General Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 00HDC01185)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Complainant / Daughter of the consumer
Mr B	Consumer (deceased)
Dr C	Provider / General Practitioner
Dr D	Consumer's General Practitioner
Mr E	Witness / Consumer's landlord
Mr F	Pharmacist

Complaint

The Commissioner received a complaint from the complainant, Mrs A, regarding the care her late father, Mr B (also known by an alias) received from the provider, Dr C. The complaint has been summarised as follows:

- *On about 13 June 1999 Dr C prescribed a medication for Mr B which made him unwell. Dr C did not explain to Mr B what the medication was and why it made him unwell.*
- *On 15 June 1999 Voltaren Emulgel was prescribed to Mr B by Dr C in error. Instructions for the taking of the medication on the script are inconsistent with the medication prescribed.*
- *Dr C had a disinterested attitude towards Mr B. When Mr B collapsed at home on 23 June 1999, Dr C came to see him only after the caller insisted that he do.*
- *Dr C did not consider a heart condition as a possible explanation for the symptoms with which Mr B presented. He did not examine Mr B and did not conduct any tests to exclude the possibility of a heart condition. Mr B died of a massive heart attack on 23 June 1999.*

Mrs A complained about two further matters, listed below, which were referred to the Office of the Privacy Commissioner as they involved requests by Mrs A to Dr C for access to information about her father. The requests were made under section 22F of the Health Act 1956. Complaints about such requests are considered by the Privacy Commissioner.

- *On 9 June 2000 Dr C would not give Mrs A answers to the questions she was seeking with regards to the treatment her father had received. Dr C refused to give Mrs A her father's records.*
- *When on 9 June 2000 Mrs A asked Dr C why her father would have said that he [Dr C] appeared disinterested in him, Dr C said that he could not answer that and that she should ask her father that. As her father was dead, Mrs A found this comment inappropriate and insensitive.*

The complaint was received on 8 September 2000 following an unsuccessful attempt to resolve the matter through advocacy, and an investigation was commenced on 28 September 2000.

Information reviewed

- Mr B's records from Mrs A, Dr C and the pharmacy
- Independent expert advice from a general practitioner, Dr Keith Carey-Smith

Information gathered during investigation

Background
Mr B, aged 81 years, had a history of renal failure and hypertension. He was also hard of hearing. During an admission to a public hospital in April 1996 for a buttock abscess, it was noted that Mr B had a longstanding inguinal hernia for which he declined surgical intervention. He also declined further investigation of his renal function and genitourinary tract. An ECG taken at that time suggested that Mr B had probably suffered an acute myocardial infarction (heart attack). Although hypertension (high blood pressure) was not mentioned, he was discharged on atenolol, a medication used for the lowering of blood pressure.

On 19 March 1998 Dr D, Mr B's general practitioner at that time, recorded that Mr B had some chest pain with exertion (walking uphill). He recorded that Mr B's blood pressure was 220/80 (very high) and that he was on atenolol. On 17 June 1998, on his last documented consultation with Mr B, Dr D recorded a blood pressure of 190/90 and that Mr B "did not feel good on Atenolol".

After moving to a town, Mr B changed his general practitioner. On 16 July 1998 he consulted with Dr C for the first time. Dr C recorded that Mr B reported recent weight loss. He weighed 63kg. His blood pressure was 170/110. Dr C wrote:

> "Counselled about diet, self control and healthy living. Cut down refined and fatty foods. Advice on diet, advice on weight control and health in general given. Advice on exercise and on stress avoidance given. Patient / caregiver happy about instructions given above and return if any problems [with] medication or the deterioration of the medical control."

Dr C prescribed Mr B Norvasc (one 5mg tablet to be taken daily for blood pressure) and Stemetil (5mg tablet to be taken three times a day as required for nausea / giddiness). No explanation for the nausea / giddiness was recorded by Dr C. Dr C also prescribed Daktarin Tincture 2% for twice daily topical application to a nail area and Tears Plus, one drop four times a day and as required. No explanation for the purpose of prescribing these medications was recorded, although I note that Dr D had previously recorded that Mr B had dry eyes, and had prescribed Tears Plus.

Blood tests were taken and the medications were dispensed that day.

The result of the blood tests taken on 16 July 1998 showed elevated serum cholesterol levels. Mr B's serum potassium level was marginally low.

During the remainder of 1998 Mr B saw Dr C on two further occasions. On 9 September Mr B presented with tiredness which Dr C thought could be related to renal failure. Mr B's blood pressure was recorded as 170/88 and blood was sent for testing of potassium and urea levels. Dr C documented that Mr B declined a 24-hour creatinine clearance (kidney function) test. On 27 November Mr B presented with endogenous depression, sinusitis and a skin infection. Dr C prescribed Prothiaden tablets for the depression, Beconase nasal spray for the sinusitis and Fucicort cream for the skin infection. At this time Dr C also changed Mr B's antihypertensive medication from Norvasc to Inhibace. Mr B's blood pressure was not recorded and the reason for the drug substitution not stated.

