**General Practitioner, Dr B**

**A Report by the**

**Health and Disability Commissioner**

**(Case 04HDC08095)**

## Parties involved

| | |
|---|---|
| Ms A | Consumer |
| Dr B | General Practitioner/ Provider |
| First Public Hospital | Public Hospital |
| Second Public Hospital | Public Hospital |

## Complaint

On 13 May 2004 the Commissioner received a complaint from Ms A about the services provided by Dr B, general practitioner. The following issues were identified for investigation:

*The adequacy and appropriateness of the care provided to Ms A by Dr B between November 2002 and March 2004. In particular:*

- *whether he adequately investigated her abdominal symptoms, and*
- *whether he appropriately treated her abdominal symptoms.*

An investigation was commenced on 18 May 2004.

## Information reviewed

The following information was reviewed:

- Ms A's clinical records (from Dr B and the first public hospital)
- Information from Ms A
- Information from Dr B

Independent expert advice was obtained from Dr Gerald Young, general practitioner. Further expert advice was received following Dr B's response to my provisional opinion, which included three expert reports made to ACC.

## Information gathered during investigation

*Overview*
Dr B is a general practitioner at a medical centre in a city, and Ms A had been his patient for 12 years. Forty-two-year-old Ms A complained that during the period from November



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2002 to March 2004, Dr B failed to fully investigate her abdominal symptoms, which resulted in a delayed diagnosis of a 14.7kg ovarian cyst.

*November 2002 to July 2003*

On 11 November 2002, Ms A visited Dr B complaining of bloating and abdominal discomfort. She was physically examined by Dr B and commenced treatment for dyspepsia[1] and dysmotility.[2]

On 10 January 2003, Ms A visited Dr B again. The clinical notes state that Ms A had: "Diarrhoea last 3/7 [three days]." Dr B noted: "Abdo – ? slightly tense … no tenderness … normal BS [bowel sounds]." Dr B recorded his impression that there was a viral cause for Ms A's symptoms. She recalled that she had suffered no diarrhoea, but frequent bowel motions. Ms A was commenced on loperamide. Ms A stated that she mentioned abdominal symptoms to Dr B at this visit but she was not examined.

On 19 February 2003, Ms A visited Dr B, having injured her back while digging her garden. There is no mention of her abdominal symptoms in the medical notes for this visit. However, Ms A stated that her stomach and its appearance were discussed. Dr B has no recollection of any abdominal symptoms being mentioned.

On 22 April and 16 July Ms A was given a repeat of her usual medications, Sotalol (heart medication) and ranitidine (duodenal ulcer medication).

*10 October 2003*

On 10 October 2003, Ms A again visited Dr B complaining of abdominal symptoms. She described her stomach as "huge", but said that she still had "skinny limbs". The clinical notes record two concerns: "1. Stomach gets bloated. ... 2. Concerned about weight." There is no physical examination recorded in the notes for this visit. Dr B, in his response to Ms A's complaint, stated:

> "[Ms A] was … seen on 10 October 2003 when she mentioned again about her stomach getting bloated after meals. Her appetite was very good and she was eating a lot. She was concerned about gaining weight. Her weight was recorded as 80.5kg."

Ms A stated:

> "[Dr B] saw the size of my stomach when he weighed me. People thought I was pregnant. I told him this. I told him I couldn't fit any pants and was considering buying maternity clothes. I showed him how I had to push my stomach down to get some relief from the heartburn. He could see my hands on this huge stomach. I had extremely

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[1] Indigestion.

[2] Abnormal digestion process involving altered passage of digesting food through the gastrointestinal tract.



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skinny limbs. He still did not examine me. He did not ask me to have any tests, examinations of any kind. He just prescribed pills."

Motilium and Duromine[3] were prescribed at this visit and Ms A was weighed.

*November 2003 to March 2004*

On 7 November 2003, Ms A visited Dr B. He recalls that at this time Ms A was complaining of an upper respiratory tract infection (URTI). Ms A disagrees that the reason for visiting Dr B was a URTI, and stated:

> "I told [Dr B] that I was having trouble with breathing deeply. My lungs couldn't expand properly. … he did not listen to my chest as I recall but if he did he would have seen my huge stomach sticking out. … Why did he weigh me and prescribe duromine if I wasn't there for my stomach?"

There is no record of a physical examination in the medical notes for this visit. However, a weight loss of 2.5kg since the 10 October 2003 appointment is recorded, together with a repeat prescription of Duromine.

