General Practitioner

A Report by the

Health and Disability Commissioner

(Case 00HDC02542)

Parties involved

The complaint was received on 7 March 2000 and an investigation was commenced on 12 April 2000. Information was obtained from:

Mr A	Consumer
Dr B	Provider/General Practitioner
Dr C	General Practitioner
Dr D	Professor in General Practice
Dr E	General Practitioner

Mr A's medical records were obtained from the medical practice, and from Dr C. Advice was also obtained from an independent expert general practitioner, Dr Chris Kalderimis.

Complaint

The Commissioner received a complaint from Mr A regarding the services he received from Dr B, general practitioner. The complaint is that:

> *When Mr A consulted Dr B on 25 December 1999 Dr B failed to undertake any tests to determine the nature of Mr A's illness. Instead, he advised Mr A that he had Hepatitis A.*
>
> *As a result Mr A was admitted to hospital on 4 January 2000 and underwent a liver transplant on 10 January 2000.*

Information gathered during investigation

Consultation with general practitioner 22 December 1999
On 22 December 1999 Mr A consulted his general practitioner, as he felt unwell and exhausted. His general practitioner's notes recorded that Mr A had experienced upper gastrointestinal discomfort for two weeks, and that it had become worse over the past five days. It was worse with food and he had "acid in [his] stomach". His general practitioner diagnosed reflux type symptoms and suggested metoclopramide tablets. Mr A stated that his general practitioner advised that he could return to work the next day. However, Mr A worked for only half a day on 23 and 24 December 1999 as he did not feel well.

Consultation with Dr B on 25 December 1999
On 25 December 1999 Mr A saw the on-duty doctor, Dr B (who was not Mr A's regular general practitioner) at his surgery because he had "turned yellow" and was not feeling well.

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

Mr A informed Dr B that he was very tired, lacking in energy and was concerned about the colour of his eyes and skin as they were "quite yellow". He advised that he was worried that these symptoms were indicative of a problem with his kidneys as he had experienced kidney problems since infancy.

Mr A recalled that Dr B looked at his eyes and skin and gave a diagnosis of Hepatitis A. He stated that Dr B informed him that nothing could be done and he had to let it take its course. He had to avoid contact with young children, along with close contact with other people, and his diet should consist of bread, cereal and fruit juice.

Mr A asked Dr B how much time he needed away from his workplace. Dr B replied that he would be well within approximately 15 days and provided a medical note which advised that he would be fit to resume work on 5 January 2000. Mr A recalled asking Dr B twice if he was sure about this, as he was not convinced. On the second occasion Dr B advised that he had had Hepatitis A when he was at University and Mr A should start to feel better in approximately four days. Mr A was advised to keep his personal hygiene spotless, use his own towels, dishes, toothbrush and razor, and wash everything that he used separately.

Mr A advised me that Dr B was quite adamant about his diagnosis of Hepatitis A. He stated that Dr B told him to see his own general practitioner when his surgery re-opened on Tuesday if he did not feel any better. Mr A advised that Dr B did not mention tests or why he was not requesting any tests.

Availability of laboratory tests
No regular laboratory facilities were available on Christmas Day. However, I was advised by the head of both the community laboratory and the hospital laboratory that urgent laboratory facilities were available. It was emphasised that these facilities would normally be used for serious urgent and potentially life-threatening cases.

Response from Dr B
Dr B stated in his response that:

> "[Mr A] consulted me on the morning of Christmas Day at a clinic I conducted for any urgent cases. He was obviously unwell, and I spent some time with him discussing the likely diagnosis of hepatitis, and giving him some advice on how he could look after himself in the ensuing holiday period. There were no laboratory facilities available on Christmas Day, and the general understanding was that he would seek follow-up with his own doctor some five days later when general business resumed. He was not sufficiently ill to admit to hospital on Christmas Day, and I tried to give him some reassurance which would tide him through. He did attend his own doctor the following week, and his full diagnosis was made at that time. Unfortunately, he developed the uncommon and disastrous complication of fulminant hepatitis, which required his admission to hospital. This complication can be seen with any of the viral forms of hepatitis, although Hepatitis B is the one most likely to be responsible."

Dr B's notes of the consultation stated:

> "Acute infection Hepatitis
>
> Dietary advice
>
> Sick note for work."

Subsequent events
Mr A returned to the medical practice on 28 December 1999 and had blood tests. (His subsequent contact with the medical practice was the subject of a complaint and investigation reported as 00HDC02542 at www.hdc.org.nz/opinions). Mr A was hospitalised on 4 January 2000 and subsequently diagnosed as suffering from fulminant hepatic failure secondary to acute Hepatitis B virus. A donor organ became available and Mr A had a liver transplant on 10 January 2000.

