Medical Centre

General Practitioner, Dr B

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC01874)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation 2
Opinion: Dr B — breach 6
Opinion: Medical centre — other comment 9
Changes made since complaint 9
Recommendations 10
Follow-up actions 10
Appendix A: Independent clinical advice to the Commissioner 11

Executive summary

1. This report reviews the care a man received from a locum general practitioner (GP) at a medical centre during a consultation in 2019. The case highlights the importance of considering other possible causes for presenting symptoms with reference to a consumer's clinical history and risk factors.

Findings

2. The man had a significant history of ischaemic heart disease and diabetes, as well as hypertension. He presented with symptoms known to be related to atypical presentations of cardiac ischaemia. During their consultation, the GP did not ask the man questions to try to identify whether there were other possible diagnoses that might explain his symptoms, or explore the cause of the man's exhaustion. The GP diagnosed the man with gastritis, despite being aware that gastritis did not explain the man's fever or headache, and that the man had been taking Mylanta (a treatment for the symptoms of gastritis) for several months, and this had not eased his symptoms.

3. The Deputy Commissioner considered that the assessment undertaken by the GP was inadequate owing to the man's significant clinical history not being considered adequately, and insufficient questioning and investigation into his symptoms to exclude other more serious cardiac conditions. The Deputy Commissioner considered that the inadequate assessment represented a missed opportunity to understand whether the man required further medical treatment. Accordingly, the Deputy Commissioner found that the GP did not provide services to the man with reasonable care and skill, and breached Right 4(1) of the Code.

Recommendations

4. The Deputy Commissioner recommended that the GP provide the man's family with a written apology; review or confirm that she has recently reviewed the Best Practice Advocacy Centre guidance on the "immediate management of acute coronary syndromes in primary care" and the region's "stable angina — suspected" clinical pathway. The GP is to provide HDC with an analysis of typical and atypical presentations of angina, what steps to take when a patient is presenting with possible cardiac symptoms, and how her services will change as a result of the review; and review or confirm that she has recently reviewed the Royal New Zealand College of General Practitioners standard, "patient records meet requirements to describe and support the management of health care provided", and provide a report to HDC describing how her documentation will change as a result.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her late husband, Mr A, by locum Dr B at the medical centre. The following issues were identified for investigation:

- *Whether Dr B provided Mr A with an appropriate standard of care during the consultation in 2019 at the medical centre.*
- *Whether the medical centre provided Mr A with an appropriate standard of care in 2019.*

6. This report is the decision of Deputy Health and Disability Commissioner Kevin Allan, and is made in accordance with the power delegated to him by the Commissioner.

7. The parties directly involved in the investigation were:

Mr A (dec)	Consumer
Mrs A	Complainant
Dr B	General practitioner (GP)
Medical centre	

8. Independent expert advice was obtained from GP Dr Gerald Young (Appendix A).

Information gathered during investigation

9. This complaint concerns the care provided to Mr A during a consultation with a locum GP, Dr B, at a medical centre two days prior to a heart attack and his death.

Background

10. In 2019, Mr A was aged in his sixties and had a history of diabetes, hypertension, and ischaemic heart disease, and he was an ex-smoker. He had been experiencing psychosocial stressors and having difficulty controlling his diabetes in the months leading up to his appointment with Dr B.

Care provided on 26 Month1

11. Mr A called the medical centre on 26 Month1[1] because he had been having gastric issues for several months. Mr A was triaged by a nurse, who documented that Mr A was complaining of being exhausted, that he had a fever, and that he felt that he had been having constant indigestion over a few months. He complained of a lack of appetite, and that the feelings of indigestion worsened when he was hungry. An acute appointment was arranged for later that day.

[1] The relevant month is referred to as Month1 to protect privacy.

Appointment with Dr B

12. Mr A presented to the medical centre and was reviewed by locum GP Dr B. Dr B documented:

> "Subjective: bad heart burn over few months, used Mylanta,[2] felt unwell [headache], fever to-day [previous history coronary artery bypass graft], work from home,
>
> Objective: [temperature] 37.2 [weight] 89.7, 85 at home [heart sounds] 1+2 chest clear. [abdomen] soft no masses, tender epigastrium[3]
>
> Assessment: gastritis ? why. Outline usual culprits
>
> advise omeprazole[4] + [review]
>
> advice shed [weight], can take antacid if [necessary]
>
> plan: see [as needed]"

13. Dr B told HDC that as a locum GP, it is her usual practice to review a patient's recent notes and a summary of past medical history and medications, before seeing a patient. Dr B said that she noted Mr A's long history of ischaemic heart disease, that he had had type 2 diabetes for 10 years, and that he had hypertension.

