Medical Officer in General Practice, Dr C

A Medical Centre

A Report by the

Health and Disability Commissioner

(Case 06HDC11343)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Ms B	Consumer's daughter
Dr C	Provider/Medical officer in general practice
A medical centre	The medical centre
Dr D	Physician
Dr E	General practitioner
Dr F	General practitioner
Ms G	Practice nurse
Dr H	General practitioner
Dr I	Consultant General surgeon
Dr J	Dr C's supervisor

Complaint

On 28 July 2006 the Commissioner received a complaint from a lawyer on behalf of his client, Mr A, about the services provided by Dr C and a medical centre. The following issues were identified for investigation:

- *The adequacy and appropriateness of Dr C's investigations and treatment of Mr A's duodenal ulcers between March and October 2004.*
- *The adequacy of the information Dr C provided to Mr A in relation to the increased risks of the medication he prescribed.*
- *Whether it was appropriate for Dr C to follow Dr D's advice regarding Mr A after his discharge from hospital.*
- *The adequacy and appropriateness of Dr C's investigations and treatment of Mr A's bowel problems between March and August 2005.*

The investigation commenced on 9 October 2006. It was extended to include the medical centre on 9 November 2006.

Information reviewed

Information from:

- Mr A
- Ms B

- Dr C
- The Medical Council of New Zealand
- The Royal New Zealand College of General Practitioners
- Mr A's general practitioner records and medical records from the District Health Board.

Independent expert advice was obtained from general practitioners Dr Stuart Tiller and Dr Caroline Corkill.

Information gathered during investigation

Overview
Dr C is a medical practitioner working in a general practice. He is not vocationally registered as a general practitioner. Dr C is a director of a large joint venture group medical practice. The medical practice has ten shareholding directors who are all active clinicians in the practice.

Mr A, who turned 64 in 2004, had a history of hyperprolactinaemia, lower back pain and anxiety. Hyperprolactinaemia is the presence of abnormally high levels of prolactin in the blood, which can cause pituitary problems.

Early consultations
Mr A first consulted Dr C at the medical centre on 16 January 2001 after moving from another town. His former general practitioner had been treating him with bromocriptine for hyperprolactinaemia. Mr A also reported a history of back pain, which he said was "inoperable". Despite noting Mr A's pre-existing health concerns, Dr C did not request a transfer of Mr A's records from his previous GP.

Mr A had been taking bromocriptine for seven years. One of the adverse effects of this medication is gastrointestinal upset and bleeding, and he had been taking ranitidine (Zantac) 150mg twice daily to guard against peptic ulceration. Dr C said that ranitidine is "a medicine that helps to treat and prevent, among other things, stomach and duodenal irritation and ulceration".

Between January and December 2001 Mr A attended the medical centre, mainly seeing Dr C, with various ailments and to renew his prescriptions.

On 18 December 2001 Mr A saw Dr C about arthritic pain in his neck and wrists. Dr C prescribed Tilcotil (tenoxicam) for pain relief. Tenoxicam is a non-steroidal anti-inflammatory analgesic (NSAI) used in the treatment of arthritis. NSAI drugs are known to cause gastrointestinal upsets, and are given with the instruction to take them

with food, and to stop taking them if gastric discomfort or vomiting is experienced. The medication is not recommended for patients with a history of gastrointestinal disease. The prescription advises that tenoxicam is to be taken "once daily with food".

During one of Mr A's consultations in 2002, he told Dr C that tenoxicam was helping his arthritis. Dr C said that he reinforced to Mr A the need to continue taking ranitidine with tenoxicam. There is no record of a discussion about the risks of taking tenoxicam in Mr A's notes.

General blood screening was also done on 14 June 2002 but was not repeated thereafter.

March to October 2004 — duodenal ulcers
Mr A said that Dr C did not respond appropriately to signs that he was suffering from duodenal ulcers between March and October 2004.

This period of Mr A's care started when he consulted Dr C with nail-bed infections and an ulcer on the buttock on 9 March 2004. Dr C prescribed the antibiotic erythromycin. Dr C explained that Mr A had an allergy to penicillin, which prevented him from prescribing a penicillin-based antibiotic.

On 11 March 2004 Mr A returned to Dr C following an episode of haematemesis (vomiting blood). Dr C thought the vomiting could have been caused by erythromycin, which he stopped, replacing it with doxycycline. He also thought the blood may have been from an oesophageal tear, caused by forceful vomiting. Dr C replaced ranitidine with omeprazole (Losec)[1] 40 mg daily to reduce stomach acid production and to allow the tear to heal. Dr C said he considered sending Mr A for an endoscopy but decided to wait and see if he improved after the change in antibiotic. However, this treatment plan was not recorded in the notes and there is also no record of any abdominal examination.

Dr C said that he would usually advise a patient to see him again for follow-up if vomiting caused by an antibiotic did not settle. However, there is nothing in Mr A's clinical notes to suggest that this advice was given to him.

On 1 June 2004 Mr A saw Dr C because of anxiety. Mr A had suffered anxiety before and had been treated with diazepam (Valium). Dr C prescribed this again, together with an antidepressant (dothiepin). Mr A did not report any problems with his stomach at that consultation.

[1] Omeprazole decreases the amount of acid produced in the stomach and is used to treat symptoms of gastro-oesophageal reflux disease.

On 21 August 2004 Mr A saw another doctor at the medical centre, Dr E, because he had coughed up "a bit of blood" and complained of fever during the night. Dr E prescribed doxycycline for a suspected chest infection and noted that Mr A had an appointment to see Dr C the following "Tuesday".[2] However, Mr A did not attend that appointment as he was admitted to hospital with suspected pneumonia.

Mr A arrived at the hospital Emergency Department at 7.00am on 23 August 2004 after he had collapsed following another bout of vomiting old blood (which he described as being like "coffee grounds"). It was thought that Mr A might have a chest infection and had vomited blood that he had swallowed. The second diagnosis considered was that the blood was from a small tear in his gullet (a Malloy-Weiss tear, an oesophageal tear caused by vomiting). It was decided to admit Mr A to hospital for observation under the care of physician Dr D.

The hospital notes confirm that Mr A had suffered long-term gastro-oesophageal reflux disease (heartburn) and query the possibility that he was suffering from a hiatus hernia. An endoscopy was recommended "to rule out other pathology".

Mr A was discharged on 24 August 2004 on his usual medications, bromocriptine and ranitidine. He was to have an endoscopy as an outpatient and be sent an appointment.

Mr A consulted Dr C a few days later on 27 August 2004 as he had recommenced vomiting. Dr C commenced omeprazole (for two weeks) and cyclizine for nausea, and stopped the tenoxicam. Dr C noted that Mr A was awaiting an outpatient appointment for a gastroscopy. He weighed 60kg. Mr A told Dr C that he was very anxious about "not being able to eat". There is no record of any abdominal examination at this consultation, and Mr A recalls that no abdominal examination was performed, even though he stressed that he was unable to eat.

Mr A said that whenever he attended the medical centre, he was asked to wait in a side room as he was "constantly on the verge of vomiting", and the staff at the clinic did not want him to disrupt other patients.

Mr A returned to see Dr C again on 31 August 2004. He had stopped vomiting since taking the cyclizine but was concerned about his loss of appetite, which had been plaguing him for some time. It was noted that Mr A now weighed 59kg, which meant he had lost 1kg in four days. Mr A was still coughing up sputum so was restarted on doxycycline. There is no record of any abdominal examination or any other tests being ordered at this consultation.

[2] In his complaint, Mr A alleged that Dr C should have referred him to hospital on 21 August 2004 but he was seen by Dr E that day.

Mr A saw Dr C again on 6 September when he recorded "looks much better than last week. Needs more pills. Still coughing. More doxycycline". Tenoxicam was also prescribed, 20mg daily for 90 days. There is no record of any abdominal examination at this consultation. Mr A still had not received an outpatient appointment at the hospital for a gastroscopy to determine the cause of his haematemesis.

On 1 October 2004, Dr C noted that Mr A still had some vomiting associated with coughing, and his weight was now 58kg. Dr C recorded a lump in the epigastrium and, as he considered that Mr A might have a hiatus hernia, he referred him to the Surgical Outpatient Clinic at the hospital. Doxycycline was prescribed.

Dr D performed Mr A's gastroscopy on 7 October 2004 (the report appears not to have arrived at the medical centre until 15 October 2004) and recorded his findings:

> "The oesophagus was unremarkable. A small hiatus hernia is present. The stomach showed no abnormality of fundus or body but in the antrum there were minor mucosal changes compatible with gastritis. The pylorus was unremarkable.
>
> The proximal duodenum showed quite intense duodenitis and kissing duodenal ulcers were found in the distal first part. Each approximately a cm in diameter.
>
> Biopsies were taken for assessment of Helicobacter. He has been started on treatment with Omeprazole 20mg and if Helicobacter is found to be present triple therapy will be required."

Mr A saw consultant general surgeon Dr I on 18 October 2004 as a result of Dr C's referral on 1 October 2004. Dr I did not find a hiatus hernia (a gastroscopy was not performed) but "a protruding xiphoid process", which means that the lower part of the sternum (breast bone) was sticking out. Dr I assumed that Mr A was Helicobacter positive because "he was receiving medical therapy against it".

