

**General Practitioner  
Physician  
Public Hospital**

**A Report by the  
Health and Disability Commissioner**

**(Case 99HDC09901)**



## Parties involved

Ms A	Complainant / Consumer's Partner
Dr B	Provider / General Practitioner
Ms C	Chief Executive Officer, a public hospital
Dr D	Physician, a public hospital
Dr E	Cardiologist
Ms F	Outpatients Administrator, a public hospital
Ms G	Clinical Quality and Risk Advisor, a public hospital
Mr H	Team Leader, Radiology, a public hospital
Mr I	Chief Executive Officer, a public hospital
Mr J	Consumer (deceased)

Independent expert advice was obtained from Dr Chris Kalderimis, general practitioner, and Dr Gerald Lewis, consultant cardiologist and physician.

## Complaint

On 8 September 1999 the Health and Disability Commissioner received a complaint regarding services provided to Mr J by Dr B, general practitioner. The complaint is that:

- *During the periods September 1997 and February 1999 Dr B did not order regular ECG tests for Mr J despite frequent requests from Ms A and instructions from Mr J's specialist.*
- *Further to this, Dr B failed to diagnose pulmonary oedema in Mr J during the month prior to his death on 23 February 1999.*

On 13 June 2000 the Commissioner extended the investigation on his own initiative to include a public hospital and the matter that:

- *Despite requests from Dr B, general practitioner, during both May 1998 and October 1998, a public hospital failed to arrange chest x-rays and echocardiograms for Mr J. Mr J had a history of significant aortic disease and died on 23 February 1999 as a result of acute pulmonary oedema due to calcific degeneration of an aortic homograft valve.*

On 5 September 2000 the Commissioner extended the investigation on his own initiative to include Dr D and the matter that:

- *Despite requests from Dr B, general practitioner, during both May 1998 and October 1998, Dr D failed to arrange chest x-rays and echocardiograms for Mr J. Mr J had a*

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*history of significant aortic disease and died on 23 February 1999 as a result of acute pulmonary oedema due to calcific degeneration of an aortic homograft valve.*

## **Information reviewed**

- Complaint letter from Ms A, received 8 September 1999
- Response from Dr B, received 21 February 2000
- Response from a public hospital, received 10 July 2000
- Additional response from a public hospital, received 20 September 2000
- Medical records relating to Mr J's care, obtained from a public hospital
- Medical records relating to Mr J's care, obtained from Dr E
- Medical records relating to Mr J's care, obtained from his insurance company
- Medical records relating to Mr J's care, obtained from Dr B
- Medical records relating to Mr J's care, obtained from a public hospital
- Notes from interview of Ms A on 4 May 2001
- Notes from interview of Ms F on 22 May 2001
- Notes from interview of Ms G on 22 May 2001
- Notes from interview of Dr D on 22 May 2001
- Notes from interview of Dr B on 23 May 2001
- Notes from interview of Mr H on 22 May 2001
- A public hospital policies and procedures

Copies of Mr J's relevant medical records were requested from a public hospital. In a letter dated 1 May 2000 Ms C, Chief Executive Officer, a public hospital, advised that the public hospital was unable to locate this information. The public hospital supplied print-outs from its patient management system and an echocardiogram report relating to the care provided to Mr J. Limited further documentation relating to Mr J's treatment was obtained from another health service, Dr B, Mr J's insurance company and Dr E. On 20 September 2000 the public hospital forwarded further medical records relating to Mr J's care. Additional records were obtained from the public hospital by investigation staff on 22 May 2001.

Dr D was given the opportunity to respond to the complaint but chose not to do so. He was interviewed on 22 May 2001.

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## **Information gathered during investigation**

Mr J was an active 29-year-old male with a history of rheumatic heart disease resulting in significant aortic disease (disease of the body's main artery). A homograft valve replacement (where a valve is transplanted from another person) was undertaken in 1986 when Mr J was aged 16.

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Mr J's medical records indicate that on 16 June 1997 Dr B, general practitioner, requested that the public hospital arrange an appointment at an outpatient clinic held by Dr D, physician, and undertake an ECG (electrocardiogram, the recording of the electrical activity of the heart) prior to the outpatient appointment. Dr B requested that these appointments be arranged for September 1997.

Medical notes record that during August 1997 Mr J presented to the public hospital and was admitted under the care of an ear, nose and throat surgeon after an episode of nose bleeds. He was found to be suffering from hypertension. During his admission Mr J was reviewed by Dr D, who found that there was evidence of recurring aortic valve disease, although at the time Mr J remained free of symptoms.

On 2 October 1997 Mr J attended Dr D's outpatient clinic. In a letter to Dr B about this appointment dated 2 October 1997, Dr D stated:

“It looks as if he [Mr J] may have mixed aortic valve disease, or at least aortic incompetence. His full blood count and renal functions were normal when he was in hospital. I have taken off blood [sample] for sugar with a copy to you, to complete investigations. ECG showed basic sinus rhythm with occasional ectopics [a heart beat due to an impulse generated somewhere in the heart outside the heart's natural pace maker] ? supraventricular [the ectopic beat possibly originates in the heart's atria].

