Dr C, General Practitioner

A Report by the

Health and Disability Commissioner

(Case 04HDC20196)

Parties involved

Ms A	Consumer
Ms B	Complainant/Consumer's sister
Dr C	Provider/General practitioner
Dr D	Director, A Medical Centre

Complaint

On 8 December 2004 the Commissioner received a complaint from Ms B about the services provided to her sister, Ms A, by Dr C. The issues arising from Ms B's complaint were identified as follows:

The appropriateness of the care and treatment provided by Dr C, general practitioner, to Ms A in relation to consultations on 3, 12 May and 2 June 2004, including whether Dr C:

- *adequately assessed, diagnosed and treated Ms A;*
- *provided adequate information to Ms A about her condition;*
- *provided adequate follow-up care and referral;*
- *adequately documented his care.*

An investigation was commenced on 29 April 2005.

Information reviewed

Information from:

- Ms A
- Dr C
- The Medical Centre

Independent expert advice was obtained from Dr Tony Birch, general practitioner.

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Information gathered during investigation

Background
This complaint concerns the medical care and treatment provided by general practitioner Dr C to Ms A, a 51-year-old tourist visiting family in New Zealand.

Ms A arrived in New Zealand on holiday on 22 March 2004, and stayed with her sister until 26 April 2004. She flew to a second town on 26 April, with the intention of staying there for three weeks, before returning to stay with her sister. However, plans changed and Ms A stayed in the second town until she left New Zealand on 19 June 2004.

Ms A advised that she went to each medical consultation with Dr C alone, as she was comfortable communicating in English.

Consultations with Dr C
Ms A saw Dr C at the medical centre on 3 May 2005.

Dr C's notes state:

> "On Holiday — from [overseas]. Now cellulitis nose after sunburn. Now quite severe — here for 3 weeks — to review if not better in one week.
>
> Rx: 30 — Augmentin Tab 500Mg With Potassium Clavulanate 125 Mg."

Ms A advised that she had a red nose and was experiencing pain and nose bleeding. Dr C does not recall Ms A mentioning that she had been experiencing nose bleeds and he did not record a history of nose bleeding.

Dr C says that on examination there was sunburn evident on Ms A's entire face, but there was no pus to swab. Ms A recalls that Dr C "felt my nose carefully while repeatedly observing (in a sympathetic tone) that it must be very painful". However, she does not recall Dr C performing a detailed examination of her nose at this consultation, and expressed concern that neither blood tests nor a biopsy were taken at this time. Dr C advised that he did not consider it necessary to order blood tests on an otherwise healthy person, presenting for the first time with cellulitis.

Ms A returned to see Dr C nine days later, on 12 May, as her nose remained swollen, she continued to have nose bleeds and was experiencing "pain more strongly than before".

In his letter dated 4 March 2005 to Mrs B, Dr C stated in relation to this second visit:

> "[Ms A's] nose was still swollen. I did not mention a specialist referral at this time, although I did mull this option over in my mind — I did not record this. We discussed that there is a group of skin bacteria that do not respond to penicillin-

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based antibiotics and that it was worthwhile trying a lower potency but wider spectrum antibiotic."

Dr C's notes state:

> "Nose very swollen still — but not sore — T36.2 [Temperature 36.2°C].
>
> Rx: 63 — E-Mycin [erythromycin] Tab 400 Mg [P] — 1 tab, Three Times Daily."

On examination, the appearance of Ms A's nose was relatively unchanged from her previous visit; "it was red and swollen and infected looking" according to Dr C. There was no evidence of blistering.

Dr C recalled that Ms A had been "adamant" that her nose had become better with the antibiotics (Augmentin) prescribed at the previous consultation but had deteriorated when she completed the ten-day course.

Ms A advised that she told Dr C that it was only when she initially started taking the antibiotics that the pain was less intense, and that over time the pain became "substantially worse".

