Medical Officer, Dr B

A Report by the

Health and Disability Commissioner

(Case 10HDC00610)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. This report is about the failure of Dr B[1] to diagnose lung cancer in his patient, Ms A, aged 52 years.

2. Ms A had an extensive history of smoking and a family history of lung cancer. She smoked approximately 50 cigarettes per day for more than 20 years and had a long-standing dependency on benzodiazepine. Between June 2008 and February 2010, Ms A presented to Dr B on multiple occasions with complaints of persistent coughing, chest and throat pain, fever and sweating, haemoptysis,[2] and shortness of breath.

3. Over the 20-month period, Dr B diagnosed Ms A with respiratory tract infections and acute pharyngitis[3] and prescribed Ms A antibiotics and cough medicine. There is no record of Dr B undertaking a physical examination of Ms A throughout this period.

4. Dr B's notes are a combination of computerised and handwritten notes. His handwritten notes are, in places, illegible and incomplete. Most notably, the handwritten notes do not comprehensively and accurately document Ms A's symptoms of persistent coughing and chest and throat pain, or what examinations, if any, were undertaken to diagnose Ms A.

5. On 26 February 2010, Ms A called Healthline for advice as the pain in her chest was unbearable. Healthline immediately sent Ms A an ambulance which transported her to hospital. A chest X-ray was ordered, revealing a large mass in Ms A's lower right lung. A computed tomography (CT) scan and lung biopsy confirmed a diagnosis of primary lung cancer with extensive metastases[4] in the liver, lung (referred to as intrapulmonary metastasis) and mediastinum.[5] Ms A was referred to palliative care and died a few months later.

Decision summary

6. Ms A's respiratory symptoms of persistent coughing, chest pain, haemoptysis, and shortness of breath called for further investigation, especially in light of her smoking history, age, and Māori ethnicity. At the very least, Dr B should have physically examined Ms A and referred her for an urgent chest X-ray in May 2009. By failing to do so, Dr B breached Ms A's rights under Right 4(1)[6] and Right 4(4)[7] of the Code of Health and Disability Services Consumers' Rights (the Code).

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[1] Dr B is registered within a general scope of practice. He is not vocationally registered as a general practitioner.
[2] Coughing up blood.
[3] Pharyngitis is inflammation of the throat or pharynx usually caused by an infection. The main symptom is a sore throat.
[4] The spread of disease from one organ or part to another non-adjacent organ or part.
[5] The mediastinum is the central compartment of the thoracic cavity. It contains the heart, the great vessels of the heart, the trachea, the oesophagus, the bronchi and the lymph nodes.
[6] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[7] Right 4(4) of the Code states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer."

7. HDC also found Dr B breached Right 4(2)[8] of the Code as his documentation did not meet professional standards.

8. Dr B will be referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

Complaint and investigation

9. On 28 May 2010 HDC received a complaint from Ms A about the services provided to her by Dr B. The following issue was identified for investigation:

- *The adequacy of the care provided to Ms A by Dr B between December 2005 and March 2010, including the adequacy of documentation.*

10. An investigation was commenced on 15 September 2010.

11. Information was reviewed from the following parties who were directly involved in the investigation:

Ms A	Consumer/complainant
Dr B	Provider
Dr C	Provider
The DHB	District Health Board/Provider

12. Expert advice was obtained from my clinical advisor, general practitioner Dr David Maplesden, attached as **Appendix A**. Dr Maplesden provided further expert advice on 22 November 2010 and 12 April 2011 attached as **Appendix B**.

Information gathered during investigation

Background

13. In December 2005, Ms A, then aged 48 years, transferred her primary medical care to Dr B at a medical centre. Prior to this, Ms A had been receiving care from a doctor at another medical centre.

14. Between 1999 and March 2007, Ms A was receiving treatment from the DHB's Alcohol and Drug Service (ADS) for her benzodiazepine dependency.[9] Ms A was able to reduce her benzodiazepine dosage but remained dependent. She was discharged

[8] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

[9] Ms A advised HDC that she had been prescribed diazepam for the previous 30 years as a result of a "very abusive de facto relationship" that nearly cost her her life. She had been receiving treatment from ADS to help with her drug dependency.

back to the medical centre on 20 March 2007 as she was not regularly attending her appointments at ADS.

Care and treatment provided by Dr B — June 2007 to December 2009

15. Ms A advised HDC that she started coughing in June 2007. She advised that she was coughing up yellow phlegm and had a sore chest and throat. She saw Dr B at that time who prescribed her antibiotics. Ms A further advised that, by the end of 2007, her cough had worsened and she was coughing up blood on occasion. She advised that she consulted Dr B who told her to "go home and stop smoking".[10]

16. There is no record of Ms A experiencing any respiratory symptoms in 2007 or from January-May 2008. The handwritten notes for Ms A's consultations during that time relate to complaints of PV bleeding,[11] menorrhagia,[12] cold feet, and symptoms suggestive of claudication.[13]

17. The first record of respiratory complaints is on 6 June 2008 where Dr B noted the following in Ms A's handwritten notes: "cough + phlegm — yellow — ½ cup/day, too unwell to smoke, fever + sweats, headaches [three days] … sore chest + throat". Dr B prescribed Ms A antibiotics, paracetamol, and a cough mixture. No diagnosis or physical examination was documented.