I would like to see him yearly but would be grateful if you could organise a chest x-ray and ECG about a month or so prior to that. In view of the aortic murmurs I think he should see a cardiologist and I will organise an appointment with [Dr E].”

On 11 December 1997 Dr E, cardiologist, examined Mr J. In a letter to Dr D dated 11 December 1997 Dr E stated:

“... I think the way to continue assessing things is by serial echocardiogram and I do not at this stage see the need for him [Mr J] to have a trans-oesophageal examination [examinations through the oesophagus]. I would suggest a further echo [echocardiogram] in 3 to 6 months just to be sure that there is no trend of declining homograft valve function. He should of course be monitored in that way long term if there is no change and if and when there is an important alteration, he will need to be considered for further valve replacement.”

Dr D forwarded a copy of this letter to Dr B and requested that Dr B check Mr J's blood pressure and organise an echocardiogram in six months' time.

Dr B advised me that on 6 May 1998 he completed a request to the public hospital for an echocardiogram. This request was completed on a standard form provided to him by the public hospital for this purpose. Mr J had a consultation with him on this date and Dr B

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recorded in his notes, “Refer for echocardiogram suggest ?” Dr B advised that a tick marked next to this note is his way of recording that the referral form had been completed.

On 13 May 1998 Mr J had another appointment with Dr B, who recorded the following in his notes:

“150-155/90-95 % [complained of] unusual feelings in chest HS [heart sounds] reg[ular] (murmur) Highly anxious – partner worried. Reassured OK – around echo. ...”.

Dr B advised me that on 15 June 1998 he was informed by the public hospital that the request for an echocardiogram had been declined for financial reasons and his declined request form returned. Dr B’s notes of 15 June 1998 stated:

“Referral [Dr D] for echocardiogram – my request declined by [the public hospital]”.

There is no information in the notes obtained from the public hospital to indicate that a request had been received or explaining why it had been declined. Mr H, Team Leader Radiology at the public hospital, explained at interview that during 1998 the public hospital implemented a system of charges for radiology services. At the time Dr B attempted to make an appointment for an echocardiogram, it is likely that he would have been told that the service was no longer provided free of charge to those who did not hold Community Services Cards, unless he was able to obtain a referral through the Outpatients Department or the Emergency Department. Mr I advised me that while it is possible that a request would have been declined, he considered it highly unlikely that the request form would be returned and the general practitioner advised that it had been declined for financial reasons. Mr I advised that the form was more likely to have been returned because it had been incompletely filled in.

Dr B stated that he sent the declined request and a new referral letter to Dr D at the Outpatients Department explaining what had happened and suggesting that Dr D might be able to arrange an echocardiogram himself.

Mr J attended Dr B’s surgery on 23 December 1998 after experiencing shortness of breath, cough and sputum. Dr B stated that on the same day he telephoned the Outpatients Department, as neither he nor Mr J had been notified of an appointment date. Dr B stated that the Outpatients Department informed him that they were unable to give a precise date for an appointment. Mr I advised me that it is likely that when Dr B rang, the staff member who answered the telephone would have checked the computerised patient management system and this would have indicated that Mr J had an appointment pending with Dr D, although no appointment had been arranged. The note that an appointment was pending would have been displayed because Dr D had recorded on 2 October 1997 that he wanted to do a yearly review and not because any specific appointment had been scheduled. Mr I also advised that it was usual practice at the time to notify only the patient, and not the referring general practitioner, of appointment dates.

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On 27 January 1999 Mr J visited Dr B after feeling unwell. Ms A, Mr J's partner, believed that at this consultation Mr J was suffering from pulmonary oedema (accumulation of extravascular fluid in lung tissues and alveoli, most commonly caused by congestive heart failure). Dr B's notes of 27 January 1999 stated:

“119/61 P76 111 kg Bicillin IM Chesty → tetralysal [an antibacterial tetracycline] 1/52”.

Dr B stated that Mr J showed no clinical signs of pulmonary oedema when seen on 27 January 1999.

Mr J died at his home on 23 February 1999, 27 days after his last consultation with Dr B. I was initially advised that he had played a game of rugby a few days before his death, but it later transpired that he had been told by Dr D not to play contact sport, although Mr J continued to play volleyball. The post-mortem reported that Mr J was “discovered at 3am struggling for breath and unconscious”. However, Ms A advised me that it was she who found him and that he was actually conscious when found and became unconscious later. A report by the Coroner dated 1 March 1999 determined that Mr J's death was the result of acute pulmonary oedema due to calcific degeneration of an aortic homograft valve and chronic rheumatic heart disease.

