Dr C / Private Medical Centre

A Report by the

Health and Disability Commissioner

(Case 99HDC09125)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Ms B	Complainant / Consumer's sister
Dr C	Provider / General Practitioner
Mr A	Consumer's husband
Dr D	Consultant Psychiatrist
Dr E	Colorectal Surgeon
Dr F	Gynaecological Oncologist
After hours medical centre	24 hour Accident and Medical Centre
Private medical centre	Medical Centre

Complaint

On 17 August 1999 the Health and Disability Commissioner received a complaint from Ms B, Mrs A's sister, regarding the medical services provided to Mrs A by Dr C, general practitioner.

The complaint summary is that:

During the period of December 1996 until April 1997, Dr C, general practitioner, did not provide Mrs A with services of an appropriate standard. In particular:

- *Dr C did not appropriately examine Mrs A when she presented to him with abdominal discomfort.*
- *Dr C did not refer Mrs A for tests to determine her diagnosis, instead diagnosing her with stress, irritable bowel and back pain for which he treated her with antidepressants and recommended back massage.*
- *Dr C did not refer Mrs A to a specialist in April 1997 when she requested him to do so.*
- *Dr C did not follow up with Mrs A after she was seen at a private after hours medical centre on 16 February 1997, after she rang him and advised him she was unwell and vomiting on 17 March 1997, and after she was seen by a colorectal surgeon on 10 April 1997.*
- *Dr C did not arrange for Mrs A to have pain management until 23 April 1997 after she had been diagnosed with cancer.*

An investigation was commenced on 27 January 2000.

Information reviewed

- Mrs A's medical records from Dr C
- Mrs A's medical records from the private medical centre
- Expert advice from Dr Chris Kalderimis and Dr John Cheesman, independent general practitioners

Information gathered during investigation

This is a report about a woman who suffered from cancer. It is a story that is familiar to thousands of New Zealanders, and to their families, who must cope with the anguish and distress of a cancer diagnosis. The report focuses on the issue of the degree of caution a general practitioner must exercise when he or she sees a patient with ongoing, general symptoms that may be indicative of cancer. It is an issue that is of widespread importance given the prevalence of cancer, and the rate at which it claims the lives of New Zealanders. Sadly, this case had a tragic outcome. What I hope to achieve through this report is the promotion of a recognition among general practitioners of the need to be particularly vigilant to the possibility of cancer, and the importance of requesting the opinion of an appropriate colleague, or of referring a patient to a specialist, if that patient's diagnosis or treatment is difficult.

Background
Mrs A was a teacher who was active in the community and a keen sports player. She had attended the private medical centre since 1984. Dr C worked as a self-employed practitioner at the private medical centre. A psychiatrist had treated Mrs A since October 1990 for major depression. In April 1993 Mrs A was found to have iron deficiency anaemia and reported bleeding from her haemorrhoids. Mrs A was referred to a gastroenterologist, who conducted an endoscopy (procedure to view the inside of the body) and a barium enema (procedure to diagnose conditions in the gastrointestinal tract), with normal results. Mrs A's anaemia responded to oral iron supplements.

1996
Mrs A's sister, Ms B, advised that in December 1996 Mrs A felt constantly tired, had marked abdominal fullness and felt unwell. On 24 December 1996 Mrs A went to the private medical centre and was seen by a GP. The GP's notes recorded that Mrs A had abdominal fullness. He felt she was suffering from stress and prescribed her with Motilium 10mg three times a day (for the relief of nausea and vomiting, flatulence and heartburn).

1997
Ms B advised that from 24 December 1996 until February 1997, Mrs A remained generally unwell.

On 16 February 1997 at 5.45pm Mrs A went to a 24 hour surgery with worsening abdominal and back pain and abdominal bloating. It was noted that she had a one-month history of these symptoms. The GP at the surgery noted that Mrs A was taking iron supplements for anaemia and Motilium 10mg; however, this was not relieving her symptoms. The doctor noted that:

- she had had an endoscopy the year before;
- she had no weight loss;
- her appetite was satisfactory;
- she was having one loose stool per day;
- she had no nausea or vomiting;
- she was not experiencing reflux or heartburn; and
- she often had bleeding haemorrhoids.

He noted that Mrs A was pale. A rectal examination was performed and "? Lesion of tip of finger? No blood" was documented. The GP prescribed ranitidine (Zantac) 150mg twice a day for three months (medication used for gastric disturbances) and Mylanta syrup (antacid with antiflatulent). Blood tests were also ordered. A copy of the consultation sheet was sent to Mrs A's general practitioner, Dr C. Mrs A told Ms B that the GP at the 24 hour surgery explained that she should take the following day off work and see her doctor. Ms B advised that Mrs A was not aware at this stage that the GP had picked up a lesion on examination, only that on investigation he felt there was something that her general practitioner should follow up.

On 17 February 1997 at about 9.00am Mrs A consulted Dr C. Dr C did not perform a rectal examination. Dr C advised Mrs A that she probably had irritable bowel syndrome and suggested that she keep a diary of what she ate and drank. Dr C documented the following information in Mrs A's notes about the consultation:

"bloating – all the time

– abdo pains 1/12

teaching for 5 yrs [primary school] started 3 years ago when husband away

On Aropax [antidepressant]. Mood is good. Coping with stress OK.

Diet poor appetite (long study related to onset of depression). Weetbix breakfast, sandwiches lunch, Husband prepares the evening meal.

Bowels regular

Periods – shorter but regular

Exercise – quite regular.

Haemorrhoids tend to bleed before period.

Was started on Mylanta and Zantac."

Dr C also noted that Mrs A had iron deficiency anaemia, investigated in 1993 with a barium enema and endoscopy, the results of which had been normal. The anaemia was related to Mrs A's poor appetite and her bleeding piles. He ordered blood tests, which included CBC and ESR, B_{12} folate, ferritin and liver function tests. The results were all subsequently noted to be within normal ranges. Dr C stated that, although it is not recorded in the notes, it is his usual practice to examine the abdomen. He thinks it probable that he did palpate and listen to the abdomen and found it normal but failed to record this.

