Medical Officer in General Practice, Dr B

A Report by the

Health and Disability Commissioner

(Case 07HDC01315)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Dr B	Provider/Medical officer in general practice
Mrs C	Mrs A's neighbour
Mrs D	Complainant/Mrs A's daughter
Mr D	Complainant/Mrs D's husband

Complaint

On 30 January 2007, the Commissioner received a complaint from Mrs D about the services provided to her mother, Mrs A, by Dr B. The following issue was identified for investigation:

The appropriateness of care provided to Mrs A by Dr B on 13 October 2006.

An investigation was commenced on 30 March 2007.

Information reviewed

Information from:

- Dr B
- Mrs C
- Mrs D
- The District Health Board

Independent expert advice was obtained from general practitioner Dr Keith Carey-Smith.

Information gathered during investigation

Chronology

12 October 2006
On 12 October 2006, Mrs C noticed that the mailbox of her neighbour, 73-year-old Mrs A, was full. Mrs C said that this was "very unusual" and she therefore decided to call on her neighbour. Mrs C stated:

> "[When Mrs A opened the door] I was very shocked as she had lost a lot of weight and looked really sick. … She was very pale with sunken eyes … and she said she was very tired and not eating."

Mrs C offered to take Mrs A to the doctor, and an appointment was made for Mrs A to see general practitioner Dr B at a medical Surgery (the Surgery) the following day, where Mrs C had been a patient since April 2002. The Surgery was jointly owned and operated by Dr B and Dr E; Dr E was Mrs A's usual doctor, and she had not previously had a consultation with Dr B.[1]

Dr B is a Fellow of the Royal College of Surgeons of England and a member of the Royal College of General Practitioners (UK). He does not hold registration within a vocational scope of general practice. He stated that he normally sees between 20 and 30 patients a day.

13 October 2006
Mrs A attended the Surgery at approximately 3.30pm on 13 October, accompanied by Mrs C. When called into the examination room to be seen by Dr B, Mrs A asked Mrs C to accompany her while she was examined. Mrs C stated that she held Mrs A's arm "as she was a little unsteady".

Dr B kept no records of the consultation, but recalled it clearly in a letter dated 5 March 2007. He stated:

> "[Mrs A] walked unaided into the surgery and was alert and orientated. She talked easily with no evidence of confusion or shortness of breath. [Mrs A] told me of her tiredness and recent dry cough. I enquired regarding any further symptoms such as shortness of breath, chest pain, and throat or ear pains. I enquired regarding her fluid intake. She had reduced her food and fluid intake but was still passing good amounts of urine. In particular I asked her how she was coping at home as she

[1] This is confirmed by medical records at the Surgery, and accepted by Dr B.

> lived by herself and the long weekend was starting the next day.[2] She felt she was managing well and did not need any further help. I also asked [Mrs C] how [Mrs A] was coping at home and was told she had been more tired than usual but was managing well at home.
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> I examined [Mrs A] for evidence of hypoxia (low oxygen), and dehydration which would produce confusion and reduced alertness. There was no evidence of any problems on this assessment. I assessed her colour, skin temperature and pulse. These were within the normal rate with pulse 84 beats per minute. Ear and throat examination was normal. I examined her chest thoroughly from the back of her chest. I listened to her lung apices (top of lungs), base of lungs, laterally up to the breast area and in the axilla (armpit). This provided the best access to assess her lungs as the access to the anterior chest was limited by the breast area and posture of her spine. Chest examination showed a normal respiratory rate of 24 and no abnormal breath sounds.
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> Based on the history and examination findings I diagnosed a viral chest infection."

Dr B did not measure Mrs A's temperature, "as it can be normal in a respiratory tract infection and does not indicate the need for admission or whether antibiotics are appropriate". He also did not measure Mrs A's blood pressure as he "did not have specific grounds for concern about her blood pressure".

Dr B decided to arrange for Mrs A to have a routine blood test, and prescribed Panadol for her symptoms. (A repeat prescription for Tamoxifen was also provided.) He also encouraged Mrs A to take Panadol regularly, and to drink "good amounts of fluid".

Dr B said that he checked with Mrs A that she was coping at home and was happy to return home, and asked Mrs C if she was happy to keep an eye on her neighbour. According to Dr B, Mrs C agreed to do so. However, Mrs C stated:

> "I am quite certain that [Dr B] did not ask what help [Mrs A] had at home."

Mrs C recalls that at the consultation Mrs A was not confused, "she appeared just to be very poorly". Dr B listened to Mrs A's chest on her back, and looked in her throat and her eyes. Dr B told Mrs A that she had "the flu", and that all he could give was Panadol, but if she was not better by the following Monday (in three days' time), she

[2] The "long weekend" that Dr B is presumably referring to is the weekend preceding Labour Day 2006, which fell on 23 October 2006 (ie, 21–22 October). The weekend following Mrs A's consultation on Friday 13 October 2006 (14–15 October) was not a long weekend.

might have to be admitted to hospital. Mrs C drove Mrs A home via the pharmacy to collect her prescription.

Early that evening, Mrs A's daughter, Mrs D, drove to stay with her mother because she was concerned about her condition, after her mother telephoned her upon her return home from the consultation with Dr B. Mrs D recalls that when she arrived she found her mother "dehydrated and delirious". Mrs D telephoned her husband, who advised her to call an ambulance if she was concerned about her mother's condition. However, Mrs D "trusted the opinion" of Dr B, who had seen her mother only a few hours earlier, and decided not to call an ambulance.