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## **Independent advice to Commissioner**

### *General practitioner advice*

The following expert advice was obtained from Dr Chris Kalderimis, an independent general practitioner:

“This is a complaint made by the partner of the late [Mr J] regarding the care [Mr J] received from his General Practitioner, [Dr B], during 1998.

As you have outlined in your background to the complaint, [Mr J] was 29 years of age and had a history of rheumatic heart disease which necessitated a surgical procedure involving the replacement of the aortic valve with a homograft valve, secured in 1986 when [Mr J] was then aged 16.

The follow-up care that [Mr J] received from 1986 to 1997 is somewhat unclear to me but in the event it would appear that in 1997 [Mr J] was seen again at [the public hospital] and was found to be hypertensive. In October 1997 [Dr D], a Physician employed by [the public hospital], wrote to [Dr B] who was [Mr J's] General Practitioner, stating that he felt [Mr J] might have mixed aortic disease, or at least aortic incompetence. He said that an ECG (electrocardiogram) should be performed a

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month or so prior to him being seen again by [Dr D] in a year's time and that [Dr D] was going to arrange for a Cardiologist to review him, the Cardiologist to be [Dr E].

In December of 1997 [Dr E] did in fact see [Mr J] and wrote back to [Dr D] stating that serial echocardiograms were appropriate for [Mr J]. He suggested, rather vaguely, that a further echocardiogram should be arranged in three to six months to see whether there was any deterioration in the valve function. [Dr D] sent a copy of this letter to [Dr B] and requested that he check [Mr J's] blood pressure and conduct the echocardiogram in six months time.

As instructed, [Dr B] completed a request for the echocardiogram to [the public hospital] in May 1998 but received a letter from the Hospital stating that this request was declined on 15 June 1998 for financial reasons. [Dr B] then went on to forward a copy of this information on to [Dr D], suggesting that he [Dr D] might be better able to arrange the echocardiogram for [Mr J].

[Dr B] stated that on 23 December 1998 when [Mr J] had not yet received a scheduled Outpatient appointment, he [Dr B] telephoned the Outpatients Department directly and was told that the Outpatients Department could not give him a precise date for the appointment.

[Mr J] consulted [Dr B] on 27 January 1999. [Ms A], [Mr J's] partner, stated that she believed that at this time [Mr J] was suffering from pulmonary oedema. [Dr B's] notes about this particular consultation are very sketchy and all he states was that he was 'chesty' and 'Teralysal' prescribed.

[Mr J] went on to die suddenly at his home on 23 February 1999, approximately one month after consulting [Dr B] for the last time.

### **1. Did [Dr B] treat [Mr J] appropriately?**

There is no question that up until the last consultation the treatment [Mr J] received from [Dr B] was entirely appropriate. In particular [Dr B] requested the echocardiogram from [the public hospital] as he was asked to do by [Dr D] and [Dr E], and Dr B cannot be blamed for the non-performance of [the public hospital] in not providing echocardiogram appointments requested.

I think it is an important point to state that the general practitioner cannot be held to account for the inadequacy of a public hospital such as [the public hospital]. [Dr B] put in the request in a timely fashion as he was asked to do and he went on to write to [Dr D] stating that he needed to order the echocardiogram himself. He also went on to ring the Outpatients Department requesting a definite date for [the public hospital] and [Dr B] clearly cannot be blamed for this.

I will deal with the question regarding the last consultation in the next item.



**2. Should [Dr B] have detected [Mr J's] deteriorating heart condition prior to his death on 23 February 1999?**

Clearly [Mr J] was unwell when he saw [Dr B] for the last time in January 1999. There is obviously a marked difference of opinion between that expressed by [Mr J's] partner, [Ms A], and that given by [Dr B] and also from his notes. His notes make no comment at all as to [Mr J's] wellbeing and merely state that he was 'chesty' and given Tetralyal. These notes are really quite inadequate.

For a man who is suffering from rheumatic heart disease, further notes should have been made. In particular, notes should have included pulse and blood pressure (which were included in the notes) as well as jugular venous pressure, auscultation of his heart and auscultation of his chest, thus giving a fuller description of findings. The presence or otherwise of pitting oedema in the feet and ankles also should have been noted as should have been the presence of an enlarged liver. None of these things was commented on in [Dr B's] notes and this was a real problem, because without this information it is impossible to say whether or not [Mr J] was in heart failure at that time.

I cannot answer the question as to whether or not [Dr B] should have detected [Mr J's] deteriorating heart condition, because we cannot say whether it was deteriorating one month prior to his death. It is notable though that the Coroner did state that [Mr J] died from acute pulmonary oedema and so it is quite possible that the pulmonary oedema only occurred within a few days of [Mr J's] death.

**3. Did [Dr B] act appropriately in the way he requested tests from [the public hospital] and should he have followed up on his requests more vigorously?**

I do not believe that [Dr B] had any responsibility to follow up his requests any more vigorously than he did. I must again emphasise my previous comments that it is inappropriate to blame a general practitioner for the failings of an institution such as [a public hospital]. I believe [Dr B] did everything he should be expected to do for [Mr J] in this respect.

