Dr B

A Report by the

Health and Disability Commissioner

(Case 02HDC11786)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Ms A	Complainant, Consumer's mother
Dr B	General Practitioner, Provider
Ms C	Health and Disability Advocate

Complaint

On 26 August 2002 the Commissioner received a complaint from Ms A concerning the services provided to her son, Mr A, by Dr B, general practitioner. The complaint was summarised as follows:

> "*On 5 July 2002 Dr B did not provide services of an appropriate standard to Mr A. In particular he did not adequately assess and examine Mr A or provide appropriate advice on the need for follow-up.*"

An investigation was commenced on 19 May 2003.

Information reviewed

- Correspondence from Ms A
- Correspondence with Dr B
- Report supplied by Advocacy Network Services Trust
- Medical notes forwarded by an After Hours Medical Centre
- Medical Centre medical history
- Medical records from the Public Hospital

Independent expert advice was obtained from Dr Steve Searle, general practitioner.

Information gathered during investigation

At 10pm on 5 July 2002 Mr A, who was 15 years old at the time, went to an After Hours Medical Centre with a headache, vomiting and stomach ache. Mr A was accompanied by a friend.

Mr A was seen by Dr B, general practitioner, who examined him and made a diagnosis of gastric infection. Dr B said he assessed Mr A's abdomen by feeling under the epigastrum,

listening to the bowel sounds, which were active, and palpating the central abdomen and the left and right lower quadrants. He noted that the abdomen was soft with no evidence of rebound or guarding. However, Mr A stated that Dr B did not examine his abdomen, but only listened to it with a stethoscope. Dr B explained that he would have palpated Mr A's abdomen while holding his stethoscope in his hand, and that this may have misled Mr A about the nature of what he was doing. I accept that Mr A may have been mistaken in his observation because Dr B's account is supported by his notes of the consultation, which record "abdo soft, no rebound, no guarding". I am satisfied that Dr B did complete an appropriate examination.

Dr B advised that Mr A had a normal temperature of 36.4°C and that he recalls noting a heart murmur.

In a letter of 2 September 2002 to the complaints officer of the After Hours Clinic, Dr B stated:

> "In [Mr A's] presentation abdominal discomfort was an associated feature of the presenting complaints. … My recollection is that [Mr A's] abdominal discomfort was in the upper abdominal area, and there was no history of pain migration."

Dr B had a telephone discussion with Mr A's mother, Ms A, and told her that he did not believe Mr A had appendicitis, but was instead suffering from gastroenteritis. Dr B recommended that Mr A rest in bed and take plenty of fluids. He also advised that if Mr A's condition did not improve, he should return to the Medical Centre.

Ms A advised me that she was in a city when she had the telephone discussion with Dr B. She said she wanted to return home to be with her son, but was reassured by Dr B's comments and stayed in the city.

Dr B's notes of the consultation state:

> "**History – present**
> 1/7 [1 day] vomiting
> off food sleeping all day
> bm √ [bowel movements] pu √ [urinating]
> fever
>
> **History – past**
> Well, ADHD
>
> **Allergies**
> No
>
> **Drugs**
> Dexamphetamine

Examination
T 38.4 [temperature 38.4°C] hydra √ [normal hydration] perla [pupils equal, reactive to light and accommodation] no rash
ent – mild phynts [mild pharyngitis – inflammation of the larynx], no neck stiffness
chest clear, HSdII [dual heart sounds] BP [blood pressure] 140/60
abdo soft, no rebound, no guarding
bs+ [increased bowel sounds]

Diagnosis
[Gastroenteritis]

Treatment
Fluid, panadol, rest
See sos [see again if necessary]"

Mr A's condition did not improve and on 7 July 2002 he was taken to another Medical Centre where he was diagnosed with acute appendicitis. Mr A was admitted to the Public Hospital where he underwent an open appendectomy. It was found that his appendix had perforated and was gangrenous. Mr A was kept in hospital for six days following the operation and was unable to sit his NCEA examinations owing to the time he had to take off school after his discharge.

Independent advice to Commissioner

The following independent expert advice was obtained from Dr Steve Searle, general practitioner:

"**Supporting information**
- Correspondence from Ms [A] …
- Correspondence with Dr [B] …
- Report supplied by Advocacy Network Services Trust …
- Medical notes forwarded by the After Hours Medical Centre …
- [Another] Medical Centre medical history …
- Medical records from [the Public Hospital] …

…

Possible missing information:

<u>There has been some comment about [Mr A's] heart murmur.</u>
I could review this further if information was provided from his background medical history. I do not think this would change my opinion. Murmurs can vary with body position, and heart rate, and vasodilatation (dilation of the body's blood vessels – which can occur for many reasons including illness) and can vary with other factors

