General Practitioner, Dr D

A Report by the

Health and Disability Commissioner

(Case 04HDC17230)

Parties involved

Mr A	Consumer (deceased)
Mrs A	Complainant/consumer's wife
Mrs B	Consumer's sister-in-law
Mrs C	Consumer's daughter
Dr D	Provider/General Practitioner
Mrs E	Manager, the rest home
Dr F	Clinical Director, the first public hospital

Complaint

On 20 October 2004 the Commissioner received a complaint from Mrs A about the services provided to her husband, Mr A, by Dr D, general practitioner. The Commissioner identified the following issues for investigation:

- *Whether general practitioner Dr D provided Mr A with services of an appropriate standard when:*
  - *Mr A consulted him at the surgery on Tuesday*
  - *Dr D spoke with Mr A on the telephone on Thursday, and*
  - *Dr D visited Mr A at his home on Friday.*
- *Whether Dr D appropriately managed Mr A's deteriorating condition on Saturday.*

An investigation was commenced on 6 May 2005.

Information reviewed

Information was received from:

- Mrs A
- Mrs B
- Mrs C
- Dr D
- Mrs E, Manager, the rest home
- Dr F, Clinical Director, the first public hospital
- The Acting Clinical Director, the first public hospital
- The Head of Medicine, the second public hospital.

- Mr A's clinical records were obtained from the medical centre, the rest home, the first and second public hospitals.

Independent expert advice was obtained from Dr Tony Birch, rural general practitioner.

Information gathered during investigation

Overview

Mr A, aged 73 years, was discharged from the first public hospital following a short admission for assessment of longstanding cardiac and renal impairment. While in hospital he scraped his left shin and the injury had required dressings. After returning home, Mr A reported to his family that he had a painful left ankle. He consulted his general practitioner, Dr D of the medical centre, over the following days and was admitted to a rest home — a small rest home/hospital complex — for management of pain and nausea. Mr A's condition deteriorated and he was transferred to the first public hospital that night. As his condition worsened, he was taken to the second public hospital in the early hours of the following day and cared for by the intensive care team. Later that day, Mr A was diagnosed with septic arthritis of his left ankle.[1] Despite treatment, his condition continued to deteriorate and he died at the second public hospital.

Chronology

Background

Mr A had a ten-year history of cardiomyopathy (heart muscle disorder) and also suffered congestive heart failure, impaired renal function and recurrent gout.[2] Mr A was a regular and frequent attendee at the medical centre. Dr D explained that there were a number of systems in place for monitoring Mr A's cardiovascular difficulties, and his general health, including fortnightly renal function tests. Dr D realised that by that time, Mr A was unable to walk more than 100 meters without having breathing difficulties and was "essentially, having palliative care for his cardiovascular problems".

Mr A was admitted to the first public hospital with chest pain and a rapid heart rate (tachyarrhythmia). He was diagnosed with mild pancreatitis (inflammation of the pancreas). Amiodarone (which had previously been prescribed to control Mr A's heart

[1] Septic arthritis is an infection in a joint. The joint is swollen, hot and tender, and movement is very restricted and painful. The infecting organism can enter the joint via the bloodstream or from a penetrating injury. Treatment includes antibiotics and irrigation of the joint.

[2] Gout is a disease in which a defect in uric acid metabolism causes an excess of the acid and its salt to accumulate in the bloodstream and the joints respectively. It results in attacks of acute gouty arthritis and chronic destruction of the joints. The excess of urates also damages the kidneys. Acute attacks of gout are treated with anti-inflammatory analgesics.

rate) was stopped and pindolol (a beta-blocker) was started. Vioxx, an anti-inflammatory medication that Mr A took for his arthritis, was stopped during his stay in the first public hospital because of his worsening renal impairment. (Vioxx is known to have an adverse effect on the kidneys.) A few days later Mr A sustained a skin tear to his left shin, which required a pressure bandage to control the bleeding. Mr A was discharged from the first public hospital the following day, and arrangements made for GP follow-up in one week. He was advised to see Dr D to have his leg re-dressed. Dr D recorded brief (handwritten) details of Mr A's hospital admission in the clinic notes, specifically in relation to the medication prescribed for Mr A's cardiac and gastro-intestinal symptoms. He noted that Vioxx had been discontinued.

Tuesday
The following morning Mrs A took her husband to the medical centre where the practice nurse re-dressed his leg. Mrs A recalls that Dr D did not prescribe any medication for her husband that day as she had already taken the prescription he was given by the first public hospital to the local pharmacy. The prescription issued by the first public hospital was for Cardizem, Duride, captopril, pindolol, Nitrolingual and the opioid analgesic DHC Continus. She and Mr A spoke to Dr D briefly about matters unrelated to the leg wound. There is a brief entry in the clinic's computerised records noting an "open wound of leg — left". The computerised notes for this consultation record Mr A's current medications, Losec, pindolol, thyroxine sodium, Frusid, warfarin, Duride, Capoten, spironolactone and Cardizem, all of which (with the exception of the pindolol and Losec) were entered in Mr A's medical centre notes as "Long Term Medications". It appears from the notes that an ACC form may have been completed in relation to Mr A's leg. Dr D recalls that Mr A "made no other complaints".

Dr D pointed out that Mr A was discharged from the first public hospital without any special instructions for the wound to his leg other than GP follow-up in one week. Dr D's practice nurse was not concerned about the wound when she reviewed it but called Dr D into the dressing room to check that the dressing was correctly applied and to complete the ACC form. Dr D recalls that Mr A was well, "after a mild form of pancreatitis with chest pain on [date] which had resulted in his hospitalisation". Dr D and his nurse viewed Mr A's leg wound as minor.

Mr A's daughter, Mrs C, telephoned him that evening. She recalls Mr A saying that his heart felt fine, but his left ankle was sore, and that he had been concerned about recurring ankle pain after stopping Vioxx. Mr A intended to call Dr D the next day to "see what he thought, as … Panadol was not helping".

Mrs A planned to be away for four days, and arranged for her sister, Mrs B, to visit Mr A each day.

Wednesday
There is no entry in Mr A's clinical records for the following day. Dr D states that he did not speak to or see Mr A that day.

However, Mrs A and Mrs C believe that Mr A telephoned Dr D to report that his foot was "very sore". They understand that Dr D told Mr A the practice nurse would visit to take a blood test, after which Mr A could resume Vioxx to alleviate his ankle pain. Mrs A and Mrs C state that Mr A was concerned about resuming Vioxx, as the first public hospital staff had told him his kidney function "was not the best".

Mrs C called Mr A at 3pm. He said that as the practice nurse had not attended, he had contacted the medical centre again. Mrs C understood that Dr D had then advised Mr A to take Vioxx, without a blood test. Mr A was again worried, but accepted Dr D's advice and took some Vioxx because his foot was so sore.

Mrs C telephoned her father again at 7.30pm, when he reported that he was lying on his bed watching television, his ankle was throbbing and he was having difficulty walking.

Thursday
Mrs C advised that that morning Mr A telephoned the medical centre to report that the pain in his ankle was preventing him from putting his foot to the ground. He asked how long it would be before the Vioxx would take effect. Mr A was asked to come in to the centre, but declined as the pain in his foot meant he was unable to drive. He was told that Dr D would visit later that day.

Mrs B recalls that Dr D visited Mr A while she was at Mr and Mrs A's home. She says that Dr D did not examine Mr A, despite repeated references to the pain in his foot, but stood in the bedroom doorway talking to him and an accompanying medical intern. Mrs B stated that Dr D advised Mr A that he should continue taking Vioxx and things should improve.

Dr D recalls the resumption of Vioxx as follows:

> "[Mr A] rang to complain about his osteoarthritis[3] pains which had been returning after his pain medication (Vioxx) was stopped in hospital in an attempt to help his renal function problem. He complained that he was becoming stiff. He did not want to come down to the surgery and he did not want a home visit. He did however, want medications for his pains. He was offered admission to [the rest home] in the first instance as I suggested that with [the] recent admission [to hospital] and renal function problem and problems with his stiffness and medications … all round that it would be best. He refused. I remember the conversation well as he had just got back from […] and was not impressed [that] they sent him home without any pain medication and he

[3] Osteoarthritis is a degenerative disease of joints resulting from wear of cartilage. The joints are painful and stiff with restricted movement. The condition is treated with analgesics, reducing the load to the joint by weight loss or the use of a walking stick or crutches, or surgery.