14 October 2006

The following day, Mrs A's condition had not improved at all and, upon his arrival at around 2.30pm, Mrs D's husband immediately decided to call an ambulance to take Mrs A to hospital.[3]

The clinical assessment by the ambulance crew recorded that Mrs A looked "flushed" and was short of breath. Her blood pressure was low (60/40), pulse fast (130bpm), and oxygen saturations low (74%).[4] It was also recorded that Mrs A had been seen by her GP the previous day for "similar symptoms", and that she had a one-week history of a productive cough.

On arrival at the Hospital Emergency Department, the triage nurse recorded Mrs A's blood pressure as 73/46, temperature as 38.8ºC, pulse as 120, respiratory rate at 36 breaths per minute, and oxygen saturations as 68%. The nurse recorded the presenting complaint as:

> "Coughing [short of breath] Dehydrated … Febrile
> Unwell for 1 week
> Gradual onset of coughing — productive of green/brown phlegm."

Mrs A was examined by an Emergency Department doctor at 4.05pm. The recorded assessment stated that Mrs A had consulted her GP the day before, and that she was "reassured" and prescribed Panadol. The provisional diagnosis recorded was "sepsis/pneumonia".

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[3] The St John's Ambulance Service documentation states that the ambulance was dispatched at 2.36pm and arrived at Hospital at 3.30pm.

[4] Oxygen saturation, or pulse oximetry, is a non-invasive method of monitoring the percentage of haemoglobin that is saturated with oxygen. The pulse oximeter consists of a probe attached to the patient's finger or ear lobe, which is linked to a computerised unit. The unit displays the percentage of haemoglobin saturated with oxygen together with an audible signal for each pulse beat and a calculated heart rate. A normal reading at sea level is 95–100%.

On further examination by a house surgeon in the Emergency Department at 6pm, Mrs A's blood pressure was still low (102/39), her pulse raised (118bpm), her temperature was 38.8ºC, and her oxygen saturation was low (68%). She was diagnosed with pneumonia and septic shock associated with the infection. Mrs A was transferred to the intensive care unit but, despite further care, she died a few days later.

Lack of records

The only records that Dr B kept of the consultation on 13 October recorded the medication he prescribed and the blood test request. They were saved in Mrs A's electronic patient records.

On 26 October, a member of staff at the Hospital contacted the Surgery, and spoke to the Practice Manager. She told Dr B that Mrs A had died. She recalls that Dr B was surprised at this news, as he said that "he had not thought that [Mrs A] was that unwell" when he last saw her.

Dr B stated that he reviewed his management of Mrs A at the consultation of 13 October immediately after he was advised by the Hospital of her death. He thought that Mrs A's death was "surprising in view of how well she appeared a day prior to her admission to hospital".

In a letter dated 22 April 2007 (in response to this investigation) Dr B explained that he "overlooked" documentation of the consultation because of a "human error" on his part, in opening the door for Mrs A as she left the consultation — "as a courtesy rather than due to a clinical requirement". Dr B believes that he did take notes during the consultation, but failed to save them in the electronic patient records ("I discovered the notes of the consultation had not been saved").

The Surgery used MedCen practice software, an electronic records system[5] in which Dr B and Dr E kept all the records of their patients. Dr B advised that he has had a "note audit system" added to the MedCen software to prevent any failure to document notes of a consultation. His receptionist uses the computer audit system to detect any missed consultation notes.

Dr B stated:

> "I am confident that my memory of this review is accurate as her death was unexpected. I am now aware that I could have documented my thoughts on the consultation at the time I realised my notes were unavailable. I thought carefully

[5] MedCen Software was contacted about the process by which a record of a consultation is saved. It advised that when users attempt to exit the system, they are asked by the MedCen system whether they wish to save the records, and are given the choice of "yes" or "no".

> through the consultation to personally determine if there was more that I could have done on the day to prevent the subsequent death. In particular I thought about the clinical findings and the support systems when she went home. I considered the alternative options of whether antibiotics or admission were warranted based on my findings on the day. However, even with the benefit of hindsight, I did not feel there were clinical grounds for further or alternative management on the day of the consultation. …
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> I have since discussed this issue with my peer and [vocational GP supervisor] … and agreed that temperatures should be documented.
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> …
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> Following discussion with my [vocational supervisor] I have an audit system in place to determine specifically the adequacy of documentation of respiratory tract infections, including temperature documentation. I will compare this data with previous documentation and present this to [him] for discussion."

Dr B did not make any retrospective notes for the assessment of 13 October 2006, nor a note of his subsequent review. He accepts that he should have done so. He stated:

> "In hindsight I should have documented this issue and my investigation of events at the time when I was informed of [Mrs A's] death."

Independent advice to Commissioner

The following expert advice was obtained from general practitioner Dr Keith Carey-Smith:

> "In order to provide an opinion to the Commissioner on case number 07/01315, I have read and agree to follow the Commissioner's Guidelines.
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> My opinion is based on my training in general medicine, and general practice, and my experience and ongoing education as a rural general practitioner in Taranaki for over 30 years. This includes care of elderly patients with cardiac and respiratory conditions. My qualifications are FRNZCGP, Dip Obstetrics (NZ) and DA (UK).