– this means Dr [B] hearing or not hearing a heart murmur in this case is unlikely to be of help. In the letter from [Ms A] dated 16/10/02 (contained in [information reviewed]) her point C suggests that the fact that the heart murmur was not noted during the examination might have a bearing on showing 'how thorough the examination may not have been'. I do not think this is of any relevance to the thoroughness of the examination because of the above factors. In addition to my comments above I note that in [the medical records from the Public Hospital] one of the hospital doctors who examined [Mr A] did not hear his murmur – they noted 'CVS I-II-0' (which means cardiovascular system heart sounds I and II heard and '0' for no murmur). Thus it is entirely possible that his heart murmur was not able to be heard around the time of his illness. Dr [B's] notes record 'HS I+II' but make no comment on the presence or absence of a murmur. I note he has said in subsequent correspondence (his letter 4 June 2003) that he did hear the murmur – given this murmur was probably known to [Mr A] and hence old and not that likely to be contributing to his assessment it was not critical that it was not recorded, but it may have been slightly more correct for Dr [B] to note the murmur in his notes and to have an entry in the past history section of his notes saying that he had a known heart murmur. Overall I think given all of the above factors that the recording or not recording of his heart murmur probably does not have a direct bearing on the case. I have discussed this issue to illustrate that I have considered it and also why I think it is not of any great significance in this case.

A typed out version of the hand written notes.
This may have been useful. In particular the 'History-Present' section of the notes is a little unclear to me in the second line – I am not sure about the first word or two in this line. However after careful consideration I think that having a typed version of the hand written notes probably would not alter my opinion.

I will outline my interpretation of the notes line by line as follows so that anyone involved in the case, and in particular Dr [B], can draw to my attention if I have made an error of interpretation. I will also try and explain some of the technical terms to assist other people reading the report but this simplification does not necessarily fully explain the technical terms, and does not necessarily allow for normal variation of professional use of these terms or for variation in the way they are practically used in examination of patients – so if someone is unsure about the meaning of these terms then they should either check with myself or another doctor.

'History – Present' section
'1/7 of vomiting' This means one day of vomiting.
'all bed (I am not sure if I am reading these two words correctly) sleeping today' I think this is some reference to him being in bed sleeping today.
'BM(tick) PU(tick)' Meaning he has had normal bowel motions and normal passing of urine.
'Fever' – He has had some fever.

In the 'History – Past' section:
'Well, ADHD' – well apart from attention deficit hyperactivity disorder.

Immune Status section:
'-' – meaning no problems with the immune system
'Allergies' section:
No – meaning he has no known allergies to medications.
'Drugs' Section:
Dexamphetamine – a medication for the ADHD
'Examination' Section:
'T 35.4. hydrn (tick). Perla (tick) No rash' – Temperature 35.4, hydration normal, pupils of the eyes equal and reacting to light and accommodation, no rash
'ENT – mild pharyngitis. No neck stiffness' – Ear nose and throat examination showed a mild inflammation of the throat. There was no neck stiffness when the neck was moved.
'Chest clear, HS I & II BP 140/60' – The chest was clear (usually meaning normal breath sounds and no added sounds when the chest/lungs were listened to), Heart Sounds both heard. Blood Pressure 140mmHg systolic with a diastolic of 60mmHg.
'Abdo soft, no rebound, no guarding' – The abdomen was soft when palpated (when the doctor presses on it with their hand(s). No rebound means that usually with sudden releasing of pressure on the abdomen there is no pain as or just after the pressure is let off (but there are other ways of checking for rebound such as percussion (a type of tapping)). No guarding means that the muscles of the abdominal wall were not contracting in response to pressing on the abdomen.
'BS +' Bowel sounds present – the '+' can mean different things to different doctors but they were certainly either present or slightly increased – Dr [B] has said 'increased bowel sounds' in his letter 2 Sep 2002.

'Diagnosis' Section.
'Gastritis' – inflammation of the stomach lining – this has a large variety of causes and usually settles on its own although this can depend on the cause.
'Treatment' Section
'Fluids, panadol, rest, see SOS' – Meaning keep up oral fluids, panadol for pain and/or fever relief (this was prescribed as per the copy of the prescription), rest, and see again 'SOS' or as required usually meaning if things are worse or different – however this term can be used differently by different doctors – I note Dr [B] stated 'to review if his condition changed' in his letter of 2 Sep 2002.

Documentation of the phone call between Dr [B] and [Mr A's] mother.
There does not appear to have been any written note made about this phone call. There probably is no separate note about this because Dr [B] recalls talking to [Mr A's] mother via the friend's mobile phone (meaning that the call probably took place whilst Dr [B] was seeing [Mr A]). I think it could have been useful to record this phone call either with some sort of brief note within the main notes concerning the consultation or on a separate note. Many 'after hours' medical centres keep separate notes and/or logs of phone calls. I am not sure if this is the case with respect to [this] After Hours Medical Centre or not. If there is a separate note about this phone call I would be happy to review it but it seems as though Dr [B]

agrees that he did state to [Mr A's] mother that he did not have appendicitis – see his letter 4 June 2003.

