15 February 2006

Dear Dr A

Complaint: Mr and Mrs B
Our ref: 04/06861

I write further to the telephone discussion between an HDC investigator and your barrister, Ms C, on 27 January 2006. Thank you for the response of 13 December 2005, submitted on your behalf by Ms C together with your letter of apology to Mr and Mrs B, dated 12 December 2005. I also acknowledge receipt of a copy of your letter of 31 October 2005 to the Medical Council of New Zealand.

I have carefully considered your and Ms C's comments, and some factual changes have been made to my letter. However, I have not been persuaded to alter my opinion that you breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) in relation to your standard of record-keeping. I acknowledge that the adverse comments in the Commissioner's provisional opinion about your management of Mr B's anaemia, and the (Nutriway) products you offered concerned a period outside the time frame of the investigation. However, as these aspects were part of the overall care you provided to Mr and Mrs B, it was necessary for the Commissioner to comment on them.

Furthermore, given that Mr B's anaemia was occurring as early as May/June 2002, his consultation with you in March 2004 could not be viewed in isolation. Although the Commissioner could have extended the time frame of the investigation to include the care you provided to Mr B from May 2002, he chose not to in the interest of time. Instead, the Commissioner commented adversely on aspects of your care that he considered unacceptable, and invited your response to his provisional decision. Should the timeframe of the investigation have been extended, the Commissioner may well have made additional findings that you breached Right 2 of the Code (defined later) in relation to the products and lifestyle programme you offered to Mr and Mrs B, and Right 4(1) of the Code in relation to your management of Mr B's anaemia.

Set out below is my final decision (which includes a discussion about Dr Steve Searle's advice), which remains largely unchanged from my provisional decision.

Complaint
By way of background, on 26 April 2004 this Office received an email complaint from Mr B, in which he set out his concerns regarding the care you provided to him and his wife during the period you were their doctor.

During the investigation, I obtained and considered information provided by you, Mr and Mrs B, and Dr D (consultant physician at the public hospital). I also reviewed copies of Mr and Mrs B's clinical records which you and Dr E provided. In addition, I obtained independent advice from Dr Searle, a general practitioner in Dunedin. A copy of Dr Searle's report is **enclosed**.

Scope of investigation

The issues arising from Mr and Mrs B's complaint that were investigated are:

- *The appropriateness of the care and treatment Dr A provided to Mrs B in February 2004, including for her:*
  - *hypertension*
  - *complaint of low energy.*

- *The appropriateness of the care Dr A provided to Mr B in March 2004, including for his:*
  - *anaemia*
  - *heart condition.*

- *The adequacy of communication by Dr A to Mr B of Mr B's results from the heart scan and X-ray, both of which were performed at a public hospital on 26 April 2004.*

While the period of notification was defined so as to focus on the most pertinent consultations, it was nevertheless intended that these consultations would be considered in light of the broader picture created by your ongoing treatment of Mr and Mrs B over a longer time frame.

Mr and Mrs B also complained about your management of Mrs B's asthma, and your attempts to promote Nutriway products to them. Again, while these aspects of your care were not included in the formal investigation, you were asked for your comments, as part of the context of the care you provided. You submitted these comments in your letter of 20 October 2004. Extracts of your letter were forwarded to Mr and Mrs B for their comment, and they responded in writing on 23 December 2004. On 14 June 2005, HDC's Investigations Manager wrote to you inviting you to comment on Mr and Mrs B's letter, which you did on 22 July 2005.

Information gathered

Background
Mr and Mrs B each have several medical conditions and received care from you over a period of two to three years. Mrs B had her first consultation with you on 1 November 2001 and her last consultation on 24 March 2004. During this period, most of the care Mrs B sought was for her asthma, migraines and hypertension. You also provided care to Mr B between 28 May 2002 and 23 March 2004 for his heart condition, dysuria and low iron count.

Mrs B's asthma
Mrs B's first consultation with you on 1 November 2001 included a discussion about her asthma, a chest examination and a note to review the medication she had been prescribed. Her subsequent consultations, from 20 December 2001 to 21 July 2003, were mostly concerned with the management of her asthma. Mrs B was concerned about Pharmac's decision to withdraw Becloforte (an asthma preventative) from the market as she was unable to take other inhaled steroids and had reacted adversely to other asthma medications prescribed previously. You explained that Pharmac had provided six to eight months' advance notice that they were withdrawing Becloforte from the market and that you had conveyed this information to Mrs B. You also explained that you did consider trying to obtain Becloforte from other sources in the event Mrs B found Pharmac's substitute asthma preventer ineffective.

Recommendation of air-treatment unit
Mr B complained that during several consultations he attended with Mrs B for her asthma, you attempted to promote the benefits of an air-purifying unit, claiming that it would improve her asthma. Mr and Mrs B were aware that they had to purchase the air-treatment unit through you as it was not available in a retail store.

Although you were unable to recall the exact consultation dates when you discussed the air treatment unit with Mr and Mrs B, you accept that such a discussion was likely to have taken place in conjunction with Mrs B's consultation about her asthma. You explained that you had purchased the air-treatment unit through your involvement with Nutriway, in which you have a financial interest separate from your medical practice at the first medical centre. You also explained that you had used the air-treatment unit in your surgery room and had found it effective for removing dust, mites, odours and minute particles. You advised that any information you provided on the air-treatment unit would have been by way of a passing comment, and you would have indicated that the purchase of such an item from Nutriway was separate from your medical practice.

Mrs B's hypertension
On 25 December 2003, Mrs B suffered a migraine. As the first medical centre was closed, she consulted the duty general practitioner at the second medical centre. The duty general practitioner observed that Mrs B's blood pressure had increased and advised her to consult her own general practitioner when the surgery re-opened. Mr B recalled that when Mrs B followed up her blood pressure with you in early January 2004, you discussed the importance of consuming more fruit and vegetables.

According to your records, this consultation took place on 10 February 2004 and you took Mrs B's blood pressure and recorded it as "135/100 mmHg". You also incorporated into your notes Mrs B's consultation on 8 February 2004 with Dr G at the second medical centre, where she had presented with a severe headache and neck pain nausea. Dr G prescribed her naproxen, Imigran and Paradex, and reiterated that, as her blood pressure had increased, it needed further investigation. In view of this, you conducted a physical examination and ordered a series of tests to check Mrs B's blood count, iron levels, glucose, thyroid function, urea, liver and lipid group. You noted that a comprehensive urine test had been undertaken on 29 September 2003, and decided that a chest X-ray was not necessary during this consultation.

According to Mr B, you considered his wife's blood pressure unremarkable and did not prescribe any course of treatment for it. Mr B recalled that during this consultation his wife enquired about losing weight. In response to her query, you advised that going on a diet was ineffective and you were unwilling to prescribe any medication for weight loss. Mr B stated that at the conclusion of the consultation you informed Mrs B about a lifestyle programme involving the daily consumption of 15 different fruits and vegetables, and provided her with printed material along with a CD. Mr and Mrs B were under the impression that this programme was part of the Nutriway business you were involved in. You clarified that the programme, called "Energy for Life", was devised by Dr John Tickell following extensive research into the diet of people in Crete and Okinawa (southern Japan), both of whose population groups have the lowest rates of heart disease internationally. You also clarified that the programme was unrelated to Nutriway. According to Mr B, you advised that the programme cost $400 and lasted for 12 weeks. Both Mr and Mrs B were dissatisfied by your recommendation of the lifestyle programme and your decision not to prescribe any medication for reducing Mrs B's blood pressure. In contrast, you recall that Mrs B was not keen on taking such medication, hence your decision to explore lifestyle changes with her.

Mrs B's complaint of low energy

On 12 February 2004, Mrs B returned to consult you about the low energy levels she was experiencing. The consultation lasted approximately 28 minutes. You reviewed the results of the tests you had ordered on 10 February, and told Mrs B that the results were essentially normal aside from an increase in her cholesterol level. You explained that as you had conducted a physical examination when Mrs B consulted you two days earlier, you did not consider it necessary to conduct another examination. However, you did record Mrs B's weight and height at 108.6kg and 161cm, from which you calculated that she had a body mass index of 41.9. You concluded that Mrs B was obese, since the ideal weight for her height of 161cm was 53.3kg. In your clinical notes, you recorded that you would "… look at life changes". You explained that, during this consultation, you had a discussion with Mrs B about health, nutrition, exercise and wellness. In addition, you carried out a melanoma check and marked Mrs B's skin for liquid nitrogen treatment by the practice nurse. Mr B subsequently clarified that it was their daughter, rather than Mrs B, who had her moles treated.

Mrs B's final consultation in March 2004

On 24 March 2004, Mrs B consulted you after falling from a collapsed computer chair the previous day. The fall resulted in Mrs B injuring her neck, shoulder, left arm and her lower back. Following your examination, which included palpation, you recorded in your notes that Mrs B was experiencing pain through neck movement and in her lower back area, but otherwise had a full range of movement in her arms and shoulder. To alleviate Mrs B's pain, you prescribed Pamol and Paradex tablets. You also encouraged her to exercise. This was Mrs B's last consultation with you before she made a decision to change general practitioners. From 1 April 2004, Drs E and F (who also practise at the first medical centre) took over Mrs B's care.

Care provided to Mr B in 2002

During Mr B's first consultation with you on 28 May, he presented with persistent flu-like symptoms and dysuria, and informed you that he had noticed blood when

passing urine. On examination, you recorded that his urinary tract, chest, ears, nose and throat were clear, and that his liver, kidneys and spleen were normal. You took Mr B's pulse and blood pressure, and ordered a full blood count. Based on the symptoms presented, you made a probable diagnosis of upper respiratory tract infection and urinary tract infection.