[At this point in his report, Dr Carey-Smith sets out the background of the complaint, the documentation sent to him, and the questions asked of him, which he repeats in the body of his report. This information has been omitted for the purpose of brevity.]

General comments:
The exact details of what happened at the consultation on 13 October 2006 cannot be clearly established. A first-hand account is available from [Mrs C] (the neighbour who accompanied [Mrs A] to see [Dr B] …, a second-hand account from [Mrs D] ([Mrs A's] daughter) …

[Dr B's] account was presumably written from memory when he wrote his letter to [Mrs A's family] on 5/3/07 …, and his response to the HDC on 22/4/07 … He had not documented the consultation, or the review of the consultation [after Mrs A's] death (notification of death dated 26/10/06 in his records …).

Content of consultation 13/10/06
[Dr B's] records suggest that this was the first time that he had seen [Mrs A]. Previous entries are by other named doctors or nurses. The accounts given by [Mrs C] on 3/4/07 (also reported by [Mrs D]) and by [Dr B] (5/3/07) confirm that the examination by [Dr B] included [Mrs A's] chest, throat and ears, and that he diagnosed 'the flu', gave her a prescription for Panadol, and indicated that if she had not improved over the weekend she might have to go to hospital. [Mrs C] does not mention any history taking and interrogation (as noted in [Dr B's] account), or examination of the pulse. Other observations mentioned by [Dr B] (for hypoxia, dehydration, respiratory rate) may not have been noticed by a non-medical support person. Both reports agree that no temperature or blood pressure was measured. Other topics in the discussion noted by [Dr B] (about fluid intake, support at home, etc) were also not mentioned by [Mrs C]. A follow-up consultation does not appear to have been arranged. Blood tests were ordered, but not as part of assessment of [Mrs A's] current illness.

[Mrs C] noted that [Mrs A] 'looked really sick … pale with sunken eyes', said she was 'very tired and not eating', and 'was a little unsteady', whereas [Dr B] stated (from his recollections of the consultation) that 'she walked unaided into the surgery … was alert and orientated … talked easily with no evidence of confusion or shortness of breath'. There is some discrepancy between these two accounts.

The history taking, interrogation, and final explanation described by [Dr B] in his letter (5/3/07) covered all appropriate areas relevant to the case. This included the history of cough and tiredness, questions about respiratory symptoms, fluid intake and urine output, and ability to manage at home without help. He also stated that he confirmed with [Mrs C] that she was managing, explained diagnosis and management, and stressed the need to seek further medical attention if she did not improve.

[Dr B] says that he performed the following examination:

- Colour, skin temperature

- Mental state (alertness, confusion)
- Pulse (noted normal at 84 beats/minute)
- Ear and throat examination
- Chest examination — all zones excluding front of chest (noting 'respiratory rate 24, no abnormal sounds'). Percussion was not mentioned.

Subsequent events

It is noted that when [Mrs D] arrived several hours after the consultation she thought her mother was dehydrated and delirious. She did not seek further medical attention at that stage, but presumably called the ambulance the next day (at approx 2.30pm). The ambulance record, (confirmed in subsequent hospital records) noted that [Mrs A] had been unwell for about a week.

Examination at the hospital revealed low blood pressure and oxygen levels, increased pulse and respiratory rates, signs ('coarse creps bibasal' and later dullness to percussion) and radiological evidence of right sided pneumonia, and metabolic derangement. Her diagnosis was recorded as septicaemia and pneumonia (strep. pneumonia was cultured from the blood), as well as adult respiratory distress syndrome and renal failure. Her subsequent downhill course and death after a week despite intensive antibiotics and life support is well documented in the hospital notes.

Documentation

The absence of a record of the consultation in question is noted, as well as a lack of documentation when [Mrs A's] case was reviewed after her death. This deficiency was stated by [Dr B] to be due to 'human error'.

OPINION

1. The standard of care provided to [Mrs A] by [Dr B] on 13 October 2006.

My opinion is limited because of the lack of consultation records (either at the time or soon after) and therefore of confirmation of the report on the consultation given by [Dr B] almost five months after the event. However [Mrs C's] recollection (also five months after the event), as far as it goes, largely agrees with that of [Dr B], except with respect to the appearance and weakness of [Mrs A] on the day.

It is therefore not possible to confirm the history, interrogation, examination findings, and discussion detailed by [Dr B]. Although [Dr B] says that he reviewed the consultation when he was notified of [Mrs A's] death 13 days later, he did not at that stage make a note of his recollections. Therefore it is surprising that he can remember the detail of the consultation, including exact questions asked, instructions given, and pulse and respiratory rate, etc. These features may be [Dr

B's] 'normal practice', but he did not state this, and it would be most unlikely that a busy practitioner could remember such details, especially exact pulse and respiratory rate, some months after the consultation. This calls into question the accuracy of the consultation account. Alternatively, [Dr B] has an unusually accurate memory.

Furthermore, there is a discrepancy between the findings of [Dr B's] examination and those performed at the hospital a day later. [Dr B] did not detect the abnormal chest sounds, although these might have developed during the intervening period. In addition [Dr B] did not check for consolidation by percussion. A cursory examination could well have missed subtle early chest signs.

