General Practitioner, Dr C

General Practitioner, Dr D

A Report by the

Health and Disability Commissioner

(Case 10HDC00753)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary 1

Complaint and investigation 2

Information gathered during investigation 3

Professional standards 11

Opinion: Breach — Dr C 12

Opinion: Breach — Dr D 13

Other comments 18

Recommendations 18

Follow-up actions 19

Appendix — Independent clinical advice to Commissioner 20

Executive summary

Background

1. This report concerns inappropriate prescribing by a general practitioner, and the subsequent inappropriate treatment by another doctor.

2. Mr A (aged 63 years at the time of the events complained about) had a history of two episodes of peptic ulceration[1] associated with bleeding, one of which was in 1993 and the other in 2008. This history was known to his general practitioner (GP), Dr C, who had been Mr A's GP since January 2008. The history was also recorded in Mr A's patient notes.

3. On 1 June 2010, Mr A consulted Dr C in relation to a sore back. Dr C prescribed Mr A ibuprofen, a drug that Medsafe advises should not be used in patients with a history of recurrent peptic ulceration or gastrointestinal haemorrhage. Dr C also prescribed Mr A prednisone, which Medsafe advises should be used with caution in patients with peptic ulcers. Dr C did not inform Mr A about the possible risks and side effects of the medication he was prescribing.

4. On 21 June 2010, Mr A consulted another doctor at the same practice, Dr D, complaining of chest pain and feeling unwell, and advising that he had had black bowel motions the previous day. Dr D assumed that Mr A had suffered a gastrointestinal (GI) bleed secondary to ibuprofen and prednisone. He ordered blood tests and advised Mr A to stop taking the medication, and to attend the public hospital's emergency department if his condition worsened. Dr D did not measure Mr A's blood pressure at the consultation or seek immediate hospital admission for Mr A.

5. The following day Mr A felt a lot worse, so his partner contacted the health clinic for advice. Dr D instructed the practice nurse that Mr A was to be told to go to hospital. Dr D did not ensure that Mr A was aware of the seriousness of his condition and should call an ambulance to transport him to hospital.

6. Mr A travelled to the public hospital's emergency department by public transport. When he was assessed, his haemoglobin[2] was 54g/L,[3] indicating acute blood loss, and he was given a blood transfusion and intravenous omeprazole.[4]

7. Mr A had a gastroscopy[5] and was diagnosed with an upper GI bleed, secondary to non-steroidal anti-inflammatory drugs (NSAIDs). Mr A was discharged to the care of Dr C. The discharge letter, a copy of which was sent to Dr C, contained written advice to Mr A that in the future he "MUST NOT take aspirin, NSAIDs (ibuprofen, diclofenac etc) or steroids as these increase your risk of an ulcer".

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[1] Erosion of the lining of the stomach or first part of the small intestine.
[2] The iron-containing protein attached to red blood cells that transports oxygen from the lungs to the rest of the body.
[3] The normal range is 130–175g/L.
[4] Omeprazole decreases the amount of acid produced in the stomach and is used to treat symptoms of dyspepsia, peptic ulcer and gastro-oesophageal reflux disease.
[5] A gastroscopy is an examination of the inside of the gullet, stomach, and duodenum using a thin fibre-optic instrument that is passed through the mouth.

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Decision summary

8. Dr C breached Right 4(1)[6] of the Code of Health and Disability Services Consumers' Rights (the Code) by prescribing NSAIDs and steroids to Mr A — a patient who had a known history of two episodes of peptic ulceration. Dr C also breached Right 6(1)(b)[7] of the Code for failing to inform Mr A about the possible risks and side effects of the medication he was prescribing. Without this information, Mr A was not in a position to make an informed choice, and provide informed consent to taking the medication. Accordingly, Dr C also breached Right 7(1)[8] of the Code.

9. Dr D breached Right 4(1) of the Code by failing to measure Mr A's blood pressure at the consultation on 21 June 2010, failing to seek immediate hospital admission for Mr A following the consultation on 21 June 2010, and failing to ensure Mr A was aware of the seriousness of his condition on 22 June and that he should call an ambulance to transport him to hospital. Dr D's documentation in relation to the consultation on 21 June was inadequate and, accordingly, he breached Right 4(2) of the Code.