You reviewed Mr B a week later, on 4 June, and observed that he had improved, although he was still experiencing a loss of energy and was passing urine frequently. You ordered a repeat full blood count, and a faecal occult blood test. You recorded in your notes a diagnosis of microcytic anaemia, and that Mr B did not report any blood in his bowels or changes in his bowel motion.

During the consultation a fortnight later on 19 June you noted that Mr B was anaemic but that he was improving. You scheduled a further review at the end of July. This took place on 1 August. Mr B presented with dermatitis and revealed for the first time that he had been having rheumatic fever since he was four, and that this condition was linked to his heart murmur. Following your examination of Mr B's heart, you recorded that he had a short, early systolic murmur with a blood pressure of 125/70. To investigate Mr B's heart condition further, you referred him to the public hospital for an echocardiogram to view his heart valves. You recorded in your notes that Mr B was "feeling a lot better" and "really feels that [he is] back to normal".

On 8 November, you received the results of the iron and blood tests ordered for Mr B on 4 June. While the blood tests did not indicate any anaemia, they showed that Mr B's ferritin level of 21 was below the normal laboratory range of 30 to 300. His haemoglobin level of 159 was within the normal laboratory range of 135 to 180.

Care provided to Mr B in 2003

You saw Mr B on 25 February, when he complained of dysuria and blood in his urine the night before, although the discomfort had eventually settled. On examination, you noted that Mr B had a soft systolic murmur, clear chest and abdomen, soft liver, and that his kidneys and spleen were normal. During the consultation, you ordered blood and urine tests to investigate Mr B's liver function, iron and cholesterol levels, and recorded your plan to refer Mr B for renal ultrasound. The results of the February blood tests showed that Mr B had a haemoglobin level of 122, below the normal laboratory range of 135 to 180.

The renal ultrasound took place on 4 March. The results did not reveal the presence of any renal tract calculi but confirmed that Mr B's kidneys and urinary bladder were normal.

On 2 April, Mr B saw Dr D, consultant physician at the public hospital, following your referral of 1 August 2002. On examination, Dr D recorded that Mr B looked well and that his general physical examination was satisfactory. He listened to Mr B's pulse, which he noted was regular with a sharp upstroke. Dr D considered that Mr B's heart sounds were normal and that there was a localised soft mid-systolic ejection murmur in his aortic area. From the chest X-ray films of 8 April, Dr D observed that Mr B's lung fields and pleural spaces were clear. He diagnosed mild aortic valve disease which he considered was likely to have originated from Mr B's rheumatic fever. In Dr D's report to you, he explained that he had made arrangements for Mr B

to undergo a cardiac ultrasound but he envisaged a delay of several months. (The cardiac ultrasound and X-rays were subsequently done at the public hospital on 26 April 2004.)

Mr B's subsequent consultations with you in May and August were for his sinusitis and an upper respiratory tract infection. On 1 September, Mr B presented with flu-like symptoms, left-sided renal pain, dysuria and blood in his urine of five days' duration. As Mr B wondered about the possibility of a kidney stone, he consulted an emergency doctor at another practice on 30 August. During Mr B's consultation with you, you examined his left loin, and noted that his abdomen was soft and his left kidney tender. You recorded your plan to continue Mr B's antibiotics and to order a prostate specific antigen test.

Care provided to Mr B in 2004
On 23 March, Mr B complained that he was feeling "tired all the time" and reported that a recent blood test offered by his employer revealed that he had low levels of red blood cells. You were aware that Mr B donated blood every six months, and you recorded your plan to have a look at Mr B's bowels and ferritin level. You also believed that the Blood Donor Service did not accept donors with anaemia. Based on the urine and occult blood tests ordered, you observed that Mr B's ferritin level was low, and a diagnosis of anaemia was made. You discussed possible factors that might be contributing to Mr B's iron deficiency, such as diet, and recommended changes to his lifestyle. During the course of providing Mr B with printed material, you attempted to promote the "Energy for Life" programme, involving the consumption of 15 different fruits and vegetables daily, similar to the information conveyed to Mrs B a month earlier. You recorded in your notes that a letter on "Changing Habits" had been given to Mr B.

Several other tests were ordered during the consultation of 23 March to investigate Mr B's liver function, lipid group, glucose, uric acid, haemoglobin, calcium, full blood count and iron levels, as well as an ultrasound for Mr B's abdominal and renal tract. However, pending the availability of the test results, Mr B made a decision to change general practitioners to Drs E and F from 1 April. You explained that, as you were no longer Mr B's doctor when the test results were received, you had no opportunity to follow up with Mr B on the test results and the echocardiogram carried out at the public hospital on 26 April 2004.

Expert advice
The Commissioner's independent general practitioner, Dr Searle, considered that in most respects appropriate care was provided to Mrs B in February 2004 and to Mr B in March 2004. (A copy of Dr Searle's complete report is **attached** at pages 16–34.) However, Dr Searle pointed out that these consultations cannot be viewed in isolation since you provided care to Mr and Mrs B for several years. Dr Searle advised that the standard of care expected of a general practitioner in this case included:

- taking and recording Mr and Mrs B's full medical history, including current symptoms, past history of similar illness(es), past family and medical history (including allergies and medications taken);

- carrying out appropriate examinations or making appropriate referrals to investigate further the symptoms presented at each consultation;
- deciding and implementing an appropriate course of management for Mr B's anaemia;
- providing appropriate advice on follow-up required and offering alternatives when promoting products in which the medical practitioner has a financial interest.

Dr Searle indicated that the care you provided to Mr and Mrs B did not reach the above standards for the following reasons:

- Mr and Mrs B's past medical histories were not documented during their initial consultation with you, and did not appear to have been documented during subsequent consultations. From reviewing your notes, Dr Searle was unable to determine whether any attempt had been made to obtain Mr and Mrs B's old notes pre-dating the period of your care.

  During a HDC investigator's telephone discussion with you on 25 May 2005, she enquired about the clinical records you held about Mr and Mrs B. As you confirmed that your earliest records in relation to Mr and Mrs B were on 6 November and 23 October 2001, respectively, we understood that you did not hold any other records preceding these dates. In your response to the provisional opinion, you clarified that you did obtain clinical records from Mr and Mrs B's previous GP, which indicated that Mr B was iron-deficient in 1997.

- Dr Searle was unable to determine from your notes whether Mr B's abdomen and rectum were examined on each occasion when he complained of dysuria.

- Although it was apparent that Mr B presented with anaemia as early as 4 June 2002, as well as on 25 February 2003 and 23 March 2004, you did not at any stage ascertain the cause of his anaemia. Dr Searle advised that the occult blood and faecal tests you ordered were initial investigations that were insufficient for ruling out a gastrointestinal source of bleeding. In addition, you should have referred Mr B for further investigation of his gastrointestinal tract when you first diagnosed anaemia on 4 June 2002. Even if the anaemia was not investigated then, you should have monitored Mr B's blood and iron levels closely, and made a referral for his gastrointestinal tract to be investigated following the consultation on 25 February 2003. While I appreciate that these consultations were outside of the notification of this investigation, they nevertheless create a poor picture against which to consider the consultations in question.

- Aside from stating in your notes that you planned to review Mr B's anaemia at the end of July 2002, you did not document any specific advice given or any follow-up measures you intended to take during the various consultations Mr B had with you. Your notes for Mrs B's consultations on 10, 12 February and 23 March 2004 do not contain any specific plan on your part to follow up her complaint of low energy. Although it was reasonable in the circumstances to advise Mr and Mrs B on the importance of maintaining healthy lifestyles, you had a financial interest in Nutriway, and did not suggest any alternative avenues where Mr and Mrs B could purchase the products you had recommended.

Code of Health and Disability Services Consumers' Rights

The following provisions of the Code of Health and Disability Services Consumers' Rights (the Code) are relevant to this case:

RIGHT 2
Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

RIGHT 4
Right to Services of an Appropriate Standard

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

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

Other relevant standards

The Medical Council of New Zealand's publication *Good Medical Practice — A Guide for Doctors* (2000, 2003) states that doctors must:

> "keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed" (pp 3–4).
>
> "be honest in financial and commercial matters relating to [the doctor's] work. In particular … before taking part in discussions about buying goods or services, [the doctor] must declare any relevant financial or commercial interest which [the doctor] or [the doctor's] family might have in the purchase." (pp 14–15).

Your response

Management of Mr B's anaemia
I note from Ms C's letter that you have accepted unreservedly that you should have investigated Mr B's anaemia earlier. You explained that other medical conditions with which Mr B presented — such as prostatitis, heart murmur and urinary tract infection — appeared more worrisome at that time, and you investigated them first to ascertain whether they were contributing to his anaemia. Although Mr B donated blood every six months, you became aware of this only during the consultation on 23 March 2004. Since you believed that the Blood Donor Service does not accept donors with anaemia, you were under the impression that Mr B was not anaemic during the occasions he donated blood. You explained that you did not have the opportunity to follow up on Mr B's complaint of chronic tiredness on 23 March since he left your care shortly after this consultation.

Lifestyle programmes, "Changing Habits" and "Energy for Life"
You clarified that the lifestyle programmes you discussed with Mr and Mrs B were unrelated to Nutriway, and your commercial interests. You do not recall offering any "Nutriway lifestyle programme" to any of your patients, including Mr and Mrs B. You do not believe that Mr or Mrs B were ever put in a situation where they were advised to purchase Nutriway products over other alternatives available to them. You clarified that where Nutriway is discussed, you advise your patients unreservedly that it is run under a separate entity. However, you have acknowledged that your clinical records are incomplete as they do not contain any documentation about the separate business interest you have in the programme(s) you recommended. You intend to amend your record-keeping to ensure that all salient details are documented.