In addition to the examination items performed by [Dr B] listed above, I consider a standard general practice examination of a patient with [Mrs A's] presentation (cough and tiredness) should include:

- Full chest examination including percussion and auscultation of chest (all areas).
- Brief examination of cardiac and peripheral vascular system (heart, blood pressure, ankle oedema, peripheral circulation), nervous system (cognition, limb weakness, coordination etc), and abdomen.

The most important features indicating the presence of severe illness according to expert opinion in a recent Medical Protection case 'Failure to diagnose pneumonia' are new mental confusion, increased respiratory rate, and a low blood pressure (systolic less than 90mm Hg) (ref 1). [Dr B] noted the first two as absent, but did not measure blood pressure.

Even though pneumonia can often develop in the elderly without physical signs, I consider the examination deficient in not checking fully for consolidation, and not examining the full chest (front and sides as well as back). Despite the presence of a normal pulse and absence of other signs of shock (dizzyness etc), the lack of blood pressure measurement is a significant deficit. However temperature is not particularly helpful in confirming or excluding serious infection in the elderly (although ideally it should be measured). A general practitioner would not be expected to have a pulse oximeter. The examination did not appear to include cardiovascular, nervous system and abdominal examination as listed above.

[Dr B's] previous records suggest that this was the first time he had seen [Mrs A]. This would make it more difficult to detect changes from her usual state. Therefore, in this situation it is more important to obtain a full history including questions to compare with her normal condition, and to conduct a fuller examination.

Pneumonia and/or septicaemia can develop insidiously and without clear physical signs and symptoms in elderly people. For this reason a fuller examination than normal, including focus on the general condition of the patient, is necessary. Further investigations including blood tests and investigations are important if there is suspicion of these conditions. The fact that [Dr B] did not proceed to further tests or admission confirms his statement that he considered [Mrs A] to have a 'viral chest infection' (presumably meaning *upper* respiratory tract infection), without evidence of serious complications. It was appropriate not to prescribe antibiotics in this situation.

2. What professional standards apply in this case?

As detailed above, a competent GP should check for clinical signs of pneumonia, and for features of serious systemic illness (confusion, elevated respiratory rate or pulse, low blood pressure) (ref 1). In elderly patients classic features of pneumonia are less likely, whereas non-specific features, such as confusion, are more likely (ref 2). General investigations, including chest X-ray are not necessary for the majority of patients with pneumonia managed in the community (ref 2).

Thorough records are important to later confirm management in cases such as this (ref 1), and the current New Zealand general practice standards for a consultation record include reason for encounter, examination findings, investigations and medications ordered, diagnosis/assessment, and management plan (ref 3).

3. Were these standards met?

[Dr B's] recollections suggest that he checked for confusion, chest signs of pneumonia, and respiratory rate. He failed to measure blood pressure. He also failed to record the consultation, other than the automatic date and entry of medications prescribed and tests ordered.

4. The adequacy of the clinical examination performed by [Dr B].

I suspect from the evidence available to me, that the examination was cursory and incomplete, as detailed above.

5. Please comment on the adequacy of the advice given to [Mrs A] at the conclusion of the examination.

Advice given (as listed by [Dr B] and in part confirmed by [Mrs C]) was adequate, and covered all appropriate aspects of diagnosis, management, and follow-up.

6. Comment on [Dr B's] 'human error' in his not documenting [Mrs A's] assessment:

a. at the time of the assessment; and

b. when he noted that the assessment had not been documented.

Lack of any records of this consultation is a serious omission, not rectified by the letter written five months later detailing [Dr B's] recollection of the episode. Apart from the comments from [Mrs C], there is no way of confirming these details.

7. *Are there any aspects of the care provided by [Dr B] that you consider warrant additional comment?*

No.

CONCLUSION

If [Dr B's] account of the consultation is correct, (only partially confirmed by other evidence provided), his care was of a standard one would expect of a general practitioner with respect to **history taking, interrogation, management, explanation and advice, and instructions** to seek further help. Evidence suggests his **examination** was cursory, and deficient in not checking for consolidation, not including the anterior and lateral chest, and inadequately assessing the patient's general and systemic condition (including blood pressure). These deficiencies are viewed with **mild disapproval.** Because of lack of records and adequate evidence, it is not possible to determine if [Mrs A's] condition at the time of the consultation warranted urgent chest X-ray, blood tests or admission.

The absence of **records** written at the time of the consultation (or afterwards when the deficit must have been detected) is a serious deficit, without satisfactory explanation, and viewed with **moderate disapproval**. It is not known if this practice is widespread, but [Dr B] is to be complemented for recently introducing a system to check for missing consultation notes.

References:

1. 'Failure to diagnose pneumonia'. Case report. Medical Protection Society Vol 14, 1, February 2006.[6]
2. Guidelines for Community Acquired Pneumonia. British Thoracic Society, 2001.
3. 'Aiming for Excellence' (An assessment tool for General Practice). RNZCGP (Revised 2006)."