> was not keen to go back into hospital. He just wanted his pain medications restarted. I said that he could go [back] onto the Vioxx and Panadol and to ring me back in a couple of hours if the pain did not settle. He did not ring back. I told him it would be alright to restart the Vioxx temporarily as it was logical to restart something we knew would work. I suggested I could start him on something better for the kidneys once the pain settled. I did not consider Vioxx for a few days would cause his kidneys irreversible damage. He was given a script for Vioxx and Panadol. He had previously tried amiptrip, Vioxx, Panadol and Codeine for pain management about a year earlier, but I wanted to use a more simple approach and told him if the Vioxx did not work quickly I would consider Tramal instead."

Dr D's handwritten clinical notes for Mr A for Thursday, in full, state: "Frozen up with pain. Panadol, Vioxx, Ring in 2 hrs." Included in the records is a copy of a prescription for Vioxx 1 x 25mg daily (90 tablets); Panadol 2 x 500mg tablet every 4 hours (360 tablets, 2 repeats); and Tramal Retard, 1 x 100mg tablet twice daily (60 tablets, 2 repeats). There is no record of Dr D visiting Mr A.

Dr D explained that he was happy to consider a short period back on Vioxx to relieve Mr A's pain. Mr A was always at risk of renal failure, and there had been a gradual deterioration over the years. However, Dr D had been routinely monitoring Mr A's renal function and, from July 2003 through to early 2004, found that it was relatively stable, even while using the anti-inflammatories. Dr D planned to continue the regular monitoring. Mr A was concerned about the extent to which the pain was interfering with his enjoyment of life. Dr D submitted that GPs are often in the situation of balancing patient needs for pain relief with the need to manage the risk of renotoxicity.

Mrs C stated that Mr A telephoned her on Thursday afternoon, and told her that Dr D had visited and advised that the Vioxx should start taking effect soon. Mrs C said:

> "I could tell [Mr A] was getting very frustrated as he was certain his foot should have been feeling better as in the past the Vioxx had worked within a day, and he was worried as to why it was taking so long."

Mrs C telephoned Mr A again at 7.30pm. He sounded very sleepy and "worn out" and reported that he had no appetite and the Vioxx had provided no relief. Mrs C was so worried about her father that she considered driving down to see him. However, Mr A told Mrs C that he would be fine by the next day once the Vioxx started to work, so she left her decision to visit until the next morning.

Friday

On Friday, Mrs B was very worried about Mr A's condition. She recalls that he could not walk, and had crawled to the bathroom to urinate down the drain of the wheelchair-accessible shower.

Mrs C spoke to her father that morning and was concerned when he told her that he was crawling to the toilet but unable to pass urine despite taking diuretics. Mr A also reported that he had called Dr D again, because he felt very sick, lethargic, hot and cold, had not

eaten properly for two days, had difficulty keeping down tea and water, and was concerned about the effect his heart medication was having on an empty stomach. Mr A told Mrs C that Dr D was intending to prescribe codeine, and Maxolon to control his vomiting and nausea, and send the practice nurse around with the prescription and some crutches. Mrs C decided to visit her father.

Mrs B confirmed that she was at Mr A's home when the practice nurse delivered the crutches. She described these as "no use" in the circumstances. Dr D explained that the medical centre has a number of hospital equipment items at the practice, such as crutches, which are made available to patients. The practice nurses, and the receptionist, know of the items that are available to be lent out, and they are approached by patients from time to time for a loan of equipment. Dr D stated, "I understand this happened in [Mr A's] case." He remembers the receptionist approaching him, in between patients, to ask if she could take time off reception to take crutches to Mr A. He regrets not enquiring further as to the reason for Mr A's request.

Dr D attended Mr A at home on Friday. The exact time of the visit has not been determined. Dr D recalls that Mr A's complaints were nausea (as a result of taking Tramal) and "ongoing pain and stiffness". Dr D provided the following explanation of the visit:

> "Further discussions covered possible diagnosis and possible treatment options. It was discussed firstly that the nausea was probably in part aggravated by the medications but it was thought that it may be in fact the pancreatitis as well. Given his recent renal failure and the importance of good fluid intake the nausea management was paramount. It was suggested he go to the first public hospital to assess and treat his nausea. I discussed that it would be impossible to know beyond the medications aggravating the problem what was definitely causing the nausea. He was offered nausea treatment in the way of Maxolon. Again he refused [the first public hospital] admission and said if he was not better tomorrow he would reconsider going to [the rest home]. He was adamant about not agreeing to hospital. He was instructed to avoid further Tramal and told the Vioxx may take a few days to treat the pain well and to just see how he went overnight.
>
> … I examined [Mr A], as I remember, without any family members in attendance. There was someone in the next room I seem to remember who may have let me in the house. I did not examine his ankle as I was not aware there was a problem there and as such was not indicated as a necessary part of the examination. I was concerned about his nausea and his general condition. I examined him accordingly."

Dr D advised that there had previously been some consideration of an arthrodesis[4] on Mr A's left ankle. However, on Friday Mr A's complaint was that he was "frozen with pain"

[4] The surgical fusion of bones across a joint space eliminating movement, which is performed when a joint is very painful, highly unstable, deformed or chronically infected.

and he did not specifically advise Dr D of any ankle pain. There was discussion about the medications and general pain management.

Mrs A is adamant that Dr D would have known, at this time, that Mr A had ankle pain and difficulty walking. She questions why Dr D would have sent crutches to Mr A otherwise. Mrs A also confirmed that Dr D had historical knowledge of Mr A's ankle pain, since prior to these events Dr D had treated Mr A for gout and initiated the orthopaedic referral leading to his placement on the second public hospital's waiting list for an ankle fusion.

Dr D's brief notes for Friday record that a home visit occurred and indicate that a referral to the rest home "for nausea and pain management" may have been considered. Dr D's clinical findings, management plan, and any discussion with Mr A about his options are not recorded. A prescription for Panadol (with the note "will not upset kidney"), codeine and Tramal (strong pain-relieving drugs) and Maxolon (an anti-emetic) as well as Vioxx (1 x 25mg tablet daily – 3 tablets) appears to have been issued. The following note is recorded in relation to Vioxx: "can upset kidney but for now will need to take until can sort out the pain".

Dr D explained why his notes are brief:

> "The earlier notes from the Surgery are not as detailed as [subsequent referral notes to hospital] simply due to there being less to document. [Mr A] was, at that time, less complicated. I did not document about his refusal to go to hospital. It is my policy to cover clinical matters in the notes or matters that will help with ongoing patient care. Normally I would not include non-management conversations in the notes such as where the patient wanted to go or not. I can however reassure you that the conversation did take place about hospital care, and I am sure the family back me up with that. Also I will reassure you … [my policy is that] if [a patient is] sick enough for a home visit they are sick enough for hospital, if not sick enough for [the first public hospital] or unwilling to agree to […]then [at] the very least they [will] be admitted into [the rest home]".

Mrs C arrived at her parents' home around 1pm. Her father was pleased to see her and was "adamant that if it wasn't for the damn foot he would be fine". Mrs C recalls that she checked her father's foot and it was very hot and swollen. He could not bear to have even the sheet on it, saying it was "throbbing" and felt as if it would explode if he tried to put it to the floor. Mr A had not felt like eating, and "wasn't even thirsty". She said that Mr A told her that he was the one who had raised with Dr D the possibility of being admitted to the rest home or the first public hospital, and that Dr D had not given him this option. Mrs C stated that her father was always willing to go to hospital when advised to by doctors. Mrs C recalls that Mrs B was worried about Dr D's lack of concern.

Mrs B recalls that when Dr D visited, he did not appear to be overly concerned, and did not examine Mr A or look at the bile he had vomited into a bucket. She says that Mr A asked whether he should go to the rest home, but Dr D responded that he did not think this was necessary.

At about 4pm Mr A took some Maxolon and codeine and slept for an hour and a half. When he woke he was very sweaty. Mrs C gave him a sponge-bath and helped him clean his teeth. At about 7pm she made him some scrambled eggs but he was able to eat only a small amount, complaining that he was experiencing waves of hot and cold, which he said was "definitely not his heart playing up". (He subsequently vomited around 10pm.) Mr A was still concerned that he was passing very little urine, as the diuretics he took for his heart condition meant that he normally passed a lot of urine during the day. Mrs C recalls that by this time, Mr A was unable to get off his bed, and needed to use a bucket. Mrs C estimated that her father "probably" passed only 200ml which she thought was a small amount for him.