Independent Advice to Commissioner

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

> "The background to this rather distressing situation is that on 22nd December 1999 [Mr A] consulted his own general practitioner because he felt unwell and had some upper abdominal discomfort. Apparently he stated that this had been going on for some two weeks but had become worse in the previous few days. His own GP at that time diagnosed reflux and gave him suitable medication for this.
>
> However, by Christmas Day 1999 [Mr A] felt he was getting more unwell and that he had turned yellow. He thus attended [Dr B], the duty doctor, on Christmas Day, stating that he was yellow, was quite unwell, lacked energy and felt tired. He was examined by [Dr B] and at this point we have a marked discrepancy in what actually took place.
>
> The notes made at this consultation were extremely brief and therefore it is quite difficult to ascertain which of the two accounts is the correct one. [Mr A] states that [Dr B] told him that he had Hepatitis A whereas [Dr B] states that he simply told [Mr A] that he had Hepatitis.
>
> No blood samples were taken and [Mr A] was told to go home and rest appropriately and have a light diet.

Unfortunately [Mr A] went on to develop fulminant Hepatitis B and was acutely admitted to [a public] hospital on 4 January, transferred to [a second public hospital] on 5 January and on 6 January transferred to [a third public hospital] where he had a liver transplant.

I will first of all deal with the questions you have raised and then go on to make some more general comments: –

1. Should [Dr B] have given [Mr A] a diagnosis, even if it was a 'likely' diagnosis, when tests had not been conducted?

It is difficult to know what [Dr B] did indeed say to [Mr A] at that consultation. From a purist's point of view, all that [Dr B] could say at that consultation was that [Mr A] was jaundiced clinically. He could have said that the most likely diagnosis was in fact a form of Hepatitis, but clearly without the outcome of blood tests it is impossible to make any diagnosis of whether it is Hepatitis A, B or C, or even other viral forms of Hepatitis such as glandular fever or C.M.V. [cytomegalovirus].

[Mr A] is quite adamant that he was informed by [Dr B] that he had Hepatitis A, whereas [Dr B] states that he simply told [Mr A] that he had a form of Hepatitis. I think if any further elucidation of this discrepancy is to be made, one would need to talk to the two individuals directly. It is interesting though that the consultation note made at the time by [Dr B] did not mention Hepatitis A but simply mentioned Hepatitis.

It is of course possible to get jaundiced from an obstructive lesion such as a gall stone or tumour in the pancreatic duct which makes someone become quite jaundiced, but in a young man with these sort of symptoms, a viral Hepatitis is admittedly a more common diagnosis.

I feel that it is appropriate for [Dr B] to have gone through with [Mr A] what the possible diagnoses were. It is also very reasonable that he might have told him what the most common diagnosis could be, but he would have had to emphasise that he could not be certain of the diagnosis without the results of blood tests.

2. Even though laboratory facilities were not available on 25 December 1999 should [Dr B] have collected samples so that he could have:

- **Sent them to the laboratory for tests when it re-opened along with a note asking the laboratory to forward the results to [Mr A's] general practitioner?**

- **Sent a note to [Mr A's] general practitioner advising what he had done?**

It is difficult for me to extrapolate what would normally happen in [the area] on Christmas Day. Certainly in [my location] if such an event occurred this is exactly

what we would have done. Blood samples would have been taken off the patient and possibly we would have reviewed the patient the next day to see how he/she was. If necessary a repeat blood sample could be taken the next day so that a comparison could be made. However, I do not know what facilities were available in [his area]. Given the fact that [the second public hospital] is not all that far away, this could probably have been done there.

As [Mr A's] horrific story tells us, Hepatitis can indeed be a very serious illness and thus I feel that this sort of management is not at all unreasonable.

3. Did [Dr B] give appropriate care instructions to [Mr A]?

I feel that the instructions, as far as they went, were reasonable. But I feel [Mr A] should have been asked to come in the next day to be reviewed.

4. Should [Dr B] have informed [Mr A] that he would feel better in approximately 4 days and that he would be well in approximately 15 days?

I feel [Dr B] would have been unwise to make this statement to [Mr A] because he did not have a working diagnosis.

If he did tell [Mr A] that he would feel better in 4 days this would have had to be on the assumption that this was in fact Hepatitis A. But since [Dr B] did not know which form of Hepatitis [Mr A] had, then I feel he could not reasonably give him this sort of advice.