**4. Are there any other issues arising from the supporting information enclosed?**

This is a very sad situation where I feel the management of [Mr J's] condition was more poorly organised and less effectively offered to him by a specialist physician than by [Dr B]. Obviously this heart valve was failing and the echocardiogram that should have been performed in May 1998 was not performed and thus the deterioration was not picked up. This is not [Dr B's] fault. Had [the public hospital] performed in the way it was expected to perform, both by [Dr D] and [Dr E], then this regrettable situation may never have arisen. This death was probably preventable had the

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deterioration in [Mr J's] aortic valve been detected. I do not believe that [Dr B] can be blamed for this because he did everything that he was asked to do.

The only criticism that I could make of [Dr B] is that his notes are minimalist in the extreme, and, in particular, the last entry that he made in January 1999 was inadequate. As outlined above, I think he should have examined [Mr J] more fully and even though it is quite possible that there was no pulmonary oedema there at the time, at least we would know from the notes whether this was in fact so. I feel that [Dr B] needs to be made aware of the fact that his notes for this particular consultation were quite inadequate.

Thus in summary I believe that [Dr B] did treat [Mr J] in an appropriate and professional manner.”

#### *Cardiology advice*

The following expert advice was obtained from Dr Gerald Lewis, an independent consultant cardiologist and physician:

“History – [Mr J] had an aortic valve homograft replacement on the 30th October 1986 for rheumatic aortic incompetence. Postoperatively he recovered well, and was very physically fit. He was able to play rugby as a prop forward, he represented [a first grade club side]. He was in fact planning also to start boxing in 1995, but was dissuaded by [Dr D]. Apparently he moved away from [the town] but when he returned in 1994, follow-up outpatient appointments were made but I note on at least two occasions he did not attend.

Then he was first seen in outpatients on the third of September 1995 where [Dr D] wrote an excellent letter to the general practitioner, noting his degree in physical fitness. He had some aortic valve murmurs which are not uncommon with aortic homografts (ejection systolic and early diastolic murmurs). [Dr D] organised an ECG, chest X-ray and echocardiogram, but [Mr J] did not attend for this (perhaps he was not happy that [Dr D] had forbidden him to box until he had a clearance).

The next information I have is that he was referred by [Dr B] for follow up on 11/6/97, but before this was actioned he was admitted to hospital with epistaxis (nose bleed) and hypertension. In-hospital referral to [Dr D] resulted in him examining [Mr J], again noting his mixed aortic valve disease – an echocardiogram (the best non-invasive test for aortic valve disease) did not show severe valve problems, in particular there was only mild aortic regurgitation – but the echo cardiographer could not measure the aortic valve jet (because the pencil probe was not available) – the valve velocity jet gives an indication of the severity of the aortic stenosis. He also noted that the left ventricular function was normal and the ventricle was not dilated. However, for completeness he referred him to [Dr E] (cardiologist) who saw [Mr J] on 11/12/97.

[Dr E] agreed with [Dr D's] assessment, and was sufficiently secure in the fact that the valve function was only mild, by stating that a trans oesophageal echocardiogram – was unnecessary. [Dr E] suggested a follow up echo in 3-6 months to make sure that the valve was not deteriorating. But there was nothing from this examination which suggested this to be so.

[Dr D] sent a copy of this letter to [Dr B] requesting in a handwritten addition that the GP organise the echo as suggested. While this is hardly ideal communication, it is excellent that it was noted by [Dr B], but in a very busy outpatient schedule, it is probably the most efficient means of doing this.

On 6/5/98 [Dr B] referred [Mr J] for an echocardiogram as suggested, but this was rejected for 'financial reasons' – a fact confirmed by [the public hospital] to be quite possible. [The public hospital] said this could be overcome by requesting an echo via the emergency dept or by an outpatient appointment. This was certainly not an emergency, and [Dr B] requested an outpatient appointment. In October 98 [Dr D] wrote saying that an outpatient appointment had been made – but in an asymptomatic man still playing rugby – it could not be considered urgent. On 23.12.98 [Dr B] rang outpatients and was told that [Mr J] was in the outpatient system. Again in an asymptomatic patient neither [Dr B] nor [Dr D] should be expected to do more at this stage.

[Mr J] then saw [Dr B] again on 27<sup>th</sup> January – I do not have copies of his clinical notes, but Dr Kalderimis mentions they merely state 'chesty, given Tetrasysal'. Dr Kalderimis notes that [Dr B] did not confirm in writing that he had examined the patient for signs of heart failure, but [Dr B] states that 'there were no signs of pulmonary oedema'.