Quality of provider's records or lack of them
I have already given my typed word for word interpretation of the notes in the previous section of this report. Generally speaking the notes are of a good standard.

In particular the after hours centre has a reasonably good template that encourages doctors to including notes about all of the following aspects of the consultation 'History-present, History Past, Immune Status, Allergies, Drugs, Examination, Diagnosis, Treatment and Follow up'. This type of template is good because it tends to reduce errors where doctors might inadvertently forget to ask about one of these aspects of the case.

Generally the notes are very good and show that Dr [B] was aware that someone presenting with vomiting and a non-localising abdominal pain or discomfort may not necessarily have an abdominal problem – he correctly checked for other illnesses including meningitis.

The notes are lacking in any description of [Mr A's] pain.
There is not a note saying he did not have pain. Clearly [Mr A] and his mother have stated he did have pain at the time he was seen. Dr [B's] letter of 02 Sep 2002 states 'In [Mr A's] presentation abdominal discomfort was an associated feature of the presenting complaints' and later states 'My recollection is that [Mr A's] abdominal discomfort was in the upper abdominal area, and there was no history of pain migration'. In his letter of 4 June 2003 Dr [B] states in his point '4' that [Mr A] was '… lying in bed through the day with a stomach ache and …'. I think that a clear description of the pain was needed in particular aspects such as the location of the pain, the type of pain, the time course of the pain, and the things that made it better or worse are important in attempting to diagnose the cause of abdominal pain (see also my comments about this in the next section of this report).

The documentation of the follow up advice.
It can be difficult to fully document all the advice given in such circumstances. The advice 'to review if his condition changed' or words to that effect could have been anything from brief advice (such as come back if things get worse) to something more detailed. I consider that the documentation of this follow up advice is within a usual standard of care and I do not think [Dr B] was outside of normal practice here. It could be useful if doctors find a way to document better their follow up advice and I will comment on this later, however the fact is that follow up advice was given to both the patient and his mother and this would be within the usual standard of care if not beyond the usual standard (most doctors might not go the extra step and discuss with a patient's relative who was not present at the time of the consultation). However because there is not more extensive documentation of the advice given it makes it difficult to know exactly what was said, or not said, to [Mr A] and his mother.

Describe the care as documented and describe the standard of care that should apply in the circumstances.

Taking a full history (previously commented on above). There were reasonable notes on the overall combination of symptoms that [Mr A] had – which is a good standard of care as not considering the overall combination of symptoms is a common error. There however was no good documentation of [Mr A's] pain. I consider that taking such a history is important in the diagnosis of abdominal pain. Either this history was not taken or it was not documented. If there was not pain then a simple note saying 'no abdo' pain' is needed when vomiting is a presenting complaint. **Thus either a good standard of care, or a good standard of note taking, did not occur with respect to considering his abdominal pain.**

The history should have included a good description of the pain including such factors as (ref. 2)

1) Main site
2) Radiation
3) Character
4) Severity
5) Duration
6) Frequency and periodicity
7) Special times of occurrence
8) Aggravating factors
9) Relieving factors
10) Associated phenomena

Do an appropriate full examination.
Dr [B] did a very good examination and in particular looking beyond the abdomen for other causes of illness such as meningococcal disease showed an excellent standard of care. I think from the notes that [Mr A's] abdomen was adequately examined.

Order appropriate investigation – In this case I do not think any investigation was needed at the time of the first consultation. Generally speaking investigations have not been that helpful in the diagnosis of abdominal pain and in particular with respect to possible appendicitis (Ref. 4,5,6,7).

Decide on appropriate management and implement this or seek advice and/or refer on for such management. The fluids and panadol and rest was reasonable treatment to recommend for this patient given the initial diagnosis of gastritis.

Give the patient appropriate advice on follow up, and any complications to watch out for that might need earlier follow up. Follow up advice within the usual standard of care was given initially prior to the comment being made that he did not have appendicitis. However follow up advice should have been modified to stress more thoroughly what should prompt a review of [Mr A's] condition once the

statement that he did not have appendicitis was made. It is clear that the advice was given that [Mr A] did not have appendicitis. Also it seems clear that some sort of general advice was given to the effect of 'to review if his condition changed', as later recalled by [Dr B]. In the context of telling someone specifically that they do not have appendicitis, it would be wise to spend some time on explaining the limitations of this advice. An alternative statement might be better – saying that if it was an appendicitis brewing up (so to speak) that there were not enough symptoms or signs currently present to warrant referring him to hospital for consideration of further investigation or possible surgery. Stressing the need for review should things change or worsen is needed if a statement is made to the effect of 'no it is not appendicitis'. I have anonymously discussed this case with a few general practice colleagues (Ref. 10) – whilst they would all have given similar initial advice to the effect of see again if worse – they all stated that they would either not specifically state that a case was not appendicitis or that they would if asked if it could be appendicitis be very careful to explain that early on it is not always possible to diagnose appendicitis and then give more specific follow up advice. One option for follow up is to consider bringing the patient back for a review at a certain time say 4 to 24 hours later – and I note Dr [B] notes in his letter of 02 Sep 2002 that he would with hindsight have used such an option – 'to review [Mr A] the next morning'.