Dr C stated that Mrs A had previously complained of the same symptoms and had been investigated by a gastroenterologist. Nothing abnormal had been found. Against this background Dr C diagnosed irritable bowel syndrome, which in his opinion did not require urgent treatment. Dr C arranged to review Mrs A's condition in two weeks' time. In the interim she was to continue the medication she had been prescribed by the after-hours doctor and keep a diary recording her symptoms and periods.

Dr C stated that Mrs A did not tell him that abnormalities had been found by the after-hours doctor. However, Ms B advised me that her sister, Mrs A, told her she did mention the examination by the after-hours doctor to Dr C, and that she had been advised to see her regular doctor urgently.

Dr C stated that the after-hours records would have arrived at his practice later in the morning and were not available when he examined Mrs A. When he reviewed the notes later in the day he did not notice the comment "? lesion at tip of finger". There was nothing to draw his attention to it. Dr C said that if he had seen the comment he would have referred Mrs A to a specialist. He admitted that, if he had done this:

> "[Mrs A's] cancer would have been diagnosed about six and a half weeks earlier than it was. As Mrs A had extensive ovarian and pancreatic cancer I do not believe that the six and a half weeks delay in diagnosis would have affected the management or outcome."

The Practice Manager at the private medical centre stated that notes from the after-hours service were couriered to the medical centre between 8.00am and 9.00am. A nurse would have matched the notes with the patient file and placed them in the relevant doctor's box between 10.00am and 11.00am. Doctors clear their boxes when they do not have patients. If the doctors are busy the boxes may not be cleared until lunchtime or later. Nurses double-check whether boxes have been cleared. The current practice at the private medical

centre is for after-hours medical notes to be distributed to doctors between 8.00am and 9.00am.

On 4 March 1997 Mrs A returned for a further consultation. Mrs A told Ms B that she felt there had been no improvement since starting the medication. Dr C recorded that Mrs A felt constantly bloated and belched often at night. Dr C arranged for a faeces sample to be taken and tested for giardia (an organism that can cause inflammation in the digestive tract), with negative results.

Mrs A rang Dr C on 17 March 1997. Ms B said Mrs A continued to be unwell and struggled to continue teaching. Mrs A told Dr C that she had vomited twice. Dr C advised her to take two tablets of Maxolon (used for the relief of nausea and vomiting) three times a day. Dr C stated he would normally advise a patient to come in if the vomiting did not settle. Dr C did not arrange a follow-up appointment.

On 19 March 1997 Mrs A returned to see Dr C. Mrs A told Ms B that she had advised Dr C that she could not sleep and was unable to lie down for long. Dr C's notes record:

> "Stomach still feels very bloated, can't lie on abdomen at night, on Aropax ½ daily. P[ulse] 80 Abdo[men] soft. Tender to palpation. Bs [bowel sounds active] Bowels move about x3 [diagnosis] irritable bowel – discussed with […] [gastroenterologist] – will refer back to gastroenterology if no improvement Prepulsid 5mg BD Review 2w[eek]."

Dr C advised Mrs A that her symptoms, normal examinations, normal blood tests and the knowledge that she had had a normal barium enema and endoscopy in 1993 strongly suggested a diagnosis of irritable bowel syndrome. Dr C stated that he phoned a gastroenterologist, explained Mrs A's situation and requested permission to prescribe Prepulsid, a specialist only medicine that helps bloating. Dr C stated that the gastroenterologist agreed to a trial of Prepulsid, and a review in two weeks' time.

At 1.30am on 1 April 1997 Mrs A went to the 24 hour medical centre complaining of a month's history of "back discomfort". The pain had worsened in the last week, particularly at night when it radiated up her spine. The after-hours doctor noted Mrs A's diagnosis of irritable bowel syndrome and depression and that she was currently taking Aropax. He observed that Mrs A appeared distressed. She had a non-tender lumbar spine and good range of motion in her lower back. The GP was unsure of the cause of Mrs A's pain and raised the possibility of fibromyalgia (a form of rheumatism). Mrs A was prescribed Voltaren 50mg (anti-inflammatory pain relief medication) to be taken as required. She was advised to see her own general practitioner in the next one to two days. A copy of these notes was sent to Dr C.

Ms B advised that Mrs A rang her later that morning in tears. Mrs A told Ms B that she was in continual pain and not sleeping at night. Mrs A felt that her family thought she was

imagining her symptoms. She felt that she was not getting anywhere with Dr C and did not know where to turn. Ms B told Mrs A to telephone Dr C for a referral to Dr G, a general surgeon who specialised in treating the bowel.

Mrs A rang Dr C on 1 April 1997. Dr C recorded that Mrs A explained that she had pain in her back between her shoulder blades and down to waist level. She said she was not sleeping well, although she got sleepy if she took one whole Aropax tablet. Mrs A told Ms B that Dr C refused to refer her to a surgeon for a second opinion. Dr C's notes record that Mrs A asked to be referred to Dr G, although this entry has been crossed out. Dr C stated that he has never refused to let a patient see a specialist of his or her choice. He said he discussed Mrs A's request with her and suggested that he take a blood test to check her amylase (an enzyme that converts starch into smaller carbohydrate molecules; an indicator of pancreatic disease) so that he could refer her to a gastroenterologist at the public hospital and save her the cost of a private consultation. Dr C said that he would have probably crossed out the entry about Dr G after Mrs A agreed to this approach.

Ms B said that Mrs A was sleeping for short periods of time only when sitting in a 'Lazy-boy' chair. Mrs A told Ms B that she had requested a referral but was told it was not necessary and to take a whole Aropax tablet, as Dr C felt that her pain was connected to her depression.

Mrs A contacted Dr D, a consultant psychiatrist who had been treating her since October 1990 for major depression. Dr D confirmed that Mrs A called him in early April 1997 to discuss whether her back and abdominal pain could be related to her depression. Dr D wrote:

> "Because there had never been any significant somatic component to her mood disorder, I told her that it was very unlikely that the physical symptoms she was experiencing were related to her depression."