18. Ms A advised HDC that by June 2008 she was coughing constantly, the pain in her chest and throat never went away and she had to sit up to breathe. Ms A said that by August 2008 her coughing had become "so unbearable", however, Dr B only prescribed her antibiotics.

19. The next entry relating to Ms A's respiratory complaints is dated November 2008 and documents "acute pharyngitis Penicillin".[14] There are no other entries in Ms A's clinical notes for the remainder of 2008 related to her respiratory symptoms.

20. On 30 April 2009, Dr B recorded in Ms A's clinical notes "[Complaining of] flu — [6 weeks] congestion in throat, no cigs [8 weeks], phlegm dark cream, no blood, fever + sweats nocte, in bed for [6 weeks], Tired chronic [respiratory tract infection]".[15] Dr B made no record of having carried out a physical examination on Ms A during that consultation.

21. Dr B advised HDC during an interview that he does not recall carrying out any physical examinations on Ms A on 6 June 2008 or 30 April 2009. Dr B repeatedly said that he would have documented an examination if he had undertaken one at that time. Dr B acknowledged that Ms A had "been unwell for sometime" and advised HDC that he believed she was suffering from an "unresolved respiratory tract infection" in April 2009.

[10] Ms A did not specify the date she consulted Dr B.
[11] Blood loss from the vagina.
[12] Abnormally heavy and prolonged menstrual period at regular intervals.
[13] Pain or cramping in the lower leg due to inadequate blood flow to the muscles.
[14] The precise date was not recorded.
[15] The most common symptom of a respiratory tract infection is a cough. Other symptoms include headaches, sore throat, muscle aches and pains and breathlessness.

22. On 7 May 2009, the practice nurse recorded the following in Ms A's computerised notes: "[patient] rang not feeling very well coughing up phlegm and blood, pain in side and back of chest, painful when breathing, advised to go to emergency Dr".

23. On 8 May 2009, Ms A was seen by another doctor at the medical centre, Dr C. Dr C advised HDC that Ms A presented with severe pain in the right side of her chest and back and advised him that she had been coughing up phlegm and blood the night before but that had since stopped.

24. On examination Dr C found Ms A had crepitations[16] on the right side of her chest and pleural rub.[17] Dr C advised HDC that the pleural rub, together with the localised and severe nature of the pain, led him to the diagnosis of pleurisy.[18] Accordingly, he prescribed Augmentin and arranged for Ms A to see Dr B on Tuesday 12 May 2009.

25. Dr C further advised, that he was "confident of the diagnosis and therefore did not consider referring Ms A for a chest X-ray at that time".

26. Ms A attended her follow-up appointment with Dr B on 12 May 2009. There is no record in the handwritten or computerised notes of any plan to further investigate her symptoms or whether Ms A's respiratory symptoms from 8 May had resolved. The notes only record that Ms A had lost her diazepam and that Dr B would not be replacing her medication in the future.

27. At a consultation on 20 August 2009, Dr B told Ms A to "find another doctor". Dr B explained to HDC that when Ms A first came to the medical centre, she was already on diazepam and that "her demeanour on a number of occasions did suggest that she had taken an excess of her benzodiazepines". The computerised and handwritten notes record numerous reports of Ms A claiming that she had lost her medication.[19] He advised HDC that although he tried to get Ms A to reduce her diazepam dosage during August 2009, she did not want to end her drug dependency therefore he told her to find another doctor:[20]

> "At that time a year ago I was trying to get her to accept the concept of withdrawing from diazepam because she was abusing the amounts of diazepam. She came to this practice already on an ongoing amount that had been prescribed from the A&D Clinic. But I thought she should try to withdraw from them but she was really adamant it was not something she could do or would want to do. I told

[16] An abnormal respiratory sound consisting of discontinuous bubbling noises heard on listening to the chest during inspiration.
[17] Pleural rubs are creaking or brushing sounds produced when the pleural surfaces are inflamed or roughened and rub against each other.
[18] Inflammation of the lining of the lungs and chest that leads to chest pain when you take a breath or cough.
[19] On 15 December 2008 "Dropped meds → sink"; 8 May 2009: "Spilled coffee over tablets"; 12 May 2009: "Diazepam lost"; 29 June 2009: "Apparently has had codeine stolen from handbag speech slurred taking excessive valium last [prescription] 25/06 becoming [incoherent] To find another Doctor"; 7 July 2009: " 'Lost' tabs".
[20] Dr C had earlier recorded on 23 July 2009 that Ms A needed to be assessed by ADS: "For assessment [Alcohol and Drug Services] … [Dr ?] to refer when [Ms A] comes back from seeing daughter in [another town]."

her it was time to find another doctor because I thought that was the way she should be going and that's exactly what had happened when she came here, she had been told to find another doctor by her previous doctor."

28. However, Ms A continued to see Dr B until February 2010.

29. Ms A advised HDC that by December 2009 her chest pain had "increased enormously and [she] started coughing non-stop".

30. On 10 December 2009, Dr B recorded in Ms A's handwritten notes "Much [shortness of breath] & coughing". When HDC asked Dr B whether he conducted an examination or diagnosed Ms A during that consultation, Dr B replied that there is no record of him doing so, only a record of prescribing her diazepam. Dr B also could not recall how long Ms A's cough had been going on for but believes it had only been for a short period of time.

January 2010

31. Ms A said that her subsequent visits to the medical centre in 2010 were characterised by Dr B not wanting to examine her and repeatedly refusing to refer her for an X-ray despite her telling him of her chest pain.

