General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 00HDC08356)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Complaint

The Commissioner received a complaint from the consumer, Mrs A, about the services provided to her by the provider, Dr B. The complaint was that:

- *Dr B did not properly investigate Mrs A's symptoms, despite repeat consultations and her worsening condition.*
- *Dr B did not recognise that Mrs A was dehydrated or take steps to hospitalise her.*

Investigation process

The complaint was received on 21 August 2000 and an investigation was commenced on 5 September 2000. Information was obtained from:

Mrs A Consumer
Dr B Provider / General Practitioner

Relevant clinical records were obtained and viewed. Independent expert advice was obtained from Dr Keith Carey-Smith, a general practitioner.

Information gathered during investigation

Mrs A gave birth to her second son at the end of January 1999, a month before he was due. On 23 March 1999 she consulted Dr B, a general practitioner at an Accident & Medical Centre (the Medical Centre). Mrs A said she had been attending the Medical Centre for at least two years prior to her second son's birth and had seen Dr B at least a dozen times in those two years. At the time of the events complained about, Dr B was working as an independent contractor at the Medical Centre.

Mrs A said she consulted Dr B on 23 March 1999 because she was sleeping most of the day and was having trouble looking after her children. She thought her lack of energy might have been caused by postnatal depression, which she had experienced after the birth of her first son 19 months previously.

Dr B's clinical notes for the 23 March 1999 consultation stated:

> "Aropax T OD [once daily] 3/12 [3 months]
> pt restarted on own [illegible]
> Contacted maternal mental health."

Dr B, through her lawyer, advised me that Mrs A had restarted taking Aropax, left over from an earlier prescription, and had also contacted maternal mental health of her own

accord. Dr B's lawyer advised me that on 23 March 1999, Dr B gave Mrs A a further prescription for Aropax, for postnatal depression.

According to Mrs A, who also had a history of haemorrhoids, at that consultation she also would have told Dr B that she was bleeding from the bowel and having trouble with haemorrhoids. There is nothing, however, recorded in the notes to that effect, and Dr B disputed that any discussion of problematic rectal bleeding took place at that consultation.

Dr B saw Mrs A on 29 March 1999. Mrs A said she attended for her six-week postnatal check-up and told Dr B that her haemorrhoids were bothering her. She said she told Dr B that she had excessive bleeding from her anus. Mrs A said Dr B performed a vaginal but not a rectal examination. However, Mrs A advised me that Dr B would have seen that she had "ulcers" as they were "hanging out".

Dr B's lawyer advised me:

> "[It was] very unlikely that [Mrs A] mentioned substantial rectal bleeding [on 29 March] since that is not in the notes. However, … [Mrs A] had a three year history of haemorrhoids and worsening of haemorrhoids was to have been expected after [Mrs A's] pregnancy and childbirth at the end of January 1999. On 29 March 1999 [Dr B] prescribed Ultraproct – a drug used for the treatment of painful haemorrhoids."

Dr B's clinical notes for the 29 March 1999 consultation stated:

> "Smear spat and brush
> Uterus
> [blood pressure] (110/80)
> Nil period
> POP [oral contraceptive] T OD [once daily] nil sI [sexual intercourse] or use condoms 2/12 [two months]
> Disc poss b'through bdg [bleeding]
> ? [query] ingrown toenail devel
> aug t'posid
> 4/7 [four days] if needed
> ultraproct r/v [review] PRN [as needed]."

Mrs A consulted Dr B on 26 April 1999. In relation to this consultation, Dr B's lawyer advised me:

> "It was when [Mrs A] saw [Dr B] on 26 April 1999 that [Mrs A] first advised of increasingly problematic rectal bleeding. Because of [Mrs A's] history of haemorrhoids and the fact that she had recently given birth, it was reasonable for [Dr B] to conclude that the haemorrhoids were the most likely cause of the bleeding. However, against the possibility of some other cause, and in case further investigation was required, [Dr B] referred [Mrs A] to [an] Outpatients Clinic for further examination. [Mrs A's] history suggested definite secondary or prolapsing haemorrhoids needing review and further treatment by a surgeon. In general practice a proctoscopy can be performed to diagnose

> haemorrhoids. However, further internal examinations, such as sigmoidoscopy or colonoscopy, could be organised by the clinic specialists. These procedures are not general practice procedures. Therefore, [Dr B's] referral was the appropriate step."

Dr B's clinical notes for the 26 April 1999 consultation stated:

> "Ref gen sg o/pt [general surgery outpatients] […] for secondary piles. Bld [blood] pr [per rectum] c [with] flatulence alone. Prolapse c [with] stool, pt has to reduce. Pain c [with] standing."

When interviewed in June 2001, Mrs A advised that at the 26 April 1999 consultation she also complained of stomach pains, vomiting and bloody diarrhoea. She said she was, by this time, completely incontinent of the bowel and had difficulty standing because of the pain. She said she had to use a sanitary pad all the time, could not leave the house because of her incontinence, was sleeping constantly and was not coping with her children. Mrs A said Dr B told her that she had a bug and sent her home with pain killers and anti-nausea medication, after taking two faeces samples.

Dr B disputed Mrs A's recollection that she had presented with stomach pains, vomiting and bloody diarrhoea at the 26 April 1999 consultation. Rather, her lawyer advised me:

> "[A]t the next consultation, on 1 May 1999, [Mrs A] did complain of vomiting with any oral intake, nausea, abdominal pains and diarrhoea up to about 10 times a day, and [Dr B] recorded in a note that [Mrs A's] stools were 'soupy'.

Mrs A said when she consulted Dr B on 1 May 1999, she was weak and losing weight, had vomiting and diarrhoea, and was in a lot of pain. She said she was spending her days lying on a mattress on the floor of the lounge so that she could keep an eye on her children. Harry was always hungry and was breast feeding constantly. Mrs A said she asked Dr B to check her iron levels because she had been bleeding for a while.