On 2 April 1997, Mrs A telephoned Dr C. Dr C wrote in her notes "will check amylase then refer to gastroenterologist". The last part of the sentence has been crossed out. Dr C states that he probably crossed it out on 4 April 1997 when the amylase results were found to be normal.

On 4 April 1997 Mrs A consulted Dr C with back pain. Dr C noted "her back now seems to be main complaint – suggested massage". Dr C said that this entry suggests Mrs A's bloating and abdominal pains were settling as a result of the medication and that he would only have suggested massage if his impression was that the backache was not severe. Dr C said that he did not refer Mrs A to a gastroenterologist as the amylase and other blood test results were normal.

Mrs A rang Ms B after the consultation. Ms B suggested that Mrs A change her doctor. Mrs A was unable to get an appointment to see Dr G, so she made appointments with Dr E, a colorectal surgeon, and another medical centre.

On 8 April 1997 Mrs A went to the Accident and Emergency Department of the public hospital with severe chest pain, but was later discharged.

Mr A, Mrs A's husband, advised that his wife's symptoms would come and go and that this frustrated her, as when she got to the doctor to advise him of what she was going through, the symptoms had disappeared or else the pain had changed places. He stated that this made Mrs A confused and embarrassed. Mr A advised that both he and Mrs A felt that something was wrong but they could not pinpoint it.

On 10 April 1997 Mrs A saw Dr E. Prior to this consultation, Mrs A had gone to Dr C's medical centre and collected photocopies of her medical notes.

Dr E wrote to Dr C after he had seen Mrs A on 10 April 1997. Dr E stated:

> "[Mrs A] suffers from left iliac pain [relating to the pelvic region] not associated with defecation, urinary frequency or any change in bowel habit or rectal bleeding. She has noticed however her periods have changed dramatically and that recently she seems to be suffering from intermittent vaginal bleeding. She has previously been investigated for iron deficiency, anaemia in 1993 with barium enema and gastroscopy with small bowel enema, which was allegedly normal. She has recently presented to A & E with chest pain and I believe this is normal. Recent blood tests, which she presents to me, show no evidence of anaemia and no evidence of B_{12} folate or ferritin abnormalities, normal liver function tests. I believe she has been diagnosed with having irritable bowel and has been treated as such. Her other complaint is intermittent abdominal distension and that she has lost half a stone in weight. She is also believed to be suffering from depression and is being treated as such.
>
> On examination abdomen is soft, non-tender and no masses palpable. There is a previously lower midline scar consistent with a classical Caesarean section and a previous scar from appendectomy. On rectal examination there seems to be a tender mass high in the pelvis and a sigmoidoscopy to 12cms is normal.
>
> In all I am suspicious of what is going on in her pelvis and I have arranged a pelvic ultrasound, CA 125 [a blood test of which the results indicate ovarian or other glandular cell cancers] and a number of blood tests, copies of which will be sent to yourself. I will see her again next week hopefully with the results of the pelvic ultrasound."

On 11 April 1997 Mrs A had a pelvic ultrasound. The scan (which was faxed to Dr C) suggested that Mrs A had an ovarian carcinoma. Mrs A's CA 125 results were above the normal range.

On 17 April 1997 Mrs A saw Dr E again. He confirmed that she probably had ovarian cancer. She was referred to Dr F, a gynaecological oncologist. Dr E wrote to Dr C on the same date advising that Mrs A probably had ovarian cancer.

Dr C said that when he received this letter he went back over his notes and discovered he had overlooked the after-hours doctor's note about the presence of a lesion. Dr C said that he was devastated by his omission. He stated that although he made no record of whether he contacted Mrs A subsequent to her diagnosis, he believes that he did try to make contact with Mrs A by telephone, but that Mrs A was in hospital at the time. He acknowledged that one failed attempt to contact Mrs A was not enough. Dr C noted that neither of the letters written by Dr E indicated that Mrs A required pain relief.

At 11.45pm on 21 April 1997, Mrs A presented to the after-hours service with pain. The after-hours doctor noted that Mrs A had been diagnosed with ovarian cancer five days earlier and that she had had an increase in lower back pain over the last three weeks. He noted that Mrs A had started taking Voltaren, which had initially helped control her pain. However, Voltaren was no longer effective, even with the addition of paracetamol. Mrs A was given Acupan 20mg IM (intra-muscular pain relief) and told to take Panadeine.

On 23 April 1997 at 6.45am Mrs A again went to the after-hours service with abdominal pain and was seen by another GP. The GP recommended that Mrs A contact Dr C that day for ongoing pain management and injected her with 20mg of Acupan.

Mrs A consulted Dr C on the same day. She told Ms B that Dr C made no apology. Dr C stated that he did offer his apologies to Mrs A, and that he explained to her why he missed the diagnosis, and that he had failed to see the line on the After Hours slip that suggested there might be an abnormality. Dr C recorded that Mrs A "had pains in upper abdo – under xiphisternum". He noted that Mrs A had an appointment with the Public Women's Hospital on 24 April 1997. Mrs A's pain was not controlled by one tablet of codeine 30mg taken four times a day and Voltaren 50mg. He noted that Mrs A had an injection of Acupan on 21 April 1997 and this settled her. Mrs A had been getting slight vaginal spotting and had abdominal pain. He documented "abdo-soft ? mass palpable LIF (left iliac fossa) – this is tender". Dr C prescribed pethidine 50mg (pain relief) one to two four-hourly. Dr C stated that he recalled discussing Dr E's findings with Mrs A and asking permission to do a rectal examination to see if he should have picked up the mass. He recorded in the notes that there was a "firm mass – non tender – palpable; rectum empty".