14. Dr B recollected that at the consultation, Mr A pointed to the stomach area and told her that the pain did not go anywhere else, and was not eased with Mylanta. She said that on that day Mr A had also complained of a headache. Dr B said that she asked Mr A about any shortness of breath, and any other symptoms that would fit for flu or infection.

15. Although not documented in Mr A's medical record, Dr B advised HDC of the following details relating to the consultation:

- Mr A informed her that he did not use his nitrolingual[5] spray much. Dr B told HDC that the records showed that nitrolingual spray had not been prescribed for several years. She said she suggested that Mr A use it as it might help his gastric symptoms as well as angina.[6]
- Psychosocial stressors that Mr A was experiencing were raised.
- Mr A's diabetes control (which was not as good as it had been previously) was discussed.
- Dr B and Mr A agreed that his diabetes control, blood pressure control, and medications would be reviewed, along with a repeat of his blood tests, at another appointment in less than one month's time.

[2] Mylanta is an antacid.
[3] The epigastrium is the upper central region of the abdomen.
[4] Medication for indigestion, heartburn, and acid reflux.
[5] Spray to be used under the tongue to prevent or relieve angina and chest pain.
[6] A type of chest pain caused by reduced blood flow to the heart.

- Mr A was in no acute distress, he was able to speak in full sentences, and he was not pale or cyanosed.[7]
- Mr A's blood pressure was acceptable (around 150/94), his pulse rate regular with no atrial fibrillation,[8] and his jugular venous pressure (JVP)[9] was not raised.

16. In response to the provisional decision, Dr B told HDC that while Mr A informed her of psychosocial stressors, he did not wish to discuss these with her, and he wanted to wait for his already scheduled appointment in three weeks' time, to discuss his diabetes management.

17. Dr B said that she told Mr A that gastritis did not explain his symptoms of feeling unwell or having a headache. She told HDC that while she was not convinced that the symptoms were solely related to gastritis, she discussed with Mr A that this was a starting point, as she noted that Mr A had been prescribed omeprazole in the past for three months. The documentation at the time of that prescription suggested similar symptoms, which were not mentioned at a follow-up appointment. In light of this, she presumed that they had been helped by omeprazole. Dr B advised HDC that she told Mr A to seek further medical review if his symptoms did not settle rapidly or got worse.

18. Dr B told HDC that she considered that Mr A's diabetes, which was not as well controlled as previously, contributed to his tiredness or, in association with his headache, may have been from a flu-like illness. Dr B advised that Mr A's blood sugar levels were elevated in 2018 and 2019. However, she said that Mr A stated to her clearly that he did not wish to discuss this with her.

19. Dr B also commented that exhaustion is multifactorial but also common, and she considered that questioning Mr A about any exacerbation of symptoms with physical activity or exertion would assist with the differential diagnosis of exhaustion.

20. Dr B said that in retrospect, there is no doubt that an ECG[10] should have been done. However, she said that at the time, Mr A's presentation appeared largely consistent with gastritis, and she recommended further follow-up if his condition did not improve.

21. Dr B stated that she deeply regrets that she did not consider ischaemic heart disease enough of a likelihood to request an ECG and/or blood tests, or consider that a dual diagnosis might be possible.

Subsequent events

22. On 28 Month1, two days after Mr A's appointment with Dr B, Mr A collapsed at home from a heart attack. Sadly, he died shortly afterwards.

[7] Discoloration of the skin, usually as a result of a deficiency of oxygen in the blood.
[8] A condition that causes an irregular and rapid heart rate.
[9] Observed pressure over the venous system, which can assist in identifying cardiovascular issues.
[10] Electrocardiogram — a test that measures the electrical activity of the heart.

Work environment at the medical centre

23. Dr B reported to HDC that she had concerns about various aspects of the working environment at the medical centre, including the new practice management system (which she had not used previously, and which created difficulties amongst staff), the layout of the practice, which isolated her from her peers, and the workload.