Another option for follow up advice is that it is reasonable based on current evidence and practice for doctors to point out that special scans and tests have not been that helpful in detecting appendicitis and that the best follow up still remains repeat review and examination by doctors that depends upon each patient's symptoms and signs.

Have appropriate systems in place to reduce errors.

I am not aware of evidence to support specific systems to reduce errors that apply directly to this case but we are in general trying to develop systems to reduce errors. With this in mind I will make some comments in the hope that it will prompt others to think about and/or research how to best do this. Thus I am saying whilst it is desirable to have such systems we are not yet at the stage where I can say that in this case it was a breach in the standard of care to not have such systems.

This is where there is great potential to improve the management for all patients. Doctors are human and errors can occur – however they can be minimised and/or the effects of these errors reduced or mitigated by having systems in place to check for errors and if possible to take action to prevent harm or to prevent sub-optimal outcomes for patients. Unfortunately to my knowledge there are not yet well researched systems for the prevention of errors with respect to the symptoms of abdominal pain and/or vomiting and/or diarrhoea. Until better research is done on errors in this area we are left with having to make informed comment based on what evidence we have about the natural history of these symptoms.

Whilst the documentation of follow up advice in this case was within normal practice it is possible that more detailed follow up advice can help avoid adverse events in cases of abdominal pain. More detailed advice could have been something

along the lines of: 'see your own doctor in a week if you are not 100% recovered, see your doctor in 2 to 3 days time if you are not improving, and see a doctor sooner if you are worse or have new symptoms – and in particular if your pain moves to somewhere else in your tummy or becomes worse when you move around'. This is however rather time consuming to write out in each and every case – but could be written 'See GP in 1w if not 100%, 2to3d if not improving, Dr sooner if worse/new symptoms'.

One way around this is that for patients with abdominal pain to be given a follow up advice hand out. This can be verbally gone over with the patients before they leave either by the doctor or one of the nurses to ensure it is understood. Such advice should help make the patient aware that conditions can change and that they may need review and that there are particular symptoms to watch out for that do require a return visit to a doctor. Such advice could also cover common symptoms that need symptomatic management – such as diarrhoea and vomiting – so that the appropriate way to take food and fluid for such conditions can be covered in some detail.

Unfortunately the issue of follow up advice needs more research and at present we can not say there is enough evidence to support the detail of what I am suggesting above – see also my comments in the later section of this report titled 'Are there any aspects of the care provided which you consider warrants additional comment?'

Describe in what ways if any the provider's management deviated from appropriate standards and to what degree.
The general standard of care was good. In particular Dr [B] showed a good standard of care in considering more serious causes of vomiting such as meningitis.

As stated above either a good standard of care, or a good standard of note taking, did not occur with respect to considering his abdominal pain. He may have either not had abdominal pain at the time of presentation – in which case there should have been a note stating this – or if he was having abdominal pain then there should have been a note describing this pain. I think this breach in the standard of care would be seen as minor if it was the non-recording of the absence of abdominal pain. The breach in the standard of care could be seen as moderate if there was abdominal pain and it was not recorded.

The follow up advice did deviate from the standard of care required once the comment was made that [Mr A] did not have appendicitis. I have commented on this in some detail elsewhere in this report. This was a moderate breach in the standard of care because the natural history of abdominal problems needs to be carefully explained alongside such a statement or it has the risk of falsely reassuring patients and their relatives without detailed explanation of the statements limitations (the statement that it is not appendicitis applies only at this point in time and should things change it could indeed turn out to be appendicitis after all – or words to that effect as previously commented on).

Answering Questions put to me by the Commissioner's office.

Did Dr [B] conduct an appropriate examination?
Yes he did in the sense of a physical examination. I have previously commented on this. It may well be that a better documentation of [Mr A's] abdominal pain might have further clarified this case and thus in the sense that taking a history is part of the overall 'examination' of a patient I think in this regard there was a breach in the standard of care in that the presence or absence of abdominal pain was not documented.

Should Dr [B] have conducted any further tests or examinations?
No, further tests were not indicated. Such tests are of limited value anyway (Ref. 4,5,6,7). Other than more clearly documenting the history of [Mr A's] pain (or the absence of pain at the time he was seen) I do not think further examination was indicated.

Was Dr [B's] diagnosis appropriate?
Yes it was appropriate.

