General Practitioner, Dr A

Opinion – Case 00HDC07636

Complaint

The Commissioner received a complaint about the standard of service the consumer, Ms B, received from a general practitioner, Dr A, in February 2000. Ms B's complaint was that:

- *On 16 February 2000, Ms B attended the provider for her first antenatal check. As part of the examination, Dr A ordered a blood test for Ms B.*
- *Ms B had the blood test at the Diagnostic Laboratory. The result of that test, which showed that Ms B had positive syphilis serology, was sent to Dr A on 18 February 2000.*
- *Dr A did not inform Ms B of the results of her blood test.*
- *On 15 May 2000, when she was 27 weeks' gestation, Ms B presented to Dr A, and reported that she had felt no foetal movements for three days.*
- *Ms B was referred to the hospital's Maternal Assessment Unit for assessment and foetal ultrasound on 15 May 2000. The ultrasound examination confirmed intra-uterine foetal death.*
- *Ms B was delivered of a stillborn female foetus on 16 May 2000.*
- *The post mortem report stated that the baby showed evidence of chronic foetal infection, and there was maternal serological evidence of active syphilis infection.*

Investigation Process

The complaint was received on 20 July 2000 and an investigation was commenced on 21 August 2000. Information was gained from:

Ms B
Dr A

Ms B's clinical records were provided by Dr A. Ms B provided clinical documents from the hospital. The Commissioner obtained the advice of an independent general practitioner.

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Information Gathered During Investigation

On 16 February 2000, Ms B, aged 33 presented for antenatal care at the Medical Centre. She was in the 14th week of her second pregnancy, with a history of a normal pregnancy and delivery in 1994. She was seen by Dr A, who performed a routine initial antenatal examination. As part of this examination, Dr A took a routine blood sample from Ms B for laboratory analysis of the standard antenatal tests, referred her for an ultrasound and arranged to see her again in six weeks.

On 18 February 2000, Dr A received Ms B's blood tests results. The syphilis serology tests showed an abnormal result.

The organism that causes syphilis is known as *treponema pallidum*. There are a number of tests that are conducted to identify this organism. The RPR/VDRL is an established screening test for syphilis and for monitoring response to treatment. A positive result may be due to:

- Current infection – rare in New Zealand, the titre will always be >1:16.
- Past inactive Treponemal infection – the titre is usually <1:16, often 1:1 or 1:2.
- Pregnancy, which is sometimes listed as an infrequent cause of a low titre false positive RPR (rapid plasma regain).
- Viral infections, malaria – positive for < 6 months.

Ms B's test results showed low RPR titre, which was reactive 1:8, and a non-reactive *treponemal pallidum* haemagglutination (TPHA) titre. The blood test result note from the laboratory suggested to Dr A that Ms B's syphilis serology blood tests should be repeated if clinically indicated. All other results were satisfactory.

Dr A noted in his records on 18 February that Ms B's syphilis serology was "*non-significant*". The result of the ultrasound was reported to Dr A on 15 March 2000, and stated, "*No adverse features are demonstrated*."

Dr A informed the Commissioner that Ms B gave "*no clinical indication of syphilis*" and that there was "*nothing in her history to suggest she was at increased risk*".

Continued on next page

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Information Gathered During Investigation *continued*

Dr A acknowledged that he did not inform Ms B that she had a positive syphilis blood test. He said that:

> "*It was my opinion at the time, that her serology result was highly likely to be a 'biological false positive'. ... I felt that discussion of this sensitive problem by phone, particularly with a patient for whom English is a second language, would be difficult, likely to create anxiety and inappropriate. It was my intention to discuss this result in person with [Ms B] at her next antenatal visit, and arrange follow-up testing. Unfortunately she did not attend for this visit and so was not re-tested.*"

Ms B next consulted Dr A on 15 May 2000, when she was 27 weeks' gestation. Ms B informed Dr A that she had not experienced foetal movement for three days. Dr A referred Ms B to the hospital's Maternal Assessment Unit for assessment of her pregnancy and a foetal ultrasound examination. The ultrasound confirmed that Ms B's baby had died.

Ms B delivered a stillborn female foetus at the hospital on 16 May 2000.

The post mortem report stated that the baby showed evidence of chronic foetal infection and that Ms B's blood tests, on 16 May 2000, showed evidence of active syphilis infection.