24. Dr B stated that on reflecting back on her time at the medical centre, she believes that the pressure of the overall working arrangements at the practice impacted on her own sense of health and safety and her ability to provide safe and proper care to patients.

25. Dr B considered that she was expected to see an unreasonably high number of patients at the medical centre. She said that during her second week at the practice, she discussed this with the Interim Practice Manager, but no changes to her workload occurred. Dr B also said that she was expected to work an extra half-day session each week.

26. In response to the provisional decision, Dr B said that her main concern was the number of complex patients being seen in one shift and the time pressure associated with this.

27. The Interim Practice Manager to whom Dr B referred no longer works at the medical centre. The medical centre told HDC that it is unable to locate any correspondence or documentation concerning a discussion between Dr B and the former Interim Practice Manager. The medical centre said that after four hours of orientation on her first day (12 Month1), Dr B saw six patients in the afternoon that day. Between 13 Month1 and 19 Month1, Dr B was consulting with 10 to 13 patients per day. In response to the provisional decision, Dr B disagreed that she saw six patients on her first day, as she worked only between 10am and 2pm, and could not have seen that many patients in that time as well as undergo four hours of orientation.

28. The medical centre said that from 20 Month1 to 30 Month1, Dr B consulted with 22 patients per day, except for 27 and 29 Month1, when she consulted with 25 patients. The Practice Manager reviewed locum templates from 2019 to 2020, and said that the number of consultations that Dr B had is consistent with what other locums have experienced, as well as the practice's permanent GPs. The medical centre said that it had a strong emphasis on recruitment in 2020 to optimise patient and practitioner safety. It noted that the region is a difficult region to recruit into, but the practice considers that it has had an improved response to job opportunities owing to its persistent approach. The medical centre said that it has increased its team successfully, which has reduced both consultation and appointment waiting times.

Further information

29. Mr A's wife believes that the medical centre let her husband down, and that the care and skill involved in her husband's health care was below an acceptable standard. Mrs A told HDC that she and her family feel that a series of events leading up to her husband's death afforded an opportunity to provide him with better medical support and guidance.

30. The medical centre told HDC that staff learnt of Mr A's passing with sadness, and it had a significant impact on several staff.

31. Dr B expressed sincere condolences to Mrs A and the family. Dr B told HDC that she deeply regrets not probing more and exploring any other worries Mr A had, which may have included concerns about his heart. Dr B is now more conscious about doing so with patients she sees.

Response to provisional opinion

Mrs A

32. Mrs A was given an opportunity to comment on the "information gathered" section of my provisional decision. She told HDC that she had no further comments to add.

Dr B

33. Dr B was given an opportunity to comment on the relevant sections of my provisional decision, as they related to her. Dr B advised that she accepted the findings in the report. Where relevant, aspects of Dr B's response have been incorporated into this report.

Medical centre

34. The medical centre was given an opportunity to comment on my provisional decision, and told HDC that it had no further comments.

Opinion: Dr B — breach

35. This report highlights the importance of health providers considering other possibilities for presenting symptoms, and of considering a person's clinical history and risk factors adequately.

Consultation on 26 Month1

Clinical assessment

36. Mr A had a significant history of ischaemic heart disease and diabetes, as well as hypertension. He presented with symptoms known to be related to atypical presentations of cardiac ischaemia.[11] During their consultation, Dr B did not ask Mr A questions to try to identify whether there were other possible diagnoses that might explain his symptoms, or explore the cause of Mr A's exhaustion. She diagnosed Mr A with gastritis, despite being aware that gastritis did not explain Mr A's fever or headache, and that Mr A had been taking Mylanta (a treatment for the symptoms of gastritis) for several months, and this had not eased his symptoms.

37. Dr B told HDC that in retrospect, she should have arranged for an ECG. However, she considered that at the time, Mr A's presentation appeared largely consistent with gastritis.

[11] Reduced blood flow.

38. My expert advisor, GP Dr Young, advised that many of Mr A's presenting symptoms were consistent with gastritis, and the finding of epigastric tenderness is supportive of the gastritis diagnosis. However, he said that some aspects of the history did not fit — in particular, that Mr A was feeling feverish and exhausted.