Mrs A arrived home at 9pm. She says that her husband was "not the type to complain and [he] said that he didn't feel quite right but really wasn't sure what was wrong".

Mrs C drove home around 10.30pm. She probably would not have left her parents, had she known how ill her father was, but she was due to attend a wedding the next day, and was reassured that Dr D had not been particularly worried about her father's condition.

Saturday
Mr A was restless overnight, was not passing urine, appeared to have a temperature and was vomiting bile. Mrs A telephoned Dr D at his home in the morning "insisting" that Mr A should be in hospital. His condition was getting worse, and he was disoriented, drowsy and sweating profusely. Mrs A recalls that "a little while" after she spoke with Dr D, an ambulance arrived and took Mr A to the rest home.

Dr D confirmed that Mr A was admitted to the rest home as a result of a telephone call to his house on Saturday morning. He is unable to recall which member of the family placed the call, but understood that Mr A had "finally agreed to an admission to [the rest home] and accordingly I arranged it". Because Mr A had problems with mobility, Dr D arranged for an ambulance to convey him the 500 metres from his house to the rest home.

Dr D did not see Mr A prior to his transfer to the rest home, and says that he "was not informed by the ambulance or by [the rest home] about ankle pain". However, he was aware that Mr A had "ongoing nausea, ongoing pain as unable to take medication due to nausea [and that] he had no symptoms or signs of sepsis".

Ambulance staff arrived at Mr A's house at 8.58am. The ambulance report records Mr A's chief complaint as pain and swelling in his left ankle and notes that he was unable to put his foot to the ground. Mr A's pulse was slow at 53 beats per minute ("bpm") and his blood pressure was low at 80/30mmHg.

Dr D telephoned the rest home to alert them to Mr A's admission, gave a verbal report to a registered nurse, and faxed the rest home details of Mr A's admission and plan of care. The referral note is handwritten over four separate standard referral forms and states:

"P/S [please see]. Recent admission for chest pain (probably not cardiac but oesophageal.) Also during admission concern re renal function so had his Cox II stopped (Vioxx.)

Few days ago developed rapidly ↑ pain again as result of stopping Cox II. He was commenced on Tramal but developed nausea. He was changed to Codeine but the plan was to continue Tramal if the Maxolon he also started settled the nausea. He remains [nauseous] and in pain.

Plan
1. Bloods Monday for renal function – LFT RhF ANA CRP FBC
2. Maxolon 10mg IMI prn and tds. Maxolon 10mg orally tds.
3. Continue Panadol and Vioxx (Cox II)
4. Losec 20mg ii bd
5. Stop Tramal
6. Codeine I – ii q4h if required
7. Normal medications as before."

Dr D explained that blood tests were included in the plan, to assess "any cause of the arthritis flare up other than medication related, inflammatory etc".

The Rest Home

Mrs E, manager of the rest home, stated that Mr A was admitted at 9.15am. His temperature was recorded as 36°C, his pulse 60 bpm and blood pressure low at 80/30mmHg. He was in "severe" pain, nauseated, orientated and anxious. The Nursing Assessment Form records that Mr A's pain was "all" in his left ankle and was "steady, constant [and] worse on movement". Mr A was given Maxolon, Panadol, codeine and Vioxx, and his nausea settled. Mrs E saw him after lunch and said that he was bright and joked with her about finally agreeing to come in. His pain relief was repeated at 1.30pm. A registered nurse took over the care of Mr A at 2.45pm. At 4.30pm she noted that Mr A began "dry retching", was nauseated, hot and sweaty and unable to drink. His temperature was recorded at 35.5°C and his blood pressure 80/40mmHg.

Mrs A stayed with Mr A all day and, worried about his deterioration, insisted that the nurses contact Dr D again. According to the rest home nursing notes, Dr D was notified at 6pm, when he ordered an intra-muscular injection of 10mg Maxolon to control Mr A's nausea. This was administered immediately. Dr D arrived at the rest home around 8pm, and arranged for Mr A to be transferred to the first public hospital. Mr A was transported to hospital by ambulance at 9pm. The Ambulance Case Slip records that Mr A's chief complaint at that time was dehydration and that he had been admitted to the rest home that morning "with [a] sore left ankle".

Dr D's referral to the first public hospital (which is also handwritten over four separate referral forms) states:

"P/S 1. Dehydration
2. Inadequate fluid intake 2° to nausea + anorexia
3. Problems started with [cessation] of Vioxx because of renal toxicity
4. Known renal failure 2° to CCF
5. H/o intermittent AF Rx in past with amiodarone
6. Amiodarone stopped because of photosensitivity + Δ of management toward B blocker and wafarinization
7. Was recommenced 2 days ago on Vioxx because of acute pain but urine not done at that time because he was bed bound with pain.

Pain Rx with Vioxx/Tramal/Pamol +/- codeine but Tramal stopped when thought to cause nausea, likewise Codeine.

Plan: Assess renal function/amylase
Rehydrate as poor intake + output over last 24 hrs or so. Manage pain + mobility once he recovers from his renal problems and dehydration."

Dr D advised that his working diagnosis at that time was pancreatitis or renal failure. He did not consider septic arthritis as a differential diagnosis, as Mr A "did not have any symptoms to support that diagnosis … he was not complaining of pain in ankle joint when I reviewed him prior to transfer". Dr D's handwritten practice notes for Mr A state only: "→ [the first public hospital] Dehydration Nausea".

At 10pm, Mrs A telephoned Mrs C to advise that Mr A was on his way to hospital because his condition had deteriorated.

The first public hospital

Mr A was admitted to the first public hospital at 10pm on Saturday. Dr F, Clinical Director, at the first public hospital, confirmed that Mr A presented "with a picture typical of severe septic shock associated with hypotension [low blood pressure] and acute renal failure". Mr A's temperature was 36°C, his pulse 40 bpm and blood pressure 80/40mmHg. He had significantly compromised cardiac and renal function. Blood tests subsequently suggested that Mr A's symptoms were caused by "a toxic or infective aetiology".

Mrs A recalls receiving a telephone call from the first public hospital shortly after midnight, and being told that Mr A was to be transferred urgently to the second public hospital.

Sunday — The second public hospital
At the time of Mr A's admission to the second public hospital, his pulse was 36 bpm and his blood pressure 72/46mmHg. His left ankle was swollen and red, and the admitting registrar queried whether this was a result of gout. It was noted that Mr A had multi-organ failure, including acute on chronic renal failure possibly secondary to dehydration, medication or bowel obstruction. His low blood pressure was thought to be due to his heart medication.

Mr A was reviewed later in the day by a physician, who felt that his situation could be explained by sepsis (destruction of tissues by disease-causing bacteria or their toxins), although bowel obstruction remained a possibility. At 7.45pm fluid was aspirated from Mr A's left ankle joint, and the laboratory examination findings were consistent with septic arthritis and underlying gout. Mr A's abdomen was distended and he developed a mild fever. He underwent a laparotomy at 11pm, which — according to the ICU registrar — was "essentially normal" and revealed no intra-abdominal pathology sufficient to cause his clinical condition. A washout of the left ankle was undertaken and showed significant pus. Mr A was diagnosed with septic arthritis causing septic shock (subsequently confirmed when blood cultures and the ankle aspirate grew the bacteria *Staphylococcus aureus*).

Mr A's condition deteriorated further and he subsequently died.

Subsequent events

Dr D wrote a letter of condolences to Mrs A, in which he stated:

> "I know you were away when [Mr A] got sick so thought it might be helpful to fill you in with the details.
>
> [Mr A] presented with increasing aches and pains and was having trouble mobilising and was wanting pain relief since hav[ing] stopped his anti-inflammatory the pain in his joints had got wor[se] again. I was not aware he had any problem with his foot and he refused to go to Hospital.
>
> The next day I was able to convince him to go to [the rest home] as he was having problems with nausea and we were wondering whether he had a bowel problem. The nausea deteriorated and I then sent him to [the first public hospital] for rehydration. At no point were we aware he had a specific ankle or foot problem. It seems his nausea and freezing up with pain everywhere was all due to sepsis where infection can get into the blood from a source somewhere in the body. Infections that get into the blood may cause bowel and joint and muscle problems elsewhere sometimes.
>
> The Hospital themselves were not aware that there was a joint sepsis causing his problems until the operation. Unfortunately any operation for [Mr A] was going to be a major problem with his heart so the risks were extremely high, but septic arthritis is not treatable without a drainage procedure so he was in a catch 22. As it turned out the bowels were fine and apparently just affected in this unusual way by the sepsis.

