General Practitioner, Dr A

A Report by the

Health and Disability Commissioner

(Case 00HDC05372)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Dr A	General practitioner
Mr B (dec)	Consumer
Mrs B	Complainant

I received expert advice from two independent general practitioners, Dr Chris Kalderimis and Dr Shane Reti.

Complaint

The Commissioner received a complaint on 26 May 2000 from Mrs B regarding the services that her husband, Mr B, received from Dr A, a general practitioner in a private medical centre. The complaint is summarised as follows:

Dr A

Dr A did not provide health services of an appropriate standard to Mr B. In particular:

- *when Mr B consulted Dr A for chest pains on several occasions during 1999 Dr A did not refer him to a specialist for further tests even though:*
    - *he knew that Mr B's father had died of a heart attack at 42 years of age*
    - *in May 1999 Mr B had a cholesterol level of 9.7.*

When Mr B consulted Dr A on 13 December 1999 Dr A failed to detect the seriousness of Mr B's chest pain and did not refer him to the hospital for urgent treatment even though:

- *Mr B had experienced chest pains between 8 and 12 December 1999, which included sharp pains while he was riding a bicycle up hill and two consecutive nights of severe discomfort*

- *he was aware of Mr B's family history, his high cholesterol level and that Mr B had been to him on several occasions that year complaining of chest pain. (Mr B's cholesterol level had gone down to 5.8 after he started taking Lipidol; on 13 December 1999 it had risen to 6.2.)*

During the consultation on 13 December 1999 Dr A stated that he intended to refer Mr B to a heart specialist as a precaution. However, he did not:

- *offer Mr B aspirin or any other pain relief for the pain*
- *caution Mr B about his workload.*

After Mr B had a fatal heart attack on 14 December 1999 Dr A did not communicate appropriately with his family. In particular:

- *when Dr A did contact Mrs A in January 2000 it was agreed that he would see her during the Wellington Anniversary weekend to discuss the events leading up to Mr B's death. It was agreed that he would ring again to arrange a specific time. However, Dr A never phoned Mrs B again and did not visit her that weekend.*

The last two points have not been specifically addressed in this investigation. The issue regarding the alleged failure to offer pain relief and aspirin is peripheral to the general issue of whether Dr A's actions during the consultation in December were appropriate. In my view it is unnecessary to address that issue in isolation from the more general enquiry.

The second of these matters concerns the allegation that Dr A did not communicate properly with Mr B's family following Mr B's fatal heart attack. This issue is outside my jurisdiction; the Code of Health and Disability Services Consumers' Rights does not afford rights to the family of competent adult consumers, except in very narrow circumstances. I therefore do not intend to address in this investigation issues surrounding Dr A's actions subsequent to Mr B's death.

The key issue is whether Dr A provided services to Mr B with reasonable care and skill during the course of his consultations in 1999.

Information gathered during investigation

Overview

This is a report about a man with heart disease. It is a story that is familiar to thousands of New Zealanders who suffer from this disease, and to their families. The report focuses on one main issue: what degree of caution must a general practitioner exercise when he or she sees a patient with symptoms indicating the possibility of heart disease? It is an issue that is of widespread importance given the prevalence of the disease and the rate at which it claims the lives of New Zealanders. Sadly, this case had a tragic outcome. What I hope to achieve through this report is to highlight the need for general practitioners to be vigilant in relation to the possibility of heart disease.

On 14 December 1999 Mr B, aged 51 years, died of a heart attack while working on his farm. During the previous year he had been seeing a general practitioner, Dr A, in relation to a number of problems, including elevated cholesterol.

The essence of the complaint, made by Mr B's wife, was that Dr A had sufficient information over the course of the year to identify that Mr B was at risk of having a major heart attack, and that he should have taken action to lessen this risk.

Mr B's final consultation with Dr A was on 13 December 1999, the day prior to his death.

History of consultations
Mrs B recalls Mr B mentioning chest pain prior to 1998. She informed me that she specifically recalls that one night in the latter half of 1998 Mr B told her that he had experienced bad pain in his upper chest and shoulder area during the day. She also recalled Mr B occasionally complaining of pain in his left shoulder/upper chest area, as well as waking with numbness in his left hand. Mrs B always considered these problems to be muscular in nature.

Consultation on 15 February 1999
Mr B did not see Dr A from late 1997 until 15 February 1999. Over that period Mr B consulted other doctors at the Medical Centre. On 15 February 1999, Mr B did consult Dr A in relation to a back strain. During that consultation Mr B asked Dr A to check his blood pressure as it had been high following surgery in December 1998. Dr A took blood pressure recordings and noted that it had settled at 130/90. He noted in his medical notes that there was "no blood pressure problem".

According to Dr A the primary reason for the consultation was Mr B's back strain. Mr B only mentioned chest pain during the course of a systems review, when directly asked by Dr A. On further questioning Mr B said that the pain was associated with excessive effort, and had been occurring for the last 15 years.

Dr A informed me that at this consultation he reviewed Mr B's cardiovascular risk status. He noted that he was a non-smoker and that he suffered "chest pain with effort". (Mrs B has pointed out that while Mr B was currently a non-smoker, he had in fact smoked for many years, and stated that Dr A was aware of this fact.)

Dr A asked Mr B to have a cholesterol blood test, and to see him again in five days. Dr A informed me that his assessment following that consultation was that as Mr B had experienced the chest pain under similar circumstances for over 15 years, it was atypical of heart disease and not significant.

Mrs B, through her solicitor, has noted that there is no mention in the clinical notes of Dr A doing a cardiovascular systems review. Although Dr A advised me that he did such a review, notes he made relating to a meeting with Mr B's family following Mr B's death are much more equivocal. In those notes he comments, "I must of done a cardiovascular systems review" and "I am sure a full seven dimensions of the symptom had been covered".

I accept that the medical notes do not reflect the full extent of what Dr A told me took place during that February consultation. Certainly, follow-up was arranged to obtain further information about Mr B's cardiovascular risk, including an ECG and cholesterol tests.

Mrs B recalled Mr B saying, following the February consultation, that he needed an ECG and blood tests (for cholesterol levels), and relaying Dr A's opinion that the pain he was experiencing was muscular in origin. Although it is not recorded in the medical notes, based on this evidence from Mrs B and others who knew Mr B over this period (discussed below), I accept that Dr A told Mr B at this consultation that the chest pain was probably muscular in origin.