39. Dr Young said that in a person with diabetes, angina can present with atypical symptoms, such as indigestion, exhaustion, and sweatiness — which can be interpreted by a patient as a fever. In order to exclude acute coronary syndrome, an ECG should have been performed during the consultation. Depending on the results of the ECG, a blood test to help to detect a heart injury[12] could also have been considered if urgent admission was not required.

40. Dr Young advised that given Mr A's clinical history, further questioning and an ECG should have been undertaken to exclude acute coronary syndrome beyond reasonable doubt. Dr Young said that it is imperative that in any presentation of chest pain or discomfort in a patient who has a high cardiovascular risk, as was the case with Mr A, a cardiac cause for the pain is excluded first, before an alternative diagnosis or another concurrent diagnosis is made. Because of this, he considers that the clinical assessment Mr A received from Dr B departed from an acceptable standard of care.

41. I accept Dr Young's advice. I consider that the assessment undertaken by Dr B on this day was inadequate, owing to Mr A's significant clinical history not being considered adequately, and insufficient questioning and investigation into his symptoms to exclude other more serious cardiac conditions. I note that it is not the role of this Office to establish whether further assessment would have resulted in further treatment, or altered the tragic outcome. However, I consider that the inadequate assessment represented a missed opportunity to understand whether Mr A required further medical treatment. Accordingly, I find that Dr B did not provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[13]

Work environment

42. Dr B has raised several concerns about the work environment that she experienced at the medical centre. After considering Dr B's concerns and the responses of the medical centre and Dr Young, I find that there is insufficient evidence that the practice management system or the layout of the practice could have reasonably affected Dr B's clinical assessment of Mr A on 26 Month1.

43. I have also considered Dr B's concerns about the workload to which she was subjected. On 26 Month1, Dr B consulted 22 patients. Dr B considers that she was expected to see an unreasonably high number of complex patients at the medical centre. She believes that the working environment affected her ability to provide safe and appropriate care to patients.

44. Dr Young advised that 22 patients is not overly demanding for a full day, and is only two more per day than Dr B was used to, and was comfortable with. Dr Young noted that the

[12] The test detects troponin, an enzyme released when the heart muscle is damaged.
[13] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

number of consultations Dr B had in one day would be considered normal in most general practices, and 15-minute consultations are the norm for many practices.

45. I accept Dr Young's advice. I note that Dr B was a highly experienced clinician. When engaging in locum work, there is an expectation that clinicians will reasonably adapt and adjust to the needs of the medical practice in which they are working. While I acknowledge that Dr B raised concerns about the level of work that was expected of her, and appropriately escalated this to the Practice Manager, I accept that her workload was reasonably within accepted parameters.

Documentation — adverse comment

46. I am concerned about the quality of Dr B's documentation from the consultation.

47. In her response to HDC dated 17 January 2020, Dr B noted information provided to her by Mr A, advice she gave to Mr A, and findings that she observed, which were not documented in the clinical notes. She said that she asked Mr A about physical symptoms (shortness of breath), and Mr A disclosed that he was experiencing psychosocial stressors, and that his diabetes control was not as good as it had been previously. She also said that she noted that Mr A was not pale or cyanosed, his blood pressure was acceptable, his pulse rate was regular with no atrial fibrillation, his jugular venous pressure (JVP) was not raised, and he did not have oedema or chest wall tenderness. Dr B also stated that Mr A informed her that he did not use his nitrolingual spray much, so she suggested that he use it. None of this information is documented in the clinical notes.

48. The Medical Council of New Zealand's *Good Medical Practice* standard for keeping records states:

> "You must keep clear and accurate patient records that report: relevant clinical information, options discussed, decisions made and the reasons for them, information given to patients, the proposed management plan and any medication or other treatment prescribed."

49. If the statement provided by Dr B is an accurate reflection of the consultation, then it is clear that Dr B's documentation did not comply with the Medical Council of New Zealand's standard of documentation.

Opinion: Medical centre — other comment

50. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code.

51. I note that Dr B has raised concerns about the workload at the medical centre. I accept that high workloads may cause stress on staff, resulting in poor clinical decision-making. However, my advisor, Dr Young, has said that Dr B's workload at the time was not outside of the norm of most general practices. Notwithstanding the above, I would expect that if a GP raised such concerns with their Practice Manager, then these concerns would be addressed in an appropriate and reasonable manner.