On 24 April 1997 Mrs A saw Dr F. Dr F advised Dr E (letter copied to Dr C) that Mrs A had:

> "… a fairly nasty pelvic tumour … her ultrasound suggests ascites [an abnormal accumulation of fluid] and bilateral ovarian masses and a CA-125 … is raised at 100. On examination there is no sign of extra-abdominal disease but on abdominal examination she obviously has ascites and vaginal examination reveals a large fixed pelvic mass mostly rising from the right ovary. …"

Dr F arranged for Mrs A to be admitted to the Public Women's Hospital for a laparotomy (a surgical incision through the abdomen) and de-bulking of her ovarian tumour, to determine what stage the cancer had reached.

On 28 April 1997 Mrs A went into the public hospital for the laparotomy. Following the operation Mrs A's family was advised that her condition involved the pancreas, spleen, liver, ovaries and bowel. She had ascites and there was little that could be done for her.

On 12 May 1997 Dr F wrote to Dr E:

> "[Mrs A] was admitted with a seven month history of lower abdominal pain, abdominal swelling and anorexia. She had been noted to have bilateral ovarian cysts on ultrasound associated with ascites. A laparotomy was performed which revealed the ascites and bilateral complex necrotic ovarian cysts which were free in the pelvis, ascites and very little intraperitoneal disease, however, a very large pancreatic tumour spreading from the body to the tail, about 10cm in diameter and about 20-30cm in length.
>
> A bilateral oophorectomy [surgical removal of both ovaries] was performed and a palliative procedure [therapy designed to relieve or reduce intensity of uncomfortable symptoms, but not to produce a cure] with a residual 2cm nodule in the Pouch of Douglas and obviously the pancreatic tumour. She made a slow recovery from the surgery with prolonged ileus and difficulty obtaining adequate pain relief. At discharge she still had some gastro-intestinal dysfunction suggestive of a degree of upper small bowel obstruction, vomiting and bile stained fluid, about once a day. …"

Following the surgery Mrs A was unable to keep down food or fluids and her weight decreased from eleven stone to under eight stone within two months.

Ms B advised that Dr H became Mrs A's general practitioner after Mrs A was discharged from hospital on 11 May 1997. Mrs A was followed up by a palliative nurse from the private Palliative Care Team.

On 14 May 1997 Mrs A was reviewed in the Oncology Clinic and noted to have intermittent problems, with vomiting and upper abdominal pain radiating through her back. Mrs A's care, disease process and prognosis were discussed with her family. Further follow-up was arranged in ten days' time. Ms B advised that her sister was unable to attend this appointment, as she became too unwell to travel.

Mrs A died on 20 June 1997.

When Dr E was asked if Mrs A's symptoms could have been diagnosed earlier, he stated:

> "This is difficult to answer four years later, but with the records I have of the events one could say it is possible although I would say not definitely probable. Without having her public hospital records to refer to at the time of writing this letter, I do not believe it would have made any difference to the ultimate outcome if she had been diagnosed any earlier, as the final diagnosis I believe was metastatic carcinoma of the pancreas and therefore an earlier diagnosis would not have changed the outcome for Mrs [A]."

Dr F was also asked if Mrs A's symptoms could have been diagnosed earlier. To this Dr F stated:

> "… [I]t is reasonably typical for patients with ovarian cancer with disseminated disease similar to the disease situation Mrs [A] presented in to have a prolonged history of symptoms without definite diagnosis being made. This is due to the fact that abnormalities are frequently not easily detected on straightforward clinical examination and the symptoms tend to be non specific and vague.
>
> If Mrs [A] had undergone a CT scan or ultrasound at an earlier date then it may have been possible that the abnormality would be detected relating a metastatic tumour, either ascites or ovarian abnormality, possibly even upper abdominal disease. However because of the nature of the disease it is unlikely that this would have achieved anything other than an earlier diagnosis. The prognosis would most likely have been identical."

Ms B emphasised that in the two months preceding her diagnosis Mrs A was suffering from extreme pain, discomfort, and distress. Ms B was concerned that throughout the time that her sister consulted Dr C, he failed to take a holistic approach and to see Mrs A as a person with real pains and problems. Ms B was concerned that Dr C's judgement was clouded by the fact that Mrs A had a history of depression. Ms B believed that if Dr C had taken a more proactive approach, Mrs A and her family could have been spared a huge amount of emotional and physical strain.

Independent advice to Commissioner

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

> "This is a complaint made by Ms [B] that the care and attention her sister, Mrs [A] received from Dr [C] during the period December 1996 to April 1997 was not appropriate.
>
> Your summary of this sad case is very adequate. It tells us of a 42 year old woman who has been known in the past to suffer from depression who presented with increasing abdominal and back pain to her GP and to an [after-hours medical centre]. She was told by Dr [C] that basically she was suffering from depression and an irritable bowel syndrome that was aggravated by stress and so treated as such. However, her pain became worse to the point where she was barely able to continue her work as a schoolteacher and had to sleep in a Lazy-Boy at night.
>
> She apparently self referred ultimately to a colorectal specialist who made the diagnosis of carcinoma of the ovary. It was clear later on that she also had a carcinoma of the pancreas.

It is somewhat unclear from the notes that I have been given whether or not the carcinoma of the ovary was a primary or a secondary spread from metastatic pancreatic cancer. Her pain relief after the diagnosis of ovarian cancer was not adequate and she needed to make appointments herself both at the After Hours and to Dr [C's] surgery to obtain suitable pain relief before a referral to the [public hospital] was followed through. Mrs [A] subsequently died on 20th June 1997 because of this disease.

With regard to the issues you have raised:–

1. Was there enough information given to Mrs [A] from Dr [C]?

There was not enough information given to Mrs [A] by Dr [C] simply because Dr [C] really did not have a correct or adequate diagnosis for Mrs [A's] symptoms. I believe Dr [C] told Mrs [A] everything he thought he knew, but the real issue was really of what investigations were done, or in this case, not done.

2. Was there enough done to prevent this outcome? If not, why not?

Ultimately unfortunately the outcome of Mrs [A's] malignant disease could not be prevented. It is impossible to prevent either ovarian or pancreatic cancer, both are very deadly diseases with no known cure. However, I do believe that a lot of anguish would have been averted if Mrs [A] had been able to be informed of the diagnosis earlier, thus not having to go through the trauma of having even people quite close to her thinking it was all an imaginary condition. Also had this diagnosis been able to be made earlier, then adequate pain relief could have been instigated at a much earlier time.

