Dr C

A Report by the

Health and Disability Commissioner

(Case 03HDC09521)

Parties involved

Mrs A	Consumer (dec)
Ms B	Complainant/Mrs A's daughter
Dr C	Provider/General Practitioner
Dr D	Radiation Oncologist
Dr E	General Surgeon
Ms F	Hospice Assessment Nurse

Complaint

On 26 June 2003 the Commissioner received a complaint from Ms B about the standard of services provided to her mother, Mrs A, by Dr C. The complaint was summarised as follows:

Whether Dr C provided services of an appropriate standard to Mrs A between February 2002 and March 2003. In particular, whether Dr C:

- *adequately assessed Mrs A following her diagnosis of bone cancer*
- *appropriately assessed and managed Mrs A's pain, including her leg pain*
- *adequately co-ordinated Mrs A's care.*

An investigation was commenced on 23 October 2003.

Information reviewed

- Information from Ms B
- Information from Dr C, including:
  - correspondence
  - Dr C's clinical records.
- Information from the hospice, including:
  - patient progress notes
- Information from the Public Hospital, including:
  - medical records
  - a bone scan, dated 1 February 2002
  - X-rays, dated 31 March 2003
- Information from the rest home, including:
  - medical records.

Independent expert advice was obtained from Dr Peter Gendall, diagnostic radiologist, and Dr Ian St George, general practitioner.

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Information gathered during investigation

Mrs A, then aged 70, was diagnosed with breast cancer in November 1997 and recovered well subsequent to a left mastectomy in December 1997. On 5 November 2001, Dr C referred Mrs A to Dr D, radiation oncologist, for a bone scan to exclude the possibility of metastatic breast cancer. Dr D referred Mrs A for a bone scan, in accordance with Dr C's request. The bone scan was conducted on 1 February 2002 by a nuclear physician.

The results of the scan suggested the existence of widespread bony metastases in Mrs A's skull, vertebral column, ribs and left hemi-pelvis. Dr D discussed these findings with Mrs A and considered that she understood her poor prognosis. Dr D informed Dr C, in a letter dated 8 February 2002, that he would review Mrs A in three months.

Subsequent to discussions with Mrs A on 11 and 15 February 2002, Dr C prescribed oxazepam and ibuprofen for anxiety and pain relief respectively. He also reviewed her pain management on 27 February 2002 and prescribed diclofenac and Panadeine to control her symptoms.

Mrs A consulted Dr C on 13 March 2002. His notes in respect of this consultation suggest that Mrs A was satisfied with the pain relief she was receiving. Dr C sent a letter to "Access ability", an assessment agency, on 13 March requesting that Mrs A receive home support. He noted: "[Mrs A] bravely continues independently but would benefit from home support." Dr C also wrote to "Progressive health" requesting a terminal care subsidy for Mrs A's treatment.

Dr C reviewed Mrs A's pain relief medication on 27 March, 3 April, and 10 April 2002. Only on 3 April did she complain that her medication was inadequate. On this occasion Dr C increased Mrs A's pain relief, substituting Panadeine with dihydrocodeine (DHC).

On 24 April Dr C visited Mrs A at her home. She complained of left leg pain and difficulty mobilising. In response to Mrs A's concerns, Dr C referred her to the oncology clinic of the Public Hospital for further assessment. He also asked staff at the hospice to arrange support for Mrs A, including access to a walker.

As a consequence of Dr C's request, Mrs A was provided with a walking frame and other mobilising equipment by staff at the hospice. She was also provided with support and regular assessments by the hospice from 26 April onwards. Mrs A was reviewed on 10 May by Dr E of the radio-oncology clinic. On examination, he considered that Mrs A displayed normal power and sensation in both legs, and that no spinal or pelvic tenderness was evident. Dr E also noted that Mrs A's pain was such that she could discontinue using DHC and re-commence Panadeine.

On 23 May Ms F, hospice nurse, visited Mrs A at home. She noted: "[Mrs A] is managing well on her new drug regime and has not had any pain."