52. However, I accept Dr Young's opinion. I note that Dr B was a highly experienced clinician, and that when engaging in locum work, there is an expectation that clinicians will reasonably adapt and adjust to the needs of the medical practice in which they are working. In my view, there is no evidence that the workload was unreasonable, and the errors that occurred were related to individual clinical decision-making on the part of Dr B, and were not a result of broader systems or organisational issues at the clinic. Therefore, I consider that the medical centre did not breach the Code. I would, however, invite the medical centre to consider the comments Dr B has raised about workload, and consider what further strategies and support could be offered to clinicians who experience high workloads.

Changes made since complaint

53. Dr B told HDC that she has focussed on making more extensive medical records that explain her reasoning and advice.

54. Dr B stated that following reflection and learning from the review of her care of Mr A, she now ensures that any patients who have difficulty breathing, chest pain, and gastritis are investigated thoroughly, including with an ECG.

55. Dr B said that she has also read widely around this topic, including reviewing up-to-date guidelines, and has discussed this with colleagues in and beyond her peer group meetings, so that the lesson is well considered by her and widely shared.

Recommendations

56. I recommend that Dr B:

a) Provide Mr A's family with a written apology for the deficiencies outlined in this report, within one month of the date of this report. The apology is to be provided to HDC, for forwarding to Mr A's family.

b) Review or confirm that she has recently reviewed the Best Practice Advocacy Centre guidance on the "immediate management of acute coronary syndromes in primary care" and the region's "stable angina — suspected" clinical pathway. Dr B should provide HDC with an analysis of typical and atypical presentations of angina, what steps to take when a patient is presenting with possible cardiac symptoms, and how her services will change as a result of the review, within one month of the date of this report.

c) Review or confirm that she has recently reviewed the Royal New Zealand College of General Practitioners standard, "patient records meet requirements to describe and support the management of health care provided", and provide a report to HDC describing how her documentation will change as a result, within one month of the date of this report.

Follow-up actions

57. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners, and they will be advised of Dr B's name.

58. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the district health board, the PHO, and NZ Locums, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from Dr Gerald Young:

"I have been asked to provide specific advice regarding whether the care provided to [Mr A] by [Dr B] was reasonable in the circumstances, and why.

13 July 2020

The adequacy of [Dr B's] clinical assessment.
[Mr A] was triaged by the nurse on 26 [Month1] and was complaining of being exhausted with fever for which he took Panadol/codeine. He disclosed that he had been feeling like he had constant indigestion over a few months which was related to eating and felt worse when hungry. It was settled at the time he was talking to the nurse. He also complained about a lack of appetite.

[Dr B] reconfirmed the history of having symptoms of bad heartburn over a few months and that [Mr A] had used Mylanta to try to treat it. He was feeling unwell and felt that he had a fever. [Dr B] noted his past history of having undergone coronary artery bypass grafting (CABG). [Dr B], in her letter of reply to the complaint, acknowledged that she was aware of [Mr A's] history of being a type 2 diabetic for 10 years, being on treatment for hypertension as well having ischaemic heart disease.

On examination; temperature was noted to be 37.2, which is marginally above normal, weight was 89.7Kg, heart sounds were normal, the abdomen was soft on examination with no abnormal masses felt. He was noted to be tender in the epigastrium.

[Dr B] made a working diagnosis of gastritis but with the query of '? why'. She outlined to [Mr A] the 'usual culprits' that cause gastritis.

The treatment plan was to take a course of omeprazole with antacids if required. Losing weight was advised.

[Dr B] made the differential diagnosis of 'gastritis' but documented in her letter of reply that she '… was not convinced (as noted in my brief patient record) that the diagnosis was solely related to gastritis', which explains her annotation in the notes '?why'.

I agree with [Dr B] that many of the symptoms were consistent with gastritis; the indigestion/heartburn which was reported as being related to eating and worse with hunger, lack of appetite. The finding of epigastric tenderness is supportive of the gastritis diagnosis.

