General Practitioner, Dr A

A Medical Centre

A Report by the

Health and Disability Commissioner

(Case 04HDC19938)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Dr A	Provider/General practitioner
Mrs B	Consumer (deceased)
Mr B	Complainant/Consumer's husband
Dr C	General practitioner
Dr D	General practitioner
Dr E	General practitioner

Complaint

On 2 December 2004, the Commissioner received a complaint from Mr B about the services provided to his wife, Mrs B, by Dr A. The following issues were identified for investigation:

- *The adequacy and appropriateness of the care and treatment provided by Dr A to Mrs B at the consultation on 18 October 2004.*
- *The appropriateness of the medication prescribed by Dr A.*
- *The adequacy and appropriateness of the information provided to Mrs B.*

An investigation was commenced on 11 April 2005.

The investigation has taken over 18 months. The investigation process was delayed for multiple reasons, including delays in obtaining information and the availability of parties. It was also considered desirable to await the conclusion of the Inquest into Mrs B's death.

Information reviewed

- Information from Mr B (including the letter of complaint dated 1 December 2004)
- Mrs B's medical records held by Dr C (including Dr A's notes of the consultation with Mr and Mrs B on 18 October 2004, and records held by her previous general practitioner, Dr E)
- Notes of evidence from Coroner's Inquest and Coroner's findings
- Statements to the Coroner from Dr A, Mr B, a pharmacist, and Dr D
- Prescription form dated 18 October 2004
- Information from ACC including reports from:
    - Dr Ian St George, general practitioner

  - Dr David Henry, general practitioner
  - Dr Carl Burgess, Professor of Medicine/Clinical Pharmacology
- Post-mortem report
- Information from Dr C on behalf of the Medical centre
- Information from Dr A
- Information from Medical Council of New Zealand

Independent expert advice was obtained from general practitioner Dr Jim Vause.

A visit to the medical centre was carried out on 12 July 2006.

The following responses to my provisional opinion were received:
— Dr A's lawyer (on behalf of Dr A), dated 7 June and 18 August 2006
— Dr C's lawyer (on behalf of Dr C), dated 15 June 2006
— Mr B, dated 20 June 2006.

Information gathered during investigation

Overview
Mrs B, aged 37, consulted Dr A at a medical centre on 18 October 2004 for treatment of a migraine headache. Dr A had not seen Mrs B before as she was the patient of another doctor at the medical centre. Dr A decided to prescribe for Mrs B propranolol, a medication used in the prevention of migraines. Dr A was not aware that Mrs B suffered from moderate to severe asthma.

Propranolol is contraindicated for people who suffer from asthma. Shortly after taking an initial dose of propranolol, Mrs B suffered a severe asthma attack. Her condition progressed to respiratory arrest and, later, cardiac arrest. She was taken by helicopter to a public hospital. She had sustained severe brain damage as a result of lack of oxygen and later died.

The Coroner held an Inquest into Mrs B's death. The Coroner found that Mrs B died as a result of a pulmonary embolism.

Dr A
Dr A has provisional vocational registration as a general practitioner, subject to ongoing supervision. This involves a supervisor reporting to the Medical Council of New Zealand on a three-monthly basis. Dr A has two supervisors, one of whom is practising at the medical centre. Dr A is currently an associate member of the Royal New Zealand College of General Practitioners, and is enrolled in its advanced vocational education programme.

Background
Over the period from late 2003 to September 2004 Mrs B attended the medical centre four times as a casual patient. She saw Dr C once, and Dr D on three occasions, twice for treatment of a migraine. On 23 April 2004, a locum for Dr C renewed Mrs B's prescription for asthma inhalers on a "prescription only" basis without seeing Mrs B.[1] During this period, Mrs B was a patient of Dr E, a general practitioner practising at a city medical centre.

On 22 September 2004 — some months after seeing Dr C — Mrs B requested that her medical records be transferred from her general practitioner at the city medical centre (Dr E) to Dr C. Mrs B's husband, Mr B, explained that Mrs B had not transferred earlier as they had initially been primarily living in the city and were not sure whether their move to the area would be permanent. In early October 2004, Mrs B's medical records were received by Dr C, given a practice number and filed. Computer records of the prescriptions provided to Mrs B while a casual patient were amalgamated with her permanent record on the medical centre computer system.

Mrs B's consultation with Dr A on 18 October 2004
On Friday 15 October 2004, Mrs B began to suffer from a migraine headache. Her condition did not improve over the weekend and, at around 9am on Monday 18 October 2004, Mr B telephoned the medical centre and made an appointment for her to see Dr C at 1.40pm (the earliest available appointment).

Mr B telephoned the medical centre again at 9.40am in an attempt to get an earlier appointment because of the level of discomfort Mrs B was experiencing from her migraine. Mrs B was given an earlier appointment to see another doctor at the medical centre, Dr A, at 10.50am. Mr B recalled that during this telephone conversation the receptionist said that she recognised the Mr and Mrs B's names, as she had completed the transfer of their records and filed them the previous week.

Dr C stated that his practice nurse also spoke to Mr B. Mr B informed her that at the medical centre Mrs B had previously attended, they had a "rapid assessment" system for patients with acute conditions, whereby patients could be seen and assessed by a nurse without an appointment, and then be seen briefly by a doctor. Dr C's practice nurse explained that the medical centre did not have such a system and that Mrs B would need to make an appointment with a doctor. The practice nurse took the physical file containing Mrs B's medical records to Dr A's reception area prior to Mrs B's appointment, and discussed "the situation and her assessment" with Dr A's nurse (a reliever).

[1] Records of the consultation with Dr C and the renewal of the prescriptions were not included in Mrs B's file but were subsequently provided by Dr C.

Mr B and their young daughter accompanied Mrs B to the consultation. A nurse took Mrs B's blood pressure while they waited for the doctor to arrive. Dr A arrived a few minutes later.

Dr A recalled that the morning of Mrs B's appointment was busy and that a number of her usual patients were unable to get appointments to see her. Dr A became aware of Mrs B only when she walked into the consulting room where the Mr and Mrs B were waiting.

Dr A looked at an arrival slip and saw that Mrs B was already registered with Dr C. Dr A initially advised me that she was not aware, at the time of this consultation, that she was the first doctor at the medical centre to see Mrs B since her notes had arrived from the city medical centre earlier that month. Subsequently, Dr A advised me that she had understood that Mrs B was "a first time attendee at the practice".

At the beginning of the consultation, Mr B outlined to Dr A his concerns about Mrs B's migraines. He said that she had been prescribed Voltaren[2] in the past but had not been using this medication while pregnant or breastfeeding. According to Dr A, Mr B was very agitated during the consultation.

In her evidence to the Coroner's Court, Dr A stated:

> "I do remember consultation starting with [Mr B] expressing the unhappiness with the way that [Mrs B] had been treated in the past, that she has been having migraine headaches and that they want both them to stop and they'd lost faith in the medical fraternity and that no one has done much about it … I remember that that was the beginning of the consultation."

Dr A stated that, while Mr B outlined his concerns, it was not possible for her to ask questions, and she thought that the best course of action was to sit quietly, giving him her full attention.

Mr B, in a letter to the Medical Council of 31 August 2005, disputed that he expressed dissatisfaction about previous treatment for Mrs B's migraines. He stated:

> "[Dr A] completely misinterpreted our reasons for the consultation with her on 18 October 2004. She believed we were dissatisfied with previous medical action on [Mrs B's] migraine headaches and were wanting a long term solution. This simply is not the case, as we made clear (we thought) to her during the consultation …

[2] An anti-inflammatory analgesic.

> We told her we had always been satisfied with medical treatment of [Mrs B's] migraines, and we certainly were not expecting a complete review and long term treatment of them by [Dr A], particularly when she was not our registered GP."

Mr B denied being agitated during the consultation and said that they were used to Mrs B suffering from migraines, so there was no reason to be highly emotive about the situation. In his letter to the Medical Council of 31 August 2005, he stated:

> "[Dr A] interrupted me several times during my initial history account to ask questions about [Mrs B's] migraine history, such as medication used, triggers, frequencies, and typical symptoms."

Dr A initially considered that, as Mrs B's problem was a chronic one and previous medication had not provided relief, the best way forward would be for Mr and Mrs B to make a double appointment to see their usual doctor and discuss options for treatment. However, because she could see that Mrs B was clearly in discomfort, Dr A decided that she would not ask them to come back at another time. Mr B stated that Mrs B's problem was quite clearly an acute one, as evidenced by the clear discomfort noted by Dr A.

Dr A stated that, after Mr B had finished his account, she elicited a history of Mrs B's migraines by directly asking questions of her. Dr A was told of the impact the migraines had had on Mrs B's quality of life and on her ability to work, and of the increasing frequency of her migraines.

Mr B recalled that Dr A had Mrs B's entire file on her desk but never referred to it during the consultation. However, Dr A stated that all she had with her at the consultation was a blank piece of paper for writing clinical notes on, and the cover sheet for the file. At the Inquest into Mrs B's death Dr A told the Coroner's Court:

> "All I had at that time was a blank sheet of paper where it was the blood pressure recorded and the cover sheet. I can't recall seeing her previous medical file …
>
> I didn't have any other file. I can't recall having any previous medical files because I understood later that [the family] were new to the medical centre and they recently transferred [to the area]. So usually when we have new patients arrive regardless of what doctor, the nurses usually go through these files and record any chronic conditions because we are not computerised, fully computerised practice. We write our notes. So it is written, handwritten in the front page, all the chronic conditions, allergies, operations. Everything that you know is a past medical history, family history as well."

Mr B stated that their recent transfer from the city was the first thing he and Mrs B discussed with Dr A. He recalled discussing with Dr A that they had registered with Dr C and that their records had recently arrived and been filed.

The cover sheet for Mrs B's file contained her address, next of kin, sex, and date of birth. The cover sheet also had sections for information about immunisations, allergies/sensitivities, past history, family history and social profile, but there was no information written in these sections other than the date of Mrs B's last tetanus vaccination. No "problem list" was included in her file.

Dr A stated that the cover sheet should set out important information about the patient. Dr A appears not to have been aware that the cover sheet for the file was missing important information. She stated to the Coroner's Court:

> "[I]n terms of the age of the patient it is nothing unusual to see that front sheet looks this way because the young people usually don't have any chronic illness yet …
>
> It didn't make me suspicious by any means."