Cholesterol test results
Mr B did not get the cholesterol tests done until 25 March, about five weeks later, and the Medical Centre received the results on 26 March. The results showed that Mr B had a cholesterol level of 9.2. As this was a very high reading, a follow-up test was arranged. This was done on 20 April and showed that Mr B's cholesterol was now 9.7.

Consultation on 26 April 1999
Between the consultation on 15 February and the consultation on 26 April, Dr A saw Mr B three times on unrelated matters. On 26 April Dr A saw Mr B to assess his cardiovascular risk factors and to conduct a resting ECG. At this point, Dr A was aware that Mr B had two cholesterol readings over 9 and a family history of heart disease, and the notes recorded that Mr B had a 15-20% risk of a cardiovascular event in the next five years. Dr A points to this assessment to indicate that he did assess Mr B as having high cardiovascular risk.

Dr A considered that Mr B's cholesterol needed to be addressed to lessen his cardiovascular risk. At the 26 April consultation Dr A accordingly informed Mr B that he would require a cholesterol-lowering pill because of his elevated cholesterol, and they discussed the treatment and side effects.

Dr A has denied on a number of occasions that Mr B mentioned chest pain during this consultation. There is no mention of chest pain in the medical notes.

The following day, 27 April, Dr A faxed a form to Pharmac requesting approval to prescribe the subsidised medication atorvastatin at 10mg per day.

Unrelated surgery
On 20 May 1999 Mr B underwent surgery for a right ulnar nerve transposition, involving repositioning a major nerve in the arm. The anaesthetist who administered the anaesthetic noted that Mr B was "low cardiovascular risk". In a letter dated 6 October 2000 to Dr A, the anaesthetist noted that the pre-anaesthetic assessment of Mr B showed a normal x-ray. There was no indication for a pre-operative ECG, but Mr B's electrocardiograph was monitored at the pre-induction stage and throughout surgery, and was completely normal at all times. Mr B made an excellent recovery and was discharged the next day.

Consultation on 27 May 1999
On 27 May 1999 Mr B saw Dr A again, and Dr A's notes reflect that he discussed the side effects of the cholesterol medication, and the need for follow-up tests to ensure that Mr B's cholesterol levels were reducing.

A follow-up test was done on 28 June 1999, and it showed that Mr B's cholesterol had markedly reduced.

Consultation on 28 July 1999
Dr A saw Mr B again on 28 July 1999. During that consultation they again discussed Mr B's cholesterol levels and Dr A indicated the need for a further follow-up test in three months' time. Mrs B has alleged that Mr B mentioned chest pain at this consultation. Again, Dr A has denied this on a number of occasions, and refers to his medical notes, in which there is no mention of chest pain during this consultation.

Consultation on 13 December 1999
Between July and December Mr B did not consult Dr A. However, in December 1999 Mr B suffered chest pains on a number of occasions. Mr B was on holiday with Mrs B and their daughter from 8-12 December. On 8 December Mr B complained that he had suffered a sharp pain in his chest while riding his bicycle up a hill. Throughout the evening, Mr B passed wind and burped frequently, and was suffering chest pain. Mrs B assumed this was indigestion, although she recalls that Mr B felt that the problems related to his heart. By Friday 10 December the problems had still not settled down, and Mr B had had two nights of severe discomfort while he was in bed. Mr B therefore rang the Medical Centre to make an appointment to see Dr A. Over the weekend of 11 and 12 December Mr B suffered the "odd pain in his chest".

Dr A informed me that he was not aware that this consultation was any different from any other consultation, nor that Mr B had been on holiday when he called to arrange the appointment. Mrs B does, however, note that this was the first time Mr B had made an appointment with Dr A "solely because of the chest pain he had been suffering, and the severity of that pain".

Dr A informed the Coroner, in relation to the December consultation, that Mr B had come in appearing generally fit and well. Mr B did, however, indicate that he had been suffering chest pain. Dr A's notes record that the chest pain had been present for more than 15 years, originating with squash. There had been some increase over the years with less effort, and Mr B had noticed it more in the last year. Certain activities (eg, using a rowing machine) provoked it, while others (eg, using an Exercycle) did not.

In his letter to the Coroner, Dr A noted that the location of the pain was "atypical" for heart pain. Mr B had "pointed largely to the upper outer quadrant of the chest almost to the region of the shoulder rather than in the chest itself". In describing pain going down his arm, he went to the level of his left bicep and occasionally touched his hand. Dr A also noted that Mr B had always been a "vague historian", and accordingly he went to deliberate lengths to ascertain the exact nature of the pain. Other physical examination of Mr B was normal.

According to Dr A, Mr B did not mention anything of the specific difficulties he had been experiencing with chest pain over the previous weekend while on holiday (discussed below). Mrs B has described Mr B's apparent failure to describe to Dr A the extent of his chest pain while on holiday as "incomprehensible" as it was "the sole reason he made the appointment". While I too find it surprising that Mr B did not mention the extent of the difficulties he had been suffering, there is no evidence to contradict Dr A's assertion that the

extent of the pain was not mentioned. Dr A's entry in the clinical records of 8 January 2000, after he had spoken to Mrs B, supports his position, as he recorded:

> "D/W [Mrs B] re IHD. I not aware of significant CP [on holiday]! – more severe than he owned up to."

In the circumstances I am satisfied that Mr B did not tell Dr A during the December consultation of the extent of the chest pains he had recently been having. Mrs B maintains that the fact that Mr B asked for painkillers during the consultation (as noted below) indicates that Mr B did describe the extent of his chest pains. While this certainly does indicate that Dr A was aware that Mr B had been suffering pain, that point is not in dispute. The fact that Mr B asked for painkillers does not provide any independent support for the assertion that Mr B fully explained the extent of his symptoms.

Mrs B has alleged that Dr A failed to ask specific questions to elicit a proper history from Mr B. Dr A, however, informed me that he spent "a great deal of time going through his set of symptoms with him". This is to some extent confirmed by the fact that in the subsequent letter that Dr A wrote to the specialist, he distinguished between activities that caused pain, and those that did not. I accept that Dr A did make a considerable effort to establish the nature of Mr B's chest pain. I am unable to determine on the evidence available to me whether or not Dr A asked the specific questions that Mrs B discusses in her response to my provisional opinion, such as "when did you have your last pain?" or "can you describe how bad the pain was?". But in my view the absence of a record of specific questions and answers in the clinical notes does not mean that Dr A did not try to elicit from Mr B an explanation of his symptoms. The evidence before me indicates that Dr A did take some care to get relevant information from Mr B.