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Dr C reviewed Mrs A's pain relief medication on 4 June. He prescribed her DHC and diclofenac to manage her pain. She was also provided with written instructions about the administration of these medications. Dr C assessed Mrs A on 12 June to determine whether her driver's licence should be renewed, and found no reason to restrict her licence. He also noted that the weakness she was experiencing in her left leg had improved, but had not entirely abated. His notes for this consultation read: "good pain control currently on Rx [prescriptions]". Hospice records for 12 June 2002 read: "Phoned [Mrs A] today. Has had her medical exam for her driving licence. She is permitted to drive locally only. [Mrs A] says she doesn't need her walking frame any more."

On 19 July 2002, Mrs A was assessed by Dr D at the Public Hospital. He noted that her energy levels had improved, and her pain had decreased. Dr D decided to review Mrs A in October, but advised her to return sooner if she experienced bone pain. Dr C discussed Dr D's findings with Mrs A on 2 August.

Mrs A consulted Dr C on 30 August. She complained of increased pain, and was prescribed an increased dose of DHC as a result. Dr C provided written advice to Mrs A about her medications in a note, dated 30 August 2002. He also sent a medical certificate to CCS in order that a mobility certificate could be obtained for Mrs A. This was to allow her access to disability parking.

Mrs A's medication was again reviewed by Dr C on 27 September. She indicated that she was pain free on the increased dose of DHC, and stated that she was "now accepting things more".

On 11 October, Mrs A consulted Dr D at the Public Hospital. Dr D noted, in a letter to Dr C dated 11 October 2002, that Mrs A felt well and was pain free apart from an area on her left chest wall. Dr D referred Mrs A for an X-ray in respect of her left chest, and observed that the results were unremarkable.

A subsequent medication review by Dr C, on 25 October, revealed that Mrs A was stable on her medication regime. Mrs A was reviewed one month later by Dr C's locum. At this consultation, Mrs A complained of pain in her right hip and groin. Dr C's locum examined Mrs A's hips and did not detect any abnormality. However, he increased Mrs A's dose of DHC to manage her pain. Mrs A was provided with a walker by Ms F, hospice nurse, on 27 November.

On 2 December, Mrs A consulted Dr C at his surgery. At this consultation Mrs A continued to complain of increased pain. In response, Dr C discontinued Mrs A's prescription of DHC and substituted morphine sulphate (MST) with morphine elixir for uncontrolled pain. He also requested blood tests to further monitor Mrs A's condition.

Mrs A was reviewed by Dr E, general surgeon, on 6 December. She complained of pain in her right hip, which periodically radiated down her thigh. Mrs A stated that her pain was not being controlled to her satisfaction. On examination, Dr E observed tenderness over Mrs A's right lumbar spine. He also noted that muscular power in her legs was normal,

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with the exception of some movements of the right hip. Dr E was concerned that Mrs A was suffering from spinal cord compression, and accordingly referred her for radiotherapy of the spine. He recommended that Dr C make some alterations to Mrs A's medications. Hospice notes for 6 December 2002, in respect of Mrs A's consultation, read: "[Mrs A] feeling really pleased with visit."

Dr C assessed Mrs A on 13 December. They discussed her consultation with Dr E, and Dr C adjusted Mrs A's medications in accordance with Dr E's advice. Hospice notes for 13 December 2002 read: "[Mrs A] feeling much more comfortable now."

On 24 December Ms F, hospice nurse, noted: "[Mrs A] only had 1 radiotherapy treatment instead of 5. Moving better and pain controlled … [Mrs A] has family around + supporting her."

Mrs A consulted Dr C on 15 January 2003. He updated her mobility certificate, and conducted another review of her medication. He also considered that she should be re-commenced on diclofenac. Accordingly, Dr C provided Mrs A with an information sheet explaining the effects of her medications, and how they should be administered. Follow-ups by Dr C on 22 and 29 January revealed that Mrs A's condition was stable, except that she was experiencing some difficulty walking. However, Mrs A indicated on 22 and 25 January that the home help she was receiving was satisfactory. These assurances were given to Dr C and Ms F respectively.