During the consultation, Mrs B confirmed that Voltaren had provided temporary relief for her migraines in the past and had not caused any side effects. However, she explained that her migraines continued to occur.

Dr A stated that she enquired whether Mrs B had any allergies, current medications or chronic illnesses and received a negative answer. Mr B disputed that Dr A made any such enquiries. Dr A did not specifically ask whether Mrs B suffered from asthma.

Dr A stated:

> "One issue that concerns me greatly is why I did not get an answer from [Mrs B] that directed me to her past history of asthma.
>
> Had [Mrs B] mentioned asthma, this would have led me to discuss with her the possible side effect of propranolol, and indeed Voltaren, which can precipitate an asthma attack. Propranolol is contraindicated for people with asthma."

At the Inquest Dr A said that the fact that Mrs B had taken Voltaren in the past perhaps "blocked" her asking specifically about asthma. Dr A also stated that in her experience asthmatic patients are very well educated about their condition and usually volunteer that they have asthma without being specifically asked.

Dr A recommended that Mrs B take a medication (propranolol)[3] that had proven successful in the prevention of migraines. She explained that the medication was used for other conditions such as arrhythmias and high blood pressure, rather than being specifically designed for the treatment of migraines.

[3] A beta-adrenergic blocking agent. Propranolol blocks the action of the sympathetic nervous system, a portion of the involuntary nervous system.

Dr A recalled:

> "I discussed the side effects of propranolol and emphasised that it was unlikely she [Mrs B] would feel there was any benefit from it for at least two weeks.
>
> I emphasised that I was starting [Mrs B] on a dose of 20mgs to be taken three times a day. I also prescribed Voltaren so she could use it if she had a headache."

As to what she said about the side effects of propranolol, Dr A stated:

> "I have a recollection of discussing the side effects of a beta blocker but I cannot now recall the particulars. I would have followed my usual practice of warning of the most recognised side effects of a beta blocker."

Dr A generated the prescription for Mrs B on the computer. The medical centre uses software where the screen for prescriptions includes a section headed "medications history". During a visit to the medical centre, Dr C brought up on screen the computer record for Mrs B. This record had a medications history section, which included all the medications she had been prescribed as a casual patient, including two asthma medications — Oxis and Beclazone inhalers. A photograph of the information displayed on the computer screen is included in the Appendix.

Dr A advised that she is not able to confirm what was on the computer screen at the time of the consultation with Mrs B. Dr A's lawyer noted that the computer record showed that Dr A was not the last person to modify it.

Dr A recommended a review by Mrs B's usual doctor, Dr C, in a month's time.

Mr B recalled that Dr A decided to prescribe "preventative medicine for migraines" rather than just giving short-term pain relief. He stated that at no time during the consultation did Dr A refer to the class of drug (the fact that it was a beta-blocker) or its trade name. Mr B's recollection of the consultation is that the only discussion of the drug's side effects was advice that Mrs B should not breastfeed while taking it, that it may cause drowsiness, and that she should avoid alcohol. Mr B recalled that Mrs B's past medical history was not raised or discussed, apart from her migraine history. He stated that no alternative medications were mentioned or discussed.

Dr A noted that Mrs B's blood pressure (which had been recorded by the nurse) was normal and did not examine her.

Dr A wrote a very brief note of her consultation with Mrs B. The notes record:

> "Has migraine, chr [chronic] problems
>
> Discussed + + +"

Dr A explained that the three plus signs mean that there was an extensive discussion. In the column headed up "Plan and Treatment", she wrote:

> "Propranolol, 20 mg tds [three times a day]
>
> Voltaren 75 mg bd [twice daily] 3/12 [three month prescription]
>
> Rev in 1/12 [Review in one month]"

By way of explanation for the brevity of her notes, Dr A stated:

> "By the time [Mr and Mrs B] left, I had spent longer with them than the allocated appointment time. I was very aware that I would have a number of acute patients who had been waiting longer than some of them would think acceptable.
>
> During the consultation, because of the high emotions of [Mr and Mrs B], I had been careful to put pen and paper down, and turn and listen to them intently, rather than recording in the notes contemporaneously as is sometimes appropriate during consultations.
>
> Because of the number of patients waiting, I wrote a very brief note rather than the usual full note that I would record for such a consultation. My notes for a consultation such as this would usually have been at least half a page. But by the time [Mr and Mrs B] left, I attached greater priority to seeing the next patient than in writing up the notes. This is something I now strongly regret, given the issues arising from that consultation."

Mr B said that the consultation with Dr A did not exceed ten minutes.

At around 11.25am, after concluding the consultation and paying at the medical centre reception, Mr and Mrs B went to the pharmacy next door to fill the prescription. Mrs B asked for a cup of water from the pharmacist and took four propranolol tablets at the counter.

Mr B stated that Dr A had instructed Mrs B to take four tablets (ie, 40mg) as soon as possible (to deal with the pain immediately), another two later in the afternoon, another two just before bed, and then two tablets three times daily. He recalled querying the initial dose with Dr A as it did not make sense to him. Mr B stated that Dr A said that Mrs B should take four tablets immediately so as to reach effective therapeutic levels as quickly as possible.

Dr A stated to the Coroner that she prescribed only 20mg doses (i.e. two tablets) and cannot explain why Mrs B took double this dose. Dr A also noted that a usual dose would be 40mg but that she had started Mrs B on a half dose as she had not taken the medication before. The prescription makes no mention of doubling the initial dose.

Less than an hour later, when Mrs B had arrived home, her asthma started to flare up badly. Mr B recalled that she used her Oxis inhaler to treat the asthma, and believes that she also used her Beclazone preventer inhaler. However, her asthma symptoms worsened.

At 12.35pm Mrs B asked her husband to telephone the medical centre to check whether the medication she had taken affected asthma. Mr B telephoned the medical centre but Dr A and her nurse were at lunch, so he telephoned the pharmacist. The pharmacist said that she looked up the prescription and, knowing that propranolol can cause breathing problems, immediately went to the medical centre and spoke to Dr D. His advice was to use a Ventolin inhaler and take one puff every five minutes to a maximum of five or six puffs, and an antihistamine, if they had any. He also said that Mrs B should come in to the medical centre immediately (and that she would be seen straight away) or call 111 for an ambulance if her asthma did not improve.

The pharmacist telephoned Mr B back (less than five minutes after first speaking to him) and passed on Dr D's advice. She recalled Mr B saying that they did not have a Ventolin inhaler but did have Ventolin nebules and a nebuliser. In response to the provisional opinion, Mr B explained that they did have a Ventolin inhaler but that he mentioned the Ventolin nebules and a nebuliser to the pharmacist as they thought it would be more effective. Despite using the nebuliser and taking an antihistamine, Mrs B's asthma continued to worsen and Mr B telephoned for an ambulance at 12.50pm.

Mrs B collapsed as the ambulance officers arrived and progressed to a respiratory arrest. Vigorous attempts were made by ambulance staff to resuscitate Mrs B but, despite this, she had a seizure indicative of cerebral hypoxia[4] and ischemia.[5] Approximately 40 minutes after her respiratory arrest Mrs B suffered a cardiac arrest. Some minutes after this, following further treatment, Mrs B's spontaneous circulation and breathing returned.

Admission to the public hospital

Mrs B was taken by helicopter to the public hospital at around 2.20pm, admitted to the Emergency Department and then transferred to the Intensive Care Unit (ICU). On being admitted to hospital it was discovered that Mrs B had sustained serious brain damage as a result of lack of oxygen.

Mrs B was assessed by a consultant neurologist at the public hospital. The consultant neurologist observed that she had progressed from an "eyes closed coma to an early vegetative state with evidence of good preservation of brain stem function but no signs of awareness or cognition". He concluded that Mrs B's clinical state was "clearly secondary to the effects of a severe prolonged cerebral hypoxic ischemic injury".

Subsequently the consultant neurologist assessed Mrs B again. He considered that she may have been emerging from a vegetative state to a minimally responsive

[4] Deficiency of oxygen supply to the brain.

[5] Inadequate flow of blood to a part of the body, usually caused by constriction or obstruction of a blood vessel.

neurological state, but that further observation would be required to confirm this. At this time he considered that her chances of making a significant neurological recovery were extremely poor.

Mrs B later died. The immediate cause of death was a pulmonary embolism.[6]

Additional information

The Medical centre
Dr A, Dr C and two other general practitioners practise at the medical centre, as well as the locum for Dr C. In the same building as the medical centre there is second medical practice. The second medical practice operates separately from the medical centre, and there is a physical division between the two. Information regarding the medical centre was obtained from Dr C and Dr A.

Dr C advised that he and the other doctors at the medical centre operate as individual practitioners. Their files are stored separately but they share the same computer system. The doctors at the medical centre meet twice a month and belong to the same IPA (Independent Practice Association) and PHO (Primary Health Organisation). Dr C stated that there are various groupings for other purposes. Dr A stated that in October 2004 she was "self employed as an associate in a four doctor practice". She explained that the four doctors were "four independent doctors sharing costs". In Dr C's view, the doctors do not share costs.

The following further information about the legal structure of the medical centre was provided in response to the provisional opinion. A property company owns the building in which the medical centre and the second medical practice are located. The property company leases the building to a medical centre company, which charges rent to the second medical practice and a private company.[7] (Aside from its leasing activities, the medical centre company owns ECG equipment and contracts a part-time gardener.) The private company, in turn, invoices Dr A, Dr C, and the other two doctors at the medical centre. The private company also owns the computer software used by the medical centre.

The medical centre had an administrator at the time of Mrs B's consultation in October 2004, but has replaced that position with a practice manager, who is now called a "business service manager". The medical centre also has a receptionist. Both

[6] Obstruction of the pulmonary artery or one of its branches by material (such as a blood clot) that is carried in the bloodstream.

[7] Shareholders in the private company include Dr D and Dr A.

the receptionist and the practice manager are employed by the private company. Each doctor employs his or her own practice nurse.

Dr C explained that "it was relatively common procedure" for his practice nurse to arrange an appointment for his patients with one of the other doctors in the building, and that this was perceived by the various practitioners to be one of the advantages of all being on the same site. Indeed, on the morning of Mrs B's consultation, Dr C's practice nurse made an appointment for Mrs B to see Dr A, as Dr C was not available until the afternoon.