32. Ms A stated that she went to the medical centre on two separate occasions to get her medical certificate for Work and Income filled in by Dr B. On one occasion Dr B wrote "drug dependency" and on another he wrote "chronic back pain" as the reasons for Ms A not being able to work:

> "On the 19th of January [2010] I went to see [Dr B] to get my medical certificate for WINZ filled in. He wrote Drug Dependency down as the main clinical condition affecting my ability to work, knowing full well that was not the reason I could not work … On the 18th February [2010] I went back to [Dr B] to try once again. I should have just stayed home as he didn't even try to hide the fact he was just mucking me around. He just wrote down Chronic Back Pain and ignored everything I said … Again I had been refused X-rays and been told the pain in my chest was just from the coughing I could not stop."

33. Dr B stated that the last time he saw Ms A was on 18 February 2010. Dr B recorded in Ms A's handwritten notes "Some [shortness of breath], [occasional] haemoptysis [five days with] clots. Non-smoking — [six weeks]…wait [one week]." There is no record of any physical examination, diagnosis, treatment or investigations ordered.

34. HDC asked Dr B whether he knew, in February 2010, what was causing Ms A's respiratory symptoms. Dr B replied that he had some ideas and wanted to review Ms A in one week's time to see how her symptoms were "panning out":

> "Everything's a possible diagnosis at that point … acute bronchitis, carcinoma, blood dycrasias, there is a long extensive list of possible reasons … I wanted to see this resolved quickly, she'd had it for five days or else at that point one would have been looking at a whole gamut of investigations."

35. Dr B said that he did not see Ms A again after the consultation on 18 February 2010. Ms A, however, advised HDC that she saw Dr B on 27 February 2010 as her prescription was not at the pharmacy. She said that at that consultation, Dr B cut her diazepam down, refused her request for an X-ray and told her to come back if her pain got worse.[21]

36. Ms A recalled that on the afternoon of 27 February, the pain in her chest was so strong that she had to call Healthline. An ambulance was immediately sent to her home.

37. Ms A was taken to hospital. It was established in the Emergency Department during triage that Ms A's mother had suffered from lung cancer.

38. A chest X-ray revealed a large mass in Ms A's lower right lung. A CT scan and lung biopsy confirmed a diagnosis of primary lung cancer with extensive mediastinal, intrapulmonary and liver metastases. Ms A stated:

> "The hospital has told me that my cancer is so far advanced that I have a few months to live. Tests were not required to come to this diagnosis[,] they only needed to feel the swelling of my liver[.] If my GP had taken the time to examine me, refer me for tests or listened to what my concerns were, I may have been in the position where I could have had treatment."

39. Ms A was referred to palliative care and died a few months later.

Consumer and provider statements

40. Ms A advised HDC that from her very first visit with Dr B she was "made to feel like [she] was just a piece of rubbish to be tossed into the rubbish bin". She recalled Dr B labelling her a "drug dependent piece of rubbish" and telling her on a number of occasions that she "depressed" him. Dr B advised that he does not recall saying these things.

41. Ms A advised HDC that she "could not believe a doctor could let [her] suffer so much pain for so long and not care". She tried to find another doctor but was always told that the doctor was not taking any new patients once they knew about her dependency. She also advised HDC that Dr B's costs were "considerably lower than anyone else" and, being on an invalid's benefit, he was the only GP she could afford.

42. Ms A advised HDC that she "kept asking for X-rays or even blood tests to be done, as I could feel something was wrong with me but not once did [Dr B] even acknowledge me". Ms A believed that "[Dr B] didn't want to examine me cause I was dirty in his eyes and he couldn't stand to touch me."

[21] There is no record in the computerised or handwritten notes of Ms A's visit on the 27 February 2010 or of any prescription. However, there is an illegible note written by Dr B in Ms A's notes on 22 February 2010. Dr B advised HDC that the illegible note was in relation to Ms A's medication dosages. He believes that he did not see Ms A on that day.

43. Dr B advised HDC that he was not aware of Ms A's family history of cancer at the time. He does not recall Ms A asking him to refer her for a chest X-ray, blood tests or ever telling him that her chest pain and coughing were persistent. He advised HDC that he did examine Ms A's chest with a stethoscope in 2010 and his impression was that she had a lower respiratory tract infection. There is however no record of this examination in the handwritten or computerised notes.

44. Dr B disputes that he "failed" to order a chest X-ray for Ms A but accepted that he did not do so. He advised that if Ms A had been persistently coughing blood he would have considered a chest X-ray to be "mandatory". However, as she had "such a short history" of that symptom, which he believed was only of five days duration, he decided that he would wait one week before considering whether an X-ray was appropriate.

45. Dr B advised that, given the incidence of lung cancer in Māori, consideration should be given to routine chest examination for all Māori over 45 years who have a smoking history of 25 years or more:

> "After reflection of this situation and being aware of the incidence of lung carcinoma and Māori, especially Māori women, I think there could be merit in routine chest examination (with a general check [blood pressure], bloods etc) and [chest X-ray] for all Māori over 45 years with a 25 year + [history] of smoking (comparable to breast screening) along with focussed discussion on smoking cessation."