On 26 October 2004, Dr C recorded in Mr A's notes after reportedly receiving a telephone call from Dr D:

> "Helicobacter wasn't found. Has stopped tenoxicam. Stay on omeprazole and perhaps lower the dose next time. Is eating small meals frequently."

Mr A believes the duodenal ulcers were caused by tenoxicam, and said that Dr C did not tell him of the effects of tenoxicam when he continued to prescribe it.

Dr C said:

> "It is my understanding that duodenal ulcers are usually caused by [helicobacter infection], rather than by the use of non-steroidal anti-inflammatory drugs such

> as tenoxicam. Tenoxicam and other similar medicines tend to cause irritation and ulceration of the stomach lining rather than that of the duodenum. I therefore submit that on the basis of a long period of time (over two years) on what appears to be a continuous intake of tenoxicam, [Mr A] did not develop any symptoms of gastric ulceration. He suddenly developed a duodenal ulcer which is, in my opinion, much more likely to have been caused by the helicobacter infection."

Dr C added that Mr A's weight remained stable over the following six months, although he did report some intermittent nausea. Dr C concluded that the treatment for duodenal ulceration (omeprazole) had therefore been effective. However, Mr A's records indicate that he received a lower than recommended dose of omeprazole for much of this period (discussed below).

December 2004–August 2005 — bowel tumour

Mr A complained that during 2005 Dr C failed to treat him appropriately. Mr A said that he consulted Dr C regularly with nausea, vomiting, loss of appetite and weight loss before he was finally taken to hospital by ambulance in August 2005 and diagnosed with a cancerous tumour in his bowel. Mr A said that Dr C should have investigated or admitted him to hospital earlier to determine a cause of his ongoing symptoms.

After the earlier diagnosis of duodenal ulcers, Dr D reviewed Mr A and informed Dr C in a letter dated 9 December 2004:

> "I saw [Mr A] in the medical clinic on 6 December. He had no continuing symptoms. He is still on Omeprazole but you have reduced the dose to 10mg daily. I guess the rationale for keeping him on Omeprazole is that he also takes bromocriptine which has listed as side effect peptic ulceration. It must be a very rare effect from Bromocriptine, but I guess it is worth covering. If one wants to use Omeprazole in the way that removes the risk of peptic ulceration, one really needs to use a 20mg dose however, since the dose response curve of Omeprazole is quite vertical, meaning that while full acid suppression is usually obtained by 20mg doses, 10mg doses will not suppress acid in a significant proportion of people at all.
>
> It is pleasing to hear that he is managing well without a non steroidal drug. Panadol and Paradex seem to work satisfactorily for him. The one musculoskeletal symptom that he does find troublesome is low back pain, which he treats with heat especially.
>
> Given that he is not requiring non steroid drugs, I do not think gastroscopy needs to be repeated. One can reasonably assume that his ulcers are healed.

> While on Bromocriptine, it is erring on the side of prudence to give him Omeprazole, but a 20mg dose would be recommended for that purpose.
>
> I have not arranged to see him further."

This letter was received at the medical centre on 20 December 2004. However, it appears not to have been included in Mr A's records.

On 23 December 2004 Dr C received and read Dr D's letter. Dr C recorded Dr D's suggestion of a 20mg dose of omeprazole in Mr A's clinical record but did not alter the dosage (from 10mg to 20mg) on the computerised list of Mr A's medication.

On 25 January 2005 Mr A called at the medical centre for repeats of his medications. The prescriptions were taken from the computer by practice nurse Ms G and signed by Dr H. Mr A was incorrectly prescribed omeprazole 10mg daily instead of 20mg daily. Dr C said that "[Ms G] and [Dr H] were probably unaware of [Dr D's] letter and may not have seen the note I made in the records about the increased dose of omeprazole".

The incorrect dose was repeated by Dr C when he saw Mr A on 29 March 2005. Dr C noted that Mr A was able to work part-time for 20 hours a week but reported being "still a bit nauseated in the mornings, eats small snacks during the day rather than large meals". Mr A had lost another 1kg, and now weighed 57kg. No abdominal examination is recorded.

Dr C reported:

> "It appears from the notes that [Mr A's] doze of omeprazole was lowered from 20mg to 10mg on 29 March 2005. I had earlier recorded in the notes [Dr D's] recommendation that the omeprazole be kept at a dose of 20mg, but this needed to be balanced with minimising the dosage of medication I was prescribing. Whether I overlooked this advice or after review and discussion reduced the dose to holistically reduce his medication load is something I cannot say with certainty.
>
> In such situation I always consult Mims, I therefore think it is relevant to note that in the MIMS New Ethicals Catalogue, three of the first five listed side effects of omeprazole are nausea, vomiting and abdominal pain. Reducing the dose of omeprazole seems most likely to be a decision made in order to avoid these side effects."

The medical centre provided the following explanation of its investigation into how Mr A's medical error occurred.

> "You have asked the medical centre to explain how the error occurred in prescribing Omeprazole. [The medical centre] understands that [Dr C] has advised HDC that the error resulted from an oversight on his part."

Mr A consulted Dr C again on 4 May 2005. He still had some epigastric discomfort and nausea, which Dr C attributed to the ulcer problem and thought might also be stress related, as Mr A was ceasing employment. Dr C decided that if Mr A's discomfort and nausea continued at the next consultation he would refer him for another gastroscopy. Dr C changed the omeprazole prescription to 20mg daily but there is no explanation recorded for the change in dose, nor is any abdominal examination recorded. Mr A attended the surgery on 30 May and 25 July for repeat prescriptions.

On 26 July, Dr C saw Mr A again. He was very nauseated and had vomited during the previous evening. Dr C saw Mr A in the treatment bay and did not have access to his notes. Dr C confirmed that a detailed examination was not performed. Mr A told Dr C that he wanted to recommence cyclizine.

On 8 August, Mr A saw Dr C again. He reported vomiting for the past two nights. Dr C said he checked Mr A's history, weight, temperature, blood pressure and pulse, looking for signs of dehydration. However, there is no record of an abdominal examination. Dr C wrote: "Note this is a side effect of bromocriptine. Bowels movement normal today". His weight was 56kg and he had a dry mouth. Dr C stopped the bromocriptine and commenced Stemetil (an anti-nausea medication).

On 12 August, Mr A saw Dr C. Mr A had continued to vomit, and the frequency had increased over the previous two nights. He now weighed 55kg and was able to eat only crackers, baby food and soup. Dr C checked Mr A's pulse, weight, and the dryness in his mouth, and auscultated his lung fields, but did not examine his abdomen.

When Dr C suggested referring Mr A to hospital to investigate the nausea and vomiting he declined. Dr C said that, if he recalls correctly, he received a telephone call from Mr A's daughter, Ms B, to ask him to consider admitting her father for investigation. She said that Dr C told her he had suggested a hospital referral to Mr A but he had declined. Ms B said she replied that if Dr C wrote the referral she would ensure her father attended. She did not hear back from Dr C.

On 16 August, Mr A saw another doctor at the medical centre, Dr F. On examination Dr F found that Mr A's stomach was swollen and he had an enlarged liver. Dr F noted that Mr A's vomiting had persisted, he had not had a bowel movement for seven days, and he had yellow discolouration of his skin and cornea. Dr F referred Mr A for an ultrasound and suggested that a referral to Dr D could be a possibility. In his response to this investigation, Dr C noted that Dr F did not recommend hospital admission.

Mr A noted that he wanted to be admitted to hospital after the consultation with Dr F. He rang his sister who telephoned the clinic on 19 August, to ask Dr C to refer Mr A to hospital. The call was taken by Ms G, who recorded: "[Dr C] advised Ambulance call."

That afternoon Mr A deteriorated and was taken to Hospital by ambulance. He arrived at the Emergency Department at about 2pm. Mr A's ambulance note included the following description of his condition:

> "CHIEF COMPLAINT: Painful abdomen — dehydration
>
> HISTORY (INCLUDE SPECIFIC OBSERVATIONS): Pt been unwell for several months — not eaten properly for 3 weeks — has been drinking water. Constant retching & passing very dark urine but normal bowel motions
>
> o/a Pt extremely emaciated but swollen painful abdomen. Tender liver ?tumour
>
> Saw [Dr F] on Tuesday — organised blood tests and an ultrasound — Has been seeing [Dr C] for several months — given medication for stomach ulcers but no follow-up on his swollen abdo & nausea. Brother died of pancreatic CA aged 41."

The doctor who admitted Mr A to hospital noted his weight loss and could see peristaltic bowel movement (sign of bowel obstruction) across the abdomen. A diagnosis of a small bowel obstruction was made and Mr A was taken to theatre that afternoon, where a 40mm tumour was removed from his colon (Hartman's procedure), and a colostomy formed. On 29 August, Mr A's family informed Dr C that Mr A had been diagnosed with cancer of the colon.

Mr A was discharged from hospital on 6 September 2005.

Subsequent events

Mr A described this period as having a major effect on his life. He experienced significant nerve damage following the operation to remove the cancerous tumour in August 2005 and required the use of a colostomy bag for almost a year. Mr A lives with the fear that the cancer will return.