10. The health clinic was not the subject of my investigation. However, consideration was given to its policies and processes in relation to recording patient histories and medication alerts. These were found to be adequate.

Complaint and investigation

11. On 29 June 2010, HDC received a complaint from Mr A about the services provided to him by his GP, Dr C. The following issue was identified for investigation:

The appropriateness of the care and treatment provided by Dr C to Mr A between 1 June 2010 and 22 June 2010.

12. On 12 July 2011, the investigation was extended to include the following issue:

The appropriateness and the adequacy of the care provided to Mr A by Dr D in June and July 2010.

13. Information was reviewed from the following parties:

Mr A	Consumer/complainant
Ms B	Mr A's partner
Dr C	General practitioner/provider

[6] Right 4(1) states: Every consumer has the right to have services provided with reasonable and care and skill.

[7] Right 6(1) states: Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including — … (b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option …

[8] Right 7(1) states: Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

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Dr D	Medical practitioner/provider
A health clinic	Provider
A district health board	Provider

Also mentioned in this report:

Dr E	General practitioner
Ms F	Practice nurse

14. Clinical advice was obtained from my in-house clinical advisor, general practitioner Dr David Maplesden, and is attached as an appendix.

Information gathered during investigation

Background information

15. The health clinic is a primary health clinic with a particular focus on addressing Māori health needs, and has approximately 6,000 patients. All consultation notes, test results and referrals are kept electronically on the computerised patient management system, MedTech 32. The individual doctors at the clinic enter any medication alerts or classifications as they arise during the consultation, and the alerts are then available for any doctor to view in the classifications and alerts section of the patient's electronic record.

16. Dr C[9] was employed as a locum GP at the health clinic. Dr D was employed three days per week at the clinic. Dr D is not vocationally registered as a GP.

January 2008

17. Mr A, then aged 60, was first seen by Dr C as a new patient on 21 January 2008. At this consultation, Dr C recorded that Mr A "has had surgery for gastric ulcer about 15 years ago at [a public] Hospital".

18. During the consultation on 21 January 2008, Mr A collapsed, then recovered. He went to the toilet and passed "a massive amount" of red and black blood. Dr C referred Mr A to the public hospital as an emergency.

19. At the hospital, Mr A was diagnosed with an acute duodenal ulcer which required clipping after an injection with adrenaline. A discharge summary noting the diagnosis was sent to Dr C. This was received by Dr C on 25 January 2008 and was filed in Mr A's notes. Dr C did not enter any diagnosis classification into the patient management system after receiving the discharge summary.

June 2008–August 2009

20. On 27 June 2008 Mr A consulted general practitioner Dr E, at the clinic, complaining of feeling nauseous when lying down at night. Dr E enquired about other symptoms,

[9] Dr C is a fellow of the Royal New Zealand College of General Practitioners.

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such as vomiting, pain in the abdomen, black stools, and bleeding per rectum, all of which Mr A denied. Dr E examined Mr A's abdomen and his findings were normal.

21. Dr E prescribed Losec[10] for Mr A for two months and recommended that Mr A return in one month's time for follow-up. Dr E entered "gastritis and duodenitis" as a diagnosis classification in Mr A's medical record.

22. Mr A did not return to the clinic until 25 June 2009, when he was seen by Dr C regarding a leg rash. He returned again on 7 August 2009 about a nose bleed.

Consultation 1 June 2010

23. On 1 June 2010, Mr A had a sore back, so he consulted Dr C. Dr C documented that Mr A had had a sore back on and off for a few years but it had been very sore over the past week. Dr C also documented: "SLRT[11] full both sides. Tender over lumbar area. Guarding[12] +." No diagnosis or management plan was documented.

24. Dr C prescribed Mr A prednisone 20mg tabs (written as "23 tablets on alternate days"), ibuprofen 400mg three times daily with meals, and paracetamol tablets.

25. Prednisone is a glucocorticoid[13] which prevents the release of substances in the body that cause inflammation. According to the Medsafe Data Sheet, caution is necessary when prescribing prednisone for patients with peptic ulcers, as glucocorticoids have been implicated in causing peptic ulceration.

26. Ibuprofen is an NSAID.[14] According to the Medsafe Data Sheet, ibuprofen should not be prescribed for patients with active, or a history of, ulcerative colitis, Crohn's disease, recurrent peptic ulceration or gastrointestinal haemorrhage, which is defined as two or more distinct episodes of proven ulceration or bleeding.