[6] www.medicalprotection.org/adx/aspx/adxGetMedia.aspx?DocID=972,6042,249,127,22,11,Documents &MediaID=707&Filename=casebook_2006_1_case_reports.pdf

Response to provisional opinion

Dr B obtained advice from general practitioner Dr David Kerr on the care provided to Mrs A. Dr Kerr advised:

> "I have read the New Zealand Health Practitioners Disciplinary Tribunal code of conduct and confirm that I agree to comply with it. I am a member of the Medical Protection Society Advisory Panel but this has not influenced the independence of my opinion.
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> I have had the opportunity to review the notes from the ambulance staff, the emergency department staff, and [the] Public Hospital case notes. In addition I have reviewed the [provisional] report by the Health and Disability Commissioner (Case 07HDC01315) and the complaint action contact notes relating to this case.
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> In addition I have reviewed the communications between [Dr B] and the Health and Disability Commissioner and [Dr B] and yourself.
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> It is clear that the absence of any case notes or subsequent file entry to support [Dr B's] contention of a file review is a major impediment to being clear about [Dr B's] assessment of the patient's status. I am not familiar with the programme MedCen but do note that [Dr E's] case notes seemed to be 'saved' on a regular basis.
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> There is an inconsistency between the neighbour's observation of [Mrs A's] physical status and the content of the consultation as described by [Dr B]. It is my suggestion that [Dr B's] memory must be in very good state to recall the details of the consultation such as he has advised without the benefit of case notes, but possibly the subsequent events have kept his recollections alert.
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> …
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> While I agree that the recording of temperature is a useful recording I would respectfully suggest that the global clinical appearance of a patient is more critical than a single clinical finding. … [I]t is relatively commonplace to find an elevated temperature in a patient with 'uncomplicated flu' (his words) of one-week duration.
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> …
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> I would therefore not regard it as being a critical clinical finding and would rather rely on a collection of clinical findings. …
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> With respect to the rest of [Dr B's] examination I agree that the auscultation of the entire chest is required and that the recording of the blood pressure would be

expected. One would also observe that [Dr B] had not met or consulted with this patient before and this does make his capacity to assess her general condition somewhat more difficult. Issues such as weight loss and general physical appearance are often important but less easy to assess if the patient has not consulted with the particular Doctor previously.

In terms of [Dr B's] actions subsequent to [Mrs A's] death.

- His initiation of procedures to ensure case notes are always saved
- His initiating contact with his vocational overseer
- His initiation of an audit of the quality of clinical assessment

I would observe that these are good and appropriate initiatives to undertake.

There is clearly a divergence of views with respect to how unwell [Mrs A] was at the time of the consultation with [Dr B]. It is possible that [Dr B's] judgement of her general health status was impaired because he had not seen or consulted with her before as mentioned above.

[Mrs A's] daughter travelled from [another city] later the same day because of her concern about her mother's condition. Apparently [Mrs A] was 'dehydrated and delirious' in [Mrs A's] daughter's opinion. This is clearly a significant change between both [Dr B] and [Mrs A's] neighbour's assessment of how [Mrs A] was in the middle of the afternoon. Delirious behaviour is not the sort of behaviour that could be overlooked. It was not until some 23 hours after the consultation in question that the ambulance transported [Mrs A]. At this time it is evident from the Ambulance officer's notes that there was a constellation of clinical findings which left little doubt that [Mrs A] was very unwell and needed urgent hospitalisation. The ambulance picked up [Mrs A] at 2.47pm.

The emergency department records at 3.40pm revealed clinical findings of rapid pulse, rapid respirations, low blood pressure, and low oxygen saturation.

The assessment at 4.05pm identified 'coarse creps bibasal'.

The patient was then referred for a chest X-ray and blood tests.

The chest X-ray identified 'right hemithorax almost obliterated by consolidation…'.

And the blood film revealed 'WBC 5100 (left shift of neutrophils)'.

[Mrs A] was then formally admitted to the Hospital at 6pm. By this time it was difficult for her to speak according to the case notes and it is evident that she is 'using accessory muscles ++ and obvious cyanosis now' and 'only managing one word between breaths'.

It would seem that this has been a rapidly progressive deterioration.

This is supported by the relative mismatch between the admitting doctor's clinical findings of bibasal crepitation being noted and yet a chest X-ray subsequent to that suggesting very extensive consolidation.

Furthermore, the white blood count would ordinarily rise rapidly with any significant infection and the only comment made about the white blood count (which was normal) was that there was 'left shift of neutrophils'.

Many patients who have pneumonia may have a white blood count up to 20,000 or more. Older people or patients in shock may be slower to respond but one would still construe from the relatively low total number of white blood cells and the increase in neutrophil numbers and the shift to the left of these neutrophils that this was a relatively recent and overwhelming infection. The presence of a shift to the left indicates the production of new white blood cells.

The rapid progress of some pneumonia cases is well described in the MPS case book dated February 2006, the Army Medical department of the Surgeon General's office, and the Pneumonia fact [sheet] produced by the American Lung Association …

There is therefore the possibility that this patient sustained a significant change in her clinical status between being seen by [Dr B] and then by [Mrs A's] daughter on her arrival from [the city where she lived] and subsequently the ambulance staff and emergency department staff.

The absence of clinical notes at the time of [Dr B's] consultation make it difficult to be clear at what stage in her declining health status she was at when he consulted with her.

In your letter you ask for comment on the likely effect of the delay between [Dr B's] examination and the family's call to the ambulance service almost a day later. I could only observe that with a rapidly progressing infection which was seemingly overwhelming her that time is always of the essence in obtaining a good outcome and this is more so the case when dealing with older and more frail patients.

You will of course appreciate that these comments are made with the intention of retaining balance to the evidence that is presented to the Health and Disability [Commissioner]."