During 1999, in the months preceding his death on 23 June, Mr B saw Dr C nine times. The consultations were for a variety of medical conditions.

On 6 January 1999 Mr B consulted Dr C. In his notes Dr C recorded:

> "Patient came in with problem of: – (1) Endogenous depression – requiring medical intervention – counselled and educated on above problems and their predicaments with emphasis on physiological and emotional wellness. (2) Fungal infection hand nail – counselled and educated on above problems and their predicaments with emphasis on physiological and emotional wellness – patient / caregiver happy about instructions given above and return if any problems with medication or the deterioration of the medical condition."

Dr C prescribed a 14-day supply of doxepin (antidepressant) 10mg capsules to be taken one twice daily and two capsules at night, and a 20-day supply of Adalat OROS (antihypertensive) 30mg tablets to be taken once daily. The doxepin was dispensed on 8 January 1999 but no record of Adalat OROS being dispensed was found until 2 February 1999.

On 2 February 1999 Mr B saw Dr C who recorded:

> "Patient came in with problem of: – (1) Endogenous depression – requiring medical intervention – counselled and educated on above problems and their predicaments with emphasis on physiological and emotional wellness. (2) Benign hypertension – on medical treatment – no problem with medication. Patient / caregiver happy about instructions given above and return if any problems with medication or the deterioration of the medical condition."

Dr C prescribed a further 90-day supply of Adalat OROS tablets. A 30-day supply of Adalat OROS was dispensed that day.

On 22 February 1999 a further consultation took place between Dr C and Mr B. Dr C recorded that Mr B presented with an infected left eye of several days' duration. Examination of the eye was unremarkable. Dr C thought it was acute conjunctivitis of unknown cause. Mr B also presented with what Dr C thought was a fungal infection of his

scalp. Dr C recorded: "Advice given with reference to above medical problems – counselled and educated …" He prescribed Fucithalmic eye drops for the eye infection and Canesten cream for the fungal rash. Mr B's blood pressure was 180/98. A nurse gave him a flu vaccine.

On 25 February 1999 Mr B was dispensed another month's supply of Adalat OROS. The Fucithalmic eye drops and Canesten (Clocreme) were dispensed on 6 March 1999. A further month's supply of Adalat OROS was dispensed on 10 April 1999.

On 23 April 1999 Mr B saw Dr C with sinusitis, chronic constipation and eye problems. Dr C recorded:

> "Counselled and educated … I certify that: the recommended treatment is based on the examination undertaken and in my clinical judgement and any diagnostic tests performed; clauses 5, 6 and 7 of the Code of Health and Disability Rights have been adhered to in all aspects of my relationship with the client, and in the preparation of my assessment; patient / caregiver happy about instructions given …"

Dr C prescribed Beconase nasal spray for Mr B's rhinitis and hayfever, Fucithalmic eye drops for his eye infection and Dulcolax for constipation.

The following day, 24 April 1999, Mr B again consulted Dr C. Dr C did not record what Mr B presented with but wrote:

> "Counselled on problems and predicaments related to changes on funding on calcium channel blockers – patient happy about changes to fully funded calcium channel blockers and about written instructions given – HFA booklet. BP 180/98. …"

Dr C prescribed a 90-day supply of Inhibace Plus (an antihypertensive with a diuretic), 5mg/12.5mg tablets to be taken once daily. A month's supply of Inhibace Plus tablets as well as Beconase (beclomethasone) nasal spray, Fucithalmic eye drops and Dulcolax tablets were dispensed on 1 May 1999.

On 24 May 1999 Mr B saw Dr C, who recorded:

> "Patient came in with problem of: – (1) Endogenous depression – requiring medical intervention. (2) Benign hypertension – on medical treatment BP – 160/75 – problems with medication – importance of medication compliance re-emphasised. (3) Benign prostate enlargement – counselled on problems and predicaments …"

Dr C prescribed more Inhibace Plus as well as a three-month supply of Aropax (an antidepressant), 20mg tablets to be taken daily, and a three-month supply of Hytrin (a medication used for the treatment of benign prostatic hyperplasia and hypertension), 2mg tablets to be taken at night.

In respect of his notes for the consultation on 24 May 1999, Dr C advised me that "endogenous depression" referred to a depressive state caused by genetic factors or the ageing process (as opposed to a reactive depression which develops following some event).

Dr C said that Mr B complained to him about "tiredness and sadness" and asked for a prescription of amphetamines for it. Dr C said that he advised Mr B that it was illegal for him to prescribe amphetamines and therefore prescribed Aropax. He advised me that the "medical intervention" referred to Aropax. Dr C also advised me that the "medical treatment" for benign hypertension referred to Inhibace [Plus] and Hytrin. When asked why he made the comment "medication compliance re-emphasised", Dr C said that he was not sure whether Mr B was taking the medications he was prescribed as Mr B "never had repeat scripts of the medications … prescribed". He said that if compliant, he would have expected Mr B to uplift three or four repeats per year.

