General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 00HDC08817)

Parties involved

Mrs A (deceased)	Consumer
Dr B	General Practitioner / Provider
Mr C	Oral surgeon
Mr D	Consumer's husband
Dr E	General practitioner, Medical Centre
Dr F	Oral physician, public hospital
Dr G	Consultant radiation oncologist, public hospital
Dr H	Consumer's dentist

Expert advice was obtained from an independent general practitioner, Dr Jim Vause.

Complaint

On 5 September 2000 the Commissioner received a complaint from Mrs A about the standard of service she had received from Dr B concerning the diagnosis of her squamous cell carcinoma of the tongue. Mrs A was diagnosed in June 1999 and died in November 2000. The complaint is that:

- *On 31 March and 14 April 1999 Dr B misdiagnosed Mrs A's cancer as mumps.*
- *Between 31 March and 14 April 1999 Dr B failed to adequately examine and appropriately refer Mrs A for specialist opinion of her glandular lump.*

An investigation was commenced on 11 October 2000.

Information reviewed

Copies of Mrs A's clinical notes were obtained from Dr B, at the Medical Centre; the consumer's dentist; Mr C, oral surgeon; and the public hospital.

Information gathered during investigation

In April 1998 Mrs A had new dentures fitted by her dentist and over the ensuing months found them uncomfortable. Mrs A was a smoker. On 11 November 1998 Mrs A consulted Dr B, her general practitioner at a Medical Centre. The reason given for Mrs A's consultation, the examination undertaken, the subsequent clinical findings, and the treatment plan are not recorded. The clinical notes of the consultation read simply as:

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

> "Probable mumps. Uncomplicated."

In his letter of response to notification of this investigation, Dr B stated:

> "[Mrs A] consulted me with glandular lumps in the neck and was found to have bilateral tender swelling in the parotid glands. I made the diagnosis of probable uncomplicated mumps infection and the symptoms and clinical signs subsequently disappeared."

Mr D advised that his late wife, Mrs A:

> "had had a swelling only in her left gland because when she came home she had joked that she had a 'mump' as opposed to the usual 'mumps'. [He said] the lump was just on the left-hand side and it was small. [He thought] the lump went down but she was left with a little bit of discomfort, it was not painful, very minor. That was why she did not go back to the doctor. [He] said [Mrs A] thought the discomfort arose from her gums and relatively new false teeth which were not comfortable."

Mrs A attended the Medical Centre again on 19 January 1999 and was seen by Dr E for "skin rash, qv, golfers elbow left strain". Mrs A was prescribed a moisturiser lotion and Voltaren and referred for a routine mammogram breast screen. She was also noted to be hypertensive with a blood pressure of 150/100, which was to be rechecked in one week. On 27 January 1999, Mrs A was seen at the Medical Centre by the nurse and had her blood pressure checked. The clinical notes read: "140/76, couldn't take Voltaren, nausea."

Dr B later wrote:

> "… The nurse further discussed the option of a steroid injection to the inflamed tendonitis and informed the patient that [Dr E] refers all of her patients to [Dr B] for this procedure."

Mrs A's next consultations were with Dr B on 31 March 1999 and 14 April 1999. The clinical notes record respectively: "Tennis elbow 2/12. Discussed options. Ken 40 L Elbow cc" and "Good response to Kenacort."

Dr B also wrote:

> "On 31 March 1999 [Ms A] consulted me for a steroid injection to be given. I discussed the options for treatment with her and then proceeded with the injection at the left elbow. I asked that she return in two weeks time for a review of that procedure. On 14 April 1999 [Ms A] consulted me as a follow-up of her tendonitis and it was noted that she had a good response to the treatment. At no time during either of those two consultations did [Ms A] indicate that she had a glandular lump in her neck or any sore on her tongue and an examination of the neck and mouth was not performed."