3. Were Dr [C's] choices of intervention for Mrs [A] appropriate and timely?

I believe that Dr [C] should have ordered an ultrasound examination of Mrs [A's] abdomen much earlier than he did. This examination really should have been performed in February 1997 rather than waiting and if this had been done, an adequate diagnosis could have been reached much earlier.

The interventions that were offered to Mrs [A] by Dr [C] were on the basis of an irritable bowel syndrome but irritable bowel syndrome is really a diagnosis of exclusion, it is a diagnosis that you reach when everything has been adequately excluded. I believe this was not done and had an appropriate investigation, such as an abdominal ultrasound scan been performed, then an appropriate diagnosis could have been achieved much earlier.

4. Should there have been earlier intervention by Dr [C] to prevent this outcome? If so, when should this have been done?

I believe I have answered this question in a large part in my previous paragraph. The outcome ultimately would not have been prevented but I believe that had appropriate

investigations been done in February, then the diagnosis made in April could have been reached at that time.

5. Could her presenting symptoms have been indicative of some other diagnosis?

Obviously because her presenting symptoms of bloating and lower abdominal discomfit, belching and vomiting, were not specific they could have been indicative of any number of diagnoses. However, these needed to have been worked through and the trouble was that Dr [C] jumped to the conclusion that her symptoms were of irritable bowel. As already mentioned, this is the diagnosis of exclusion and thus Dr [C] should have worked very hard to exclude all other diagnoses that could lead to the presenting symptoms before reaching a conclusion of irritable bowel syndrome.

6. Were Dr [C's] actions in treating Mrs [A] appropriate to meet professional standards required of a general practitioner?

I believe ultimately they were not because he did not adequately investigate the symptoms Mrs [A] presented with and, as well, he missed the comment of 'mass' felt in the [after-hours private medical clinic]. I believe this should have been followed through and seen to earlier. Therefore Dr [C] did not meet professional standards in this situation.

7. Should Dr [C] have undertaken or referred Mrs [A] to have tests to identify the cause of her presenting symptoms?

I believe I have answered this question above in that had adequate tests, such as an ultrasound scan been done, of Mrs [A's] abdomen then the diagnosis would probably have been reached much earlier than April 1997. Dr [C] could have had these tests done either in the private sector or, if Mrs [A] preferred, he could have referred her to the public hospital for these to be done.

8. Were the written notes from Dr [C] reasonable?

I believe that the notes were by and large reasonable, although minimal.

What care should Mrs [A] reasonably have expected from her general practitioner?

The care that Mrs [A] should have expected from Dr [C] is that he should have taken all steps to ascertain a diagnosis for her symptoms. Failing this he should have referred her for appropriate specialist consultation if a diagnosis could not be reached. I believe that this is especially prudent if you are going to reach a diagnosis of irritable bowel syndrome.

I also feel that Dr [C] should have rung Mrs [A] once a diagnosis of ovarian cancer was in fact reached and he should have seen her really the very same day, to talk with her and

discuss appropriate pain relief from that point onwards. I believe that fact that he did not do so is a significant mistake and one that I see Dr [C] is cognisant of also.

I also feel Dr [C] did not appreciate Mrs [A's] anguish appropriately and thus did not treat her appropriately. She deserved intensive investigation for her symptoms and effectively all that happened was that Dr [C] reached a conclusion as to the cause of her pain and did not deviate from this conclusion or attempt to look at any other possible reasons for the symptoms.

10. Any other issues that arise from the supporting information?

The issue really that arises is that this very sad case illustrates the problem that can occur when a doctor has fixed in his or her mind what a patient is suffering from and does not wish to think outside this diagnosis. Dr [C] had it fixed in his mind that Mrs [A] was depressed and that she was suffering from an irritable bowel syndrome. The steps he then took were in line with these fixed ideas and he really did not adequately follow through with the investigations that should have been done.

I do not think that anything Dr [C] could have done would have necessarily prolonged Mrs [A's] life, but her suffering could well have been eased. Certainly the pain relief she got, until more appropriate care was initiated for her by [the public hospital], was inadequate. For example, the use of Pethidine tablets for malignant pain relief has long fallen into disrepute."

Dr Kalderimis subsequently provided the following clarificatory expert advice:

"[T]his is a follow-up to the complaint made by Mrs [A] about the service she received from Dr [C].

I do feel a certain sympathy for Dr [C's] predicament, and I think two things need to be said about the consultation at the [after-hours medical centre]. Firstly, most of us will look at our mail following the weekend either during lunchtime on the Monday or possibly even later at the end of the day. It is often simply not feasible to do it before surgery starts. Secondly, if you look at the consultation slip from the [after-hours medical centre], you will note it is fairly messy and in fact the comment '? lesion on tip of finger?' is actually quite easy to miss. I think it would not be at all difficult to overlook that comment.

Thus I feel all in all it is reasonable to perhaps state that it could have been overlooked and I think Dr [C] is correct in stating that there would not have been a significant difference to the outcome in the end."

Dr Kalderimis was asked whether Dr C was correct in stating that had he known about the lesion observed at the after-hours consultation, the diagnosis could have been made six and a half weeks earlier. Dr Kalderimis responded that knowledge of the lesion would only have

raised a suspicion and that it may still have been appropriate to wait and see. If Dr C had examined Mrs A the cancer may not have been palpable.