Dr A states that he discussed with Mr B his opinion that the pain was atypical of heart pain, but that in light of the elevated cholesterol and family history of heart disease it would be wise to get an exercise check performed within the next couple of weeks, just to double-check.

Following the appointment Mrs B recalls Mr B returning and confirming that Dr A also thought the pain was muscular. Mr B indicated the bottom of his rib cage and said that Dr A had said if the pain was heart-related, the pain would have been there. On the basis of this evidence from Mrs B I accept that Dr A again told Mr B during this consultation that the pain was probably muscular in origin.

Mr B also told Mrs B that he had asked for painkillers but Dr A had not prescribed any, and also that his cholesterol had increased slightly.

On 14 December 1999, Mr B worked on the farm from 6.30am to 4.30pm, when he had a fatal heart attack.

Referral to specialist
Dr A's letter to Dr E, a cardiologist at a specialist medical centre, noted:

> "Thanks very much for catching up with Mr [B] who presented on the 13th December with chest pain in the left anterior chest with some radiation down the left upper arm. He seems to feel that he has had this pain for over 15 years (began with squash). He has noticed that the discomfort has increased over the last couple of years and seems to be effort related. It has become more prominent over the last few months. It is precipitated by certain activities (e.g. using the rowing machine) but not so by others (e.g. the exercycle). His overall health is good.
>
> PHX: Mr [B]'s father died in his early 40's of a heart attack. Mr [B] also has an elevated cholesterol for which he is on Zocor 20 mg daily. No drug allergies known.
>
> O/E: Mr [B] appears generally fit and well. He has a normal heart rate of 72 beats a minute regular. Blood pressure is 118/72. Heart size and sounds are normal. Chest is clear.
>
> I greatly appreciate it if you could catch up with Mr [B] with regard to exercise test and/or other tests to exclude IHD."

It was as Dr A was signing this letter of referral that he received the sad news of Mr B's death.

In response to my second provisional opinion, Mrs B notes that I had not discussed in my opinion the issue of why Dr A did not come to the farm immediately on hearing the news of Mr B's heart attack. This issue has not been under investigation; it is doubtful whether the matter even comes within my jurisdiction. I do not intend to address the issue here as it is not a matter on which Dr A has been specifically asked to comment, nor was it part of the terms of reference for my investigation. I am therefore unable to review this matter as part of my investigation.

Meeting following Mr B's death
A meeting was arranged for 25 March 2000, to discuss the events leading up to Mr B's death. Present at the meeting were Mrs B, family members, a patient advocate, Dr A and a GP.

Mention of chest pain at April and July consultations
Mrs B has stated that during the meeting Dr A outlined Mr B's medical history, with the medical notes in front of him. In a signed statement provided through her lawyer, Mrs B stated:

> "It was confirmed by Dr [A] that he had had little to do with [Mr B] prior to February 1999 – he had not seen Mr [B] for any '*significant*' consultation during the period 1995 to early February 1999. He outlined what had occurred at each of the consultations that Mr [B] had had with him throughout 1999. Dr [A] confirmed that at none of the consultations that took place prior to December 1999 did he link the

> chest pains from which Mr [B] was suffering, with heart disease, despite the … family history and Mr [B]'s very high cholesterol level. Dr [A] indicated quite clearly that he was aware that Mr [B] had a family history of cardiovascular disease and that his father had died at an early age of a heart attack.
>
> Dr [A] informed us that Mr [B] had complained to him that he had been experiencing chest pain at the consultations held in February 1999, April 1999, and July 1999. When I learnt that Mr [B] had mentioned that he was experiencing chest pain at the April and July 1999 consultations, I was very surprised that he had not linked the chest pains from which Mr [B] was suffering with some form of cardiovascular disease."

Member of Mr B's family support Mrs [B]'s recollection. Mr B's sisters' statement notes:

> "It was confirmed by Dr [A] that he had little to do with Mr [B] prior to February 1999 – he had not seen Mr [B] for any '*significant*' consultation during the period 1995 to early February 1999. He outlined what had occurred at each of the consultations that Mr [B] had had with him throughout 1999. Dr [A] confirmed that at none of the consultations that took place prior to December 1999 did he link the chest pains from which Mr [B] was suffering, with heart disease, despite the […] family history and Mr [B's] very high cholesterol level. Dr [A] indicated quite clearly that he was aware that Mr [B] had a family history of cardiovascular disease and that his father had died at an early age of a heart attack.
>
> Dr [A] informed those present that Mr [B] had complained to him that he had been and/or was getting chest pain at the consultations held in February 1999, April 1999 and July 1999. I recall that when Dr [A] mentioned that Mr [B] had told him that he was suffering chest pains at the consultations held in April 1999 and July 1999, Mrs [B] let out a cry of 'disbelief'."

Further supporting evidence was provided by another family member, whose notes of the meeting also indicate that Dr A told the meeting that chest pain was mentioned on four occasions throughout 1999.

Mrs B also informed me that she questioned Dr A as to whether at the December consultation he had asked Mr B "certain basic questions" about recent chest pain Mr B had been experiencing. Mrs B says that Dr A was evasive, and said that he "must have asked those questions".

Dr A's response

Dr A denies that he told the meeting that chest pain had been mentioned at the consultations in April and July. The clinical notes support his position; chest pain is mentioned only at the February and December consultations. Dr A advised me:

"I have referred to both my clinical notes and the notes I took relating to the meeting on 25 March 2000 (both written and dictated by me immediately following that meeting).

I most certainly did not say at the meeting on 25 March 2000 that Mr [B] had spoken to me of chest pains during his April and July 1999 consultations. To have said so would not have been true.

There is no mention of chest pain in the notes of April and July 1999 consultations despite cardiac illness being one of the focal points of the April 1999 consultation. It is my invariable practice to note in the patients' records any significant reported symptoms. Given that Mr [B] had, in response to my questioning, reported chest pains in his February 1999 consultation, had he mentioned them again in any subsequent consultations, I would have recorded that in his patient notes. In fact that is what I did when on his February and December 1999 consultations, he spoke of chest pains.

My patient notes show clearly that, at the April 1999 consultation, I discussed with Mr [B] his cardiovascular risk based on National Heart Foundation figures. Part of that discussion involved questioning him about possible cardiac symptoms including chest pains, shortness of breath and swelling of the ankles. The fact that my notes for that consultation make no mention of any of these symptoms confirms to me that he, in answer to my questions, reported no such symptoms.