From the perspective of a patient attending the medical centre, Mr B said that the medical centre appeared to be one group practice, rather than four individual practices.

Patient files and filing systems at the medical centre
At the time of Mrs B's consultation, the medical centre had a computer system for storing patient information but the doctors did not use it for the purpose of retaining patients' medical records, except for those of casual patients. Rather, they relied on hard copy files of medical records, which each doctor kept and stored separately. Each doctor could access information about the other doctors' patients stored on the system.

Dr C did not recall being informed about the assignment of Mrs B as his patient, the request to transfer her records to the medical centre, or the receipt of her records (although he was subsequently able to confirm, from computer records, the date that her file was received by the medical centre). He stated that he would usually see a new patient before a request was made for their records to be transferred and would, when he saw the patient, ask them to sign a written form requesting the transfer of their records. He would then record the date of the request in the computer. However, he acknowledged that there are variations in this procedure amongst the doctors practising at the medical centre.

Dr C explained that when medical records are received by him, his practice nurse would usually place these in the patient's file together with the request to transfer records, and would ensure that the cover sheet adequately reflected the records. Dr C indicated that the cover sheet from the previous general practitioner's file might be used (and would be altered if necessary) or a new cover sheet would be completed for the file. The information would then be reviewed with the patient at his or her first appointment. Also, a "problem list" would often be kept on the inside cover of the file and filled out after discussion with the patient. There was no specific flag on a new patient's file that they had not yet had their first consultation, although this would be obvious from the fact that the notes page is blank. Dr C explained that the receptionist at the medical centre also had some involvement in the filing of medical records, as the nurse "had some despair over the availability of file numbers".

Dr C stated:

> "As with all entries in such [clinical] notes, allergies and significant medical conditions are considered to be as recorded until the opportunity presents to discuss/confirm/clarify these with the patients, usually at the first appointment. This review can be important eg frequently records of 'allergies' turn out to be sensitivities only; some diagnoses may have been further clarified, disproved or occasionally denied."

According to Dr A, it was her practice when taking on a new patient that she or her nurse would go through the patient's file to highlight and record all important past history and allergies. Dr A stated that she used a highlighter or pen to emphasise anything that could pose particular risk to patients, such as a penicillin allergy or conditions such as asthma. In answering questions put to her in the Coroner's Court, she stated:

> "I have had the practice in the past that usually with new patients coming to the practice, we would go through the file and it would be either my nurse or I there we would record all necessary things that needed to be recorded on the front sheet. But I can't influence the other doctors in their practices the way how I would practice and in particular since this case I now introduce a double checking where my nurse will go first through the file and then I will do on my first visit after I've seen the patient, new patient who is new to the practice so its not a casual patient. It is someone who had transferred the file. So I go together with the patient through that file and double check that everything is recorded on the front page."

Dr A stated that all chronic illnesses, such as diabetes, asthma or emphysema, should be recorded in the "past history" section of the cover sheet for a patient's file. In her view, the cover sheet was designed to ensure that important information is available to any doctor treating the patient.

Mrs B's medical records (which were in her file) contain numerous references to asthma and the asthma medication that Mrs B was taking. The first page of her records includes the following record of asthma medications being prescribed to Mrs B:

> **"Long Term Medications**
>
> | | |
> |---|---|
> | 15 Sep 2004 | Beclomethasone Dipropionate (250mcg/1 dose Inhaler 200 doses) QTY: 1, 2 bd[8] |
> | 30 Apr 2003 | Ventolin (**100MCG INH) QTY: 2

1–2 inhalations sos 2–4 hourly as directed" |

[8] This entry refers to a prescription from city medical centre.

This information had not been transferred to the cover sheet of the file. The cover sheet from the city medical centre also did not contain this information.

ACC
Mr B made a medical misadventure claim to ACC in relation to Mrs B's death. ACC accepted the claim on the basis that Mrs B suffered a personal injury as a direct consequence of being prescribed propranolol. ACC found that this injury was caused by medical error in that Dr A failed to observe a standard of care and skill reasonably to be expected in the circumstances.

ACC's finding was supported by three independent advisors, general practitioner Dr Ian St George, general practitioner Dr David Henry, and Professor of Medicine/Clinical Pharmacology Dr Carl Burgess.

Dr St George concluded:

> "There is a direct causal link between [Mrs B] taking propranolol and the acute asthma. This is a well recognised effect of beta blocking drugs and can happen at low doses. That [Ms B] had appeared to have taken 40mg in error is probably unimportant.
>
> While there were extenuating and related circumstances (the busy nature of practice in [the town], the poorly completed cover page of her file), [Dr A] should have ascertained with certainty that [Ms B] had no past history of asthma.
>
> She should have referred to the computer files, and not relied on the clearly incomplete front cover.
>
> She should have asked the direct question, 'Have you ever, at any time, suffered from asthma or wheezing?' That is simply a mandatory question before prescribing a beta blocker: a general question about past illnesses is insufficient (many people do not think of their asthma as an illness, nor their inhalers as medications)."

Dr St George stated that not completing front cover sheets for files was "unsafe practice".

Dr Henry stated that it is always essential that a consulting doctor take a thorough past medical history when seeing a patient for the first time. He concurred with Dr St George that specific questioning about asthma was required in this case. He stated:

> "In this case, as [Dr A] had decided to prescribe propranolol, I would have expected her to enquire directly about a past history of asthma because propranolol is contraindicated for asthmatics for reasons already outlined. There is no record of her having done this and had she done so, I'm sure [Mrs B] would have confirmed she was an asthmatic on regular medication."

Dr Henry commented:

> "[Mrs B] had a long history of asthma for which she needed to take two regular inhalers to control the condition. Her previous general practice notes clearly record this fact."

Dr Henry concluded that it is "totally inappropriate to prescribe propranolol, or any beta-blocker, to an asthmatic".

Dr Burgess also concluded that there was likely to have been a medical error in Mrs B's case, in that Dr A did not obtain an adequate history. He noted that an adequate history was certainly not recorded in Dr A's notes of the consultation.

Independent advice to Commissioner

The following expert advice was obtained from Dr Jim Vause, general practitioner:

> "Thank you for the Commissioner's request to provide expert general practitioner advice about whether [Dr A] provided an appropriate standard of care to [Mrs B].
>
> I am a vocationally registered general practitioner, having graduated MBChB from Otago University in 1976. I have practised as a general practitioner since 1979 and gained Membership of the Royal New Zealand College of General Practitioners (RNZCGP) in 1989 which was converted to Fellowship in 1998. In 2001 I gained a Diploma of General Practice from Otago University. For my first five years I practised as a rural general practitioner and have spent my subsequent years in provincial practice firstly solo before slowly expanding into a 5 doctor practice. I have been extensively involved in matters of professional standards in general practice and am currently a practice assessor for the RNZCGP Cornerstone practice accreditation program.
>
> With respect to any conflict of interest, I do not know any of the persons mentioned in the documentation. I have met one of the general practitioners at [the medical centre], [Dr C's locum] whose previous practice in [a town] I took over in 1979. I have had no further contact with him since then.
>
> I have read and agree to follow the Health and Disability Commissioner Appendix H: Guidelines for Independent Advisors.
>
> I have perused the following supporting information supplied by you in relation to this enquiry:
>
> - Complaint letter dated 1 December 2004 (pages 1–3)
> - Coroner's report (pages 4–36)

- Statements to the Coroner from [Dr A], [Mr B] and [Dr D] (pages 37–51)
- [Dr A's] notes (page 52)
- Prescription form (page 53)
- [Mrs B's] medical records (including the cover sheet completed)
- [The medical centre] and the cover sheet from her previous general practitioner, [Dr E] (pages 54–79)
- ACC decision and reports from advisors (pages 80–96)
- Correspondence from [Mr B] dated 24 March 2005, 31 August 2005, 8 October 2005 (pages 97–118)
- Correspondence from [the medical centre] dated 5 September 2005 and notes of telephone calls between [Dr C] and [an HDC investigator] on 26 August 2005, 23 August 2005 (pages 119–124).

Background information as supplied

[Mrs B] saw [Dr C] at [the medical centre] once as a casual patient. Some months later on 22 September 2004 she requested that her notes be transferred from her general practitioner [at a city medical centre] to [Dr C]. [Mrs B's] notes were received at [the medical centre] in early October, allocated a practice number and filed.

On Friday 15 October 2004 [Mrs B] began to suffer from a migraine headache. Her condition did not improve over the weekend and early on Monday 18 October 2004 her husband, [Mr B] contacted [the medical centre] and arranged for an appointment to see [Dr C] at 1.40pm (the earliest appointment available).

At 9.40am [Mr B] called [the medical centre] again in an attempt to get an earlier appointment due to the level of discomfort [Mrs B] was experiencing from her migraine. An appointment was made available for 10.50am with another doctor at the medical centre, [Dr A]. A nurse at [the medical centre] took [Mrs B's] blood pressure while she was waiting for her appointment. [Mr B] accompanied [Mrs B] to the consultation along with their young daughter.

[Mr and Mrs B] discussed [Mrs B's] history of migraines with [Dr A]. According to [Dr A], [Mr B] outlined that Voltaren had been prescribed to [Mrs B] in the past. She recalled that he was very agitated and that [Mrs B] was clearly in discomfort. [Dr A] stated that she did not have [Mrs B's] full medical file at the consultation, only a cover sheet. This cover sheet included the date of [Mrs B's] last tetanus shot but did not include any details of her past history, allergies or sensitivities.

[Dr A] recommended to [Mrs B] that she take propranolol to prevent further migraines. She recalled that she discussed the side effects of propranolol and emphasised that it was unlikely [Mrs B] would feel any benefit from it for at least two weeks. [Dr A] prescribed a dose of 20mg to be taken three times a day and also prescribed Voltaren. [Dr A] stated that she enquired specifically about whether [Mrs B] had any allergies, current medications or chronic illnesses and

received a negative answer. [Dr A] did not specifically enquire whether [Mrs B] suffered from asthma.