In relation to the entry on 24 May 1999 that he "undertook a physical examination and performed appropriate tests", Dr C said that these were recorded separately and that the "appropriate tests" referred to the blood pressure taken. Dr C advised me that the 15 minutes he allocates per consultation does not allow him to write "extensive" notes. He therefore does not record specifics of any physical examination.

Mrs A advised me that her father had told her that Dr C did not discuss with her father the medications he prescribed to him or their side effects. She said Dr C did not inform her father that nausea, which her father experienced, was a potential side effect of taking Aropax. Mrs A stated that Dr C stopped the medication only after her father went to him and informed him that it was making him feel sick. She believed that Aropax was not a suitable medication for a patient with a heart condition.

Dr C advised me that he could not recall what medication was making Mr B unwell. He said it could have been any one of the medications Mr B was on at that time.

Mr E, Mr B's landlord, who was also a patient of Dr C, advised me that Mr B told him that Dr C gave him tablets that upset him and felt that Dr C was "not doing his job right". Mr B felt that Dr C should have sent him to a hospital to be checked out before giving him different medications. Mr E said he advised Mr B to go back to Dr C, inform him that he was having problems with the tablets he prescribed and get Dr C to change the medications.

On 5 June 1999 Mr B was dispensed a month's supply of Hytrin, a month's supply of Aropax, and two lots (60 days' supply) of Inhibace Plus. Mr F, the pharmacist at the pharmacy where Mr B obtained his medications, confirmed that two prescriptions of Inhibace Plus were dispensed on 5 June 1999. He could not explain why two prescriptions of the same drug were dispensed on the same day. He said this normally does not happen unless it is specifically requested. Mr F informed me that the pharmacy's computer system "alerts" if a script for the same medication is presented within 20 days of a previous one. For this to have occurred, the system would have had to be overridden by the pharmacist at the request of either the patient or the doctor.

Mr F advised me that the normal process employed by his pharmacy was for the prescribing doctor to fax the prescription to the pharmacy. The prescribed medications would then either be delivered by the pharmacy to the general practitioner or to the patient's house, or would be uplifted by the patient from the pharmacy. Mr F recalled Mr B and said that he occasionally came in person to uplift his medications. Mr F recalled that on several

occasions Mr B's medications were delivered to Dr C's surgery or to Mr B's home because he was not well.

No record was found of a consultation between Dr C and Mr B on 13 June 1999, as claimed by Mrs A.

On 15 June 1999 Mr B presented to Dr C with "(1) Endogenous depression – requiring medical intervention – problem with medication – dizziness, advised stop alleged culprit medication – change culprit medication to script – importance of medication compliance re-emphasised. (2) Sciatica – inflammation resulting from an irritation of the sciatic nerve – counselled and educated …". Dr C prescribed Voltaren Emulgel (topical non-steroidal anti-inflammatory / analgesic). In the notes Dr C recorded: "1 measure bid [twice daily] prn [as required] topical anti-inflammatory Emulgel, use straight after food for pain. If any stomach pain stop medication and see your doctor." This wording also appeared on a copy of the prescription provided by Mrs A.

Dr C advised me that he thought Aropax was the "culprit medication" which caused the dizziness referred to in his notes of 15 June 1999. He said that he advised Mr B to stop taking his "current anti-hypertensive medication [Hytrin and Inhibace Plus] as it may have been causing postural hypotension". As it was not recorded Dr C could not recall what the "culprit" medication was replaced with.

Mrs A advised me that she did not know which medication made her father feel unwell but that it was one of the tablets he was taking for the three complaints he presented to Dr C with. She said Dr C prescribed Voltaren Emulgel to replace that medication. Mrs A believed that Aropax and Voltaren were contraindicated for patients with a heart condition. She thought that Voltaren was "deadly" if taken internally. Mrs A stated that Dr C intended her father to take the Voltaren internally and alleges that "because of his [Dr C's] carelessness, he made a mistake and prescribed it externally". She said that Dr C's instructions for the Voltaren to be taken after meals reflected that intent; she did not accept that Voltaren Emulgel had to be applied after meals.

Dr C advised me that there was no prescription error regarding the Voltaren Emulgel and that one can suffer gastric problems with non-steroidal anti-inflammatories. He said: "Voltaren taken systematically can cause gastric irritation and in an extreme, ulceration and gastric bleeding. Although such an effect is very unlikely with topical preparation, for reasons of cautious safety, it is usual for me to add to this [to the] prescription …"

23 June 1999

On 23 June 1999 Mr B collapsed and died at home. Mrs A alleged that when her father collapsed and Mr E telephoned Dr C to inform him of the collapse, Dr C responded that he had patients to see and could not come immediately. Mrs A alleged that Dr C attended to Mr B only because Mr E insisted he did. However, Mrs A did acknowledge that by the time she arrived, some 20 minutes after receiving Mr E's telephone call, Dr C had already been to see her father.