However as indicated by [Dr B] some aspects of the history did not fit, in particular feeling feverish and exhausted. In the history it was noted that [Mr A] had tried Mylanta, an antacid, which [Dr B] noted didn't seem to help the symptoms. This in addition with the known history of ischaemic heart disease requiring coronary bypass grafting, diabetes and hypertension on active treatment, further questioning was required to try

to determine if there were other possible diagnoses which may explain the presenting symptoms and findings or to be able to exclude acute coronary syndrome beyond reasonable doubt.

Further questions were required to elucidate exactly what [Mr A] meant by 'exhaustion' and the nature of it, he should have been specifically asked if the symptoms were worse with exercise/exertion? If this episode of gastritis felt the same as the one he had a few months earlier? Was the gastritis waking him through the night and disturbing his sleep? (As this might have contributed to the exhaustion.)

In a person with diabetes, angina can present with atypical symptoms, such as indigestion, exhaustion and sweatiness (which could be interpreted by a patient as a fever). Eating has also been documented to bring on angina, especially in unstable angina (6, 8). To exclude acute coronary syndrome then an ECG should have been performed and depending on the findings of the ECG, a troponin blood test could also have been considered if urgent admission was not required (5).

The diagnosis of gastritis was appropriate but the clinical evaluation should have been further pursued to determine the exact nature of the exhaustion, in particular whether physical activity or exertion aggravated the symptoms.

An ECG should have been performed to exclude beyond reasonable doubt any cardiac cause, including acute coronary syndrome, for [Mr A's] symptoms.

The clinical assessment was a mild to moderate departure from an acceptable standard of care with the omission of the further questioning and not performing an ECG.

Whether any further action by [Dr B] at this appointment could have been reasonably undertaken;

As discussed above an ECG should have been performed. Further actions would have been dictated by the findings on the ECG. If there were signs of acute coronary syndrome then hospital admission would have been indicated.

If there were no ECG changes then a troponin test would have been appropriate. If the test showed elevated levels then hospital admission would again be indicated.

If the ECG was normal, the troponin test was negative and questioning did not indicate any possibility of angina then treating [Mr A] for gastritis would have been reasonable. If there were any indications of angina disclosed by further questioning, then a referral for cardiac assessment would have been appropriate.

Other Comments;

Presentation of cardiac ischemia in diabetics can be atypical to the point that symptoms of ischemic heart disease and gastric symptoms are remarkably similar. It can be difficult to change the train of the diagnostic thought process when the patient suggests that their symptoms are caused by a specific problem, in this case indigestion/heartburn,

which he had suffered from previously. The presenting symptoms of feeling exhausted with 'fever' is not explained by the gastritis diagnosis.

[Mr A] also had a known history of ischemic heart disease requiring coronary vein grafting with type 2 diabetes making his cardiovascular risk very high, recorded as being greater than 20%. In this scenario the diagnosis of acute coronary syndrome needed to be excluded beyond reasonable doubt.

Reference list

Best Practice Advocacy Centre. (2015). *The Immediate Management of Acute Coronary Syndromes in Primary Care.* https://bpac.org.nz/bpj/2015/april/coronary.aspx

Heart Foundation. (n.d) *Angina.* https://www.heartfoundation.org.nz/your-heart/heart-conditions/angina

Mayo Clinic. (2017). *Heartburn or Heart Attack: When to Worry.* https://www.mayoclinic.org/diseases-conditions/heartburn/in-depth/heartburn-gerd/art-20046483

Ministry of Health. (2017). *Angina*. https://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/heart-disease/angina"

The following further advice was received from Dr Young:

"**Re: Complaint: [Dr B] at [the medical centre] 19HDC01874**

I have been asked to review further documentation relating to this case as listed.

1. [Dr B's] response to the HDC notification letter and your expert advice dated 13 November 2020
2. [Dr B's] evaluation report to NZ Locum dated … 2019
3. [Dr B's] locum experience report sent to the Medical Protection Society dated 22 June 2020
4. [The medical centre's] response letter to HDC's notification letter dated 3 December 2020
5. [The medical centre's] response to [Dr B's] comments dated 23 December 2020
6. [The medical centre's] Health and Safety Culture Plan (issued 12 Month1)
7. [The medical centre's] HR Guidelines (issued 27 June 2019)
8. [The medical centre's] Practitioner Orientation Checklist (updated as at 17 November 2020)

I have been requested to address specific issues as noted.