After Dr C learned of Mr A's diagnosis he revisited the medical history and reported:

> "I have reviewed his notes very carefully and, knowing his diagnosis as I do, it is possible that [Mr A] could have been referred to hospital at an earlier time. He was, as my notes show, also being cared for by a very experienced physician at [Hospital], from the October to December time period in 2004.
>
> At the relevant time, I assumed that a lot of his symptoms were due to his significant previous gastro-intestinal problem. In this respect, and having

> reviewed my notes, I wish that I had been more assertive in managing his illness."

Dr C also discussed this case with his supervisor, Dr J, and his peer review group.

> "Internal or peer review or investigation of this matter includes discussion with my peer group and my supervisor, [Dr J]. No detailed notes have been made of this conversation. In light of the current investigation by your office, I have put all other planned reviews on hold for now.
>
> I am not a member of any professional College; I am a member of the NZ Medical Association.
>
> Since this incident I have discussed and presented this case to colleagues with emphasis on what can be learned, discussions have included assertiveness in managing patients who the doctor feels should be urgently investigated, when symptoms fail to resolve rethinking the working diagnosis from first principles even when there is confirmatory specialist opinion, referral of patients to a general practitioner colleague when there is failure to improve so the patient can benefit from a fresh review."

Supervision

Dr C is not vocationally registered as a general practitioner. It is a Medical Council of New Zealand requirement that any doctor not vocationally registered be supervised.

Dr J is Dr C's supervisor and has been supervising him since 2004. Dr J advised me that he has face-to-face meetings with Dr C monthly, for about half an hour. They discuss issues of patient management, time management and philosophical issues pertinent to general practice, principally ethics. Dr C also has the benefit of monthly peer group meetings with the other nine doctors in the practice, where attendance is compulsory and the meeting lasts an hour. The practice also reviews its systems frequently, and Dr C is a part of that review process.

Dr C is undertaking the New Zealand College of General Practitioners Fellowship examinations.

The medical centre advised me of the steps it has taken to ensure the ongoing competence of its partners, in particular:

> "[T]he GPs meet on a regular basis for business and clinical issues where the main objective of the clinical meeting is to improve the quality of care provided to patients and to provide clinical leadership to the practice. The practice achieved Accreditation in 2006. The GPs formed and registered a peer group with the College. The peer review group has met regularly."

The Medical Centre — accreditation
Part of my investigation included the systems that were in place at the medical centre for recording patient information. The medical centre advised:

> "In response to the first issue on what systems we have put in place to ensure we deliver a high standard of health care.
>
> Our practice made a commitment early in 2005 to achieve accreditation with the Royal New Zealand College of General Practitioners. This programme was entitled '*Aiming for Excellence — Cornerstone*'.
>
> This decision arose in our Strategic Planning cycle early in 2005 where we committed to Practice Accreditation:
>
> '*Accreditation is a self assessment and external peer review process used by health care organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health care system.'*
>
> [The medical centre] achieved Cornerstone accreditation two years later in November 2006.
>
> I am sure the office of the HDC will be aware of the details of the Cornerstone programme but for full information all the indicators can be found on the website of the College at http://www.rnzcgp.org.nz/. Achieving certification demonstrates a practice's commitment to their patients by meeting legal and safety standards as well as the standards set by the profession.
>
> Issues around patient confidentiality and the retrieval of patient notes are a performance indicator on the Cornerstone programme. This has led to the appointment of a Privacy Officer in the practice as well as a specialised role in the mail room which deals specifically with the handling, storage and retrieval of patient information and patient notes.
>
> Arising out of the Cornerstone programme [the medical centre] initiated a review of nursing services in 2005. This review led to the appointment of a fulltime permanent Manager: Nursing Services. A key role assigned to the Nursing Services Manager is to follow up all critical incidents which occur in the day to day running of the practice. These critical incidents are dealt with following the processes and procedures which were developed through the Cornerstone programme.

The dispensing of an incorrect dose of medication would today be formally followed up and reviewed through our critical incident programme under the leadership of our nurse manager in conjunction with the relevant clinician."

Responses to Provisional Opinion

Dr C did not respond to my provisional opinion.

Independent advice to Commissioner

Expert advice was sought from general practitioners Dr Stuart Tiller and Dr Caroline Corkill.

Dr Tiller
Dr Tiller provided expert advice on 7 September 2006 as follows:

"1. At the time of the first presentation by [Mr A] to [Dr C] in January 2001, it was recorded that he was taking bromocriptine for 'pituitary problems' and long term ranitidine, but no explanation of the need for ranitidine was recorded. There appears to have been no attempt to obtain the former medical records relating to these and other conditions from [the former general practitioner]. This would be a standard procedure in any general practice in New Zealand, particularly where there had been significant findings in relation to pituitary and upper gastrointestinal complaints requiring long term treatment. When a doctor from [the Hospital] phoned the practice nurse at the time of the admission in August 2004, the nurse could not find any information to explain the nature of the 'pituitary problem'.

2. At the time of this initial consultation with a new patient transferring into his practice, [Dr C] did not order any baseline blood tests other than a prolactin level to monitor the 'pituitary dysfunction'. It would be standard practice, especially if the old notes were not available, to request base line assays of blood count, thyroid function, liver and renal function and a urine test for a man of the age of [Mr A] who was aged 60 years at that time.

3. At the time of the second consultation [Mr A] described back pain resulting from a lumbar disc that was said to be 'inoperable'. [Mr A] had continuous back pain since and required regular analgesia, paradex tablets taken as two

tablets three times a day. The old medical records should have been requested for this condition also to establish the exact nature of the problem and any specialist recommendations given in the past.

4. On 18 December 2001 [Dr C] prescribed long term tenoxicam for presumed arthritis of the wrists and neck. [Mr A] was already taking long term ranitidine twice daily for an unknown condition. Ranitidine is usually prescribed for relief of gastro-oesophageal reflux or peptic ulcer disease. If a non-steroidal anti-inflammatory was to be added it was necessary to ascertain the reason for long term ranitidine and to warn [Mr A] of the risk of aggravation of pre-existing gastric conditions by this medication. He should have been warned to stop the tenoxicam at the first sign of any gastric symptoms. Such advice should be documented in the clinical notes. None of these actions were documented.

5. On 11 March 2004 [Mr A] had vomited blood. On 27 August 2004 [Mr A] was vomiting++ following his discharge from hospital after haematemesis. On 31 August 2004 [Mr A] had stopped vomiting but 'hasn't eaten much yet for 2 weeks'. He had lost 1kg in weight in four days. [Dr C] made no attempt to contact the hospital to advise them of the deteriorating state of his patient in order to request more urgency for the awaited gastroscopy. At none of these presentations did [Dr C] examine the abdomen of his patient or order blood tests to check electrolyte status or renal and liver function. Vomiting is a symptom and the underlying cause needs to be determined. [Dr C] took no action other than to wait for the gastroscopy. There is nothing in his notes that indicates that he made any effort to determine how long the wait would be for this important investigation while in the meantime his patient was deteriorating and losing weight. An abdominal examination was mandatory in my opinion.

6. On 6 September 2004, tenoxicam 20mg daily was prescribed for 90 days supply. This was within 2 weeks of the discharge of [Mr A] from hospital after an episode of acute haematemesis and before a gastroscopy had been done to determine the presence, or otherwise, of active peptic ulcer disease.

7. On 23 December 2004 [Dr C] made an entry into his notes that [Dr D] had suggested that [Mr A] be prescribed omeprazole 20mg daily for his duodenal ulceration. At the next consultation on 29 March 2005, [Dr C] prescribed omeprazole in daily dosage of 10mg despite his earlier documentation of the recommended dosage of 20mg.

8. It is noted that general blood screening was done on 14 June 2002 but was never repeated thereafter.

9. Leading up to the hospital admission in August 2005 when an obstructing bowel tumour was diagnosed, [Mr A] was seen on 26 July 2005, 8 August

and 12 August with vomiting, weight loss and poor appetite. On none of these occasions was there documentation of any examination of the abdomen. When [Mr A] presented to [Dr F] on 16 August he correctly examined the abdomen and identified an enlarged liver and discolouration of the eyes suggestive of jaundice. [Dr F] ordered investigations."

In a letter dated 26 October 2006, as part of his response to my investigation, [Dr C] explained the care he had provided to [Mr A]. Dr Tiller addressed [Dr C's] responses in his advice:

"1. A Mallory Weiss oesophageal tear from forceful vomiting was a reasonable provisional diagnosis to make. [Dr C] has pointed out that this was the provisional working diagnosis at [the Hospital] also. But [Dr D], the gastroenterologist, recognised the need to also order an outpatient upper GI endoscopy in order to rule out ulcer disease. It is common in general practice to commence treatment empirically while awaiting definitive investigations that may be subject to waiting time delay. It was necessary in the meantime for all involved, including the general practitioner [Dr C], to remember that the diagnosis of Mallory Weiss tear was provisional and other alternative diagnoses needed to be kept in mind. In the case of [Mr A] he was subsequently found to have duodenal ulcer disease. [Dr C] had prescribed three concurrent medications with potential to cause gastric irritation, namely Bromocriptine, Tenoxicam and Erythromycin. Ulcer disease was a possible differential diagnosis despite the long-term ranitidine for gastric acid suppression.