The following additional expert advice was obtained from a second independent general practitioner, Dr John Cheesman:

> "…
>
> When Mrs [A] presented to Dr [C] on the 17th of February 1997 he did not examine her and in particular a vaginal examination was not carried out. Even if he did examine her, it was not recorded. Appropriate blood tests were carried out. The after hours consultation slip stated that there was a possible lesion at the tip of the finger on vaginal examination and this should have alerted him to possible gynaecological pathology. Further investigations would have included an ultrasound of the pelvis/abdomen. He again saw her on the 4th of March 1997, again she was not examined (if so not recorded). But appropriate tests i.e. stool, cultures, for giardia were carried out. On the 19th of March she was examined and discussed with [a] colleague [gastroenterologist]. On 4th of April 1997 she was seen again. The main complaint was now back pain an examination again was not carried out (if so not recorded).
>
> However the outcome of the consultations on 4th of March, 19th of March and 4th of April 1997 would have been different if the initial examination and investigations had been carried out.
>
> The diagnosis of irritable bowel syndrome, in light of past history (also negative barium enema and endoscopy 1993) and present symptoms was appropriate but again an initial abdominal ultrasound would have changed the diagnosis. Blood tests were appropriate and normal. Dr [C] had also discussed Mrs A with a gastroenterologist […] and planned referral if no improvement with medication.
>
> The advice given to Mrs [A] was appropriate on 17 March 1997 but an appointment to see her should have been made, as the vomiting was a new symptom.
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> On 1 April Mrs [A] complained of back pain [phone call]. She should have been again seen. It is not clear but the request for referral was crossed out in the notes and if this was the request this should have been carried out.
>
> There was another phone call on 2nd April where blood tests were arranged [appropriate] but another referral request crossed out why?
>
> Dr [C's] explanation that he checked the amylase blood test was reasonable but then he should have referred to a specialist following this as she was still having considerable problems.
>
> Mrs [A] was seen by a colorectal surgeon on 10 April 1997 and Dr [C] should not necessarily have followed up Mrs [A] after this as the specialist was seeing her again in

one week (Dr [C] wouldn't be aware of the consultation initially as he hadn't referred her).

Dr [C] would have seen the result of the ultrasound examination (11 April) and this should have prompted some immediate follow up at least a phone call to Mrs [A]. Dr [C] should have also followed up Mrs [A] after he was informed that she had cancer whether she needed pain relief or not.

Dr [C] saw Mrs [A] again on 23 April and prescribed appropriate pain relief [the next step after codeine and anti-inflammatory agents would be a narcotic i.e. pethidine on a regular regime]. He would have also known that she was also going to be seen the next day.

In summary the services provided did not comply with professional standards but the sequence of events, regardless of the final diagnosis and outcome, may have been quite different if the diagnosis had been made earlier i.e. by acknowledging and acting on the examination record in the [notes by the GP at the after-hours medical clinic] of 16 Feb 1997. All 'After Hours' consultations should be recorded accurately in the notes."

Response to Provisional Opinion

Dr C noted, in response to the provisional opinion, that the fact that Mr A stated that Mrs A's symptoms would come and go led him to suspect that Mrs A might not always have explained to him the severity of the symptoms from which she was suffering. Dr C stated that he certainly did not understand that Mrs A's symptoms were as severe as those described by Ms B; if they were, Mrs A did not communicate this to him.

Dr C reiterated that when he saw Mrs A on 17 February 1997 it was not unreasonable from his knowledge of her medical history and findings to think that "irritable colon" was the most likely diagnosis. Dr C stated that some of Mrs A's symptoms dated back to 1984, and that irritable bowel syndrome was first mentioned in her medical notes in 1985 by her GP at the time. Dr C advised me that his notes indicated that Mrs A had been suffering from abdominal pain for one month, and abdominal bloating for three years.

Dr C stated that it was on this basis that irritable bowel syndrome was at the top of his list of diagnostic probabilities. He considered that, on the basis of Mrs A's medical history, the provisional diagnosis of irritable bowel syndrome was appropriate, and in the absence of any "red flag alerts" an empirical approach with a trial of medication was appropriate. Dr C advised that such an approach is supported by the literature, as is the fact that an ultrasound is not an appropriate investigation for irritable bowel syndrome.

Dr C requested that my expert advisors reconsider their advice in the light of Mrs A's long history of tiredness, stomach pains, chest pains, and the fact that irritable bowel syndrome was first mentioned in her notes in 1985 by her then general practitioner. In addition, Dr C requested that the expert advisors consider that he perhaps did not appreciate Mrs A's "anguish" or the severity of her symptoms because she did not communicate them to him.

Dr C advised me that he has now stopped work as a full-time general practitioner:

> "I have continued to review my functioning as a medical practitioner. Although the past two years have been very stressful and difficult I have learnt from the mistakes I made and have made alterations to my medical practice and my approach to diagnosis and investigations."

Further independent advice

In light of Dr C's response to the provisional opinion, the following additional expert advice was obtained from Dr Cheesman:

> "As stated previously, I feel the diagnosis of 'irritable bowel syndrome' in the light of the past history (normal barium enema and endoscopy by Gastroenterologist in April 1993) and present symptoms of abdominal bloating for three years along with abdominal pain and poor diet is reasonable. Again as stated previously an examination particularly of the abdomen should have been carried out (and if done so should have been documented).
>
> However should the symptoms of abdominal bloating be present for only one to two months along with a possible diagnosis of 'irritable bowel syndrome' by a previous doctor I feel this diagnosis is much less likely and some other cause for Mrs [A's] abdominal symptoms should be sought.
>
> It is noted that the reference to 'pv' in the after hours records was difficult to read and was actually 'pr' (rectal examination). See transcript of after hours consultation (K.). Nevertheless this would not change the situation and an examination should still have been done.
>
> Looking at Mrs [A's] diary I am not sure what Dr [C's] action would be as the diary is a little hard to follow. However one can see that she was having significant problems with back pain with some belching/indigestion. Mrs [A] was on medication at the time and perhaps a change in this could have been considered. Also a review of diagnosis and further investigation would be warranted. (Assuming Dr [C] saw the diary.)

As mentioned in my previous report an ultrasound should have been requested earlier in the sequence of events as Mrs [A's] symptoms were persistent and not responding to medication.

For bowel symptoms the diagnostic tests available, apart from routine blood tests would include barium examinations (either barium enema or meal) and an abdominal ultrasound.

