General Practitioner, Dr B
Medical Centre

A Report by the
Health and Disability Commissioner

(Case 19HDC01795)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man by a general practitioner (GP). The man had several co-morbidities, including a hernia. In 2017, the man saw the GP for the first time at an after-hours service. The full medical notes were not available to the GP as the man's usual GP was at another clinic.

2. Initially a nurse assessed the man and recorded that he had been experiencing abdominal cramps. The GP then assessed the man, but did not examine his abdomen, and did not record a provisional diagnosis. The man continued to deteriorate, and he died two days later.

3. This report highlights the importance of appropriate examinations and assessments, and of adequate documentation.

Findings summary

4. The Commissioner found the GP in breach of Right 4(1) of the Code for not conducting an abdominal examination when it was clinically indicated, and not documenting the provisional diagnosis in the clinical notes.

5. The Commissioner considered that the errors that occurred did not indicate broader systems or organisational issues, and found that the medical centre did not breach the Code.

Recommendations

6. The Commissioner recommended that the GP apologise to the man's wife, arrange an independent audit of his clinical notes to check that appropriate records have been made, and undertake further training at the Medical Protection Society workshop "Achieving Safer and Reliable Practice".

7. The Commissioner recommended that the medical centre report back to HDC on the implementation and effectiveness of the changes it has made as a result of this investigation.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a referral from the Coroner following an inquiry into the cause of Mr A's death. The following issues were identified for investigation:

- *Whether Dr B provided Mr A with an appropriate standard of care in 2017.*
- *Whether Medical Centre 1 provided Mr A with an appropriate standard of care in 2017.*

9. This report is the opinion of the Commissioner.

10. The parties directly involved in the investigation were:

The Coroner	
Mrs A	Mr A's wife/complainant
Dr B	General practitioner (GP)
Medical Centre 1	

11. Also mentioned in this report:

Dr D	GP

12. Further information was received from Medical Centre 2.

13. In-house clinical advice was obtained from vocationally registered GP Dr David Maplesden, and is included as Appendix A.

Information gathered during investigation

Background

14. This report concerns the after-hours care Mr A, aged in his seventies, received from Dr B at Medical Centre 1.

15. Mr A had numerous co-morbidities including chronic renal failure, hypertension,[1] osteoarthritis,[2] gout,[3] congestive heart failure, atrial fibrillation,[4] gastro-oesophageal reflux,[5] peripheral vascular disease,[6] pre-diabetes,[7] and a right inguinal hernia.[8] He was reliant on a mobility scooter to move around.

16. Mr A's usual GP was Dr D at Medical Centre 2. Medical Centre 1 contracts and provides after-hours services to three general practices within the region, including Medical Centre 2.

17. In late 2017, at 9.24am, Mr A contacted an after-hours phone triage service as he had not been feeling well for the past two days. The consultation report noted that Mr A's symptoms were "Vomiting, Personal context, Abdominal Pain", and advised referral to the

[1] High blood pressure.
[2] Degeneration of joint cartilage and underlying bone.
[3] Inflammation of a joint.
[4] An irregular and often rapid heart rate.
[5] Back-flow of stomach acid into the oesophagus.
[6] A blood circulation disorder that causes blood vessels outside the heart and brain to narrow, block, or spasm.
[7] A high amount of glucose in the blood.
[8] A protrusion of tissue through a weak spot in the abdominal muscles.

GP on call. The assessor then contacted Medical Centre 1 and discussed Mr A's symptoms with the practice nurse.

18. Mr A attended Medical Centre 1 and initially was seen by the practice nurse, who assessed Mr A and noted his temperature, blood pressure, respiratory rate, and oxygen saturation. The nurse recorded in the clinical notes:

> "Phone call from [the phone triage service]. [Mr A] has been unwell for past 2 days, vomited this morning, wife very concerned as has history heart failure … states has felt unwell for past 2 days, not eaten and [bowel not open]. Having some ab[dominal] cramps."

19. Mr A was then reviewed by Dr B, who was the rostered GP for the after-hours care at Medical Centre 1 that day. Dr B told HDC:

> "I looked at my computer screen before [Mr A] entered my consultation room to review what medical information we held relating to [Mr A], but as he was not registered with our practice we did not have any recent information that could have helped."