2. [Dr C] did document on 26/10/04 that the helicobacter pylori result was negative. The responsibility to follow-up with triple therapy was his responsibility as the general practitioner, but the negative result eliminated the need for triple therapy treatment.

3. [Dr C] has advised that he had formed the view regarding the vomiting between March and August 2004 that this had resulted from the antibiotic treatment. He has advised that 'my normal practice would be to advise the patient that if vomiting did not settle then they should present again for follow-up'. There is no documentation of any such advice given during this time period. Further, of more concern in my opinion, was his failure to ever examine the abdomen at any of the five consultations during this time. Vomiting is a symptom, not a diagnosis and the reasonable clinical evaluation of a vomiting patient should include an abdominal examination. This failure to examine the abdomen was the most significant clinical omission by [Dr C] in my opinion.

4. [Dr C] never documented consideration of a referral for endoscopy in his notes during this period of March to August 2004. It is necessary to

document such possible future plans for the benefit of any other doctors who might see the patient in the absence of the usual doctor.

5. See point one above.
6. In the context of the information we have, the symptoms of vomiting and abdominal pain had antedated the prescription of omeprazole. It was unlikely that omeprazole was the cause of the symptoms. A Pharmaceutical text, New Ethicals Compendium of 2000, states that 'Omeprazole is well tolerated and adverse reactions have generally been mild and reversible'. 'Abdominal pain and nausea/vomiting' are listed as adverse events in clinical trials or routine use, 'but in many cases a relationship to treatment with omeprazole has not been established'.
7. It is my opinion that if a patient resists admission that it is the responsibility of the concerned clinician to emphasise and explain the reasons for the recommended admission and likely sequelae of delayed treatment. If in the face of full explanation, a patient still resists the recommended hospital admission then this should be documented. It would be appropriate to seek the help of family members in encouraging the patient to agree to admission, or at least assessment in the emergency department.
8. It is my opinion that all three presentations on 26 July, 8 August and 12 August 2005, necessitated an abdominal examination. [Mr A] was nauseated and vomiting and eating very little. Such symptoms always necessitate an abdominal examination amongst other assessments."

Dr Tiller concluded:

> "It is my opinion that the standard of care provided by [Dr C] was deficient over a sustained period of time. During two periods of ill health with nausea, vomiting, abdominal pain, and weight loss between March and August 2004 and again between July and August 2005, [Dr C] failed to carry out an adequate physical examination of his patient by omitting to examine the abdomen."

Dr Corkill

The following expert advice was obtained from independent general practitioner Dr Caroline Corkill:

> "Thank you for your request of the 17 November 2006 asking me to provide expert advice on the above case, reference 06/11343. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am a Vocationally Registered General Practitioner working in Invercargill. I have provided opinions for you in the past.

Expert Advice — answers to questions

1. What standards apply in this case?

In my opinion the main standard which applies in this case is that of 'Good medical practice'. The Medical Council of New Zealand says this involves a level of competence that is, 'reasonably to be expected of a health practitioner practising within that health practitioner's scope of practice'. [Dr C] is working in the scope of General Practice with General registration on the New Zealand Medical Register. This means he is obliged to work in a collegial relationship with another General Practitioner.

2. Did the care provided by [Dr C] meet those standards, particularly in relation to his examination/s, investigations and timeliness of treatment?

This answer is limited by the fact I base my judgement on the written evidence provided as listed above and that I was not present at the consultations to witness what actually happened. Some of the interactions between doctor and patient will not have been recorded.

On 9 March 2004 [Mr A] went to see [Dr C] for repeats of his regular medication, tenoxicam, ranitidine and bromocriptine. He was also noted to have an ulcer in his right buttock and was given antibiotics (erythromycin orally and topical bactroban) for a nail bed infection of two fingers. He had his weight and blood pressure recorded, his buttock and fingers examined, and was given the prescription. He was noted to have an allergy (wheezes) with penicillin. His prolactin level had been monitored less than 6 months previously and was consistent with what it had usually been over the preceding couple of years, although this level was lower than the normal range. This all seems appropriate.

Two days later [Mr A] reported vomiting blood in the toilet and [Dr C] assumed this was due to the Erythromycin causing vomiting, and the vomiting in turn causing a tear and some bleeding. Given the timing of this symptom I think this was a realistic assumption. Subsequent events do not show this was a mistaken diagnosis, but this was unlikely to be the whole story.

In my opinion, [Dr C's] decision to change the antibiotic to doxycycline and add a proton pump inhibitor (losec) to settle stomach acid, for a week, was reasonable. I think it is also reasonable to expect the patient to have returned or made contact if the stomach symptoms (bleeding, vomiting or pain) returned, and he did not. The next time he consulted [Dr C] was in June when stomach symptoms were not mentioned. He received his usual medications and discussed anxiety. His weight was down 1 kilogram at that time. It is appropriate to record weight in someone with anxiety and or stomach problems.

The next interaction [Mr A] had with the General Practitioners of [the medical centre] was on 21 August 2004 when he saw [Dr E], who diagnosed a chest infection and gave him doxycycline for that.

Two days later he was admitted to [Hospital] after collapsing following vomiting 'coffee grounds'. This is a term to describe how blood vomited from the stomach looks if it has been sitting in the stomach for a while before being vomited up. At this admission routine blood tests were done and a chest X-ray. The hospital staff thought [Mr A's] illness was predominantly a 'chest infection — likely viral', but did admit him under [Dr D] for one night. [Dr D] arranged to perform a gastroscopy as an outpatient, which suggests that he agreed with [Drs C and E] that at this stage there were no obvious clinical reasons to do this investigation any earlier. It is interesting to see that the hospital discharge summary about that admission appears to have been dictated on 09.09.04 and stamped on the 7 Oct 2004 which suggests to me it was not sent to the General Practitioners till that time. This seems a long delay for information to go from the hospital to the general practice.

[Mr A] went to see [Dr C] on 27 August 2004, when he presented with more vomiting since his discharge from hospital. I think it was appropriate to stop the tenoxicam (the hospital had stopped this but I do not think [Dr C] would have received the discharge summary at this point), add omeprazole (losec) and cyclizine. He records that [Mr A] was awaiting gastroscopy as an outpatient. This was the appropriate next test and the fact that he was waiting for one would have reassured [Dr C] that the hospital were following up on [Mr A] appropriately. [Mr A's] weight had dropped another 5 kilograms by this time. This was recorded in his notes. We do not know if [Dr C] examined [Mr A's] abdomen this day because it is not recorded. In retrospect it would have been a good idea, but [Dr C] may have assumed that several doctors at the hospital had done this three days earlier and felt it was unnecessary. I think that was reasonable.

31 August 2004 [Dr C] saw [Mr A] again with loss of appetite. Apparently he had stopped vomiting but was not eating. [Dr C] gave him more cyclizine to keep the vomiting under control and seems to have diagnosed a chest infection on the basis of the history of coughing up 'custard-like sputum'. There is no record of his examining [Mr A's] chest or abdomen. He may or may not have. Making a diagnosis of chest infection on the basis of sputum as described is reasonable but it would have been better practice to record examination findings. Again [Mr A's] weight was noted and recorded and Ensure Plus was started to help him gain weight.

He was seen again a week later (6 September 04) for more pills and was given more doxycycline for the chest infection and put back on tenoxicam for his arthritis. We do not know what cautions [Dr C] gave [Mr A] about taking tenoxicam as there is no record of this. Most general practitioners would advise these tablets be taken with or after food, and should be stopped if the patient gets indigestion or any sign of bleeding from the stomach. It is more important that the GP does this than records it, so I think it is reasonable that it was not recorded, but we do not know whether this was discussed or not. The added problem here is that with hindsight we know that [Mr A] has irritation of his stomach and duodenum, but at this time he and [Dr C] do not. They think his recent vomiting of blood was from a Mallory Weiss tear, which does not carry any extra risk with use of nonsteroidal anti-inflammatories like tenoxicam.

On 1 October 2004 [Dr C] saw [Mr A] with a lump in his epigastrium. He noted he was still coughing and occasionally vomiting with coughing. He thought this was a hernia from the coughing and referred him to surgical outpatients at [the Hospital], noting that his gastroscopy was coming up soon.

He was seen for his gastroscopy on 7 October where he was found to have a small hiatus hernia, mild gastritis, intense duodenitis and 1 centimetre diameter 'kissing ulcers' of the duodenum. He was put back on omeprazole 20mg by the physician [Dr D].

He was seen at Surgical Outpatients on 18 October 2004 where it was noted he felt much better on omeprazole. His abdomen was examined and he was found to have a protruding xiphoid process and no abdominal wall hernia. The surgeon, [Dr I], thought [Mr A] was on medical therapy for helicobacter pylori so assumed he was positive for this organism. I think this was incorrect. [Mr A] was on the omeprazole (losec) for his gastritis and duodenal ulcers and doxycycline for his chest infection, not a deliberate combination of drugs to treat helicobacter. About this time, the result of the biopsies [Dr D] took when he was doing the gastroscopy became available. These showed [Mr A] did not have helicobacter.