[Mr J] continued to play rugby and he played a game a few days prior to his death. According to the pathologist's report – he "went to bed on the evening of 22 Feb 1998 and **appeared to be in good health**". He was then 'discovered at 3am struggling for breath and unconscious'. Resuscitation was unsuccessful.

Comments on [Mr J's] condition – the examinations of both [Dr E] and [Dr D] and the echocardiogram only suggested mild to at the most moderate aortic valve disease. Aortic homografts are known to slowly deteriorate over the years, but as they do so they produce symptoms of increasing breathlessness with exertion and on lying flat (orthopnoea). Sudden failure and obstruction are not common causes of death with homografts. Certainly no one in pulmonary oedema could complete a game of rugby as a prop forward. The fact that [Mr J] could play rugby and was also 'in good health' when he went to bed, coupled with the fact that he was unconscious when discovered at 3am, suggests to me that the final cause of death was a cardiac arrhythmia (abnormal heart rhythm) – probably ventricular tachycardia leading to fibrillation – not simple failure of the heart from valve disease in a normal rhythm. At

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PM [post-mortem] the pathologist notes he had a normal coronary arterial blood supply.

**In response to your questions:**

1. Who was responsible for the post 11 December echocardiogram – it is important to note this was very much a precautionary echocardiogram, not one to demonstrate an existing or exacerbated problem. [Dr D] asked [Dr B] to do this, he tried but was refused, he asked [Dr D] to organise an outpatient appointment – which he did, but in a very busy outpatient setting there was a delay for this. With the information I have, it would be unreasonable for other sick patients to have to wait for an outpatient appointment while an asymptomatic patient is seen – simply because [the public hospital] refused to do an echocardiogram on request. Especially as the echo was simply a precautionary one and did not warrant an outpatient appointment at all. The OPD appointment was simply a way of getting round [the public hospital] administrative refusal, and presumably a way for [the public hospital] to reduce the number of echocardiograms done.

I suspect however the echocardiogram would not have suggested any deterioration. But it should have been done – and [Dr B] and [Dr D] knew that the procedures to do it were in the pipeline. The main fault for the delay was [the public hospital] who should have done the echo in the first place, or notified [Dr D] of their refusal. This is not a clinical decision which should be taken by non-medical professionals without first discussing with the doctor looking after the patient.

2. What action should [Dr D] have taken – this is partly covered in question 1. The role of a busy consultant in a peripheral hospital with a huge workload must be accepted. [Dr D] in his interview gives an indication of his frustration, especially when patients do not attend outpatient appointments or examinations, which [Mr J] did on at least 2 occasions. He must also have been frustrated that he was forced to see [Mr J] in his busy outpatient clinic – simply because some administrator was using this as a way of saving the hospital money. [Dr D] did arrange for [Mr J] to be seen at outpatients, and as there was no indication given to him that his clinical condition had changed, and thus as this was simply a routine precautionary echocardiogram, a few months delay would seem acceptable. I believe both doctors acted appropriately in this case.
3. Is the process for making appointments at [the public hospital] appropriate – the technique appears to be very similar to that of most provincial hospitals. I do not however feel that hospitals should refuse to do an investigation as requested by a consultant (even if it is on a form filled by a GP), without discussing the matter with the consultant.

4. Would [Mr J's] chances be improved if he had the ECGs – I presume you mean the echocardiogram (an ECG in this situation where a patient has a long standing history of aortic valve disease, is an athlete and was overweight – is of very little benefit). As mentioned above – I believe that the cause of death was a rhythm disturbance not simply progressive heart failure. An echo would not have detected this and I personally doubt that an echocardiogram would have made any difference.
5. Other issues:
  - (a) [Dr B] is accused of missing pulmonary oedema in his consultation 1 month prior to death. I do not have his notes, but brief GP notes are not uncommon. I feel the comments by Dr Kalderimis are a little harsh. Pulmonary oedema signs in an overweight man are very subtle (third heart sound and basal crepitations). The heart sounds would be almost inaudible with his other known heart murmurs – especially the early diastolic murmur which occurs at the same time as the third sound, and basal crepitations can also occur in bronchitis.

Considering that [Mr J] could still play rugby, I think it would be most unlikely that he had both left and right heart failure (and I note the pathologist noted the right ventricle was normal). Thus any signs of right heart failure – ankle oedema, enlarged liver and raised jugular venous pressure as mentioned by Dr Kalderimis would not be expected to be present. Right heart failure is not common in patients with aortic stenosis – I do not believe [Mr J] had pulmonary oedema at that stage. A patient with pulmonary oedema could not complete a game of rugby.

- (b) I do not feel [the public hospital] has come out of this with great credit. While some of their documentation is excellent, lost notes and refusal to do an echocardiogram on financial (not clinical) grounds – a practice which I feel is quite unacceptable. If a patient is to be refused an examination, this must be first discussed with the clinician looking after the patient. I also note that the echo technician was unable to measure the peak aortic valve flow velocity 'because there was not a pencil probe available' – these are not expensive and in assessing aortic stenosis they are important.