Dr B's lawyer advised me:

> "At this consultation [on 1 May] [Dr B] examined [Mrs A] and on that basis reached the view that [Mrs A] was stable and most probably suffering from viral gastroenteritis. [Dr B's] view was consistent with and supported by the results of her initial analysis (blood pressure 130/90 mmHg, HR60, temperature 37 degrees Celsius) and [Mrs A's] history. Therefore, [Dr B's] view was entirely reasonable. On the basis of that view [Mrs A] was given medication to ease her symptoms and asked to stay to give an opportunity to check that the medication was effective. Unfortunately, [Mrs A] left of her own accord before further assessment and advice could be given and tests could be performed."

Mrs A was given Buscopan (an antispasmodic) and Maxolon (for vomiting). She said she took the Buscopan but was crying and telling Dr B that it did not work. She said she was put in a room by herself and waited for well over an hour without anyone coming to check on her. She said she left because she could not see any point in staying. However, Dr B's notes record that she checked on Mrs A, who later left of her own volition.

Dr B's clinical notes for that consultation recorded:

> "~ [approximately] 1/52 [one week]
> nausea anorexia any food – vomit, stool
> ≥ 10/day soupy no bld
> abdo pain everywhere
> reqs bld test Fe
> o/e [on examination] afeb [afebrile (without fever)]
> pale & distressed
> abdo soft sl tender gen
> < > active BS [bowel sounds] (N) [normal]
> renal angles ✓✓
> left before r/v [review] & bld tests saying still felt [illegible] to receptionist. I had looked in on her [illegible] left [illegible] for further [illegible] as she still felt [illegible].
> BP [blood pressure] 135/90 mm Hg
> […] [nurse's name]
> Please
> HR [heart rate] – 60
> Temp 37
> 10mg maxolon Im [intra-muscularly]
> 20mg Buscopan Im [intra-muscularly]
> Please bloods
> 12.40"

Mrs A returned to the Medical Centre on 4 May 1999. She said she had been lying on the mattress all day and was vomiting, and her husband had had to have time off work to look after her. She said Dr B gave her more Maxolon and Buscopan and sent her home. Mrs A said she was told that if she was feeling no better by the afternoon then she should return.

Dr B disputed seeing Mrs A in person on 4 May 1999. She advised me that the late Dr … may have done so. The Medical Centre's records indicate that on 4 May 1999 another doctor (unnamed) administered more Buscopan to Mrs A.

Dr B's lawyer advised me:

> "On 4 May 1999 [Dr B] telephoned [Mrs A] because she had not remained [on 1 May] or returned for the further assessment, testing and consultation [Dr B] had previously recommended. [Mrs A] said that her nausea had gone. On [Dr B's] advice [Mrs A] agreed that she would return to the clinic for review.
>
> The [Medical Centre's] notes record that, on 4 May 1999, more Buscopan was administered to [Mrs A], as prescribed by another doctor."

Dr B's clinical notes dated 4 May 1999 recorded:

> "15.55 [3.55pm] phoned pt, nausea gone, still gut spasms. Will come for r/v [review] +/- further Buscopan Im [intra-muscularly]."

Mrs A did not remember Dr B telephoning her. However, she said her nausea did not go and she went back to the clinic on 6 May 1999. She said she was running out of milk and could not feed her baby. She said she could not walk upright and had lost 10kg within the previous two weeks. She said Dr B's advice was to go home and continue taking her medication.

Dr B's clinical notes dated 6 May 1999 recorded:

> "c [with] husband
> nausea
> yellowy green occas floating offensive semi solid stool
> afeb [afebrile]
> gen tender soft abdo
> c [with] active (N) BS [normal bowel sounds]
> renal angles✓
> lifts shoulders off bed spont
>
> 3 stool specs
> Buscopan 20mg IM [intra-muscularly]
> IM [intra-muscular] Stemetil 12.5mg
> 14.30 hrs [2.30pm] Fifi (nurse)
> 15.46 [3.46pm] further 20mg Buscopan
> 16.03 [4.03pm] Fifi (nurse)
> sleepy
> somewhat improved
> still sore
> Volt [Voltaren] pr [per rectum] 100 PRN Q 24 hrly [100 mgs daily as necessary]
> Buscopan 1-2 top po PRN Q12hrly [orally as necessary 12 hourly]
> Ornidazole 500mg 3 po stat [3 orally immediately]
> r/v PRN [review as necessary]."

Dr B's lawyer advised me:

> "[Mrs A] presented [on 6 May] with nausea and a generally tender but soft abdomen. As it is recorded in [Dr B's] notes, [Mrs A] described her stools as offensively smelling, yellowy-green, semi-solid and floating. However, from [Dr B's] examination, it appeared that there was no need for any urgent surgical review. In particular, the fact that [Mrs A's] stools had by that time become 'semi-solid' suggested improvement. [Mrs A's] history at that stage suggested a resolving picture and oral intake and hydration could be expected to improve from that point. Also, contrary to what [Mrs A] says … she was not unable to walk properly. While some degree of dehydration would be expected after a gastroenterological infection, [Mrs A] did not appear significantly impaired.
>
> [Mrs A's] description of her stools, coupled with her nausea, suggested a possible clinical diagnosis of giardia [a parasitic infection of the intestines]. [Dr B] requested [Mrs A] to provide three stool samples and medicine was administered to ease [Mrs

A's] nausea and gut spasm. Also, [Dr B] prescribed medication (for nausea, gut spasm, pain and an antibiotic for giardia). [Dr B] advised [Mrs A] to seek further medical review if her symptoms did not improve."

Mrs A's husband took her to a public hospital on the evening of 6 May 1999. Mrs A said she was told by a nurse she was severely dehydrated and would have died if she had waited another day.