On 26 October 2004 he was seen by [Dr C], who noted he was eating small meals frequently, that he had stopped the tenoxicam, and that his weight and blood pressure were stable. A disability allowance form was signed and they discussed lowering the dose of omeprazole. This is all quite reasonable in my view.

[Dr D] reviewed [Mr A] at Medical Outpatients on 6 December 2004. He wrote a letter about this consultation on 9 December in which he essentially said [Mr A] was much better, i.e. 'has no continuing symptoms', 'is managing well without a non steroidal drug', and 'I do not think gastroscopy needs to be

repeated'. He discussed the ongoing use of omeprazole, 'I guess the rationale for keeping him on omeprazole is that he also takes bromocriptine which has listed as a side effect peptic ulceration. It must be a very rare effect from bromocriptine, but I guess it is worth covering.' 'While on bromocriptine, it is erring on the side of prudence to give him omeprazole, but a 20mg dose would be recommended for that purpose.'

When he received this letter later in December [Dr C] put in [Mr A's] notes a comment to the effect that '[Dr D] suggests a 20mg dose of omeprazole.' I note that the next time [Mr A] gets a repeat prescription it is simply that, a repeat prescription without a consultation, and it was a nurse, [Ms G], who probably printed out the repeat prescription in the dose previously given and had it signed by [Dr H]. I think [Dr C's] actions in this sequence of events are reasonable.

29 March 2005, is the beginning of the second sequence of consultations and at that visit [Dr C] recorded that [Mr A] was still getting a bit of nausea, eating small snacks, and had lost another 1 kg. He noted this was a considerably slower rate of weight loss and saw it as a good thing rather than as a warning that [Mr A's] health was deteriorating. He unfortunately missed his previous note to increase the dose of omeprazole and kept it at 10mgs a day. He did not record examining his abdomen but did record regular blood pressure and weight which indicates some level of examination took place.

On 4 May 2005, [Mr A] complained of epigastric discomfort and nausea still and his omeprazole was increased to 20 mg daily again and his paradex changed to panadeine. [Dr C] notes in the record that 'If still getting GI problems at next visit consider referral for gastroscopy'.

[Mr A] was seen in the treatment area by the nurse on 26 July after vomiting all night. Parallels were drawn between how he had similar symptoms a year earlier when cyclizine helped his nausea and vomiting and his duodenal ulcers were diagnosed. It is unfortunate that [Dr C] did not check his own recommendation in the notes from his previous consultation at this point. It is an easy trap to fall into when seeing a patient away from the computer where the notes are held. It was reasonable to try cyclizine when both [Mr A] and [Dr C] thought it had helped the previous year.

On 8 August 2005, [Mr A] presented having been vomiting for the past two nights again. [Dr C] seems to have thought this might be due to the bromocriptine and suggested stopping it. He made some enquiries about [Mr A's] bowel habit and on the basis of a normal motion that day did not record any further history taking along that line of possible diagnosis. It would have been appropriate, I think, to enquire about blood, mucous, blood in the

vomit again and record something about those possible symptoms. As I noted earlier, he may have asked about these things without recording them so I am not sure if he did or not. It would have also been good to have some more examination findings in the notes to indicate whether he had examined [Mr A's] gastro-intestinal system any further, in particular whether his tongue was dry or coated, presence or not of jaundice, whether his abdomen was tender, etc.

On 12 August, [Dr C] saw [Mr A] again and wanted to admit him but, according to the notes, this was declined by [Mr A]. This may have avoided the distress of the next few days, but I think [Dr C] was right in suggesting admission at this point and also right not to force the issue.

On 16 August, he saw [Dr F] as he was still vomiting. [Dr F] recorded some abdominal findings which makes it easier to see what he checked. We do not know if these signs had just developed over the preceding few days, or over a longer period, because of the absence of examination details in the previous notes. It is possible they had just developed and that is why [Dr F] recorded them and [Dr C] did not. It is interesting that [Dr F] also chose further tests as an outpatient at this stage (blood tests and abdominal ultrasound) rather than admission. This suggests to me that the development of 'emaciation' and 'dehydration', noted by the ambulance officer on the 19th, became much worse over these last few days prior to admission. I note in his history on admission he said he had had rigors and fevers on and off for the past ten days. We do not know if he would have mentioned these or was asked about them on the 12th or 16th of August.

On 19 August he was admitted to hospital and a carcinoma of the bowel was diagnosed.

3. Should [Dr C] have taken steps to obtain [Mr A's] medical records from his previous GP?

I think the answer to this question is 'probably, but it was not essential'. Some doctors take more notice of previous doctors' opinions than others. Some patients are not keen for their old notes to follow them. Some doctors are poor at sending records on even if asked. I cannot tell from the records provided whether [Dr C] did attempt to obtain [Mr A's] old notes or not.

4. Was [Dr C's] management of [Mr A's] medication regime appropriate? Please explain.

I have discussed [Dr C's] management of [Mr A's] medication in chronological order in my answer to question 2. The issues with medication as I see them are:

(a) His use of a non steroidal medication in someone with a history of stomach irritation. When [Mr A] joined [Dr C's] practice in 2001 he was taking ranitidine which is a medication to reduce stomach acid. This suggests that [Mr A] had a history of indigestion or something similar. Using any non steroidal medication in someone like this needs care and explanation. Tenoxicam is the non steroidal medication which [Dr C] uses for [Mr A] and it should have been used with care and [Mr A] should have been cautioned on its use. There is no evidence of this, but neither is there evidence that it was being used too freely. It was stopped when the diagnosis of gastritis, duodenitis and ulcers was made, but restarted when [Mr A] had pain. I think you would find some general practitioners would say he should not have had this drug given his history, and others who might also have used it in the same circumstances. My view is [Dr C] should have considered using one of the non steroidals of lesser strength e.g. ibuprofen or naproxen. (Refer to NZ Guidelines Group 'Management of Dyspepsia and Heartburn' 2004) after the gastroscopy. He may have considered this, and he may have discussed this with [Mr A], but we do not know.

(b) The use of 10 mg omeprazole when [Dr D] had suggested using 20mg. I think this was simply a mistake, twice. Firstly when [Ms G] printed the script and had another doctor sign it. Secondly when [Dr C] gave 10mg the next time he saw [Mr A]. [Dr D] does say that using omeprazole to protect against peptic ulcer disease from bromocriptine is 'erring on the side of prudence' so I do not think this is a major issue.

(c) The continued use of doxycycline without a firm diagnosis of chest infection is a bit vague but again, not a major problem in my opinion.

(d) The use of combination of bromocriptine, erythromycin and tenoxicam together with ranitidine I do not see as a problem. [Mr A] may have been at risk of having helicobacter infection but did not have it. The increased risk of these medications together is roughly the same as the risk of using tenoxicam in someone with stomach problems, that is, an increased risk of peptic ulcer disease, not an increased risk of bowel cancer.

(e) Avoiding use of medication to which [Mr A] is allergic. This seems appropriately recorded and referred to. [Dr C] has recorded penicillin allergy and what sort of allergic reaction [Mr A] had (wheeze), erythromycin reaction (vomiting) and avoided these appropriately. Perhaps tenoxicam or non steroidals should have been added to his list of medication alerts after the diagnosis of gastritis and duodenitis.

5. In relation to this medication, what particular instructions, if any, should [Dr C] have given [Mr A] about the side-effects or drug interactions?

Tenoxicam is a reasonably potent nonsteroidal anti-inflammatory and when [Dr C] prescribed it for [Mr A] he should have advised him that it was capable of inflaming his stomach, to take it with or after food and to be careful if it gave him indigestion. That is if it upset his stomach he should cease taking it or get in touch with [Dr C].

I do not think [Dr C] would expect to discuss the bromocriptine with him as he had been taking it for years with little or no problems. It was quite possible that it exacerbated the nausea with the erythromycin but erythromycin can cause nausea on its own account. Similarly it can cause peptic ulcer disease but is less risky for that than the non steroidals.

Many antibiotics, like erythromycin and doxycycline, can upset bowels with vomiting and/or diarrhoea. Doctors should warn people about this, but sometimes forget as they are used so frequently. Pharmacists play a part in giving advice about medication and tend to reinforce warnings to people when side effects or interactions are common or potentially serious.

Summary

In my answers above I believe [Dr C's] care of [Mr A] at the time it was given was of an appropriate standard. The two main areas of weakness in the care provided seem to me to be (1) more caution should have been used in the prescription of tenoxicam after the gastroscopy showed there was gastritis and duodenal inflammation and (2) it would have been good from my point of view to see more examination findings recorded in the notes overall. These weaknesses did not appear to me to be at a level suggesting substandard care."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

…

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

RIGHT 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —

(a) An explanation of his or her condition; and

(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Other relevant standards

The Medical Council of New Zealand (the Medical Council) issues statements and guidelines to assist doctors in meeting professional standards. The Medical Council's 'Statement on the Maintenance and Retention of Patient Records' states:

> "Information should be accurate and updated at each consultation. Patient records are essential to guide future management, an invaluable in the uncommon occasions when the outcome is unsatisfactory."

There are two relevant professional standards for medical centres in relation to managing patient health records — the Royal New Zealand College of General Practitioners' publication, *Aiming for Excellence* and NZS 8153:2002, *New Zealand Standard Health Records*.