Dr B submitted:

"I accept that there are aspects of my interaction with [Mrs A] that I could have improved upon and for that I am happy to apologise. However, I am concerned at the referral to the Director of Proceedings, and I would like you to reconsider that recommendation for the reasons set out below.

Assessment of [Mrs A]
I acknowledge and recognise that I should have conducted a more thorough examination of [Mrs A]. I agree that I did not measure her temperature or take her blood pressure, which I accept would have added to the whole picture of her condition at the time. Of course, I wish as well that the notes that I thought I had made had been preserved to support now my recollections of the assessment.

I have discussed the case with my [vocational overseer]. While he felt that temperature did not usually alter management in a situation such as this, it would add to the assessment. I now have in place an audit to present to [him] regarding the quality of my documented clinical assessment, including the taking of temperature.

[The vocational overseer's] comments on temperature are supported by Dr Kerr, whose opinion I accept, when he says that elevated temperature is a relatively commonplace finding in a patient with uncomplicated flu. I can only speculate as to whether this would have changed my treatment of [Mrs A].

Comments on the Provisional Opinion
At page 3 you have recorded that [Mrs C] was quite certain that I did not ask what help [Mrs A] had at home. The impression given in the provisional opinion is that [Mrs C] disputes my recollection of the discussion that I had with [Mrs A]. It may just be the way in which the provisional opinion is worded, but I do not see my recollection and [Mrs C's] as being in conflict. I understood from my discussions with [Mrs A] that she had no help at home. I might not have asked [Mrs A] directly if she had help at home because I had already gathered that she did not need help. I did offer her assistance if she felt she could not cope, but [Mrs A] felt that this was not required. [Mrs C] also gave me the clear impression that she would look out for her friend and neighbour. This reassured me that there was some safety net present in case [Mrs A] deteriorated further. The presence of some form of safety net was important in assuring me that [Mrs A] would not sit at home and deteriorate without someone looking in on her and able to initiate further action.

However, I must disagree with [Mrs C's] statement that she recalled me saying that [Mrs A] might have to be admitted to hospital if she was not better by the following Monday. Instead, I recall that I insisted — as I do with all my patients — that she seeks further medical review if she was not improving.

I must say that I am concerned to see that [Mrs D] states that when she arrived a few hours after my assessment she found [Mrs A] *'dehydrated and delirious'*. It was certainly not the impression I gained from [Mrs A] when I assessed her, and it was not how [Mrs C] described [Mrs A]. Had [Mrs A] presented in that fashion to me then I most certainly would have arranged for her immediate admission to hospital. I am also concerned that if this was the position [Mrs D] found her mother later that day, it took 23 hours for an ambulance to be called to take [Mrs A] to hospital.

Once [Mrs A] was admitted to hospital, she was clearly in a debilitated state. However, it seems that her condition was rapidly progressing and had moved on significantly since I had examined [Mrs A]. The assessing doctor identified *'coarse creps bibasal'*. This does not suggest the degree of compromise to the lungs that was found when the chest X-ray was performed, which identified very extensive consolidation. I do not consider it reasonable to conclude that my examination of [Mrs A's] chest may have been reassuring when I examined her the day before.

Dr Carey-Smith accepts … that the abnormal chest sounds may have developed during the intervening period between my assessment and [Mrs A's] presentation at the hospital.

Of course, I wish now that my notes had been saved. I certainly accept the need for notes at the time of the consultation. When I reviewed the matter after being informed of [Mrs A's] death, and seeing that the notes were no longer there, it did not occur to me to retrospectively make new notes. I had always understood that this was illegal. I now understand that I could have made retrospective notes including the date the notes were made and an explanation of the reason for the retrospective note.

You have commented negatively on my recollection, particularly in light of my confusion about the long weekend. I honestly believed, at the time that I wrote my letter of 5 March 2007, that the weekend had been a long weekend. I wonder if the reason for this is that, in my mind, I was not going to be able to review [Mrs A] again for three days, until the Monday, and this led me to think it was the long weekend.

I was also confused about the long weekend by the fact that [Mr and Mrs D] had commented about my lack of availability when they had tried to ring me on Monday. I took that to mean Monday 23 October when the surgery was closed. I must have become confused in my mind about which Monday we were talking about.

However, I do not accept that this is a reason for my entire recall to be questioned. There are extenuating circumstances here that preserved my recall. It is certainly not usual for me to recall consultations five months later, but here I had been told that [Mrs A] had died soon after I had treated her. This was surprising news to me, and therefore memorable. My impression when I assessed [Mrs A] was of someone with a viral chest infection, and certainly not of someone with a developing pneumonia.

When I was informed of [Mrs A's] death, I stopped my routine and assembled all the available information to review what I had done. I mentioned my surprise to my [practice manager] at the time, and asked her to assemble the information. At that point, I realised my lack of documentation. I carefully reviewed all of my clinical management on that day. I specifically asked myself two questions:

1. whether there were grounds for prescribing antibiotics; and
2. whether there were grounds for encouraging admission to hospital.

I reconstructed events, and the critical features of my consultation with [Mrs A] became firmly embedded in my memory as a result. Just as patients say that they recall consultations vividly because they do not have them very often, so can I recall my consultation with [Mrs A]. I suggest this is not as surprising or unusual as you or Dr Carey-Smith believe. Of course, that does not detract from the fact that I regret not having my notes to rely on to confirm my recollections.