You also clarified that you do not have any financial interest in "Changing Habits", a leaflet you produced based on international medical research by Dr Tickell and other health practitioners. This leaflet is available free of charge to your patients, and is unrelated to Nutriway or your private company. You stated that you frequently utilise other options, such as "the green prescription", and talks with dietitians and practice nurses, when advising patients about the choices available to them, and had also informed Mr and Mrs B about such options.

While you did discuss "Energy for Life" with Mr and Mrs B, the programme was offered to them for their consideration only. You advised that "Energy for Life" was a separate business you ran which had a cost associated with it (similar to Weight Watchers and Jenny Craig) should Mr and Mrs B choose to sign up.

Management of Mrs B's asthma
You are concerned that you were quoted as having said to Mrs B that "asthma preventatives give you a high when you take them, therefore you prefer not to prescribe them". You stated that there is no truth in this or any similar statement, and consider that information you conveyed on asthma preventatives was likely to have been misheard or misunderstood by Mr and Mrs B.

Final Opinion

Standard of record-keeping — Breach
Based on my review of the information provided by you, Mr and Mrs B, Dr D, and the advice from Dr Searle, I remain of the view that the care you provided to Mrs B in February 2004 and to Mr B in March 2004 was in most respects appropriate. Given that Mrs B had consulted you about her hypertension (on 10 February) and complaint of low energy (on 12 February), it was reasonable for you to provide advice on keeping a healthy lifestyle, which included the consumption of fruits and vegetables and the need for regular exercise.

However, as pointed out by Dr Searle, the specific lifestyle advice you gave Mr and Mrs B and the manner in which the advice was given were inappropriate. To encourage a healthier lifestyle, you provided Mr and Mrs B with information on "Energy for Life" and "Changing Habits" (which contains a recommendation about consuming 15 different plant foods a day).

Mr and Mrs B associated "Energy for Life" and "Changing Habits" with your involvement in Nutriway, as you had mentioned Nutriway on previous occasions. While you had no interest in "Changing Habits", it was not unreasonable in the circumstances for Mr and Mrs B to assume that it was similar to "Energy for Life", since the leaflet for the former is based on the same research as that behind "Energy for Life".

You consider "Energy for Life" to be similar to weight-loss programmes such as Weight Watchers and Jenny Craig where there is a cost involved should someone sign up for the programme. I disagree. Unlike the set-up of Weight Watchers and Jenny Craig, which have several branches operating in different locations, signing up for "Energy for Life" involves your patients providing you with their personal contact details on the back of your business card when they return the "Energy for Life" CD. As highlighted by my advisor, it becomes apparent over time which patients have and have not signed up for the programme, and their decision could potentially bias any future communication you may have during the consultations.

In the context of a doctor–patient relationship, there is inherent power imbalance, and the doctor's recommendation of products or programmes in which the doctor has a financial interest is likely to be perceived by the patient as coercive. The doctor runs the risk of blurring the boundaries between medical practice and other commercial interests. In my view you exceeded the boundaries of proper practice, as reflected in Mr and Mrs B's comment that you should not practise medicine and sell Nutriway products simultaneously. Although I cannot ascertain the total number of consultations where you provided information on Nutriway products or the "Energy for Life" programme to Mr and Mrs B outside of the consultations in February and March 2004, I consider it probable that there were other such consultations prior to February 2004, and that this had been ongoing for sometime. From the time you first became involved with Nutriway, it would have been prudent for you to consider and manage the potential conflict of interest your involvement raised, and to ensure that the steps you took to manage that conflict were apparent to patients such as Mr and Mrs B. Such measures should have included advising Mr and Mrs B about Nutriway in premises separate from the first medical centre, and directing them to contact other Nutriway suppliers in the area in the event they were interested in any of the products you discussed. I note from your response that you do explain to your patients that you receive a profit on transactions involving Nutriway products and that you have set up a private company to separate your business from your medical practice. However, from reviewing your notes it is not apparent that you took such steps prior to, or between, February and March 2004.

I do not accept your submission that "everyday, doctors are providing items at a profit to patients, such as vaccines, speculums, dressings, neck braces, retail drugs, local anaesthetics, anti-snoring aides, etc. and these are never questioned as being a conflict of interest". Such items are part and parcel of what a medical centre should have on its premises in order to deliver appropriate care. In contrast, the unavailability of Nutriway products and the "Energy for Life" programme are unlikely to compromise the quality of medical care provided, and these are above and beyond the scope of day-to-day medical care provided by doctors.

Of even greater concern is your failure to offer Mr and Mrs B alternative avenues for purchasing the products you recommended. In your response, you clarified that Mr and Mrs B were provided with other options such as "the green prescription" and the services of dieticians and practice nurses. You also stated that your clinical records are "shorthand" for your discussions on lifestyle issues with your patients. However, even if you did advise Mr and Mrs B of other sources, you did not document in your notes that you had done so. As pointed out by my advisor, the absence of any such record on your part makes it difficult to ascertain exactly what options you did provide to Mrs B in February 2004 and to Mr B in March 2004. Given the potential conflict of interest your involvement in Nutriway raised, it was essential for you to suggest alternative ways to obtain the same or similar products from another provider, and to record this in your clinical notes. I do not accept that this was done. Accordingly, I remain of the view that your failure to document in your notes your involvement with Nutriway (and the potential conflict of interest) or any options or alternatives offered to Mr and Mrs B amounts to a breach of Right 4(2) of the Code.

Management of heart condition — No Breach
I remain of the view that the care you provided for Mr B's heart condition was adequate. An appropriate referral to the public hospital was made on 1 August 2002 for Mr B to have an echocardiogram. This took place on 2 April 2003. I note my advisor's comment that Dr D's findings of mild aortic valve disease did not indicate that Mr B's heart required further investigation as a cause of the persistent tiredness he complained of on 23 March 2004. My advisor pointed out that the tiredness which Mr B presented with on that date was more likely to have been caused by anaemia than by his heart murmur.

I note that there was a lapse of approximately one year from the time Mr B had his echocardiogram at the public hospital on 2 April 2003 to 26 April 2004 when he had a cardiac ultrasound, as Dr D did not consider the ultrasound to be of immediate priority. While Mr B may have found the waiting period frustrating, I acknowledge that the time frame was beyond your control.

Adverse comments

As noted already, the issues notified as under investigation were necessarily viewed in a broader context. It is therefore important to comment on several areas which arose as side issues but were not formally notified, namely:

Management of Mr B's anaemia
In my provisional opinion, I commented adversely on your management of Mr B's anaemia, and I remain of the view that it was inadequately managed throughout the period you provided care to him. As highlighted by my advisor, it was clear that Mr B presented with anaemia as early as June 2002. You were aware of the anaemia, as you documented it in your notes on 4 and 19 June. There were also indications that the anaemia had not resolved over time when investigations done on 25 February 2003 showed that Mr B had low iron levels, and that his haemoglobin count had decreased to 122. This was well below the normal laboratory range of 135 to 180, and was lower than the 159 reading taken three months earlier on 8 November 2002. There were further indications that Mr B was still anaemic when he complained of persistent tiredness and low haemoglobin levels a year later on 23 March 2004.

Despite all these opportunities, you failed to make a referral or to investigate the cause of Mr B's anaemia.

You explained that you were diverted by other medical conditions that Mr B presented (prostatitis, heart murmur and urinary tract infection) and which he was more worried about. You also explained that these conditions appeared more worrisome to you, and you therefore investigated them first to ascertain if they had any bearing on Mr B's anaemia. However I agree with my advisor that iron deficiency needs investigation. I remain of the view that Mr B should have been referred for further investigation on 4 June 2002 when you first discovered his anaemia. While the improvement you noted in Mr B on 19 June 2002 and the subsequent blood tests on 8 November 2002 (which showed no anaemia) may have led you to believe that his anaemia was improving, Mr B's iron stores were still low. I note that in November 2002 Mr B had a ferritin level of 21, below the laboratory normal range of 30 to 300. Despite the results of 8 November 2002, showing both low haemoglobin and ferritin count, you failed to document any follow-up plan for managing Mr B's anaemia. Although you did arrange for faecal occult blood tests, I note my advisor's comment that such tests were initial investigations that were insufficient for ruling out a gastrointestinal source of bleeding.

Accordingly, I maintain that your failure to refer or investigate further Mr B's anaemia on 4 and 19 June, 8 November and 25 February 2003 was not a good standard of care. However, as these consultations occurred outside the period of my investigation, I have not made a formal finding under the Code about your care in this respect. I note that you have accepted my findings, and you intend to review your practice to ensure that patients with similar presentations to Mr B are referred promptly for investigation.

Management of Mrs B's hypertension

In your notes of 12 February 2004, you recorded that Mrs B was obese. In your response of 15 November 2004, you commented that "Mrs B's blood pressure, given her morbid obesity, was not at such an unacceptably high level that immediate medication was indicated." While I accept that Mrs B's overall cardiovascular risk, including her blood pressure, was not unduly high and did not warrant immediate medication in February 2004, my advisor highlighted the need to consider treating Mrs B's hypertension at that time, since obesity is a risk factor for hypertension. By not treating Mrs B's hypertension other than "looking at life changes", my provisional decision was that you appeared not to have recognised the risk that Mrs B's obesity posed. I made a recommendation that you review your approach in managing the cardiovascular risk of patients who present with one or more risk factors for hypertension.