The same comments apply in relation to the July 1999 consultation. I reviewed his cholesterol at 5.8 and arranged for a follow-up cholesterol to be done. It is clear that one of the facts of that consultation was the ongoing review of his cardiovascular risks and that the same questions would have been asked to him as to symptoms. Had he mentioned chest pains, that would have been noted."

When was chest pain mentioned?

It is clear that I need to make a finding about the number of occasions on which chest pain was mentioned during 1999. The issue is material to the issues at the core of this investigation. If Dr A was informed on two additional occasions that Mr B was suffering chest pains, he should have been even more aware of the risk of heart disease and the need for a specialist referral.

In the circumstances, I do not consider there is sufficient evidence to find that Mr B mentioned chest pain during the April and July consultations. The clinical notes support Dr A's position. While I accept that in some instances Dr A's notes are not entirely full in their explanation of what happened at consultations, I am satisfied that Mr B was a "vague historian", as Dr A described him, evidenced by the fact that he did not describe to Dr A the severe chest pain he experienced over a number of days in Auckland during December 1999. (The fact that Mrs B would never have described her husband in this way is not germane – she was not his doctor.) For Mr B not to mention chest pain during the April and July consultations would be consistent with his apparently relaxed attitude to describing to his doctor a full account of his symptoms. Dr A has denied that chest pain was

mentioned on those two occasions; he says he would have recognised it as a highly relevant symptom and noted it in the medical records. I find Dr A's evidence credible. He assessed Mr B as having a high risk cardiovascular status and, in my view, even though he had earlier diagnosed the chest pain as muscular chest pain, he would have noted any ongoing symptoms.

Mrs B, through her lawyer, has provided me with statements of three witnesses indicating that at the 25 March meeting Dr A said that chest pain was mentioned during the April and July consultations. The notes taken by a family member at that meeting record Dr A as indicating that Mr B mentioned the pain on the two additional occasions. The evidence of Mr B's sister and Mrs B also support this position.

Ultimately, the determining factor in deciding this factual conflict is that the only direct evidence of what took place at the consultations between Mr B and Dr A has come from Dr A. Even if I accept the evidence of Mrs B and the family members, it is hearsay. It is direct evidence only of the fact that at the meeting following Mr B's death, Dr A said that chest pain was mentioned during the April and July consultations. That is not the same as direct evidence that chest pain was in fact mentioned at those consultations; that conclusion requires a further step for which there is no direct evidence. There is direct evidence from Dr A, supported by the clinical records, that he did not.

I am not satisfied that Mr B mentioned chest pain during the April and July consultations. I will proceed on that basis.

Other information
Mrs B, through her lawyer, also provided me with statements from an insurance broker, and a farm-worker on the family farm. The insurance broker confirms that Mr B was suffering chest pain in June 1999, and that Dr A had diagnosed this as being muscular in origin.

The farm worker states that throughout 1999 Mr B suffered chest pain when exercising, and confirms that a muscular diagnosis had been made. He also outlines the circumstances leading to Mr B's fatal heart attack.

Independent advice to Commissioner

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

> "This is a complaint made by Mrs [B] regarding the services that her late husband, Mr [B], received from Dr [A], general practitioner, […].

The history that you have outlined is comprehensive. Briefly it appears that Mr [B] did have a high risk cardiovascular history in as much as his father had died in his early 40's of heart disease, and as well, Mr [B] was recognised to have an elevated cholesterol.

There is some dispute about how often Mr [B] attended Dr [A] during 1999 to discuss chest pains. Mrs [B] says that he attended a number of times but, in fact, when you look at Dr [A]'s reply, and when you look at his practice notes, there is only one mention made of it prior to the attendance on 13th December 1999 and it would appear that that was not the major reason for the consultation in any event. Thus it would appear that although Mr [B] may well have had problems with chest pain prior to December of 1999, and certainly he probably mentioned them to his wife and others, this is not recorded by Dr [A] prior to December of 1999.

In any event, on 13th December 1999, after a trip away when he did experience chest pains while riding a bicycle and in bed during two nights, he attended Dr [A] and really the crux of the complaint revolves around this consultation.

Diagnosis of angina can only really be made from the history given to a medical practitioner. A general practitioner has got no facilities to make a positive diagnosis of myocardial insufficiency or angina, and a physical diagnosis can only be made really when the patient attends a cardiologist for a stress ECG or coronary artery angiography. Thus the history that Mr [B] gave Dr [A] was crucial in this instance. The problem is that we have two quite separate accounts.

Firstly we have the account given by Mrs [B] regarding her husband's obvious pain whilst [on holiday]. Secondly, we have a description of the pain given by Dr [A] and in his letter to the [private hospital] cardiologists which implied the pain had been present for a long period of time, namely, some 15 years, and that there were certain strenuous activities which could be performed by Mr [B] that did not result in any cardiovascular pain. The problem really comes in deciding what took place at the consultation and did Mr [B] give a true and complete account of the symptoms or did he try and minimise them to the point where they were not properly interpreted by Dr [A].

In the event Dr [A], after that consultation, decided that Mr [B] did need a stress ECG and this was duly organised at the [private hospital]. However, Mr [B] went back to work on his farm and it would appear that he died from a fatal heart attack the next day.

Postmortem revealed that he had suffered a myocardial infarction (heart attack) one or two days previously and one could say that possibly this happened when he had the bad chest pain in bed while [on holiday].

In answer to the issues you have raised:

1. *Should Dr [A] have referred Mr [B] to a specialist for further tests and investigations on:*
   (i) 15 February 1999
   (ii) any of the other consultations before 13 December 1999.
   If so, why should Mr [B] have been referred? If not, why was a referral not necessary?

(i) Looking at the notes made on 15 February 1999 and given the nature of the history recounted to Dr [A] and Dr [A]'s own notes, it would be impossible to say that really there would have been any justification for referral to a specialist on that date.

(ii) There were no consultations prior to that date that in my opinion would have necessitated a specialist referral.

2. *What, if any, signs of cardiovascular disease did Mr [B] display prior to 13 December 1999?*

Mr [B] did not display any signs as such of cardiovascular disease, but might have displayed symptoms of it. Symptoms of ischaemic cardiac disease are basically those of chest pain, arm pain, neck pain or jaw pain on exercise. The symptoms that he presented prior to 13th December 1999 did not reflect this sort of problem. Once again, Mr [B] may well have had symptoms that his wife identified prior to this date, but it would appear to me that he did not communicate them to Dr [A] and so Dr [A] was unaware of them.