Mr E advised that Mr B collapsed while the two of them were having an argument. He said that he tried to resuscitate Mr B for approximately ten minutes without success. Mr E then telephoned Dr C at his surgery and told him that Mr B had died and to "come and check him out". He said there was no hesitation or delay in Dr C's coming to see Mr B. Mr E said: "I'll give him [Dr C] his due, he was right on the ball." After speaking to Dr C, Mr E telephoned an ambulance and the Police. He then telephoned Mrs A.

On 23 June 1999 Dr C completed Mr B's death certificate. On the certificate he recorded the cause of death as "myocardial infarction secondary to ischaemic heart disease 4 years, hypertension many years, old age 80 years".

Mr B's heart condition
Mrs A said that if her father died of a heart attack, he would have had a heart problem. Mrs A also said that Dr C claimed her father did not have a heart condition, yet on the death certificate he recorded her father had had a heart condition for four years. She claimed that Dr C did not consider her father's heart condition as a possible cause of his illness and did not treat it. Apart from taking Mr B's blood pressure, Dr C did not examine him or carry out tests to exclude a heart condition.

Dr C advised me that when he saw Mr B there were no clinical indications that he was suffering from a deteriorating cardiac condition. Mr B was not complaining of angina or shortness of breath or other signs suggestive of heart failure. He said: "I believe that the symptoms revealed in the consultation on Tuesday 15 June 1999 were not related to the heart attack which unfortunately occurred on 23 June 1999. Regrettably, not all serious or fatal heart attacks are preceded by warning symptoms."

Independent advice to Commissioner

Dr Keith Carey-Smith, an independent general practitioner, provided the following expert advice:

"**Expert advice**:

I will comment on each of the points requiring my decision separately, giving my opinion on the standard appropriate to general practice.

Was the service provided by [Dr C] of reasonable care and skill?

Overall, service was adequate, but several specific deficiencies not significantly contributing to [Mr B's] death are detailed below and under Conclusions.

Additional questions:

<u>Question 1</u>: What specific professional and other relevant standards apply in this case and did [Dr C] follow them?

1. *Provision of services of an appropriate standard (HD Code Right 4). In particular in this case competent examination, diagnosis, and prescribing.*

a. **Alleged failure to examine, investigate and diagnose a heart condition** (Complaint 4). Although chest pain was not complained of to alert [Dr C] to possible heart disease, hypertension was present, and there was a documented history of heart trouble. Regular cardiovascular examination was therefore indicated. It is difficult to decide whether care was adequate because of lack of documentation in [Dr C's] records of the presence or absence of cardiac symptoms, particularly the shortness of breath apparently complained of by [Mr B] (see Document A)[1], and lack of record of any examination findings. [Dr C] states that he undertook physical examination and performed appropriate tests on 24 May, but there is no documentation of this. [Dr C's] standard of care is therefore considered to be below appropriate standard either in respect of failure to interrogate and examine regularly, or of failure to keep adequate records.

It is clear that the final event causing [Mr B's] death was a heart attack. However there is no mention of specific cardiac symptoms complained of by [Mr B] to [Dr C] (even though [Mrs A's] letter of 4/9/00 states that her father complained of shortness of breath). It is very common for heart attacks to occur without pre-existing warning symptoms or signs. Even if [Dr C] had elicited a history of increasing breathlessness (or other cardiac symptoms) and had carried out a full examination including blood tests and electrocardiogram, this would have been unlikely to reveal evidence of a forthcoming preventable heart attack. The leg and back pain are unlikely to have been related to any heart condition.

[Dr C] stated on the death certificate that there was a 4-year history of ischaemic heart disease (consistent with the past history). The fact that the patient had no history of chest pain does not exclude ischaemic heart disease and heart attack as the cause of death.

b. The absence of examination (in particular blood pressure) recorded on 15 June is particularly concerning in view of the fact that [Dr C] diagnosed possible postural dizziness. In this respect [Dr C's] care falls below appropriate professional standards, either by not measuring, or not recording, blood pressure.

c. The alleged delay in attending on 23/6/99 when [Mr B] collapsed and died (complaint 3) appears to be contradicted by Mr E's statement (see document I)[2] that

[1] [Mrs A's] letter to the Commissioner dated 4 September 2000.

[2] Record of telephone conversation with [Mr E] on 16 November 2001.

he called [Dr C] and told him that [Mr B] had already died, and that, despite this, [Dr C] 'came straight away'. There is therefore a discrepancy between [Mr E's] and [Mrs A's] version of events which is not surprising given the distress likely on the day of the death.

d. There is no information to allow comment on the complaint of 'disinterested attitude' (complaints 3 & 6). With regard to complaint 6, the apparent insensitive comment appears to be due to an unfortunate misunderstanding of the tense of the verb used by [Dr C] (as explained in his letter of 6/11/00).