You responded by saying that treating hypertension is "very difficult at the best of times as it is not an exact science". As Mrs B was not keen to take medication, you considered it appropriate to explore lifestyle changes with her first. You emphasised that you are aware of the risks associated with having hypertension and being obese, and consider the combination of both factors in a patient to be significant.

In general, I consider it reasonable to look at lifestyle changes in managing hypertension. However, there is a need to document details of the lifestyle changes

being considered, such as a low-fat diet and regular exercise. Aside from recording Mrs B's actual and ideal weight, your notes of 12 February 2004 stated "will look at life changes". Even if you did recognise the risks associated with having hypertension and being obese, your clinical records did not reflect your concerns as they failed to include specific measures being taken to manage the risks. While I accept that Mrs B may have been unwilling to take medication for her hypertension, I note that you did not document details of such discussions you had with her. Therefore, I maintain that your management of Mrs B's hypertension was inadequate, and recommend that you review your practice in this regard.

Summary
For the reasons explained, I remain of the view that you breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) in relation to the standard of your record-keeping in February and March 2004.

Recommendations
I acknowledge that errors can and do occur in medical practice. However, as noted by my advisor, such errors can be minimised by having systems in place to check for errors and to take action to prevent harm or suboptimal outcomes. In his provisional decision, the Commissioner recommended that you take the following steps to improve your standard of care:

- keep a record of each patient's cumulative past history in one place within their file;

- implement specific review and recall policies for problems or medical conditions that can potentially recur or that require longer-term follow-up;

- investigate in detail any patient who presents with the same illness, where the cause has not been ascertained;

- devise a method of clinical decision-making that enables presenting symptoms to be diagnosed accurately;

- record all significant telephone calls to and from patients. (While you have commented that it is unrealistic for your practice to record every telephone discussion, it is important that you consider documenting all telephone calls with patients where clinical advice was provided by you or your colleagues).

Your response to the Commissioner's recommendations
In response to the Commissioner's recommendations, you stated the following:

- All patients' cumulative records and past histories are, and have always been, kept in one place, and that you intend to continue this practice.

- Your practice already has specific review and recall policies for differing medical conditions which are often reviewed, especially in light of audit requirements and changing developments in different computer software.

- You acknowledge that you did not adequately investigate Mr B's presenting symptoms, as you would have referred him earlier for further investigation of his anaemia if you had. You intend to review your practice to ensure that patients with similar presentations are referred promptly for further investigation.

- You do not consider that you have the necessary skills to design clinical decision-making paths. However, you do keep abreast of, and endeavour to use, guidelines published from time to time, and intend to review your practice in this regard.

- As a result of Mr B's complaint, your practice has implemented a change so that clinically significant telephone calls are documented in the medical notes. This is an ongoing endeavour which will be reviewed and audited.

Referral for competence review

As discussed above, I remain of the view that there are serious concerns about your standard of record-keeping, the inadequate care you provided to Mr B in relation to the management of his anaemia, and the potential conflict of interest your involvement in Nutriway raises with your practice of medicine. Therefore, I have written to the Medical Council of New Zealand with a recommendation that the Council considers whether a competence review is warranted in the circumstances. I am aware that the Council has to date made a decision to refer you to the Professional Conduct Committee in relation to a separate complaint my Office received. A copy of my letter to the Council is enclosed for your reference.

Apology

Thank you for your written apology of 12 December 2005 which I have forwarded to Mr and Mrs B. I thought your apology was very gracious and sincere.

I acknowledge that you have been understandably affected by the investigation. However, there are important lessons to learn from the complaint, and I am encouraged to see that you have begun implementing changes to your practice in relation to your record-keeping and the giving of information to patients.

A copy of my final decision has been sent to Ms C, Mr and Mrs B, the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.

Thank you for your assistance with this investigation.

Yours sincerely

Tania Thomas
Acting Health and Disability Commissioner

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

Enc. Copy of Dr Searle's report

Cc. Ms C, Barrister
Mr and Mrs B
Medical Council of New Zealand
Royal New Zealand College of General Practitioners

Expert advice received from Dr Steve Searle

Report on complaint file 04/06861

This report has been prepared by Dr S J Searle, under the usual conditions applying to expert reports prepared for the Health and Disability Commissioner. In particular Dr Searle has read the guidelines for Independent Advisors to the Commissioner (Ref. 1) and has agreed to follow them. He has been asked to provide an opinion to the commissioner on case number 04/06861.

He has the following qualifications: MB.ChB (basic medical degree Otago University), DipComEmMed (a postgraduate diploma in community emergency medicine — University of Auckland), FRNZCGP (Fellow of the Royal New Zealand College of General Practitioners — specialist qualification in General Practice which in part allows him to practice as a Vocationally Registered Practitioner). As well as the qualifications listed Dr Searle has a Certificate in Family Planning and a Post Graduate Diploma in Sports Medicine. He has completed and renewed a course in Advanced Trauma — ATLS (Advanced Trauma Life Support). He has a certificate (Nov 2003) in Resuscitation to Level 7 of the NZ Resuscitation Council. More recently he has completed a PRIME course (May 2004). He has worked in several rural hospitals in New Zealand as well as in General Practice and Accident and Medical Clinics and currently works in his own practice as well as in the Emergency Department in Dunedin Hospital. Dr Searle has worked at rest homes with residents who have a variety of physical and intellectual disabilities and has patients who reside in residential facilities who have a variety of disabilities. He is also actively involved in local search and rescue missions and training.

Dr Searle is not aware of any conflict of interest in this case — in particular he does not know the health provider(s) either in a personal or financial way. Dr Searle has not had a professional connection with the provider(s) to the best of his knowledge.

Basic Information:

Patients concerned: [Mr and Mrs B]
Nature of complaint: General concerns about standard of care and concerns about attempts to sell them certain products.
Complaint about: [Dr A]
Also seen by: Subsequent General Practitioner and Various specialists.

Introduction:

I will attempt to summarise the time course of the events here to help clarify things for readers of this report. Of note there was considerable information that was reviewed for this report and a simple summary will always be problematic but I have provided one to help make the report easier to use.

Summary of events: Both [Mr and Mrs B] were seen by [Dr A] over a period of about 2 years and 7 months from October 2001 to March 2004.

[Mrs B] was seen on several occasions mostly for asthma but also for headaches and minor injuries and illnesses over this time period. In February 2004, a raised blood pressure was noted and [Mrs B] also complained of low energy. Life style changes

were suggested in February 2004 and then she was seen once more by [Dr A] with a minor injury in March 2004.

[Mr B] was seen with urinary problems and other health problems over this time period and on several occasions anaemia was detected by the investigations that [Dr A] requested. [Mr B] returned to [Dr A] in March 2004 with tiredness and a recent blood test done elsewhere showing anaemia.

Other Introductory Comments

Whilst it is always best to use only the information available at the time of the alleged breach in the standard of care, in this case it was hard to establish just what information was or was not available to [Dr A] at the time. Hence notes and information after the fact were requested. Where such information about future events could potentially be seen to influence my decision I have been careful to seek the opinions of other doctors in such a way that they only had the information [Dr A] would have had.

Documents and records reviewed:

The supporting information was originally that material marked 'A' through to 'K' below and then in early June 2005 sections 'L' to 'Q' were provided and later in June 2005 sections 'R' to 'U' were provided.

Supporting Information

- Letter of complaint from [Mr B], dated 26 April 2004, marked 'A' (Pages 1–2)
- Copy of notes taken during telephone conversation between the investigator and [Mr and Mrs B] on 1 September 2004, marked 'B' (Pages 3–4)
- HDC letter to [Dr A], dated 8 October 2004, marked 'C' (Page 5)
- Written response from [Dr A], dated 20 October 2004, marked 'D' (Pages 6–8)
- Copies of [Mr and Mrs B's] clinical notes, marked 'E' (Pages 9–21)
- Letter from [Dr D], dated 7 April 2003, marked 'F' (Pages 22–23)
- HDC notification letter to [Dr A], dated 23 November 2004, marked 'G' (Pages 24–27)
- Written response from [Dr A], dated 15 November 2004, marked 'H' (Pages 28–34)
- Letter from [Mr and Mrs B] dated 23 December 2004, marked 'I' (Page 35)
- Written information on 'Changing Habits', marked 'J' (Pages 36–37)
- Written information on 'Energy For Life', marked 'K' (Page 38)
- Energy 4 Life CD Rom (supplied by [Dr A])
- Nutriway Product Information Booklet (supplied by [Dr A])
- Referral letter of 1 August 2002 to [the public hospital] Outpatients, Marked L (Page 39)
- Echocardiography results of 8 May 2004, marked 'M' (Page 40)
- Letter of 18 May 2004 from [Dr D], [a District Health Board], marked 'N' (Page 41)
- Letter of 27 February 2003 to [the testing laboratory], marked 'O' (Page 42)

- Letter of 4 April 2003 from [the testing laboratory], marked 'P' (Page 43)
- Copies of [Mr B's] clinical records from 28 May 2002 to 23 March 2004 including test results ordered, marked 'Q' (Pages 44–58)
- Clinical Records for [Mrs B] from 24 March 2004 to 25 May 2005, marked 'R' (pages 59–67)
- Clinical Records for [Mr B] from 23 March 2004 to 20 Oct 2004, marked 'S' (pages 68–70)
- Test results for [Mr B] dated 23 and 24 March 2004, marked 'T' (Pages 71–76)
- Letters from [a general and laparoscopic surgeon], to Drs F and E, dated 4, 12 & 24 August 2004, 23 November 2004, and 20 May 2005, marked 'U' (pages 77–82)
- Letter from [Mr and Mrs B] 23/12/04 and letter from [Dr A] 22 July 2005.