As abdominal pains, nausea and bloating were the main symptoms initially, I feel an ultrasound would have been appropriate at least initially. This could have been done early in March 1997 particularly as Mrs [A's] symptoms were not settling.

I feel Dr [C] should probably have referred Mrs [A] to a specialist earlier in the course of events. It is noted however that Dr [C] discussed Mrs [A] with a Gastroenterologist on 19th March 97 and planned to refer if no symptomatic improvements. This was quite a reasonable plan of action.

When Mrs [A] asked for a referral (probably by telephone on 1/4/97) Dr [C] should have arranged this, particularly in light of Mrs [A's] persistent symptoms.

I feel once Dr [C] had received confirmation of Mrs [A's] diagnosis he should have made contact with her even if it took a number of phone calls. He should have done this to provide Mrs [A] with any support she needed. It is documented that Dr [C] said he spoke to Mrs [A's] husband who confirmed that (letter of 16/5/2002 attached to interview marked 'N') but Dr [C] should have spoken to Mrs [A] herself.

After reviewing Dr [C's] response my opinion still remains essentially the same. Dr [C's] actions did not meet Professional Standards in that he did not examine Mrs [A] initially and did not fully investigate her symptoms after they did not respond to initial treatment. In particular an ultrasound scan was not performed and referral to an appropriate specialist was not arranged when Mrs [A] requested this.

Dr [C] did not see the comment in the after hours notes of a 'mass at the tip of finger'. Acting on this with an appropriate examination may have hastened the referral for a specialist opinion and expedited the diagnosis.

However I concede that the [after-hours] Consultation note is quite untidy and difficult to read and the above comment could easily have been overlooked.

I feel Dr [C's] initial diagnosis of 'irritable bowel syndrome' was reasonable (see above comments) and a short trial of medication (already started by [after] hours Dr) would be acceptable as long as adequate follow-up was arranged particularly as in this case Mrs [A's] symptoms did not settle. In that case further investigation would be necessary."

Dr Chris Kalderimis provided the following additional expert advice in light of Dr C's response to the provisional opinion:

> "I have looked at the Complaint file that you have sent back to me and to Dr [C's] response.
>
> After looking at [Dr C's] response, it does not change my opinion in any substantial way. While I acknowledge that it is possible that Mrs [A] minimised her symptoms or did not recount them accurately to Dr [C], and while it is certainly possible that Dr [C] had a different view of Mrs [A's] symptoms to what Mrs [A] felt herself, I would nevertheless feel that a diagnosis of irritable bowel syndrome is one that is made by exclusion of other conditions and this should have been done.
>
> Thus, in summary, I do not feel that my report would be changed in any substantial way."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 2
Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

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.*
3) *Every consumer has the right to have services provided in a manner consistent with his or her needs.*

Other relevant standards

New Zealand Medical Association Code of Ethics (1989)

"*Consultation*

…

36. Request the opinion of an appropriate colleague acceptable to the patient if diagnosis or treatment is difficult or obscure, or if the patient requests it. …"

Opinion: Breach – Dr C

Right 4(1)

In my opinion Dr C did not provide Mrs A with services with reasonable care and skill between 17 February and 23 April 1997.

Examination, assessment and diagnosis
Mrs A saw Dr C on 17 February 1997 with continued bloating and one month's history of abdominal pain. She had previously presented to the private medical centre on 24 December 1996 with abdominal fullness, and to the after-hours service on 16 February 1997 with bloating and pain. My advisors informed me that, in these circumstances, Dr C should have undertaken a physical examination, including a rectal examination, and ordered an ultrasound. Dr C also did not undertake a physical examination or order an ultrasound when Mrs A consulted him on 4 March, 19 March and 4 April 1997.

Mrs A's symptoms of bloating, abdominal pain, belching and vomiting were not specific and could have indicated a number of diagnoses. The diagnosis of irritable bowel syndrome reached by Dr C was based on an assessment of Mrs A's presenting symptoms, history and blood test results. Specifically, Dr C stated that his diagnosis was based on the fact that Mrs A's symptoms dated back to 1984, and that her previous general practitioner had mentioned irritable bowel syndrome as a possibility in 1985. In addition, Dr C stated that Mrs A had been suffering from abdominal bloating for three years.

The assertion that Mrs A had been suffering from abdominal bloating for three years is not clearly reflected in Mrs A's notes and is not supported by the evidence. The evidence indicates that Mrs A's bloating was a recent complaint, having been present for only one or two months. My second expert advisor noted that if Mrs A's bloating had been present for only one to two months, Dr C should have sought some other explanation for Mrs A's abdominal symptoms. In the absence of a physical examination, the diagnosis of irritable

bowel syndrome was presumptive only, particularly as irritable bowel syndrome can be diagnosed only after other conditions are excluded.

During the rectal examination undertaken by the after-hours doctor at Mrs A's consultation on 16 February 1997, the doctor discovered a possible lesion and recorded this in the patient notes. These notes were sent to Dr C's surgery on 17 February 1997. The notes were not available to Dr C at the time of the consultation but he reviewed them later in the day. Dr C admits that he overlooked the comment about the lesion; had he seen the comment, he would have referred Mrs A to a specialist.

Dr C states that Mrs A did not tell him that any abnormality had been found. It is not, however, the patient's responsibility to relay clinical findings. Patients may not appreciate the significance of information they have received. It is the doctor's responsibility to thoroughly read any documentation about a patient forwarded by another doctor.

In my opinion Dr C failed to read the clinical records from the after-hours doctor thoroughly and so failed to notice the comment about the suspected lesion. This was a lapse by Dr C. This finding should have been noticed and aggressively followed up. Had this occurred, the diagnosis of cancer could have been advanced and saved Mrs A much suffering.