> I hope this fills in some of the details. I was devastated to hear that [Mr A] deteriorated the way he did and I was disappointed that more could not have been done. It seems that the hospital did do a good job and did what they could. It just wasn't going to be enough to overcome his handicap of heart disease as his heart was barely holding on at the best of times."

Mrs A says that points in Dr D's letter are factually incorrect and inconsistent. She questions why Dr D would have sent one of his nurses to see Mr A with crutches, if he was unaware of Mr A's immobility and foot pain; and disputes that Dr D was "able to convince" Mr A to go to the rest home, stating that it was her own telephone call to Dr D on Saturday that had "got some action". Summarising her complaint, Mrs A stated:

> "I fully understand that my husband was not a well person having a long history of heart problems, but if more care had been taken when [Dr D] was first called, [Mr A] could possibly still be here. Ironically we had always thought [Mr A's] heart condition would eventually become difficult to control and lead to his death. It certainly would have been easier to cope with if this had been the case."

Dr D explained that the letter was intended to offer an explanation of the hospital findings and that he is sorry if Mrs A did not find it helpful. He does not accept that the letter is inaccurate.

Clinical views

Dr D emphasised that he "did not know about [Mr A's] foot being sore" and believed this would have been first noticed by the ambulance and hospital staff when they moved Mr A to and from bed. Dr D explained:

> "In regards to septic arthritis, this is an acute event, developing over hours to a day, that will cause complete loss of function of a joint with excruciating pain on movement. The sudden event causes such a severe disabling pain when [the] patient moves the joint that [Mr A] would not have been able to walk around home for the three days in question, if in fact he had septic arthritis while at home.
>
> Septic arthritis is so extremely rare that I have not seen a single case … in my entire GP working life, other than trauma cases with penetrating injury. This did not happen in this case. It therefore seems reasonable to say that it was reasonable for me to have assessed [Mr A] as reacting to medications with nausea, a common problem with the medications he was taking. The septic arthritis started on the [Saturday], when he became septic suddenly deteriorating and the staff noted ankle pain, when I was informed of the deterioration and he ended up being transferred with sepsis, thought to be acute abdomen. I was not informed of the pain in the ankle.
>
> He had generalized arthritis prior to all this. Our discussions were about treatments for his aches and pains of the arthritis he had had for years that had recurred because his

> NSAID [non-steroidal anti-inflammatory drug, Vioxx] was stopped because of his renal failure some days earlier. No one had mentioned the ankle being an issue at any time prior to or … during the admission to [the rest home] on Saturday.
>
> He did have a minor incident in [the first public hospital] prior to discharge a few days earlier in the week, lacerating his left leg that we ended up dressing at the surgery and that healed well and his care was appropriate …
>
> Even if he had agreed to hospital care prior to Saturday, it would not have changed his subsequent management by the hospitals — they did not know he had septic arthritis until after the abdomen was explored and found to be normal.
>
> The deterioration on Saturday occurred in [the rest home] under nursing observation and despite being a weekend [Mr A] was monitored by myself and transferred when deterioration was noted by the staff."

Dr F, Clinical Director of the first public hospital, advised that the source of Mr A's staphylococcal infection was not clear. He said:

> "Mention is made … of a laceration to [Mr A's] leg apparently sustained by bumping into a trolley while he was in [the first public hospital] during his previous admission [the previous week]. This was evidently severe enough to require dressings as mentioned in the hospital notes at the time and may have been a portal of entry for the organism. During the same admission [Mr A] had a venous cannula inserted into the veins of his arm and from time to time this can provide a portal of entry to the blood stream for infective organisms although there was no mention of any obvious infection at the cannula site …
>
> The acute severe deterioration in renal function, which probably contributed to his death and may have been the direct consequence of the staphylococcal septicaemia, may also have been aggravated by the fact that his Vioxx therapy had recently been recommenced (it had been stopped previously for fear of renal complications). The aggravation of already abnormal chronic renal dysfunction is a well-recognised side effect of Vioxx therapy."

The Head of Medicine at the second public hospital commented that staphylococcal septicaemia has a very high mortality rate, even in otherwise healthy adults. He said: "Given the fulminant nature of staphylococcal septicaemia it is unlikely that the condition existed for anything more than a few days prior to admission." The Head of Medicine also stated:

> "[Mr A] … had severely impaired heart muscle function with very little cardiac reserve. A major insult such as septicaemia would have meant that his cardiac output would have been insufficient to sustain the increased requirements of blood circulation, leading to hypotension and generalised organ failure, including bowel and kidney. In a man with severe heart failure, gout is many times more likely to be the cause of a painful swollen joint than any other cause. It took the full resources of a major

metropolitan hospital nearly 20 hours to come up with a diagnosis. Given [Mr A's] severe underlying cardiac condition and the inevitable delay in diagnosis occasioned by his heart failure and the strong possibility of gout (which indeed he had) I think it exceedingly unlikely that he could have survived this event under any circumstances."

Independent advice to Commissioner

The following expert advice was obtained from Dr Tony Birch, rural general practitioner:

"I have some knowledge of [Dr D's] situation having visited him as Chairman of a Competency Review Committee a few years ago. I can confirm, however, that I have no personal or professional conflict in this case. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I understand also that my report is subject to the Official Information Act and that my advice may be requested and disclosed under that Act and that the Commissioner's policy is to name his advisors where any advice is relied upon in making a decision.

I qualified MB, ChB in 1968 from Victoria University of Manchester, UK. I also hold a Diploma in Obstetrics from the Royal College of Obstetricians (1970) and a Diploma in Health Administration from Massey University (1985). I have been a Member — now Fellow [of] the Royal New Zealand College of General Practitioners since 1980. Prior to working in New Zealand I worked in an isolated area of Fiji for three years. For the past 31 years I have worked as a rural general practitioner in Rawene, Hokianga. This practice involves on call work and the care of patients in a small rural hospital.

Complaint

- *Whether general practitioner [Dr D] provided [Mr A] with services of an appropriate standard when:*
  - *[Mr A] consulted him at the surgery on [Tuesday]*
  - *[Dr D] spoke with [Mr A] on the telephone on [Thursday], and*
  - *[Dr D] visited [Mr A] at his home on [Friday].*

- *Whether [Dr D] appropriately managed [Mr A's] deteriorating condition on [Saturday].*

I have read the **supporting information** supplied by the Commissioner, viz:

- Letter of complaint to the Commissioner from [Mrs A], dated [Friday], marked with an 'A' (pages 1 to 17)
- Letter from [Mrs B], dated 15 November 2004, marked with a 'B' (page 18)
- Letter from [Mrs C], dated 25 January 2005, marked with a 'C' (pages 19 to 21)
- Letter and accompanying documentation from [Mrs E], [manager at the rest home], dated 9 December 2004, marked with a 'D' (pages 22 to 37)

- Letter from [the acting Clinical Director], [the first public hospital], dated 22 November 2004, marked with an 'E' (pages 38 & 39)
- Letter from [Dr F], Clinical Director, [the first public hospital], dated 15 December 2004, marked with an 'F' (pages 40 & 41)
- Letter from [the Head of Medicine], [the second public hospital], and accompanying documentation, dated 12 January 2005, marked with a 'G' (pages 42 to 86)
- Letter of response from [Dr D], dated 17 April 2005, marked with an 'H' (pages 87 to 90)
- Letter of response from [Dr D], received 7 June 2005 and accompanying documentation, marked with an 'I' (pages 91 to 120)
- Letter of response from [Dr D], dated 30 May 2005, marked with a 'J' (pages 121 and 122)

Brief Factual Summary

[Mr A] (aged 73 years) was admitted to [the first public hospital] for adjusted treatment of a heart condition. … His Vioxx was stopped due to concern about his impaired renal function. [Mr A] sustained a skin tear to his [left shin] …

[Mrs A] took her husband to [the medical centre] on the morning of [Tuesday] to have the leg redressed. [Mr A] was concerned about pain in the left ankle.

[Mrs A] believes that her husband contacted [Dr D] on the morning of [Wednesday] to complain that his left foot was very sore and that [Dr D], suspecting that [Mr A] was suffering from gout, advised him to recommence his Vioxx. [Mr A] reminded [Dr D] that this medication had been stopped when he was in hospital because of impaired renal function. [Dr D] stated that he would ask his nurse to visit to take bloods. [Mr A] contacted [Dr D] later that day (the nurse had not visited) and he was advised to commence the Vioxx. (There is no record of this consultation taking place.)