Hospice notes from 31 January 2003, in respect of Mrs A, read: "Walking not so good but has no pain at present."

According to Dr C, the hospice was increasingly involved in Mrs A's care from 5 February 2003 onwards. This is confirmed by the progress notes received from the hospice. On 5 February, Ms F visited Mrs A at home. Mrs A complained of increased pain to Ms F, who contacted Dr C. In response to Ms F's query, Dr C increased the dose of morphine elixir. Subsequently, Dr C requested further blood tests to assess Mrs A's condition.

On 14 February, Mrs A telephoned Ms F in a state of distress. She complained of increased pain and difficulty mobilising. Ms F contacted Dr C about Mrs A's anxiety and an agreement was reached to admit her to the hospice. She was admitted at 10am that day. Mrs A was provided with continuous care by the hospice until her discharge on 21 February 2003.

Hospice notes for 25 February read: "[Mrs A] managing at home. All services in place and working well." However, Mrs A signalled distress on 26 February, with an alarm designed for the purpose. This led to a discussion between Ms F, Mrs A and Ms B as to whether Mrs A should remain at home. Ms F noted: "Suggested a meeting early next week to look at different options."

On 6 March, Ms F observed: "Daughters concerned about how long [Mrs A] has as they don't want to have to put her in a rest home for a short while. Asked GP who … felt that a

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rest home was the best option." However, she noted on 11 March: "Daughters staying where possible. [Mrs A] states she is feeling better."

Dr D reviewed Mrs A on 14 March. In his letter to Dr C of the same date, Dr D noted that the radiation therapy used to treat Mrs A had resulted in a significant decrease in her pain. He further stated that Mrs A felt herself to be "on the upswing". During this period Mrs A was confined to a wheelchair, though managing at home.

On 28 March, Ms F observed that Mrs A was troubled by pain and weakness in her left leg. In response to these concerns, she arranged for Mrs A to be reviewed by Dr C at home. His notes of this consultation read: "visit to assess increasing left leg pain and disability – comfortable apart from this problem – we know from last year's bone scan that there are metastatic deposits in L pelvis and also widespread other sites so there doesn't seem much point in checking any investigations initially – need to keep in mind possibility of pathological fracture L hip/femur so => initially increase MST [morphine] … and review according to progress. Arrange X-ray left hip/femur if pain is difficult to control."

Ms F noted, on 31 March, that Mrs A's pain had not improved. She also received a telephone call, at 2.00pm, from Ms B. Ms B informed Ms F that Mrs A could only be mobilised by others, who were required to carry her. In response to Ms B's concerns, Ms F contacted Dr C. He subsequently arranged for Mrs A to be transferred to the Public Hospital for an X-ray of her left hip and femur. The radiologist who reported on these X-rays considered the findings to be "consistent with [a] pathological fracture of the left neck of femur".

Ms B stated that a surgeon who later assessed Mrs A, in order to determine whether she was fit for surgery, informed her that Mrs A's fracture was historical in nature. In particular Ms B made the following comments:

> "A stress fracture of the femur was diagnosed. The surgeon stated that the fracture would have started about the time Mum's pain increased last July and had gradually worsened. [Further, that] it was now inoperable."

An orthopaedic surgeon met with Ms B on 1 April 2003. Subsequent enquiries reveal that the radiologist also considered Mrs A's fracture to be historical, though this is not noted in his radiological report dated 31 March 2003. Nonetheless an expert opinion obtained by the Commissioner from Dr Peter Gendall, diagnostic radiologist, reveals that Mrs A's femur fracture was acute. Dr Gendall's advice is set out at pages 7-9 below.

Mrs A subsequently died on […] 2003.

Ms B's complaint
Ms B made a number of general allegations about the care provided by Dr C, to which he provided comprehensive responses. Some of these responses are referred to by my expert advisor, Dr St George. Consequently, I have set out Ms B's allegations with Dr C's responses below.