On 9 December 2003, Ms A visited the surgery to collect a repeat prescription, but did not see Dr B. Ms A stated:

> "My next visit for Duromine was in December however I phoned the doctors and had a prescription written out for this without a consultation. The doctor never asked to see me or for me to be weighed."

A repeat prescription for Sotalol (to treat a heart condition), ranitidine (to prevent gastric ulcers) and Duromine was recorded in the clinical notes.

Ms A next visited Dr B on 24 February 2004. He recorded in the notes two reasons for the visit: Ms A wanted to make claims for an Independence Allowance and "wants to get 1 more lot of Duromine". Ms A stated that she was in considerable abdominal discomfort by this date:

> "I went for my stomach pain. I was in agony at this time. I had severe heartburn. I was told by [Dr B] that this was due to being overweight. I had pain in my right side and was constantly going to the toilet. I was lifeless, had no energy. I told him Duromine helped with this. He prescribed me more even though we had discussed tak[ing] it for 3 months only which was up in January."

There is no record of a physical examination in the notes for this date.

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[3] Duromine is a drug that suppresses the appetite and is chemically related to amphetamine. *The New Ethicals Compendium* 7th Edition states: "Secondary causes of obesity should be excluded before prescribing this [drug]. … Patients require medical review after a defined course of treatment which ideally should not exceed 3 months."



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In respect of the appointments during 2003 (excluding that of 10 October) and in February 2004, Dr B stated: "I do not recall [Ms A] mentioning abdominal pain … and I would have examined her abdomen if she had done."

On 11 March 2004, Ms A visited Dr B. She stated:

> "Same pain. Same complaints. But now unbearable. [Dr B] finally examines me for the first time since Nov 2002. He said he could do nothing about my pain other than pills and waiting lists. I begged him for help. I was crying in agony. Everything hurt."

Dr B recorded: "Some pain upper abdomen recently." Following a physical examination of Ms A, he queried the possibility of a mass on the left side of her abdomen and arranged an urgent scan, sending the referral on the same day. Paradex was prescribed for pain.

Dr B recalled:

> "11 March 2004 … [Ms A] complained of upper abdominal pain, more on the right side and some back pain. She had been taking more Ranitidine than usual. Her abdomen looked distended and there was a suggestion of a mass on the left side. A urine sample was tested and was normal. I thought that she had a lower abdominal mass and sent an urgent requisition for an abdominal ultrasound to [the first public hospital], which was sent that day. Later that week, she was seen at an After Hours Clinic and admitted to [the first public hospital]."

*13 March 2004*

Ms A presented to the Emergency Department at the first public hospital, where she was admitted. After transfer to the second public hospital on 16 March 2004, she had a laparotomy,[4] a left salpingo-oophorectomy,[5] and removal of a 14.7kg ovarian cyst.

In response to my provisional opinion, Ms A stated:

> "I would like to express that I do agree ovarian cysts are difficult to diagnose in [their] early stages, however with all the symptoms, unable to lay on stomach, increased heartburn, large stomach, wiggly feeling in stomach, Motilium not helping, inability to eat a meal, constant toilet, frequent bowel movements, back pain, severe stomach pain (perforation of stomach), side pain, months of stomach pressure, difficulty to breathe, skinny limbs along with talking about diets, juicing vegetables and exercise which were not working, I know this cyst should not [have] gone past Oct 2003. I only visited [Dr B] approx two/three times a year for the last 10 years, until the cyst appeared then visiting 8 times within the next 17 months

[4] Laparotomy: an exploratory operation of the abdomen.

[5] Salpingo-oophorectomy: removal of ovary and fallopian tube.

> along with picking up prescriptions. This should have been sufficient visits to be sent for further tests."

On 6 December 2004 ACC declined Ms A's claim for medical misadventure. ACC summarised the "Medical Misadventure Report to Claimant", dated 6 December 2004:

> "ACC has been unable to establish that there has been a physical injury with a causal link to your medical treatment and as this does not fit the criteria required by the Injury Prevention, Rehabilitation and Compensation Act 2001, your claim is declined."