Aiming for Excellence sets out the criteria that must be met by a practice before it can achieve Cornerstone accreditation. I note that the medical centre was accredited as a practice in November 2006. It will therefore have been assessed as meeting these criteria before accreditation was awarded.

In *Aiming for Excellence*, Section D sets out the essential elements for a patient's health record. This includes a current medications list. Referrals and responses must also be easily accessible in clinical records. Indicator D.8.2 states that a medical

practice must have "a system to manage patient test results and medical reports". To meet this standard, a medical centre is expected to ensure:

- There are procedures to ensure that all incoming medical reports are seen and actioned by the appropriate member of the practice team who requested these or a designated deputy.
- There are procedures to track and manage patient test results, medical reports, investigations and follow-up missing reports.

NZS 8153:2002, *New Zealand Standard Health Records* gives broad guidance on the minimum requirements for health records. Standard 1 reinforces the importance of accuracy and requires the documentation of each consultation. Standard 2 requires the organisation to have a clearly documented policy on the structure of health records and sets out the key components for what should be included. Standard 4 requires the organisation to maintain "a brief summary of all key health information" at the front of the active health record. This must be readily available, up-to-date and should clearly identify:

a) Active problems/conditions:
   i. Major allergies and/or sensitivities
   ii. Serious and/or sentinel events
   iii. Major diagnoses/problems
   iv. Salient current treatment
   v. Significant social/lifestyle clinical risks
   vi. Other significant risks
   vii. Advance directives

b) Key historical information
   i. Resolved diagnoses of importance
   ii. Previous treatments of importance
   iii. Major operative and non-operative procedures
   iv. Immunisation status.

Standard 4.1.3 states that "all significant health-related information shall be promptly added to the summary by the health professional currently responsible for the care of the consumer/patient".

Opinion: Breach — Dr C

Mr A's complaint against Dr C mainly relates to two periods: March to August 2004, when he was diagnosed with duodenal ulcers, and December 2004 to August 2005, when he was found to have a cancerous tumour of the colon.

Mr A believes that Dr C did not treat him appropriately because he prescribed medications likely to exacerbate his duodenal ulcers and did not explain the risks associated with those medications. Furthermore, Dr C did not refer him for any investigations in an attempt to find the cause of his ongoing gastrointestinal problems.

Mr A believes Dr C's failure to do so meant that the cancerous tumour in his colon was not found sooner. He experienced significant nerve damage following the operation to remove the cancerous tumour in August 2005 and required the use of a colostomy bag for almost a year. Mr A lives with the fear that the cancer will return.

It is difficult to say, with any certainty, that Mr A's cancerous tumour would have been diagnosed earlier if Dr C's care had been more proactive. There is certainly no clinical evidence to suggest that a tumour in the colon should have been obvious to Dr C prior to August 2005. I am, however, concerned that Dr C did not take more action to investigate the escalating nature of Mr A's symptoms during 2004 and 2005. As his general practitioner, Dr C needed to consider the underlying causes of Mr A's symptoms, rather than treating each issue in isolation.

In my opinion, Dr C did not provide services in a manner that minimised harm to Mr A. His overall management fell short of the standard of care expected of a general practitioner. He also provided Mr A with insufficient information about the risks associated with the medicines he prescribed, made an error in his prescription of omeprazole, and did not keep detailed notes of his consultations. Dr C has therefore breached Rights 4(1), 4(2), 4(4) and 6(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

The reasons for my decision are detailed below.

Diagnosis of duodenal ulcers 2004

Mr A was diagnosed with duodenal ulcers in October 2004, after three months of vomiting, nausea and weight loss. The key issues in relation to Dr C's care during this period are whether he gave adequate consideration to the possible causes for Mr A's symptoms and whether he managed Mr A's deteriorating condition appropriately.

When Mr A first saw Dr C in January 2001, he had been taking bromocriptine for several years. Bromocriptine is known to cause gastric irritation and is usually prescribed in conjunction with ranitidine to guard against peptic ulceration. In December 2001, Dr C decided to prescribe tenoxicam to treat Mr A's arthritis. Tenoxicam is also a known gastric irritant. Finally, on 9 March 2004, Dr C prescribed a third medication that had the potential to cause gastric irritation — erythromycin. Dr C decided to use this antibiotic to treat Mr A's nail bed infection because Mr A had an allergy to other penicillin-based antibiotics.

Mr A returned to see Dr C a few days after he had started taking erythromycin because he had been vomiting blood. Dr C suspected the vomiting had been caused by the erythromycin and prescribed another antibiotic, doxycycline. However, Dr C did not physically examine Mr A's abdomen and there is no record of Dr C giving Mr A advice on what he should do if the vomiting continued.

Mr A's gastric upset did improve for a period but he began to vomit blood again in August 2004. This was thought to be associated with a possible chest infection and Mr A was admitted to hospital with pneumonia a few days later. The differential diagnosis from the hospital was that Mr A had suffered a small tear in his gullet from forceful vomiting. However, the notes also confirmed that Mr A had suffered long-term gastro-oesophageal reflux disease (heartburn) and queried the possibility that he was suffering from a hiatus hernia. An endoscopy was recommended "to rule out other pathology".

Mr A's vomiting, weight loss and nausea continued after he was discharged from hospital. Dr C saw him on 27 August, 31 August and 6 September 2004 while Mr A was awaiting his endoscopy at hospital. Dr C continued to treat Mr A's escalating symptoms by prescribing anti-nausea medication and antibiotics. There is no record of any abdominal examinations, blood tests or referrals for further investigations during this period.

At a consultation on 1 October 2004, Dr C referred Mr A to hospital for investigation of a possible hernia but, again, did not adequately document his findings.

Dr D performed Mr A's gastroscopy on 7 October 2004 and diagnosed "intense" duodenitis. He also took a biopsy to test for Helicobacter, a common infection. However, this test was confirmed as being negative on 26 October 2004.

Mr A believes the duodenal ulcers were caused by the medications that were prescribed by Dr C. Dr C said that medications tend to irritate the stomach lining, rather than the duodenum, and that duodenal ulcers are usually caused by a Helicobacter infection. However, I note that Mr A tested negative for Helicobacter.

My expert advisor, Dr Corkill, considered that Dr C's approach to Mr A's treatment was reasonable during August, September and October 2004 as he was guided by the provisional diagnosis of an oesophageal tear and reassured that Mr A's symptoms would be followed up with an endoscopy. Dr Corkill noted that Dr D's decision to refer Mr A for an endoscopy as an outpatient on 24 August 2004 confirmed that Mr A's symptoms did not warrant urgent investigation at that time.

Dr Tiller advised that a Mallory Weiss oesophageal tear from forceful vomiting was a reasonable provisional diagnosis to make but noted that a general practitioner should also "commence treatment empirically while awaiting definitive investigations that may

be subject to delay". Dr Tiller said that other diagnoses needed to be kept in mind and noted that Dr C had prescribed three concurrent medications with potential to cause gastric irritation, namely bromocriptine, tenoxicam and erythromycin. Ulcer disease was therefore a possible differential diagnosis, despite the long-term ranitidine for gastric acid suppression.

Dr Tiller noted that Dr C did not conduct an abdominal examination during August, September and October 2004, when Mr A's symptoms remained unexplained. Dr Tiller stated:

> "Vomiting is a symptom, not a diagnosis and the reasonable clinical evaluation of a vomiting patient should include an abdominal examination. This failure to examine the abdomen was the most significant clinical omission by [Dr C] in my opinion."

Finally, Dr Tiller noted that Dr C did not order any blood tests or take any other action while Mr A was waiting for his endoscopy. Dr Tiller observed that "there is nothing in his notes that indicates that he made any effort to determine how long the wait would be for this important investigation while in the meantime his patient was deteriorating and losing weight".

It is not unusual for me to receive conflicting advice during the investigation of a complaint. The legal principles that apply when I am considering such advice are well settled. For many years the English case of *Bolam*[3] was the leading decision on the standard of care expected of a medical practitioner. In that case, Justice McNair stated:

> "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in a particular art. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice merely because there is a body of opinion that takes a contrary view."

However, in the subsequent case of *Bolitho v City and Hackney HA*,[4] the House of Lords qualified the *Bolam* principle in the rare cases when professional opinion is not capable of withstanding logical analysis. The House of Lords held that a court is entitled to hold that a body of opinion is not reasonable or responsible if a standard practice is flawed or illogical.

The Code confirms that the Commissioner as decision-maker is expected to form an independent opinion on the reasonableness of the care provided. While I accept that

[3] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.
[4] [1998] AC 232.

there can often be a legitimate range of responsible opinion and practice, I am also conscious of my responsibility, as an independent guardian of patients' rights, to distinguish between mediocre and good practice.

Dr C appears to have treated Mr A symptomatically, even though his condition was deteriorating, because he was awaiting the further investigation of an endoscopy. This is a common approach by a general practitioner when a patient is waiting for further tests or procedures from secondary care.