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Ms B made the following comment about Dr C's management of her mother's pain:

> "In February 2002 after a bone scan Mum was diagnosed with bone cancer. Between July 2002 until 31 March 2003 Mum was in excruciating pain and her mobility was rapidly decreasing. Dr [C] kept increasing her painkillers with absolutely no effect."

Dr C responded:

> "This is simply not true. My recollection of the period and my clinical notes indicate that [Mrs A] had good pain control. As expected with any progressive cancer disease, she had incremental pain and therefore she was seen regularly to ensure she had appropriate increases in her pain medication."

In terms of Dr C's co-ordination of her mother's care, Ms B stated:

> "Every time we had any contact with Dr [C] there was a problem. Some examples are:
> 1. The Hospice Assessment Nurse requested a blood test to be done – it took ten days to get the form completed;
> 2. On two occasions prescriptions that were to be faxed through to the pharmacy [were] not done and constant phone calls [were] needed to chase these up;
> 3. [Dr C] expecting mum to come to the surgery on a regular basis even though a home visit would have been more appropriate; …
> 4. On the 15th April mum was admitted to [the] Rest Home. She chose to change to the Rest Home GP as she was extremely unhappy with her treatment from Dr [C]. A form was signed to transfer her medical records. The following day Dr [C] rang mum, obviously worried about mum changing GPs. Mum refused to speak to him … The following day Dr [C's] nurse rang mum … I rang the doctor's surgery and spoke to the nurse who informed me very quickly that she had not known that the doctor had rang mum the previous day and 'just wanted to catch up with [Mrs A]'. I told her to stop harassing my mother. We find this appalling and totally unethical … that these people can harass and bully a dying woman."

Dr C responded:

> "If there were problems (as there can easily be in any situation where we are providing care to a patient with a changing clinical situation) why didn't Mrs [B] phone me personally, or write to me, or ask the hospice nurse to advise me? I am available for such phone calls."
> 1. "I cannot recollect this specific situation. Our practice is to respond to hospice nursing requests (as we do with all community nursing requests) on the day of the request."
> 2. "I believe that Mrs [B] needs to provide some specific dates for these calls so that I can check them against our call log. As I state above, our policy is for same day service in response to calls."
> 3. "[Mrs A] explicitly requested surgery consultations. In spite of my offers to visit her at home (a common practice at my surgery …), [Mrs A] wished to come to the

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surgery. She cherished the sense of independence and normality that visiting the surgery provided."

4. "When I heard [Mrs A] was … admitted to [the] Rest Home, I presumed I would need to visit her at which time I heard she had transferred under the care of the home doctor. This is not an uncommon practice but I asked my nurse to check as it was unexpected given my extensive involvement with [Mrs A] over the last year. There was never any 'harassment', simply checking that the communication we received was accurate … I wanted to check that now [Mrs A] was not under hospital or hospice medical supervision, her medications and other needs were appropriately organised. I do not understand how Mrs [B] could state that this was 'harassing and bullying a dying woman'."

Ms B also complained about her mother's diagnosis with breast cancer in 1997, which she considered to have been delayed as a result of care provided by Dr C. However, she was informed in correspondence, dated 23 October 2003, that this matter would not be investigated because of the time that elapsed since the incident (seven years). I also noted that Mrs A chose not to complain about Dr C's care in respect of this matter at the time.

Independent advice to Commissioner

The following expert advice was obtained from Dr Peter Gendall, diagnostic radiologist:

"I have been asked to comment on X-rays of Mrs [A], on the appropriateness of a report written by the radiologist and to comment on whether Mrs A's medical condition is likely to have contributed to the fracture of her femur.

[**Expert advice required:**

Please advise whether the fracture, reported in an X-ray taken of Mrs [A's] femur on 31 March 2003, is recent or historical.
If historical, please:

- *estimate the probable age of the fracture; and*
- *advise whether analgesics could disguise the symptoms of such a fracture.*

Please comment on whether Mrs [A's] medical condition is likely to have contributed to the fracture of her femur.