2. *Effective communication (HDC Right 5)*
3. *Full information, explanation and answers to questions (HDC Right 6).*

Complaint 5 relates to lack of satisfactory reply to questions from [Mrs A] relating to the treatment received by [Mr B]. [Dr C] in his letter (B)[3] indicates that he had no intention of obstructing access to health information, and offered to provide a copy of the notes to [Mrs A]. The initial reluctance to provide the records to [Mrs A] may have been due to uncertainty about next-of-kin rights in this matter ([Dr C] states that he was not aware at that time that [Mr B] had a daughter), and concerns about confidentiality (see document D, bullet point 5)[4].

It is clear from [Dr C's] records (eg consultation of 15 June 1999) that his normal practice is to 'counsel and educate' on the problems, check that the patient/caregiver is happy about the instructions given, and give instruction to 'return if any problems with medication of deterioration of the medical condition'. These standard templates do not however indicate the exact nature of the information/explanations given.

Communication difficulties are suggested by the reported comment by [Mr B] to his daughter (as stated in [Mrs A's] Fax of 2 Feb 2000): that on 15 June 1999 '[Dr C] made no comment and expressed no concern … but just gave him another prescription'. There is no way of knowing whether this discrepancy is due to lack of explanation by [Dr C], or inability to understand or recollect by [Mr B].

<u>Question 2</u>: Given [Mr B's] medical history and presenting symptoms, was the prescription for Aropax, Hytrin, Inhibace, and/or Voltaren contraindicated?

It is considered that all these medications are appropriate to the relevant diagnoses of depression, prostatism, hypertension, and 'sciatica'. Neither Aropax nor Voltaren (topical or oral) are contraindicated in patients with heart conditions. There is a theoretical renal function interaction between ACE inhibitors (Inhibace) and NSAIDs (Voltaren) (ref: BNF 40, 2000, p 89); however this is not relevant in the case of topical Voltaren because of low systemic absorption.

[3] [Dr C's] letter to the Commissioner dated 6 November 2000.
[4] Transcript of the interview with [Dr C] on 27 March 2001.

Topical Voltaren is unlikely to be of benefit in sciatic nerve root pain; however the symptoms and signs are not stated, and it is possible that an element of local soft tissue pain susceptible to Voltaren Emulgel was present (see also below).

Question 3: Is there any evidence to suggest that Voltaren Emulgel was prescribed in error?

There is no evidence that Voltaren Emulgel was prescribed in error, however the instructions relating to food were unnecessary, and are presumably due to a computer generated comment applied to all formulations of Voltaren, whereas only the oral forms necessitate this instruction. No harm, other than confusion to [Mr B] or his carers, is likely.

Question 4: Can topically applied Voltaren Emulgel cause gastric irritation?

Since plasma concentrations of diclofenac after topical application are about 100 times lower than after oral administration, systemic side effects (including gastric irritation) are extremely unlikely. Systemic effects are only likely after prolonged application over large areas of skin (Ref: New Ethicals Compendium 6th edition 1997, p 2148).

Question 5: How appropriate or necessary was [Dr C's] instruction for the Voltaren Emulgel to be used 'straight after food for pain'?

This computer template error was inappropriate, unnecessary, potentially confusing, but unlikely to lead to any significant harm (see above under Question 3).

Question 6: Were [Dr C's] records of an appropriate standard?

[Dr C] appears to use a number of computer generated standard template statements and comments in his records (often related to clauses in the H & D Code), some of which are not entirely appropriate to the clinical situation, and raise questions of accuracy and relevance.

In contrast to the careful documentation of life style and preventive advice, and issues such as informed consent, the records suffer from lack of specific and accurate clinical detail. For example under the entry for 15th June 1999 under the section headed 'endogenous depression' there is said to be a problem of dizziness with medication. This I presumed from the notes to be Aropax (also suggested by [Mrs A's] comments in document E[5], and [Dr C's] in document D[4]) but [Dr C] in his letter of 6/11/00 states that the problem was due to antihypertensive medication (much more likely since an excess of Inhibace Plus as well as Hytrin had been dispensed on 5/6/99) (see question 7, paragraph 1 below). The notes state 'stop alleged culprit medication' and 'change culprit medication to script'; however it is not clear which medication was stopped (even

[5] Record of the meeting with [Mrs A] on 11 April 2001.

to [Dr C]). No new medication for depression, hypertension or the prostate problem was recorded as being prescribed (the Voltaren Emulgel was prescribed for a different condition). As a result of the lack of detail it is not possible to give a firm opinion in relation to Complaint no. 1 (listed above).

In addition, there is sometimes a lack of sufficient clinical information (symptoms, signs). For example, no record of examination findings (including blood pressure) is included in the notes for 2/2/99, 23/4/99 and 15/6/99, and no record of prostate symptoms/signs on 24/5/99. It is notable that no cardiovascular symptoms or examination findings (apart from occasional blood pressure and weight measurements) are recorded over the period of records provided (July 98 – June 99), even though [Mr B] had a history of probable heart attack, and the records (21/7/98) state that notes had been received from the previous doctor. As observed under question 1, para l(a) above, this could be due to a failure by [Dr C] to interrogate and examine, or to a failure to record adequately.