Once again, we do not know just how aggressive [Mr A] was about this because, on reading the notes further on, [Mr A] was fairly abrasive and swearing at the nurse when he rang her some days later. Thus, it is possible that he may have been abrasive towards [Dr B] at this time and this might have resulted in [Dr B] giving this sort of prognosis.

5. Should [Dr B] have taken any other action at the consultation on 25 December 1999?

As outlined above I think what [Dr B] should have done was to take blood samples at the time to ascertain liver function and asked [Mr A] to come back the following day. It did not actually matter whether or not the laboratory was functioning in [his area] at the time as the bloods could have been stored until the laboratory did open or else they could have been forwarded to [another area] and dealt with there.

6. How much do the test results received by [Mr A's] general practitioner deviate from the norm (ie, do the results indicate a level of seriousness in respect to [Mr A's] condition)?

I believe the test results deviate significantly from the norm, but they don't necessarily indicate a requirement for immediate admission to hospital.

There is no doubt on the basis of the blood tests as received by [Mr A's] general practitioner that the indications were that he had Hepatitis B and that there were very significant alterations in his liver function tests. I feel the results indicated that he should have been monitored on a daily basis with the prospect of hospital admission always a possibility.

7. Are there any other issues arising from the supporting information?

I believe the key issue here is that [Mr A] was very unlucky to have a form of fulminant Hepatitis B that resulted in the need for him to have a liver transplant. I would have to say that the great bulk of Hepatitis A and B cases that I diagnose do not require admission to hospital, but simply require close monitoring.

If a diagnosis of significant Hepatitis B had been made any earlier, I still do not believe the outcome would have been any different. I am sure that [Mr A] would still have required admission to [the third public hospital] and he would still have required a liver transplant. An earlier diagnosis would not have changed this outcome.

The consultation slip that was completed for [Mr A] at the time of the consultation on 25th December 1999 was in my opinion inadequate. I do believe that basal blood tests should have been done on 25th December irrespective of whether or not they could have been analysed on the same day in [his area].

The reassurance that was given to [Mr A] was inappropriate but in this case it is hard to know whether or not this was said in response to [Mr A's] own insistence that he be reassured.

If [Dr B] did in fact tell [Mr A] that he had Hepatitis A at the consultation on 25th December 1999 then this was patently incorrect and he should not have said this because he did not have any evidence to support this statement.

Obviously [Mr A] is quite certain it was said to him and, if this is the case, then this is a significant error on the part of [Dr B].

Overall, however, one would have to say that although the consultation with [Dr B] was somewhat inadequate, it would not have materially changed the outcome for [Mr A] had a more appropriate consultation taken place."

Response to provisional opinion

In my provisional opinion, I made some comments critical of the way in which Dr B conducted the consultation with Mr A, and in particular Dr B's failure to conduct basal blood tests that could be stored until regular laboratory facilities were available. In response to my opinion, Dr B sought a report from Dr D, Professor of General Practice and part-time general practitioner.

Dr D disagreed with the opinion of Dr Kalderimis, and considered that Dr B took the appropriate action in his consultation with Mr A. Dr D's opinion is attached in full to this opinion, as Appendix 1. However, a summary of the key points of his opinion is as follows:

- Regardless of what Dr B had done at the consultation, the outcome for Mr A would have been no different;
- There would have been no benefit in Dr B taking blood on the day of the consultation as, because of the lack of immediately available lab facilities, the blood tests would not have assisted in making a diagnosis;
- While some practitioners may have taken blood for the purpose of establishing basal liver function, this was not a definite requirement in the circumstances;
- Dr B acted appropriately in giving Mr A a diagnosis even in the absence of confirmatory blood tests. It was not necessary for the purposes of this consultation to accurately identify the exact type of hepatitis;
- Dr B's advice regarding follow-up with another general practitioner was appropriate;
- The results of the blood tests taken on 28 December did not indicate the need for an immediate hospital admission.

Dr D's response was provided to Dr Kalderimis for his review and further consideration of the issues raised. Dr Kalderimis commented that he considered Dr D's response to be a "fair response" and noted that the points of difference between his opinion and that of Dr D were "more academic than practical". Dr Kalderimis did, however, give his further opinion as follows:

> "I feel that when [Dr B] was discussing with [Mr A] the diagnosis of hepatitis he still needed to state that he did not know what type of hepatitis he had or how serious it was. I accept the point that Hepatitis A is more common and the one we are most likely to see but, as [Dr D] himself points out, general practice is often dealing with diagnoses of uncertainty and the uncertainty in this diagnosis needed to be made clear to [Mr A]. There is no way that [Dr B] could say with certainty to [Mr A] that he had Hepatitis A. He could tell him and reassure him that Hepatitis A was the

most likely of the diagnoses but there was no way that he could know this until the appropriate blood tests had been done.