On 28 April 1999, Mrs A again saw Dr B. His clinical notes record:

> "Earache for a few days – mainly R ear. Recent mumps in New Year week, also new dentures and recent tongue bite (due to new dentures). O/E Sl. bulging L ear drum with

> no movement with blow. Imp: Possible viral infection ? bacterial. Plan 1. Trial of antibiotics. Augmentin (500mg Tab) Qty: 15 Qty. Take 1 po tds (one tablet orally 3 times a day)."

Dr B later wrote:

> "On the 28 April 1999 [Ms A] consulted with me complaining of pain in both ears, mainly on the right side. It was noted as part of her personal medical history that she had been diagnosed with mumps in January of 1999 (actually Nov 1998), that she had new dentures and that she had bitten her tongue recently. Sometimes mumps will present as pain in both ears before any swelling to the gland occurs but this personal history of mumps excludes it as a possible diagnosis as mumps does not recur in the same patient. I examined [Ms A] and found her to have a normal right ear, normal throat, no lumps in the neck, and a bulging left ear drum that did not move to gentle blowing suggesting a blocked left eustachian tube. …"

Dr B ruled out a diagnosis of mumps on this occasion because Mrs A's recent history of mumps excluded that possibility. Dr B concluded by stating that "had a swollen lymph node been found in the neck it would still be consistent with the diagnosis of an upper respiratory tract infection." This was Mrs A's last consultation with Dr B.

On 10 May 1999 Mrs A consulted her dentist who noted: "Pain and inflammation +/- infection L tonsillar region and base of tongue – saline m/w – check 5 days." On 14 May 1999, the dentist recorded: "Looking better, G Violet [Gention Violet] see seven days." On 21 May 1999 the dentist noted: "Much improved – see two weeks." However, on 4 June 1999 the dentist recorded: "Better – but not right. Refer to [Mr C]."

On 8 June 1999, Mrs A was examined by oral surgeon [Mr C]. He reported that Mrs A "had a large hard ulcerated lump on the left side of her tongue" and referred her immediately to [a public hospital].

On 11 June 1999, Mrs A was seen at the public hospital by Dr F, oral physician, and referred to the Head and Neck Clinic. On 15 June 1999, Dr G, the consultant radiation oncologist, noted:

> "**History:** [Mrs A] was seen at the combined Head and Neck Clinic on 11/6/99. She complained of a pain on the left side of the tongue for the previous 3 months, it was associated with pain in the left ear and neck. She had noted ill fitting dentures for the previous year. She had odynophagia but no dysphagia or dypsnoea. However, she has changed to a soft food diet. She says she has not lost weight. …
>
> **Clinical Examination:** On examination she was in good general condition. There was a 2.5cm mobile Level II node on the left. There was no other lymphadenopathy. Oral cavity: she was edentulous and there was no trismus. There was a large ulcer with round edges involving the left lateral posterior tongue, anterior faucal pillar and on to the alveolus. The induration extended to the mid-line. The tongue was mobile.

Assessment: [Mrs A] has a clinical T4 N2a carcinoma of the left oropharynx … [left base of tongue/tonsils]."

Mrs A died approximately 18 months later on 1 November 2000, aged 57.

During the course of this investigation I referred the matter to the Medical Council of New Zealand with a request that the Council undertake a competence review of Dr B. The Council confirmed the matter was considered by the Professional Standards Committee and was dealt with in accordance with the provisions of the Medical Practitioners Act. Dr B advised that the outcome of the competency review was "fine".

Independent advice to Commissioner

The following independent expert advice was obtained from a general practitioner, Dr Jim Vause:

"… In reply to your questions

Was the diagnosis of mumps in November 1998 reasonable?

The incidence of mumps in this age group is exceedingly low. In 1997 there were no reported cases of mumps in persons age 50-57 in New Zealand (mumps was a notifiable disease as of 1996). At the time of [Mrs A's] diagnosis the rate for that month in New Zealand was 2.4 persons per 100,000 for all age groups. On a statistical likelihood, a diagnosis of mumps would have to be unusual and other pathology would need to be excluded particularly in a person of this age who was a smoker.