20. Dr B's full clinical notes of the consultation were:

> "History:
> Been unwell x2 days
> Felt better this morning, but vomited after breakfast
> No more s[hortness] o[f] b[reath] than usual; uses inhaler [3 times a day] on average
>
> On Examination:
> See nurses obs[ervation] b[lood] p[ressure] adequate. Hydration adequate
> Mild wheeze, can easily speak full sentences
> Known with comorbidities which seem well controlled
>
> Management:
> Ondansetron 4 mg wafers[9] provided for nausea
> Review when no improvement"

21. Dr B did not examine Mr A's abdomen or record a diagnosis or provisional diagnosis[10] in the clinical notes. Mr A remained on his mobility scooter throughout the consultation. Dr B told HDC:

> "I regrettably did not consider it necessary to perform an abdominal examination … I stood next to [Mr A's] mobility scooter and checked his pulse rate, as well as auscultating his chest. This was due to [Mr and Mrs A] having expressed concern about possible increased heart failure during our consultation."

[9] Medication used to alleviate nausea and vomiting. Also known as Zofran Zydis Wafers.
[10] A diagnosis that is not definitive.

22. Dr B told the Coroner:

> "Apart from some mild abdominal cramps, there was no report of upper abdominal signs like bloating, abdominal dis[t]ention, [11] localised abdominal pain or peritonitism,[12] or diarrhoea. He did not mention the pre-existing inguinal hernia … I concluded that he seemed to have a mild gastric upset, possibly from viral origin and in the absence of red flags, I then explained my findings to him … and advised him to return for review should his symptoms persist, change, worsen or if new symptoms emerged."

23. Dr B also stated: "[W]e do not have direct access to the electronic medical records of the practices for which we provide after-hours care." He told HDC: "I could not access the medical notes of [Mr A's] regular practice … I did not have access to [Mr A's] full medical history." As a result, Mr A's history of hernia was also not accessible to Dr B via the medical notes available.

24. Medical Centre 2 told HDC that its "patients" notes would have not been available to [Medical Centre 1]". Medical Centre 1 also confirmed that "[Dr B] had no ability to review the medical records of Mr A as recorded within the PMS[13] of [Medical Centre 2]".

25. Mr A had visited Medical Centre 1 after-hours care previously — on one visit regarding dehydration and sepsis, and on another visit regarding an exacerbation of heart failure. The clinical notes of both these consultations contain no reference to Mr A's medical history of hernia.

Subsequent events

26. Mr A continued to deteriorate, and two days later, Mrs A called an ambulance and Medical Centre 2. However, Mr A died prior to the arrival of the ambulance.

27. Dr D (Mr A's regular GP) attended Mr A at his home after he died, and noted in the clinical notes: "[I]t would appear nobody examined [Mr A's] abdomen. He was uncomfortable yesterday and still nauseated and vomited and did not want to eat."

Coroner's findings

28. As the cause of Mr A's death was unknown, the matter was referred to the Coroner. The Coroner found that Mr A died from septicaemia[14] secondary to aspiration pneumonia[15] in the context of a bowel obstruction.[16]

[11] Expansion of the abdomen caused by the accumulation of substances such as air or fluid.
[12] Localised inflammation of the peritoneum (the tissue that lines the inner wall of the abdomen).
[13] Practice Management System.
[14] A potentially life-threatening infection of the blood.
[15] A lung infection that develops following the inhalation of food, liquid, or vomit.
[16] Obstruction of the normal movement of food through the intestines.

Further information

29. Dr B told HDC:

> "I regret not being more alert to possible other causes for [Mr A's] symptoms and in hindsight I accept I should have performed an abdominal examination on [Mr A] … I accept that it is a practitioner's duty to make full enquiries as to a patient's symptoms … I accept it would have been reasonable in the circumstances to take a more comprehensive history than I otherwise would have if I had been able to review his medical information."

30. Dr B also stated: "I feel strongly that I missed an opportunity, and I would once more like to sincerely apologise to [Mrs A] and her family for my possible failing in the care of her husband."

31. Medical Centre 1 told HDC that Dr B has been "co-operative, open, honest and transparent, all being characteristics that were appreciated and acknowledged in the Coroner's report". Medical Centre 1 said that "it believes [that this] reflects on the integrity, competence and high professional standard of [Dr B]".

Medical Centre 1's policies

32. Medical Centre 1's General Practice Health Records Policy states:

> "The Health Records Policy guides the management of Health Records to ensure accuracy, consistency and effectiveness of the information contained in the health record …
>
> The following information, if obtained, will be recorded in the Health Record …
>
> 3.3 Diagnosis
>
> Patient's clinical diagnosis. For each consultation with the service there is a documented diagnosis by a health professional. This may be provisional."