Opinion: Breach — Dr B

Introduction

46. This complaint is about Dr B's failure to diagnose lung cancer in Ms A, a 52-year-old woman who was at increased risk of lung cancer. Ms A presented to Dr B on several occasions complaining of chest and throat pain, coughing, and exhibiting other respiratory symptoms. Ms A stated that she had asked Dr B on numerous occasions for an X-ray, blood test, and to be physically examined. Dr B did not physically examine Ms A or take any steps to investigate her respiratory symptoms.

47. Under the Code, consumers have rights and healthcare providers have duties.[22] Ms A had the right to receive an appropriate standard of care from Dr B. Dr B, as her primary health care provider, had a duty to adequately assess her condition, take account of her history and views, and perform examinations as appropriate.[23] The key issue in this case is whether Dr B discharged his duty of care.

[22] Clause 1 of the Code.
[23] Ian St George (ed) "Good medical practice: a guide for doctors" *Cole's Medical Practice in New Zealand* (2009), at pg 9. Available from www.mcnz.org.nz.

Investigations and management of respiratory symptoms

48. Between June 2008 and February 2010, the clinical notes record that Ms A presented on seven separate occasions with complaints of respiratory symptoms, including cough (three times), phlegm (four times), sore chest and/or sore throat (three times), haemoptysis (three times), and shortness of breath (twice). She was diagnosed with acute pharyngitis on one occasion, chronic respiratory tract infection on two occasions, and pleurisy on one occasion.

49. My clinical advisor, Dr David Maplesden, is concerned at the absence of any physical examination findings by Dr B, particularly in relation to the consultations on 6 June 2008, 30 April 2009, and 10 December 2009, when Ms A presented with what Dr Maplesden considers were "significant respiratory symptoms and unwellness". Dr Maplesden is also concerned about the failure of Dr B to undertake a physical examination on 12 May 2009, despite Ms A having been seen by Dr C with abnormal chest signs and symptoms on 8 May 2009.

50. Dr Maplesden advised me that the standard practice for managing respiratory symptoms suspicious for lung cancer is to make urgent specialist referral for smokers with unexplained haemoptysis and who are aged over 40 years.[24]

51. It is standard practice to make an urgent chest X-ray for patients with unexplained haemoptysis, or who suffer any of the following unexplained signs or symptoms for *more* than three weeks:[25]

- Chest and/or shoulder pain
- Shortness of breath
- Weight loss/loss of appetite
- Abnormal chest signs
- Hoarseness
- Finger clubbing
- Cervical and/or supraclavicular lymphadenopathy[26]
- Cough
- Features suggestive of metastasis from a lung cancer.

52. If a patient has "known risk factors", such as being a current or ex-smoker, an urgent chest X-ray for patients with unexplained haemoptysis, or who suffer any of the listed unexplained signs or symptoms for *less* than three weeks, is recommended.

[24] This practice has been incorporated into the "*Suspected Cancer in Primary Care: Guidelines for investigation, referral and reducing ethnic disparities"*. These Guidelines were released in September 2009 (after the events in question) and are a statement of what is expected of primary care practitioners in the investigation of symptoms that are suggestive of lung cancer. I have determined whether Dr B adequately investigated and managed Ms A's respiratory symptoms according to what was standard practice at the time of the relevant events.
[25] This practice is reflected in the Guidelines.
[26] Swollen or enlarged lymph nodes in the head and neck area.

53. Dr B should have considered referring Ms A for a chest X-ray as early as June 2008, but at the very least should have considered referring Ms A for a chest X-ray following the consultation on 12 May 2009.

54. Dr Maplesden advised that there is no indication that Dr B took "anything other than an episodic approach without investigation or follow-up" to manage Ms A's symptoms. Her late diagnosis of lung cancer was a "direct result of the failure by [Dr B] to consider this diagnosis in a patient at significant risk and with a suspicious presentation in a timely manner".

55. While Dr Maplesden noted that Ms A's benzodiazepine dependence and apparent escalating abuse of that medication may have "distracted" Dr B at times, this did not obviate the need to exclude a serious underlying pathology. He advised that the nature of Ms A's symptoms were not such that they could have been put down to her benzodiazepine dependency.

56. Dr Maplesden concluded that Dr B's overall clinical management of Ms A, including his failure to undertake a physical examination and refer her for a chest X-ray, was a moderate to severe departure from the expected standards.

57. Dr B should have been capable of managing Ms A's drug dependency without overlooking the clear need to investigate Ms A's respiratory symptoms. In my view, Ms A's presentation on 6 June 2008 should have raised Dr B's suspicions of an underlying pathology and consideration should have been given to a chest X-ray at that time, but most definitely by 12 May 2009.

58. This Office has previously found doctors in breach of Rights 4(1) and 4(4) of the Code for failing to adequately investigate symptoms, rule out serious underlying causes,[27] and for failing to exercise a higher degree of caution in circumstances where the patient has known risk factors for a particular condition or disease.[28]

59. This is a case of a doctor failing to discharge his duty of care to his patient. Dr B's failure to get the basics right compromised Ms A's safety and wellbeing. Ms A presented repeatedly with history and symptoms that should have prompted enquiry. His failure to appropriately investigate and manage Ms A's respiratory symptoms breached her rights under the Code, in particular her right to have services provided with reasonable care and skill (Right 4(1)), and her right to have services provided in a manner that minimised her potential harm, and optimised her quality of life (Right 4(4)).