Emergency Department notes recorded that Mrs A was seen by a doctor at 12.40am on 7 May 1999. Notes also recorded:

"PC [presenting complaint]: Unwell 2/52 [two weeks]
HPC [history of presenting complaint]: Feeling 'flu-y' last 2/52 [two weeks]. Green mucus from nose, coughing up thick phlegm – green also. 7/7 [seven days] ago began getting abdo cramps, diarrhoea and vomiting.
Abdo pains – every 10 minutes, like period pain sometimes, others – worse than childbirth.
Diarrhoea – every day >12x/day
Blood in stools (liquid)
? from piles (which she developed with pregnancy)
Vomiting – every day
↓ appetite – says has lost 10kgs in these 2 weeks. No overseas travel. No one else sick at home. No drinking from streams etc.
Seen GP: ? giardia. Started on Ornidazole, Buscopan and pr Voltaren.
Is breastfeeding 3/12 [three month] old baby.
PMHX [past medical history]: Nil
Meds: As above
Allergies: Erythromycin [an antibiotic] – rash

Social: Non smoker. No alcohol."

Mrs A was examined and admitted. The doctor's clinical notes recorded, under the heading "Impression", "? infective diarrhoea, ? colitis [inflammation of the colon]". Mrs A was given pain relief and commenced on intravenous fluids "stat" (immediately).

Dr B's lawyer advised me:

"… [Mrs A] says she was severely dehydrated when she arrived at [the hospital] …. In fact, while the hospital records show that [Mrs A] was put on a drip, they also show that [Mrs A] was not severely dehydrated. The Emergency Department assessment and treatment record …, which was completed at 12.20am on 7 May 1999, records [Mrs A's] blood pressure as 136/91 and her heart rate at 109. These figures are not consistent with severe dehydration. Also, the hospital discharge sheet for [Mrs A] … contains no coding for dehydration. Still further, in a hospital letter written after [Mrs A's] discharge, there is no mention of dehydration."

Dr B's lawyer also noted that when the doctor took Mrs A's pulse 20 minutes later, it was 80, within the normal range.

On 10 May 1999 it was decided that Mrs A would undergo a colonoscopy (an examination of the colon). The procedure was performed on 12 May. Clinical notes recorded "most probably ulcerative colitis". On 14 May it was recorded that symptoms were resolving with treatment. Clinical notes on 17 May recorded "no significant improvement". Notes on 25 May recorded "improving lab results, stable clinically". Following a reduction in steroid medication Mrs A had a "flare of colitis" on 3 June. Her consultant concluded that she would require a total colectomy (surgical removal of the colon) and ileostomy (a surgically made artificial anus) the following morning.

Mrs A was discharged on 14 June 1999.

Mrs A's concerns relate to the way she was treated by Dr B. She queried why her 'piles' were not investigated further when she was bleeding so much. She also queried why Dr B did not recognise that she was dehydrated and take steps to hospitalise her. Mrs A commented: "I almost lost my life over something that is very easy to diagnose and treat."

Dr B's lawyer advised me:

> "It is clear that in mid 1999 [Mrs A] was quite unwell – her condition was a serious one and [Dr B] treated it as such. In particular, [Dr B's] referral to the […] Outpatients Clinic was appropriate. A colonoscopy could have been carried out by the clinic. [Dr B's] initial view that [Mrs A's] nausea and abdominal tenderness could be the result of an infection was also reasonable in the light of the information available and the circumstances. The hospital also investigated that issue first. Still further, the extent of [Mrs A's] rectal bleeding is perhaps exaggerated in her letter. The hospital's assessment and treatment record dated 7 May 1999 recorded simply that [Mrs A] had 'noticed blood' in her faeces.
>
> Lastly, while clearly [Mrs A] was given fluid after admission to hospital, it also seems clear that she was not severely dehydrated. Certainly, she did not present as such when she was last examined by [Dr B]."

Independent advice to Commissioner

Independent expert advice was obtained from Dr Keith Carey-Smith, a general practitioner:

"**Purpose**

To provide independent advice about whether [Mrs A] received an appropriate standard of care from [Dr B].

Complaint

The complaint was that:

1. [Dr B] did not properly investigate [Mrs A's] symptoms, despite repeated consultation and her worsening condition.
2. [Dr B] did not recognise that [Mrs A] was dehydrated or take steps to hospitalise her.

Documents and records reviewed

- HDC Medical/Professional Advice outline document.
- Letter from [Mrs A] to the Commissioner, 18 August 2000 (Item A).
- Letters from [Dr B's lawyer] to the Commissioner, with attachments, including [Dr B's] consultation notes and transcripts, 6/3/2001, 15/2/2001 (Items B & C).
- Notes of interview between [Mrs A] and [investigation officer] 14/6/2001 (Item D).
- Clinical records from [the Medical Centre], [a] Family Health Centre, [a] Health Centre and [the public hospital's records].

Introductory comments

In commenting on this case, an opinion will only be given in relation to the care provided by [Dr B]. Hospital management will be mentioned only where it relates to or clarifies the care provided by [Dr B]. It should be noted also that:

- I do not have experience in Accident and Medical clinics, and although most of the standards applied in general practice also apply in such clinics, minor variations in usual and acceptable standards of care may occur that I could be unaware of.
- [Dr B's] clinical records are brief with poor legibility, and the transcripts incomplete (eg no transcript for 6/5/99 was provided). However omissions from the records may not always reflect omissions in standards of care. The evidence for the standard of care provided is therefore inadequate to make a clear decision about several of the questions.
- After studying the documents and letters, I have concluded that the consultation assumed to have occurred on 1 May 1999 probably occurred on 4 May, with the telephone call and patient re-attendance for an injection later the same day. This does not materially affect the evidence and opinions supplied.

I will comment on each of the points requiring my decision separately, giving the standard appropriate to general practice where relevant.

Question 1: What are the specific standards that apply and were they followed?

- Diagnosis and management of lower bowel disorders, including diarrhoea, bleeding and ulcerative colitis: Large bowel disorders. Discussion paper by Prof Eru Pomare, August 1991; Rectal bleeding and large bowel cancer diagnosis and management – Dr John Durham 1991; The Merck Manual 16th Edition.

- Diagnosis and management of sodium and water depletion: Davidson's Principles and Practice of Medicine 12th Edition.

- Clinical records and equipment: Aiming for Excellence in GP (Standards for GP), RNZCGP 2000; Standards for Accident and Emergency Clinics 29/7/98 (Attachment 1).

- Right to information and explanation, appropriate to a 'reasonable consumer' (HDC Code Right 6).