Changes made since incident

33. Dr B told HDC that as a result of this incident he has made changes to his practice, including:

a) He attended the Medical Protection Society courses "Mastering Consent and Shared Decision making Workshop" and "Medical Records for GPs".

b) He now records his notes by dictating instead of typing, which enables him to make more comprehensive and logical notes.

34. Dr B also told HDC:

> "[S]ince this event, I am of course more alert to differential diagnoses, even when patients' presenting symptoms are not alarming [and I] place more weight on

recording a patient's understanding of, and agreement with the outcome of consultations and possible follow-up."

35. Medical Centre 1 told HDC that as a result of this incident:

> "[T]he general practice has adopted to date two additional undertakings which it believes provides the clinician and the patient the opportunity to review the efficacy of treatment provided:
>
> a. Patient: for patient presenting to the weekend after hours clinic and where the clinician has reservations regarding their likelihood to respond to the prescribed treatment, patients are provided with the Triage Nurse's direct line cell phone number. By this the patient may contact the treating clinician the same or following day if they have either not improved as anticipated or consider they have deteriorated. This facility does not replace or remove the standard advice to patients that should they not improve or deteriorate then they should re-present to the general practice. Rather, it is intended to improve access to the clinician by removing the need for the patient to go through Medical Centre 1 after hour's [telehealth provider].
>
> b. Clinician: where the attending clinician wants to reassure themselves that the patient is responding to the prescribed treatment they will make an entry within the patient management system via the Task Bar which will alert them to a planned action, in this case the reminder that they are to make contact with the patient for the purposes of a follow up call."

36. Medical Centre 1 told HDC that as part of Dr B's induction into the Royal New Zealand College of General Practitioners (RNZCGP) in 2019, he undertook a Professional Assessment Visit. A copy of the RNZCGP assessor's report was provided to HDC. The assessor observed that Dr B met all the requirements, and noted that Dr B's "communication is excellent". The assessor also commented: "I suggest giving a little more weight to your examinations as a means to patient reassurance and comfort as well as confirmation of the impressions gained from the history."

Responses to provisional opinion

Mrs A

37. Mrs A was provided with an opportunity to comment on the "Information gathered" section of the provisional opinion. She reiterated that if Dr B had undertaken an appropriate examination, he would have discovered the hernia. She also emphasised that Mr A remained on his mobility scooter throughout the examination.

Dr B

38. Dr B was provided with an opportunity to comment on the provisional opinion. He told HDC: "I do not have any specific comments to the contents of this report."

Medical Centre 1

39. Medical Centre 1 was provided with an opportunity to comment on the provisional opinion. Medical Centre 1 stated:

> "[Medical Centre 1] has no further information or comments to make … we accept the findings of the provisional report and send our appreciation for the consideration of the HDC office in relation to this case."

Relevant standards

40. The requirement for doctors to keep clear and accurate clinical records is set out in the Medical Council of New Zealand's statement, "The maintenance and retention of patient records".[17] The statement notes 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".

Opinion: Dr B — breach

Introduction

41. Mr A had several co-morbidities, including diabetes, cardiovascular disease, chronic renal failure, hypertension, and a hernia. Mr A visited Medical Centre 1's after-hours service with a two-day history of feeling unwell and experiencing abdominal pain, and was seen by Dr B.

Examination

42. Initially, Mr A was reviewed by a practice nurse, who noted that he had abdominal cramps. Mr A was then examined by Dr B, who auscultated Mr A's chest and checked his pulse rate, but did not carry out an abdominal examination. Dr B said that he did not perform an abdominal examination because Mr A's history of hernia was not available to him via the clinical notes, and Mr A did not inform him of the pre-existing inguinal hernia. Dr B also said that there was no report of upper abdominal symptoms, apart from abdominal cramps. Nevertheless, Dr B accepts that he should have performed an abdominal examination on Mr A.

43. HDC's in-house clinical adviser, GP Dr Maplesden, provided the following advice:

> "I feel [Dr B's] assessment of [Mr A's] general wellbeing and cardiorespiratory status was adequate. In my opinion, [Mr A] was exhibiting symptoms that were most suggestive of a gastrointestinal issue and performing an abdominal examination is

[17] Available from https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Maintenance-and-retention-of-records.pdf

> accepted practice in this circumstance … I believe the failure by [Dr B] to perform an abdominal examination in the clinical scenario presented by [Mr A] represents a moderate departure from accepted practice whether or not the history of hernia was disclosed."