[27] See Opinions 10HDC00253 and 03HDC11066. In both cases the doctor was found to have breached Right 4(1) of the Code for failing to adequately examine the patient and investigate symptoms, resulting in a failure to diagnose bowel cancer.
[28] See Opinion 00HDC05372. A doctor was found in breach of Right 4(4) of the Code for failing to take a more risk-averse approach to the management of a patient with known risk factors of heart disease.

Documentation

60. Dr B had a professional and legal responsibility to keep "clear and accurate patient records that report relevant clinical findings, decisions made, information given to patients, any drugs or other treatment prescribed."[29]

61. The importance of good record keeping cannot be overstated. It is the primary tool for continuity of care and it is a tool for managing patients. A patient's clinical record must therefore be dated, legible, accurate and comprehensively document all relevant aspects of a patient's symptoms, signs, diagnosis and treatment.[30] As an independent expert advisor has noted in a previous opinion:[31]

> "Adequate notes are important for many reasons. These reasons include allowing more reliable comparison of findings than simple memory of events should a patient return for review of the same or a different problem by the same doctor. Notes are critical for informing another doctor in the practice, or a locum, of the prior status of the patient, which can have a large impact on the current and future care of patients."

62. To ensure continuity of care, handwritten and computerised notes need to be appropriately integrated.[32] Dr B's notes for Ms A are a combination of handwritten and computerised notes. Dr B's notes are not only illegible and of poor quality and structure, but medication entries and clinical consultations appear in one or both sets of notes which distracts from effective continuity of care. Furthermore, Dr B has failed to comprehensively and accurately document Ms A's presentation, particularly during the period of June 2008 to February 2010.

63. Unfortunately, breaches of the Code by health professionals for failing to accurately and comprehensively document the patient's presentation, examination findings, and diagnosis, are all too common.[33] By failing to write legibly and to include all the relevant details of the consultation, Dr B breached Right 4(2) of the Code.

Response to the provisional opinion

64. Dr B advised HDC that he did not wish to make any comment in response to the provisional opinion. However, he advised that his decision "should not be interpreted as [his] agreement with the truth or accuracy of any part or statement within [the provisional opinion]".

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[29] MCNZ "The maintenance and retention of patient records", August 2008. Available from www.mcnz.org.nz.
[30] Ian St George (ed) "The medical record" *Cole's Medical Practice in New Zealand* (2009) at pg 90. Available from www.mcnz.org.nz.
[31] Dr Steve Searle in Opinion 06HDC12164.
[32] Opinion 09HDC01765.
[33] See Opinions 04HDC17230, 03HDC11066 and 01HDC04847.

Additional comment

Missed opportunity

65. Ms A presented to Dr C on 8 May 2009 with severe pain in the right side of her chest and back. Although Dr C advised that he was confident of his diagnosis of pleurisy and made follow-up arrangements for her to be seen by Dr B four days later, I note Dr Maplesden's comment that in the context of her smoking history and ongoing symptoms, Dr C should have considered referring Ms A for a chest X-ray.

66. In my view, Dr C had an opportunity to make a referral or could have recommended that Dr B do so at the follow-up appointment. By not doing so, an opportunity to further investigate her respiratory symptoms was missed.

Recommendations

67. Dr B has retired from practice and no longer holds a current practising certificate. However, should Dr B decide to return to practice, I recommend that he takes the following steps before applying for a new practising certificate with the Medical Council of New Zealand:

- Familiarise himself with the contents of the New Zealand Guidelines Group publication, "Suspected Cancer in Primary Care" and report back to HDC on completion of this, and advise what he would do differently in the future if a patient presents with a clinical picture similar to Ms A's;
- undergo additional training on clinical documentation and report back to HDC on the steps he has taken to achieve this; and
- reorganise his medical records in light of this report, to comply with professional standards, and advise HDC what changes he has made in this respect.

68. I recommend that the Medical Council undertakes a competency review before issuing a practising certificate to Dr B. Dr B must report back to HDC on the outcome of any review before recommencing practice.

Follow-up actions

- Dr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand and the DHB and they will be advised of Dr B's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, 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.

Addendum

The Director of Proceedings decided not to issue proceedings.

Appendix A — Independent advice to Commissioner

The following expert advice was obtained from my in-house clinical advisor, general practitioner Dr David Maplesden:[34]

"My full name is Dr David Vaughan Maplesden. I qualified MBChB from the University of Auckland in 1983. I achieved a Diploma in Obstetrics in 1984 and FRNZCGP in 2003. I have practiced as a full-time General Practitioner since 1986 and part-time General Practitioner since 2005.

Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided to her by [Dr B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest.

1. Documents reviewed
1.1 Complaint from [Ms A] received 28 May 2010
1.2 Response from [Dr B] received 6 August 2010
1.3 GP notes [the] Medical Centre
1.4 Hospital notes [the] Hospital

2. Complaint summary
2.1 [Ms A] has recently been diagnosed with terminal lung cancer. She states that [Dr B] failed to act on her long history of coughing, including coughing up blood. He never took her blood pressure or examined her or ordered appropriate blood tests or X-rays. He just told her to give up smoking and prescribed medication for her longstanding benzodiazepine addiction.

2.2 [Ms A] states that [Dr B] always made her feel like 'rubbish' and told her that she 'depressed him' and on one occasion he accused her of selling her medication. She complains that [Dr C] declined to prescribe her medication when [Dr B] was away in January 2010 even though she was running out. [Ms A] complains that [Dr B] recorded 'drug dependency' rather than 'chronic back pain' on her WINZ sickness benefit certificate in January 2010.