Having made his diagnosis, should Dr [B] have taken any additional action? Please include comment on the issue of follow-up care.
I have already commented on this issue extensively in the rest of my report. My overall comment is that the documentation of the follow up advice was within the usual standard of care if specific comments about appendicitis had not been made. I do think however that given advice was made to both [Mr A] and his mother that this was specifically not appendicitis that more specific advice about what change in [Mr A's] condition might require him to be seen again should have been given and documented.

Are there any aspects of the care provided which you consider warrants further exploration by the investigation officer?
I do not think so. I have already commented on possible missing information and why I think that obtaining such information would be unlikely to change my opinion.

Are there any aspects of the care provided which you consider warrants additional comment?

I have commented elsewhere in some depth about the issue of follow up advice. More research is needed. I think the key thing here is that not only should the doctor be responsible for this, but that for certain conditions that can change over time and need another visit to a doctor that appropriate pre-determined advice should be available in printed form and gone over with the patient. This responsibility could be shared or jointly covered by management protocols and a team effort involving nurses and other health professionals where appropriate. It could also be used to help manage any subsequent requests for advice over the phone – a systems approach such as this has the advantage of reducing the risk that any patient might not get the necessary advice. This is an area that needs further research because medical research has focused more on drugs and surgery than on

follow up advice – care should be taken as it is possible that follow up advice could worsen rather than improve outcomes. Further research is required. Conditions that are known to cause problems are of particular concern. Such conditions could include 'flu' like illness that could turn into meningitis, or abdominal pain, or vomiting and/or diarrhoea that could have complications such as dehydration, or be the start of a more serious problem such as appendicitis or a perforated bowel etc. The conditions of particular concern can be identified from cases that are brought to the Commissioner's attention and also from the experience of organisations such as the Medical Protection Society. This type of approach is in the best interests of everyone including patients, doctors, nurses, management of clinics, medical insurance organisations etc.

Comments on causation:

Whilst the questions asked of myself by the Commissioner clearly focus appropriately on the standard of care, the overall context of this case and the complaint and publicity surrounding the case clearly have the implication that some sort of simple diagnostic error caused an adverse outcome. I think an explanation of events is helpful in this case to clarify what happened and where a different type of care might have made a difference. I have made these comments with some reluctance as my role is to consider the standard of care that should apply and not to make 'rulings' on causation. I would like to point out that I have taken some considerable effort to separate out any thoughts I have on causation from my comments on the standard of care. I make the comments on causation because without such comments I think the overall context of this report as an independent doctor's comments on the case would seem rather 'hollow' in the light of all the material I have been asked to review including the information from the media.

Whilst it is possible that if [Mr A] had been operated on sooner he might have had a better outcome it is actually very difficult to say at just what point it would have been possible to make an earlier diagnosis. Of note I think that in today's world where nearly everyone has heard of appendicitis there is an expectation that it is something that doctors will get 'right'. Unfortunately this is not the case – 'Despite more than 100 years' experience, accurate diagnosis still evades the surgeon.' (Ref. 4).

With his symptoms (what he noticed) he may well have either not had appendicitis at all at the time of his presentation to Dr [B], or if his symptoms were due to appendicitis it was still too early to diagnose. With his signs (what Dr [B] found on examination) there was nothing to suggest he needed an operation. This is a common problem with any case of appendicitis and there is much medical debate as to if appendicitis can spontaneously resolve (Ref. 8 & 9) and come back again months later, or if other conditions such as gastritis or gastroenteritis can either develop into appendicitis or in some way trigger appendicitis. In [Mr A's] case the hospital notes clearly state that he had right sided abdominal pain but that it started as general pain (a pain in the abdomen felt more all over rather than in one particular place) 3 days ago (about the time Dr [B] saw him or just before) and settled for a short period (it is not clear if this was before Dr [B] saw him, or when Dr [B] saw

him, or just after). This history combined with Dr [B's] note which clearly demonstrated a doctor who was concerned with checking for serious causes of vomiting such as meningitis and examination findings not showing any signs of appendicitis suggest that the pain [Mr A] had at the time of seeing Dr [B] was either gone, or general and not a clear cut case of right sided pain at the time Dr [B] saw him.