Question 7: Are there any other issues that arise from [Dr C's] response and other information provided?

1. A potentially serious duplication of prescription appears to have occurred on 24/5/99, with the result that a double dose of Inhibace Plus as well as Hytrin was recorded as being dispensed on 5/6/99 (see Pharmacy record document N). This error, if confirmed, constitutes inadequate care by both [Dr C] and the pharmacy, and had the potential to cause hypotension or serious metabolic upset (BNF 40, 2000, p 89). There is insufficient information to indicate if [Mr B] actually took the double dose, or if this contributed to his death. However since he was said to be in an excited or agitated state after an argument at the time of the collapse (see document 1, para 3), hypotension is unlikely to have been the precipitating event. There is no record of blood tests to determine electrolyte status.

2. Some inconsistencies suggesting lack of care were noted in the prescribing of antihypertensives and Hytrin over the months preceding [Mr B's] death. In particular, reasons for adding Inhibace to Norvasc on 27/11/98, and changing Norvasc to Adalat Oros on 6/1/99, are not stated. A further switch to Inhibace Plus on 24/4/99 appears to be related to changes in the pharmaceutical schedule, and is considered appropriate in the circumstances. However there is no record of renal function and electrolyte monitoring since first commencing Inhibace on 27/11/98. These investigations are recommended for patients (especially elderly or with compromised renal function) at least after commencing an ACE inhibitor such as Inhibace, especially if a diuretic is also prescribed (as in Inhibace Plus), and especially if the patient is also on a calcium channel blocker (Adalat) (ref: BNF 40, 2000, ps 89-90).

CONCLUSIONS

Overall [Dr C's] standards of care in respect of the issues complained about are satisfactory, and appropriate drugs were prescribed, though not always with adequate

care. The confusion about medication indicates that communication about therapy and the reasons for each preparation may have been below standard in this case. However without evidence of exactly what was communicated, and [Mr B's] ability to remember it, no firm conclusion about poor communication can be reached.

[Dr C] does not seem to have an adequate system to ensure that new drugs and changes in medication are understood, monitored, and repeated regularly, and that the current medication list is clearly recorded. There appears to be no system to determine what the patient has in stock and is currently taking before prescribing new or repeat medications. This is especially important in older people in whom likelihood of confusion, interaction and side effects is greater. With patients like [Mr B], ideally a follow-up appointment should be made at the appropriate time, and the patient contacted if he does not request a repeat prescription or attend for appointment. Monitoring of metabolic and renal function is also recommended. A medication list or card should be held by the patient and devices such as blister packs can be used to avoid confusion. Responsibility for prescribing issues, such as duplication and drug interactions, should be shared between doctor and pharmacist.

In addition much of the confusion would have been averted if
a. [Dr C] had enquired about [Mr B's] daughter, and requested [Mrs A] attend consultations.
b. [Dr C's] records were more specific with regard to exact symptoms/ signs and examination carried out, with less emphasis on standard templates.

It is not possible to determine the adequacy of clinical history taking and examination from the records and information given, partly because of inadequate recording, and also because [Mrs A] was not present on the occasions that [Mr B] saw [Dr C].

References:

British National Formulary (BNF) volume 40 (2000)
New Ethicals Compendium 6th edition (1997)."

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.

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; …

RIGHT 10
Right to Complain

…

3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

Opinion: No breach – Dr C

Right 4(1)

Response to emergency
Mrs A alleged that when her father collapsed at home on 23 June 1999, Dr C was reluctant in his response and made a house call only after Mr E, Mr B's landlord, insisted that he do so.

Mr E advised me that Mr B collapsed in his presence. After an unsuccessful attempt to resuscitate Mr B, Mr E telephoned Dr C at his surgery and informed him that Mr B had died. Mr E asked Dr C to come and confirm the death. Mr E advised me that Dr C came promptly and that there was no hesitation or delay in Dr C's response. Mrs A acknowledged that by the time she arrived at her father's house some 20 minutes after receiving Mr E's telephone call, Dr C had already been to see her father. In my opinion Dr C responded appropriately in the circumstances and did not breach Right 4(1).

Opinion: Breach – Dr C

Right 4(1)

Error in prescribing Voltaren Emulgel
Mrs A alleged that on 15 June 1999 Dr C prescribed Voltaren Emulgel to Mr B in error. She claimed that the instructions for the taking of the medication on the script were inconsistent with the medication Dr C prescribed. Mrs A maintained that Dr C intended to prescribe an oral form of Voltaren but in error prescribed the topical form. She said the instructions for the Voltaren to be taken after meals reflected Dr C's intent.