I am concerned that Dr Carey-Smith *suspects* and speculates that my examination of [Mrs A] was cursory. I presume the basis of this is that the notes were not saved and I was recalling facts from memory. He perhaps did not take into account the fact that the news of my patient's death was surprising to me at the time and that reinforced my recall of the discussion. I must dispute that the examination was cursory. It may have been incomplete but it was not cursory. I would not have conducted a cursory examination of any patient, let alone with [Mrs C] present, and obviously concerned about her neighbour.

The provisional opinion goes on to say that a cursory examination could well have missed subtle early chest signs indicative of pneumonia. This comment is at odds, somewhat, with the observations made by Dr Carey-Smith (and supported by Dr Kerr) that pneumonia can often develop in the elderly 'without physical signs' … and 'pneumonia and/or septicaemia can develop insidiously and without clear physical signs and symptoms in elderly people' …

Following this case, I have been reminded — and, indeed, have taken on board very seriously — the need for increased vigilance in the assessment of elderly patients. They, like very young children, can have very subtle evidence of disease

processes and can subsequently deteriorate rapidly. I fully accept comments that further information such as blood pressure would have given a fuller picture of [Mrs A] and I have a much lower threshold for seeking such information. However, I do not accept that my examination of [Mrs A] was cursory.

In relation to the heading 'Documentation' … , while I accept that I should have ensured that a record was kept of the consultation, and I now greatly regret that this did not occur, I do not accept that I was in any way flippant with regard to my responsibilities. The fact that I took the time out to review the case as recognised by my Manager at the time, when I found my patient had died, indicates my sensitivity to my responsibilities. I think credit should also be given in the opinion to the steps that I have taken subsequently to address this issue, as Dr Carey-Smith suggests. I have taken measures within the whole practice in terms of computer software, and staff procedures, to prevent future mistakes of this nature.

To conclude, I regret that my consultation may not have been as full as I would now like. However, I am sure that there were no signs present, at the time that I assessed [Mrs A], that indicated that she was in a perilous state requiring admission to hospital or the early prescription of antibiotics. I accept, as well, that I should have made notes of the consultation, at the very least when I reviewed the matter upon learning of [Mrs A's] death.

However, I believe that a referral to the Director of Proceedings is a draconian response. I do not accept that my credibility should be seriously questioned. My consultation with [Mrs A] has been embedded in my experience, by the surprise and shock I felt on learning of her death. Your expert accepts that pneumonia can develop insidiously, and there are a number of features in this case which suggest that she progressed rapidly.

Dr Carey-Smith viewed my examination with mild disapproval but he commended me for my introduction of systems to check regarding missing notes. I think I should receive some acknowledgement for this.

I am happy to accept the recommendation of a referral to the Medical Council for a review of my practice. I have already reviewed this case with my practice with [my vocational overseer] and I would be prepared to do so again when this opinion is finalised."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.

Other relevant standards

"Good Medical Practice — A Guide for Doctors" (Medical Council of New Zealand, 2004):

"Domains of competence:

…

2. Good clinical care must include:

- an adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination
- providing or arranging investigations or treatment when necessary
- taking suitable and prompt action when necessary.

3. In providing care you must:

…

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

Opinion: Breach — Dr B

Introduction
Mrs A was an elderly, unwell patient when she consulted Dr B on 13 October 2006. He was not her usual GP. Under Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Mrs A was entitled to have medical services provided by Dr B with reasonable care and skill, and in compliance with legal, professional, ethical and other standards. Dr B was required to perform an appropriate assessment of Mrs A's condition and to accurately document his findings. In my view he did neither, and consequently breached the Code. The detailed reasons for my opinion are set out below.

Standard of care
The accounts by Dr B and Mrs C differ as to whether or not Mrs A required assistance to walk into the examination room. I prefer Mrs C's account that Mrs A needed the assistance of her arm "as she was a little unsteady", to Dr B's memory (unsupported by any documentation) that Mrs A "walked unaided into the surgery". In my view, a patient's neighbour and support person is likely to have a more reliable recollection of a single consultation (with a friend who died a short time later) than a doctor who sees on average 20–30 patients a day.

There is no substantive dispute about the assessment Dr B performed. He gave a detailed account of his clinical examination, but agreed that he did not measure Mrs A's blood pressure or temperature, or listen to the front and side of her chest when he assessed her breathing. Dr Keith Carey-Smith, my expert advisor, stated that a general practitioner — when faced with a patient presenting as Mrs A did — would be expected to perform a full chest examination and a "brief examination of cardiac and peripheral vascular system", and to check blood pressure. Dr Carey-Smith summarised his view of Dr B's assessment:

> "Even though pneumonia can often develop in the elderly without physical signs, I consider the examination deficient in not checking fully for consolidation, and not examining the full chest (front and sides as well as back). Despite the presence of a normal pulse and absence of other signs of shock (dizziness etc), the lack of blood pressure measurement is a significant deficit."

Dr David Kerr, in providing advice to Dr B's lawyer, stated:

> "I agree that the auscultation of the entire chest is required and that the recording of the blood pressure would be expected. One would also observe that Dr B had not met or consulted with this patient before and this does make his capacity to assess her general condition somewhat more difficult. Issues such as weight loss

> and general physical appearance are often important but less easy to assess if the patient has not consulted with the particular Doctor previously."