My advisors concluded that Dr C did not adequately investigate the symptoms Mrs A presented with during any of her four appointments with him so that he had enough information to exclude potential causes of her symptoms and make an appropriate diagnosis. Dr C did not revisit his diagnosis when Mrs A's symptoms continued and worsened. Dr C considered a specialist referral and a referral was requested by Mrs A on 1 April 1997. Dr C chose not to make a referral on the basis of the normal blood test results received on 4 April. My second advisor informed me that Dr C should have referred Mrs A to a specialist at this point, since despite the clear blood test results Mrs A was still having considerable problems. The New Zealand Medical Association's 'Code of Ethics' requires that a doctor seek the opinion of a colleague if the patient requests it or if diagnosis or treatment is difficult or obscure. Clearly, Mrs A needed a second opinion.

My second expert advisor advised me that Dr C should have arranged to see Mrs A after he had spoken with her on the phone on 17 March and 1 April 1997, as on each occasion she was reporting new symptoms. Dr C failed to do this.

Mrs A's life could not have been saved if Dr C had conducted the appropriate examinations and detected the cancer at an earlier point, and it is unlikely that her life could have been prolonged. However, Mrs A could have been spared much emotional and physical suffering had the diagnosis been made earlier. In my opinion, Dr C failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Right 4(3)

Actions after preliminary diagnosis of cancer
Dr E wrote to Dr C on 10 April 1997 to inform him that during a rectal examination of Mrs A he had found a tender mass high in the pelvis and was suspicious of what was going on in her pelvis. Dr E stated that he would see Mrs A again the following week when the ultrasound results were through. Dr C received a faxed copy of the ultrasound report on 11 April 1997. The report stated that the findings of the ultrasound were consistent with carcinoma of the ovary. Dr E wrote to Dr C on 17 April 1997 advising him that he had met with Mrs A and advised her that she probably had ovarian cancer.

Dr C advised that he made one attempt to contact Mrs A by telephone subsequent to her diagnosis of cancer, but that he did not speak to her as she was in hospital. My advisors noted that Dr C should have contacted Mrs A once a diagnosis of cancer had been reached. He should have met with her on that day or the following day to talk with her about the diagnosis and its implications, and about any assistance, such as pain relief, she might need. Dr C, as Mrs A's general practitioner, had a closer relationship with her than a specialist she had seen on one occasion. While I accept that Dr C did attempt to contact Mrs A on one occasion, in my opinion one failed attempt to contact her was not sufficient. Dr C's duty of care to his patient required that he contact Mrs A, once he became aware of the diagnosis, to offer her any assistance or support she might need, even if this meant making several phone calls. Accordingly, in my opinion, Dr C failed to provide services in a manner consistent with Mrs A's needs and breached Right 4(3) of the Code.

Opinion: No Breach – Dr C

Right 4(2)

In my opinion Dr C did not breach ethical standards by failing to refer Mrs A for a second opinion from a specialist, at her request.

It is documented in Dr C's medical notes for Mrs A, on 1 April 1997, that she had telephoned seeking a referral to Dr G, a general surgeon, for a second opinion. Mrs A told her sister that Dr C refused to make a referral. Dr C denied this, and said that following a discussion, Mrs A agreed that he would refer her to a gastroenterologist at the public hospital. Dr C said this was the reason the recorded request for a referral to Dr G had been crossed out in his notes.

Sadly, Mrs A is not able to give evidence of her recollection of the telephone call on 1 April 1997, and I have only the hearsay evidence of her sister, Ms B, to support the allegation that the request for a referral to a surgeon was denied. However, Dr C has provided a credible explanation for his documented non-referral.

Accordingly, in my opinion, Dr C complied with ethical standards and did not breach Right 4(2) of the Code.

Opinion: No Breach – private medical centre

Employing authorities may be vicariously liable for the acts or omissions of employees, agents or members, under section 72 of the Health and Disability Commissioner Act 1994. Dr C was a self-employed medical practitioner at the private medical centre. There is no evidence before me to suggest that Dr C, who was clearly not an employee of the medical centre, acted as an agent or member of the centre. Accordingly, the centre is not vicariously liable for Dr C's breaches of the Code.

Other Comment

Unnecessary examination on 23 April
On 23 April 1997 Mrs A consulted Dr C for ongoing pain management as requested by the after-hours doctor. During the consultation Dr C discussed Dr G's findings with Mrs A, including the result of the rectal examination undertaken by Dr G which found a mass in Mrs A's pelvis. Dr C asked permission to do a rectal examination to determine whether he would have picked up the mass if he had decided to undertake such a procedure.

A rectal examination is an invasive and intimate procedure that in my opinion should only be performed when there is a genuine clinical reason for it. Dr G had reported the results of the rectal examination. They were confirmed by the results of the ultrasound. There was no clinical necessity for a second rectal examination. Mrs A had recently been diagnosed with ovarian cancer, and was in great pain. She needed the pain medication regime that Dr C was to arrange, and may well have felt constrained to agree to the rectal examination.

Distribution of medical notes
The private medical centre had a system in place in early 1997 that, between 10.00am and 11.00am, distributed to the centre's doctors medical notes from the after-hours service. This was too late for doctors to refer to after-hours medical notes for any patients who came in for an early morning appointment and potentially impacted on the quality and continuity of the services offered to those patients. The inadequacies of this system may have impacted on the quality of care received by Mrs A. I note that the current system in place at the private medical centre distributes notes to doctors between 8.00am and 9.00am so that they are available for early morning patients.

Apology
Dr C enclosed a written apology to Ms B and to Mrs A's family with his response to the provisional opinion. The apology has been forwarded to Ms B.

Recommendations

- I recommend that Dr C contact the Royal New Zealand College of General Practitioners to discuss appropriate training or a refresher course in light of this report.

Actions

- I have decided to refer this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any further action should be taken.

- A copy of this opinion will be sent to the Medical Council of New Zealand, with a recommendation that the Medical Council review the competence of Dr C to practise medicine.

- A copy of this opinion will be sent to the Royal New Zealand College of General Practitioners, to facilitate implementation of the above recommendation.

- An anonymised copy of this opinion will be sent to the Royal New Zealand College of General Practitioners and the Pegasus Medical Group, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

After a thorough review of this matter, and receipt of further expert advice, the Director of Proceedings decided that this matter was unlikely to meet the disciplinary threshold and, accordingly, took no further action.