Dr A informed the Commissioner that:

> "*Naturally I am distressed at the outcome of [Ms B's] pregnancy and the distress it has caused her family. I have since discussed her case with a Clinical Microbiologist at Diagnostic MedLab Laboratory and his advice is that while syphilis continues to be very rare in NZ, false positive tests are quite common. His advice would be to re-test at one month in this case.*
>
> *I have also contacted a Venereologist with a Sexual Health Service, and have also attended the ProCare Sexual Health Seminar on 22/8/00.*

Continued on next page

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Information Gathered During Investigation *continued*

I am now aware that there is a recently increased incidence of syphilis in Asian immigrants, and that an interpretation of biological false positive serology cannot be assumed to be as likely. Also the available serological tests for syphilis in NZ are not completely satisfactory and may give ambiguous results in early disease. Because of this, re-testing is indicated earlier than was planned for [Ms B].

In light of this, I would certainly handle her case differently now and in particular would make much greater efforts to trace her and arrange for early repeat testing. I deeply regret the circumstances that led to this foetal death. However I feel that this case was unusual and the problems involving syphilis serology and interpretation are not widely known amongst my colleagues.

I have spoken with [Ms B] and her husband several times while she was at National Women's Hospital, before and following the delivery, and I felt I had conveyed my regrets and apologies then. I have not seen her following discharge, but am very happy to offer apology verbally or in writing."

Independent Advice to Commissioner

An independent general practitioner advised the Commissioner that:

"*From what I can gather from the information provided, [Ms B] consulted [Dr A] for the first time on February 18th 2000, and then not again until May 15th 2000 by which time she had not noted foetal movements for three days. In the interim, at 18 weeks' gestation she had a 'normal' ultrasound scan.*

At the first visit [Dr A] ordered routine antenatal blood screening which showed a weekly positive RPR Titre and a negative TPHA Titre with an addendum that these tests should be repeated if clinically indicated. [Dr A] did not see [Ms B] again until she had suffered a foetal death, by which time it was too late.

Continued on next page

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Independent Advice to Commissioner *continued*

[Dr A] has provided you with copies of the relevant pages of Diagnostic MedLab's handbook: 'The Interpretation of Laboratory Tests'. My interpretation of these is that [Ms B] could not have had active syphilis. He furthermore states that he discussed the result informally with his colleagues who felt that this was a 'false' positive which is common with this test. The qualification from the lab in its reporting that a repeat of the test should be made if clinically indicated is a common one in slightly abnormal test results and were it to be automatically acted on would generate significant quantities of repeats. As [Dr A] points out such fairly routine advice does not indicate particular concern or urgency.

Like [Dr A], I have rarely encountered Syphilis in General Practice in Auckland. In 22 years I have seen one case requiring treatment. As in the case of [Ms B], there was no obvious cause of infection, the patient being at low risk of STI.

Given that [Dr A] only saw this patient on the one occasion, a common occurrence in a central city practice where a significant proportion of files are 'once only' files, and that he had strong grounds for making his incorrect assumptions, it would be unreasonable to conclude that he did not exercise a reasonable standard of care and skill. There needs to be a clear deliniation between disastrous outcomes that are due to negligence and those that occur despite care that equals or betters the standards of peers.

I note that he has consulted widely on the case, has attended a sexual health seminar, and that he is prepared to revise his practice based on his upgraded knowledge. He also apologises for his own perceived lack of knowledge in this case."

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Response to Commissioner's Provisional Opinion

Dr A responded to the Commissioner's provisional opinion stating:

"*Thank you for your invitation to comment on your provisional findings on [Ms B's] complaint. I wish to make the following comments.*

- *I am in agreement with the information gathered during the investigation, as set out in the report.*
- *It is clear now that an earlier repeat of the RPR test was desirable, however this seems clear in hindsight and was not apparent given the incorrect assumptions made within a 'reasonable standard of care and skill'.*
- *I have concerns as to the practical significance of your statement that 'providers have a responsibility under Right 6(1)(f) to ensure that Ms B is fully informed of results of tests. This is irrespective of whether the results are positive or negative'. Whilst I accept that there is such an obligation in relation to abnormal results, the impact upon practice, of a positive duty to actively inform of all the normal results would indeed be onerous. Clearly there are some normal results where we accept a positive duty, such as for cervical smear results. However if we had to phone every patient to tell them their haemoglobin result, a busy practice would, I suggest with respect, seize up. Often in General Practice we need to run a 'battery' of tests to follow up a condition or screen for disease. It is usual practice to make a statement such as 'We will let you know if there is anything wrong with the results'. By implication, the practitioner is stating that all results can be assumed to be normal unless otherwise notified. I believe this is what prudent practitioners believe is the standard of care in this regard. If a greater standard is being indicated here, it needs to be communicated to the profession.*
- *I have no difficulty in agreeing to submit a written apology via the Commissioner.*
- *My current practice on test results is already under review, particular arranging a computerised recall for later follow-up of abnormal results.*