3. *What, if any, indication of cardiovascular disease, was the pain that Mr [B] had experienced for the past 15 years?*

This I feel is the big red herring in the history that was given to Dr [A]. Angina for a man of Mr [B]'s age would not have gone on for 15 years. Thus when a GP hears that chest pain has been present for 15 or more years, one is inclined to state that is probably not angina. We are inclined to believe that this is either muscular or ligamentous in origin. This is probably what Dr [A] was led to believe. It was very unfortunate that Mr [B] felt the pain he was getting from his rather obvious ischaemic heart disease was no different from the muscular ligamentous pain he may well have experienced over the past 15 years.

4. *What, if any, other action should Dr [A] have taken in his management of Mr [B] from 15 February to 13 December 1999? In answering this question please comment on whether a stationary test was sufficient or whether Dr [A] should have undertaken an exercise test.*

I feel that it was certainly prudent for Dr [A] to organise an exercise ECG at the consultation on 13 December 1999, but really before that time he really

had no significant reason to do so. It has to be remembered that the stationary resting ECG cannot diagnose angina and a stress or exercise ECG is needed to do this. GPs do not do this in their rooms as it carried a significant mortality rate and so this test is only done in the rooms or offices of specialists in a cardiological institution where resuscitation can be offered if needed.

5. At the consultation of 13 December 1999, should Dr [A] have:

(i) made a diagnosis of muscular pain or was the description given by Mr B indicative of cardiovascular disease?

This is the crucial question. With the advantage of hindsight we can clearly say that what Mr [B] was describing was not muscular pain, but cardiovascular disease, but the trouble is that we do not know how he phrased his description of the pain to Dr [A]. If he told Dr [A] that this was exactly the same pain as some 15 years ago and only occurred during some types of exercise and not others, such as riding an exercycle, then one can easily see how Dr [A] was led to the erroneous conclusion that this pain was muscular. Thus, even with the advantage of hindsight, I can see how Dr [A] reached the wrong conclusion that the pain was muscular. But he did cover himself by asking for a stress test to be done at [the private medical hospital].

(ii) prescribed pain relief or cardiovascular medication?

Given the way that it appears Mr [B] described his pain to Dr [A] and the fact that Dr [A] made a diagnosis of muscular pain, then I feel that prescribing pain relief in this situation would have been of little value and certainly prescribing cardiovascular medication would have been irresponsible until a proper diagnosis was reached.

(iii) cautioned Mr [B] about his workload?

If Dr [A] believed that the pain described by Mr [B] was similar to what he had been experiencing for the last 15 years or so, then perhaps there was no justification to caution him about his workload. Obviously, with hindsight, it would have been very prudent to caution him about his workload and probably also with hindsight, the appropriate course of action would have been to admit him forthwith to hospital. But at the time when the consultation took place, all that Dr [A] had was Mr [B]'s history and thus there probably would not have been any justification in cautioning him about his workload.

(iv) referred Mr [A] to hospital for tests, and/or treatment?

Mr [B] was in fact referred for tests but not acutely. Again, with the advantage of hindsight, one could say that he should have been referred acutely for tests, but with the information he had at his disposal, Dr [A] felt that the tests could be done within the next few weeks rather than the same day.

(v) made an urgent referral to a specialist for further tests and investigation?

Dr [A] did in fact refer Mr [B] to a specialist for further tests but in fact the referral was not urgent and I think, given the history as Dr [A] understood it, this was a very reasonable course of action.

6. How significant was the rise in Mr [B]'s cholesterol level from 5.8 to 6.2 on 13 December 1999?

I do not believe this was significant although in general it would be prudent to lower the cholesterol further if the patient was already on cholesterol lowering medication.

7. If Mr [B] did not mention the chest pain that he experienced between 8 and 12 December 1999 at his consultation with Dr [A] on 13 December, what, if any, reflection does this have on the appropriateness of Dr [A]'s information gathering abilities.

I think this is an unfair question. History taking is very complex and difficult and if the patient does not give an appropriate history, then I think it is very unfair to blame the doctor for his/her information gathering abilities.

8. What, if any, signs did Mr [B] show of cardiovascular disease on 13 December 1999? What, if any, symptoms did Mr [B] display which would indicate that he would have a fatal heart attack the following day?

Looking at Dr [A]'s notes I could not see any signs that Mr [B] might have shown that he had cardiovascular disease, but the symptoms that Mr [B] had might not have been displayed to Dr [A]. As I mentioned before, that is really the key – did Mr [B] tell Dr [A] of the symptoms of chest pain on exercise, or did he minimise the pains by saying that they were the same pains he had been having for the previous 15 years? Certainly Dr [A] did take this situation seriously and went to some length to differentiate as to whether or not there was a cardiovascular problem and went so far as to refer Mr [B] on for cardiological evaluation at the [private hospital].

Thus, as I have already said, this whole case really hinges on what was actually said by Mr [B] to Dr [A] at that appointment on 13 December 1999. I agree that it was a great pity that Mrs [B] was not present at that appointment because I suspect that, had she been present, quite a different story might have been given to Dr [A]. In medicine, the crucial evidence that is presented to the doctor is often in the history rather than in the examination of the individual. It may well be that the history offered to Dr [A] was not sufficient for him to reach an appropriate conclusion.

9. Are there any other issues arising out of the supporting information?

I feel this is a situation where, with the advantage of hindsight, we can certainly reach the appropriate conclusion, but I think we need to be cognisant of the fact that quite possibly Dr [A] was not offered the right history to enable him to reach the correct conclusion. I think that Mr [B] probably did minimise his symptoms and probably therefore the full story of what happened [while on holiday] was never told to Dr [A].

I think it is certainly regrettable that Dr [A] did not go and see Mrs [B] after the funeral, but in human terms I can understand the reticence he might have felt to do so. Clearly, Mrs [B] was very angry with Dr [A] and he knew this. I am not sure that anything useful would have eventuated from such a visit. Nevertheless I think he should have gone to see Mrs [B].

Thus, in summary I do feel that Dr [A] did provide Mr [B] with services that comply with professional and other standards. …"

Response to provisional opinions

In April 2001 I issued my first provisional opinion in which my conclusions were based on the advice I received from Dr Kalderimis. In response to my provisional opinion Mrs B instructed solicitors and a highly detailed response was provided. Mrs B's solicitors provided a number of briefs of evidence, in order to correct what they considered to be factual deficiencies in the provisional report I had drafted. It is not necessary at this point to discuss the detail of those briefs, as all relevant material has now been incorporated into the 'Information Gathered' section of this report. Furthermore, Dr A has seen the briefs and been given the opportunity to comment on the information.