2.3 [Ms A] states that she started coughing about June 2007. She saw [Dr B] who prescribed antibiotics. By the end of the year the cough had worsened and she was coughing up blood on occasions. She saw [Dr B] — *as usual I was told to go home and stop smoking and he refused to help me any further until I gave up smoking.* By June 2008 [Ms A] had a persistent sore throat and chest, persistent cough and difficulty breathing. She saw [Dr B] and was prescribed more antibiotics and a cough mixture. *The antibiotics reduced my coughing a little bit but by the end of the year the heavy bleeding had started again.* By August 2008 the coughing had become so unbearable that [Ms A] returned to [Dr B] who gave her more antibiotics. Her chest pain and cough continued to increase.

[34] The use of italics denotes the words of another party.

2.4 In December 2009 there was a further worsening of chest pain and cough and [Dr B] prescribed more antibiotics. A couple of days later she began coughing up blood again and saw [Dr C] who examined her and diagnosed pleurisy. No further tests were ordered and the antibiotics were continued. [Ms A] was increasingly concerned at [Dr B's] apparent lack of concern at her condition, and his failure to examine her or investigate further. *I felt like he didn't want to examine me [be]cause I was dirty in his eyes and he couldn't stand to touch me.* [Ms A] continued to mention her chest pain to [Dr B] at consultations in 2010 but he told her it *was just from the coughing.* The final consultation was 27 February 2010 and [Dr B] told her to come back if the pain got any worse. That afternoon she rang Healthline who told her to call an ambulance. She was taken to [hospital] where advanced lung cancer with lymph node and hepatic metastases was diagnosed. Palliative care was given and [Ms A] has since passed away.

3. Provider response(s)

3.1 [Dr B] provides a handwritten response. He notes he failed to make a diagnosis of lung cancer *which may (or may not) have been amenable to treatment if she had been seen a year earlier. If she had as I advised her, found a new doctor in August 2009, her prognosis might have been different.* [Dr B] notes that he frequently advised [Ms A] to cease smoking which he believes she did in early 2009. He does not recall ever telling [Ms A] that she depressed him. He notes that her demeanour at times *did suggest she had taken an excess of her benzodiazepines and communication was not always straightforward at these times.* He notes that his attempts to reduce [Ms A's] benzodiazepine use over the years was always met with resistance from her.

3.2 [Dr B] does not provide any response to [Ms A's] complaints about his failure to examine her or order investigations during her period of respiratory symptoms described in the complaint.

4. Review of clinical records

4.1 The clinical records are a mixture of hand written notes and computerized notes. It is difficult to identify the provider at each hand written consultation. Prescription and consultation information is present in both sets of notes. Handwritten notes commence in December 2005 with a consultation for chronic lower back pain and repeat of benzodiazepine prescriptions. [Ms A] had been under the local Alcohol and Drug service (ADS) and had recently been asked to leave her previous GP provider because of unpaid accounts. There are consultations recorded through the second half of 2006 for complaints of leg pain and cramps with [Dr B] recording an orthopedic referral in June 2006 (unclear if this was ever made), blood tests in September 2006 and ordering of a back X-ray in December 2006. A history of chronic heavy smoking is recorded in November 2006.

4.2 In May and June 2007 are consultations for PV bleeding treated with Primolut. Discharge from the ADS is noted in July 2007 with a note *?refer pain clinic* recorded on 13 August 2007. The notes on this occasion are somewhat difficult to

decipher but there is no obvious reference to chest pain or cough. In November 2007 there is a further consultation for menorrhagia and Microlut is prescribed.

4.3 On 4 April 2008 [Ms A] presents with cold feet and symptoms suggestive of claudication. Blood tests are taken and some results transcribed into the notes on 29 November 2008 (HbA1c 6.7, Chol 6.5, another result indecipherable). Quinine is prescribed. The first documentation of respiratory symptoms is 6 June 2008 – *cough + phlegm – yellow – ½ cup/day, too unwell to smoke, fever + sweats, headaches 3/7 … sore chest + throat.* No examination findings are recorded. Augmentin, paracetamol and a cough mixture are prescribed. On 23 July 2008 the comment *Has stopped smoking* is recorded. There is a consultation in November 2008 (date illegible) that states [illegible word] *pharyngitis Penicillin.* Most other documentation in 2008 refers to [Ms A's] benzodiazepine prescriptions including a comment recorded on 23 September 2009 that [Ms A] might have been abusing the medication. Strict weekly prescribing is instigated after this. There are a significant number of occasions recorded in which [Ms A] claims her medication has been stolen, misplaced, dropped down the plug or in the dishwasher etc. and she needs replacement prescriptions. These incidents combined with the comments made on 19 September 2008 might indicate a significant chance that [Ms A] was abusing her medication.