44. I accept Dr Maplesden's advice. An abdominal examination was clinically indicated in this situation. Despite not being informed of Mr A's hernia, Mr A displayed other symptoms that warranted an abdominal examination, and I am critical that this did not occur. This was a missed opportunity to identify further intervention needed by Mr A.

Documentation

45. Dr B did not record a provisional diagnosis in the clinical notes.

46. Medical Centre 1's General Practice Health Records policy states that a patient's clinical diagnosis or provisional diagnosis should be recorded in the clinical notes. The Medical Council's statement also requires doctors to "keep clear and accurate patient records that report relevant clinical findings".

47. Dr Maplesden also advised: "I am mildly to moderately critical there was no provisional diagnosis recorded in the consultation note."

48. I agree. I am critical that Dr B did not record a provisional diagnosis in the consultation notes. Given that Dr B was not Mr A's regular GP, it was imperative that he document his consultation adequately to ensure continuity of care. It is also an expectation in Medical Centre 1's policy and the Medical Council's standards.

Conclusion

49. In my opinion, Dr B did not provide services to Mr A with reasonable care and skill for the following reasons:

a) Dr B did not carry out an abdominal examination when it was clinically indicated; and

b) He did not document his provisional diagnosis in the clinical notes.

50. As a result of the above, Dr B missed an opportunity to provide further intervention to Mr A, and Mr A's continuity of care may have been compromised. Accordingly, I find that Dr B breached Right 4(1)[18] of the Code of Health and Disability Services Consumers' Rights (the Code).

[18] Right 4(1) provides: "Every consumer has the right to have services provided with reasonable care and skill."

Opinion: Medical Centre 1 — no breach

51. As a healthcare provider, Medical Centre 1 is responsible for providing services in accordance with the Code. As detailed above, I have found that Dr B breached the Code.

52. Dr B was unable to access Mr A's Medical Centre 2 clinical notes at Medical Centre 1 and, as a result, he was not aware of Mr A's hernia. Both medical centres confirmed that it was not possible to access Mr A's full clinical notes in the different practices, as the practices have different patient management systems.

53. Dr Maplesden advised:

> "[Medical Centre 2] clinical notes are not readily available to GPs at [Medical Centre 1] as different practice management systems (PMS) are used. The difficult sharing of electronic medical records between different PMSs is a national issue with a resolution unlikely until a universal cloud-based PMS is in place … I would not regard the lack of real time access to [Medical Centre 2] primary care records by [Medical Centre 1] staff as being unusual or a departure from current accepted practice regarding sharing of health information."

54. Dr Maplesden also advised that "the various policy and process documents provided by Medical Centre 1 appear consistent with accepted standards".

55. I accept Dr Maplesden's advice. I consider that the errors that occurred did not indicate broader systems or organisational issues at Medical Centre 1. Therefore, I consider that Medical Centre 1 did not breach the Code.

Recommendations

56. I recommend that Dr B:

a) Provide a written apology to Mrs A and her family for the breach of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Mrs A, within three weeks of the date of this report.

b) Undertake further training at the Medical Protection Society workshop "Achieving Safer and Reliable Practice", as recommended in Dr Maplesden's advice (Appendix A), and provide HDC with evidence of having completed the training within four months of the date of this report.

c) Arrange an independent audit of 20 patients to check that appropriate records have been documented in the clinical notes. The results of the audit are to be sent to HDC within four months of the date of this report, and if any concerns are identified, Dr B is to advise HDC of the further action that will be taken.

57. I recommend that Medical Centre 1 report back to HDC regarding the implementation and effectiveness of the changes stated at paragraph 35 of this report, within four months of the date of this report.

Follow-up actions

58. A copy of this report will be sent to the Coroner.

59. 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.

60. 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 and the Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following in-house clinical advice was obtained from Dr David Maplesden:

"1. Thank you for the request that I provide clinical advice in relation to the care provided to the late [Mr A] by [Dr B] of [Medical Centre 1]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the available information: internal HDC memorandum and file summary; response to HDC from [Dr B], GP [Medical Centre 1]; response to HDC from [CEO of Medical Centre 1]; GP notes and relevant organisation policies [Medical Centre 1]; clinical notes [Medical Centre 2]; letter to Coroner from [Medical Centre 2] GP [Dr D]; response to HDC from [Medical Centre 2 practice manager].