Ms A was advised to return to see Dr C if her nose deteriorated or did not improve with the new course of wider-spectrum erythromycin antibiotics.

Ms A returned to see Dr C on 2 June 2004 because of what she recalls as "almost no longer bearable pain".

Dr C's notes state:

> "Nose looks worse — says that getting better now with the cat out of the house — back [overseas] in 3 weeks and wishes to see spec [specialist] [when she returns to her home country].
>
> Rx: 30 — Keflex 500mg Tab — 1 tabs, Three Times Daily."

Dr C does not recall Ms A being concerned about her nose being painful. In retrospect, he believes that he would have prescribed a codeine-based analgesic for Ms A if she had described "even moderate pain".

Dr C advised that he was told by Ms A that her nose had been better once her problem of an allergy (to a cat) was under control. On examination, Dr C observed that the swelling had increased and Ms A's nose remained red. There was no sign of either blistering or bleeding. Dr C prescribed a third antibiotic for Ms A at this consultation. He doubted that this antibiotic would be effective for Ms A, but "prescribed [it] under pressure from the patient".

Ms A denies that Dr C examined her nose during this consultation.

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Ms A said that there was no further information given by Dr C as to the reasons for the infection or any further diagnoses. Dr C said that he had previously considered squamous cell carcinoma or basal cell cancer as possible differential diagnoses, but the history given to him by Ms A "sent me down a different path" at the first two consultations. However, on 2 June he was "very concerned" that cancer was a possibility. He did not specifically advise Ms A about a differential diagnosis of cancer, because he did not have the histological evidence to support it. However, he says he made it clear that Ms A needed to see a specialist and have a biopsy.

Dr C advised that it is his usual practice to initiate a biopsy and screening blood tests in such situations.

He told Ms A there would be a wait of approximately three to six weeks to see a specialist in the public system. Dr C stated that time frames for seeing a specialist in New Zealand were difficult given Ms A's return travel plans. (She was due to fly home 17 days later.)

Dr C said that he also spoke with Ms A about the possibility of a referral to a private specialist. He stated:

> "I attempted to telephone a New Zealand specialist but [Mrs A] was very firm in her resolve to see her own specialist [in her home country] and I eventually concurred with her decision."

Ms A and Dr C agreed that she would see a specialist soon after her return home.

Dr C says Ms A told him that she had an appointment to see a specialist on the day she returned home. However, Ms A advised that she had not made an appointment with a specialist in her home country prior to this consultation with Dr C, but that the appointment was made with an ear, nose and throat specialist in her home country (whom she sees regularly for deafness in her left ear) the day she returned home. In any event, Dr C's view is that given the time frames involved in facilitating specialist referral and any required treatment for cancer in New Zealand, and Ms A's pending return home, consulting a specialist in her own country was the best option.

Subsequent events

Ms A advised that approximately one week following her last consultation with Dr C she telephoned the medical centre:

> "… in order to [ask for] the address of a specialist in [a city]. A receptionist told me, to come to see [Dr C]. She also told me, a date with a specialist is difficult and can take about 2–6 weeks. Due to this information I decided against a visit to [Dr C], as I was flying back [overseas] a few days later."

Dr D, Director of the medical centre, advised that none of his staff remember the telephone call from Ms A. A written log is not kept of the details of each telephone call to the surgery, as it would be impractical to do so with over 200 telephone calls

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received each day. However, it is now the clinic's policy to have front-desk staff pass on any telephone request for specialist referral to a practice nurse or doctor for further assessment of the request. The medical centre policy dated August 2005 requires a record of such requests to be made.

Ms A returned to her home country on 21 June 2004 and attended an appointment with an ear, nose and throat specialist, the same day. Further investigations and surgery approximately two weeks later revealed squamous cell carcinoma (cancer) of the nose.

Ms A's nose has been amputated and she has undergone a number of other operations. The cancer has spread to her left upper lip and the right floor of her mouth. Ms A has received radiotherapy and chemotherapy.