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## Independent advice to Commissioner

The following expert advice was obtained from Dr Gerald Young, general practitioner:

> "I have been asked to provide an opinion to the Commissioner on case number 04/08095.
>
> I declare that I have read and agree to follow the 'Guidelines for Independent Advisors'.
>
> In preparing independent advice on this case to my knowledge I have no personal or professional conflicts of interest.
>
> My qualifications are B.H.B, MB,Ch.B. (Auckland), FRNZCGP. My training included 3 years as a surgical registrar in the Auckland Surgical training programme. I have been in general practice for 16 years. I have a special interest in surgical problems in general practice.
>
> **I have been asked to consider the issues as listed below:**
>
> 1. Was the assessment of [Ms A] by [Dr B] on 11 November 2002 appropriate?
> 2. Was the assessment of [Ms A] by [Dr B] on 10 January 2003 appropriate?
> 3. Was the assessment of [Ms A] by [Dr B] on 24 February 2003 appropriate?
> 4. Was the assessment of [Ms A] by [Dr B] on 10 October 2003 appropriate?
> 5. Should [Dr B] have requested further tests specifically on 10 October 2003 or at any earlier stage?
> 6. Should [Dr B] have physically examined [Ms A] on:
>    - 6.1 10 January 2003,
>    - 6.2 24 February 2003,
>    - 6.3 10 October 2003?
> 7. Duromine was prescribed on 10 October 2003, 7 November 2003, 9 December 2003 and 24 February 2004. Is this drug regime appropriate for treating dyspepsia/dysmotility?



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8. Does the prescription of Duromine on 7 November 2003, 9 December 2003 and 24 February 2004 imply that there was a discussion that would have involved [Ms A's] abdominal symptoms?
9. Is the standard of record keeping acceptable?
10. Is it probable that [Ms A's] ovarian cyst was detectable prior to 11 March 2004 by a GP examination? If so, at what time?
11. If, in answering any questions, you believe that [Dr B] did not provide an appropriate standard of care, please indicate the severity of his departure from that standard. To assist you in this last point I note that some experts approach this question by considering whether the provider's peers would view the conduct with mild, moderate, or severe disapproval.
12. Are there any aspects of the care provided by [Dr B] that you consider warrant additional comment?

**My opinions and advice to the Commissioner on this case have been based on the documents supplied:**

1. Letter of complaint dated 9 May 2004 from [Ms A] (pages 1 to 2)
2. Response to complaint by [Dr B] dated 30 August 2004 (pages 3 to 4)
3. GP clinical record (pages 5 to 7)
4. Response by [Ms A] to [Dr B's] letter of 30 August 2004 (pages 8 to 9)
5. Clinical record from [the first public hospital] Emergency Department and [the second public hospital] (pages A1 to A90)

**Additional documents used for reference**

1. 'General Practice' textbook by John Murtagh
2. Communication with [a specialist gynaecological oncologist].

**Background**

From 11 November 2002 until 13 March 2004, [Ms A] made a number of visits to [Dr B]:

11 November 2002:
Ms A complained of bloating and abdominal discomfort. She was examined ('Abdo — tense. ? some distension no tenderness. No masses') and commenced treatment for dyspepsia/ dysmotility (Motilium).

10 January 2003:
The clinical record records: 'Diarrhoea last 3/7', and Dr B's examination showed, 'Abdo — ? slightly tense no tenderness normal BS [bowel sounds]'. Ms A was commenced on Loperamide. Ms A's recall is that she had no diarrhoea but frequent bowel motions. In her letter of complaint, she states that her stomach was mentioned at this and subsequent visits and that she was not examined at this appointment.



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19 February 2003:
Ms A visited Dr B having injured her back whilst digging her garden. There is no mention of her abdominal symptoms, but Ms A claims that her stomach and its appearance were discussed.

22 April 2003 and 16 July 2003:
Visits for repeat prescriptions.

10 October 2003:
Ms A had an appointment complaining of abdominal symptoms. She describes her stomach as 'huge', with 'skinny limbs'. The clinical record records two concerns: '1. Stomach gets bloated. .. 2. Concerned about weight'. There was no physical examination by Dr B of Ms A at this visit. Motilium and Duromine were prescribed at this visit and she was weighed (80.5kg).

7 November 2003:
Ms A attended the surgery, complaining of an upper respiratory tract infection (URTI). The clinical record notes a loss of 2.5kg from the 10 October appointment, and a repeat prescription of Duromine was provided. Ms A disputes the diagnosis of URTI, based on her not being examined by Dr B, and states that she had difficulty 'breathing deeply. My lungs couldn't expand properly. … He did not listen to my chest as I recall but if he had he would have seen my huge stomach sticking out.' Dr B did not record any physical examination.