Thus I feel that [Mr A] should have been better informed of what ***might happen*** with his physical state, but once again I would reiterate that really nothing that [Dr B] could have done at the time would have in any way changed the very fulminant nature of this man's hepatitis and the eventual liver transplant that he needed."

Code of Health and Disability Services Consumers' Rights

RIGHT 4

Right to Services of an Appropriate Standard

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

Opinion – No Breach – Dr B

Right 4(1)
In my view Dr B treated Mr A appropriately at the consultation on 25 December 1999. It is clear with the benefit of hindsight that Mr A had a very rare and severe case of fulminant Hepatitis B. However, it is also apparent that at the consultation with Dr B, and even some days later when blood test results became available, there was no indication of the very serious nature of Mr A's condition.

Dr Kalderimis informed me, in discussions relating to his initial advice, that there was no reason for Dr B to have considered the possibility that Mr A could develop a fulminant condition, as it is such a rare occurrence. Dr Kalderimis noted that in his career he has never seen a case of fulminant hepatitis.

Blood tests
In my opinion it was not necessary for Dr B to take blood tests during the consultation. There were two possible reasons for taking blood: first, for immediate diagnostic purposes, and second, to establish base liver function in comparison with later samples to observe the relative change.

There were no regular laboratory facilities available for diagnostic blood analysis on Christmas Day. There were urgent facilities available but in my view the nature of this case was such that there was no requirement for Dr B to explore whether urgent after-hours

blood analysis could be arranged for Mr A. Mr A did not present as being acutely ill. This is confirmed by blood tests done several days later. Although they showed a clearly abnormal liver function, they did not indicate a need for urgent hospital admission. The head of both the community laboratory and the hospital laboratory emphasised that while urgent laboratory facilities were available on Christmas Day, it would be expected that these facilities would be used for urgent and serious matters. In these circumstances, I consider that the approach of Dr B in suggesting that blood tests be carried out after the holiday period was appropriate.

On the issue of taking basal blood tests, Dr Kalderimis initially advised that he thought that basal blood tests should have been done as a point of comparison with later tests. Dr D disagreed with this view and stated that while some practitioners might take that course of action, others may not, and there was no "correct" approach. Dr Kalderimis subsequently agreed that while taking basal blood samples would have been appropriate, it was not a fundamental aspect of Mr A's management.

For the above reasons, I do not consider that Dr B's failure to take blood tests during the consultation with Mr A amounted to a failure to exercise reasonable care. Accordingly, Dr B did not breach Right 4(1) of the Code.

Management

In my view Dr B's management of Mr A was appropriate. Dr Kalderimis notes that it would have been preferable to have made an appointment for him to come back the following day. However, in light of the fact that Mr A did not present as being acutely ill at the consultation, and that Dr B indicated he should see his regular general practitioner in a few days' time for further tests, I am satisfied that Dr B's management of Mr A's condition was appropriate and did not breach Right 4(1) of the Code.

Diagnosis

There is some conflict in the evidence as to whether Dr B told Mr A that it was specifically Hepatitis A that he was suffering from. I am unable to resolve, on the evidence available to me, the degree of specificity with which Dr B indicated a diagnosis to Mr A. However, even if Dr B was specific in discussing Hepatitis A with Mr A, I do not consider that this amounted to a breach of the Code. In the circumstances at the time, Hepatitis A was the most likely cause of Mr A's symptoms, and it was reasonable for Dr B to draw that conclusion. There was no reasonable possibility of Dr B being able to diagnose, in the absence of appropriate diagnostic tests, whether it was in fact Hepatitis B, or some other form of hepatitis. Furthermore, even if he did have such facilities reasonably available, it would still not have been possible to predict that it was likely to develop into a fulminant case.