Is the radiology report, written by [the radiologist] in respect of Mrs [A's] fractured femur, appropriate?

Are there any issues relating to Mrs [A's] fractured femur that you consider warrants either:

- *further exploration by an investigator?*
- *additional comment.*]

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I have been provided with:
1. Whole Body bone scan (WBB) of 1 Feb 2002 (copy films)
2. Xrays Pelvis, left hip, left femur 31 March 2003 ([the Public] Hospital, copy films and originals)
3. Reports on the above studies and on other X-ray examinations and consultations.

- The Whole Body Bone scan (WBB) of 1 Feb 2002 shows multiple focal regions of increased radioisotope uptake in skull, spine, ribs, right scapula and in the pelvis. Pelvic lesions are shown in left ischium, left inferior ischiopubic ramus and in left pubis. Importantly the femoral necks are of normal appearance in this study with no sign of deformity of the left femoral neck and no sign of shortening of the left femur.

In Summary the WBB scan appearances are typical of multiple bone metastases from the known breast carcinoma.

- The X-rays of 31 March 2003 show a patchy appearance in the pelvis which is due to multiple sclerotic and lytic foci of varying sizes, typical of metastatic breast carcinoma. Lytic changes are shown in the proximal femoral shafts and intertrochanteric regions with endosteal scalloping particularly evident in the proximal femoral shafts, consistent with multiple small metastatic deposits in these regions. There is an impacted and displaced subcapital fracture of the left femoral neck but no sign of any lucent or sclerotic lesion at or adjacent to this fracture. No sign of healing sclerosis at this fracture site, no sign of bone resorption at the fracture site. Old healed fractures are noted in the right superior ischiopubic ramus and the right pubis with alteration of the normal smooth ischiopubic curve, further sclerotic change in the left pubis and left superior and inferior ischiopubic rami adjacent to the pubis has the appearance of healed or healing fractures. A heavily calcified 5cm diameter rounded nodule in pelvic soft tissues to the left of the midline has the typical appearance of a calcified uterine fibroid of moderate size.

In Summary: The appearances are of multiple sclerotic and lytic bone metastases in pelvis and both upper femora; a typical appearance of metastases from breast carcinoma. Well healed pelvic fractures on the right appear old, at least 3 to 6 months old and fractures of the left pubis and ischiopubic rami are at least several months old, in fact the increased uptake shown in the left pubis/ischiopubic rami on the WBB scan of 1 Feb 2002 may be due to these fractures. The subcapital fracture of the femoral neck is not clearly secondary to a metastatic deposit and is most likely secondary to osteoporosis, of similar aetiology to the right pubic and ischiopubic rami fractures.

ANSWERS TO QUESTIONS

1. My opinion is that, as there is no plain X-ray evidence of a metastatic deposit in the left femoral neck, the fracture of the left femoral neck is most likely due to minor trauma plus underlying osteoporosis. I consider the X-ray appearances to be entirely consistent with an acute fracture which probably occurred within hours or

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days of the X-rays and is unlikely to be more than two weeks old. This opinion is substantiated by a lack of healing sclerosis and a lack of bone resorption about the fracture. Analgesic medication could mask much of the pain of such a fracture.

2. Mrs [A's] medical condition and treatment may have contributed to the fracture of the left femoral neck in several ways:-
   a. despite the lack of radiographically visible tumour in the femoral neck microscopic tumour infiltration could have weakened the bone
   b. Loss of calcium from the skeleton (osteoporosis) could have been accelerated by the treatment of the malignancy, increasing the fragility of the bones and predisposing to fracture. Bed rest/immobility would have a similar effect
   c. The sedative effect of painkillers can predispose to accidents and falls and these drugs could mask fracture pain.

3. [The radiologist's] report on the films of 31.03.03 is, in my opinion, appropriate

4. I do not see other issues about this fracture that require further investigation. I would comment that I cannot exclude metastatic tumour as an underlying cause of this fracture but the evidence points to osteoporotic fracture as more likely."