A. Please review the **enclosed** documentation above and advise if it causes you to add or to amend the comments in your initial advice about the standard of care [Dr B] provided to [Mr A].

B. Please also review the enclosed documentation above and advise whether you consider the care provided to [Mr A] by [the medical centre] was reasonable in the circumstances, and why.

In particular, please comment on:

I. Whether the guidelines/policies that were in place at the time of events were appropriate?

II. Whether the orientation checklist is appropriate for new locum general practitioners.

III. [Dr B's] workload including the number of patients [Dr B] saw on average during her placement at [the medical centre] from 12 to 30 [Month1] and any other comments about the working environment as described by [Dr B].

IV. The working environment as described by [the medical centre].

V. Any other matters in this case that you consider relevant.

A. Standard of care provided by [Dr B] to [Mr A].

I have reviewed the further information as listed. The reply from [Dr B] does not cause me to alter my findings that the standard of care, in my opinion, was a mild to moderate departure from a reasonable standard of care.

[Dr B] has raised the issue that the references that I previously cited did not support my findings in her view. I have added more references that provide more details of the assessment and management that is expected in the assessment of patients with chest pain/discomfort and other symptoms suggestive of coronary disease.

I have referenced the [region's] collaborative clinical pathway for 'Stable Angina — suspected'[1] — this clinical pathway was the clinical assessment and management pathway in place for chest pain in [the region] at the time [Dr B] was a locum in this area. The document states that atypical angina symptoms are particularly likely in those with diabetes. It also states that patients with cardiac chest pain can also experience non-cardiac chest pain, including oesophageal disorders e.g. gastro-oesophageal reflux. The guideline advises that it is important to distinguish between the two causes early.

The guideline goes into detail on the expected history interrogation required to assess if the chest pain and symptoms are possibly cardiac in origin. The clinical examination to be performed and the investigations to be completed which includes a 12 lead ECG.

[Dr B] may have misinterpreted my comments regarding the symptoms that support the differential diagnosis of gastritis/oesophagitis. I was not suggesting that reflux and/or heartburn was a cause of cardiac symptoms as [Dr B] seems to imply with her statement that my reference does '… not mention reflux or heartburn symptoms in the differential of cardiac symptom causes'. To clarify this, it is imperative that in any presentation of chest pain/discomfort in a patient that has high cardiovascular risk, as was the case with [Mr A], that a cardiac cause for the pain is excluded first, before an

alternate diagnosis or another concurrent diagnosis is made. [Dr B] appears to be presenting a position that it was reasonable to make a diagnosis of gastritis as there were no red flags to suggest otherwise. [Dr B] references 'Managing Gastro-Oesphageal Reflux Disease (GORD) in adults. *Best Practice Journal,* 61:17–22' to support this view, however this article is only addressing red flag issues for patients with an established diagnosis of gastroesophageal disease. The article does not consider the issue of making the differential diagnosis of gastro-oesophageal disease in a patient presenting with symptoms in the first instance. It was often taught through my training that patients can attribute the chest pain of acute coronary syndrome to indigestion or heartburn and that clinical acumen was required to establish the correct diagnosis.

[Dr B] draws attention to the study by Khafaji and Sudwaidi to support her contention that diabetes is not a predictor of atypical chest pain symptoms, including dyspepsia, heartburn and GORD. This paper was a literature review of atypical presentation of acute and chronic coronary artery disease in diabetics. It found that overall diabetics have a high rate of coronary artery disease at 55%. The paper focussed on silent myocardial ischaemia (i.e. ischaemia with no symptoms), it did not look at other atypical symptoms of presentation in diabetics. Other published articles[1,2,3,4.5] that look at atypical presentation of acute coronary syndrome invariably mention indigestion/epigastric tenderness or pain/gastric symptoms as some of the atypical presentations; 'most commonly, they attributed their symptoms to indigestion leading to self-medication with antacids for this.'[3]

[Dr B] raises the use of an 'edaculator' score to access acute coronary syndrome, and [Mr A] having a score of 6, indicating a mild risk. This low score is only achieved if the pain/discomfort that was experienced by [Mr A] is attributed wholly and solely to the gastritis/oesophagitis without any other possible cause, and as already stated this was not possible without an ECG and/or other cardiac investigations. The tool does also state that its score is only valid if assessing 'chest pain consistent with acute coronary syndrome'.