From the clinical notes 'D' it is very difficult to assess the accuracy of the diagnosis in November 1998 as there is no record of the examination findings such as whether the presentation was one of bilateral neck gland swelling, or other symptoms suggestive of parotid infection (eg pain with salivation). This lack of data is unfortunate.

From [Dr B's] letter of 20 October 2000 'C' he is more explicit, referring to bilateral parotid gland swelling which would definitely favour mumps. This suggests that either [Dr B] has other clinical records that have not been presented, or he has extrapolated this information from his computer notes.

Should the lesion have been palpable or otherwise apparent to [Dr B] on or before 28 April 1999?

It is probable that the lesion was not palpable at this examination on 28 April 1999. [Dr B's] note refers to pain about [Mrs A's] right ear although her subsequent cancer originated on the left side of her tongue. The dentist [Dr H] noted an inflamed infection about the patient's left tonsillar region on the 10-5-99, which would have been the cancer. It is likely that this would have been evident on examination a week and a half earlier but this would be by no means certain.

> The problem is the lack of clarity of the medical notes, especially the examination finding, namely whether [Dr B] palpated [Mrs A's] neck to check for enlarged lymph glands and whether [Dr B] examined the inside of her mouth. These two important examination procedures would be essential I believe given [Mrs A's] recent history of 'mumps', her smoking and the fact that she was complaining of malfitting dentures, an important symptom requiring close examination.
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> But for this lack of examination recording, [Dr B's] management would be entirely appropriate given the time and place of [Mrs A's] presentation. It would have been essential to follow up [Mrs A] following her trial of antibiotics and this plan should have been noted in [Dr B's] records. The other option would have been referral to a dentist, a line that also was not taken judging from the clinical records.
>
> *Any other relevant matters?*
>
> The length of time [Dr H] treated [Mrs A] would suggest the diagnosis was not immediately evident to the dentist either.
>
> In summary, it is possible that [Mrs A's] cancer was not particularly evident when she presented to [Dr B]. If he had made normal clinical examination of [Mrs A] at the time of her presentation, that is looking inside her mouth and palpating her neck for lymphadenopathy in addition to the recorded examination of her ear and found no sign of her cancer, the management of this case would appear appropriate. The poor clinical notes make it difficult to judge these matters.
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> The only significant clinical judgement was that a higher index of suspicion that this lady was unlikely to have mumps may have helped focus [Dr B] on a need to rule out cancer. This, combined with her 28 April 1999 presentation should have raised the doctor's suspicions."

My advisor was asked to clarify whether the glandular lump or lumps Mrs A presented with in November 1998, diagnosed as "probable mumps", was in any way related to the lesion on her tongue, which was diagnosed as a carcinoma in June 1999.

My advisor responded that "it is possible but not certain".

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.

Other Relevant Standards

New Zealand Medical Association 'Code of Ethics'

Responsibilities to the Patient:
Standard of Care –

3. Ensure that every patient receives a complete and thorough examination into their complaint or condition.

...

4. Ensure that accurate records of fact are kept.

...

The Medical Council of New Zealand, 'Medical Practice in New Zealand: A Guide to Doctors Entering Practice' (1995)

13. THE PATIENT'S MEDICAL RECORD

13.1 *[A] doctor is expected as part of the quality of service provisions to maintain adequate records.*

13.2 *... [T]he absence of some written, possibly computer, record or annotation invariably makes the task of establishing the truth very difficult.*

Opinion: Breach

Right 4(1)

Mrs A consulted Dr B on 11 November 1998 and was diagnosed with probable uncomplicated mumps. In June 1999 Mrs A was diagnosed with a carcinoma of the left oropharynx (base of the tongue/tonsils). The essence of Mrs A's complaint is that the glandular lump about which she consulted Dr B in November 1998 was the carcinoma, and that it was misdiagnosed as "mumps".

There are two issues. First, whether the condition Mrs A presented to Dr B in November 1998 could reasonably have been diagnosed as mumps and, secondly, whether the lump complained of in November 1998 was related to Mrs A's carcinoma diagnosed in June 1999.