Conclusion – I personally believe that both doctors looking after [Mr J] did their best in busy clinical situations. They were frustrated by a hospital system which allowed financial restraint to overcome clinical decision – but sadly in the present health system some rationing does occur. [Mr J] had only mild aortic valve disease when seen by [Dr E] and [Dr D] in 1997, he continued to play rugby until a few days prior to his death, which makes me reasonably confident that a rhythm disturbance on top of his aortic valve was the most likely cause of his terminal illness. Thus any investigations done within a few months of this event would probably have played

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little part in preventing his death. In any large organisation communications between consultants, general practitioners and administrators are difficult, and it is virtually impossible for a consultant to keep track of where people are on his or her waiting list. They really do need to be able to rely upon a system which works – where a request is actioned and proceeds to the desired conclusion. I do know that [Dr D] has a very busy in and outpatient practice, and having worked in a hospital of similar size I can understand the frustration expressed. These consultants with few experienced junior medical staff have a huge clinical responsibility and frequently because of their experience and lack of local expertise, they are also asked to advise the administration as well.

Thus an outpatient administration service which works smoothly, can easily give reports to both consultants and general practitioners is essential for the efficient and safe running of provincial hospitals.

However in this case, despite the administrative shortcomings, I do not believe it had any effect upon [Mr J's] clinical situation.”

## **Dr B's response to provisional opinion**

In response to my provisional opinion, Dr B made the following submissions:

“Thank you for inviting me to make comments on your provisional opinion dated 29 April 2002. I would like to comment on only one area – your opinion that I breached Right 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights. I strongly deny that I have breached any part of the Code.

### **Right 4(1)**

I cannot accept your statement that I failed to conduct a full examination of [Mr J]. Between December 1985 and January 1999 [Mr J] had consulted me on 110 occasions. Although some of these consultations were only for injections, on many occasions I was checking his cardiovascular system as well. The area of cardiology is my major area interest and I have extensive experience in this field both in New Zealand and the United Kingdom. I consider that my reading in cardiology is up to date and I have attended all Continuing Medical Education meetings held in [this area] over the past ten years. As my practice has a higher proportion of elderly patients than the average, I am looking for pulmonary oedema and monitoring heart failure in up to ten patients each day. Patients with physical signs of heart failure that are severe are sent to [a public hospital] for assessment and treatment. [Mr J] presented to me unwell on 27 January 1999. He was unwell with a lower respiratory tract infection which I treated appropriately and presumably successfully with antibiotics. He was not ill enough to be sent to hospital. If he had had pulmonary oedema his condition would have been worsened and he would not have been able to play rugby. My assessment with [Mr J] on 27 January certainly included an examination of his jugular venous pressure, auscultation of his heart and checking for oedema in his feet and ankles. I cannot remember checking his liver. The examination was done rapidly, efficiently and accurately. The 27<sup>th</sup> of January 1999 was an exceptionally busy work day for me. My practice is of comparatively modest size compared with many of my colleagues in [the public hospital] and I take pride in being able to see patients such as [Mr J] who do not keep strictly to appointment times as allocated or who arrive at the surgery without an appointment. My records show that [Mr J] arrived approximately an hour late for his appointment that day and by that time I was very busy with other ill patients. Because of my experience and detailed knowledge of [Mr J's] condition I strongly make the claim that my examination, although done under time constraints, was full and proper. I strongly refute any claim to the contrary.

### **Right 4(2)**

I consider that Dr Kalderimis' statement that my notes are 'minimalist in the extreme' as using exaggerated language. I will concede that my notes for that day were brief but that they had to be because of time pressures although I do regard them as being clear and accurate, recording the diagnosis and treatment given. I would certainly not record every negative finding in relation to the cardiovascular system in every patient who has a heart disease in each and every consultation as I used to as a house surgeon. Relevant records of fact are kept. As Dr Lewis stated – 'brief GP notes are not uncommon'. I

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have shelves full of GP notes from patients who have transferred from other GPs around the country and the notes are far more brief than mine have ever been. I do not accept that my standard of record keeping has breached Right 4(2) of the Code ...”

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## **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.*
  - ...
  - 5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*
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## **New Zealand Medical Association Code of Ethics**

### *Standard of Care*

- ...
  - 4) *Ensure that accurate records of fact are kept.*
  - ...
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## **Opinion: Breach – Dr B**

### **Right 4(2)**

#### *Record-keeping*

Dr Kalderimis advised me that Dr B’s notes are minimalist in the extreme and in some cases may be inadequate. Clause 4 of the New Zealand Medical Association Code of Ethics requires doctors to keep accurate records of fact. In addition, *Good Medical Practice: A guide for doctors* (Medical Council of New Zealand, 1999) states that in providing care

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doctors must “keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed”. The documentation relating to the care of Mr J is not always clear and accurate and does not fully record the decisions made by Dr B. For these reasons, in my opinion, Dr B breached Right 4(2) of the Code.