Possible missing information

I am not clear if I have all the general practice notes that would have been available to [Dr A] at the time the [Mr and Mrs B] were being seen. In particular I have not been able to establish if there were any old notes held in the practice. This could either be from pre-computerisation of the notes (i.e. old hand written notes) and/or from previous doctors [Mr and Mrs B] may have seen prior to [Dr A] being their usual doctor.

I am also not clear if there was information held either in [Mr and Mrs B's] paper records or their computerised records that summarised their past medical history or their family histories.

It is important in medicine to make decisions about what is best for patient care based not only on the current symptoms and examination findings but also on the past history, and family history and occasionally other information.

General practice as a discipline has been shown to give better outcomes due to continuity of care compared with episodic care (Ref. 8). Part of the continuity of care is having access to the patients' medical records.

If the past records are not available often the information can be obtained from asking the patients. It is not clear to me if an attempt was made to seek [Mr and Mrs B's] medical records from the time prior to when [Dr A] saw them. It is not clear if [Mr and Mrs B] were asked about their past medical events and family histories at any stage by [Dr A]. It may well have been that these things were asked about but that I have been unable to find where the information was recorded, if it was recorded.

[Mr B] states his iron was low in February 2004 when he went to donate blood. I am unclear as to how often [Mr B] has donated blood before and if [Dr A] was aware of this or not prior to 23/3/04 ([Dr A] did note 'giving blood every 6 months' on 23/3/04).

[Mr B's] notes state 'Health works general health questionnaire sheet filled in' and 'New patient checks done' on 6/11/01 – I am not sure if the answers to this questionnaire have any relevant information or not; or if the 'New patient checks' included anything beyond what was written after this in the notes. The reason I mention this is that it is possible to store information on the practice computer system that may not have been printed out and passed on to the H&DC. This does not mean any deliberate attempt was made to hide information, but rather reflects the increasingly complex information systems used to store patient information.

I am also not sure if any advice was given by phone that is not in the notes. I note that on at least one occasion such advice was given and recorded in the notes ([Mr B's] notes 31/5/02 – note by [Dr A]). However [Dr A] has stated that it is possible that phone calls have occurred without being documented.

Quality of provider's records or lack of them

In general the notes are fairly brief, but within a typical acceptable standard of practice. As already stated I may not have been able to see all the information available to [Dr A] as simple notes printouts can miss some of the information in the computer system, and also because there may well have been old notes available to [Dr A] that I have not seen.

[Mrs B's] notes;

There does not appear to be a copy of old notes, or a written record of her past history or family history, neither is there written record of if she smokes or not. These pieces of information were and are relevant to making decisions about her treatment including about her blood pressure.

Some of this information was recorded in the note from [the second medical centre] 9/2/04 (presumably from the doctor providing after hours care obtaining this information from [Mrs B]). It is not clear to me if [Dr A] ever obtained this information prior to 9/2/04. The absence of this information in the notes is not in and of itself a breach in the standard of care, as it is possible that the information was either obtained and not written down, or that it is contained elsewhere in the practice information system or old notes.

It is not clear to me if a specific plan was made to follow up [Mrs B] — it does not seem to have been recorded in the notes [Dr A] made in Feb/Mar 2004. It is possible that a recall or reminder system operated in the practice could have been used to ensure follow up occurred but I have no record of this. It is also not clear as to if [Mrs B] was told when to come back to have her blood pressure checked — however as she was on some regular medicine for her asthma it may have been that the plan was to follow up her blood pressure when she was next in for her asthma. Following up things at subsequent visits would have been acceptable in her case as she clearly came to the doctor several times a year.

[Mr B's] notes;

There does not appear to be a copy of old notes, or a written record of his past history or family history or as to if he was a smoker or not. It is not clear to me if [Dr A] was aware of [Mr B's] previous bowel problems as it does not appear to be recorded in the notes I have been sent.

It is clear that on 1/8/02 [Dr A] was aware of the past history of rheumatic fever; but not if [Dr A] was aware of this or had enquired about this prior to 1/8/02. On the 28/5/02 I would have expected [Dr A] to have documented any past history of [Mr B] as this appears to have been the first time [Dr A] saw [Mr B] — this does not appear to have been done. It also does not appear to have been done at any time since then. It may be that such information is contained in the notes prior to 28/5/02 and the H&DC has just not been sent these notes. [Dr A] thought notes prior to this date were not relevant and wrote 'Pages 25/026 are pre 28/5/02 before I had seen him for the first time' when more notes were sent by him on 25/5/05 — however I consider all information that was available to [Dr A] is relevant to the case and it would be useful to know what the notes contained. I am particularly interested in knowing if [Dr A] was aware of [Mr B's] prior history of bowel problems. I note in [a general surgeon's] letter of 4 August 2004 — that [a general surgeon] had seen [Mr B] some 5 years prior to that with possible Crohn's disease (but histology was uncertain (what was seen under the microscope when biopsies (tissue samples) were obtained)). To avoid further delays I have allowed for any of these possibilities in my opinions rather than trying to go back and clarify each of these points.

Whilst I have been asked about the standard of care in March 2004 this issue cannot be addressed in isolation as [Mr B's] anaemia clearly was occurring as far back as May/June 2002 when [Dr A] noted 'microcytic anaemia'. I do not have a copy of the results from back then but I think having such results is unlikely to change my opinion.

Follow-up tests were done in July and August 2002, which is a good standard of care in that it helped to ensure [Mr B] was not worsening, but definitive tests and/or investigations to work out the cause of [Mr B's] anaemia were not done. An attempt to test for blood in his faeces (or bowel motions) was made — however I do not have a copy of the result. I will comment on this later but positive or negative it probably does not change the management.

It is clear that the anaemia was still present in June 2002 as [Dr A] noted '19/6/02 anaemia but improving, for bloods and rv (review) end of July'.

On 1/8/02 [Dr A] prescribed iron tablets. He also referred [Mr B] for investigation of his heart murmur and prior rheumatic fever — this was a good standard of care for the heart murmur.

On 8/11/02 blood tests showed no anaemia but that the iron stores were still low. The ferritin (a marker of body iron stores) was 21, which was low by the stated lab normal range of 30 to 300). This information was provided to me in section 'Q' of the supporting information and was not in section 'E' of the original information provided. There is no documented plan of follow-up made in the notes I have.

On 25/2/03 [Mr B] was seen for urinary problems and a subsequent referral for a specialist opinion was made which was a good standard of care. However at the same time investigations were done which showed low iron levels and that [Mr B's] haemoglobin (the red stuff that carries oxygen in the blood) was decreasing — it was now 122 (low by laboratory normal range given as 135 to 180 and also lower than the 159 it had been on 8/11/02).

The note back from the urologists (or the summary of it — supporting information 'P') — was clear that he did not need any follow-up from a urology point of view. This urology opinion did not comment on the anaemia which seems reasonable as [Dr A's] letter to them (supporting information 'O') did not ask the urologists about [Mr B's] anaemia.

There appears to have been no follow-up plan for the anaemia (low haemoglobin) that was found in February 2003.

The next visit was for a sinus infection in May 2003 and the visit after this for an upper respiratory tract infection in August 2003. At neither of these visits was there documented any follow-up plan for the prior anaemia — if there had been a simple error of oversight back in February 2003 then follow up visits are an opportunity to pick up on such an error — a good standard of care is to look back at the prior visits and see if there is any follow up needed even when patients come in for something different. However given the urology problem was resolved it is possible that this put [Dr A] 'off the scent' so to speak, regarding the low haemoglobin.

The next time [Dr A] saw [Mr B] was 23/3/04 and the notes contain a reasonable plan regarding his anaemia, although exactly how [Dr A] was going to implement the plan to 'have a look at bowels' is not clear. It is clear that he did at least organise for two tests for blood in his faeces (or bowel motions). It is not clear what if any further checks on the bowels [Dr A] planned.

Describe the care as documented and describe the standard of care that should apply in the circumstances.

Taking a full history — this should include current symptoms (e.g. fever, any pain, or loss of function), past history of similar illness, past medical history including medications and allergies. As already mentioned the past medical history for both [Mr and Mrs B] was not clearly documented by [Dr A] in the information I have received.

Do an appropriate examination.

This in [Mr B's] case should have included an abdominal examination, and a rectal examination (gloved finger in the bottom to check for tumours/cancers), and checking of his weight for comparison with previous weights and for future comparison. From the notes I do not think these things were done each time [Dr A] saw [Mr B] but given he had seen a urologist in 2003 it is likely that these things had already been checked. However knowing if [Mr B's] weight was changing or not would have been an appropriate thing for [Dr A] to check and this does not appear to have been done.

Order appropriate investigation at an appropriate time.

Appropriate tests were ordered at various times, but the follow up testing was not always specifically planned or documented in [Mr B's] case.

In [Mrs B's] case there was no urgency to do tests for her hypertension and it is possible that further tests would have been done by [Dr A] if her blood pressure had remained high despite lifestyle advice. However [Dr A] did do some

investigations for [Mrs B] in February 2004 and found a number of things including that she was not diabetic, which helped to confirm that she was not at high cardiovascular risk.

My colleagues (Ref. 2) all had a slightly different set of investigations that they would do for raised blood pressure depending on the patient's overall medical profile and presentation. Some would order a chest x-ray but most would not. From the information I have it is hard to determine if [Mrs B's] cardiovascular risk over the next 5 years (as of February 2004) was as low as 2.5 to 5% or as high as 10 to 15% — largely because of lack of information on smoking and family history. Given her tests showed she was not diabetic her risk was certainly not higher than this. In this situation it is entirely reasonable to try lifestyle measures for reducing blood pressure and seeing what happens — this is what [Dr A] appeared to have planned. When [Mrs B] complained of tiredness two days after a fairly extensive set of investigations that did not show any anaemia, diabetes or thyroid problems and normal liver and kidney function I think it was also reasonable to look at lifestyle management (diet and exercise etc.).