Independent advice to Commissioner

The following expert advice was obtained from Dr Tony Birch, general practitioner:

> "**Medical/Professional Expert Advice — File 04/20196: [Dr C].**
>
> Thank you for your letter of 22nd August 2005 requesting I provide an opinion to the Commissioner about the services provided by [Dr C] to [Ms A], as detailed in the documents you supplied. I can confirm that I have no personal or professional conflict in this case. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I understand also that my report is subject to the Official Information Act and that my advice may be requested and disclosed under that Act and that the Commissioner's policy is to name his advisors where any advice is relied upon in making a decision.
>
> I qualified MB, ChB in 1968 from Victoria University of Manchester, UK. I also hold a Diploma in Obstetrics from the Royal College of Obstetricians (1970) and a Diploma in Health Administration from Massey University (1985). I have been a Member — now Fellow — of the Royal New Zealand College of General Practitioners since 1980. Prior to working in New Zealand I worked in an isolated area of Fiji for three years. For the past 31 years I have worked as a rural general practitioner in Rawene, Hokianga. This practice involves on call work and the care of patients in a small rural hospital.
>
> I have read the **supporting information** supplied by the Commissioner, viz:
>
> **Supporting Information**
>
> - Two photographs dated 13.5.04 and 12.6.04 (pages i and ii)
> - Complaint letters (pages 1–4)

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- Notification letters (pages 5–15)
- Correspondence from [Ms A] (pages 16–20)
- Correspondence from [Dr C] (pages 21–36)
- Correspondence from [the medical centre] (pages 37–39)

I have also read the 'Purpose' and 'Background' sections of the 'brief' as supplied to me. As, however, these have not been presented in electronic form, I will not type them out.

I have also read the pathology reports which have been translated into English. These were forwarded to me on 30th August 2005. These are purely histology reports on biopsy specimens. There is no record of any 'blood tests'.

Report

1. Was [Dr C's] care and treatment of [Ms A] on 3 May 2004 adequate and appropriate?
   [Dr C's] care and treatment seems adequate and appropriate. Infection in skin damaged by sunburn is not uncommon and, in the absence of any significant previous history, his diagnosis and management are unremarkable.

2. Was [Dr C's] care and treatment of [Ms A] on 12 May 2004 adequate and appropriate?

   Although there is a discrepancy between the patient and [Dr C] in some aspects of the history, I concur with [Dr C] that, if pain had been a prominent feature, analgesia would have been prescribed. His assessment of initial improvement and subsequent relapse due, possibly, to an organism resistant to Augmentin, was reasonable.

3. Was [Dr C's] care and treatment of [Ms A] on 2 June 2004 adequate and appropriate?

   It seems clear that [Dr C] was now wondering what it was that he was dealing with. Again, there is a discrepancy between his and the patient's view regarding any pain with the condition. [Dr C] was obviously considering referral but considered that she was more likely to be seen more quickly back [in her home country]. The difficulty in obtaining speedy specialist appointments is, unfortunately, a feature of the New Zealand health service these days.

4. Are [Dr C's] clinical records of an appropriate standard?

   It is easy to understand [Dr C's] thinking from his clinical records. There is, however, no clear record of his examination findings. I find that using the 'SOAP' (Subjective, Objective, Assessment, Plan) system of recording a

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consultation a good discipline. That being said, [Dr C's] records are of an adequate standard in my opinion.

5. Should [Dr C] have referred [Ms A] to a specialist in New Zealand at the consultation on 12 May 2004?

   At face value this problem appeared to be a simple matter of a skin infection which we see every day in general practice. It now seemed to be an infection resistant to the first antibiotic of choice and was treated accordingly. It would not have been appropriate to refer at this time.

6. Should [Dr C] have referred [Ms A] to a specialist in New Zealand at the consultation on 2 June 2004?

   By this time [Dr C] was planning to refer [Ms A]. As it happened, she was seen [in her home country] within the normal time frame for a specialist appointment in New Zealand. I agree with [Dr C] that this was probably a more satisfactory outcome for the patient.