9 December 2003:
A visit for repeat prescription.

24 February 2004:
Dr B recorded two reasons for the visit: making claims for Independence Allowance and, 'Wants to get 1 more lot of Duromine'.
Ms A claims that she was in considerable abdominal discomfort at this stage. No examination is recorded.

11 March 2004:
Dr B recorded: 'Some pain upper abdomen recently'. Following examination, queries the possibility of a mass on the left side and arranges an urgent scan, which was sent on 11 March 2003.

13 March 2004:
Ms A attended the Emergency Department at [the first public hospital] and was admitted acutely. On 16 March she had a laparotomy, left salpingo-oophorectomy and removal of a 14.7 kg ovarian cyst.



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**Advice on the specific questions:**

1. **Was the assessment of Ms A by Dr B on 11 November 2002 appropriate?**

The assessment on 11th November 2002 is appropriate.

The reason for my opinion is that it is not possible to be confident beyond reasonable doubt at this point in time that Ms A's symptoms are entirely due to an ovarian tumour. It was also known to Dr B that she had a past history of peptic ulceration and she was on long term treatment for this. The symptoms and findings at this time could reflect abdominal dysmotility for which motilium was prescribed.

It is noted that the comment was made to review in 2 weeks, presumably if symptoms did not settle.

2. **Was the assessment of Ms A by Dr B on 10 January 2003 appropriate?**

The assessment on 10th January 2003 is appropriate.

The reason for my opinion is that it is not possible to be confident beyond reasonable doubt at this point in time that Ms A's symptoms are due to the ovarian cyst. The symptoms and documented findings could well have been caused by a viral infection of the gastro-intestinal tract. The treatment offered was consistent with the assessment. It is noted that advice was given to the patient to be reviewed as required.

3. **Was the assessment of Ms A by Dr B on 24 February 2003 appropriate?**

The assessment on 24th February 2003 is appropriate.

Ms A's history and findings of her lower back strain are recorded. The treatment given at this time is consistent with the clinical assessment.

4. **Was the assessment of Ms A by Dr B on 10 October 2003 appropriate?**

The assessment on 10th October 2003 was not adequate or appropriate.

I have arrived at this opinion based on the following: Ms A presented with stomach bloating and weight gain. Bloating has not been documented as a problem by Dr B since 11th Nov 2002. It therefore cannot be assumed that it is a continuing problem. Because it may be a new problem the symptoms should be treated as such, with a full history taken of the symptoms followed by an appropriate clinical exam. In this case the exam should have included a full abdominal exam with a rectal examination as a minimum, a vaginal exam would probably have been appropriate as well.

The weight gain should not have been treated as a separate problem without clinically demonstrating that it was indeed a separate problem. It is one of the axioms of medicine that symptoms should in the first instance be attempted to be explained by one diagnosis.



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There is documented evidence which strongly indicates that abnormal findings would have been discovered if an examination had been performed at this consultation. The first is from the hospital records on pages 2 & 23, on the day of admission to hospital it is documented that Ms A stated that she had been 'unwell for 9 months' with 'low abdominal and pelvic pain for the last 6 months.' This means that at the time of the consult of 10th Oct 2003, 5 months before admission, Ms A was experiencing significant symptoms caused by the ovarian tumour and clinical signs would have been found at this time.

The second indicator comes from Dr B's records. It was recorded that Ms A weighed 80.5kg at this time. Ms A stated in her letter of complaint that her weight 'should be 65kg' which would be consistent with an ovarian tumour of approximately 15kg.

For most women weighing 65kg (assuming Ms A's height, which has not been documented, is over 1.55 metres) a 15kg abdominal mass would have been very obvious, making her look like she is very pregnant (the average pregnancy weight gain being in the range 12-15kg). This would be consistent with Ms A's question in her letter of complaint that she asked Dr B 'look at my legs doc, they are skinny, why is it only my stomach that is getting fat?'

**5. Should Dr B have requested further tests specifically on 10 October 2003 or at any earlier stage?**

Dr B should have requested further investigations on 10th October to help him delineate the cause of the abdominal bloating and weight gain. As a minimum this should have included an ultrasound scan of the abdomen.

**6. Should Dr B have physically examined Ms A on**
**10 January 2003,**
**24 February 2003,**
**10 October 2003?**

Dr B recorded in his medical records that he did physically examine Ms A on 10th Jan 2003. In my response to question number 2, my opinion is that the assessment at this time was appropriate.