Additional advice

In response to enquiries made by my staff on 16 March 2004, Dr Gendall clarified that Mrs A's femoral fracture could have been misconstrued as a historical one because of the impacted nature of the fracture. He advised that impacted fractures can create the false impression that healing has occurred. Dr Gendall also considered that the presence of other historical fractures could have been misleading. He re-iterated, on 30 March 2004, that these historical fractures were likely attributable to osteoporosis, including those of the left pubic and ischiopubic rami.

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Further advice to Commissioner

The following expert advice was obtained from Dr Ian St George, general practitioner:

"My full name is Ian Michael St George. I am an Otago Medical School graduate and have MD, FRACP, FRNZCGP. I work as a general practitioner in Wellington, am Medical Advisor to the Medical Council of NZ, and Medical Director of Healthline. I have held various academic appointments at Senior Lecturer level, and was Postgraduate Dean at the Wellington School of Medicine, and recently Chief Censor for the Royal NZ College of General Practitioners. I am an advisor for the Health and Disability Commissioner, and have given independent advice on medical misadventure for the ACC since 2001.

I respond to your letter of 7 April 2004 seeking advice in relation to Ms [B's] complaints against Dr [C]. I am asked to advise the Commissioner whether Dr [C] provided services to Ms [A] that complied with appropriate standards.

Expert advice required

1. Dr Peter Gendall, diagnostic radiologist, made the following comments in respect of Mrs [A's] fractured femur:

'I consider the X-ray appearances to be entirely consistent with an acute fracture which occurred within hours or days of the X-rays and is unlikely to be more than two weeks old'.

Given these comments by Dr Gendall, did Dr [C] refer Mrs [A] for an X-ray of her left hip and femur in a timely manner?

2. Dr Gendall identified historical fractures in the X-rays taken of Mrs [A's] left hip and femur on 31 March 2003. In particular, he noted healed fractures of the left and right pubic and ischiopubic rami. Dr Gendall claims that these fractures are likely secondary to osteoporosis. Please comment on whether it was reasonable for Dr [C] not to have identified that Mrs [A's] symptoms, in respect of these fractures, required further investigation.

3. Subsequent to Mrs [A] being diagnosed with metastatic breast cancer, did Dr [C] appropriately assess and manage her pain; including her leg pain?

4. On the evidence available, did Dr [C] adequately coordinate Mrs [A's] care?

Are there any aspects of the care provided by Dr [C] that you consider warrants additional comment?

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Supporting information

Letter of complaint, from Ms [B], dated 26 June 2003. (p1-3)
Action note clarifying Ms [B's] complaint, dated 14 August 2003. (p4)
Action note, detailing the recollections of Ms [B], dated 12 December 2003. (p5)
Letter of notification, to Ms [B], dated 23 October 2003. (p6-7)
Response from […] the New Zealand Medical Council, dated 9 January 2004. (p8)
Request for expert advice to Dr Peter Gendall, diagnostic radiologist, dated 29 January 2004. (p9-10)
Response from Dr Gendall, dated 15 March 2004. (p11-12)
Action note, detailing Dr Gendall's opinion, dated 16 March 2004. (p13)
Action note, clarifying Dr Gendall's report, dated 30 March 2004. (p14)
Response from Dr [C], dated 5 November 2003. (p15-67) Including:

- a summary of Dr [C's] involvement with Mrs [A] (p16)
- a response to Ms [B's] complaint (17-20)
- a summary of the services Dr [C] provided to Mrs [A] (p21-24)
- Dr [C's] clinical notes, dating from 6 December 2000 to 29 April 2003 (p25-30)
- Correspondence from Dr [E], [the nuclear physician], Dr [D] and Dr [C] (p31, 33, 34, 36-39, 41, 44, 45, 47, 50-56, 59-60, 67)
- Mrs [A's] medical records (p32, 35, 40, 42, 43, 46, 48, 57, 58, 61-67)

Response from [the] Hospice […], dated 28 November 2003. (p68-151) Including:

- Records of the care Mrs A received from [the] Hospice […] (p69-151)

Response from [the Public Hospital], dated 7 January 2004. (p152-318) Including:

- Mrs [A's] medical records (151-318)

Response from [the rest home], dated 2 December 2003. (p319-389) Including:

- Records pertaining to Mrs [A's] care from 10 April 2003 until her death on […] 2003. (p320-389)

I have assessed whether the doctor's actions were reasonable in the circumstances by the standards of the profession, as far as they have been stated or previously judged, at the time of the incidents. I state here I have no personal, financial or professional connection with any party that could bias my assessment.