7. Please advise whether, in your opinion, [Ms A] was adequately and appropriately informed about the condition of her nose, and options available at the consultation on 2 June 2004.

   It appears from [Dr C's] clinical records and his recollection of the consultation, that he was considering referral at that point. There is no way I can objectively say that [Ms A] was or was not 'adequately and appropriately informed about the condition of her nose, and options available'. This was, and is, a very unusual case in extremely unusual circumstances. I believe that [Dr C] exercised his best judgment in this case. I should add that, in my opinion, it is unlikely that seeing a specialist in New Zealand would have changed the outcome in this case.

Further comments

I share [Dr C's] bewilderment regarding this case. [Ms A] appears to have an invasive squamous cell carcinoma — something that usually shows itself on the skin surface. This seems to have arisen in deeper layers and spread internally. In my experience — admittedly limited in this field — this usually arises when a surgical excision or other treatment has not fully removed the superficial tumour. I see many cases of squamous cell carcinoma of the skin in my practice and perform cryo-therapy and local excision for this condition. I do not recall, in thirty years of practice, seeing a case of this nature where the carcinoma has been so aggressive and so invasive.

I have the sense, in this case, of being in the dark about many aspects of [Ms A's] situation. This can often be the case with an overseas visitor. We have no previous history, but it is interesting that she already had previous contact with a

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surgeon which she was able to re-establish at very short notice on her return [to her home country].

I also share [Dr C's] interest in what blood test [Ms A] states would be able to detect a cancer. I know of none.

In summary, I believe that this is a very unusual case of a rare condition in a situation fraught with difficulty. I believe that [Dr C] acted as best he could for the patient and should be commended rather than sanctioned.

I trust that this report is of assistance to the Commissioner in reaching his judgment. Please do not hesitate to contact me if any further clarification is required."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4

Right to Services of an Appropriate Standard

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

RIGHT 6

Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —*
   a) *An explanation of his or her condition; and*
   b) *An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and*
   c) *Advice of the estimated time within which the services will be provided; …*

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Relevant standards

The Medical Council of New Zealand's publication "Good Medical Practice — A Guide for Doctors" (2003) states that doctors must:

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

Opinion: No Breach — Dr C

Care and treatment

Ms A attended three consultations with Dr C over the period 3 May to 2 June 2004 for symptoms related to her nose.

At the initial consultation Dr C diagnosed cellulitis of the nose, secondary to sunburn, and prescribed an appropriate penicillin-based antibiotic. Nine days later, Ms A returned to see Dr C. Following an examination of Ms A's nose, Dr C prescribed a different type of antibiotic of lower potency but wider spectrum, on the basis that if Ms A had an infection it was resistant to penicillin.

At the final consultation on 2 June, there was discussion about the need for Ms A to see a specialist for further investigations, specifically a biopsy. It was agreed that Ms A see a specialist on her return home. Dr C supported this decision as he believed that it would be easier for Ms A to face investigations and treatment in familiar surroundings. A third antibiotic was prescribed by Dr C at this consultation.

My general practitioner expert, Dr Birch, was asked to comment on the adequacy of Dr C's assessment, diagnosis, treatment and follow-up of Ms A's condition during these consultations. Dr Birch advised that infection following sunburn is a common presentation in general practice. It was reasonable for Dr C to diagnose an infection of Ms A's nose based on the history she provided, and to prescribe an antibiotic at the initial consultation and a different type of antibiotic at the second consultation. I agree with Dr C's view that blood tests and other investigations, in an otherwise healthy patient, were not necessary. It would have been inappropriate to refer Ms A to a specialist following these initial consultations.