It should be remembered that just because there is a good or a bad outcome does not necessarily mean there was a good or a bad standard of care. Indeed sometimes patients have no adverse event but the standard of care is not good and sometimes it is the other way around with an adverse event or outcome with a good standard of care (Ref. 3). It is important to remember this in this case because although it is clear that [Mr A] has suffered from his perforated appendix it does not necessarily mean it was preventable. My own opinion is that whilst it is possible that if he was operated on sooner he would have avoided most of his complications it is by no means certain as some cases of appendicitis are not easy to diagnose (Ref. 4,5,6,7,8,& 9). The point at which his operation could have taken place was probably at some time after Dr [B] saw him and before he was sent to hospital. This opinion is based on the notes Dr [B] made about examining [Mr A] and on the notes the hospital doctors made about the history of his pain. It is possible that more detailed follow up advice might have alerted [Mr A] or his mother to the possibility that he should be seen again before they next had an opportunity to see their own doctor. I suspect that the advice given by Dr [B] that [Mr A] did not have appendicitis might have contributed to the delay by giving [Mr A] and his mum the impression that his current problem was not and could not develop into appendicitis. I realise that Dr [B] would not have said specifically that 'it was not appendicitis and could not develop into appendicitis' – but I think any doctor could easily make a statement such as Dr [B] did saying 'no it is not appendicitis' without realising that this advice might be used again sometime later. What can easily happen is that time passes and someone does not get better and then later on the advice that it was not appendicitis is thought to apply for the duration of the current illness providing delayed but false reassurance. I consider this is an entirely understandable thought. It is possible that if a careful explanation was given along the lines of 'that there was a good chance that [Mr A] would get better, but that it could not be guaranteed, and that they should watch out for a developing appendicitis in the next few hours and days and if there was any concern then he should be seen again' that a better outcome might have occurred.

Conclusion:

I do not think there was an incorrect diagnosis made at the time of [Mr A] being seen by Dr [B]. I think there was a deficiency in the records in that there was no note about the presence or absence of pain. I think the physical examination of [Mr A] was of a good standard. I think that the follow up advice was not of a good standard given the statement was made that [Mr A] did not have appendicitis. I am not sure if better follow up advice could have made a difference to [Mr A's] outcome – it may well have – however this does not change my comments about the standard of care.

Recommendations:

For [Dr B]

He should note my comments on the recording, or not recording, of abdominal pain in his written notes – see my comments in my section of the report titled 'Quality of provider's records or lack of them'. In the same section of my report I also comment on the recording of follow up advice. But in particular with respect to abdominal pain [Dr B] should note my comment that either a good standard of care, or a good standard of note taking, did not occur with respect to considering [Mr A's] presence or absence of abdominal pain.

Overall I think [Dr B's] notes in this case suggest that he provides a good standard of care – the notes clearly demonstrated a doctor who was concerned with checking for serious causes of vomiting such as meningitis and examination findings not showing any signs of appendicitis. I think this shows a good standard but having a good standard in one area unfortunately does not always make up for a deficiency in another area. Clearly he is a caring doctor who has taken the time to review issues with the diagnosis and follow up of abdominal pain (as per his letter of 02 Sep 2002) and I think this is good. I agree with him that a good option if there is any doubt or concerns is to get the patient back again 'the next morning'.

I think the follow up advice [Dr B] gave was below the standard of care required given he made the statement that [Mr A] did not have appendicitis. [Dr B] should take note of my comments on follow up advice as this seems to be the key area of this case.

Other matters I have noted in my report that he should consider with respect to the writing of his notes:

He should refer to my comments on the heart murmur – see section on possible missing information – I note he has said in subsequent correspondence (his letter 4 June 2003) that he did hear the murmur – given this murmur was probably known to [Mr A] and hence old and not that likely to be contributing to his assessment it was not critical that it was not recorded, but it may have been slightly more correct for [Dr B] to note the murmur in his notes and to have an entry in the past history section of his notes saying that he had a known heart murmur.

For the '[…] After Hours Medical Centre'

They should note that their notes template is of a reasonable standard – well done. They should review any policy they have on giving advice over the phone and the recording of such advice. It may well be that they already have good systems in place for this and that nothing needs to be done to change this except to remind doctors and nurses to record conversations or advice that may occur via cell phones or clinic phones within a consultation.

For other doctors.

They should particularly note my comments on follow up advice as this seems to be the key aspect of this case that could have made a difference, and is perhaps an area of medicine that doctors need to pay more attention to.

For [Mr A] and his family.

I hope this report gives an understanding of what happened from another doctor's point of view. I think it is good that they have made the comment 'I understand that Doctors are not gods, but they are people with whom we place an immense amount of trust and in fact our lives'. I hope that this report can show the limitations of medical knowledge and how that good communication can help overcome these limitations and lead to better outcomes in any similar cases. I thank them for bringing this matter to the attention of doctors.

References.

1) Guidelines for Independent Advisors – Office of the Health and Disability Commissioner – Appendix H of the Enquiries and Complaints Manual – effective date: 1 September 2003.

2) Clinical Examination – A textbook for students and doctors by Teachers of the Edinburgh Medical School, edited by J Macleod & J Munro, Seventh Edition 1986, published by Churchill Livingstone.

3) Statements about Health and Disability decisions: One of the principles of giving advice to the Health and Disability Commissioner is that the 'outcome of the care is irrelevant' – it may be that there was no departure from the accepted standards but the care still resulted in an adverse outcome for the consumer. Conversely there may have been no adverse outcome for the consumer but the care may have been substandard.

4) BMJ 2002;325:505-506 (7 September) Editorials, Managing acute appendicitis.