Was the diagnosis of mumps in November 1998 reasonable?
My advisor stated that the presence of bilateral swelling of the parotid glands would favour a diagnosis of mumps. There is, however, a conflict of evidence about the presence of this symptom when Mrs A visited Dr B on 11 November 1998.

Mr D advised that his late wife's visit to Dr B in November 1998 concerned a small lump on the left-hand side of her throat. He said that she:

> "had had a swelling only in her left gland because when she came home she had joked that she had a 'mump' as opposed to the usual 'mumps'. [Mr D said] the lump was just on the left-hand side and it was small. [He thought] the lump went down but she was left with a little bit of discomfort, it was not painful, very minor. That was why she did not go back to the doctor. [He] said [Mrs A] thought the discomfort arose from her gums and relatively new false teeth which were not comfortable."

Mrs A referred in the singular to a "glandular lump" in her letter of August 2000 as being the lump diagnosed as "mumps". However, at this stage Mrs A was close to death. Her reference to consultation dates in March or April 1999 as being the dates when she had "mumps" are clearly confused with consultations from the period when a lesion was first noticed by the dentist in April 1999 and later diagnosed as a carcinoma.

Dr B advised in his letter of 20 October 2000 that "[Ms A] consulted me with glandular lumps in the neck and was found to have bilateral tender swelling in the parotid glands".

I acknowledge that Mr D was familiar with his wife's condition and knowledgeable about her complaints. He specifically recalls Mrs A's lump and her comments after the November 1998 consultation about her singular glandular "mump". However, he was not at the consultation himself. I also acknowledge that although it is possible that Mrs A was confused about the dates of her consultations with Dr B about this lump, she was not necessarily confused about its singularity. Dr B, on the other hand, states that there were bilateral lumps. However, in the absence of a clear clinical record, he has had to rely upon his memory of a single consultation some 23 months after it took place.

I am therefore unable to ascertain with any certainty whether or not Mrs A had bilateral swelling of the parotid glands, the presence of which would favour a diagnosis of mumps, at the time she consulted Dr B in November 1998.

A further consideration is that Mrs A was aged 55 years in November 1998. I accept my independent advisor's advice:

> "[T]he incidence of mumps in this age group [50–57] is exceedingly low. In 1997 there were no reported cases of mumps in persons aged 50-57 in New Zealand (mumps was a notifiable disease in 1996). At the time of Mrs A's diagnosis the rate for that month in New Zealand was 2.4 persons per 100,000 for all age groups. On a statistical likelihood, a diagnosis of mumps would have to be unusual and other pathology would need to be excluded particularly in a person of this age who was a smoker."

Dr B's clinical notes simply state:

> "Probable mumps. Uncomplicated."

There is no evidence that Dr B considered any other pathology.

My independent advisor stated:

> "[F]rom the clinical notes … it is very difficult to assess the diagnosis in November 1998 as there is no record of the examination findings such as whether the presentation was one of bilateral neck gland swelling, or other symptoms suggestive of parotid infection (eg pain with salivation). This lack of data is unfortunate."

When asked whether there was a relationship between the glandular lump or lumps found in November 1998 and the tongue lesion diagnosed as carcinoma in June 1999 my advisor commented that "it is possible but not certain".

There is therefore no conclusive evidence that the glandular lump or lumps Mrs A complained of in November 1998 developed into the carcinoma diagnosed in June 1999.

However, as noted by my independent advisor, there was clearly a need for Dr B to have a "higher index of suspicion" and to "focus … on the need to rule out cancer" in a patient with Mrs A's history of smoking and malfitting dentures. An opportunity for earlier investigation was lost. In these circumstances, Dr B did not exercise the reasonable skill and care expected of a general practitioner, and breached Right 4(1) of the Code.

Opinion: No Breach

Right 4(1)

Alleged failure to adequately examine and refer for specialist opinion
In my opinion Dr B did not breach Right 4(1) in relation to his alleged failure to adequately examine Mrs A and refer her for a specialist opinion.

Mrs A consulted Dr B on 31 March and 14 April 1999 about treatment for and review of her "tennis elbow". These consultations were unrelated to her complaint concerning the cancer Mrs A developed in her tongue.