27. Dr C advised Mr A to return to see him if he did not improve. Dr C cannot recall what, if any, information he gave Mr A about the risks, benefits, and side effects of the medication he had prescribed, and nothing has been documented. Mr A advised HDC that he does not recall Dr C giving him any information about the risks, benefits and side effects of the prescribed medication.

28. Mr A advised HDC that he began passing black, and at times blood-stained, stools. Mr A said that he became aware of blood in his bowel motion on 18 June 2010 and presented to Dr D on 21 June as a result of this.

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[10] This is a trade name for omeprazole.
[11] Straight leg raising test.
[12] *Guarding* is behaviour that prevents or reduces pain. Guarding behaviour may include stiffness, limping, bracing a body part, and flinching.
[13] Glucocorticoids are a class of steroid hormones.
[14] Non-steroidal anti-inflammatory drug.

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Consultation 21 June 2010

29. On Monday 21 June 2010 Mr A consulted Dr D. Mr A was a walk-in patient who had no appointment booked, and he attended the consultation with his partner, Ms B.

30. The notes from this consultation read:

> "Shifting furniture on [18 June 2010] and developed lower chest pain [on 19 June 2010]. Noticed 2–3 black motions yesterday afternoon. Normally 4–5 motions daily, mainly in the AM. Was given brufen 400mg [twice daily], prednisone 20mg 2 alternate days and paracetamol [on 1 June 2010] for back pain.
>
> [On examination] localised lower sternal and adjacent costal margin pain with all ranges of movement. Localised tenderness same area. Some epigastric discomfort otherwise abdomen normal. Assume 1. GI bleed secondary to brufen and prednisone and 2. Musculoskeletal cause for his lower sternal pain. For bloods. Advised."

31. The advice that was given to Mr A is elaborated on by Dr D in retrospective documentation on 28 June 2010. Dr D recorded: "[W]as initially seen by me 22/6/10[15] and advised by me to stop the prednisone and ibuprofen and attend A&E urgently if bleeding or faintness [recurs] (as stated to me by the patient and his wife today)."

32. In contrast, Mr A and Ms B both recall that Dr D advised Mr A to stop taking the medication, go home and rest up, and "if things get worse", to go to hospital.

33. Dr D entered diagnoses of "Musculoskeletal symptoms" and "Gastritis and duodenitis (probable) — Melaena[16] from suspected Gastric [ulcer]" as long-term classifications in Mr A's medical record.

34. Dr D advised HDC that Mr A gave a history of shifting furniture three days earlier and developing chest pain the following day. Dr D recalls that Mr A told him that his bowel motions had now returned to normal. Dr D said that Mr A told him that he had felt unwell on Sunday but now felt "alright", and that Ms B said that Mr A had looked "pale and unwell" on Sunday, but that he now looked much better. Dr D did not record any of this information.

35. In contrast, Mr A advised HDC that his bowel motions had not returned to normal before seeing Dr D. Mr A said that he had passed black/blood-stained stools in the morning before the appointment, and he told Dr D this. Ms B recalls that Mr A told Dr D that Mr A had been up during the night and passed abnormal stools. She stated that Dr D did not ask Mr A whether he had had any normal bowel motions since the abnormal ones.

36. Mr A denies that he told Dr D that he now felt "alright". Ms B said she did not tell Dr D that Mr A now looked much better. Ms B said that if Mr A had been feeling much better on the Monday, they would not have gone to the doctor.

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[15] This should read 21/6/10.

[16] Black, tarry stools most often caused by bleeding in the stomach or upper gastrointestinal tract.

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37. In response to my provisional opinion, Dr D stated that he is "certain" that at the consultation on 21 June 2010 he was told that Mr A had experienced normal bowel motions since his episode of black bowel motions the previous day. Dr D added that, if Mr A had been continuing to experience dark stools, he would have referred Mr A to hospital and not simply advised him to attend the hospital if he had another espisode of dark stools.

Cardiovascular assessment and documentation

38. Dr D did not record Mr A's pulse or blood pressure, or record any comment about Mr A's general condition or appearance. Dr D subsequently advised HDC that Mr A "did not look pale and appeared of quite normal colour … he did not look particularly unwell". Dr D further advised that if Mr A had been "obviously pale and/or felt faint" he would have noted and documented this.