Decide on appropriate management and implement this or seek advice and/or refer on for such management.

As discussed above [Mrs B's] management was appropriate for both her blood pressure and tiredness.

In [Mr B's] case on several occasions over the course of time [Dr A] saw him I believe referral for further investigation of his gastro-intestinal tract was needed. This included back in June 2002 when [Dr A] first noted an anaemia and on the subsequent occasions [Dr A] saw him. Whilst [Dr A] may have been distracted by other health problems (e.g. Rheumatic fever, urinary problems) on several occasions [Mr B's] anaemia did require follow up despite these other problems. [Dr A] did specifically focus on his anaemia during the consultation on 4/6/02 and planned follow up tests to see if the anaemia was improving or not (which is part of a good standard of care) — however on this occasion he did not refer [Mr B] for investigation as to the cause of his anaemia. This failure to refer was not a good standard of care.

Give the patient appropriate advice on follow up, and any complications to watch out for that might need earlier follow up. This could have included advising [Mr B] of the need to not only follow up his anaemia to see if it got better but to look into why he had the anaemia in the first place. If patients are given information on what doctors are thinking of then it becomes easier for them to pick up on any errors in their own management — such as a lack of an appointment to see a specialist. In [Mr B's] case [Dr A] documented advice about the follow up of his urinary problems, including some phone call advice on 31/5/02, but other than the advice in June 2002 to be seen at the end of July to review his anaemia there is no specific advice documented about the follow up of his anaemia. The follow up visit on 1 August 02 included a prescription for iron tablets but no advice on the follow up of the anaemia other than to note he was 'feeling a lot better...'

In [Mrs B's] case lifestyle advice was appropriate but she should have been given options other than [Dr A's] own programme from which he would appear to have a vested interest — trying to sell the programme for financial gain. For example, could the practice nurse have seen [Mrs B] or could she have been referred to the local hospital dietitian/lifestyle educator? Another option would be through the local 'green prescription' service (a type of exercise advice programme). There is no evidence that these alternatives were offered to [Mrs B]. I think when [Dr A] was offering her something that he had a vested interest in it was even more important than usual for him to offer alternatives for the same or similar treatment and to document in the notes that he had done so. I think his lack of documentation of offering alternative options in this context is a moderate breach of the standard of care.

Have appropriate systems in place to reduce errors.

This is where there is great potential to improve the management for all patients. Doctors are human and errors can occur — however they can be minimised and/or the effects of these errors reduced or mitigated by having systems in place to check for errors and if possible to take action to prevent harm or to prevent sub-optimal outcomes for patients. Systems relevant to this case could have included:

1. To keep in one place within the patient's record a record of their cumulative past history. If an effort to do this had been done then it is possible [Mr B's] past history of bowel trouble might have come to [Dr A's] attention. There are various ways of doing this from problem lists and classification systems to simply writing down/typing in the past history into an appropriate place in the medical record.

2. Having specific review and recall policies in place for problems that either can potentially recur or need longer term follow up. For example if one problem such as in [Mr B's] case his urinary problem is being actively followed then if another problem comes to light in the course of investigating the first problem then a reminder can be placed to prompt the doctor to look into the second problem at a later date. There are many ways of doing this – e.g. simple hand written lists of things to do that each doctor has, task lists on computer systems, and recall systems (both manual and computerised).

3. For patients who re-present with the same illness when a cause has not been determined there is a need to look into things in more detail. In [Mr B's] case his anaemia first came to [Dr A's] attention in February 2002 and was followed up in a limited way through to August 2002. It then re-presented in February 2003 and should have alerted [Dr A] to consider looking into a cause for this. If significant events such as anaemia are entered into patients' past histories or problem lists routinely then it is more likely it will come to the doctor's attention that such a problem had occurred before — rather than simply relying on the doctor's memory of past events.

4. Having a method of thinking about decision making that helps pick up errors (Ref. 7). In this case at various times [Mr B's] anaemia was picked

up in the context of other problems (e.g. urinary problems). It is important for doctors to recognise that when they do a test for one thing and find 'something else' that there is a need to make sure they do not overlook the need to follow up the 'something else'.

Having such systems in place to reduce errors is not yet common place but such systems are gradually being developed. The absence of such systems cannot be seen to be a breach in a reasonable standard of care at the time of this case, but I include this information to give options for improving the standard of care, and for reducing future errors for those who might read this report.

It concerns me that [Dr A] in his letter of 15 November 2004 states under his point 'h' Internal reviews and changes made to practice — 'As I am not aware of having provided care that is not up to the standard expected, I am unsure how to respond to this'. It could be that he might consider he is under investigation and that he should not admit to having done anything 'wrong' so to speak. But at this point he has already noted [Mr B's] past history of Crohn's disease and that he had seen [Mr B] on several occasions with anaemia — if [Dr A] can not see in hindsight that lack of adequate investigation and/or referral was a problem then he may need to review his management of anaemia.

Describe in what ways if any the provider's management deviated from appropriate standards and to what degree.

Re [Mrs B's] standard of care.

I think the standard of care was in most respects satisfactory. It is true that her asthma inhalers were difficult to sort out because of the problems she had with various types of inhaler and the problems with accessing funding for the remaining inhalers if they remained available in New Zealand at all. I have come across patients intolerant to one type of inhaler but not to several types as [Mrs B] appears to be and hence the situation was unusual. I do not think it is clear whether [Mrs B] had run out of her Becloforte inhaler at any stage whilst under [Dr A's] care and his plan to try Respocort (another type of steroid inhaler) was reasonable. I am unable to determine from the notes if [Mrs B] had asked for another steroid inhaler from [Dr A] after he last prescribed her Becloforte.

The plan to have lifestyle advice as the initial management of her blood pressure was satisfactory.

However the type of lifestyle advice given and/or the way it was given may well have been problematic. For the purposes of this report I have not made an attempt to analyse [whether] the content of [Dr A's] lifestyle advice package or the air purifier he recommends are of proven benefit. This is for two reasons:

a) it is beyond my resources to determine the scientific validity of these issues
b) even if they were scientifically proven it would not change my opinion.

The key thing for [Dr A] if he is to offer patients treatments or other information/products that he has a vested interest in, is for him to make this clear to patients and to offer them an alternative way of obtaining similar or the same options from another provider. My colleagues (Ref. 2) when asked about this aspect of the

case all considered that it was important that if the doctor is financially advantaged that this interest must be declared to the patient.

[Mr B's] standard of care.

The main problem here was that despite anaemia being found on more than one occasion prior to March 2004 no referral or investigation(s) were made to find out the cause of the anaemia. In this respect [Dr A's] care was inadequate. His other care prior to March 2004 for the urology problems and heart problems was adequate. [Dr A] possibly did not examine [Mr B] adequately but I am not sure from the notes if this is the case or not. I am also not sure if [Dr A] made any attempt to keep an eye on [Mr B's] weight over the two year period where he was having anaemia on and off — I think this should have been done but from the information I have it appears to have not been done. This is a minor breach in the standard of care.

Answering Questions put to me by the Commissioner's Office.

Was the care provided by [Dr A] to [Mrs B] in February 2004 appropriate?

Yes it was as it is documented. The issue of exactly what advice was given re 'life changes' is discussed below.

Was the care provided by [Dr A] to [Mr B] in March 2004 appropriate?

The care provided in March 2004 was appropriate. With respect to the heart condition in March 2004 the symptoms were consistent more with the anaemia than the heart condition and [Mr B's] heart had already been looked into by a referral to a specialist. Further tests on his heart had been ordered by the specialist and were due to occur in due course (and did occur later that year). A letter from the specialist ([Dr D]) from April 2003 suggested [Mr B] had mild aortic valve disease. This would not particularly suggest that [Mr B] needed further heart investigation for his tiredness as of March 2004. Also the fact that a heart scan (Echo) was due to be performed within a few months was a good back up in case there was some heart contribution to his tiredness. I think the fact the [Mr B] presented with both tiredness and a known low haemoglobin was enough to let [Dr A] focus on the anaemia as the cause of his tiredness.

It is not possible to determine, if [Mr B] had returned to [Dr A] after this, exactly what [Dr A] would have done to further investigate the cause of his anaemia. However in considering the standard of care in March 2004 regarding his anaemia I needed to review the previous medical history including [Dr A's] own notes and I comment on that further as outlined below.

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

It is clear that [Dr A] had, on more than one occasion prior to March 2004, noted [Mr B's] anaemia. At no stage did [Dr A] go beyond initial investigations, that showed the anaemia, to work out the cause of the anaemia. Checking of the faeces for hidden blood, which was done, was not sufficient to rule out a gastro-intestinal source of bleeding. It should be noted I do not have the results for the first time these tests were done back in June 2002. However, even if the faeces was clear, or negative for blood, I still consider further investigation and/or referral was needed — see below.