Continued on next page

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Response to Commissioner's Provisional Opinion *continued*

- *I have discussed the lessons from this case with my obstetric GP colleagues and others, and I agree that they should be disseminated more widely.*"

Ms B responded to the Commissioner's provisional opinion stating:

"*I acknowledge that I do not quite understand the points from medical perspective, but I wish to make some comments on [Dr A's] response to my complaint, which I knew from your investigation report.*

[Dr A] said that:
'I felt that discussion for this sensitive problem by phone, particularly with a patient for whom English is a second language, would be difficult, likely to create anxiety and inappropriate. It was my intention to discuss this result in person with [Ms B] at her next antenatal visit, and arrange follow-up testing. Unfortunately she did not attend for this visit and so was not re-tested.'

I think that English as my second language can not be an excuse for him not to inform the abnormal blood test result at the first time. I am undertaking a degree programme at AUT, and doing well without any difficulties in communicating with my lectures or classmates. Furthermore, I believe that lots of good interpreters in this country would be very helpful to make me clear of my circumstance by explaining some jargon as they did while I was in the hospital's Maternal Assessment Unit and in National Sexual Health Service. He should have made an appointment with me and discuss the problem face to face if he felt difficult by phone. The reason why I disagree with him on this point is that I insist that even if I am an Asia immigrant with English as a second language, I had the equal right to know what was happening to me. Racism is not allowed in this democratic country!

Continued on next page

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Response to Commissioner's Provisional Opinion *continued*

I did not attend for the next antenatal visit because I had not received any bad news from [Dr A], and I had a first pregnancy and normal vaginal delivery in 1994. Actually, I felt nothing wrong with my baby until 3 days before I visited him again.

I noted in your letter that [Dr A] informed the Commissioner that he discussed my case with a Clinical Microbiologist at Diagnostic Medlab Laboratory after the outcome of my pregnancy. The Microbiologist's advice would be to re-test at one month. If [Dr A] had been responsible for me, he should have discussed my case with the microbiologist in Feb. 2000 rather than after the disaster happened to me. I am aware that I had missed another opportunity to be informed at least in March 2000.

At early stage, my syphilis serology was 'non-significant' and result of the ultrasound stated 'No adverse features are demonstrated', why hadn't [Dr A] traced my case closely and let me have prompt treatment?

If things like he said: '... the problems involving syphilis serology and interpretation are not widely known amongst my colleagues'. Why hadn't he sought for more specialist consultant before the worst thing happened?

If he thinks '... the available serological tests for syphilis in NZ are not completely satisfactory and may give ambiguous results in early disease ...' why hadn't he informed me and let me decide where to get accurate results.

[Dr A] stated:
'I have spoken with [Ms B] and her husband several times while she was at the hospital, before and following the delivery, and I felt I had conveyed my regrets and apologies then ....'

Continued on next page

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Response to Commissioner's Provisional Opinion *continued*

Here I'd like to tell you the story. On 15 May 2000, he referred me to the hospital's Maternal Assessment Unit with a letter in an envelope. At that time, I was standing in his office with tears in my eyes and had no idea how to get there by myself (I had been in NZ only for several months then and not familiar with roads and streets). He let me use his phone and I called a friend of mine to drive me to the hospital. Not until the second day after the delivery, he dropped in the ward while he sent another patient to MAU. He stood there for no more than three minutes and said 'sorry' just like somebody else who was not involved. My husband and I don't think he gave a formal apologise.

I lost my baby! I've been deeply hurt physically and emotionally by this accident. And I will always regret in my life that I had chosen [Dr A] as my maternity carer at that time. And I hope that my complaint could remind him to be responsible for his patients at any time in his future career, no matter which ethnic groups the patients are from."

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.

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 –

...

f) The results of tests.

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Opinion: No Breach

In my opinion Dr A did not breach Right 4(1) of the Code.

Right 4(1)

Failure to diagnose Ms B's syphilis
Ms B presented at the Medical Centre on 16 February 2000, in the 14th week of her second pregnancy. Ms B's first pregnancy was normal. Dr A performed a routine initial antenatal examination on Ms B. He referred Ms B for a routine antenatal blood test and an ultrasound scan, and made a further appointment for her for six weeks.