39. In contrast, Ms B stated that Mr A "was pale and unwell and could not walk properly on the Sunday and the Monday".

40. Dr D recalled that Mr A did not exhibit any postural hypotensive symptoms[17] or faintness, and that on examination of his chest "there appeared to be a clear, localised, 'musculo-skeletal' cause for his lower chest pain arising from the region of the inferior sternum and sterno-costal joints and adjacent costal margin".

41. Dr D further recalled that on examination of Mr A there was minimal superior epigastric tenderness but otherwise his abdomen was normal, his chest was clear, his pulse rate was regular and within the normal range, his pulse volume was normal and his skin was warm. He did not consider there was any evidence of a cardiac cause for Mr A's lower chest pain.

42. Dr D acknowledged that he should have recorded Mr A's pulse rate in the notes, and added that if Mr A's pulse had been above 80–85 beats per minute (bpm), he would have documented this. Although he cannot recall taking Mr A's blood pressure, Dr D believes he would have done so if Mr A had appeared pale or felt faint.

43. While accepting that his record-keeping for the consultation on 21 June 2010 "was not detailed", Dr D advised HDC that he has "a clear recall of the consultation" because "there were several attendances [by Mr A] within fairly close succession of one another rather than a one-off consultation".[18]

44. Dr D advised HDC that, as Mr A had had some normal bowel motions since the initial black motions, and in light of Mr A and Ms B saying that Mr A was feeling and looking much better than the previous day, he made the decision not to admit Mr A to hospital and instead to observe him, but with a low threshold for admission to hospital. He also requested immediate blood tests for Mr A, and recalls advising Mr A

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[17] Postural hypotension is commonly referred to as "head rush" or "dizzy spell". It is a form of hypotension in which a person's blood pressure suddenly falls when the person stands up or stretches.

[18] The "further attendances" that Dr D refers to include a telephone call from Ms B to the health clinic the day following the consultation (22 June), which is detailed below; a consultation with Mr A on 28 June; receipt of a hospital discharge summary (detailed below); and contact with Mr A in relation to his ACC claim.

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to attend the emergency department immediately if any of his previous symptoms occurred. Dr D advised that he has always maintained thorough records and was disappointed with the level of detail in Mr A's records, which he does not consider is representative of his usual standard. Dr D added that, on 21 June 2010 he was the doctor designated to see "walk-in" patients. He recalls that a significant number of patients presented with multiple problems, consultations were frequently lengthy, and the waiting room was frequently full. He said that he is sure that his awareness of patients waiting influenced his standard of documentation on this date, although he does not intend that to be an excuse.

45. The Chief Executive Officer of the health clinic advised HDC that Dr D's clinical records were audited as part of its Cornerstone accreditation[19] in 2010 and "no difficulties were found with them". Similarly, when Dr D underwent a routine performance appraisal by the primary health organisation[20] in 2011 "no difficulties were found" with Dr D's clinical documentation.

Telephone call to the health clinic

46. Mr A advised HDC that the following day, 22 June, he felt "a lot worse". Ms B initially told HDC that she called the hospital; however, she later said she called the health clinic. Ms B spoke to the practice nurse, Ms F. Ms B advised Ms F that Mr A was feeling worse. Ms B recalls that Ms F told them to go straight to hospital, but did not tell them to call an ambulance.

47. Ms F recalls that Ms B told her during the telephone call on 22 June that Mr A was not feeling any better, he had continued to have blood in his bowel motion, and he was white and lethargic with lower abdominal pain. Ms F relayed this information to Dr D, who advised Ms F to tell Mr A "to go straight to hospital". Dr D cannot recall whether he instructed Ms F to tell Mr A to go to hospital by ambulance.

48. Ms F recorded the following in Mr A's notes on 22 June 2010:

> "Received ph call from pt's partner to inform pt still nil better, continues to bleed with bowel motion, lethargic lower sternal pain. Advised to go straight to [Hospital] as informed by [Dr D] for [review] ASAP."

49. There is no record of what time this telephone call took place. However, Dr D advised HDC that he recalls it was "early to mid-morning".