I agree with [Dr B] that his measured temperature at 37.3 is in the normal range but [Mr A] felt that he had a fever which raises the question of why he was feeling like this. Feeling hot/sweaty with a normal temperature is known medically as diaphoresis and can be a symptom of acute coronary syndrome.

[Dr B] raises a concern that my opinion was strongly influenced by hindsight bias, but any patient with the presenting history of 'feels like constant indigestion over a few months, exhausted and fever', symptoms not improved with use of Mylanta, codeine and paracetamol requires adequate exclusion of a cardiac cause. This clinical presentation in a type 2 diabetic, with a past history of coronary artery grafts and with hypertension would always require confirmation that the indigestion type chest pain and other symptoms were not cardiac in origin beyond reasonable doubt, as documented in the local DHB guideline[1].

The clinical axiom that applies here to guide management, where the downside risk could be catastrophic, is to do what is clinically safe.

B. Standard of care provided to [Mr A] by [the medical centre]

The care provided to [Mr A] by [the medical centre] for this clinical episode was appropriate. The involvement of [the medical centre] was of nurse triage of [Mr A] prior to seeing [Dr B]. The nurse triage was of acceptable standard.

The only missing clinical information was the recording of [Mr A's] height so that his BMI could be calculated. This is a minor omission for a long-term patient as the clinical focus would have been on his weight gain or loss.

There were no other issues noted with respect to [the medical centre] relating to the care provided to [Mr A].

B.I) The guidelines and policies reviewed are very comprehensive and appropriate.

B.II) The orientation check list is very comprehensive and covered all areas expected for a locum orientation.

B.III) [Dr B] found the clinical work load difficult, with respect to the number of patients seen and their complexity and/or number of clinical problems. She felt that 15-minute appointments were too short a duration for her to conduct the consultations in. It was noted that, an additional morning tea break of 15 minutes was inserted but [Dr B] found this not to be adequate.

On the 26 [Month1], the day that [Dr B] consulted [Mr A] it was recorded that [Dr B] consulted 22 patients which is not overly demanding for a full day. [Dr B] documented that she is comfortable with 10 patients per session, so 22 would be just one patient over that per session on that day. It was documented that on two of the days the numbers were higher at 25 patients.

These numbers would be normal in most general practices with 15-minute consultations the norm for many practices. With 4-hour sessions allowing 30 mins per session for non-contact work that averages to be 14 patients per session or 28 patients per day.

[Dr B] notes that she was unaware prior to starting the locum at [the medical centre] that she would be using an unfamiliar new practice management system. [Dr B] had problems using the new practice management system … that was being commissioned at [the medical centre] and that staff also seemed to be having issues using the system. This definitely would have added to frustrations during the consultations and increased the time taken per consultation.

B.IV) The work environment as described by [the medical centre] seems to detail a fairly standard general practice set up, with the added bonus of having a café on site. There did not seem to be anything significantly different from [the medical centre's] work

environment compared to other practices, however it would require a site visit to be absolutely sure that there were no work environment issues.

B.V) There are no other matters that I have comment on.

Please contact me if there are any issues that need further clarification.

Regards, **Dr Gerald Young**

Further references list

1. Stable angina — suspected; collaborative clinical pathways. [DHB & PHO] April 2018
2. Medical management of stable angina pectoris. BPJ Issue 39 p38–47. Oct 2011
3. 'Just like a normal pain', what do people with diabetes mellitus experience when having a myocardial infarction: a qualitative study recruited from UK hospitals**.** Nikita Berman, Melvyn Mark Jones, Daan A De Coster. BMJ Open Jul 2017
4. Atypical presentation of acute coronary syndrome: A significant independent predictor of in-hospital mortality. Ayman El-Menyar (MBchB, MSc) a,b, Mohammad Zubaid (MBChB)c, et al. Journal of Cardiology (2011) **57**, 165–171
5. Postprandial angina pectoris: Clinical and angiographic correlations. Rubin Berlinerblau MD, FACC. Jacob Shani MD, FACC. Journal of the American College of Cardiology Volume 23, Issue 3, 1 March 1994, Pages 627–629."