On 18 February 2000, Dr A received the results of Ms B's blood tests. The laboratory advised that the syphilis serology results were abnormal and that these should be repeated if there was any clinical indication. Ms B had not exhibited any clinical signs of syphilis. She did not provide a history which would indicate that she was likely to have contracted syphilis.

At the time that Ms B consulted with Dr A he was unaware that there was an increased incidence of syphilis in New Zealand. Dr A was however aware that syphilis serology testing can be ambiguous, and that certain conditions such as pregnancy can produce false positive results.

Dr A planned to follow up these blood tests with Ms B when she returned for her second antenatal visit at 20 weeks' gestation. Ms B did not return to see Dr A until she was 27 weeks' gestation and concerned that she had not felt the baby move for three days.

Dr A referred Ms B to the hospital's Maternal Assessment Unit for an assessment of her pregnancy and a foetal ultrasound. The ultrasound confirmed that Ms B's baby was dead. A post mortem examination of the baby revealed that the baby showed evidence of chronic infection and further blood tests on Ms B while she was in the unit showed that she had active syphilis.

Continued on next page

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Opinion: No Breach ***continued***

Dr A documented the results of Ms B's abnormal antenatal syphilis serology test results, and planned to follow up these results when Ms B next consulted him as he anticipated, in six weeks. The incidence of syphilis in the New Zealand population is rare, and false positive syphilis serology is relatively common. I am advised that Dr A had strong grounds for making his incorrect assumptions and that it would be unreasonable to conclude that he did not exercise a reasonable standard of care and skill in providing a service to Ms B. In these circumstances, in my opinion Dr A did not breach Right 4(1).

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Opinion: Breach

In my opinion Dr A breached Right 6(1)(f) of the Code.

Right 6(1)(f)

Failing to inform Ms B of the result of her blood tests
Dr A received the results of Ms B's syphilis serology tests on 18 February 2000, two days after she had first consulted him for antenatal care. Dr A did not contact Ms B to convey the results of this test to her, as he was concerned that relaying sensitive information over the telephone to Ms B would cause her unnecessary distress. Dr A decided to discuss the result with Ms B at her next visit, which was planned for six weeks, and refer her for further blood tests at that time. Ms B did not return to see Dr A until she was 27 weeks' gestation, ie, 13 weeks after her blood tests. By that time her baby had died.

Ms B said that she did not attend her 20 weeks' antenatal visit because she had not received any "bad news" from Dr A. I note that Dr A himself admitted that he told his patients "we will let you know if there is anything wrong with the results".

Providers have a responsibility under Right 6(1)(f) to ensure that patients are fully informed of the results of tests. This is irrespective of whether the results are positive or negative. However, I accept that it is reasonable practice for a provider to indicate that the patient will only be notified if the results indicate a problem that needs follow-up, so long as the patient is given the option of being notified regardless.

Dr A was Ms B's general practitioner and primary health care provider. Dr A had a responsibility to keep Ms B informed about all test results in the manner described above.

In my opinion, Dr A's failure to provide with Ms B with timely information about the results of her blood tests meant that follow-up blood tests were not able to be carried out. Early notification may have enabled Ms B to consider the possible outcomes for her and her baby. In these circumstances, in my opinion, Dr A breached Right 6(1)(f) of the Code.

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

General Practitioner, Dr A

Opinion – Case 00HDC07636, continued

Actions Taken

- Dr A visited Ms B at the hospital before and after the delivery of Ms B's baby and conveyed his regrets and apologies at that time.
- Dr A recognised his lack of knowledge of syphilis and consulted with a Clinical Microbiologist, Diagnostic MedLab Laboratory, and a Venereologist with a Sexual Health Clinic, experts in syphilis serology.
- Dr A attended a ProCare Sexual Health Seminar on 22 August 2000.
- Dr A acknowledged to the Commissioner that he would now handle cases such as Ms B's differently, and make more effort to contact patients to arrange for earlier repeat blood testing.

Actions

I recommend that Dr A:

- Apologise in writing to Ms B for breaching the Code. This apology is to be sent to the Commissioner and will be forwarded to Ms B.
- Review his current practice to ensure that tests results are made available to patients.

Other Actions

- A copy of this opinion will be sent to the Medical Council of New Zealand. A copy of this opinion with identifying features removed will be sent to the Royal New Zealand College of General Practitioners.

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