- Right to service provided with reasonable care and skill, to an appropriate standard consistent with the patient's needs (Right 4).

Question 2: What are the symptoms of ulcerative colitis and how is it diagnosed?

Ulcerative colitis symptoms: This condition can present acutely with profuse violent diarrhoea, fever, toxaemic symptoms (sodium and water depletion, shock), and abdominal pain, but more commonly presents insidiously, with urgency of defaecation, abdominal cramps, and blood and mucous in the stools (see refs above). It is possible that proctitis (part of ulcerative colitis) could cause a feeling of prolapsed piles due to oedema of the rectal mucosa.

Ulcerative colitis diagnosis: Although a presumptive diagnosis can be made from symptoms, examination of stools, and blood tests including leucocytosis and elevated ESR/CRP, along with exclusion of infective causes, definitive diagnosis requires sigmoidoscopy and sometimes full colonoscopy, assisted by biopsy (see refs above). Rectal examination (even with a proctoscope) is usually non-contributory.

Question 3: Did [Mrs A] have haemorrhoids?

Clearly a presumption of haemorrhoids has been made by [Dr B] (as stated in her referral letter to the outpatients of 26/4/99), presumably because of the bleeding post-partum and the history of the piles 'hanging out' and having to be pushed back, and because [Mrs A] had been treated for these before ([Mrs A] states this in item D, and also in the hospital history). However, I could find no reference in the records from [the Medical Centre] of a previous diagnosis or treatment for haemorrhoids (a problem list would have assisted here – see under conclusions). It would appear that [Dr B] did not specifically examine [Mrs A's] anal area or rectum at either visit, so this was purely a

presumptive diagnosis. Interestingly, [Dr B] carried out a vaginal examination on 29/3/99 at the time she prescribed Ultraproct for the presumed haemorrhoids, but there is no mention in the notes that external haemorrhoids were seen. [Mrs A] states that the 'ulcers' were 'hanging out' at this examination, and should have been seen by [Dr B]. It is likely that symptoms of haemorrhoids were complained of by [Mrs A] (although some of the symptoms of haemorrhoids, particularly bleeding and pain, can also be caused by proctitis associated with ulcerative colitis). [Mrs A] confirms this in the 14 June transcript. There is no elaboration in [Dr B's] explanation letter of whether diagnosis was made from symptoms or by examination; hence the opinion that this was a reasonable presumption rather than an objective diagnosis.

At admission, hospital records do not mention haemorrhoids, apart from a note in the nursing admission record under past history, and a note in the admission past history of 'haemorrhoids post partum', information presumably obtained from [Mrs A]. Rectal examination, and later colonoscopy, were performed, with no mention of haemorrhoids. However, this does not exclude the diagnosis, since more serious disease was present, relegating the haemorrhoids to a minor priority, not justifying mention in the minds of the hospital doctors.

I conclude that [Mrs A] may have had haemorrhoids in the past (no direct evidence available), and from the history given is likely to have had them on 26 April. However, if haemorrhoids were present over this period, they were mild, not sufficient to warrant mention by the hospital when she was admitted.

<u>Question 4</u>: Was it reasonable for [Dr B] to conclude, on 29 March 1999, that [Mrs A] had worsening haemorrhoids and to treat her with Ultraproct?

A common cause of bleeding in pregnancy and immediately postpartum is haemorrhoids, and if (as she maintained) [Mrs A] complained of bleeding (this is not mentioned in the notes), it is reasonable to consider haemorrhoids and prescribe Ultraproct. However standard practice with rectal bleeding is to examine the patient (including a rectal examination) to confirm or exclude haemorrhoids before prescribing, and this does not appear to have been done. I cannot exclude the possibility that [Dr B] observed external haemorrhoids when she did the smear test, but this is not stated in the notes, or in the explanation letter (see above). It is likely also that [Dr B] was aware of a previous diagnosis of haemorrhoids during pregnancy, and assumed the same diagnosis. However, again there is no evidence of this in the records. Clearly [Dr B] is aware of the need to refer patients with significant haemorrhoids, since she did so on 26 April. This suggests that the haemorrhoids, if present, were not severe on 29 March, and had worsened (at least symptomatically) by 26 April. There is no evidence to suggest that [Dr B] considered the haemorrhoids to have worsened on 29 March, since their existence or severity had not been mentioned in the notes of previous consultations.

Question 5: Was it reasonable for [Dr B] to conclude, on 26 April 1999, that [Mrs A's] haemorrhoids were worsening?

Taking the evidence of the GP records and the referral letter of 26 April, a more clear-cut picture of haemorrhoids now emerges. The piles are stated (presumably from the history) to be prolapsing necessitating the patient having to reduce them, with bleeding and pain. They are described by [Dr B] as secondary piles, meaning that they prolapse but can be manually reduced by the patient. All these symptoms are typical of haemorrhoids although rectal prolapse (rare) could give similar symptoms (but see also under Question 2 above).

Clearly the condition from the history was 'worsening' compared with 29 March, when none of these features are mentioned. However, a clinical examination usually with proctoscopy is the standard method of diagnosis (and assessment of severity) in general practice, and was not performed at this consultation. [Dr B] may have omitted the examination because she knew one would be performed at the outpatients clinic. However, some appointment delay is usual, and examination is useful to determine the severity of the condition, confirm the history, and exclude other causes. Lack of availability of a proctoscope might be another reason for failure to examine the rectum. However since a proctoscope is considered essential basic equipment in general practice (RNZCGP Standards) this is unlikely to be the reason.

Question 6: Was it reasonable, on this date, for [Dr B] to refer [Mrs A] to the […] Outpatient Clinic for further examination?

It was entirely appropriate to refer [Mrs A], since, as noted by [Dr B], further examination and appropriate treatment is a specialist procedure. However, as discussed above, full examination was omitted. An examination would have allowed a more informed referral and allowed the hospital to better prioritise the patient.

Question 7: Was it reasonable for [Dr B] to conclude, on 1 May 1999, that [Mrs A] was stable and most probably suffering from viral gastroenteritis?