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## **Opinion: No Breach – Dr B**

### **Right 4(5)**

#### *Referral*

In October 1997 Dr D wrote to Dr B saying that he wished to see Mr J on a yearly basis and asking for an ECG and chest x-ray to be performed a month prior to the appointment. Dr D also stated that he would arrange an appointment for Mr J with a cardiologist. Dr E, cardiologist, examined Mr J. Dr D forwarded the letter written by Dr E on 11 December 1997 to Dr B and requested that Dr B check Mr J's blood pressure and arrange an echocardiogram in six months' time, as requested by Dr E. On 6 May 1998 Dr B completed a request for an echocardiogram and forwarded it to the public hospital. Although the request form could not be located during the course of my investigation, a tick in Dr B's notes indicates that he did complete it. Dr B advised me that he was informed on 15 June 1998 that his request had been declined. Dr B forwarded the declined request and a new referral letter to Dr D and asked Dr D to arrange the echocardiogram himself.

On 23 December 1998 Dr B, concerned that Mr J had not been given an appointment date, rang the Outpatients Department but was unable to obtain an appointment date. My general practitioner advisor informed me that the actions taken by Dr B to arrange an echocardiogram appointment for Mr J were timely and appropriate. My advisor added that he did not believe that Dr B had any responsibility to follow up his requests more vigorously.

I accept that Dr B did attempt to arrange an echocardiogram as instructed by Dr E and Dr D, first by contacting the public hospital's Radiology Department and, when that Department was unable to assist, by referring Mr J to Dr D for his yearly appointment and asking Dr D to arrange the echocardiogram. When no communication had been received about the appointment date Dr B made a further attempt to organise an outpatient appointment and arrange a chest x-ray and echocardiogram. In my opinion, Dr B attempted to co-operate with Dr D and the public hospital to provide continuing follow-up care and diagnostic services for Mr J, and did not breach Right 4(5) of the Code.

### **Right 4(1)**

#### *Examination*

On 27 January 1999 Mr J presented to Dr B feeling unwell. Dr B recorded Mr J's pulse and blood pressure and noted that he was “chesty”. My general practitioner advisor informs

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me that for a man suffering from rheumatic heart disease the examination should have included jugular venous pressure, auscultation of his heart and auscultation of his chest. Dr Kalderimis further stated that the presence or otherwise of pitting oedema in the feet and ankles should also have been checked as well as the presence or otherwise of an enlarged liver.

In his notes Dr B recorded that Mr J showed no signs of pulmonary oedema at the appointment on 27 January 1999. However, Dr B recorded no information indicating what tests he performed to make this determination. In response to my provisional opinion, Dr B advised that his examination did include an examination of Mr J's jugular venous pressure, auscultation of his heart and checking for oedema in his feet and ankles. Dr B cannot recall whether he checked for an enlarged liver. In light of this information, it is my opinion that Dr B conducted a full examination, provided medical services with reasonable care and skill, and did not breach Right 4(1) of the Code.

#### *Diagnosis of pulmonary oedema*

It is alleged that Dr B failed to diagnose pulmonary oedema in the month before Mr J's death. Although Dr B's record of Mr J's symptoms are minimal, it does not follow that Dr B erred in not diagnosing pulmonary oedema. Indeed, three pieces of evidence lead me to conclude that Mr J was not suffering from pulmonary oedema at the time of his appointment with Dr B, namely:

- He played sport a few days before his death;
- On the night of his death he was described as being "in good health";
- The Coroner concluded that Mr J suffered "acute" pulmonary oedema (ie, the condition developed shortly before his death).

Dr Lewis noted that Mr J's death was unlikely to have been caused by simple failure of the heart from valve disease in a normal rhythm (ie, a condition of slow deterioration), and more likely to have resulted from an abnormal heart rhythm (ie, a one-off heart event). Dr Lewis advised me that he did not believe Mr J had pulmonary oedema at the consultation.

I am guided by my expert cardiology advisor. In my opinion, Mr J is unlikely to have been suffering from pulmonary oedema at the time of his consultation with Dr B on 27 January 1999. Accordingly, Dr B did not err in failing to diagnose pulmonary oedema and did not breach Right 4(1) of the Code.

## **Opinion: No Breach – Dr D**

### **Right 4(1)**

Dr D did not respond to notification of this investigation. There is scant evidence available concerning the interaction between Dr D, Dr E, Dr B, Mr J and the public hospital. However, I am satisfied on the information before me that on 15 June 1998 Dr B completed a referral letter to Dr D and sent him the letter from the public hospital declining the echocardiogram and suggested that Dr D arrange the appointment himself. Dr B heard nothing more from Dr D. On 23 December 1998 Dr B was informed by a staff member at the Outpatients Department that they were unable to give him a precise date for an appointment for Mr J. I have been unable to view complete medical records from the public hospital. However, from the information available to me, I conclude that Dr B made timely and appropriate contact with Dr D and asked him to arrange an echocardiogram and an appointment for Mr J; and that Dr D attempted to make arrangements for an appointment and that there was a delay in actioning his request.