In addition to the briefs of evidence, Mrs B's solicitors also provided reports from two general practitioners, Dr C and Dr D. Drs C and D both reviewed the provisional report and disagreed with my conclusions. Both were of the view that Dr A's conduct fell below an acceptable standard in failing to treat Mr B's cardiac disease.

In my second provisional opinion, I noted the possibility that the reports provided by Dr C and Dr D had not in fact been fully drafted by them, as there were significant passages in the reports that were practically identical. This provoked a strongly worded response from both Mrs B's solicitors and from the doctors involved, maintaining that the reports were indeed fully independent and were reflective of the doctors' true opinions.

I accept that Dr C and Dr D (who are, in Dr C's words, "senior and respected members of the medical profession […]") concluded that Dr A's conduct in this case was deficient and did not collaborate the preparation of the reports, and advised Mrs B's barrister accordingly.

I note, however, that key passages in the reports presented to me, setting out the authors' clinical opinions, are strikingly similar. I refer to the following:

> "The highly elevated cholesterol levels together with a family history of fatal premature heart disease should have alerted Dr [A] to the fact that Mr [B's] chest pains were very likely due to an inherited disposition of coronary artery disease." *(Dr D, pp 6-7 of his original report.)*

> "Cholesterol levels such as these, along with a family history of fatal premature heart disease, should have alerted Dr [A] to the fact that Mr [B]'s chest pains on exercise were very likely due to an inherited predisposition of coronary artery disease." *(Dr C, p 7 of his original report.)*

And:

> "However, even putting this aside, the mere fact that Mr [B] had been experiencing chest pain for some fifteen years which had increased over recent times with less effort, particularly in the preceding ten months, was sufficient justification for Dr [A] to have conducted an ECG in his rooms on 13 December 1999. Had this been performed, it is highly likely that it would have been confirmed that Mr [B] had suffered a myocardial infarction a few days previously."*(Dr C, p 8 of his original report.)*

> "In my view, the fact that [Mr B] had been experiencing chest pain for at least fifteen years which had become more frequent and had increased with less effort in the preceding months … was sufficient justification for Dr [A] to have conducted a resting ECG in his rooms on 13 December 1999. … If he had done so, it is highly likely that it would have been confirmed that [Mr B] had suffered a myocardial infarction a few days previously." *(Dr D, p 10 of his original report.)*

And also:

> "Although Dr [A] had originally diagnosed chest pains as muscular on 15 February 1999, his diagnosis was now highly unlikely ten months later in a supposedly fit 51

> year old farmer, particularly when the pain was occurring more frequently and with less exercise during that time." *(Dr C, pp 8-9 of his original report.)*
>
> Further, although Dr [A] had originally diagnosed the chest pain as muscular on 15 February 1999, this diagnosis was now very unlikely some ten months later in a supposedly fit 51 year old farmer particularly when the pain was occurring more frequently and with less exercise during that time." *(Dr D, p 9 of his original report.)*

I put to one side the issue of the striking similarity – which as the doctors and Ms B's solicitors protest may simply be evidence of concurrence in their opinions. It remains the case that, as with any expert report commissioned by a party to an investigation (whether by the complainant or by the doctor under investigation), I do not attribute the same weight to such advice as to the independent clinical advice obtained by the Commissioner from peers endorsed by the relevant professional College as suitable to provide such expert advice.

The reports from Dr D and Dr C disputed the conclusions drawn by Dr Kalderimis in his advice to me, and concluded that Dr A's actions fell short of the standard that could reasonably be expected of a competent general practitioner. I considered that as the reports raised sufficient doubt about whether Dr Kalderimis' conclusions accorded with the wider body of medical opinion, I needed to put the matter to a further independent expert advisor for consideration.

Accordingly, I obtained the following advice from Dr Shane Reti, an independent general practitioner:

> "With regard to the information forwarded to me by the commissioner, and in my own personal and professional opinion as a medical practitioner given the information is correct, I would make the following points:
>
> **1. WAS THE FEB 99 CONSULTATION APPROPRIATE ?**
>
> **Yes.** It is my view that the consultation in February 1999 was conducted to a satisfactory general practice standard. This statement is made considering the risks which were as follows:
>
> – chest pain for 15 years unchanging
>
> – chest pain exacerbated by exercise
>
> – poor family history for heart disease
>
> – 4 out of 5 elevated BP recordings at this consultation (with no substantive reason given for correctly identifying and circling the first 2 elevated recordings).
>
> The differential diagnosis here would need to have included ischaemic heart disease as well as a muscular cause which became the initial working diagnosis. In this regard, most importantly, Dr [A] arranged for further investigations and assessment

of a diagnosis of ischaemic heart disease. Accordingly, this consultation was of a suitable standard.

2. WAS THE APRIL 99 CONSULTATION APPROPRIATE ?

No. At this consultation there was further information that added to the overall risk profile for ischaemic heart disease in the form of 2 significantly elevated lipid profiles. The ECG was normal which while useful, did not provide enough of a reason by itself to exclude ischaemic heart disease. At this point, it is my view that there were enough risk factors for ischaemic heart disease to warrant referral to a specialist for further investigations.

3. SUBSEQUENT CONSULTATIONS

July 99 – I note the ACC consultation of July 99 with an elevated BP, that in the overall context of the possible differential diagnoses for this man, should have served as another warning sign for further investigation. I accept that any pain associated with ACC type consultations could account for this, but also note Dr [A]'s subsequent explanation of his routine management of 'white coat hypertension' and would note that that protocol was not applied to this consultation.

December 99 – The information provided to me states that Mr [B] presented with chest pain at this consultation. Reviewing Dr [A]'s response (Ref: RWC0100) he appears to be reassured by what he relates as an atypical distribution of the chest pain. It is my view that in the context of all of the other risk factors this man had, and this new presentation of chest pain, this interpretation is incorrect and falls below the reasonable standards expected of a general practitioner. It is my view that at this consultation the following should have occurred:

a. measurement of acute phase ischaemic events e.g. troponin T, cardiac enzymes, ECG, trial of Nitrolingual spray

b. specialist assessment either in the form of a phone call, or referral.

4. STANDARD OF NOTE TAKING

It is my view that the standard of note taking is satisfactory at a minimum level. There are a number of chronological errors, and the information recorded would benefit from greater substance. I do accept that the use of phrases such as 'CVS RF' may substantiate a well defined repetitious process, which is acceptable, however within this, some minimum recordings such as pulse rate and characteristics and heart sounds should still be recorded.