[Dr B] appears from the records to have taken a brief but adequate history and performed an appropriate clinical examination. Symptoms and signs noted in the records were suggestive of gastroenteritis, and there was no clear association with the rectal bleeding noted previously. It is entirely reasonable to diagnose gastroenteritis, and the recorded observations of pulse, temperature and blood pressure do not indicate major systemic disturbance. [Dr B] clearly had some concern, however, since she took the precaution of telephoning [Mrs A] later (times are difficult to interpret but it would appear that the phone call was at 15.55hrs, about 3 hours after the consultation – see also explanation of errors in dates above). She discovered that the nausea had gone, but pain was still present, so invited [Mrs A] back for another injection of antispasmodic.

<u>Question 8</u>: Was it reasonable for [Dr B] to conclude, on 6 May 1999, that [Mrs A's] symptoms were improving and that further medical intervention was not required?

The consultation notes of this attendance (not transcribed), along with the further observations from [Dr B], indicate that diarrhoea was the main problem. There is no mention of rectal bleeding or pain, even though clearly these were present (recorded in the history at hospital emergency department and on admission 7 May). A brief abdominal examination was performed, with findings of abdominal tenderness, but further details are illegible. There is no recording of vital signs in the records provided. This could mean that observations were done but not recorded (unlikely in a A&M Centre since nurse observations are normally routinely recorded), or that the patient was not considered ill enough to justify measuring vital signs such as pulse, blood pressure and temperature. This latter explanation is unlikely since [Dr B] was concerned enough about the patient's condition to keep her under observation for almost 2 hours (injection times recorded by the nurse were 1430 hrs and 1603 hrs). In addition, she prescribed medication for giardia, which is normally only done if the infection results in significant continuing symptoms. Furthermore, it is unusual to prescribe for this condition before a diagnosis is made, suggesting [Mrs A's] disease was considered of at least moderate severity.

At the time of discharge [Dr B] prescribed oral medication to take home which suggests that she saw the patient and considered her fit for discharge. [Dr B] states that she advised [Mrs A] to seek further medical review if her symptoms did not improve, but I could not locate any confirmation of this in the records, and [Mrs A] denies receiving this advice.

There is insufficient information to make a judgement on this question. On the available information, [Dr B] did not have enough clinical history and examination data to decide whether the patient had improved or worsened since 4 May; nor is it clear whether the patient improved during the approximately 2 hours she was observed at the Centre.

[When Dr Carey-Smith provided his expert advice, he had a copy of the clinical notes from the 6 May appointment, but not a transcript. In response to my provisional opinion, [Dr B's] lawyer provided a transcript of that appointment. I note that [Dr B] recorded that [Mrs A] was 'somewhat improved' after the approximately two hours she spent at the clinic, and that she recorded 'r/v PRN (review as necessary)'.]

<u>Question 9</u>: Was [Mrs A] dehydrated by 6 May 1999?

Again, the notes made by [Dr B] do not provide any evidence for or against dehydration. No questions were asked about weight loss, fluid input or output, or volume and frequency of diarrhoea, and no signs indicating presence or absence of dehydration are recorded (eg pulse, blood pressure, skin and tongue condition). As observed above, this could mean that [Dr B] was not concerned from general observations about the possibility of dehydration. A&M centres are equipped for

intravenous therapy and since this was not administered, nor the patient admitted, it is unlikely that [Dr B] thought [Mrs A] was significantly dehydrated at that time.

The hospital records are slightly ambiguous. The Emergency Department records (about 8 hours after she was last seen by [Dr B]) do not mention dehydration, however, dehydration and hypokalaemia [abnormally low potassium levels in the blood; occurs in dehydration] are recorded by the admitting doctor. The initial intravenous management with rapid administration of several litres of normal saline, is the normal regime for significant dehydration. The initial blood pressure was satisfactory, but the pulse mildly elevated at 109 (compared with her normal pulse later recorded at 60-70/min in the ward records). Urine ketones were recorded as 'moderate'. All these actions and findings suggest significant dehydration. Blood results (eg hypokalaemia but normal sodium and renal function) are not helpful in making a judgement about dehydration. On 8 May notes recorded 'dehydration' but findings included 'good tissue turgor', presumably because IV fluids had already been effective.

I conclude that [Dr B] did not examine sufficiently (or record her findings) to decide whether [Mrs A] was seriously dehydrated on 6 May, but that it is likely that mild dehydration was present. Eight hours later at the hospital significant dehydration had developed. Over a period of 8 hours a patient with severe diarrhoea can progress from mild to moderate or severe dehydration.

Question 10: Was [Mrs A's] condition life threatening by the time of her hospital admission?

Although clearly [Mrs A] was seriously ill on admission, with hydration she improved rapidly enough to be considered fit for discharge two days later, although she then deteriorated and was not sent home. Without appropriate treatment, however, severe colitis is certainly a life threatening disease. The fact that [Mrs A] failed to settle with conservative treatment and required major bowel resection suggests a potentially fatal severity of disease. This would not have been apparent to [Dr B] prior to admission.

Question 11: Was [Dr B's] observation that [Mrs A] did not appear 'significantly impaired' by dehydration reasonable in the circumstances?

This statement appears in the subsequent explanation rather than in the clinical records, and presumably was an observation from memory almost two years after the event. Without qualification, the statement 'significantly impaired' is not a standard clinical term. It is not stated in what respect [Mrs A] was not impaired: hydration, distress, mobility, mental state or other impairment. The fact that [Mrs A] was able to walk out and return home could be taken to confirm that in some respects she was not significantly impaired; however the precaution of keeping her for several hours observation suggests some concern about her condition. However there is no evidence in the records to assess cardiovascular or metabolic impairment.

Question 12: Was it reasonable in the circumstances for [Dr B] not to have diagnosed ulcerative colitis?

Ulcerative colitis can only be presumed from the history, and needs confirmation by sigmoidoscopy or colonoscopy and exclusion of infective and other causes (such as cancer). As stated above, rectal examination, even if it had been done by [Dr B], is not usually helpful in diagnosis of colitis.

