely cause, but spinal metastases were not ruled out. Dr B referred Mr A to the Orthopaedic Department at the public hospital on 2 September 1999, for investigation to exclude metastases. However, the public hospital stated that it did not receive the referral.

Dr B made a further referral on 4 December but this time he did not specifically refer to Paget's disease or metastases. He changed Mr A's pain management regime again. On 21 December Mr A re-presented to Dr B, who referred him to the Emergency Department at the public hospital. He was seen that day and was admitted when an x-ray showed that advanced metastatic lung cancer was the likely cause of his pain.

Mr A's family expressed particular concern about Dr B's referral to the public hospital on 2 September in which he asks for cancer to be "excluded". Mr A's family seem to believe that Dr B had "ruled out" the possibility of cancer, thus delaying Mr A's diagnosis. This is not the case. By asking for cancer to be "excluded", Dr B was not suggesting that this possible diagnosis should be ignored, but rather that further investigations should be undertaken to determine whether cancer was causing Mr A's symptoms. If cancer was not causing Mr A's pain, then it could be "excluded" as a diagnosis, and other (less serious) causes investigated.

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

HDC

My advisor considers that Dr B appropriately investigated the causes of Mr A's pain. She advised that it was unlikely that any general practitioner would have made the diagnosis of cancer before June 1999:

> "The resulting bone scan report and subsequent blood results did not help much to support the metastatic diagnosis and therefore made [Dr B's] job much more difficult to confirm a 'cancerous' cause for [Mr A's] pain."

I am guided by my advisor. In my opinion, in attempting to diagnose Mr A's condition, Dr B exercised reasonable care and skill and did not breach Right 4(1) of the Code.

Response to family concerns
Ms D, Mr A's partner, advised me that she raised the possibility of Mr A having cancer on a number of occasions with Dr B. He told her that it was "nothing as serious as that" and did not investigate her concerns. Dr B advised me that Mr A invariably attended his consultations alone and on only a few occasions was he accompanied by Ms D. Ms D was unable to recall specific occasions when she may have raised her concerns with Dr B or instances when she attended consultations with Mr A. She informed me that she would have tried to talk to Dr B "on the quiet" as she knew Mr A was likely to interpret her involvement as interference.

In light of the lack of evidence to support Ms D's allegations, I conclude that Dr B did not fail to respond appropriately to family concerns about the possibility that Mr A had cancer.

Management of pain
Mr A's family were concerned that Mr A's back pain was not adequately investigated and treated.

My advisor considers that Dr B took reasonable measures to manage Mr A's escalating pain and offered appropriate analgesia, in light of the diagnosis at the time. As the diagnosis of cancer was not made until December 1999, morphine was not introduced into Mr A's pain management regime until then. Therefore, it was possible that Mr A's symptoms had been under treated for a four to six week period. However, my advisor noted that most general practitioners would be "uncomfortable" prescribing morphine when a diagnosis of cancer had not been made.

With the exception of the 2 September 1999 referral made to the public hospital (discussed below) I accept that Dr B undertook the appropriate investigations in a timely manner and responded to suggestions made by other health professionals involved in Mr A's care.

I am guided by my advisor. In my opinion, Dr B managed Mr A's condition with reasonable care and skill and did not breach Right 4(1) of the Code.

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Opinion: Breach – Dr B

Investigations
Mr A's diagnosis was delayed because the public hospital appears not to have received Dr B's referral of 2 September 1999, in which he stated that he wanted metastatic disease excluded. The referral of 15 November to the Rheumatology Clinic is also not in the public hospital notes.

There is insufficient evidence to conclude where the communication breakdown occurred between Dr B and the public hospital on these two occasions. However, in my opinion Dr B had a duty to follow up the referrals he made. Having recognised the possibility of "metastatic disease" in his referral to the orthopaedic department, Dr B needed to satisfy himself that the referral was being acted on. My advisor commented that a telephone call from Dr B to follow up on the 2 September referral may have "fast-tracked" the referral. Although Dr B saw Mr A every three to four weeks following the 2 September referral, he took no action to follow up the referral until December, three months later.

In these circumstances, in failing to follow up on his request for investigations, Dr B did not meet the standard of care and skill expected of a responsible general practitioner and breached Right 4(1) of the Code.

Examination on 4 February 2000
Mr A's family complained that Dr B's examination of Mr A was inadequate.

Dr B knew that Mr A had been treated with radiotherapy and was therefore at greater risk of developing a chest infection/pneumonia. In the circumstances, I would have expected Dr B's examination of Mr A to be thorough. My advisor commented on the brevity of Dr B's examination of Mr A on 4 February 2000. I have difficulty accepting Dr B's assessment of Mr A's chest and recording that it was "clear" when only a few hours later another doctor noted Mr A's chest was not clear, diagnosed pneumonia and arranged for Mr A's admission into hospital. Shortly after, the presence of chest sounds and the diagnosis of pneumonia was confirmed at the public hospital.

In my opinion Dr B failed to examine Mr A with reasonable care and skill on 4 February 2000 and beached Right 4(1) of the Code.

Admission to hospital 4 February 2000
Mr A's family were concerned that Mr A was not referred to hospital.

Dr B explained that he did not admit Mr A to hospital, as he understood that Mr A was "on leave" from the Oncology Ward and could therefore return. However, there is no record of Dr B discussing the option of returning to the ward with Mr A, nor can Ms C recall such a discussion taking place. Dr B also stated that he was "not asked to send the patient to hospital" and that he understood that the "overwhelming majority of Maori patients … wish to stay at home with the whanau when they are terminally ill".

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HDC

From Mr A's medical record from the public hospital and Dr E's consultation notes it is clear that Mr A had pneumonia, which required inpatient treatment. My advisor considers that Dr B's decision not to admit Mr A to hospital fell well short of best practice.

I do not accept Dr B's explanation that he was following what he believed to be the wishes of the family. There is no evidence to show that he took steps to ascertain the wishes of Mr A or explained to Mr A or his family the options of home care or hospital care. It is Dr B's clinical responsibility to identify whether patients require hospitalisation, and to advise them and their family accordingly. It is inappropriate to expect patients and their families to recognise when hospitalisation is necessary and request it.

Although it is commendable that Dr B took Mr A's ethnicity into account (see Right 1(3) of the Code), it is not appropriate to make assumptions based on a patient's ethnicity that deprives that consumer of an informed choice.

In my opinion Dr B failed to provide Mr A with the information that a reasonable patient in his circumstances would expect to receive and breached Right 6(1)(b) of the Code.

Actions taken

- Dr B has provided an apology to be forwarded to Mr A's family.
- Dr B has confirmed that, since these events, he has reviewed his practice and attended a seminar on 'Cultural Differences'.

Further actions

- A copy of this opinion, with identifying features removed, will be sent to the Medical Council of New Zealand.
- A copy of this opinion, with identifying features removed, will be sent to the Royal New Zealand College of General Practitioners and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.