5) BMJ 2000;321:907-908 (14 October) Editorials, Can we improve diagnosis of acute appendicitis?

6) BMJ 2002;325:1387 (14 December) Evaluation of early abdominopelvic computed tomography in patients with acute abdominal pain of unknown cause: prospective randomised study, Chaan S Ng et al.

7) BMJ 2000;321:919 (14 October) Randomised controlled trial of ultrasonography in diagnosis of acute appendicitis, incorporating the Alvarado score, Charles D Douglas et al.

8) Heller MB, Skolnick ML. Ultrasound documentation of spontaneously resolving appendicitis. Am J Emerg Med 1993; 11: 51-53 [Medline].

9) Velanovich V, Savata R. Balancing the normal appendectomy rate with the perforated appendicitis rate: implications for quality assurance. Am Surg 1992; 58: 264-269.

10) My discussion of the case anonymously (details of the case without revealing the names of the parties concerned or the location within New Zealand) with six different general practitioners."

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is 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.

Other relevant standards

'Good Medical Practice: A Guide for Doctors' (Medical Council of New Zealand 2000) states:

"*3. In providing care you must:*

…

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

Opinion: No breach – Dr B

Assessment and examination
Ms A complained that Dr B did not appropriately examine and assess Mr A, and spent only 8-10 minutes with her son. Mr A stated that Dr B did not examine his abdomen, but only listened to it with a stethoscope. As stated above ("Information gathered during investigation"), I accept that Dr B did assess Mr A's abdomen by feeling under the epigastrum, listening to the bowel sounds, which were active, and palpating the central abdomen and the left and right lower quadrants. Dr Searle advised me that this assessment amounted to an adequate examination of Mr A's abdomen and that overall the examination was excellent in that Dr B looked beyond the abdomen for other causes of illness such as meningococcal disease.

I am guided by my expert advice. In my opinion, Dr B's examination and assessment of Mr A was conducted with reasonable care and skill. In these circumstances, he did not breach Right 4(1) of the Code.

Opinion: No further action – Dr B

Advice to Mr A
Ms A complained that Dr B did not adequately advise Mr A on the need for follow-up. Dr Searle advised me that Dr B's advice to Mr A during the consultation on 5 July 2002 was reasonable, prior to the discussion about appendicitis. It appears that Dr B then said something that reassured Mr A and his mother (in the telephone conversation with her) that Mr A did not have appendicitis. I am, however, satisfied that Dr B did indicate to Mr A and his mother that the situation should be reviewed if Mr A's condition changed.

Dr Searle advised me that at the time Mr A was seen by Dr B, he either did not have appendicitis, or the illness was still in such an early stage that Mr A was not presenting with symptoms. It is likely that the symptoms Mr A experienced on 5 July 2002 arose from some other condition, possibly gastroenteritis. However, although at the time Dr B was likely to have been correct in his statement that Mr A did not have appendicitis, it would have been wise for him to have spent some time explaining the limitations of his advice and to have stressed the need for review should things change or worsen.

Overall, I am satisfied that Dr B made an appropriate diagnosis and that his advice, based on this diagnosis, was reasonable. I draw Dr B's attention to Dr Searle's comments about stressing the need for review, but I consider that any further action is unnecessary.

Medical records and examination for history of abdominal pain
Dr Searle advised me that Dr B's notes in relation to Mr A were generally very good. Dr Searle suggested that it would have been useful for Dr B to have recorded the details of his telephone discussion with Ms A and that he should have recorded a note about whether Mr A was suffering abdominal pain. Taking such a history is important in the diagnosis of

abdominal pain. I am satisfied that Dr B did take such a history, as later documented in his letter to the After Hours Clinic complaints officer of 2 September 2002.

I draw Dr B's attention to Dr Searle's comments and to the Medical Council of New Zealand guidelines, which state that in providing care doctors must "keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed". In the circumstances, I consider that further action is unnecessary.

Presentation of appendicitis
In response to my provisional opinion Dr B raised a concern about the manner in which medical practitioners are taught about the presentation of appendicitis. Dr B recently attended a lecture on the presentation of the illness and remarked that so long as appendicitis is described only in the classical form, then practitioners are denied the insight of seeing appendicitis as a disease in evolution. I will draw his remarks to the attention of the Royal New Zealand College of General Practitioners.

Other comment

Media publicity
Ms A initially sent a written complaint to the After Hours Medical Centre about the care Mr A received from Dr B. The Medical Centre responded to Ms A by letter dated 9 September 2002 and enclosed an explanation from Dr B, dated 2 September 2002. However, in the interim Ms A contacted a newspaper and told a reporter her concerns about Mr A's consultation.