Background

You have traversed the chronological sequence of the events in your paper, and I will not reiterate them here. The substance of the family's complaints appears to be:

- Dr [C] had never examined Ms [A's] breasts 1990-1997 or ordered mammography;
- He treated her pain inadequately between July 2002 and March 2003;
- He was unresponsive to requests for prescriptions and tests;
- He required surgery visits rather than doing house calls;
- He missed the diagnosis of pathological fracture of the femur between July 2002 and the end of March 2003;

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- His attempts to contact Ms [A] after her admission to the nursing home amounted to harassment.

In my opinion

- It is pure speculation as to when Ms [A's] breast cancer would first have been detectable; the surgeon who suggested five to seven years was guessing. In 1990 Ms [A] was 63; the NZ guidelines for screening mammography at that time were still being developed, but it was generally accepted that women aged 50-65 should have triennial examinations; there was no acceptance then or now that breast examination of asymptomatic women by a physician was useful, nor was there any acceptance that it was the general practitioner's responsibility to initiate screening mammography. On the contrary, the advice was that women should report abnormalities early. By 1992 she was 65, and was no longer in the age group when screening mammography was or is recommended.
- Dr [C's] records are exemplary and they clearly show great care in trying to address Ms [A's] pain; there is no doubt his attempts were not entirely successful, but that is in the nature of pain from bony metastases. He titrated the doses of analgesia according to her reported pain, he withheld opiates until they were needed, he referred properly for help when indicated.
- I cannot assess his responsiveness to requests, except to note Dr [C's] letter disputes that interpretation: '[Mrs A] had telephone contact with me at any time she required…. I remained available over this period and provided prescriptions as requested….'
- Dr [C] wrote, '[Mrs A] was quite clear she preferred to attend the surgery, as a means of maintaining her independence and maintaining as normal a life as possible'.
- The age of the pathological fracture was misdiagnosed at the hospital; clearly (from Dr Gendall's report) it was a recent fracture, and Dr [C's] records show he considered the diagnosis early, and then referred her promptly when the diagnosis became obvious.
- His attempts to contact her after her admission to the nursing home, far from being harassment, were the proper and human actions of a doctor concerned for his patient. Furthermore doctors are human, and their relationships with patients are human ones which they tend and value. When such a relationship is unilaterally terminated, doctors need and deserve an explanation.

I will answer your specific questions:

- Dr [C] suspected, and then diagnosed pathological fracture of the hip in a timely manner. The fracture was new on X-ray. Even if it had been present for longer, no active treatment would have affected the outcome.
- Pathological fracture is part of metastatic bone disease, and contributes to the pain experienced. The old fractures of Ms [A's] pelvic bones would likely have been treated no differently if they had been diagnosed earlier. Even if they had been suspected, further investigation (ie X-rays) would have been useful only in confirming the diagnosis.
- Dr [C] was careful and thorough in assessing and managing Ms [A's] pain.

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- Dr [C] was careful and thorough in liaising with and coordinating the team caring for her.
- You ask me for additional comment on Dr [C's] care if I consider it warranted. I will say this: it is not the tragic dimension of the outcome, nor the vehemence of the complainant that should be considered, but the blameworthiness of the processes. In Ms [A's] case, the outcome was a sad death after considerable suffering from an incurable disease, and her family naturally seek to find cause. But the process of care provided by her general practitioner was beyond reproach, and in fact appears to have been exemplary."