[Mr B's] recollection of the consultation is that [Dr A] recommended propranolol and there was no discussion of the drug's side effects except that [Mrs B] should not breast feed while taking it, that it may cause drowsiness and that she should avoid alcohol. [Mr B] recalled that [Mrs B's] past history was not raised or discussed apart from her migraine history. He stated that [Dr A] did not appear to refer to [Mrs B's] medical file either in a folder or on the computer. He also recalled that [Dr A] noted that [Mrs B's] blood pressure was normal and did not examine her. He denied being agitated during the consultation.

[Mr B] stated that [Dr A] instructed [Mrs B] to take four propranolol pills (i.e. 40mg) as soon as possible, another two later in the afternoon and another two just before bed and then two pills three times daily. [Dr A] stated to the Coroner that she only prescribed 20mg doses (i.e. two pills) and cannot explain why [Mrs B] took double this dose.

After concluding the consultation with [Dr A], [Mr and Mrs B] went straight to the pharmacy next door to fill the prescription. [Mrs B] asked for a cup of water from the pharmacist and immediately took four pills at the counter. Less than an hour later, when [Mrs B] had arrived home her asthma started to flare up. She used her Oxis and Beclazone inhalers but her asthma worsened. At l2.35pm [Mrs B] asked her husband to phone [the medical centre] to check whether the medication she had been prescribed affected asthma. [Mr B] phoned the medical centre but [Dr A] was not available so he phoned the pharmacist. The pharmacist consulted another doctor at [the medical centre] and then passed on the advice that [Mrs B] should take any antihistamine pills they had and Ventolin immediately and to phone an ambulance if her asthma did not improve.

[Mrs B's] asthma continued to worsen despite using a nebuliser and [Mr B] phoned an ambulance at approximately l2.50pm. [Mrs B] collapsed as the ambulance arrived. The ambulance officers performed CPR on [Mrs B] and a helicopter airlift to [a public hospital] was arranged. On being admitted to hospital it was discovered that [Mrs B] had sustained serious brain damage as a result of the lack of oxygen and was unable to breathe without the aid of a ventilator.

[Mrs B passed away a short time later].

Coroner
[An Inquest] into the death of [Mrs B] was held. The Coroner found that [Mrs B] died [at a public hospital] as a result of pulmonary embolism.

ACC
[Mr B] made a claim to ACC in relation to [Mrs B's] death. ACC accepted the claim on the basis that [Mrs B] suffered a personal injury as a direct consequence of being prescribed propranolol and that this injury was caused by medical error.

In reply to your specific questions

1. **Was [Dr A's] care and treatment of [Mrs B] on 18 October 2004 adequate and appropriate?**

   There were two key points in [Dr A's] care and treatment where her decision making led to the adverse outcome of the consultation. They are the decision to only prescribe Voltaren for acute pain relief (a medication [Mrs B] had used with debatable benefit in the past) and the decision to use propranolol as prophylaxis. Factors operating behind the adverse outcome were the system failure in the medical records at [the medical centre] and some communication problems between [Dr A] and [Mr and Mrs B]. These issues are discussed below.

   Otherwise, judging the care provided by [Dr A] is difficult due to the poor clinical notes. I note many matters of the care provided by [Dr A] were discussed in the documentation, especially in [Mr B's] letters and the Coroner's Court proceedings. While the critical aspects of care are covered in the questions below, one issue of medical importance is [Dr A's] physical examination of [Mrs B]. I cannot find any recording of examination findings, other than [Mrs B's] blood pressure, which was taken by a practice nurse. There is no mention of [Dr A] performing such in any of the documentation.

   The deficit in [Dr A's] records could simply be due to her failure to record examination findings. However the lack of reference to examination in either her written statement or in her comments to the Coroner's Court, combined with there being no account of this in [Mr B's] letters, raises concern of the doctor's care for [Mrs B]. It may seem of little relevance in a patient presenting with a typical migrainous headache who has a significant past history of migraine, but a general practitioner, seeing such a person for the first time and without having access to previous clinical records, should complete some examination to exclude non-migrainous causes for headache.

2. **Was it appropriate to prescribe propranolol to [Mrs B]?**

   A beta-blocker is specifically contraindicated in asthmatics. The following is taken from the Medsafe datasheet on propranolol.

   > 'Propranolol should not be used if there is a history of bronchospasm, bronchial asthma or other obstructive lung disease or after prolonged fasting or in patients with metabolic acidosis.'[i]

   This contraindication to beta-blocker usage is standard knowledge in general practice.

An important consideration is that the beta blocker class of medications is subdivided into two categories, cardio selective beta blockers which preference their effects for beta receptors in heart muscle, and non selective such as propranolol which cover all beta receptors, including those in the lung.

> 'Beta blockers have also been contraindicated for patients with obstructive lung diseases, such as asthma and chronic obstructive pulmonary disease, due to the potential risk for bronchospasm. However, new evidence has shown that cardio selective beta blockers are safe in patients with obstructive lung diseases, and may actually be beneficial by enhancing sensitivity to endogenous or exogenous beta-adrenergic stimulation.'[ii]

A recent Cochrane review suggested similarly.[iii]

Propranolol, as a non selective beta blocker, is therefore unaffected by the 'new evidence' referred to in the statement above, thus establishing that [Dr A], in prescribing propranolol, did not understand that [Mrs B] was an asthmatic.

To establish any such contraindication, a doctor would have two courses of action, neither mutually exclusive:

- One would be to refer to previous medical records.
- The other would be to question [Mrs B] and her husband for contraindications to the use of propranolol.

On the first:

[Dr A] indicates she did not have [Mrs B's] previous general practitioner notes at hand during the consultation. She only had the 'front page' which appears on page 55 of the documentation, [the supporting information supplied to Dr Vause by the HDC investigator].

From [Dr A's] testimony at the Coroner's Court (page 14 of the documentation):

> 'I can't recall having any previous medical files because I understood later that [the family] were new to the medical centre and they recently transferred [into this area]. So usually when we have new patients arrive regardless what doctor, the nurses usually go through these files and record any chronic conditions because we are not computerised, fully computerised practice. So it is written, handwritten in the front page …'

[Mr B] in his letter of 1 December 2004 (page 1 of the documentation) states:

> '[Mrs B's] past medical history was not raised or discussed apart from her migraine history and she ([Dr A]) did not appear to refer to [Mrs B's] medical file either in a folder or on the computer.'

He also states, in his letter of 31 August 2005 (page 112 of the documentation):

> 'I was sure at the time of writing my statement for ACC, HDC and the Coroner that [Mrs B's] entire medical file was on [Dr A's] desk during our consultation but it was never opened or referred to by [Dr A].'

[Dr C] from [the medical centre], in his letter of 5th September to the Health and Disability Commissioner (page 120) writes of his practice nurse:

> '[The practice nurse] recalls drawing the notes and conveying them to [Dr A's] reception area. She had previously discussed the situation and her assessment with the nurse there (who on the day was a reliever).'

Thus it appears the previous general practitioner's notes containing references to [Mrs B's] asthma were either with [Dr A] or her nurse at the time of the consultation.

It has been established that [Dr A] referred to the 'front page' during the consultation. Whether or not she had the notes available on her desk at the time of the consultation, a key question is did she recognise that the 'front page' upon which she was relying lacked important information?

In her statement to the Coroner's Court (page 23) [Dr A] states:

> '[I]t is nothing unusual to see that front sheets look this way because the young people do not have any chronic illness yet … It didn't make me suspicious.'

Thus [Dr A] seems assured that the practice system for transferring key information to the 'front page' was sufficiently reliable to not need to read the previous general practitioner notes or, if they were not in the consultation room, to attempt to find these notes. The practice system for the medical records at [the medical centre] is discussed in question 5 below, including the doctors' acknowledgement of the system problems.

Having placed her reliance on the 'front page' [Dr A] therefore was dependent upon option two above to identify [Mrs B's] contraindication to propranolol prescribing, namely questioning [Mrs B] or her husband.

The clinical records of the day (page 52 of the documentation) are of little help in this matter.

Considering [the family's] possible failure to reply positively to any question on asthma or respiratory disease: [Mrs B's] asthma was of moderate to severe intensity as can be ascertained from her previous general practitioner records. She was using (or should have been using) preventer inhalers twice a day.

While there is no problem list on the opening pages of the previous general practitioner records, page 1 (page 57 of the documentation) has, at the bottom of the page, [Mrs B's] long term medication namely beclomethasone diproprionate and Ventolin inhalers, both medication only used in asthma or other similar restrictive lung diseases. The dose of beclomethasone is also high at 1000mcg per day indicating [Mrs B's] asthma was of moderate to high severity.

Similarly the next page of the transferred clinical records contain prescription records for Oxis, a medication that when used in conjunction with the 1000mcg/day of beclomethasone, is further indicative of moderate to severe asthma. Oxis is a long acting beta2 adrenergic agonist or LABA. The NZ Guidelines Group Evidence Based Guidelines on Asthma gives the severity of asthma when LABA usage is recommended.

> 'Long-acting ß2-agonists in moderate to severe asthma improve day and night symptom control, improve lung function and reduce exacerbation rate.'[iv]

Given this severity, it is unlikely she ([Mrs B]) would have failed to mention asthma when questioned by [Dr A] on possible lung problems or asthma. Similarly [Mr B] would have been well aware of his wife's asthma and would similarly reply to any questioning.

A possible qualifier to this might be if the consultation between [the family] and [Dr A] was significantly dysfunctional in terms of communication. This requires considering the 'process' of the consultation.

This was the first time [Dr A] had met [Mr and Mrs B] who were registered with another doctor in the medical centre which given the organisation of [the medical centre] may have been of some significance.

[Mr B] was answering the questions due to his wife's debility with the migraine and he was a clear driver of the consultation.

[Dr A's] statement [on] page 42 of the documentation describes [Mr B] as being 'clearly very agitated' and 'clear frustration that her (his wife's) migraines were not being resolved'.

She also describes: 'while he outlined his concerns, it was not possible for me to ask questions'.

This picture is also reiterated in [Dr A's] reply to questioning by [Mr B's counsel] during the Coronial Court (page 27):

> 'I do remember consultation starting with [Mr B] expressing the unhappiness with the way that [Mrs B] has been treated in the past, that she has been having migraine headaches and that they want both them to stop and they'd lost faith in the medical fraternity and that no one has done much about it and yeah. I remember that that was the beginning of the consultation.'