The next day [Mr A's] foot was worse and he contacted the surgery. [Mr A] did not want to call at the surgery or for [Dr D] to visit. [Dr D] advised him to continue the Vioxx. [Dr D's] record of the consultation was, 'Frozen up with pain. Panadol, Vioxx. Ring in 2 hrs.'

On [Friday], [Mr A] telephoned [Dr D] to report that he was nauseated and had vomited and his foot was worse. He was also not taking much in the way of food or fluids. The practice nurse visited and delivered crutches, anti-emetics and Codeine. [Dr D] visited later in the day while [Mr A's] sister-in-law was present, but did not examine [Mr A]. [Dr D] stated that [Mr A] refused to be admitted to [the first public hospital] but said that he would consider admission to [the rest home] the following day if he was no better. [Dr D's] record for this visit was, 'Home visit → [the rest home] for nausea and pain management.' [Mr A's] daughter visited him later in the day and noted that he was 'sweaty and clammy'.

On the morning of [Saturday] [Mrs A] (who had returned home after being away from [Tuesday]) telephoned [Dr D] to report that she was concerned about her husband who appeared to have a temperature, was continuing to vomit and had passed little urine. Shortly afterwards an ambulance arrived to transport [Mr A] to [the rest home].

At [the rest home] [Mr A's] condition continued to deteriorate, he became disorientated, drowsy and was sweating profusely. [Mrs A] asked [a registered nurse], to contact [Dr D] again. [Dr D] advised [the registered nurse] to give [Mr A] further Codeine and visited again at about 8.00pm.

[Mrs A] was contacted at home at 9.00pm by [the rest home] to advise that her husband was being transferred to [the first public hospital] for rehydration. [Mr A] was assessed at [the first public hospital] and transferred to [the second public hospital] that night.

An aspiration was performed on his left ankle which confirmed septic arthritis. [Mr A] developed septicaemic multiple organ failure. He underwent an exploratory laparotomy which did not show any abnormality. He was transferred to Intensive Care for treatment of elevated potassium and severe metabolic acidosis, but he [later] died.

NB: It appears that the laparotomy was performed because of suspected obstruction and the joint was aspirated at the same time. If there had been a differential diagnosis of sepsis, [Mr A] may not have had the added stress of major surgery.

Report
I will answer the specific questions raised and follow this with some other comments which I believe are relevant to this case.

1. *Was [Dr D's] management of [Mr A] on [Wednesday] reasonable? In particular:*
   - *How appropriate was his advice about Vioxx?*
     It was understandable, but hardly appropriate. In the presence of renal failure, any non-steroidal anti-inflammatory drugs are contraindicated. With a diagnosis of ischaemic heart disease, this contraindication is even stronger. I can only assume that [Dr D] considered that gout was the cause of the pain in [Mr A's] left foot and that, as Vioxx had worked in the past, it was reasonable to use it for a short time now.

     This assumption is challenged, however, by the statement of [Dr D] that he was unaware of pain in [Mr A's] foot. If [Dr D] considered that the pain was due to general degenerative changes, simple analgesics were indicated.

   - *Was a blood test indicated?*
     I do not believe a blood test was indicated. He had been discharged from hospital only days before, where extensive biochemical tests had been performed. I do not know whether [Dr D] had received these electronically but they would have been available to him with a simple phone call.

- *Was a physical examination warranted?*
  At this stage it was not unreasonable for [Dr D] to respond to [Mr A's] phone call by giving advice. At a busy practice it is not always possible to visit every person who calls.

- *Is the standard of documentation adequate?*
  As there is no documentation, the answer must be no. It should be normal practice to document phone consultation[s], and record the advice given.

2. *Was [Dr D's] management of [Mr A] on [Thursday] reasonable? In particular:*
   - *How appropriate was his advice about medications?*
     At this time it was even less appropriate than the day before. [Dr D] had 'chanced' giving Vioxx in the hope, I presume, that it would provide speedy relief and be quickly discontinued. This had obviously not happened.

   - *Was a blood test indicated?*
     No.

   - *Was a physical examination warranted?*
     This, it seems to me is the crux of this case. We have a conflict between [Dr D] and [Mr A's] sister-in-law about what happened here. (Perhaps the 'intern colleague' might be able to shed some light on this.) They agree, however, that [Dr D] did not examine the ankle. [Dr D] (in his letter of 24 May) states that he was not aware of [Mr A's] painful left ankle, though we have notes from the practice dated [Tuesday] regarding an 'open wound of leg — left' and the fact that crutches were ordered by [Dr D]. Unfortunately the standard of the notes available are so poor that we are left with only circumstantial evidence.

3. *Was [Dr D's] assessment of [Mr A's] condition on [Friday] reasonable? In particular:*
   - *Should he have examined [Mr A] and, if so, what examinations should he have conducted?*
     The issues are the same as those on the previous day. There is no record of any examination being performed. Given [Mr A's] symptoms, I would have expected [Dr D], at the very least, to have taken [Mr A's] temperature, measured his blood pressure, palpated his abdomen and looked at the wound on his leg, if not his ankle, where all except [Dr D] state that the pain was coming from.

   - *Was a blood test indicated?*
     I do not believe a blood test would have assisted in the diagnosis at this point.

- *Should [Mr A's] wishes regarding not being admitted have been documented?* [Dr D] is the only one who states that [Mr A] was strongly averse to going into hospital. [Mrs A] writes that her sister told her that [Mr A] himself asked about going into [the rest home] that day. [Dr D's] understanding — that [Mr A] was refusing admission to hospital — should certainly have been documented.

- *How appropriate was the medication regime ordered?*
  Apart from my earlier comments about Vioxx, this is impossible to assess. [Mr A's] family write regarding signs of fever, shock and vomiting. In these circumstances, the Panadol that was suggested would hardly have been of great benefit.

4. *Was [Dr D's] assessment of [Mr A's] condition on [Saturday] reasonable? In particular:*
   - *Was [Dr D's] examination of [Mr A] adequate and/or appropriate?* Apart from the note in [Dr D's] letter [to the Commissioner] ('H'), 'He was not complaining of the pain in ankle joint when I reviewed him prior to transfer', there is nothing in the documentation to suggest [Dr D] examined [Mr A] in [the rest home].
     I should note here, however, that the nursing notes from [the rest home] in the first line state, 'Admitted to [the rest home] 0915 with history of severe pain — L ankle'. The notes of the ambulance officer also state, 'O/E [on examination] Pain & swelling (L) ankle. Unable to put weight on this foot.' There appears to be no letter from [Dr D] for the transfer to [the first public hospital] at 2030 that evening, but the note from the nurse states, 'Admitted to [the rest home] at 9am with history of severe pain L ankle.' I can only presume that [Dr D's] admission note to [the rest home], such as it was, was photocopied and sent with [Mr A]. This mentions no history of ankle pain, no examination findings and no clear assessment. On his transfer to and while he was in [the rest home], [Mr A's] blood pressure was measured as 80/30mmHg and 80/40, and even as low as 65/30 in the ambulance prior to transfer. In the presence of dehydration and renal failure this should have set alarm bells ringing but seems to have been ignored by [Dr D].

   - *If not, what else should he have done?*
     It appears that [Dr D] consistently failed to examine [Mr A]. At the very least he should have reviewed the notes of the nurses at [the rest home], considered the causes of [Mr A's] extremely low blood pressure and looked at his wound and his ankle.

   - *Was his decision to admit [Mr A] to [the rest home] appropriate?* There is no documentation to allow me to answer this question. In the presence of a differential diagnosis of sepsis, a transfer to [the second public hospital] to — or at the very least [the first public hospital] — would have been indicated.

- *If not, what actions should he have taken?*
  Yet again, I cannot avoid the view that, if [Dr D] had examined [Mr A's] wound and ankle, things might have turned out differently. From all the documentation I have reviewed, this seems to me to be an entirely avoidable death.

Further comments
There is a body of evidence that the referring GP's assessment of a patient determines the line of thinking and investigation of the person to whom a patient is referred. It seems likely to me that, if [Dr D] had examined [Mr A's] leg and ankle and put this together with his other symptoms and his clinical picture, he should have had sufficient clinical suspicion to refer earlier, and with a differential diagnosis between severe gout and septic arthritis. If this had happened [Mr A] would have had a significantly better chance of survival.