On 24th February 2003 the recorded problem was a back injury after digging in the garden. Physical examination findings of the back were recorded. There was no abdominal symptoms or physical exam recorded. I am not able to determine if an abdominal exam should have been performed at this consult as no symptoms of an abdominal complaint were recorded.

Dr B should have performed a full abdominal exam on 10th October 2003 for the reasons indicated in my response to question 4.



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**7. Duromine was prescribed on 10 October 2003, 7 November 2003, 9 December 2003 and 24 February 2004. Is this drug regime appropriate for treating dyspepsia/dysmotility?**

Duromine is not an appropriate treatment for dyspepsia / dysmotility. My interpretation of the medical records is that it was prescribed for weight loss.

**8. Does the prescription of Duromine on 7 November 2003, 9 December 2003 and 24 February 2004 imply that there was a discussion that would have involved Ms A's abdominal symptoms?**

The re-prescribing of the duromine on these dates does not necessary imply that there was a discussion about abdominal symptoms as duromine is primarily a weight loss medication. This does not exclude that there may have been discussions of the abdominal symptoms associated with weight gain.

**9. Is the standard of record keeping acceptable?**

I am not able to determine the acceptability of the medical records. The medical notes are brief but the information recorded is of a reasonable format and acceptable. The issue that I am not able to judge is if all the salient information from each consult has been actually recorded. There appear to be significant differences in some of the consultations between what has been documented by Dr B and the recollections of Ms A of the consults.

**10. Is it probable that Ms A's ovarian cyst was detectable prior to 11 March 2004 by a GP examination? If so, at what time?**

The ovarian cyst would have been detectable prior to 11th March 2004. The exact time is not able to be stated exactly, however it can be deduced from the hospital records that the ovarian tumour was of a reasonable size 6 to 9 months prior to March 2004. The evidence that supports this comes from the hospital records on pages 2 & 23 on the day of admission to hospital it is documented that Ms A stated that she had been 'unwell for 9 months' with 'low abdominal and pelvic pain for the last 6 months.'

The ovarian tumour in the histology report (pages 72 & 73 of the hospital records) states that the solid component of the tumour was 4.7kg and ten litres of fluid was drained from the cystic component, the two components giving a combined weight of approximately 14.7kg.

[A specialist gynaecological-oncologist] has advised me that in his opinion an ovarian mucinous cystadenoma with a 4.7kg solid component with a 10 litre fluid component would take 2-3 years to develop, although the fluid component can develop more quickly possibly over months. ([The specialist gynaecological-oncologist] has indicated that he can provide an independent report if requested by the HDC.)



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The weight recordings provide strong corroborative evidence that the ovarian tumour was a significant size when seen on 10th October 2003.

**11. Did Dr B provide an appropriate standard of care?**

In my opinion Dr B did not provide an appropriate standard of care to Ms A. Ms A had significant ovarian pathology that Dr B had the opportunity to, and should have diagnosed at least 5 months prior to her eventual admission on March 13th 2004. It was inappropriate for Dr B to have prescribed duromine, and continuing to prescribe duromine for 4 months, before an adequate examination and investigations for her complaint of stomach bloating and weight gain.

The breach of standard of care would fall into the moderate to severe category.

**12. Are there any aspects of the care provided by Dr B that you consider warrants additional comment?**

I do not have any further comments on any other aspects of the care provided."

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## Further independent advice

In his response to my provisional opinion, Dr B provided reports from a general practitioner, an oncologist, and an obstetrician and gynaecologist. These doctors had provided reports for ACC. Further advice was sought from Dr Young as a result of Dr B's response to my provisional opinion. Dr Young was asked:

1. Is there anything within the reports from the general practitioner, oncologist, or the obstetrician and gynaecologist that cause you to alter your advice to the Commissioner?
2. Is there anything within Dr B's response of 5 January 2005 that causes you to alter your advice to the Commissioner?
3. Is there anything within Ms A's response of 13 December 2004 … that causes you to alter your advice to the Commissioner?
4. Please comment on the obstetrician and gynaecologist's comment:

   "Ovarian cysts can present with very few symptoms and it is not uncommon for ovarian cysts in young women to reach a very large size before they are diagnosed."