SUMMARY

Overall it is my view that a competent general practitioner would have acted on a diagnosis of potential ischaemic heart disease, on the collective information available at the April 99 consultation if not sooner. Subsequent consultations only served to validate the possibility of ischaemic heart disease as a diagnosis rather than a muscular cause. I note the difficulty in differentiating between muscular and cardiac causes, however, the information here was progressively pointing towards a cardiac cause."

Response to second provisional opinion

Both Mrs B and Dr A responded to my second provisional opinion in detail. The response on behalf of Mrs B did not contain any new factual information, but made a number of submissions in relation to matters discussed in my second provisional opinion. Rather than set out those submissions here, I have dealt with the majority of them as they arise throughout this report. One issue, relating to Dr Kalderimis' advice, is discussed below.

Reliance on Dr Kalderimis' advice
In response to my second provisional opinion, Mrs B's solicitors submitted that I should not rely on the advice provided to me by Dr Kalderimis. The submission was made on the basis that Dr Kalderimis was not in possession of all the relevant information at the time he gave his opinion. Furthermore, it was submitted that Dr Kalderimis' opinion was based on a mistake of fact.

The alleged mistake of fact is based on a sentence in Dr Kalderimis' advice that stated that it was "… very unfortunate that Mr [B] felt the pain he was getting from his rather obvious ischaemic heart disease was no different from the muscular ligamentous pain he may well have experienced over the past 15 years".

This is held out as an indication that Dr Kalderimis had failed to take into account the fact that Mr B had stated to Dr A at the December consultation that the pain had increased with less effort over the last couple of years and had become more prominent in the last year.

Having reviewed Dr Kalderimis' advice, I accept that there is nothing to indicate that Dr Kalderimis specifically took into account the fact that the pain Mr B was experiencing had increased with less effort, and had become more prominent over recent months. This was obviously a critical factor. There is some force to the submission that I should disregard Dr Kalderimis' advice, at least in relation to the December consultation when the information about the change in the nature of Mr B's pain became available.

I have therefore not relied on Dr Kalderimis' advice in relation to the December consultation. There is, however, no reason to discount his advice in relation to the previous consultations.

Dr A's response
Dr A, in his response, refuted my opinion that he had breached the Code. To summarise his response, he submitted:

- It is not standard or recommended practice to seek a cardiologist review based on the symptoms Mr B displayed at the consultation in April.

- Based on the information he was given at the December consultation, Dr A considers that he gave Mr B the best medical opinion he could at the time, and provided a management plan that involved a full cardiac review.

- Mr B did not mention being on holiday the previous weekend and suffering the severe symptoms.

- The conclusion at the December consultation was that Mr B's pain was of musculoskeletal origin, but because cardiac disease can present with atypical pain, a management plan was devised to address this potential issue.

Dr A also sent me a medical opinion on the matter, written by a cardiologist based at a medical centre. (I note the cardiologist is not a peer of Dr A – since he is a cardiologist, not a general practitioner – and that his report (like that of Drs C and D) has been commissioned by a party to the investigation and is not truly independent.) His expert opinion is set out below:

> "I am a Cardiologist working in full-time private practice based at [a private medical centre], where we provide both an acute and outpatient service for cardiac patients and have a wide referral base, […]. I have had a chance to review the medical records, reception staff affidavits, coroner's letter and post-mortem report, HDC reports and findings, including the responses of Drs Chris Kalderimis and Shane Reti.
>
> In my view, when trying to come to the conclusion regards the management of this patient, it is only appropriate to focus on the medical record taken at the time, as these have been accepted as being an accurate and adequate account of the consultation, rather than canvassed opinion and reports since. I will restrain my comments to what are essentially two issues.
>
> **1. Should Mr [B] have been referred for a Cardiology opinion in April 1999?**
>
> By this time Dr [A] had established Mr [A] had:
>
> - hypercholesterolaemia
> - a family history of coronary artery disease
> - a 15 year history of atypical chest pain

- normal blood pressure
- normal resting ECG at this consultation.

Dr [B] used the National Heart Foundation guidelines and estimated that his cardiovascular risk was approximately 15-20% over the next five years. Appropriately, he made an application for cholesterol lowering medication to Pharmac and started him on cholesterol lowering therapy.

In my opinion, this was entirely appropriate. General Practitioners are well able to manage hypercholesterolaemia with lipid lowering therapy, without needing any Specialist involvement unless there are problems with drug side effects or the patient does not respond to therapy. Maybe Dr Shane Reti does refer patients with multiple risk factors, but in my experience he would be the exception, as it is just not possible for our present health systems, public or private to cope with what would be an overwhelming amount of work. Accordingly subsequent blood tests showed Mr [B]'s cholesterol reduced appropriately. Of course, if Mr [B]'s 15 year history of atypical chest pain was suspected to be angina, then this would have warranted a Cardiology referral and investigation.

2. December consultation

In the consultation between Dr [A] and Mr [B] on the 13th December 1999, the medical record and the Cardiology referral letter dictated at the time, indicates that Mr [B]'s long standing chest pain has been increasing over the last year and in particular the last few months. Importantly, no unstable symptoms or recent prolonged chest pain were noted. His examination findings were essentially normal.

Given that Mr [B] did not complain of any unstable or prolonged pain, Dr [A] appropriately arranged for an outpatient Cardiology Review including exercise stress test to be performed. Typically, at the [private medical centre] this would have been performed within one week of receiving this type of referral.

As no unstable symptoms or prolonged chest pain were volunteered or elicited, measuring cardiac enzymes, including Troponin T, performing an ECG and administering Aspirin and anti-anginal therapy was not necessarily indicated at the time. Similarly, unless Mr [B] complained of unstable or prolonged chest pain, acute referral to hospital was not indicated.

Doctors require a forthcoming and honest history in order to make a provisional diagnosis, 90% of which is derived from the history. Therefore, given the history that was available to Dr [A] at the time of the final consultation, I think he acted with reasonable care and skill in executing his duties as a General Practitioner.

I believe that the views of Dr Reti are not what Cardiologists would expect of a General Practitioner in this situation. I would not be critical in any way of Dr [A]'s management of Mr [B]."

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.

…

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

Opinion: Breach – Dr A

Summary
In my opinion Dr A breached the Code of Health and Disability Services Consumers' Rights. Dr A should have responded in a more proactive way to the symptoms that Mr B had displayed at the consultations over the course of 1999.