[Mr B's] account of the consultation in his 31 August 2005 letter (page 113 of the documentation) gives some indication of difficulties with the consultation:

> '[Dr A] interrupted me several times during my initial history account to ask questions about [Mrs B's] history.'

With this 'picture' of a somewhat stressed consultation, [Dr A] took appropriate steps as she described in paragraphs 12 and 13 of her statement on page 42:

> 'I decided the best course was to sit quietly, giving him my full attention, until he had expressed all of his concerns.
>
> I concentrated on what [Mr B] was telling me. It was my intention to try to calm the situation down and try to think how best to help.'

[Dr A's] communication skills seem appropriate judging from the Coroner's Court proceedings.

A difficult consultation can place significant demands on a general practitioner and impede the normal process of establishing an appropriate management plan for the patient's problem. Nevertheless, as [Mr B] points out in his 31 August letter:

> 'Patients displaying high emotions must be a common issue for general practitioners and is surely no excuse for poor practice at any time.'

In pointing out this process problem [Dr A] faced, I do not believe it excuses the necessity for her to have established [Mrs B's] asthma past history, but that this demonstrates the problem practitioners frequently face that can lead to mistakes of a genuine nature.

Ultimately, it appears [Dr A] did not ask the critical question of [Mrs B], namely did she have asthma or any significant lung problems. In her statement

beginning page 37 of the documentation, [Dr A] does not mention asking such questions (although there is a reference to allergies).

At the Coroner's Court (page 15 of the documentation), in reply to a question from [Mr B's counsel],

> *'Do you accept that you didn't or you don't recall making a specific enquiry about asthma?'*

[Dr A] replied:

> *'I did ask for the allergies and chronic conditions but I wish I did but I didn't make [it] and that's something that I will regret for the rest of my life.'*

Thus in conclusion it appears that [Dr A] did not adequately exclude the important contraindication to propranolol prescribing of asthma.

3. **Are [Dr A's] clinical records of an appropriate standard? If not why not?**

Appropriate standards for clinical records for general practitioners are covered by indicator D.7.1 of *Aiming for Excellence*, the tool used in the RNZCGP Cornerstone Practice Accreditation programme.[v] Other standards applicable are those of the Medical Council of New Zealand.[vi]

The only clinical record available in the documentation and written by [Dr A] is the entry dated 18-10-04 on page 52 of the documentation. It is inadequate, for reasons described by [Dr A] on page 23 of the documentation. The record does not describe [Mrs B's] symptoms with any adequacy, gives no summary of examination findings and does not provide a clear plan of action.

One entry in a patient's notes is not adequate to assess the quality of a doctor's clinical records, for to make such an assessment, a number of records should be assessed. In addition this should involve identification of other key elements of medical records that in [Mrs B's] case were not under the jurisdiction of [Dr A], such as recording of past medical history, medications, problem list as covered in indicator D.7.1 of *Aiming for Excellence*. For further discussion, please refer to my comments below in reply to question 5.

4. **What information should [Dr A] have provided to [Mrs B] about her treatment options?**

The first option would have been the immediate treatment of [Mrs B's] migraine. The need for this is established by the fact that [the family] did not wish to wait to a later appointment. [Dr A] indicates this in her statement (page 38 of the documentation) where she states:

> 'I agreed that some form of medication needed to be prescribed there and then.'

[Dr A] chose to prescribe Voltaren (generic name diclofenac) which she states on page 39:

> 'I confirmed that Voltaren provided temporary relief with no side effects … I also prescribed Voltaren which she could use if she got a headache.'

This is entirely appropriate except that I cannot find any indication if other options for immediate pain relief were considered. [Mr B], in his letter (page 1 of documentation), indicates an expectation his wife would receive an injection for pain relief based on his previous experience.

I believe [Dr A] should have considered or discussed other options for acute pain relief other than Voltaren tablets with [the family], especially as in the Coroner's Court, [Dr A] stated (page 16):

> '[Mrs B] had said that she was taking Voltaren and Voltaren wouldn't help her with her headache.'

There are a number of options for the acute treatment of migraine. The April 2004 edition of the New Zealand Family Physician which is sent to every vocationally registered general practitioner in NZ contained a review paper on management of migraine, both acute and chronic. This lists six options for medication in addition to analgesia such as paracetamol or narcotics.[vii]

[Mrs B's] breastfeeding of [her daughter] clearly influenced [Dr A's] choice of acute pain relief medications.

Acute administration
Options for acute treatment, in addition to NSAIDs such as Voltaren or other simple pain relief (e.g. paracetamol or codeine) are:

1. Sumatriptan, either by injection or orally. This and similar class drugs are the most effective available for acute migraines especially in the injectable form.[viii] However the datasheet for this medication from Medsafe NZ quotes:

   > 'It has been demonstrated that following subcutaneous administration sumatriptan is excreted into breast milk. Infant exposure can be minimised by avoiding breast feeding for 12 hours after treatment.'[ix]

   Ergotamine is commonly used along with caffeine in acute migraines in the combination tablet Cafergot. In an established migraine, it is not particularly effective and it should not be used when breastfeeding due to

the Ergotamine being passed through breast milk to a feeding infant and causing significant side effects.

2. Antiemetics: metoclopramide and prochlorperazine are commonly used in migraine especially for treating the nausea and vomiting which often significantly inhibits the absorption of pain relief medications taken orally. However they are present in breast milk and because of the high risk of dystonic reactions in infants they should not be used.

Thus the options for acute treatment of [Mrs B's] migraines were limited by the breast feeding. Nevertheless, options were available and needed to be discussed with [the family].

Clearly [Dr A] gave [Mrs B] advice on cessation of breastfeeding according to her husband's letter of 1 December 2004 (page 1 of the documentation) but it is uncertain if the option of withholding breastfeeding following administration of more effective pain relief such as sumatripthan was given. The documentation available does not help me reach a clear decision on this matter.

For example [Mr B] states in his letter of 1 December 2004 (page 1 of documentation):

> '[Dr A] … then decided to prescribe preventative medicine for migraines rather than just giving short term pain relief jab.'

Yet [Dr A] also prescribed Voltaren orally for acute pain relief. This dissonance appears to reflect some of the communication problems also evident from the manner in which [Mrs B] took propranolol after she filled [Dr A's] prescription from the pharmacy.

The option of an injection of Voltaren does not seem to have been considered. Injected pain relief is usually more effective in migraines than oral, for a variety of reasons such as better absorption, reduced stomach side effects and enhanced placebo response.[x]

Prophylaxis of migraines
There are a great many medications which have been shown to be effective in the prophylaxis of migraines.

Table two in the Murdoch NZFP article provides an excellent list of preventive therapies for migraine based on the US Consortium Guidelines. Propranolol is listed at the top of the medium/high efficacy column and would be an entirely appropriate choice but for the asthma problem. There are a number of other medications on this list which could have been used had [Mrs B] not been breast feeding. This limited the choice of prophylactic medication

to a significantly degree. The calcium channel blocker verapamil probably would have been the best option.

As best as I can judge from the documentation other options for prophylaxis medication do not appear to have been given to [Mrs B].

5. Were [the medical center's] record keeping and filing systems adequate and appropriate?

The contribution of the practice systems to [Mrs B's] untimely death was through the lack of transfer of important clinical information to the practice 'coversheet' upon which [Dr A] relied to some extent for [Mrs B's] previous medical history. Had the very important and very clear information from the medical records been presented to [Dr A], this tragedy would have been prevented. Thus an important backup for [Dr A] was lacking.

Although the practice had a computer system for practice management at the time of this event it had not implemented computerised clinical records. Thus it used a manual system for the structure, storage and processes of retrieval of medical records. Generally such manual systems are designed largely by the practice rather than being standardised as are computer based systems. The documentation as provided and discussed below indicates these systems at [the medical centre] had deficiencies that were contributory to [Dr A's] error. It is difficult to appraise the design and functionality of the note system in any great depth, but the outcomes of this case indicate a need for significant improvement.

Key elements to highlight in the note system are as follows:

[Mrs B's] medical records from her previous general practitioner were in [the medical centre] on the day of [Mrs B's] consultation, namely 18th October 2004, having been requested from her previous general practice on the 22 September and arriving on the 4 October 2004.
[Dr C] in his letter of 5th September to the Health and Disability Commissioner (page 120) indicates that he recorded the request for notes and their subsequent arrival in the practice. Assuming it is consistent across the whole practice (see below) this is an appropriate standard as per indicator D.8.4.4 of the RNZCGP *Aiming for Excellence* practice accreditation tool.

In the same letter, he writes of his practice nurse:

> '[The practice nurse] recalls drawing the notes and conveying them to [Dr A's] reception area. She had previously discussed the situation and her assessment with the nurse there (who on the day was a reliever).'

[Mr B], in his letter of 31 August 2005 (page 112 of the documentation) states:

> 'I was sure at the time of writing my statement for ACC, HDC and the Coroner that [Mrs B's] entire medical file was on [Dr A's] desk during our consultation but it was never opened or referred to by [Dr A].'

[Dr A] states that she only had the 'front page' during the consultation (page 55 of the documentation) which lacked any significant past medical history.

Thus, as discussed in question two, the notes appear to have been in [Dr A's] practice but either they were not in the consultation room at the time or she did not refer to them.
On the matter of the 'front page' at [the medical centre].

There was a process in place, according to [Dr A] (Coroner's Court proceedings, page 14 of the documentation) to transfer important previous medical information to the 'cover page' of [the medical centre] notes. [Dr C] with whom [Mrs B] was registered indicates in his letter of 5 September 2005 (page 119):

> 'As with all entries in such notes, allergies and significant medical conditions are considered to be as recorded until the opportunity presents to discuss/confirm/clarify these with the patient, usually at the first appointment.'

This suggests that the doctors were responsible for verification of the transferred information, something not iterated by [Dr A] in her accounts.

[Mr B], in his letter of 31 August 2005 (page 112) identifies what appears to be the likely factor behind this problem:

> 'Are there specific written procedures to be followed in order to ensure key medical history information is fully and accurately summarised on the cover sheet?'

Many of his comments in the same section of this letter pose some important questions which I can only partially answer from the documentation.