Obtaining old notes;
My opinion is that old notes are important for patient care. I consider at least one attempt should be made to obtain old notes for patients who are to be regular and/or 'enrolled' patients. I think this is supported by the evidence that continuity of care improves patient outcomes in a general way for most patients (Ref. 8). In order to clarify this opinion I asked two groups of doctors about this (Ref. 2, 3). Both groups of doctors considered that at least one attempt should be made to obtain old notes for patients who had become regular patients. One doctor pointed out that since PHOs (Primary Health Organisations) have been established that the business rules of enrolment for PHOs requires you to seek old notes and in their view since PHOs were established it was a more serious offence not to seek old notes. It was generally considered a minor breach of care to not ask for old notes. Some doctors felt that failure to obtain old notes could be serious if the past history (obtained by asking the patient about their past medical events) suggested that there was a significant problem. There was no clear agreement on what if anything should be done if the first attempt to obtain old notes was not successful. It was also pointed out that it can be time consuming trying to obtain old notes and patients often can't say where their old notes are — however the consensus was that at least one attempt should be made to obtain old notes.

Recording phone calls.
When I was asking for more information about this case I wondered if the practice kept information about phone calls separate to the usual notes. If that was so could there be information about any advice given to [Mr and Mrs B]? Apparently [Dr A] stated that there could have been such calls. While his clinical notes do not reflect these correspondences, it does not mean that they were recorded elsewhere. [Dr A] commented that it was impossible and unrealistic for a busy practice to record every single telephone call between the practice and its patients. My own opinion is that all significant phone calls should be documented. If we rule out simple enquiries about appointments and non-clinical matters and instead consider any advice from doctors and/or nurses about patient care then this puts a realistic focus on the issue. The group of colleagues I asked about this issue all stated that they would record in the notes telephone conversations to and from patients (Ref. 2). Thus I would disagree with [Dr A] regarding this matter.

Examining patients.
From the notes I have [Mr B] did not appear to have been examined by [Dr A] with respect to an abdominal, or rectal examination. I am also not sure if [Dr A] made any attempt to keep an eye on [Mr B's] weight over the two year period when he was having anaemia on and off. I think [Mr B's] weight should have been regularly monitored but from the information I have it appears to have not been done which is a minor breach in the standard of care.

The lack of examination is a minor breach in the standard of care. If [Mr B] had been promptly and thoroughly investigated and referred for working out the cause of his anaemia then the absence of such examination is minor. Given that he was not referred I think it is a moderate breach of the standard of care not to do a rectal examination for an iron deficiency anaemia in a man of his age.

Investigating the cause of anaemia.
It was clear that [Mr B] had an anaemia back in June 2002 as well as in February 2003 and again in March 2004. My own opinion is that an iron deficiency needs investigation. My colleagues agreed with this. My colleagues also agreed that a history of donating blood makes the issue less straightforward but most of them would investigate anyway. If not investigating straight away because of the history of blood donation they would track iron and blood levels closely and certainly at the time of recurrence of anaemia (in this case Feb 2003) they would have referred on for investigation if they had not done so in the first place. My colleagues all wanted to know about family history — as far as I can tell [Dr A] has not documented this. The failure to ask about this would be a minor breach in the standard of care. From the information I have I am unable to say if [Dr A] asked about family history or not.

Some of my colleagues would do faecal occult blood tests in the hope that positive results would speed up any hospital based investigation but others like myself would not have done such tests as they do not change the management. Certainly if the faecal occult blood tests were negative they would have still referred on for specialist investigation. After asking about this in a general way for any patient with a similar problem when I later revealed to my colleagues the past history of an inflammatory bowel disease with unclear histology from the past colonoscopy they all considered this would make it more important to investigate not less important.

Offering lifestyle advice.
The benefits of a good diet and exercise are well known. [Dr A] was offering a 'Nutriway lifestyle programme' — it is beyond my resources to determine the scientific validity of this programme. However even if we assume it was a good programme it is clear that [Dr A] had a vested interest in this programme. Thus it was important for him to make this clear to patients and to offer them an alternative way of obtaining similar or the same options from another provider(s). I think this is so important that he should have documented this in the notes — he did not and this is in my opinion a minor breach in the standard of care.

My colleagues (Ref. 2) when asked about this aspect of the case all considered that it was important that if the doctor is financially advantaged by the product that is being suggested that this interest must be declared to the patient. If [Dr A] did not declare this interest it would have been a moderate to serious breach in the standard of care. I think it is likely that he did declare his interest and that in any case the patients seemed to have worked it out. What concerns me more is his failure to offer them alternatives — I think this is a mild to moderate breach in the standard of care.

Various Medical Council statements make comment on this issue (Ref. 4, 5). One of these statements was not published at the time of [Dr A] seeing [Mrs B] but I consider that the statement reflects consensus medical opinion over a period of time prior to the statement being published by the Medical Council and as such is not an unreasonable thing to consider in this case. Furthermore I have seen overseas medical association comments that suggest it is important for doctors directly selling treatments to patients to offer them an alternative way of obtaining the same or similar products in order to help preserve some of the independence in the doctors' decision to offer the treatment in the first place. I note [Mr and Mrs B's] suggestion that [Dr A] should either sell certain products or be a doctor but not both. Whilst this would avoid a conflict of

interest it could also limit the availability of some potentially useful treatments to patients — for example some doctors sell Viagra to their patients who for what ever reason (e.g. patient confidentiality) do not want to buy it at the local chemist. However doctors who sell Viagra should be obliged to offer their patient a script so that patients can obtain their Viagra elsewhere. This is my stance in [Dr A's] case — that he should be clearly offering the patients the same or similar products through someone else as an alternative and that he should document this in the notes.

Air purifying unit.

My comments above on the 'Nutriway lifestyle programme' can also be applied to the air purifying unit that it seems likely that [Dr A] also offered to [Mr and Mrs B] — namely that he should have given them alternative options. In the case of his possibly recommending it for asthma he could also have advised them to seek independent advice — for example from the local asthma society. Also although the product might have been an 'Amway' product and not available in the usual shops I think it would have been possible for [Mr and Mrs B] to be referred to another person dealing with 'Amway' products or given advice on how to obtain a similar product from another supplier.

'Changing Habits' (supporting information J).

This is an information handout that [Dr A] gives to patients. I note in this it is stated that 'diets don't work'. This is not an unreasonable statement and has a moderate amount of evidence behind it (Ref. 6) and I tend to agree with him on this point. It is somewhat ironic that in the very next sentence a diet of 'Try 15 plant foods a day.' is suggested — [Dr A] does not use the word 'diet' in this handout, but one definition of 'diet' is 'a prescribed course of food, a regimen'. I consider that trying '15 plant foods a day' is a prescribed course of food but if [Dr A] chooses not to call this a 'diet' then I suppose that it is not that unreasonable in today's world where the meaning of words can change. I think this flexibility in the use of the word 'diet' is illustrated by [Dr A's] letter of 22 July 2005 where he states 'As is apparent from my letter 'Changing Habits' I did recommend a healthy diet ...'. I am not aware of any evidence to show that trying 15 plant foods a day is a sustainable and safe type of eating and I note that it is beyond the usual recommendations of 5 servings of fruit or vegetables a day. A search of the internet (August 2005) for '15 plant food' was unable to result in any studies to back up this type of food regimen. I do not think on its own that the advice to 'Try 15 plant foods a day' can be considered a breach in the standard of care but in the absence of offering patients alternative well accepted medical advice on healthy eating I think it is a minor breach in the standard of care. The other information including some exercise advice is reasonable general advice.

'Energy for Life'

This health promotion package was not checked for evidence of effectiveness as it was beyond the scope of this report. However the use or recommendation of such a package has the same type of problems as per the above discussion on the 'Nutriway lifestyle programme' and the air purifying unit.

Other matters:
[Dr A] states in his letter of 15 November 2004 that '[Mrs B's] blood pressure, given her morbid obesity, was not at such an unacceptably high level that immediate medication was indicated'. Whilst I agree that her overall cardiovascular risk, including her blood pressure, was not that high that immediate medication was indicated I do not follow why he added the 'given her morbid obesity' comment in. If you ignore the obesity the risk is a certain level and if you pay attention to the obesity her risk is either the same or higher (some medical debate about this) but it is certainly not lower. I think [Dr A] should review this line of thinking. In general if risk factors such as smoking or obesity are present as well as high blood pressure it becomes more, not less important to consider treating the blood pressure.

Conclusion:

I would like to focus on some key issues. I have tried to write this report to cover all the possibilities for what information [Dr A] did or did not have at the time as I think further attempts to obtain more information is unlikely to change my opinions.

Recording phone calls.
I consider phone calls to and from patients that give clinical advice need to be recorded in just the same way that an actual practice visit for health care needs recording. I am not sure if [Dr A] in his statement to the H&DC realised what sort of phone calls were being asked about when he said that it was impossible and unrealistic for a busy practice to record every single telephone call between the practice and its patients — clearly for clinical advice he needs to review his opinion on this.

Obtaining old notes.
I am not sure if old notes were obtained or not. If there was not even at least one attempt to obtain old notes then this was a mild breach in the standard of care. If an attempt was made to obtain old notes but they did not arrive then it is even more important that previous bowel or anaemic problems were asked about in this case and it would be important that this was documented somewhere. I have not been able to find such documentation in [Dr A's] notes — this is a minor breach in the usual standard of care.

I am a little surprised that [Dr A] in his letter 15 November 2004 noted 'On 1/8/02 [Mr B] first mentioned a past history of rheumatic fever ...'. Given this I would have thought this would have rung a bell so to speak for [Dr A] to take a full past history off [Mr B] to see if anything else in his past history had been overlooked. This may well have revealed the past history of bowel investigation. Once again it would appear that another opportunity was missed for obtaining a full past history (an opportunity after [Dr A] first met [Mr B]).

It is usual practice to obtain a full past history when first meeting a regular patient (i.e. back on 28/5/02) but if it was not obtained for whatever reason a presentation that suggests [that] past history has been overlooked (e.g. the rheumatic fever) [and] should have prompted [Dr A] to take a full past history or seek old notes about all past medical events.