Dr B disagrees with Dr Carey-Smith's view that the assessment was "cursory", although he accepts that he "should have conducted a more thorough examination of [Mrs A]".

I concur with my expert's view that Dr B's examination was "cursory and incomplete". I am not convinced that Dr B took an adequate history to detect changes from Mrs A's usual status. As noted by Dr Carey-Smith (and remarked on by Dr Kerr), a full history and examination was all the more important since Dr B was not Mrs A's usual doctor, and was seeing her for the first time.

I agree with Dr Carey-Smith that Dr B's "cursory examination could well have missed subtle early chest signs" indicative of the pneumonia that was diagnosed 24 hours later.

Documentation
According to professional standards set by the Medical Council of New Zealand, Dr B was required to "keep clear, accurate, and contemporaneous patient records that report the relevant clinical findings, the decision made, the information given to patients and any drugs or other treatment prescribed". Although Dr B recorded the medication he prescribed and the blood test request, he neglected to record his history taking, examination and findings. I endorse my expert's view that this is a serious omission.

Dr B has provided conflicting explanations for his failure to record any other details of the consultation. On the one hand, he says that he "overlooked" documentation when he was distracted in showing Mrs A to the door, as a courtesy. On the other hand, he states that he did make other records, but failed to save them in the electronic notes. Dr B has repeated this explanation in his response to the provisional opinion, yet it is difficult to square this with two facts: (1) the MedCen software system would have given a prompt ("yes" or "no") to save any notes Dr B made; and (2) Dr B did manage to save his notes of the medication prescribed and the blood test request.

As Dr Kerr noted, "Dr E's [Dr B's practice colleague] case notes seemed to be saved on a regular basis".

Dr B stated that he reviewed his management of [Mrs A's] care when he was made aware 13 days later (on 26 October 2006) that she had died. If he did perform this review as he claims, Dr B would surely have noted that he had failed to make a record of his assessment. His excuse that he thought it "illegal" to do so is rather unconvincing. He now accepts that he should have made a retrospective, post-dated note of his care.

In any event, it is hard to believe that Dr B could perform a review in the detail in which he claims, without documentation. Dr B also claims that he recalled the events of the consultation because Mrs A's death was "surprising news to [him], and therefore memorable". He stated:

> "I reconstructed events, and the critical features of my consultation with [Mrs A] became firmly embedded in my memory as a result. Just as patients say that they recall consultations vividly because they do not have them very often, so can I recall my consultation with [Mrs A]. I suggest this is not as surprising or unusual as you or Dr Carey-Smith believe."

I note Dr Kerr's comment:

> "It is my suggestion that [Dr B's] memory must be in very good state to recall the details of the consultation such as he has advised without the benefit of case notes, but possibly the subsequent events have kept his recollections alert."

Five months after the consultation, and without the benefit of a record of his assessment, Dr B described a total of 29 clinical or social observations from the assessment he performed — including precise pulse and respiratory rates, and the reasons why he did not record Mrs A's blood pressure. I agree with Dr Carey-Smith's comment that it would be "most unlikely that a busy practitioner could remember such details … some months after the consultation". I note that Dr B does not have a perfect memory — for example, he mistakenly recalled that Friday 13 October 2006 was the day before Labour weekend.

Although Dr B stated that the details of the consultation became "embedded in [his] memory" as a result of his reconstruction of the events, I am sceptical that he could recall details with such precision 13 days after the consultation, and that he could then mentally retrieve this information, without the benefit of notes, some five months later when writing his letter of 5 March 2007. In my view, the unlikelihood of such a precise recollection also casts doubt on the credibility of Dr B's account of the consultation with Mrs A.

Finally, I note the comment of Baragwanath J in *Patient A v Nelson–Marlborough District Health Board*,[7] that it is through the medical record that doctors have the power to produce definitive proof of a particular matter. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof), may find their evidence discounted.

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[7] *Patient A v Nelson–Marlborough District Health Board* (HC BLE CIV–2003–406–14, 15 March 2005). The comment was made in relation to informed consent, but in my view is equally applicable to failure to document other key elements of a consultation, including examination findings.

Conclusion
Dr B's examination of Mrs A on 13 October 2006 was cursory and incomplete. The deficiencies in his assessment were significant and represent a major failing in the care of an unwell 73-year-old patient who was unfamiliar to the treating doctor. Dr B also failed to record his assessment at the time, or retrospectively when he claims he undertook a subsequent review. Dr B failed to provide medical services to Mrs A with reasonable care and skill, and that complied with professional standards.

In these circumstances, Dr B breached Rights 4(1) and 4(2) of the Code.

Dr B's omissions are compounded by the question marks over the credibility of his responses to Mrs D's complaint and to this investigation.

Mitigating factors
Dr B deserves credit for the steps he has taken since these events. He has discussed the case with his vocational overseer, initiated procedures to ensure consultation notes are always saved, and arranged an audit of the quality of his clinical assessment.

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 will be sent to the Medical Council of New Zealand, with a recommendation that the Council consider whether a review of Dr B's practice is warranted, and to the Royal New Zealand College of General Practitioners.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings considered the matter and decided not to issue any proceedings. Whilst there were some deficiencies in Dr B's assessment of Mrs A, it was considered unlikely that the Health Practitioners Disciplinary Tribunal would find that those failings amounted to professional misconduct.