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights (the Code) is 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.*

Opinion: No breach – Dr C

Femoral fracture: assessment, diagnosis and referral
According to Ms B, she was advised that her mother's femoral fracture was historical in nature. In particular she referred to July 2002, approximately eight months prior to Dr C's referral of Mrs A for an X-ray on 31 March 2003. However, Dr Gendall stated that the X-rays taken of Mrs A's left hip and femur on this date report no sign of healing or bone resorption at the fracture site. He concluded that the fracture likely occurred within hours or days of the X-rays being taken. I accept Dr Gendall's comments about the probable age of Mrs A's femoral fracture.

On the basis of Dr Gendall's report, Dr St George stated that Mrs A's pathological fracture had been misdiagnosed at the Public Hospital. He further commented that Dr C suspected a pathological fracture at an early stage, and referred Mrs A appropriately when this diagnosis was confirmed. In his view, Dr C's diagnosis and referral were made in a timely manner. I accept Dr St George's comments and conclude that Dr C did not breach the Code.

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Historical fractures
On reviewing X-rays taken of Mrs A's left hip and femur on 31 March 2003, Dr Gendall identified healed fractures of the right pubis and right superior ischiopubic ramus. He considered that these fractures were sustained at least three to six months prior to 31 March 2003. Dr Gendall also noted sclerotic changes of the left pubis, and left superior and inferior ischiopubic rami, which had the appearance of healed fractures. According to him these were months old and could have dated back to Mrs A's bone scan, performed on 1 February 2002. In Dr Gendall's view, the historical fractures identified were most likely attributable to osteoporosis. However, he also noted the appearance of multiple bone metastases in the pelvis and upper femora. He further commented on the possibility of bones being weakened by the process of microscopic tumour infiltration.

Dr St George also observed that pathological fractures are an inevitable part of metastatic bone disease. Dr St George noted that Mrs A's care would not have differed had these fractures been discovered, and described the process of care provided by Dr C as "exemplary". On the basis of my expert advisors' comments, I consider that it was reasonable for Dr C not to have further investigated Mrs A's symptoms in relation to these fractures. Consequently, I do not consider that he breached the Code.

Pain management and assessment
Dr St George acknowledged that Dr C's attempts to control Mrs A's pain were not always successful. However, he suggests that this was a natural consequence of the type of pain caused by bony metastases. He further notes that Dr C's records reveal "great care in trying to address Mrs A's pain". In Dr St George's view, Dr C prescribed analgesia in accordance with reported pain, withheld opiates until necessary and referred Mrs A appropriately when it was indicated.

In addition to the comments made by Dr St George, I note that Dr C reviewed Mrs A's pain management, in some form, on at least eighteen occasions between 15 February 2002 and 28 March 2003. The progress notes from the hospice, from 26 April 2002 to 7 June 2003, appear to corroborate Dr C's interventions to manage Mrs A's pain. On the evidence available, I find Dr C's assessment and management of Mrs A's pain to have been more than adequate. Accordingly, I do not consider that he breached the Code.

Co-ordination of Mrs A's care
I note Dr St George's comments about the co-ordination of Mrs A's care by Dr C, which he described as "careful and thorough". I also acknowledge his description of the process of care provided by Dr C. Dr St George's comments appear to be substantiated by the regular communication between Dr C, Ms F and staff at the radiation oncology clinic of the Public Hospital. I agree with Dr St George's comments about the co-ordination of Mrs A's care by Dr C, and consequently find that he did not breach the Code.

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

Other comment

I note the following comments, made by Dr C:

> "Although I do take issue with Mrs [B's] allegations which I strongly feel are unwarranted and unfair, I do wish to put that to one side for the purpose of extending my heartfelt sympathies to Mrs [B]. [Mrs A] was a courageous and independent woman who had my greatest respect. It was a privilege and a pleasure to be her doctor."

Follow-up actions

Medical Council of New Zealand
A copy of my final report will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.

Public Hospital
A copy of my final report will be sent to the Public Hospital.

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

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