I have other concerns on [the medical centre] medical records as follows:

The only medical records present are [Dr A's] short entry on page 52 of the documentation. [Dr C] indicates in his letter of 5th September to the Health and Disability Commissioner (page 119) that [Mrs B] had been seen once previous by himself some months before the untimely events of October 2004. There is no record of this consultation in the presented notes.

There is another reference in the documentation (page 123) to a phone discussion between [Dr C] and the HDC [investigator] which states:

> '[Mrs B] was also seen by another doctor at the practice in March 2004 for a possible fracture of her left tibia.'

Again this consultation is not recorded in the presented notes. Some explanation of this deficit is necessary.

In the same phone call, [Dr C] is recorded as stating, on the manner in which the transfer and receipt of notes was managed at [the medical centre]:

> 'There were variations in this procedure in the practice.'

Page 123 of the documentation also states:

> 'However the receptionist was also sometimes involved in the filing as the nurse had "some despair" over the availability of file numbers.'

There are other hints at management and governance problems at [the medical centre] in the documentation, much of this possibly due to historic factors inherited when a number of independent general practitioners came together into the current medical centre.

Also consider [Dr A's] statement to the Coroner's Court (page 24):

> 'But I can't influence the other doctors in the practice the way how I would practice.'

While I make this tentative observation on the contribution of the practice's organisational problems to [Mrs B's] untimely death, further in depth analysis of the practice in a face to face context would need to be made. This is outside the scope of this assessment.

There may be lapses in the documentation sent to the Health and Disability Commissioner that account for the perceived problems with the medical records at [the medical centre]. However, unless evidence to the contrary is presented I believe the following matters need to be addressed by [the medical centre]:

1. Consistent practice policy on the transfer of information from previous notes for all of [the medical centre] should be produced and implemented, defining the responsible person and a timeframe from receipt of notes to entry of data. This may be at the first general practitioner consultation or by a practice nurse, doctor or administrator. However the system must be

of sufficient reliability for the general practitioners to be assured that critical data is not missing.

2. Audit is performed of the system performance three and six months after implementation, and annually thereafter.

3. The practice manager/administrator should be responsible for oversight of this process and provided with training on the process of audit.

4. Efforts should be made to record all patient medical information held in [the medical centre] in one file with progress notes recorded contiguously. Full implementation of computer based medical records would greatly facilitate this but the points 1–3 would still be essential.

Final Comment

One final comment is concerning the supervision of [Dr A]. She is listed on the Medical Council of NZ website as being under provisional vocational registration having obtained this in April 2002. Thus she would be required to be under the supervision of another doctor who would need to be a vocational registered general practitioner in the same practice as per the following Medical Council requirements:

> 'In most cases direct or active supervision will be required, where the supervisor works in the same place as the doctor, and is readily available.'[xi]
>
> Assuming that the information posted on the Medical Council website concerning [Dr A's] registration status is accurate, [Dr A's] supervisor should be able to report on the sentinel event process initiated by this tragic event and the improvement strategies put into place as a consequence of this and other quality improvement processes.

In Summary

[Dr A's] failure to directly question [Mrs B] as to any past history of respiratory disease or asthma, in conjunction with her failure to locate and read [Mrs B's] previous medical records, led to prescribing of a medication which resulted in [Mrs B's] untimely death. Contributory were the poor systems at [the medical centre] which failed to provide a safeguard against what appears to be a genuine mistake with tragic consequences.

References

i. Data Sheet APO-PROPRANOLOL Propranolol Hydrochloride 10mg and 40mg Tablets BP. Medsafe NZ. Available on line at http://www.medsafe.govt.nz/DatasheetPage.htm.

ii. Ormiston TM, Salpeter SR. Beta-blocker use in patients with congestive heart failure and concomitant obstructive airway disease: moving from myth to evidence-based practice. *Heart Fail Monit*. 2003;4(2):45–54.

iii. Salpeter S, Ormiston T, Salpeter E. Cardioselective beta-blockers for reversible airway disease. *Cochrane Database Syst Rev*. 2002;(4):CD002992.

iv. THE DIAGNOSIS AND TREATMENT OF ADULT ASTHMA. New Zealand Guidelines Group SEPTEMBER 2002. Available online at http://www.nzgg.org.nz/guidelines/0003/Full_text_Guideline.pdf#page=48

v. Aiming for Excellence. Royal New Zealand College of General Practitioners. Available online at http://www.rnzcgp.org.nz/quality/cornerstone/docs/aiming_for_excellence.pdf

vi. The maintenance and retention of patient records. Medical Council of New Zealand. Available online at http://www.mcnz.org.nz/portals/1/Guidance/Patient%20Record%20guidelines.pdf

vii. Lynette Murdoch. Migraine: Some answers to some challenging questions. *NZ Family Physician* Volume 31 Number 2, April 2004. Available online at http://www.rnzcgp.org.nz/news/nzfp/April2004/Murdoch_Apr04.pdf

viii. Migraine Special Issue: Bandolier Extra January 2002. Available on line at http://www.jr2.ox.ac.uk/bandolier/Extraforbando/migspec.pdf

ix. Medsafe. Information for health professionals. Available on line at http://www.medsafe.govt.nz/DatasheetPage.htm

x. A. J. M. de Craen, J. G. P. Tijssen, J. de Gans, J. Kleijnen. Placebo effect in the acute treatment of migraine: subcutaneous placebos are better than oral placebos, *Journal of Neurology* Volume 247, Number 3 March 2000 Pages: 183–188

xi. Guidance for doctors working in supervised practice and their supervisors. Medical Council of New Zealand. Available on line at http://www.mcnz.org.nz/portals/1/supervision.pdf

… ”

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's name.

Additional advice
Additional advice and clarification of his earlier advice was obtained from Dr Vause on 23 January 2006. He stated:

> "[Dr A] did not provide care of an appropriate standard and this was a significant departure from an accepted standard of care. The problem is to define the 'degree' of departure: [Dr A] seems to have made a genuine error in her management of [Mrs B] and there does not appear to have been any deliberate effort to mislead the Bs or the investigation. The prescribing of propranolol to a known moderate to severe asthmatic is not a minor error. Based on this logic I rate the departure as moderate but point out that I do not have a good framework of judging the degree of departure.
>
> On the matter of the cover sheet. You have identified an important point which highlights some of the inadequacies of [the medical centre] record system, as exemplified by the known previous consultations at the centre not appearing in any of the documentation.
>
> In most GP medical records, there is a page of progress notes arranged in a sequential order of time in the patient's records. Thus on a patient's first visit to a clinic, it should be evident from the empty progress notes. [Dr A] indicated that she had a 'clean sheet' of progress notes accompanying the cover page.
>
> The issue of who should be responsible for checking the patient's previous records needs to be identified by each practice. I have not explored the arguments as to whether this should be a doctor or a nurse, but in any circumstances the ultimate responsibility must fall back onto the clinician providing the patient care at the time. In the event of there being no previous doctor records available, the clinician needs to establish their whereabouts. Ideally the practice should also flag in the progress notes when the previous doctor records arrive."

Responses to provisional opinion

Dr A
Dr A's lawyer provided a response to the provisional opinion on behalf of Dr A. Dr A's lawyer noted that Dr A's evidence to the Coroner had been tested by cross-examination and submitted that it should therefore be given greater weight than untested evidence.

Dr A's lawyer submitted that given Dr A's experience of asthmatic patients volunteering information about their condition, her assumption that Mrs B did not have asthma had some validity. Dr A's lawyer expressed the view that this case highlighted the benefits of patient records being fully integrated and computerised — something that Dr A wanted to occur.

Mr B

Mr B reiterated that the consultation with Dr A was not dysfunctional or highly emotive and he disputed the accuracy of Dr A's suggestions to the contrary. Rather, at the end of the consultation Mr B said that he and Mrs B felt happy and asked whether they should see Dr A again. Mr B expressed concern that Dr A had misinterpreted the purpose of the consultation, that is immediate treatment of an acute problem rather than a chronic one.

Mr B stated that he was surprised and shocked at the deficiencies in the medical centre record-keeping system. However, he said that he was "more concerned that it appears that nothing has been changed at the medical centre to improve the level of recording by GPs, to improve the filing system, and to ensure that other GPs are protected from making mistakes because of inadequate record keeping".

In Mr B's view, it was unfortunate and ultimately misleading to Dr A that somebody had started entering data onto the cover sheet of Mrs B's file by noting a tetanus vaccination in 1997, but then failed to review the file and complete the health history summary on the cover sheet before it was filed, and without any indication that this review had not been carried out. Mr B expressed the view that there should be an agreed file and cover sheet creation system across the medical centre.

Mr B commented that from the information in the provisional opinion it seemed even less likely that a cover sheet would be detached from the file it belonged to. Also, in his opinion, given that Mrs B's whole file was taken to Dr A's reception and the nurse recorded her blood pressure, it was unlikely that the nurse would then have separated the cover sheet from the file. If the cover sheet had been separated, the file would not have been far away, and it would have taken no great effort for Dr A to get it. Mr B stated that when it is the first consultation at the practice he does not think it is acceptable practice for health practitioners to rely on the cover sheet and general queries, instead of a thorough review of the file and/or detailed questioning. In Mr B's view, it would be poor practice to routinely separate cover sheets and notes from full medical files, and he doubts that any practice operates in this manner.

Mr B noted that the cover sheet from the city medical centre may have contributed to the incomplete and inaccurate creation of the cover sheet at the medical centre but that the responsible staff should still have checked the information in the file.

Mr B stated: "Regardless of all these deficiencies in the filing system at [the medical centre], I do not accept that any of these can be used to justify or excuse [Dr A's] fundamental failures in her practice during our consultation on 18 October 2004."

Dr C

Dr C's lawyer responded to the provisional opinion on behalf of Dr C.

Dr C's lawyer commented that "what is apparent from [Mrs B's] notes is that there is little information on the cover sheet and the next page" and that it is the third page (from the city medical centre) that sets out Mrs B's details and her long-term

medications. He states that "it is [Dr C's] view, and the view of a number of his colleagues who have looked at [Mrs B's] notes as presented, that it is very evident that asthma was a likely diagnosis to be considered in this patient".