4.4 On 5 March 2009 the comment *Off cigs 6 days* is recorded and on 31 March 2009 *Off cigs 31 days, cramps much reduced.* On 30 April 2009 *c/o Flu – 6/52, congestion in throat, no cigs 8/52, phlegm dark cream, no blood, fever + sweats nocte, in bed for 6/52, Tired Δchronic RTI* Amoxicillin and a cough mixture are prescribed. No examination findings are recorded. On 7 May 2009 *Pain L chest O/E Creps++ I: Bronchitis ?pleurisy …* Augmentin is prescribed. On 23 July 2009 it seems that [Ms A] is referred back to ADS due to her escalating medication abuse behaviour (increasingly frequent reports of scripts being lost, damaged or stolen) and on 20 August 2009 there is an entry *told to find another doctor.* [Ms A] continues to attend the medical centre. The final entry for 2009 is *Much SOB & coughing* on 10 December 2009. There is no record of a physical examination, diagnosis or any treatment for this.

4.5 On 3 February 2010 consultation notes record *some SOB, occas haemoptysis 5/7 with clots. Non-smoking – 6/12 … wait 1/52.* There is no record of a physical examination, diagnosis or investigations. Medications supplied appear to be the usual benzodiazepines, Aqueous cream and codeine phosphate tablets. On 22 February 2010 nursing notes record a request by [Ms A] for more diazepam and an appointment is made for her to see the GP. The notes for the GP consultation that day appear to be just a record of the medication doses [Ms A] is taking although it is largely indecipherable. There are no further handwritten GP notes provided.

4.6 The computerized notes appear to be largely prescription records and in-box records. There are occasional entries relating to [Ms A's] claim that prescriptions have been misplaced or stolen. There is a reasonably comprehensive entry on 19 September 2008 (Provider [initials]) which includes reference to [Ms A's] social

situation, explaining of blood results and history of *c/o cough.* Examination findings include measurement of blood pressure, pulse and heart examination (the only example of such recordings in the entire notes provided) and note *chest — clear.* On 7 May 2009 there is a note (provider [initials]) *pt rang not feeling very well coughing up phlegm and blood pain in side and back of chest painful when breathing advised to go emergency dr* and on 8 May 2009 (provider [Dr C]) *Coughing up blood has apparently stopped overnight Severe pain chest R side and side of back. On examinations crepes ? pleurisy Augmentin 2 tds…* [reference to request for more codeine] *disheveled, ataxic, smelling strongly of cigarette smoke. Appt made to see [Dr B] next Tues…* There is a handwritten note from [Dr B] dated 12 May 2009. This note refers only to [Ms A's] diazepam prescribing. There is no reference to her presenting symptoms of four days previously, nor to any physical examination reviewing the clinical signs found at that consultation. I can find no other reference in [Ms A's] computerized notes to respiratory symptoms or examinations.

4.7 Hospital notes record an admission on 24 February 2010. History obtained by the medical registrar includes *5/52 hx of abdominal pain that started in the epigastrium … associated weight loss ?how much … haemoptysis – coughing up clots over the last 4/12. Went to see GP who diagnosed pleurisy and gave pain relief … sweats at night …* examination findings include decreased air entry and dullness at the right lung base and a hard tender mass filling the epigastrium. A positive family history of lung cancer (mother) is noted as is current smoker status. Chest X-ray report notes that a report from January 2003 has assessed the lungs as clear at that point. Result of 26 February 2010 shows a large right bronchogenic malignancy. Subsequent CT scan shows *a very large lobulated mass occupying most of the right lower lung lobe. Probable lung carcinoma with extensive mediastinal, intrapulmonary and liver metastases.* A lung biopsy confirms poorly differentiated non-small cell carcinoma of the lung and [Ms A] is referred for palliative care. The medical oncologist notes for 21 April 2010 include the history *… 53 year old female who has had a cough for the past four years and has had some right upper quadrant pain according to her for three years …* I note in the hospital records that [Ms A's] lung lesion and abnormal X-ray and examination findings have been recorded as left sided on 27 February and 1 March 2010, and again as left sided in the referral to oncology services on 22 March 2010. Fortunately, the lung biopsy was performed on the correct (right) side.

5. Comments

5.1 GP Documentation: GP documentation is generally poor. There is a combination of handwritten and computerised notes that distracts from effective care continuity. There are medication entries and clinical consultations in both sets of notes. It is difficult to establish the provider from the handwritten notes, and the content of the handwritten consultation notes is generally poor in quality and structure. The clinical documentation does not generally support [Ms A's] recollection of her symptoms in terms of their timing and persistence, particularly with regard to chest pain and shortness of breath. However a history more consistent with her recollections has been gained by the hospital doctors. In the

approximate four year period the notes cover, documentation of a physical examination is recorded on only two occasions – 19 September 2008 and 8 May 2009, with neither of these consultations undertaken by [Dr B]. Of particular concern is the absence of any physical examination findings when [Ms A] has presented with significant respiratory symptom and unwellness on 6 June 2008, 30 April 2009 and 10 December 2009 (see 4.3, 4.4). I am also concerned there was no appropriate clinical examination recorded by [Dr B] on 12 May 2009 when [Ms A] had been seen with abnormal chest signs and symptoms on 8 May 2009 (4.6). Overall, it is my opinion that the standard of documentation in this case would be met with moderate to severe disapproval by my peers.

[Para 5.2 has been removed as it relates to comments about documentation at the hospital which have been addressed separately.]