In forming my opinion I have relied on the advice provided to me by Dr Reti, having also considered, in part, the advice provided to me by Dr Kalderimis. With the benefit of hindsight, it is clear that throughout 1999 and indeed possibly for years prior to that, Mr B was displaying symptoms of heart disease. The issue for me to determine is whether Dr A's response to the symptoms Mr B displayed in 1999 was appropriate in the circumstances or whether Dr A should have picked up on the indicators of heart disease and taken more active steps to diagnose and treat it.

There were several key periods during 1999 where Dr A's actions are under scrutiny. The first is the consultation on 15 February 1999. The second is the consultation on 26 April 1999, at which it first became apparent that Mr B's cholesterol was severely elevated, and the subsequent follow-up consultations for management of the cholesterol problem. The final period was in December 1999, when Mr B saw Dr A shortly before suffering the fatal heart attack.

February consultation
In my opinion Dr A's management of Mr B at the February consultation was appropriate. Both Dr Kalderimis and Dr Reti agree that Dr A took the appropriate steps. Dr Reti noted

that given Mr B's presentation in February the differential diagnosis should have included ischaemic heart disease, as well as the initial working diagnosis of a muscular problem. However, Dr Reti also noted that Dr A did arrange further investigation of Mr B's symptoms with a view to determining whether heart disease was in fact the underlying cause.

Dr Kalderimis noted in relation to the February consultation that a specialist referral at that time was not required given the nature of the information available to Dr A.

April consultation
By the time of the April consultation Dr A had become aware of a further critical factor that significantly increased Mr B's risk profile, namely his very elevated cholesterol levels. Dr A clearly recognised that these test results indicated a further area of risk for Mr B, as he took action to prescribe him cholesterol-lowering medication and in fact performed an ECG in his rooms.

Dr Kalderimis did not consider that there was anything at this stage demanding an immediate referral to a specialist. Dr Reti had a different view. Dr Reti noted that at this consultation the balance of the risk factors warranted a referral to a specialist. Although the ECG performed was normal, this in itself did not enable heart disease to be ruled out. In relation to this point, I refer to Dr Kalderimis' advice in which he notes that angina can only be diagnosed with an exercise ECG, rather than a resting ECG as performed by Dr A on 26 April.

The cardiologist noted that Dr Reti would be an exception as a GP in referring patients with multiple risk factors, as this would result in an overwhelming amount of work for the existing health system; only if the chest pain were suspected to be angina would a specialist referral have been justified.

Right 4(4) of the Code requires a provider to provide services in a manner that minimises the potential harm, and maximises the quality of life, of consumers.

In my view, in failing to exercise a higher degree of caution at the April consultation, Dr A failed to minimise the risk of potential harm to Mr B. There were sufficient factors known to Dr A that he should have taken a more risk-averse approach. In forming my opinion, I am guided by the advice of Dr Reti. It is a well-known fact that heart disease is a serious problem affecting men in New Zealand. The website of the New Zealand National Heart Foundation notes that coronary heart disease is the leading single cause of death in New Zealand. Because heart disease is so prevalent in New Zealand and gives rise to tragic and potentially avoidable consequences, general practitioners need to be vigilant for possible signs of the disease, and to respond appropriately so as to minimise the potential of harm to the patient.

I am satisfied that, in failing to refer Mr B to a specialist in light of his increasing risk profile following the April consultation, Dr A failed to minimise the risk of harm to Mr B, and breached Right 4(4) of the Code.

Other consultations
Dr Reti also notes that in July 1999, when Mr B presented following a motorbike accident, Mr B's blood pressure was high. Dr Reti notes that in the context of the differential diagnosis of heart disease for Mr B, this elevated reading should have served as another warning sign for further investigation. However, I consider that there is insufficient evidence to suggest that Dr A's management of Mr B, in the context of the ACC consultation following the motorbike accident, failed to meet the requisite standard of care.

December consultation
Dr A's response to Mr B's presentation during the December consultation is central to Mrs B's complaint about her husband's management. The issue is whether at the December consultation Dr A had sufficient information available to indicate that immediate action was required to manage the risk that Mr B's symptoms were due to heart disease. At that consultation Mr B noted that the effort-induced chest pain had become evident with less effort in recent times, and that the pain was distributed down the arm. By this stage, Dr A was also undoubtedly aware that Mr B had a family history of heart disease, and he clearly considered this issue during the consultation as it was noted in the margin of the medical records.

In my opinion, at the December consultation Dr A should have recognised the possibility that Mr B's chest pain was attributable to a serious underlying heart condition and taken immediate steps to manage that risk. Faced with the new information about the presentation of his chest pain – in particular, the pain radiating down the arm – and in the context of the other cumulative risk factors known to him, Dr A could not reasonably maintain that Mr B's chest pain was muscular in origin.

Dr Reti considered that Mr B's presentation at the December consultation, in the context of his previous symptoms, served to validate ischaemic heart disease as the cause of Mr B's symptoms, rather than to point to a muscular problem. (As explained above, in forming my opinion in relation to the December consultation, I have not relied on the advice provided by Dr Kalderimis.) Dr Reti advised me that Dr A should have:

(i) measured Mr B's cardiac enzymes, performed an ECG and/or prescribed a trial of nitrolingual spray; and

(ii) arranged for a specialist assessment, either by a phone call or by a referral. (In this context, I note that Dr A did decide that a specialist consultation was wise as a precautionary measure, but did not act with urgency.)

Right 4(1) of the Code requires that providers exercise reasonable care and skill. Dr Reti's expert advice is that there was sufficient information available at the December consultation to suggest that further investigations needed to be conducted immediately. Given his status as an independent general practitioner advisor, nominated by the Royal New Zealand College of General Practitioners, I accept Dr Reti's views as being reflective of reasonable, safe general practice standards. The fact that a cardiologist disagrees with these views,

from his perspective as a cardiologist, is not sufficient to persuade me to alter my opinion in this regard.

On this basis, I consider that in failing to take more appropriate diagnostic steps at the April and December 1999 consultations, Dr A failed to exercise reasonable care and skill and accordingly breached Right 4(1) of the Code.

Actions

I recommend that Dr A:

- Apologise to Mrs B for breaching the Code. This apology is to be sent to my Office and will be forwarded to Mrs B.
- Contact the Royal New Zealand College of General Practitioners, to discuss appropriate training or a refresher course.

Other Actions

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

A copy of this report, with details identifying the parties removed, will be sent to the Royal New Zealand College of General Practitioners, the Royal Australasian College of Physicians, and the National Heart Foundation, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.