Dr C's instruction on the prescription form of 15 June 1999 was for the Voltaren Emulgel to be applied topically twice daily as required for pain "straight after food". Dr C advised me that there was no error in relation to the prescription.

Although my advisor expressed some doubt about the benefit of prescribing topical Voltaren for sciatic nerve root pain, no evidence was found to suggest that the Voltaren Emulgel was prescribed in error. However, my advisor was of the opinion that the instructions relating to food were "inappropriate, unnecessary" and "potentially confusing" to the patient.

My advisor stated that only oral forms of Voltaren necessitated the instruction for the medication to be taken with food. Such an instruction for a topical application of the medication presumably resulted from a computer-generated comment applied to all formulations of Voltaren. In light of the much smaller quantity of Voltaren absorbed by the body through topical application, my advisor was of the opinion that it is unlikely that any harm, other than potential confusion to Mr B, would have resulted from the instruction.

As a general practitioner, Dr C is required to provide his patients with accurate information when prescribing medications. Accepting Dr C's statement that there was no prescription error, it is of concern that he did not seem to appreciate the importance of providing patients with accurate instructions when prescribing medications or to show any awareness of the confusion that inaccurate information may cause, particularly in elderly patients who attend consultations on their own. In my opinion, Dr C did not provide medical services to Mr B with reasonable care and skill and accordingly breached Right 4(1) of the Code.

Heart condition
Mrs A alleged that Dr C did not consider a heart condition as a possible explanation for the symptoms with which Mr B presented. He did not examine Mr B and did not conduct any tests to exclude the possibility of a heart condition. Mr B died of a heart attack on 23 June 1999.

Mr B had a documented history of high blood pressure and heart disease. Previously he had experienced chest pain on exertion, and an ECG, taken during his admission to hospital in April 1996 for an unrelated condition, was suggestive of an acute myocardial infarction. His previous general practitioner noted episodes of irregular heartbeat and chest pain on

exertion. My expert advisor has said that a regular cardiovascular examination was indicated in such circumstances.

My advisor noted that apart from occasional blood pressure and weight measurement, no cardiovascular symptoms or examination findings were recorded over the entire period Mr B was under the care of Dr C. No record of examination findings (including a blood pressure reading) was included in the notes for 2 February 1999, 23 April 1999 and 15 June 1999. The absence of a blood pressure recording on 15 June 1999 is particularly concerning in view of the fact Dr C diagnosed possible postural dizziness. My advisor noted that Dr C's care "fell below appropriate professional standards, either by not measuring, or not recording blood pressure".

In light of Mr B's history of suspected myocardial infarction and subsequent episodes of shortness of breath and chest pain, my advisor was of the opinion that Dr C should have regularly questioned Mr B about any cardiac symptoms and examined and tested him for a heart condition. No such evidence was apparent in Dr C's records; his examination essentially consisted of blood pressure recordings. In my opinion, Dr C failed to adequately assess, test and monitor Mr B for his heart condition, and therefore breached Right 4(1) of the Code.

I note that although Mr B died of a heart attack, my advisor was of the opinion that even if Dr C had carried out a full examination and carried out relevant blood tests and electrocardiogram, it is unlikely that they would have shown an imminent, preventable heart attack.

Opinion: Insufficient evidence

Right 6(1)(b)

Explanation about medication prescribed
Mrs A alleged that on or about 13 June 1999 Dr C prescribed a medication to Mr B that made him unwell and that Dr C did not explain what the medication was and why it made Mr B unwell. Mrs A advised me that her father had told her that Dr C did not discuss with him the medications Dr C had prescribed or their side effects. Mrs A did not know which medication made Mr B unwell other than that it was one of the tablets he was taking at that time and the one that Dr C replaced with Voltaren Emulgel. Mrs A also maintained that the Aropax and Voltaren Dr C prescribed were not suitable for a patient with a heart condition.

Mr B saw Dr C on 15 June 1999. In his notes Dr C recorded that Mr B experienced dizziness related to medication and that he advised Mr B to stop taking the "alleged culprit medication" and substituted it with another. At the time, Mr B was taking Aropax, Inhibace Plus and Hytrin. Dr C advised me that he could not recall what medication was making Mr B unwell but thought Aropax was the "culprit medication" that caused the dizziness. Dr C

also stated that he advised Mr B to stop taking the antihypertensive medications (Inhibace Plus and Hytrin) as they could be causing his postural hypotension.

Dr C also prescribed Voltaren Emulgel for the first time for Mr B's sciatica. Its prescription was unrelated to any documented existing condition.

My advisor stated that the medications prescribed by Dr C (Aropax, Hytrin, Inhibace and Voltaren) were appropriate to the relevant diagnoses of depression, prostatism, hypertension and "sciatica". Neither Aropax nor Voltaren (whether oral or topical) was contraindicated in patients with a heart condition as claimed by Mrs A.