5.3 GP management: The lack of adequate clinical documentation does make it somewhat difficult to ascertain how persistent [Ms A] was in her complaints of respiratory symptoms and pain, and the absence of documentation of physical findings does not necessarily mean an examination did not take place. Nevertheless, [Ms A] was adamant that she was not examined on many occasions and the general standard of care offered leads me to suspect that, in general, any examinations that did occur were likely to be inadequate in content as well as documentation. The first documentation of respiratory symptoms is 6 June 2008. There are several references to shortness of breath, cough, haemoptysis and chest pain after this period but no indication from the notes whether the problems were episodic or persistent, and no sign that anything other than an episodic approach without investigation or follow-up was taken towards managing the symptoms. A recent guideline[35] distributed to all GPs in New Zealand notes that lung cancer was the leading cause of cancer death among Māori during the period 1996-2001 with the incidence in Māori being more than three times that of non-Māori. Māori were more likely than non-Māori to be diagnosed late. Risk factors relevant in [Ms A's] case were her long history of heavy smoking and family history of cancer. Relevant initial symptoms of lung cancer include persistent or unexplained cough, chest and/or shoulder pain, dyspnoea and haemoptysis. The current relevant guideline (released in November 2009 but reiterating what I would regard as accepted practice prior to that time) recommends urgent specialist referral for smokers with persistent haemoptysis and aged over 40 years, and urgent chest X-ray if they have unexplained haemoptysis or more than three weeks of any unexplained chest/shoulder pain, shortness of breath, abnormal chest signs and cough. It is my opinion that [Ms A] was likely to fulfil the recommended criteria for further investigation with a chest X-ray at least as early as June 2008 (if not earlier if the history of four years of cough noted by the oncologist was accurate (4.7)) and that her late diagnosis of lung cancer has been a direct result of the failure by [Dr B] to consider this diagnosis in a patient at significant risk and with a suspicious presentation, in a timely manner. Whether [Ms A's] final outcome would have altered with a diagnosis a year or so earlier is unclear, but she was

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denied the chance of any earlier intervention that might have prolonged her life. I acknowledge that [Ms A's] care might have been influenced by her benzodiazepine addiction and apparent escalating abuse of the medication. Nevertheless, I feel that the care of [Ms A] by [Dr B] raises sufficient concerns to warrant referral to the Medical Council for consideration of a competency review.

6. Clinical advice

6.1 On the basis of the records available to me, and referring to comments in section 5, I am of the opinion that the clinical management of [Ms A] by [Dr B] departed from expected standards to a moderate to severe degree, and that referral to the Medical Council for a review of his clinical competency should be considered. It would also be appropriate for him to offer [Ms A's] family a sincere apology for any distress caused to them by his failing to diagnose [Ms A's] lung cancer in a more timely fashion.

6.2 On the basis of the records available to me, and referring to comments in section 5, I am of the opinion that the clinical management of [Ms A] by [the DHB] was consistent with expected standards but draw their attention to my comments regarding clinical documentation in 5.2."

Appendix B — Further independent advice

Dr Maplesden provided further advice on 22 November 2010:

> "Thank you for forwarding the written response to my original advice from [Dr B], and transcript of a telephone interview undertaken with him on 27 October 2010.
>
> 1. In his written response [Dr B] questions the veracity of [Ms A's] complaint as he *did examine her chest with stethoscope this year and my impression was that she was developing a further lower respiratory infection. Additionally I reject the notion that I failed to order investigations but accept that I did not do so.*
>
> 2. The interview results appear to confirm the impression I gained from original perusal of the notes in that antibiotics had been prescribed for respiratory tract infections on occasions since mid-2008 with no physical examination being undertaken. [Dr B's] response regarding the consultation of 30 April 2009 includes *I don't recall carrying out an examination. But when I spoke to her it was my impression that she'd had a flu-like illness for 6 weeks. I would have recorded if I had laid a stethoscope on her chest that day. She'd been unwell for some time, and I thought there was an unresolved chronic respiratory infection going on for the time I had not seen her prior to that.*
>
> 3. The additional information presented does not alter my initial advice. It appears to confirm my impression of inadequate clinical documentation, sub-optimal clinical examination, and failure to follow-up abnormal symptoms —specifically persistent cough, shortness of breath, chest pain and haemoptysis in a female Māori with a long smoking history. While I acknowledge the presence of [Ms A's] diazepam dependency and drug-seeking behaviour may have distracted [Dr B] at times, this does not obviate the need for appropriate recording and clinical management of symptoms that, without the benefit of hindsight, required exclusion of serious underlying pathology given [Ms A's] smoking history, age and ethnicity."

Further advice was also provided on 12 April 2011 following [Dr C's] response to HDC's investigation:

> "I have viewed [Dr C's] response to specific questions you posed. His consultation of 8 May 2009 was reasonable in content and he confirms follow-up arrangements were made for [Ms A] to be seen by [Dr B] for review on 12 May 2009. In the context of [Ms A's] long history of recurrent cough and smoking, her symptoms at this time should, in my view, have led to consideration of chest X-ray by either [Dr C] or certainly by [Ms A's] usual provider, [Dr B]. The follow-up consultation by [Dr B] took place on 12 May 2009 as planned but there is no reference in the consultation note to [Ms A's] original presenting symptoms of chest pain and haemoptysis, no examination to determine whether her chest signs (crepitations and rub) had resolved, and no plan for further investigation of her chest symptoms. My original advice regarding the standard of service provided to

> [Ms A] therefore remains. I have amended my original advice in 4.6 and 5.1 to reflect the additional information obtained from [Dr C's] statement."

Please note that Appendix A is the final amended advice provided by Dr Maplesden to the Commissioner following his advice of 12 April 2011.