However, as a general practitioner, Dr C had a responsibility to take a holistic approach to managing Mr A's deteriorating condition. I agree with Dr Tiller that, rather than just treating his symptoms, Dr C should have considered other causes for Mr A's continued vomiting and weight loss and, at the very least, carried out physical examinations of Mr A's abdomen. Dr D had recommended an outpatient endoscopy based on Mr A's condition during his hospital admission on 24 August 2004. However, that condition did not remain stable. Mr A continued to seek appointments with Dr C as his condition deteriorated. Dr C had a responsibility to notify Dr D of the change in circumstances and seek a more urgent endoscopy on Mr A's behalf.

I also accept Dr Tiller's advice that some consideration should have been given to the combined effect that bromocriptine, tenoxicam and erythromycin would have on a patient who had been using bromocriptine for many years. As Mr A's general practitioner, Dr C was in the best position to consider the overall impact that new medications could have on his condition. In Opinion 03HDC04996 (29 June 2004), I noted the caretaker role of a general practitioner:

> "A patient's regular general practitioner is best placed to maintain the most complete record of the health problems of an individual under his or her care and to understand the individual's personal circumstances. A primary health service such as a medical centre may be the only health service that knows about any departure from a patient's expected pattern of heath care."

Dr C did not maintain a holistic oversight of the symptoms Mr A was experiencing during 2004. An earlier or more urgent referral for an endoscopy could have occurred if Dr C had carried out basic physical examinations and remained alert to alternative causes for Mr A's symptoms. In my opinion Dr C's overall care of Mr A was not of an appropriate standard and was not provided in a manner that minimised the potential to harm or optimised the quality of Mr A's life. Accordingly, Dr C breached Rights 4(1) and 4(4) of the Code.

Information about medicines

When Mr A first developed nausea and vomiting in March 2004, he was taking three medications that had the potential to cause gastric irritation — bromocriptine, tenoxicam and erythromycin. Under Right 6(1) of the Code, every patient has the right

to the information that a reasonable patient, in that patient's circumstances, would expect to receive, including the expected risks, side effects, benefits, and costs of treatment. A practitioner therefore has a duty to explain the expected risks and side effects of medications that are prescribed.

Mr A was already taking bromocriptine when he transferred to Dr C's care. Dr C subsequently prescribed tenoxicam in January 2001 and erythromycin in March 2004. Mr A was concerned that Dr C did not tell him about the risks associated with these medications.

Dr Corkill advised that Dr C would not be expected to discuss the bromocriptine with Mr A as he had been taking it for years with little or no problems. Dr Corkill noted that it was quite possible that the bromocriptine with the erythromycin exacerbated the nausea, but that erythromycin can cause nausea on its own account. Dr Corkill stated:

> "Many antibiotics, like erythromycin and doxycycline, can upset bowels with vomiting and/or diarrhoea. Doctors should warn people about this, but sometimes forget as they are used so frequently. Pharmacists play a part in giving advice about medication and tend to reinforce warnings to people when side effects or interactions are common or potentially serious."

Dr C explained that he decided to use this antibiotic to treat the nail bed infection because Mr A had an allergy to other penicillin-based antibiotics. However, there is no evidence that Dr C provided Mr A with any information about the risks of taking three medications that had the propensity to cause gastric irritation.

Dr Corkill advised that tenoxicam is a potent non-steroidal anti-inflammatory and Dr C should have told Mr A that it was capable of inflaming his stomach, to take it with or after food, and to be careful if it gave him indigestion. Dr Corkill advised that Mr A should have been told to cease taking it or get in touch with Dr C if it upset his stomach.

Dr Tiller noted that when Dr C prescribed tenoxicam in 2001, Mr A was already taking long-term ranitidine and should have been warned of the risk that tenoxicam would aggravate pre-existing gastric conditions. There is no evidence that such warnings were given.

The 2001 prescription noted that tenoxicam was to be taken with food, and Dr C advised Mr A to make sure he continued to take ranitidine with tenoxicam. However, there is no evidence that Mr A was given any specific information about the risk that tenoxicam might cause gastric irritation.

Mr A also complained that Dr C prescribed tenoxicam inappropriately during the period when the cause of Mr A's haematemesis had not been confirmed.

Mr A was first prescribed tenoxicam in December 2001 when he was experiencing pain associated with arthritis. Dr C stopped the tenoxicam on 27 August 2004 when Mr A was discharged from hospital after an episode of haematemesis and pneumonia. The cause of Mr A's haematemesis had not been confirmed; however, the provisional diagnosis was that he had experienced an oesophageal tear. While Mr A was awaiting an appointment for an endoscopy, he saw Dr C with arthritic pain on 6 September 2004, and Dr C recommenced treatment with tenoxicam.

On 7 October, Dr D advised Dr C to stop tenoxicam, and Dr C did so at Mr A's next consultation on 26 October. Dr Tiller advised that Dr C was imprudent to restart tenoxicam two weeks after Mr A had been discharged from hospital, with no cause of the bleeding found and his gastroscopy still pending.

Dr Corkill said that Dr C should have been more cautious in how he used tenoxicam. In her opinion it was appropriate for Dr C to stop tenoxicam on 27 August 2004 but not to restart the drug before Mr A had undergone the gastroscopy.

I accept the advice of my experts that it was inappropriate for Dr C to prescribe a medication that carried a well-known risk of causing gastric irritation for a patient with unresolved haematemesis. I also consider that a reasonable patient, in Mr A's circumstances, would expect to receive information about the risk that his medications could cause gastric irritation, together with advice on what to do if that occurred. Dr C therefore breached Rights 4(1) and 6(1) of the Code.

Error in prescription
Omeprazole decreases the amount of acid produced in the stomach and is used to treat symptoms of gastro-oesophagal reflux disease.

Dr C first prescribed omeprazole for Mr A in March 2004 when he experienced an episode of vomiting. The dose was 40mg daily for one week. The same dose was precribed again on 27 August for two weeks. This was reduced to 10mg a day for 60 days from 26 October 2004.

On 9 December 2004 Dr D reported on the outcome of the endoscopy and advised Dr C to prescribe a 20mg dose of omeprazole, if it was to be used to prevent the side effects of bromocriptine. Dr C documented Dr D's instructions in Mr A's notes but did not alter Mr A's medications list. This meant that when Mr A went back to the medical centre in January 2005 to get his prescriptions renewed, his 10mg omeprazole prescription was repeated by the practice nurse (Ms G) and signed by another general practitioner. Dr C repeated the 10mg omeprazole prescription when he saw Mr A on 29 March 2005. However, the dose was increased to 20mg daily on 4 May 2005.

Dr Corkill advised:

> "I think this was simply a mistake, twice. Firstly when [Ms G] printed the script and had another doctor sign it. Secondly when [Dr C] gave 10mg the next time he saw [Mr A]. [Dr D] does say that using omeprazole to protect against peptic ulcer disease from bromocriptine is 'erring on the side of prudence' so I do not think this is a major issue. Dr Tiller also refers to [Dr C's] failure to correct the record and incorrectly prescribing omeprazole."

Dr C was unable to provide me with a clear explanation of his treatment plan in relation to omeprazole. He noted the 10mg omeprazole prescription on 29 March 2005 and stated:

> "I had earlier recorded in the notes [Dr D's] recommendation that the omeprazole be kept at a dose of 20mg, but this needed to be balanced with minimising the medication I was prescribing. Whether I overlooked this advice or after review and discussion reduced the dose to holistically reduce his medication load is something I cannot say with certainty."

Dr C said he always consults "MIMS New Ethicals Catalogue". In this case there are five side effects listed for omeprazole including nausea, vomiting and abdominal pain; therefore, he is likely to have kept omeprazole at the lower dose in order to reduce these side effects.

However, Dr Tiller advised:

> "The symptoms of vomiting and abdominal pain had antedated the prescription of omeprazole. It was unlikely that omeprazole was the cause of the symptoms. A Pharmaceutical text, New Ethicals Compendium of 2000, states that 'Omeprazole is well tolerated and adverse reactions have generally been mild and reversible'. 'Abdominal pain and nausea/vomiting' are listed as adverse events in clinical trials or routine use, 'but in many cases a relationship to treatment with omeprazole has not been established'."

In my opinion, Dr C had two options when he received Dr D's advice in relation to the omeprazole dose. He could have either accepted the advice, and changed the dose on Mr A's medications list, or made a deliberate decision to minimise Mr A's medications, in which case this should have been discussed with Mr A and noted in the clinical record. There is no record of such a discussion or treatment plan in Mr A's clinical notes in December 2004, nor is there any explanation recorded for the increase in dose back to 20mg in May 2005. Dr D recommended a 20mg dose of omeprazole to counter the effects of the bromocriptine and, in light of Mr A's recent peptic ulcer disease, it would be unusual for a general practitioner to depart from specialist advice on ways to minimise gastric irritation unless there was a reasoned basis for doing so. While I accept that it was Dr C's responsibility to monitor the overall medication load, Dr Tiller has advised that omeprazole did not pose a significant risk of nausea; the

vomiting and abdominal pain and Mr A's symptoms had predated the omeprazole treatment.

In my opinion, it is more likely that the 10mg omeprazole prescriptions in January and March 2005 were simply prescription errors. Dr C entered Dr D's advice in the notes but forgot to update Mr A's medications list. This is the explanation offered by the medical centre.