   Dr Young provided the following additional advice:

   "Please find below further advice on this case as requested:



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1. There is not anything in the reports from [the general practitioner, oncologist, and obstetrician and gynaecologist] that would cause me to alter my advice on the standard of care offered. It must be noted that the thrust of these reports for ACC are significantly different from my brief, as was noted in the report by [the general practitioner]. Their reports were essentially to assess if a delay in diagnosis would have led to a different clinical outcome for Ms A. I would agree that the delay in diagnosis in the time frame that I have suggested of 6-9 months, is unlikely to have altered the clinical outcome. However this does not make the level of care leading to the delay acceptable.

   The only change that may be warranted is to lower the breach to a moderate breach only from the moderate to severe degree that I originally indicated.

   The reason for this change is that all three have commented that ovarian cysts and cancers are known for being diagnosed late which is true. Also that Dr B did remind Ms A that smears were overdue. Possibly this should count more positively in favour of Dr B than I have initially allowed. This however does not change my opinion that the standard of care was inadequate.

   I will expand on my report with further details of the reasoning leading to this finding. Although the diagnosis of the ovarian cyst potentially could have been made at any time in the period under review, the consultation on 10th October 2003 should have led to the diagnosis being made. The consultation on this date did not adequately address Ms A's concerns about her symptoms and a clinical exam should have been performed.

   The ovarian cyst was large by this time, so her symptoms from the pressure of the cyst would have been significant. The distension of her abdomen by the cyst would have been obvious to Ms A so it is very likely that she did complain of abdominal distension with her weight gain, not just the weight gain as Dr B documented at the time and subsequently claims. Dr B in his reply states that he was not in a position to ascertain whether Ms A was gaining or losing weight as he states '… no previous weight records had been taken.' I also could not find any record of her weight in Dr B's notes. However it was Dr B's duty to have established some basic facts about her weight history before prescribing the duromine for weight loss. As a minimum Dr B should have questioned Ms A about her weight history; how much weight she thought she had put on and over what time period.

   An examination should have been done at the time as I have previously stated. This should have included a height, to calculate her body mass index (BMI) to establish if Ms A was overweight for her height. As



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previously stated an abdominal exam should have been performed. The abdominal exam may have revealed the fluid filled cyst and / or the solid mass. I accept that on clinical exam that the cyst or the mass may not have been easily identified but the abdomen itself would have been very distended in an atypical fashion. This is supported by the report from [the oncologist] in which he states 'Probably the most typical symptom of a large ovarian cyst is abdominal distension as distinct from thickening of the abdominal wall and fat disposition within the abdomen as a part of generalized obesity. Patients with large ovarian cysts often show this differential 'weight gain' looking as if they are putting it on in the abdomen losing weight elsewhere.' So even if Dr B did not feel the cyst or the ovarian mass on the exam he should have noted that Ms A's abdomen was very distended and that she had very little external somatic fat which is inconsistent with female obesity. Female obesity is typically described as a 'saddle pattern' with somatic fat being deposited on the lower aspect of the abdominal wall, into the thighs and buttocks; a large distended abdomen with minimal abdominal wall fat is a male pattern of obesity. As I stated in my initial report these findings should have then led on to include a rectal exam and possibly a vaginal pelvic exam. Again I accept that there is a possibility that a rectal and pelvic exam may not reveal an ovarian cyst or mass however the degree of abdominal distension and findings that would have been inconsistent with female obesity should have led to either further investigation with an ultrasound scan and / or referral to a specialist to review.

Therefore I do not have any reason to alter my advice that Dr B did not provide an appropriate standard of care.

2. There is not anything in Dr B's response that would cause me to alter my advice. I would like to reply to some of the comments and concerns that Dr B made in his reply.

   Dr B is concerned that I have not considered his response to the complaint. I have clearly listed in my report that his response was one of the documents that was reviewed and considered. In forming my opinions I have placed more evidential weight on Dr B's medical records as I have tried to reconstruct what would have reasonably transpired at the time. Dr B had the opportunity to record his interpretation of the events at the time in his medical records whereas Ms A obviously did not. This is obviously why I have had to use the reported comments from Ms A to reconstruct her versions of events. I stated in my report that there are significant differences between what has been documented by Dr B and the recollections of Ms A. In the consultation of 10th October 2003 I believe the symptoms Ms A was experiencing and physical signs she noted in herself by this time led her not only to be concerned about her weight but also in all probability



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about her shape. I have used objective evidence, direct or indirect, wherever possible to formulate my opinions.

Dr B raises the issue that abnormal findings may not have been found if an exam was performed at the time. I have addressed this in my comments above that even if the fluid cyst or ovarian mass was not palpable the abdomen would have been noted to be very distended and inconsistent with female obesity.