On 28 April 1999 Mrs A consulted Dr B complaining of an earache of a few days' duration. He also noted her recent medical history, new dentures and recent tongue bite. Dr B's impression was a possible infection and he prescribed a trial of antibiotics. There is no detail in the clinical notes of whether Dr B examined Mrs A's throat and, if so, of his findings. My advisor said that palpation of the neck glands and examination of the inside of the mouth would be essential given Mrs A's history of smoking and malfitting dentures. However, in Dr B's later response, he stated that he "examined [Ms A] and found her to have a normal right ear, normal throat, no lumps in the neck, and a bulging left eardrum …".

My independent advisor noted that "it is probable that the lesion was not palpable at [the] examination on 28 April 1999", but that it was "likely [the lesion] would have been evident on examination … but this would be by no means certain".

On examining Mrs A on 10 May 1999 Mrs A's dentist noted:

> "Pain and inflammation +/- infection L tonsillar region and base of tongue. …"

I accept my expert advice that:

> "[Mrs A's] cancer was not particularly evident when she presented to [Dr B]. If he had made a normal clinical examination of [Mrs A] at the time of her presentation, that is looking inside her mouth and palpating her neck for lymphadenopathy in addition to the recorded examination of her ear and found no sign of her cancer, the management of this case would appear appropriate."

I agree with my independent advisor that "poor clinical notes make it difficult to judge these matters". I also note that it is only Dr B's later advice that he examined Mrs A's throat, rather than his contemporaneous clinical notes, that mitigates an impression of a significant omission in his physical examination of Mrs A on 28 April 1999.

In my opinion there is insufficient evidence to conclude that Dr B breached the Code in failing to notice Mrs A's cancer and appropriately refer her to a specialist when he examined her on 28 April 1999.

Opinion: Breach

Right 4(2)

Failure to maintain adequate records
Dr B's notes on his examination of Mrs A on 11 November 1998 simply state:

> "Probable mumps. Uncomplicated."

Dr B did not record the symptoms Mrs A complained of, whether any examination was undertaken, details of the treatment plan or any follow-up arrangements. This paucity of recorded clinical detail is also evident in later consultation records. On 28 April 1999 there is no direct mention of whether Mrs A's neck glands were palpated or her throat and mouth internally examined and, if so, the findings. My advisor stated:

> "It is probable that the lesion was not palpable at this examination on 28 April 1999. … The dentist [Dr H] noted an inflamed infection about the patient's left tonsillar region on the 10-5-99, which would have been the cancer. It is likely that this would have been evident on examination a week and a half earlier but this would be by no means certain.
>
> The problem is the lack of clarity of the medical notes, especially the examination finding, namely whether [Dr B] palpated [Mrs A's] neck to check for enlarged lymph glands and whether [Dr B] examined the inside of her mouth. These two important examination procedures would be essential I believe given [Mrs A's] recent history of 'mumps', her smoking and the fact that she was complaining of malfitting dentures, an important symptom requiring close examination."

I agree with my advisor's further observation that Dr B's "poor clinical notes make it difficult to judge".

When the nature and findings of Dr B's examinations of Mrs A later became the subject of investigation, key evidence in the form of well documented, contemporaneous clinical notes were not available. Later advice received from Dr B relies upon the accuracy of human recall nearly two years after the consultations. Unverifiable recall evidence is often inaccurate and may be self-serving.

As noted by the Medical Council of New Zealand, Medical Practice in New Zealand: A Guide to Doctors Entering Practice (1995), "there is a strong ethical duty to maintain adequate records … a doctor is expected as part of the quality of service provisions to maintain adequate records …".

In my opinion Dr B breached Right 4(2) of the Code in failing in his ethical and professional duty to keep full and accurate notes of consultations.

Actions

I recommend that Dr B take the following actions:

- Apologise in writing to Mr D for breaching the Code.
- Review his practice in light of this report.

Further actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.
- An anonymised copy of this opinion 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.