However, I note Dr Kalderimis's comments in relation to this issue. Dr Kalderimis notes that Dr B should ideally have discussed with Mr A that there was some degree of uncertainty both as to the exact diagnosis, and also the seriousness of the condition. I accept Dr Kalderimis's comments in this respect. In my opinion, regardless of whether Dr

B gave a specific diagnosis of Hepatitis A, as a matter of good practice it would have been preferable if he had discussed with Mr A the possible variances within the broad diagnosis of hepatitis, and the fact that he was unable without further investigation to determine the exact nature of the disease. However, I also note that regardless of what was discussed, there was nothing Dr B could reasonably have done that would have altered the ultimate outcome, and that his overall management was appropriate. For these reasons, while I would recommend that Dr B note Dr Kalderimis's comments in relation to this issue, I do not consider that Dr B's actions amounted to a breach of the Code.

Other comments

Dr B's notes of the consultation on 25 December 1999 were brief and inadequate. A general practitioner is responsible for completing a full and contemporaneous record of what occurred in the consultation, the advice given and actions taken. This provides a clear picture of the clinical situation and what took place during the consultation. Dr B's notes did not meet this standard.

I do, however, note the point made by Dr D that Dr B was at the time the sole general practitioner covering the area, and that a practitioner in this role is expected not only to see patients but also to field telephone enquiries. Dr D notes that in this situation "there is often brevity in the notes made by practitioners when they see patients out of hours".

I recommend that when conducting after-hours consultations in the future, Dr B be aware of the need to include sufficient detail in his clinical records.

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 and placed on the Health and Disability Commissioner website, www.hdc.org.nz.

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APPENDIX 1

Report prepared by [Professor D], BSC, MBChB, MD, DipObs (Otago) FRNZCGP

"… I have … been actively involved in General Practice since 1984 and currently still care for my own practice population, seeing approximately 50-60 patients per week. I have been asked to comment on the case of [Dr B] and patient [Mr A]. In providing this opinion, I have had access to:

- a letter from [Mr A] to [Dr B] dated 1.03.2000,
- a copy of the letter to [Dr B] from the Health and Disability Commissioner [HDC] dated 12.04.2000,
- a copy of the letter from [Dr B] to [HDC] dated 28.04.2000,
- a copy of the letter from [HDC] to [Dr B] on 2.10.2000,
- a copy of the letter to [HDC] from [Dr B] of 11.10.2000,
- a copy of the letter from [HDC] to [Dr B] on 31.10.2000,
- a copy of a letter and the provisional opinion of the Health and Disability Commissioner dated 5.04.2001.

I have also received copies of:
- the consultation notes made by [Dr B] on the 25.12.1999,
- copies of notes made by [Dr E] on 4.01.2000 in regards to [Mr A] and his admission to [a public] Hospital,
- and copies of laboratory investigations undertaken on 29.12.1999 by [Dr C] in regards to [Mr A].

The issue is whether [Dr B] breached the Right 4(1) of the Code of Health and Disability Services Consumers' Rights in relation to his consultation with [Mr A]. In particular:

1. Whether [Dr B] breached the right by failing to take basal blood tests;
2. Whether he breached the right by failing to ensure that [Mr A] returned for review the following day;
3. Whether [Dr B] breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights in relation to his notes of the consultation with [Mr A].

1. BACKGROUND

From the letter of [Mr A] and the consultation records of [Dr B], there is no dispute that [Mr A] consulted him on 25th of December 1999 (Christmas Day). At that stage, [Dr B] was the duty doctor and not the usual attending doctor of [Mr A]. In the patient's own words, he said that he told [Dr B] he was concerned about the colour of his eyes and skin, and that he was extremely tired with no energy. He also told [Dr B] he was concerned that maybe his kidneys were playing up as he had a past history of kidney problems from an early age. Following the presentation of the history and the examination, he said that [Dr B] made a diagnosis of Hepatitis A and stated that it had to be allowed to run its course, and

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nothing could be done. In the patient's words, he was then advised to avoid close contact with other people, and was given dietary advice, as well as advice in regards to work and the expected duration of the illness. Following the consultation with [Dr B], the patient was seen on the 28th of December 1999 by [Dr C]. He was subsequently admitted to [a public hospital] on the 4th of January 2000, and on the 5th of January 2000 transferred to [a second] Public Hospital. On the 6th of January 2000 he was transferred to [a third] Public Hospital and underwent a liver transplant on the 10th of January 2000.

It is also important to note that [Mr A] had been seen prior to the consultation by [Dr B]. He was seen by his own general practitioner on 22nd of December 1999.

I will now comment on the information I have available, based on that sequence of events. I provide this opinion, in the knowledge that [Mr A] had Hepatitis B, and went on to develop fulminant liver failure.