2. I have been asked to comment on:

The appropriateness of the care provided to [Mr A] (dec) by [Dr B] at [Medical Centre 1]

Relevant policies and practices in place at [Medical Centre 1] including access to electronic clinical records from other GP providers

Any other matters warranting comment

3. [Mr A] (aged [in his seventies]) was a patient at [Medical Centre 2]. He had multiple co-morbidities including atrial fibrillation, hyperthyroidism, gout, osteoarthritis, hypertension, gastro-oesophageal reflux, peripheral vascular disease (previous toe amputations), pre-diabetes, cardiac failure and chronic kidney disease. He also had a large right inguinal hernia diagnosed around 2013. He was reliant on a mobility scooter to get around. Prior to the GP consultation in question, he had last been reviewed at [Medical Centre 2] (foot ulcer treated with antibiotics). [Mr A] had been admitted to [hospital] [in early] 2017 with sepsis secondary to presumed respiratory infection and ulcers. During that admission management of his right inguinal hernia was discussed noted as: *discussion with patient: advised re risks of bowel obstruction and ischaemic bowel. Does not want further intervention currently … please seek medical attention if concerned: abdominal pain ++, nausea, vomiting, increasing SOB.*

4. [Medical Centre 2] clinical notes are not readily available to GPs at [Medical Centre 1] as different practice management systems (PMS) are used. The difficulty sharing electronic medical records between different PMSs is a national issue with a resolution unlikely until a universal cloud-based PMS is in place (unclear when this is likely to be achieved). There is increasing access to primary care records by secondary care and vice versa in some DHBs, and limited shared access to primary care records between providers sharing the same PMS within some PHOs. Nevertheless, I would not regard the lack of real-time access to [Medical Centre 2] primary care records by [Medical Centre 1] staff as being unusual or a departure from current accepted practice regarding sharing of health information. I note [Medical Centre 1] is actively investigating the possibility of improving current shared record capability.

5. [Mr A] had been seen at [Medical Centre 1] prior to the consultation in question and there was limited clinical information available in the [Medical Centre 1] records. There were consultation notes [at a visit] (leading to admission with dehydration and sepsis referred to above), and [another visit] (exacerbation of heart failure). I could find no reference to the hernia history in these notes.

6. [On Saturday morning], [Mr A] contacted the after-hours [phone triage service] with symptoms listed as *vomiting abd pain 2/7, not eating, vomited x 1, lethargic, no BM for 2/7, wheezing under care … caller hung up while arranging appointment, tried to call back, engaged …* The assessor apparently contacted the practice nurse at [Medical Centre 1] which was providing GP after-hours service that day, and [Mr A] attended for review. Practice nurse notes include: *Phone call from [phone triage service]. [Mr A] had been unwell for past 2 days, vomited this morning, wife very concerned as has history of heart failure … Obs as per screening* [temp 37, P 76, BP 120/70, resps 24, O2 sats 90%], *states has felt unwell for past 2 days, not eaten and BNO. Having some abdominal cramps.*

7. [Mr A] was then reviewed by [Dr B]. Notes are: *History: been unwell x 2 days, felt better this morning but vomited after breakfast. No more sob than usual, used inhaler tds on average. On examination: see nurses obs, bp adequate, hydration adequate. Mild wheeze, can easily speak sentences, known with comorbidities which seem well controlled Management: ondansetron 4mg wafers provided for nausea, review when no improvement.* [Dr B] did not examine [Mr A's] abdomen and agrees, in his response, that [Mr A] remained on his mobility scooter during the assessment process. Although not obvious from the clinical notes, [Dr B] refers in his response to a provisional diagnosis of constipation.

8. [Mr A] apparently remained unwell over [the weekend and on Monday] [Mr A's] wife contacted [Medical Centre 2] and spoke with a practice nurse, stating she had called an ambulance to bring [Mr A] to the medical centre for review. Shortly after this [Mrs A] rang again to state she and a friend who had arrived thought her husband has passed away while in his mobility scooter. The practice nurse, followed by [Medical Centre 2] GP [Dr D], attended [Mr A] at his home. The practice nurse observed [Mr A] to be *sitting upright waxen and no pulse or respiration also with faecal smelling vomit down his clothes and once we moved him to lie him down a large amount of faecal matter welled out from his nose and mouth.* [Dr D] gained the brief history: *Apparently was seen on Sat at [Medical Centre 1] but from the notes it would appear nobody examined his abdomen. He was uncomfortable yesterday and still nauseated and vomited and did not want to eat.* [Dr D] was unsure of the cause of death and referred [Mr A's] death to the Coroner. An autopsy was evidently performed but I do not have access to the results of this.