With respect to Mrs A's allegation that her father told her that Dr C did not explain to him what medication was making him feel unwell and why, it has not been possible to investigate this matter. Mr B is deceased and his account about what Dr C told him cannot be obtained. It also appears that Dr C did not himself know which medication was making Mr B feel unwell. It is possible that Mr B's recollection of that consultation was that Dr C told him he did not know which of the discontinued medications was causing the problem. In the circumstances, I am unable to form an opinion about this matter.

Other comment

Prescribing, documentation and monitoring of medication use
My advisor noted some inconsistencies in Dr C's records suggesting a lack of care in the prescribing of antihypertensives and Hytrin over the months preceding Mr B's death. In particular he noted that reasons for adding Inhibace to Norvasc on 27 November 1998, and changing Norvasc to Adalat OROS on 6 January 1999 were not stated. Whereas a further switch to Inhibace Plus on 24 April 1999 appears to have been related to changes in the pharmaceutical schedule and was considered appropriate, there is no record of renal function and electrolyte monitoring by Dr C after first commencing Mr B on Inhibace on 27 November 1998.

Mr B was on a relatively high dose of Inhibace Plus and Hytrin. My advisor was of the opinion that these medications should have been introduced and increased gradually and that Mr B's renal function should have been monitored. He stated that renal function tests and electrolyte monitoring are recommended for patients (especially the elderly or those with compromised renal function) at least after commencing an ACE inhibitor drug such as Inhibace, and especially if a diuretic (as in Inhibace Plus) is also prescribed and the patient is taking a calcium channel blocker (Adalat).

On 24 May 1999 Dr C prescribed Hytrin to Mr B. On 5 June 1999 the Hytrin as well as two prescriptions of Inhibace Plus were dispensed to Mr B. The duplication prescription of Inhibace Plus had the potential to cause hypotension or serious metabolic upset. Although there is insufficient information to indicate that Mr B actually took the double dose, the

dizziness reported on 15 June 1999 could have been related to hypotension caused by an increased intake of Inhibace Plus.

My advisor noted that Dr C "does not have an adequate system to ensure that new drugs and changes in medication are understood, monitored and repeated regularly, and that the current medication list is clearly recorded. There appears to be no system to determine what the patient has in stock and is currently taking before prescribing new or repeat medications." Such a system is particularly important when treating elderly patients, who are more likely to be confused and to suffer side effects from medication. Mr B was 81 years old, English was not his first language, and he was hard of hearing. He was a vulnerable patient who depended on Dr C to monitor his medications.

Record keeping
My advisor noted that Dr C used a number of computer generated standard template statements and comments in his records. Dr C did not indicate the exact nature of any information or explanation given. In the absence of sufficient clinical information about signs and symptoms, the use of the templates is questionable. In his records of 16 July 1998 Dr C did not offer any explanation or differential diagnosis for Mr B's nausea and giddiness, or document the reason for prescribing Daktarin Tincture and Tears Plus. Dr C did not record signs and symptoms of Mr B's "benign prostate enlargement" presentation on 24 May 1999 and his "sciatica" presentation on 15 June 1999.

In his notes of 15 June 1999 Dr C referred to Mr B's problem of dizziness with medication. He wrote: "stop alleged culprit medication" and "change culprit medication to script". However, it was not clear, even to Dr C, which medication was thought to be causing the problem. On one occasion he said that he thought the dizziness was due to Aropax; on another he stated that he advised Mr B to stop taking his antihypertensive medications (Inhibace Plus and Hytrin) as they could be causing his postural hypotension. It is not clear what medication was stopped and what medication was substituted. No new medication for depression, hypertension or the prostate problem was recorded as being prescribed.

In the documents forwarded to me by Dr C, no record was found of a registration form for Mr B. Such a form is usually completed by a patient when registering with a new general practitioner, and contains useful information, including the name and contact details of the next-of-kin. Dr C stated that he was unaware that Mr B had a daughter. Had an initial registration record been completed, it may have assisted Dr C to identify family support available to Mr B.

Co-operation with investigation
My staff received less than full co-operation from Dr C during this investigation. I take this opportunity to remind Dr C that it is the Commissioner's statutory function to investigate complaints, and that providers are required to facilitate the fair, simple, speedy, and efficient resolution of complaints (Right 10(3) of the Code). Dr C's failure to respond to requests for information in a timely manner did not facilitate the speedy resolution of this investigation.

Actions

I recommend that Dr C take the following actions:

- Review his practice in light of this report, in particular in relation to:
    - Documentation of presenting signs and symptoms, and of any examination or tests undertaken.
    - A system for ensuring and monitoring that patients, especially the elderly, understand the instructions for prescribed medications.
    - A system for recording medications prescribed to patients, their current medications, and their stock of medications, before prescribing new or repeat medications.

Further actions

- A copy of this opinion will be sent to the Medical Council of New Zealand for it to consider whether a review of Dr C's competence is required.

- A copy of this opinion, with all identifying features removed, will be sent to the Royal New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.