The newspaper reported the case. Dr B was named in the article as the doctor who had treated Mr A at the After Hours Medical Centre. The article reported that Ms A had sent a formal complaint to Dr B asking for an apology and some form of compensation, and lodged a complaint with the After Hours Medical Centre. The opening sentence of the article stated: "Health and Disabilities [sic] Commissioner Ron Paterson is investigating the case …" In fact, the Health and Disability Commissioner had not commenced an investigation in September 2002. A written complaint was received by the Office of the Health and Disability Commissioner on 26 August 2002, but it was still being assessed when the newspaper article was printed. No journalist checked whether the Office had commenced an investigation. The case was initially referred to Advocacy Services, for the purpose of resolving the complaint, in November 2002, but in March 2003 the Advocate reported that, in light of the media involvement and the way in which the parties' positions had become polarised, advocacy was unlikely to be effective in resolving the complaint. A formal investigation was then commenced by the Health and Disability Commissioner, on 19 May 2003.

Dr B advised Ms A, in his letter dated 2 September 2002 about Mr A's consultation (enclosed with the After Hours Medical Centre's response of 9 September 2002 to Ms A's complaint):

> "I was notified of this complaint by […] (a reporter for the [newspaper]) on 21/8/02, and received a copy of the letter of complaint by mail on Friday 23/8/02."

Dr B later advised me that the media reporting of this case has impacted on his professional reputation, self-esteem, and trust in his patients.

Ms A was naturally very upset that Mr A's appendicitis was not diagnosed by Dr B, and that his appendix later ruptured and he had a slow and difficult recovery from surgery, and his school work suffered. She wrote in her letter of complaint:

> "For Dr B this incident is over, and life goes on, for Mr A the related problems are ongoing and he feels this is grossly unfair to say the least."

Ms A advised me that she contacted the media at Mr A's request because she did not want another member of the public to suffer as he had.

It is regrettable that Ms A did not give Dr B an opportunity to explain before she spoke to the media. It is also regrettable that the newspaper chose to publish an article that publicly identified Dr B, incorrectly stating that he was already under investigation.

The newspaper advised me that "the newspaper is perfectly within its rights to name anyone in this context". However, by naming Dr B, setting out vividly the details of Mr A's ruptured appendix, and stating (incorrectly) that he was under investigation, the newspaper created an impression that Dr B had been negligent. Admittedly, Dr B was given an opportunity to comment, and was reported to have said that he was "confident he had thoroughly examined Mr A", but in hindsight realised "a review of Mr A's condition the next day might have been helpful". The Royal New Zealand College of General Practitioners President was reported as stating that "diagnosis of appendicitis could be difficult" and that "[f]or every child with appendicitis, there were 10 with a stomach virus". However, the overall impression was of a "guilty doctor".

Patients and families are free, in a democratic country, to voice to the media their concerns about medical treatment. There is obviously a public interest in the quality of health care, and it is entirely appropriate for the media to publicise stories (hopefully positive as well as negative) about "near misses" and adverse events in health care.

It is not, however, necessary for the media to publicly identify a doctor (or other health professional) while a complaint or investigation is still in process.[1] The situation is distinct

[1] There may be exceptional cases where the number and type of complaints about one health professional and/or the raising of concerns about the competence of an identified health professional in Parliament, mean that the public interest in disclosure outweighs the individual professional's privacy interest.

from criminal prosecutions,[2] since health professionals are not charged with a criminal offence, and there has been no investigation and decision that there is a *prima facie* case (as precedes any criminal prosecution). It is therefore disappointing that the newspaper chose to publicly identify Dr B.

Ms A suggested that for Dr B, "this incident is over". In fact, her complaint to the Health and Disability Commissioner in itself ensured that Dr B's actions would be subject to a thorough, independent review, with an emphasis on learning any lessons from the case. The media publicity was, in my view, an unnecessary additional stressor on Dr B. I have no doubt that the publicity has had an adverse impact on his professional reputation and his self-esteem.

My investigation has found that Dr B's examination and assessment complied with professional standards. My expert commented that Dr B's examination was "very good" and the overall standard of care was "good". Those comments will probably never appear in the media. Dr B can, and I am sure will, learn lessons from this case in relation to telling patients (and their families) about the need for review of their condition, and keeping good patient records. It would, however, be very unfortunate if Dr B were to lose trust in his patients as a result of this case and its publicity.

Follow-up Actions

- A copy of my final report will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.

- A copy of my final report will be sent to the Editor of the newspaper, with a request that it not identify Dr B in any further publicity about this case.

- A copy of my final report, with details identifying the parties and the newspaper removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[2] The situation is also distinct from pending disciplinary proceedings before the Medical Practitioners Disciplinary Tribunal where the Director of Proceedings has filed a disciplinary charge, and there has already been an investigation by the Health and Disability Commissioner, a finding that the doctor breached the Code of Health and Disability Services Consumers' Rights, and a decision by the Director that the matter warrants disciplinary proceedings. In such cases, although there is no allegation of criminal offending, there may well be a public interest in reporting the pending case (and identifying the doctor), subject to any decision by the Tribunal to grant the doctor interim name suppression.