Dr C's lawyer noted that the provisional opinion and the expert advice proceed on the basis that Dr A and Dr C are part of a group practice known as the medical centre, and that this entity has some form of control over the doctors and their practice. However, Dr C's lawyer stated that there is no group practice. Rather, the medical centre is a company that owns ECG equipment, contracts a part-time gardener and collects rental. The property company owns the building and leases it to the medical centre company. The medical centre company charges rent to a second medical practice and a private company. The private company then invoices Dr A, Dr C, Dr D, and a fourth general practitioner. Each of these four doctors practise "individually and entirely separately from the others". There is no profit share between the four doctors, although some of them are shareholders in the property company and receive dividends. Doctors have practised from the building in which the medical centre is located for some years, which is why it was known locally as "[the medical centre]".

Dr C's lawyer argued that essentially there was no entity that could be held vicariously liable for Dr A's breach of the Code. He stated that the medical centre company is not a health care provider and had no relationship or contract with Dr A. There is no medical centre or group practice of which Dr A is or could be a member. Rather, Dr A is an independent practitioner "in business entirely on her own account". Dr C's lawyer stated that neither the medical centre company nor any of the four individual doctors could direct or order one of the doctors to practise in a particular way. Therefore, it was not possible to find the medical centre company or the other doctors in the building vicariously liable for Dr A's conduct.

Dr C's lawyer stated that the doctors operate in an entirely independent manner and "are therefore no more reliant on each other's systems relating to patient files and patient information than they are on the systems of doctors practising elsewhere in the area and throughout New Zealand". Safe medical practice is the responsibility of each individual doctor practising separately from the same building. The fact that they practise from the same building does not make them responsible for each other's practice. Dr C's lawyer stated that there is no entity with the power or authority to implement systems to facilitate safe medical practice. The medical centre "has no responsibility for safe medical practice".

Visit to medical centre

Dr C also provided an oral response to the provisional opinion during the visit of 12 July 2006. Dr D and one of the other general practitioners who works there was also present at this meeting. Dr C expressed the view that the events in question had nothing to do with the medical centre company, the medical centre, or the other doctors who work there. This view was shared by Dr D and his colleague.

Dr C stated that the medical centre does not advertise or hold itself out as a medical centre. In Dr C's view the information on the cover sheet should not be relied upon. While he does not have a specific flag on the files of new patients to indicate that they have not yet had their first consultation, this should be obvious from the fact that the notes page is blank. Dr C stated that it was clear from the file that Mrs B suffered from asthma.

Dr C provided copies of the prescriptions provided to Mrs B when she was a casual patient. He also provided a copy of the record of his consultation with Mrs B on 20 April 2004.

Dr C stated that when seeing patients from other practices in the town he often tells them to get their file from their doctor and bring it to the appointment. For doctors at the medical centre, seeing each other's patients is no different from seeing the patients of other doctors in the area.

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.

RIGHT 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —

…

(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option;…

Professional standards

The following professional standard from the Royal New Zealand College of General Practitioners "Aiming for Excellence" (2002) is applicable in this case:

> "Indicator D.7.1
> Records are sufficient to meet legal requirements to describe and support the management of health care provided.
>
> Criteria …
>
> Recent consultations recorded
>
> - Reason for encounter
> - Examination findings
> - Investigations ordered — office and laboratory
> - Assessment/investigations
> - Diagnosis
> - Management plan including medication change, additions, follow up arrangements …
>
> Medical records show
>
> - Clinically important drug reactions & other allergies are easily identified
> - Awareness alert for specific disability etc.
> - Problem lists are easily identifiable
> - Preventative care
> - Current medication list …"

Opinion: Breach — Dr A

Introduction
Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) Mrs B had the right to have medical services provided with reasonable care and skill. The central issue that has been the subject of the investigation is whether Dr A met this standard when she prescribed propranolol to Mrs B. From the information gathered it is clear that Dr A should not have prescribed propranolol to Mrs B. The fact that Mrs B suffered from asthma meant that propranolol was clearly

contraindicated. There are circumstantial and systemic factors that go some way to explaining how Dr A made what can only be described as a tragic mistake. Taking these factors into account, I have formed the opinion that Dr A failed to exercise reasonable care and skill when she provided services to Mrs B, and therefore breached Right 4(1) of the Code. The reasons for my opinion are set out in more detail below.

Key findings

Mrs B saw Dr A on Monday 18 October 2004 for treatment for a debilitating migraine headache, from which she had been suffering from since the previous Friday.

Mrs B's medical records from her previous general practitioner had been transferred to Dr C and arrived at the medical centre in early October 2004. The medical centre's file containing Mrs B's previous medical records was available to Dr A. The file had been passed to the relieving nurse and I consider it probable that, consistent with usual practice, the nurse would have given the file, together with the cover sheet, to Dr A before she entered the consulting room where Mr and Mrs B were waiting.

Dr A denies that she had Mrs B's file containing the records in front of her during the consultation. In any event, it is clear that Dr A did not refer to anything other than the cover sheet of Mrs B's file. Had Dr A referred to the medical records there is little doubt that she would have identified that Mrs B suffered from moderate to severe asthma. Regrettably, the cover sheet of Mrs B's file did not alert Dr A to this important information. In fact, no information at all was recorded as to Mrs B's past history, something that did not stand out as unusual to Dr A given Mrs B's age.

At the consultation, Dr A obtained a history of Mrs B's migraines — partly from Mr B's account and partly by asking questions of Mrs B. Dr A decided to prescribe propranolol, a medication that had proven successful in the prevention of migraines. She prescribed a dose of 20mg to be taken three times a day. She also prescribed Voltaren for Mrs B to use if she had a headache.

Propranolol is contraindicated for people with asthma and it is well recognised that beta-blocking drugs (including propranolol) can precipitate an asthma attack in patients who have a history of asthma. Dr Henry, in his advice to ACC, noted that it was "totally inappropriate to prescribe propranolol, or any beta-blocker, to an asthmatic". Dr A knew this and was clearly unaware, when prescribing propanolol to Mrs B, that she suffered from asthma. My expert advisor, Dr Vause, commented that as Dr A had not established this contraindication from Mrs B's records she was dependent upon obtaining this information from Mr and Mrs B.

Dr A stated that she enquired whether Mrs B had any allergies, current medications or chronic illnesses and received a negative answer. Mr B disputes this and maintains that Mrs B's past history was not raised or discussed, apart from her migraine history. Unfortunately, Dr A's very brief note of the consultation does not assist in determining what was discussed regarding Mrs B's medical history. What is clear,

however, is that Dr A did not specifically ask Mrs B whether she had a past history of asthma or any other respiratory disease. I concur with Dr Vause that — given the moderate to severe intensity of Mrs B's asthma — had Dr A enquired about asthma, Mrs B or Mr B would have confirmed that she was an asthmatic.

Dr A's failure to question Mrs B about any past history of asthma, together with her failure to locate and read Mrs B's previous medical records, led her to prescribe a medication that was contraindicated for someone with a history of asthma. Dr A needed to be quite sure that Mrs B had no past history of asthma before prescribing her a beta-blocker. This required Dr A to ask what Dr Vause describes as "the critical question", namely did she have asthma or any other significant lung problem.

This view is supported by the independent advisors to ACC. Dr St George stated that Dr A should have asked the direct question, "Have you ever, at any time, suffered from asthma or wheezing?" and commented that this was "simply a mandatory question before prescribing a beta-blocker". A general question about past illness was not sufficient, as many patients do not think of their asthma as an illness, nor of their inhalers as medications.

Dr A has stated that asthmatic patients usually volunteer information about their asthma. While this may well be the case, I do not consider that it is safe or reasonable practice to rely upon their doing so. It is the responsibility of the doctor to ask the questions necessary to establish whether there are any contraindications to the medication they propose to prescribe.

Dr A placed some reliance on the incomplete front cover sheet for Mrs B's file. She indicated that this led her to believe that Mrs B did not have any chronic illnesses because there was no information on the "past history" section of the form. In doing so, she made the assumption that someone had, by the time she saw Mrs B, been through the clinical notes and recorded any important information on the cover sheet. It had been her practice that she or her nurse would do this with the files of new patients.

Dr A was aware that Mrs B was registered as Dr C's patient. Yet she did not confirm that Dr C or his nurse had completed the cover sheet prior to her consultation with Mrs B. She stated in her evidence to the Coroner's Court that she could not influence the other doctors in the medical centre as to the way they should practise. In these circumstances, she could not have been confident that the cover sheet contained an accurate record of Mrs B's past history. Given that she had not read Mrs B's file, nor seen her before, it was not safe for her to assume that the cover sheet was complete and reliable.

As Dr St George noted in his advice to ACC, notwithstanding the poorly completed cover sheet, Dr A should have "ascertained with certainty" that Mrs B had no past history of asthma. She failed to meet this standard.

It appears that there may also have been information indicating that Mrs B was asthmatic available on the computer when Dr A completed the prescription. She cannot confirm what was on the screen when she wrote the prescription, but notes that she was not the last person to modify the record. Even so, I consider it likely that the information regarding past medications was available on the computer. Had Dr A looked at the medications history she would have seen that Mrs B had been prescribed asthma medication by another doctor at the medical centre.

Dr A stated that Mr B was very agitated during the consultation and that she was not able to ask questions until he had finished outlining his concerns about Mrs B's condition. This is disputed by Mr B. Irrespective of the conflicting accounts, I note that Dr A was able to question Mrs B about various aspects of her migraine history and to explain the use of propranolol (although she may not have referred to the name of the medication) in the prevention of migraines. I share Dr Vause's view that any difficulties Dr A encountered during the consultation do not excuse her failure to exclude a past history of asthma before prescribing propranolol.

There is some confusion regarding how many propranolol tablets Mrs B was told to take. Mr B recalls that Dr A told Mrs B to take four tablets initially to deal with the pain she was experiencing. However, Dr A prescribed 20mg (two tablets) and denies that she told Mrs B to take four propranolol tablets. The fact that Mrs B took 40mg of propranolol in error appears to be of no particular significance. Dr St George, in his advice to ACC, noted that beta-blockers can cause an asthma attack at low doses, and that the amount Mrs B took was probably unimportant.