The symptoms and signs recorded on 4th and 6th May were consistent with gastroenteritis, a very common condition in general practice (whereas an acute presentation of ulcerative colitis is very rare). It is possible that a more extensive history and a fuller examination may have led [Dr B] to include inflammatory bowel disease in her differential diagnosis, but often in a primary care situation time pressures do not allow as complete an assessment as would be undertaken in hospital. In fact, both the hospital emergency department and admitting doctors included colitis as a possible diagnosis (confirmed later).

I conclude that [Dr B] ideally should have considered inflammatory bowel disease in the differential diagnosis, at least on 6th May, and possibly on 4 May also. However it was not unreasonable to diagnose gastroenteritis, a more common condition, as the most likely problem.

Question 13: Would a diagnosis in March 1999 have affected the outcome for [Mrs A]?

Diagnosis of inflammatory bowel disease in March would have allowed treatment to be commenced and reduced the likelihood of more severe symptoms necessitating prolonged hospital admission. Similarly a more complete diagnostic formulation in the OPD referral letter of 26 April may have resulted in higher priority status and an earlier appointment. I am not able to state whether the major surgery would have been avoided with an early diagnosis (this question would be best answered by a gastroenterologist).

Question 14: Any other matters in relation to the standard of care provided to [Mrs A]?

Standard of records:

In my opinion [Dr B's] clinical records are below the normal RNZCGP standards, particularly in respect of legibility, clear recording of history, assessment, problem list, and management plan. Furthermore, the notes do not reach 1998 Minimum Patient records standards for A&M centres (presumably still in effect in 1999) in relation to diagnosis, results of tests, follow up arranged, and specific advice given.

Confounding factors

The fact that [Mrs A] had a history of haemorrhoids and was only 6 weeks postpartum could have distracted [Dr B] from consideration of other possibilities. However known haemorrhoids are not an adequate reason to omit full examination when there is a

history of rectal bleeding or altered bowel habit, even in a young patient (unless the doctor knew that an examination had been carried out previously). Organic disease needs exclusion if systemic features such as weight loss are present, but it is not known if [Dr B] was aware of, or asked about, the weight loss mentioned by [Mrs A].

Similarly [Mrs A's] previous and recent depression may have provided an explanation to [Dr B] for her weight loss and anorexia, in retrospect clearly due to her colitis.

[The] Medical Centre

I am concerned about the apparent lack of protocols and inadequate data recording in the documentation provided by this Centre. A case such as this requires initial and ongoing vital signs monitoring during observation in the Centre, and medical officers employed by the Centre should be provided with clear protocols and appropriate recording forms to ensure adequate documentation of history, examination findings, treatment and management/follow up plans, as well as clear designation of date, times, and identification of doctor responsible. All of these aspects were lacking in the records seen.

CONCLUSION

In my opinion [Dr B] provided services with reasonable care and skill in relation to the initial diagnosis and management of haemorrhoids and later gastroenteritis, but fell short by not carrying out a rectal examination on 29 March or 26 April, not adequately recording and/or assessing vital signs on 6 May, and in the standard of her records. I am unable to determine from the information available how dehydrated [Mrs A] was, or whether or not hospitalisation was appropriate on 4 or 6 May.

Overall, the standard of care fell slightly below that appropriate to a fully qualified general practitioner.

Since patients attending A&M Centres tend to see a number of different practitioners, better clinical protocols and record-keeping arrangements in the Centre may have allowed [Dr B] to function to a higher level of care and skill, and certainly would have enabled a more adequate judgement to be made on the matters in question."

Appendix

The following extract is from the *RNZCGP's Standards for General Practice*, 2000:

"D.7.1.1

Medical records show:
Medical records contain information to identify the patient and to document the assessment, management, progress and outcomes sufficiently for another doctor to carry on the management.

1. Demographic data:

- Name of patient
- NHI no.
- Gender
- Address
- Date of birth
- Ethnicity
- Registration status – registered/casual
- Principal caregiver
- Contact phone number
- Community Services Card – Group 1, 2, 3

Ethnicity data provides valuable information to assist in meeting strategic targets (national and practice).

Note: Ethnicity data collected by the NZHI Service is: NZ Maori, NZ European or Pakeha, Other European (Dutch, English, Australian, Scottish, Irish, other), Samoan, Cook Island Maori, Tongan, Niuean, Chinese, Indian, Other.

2. Consultation records:

- The person making the entry is identifiable
- The entry is dated
- The entry is legible

3. Recent consultations recorded:

- Reason for encounter
- Examination findings
- Investigations ordered – office & laboratory
- Assessment
- Management plan including medication change, additions, follow up arrangements
- Medications are clearly identifiable: drug name / dose / frequency / amount / time / volume

4. Medical records show:

- Clinically important drug reactions and other allergies are easily identified
  - **Awareness alert** – communication requirements for specific disability eg language & comprehension, blind, deaf
- Problem lists are easily identifiable in all records
- Current medication list
- Risk factors are identified and markers used, eg
  - Family history
  - Smoking history (over 15)
  - Alcohol and Drug history
  - Blood pressure in adult records
  - Weight/height/BMI
- Immunisation
- ADT recorded
- Referrals and responses are easily accessible in clinical records
- Investigations are easily accessible:
  - Laboratory
  - Xray
  - Other tests
  - Other health information."

The following extract is from *ACC's Standards for Accident and Medical Centres*, July 1998:

"**Attachment 1 – Minimum Patient records**

Patient details: name, address, date of birth, contact phone number, NHI number, CSC number and expiry date, date of last visit, HUHC number and expiry date, gender, ethnicity, preferred primary provider

Consultation details: date and time of consultation, practitioner providing consultation (NPI)

Medical details: diagnosis, treatment (including details of the prescribed drugs – name), results of tests, reports and investigations

Referral details: date of referral, type of referral, name and address if applicable

Follow-up data: lab tests ordered (including laboratory name), follow-up arranged (clinic – nature and time) and specific advice given by the treating doctor."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

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

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

Opinion: Breach – Dr B

In my opinion Dr B breached Right 4(1) and Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

Right 4(1)

Investigation of symptoms
Mrs A was concerned that Dr B did not properly investigate her symptoms, despite repeat consultations and her worsening condition.