Dr B notes that from the medical records a trainee intern and a house surgeon could not feel the cyst or tumour. I note that rectal and pelvic examinations were not done by these doctors. This does not alter my opinion that a GP providing adequate care would have noted on examination that the findings would be inconsistent with obesity and referred the patient on for a scan and / or specialist review.

3. I agree with [the obstetrician and gynaecologist's] comment that 'ovarian cyst can present with few symptoms and it is not uncommon for ovarian cysts in young women to reach a very large size before they are diagnosed.'

   This was the case with Ms A. The cyst had got to a large size even by 10th October 2003 when the diagnosis could have been made. By the consultation on 10th October 2003 Ms A was symptomatic from the large cyst and had external signs. Ovarian cysts and tumours can be especially difficult to diagnose in women who are already obese. This did not appear to be the case with Ms A as she states her 'normal' weight was 65kg and her weight after the cyst was removed was recorded as 57kg."

## Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights 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*



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## Other relevant standards

"Good Medical Practice — A Guide for Doctors" (Medical Council of New Zealand, February 2000 and December 2003):

"Domains of competence: …

2. Good clinical care must include:
   - an adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination
   - providing or arranging investigations or treatment when necessary
   - taking suitable and prompt action when necessary.

3. In providing care you must: …
   - keep clear, accurate, and contemporaneous patient records that report the relevant clinical findings, the decision made, the information given to patients and any drugs or other treatment prescribed."

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## Opinion: Breach — Dr B

Under Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Ms A had the right to have services provided by Dr B with reasonable care and skill and in accordance with professional standards. Ms A complained that Dr B did not provide services of an appropriate standard because he failed to assess her symptoms adequately, which resulted in a delayed diagnosis of an ovarian cyst.

*November 2002*
Dr Young advised me that Dr B's assessment was appropriate on 11 November 2002 and that "the symptoms and findings at this time could reflect abdominal dysmotility for which Motilium was prescribed". I accept Dr Young's advice.

*10 January 2003*
In relation to these three further visits to Dr B, Ms A stated that worsening abdominal symptoms were discussed. They are not documented in the clinical notes. My advisor stated that in relation to the assessments performed by Dr B during these consultations, he was unable to reconcile the different recollections of Dr B and Ms A. I am also unable to do so. I accept that Dr B undertook an appropriate assessment of Ms A on 10 January 2003.

*10 October 2003*
Ms A saw Dr B on 10 October 2003 because her abdominal symptoms were giving her increasing cause for concern. Dr Young considered that Dr B's assessment of Ms A on this



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date was neither adequate nor appropriate. A full history should have been taken, followed by an appropriate clinical examination.

Dr Young advised that the ovarian cyst would have been of a "significant size" in October 2003. It is probable that, had an adequate and appropriate assessment been performed, a referral for further investigations would have ensued, leading to an earlier diagnosis of the ovarian cyst. I accept Dr Young's advice.

I note that when referring to the visits Ms A made after 11 November 2002 until March 2004 (excluding her appointment on 10 October 2003), Dr B stated:

> "I do not recall [Ms A] mentioning abdominal pain during these consultations and I would have examined her abdomen if she had done."

In light of this statement by Dr B, it is worthy of specific comment that when Ms A did complain of abdominal symptoms on 10 October 2003, Dr B failed to perform an examination.

In response to my provisional opinion on this particular issue, Dr B stated:

> "On 10 October 2003, Ms A most certainly did not state to me that she was worried about a huge stomach and extremely skinny limbs. I cannot be certain whether or not I did examine Ms A's abdomen on that occasion. I was not in a position to determine whether or not she was gaining or losing any weight because no previous weight records had been taken."

In respect of this point, Dr Young stated in his further advice:

> "The ovarian cyst was large by this time, so her symptoms from the pressure of the cyst would have been significant. The distension of her abdomen by the cyst would have been obvious to Ms A so it is very likely that she did complain of abdominal distension with her weight gain. … Dr B in his reply [to the provisional opinion] states that he was not in a position to ascertain whether Ms A was gaining or losing weight as he states '… no previous weight records had been taken.' I also could not find any record of her weight in Dr B's notes. However it was Dr B's duty to have established some basic facts about her weight history before prescribing the duromine for weight loss. As a minimum Dr B should have questioned Ms A about her weight history; how much weight she thought she had put on and over what time period."