In [Dr A's] letter of 15 November 2004 he states 'It was also known that in the past he had undergone investigations for Crohn's disease and hence looking at his bowels for a cause of anaemia and tiredness was appropriate'. I am not sure when [Dr A] knew about this as it is not clear from the notes. It could be that he only found this out after he last saw [Mr B]. In any case as stated elsewhere in this report if [Dr A] knew this when he was seeing [Mr B] it would have only made it even more important to have referred [Mr B] for proper investigation.

Past Medical History.
If the old notes were available, then the record of [Mr B's] past bowel problems would have made it even more important to have referred him for repeat investigation given the uncertainty of the diagnosis at prior investigation. If the old notes were not available then it was important to ask about past problems and medical history. I think it is unlikely that [Mr B] would have forgotten about a colonoscopy, and I suspect he would have mentioned this to [Dr A] if he had ever been asked specifically about any previous bowel problems. Even if this past history was not obtained I think it was important for the cause of [Mr B's] anaemia to have been investigated.

Failing to investigate the cause of anaemia.
As stated before this is the key area where there has been a serious breach in the standard of care. Regardless of what information about [Mr B's] past history was available to [Dr A], failure to seek a cause for [Mr B's] anaemia was a serious breach in the standard of care.

I do not accept [Dr A's] statement in his letter 15 November 2004 that '[Mr B's] symptoms therefore appear to have not been severe enough for [Dr E or Dr F] to pick up on earlier.' The severity of symptoms is not in and of itself with iron deficiency anaemia a reason to investigate or not investigate. The severity of symptoms may influence how quickly to investigate and whether other treatment is needed in the meantime, such as blood transfusion or iron therapy, but not the need to investigate per se. I also think [Dr A] is implying in this statement that because [Mr B] was not referred by his new doctor(s) until July 2004 that in some way this justifies his own lack of referral. I think his subsequent doctors did well to refer [Mr B] in July 2004 when they would have seen in his old notes that he had a recurring anaemia over the preceding two years that for some reason [Dr A] had not referred him for investigation for. The prior lack of referral probably falsely reassured them that [Dr A] must have known something about [Mr B] that justified the lack of referral. It was only in July 2004 once they discussed with [Mr B] about his then resolved anaemia that they picked up on his past history of possible Crohn's disease. This then triggered them to make the referral for a specialist opinion. Clearly the new doctor's discussion with [Mr B] was able to find this past history and recognise the significance of it when for some reason [Dr A] either did not find out this past history or if he did then he did not realise the significance and make the necessary referral — either way [Dr A] failed to provide an adequate standard of care.

I note [Dr A] in his letter of 22 July 2005 states that 'I organised the initial tests that indicated [Mr B] had low iron levels. I suggested the further investigations that I considered he required. This took place on 23 March 2004, which was the first occasion on which [Mr B] presented with symptoms leading to investigation of his iron levels'. I disagree with this statement in that the notes clearly state on 4/06/02 '...

still has loss of energy ...' and further tests were organised by [Dr A] at that time. As previously stated back in June 2002 [Dr A] did not take the tests to the next level to find the underlying cause of the anaemia. [Dr A] states in his letter of 22 July 2005 that 'I am certain that had [Mr B] continued as my patient I would have referred him for further testing and specialist advice' — this would have been good practice. However I am not sure why [Dr A] would have referred him at this point in time when in the past with at least two occasions of anaemia he had not done so.

Vested interest in products recommended to patients.

It is clear that [Dr A] has offered the 'Nutriway lifestyle programme' to [Mr and Mrs B] and/or to other patients and also an air purifier. What is not clear is that [Dr A] has adequately managed his being financially advantaged by the products that are being suggested. This interest must be declared to the patient and in my opinion [those] patients must be offered alternative options for obtaining the same or similar products and/or advice. Because of the potential conflict of interest I think this is important enough that it should be recorded in the notes. The absence of any record of this in the notes is a minor breach in the standard of care. The absence of any record about this makes it hard to know exactly what options were given to [Mr and Mrs B]. If they were not offered alternatives to the products [Dr A] could have been financially advantaged by then this is a serious breach in the standard of care.

Although the product(s) might have been Amway products and not available in the usual shops I think it would have been possible for [Mr and Mrs B] to be referred to another person dealing with Amway products or given advice on how to obtain a similar product from another supplier. Alternatively they could have been offered second opinions from other doctors or independent opinions from for example the local asthma society. There may well be other ways to manage the potential conflict of interest that [Dr A] has, but whatever he does to mange this conflict of interest needs to be not only done, but be apparent to the patients so that their range of health care options is not restricted in any way.

I note [Dr A's] statement in his letter 15 November 2004 'In such discussions I make it very clear that this is a separate business to my medical practice and I have a financial interest. There is however never any pressure applied. I am committed to providing people with health choices that may assist with their condition, whether by way of medication, "Green prescriptions" and lifestyle choices, or other aides'. This is a reasonable start to managing his potential conflict of interest but I think he needs to go further and ensure patients are given alternative sources for the same or similar products and that some sort of brief documentation that this has occurred is made. In supporting information 'K' [Dr A] discusses how he recommends the 'Energy for Life' health promotion CD. He states 'The instructions are very clear. If the individual would like to look at the programme they need to put their private contact details on the back of my business card when they return the CD'. This in my opinion does not go far enough as it does not give the patients a clear option for obtaining the same material from an alternative provider, and also I think it becomes obvious to [Dr A] who has not taken up the 'Energy for life' programme which could potentially bias future doctor patient communication. Furthermore at the same time he does not appear to offer alternative providers of health promotion such as local supporters of the green prescription (exercise promotion) programme. I think it is the need to provide patients with alternatives at the point in time that any particular lifestyle

programme is promoted that is the key issue to ensuring patients' rights ——including the right to effective communication, the right to be fully informed, and the right to make an informed choice.

I note [Mr and Mrs B's] suggestion that [Dr A] should either be a doctor or an Amway salesman and not both. This is one way of avoiding a conflict but it may be with adequate other measures [Dr A] can continue to do both things but it would need careful management.

Note for Commissioner

A number of points have been raised by [Mr and Mrs B] that could be of concern — where I have been unable to verify them (for example in the notes or by admission from [Dr A] in his correspondence with the H&DC) I have not always commented on them. For example in supporting information 'B' answer 6 (A6) it states that '[Dr A] informed [Mrs B] that the asthma preventatives give you a high when you take them therefore he prefers not to prescribe them.' If the Commissioner wishes me to comment on any of these statements I am happy to do so but overall I suspect they will not add in substance to the overall issues in this report.

References.

1) Guidelines for Independent Advisors — Office of the Health and Disability Commissioner — Appendix H of the Enquiries and Complaints Manual – effective date: 1 September 2003.

2) I asked a small group of local colleagues (five other general practitioners) about several aspects of this case in a way such that the details of the doctor and patients involved were not revealed. I asked first about recording phone calls and then about obtaining old notes in a general manner without any details of the case. I then asked about the more specific issues of the case.

3) I asked for an opinion on obtaining old notes from doctors around New Zealand including two in similar sized towns to the one involved, as well as doctors from a variety of locations within New Zealand. This was to help ensure that my opinion from local colleagues about obtaining old notes was not biased by a potentially less mobile southern population. Eight colleagues responded and they considered that at least one attempt should be made to obtain old notes for patients who had become regular patients. One doctor pointed out that since PHO (Primary Health Organisations) have been established that the business rules of enrolment for PHOs requires you to seek old notes and in their view since PHOs were established it was a more serious offence not to seek old notes. It was generally considered a minor breach of care to not ask for old notes. Some doctors felt that it could be more serious if the past history (obtained by asking the patient about their past medical events) suggested that there was a significant problem. There was no clear agreement on what if anything should be done if the first attempt to obtain old notes was not successful. It was also pointed out that it can be time consuming trying to obtain old notes and patients often can't say where there old notes are — however the consensus was that at least one attempt should be made to obtain old notes.

4) Medical Council of New Zealand; Statement on complementary and alternative medicine (CAM); March 2005. Part of this statements states 'Where a patient is making a choice between conventional medicine or CAM, the doctor should present the patient with the information that a reasonable patient, in that patient's circumstances, would expect to receive about the treatment the doctor is recommending. This information includes an explanation of the options available including an assessment of the expected risks, side effects, benefits and cost of each option. This allows competent patients to make an informed choice.'

5) Medical Council of New Zealand; ETHICAL GUIDELINES FOR DOCTORS' DUTIES IN AN ENVIRONMENT OF COMPETITION OR RESOURCE LIMITATION October 1999; Part of this guideline states 'Doctors must not allow their own commercial interests, or those of an employer or funding agency, to override their ethical responsibilities to their patients. Nor is it acceptable for doctors to promulgate or participate in programmes which restrict the provision of health care, or advocate a particular form of investigation or treatment, for their own pecuniary advantage in opposition to the interests of patients.'

6) The Obesity Myth — Paul Campos — Gotham Books, May 2004, ISBN: 1-592-40066-3 — this book is well written and contains extensive references to the medical literature.

7) Cognitive Forcing Strategies in Clinical Decisionmaking, Pat Croskerry, Annals of Emergency Medicine 41:1, Jan 2003, p110–120.

8) The Value of General Practice — the key role general practice plays in the provision of Primary Health Care — publication by RNZCGP (Royal New Zealand College of General Practitioners), NZ 2002, ISBN 0-9582272-4-1 — this reviews some of the evidence for General Practice Care.

Dr SJ Searle, 25 August 2005