Mrs A consulted Dr B on 23 and 29 March, 26 April, and on 1 and 6 May 1999. Mrs A advised me that she also consulted Dr B on 4 May. However, I note that Dr B recorded in the clinical notes for that day that she telephoned Mrs A at 3.55pm and that Mrs A told her she would return for further intra-muscular Buscopan. Another doctor (possibly the late Dr …) made a further entry in the notes dated 4 May that Buscopan had been administered. I therefore conclude that Mrs A was mistaken in her recollection that she saw Dr B in person on 4 May.

At the consultation on 23 March, Dr B prescribed Aropax. Dr B advised me that Mrs A had attended for suspected postnatal depression and that she treated her for this. She disputed Mrs A's recollection that problematic rectal bleeding was discussed during that consultation. I note that Dr B's clinical notes for 23 March do not mention rectal bleeding, whereas six days later on 29 March they record that she prescribed Ultraproct for haemorrhoids. I am inclined to prefer Dr B's recollection that rectal bleeding was not discussed until 29 March.

On 29 March, Mrs A attended Dr B for her six-week postnatal checkup and a smear test was performed. The parties agree that at that consultation there was a discussion about Mrs A's haemorrhoids, but do not agree on how much rectal bleeding was involved. I note the advice of my independent expert:

> " … standard practice with rectal bleeding is to examine the patient (including a rectal examination) to confirm or exclude haemorrhoids before prescribing, and this does not appear to have been done. I cannot exclude that [Dr B] observed external haemorrhoids when she did the smear test, but this is not stated in the notes, or in the explanation letter. It is likely also that [Dr B] was aware of a previous diagnosis of haemorrhoids during pregnancy, and assumed the same diagnosis. However, again there is no evidence of this in the records."

I am concerned that Dr B prescribed Ultraproct for haemorrhoids without first carrying out a rectal examination to confirm her diagnosis, in accordance with standard general practitioner practice.

The parties agree that Mrs A's symptoms had increased by 26 April, but disagree on the degree of severity. When I interviewed her, Mrs A recalled complaining of stomach pains, vomiting and diarrhoea on that occasion. However, I note that those symptoms are not recorded in Dr B's clinical notes until the following consultation on 1 May, when she wrote:

> "~ [approximately] 1/52 [one week]
> nausea anorexia any food – vomit, stool
> ≥ 10/day soupy no bld [no blood]
> abdo pain everywhere
> …"

I am unable to conclude that Mrs A told Dr B of those symptoms on 26 April.

On 26 April, Dr B referred Mrs A to an Outpatient Clinic because she considered that Mrs A's history suggested definite secondary or prolapsing haemorrhoids needing review and further treatment by a surgeon.

In relation to that consultation, my independent expert noted:

> "Clearly, the condition from the history was 'worsening' compared with 29 March when none of these features [rectal bleeding, prolapse and pain] are mentioned. However, a clinical examination usually with proctoscopy is the standard method of diagnosis (and assessment of severity) in general practice, and was not performed at this consultation. [Dr B] may have omitted the examination because she knew one would be performed at the outpatients clinic. However, some appointment delay is usual and examination is useful to determine the severity of the condition, confirm the history, and exclude other causes. Lack of availability of a proctoscope might be another reason for failure to examine the rectum. However, since a proctoscope is considered essential basic equipment in general practice … it is unlikely to be the reason."

I accept that Dr B's assumption that Mrs A had haemorrhoids was reasonable and that it was reasonable, on 26 April, for Dr B to have referred Mrs A to the Outpatient Clinic. Further, I note my expert's advice that rectal examination is not usually helpful in diagnosing colitis. Nonetheless, I consider that standard practice required Dr B to conduct a rectal examination on that date and, in failing to do so, she did not provide services to Mrs

A with the level of skill and care expected of a general practitioner. I also note my expert advice:

> "An examination would have allowed a more informed referral and allowed the hospital to better prioritise the patient."

In Dr B's response to my provisional opinion, her lawyer advised me that, although Dr B regretted not performing a rectal examination, she did not accept that such an examination *would necessarily* have allowed a more informed referral or better prioritisation of Mrs A by the hospital. He noted that ulcerative colitis is a generally unpredictable disease, that it is not known what the actual results of a rectal examination on 29 March or 26 April would have been, and that rectal examination is not usually helpful in diagnosing colitis. He submitted that, at the very most, the results of a rectal examination *may* have helped the hospital and resulted in a higher priority status for Mrs A, and that Dr B's failure to perform a rectal examination may not have had a significant effect in the event.

I accept that even if Dr B had performed a rectal examination, the results may well have had no material effect on subsequent events. I also accept that earlier diagnosis and/or treatment may well not have avoided the need for Mrs A's major surgery. However, regardless of its impact on subsequent events, I consider Dr B's failure to perform a rectal examination, having diagnosed haemorrhoids, was a departure from the appropriate standard of care.

My expert advisor also noted:

> "The fact that [Mrs A] had a history of haemorrhoids and was only 6 weeks postpartum could have distracted [Dr B] from consideration of other possibilities. However, known haemorrhoids are not an adequate reason to omit full examination when there is a history of rectal bleeding or altered bowel habit, even in a young patient (unless the doctor knew that an examination had been carried out previously). Organic disease needs exclusion if systemic features such as weight loss are present, but it is not known if [Dr B] was aware of, or asked about, the weight loss mentioned by [Mrs A]. …"

Mrs A was concerned that Dr B failed to assess her condition adequately on 6 May and consequently failed to recognise that she was dehydrated.

In relation to the 6 May consultation, my expert advisor commented:

> "At the time of discharge [Dr B] prescribed oral medication to take home which suggests that she saw the patient and considered her fit for discharge. [Dr B] states that she advised [Mrs A] to seek further medical review if her symptoms did not improve, but I could not locate any confirmation of this in the records, and [Mrs A] denies receiving this advice.
>
> … nor is it clear whether the patient improved during the approximately 2 hours she was observed at the Centre."

