Do the basics right

The requirement for doctors to keep clear and accurate clinical records is a fundamental obligation, which can at times be overlooked by time-poor GPs seeing multiple patients in the course of a day. In recent HDC cases a failure to maintain adequate records has contributed to the issues that arose.

In case 18HDC00918, a woman presented to a medical centre for an appointment with her GP to receive the flu vaccine. When the doctor took the vaccine from the practice's vaccine fridge he did not check the contents of the syringe visually or ensure that the plunger was not already decompressed, and proceeded to administer the vaccine to the woman. Afterwards, he realised the syringe he had used was already empty and had no label, and that the plunger was fully decompressed prior to administration. He proceeded to administer another flu vaccine successfully, but made no record of either vaccine in the woman's PMS immunisation module or the clinical records.

The doctor and the patient gave different accounts regarding the second flu vaccine. The doctor stated that he could not recall whether he gave the second vaccine, and suggested that the lack of documentation meant that it was unlikely that he did so. On the other hand, the woman had a specific memory of the vaccine being administered. Accordingly, the Commissioner found that it was more likely than not that the second vaccine was administered. The doctor explained that he did not document the first vaccine because he did not believe it had been administered successfully; however, the Commissioner stated that he would have expected to see documentation of the consent for the first vaccine, and also documentation of the successfully administered vaccine. It was found that by failing to check the flu vaccine visually before it was administered to the woman, the doctor did not provide her with services with reasonable care and skill and breached Right 4(1) of the Code. In addition, by failing to document the required information for both flu vaccines, the doctor did not provide services to the woman that complied with relevant standards, and breached Right 4(2) of the Code.

In another case, 18HDC00740, a woman visited a medical centre regarding her high blood pressure and bowel issues, including rectal bleeding. Her regular GP was unavailable, so she was seen by a different doctor at the medical centre's acute clinic, where there was a "walk-in" service. The doctor arranged a follow-up consultation to review the woman's bowel issues further, but did not record the bowel issues in the clinical notes. The doctor said she did not make any entry in the clinical notes regarding the woman's bowel issues or rectal bleeding because she did not undertake a thorough examination on that day with regard to those issues.

At the end of the consultation, the doctor gave the woman a laboratory form for blood tests and a container for a faeces sample for a faecal occult blood test (FOB test). However, the doctor did not give her a laboratory form for the FOB test. When the woman went to the laboratory to undergo the blood tests she took a faeces sample for the FOB test. As there was no paperwork for the FOB test, the laboratory staff contacted the medical centre and spoke to a nurse, who advised the laboratory to discard the faeces sample as the FOB test was not documented in the clinical notes.

The woman subsequently returned and saw the doctor again. The woman told HDC that that the doctor did not perform a digital rectal examination (DRE) during that consultation. The doctor recorded: "No haemorrhoids on PR examination." Subsequently, the doctor said that although her usual practice would have been to do a DRE, she cannot recall whether she did so on this occasion. The doctor decided to refer the woman for a colonoscopy, but did not set up the referral in MedTech or create a task in MedTech to remind her to make the referral. No referral was sent.

Over four months later, the woman rang the medical centre about the referral because she had not received an appointment. The doctor then realised that the referral had not been sent and processed the referral. Subsequently, the woman underwent a colonoscopy and was diagnosed with cancer of the rectum.

The Commissioner's findings were critical of the doctor having attempted to order an FOB test that was not appropriate for a patient presenting with the woman's symptoms. As there was no record of a DRE or consent to a DRE, the woman's account that one was not performed was accepted. In addition, the process with regard to the referral was inadequate. It was found that the doctor failed to provide the woman's services with reasonable care and skill, and breached Right 4(1) of the Code.

Many medical practices have systems that result in patients being seen by different doctors. In this situation it is particularly important to maintain adequate records. Adequate record-keeping[1] is not just a legal and professional requirement. It is also necessary in order to ensure continuity of care and to provide evidence of what actually happened. Despite the time pressures that GPs face in their day-to-day work, it is essential to be mindful of the importance of keeping adequate records.

Meenal Duggal, Deputy Commissioner — Complaints Resolution
New Zealand Doctor, 11 September 2019

[1] The Medical Council requirement that doctors "must keep clear and accurate patient records that report relevant clinical findings; decisions made; information given to patients [and] any drugs or other treatment prescribed".