[Dr D] makes the point that septic arthritis is rare. This is so. The outcome of not responding quickly to this, however, is so devastating that it should always be in the back of one's mind. There were significant risk factors in this case, of which [Dr D] should have been aware: [Mr A] suffered a laceration on his leg in a hospital context (where pathogens are more common), it had required re-dressing immediately on arriving home from hospital, he had a history of joint inflammation (which might fool one as to the diagnosis).

Given the appalling standard of [Dr D's] notes, even reading between the lines I can find little indication of his thought processes. If his working diagnosis was a recurrence of osteoarthritis pain following withdrawal of Vioxx, then it should have been revisited when reinstituting the Vioxx made no difference, and his condition even deteriorated.

[Dr D] mentions 'pancreatitis'; this was mentioned by the doctor on [Mr A's] discharge from [the first public hospital], but is only supported by a slightly raised Lipase. If [Dr D] suspected this life-threatening illness, I would have expected immediate transfer.

In summing up I would make the following comments:

- Apart from [Dr D's] statement in his letter of [17 April], there is no evidence that he ever examined [Mr A]. He, by his own admission, never examined [Mr A's] leg and ankle, despite overwhelming evidence that this was where [Mr A's] pain was coming from. This is well below expected standards and would be viewed with severe disapproval.

- [Dr D] rightly says that septic arthritis is rare, but the symptoms and signs appear to have been there and he was septicaemic. Had they been discovered and acted upon in a timely fashion, there is every expectation that [Mr A] would have survived.

- The standard of [Dr D's] clinical notes are well below expected standards and would be viewed with severe disapproval by his peers.

- There is every indication that [Dr D] was responsive to concerns of the family and of [the rest home] and visited appropriately. Unfortunately his behaviour as a medical expert seems to have been inadequate. From the evidence of the family and the few documented signs, it seems that [Mr A] was deteriorating inexorably from [Tuesday] and no cause was adequately looked for.

Finally, my response to the questions in the 'Complaint' above must be 'no' to each issue.

As an aside and unrelated to the main issues, I wonder whether an Incident Report was filled out at [the first public hospital] regarding [Mr A's] leg injury. This would have been helpful in this case and, I would have thought, be standard practice.

I also have a general concern about the general level of note keeping in both [the first and second public hospitals]. As a reviewer of these notes, I find it very difficult to discover what the doctors' thought processes were. On ward rounds at our small hospital we try to systematise our notes into 'Subjective: Objective: Assessment: Plan'. This makes for clarity of communication between all the health professionals involved in the care of the patient."

Response to Provisional Opinion

Dr D

In response to the provisional opinion, Dr D explained the background to his practice, the situation at the time of the events in question, and changes that have since occurred. Dr D began practising in 1995, taking over a practice with a patient base of 2,400 patients, which had previously been managed by three doctors. He advised that his patient base is, and always has been, predominantly elderly, Māori, and from a lower socio-economic group, and that his patients often have a number of co-morbidities. Dr D stated that as a rural GP he is on call 24 hours a day, seven days a week. Due to his ageing patients with significant illnesses, in 2004 he was "under high levels of stress" and finding it difficult to maintain the demands of work placed on him.

Dr D advised that another general practitioner has since started in the area, which means that he feels as though he can now cope with his workload and write fuller notes. He stated: "I do not offer pressure of time as an excuse for the inadequacies of my medical notes in 2004, but taking into account the reality of the situation, it was certainly a factor. … The reality is that notes in 2004 would vary in quality, at time[s] ranging from comprehensive to what I consider poor, as a result of medical priorities that arose from time to time." Dr D informed me that he has since spent considerable time improving the

medical centre's computerised note system, and that this has also enabled him to improve his note-keeping.

Dr D said that in 2004, due to pressures of his practice, he did not make house-calls as a matter of course. If patients were not well enough to come into the surgery and requested a home visit, they were best managed in the hospital section of the rest home, which provides care and assessment services for the town, as the area's public hospital was closed a number of years ago. Dr D advised that his practice is to use the rest home to reduce his workload and help monitor patients in the community who may otherwise deteriorate without immediate medical input. Dr D visited Mr A because he would not agree to go to the rest home. He acknowledges that his notes have let him down on this occasion but states that his version of events can be confirmed by other sources.

As a result of the crutches being supplied to Mr A without him being aware of the reason or need for the request, Dr D has implemented a system at the medical centre where all equipment loans are recorded (with the reason for the loan).

Dr D provided a history of Mr A's blood pressure measurements, noting that his blood pressure had been as low as 70/50 even when he was well.

Dr D said that his understanding is that "the ankle, in all likelihood, had deteriorated quickly that afternoon between aspirate and operation, and the sepsis that caused his admission to hospital (staphylococcal) may have caused the ankle sepsis, rather than the other way round". In his view both the first and the second public hospital took the same approach as he had, which was to focus on the abdominal symptoms and renal function and fluid maintenance issues.

Dr D expressed concern that (the first public hospital consultant) Dr F's comments are being taken out of context. He agrees with Dr F's comment that Cox II is not considered good for renal function, being potentially renotoxic. However, despite this risk and other side affects, the majority of older patients are on some form of Cox II and NSAID because the risks are often manageable and the benefits outweigh the risks. Dr D stated that it is acceptable for even patients with renal disease to be on Cox II or NSAID as long as the renal function remains stable. GPs are often in the situation of balancing patient needs for pain relief with the need to manage the risk of toxicity, and whether anti-inflammatories contribute to renal function deterioration is considered on a case-by-case basis through renal function observation over a period of time. Dr D noted that Captopril, another medication taken by Mr A, can also be renotoxic, but that without it Mr A would have gone into worsening heart failure.

Dr D provided references from two doctors who had worked with him on a locum basis. The references refer to Dr D having many patients with "very high co-morbidities" and an "enormously heavy workload". The practice manager provided a statement including information about services offered by the medical centre, its record-keeping systems, and the difficulty in recruiting GPs and obtaining locum cover. The practice manager also stated that every endeavour was made to reply promptly to requests for information from my Office.

Dr D also provided a letter from Mrs E, manager of the rest home, in response to the provisional opinion. She stated that admissions are often handled by phone and fax and that the rest home staff are grateful for Dr D's availability and willingness to provide assistance. Mrs E noted that Dr Birch's reference to "renal failure" is not correct; Mr A had renal impairment. She also stated that Mr A had a history of low blood pressure, so his blood pressure on admission was not a signal for concern. When his blood pressure deteriorated he was transferred to the first public hospital.

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.*

Other relevant standards

New Zealand Medical Association "Code of Ethics" (March 2002)

> "*Responsibilities to the Patient*
>
> …
>
> 4. Doctors should ensure that every patient receives appropriate investigation into their complaint or condition, including adequate collation of information for optimal management.
>
> 5. Doctors should ensure that information is recorded accurately and is securely maintained."

Cole's *Medical Practice in New Zealand* (Medical Council of New Zealand, 2003)[5]:

> "*The medical record*
> An important part of a good doctor–patient relationship is the keeping of a proper medical record. It is a tool for management, for communicating with other doctors and health professionals, and has become the primary tool for continuity of care in many large practices, as well as in hospitals. To fulfil these tasks the record must be comprehensive and accurate.
>
> …
>
> *General matters about patient records*
> There is a strong ethical duty to maintain adequate medical records, as well as some legal obligations to similar effect. The notes and other record entries should be sufficient to be understood by other medical professionals, and not so coded or abbreviated that they only make sense to the original author. Inadequacy of patient records may itself amount to professional misconduct. In any other matter of complaint, the medical record will often be vital, particularly where the complaint is made and investigated a long time after the incident in question. Thus it is not only in the patient's interest that accurate and detailed medical records be maintained, but it is often in the doctor's interest too."

[5] Pages 68 and 74

Opinion: Breach — Dr D

Overview
Under Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Mr A had the right to have services provided with reasonable care and skill and that complied with relevant standards. Fundamental to the provision of services of an appropriate standard is a provider's adequate assessment and treatment of the patient's condition and appropriate recording of his or her observations, discussions and the treatment plan.