Based on Ms A's presentation at the third and final consultation, specialist referral was required. I accept Dr C's evidence that by this stage he was concerned about the possibility of cancer (although he did not record this in his notes or mention it to Ms A) and that the need for specialist referral and biopsy was discussed. I also note Dr Birch's advice that it was appropriate for Dr C to agree that Ms A should seek specialist attention in her home country, adding that "[t]he difficulty in obtaining speedy specialist appointments is, unfortunately, a feature of the New Zealand health

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service these days." My expert stated that, in his view, the outcome for Ms A is unlikely to have been different had she been referred to a specialist in New Zealand.

I am satisfied that the assessment, care and treatment provided to Ms A by Dr C (notwithstanding the dispute about the presence of nose bleeds and pain) was appropriate. Ms A had a rare and aggressive cancer, the consequences of which have been devastating for her and her family. However, in my opinion, Dr C's care and treatment of Ms A was of an appropriate standard and did not breach Right 4(1) of the Code.

Information

Right 6(1) of the Code provides that every patient has the right to information, which a reasonable patient, in that patient's circumstances, would expect to receive. This includes an explanation of her condition and a full explanation of the options available, and the time frames within which services will be provided.

Ms B was concerned on behalf of her sister about the discussion at the third consultation concerning specialist referral and why such a referral was not made in New Zealand. Dr C advised that he discussed with Ms A the possibility of seeing a specialist in New Zealand, but the time frame for seeing a specialist (three to six weeks) was too long given Ms A's proposed travel dates to return home. A decision was made at this consultation for Ms A to see a specialist on her return home, for further assessment and investigations.

Ms A expressed some concern that Dr C had not spoken with her about the possibility of cancer. Dr C said that he considered cancer to be a differential diagnosis for Ms A's symptoms, but, in the absence of histopathology results to support this diagnosis (following a biopsy), he did not consider it appropriate to inform Ms A of this possibility. He advised that it was more important for him to encourage Ms A to see a specialist for a biopsy, which would confirm or discount cancer as the cause of Ms A's problems.

In my view, Dr C's actions were reasonable in light of the difficult circumstances. There appears to have been a full discussion about Ms A's condition and the need for specialist referral, and an understanding reached that Ms A would see a specialist in her own country. In these circumstances, Dr C acted appropriately and did not breach Right 6(1) of the Code.

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Adverse comment

Documentation

Right 4(2) of the Code gives patients the right to have services provided according to relevant professional standards, such as those formulated by the Medical Council of New Zealand. Providers have a responsibility to adequately document consultations with patients.

There is no reference, in any of Dr C's consultation notes, to an examination of Ms A's nose. Dr C advised that he did examine Ms A's nose at each consultation. Ms A disputes that she was examined by Dr C at the initial and final consultations. There are other aspects of the consultations between Ms A and Dr C which are disputed, for example Ms A's description of her pain and nose bleeds. Had Dr C made more detailed notes, a clearer picture would be available of exactly what was discussed.

My expert commented on Dr C's documentation. He concluded that overall Dr C's documentation was adequate, although Dr C had not documented any examination of Ms A's nose.

I acknowledge that Dr C works in a very busy general practice without a full complement of doctors. However, it remains important for any general practitioner to adequately document his consultations. I recommend that Dr C reflect on this aspect of his practice.

Other matters

Ms A described telephoning the medical centre to request a referral to a specialist. She says that she was asked by the receptionist to see Dr C and told that it could take approximately two to six weeks to be seen by a specialist. Ms A advised that as the result of this discussion she decided against a further consultation with Dr C.

Despite interviewing their reception staff, the medical centre was unable to provide any information with regard to this issue. The four receptionists working at the clinic at the time cannot recall any such telephone call; the clinic's director, Dr D, acknowledges that staff were not required to document all calls.

At the time of these events, the medical centre had an informal telephone policy regarding the limits of the advice that could be given by reception staff. A formal telephone policy for reception staff has since been written and this requires any requests from patients for specialist referral to be recorded and referred to the GP or nurse. I commend the medical centre on the new policy.

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Follow-up actions

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

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