My advisor also expressed concern that Dr A did not physically examine Mrs B during the consultation. This is supported by Mr B's account, and is not disputed by Dr A. I also note that Dr A's notes of the consultation do not contain any record of physical examination findings (other than the blood pressure record entered by the nurse). As noted by my advisor, a general practitioner seeing a patient for the first time and not having read previous clinical records should complete some examination to exclude non-migrainous causes of headache.

Summary

In summary, Dr A failed in a number of respects to provide an appropriate standard of care to Mrs B at the consultation on 18 October 2004. Her failings were significant and had tragic consequences. They are only partly explained, and cannot be excused, by circumstantial and systemic factors. Accordingly, in my opinion, Dr A did not provide services to Mrs B with reasonable care and skill and breached Right 4(1) of the Code.

Record-keeping

As acknowledged by Dr A, her record of the consultation with Mrs B is very brief and does not include the results of any discussion regarding Mrs B's medical history. As noted by Dr Vause, Dr A's record of the consultation does not describe Mrs B's symptoms adequately, gives no summary of examination findings, and does not

provide a clear plan of action. Several applicable standards for clinical records in general practice were identified by Dr Vause, in light of which he described Dr A's record of the consultation as "inadequate". These standards are relevant and enforceable under Right 4(2) of the Code.

Appropriate standards for clinical records in general practice are set out by the Royal New Zealand College of General Practitioners in "Aiming for Excellence". These standards require that key aspects of consultations are recorded, including examination findings and management plans. The need for sufficiently detailed records is heightened when a patient is seeing a doctor who is not the patient's usual general practitioner. In this situation, appropriate documentation of a "casual" consultation is necessary to ensure continuity of care by enabling the patient's usual general practitioner to ascertain what took place.

In my opinion, by her inadequate records of the 18 October 2004 consultation, Dr A breached Right 4(2) of the Code.

Other comment

Adequacy of information
The adequacy of the information provided by Dr A to Mrs B was one issue in my investigation, and the subject of some discussion at the Coroner's Inquest. Right 6(1)(b) of the Code affirms a patient's right to information about treatment options and associated risks and benefits. Dr Vause identified a number of other treatment options that Dr A should have considered or discussed with Mrs B. It appears that propranolol and Voltaren (which are appropriate medications for treating migraine in a patient who does not suffer from asthma) were the only options that Dr A discussed with Mrs B, which in my view is less than optimal. However, I accept that it may be reasonable for a GP to recommend a preferred treatment option (having established that there are no contraindications) without canvassing all other possible medications, in circumstances where time is limited and the patient is experiencing discomfort.

I note that Dr A also does not appear to have provided Mrs B with adequate information about the side effects and risks of propranolol. However, this issue is subsumed by the fact that Dr A should not have prescribed propranolol to Mrs B in the first place.

Opinion: No breach — The Medical Centre Company

Under sections 72(2) to 72(4) of the Health and Disability Commissioner Act 1994 (the Act) health care providers may be vicariously liable for the acts and omissions of employees, agents or members. Section 72(5) provides a defence to such liability if the health care provider can prove that it took such steps as were reasonably practicable to prevent the acts or omissions in question.

My initial view was that the medical centre was vicariously liable for Dr A's breach of the Code. The basis for this view was that Dr A was a member of the medical centre. Given the lack of uniform systems for recording key patient information, I was concerned that the medical centre had not taken such steps as were reasonably practicable to prevent Dr A's breach of the Code, and therefore had no defence to vicarious liability for her actions.

The response (made by Dr C) was essentially that there was no legal entity that could be held vicariously liable for Dr A's actions. Each of the companies related to the medical centre (of which there are over half a dozen) have distinct functions, and none of them can be classified as a health care provider. Furthermore, the doctors at the medical centre are completely independent and have no responsibility for each other's acts or omissions. The medical centre "has no responsibility for safe medical practice".

In this instance I accept that, legally, the entity notified of the investigation, namely the medical centre company, cannot be held vicariously liable for Dr A's breach of the Code. Having arrived at this conclusion I remain uneasy at the assertion that the independence of the doctors at the medical centre means that safe medical practice is an entirely individual matter. Taking such an approach seems to overlook patient expectations and the possible benefits of having agreed policies and procedures.

It has been submitted that the position of doctors at the medical centre when seeing each other's patients is no different than when seeing the patient of any doctor outside the practice. While other providers may have occasion to rely on a doctor's notes, in this instance the proximity of the doctors and their practice of seeing each other's patients where necessary, makes it more likely that their records will be referred to and used by other doctors at the medical centre. Patients would reasonably expect the doctors to have access to each other's records and may therefore be less mindful of the need to give their medical background than if consulting a doctor outside the medical centre. Patients are unlikely to have much appreciation or interest in the legal structure of their doctor's practice. They are likely to expect some level of co-ordination and co-operation between doctors operating in such close physical proximity. Mr B's response exemplifies such an expectation.

The way in which doctors collect, store, transfer and use a patient's information has the potential to impact on the ability of other providers to care to that patient. In this case, important information about Mrs B's medical history could have been made more readily available to other doctors seeing her. Dr C's usual approach to the transfer of a new patient's records was not followed, and important information about Mrs B was not recorded on the cover sheet of the file. While Dr C would probably have recognised the need to review this information with Mrs B at her first appointment, this requirement was not obvious to Dr A. As Dr Vause noted, "an important backup for [Dr A] was lacking".

The reversal of my provisional vicarious liability finding should not obscure the fact that these events clearly afford an opportunity for learning and improvement. I intend to send a copy of my opinion to each of the doctors at the medical centre, recommending that they individually or collectively consider Dr Vause's recommendations and review the patient information management requirements set out in "Aiming for Excellence".

Actions taken

Dr A

Dr A has provided a written apology to Mr B and advised that she has reviewed her practice and made the following changes:

- Each time she sees a new patient, his or her medications and history are checked directly with the patient in addition to reviewing available notes.
- When seeing people who are not her patients, she double-checks with the patient the information set out on the cover sheet of his or her file.
- She does not see patients with chronic conditions when doing the acute list.
- When seeing a patient with a chronic condition for the first time, she insists on either a double appointment or having access to the patient's past notes in advance of the consultation.
- She specifically asks about asthma, outlines the symptoms of asthma, requests a list of current medications, and double-checks these with the patient.

Dr A advised that she has computerised her notes and is also trialling a new system of asking patients to complete an agenda identifying the key objectives of the consultation.

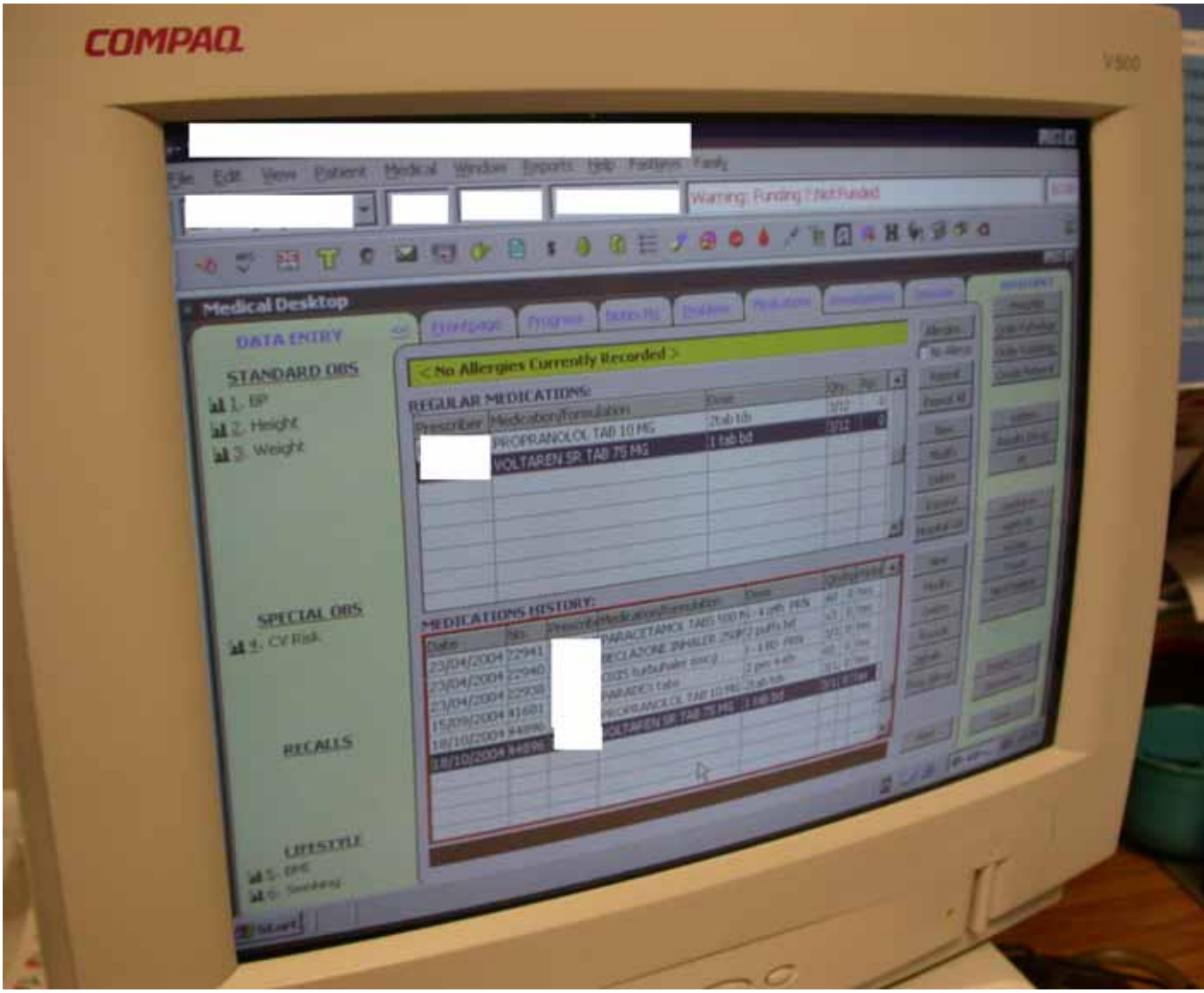
Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand, with a recommendation that the Council consider whether a review of Dr A's competence is necessary, and to the Royal New Zealand College of General Practitioners.

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

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

APPENDIX



Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's name.