Dr Corkill has minimised the error on the basis that a 20mg dose of omeprazole was only recommended as erring on the side of prudence. However, in my view, any prescription error is significant, regardless of the medication involved. Patients trust that when a medication is prescribed, they will receive the dose that is appropriate to their condition and treatment. Prescription errors have the potential to cause considerable harm, and practitioners are therefore expected to have adequate systems in place to ensure that they do not occur.

On the balance of probabilities, I am satisfied that Dr C's failure to amend Mr A's omeprazole dose in December 2004 was an error. This meant that Mr A received less than the 20mg recommended dose for five months until May 2005, and represents a breach of Right 4(1) of the Code.

2005 treatment
Mr A consulted Dr C regularly between May and August 2005 with nausea, vomiting, loss of appetite and weight loss before he was finally taken to hospital by ambulance in August 2005. The key issue in 2005 is whether Dr C should have referred Mr A to hospital for investigation of these symptoms rather than continuing to treat him as a general practice patient.

Dr C saw Mr A in March, May, July and August 2005. After the May consultation Dr C indicated that he would refer Mr A for another endoscopy if his symptoms did not settle. However, the next time Dr C saw Mr A in July he did not take his own advice. It appears that he saw Mr A in the treatment room and did not have his notes readily at hand.

Mr A's symptoms continued on 8 and 12 August 2005. Mr A's loss of appetite was becoming a problem and he had lost a further two kilograms in weight. On 12 August 2005 Dr C suggested admission to Mr A but he declined. Mr A's daughter, Ms B, also telephoned Dr C in an effort to have her father admitted to hospital. On 19 August, Mr A was admitted to hospital as an emergency, and a malignant tumour of the colon was found.

Dr Corkill stated:

> "It would have been appropriate I think, to enquire about … blood in the vomit again and record something about these possible symptoms. As I noted earlier, he may have asked about these things without recording them so I am not sure if he did or not. It would have also been good to have some more examination findings in the notes to indicate whether he had examined [Mr A's] gastro-intestinal system any further, in particular whether his tongue was dry or coated, presence or not of jaundice, whether his abdomen was tender, etc.
>
> … it would have been good from my point of view to see more examination findings recorded in the notes overall."

Dr Tiller advised:

> "Leading up to the hospital admission in August 2005 when an obstructing bowel tumour was diagnosed, [Mr A] was seen on 26 July 2005, 8 August and 12 August with vomiting, weight loss and poor appetite. On none of these occasions was there documentation of any examination of the abdomen. When [Mr A] presented to [Dr F] on 16 August he correctly examined the abdomen and identified an enlarged liver and discolouration of the eyes suggestive of jaundice. [Dr F] ordered investigations."

Given the difficulties Mr A had experienced with similar symptoms in 2004, Dr C should have had a low threshold for investigating Mr A's unexplained weight loss and nausea in 2005. While Dr C did consider a referral for an endoscopy in May 2005, this referral was not reconsidered when Mr A returned to the clinic in July and August. I have some concern that, again, Dr C did not consider the overall significance of Mr A's deteriorating health, and approached each consultation in isolation. Dr C acknowledged that his care was not proactive during this period:

> "At the relevant time, I assumed that a lot of his symptoms were due to his significant previous gastro-intestinal problem. In this respect, and having reviewed my notes, I wish that I had been more assertive in managing his illness."

My experts have found it difficult to advise on the adequacy of Dr C's care because his clinical notes did not adequately record his examination findings. Every health professional has a responsibility to comply with professional standards under Right 4(2) of the Code, including the responsibility to keep detailed and accurate clinical documentation. The Medical Council's 'Statement on the Maintenance and Retention of Patient Records' states:

> "Information should be accurate and updated at each consultation. Patient records are essential to guide future management, an invaluable in the uncommon occasions when the outcome is unsatisfactory."

Cole's Medical Practice in New Zealand (Medical Council of New Zealand, 2004) states:[5]

> "An important part of a good doctor patient relationship is the keeping of a proper medical record. It is a tool for management, for communicating with other doctors and health professionals, and has become the primary tool for continuity of care in many practices as well as in hospitals. To fulfil these tasks, the record must be comprehensive and accurate."

In the absence of any clinical documentation to record them, I can only conclude that physical examinations did not occur during the consultations in May, June, July and August 2005. In my view, the May 2005 consultation should have been followed up with a referral for an endoscopy, and physical examinations should have occurred at each consultation. I agree with Dr Tiller's advice that Dr C's care was deficient over a sustained period of time, and Dr Corkill's advice that Dr C's documentation was inadequate. Accordingly, in my view, Dr C breached Rights 4(4) and 4(2) of the Code.

Opinion: No Breach — the medical centre

Direct liability

The professional standard in relation to health records requires a medical practice to have a system in place for managing patient information. This includes the responsibility to update patient health records to reflect specialist advice. If a medical practice does not have an adequate system in place, it will be directly liable for a breach of Right 4(2) of the Code.

The effect of these provisions in practice is that a medical centre must have a system for documenting a patient's health record. This should include the components set out in standard 2 of *New Zealand Standard Health Records*, ie, the notes from each consultation and a key health information summary. A medical centre must also have a system for tracking and managing medical reports and ensuring they are seen and actioned by the person who requested them.

Once those systems are in place, the responsibility then lies with individual health professionals to record consultations fully and accurately and to update the key health information summary. *Aiming for Excellence* confirms that the individual who requested a medical report is responsible for actioning it once it has been received and passed on by the medical centre.

[5] Chapter 10: The Medical Record, p 68.

It appears that the medical centre had a computerised system for recording consultations, test results and notes from other providers. I also note that the medical centre was accredited as complying with the information management criteria outlined in *Aiming for Excellence* in November 2006.

I am satisfied that the errors in Mr A's omeprazole prescriptions in January and March 2005 occurred as a result of Dr C failing to update Mr A's medications list after he had received Dr D's instructions. I am satisfied that the errors were not caused by any deficiencies in the systems used by the medical centre.

Vicarious liability
Under section 72 of the Act, an employing authority may be vicariously liable for acts or omissions by an employee, an agent or a member. For vicarious liability to arise there must be relationship of employment, agency or membership between Dr C and the medical centre. A defence is available to employers under section 72(5) if it can show that it took reasonable steps to prevent the employee from breaching the Code.

There is no employment relationship between Dr C and the medical centre. The doctors at the medical centre have formed a joint venture and describe themselves as the directors and shareholders of the medical centre. The issue is whether Dr C was acting as an agent or member of the medical centre.

The joint venture contract specifically states that nothing in the contract should be construed as giving rise to a partnership or agency relationship. Even so, there are circumstances in which the actions of a person can lead to a relationship of agency being implied. As noted by the Court of Appeal:[6]

> "The legal principles relating to ostensible or apparent agency are well settled. A person who by words or conduct has allowed another to appear to a third party to be his or her agent cannot afterwards repudiate that agency."

A key factor in determining whether there is an ostensible agency relationship is the outward appearance to third parties. From the public's perspective, Dr C is a doctor working at the medical centre and therefore appears to be an agent or an employee of the medical centre. In my view, a relationship of ostensible agency therefore exists.

The wording in section 72 suggests that the section 72(5) defence is only available in the case of an employment relationship. However, I have taken the view that the defence in section 72(5) is also available in relation to the acts or omissions of agents (see Opinion 04/04456 (15 November 2005)).

[6] *Arthur Watson Savage v Kathleen Taylor* (19 March 1996, Richardson P, CA 103/95).

In this case I am satisfied that Dr C's breaches of the Code relate to individual clinical decisions he made in the course of providing medical services to Mr A. Such actions and decisions were beyond the reasonable control of his fellow directors, and the medical centre is therefore not vicariously liable for his breaches of the Code.

Supervision
Dr C is not vocationally registered, and the Medical Council requires that he be supervised by a vocationally registered general practitioner. Dr J is a director of the medical centre and Dr C's supervisor. The Medical Council has issued guidelines for doctors working under supervision and their supervisors, which assist me in determining whether Dr J met his obligations as a supervisor.

I have reviewed samples of the documentation provided by the medical centre in relation to Dr C's supervision. He discussed Mr A's care with Dr J, but unfortunately no notes were taken. Dr C discussed Mr A again with his peer review group and provided notes taken of the discussion on 2 November 2006.

The Medical Council guidelines state that a supervisor should prepare reports for discussion with colleagues and the doctor under supervision.[7] However, in this case, Dr C was an experienced medical practitioner who did not require the same level of reporting as a "raw recruit", and also had some shared responsibility to identify his own learning needs.

Dr C could have discussed any concerns he had about the care he was providing to Mr A directly with Dr J or at peer review meetings. In my opinion the medical centre provided appropriate mechanisms for him to do so. Accordingly, the medical centre provided adequate supervision and did not breach the Code.

Recommendations

I recommend that Dr C:

- apologise to Mr A for his breaches of the Code. This apology is to be sent to this Office for forwarding to Mr A
- review his practice in light of Dr Corkill's and Dr Tiller's advice.

[7] Medical Council of New Zealand *Guidelines for Doctors working in supervised practice and their supervisors* (August 2004).

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand with the recommendation that Dr C's competence to practise be reviewed.

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

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