2. INITIAL CONSULTATION WITH HIS OWN GENERAL PRACTITIONER ON 22ND OF DECEMBER 1999

From the report of the Health and Disability Commissioner, it appears that [Mr A] consulted his General Practitioner on 22nd of December 1999. At that stage he felt unwell and tired. His General Practitioner noted that the patient had experienced upper gastrointestinal discomfort for two weeks, which had become worse over the past five days. It was worse with food and he appeared to have acid in his stomach. The diagnosis was of reflux-type symptoms and metoclopramide tablets were prescribed. He was advised that he could return to work the next day. It is fair to say that this was the first presentation of the patient with his Hepatitis B infection. I have researched the presentation of viral hepatitis in Harrison's textbook of Medicine and the Merck Manual Volume 1, General Medicine. Under Symptoms and Signs in the 17th Edition of the Merck Manual, it states *'Hepatitis varies from a minor flu-like illness to a fulminant fatal liver failure depending on the patient's immune response and other poorly understood virus/host factors'*. They then document the prodromal phase, *'usually begins suddenly with anorexia, malaise, nausea and vomiting and often fever. After 3-10 days dark urine appears followed by jaundice. Systemic symptoms typically regress at this point, and the patient feels better despite worsening jaundice. Jaundice usually peaks within 1-2 weeks, and then fades during 2-3 weeks recovery phase. Physical examination shows variable jaundice, the liver may be enlarged and is often tender'*. They also state under Differential Diagnosis that *'in the prodromal phase, Hepatitis mimics a variety of flu-like illnesses and is difficult to diagnose'*. Therefore it is not surprising that [Mr A's] usual General Practitioner failed to reach a diagnosis on the first presentation of the 22nd of December 1999.

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3. CONSULTATION WITH DR B ON THE 25TH OF DECEMBER 1999

I have reviewed the copy of the records which state *'acute hepatitis, dietary advice, sick note for work'*. It is my opinion that these notes do not meet the currently accepted standard. I would have accepted some pertinent history to be recorded as well as relevant physical findings, i.e. presence of absence of jaundice, liver enlargement and tenderness. During the consultation, [Dr B] formed a diagnosis of acute infectious hepatitis. The diagnosis was in fact quite correct. What [Dr B] did not diagnose according to the records was whether the acute infectious hepatitis was caused by Hepatitis A, B or one of the other viral causes. Of course it would not have been possible for Dr B to have formally reached a conclusion in regards to the causative agent without appropriate investigation. However, as Hepatitis A is the commonest type of viral hepatitis and causes 20-40% of clinically apparent hepatitis, it is not unreasonable to suspect that this could have been discussed as the most likely cause with the patient. I have provided the appropriate pages from Murtagh's Textbook of General Practice that is currently accepted as the gold standard General Practice textbook in New Zealand. Following the diagnosis of acute infectious hepatitis, the records state that dietary advice was given, and a sick note for work. If one refers to page 469 from Murtagh's textbook, you will see that this was most appropriate under the heading Outcome and Treatment. 'Reassurance and patient education should be provided with appropriate rest and diet and alcohol modification. Also advice should be given on hygiene at home in regards to food handling and close contact'. From the patient's letter, it appears that this advice was given. I would also like to point out that the advice regarding time off work was extremely appropriate given the provisional diagnosis of infectious hepatitis. What is of importance is that [Mr A] accepts that he was told by [Dr B] to see his own General Practitioner when the surgery opened on the 28th of December 1999.

The question arises as to whether [Dr B] should or should not have undertaken any laboratory investigations on the 25th of December 1999. I am aware that on that day (Christmas Day) the Laboratory was closed and there were no facilities available for blood investigations to be undertaken in [the area]. However, [Dr B] could have considered taking a sample and storing it until the Laboratory was open on the 28th of December 1999. The question that therefore needs to be addressed is, would the taking of laboratory samples on the 25th of December 1999 have altered the provisional diagnosis and subsequent advice that [Dr B] gave, and/or would the taking of these samples on the 25th of December 1999 have altered the subsequent management of [Mr A's] care in any way.

The answer to the first question is NO, as there was no facility available for the bloods to be analysed and [Dr B] would not have had the luxury of the laboratory results being available to further confirm or rule out his clinical diagnosis. Therefore, I reject the need for the bloods to have been taken on that day to assist [Dr B] in reaching his clinical decision. The question that therefore remains, is whether taking blood samples on the 25th of December 1999 would have altered the subsequent management and hence outcome of [Mr A's] disease process. In my opinion, the answer to this is NO, as all appropriate management appears to have occurred once the definitive diagnosis was reached. The blood tests, which

confirm the diagnosis of Hepatitis B as the cause of the viral hepatitis, were on the 28th/29th of December 1999.