My advisor, Dr Birch, expressed concern that because of the "appalling standard" of Dr D's clinical notes there is no conclusive evidence that Dr D examined Mr A between Tuesday and Saturday, "little indication" of Dr D's thought processes for Mr A's management, and only "circumstantial" evidence of what occurred and when. I too am concerned by the brevity of Dr D's notes, and his explanation for it. He states that his "policy" is to cover only clinical matters or "matters that will help with ongoing patient care", yet this is not reflected in his clinical record for Mr A, which between Tuesday and Saturday amounts to six handwritten lines excluding prescriptions and referral notes to the rest home and the first public hospital. The latter are also of a poor standard as they do not report Dr D's examination findings or assessment, and are not specific as to the site or type of pain. This is unacceptable given the concern undoubtedly expressed by Mr A and his family about his deteriorating health.

Dr D has acknowledged that at the time of these events the quality of his notes was variable and in some instances poor. He was under considerable stress due to the demands he faced as the only general practitioner in the area. I have noted this explanation, along with the steps taken by Dr D since that time in an effort to improve his record-keeping. I appreciate the difficulties and demands faced by rural general practitioners, and the significant work burden they carry. It is clear that Dr D provides an invaluable service to his community. However, like Dr Birch (himself a rural GP) I find it difficult to excuse such poor records.

Dr D has repeatedly said that he was unaware that Mr A's foot or ankle was sore, and the fact that even his referrals to the rest home and the first public hospital make no mention of ankle pain tend to support his lack of awareness. He considered that Mr A had generalised osteoarthritic pain – he was aware of Mr A's history of ankle pain. Mr A's family insist that Mr A had reported increasingly severe pain specific to his left ankle from Tuesday onwards. The rest home nursing assessment form recorded Mr A's "severe" pain, "all" in his left ankle, on Saturday.

The paucity of Dr D's notes, the inconsistency of his recollections regarding contact with Mr A, and his inadequate explanations and reasoning for his clinical decisions in this case lead me to prefer the evidence of Mr A's family. I consider that Dr D must have known about Mr A's injured left shin, and been aware of his ankle pain and decreasing mobility from [Thursday], if not earlier. He failed to respond to these issues appropriately, provided an inadequate standard of care, and kept poor records. In these circumstances, Dr D

breached Rights 4(1) and 4(2) of the Code. The detailed reasons for my opinion are as follows.

Tuesday
Mr A and his wife attended the medical centre on Tuesday, the day after his discharge from the first public hospital. Mr A's left shin was dressed by Dr D's practice nurse, who briefly recorded in the computerised notes that he had an "open wound". In response to the provisional opinion, Dr D acknowledged that Mr A's leg wound was brought to his attention on Tuesday by the practice nurse. The practice nurse asked Dr D to check her dressing and complete an ACC form. Dr D stated that he and his nurse were unconcerned about the wound. It appears that Dr D was aware of the wound to Mr A's leg but that it slipped his mind in his consultations with Mr A over the following days.

Wednesday-Friday
There is dispute as to whether Mr A spoke to Dr D on [Wednesday]. Mrs A and Ms C believe Mr A telephoned Dr D to advise that his foot was "very sore". Dr D says that no such conversation occurred. There is no entry in Mr A's clinical records for this date. However, as Dr D's notes are so scant, I am not convinced this means that no such discussion took place. Dr D should have documented all telephone calls with Mr A, and recorded any advice given. This does not seem to have been Dr D's practice.

In my view, it is probable that Mr A *did* telephone Dr D on [Wednesday], that he complained of a painful left foot, and was advised to recommence Vioxx. I am persuaded by the evidence of Mrs A and Mrs C, who understand that Mr A was worried about restarting Vioxx, because the doctors at the first public hospital had said it could have an adverse effect on his impaired kidney function, and Dr D's practice nurse had not taken a blood test.

On [Thursday], there *was* a telephone discussion between Mr A and Dr D. Mr A was unwilling to go into the surgery as the pain in his foot prevented him driving. Dr D stated that Mr A's osteoarthritic pain had returned and he wanted pain relief medication (the first public hospital having stopped his Vioxx). Mrs B states that Dr D visited Mr A at home that day. She expressed surprise that despite repeated references to the pain in Mr A's foot, no examination was performed. Although Dr D has not referred to a home visit in his notes for [Thursday], or in his response to this investigation, point 7 of his plan in the referral note to the first public hospital dated [Saturday] — "Was recommenced on Vioxx 2 days ago … but urine not done at that time because he was bed bound with pain"— confirms that Dr D had some contact with Mr A that day. The only history recorded in the clinical notes for [Thursday] is Dr D's brief observation that Mr A was "frozen up with pain". The site or type of pain is not recorded, although Dr D has since stated that Mr A's pain was caused by "generalised arthritis", which he had elected to treat with Vioxx on the basis that it was "logical to restart something we knew would work".

The family's evidence is that by Friday, Mr A could not walk, was vomiting bile, experiencing waves of hot and cold, had no appetite, and was passing little urine despite diuretic medication. Mr A was worried about his medication regime. Dr Birch advised that

at the very least, an assessment by Dr D of Mr A's temperature and blood pressure, physical palpation of his abdomen, and an examination of the wound on his leg were warranted. Dr D says he attended Mr A at home and that no family member was present while an examination was undertaken. However, he has not described the nature of the examination performed or his findings in either the contemporaneous clinical notes or his response to this investigation. Mrs B, who was at the house, believes that Dr D did not examine Mr A. Dr D recalls that his main concern was Mr A's complaint of nausea, which he believed was due to medication (particularly Tramal), and possibly the pancreatitis that had been diagnosed during his recent admission to the first public hospital. Dr D admits that he did not examine Mr A's ankle. He was aware that Mr A had asked for crutches but had not enquired further as to the reason for this request.

Dr D says that on [Thursday], he told Mr A to take Vioxx and Panadol and "ring me back in a couple of hours if the pain did not settle". Dr D also claims that his plan was for Mr A to take Vioxx "for a few days", and to replace it with Tramal if it did not work. No examination findings or plans for management are recorded to support this approach. The prescription issued by Dr D for Mr A on [Thursday] was for Panadol, 90 Vioxx and 60 Tramal tablets. The amount of Vioxx prescribed casts some doubt on the extent to which this part of Dr D's treatment plan was temporary.

Non-steroidal anti-inflammatory drugs are contraindicated in the presence of renal failure and particularly in a patient with ischaemic heart disease. It may have been understandable (but, as Dr Birch states, "hardly appropriate") to resume Vioxx on a temporary basis, subject to close monitoring and careful review. In response to the provisional opinion, Dr D agreed that Vioxx is not considered good for renal function but that he balanced this against the need to provide pain relief and improve Mr A's quality of life. He points out that he had been routinely monitoring Mr A's renal function for six months prior to these events, and knew that it was relatively stable even when using the anti-inflammatories.

If Dr D was unaware of Mr A's ankle pain, then, as Dr Birch notes, simple analgesics (for instance, Panadol only) would have been appropriate for "general degenerative changes". While Dr D states that on Friday he advised Mr A to "avoid further Tramal" and continue Vioxx, the prescription he wrote on that date includes Tramal, together with further Panadol — which would have been of little benefit given Mr A's fever, shock and vomiting. Moreover, when prescribing an additional three tablets of Vioxx that day, Dr D acknowledged that it could cause problems for Mr A's kidneys, but that he should nevertheless take it until pain relief was achieved. Mr A had apparently told his family that, in the past, Vioxx had worked within a day and he was worried about why it was not working this time after two days. Dr D does not appear to have taken this into account.

A doctor has a duty to ask the patient those questions necessary to determine the nature of his or her current illness, and a responsibility to fully inform the patient about his or her possible diagnoses. In the absence of clear, detailed medical records, the inference is that Dr D did not comply with these obligations when Mr A consulted him. While it is impossible to be sure what Dr D's thought processes were and what, if any, differential

diagnoses he had in mind based on Mr A's reported symptoms, Mrs B's evidence — which I accept — is that Dr D did not appear to be overly concerned about Mr A's condition.

The brevity of the clinical records, and Dr D's muddled explanation and rationale for his prescription regime and clinical decisions, are indicative of his failure to fully appreciate the severity of Mr A's developing illness. As Dr Birch advised, Mr A's presenting symptoms on the morning of Friday warranted a differential diagnosis of sepsis, on the basis of which transfer to the second public hospital or the first public hospital at the very least was indicated. Dr D knew that Vioxx had not relieved Mr A's pain after at least two days, and should have revisited his working diagnosis at this point. In these circumstances, he should have recognised that he was dealing with a more complex issue than the "aches and pains of [longstanding] arthritis".