When Dr Carey-Smith provided his advice, he had a copy of the clinical notes from the 6 May appointment, but not a transcript. Dr B's lawyer subsequently provided me with a transcript of that consultation. I accept that Dr B recorded in the notes on 6 May that Mrs A was "somewhat improved" after the approximately two hours she spent at the clinic. I accept that she also recorded "r/v PRN [review as necessary]".

Dr B's clinical records of 6 May do not provide any evidence as to whether Mrs A was dehydrated. My advisor noted that no questions were asked about weight loss, fluid input or output, or volume and frequency of diarrhoea. In response to my provisional opinion, Dr B's lawyer observed that Dr B recorded a detailed description of Mrs A's stools in the clinical notes, and specifically noted that Mrs A was able to spontaneously lift her shoulders off the bed. He drew my attention to Dr Carey-Smith's conclusion that any omission by Dr B on 6 May may have been limited to not *recording* Mrs A's vital signs.

Nonetheless, in the absence of any record in the notes indicating the presence or absence of dehydration, I am not satisfied that Dr B did examine Mrs A sufficiently to decide whether she was dehydrated on 6 May.

I accept the advice of my independent expert that Dr B provided services with reasonable care and skill in relation to her initial diagnosis and management of haemorrhoids and later gastroenteritis. However, in my opinion, Dr B failed to exercise reasonable skill and care by failing to perform a rectal examination on either 29 March or 26 April and failing to examine Mrs A sufficiently to decide whether she was dehydrated on 6 May. Accordingly, Dr B breached Right 4(1) of the Code in relation to this matter.

Right 4(2)

Records
My advisor considered Dr B's clinical records to be below the required standards:

> "In my opinion [Dr B's] clinical records are below the normal RNZCGP standards, particularly in respect of legibility, clear recording of history, assessment, problem list, and management plan. Furthermore, the notes do not reach 1998 Minimum Patient records standards for A&M centres (presumably still in effect in 1999) in relation to diagnosis, results of tests, follow up arranged, and specific advice given."

In response to my provisional opinion, Dr B's lawyer advised me that Dr B regretted that her notes were in some places illegible and in some aspects incomplete. He advised me:

> "At least in part, these matters were the product of the working environment and systems at the […] Medical Centre. [Dr B] no longer practises at [the Medical Centre] and she has already addressed the record keeping issues mentioned in your provisional opinion."

In my opinion, Dr B failed to provide services that complied with professional standards by not adequately recording relevant information on 6 May, and in the overall standard of her record keeping. Accordingly, Dr B breached Right 4(2) of the Code. I am pleased to note

that Dr B has confirmed, through her lawyer, that she has addressed her standard of record keeping in the interim.

Opinion: No breach – Dr B

Dehydration and hospitalisation
Mrs A was concerned that Dr B did not recognise that she was dehydrated or take steps to hospitalise her.

My advisor concluded that Dr B did not examine Mrs A sufficiently to decide whether she was seriously dehydrated on 6 May. However, my advisor also noted that Mrs A was likely to have been only mildly dehydrated. Significant dehydration had developed by the time Mrs A was admitted to hospital eight hours later. However, over a period of eight hours a patient with severe diarrhoea can progress from mild to moderate to severe dehydration. It is possible that from general observations made during the consultation on 6 May, Dr B was not concerned about the possibility of dehydration.

I am unable to determine from the information available how dehydrated Mrs A was when she presented to Dr B on 6 May, or whether immediate hospitalisation was appropriate. I accept my expert advice that Mrs A's dehydration may not have developed to the degree where hospitalisation became necessary until some time after her consultation with Dr B. Although Dr B failed to examine Mrs A's symptoms with sufficient care, I do not accept that Mrs A was so obviously dehydrated during her consultation with Dr B on 6 May as to require immediate hospitalisation.

Accordingly, in my opinion Dr B did not breach Right 4(1) of the Code in relation to this matter.

Action

I recommend that Dr B take the following actions:

- Apologise in writing to Mrs A for her breaches of the Code. The apology is to be sent to the Commissioner and will be forwarded to Mrs A.

- Review her practice in light of this report.

Other actions

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

Other comment

The Medical Centre
I note the advice of my general practitioner advisor:

> "I am concerned about the apparent lack of protocols and inadequate data recording in the documentation provided by this Centre. A case such as this requires initial and ongoing vital signs monitoring during observation in the Centre, and medical officers employed by the Centre should be provided with clear protocols and appropriate recording forms to ensure adequate documentation of history, examination findings, treatment and management/follow up plans, as well as clear designation of date, times, and identification of doctor responsible. All of these aspects were lacking in the records seen."

Patients who attend an Accident and Medical Centre may not always see their doctor of choice. Therefore, it is essential that notes of previous consultations are legible and sufficiently detailed to allow the treating doctor to know the medical history. In my opinion the Medical Centre has an obligation to have in place a quality assurance system (with provision for regular audits) to ensure that the notes taken by its independent contractors are legible and complete.

When I formed my provisional opinion on this complaint, I recommended that the Medical Centre review its protocols in light of this report.

The Chief Operating Officer for the company that currently owns the Medical Centre subsequently advised me that the company that owned the Medical Centre at the time of the events complained about (also with the same name) had been placed into receivership. He advised me that his company had recently purchased from the receiver five accident and medical clinics from the former company, including the Medical Centre.

The Chief Operating Officer informed me that his company had contracted the services of another company to provide operational, clinical and auditing systems at the clinics. He advised me that the clinical audit team's preliminary assessment of the Medical Centre had "highlighted the same issues" raised in this report.

He advised me:

> "Therefore, an action plan is currently being formulated to implement standard operating protocols and clinical services at this clinic. This will also be complemented by a full upgrade of the data recording and documentation systems, supported by full training for all staff. We are also currently advertising for a new General Manager for this clinic who will be responsible for the implementation, monitoring and management of all on-site clinical procedures.
>
> This action will include ongoing auditing of these systems as we have made a commitment to upgrade the standard of services being provided by all of the clinics in our Group."