4. CONSULTATION WITH [DR C] ON THE 28TH OF DECEMBER 1999

In this consultation, [Dr C] recorded that the patient was jaundiced with a tender abdomen, particularly in the right upper quadrant. He ordered appropriate laboratory investigations, which confirmed a diagnosis of jaundice, secondary to Hepatitis B infection. There was also a slight elevation in the patient's prothrombin ratio consistent with the level of derangement of the liver function tests. [Mr A] was admitted to [a public hospital] on the 4th of January 2000 and the outcome of his illness is as documented in the Health and Disability Commissioner's provisional opinion.

5. OPINION OF DR CHRIS KALDERIMIS

Dr Kalderimis states that in the consultation with [Dr B] there is a marked discrepancy in regards to what actually took place in the consultation between [Dr B] and [Mr A]. However, I could not find the discrepancy that Dr Kalderimis was alluding to, in fact I found a high degree of concurrence in the provisional diagnosis given by [Dr B], and the advice provided from both the clinical notes and the letters from the patient. In Dr Kalderimis's report he does not comment on the rarity of acute Hepatitis B infection leading onto fulminant liver failure. I have enclosed Figure 49.4 Natural History of Hepatitis B Infection from Murtagh's textbook of General Practice. You will see that fulminant liver failure from Hepatitis B occurs in less than 1% of all Hepatitis B infections. Given that Hepatitis B is not the commonest cause of viral hepatitis in this country, and in fact hepatitis itself is relatively rare, it is quite probable that the majority of New Zealand General Practitioners will go through their practicing life without seeing a case of fulminant liver failure secondary to Hepatitis B. One of the issues that Dr Kalderimis raises is the question of whether [Dr B] should have been able to determine whether the patient had Hepatitis A or B, however [Dr B] formed a correct diagnosis (Viral Hepatitis) and assessed the severity of the illness that the patient was suffering from at the time of the consultation as opposed to the distinct aetiology.

Dr Kalderimis was then asked to comment on some specific questions.

1. *Should [Dr B] have given [Mr A] a diagnosis, even if it was a likely diagnosis when tests had not been conducted?*
   In my opinion the answer to that is YES. It is entirely appropriate for a practitioner to give a provisional diagnosis to a patient if one is apparent. If no provisional diagnosis is apparent, then I believe a practitioner should say so. In this case, [Dr B] had made a provisional diagnosis of hepatitis, whether it is Hepatitis A or B is, I believe immaterial in regards to giving a provisional diagnosis. He passed this diagnosis on to the patient and also provided advice regarding appropriate follow up. Other practitioners may have given a diagnosis of jaundice, but in my opinion that would not have been correct. The reason is that jaundice is merely a sign as

opposed to a diagnosis. A diagnosis is based on the underlying cause of the jaundice.

Dr Kalderimis then states appropriately that it is impossible to make a specific diagnosis of Hepatitis A, B or C. However, as stated previously, I believe this was not, and should not have been an issue at the time of the initial consultation. What was required was for the practitioner to appropriately assess the severity of the illness and take appropriate action based on those findings. [Dr B's] opinion was to make a provisional diagnosis and then offer advice in regards to that diagnosis. The advice offered was appropriate in regards to diet, rest and follow up by his own practitioner 3 days later. Dr Kalderimis comments on the possibility of jaundice from an obstructive lesion. It is my opinion that if a stone had been the cause, there would have been significant pain. As pointed out by Dr Kalderimis, tumour is most unlikely in a man of this age.

2. *Even though laboratory facilities were not available on the 25th of December 1999, should [Dr B] have collected samples so that he could have (a) sent them to the laboratory for tests when it reopened along with a note asking the laboratory for the results to be sent to [Mr A's] General Practitioneror (b) sent a note to [Mr A's] General Practitioner advising what he had done?*
As I have commented previously, it is my view that a number of practitioners would have followed the process undertaken by [Dr B] while others would have taken blood samples for later analysis. I do not believe that any one approach is particularly more correct than the other.

One must remember that there were no facilities available on Christmas Day for laboratory analysis to occur. [Dr B's] opinion was that the cause of the illness was infectious hepatitis, and based on that opinion concluded that laboratory investigations on Christmas Day were not required. With the benefit of hindsight, one always can criticise an approach by a colleague and state that in this case, that it would have been appropriate for blood to be drawn. However, given the circumstances, as I understand them from the information provided, I do not believe that [Dr B] was at fault in not obtaining laboratory samples.