My cardiology advisor informed me that the delay following Dr B's request to Dr D was acceptable. Although the echocardiogram should have been performed, Mr J was asymptomatic, there was no indication that his condition had changed and it was a precautionary test. In these circumstances and in a busy outpatient clinic, a delay of a few months is acceptable.

I am guided by my expert cardiology advisor. In my opinion, although the level of communication between Dr D and Dr B was not ideal, Dr D acted appropriately in trying to arrange an outpatient appointment for Mr J. Accordingly, Dr D provided specialist services to Mr J with reasonable care and skill and did not breach Right 4(1) of the Code.

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## **Opinion: Breach – The Public Hospital**

### **Right 4(1)**

#### *Decision to refuse request for an echocardiogram*

As noted above, there is scant evidence available concerning the interaction between Dr D, Dr E, Dr B, Mr J and the public hospital. However, I am satisfied on the information before me that on 6 May 1998 Dr B completed a request for an echocardiogram to be performed by the public hospital. Dr B was informed on 15 June 1998 that his request had been declined. Mr I advised me that it is likely that the request was declined because the form he submitted was not completed correctly. However, this was not the view of Dr B, who understood simply that his request had been declined for financial reasons. It appears that the decision to decline this request was taken without consultation with Dr D. My cardiology advisor noted that this was a clinical decision and should not have been made by non-medical staff without discussion with the consultant responsible for the patient's care. I

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agree. The system in place at the public hospital which allowed a general practitioner's request for an echocardiogram to be rejected without specialist consultant input, was not appropriate. In my opinion, the public hospital failed to provide clinical services with reasonable care and skill and breached Right 4(1) of the Code.

### **Right 4(5)**

#### *Communication between providers*

When his initial request was declined, Dr B completed a new referral letter to Dr D on 15 June 1998 and followed this up by contacting the Outpatients Department at the public hospital on 23 December 1998. Dr B did not receive a response to his referral of 15 June 1998 or any written response to his telephone call of 23 December 1998.

Mr I advised me that the practice in 1998 was to advise only the patient, and not the referring general practitioner, when appointments had been scheduled. He also explained that it is likely that when Dr B telephoned he was misled by the advice that an appointment with Dr D was pending, and that this was due to the manner in which patient details were recorded on the computerised patient management system.

In my opinion, the failure of the public hospital to communicate with Dr B, acknowledge his requests and advise him of the steps taken to schedule an appointment amounted to a failure to co-operate with other providers to ensure quality and continuity of care, in breach of Right 4(5) of the Code.

I note that the public hospital reviewed its outpatient referral processes in 1999 and 2000. Mr I advised me that all general practitioner referrals are now assessed with appropriate clinical input and that general practitioners are now updated monthly with a status report indicating the waiting list status of their patients and any appointment dates. A similar update system for general practitioners who have referred patients to Radiology is currently being implemented.

### **Other comments – The Public Hospital**

#### *Lack of a pencil probe*

In June 1997 an echocardiograph technician involved in Mr J's care was unable to measure peak aortic valve flow velocity because no pencil probe was available for him. My cardiology advisor noted that this test is important in assessing aortic stenosis and pencil probes are not expensive. If the public hospital is to provide such a service, it should ensure that all necessary equipment is available.

#### *Communication with general practitioners*

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I also note my cardiology expert's comment that Dr D's practice of handwriting notes on the bottom of letters forwarded to general practitioners is not a good method of communicating instructions. Although this may have been a pragmatic response by Dr D to his work environment, it would be easy for a general practitioner to overlook such an instruction.

#### *Storage of medical records*

During the course of this investigation, the public hospital had difficulty in locating Mr J's medical records. It is important that the public hospital ensure that proper systems are in place to store and trace medical records.

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### **Actions**

I recommend that Dr B take the following action:

- Arrange peer review of his note taking, to ensure that in future his records are accurate and comprehensive.

I recommend that the public hospital:

- Apologise in writing to Ms A for breaching the Code. This apology is to be sent to my Office and will be forwarded to Ms A.
  - Implement the proposed update system for general practitioners who have referred a patient to Radiology and confirm to the Commissioner by 30 September 2002 that this has been done.
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### **Other Actions**

- A copy of this opinion will be forwarded to the Medical Council of New Zealand.
  - A copy of this opinion, with personal identifying features removed, will be sent to the Royal New Zealand College of General Practitioners, Quality Health New Zealand, and the Deputy Director-General, Clinical Services, for distribution to the Chief Medical Advisor of each District Health Board, and will be placed on the Health and Disability Commissioner's website, [www.hdc.org.nz](http://www.hdc.org.nz).
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