I agree that it is not sufficient for Dr B to claim he could not determine weight changes for his patient, when it was his responsibility to have noted such a basic element of her history before prescribing Duromine.

In my opinion, at this consultation, Dr B failed to discharge his duty of care to Ms A because he failed to adequately and appropriately assess her. Accordingly, he breached Rights 4(1) and 4(2) of the Code.



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*7 November 2003 and 24 February 2004*
Ms A stated that during her two appointments with Dr B on 7 November 2003 and 24 February 2004, her main concern was her increasing pain and discomfort, allied with abdominal distension. Dr B stated that he does not recall Ms A's complaints of a distended abdomen during these appointments. There is no record of such a discussion in the clinical notes. However, I have no reason to disbelieve Ms A's clear and cogent account of what she told Dr B, particularly since it is likely that the cyst was causing her considerable pain by the time of those consultations.

Dr B stated that Ms A's visit on 7 November 2003 was because of an upper respiratory tract infection. However, there is no record of any assessment of respiratory function on this date. In response to my provisional opinion, Dr B stated:

> "It is my invariable practice to listen to a patient's chest if that is the complaint to see if there is a more significant infection. I have not recorded that in the medical notes."

Ms A stated that Dr B had not listened to her chest. It is not critical for me to determine this because the key issue is the assessment of Ms A's abdominal symptoms.

As noted above, Dr Young advised that the ovarian cyst would have been of a significant size in October 2003, and it would have been getting larger. I consider it probable that Ms A would have discussed her abdominal symptoms with Dr B on 7 November 2003 and 24 February 2004 and that he failed to assess this or make a record in the notes. Accordingly, Dr B breached Rights 4(1) and 4(2) of the Code.

*Prescription of Duromine*
Dr B commenced the prescription of Duromine in October 2003 without first excluding a secondary cause of Ms A's suspected obesity. This was contrary to the guidelines in the *New Ethicals Compendium* (7$^{th}$ ed).

Dr Young advised that by prescribing Duromine without performing a clinical examination, and by continuing with this course of treatment for four months before further investigations were considered, Dr B acted inappropriately. I accept Dr Young's advice.

In response to my provisional opinion on this issue, Dr B stated:

> "With hindsight, I do acknowledge that it would have perhaps been wise to perform a physical examination of Ms A before continuing to prescribe Duromine, but again I do not know whether this would give any reason to find the cyst before the time I did, particularly in the face of Ms A's insistence that she continue to have the Duromine."

Dr B went on to say in relation to Ms A's appointment on 24 February 2004:

> "My recollection … is that Ms A specifically requested the Duromine. Because of her weight loss, and the benefit it appeared to be having to her, I was prepared to continue prescribing that to her."



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I am concerned that Ms A's alleged "insistence" and her specific request for Duromine are given by Dr B as influencing factors in his decision to continue prescribing the drug. As noted in HDC case www.hdc.org/99/HDC01756, doctors are not beholden to their patients' demands for services. Providing services in a manner consistent with patient needs is not the same as providing inappropriate services in accordance with patients' wishes. It is also disappointing that Dr B considers, with the benefit of hindsight, that it would have "perhaps been wise to perform a physical examination of Ms A before continuing to prescribe Duromine". In my view, and based on Dr Young's advice, this was a fundamental prerequisite of such a course of treatment.

In my opinion, Dr B failed to adequately assess Ms A prior to prescribing Duromine. He also failed to reassess this course of treatment in light of Ms A's clinical symptoms on 7 November 2003 and 24 February 2004. Accordingly, Dr B breached Rights 4(1) and 4(2) of the Code.

## Follow-up actions

- This matter will be referred to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the New Zealand Medical Council with the recommendation that the Council consider whether a review of Dr B's competence is warranted.
- A copy of this report will be sent to the Royal New Zealand College of General Practitioners and the Accident Compensation Corporation.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, upon completion of the Director of Proceedings' processes.

## Addendum

The Director of Proceedings issued proceedings before the Health Practitioners Disciplinary Tribunal and, at a hearing on 31 August 2006, a charge of professional misconduct was upheld. The Tribunal considered that Dr B's acts and omissions were well short of the standards that the Tribunal reasonably expects of a general practitioner. Dr B was censured and ordered to pay costs of $15,000 to the Director of Proceedings, plus $7,500 to the Tribunal. The Tribunal also ordered that Dr B attend a residential practice development training programme. Permanent name suppression was granted.