3. *Did [Dr B] give appropriate care and instructions to [Mr A]?*
I would agree with Dr Kalderimis that the instructions given to the patient were reasonable. However, I would disagree with Dr Kalderimis that the patient should have been instructed to come in the next day for review. It is my view that requesting a patient to see his own practitioner in 3 days time was not inappropriate. As [Mr A] was not admitted to [a public hospital] until the 4th of January 2000, it is hard to see how seeing [Mr A] on the 26th of December 1999 would have given the practitioner any further information which may have led to a different course of action in regards to his care. I would however, have instructed the patient to seek medical care should there be any sudden and/or significant deterioration in his

condition. The features that I would have asked the patient to be alert to would have been pain, fever, vomiting etc.

4. *Should [Dr B] have informed [Mr A] that he would feel better in approximately 4 days and that he would be well in approximately 15 days?*
Dr Kalderimis stated that [Dr B] was unwise to make this statement because he did not have a working diagnosis. This is in fact incorrect. Dr B did have a working diagnosis. This diagnosis was acute infectious hepatitis as recorded in the consultation records. [Dr B] also believed that the likely aetiological agent of acute infectious hepatitis was Hepatitis A. Given the case, and on reviewing the literature, the information he gave to the patient in regards to when he should start to improve was quite appropriate. I personally believe that informing the patient of the likely course of the illness is critical. First it empowers the patient. Secondly, in mapping out the probable course of the illness, it allows the patient to be alerted should the subsequent progression not follow the mapped out course. This would then alert the patient to seek further medical review. I believe that the response to this question by Dr Kalderimis is incorrect. Dr Kalderimis also raised the issue of whether the patient was aggressive. This, in my view is not relevant to this issue.

5. *Should [Dr]B have taken any other action at the consultation in 1999?*
I have previously commented on the issue of whether blood for laboratory examination should or should not have been taken.

6. *How much do the test results received from [Mr A's] General Practitioner deviate from the norm (i.e. do the results indicate a level of seriousness in respect to [Mr A's] condition)?*
The test results I have available from the consultation on the 28th of December 1999 do deviate significantly from the norm. However, as pointed out by Dr Kalderimis they do not indicate a requirement for immediate hospital admission. This is also borne out by the sequence of events in which [Mr A] was not admitted to [a public] hospital until the 4th of January 2000. As pointed out by Dr Kalderimis, the blood tests do indicate that the final diagnosis was that of Hepatits B which is a subcategory of acute viral hepatitis. I do not agree that the results indicate that he should have been monitored on a daily basis. I have discussed this with a colleague in Chemical Pathology who indicated that it would be most unusual to have significant changes in liver function on a daily basis. However, he certainly pointed out, and I would agree, that this patient should have been monitored at least twice weekly.

7. *Are there any other issues arising from the supporting information?*
I agree completely with Dr Kalderimis that fulminant Hepatitis B is extremely rare. I have previously pointed out that this is less than 1% according to the medical literature. I also agree with Dr Kalderimis that if a diagnosis of Hepatitis B had been made in the area, it would not have altered the outcome for this patient. I have previously commented on the consultation notes recorded by [Dr B]. However, in

mitigation, I would point out that [Dr B] was the sole covering General Practitioner for [the area] on Christmas Day. In this role he not only had to field the telephone calls which were made by patients, but also arrange any home visits and see patients as required in his surgery. It is therefore not surprising that there is often brevity in the notes made by practitioners when they see patients out of hours.

Dr Kalderimis then comments that the reassurance given to the patient was inappropriate. However, I strongly disagree with this. [Dr B] made a provisional diagnosis of acute infectious hepatitis, which is correct. What he didn't diagnose, nor do the records suggest that he did, was whether Hepatitis A or B caused it. If in fact, he did state that the most likely cause of the acute viral hepatitis was Hepatitis A, then this is based on the probability diagnosis i.e. the commonest cause of acute hepatitis in New Zealand is Hepatitis A. I therefore disagree with Dr Kalderimis that it would have been incorrect for Dr B to have mentioned Hepatitis A as he did not have any evidence to support the fact. When provisional diagnoses are being discussed with patients in General Practice, it is common for us not to have any supporting evidence. That is in itself, the very nature of General Practice – we deal with uncertainties.

Finally, I would agree with Dr Kalderimis that the care provided by [Dr B] or any other medical practitioner who may have seen [Mr A] on that day would not have altered the outcome for this patient."