9. Comments

(i) [Mr A] had a complex past medical history with multiple comorbidities. This placed him at increased risk of suffering complications such as exacerbation of heart failure or acute kidney injury secondary to a concurrent acute illness, and necessitated

particularly careful history taking and assessment. There was limited medical history available in the historical clinical notes, but there was reference to the history of heart failure and blood results ([early] 2017) showing impaired renal function. I could not find any reference to [Mr A's] hernia in the limited notes available to [Dr B].

(ii) The history provided to [phone triage service] referred to a two day history of abdominal pain, intermittent vomiting, lethargy, loss of appetite and bowels not open. The history obtained by the [Medical Centre 1] practice nurse the same day was similar, with reference to abdominal cramps rather than abdominal pain. An adequate triage assessment was performed by the nurse with pulse, blood pressure and temperature being within the normal range, mild elevation in respiratory rate and lower oxygen saturation than had been recorded in the notes at an assessment in [mid] 2017, but above that recorded in [early] 2017. The vital signs were not particularly alarming or suggestive of extreme unwellness.

(iii) [Dr B] reviewed the nurse notes and recordings, and states he also reviewed the available historical notes before assessing [Mr A]. He states he felt [Mr A's] pulse and auscultated his lungs but did not examine his abdomen. The history recorded by [Dr B] is adequate if the additional nurse history is also taken into account. Best practice would be to further explore the abdominal pain history (for example, using the SOCRATES mnemonic[1]) and to ask about previous history of abdominal surgery. It is not clear that [Mr A] disclosed his history of inguinal hernia but I note the medical advice previously provided to him in this regard (see section 3).

(iv) Taking into account the vital signs already recorded, I feel [Dr B's] assessment of [Mr A's] general wellbeing and cardiorespiratory status was adequate. In my opinion, [Mr A] was exhibiting symptoms that were most suggestive of a gastrointestinal issue and performing an abdominal examination is accepted practice in this circumstance. This would include: inspection of the abdomen for surgical scars, distension and any obvious masses or herniae (hernial orifices assessed); palpation of the abdomen for tenderness, masses or signs of peritonism; auscultation of the abdomen to determine presence and nature of bowel sounds. Digital rectal examinations might be indicated depending on presenting symptoms and suspected diagnosis.

(v) I believe the failure by [Dr B] to perform an abdominal examination in the clinical scenario presented by [Mr A] represents a moderate departure from accepted practice whether or not the history of hernia was disclosed. The differential diagnosis for the symptom picture disclosed is quite broad (including simple gastroenteritis, constipation, diverticulitis, subacute bowel obstruction, hernia incarceration) and abdominal examination can help in the diagnostic formulation, but particularly in excluding those conditions that might require emergency care such as peritonitis and hernia incarceration. However, I am unable to state that had an abdominal examination been performed there would have been abnormal findings leading to a change in [Dr B's] provisional diagnosis or initial management advice. Many abdominal

[1] https://www.revolvy.com/page/SOCRATES-%28pain-assessment%29 Accessed 19 November 2019

conditions evolve over a period of hours or days, and initial observation (with provision of adequate safety-netting advice) may be a clinically appropriate management strategy depending on the overall condition of the patient, abdominal findings and suspected diagnosis. I am also unable to state, in the absence of recorded abdominal assessment findings, whether the management advice and treatment provided to [Mr A] by [Dr B] was clinically appropriate. Had there been no findings suggestive of an 'acute abdomen' and no evidence of subacute obstruction or hernia incarceration, it might have been reasonable to manage [Mr A] as [Dr B] did, noting safety netting advice was provided and eventually heeded by the patient's wife. I am mildly to moderately critical there was no provisional diagnosis recorded in the consultation note. I note reference in [Dr B's] response to a diagnosis of constipation although I cannot see that any specific treatment or advice was provided to [Mr A] in this regard.

(vi) The various policy and process documents provided by [Medical Centre 1] appear consistent with accepted standards and I have commented previously in the issue of access to historical notes. I have no other comments or recommendations."

The following further in-house clinical advice was obtained from Dr Maplesden:

"I have reviewed additional responses received from [Dr B] (5 December 2019) and [the clinical director of Medical Centre 1] (1 December 2019). There is no additional information contained in the responses which causes me to alter the comments in my original advice dated 25 November 2019. Appropriate remedial recommendations for [Dr B] might include attendance at the MPS workshop 'Achieving Safer and Reliable Practice'[2]."

[2] https://www.medicalprotection.org/newzealand/events-e-learning/workshops/workshops/achieving-safer-reliable-practice-nz