There is further dispute as to whether — and when — Dr D offered Mr A admission to hospital. Dr D states that he suggested admission to the rest home on Thursday but Mr A refused this. Dr D says his philosophy is that if a patient is "sick enough for a home visit they are sick enough for hospital" and that he uses the rest home to reduce his workload and help monitor patients in the community who may otherwise deteriorate without immediate medical input. Dr D states that during the home visit on Friday Mr A agreed to reconsider admission to the rest home if he was not better the following day. The manager of the rest home recalls that when Mr A was admitted on Saturday he joked with her about "finally agreeing to come in". In contrast, Mrs B recalls that during the home visit on Friday, Mr A asked whether he should go to the rest home but Dr D told him it was unnecessary. There was certainly discussion about the possibility of admission to the rest home that day, as Dr D recorded that Mr A's nausea and vomiting required management. However, Dr D's brief notes of his visit refer only to the rest home and in themselves provide no indication of what might have been discussed.

These conflicting accounts provide further illustration of why clear, detailed clinical notes are so important. As noted by the High Court, it is through the medical record that doctors have the power to produce definitive proof of a particular matter. Doctors whose evidence is based solely on their subsequent recollections (in the absence of written medical records offering definitive proof) may find their evidence discounted.[6] It is possible that Mr A *was* reluctant to accept admission to a hospital on Friday as Dr D has suggested, but if that was the case, it should certainly have been recorded in the notes, together with details of Mr A's medication regime, his presenting symptoms, and confirmation that his pain had not responded to Vioxx. Dr D's position is that a discussion with a patient regarding hospital admission is a "non-management" matter which he does not normally include in his patient notes. This approach is not consistent with accepted professional standards.

[6] *Patient A v Nelson-Marlborough District Health Board* (HC BLE CIV-2003-204-14, 15 March 2005)

Saturday
On Saturday morning, Mr A was transferred to the rest home by ambulance at approximately 9am. There is again some conflict in the information obtained regarding the transfer. Mrs A states that she called Dr D at his home to request admission. Dr D recalls that he received a call at his house that morning from an unknown member of Mr A's family to inform him that Mr A had "finally agreed to an admission to [the rest home], and accordingly I arranged it".

Dr D said that he "monitored" Mr A and noted that he had "no symptoms or signs of sepsis". However, any monitoring was fairly scant as the only time Dr D saw Mr A was briefly around 8pm before his transfer to the first public hospital, and the only phone contact with the rest home staff was at 6pm when they informed him of Mr A's further deterioration and he ordered an intramuscular injection of Maxolon. Dr D's clinical records contain no reference to the events of that morning, or Mr A's condition, and state only that he was admitted to the first public hospital with dehydration and nausea.

There are at least five separate and specific references to Mr A's left ankle pain being his chief complaint on Saturday: in the ambulance case slips regarding his transfer to the rest home and to the first public hospital, in the rest home Nursing Assessment Form and discharge/transfer form, and in the triage form at the first public hospital. This evidence casts further doubt on Dr D's claim that he was "unaware" that Mr A "had any problem with his foot". It is difficult to believe that Mr or Mrs A would have informed ambulance and nursing staff — but not Dr D — of the soreness and swelling in his ankle.

As Dr Birch observed, Dr D's referral note to the rest home made no mention of the specific site of Mr A's pain, and contained no examination findings or assessment. It included a plan that blood tests "for renal function" be taken in two days' time. Dr D has explained that the blood tests were intended to assess "any cause of the arthritis flare up other than medication related, inflammatory etc".

Dr D evidently believed that Mr A had gout or a recurrence of "generalised arthritis" following withdrawal of Vioxx, though neither possibility was recorded. Dr D may well also have been swayed towards renal and gastrointestinal causes for Mr A's additional symptoms, and this may have clouded his judgement. Dr D should have been far more concerned by Mr A's failure to respond to the resumption of Vioxx, and his generalised complaints of nausea, "waves of hot and cold" and sweating. Mr A's leg wound — a possible portal of entry for infection — and his recent hospital admission would have alerted a more careful doctor to the possibility of sepsis in an adjacent painful joint. These circumstances warranted close and careful examination, and when subsequently combined with Mr A's subnormal temperature and extremely low blood pressure — as identified by the rest home nursing staff — should have alerted Dr D to reconsider his working diagnoses and consider the alternative of septic arthritis rather than common gouty arthritis.

Dr D should also have attended Mr A much sooner after his admission to the rest home and examined his left leg wound and ankle. In the presence of dehydration and renal

impairment, Mr A's low blood pressure in itself should "have set alarm bells ringing", and warranted a differential diagnosis of sepsis and immediate transfer to the second public hospital. Dr D's failings in this respect amount to a very poor standard of care in an experienced medical practitioner and, as Dr Birch noted, may well have influenced the subsequent thought processes and investigations initially adopted by clinicians at both the first and second public hospitals.

Conclusion
The fact that there are so many documented recordings of Mr A's left ankle as the primary source of his pain supports the allegation of his family that Dr D did not undertake an adequate history or examination. That there are so many discrepancies in the recollection of events between Dr D and Mr A's family only highlights the poor quality of Dr D's record-keeping. While Mr A may have been stoic and reluctant to return to hospital, that does not absolve Dr D from taking a good history, conducting a careful examination, and keeping comprehensive and accurate clinical records.

I accept Dr Birch's advice that although septic arthritis is rare, the outcome of not responding to it quickly is so devastating that it should always be in the back of a GP's mind. I do not accept Dr D's claim that it was "reasonable" for him to have assessed Mr A as reacting to medications with nausea, and that the septic arthritis started when Mr A deteriorated suddenly while "under nursing observation" late on Saturday. There were "significant" risk factors in Mr A's recent medical history to which Dr D should have been alert, particularly the skin tear on Mr A's left shin (which was dressed at Dr D's clinic), the history of joint inflammation, and the failure to respond to Vioxx, which had worked in the past. Dr D missed an opportunity to review the total picture on Friday when he was informed that crutches were being delivered to Mr A. He should have queried why a man with "generalised aches and pains" needed crutches. Even though he was in the middle of a busy surgery, Dr D (as he now acknowledges) should have asked why the request was being made.

My view is that Mr A's deterioration was gradual, not sudden, and that it warranted far closer attention by Dr D in order to determine its cause. Between Tuesday and Saturday, Dr D failed to examine Mr A's left leg and ankle — despite the obvious evidence of the open wound and escalating pain — or consider the possibility that Mr A's reported signs and symptoms were indicative of septicaemia. His standard of care and records was well below the level acceptable for a rural GP. In these circumstances, Dr D breached Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights.

Other comment

My Office first advised Dr D of Mrs A's complaint on 12 November 2004 and invited him to respond to her allegations so that I could decide what action to take. Dr D was overseas on annual leave in November, and then busy with summer influx of visitors to the area

over December/January. However, despite further requests for information, Dr D did not provide a substantive response until 17 April the following year. I notified Dr D of my decision to investigate Mrs A's complaint shortly thereafter.

Responding to complaints from patients, or an investigation by the Commissioner, is part of the professional responsibility of a registered medical practitioner. Good communication, respect and trust are the cornerstones of an effective doctor–patient relationship. They are also helpful qualities when doctors respond to complaints by third parties, or enquiries by regulatory authorities. In this case, Dr D wrote to Mrs A just over five weeks after Mr A's death, to "fill [her] in with the details". He took five months to respond to me. Dr D's delay and the somewhat inconsistent nature of his responses raise further questions about his professional competence. Accordingly, I intend to draw these matters to the attention of the Medical Council of New Zealand.

Recommendations

I recommend that Dr D take the following actions:

- Apologise to Mrs A for his breaches of the Code. A written apology should be sent to the Commissioner, for forwarding to Mrs A.
- Review his practice in light of this report.

Follow-up actions

- Dr D will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of my final report will be sent to the Medical Council of New Zealand, with a recommendation to the Council that it review Dr D's competence, and to the Royal New Zealand College of General Practitioners.
- A copy of my final report, with details identifying the parties removed, will be sent to the Rural General Practice Network and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, on completion of the Director of Proceedings' processes.

Addendum

The Director of Proceedings decided to file proceedings before the Health Practitioners Disciplinary Tribunal. However, after receiving additional information and further reviewing the matter, the Director considered that the public interest had been served by the referral for a competence review and decided to withdraw the charge.