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[19] Cornerstone accreditation is a programme specifically designed by the Royal New Zealand College of General Practitioners to improve the quality of care provided to patients by general practices in New Zealand by setting standards relating to practice systems, practice and patient information management, quality improvement and professional development.

[20] Primary health organisations (PHOs) are not-for-profit organisations which are funded by district health boards. PHOs support the provision of essential primary health care services through general practices to people who are enrolled with the PHO.

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Mr A's blood test results

50. Dr D advised HDC that, after requesting blood tests for Mr A the previous day, he "was very interested to see these results on the morning of Tuesday 22 June".

51. According to information from the medical laboratory, Mr A's blood test results were sent to the health clinic on the evening of 21 June 2010. One of the results was sent out at 5.42pm and the other results were sent out at 7.07pm. Dr D advised HDC that, as he normally left the practice at 4.30pm, he would not have been able to access Mr A's blood test results until the following morning.

52. Dr D advised HDC that his normal practice is to arrive at the practice about 25–30 minutes before the first appointment at 8am to "deal with as many Provider Inbox results as was possible". However, on the morning of 22 June he recalls that his computer was "down" and not able to be used. He believes it is possible that other computers at the practice were also "down" at this time.

53. Dr D said that he thinks he probably became aware of Mr A's blood test results soon after the telephone call from Ms B. However, due to the passage of time, he cannot be certain of this. The health clinic advised HDC that Mr A's blood test results were "received into" Dr D's inbox at 9.03am on 22 June 2010.

54. The blood test results showed significant anaemia with a haemoglobin of 71g/L and reduced haematocrit consistent with acute blood loss. Dr D advised HDC that he was surprised by Mr A's haemoglobin level, as he had presented as well during the half hour he had spent with him the previous day. He recalls that when he became aware of Mr A's results he organised for the results, together with relevant pages of Mr A's clinical record, to be faxed to the public hospital's ED. These are recorded as being received by the hospital at 10.06am on 22 June.

55. Dr D did not contact Mr A himself, or ask the nurse to contact Mr A, to alert him to the urgency of the situation and advise him to call an ambulance to transport him to hospital.

Journey to hospital and admission

56. Mr A advised HDC that after receiving the advice to go to hospital, he took public transport there from his home as he did not realise the urgency of the situation. During the journey he felt weak and thought he was going to pass out, he could not feel his fingertips and his heart was racing. Ms B advised HDC that, because they had to wait for the public transport, it took them nearly an hour to get to the hospital.

57. Notes from the hospital record that Mr A arrived at the emergency department at 11.45am on 22 June 2010. He was noted to be very pale but not distressed. He gave a history of upper epigastric pain, passing large black stools, and being prescribed ibuprofen for back pain by his GP. He complained of feeling nauseated, dizzy and weak, had increased shortness of breath on exertion, and had passed melaena and frank blood that day. His blood pressure was 149/65mmHg,[21] and he had a pulse of

[21] 110–140/70–80mmHg is considered normal.

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82bpm.[22] His haemoglobin had decreased to 54g/L and he was given a blood transfusion of 3 units and intravenous omeprazole.

58. Mr A had a gastroscopy and was diagnosed with an upper GI bleed, secondary to NSAIDs. Mr A was discharged the next day, 23 June, with advice that in the future, he "MUST NOT [original emphasis] take aspirin, NSAIDs (ibuprofen, diclofenac etc) or steroids as these increase your risk of an ulcer".

59. When Mr A was discharged, the hospital's general medicine department advised Dr C:

> "Thank you for accepting the ongoing care of this patient, we recommend the following: This patient who has a history of duodenal ulcer and bleed has had a recurrent bleed after being prescribed NSAIDs and prednisone, he must not be prescribed these in the future, thanks."

60. A medication alert was placed on Mr A's computerised medical record on 9 July 2010. The alert code is "Adverse Reaction" and the note under it states "NSAIDs, Aspirin, Steroids. See letter from hospital".

Dr C's response to complaint

61. Dr C acknowledged that he had prescribed a medication that was not suitable for Mr A and offered his deepest apologies for his oversight. Dr C advised that he did know about Mr A's history of gastric ulcer and bowel haemorrhage two years prior to this incident but, as this information had not been "classified or alerted"[23] in Mr A's notes, it "escaped" his mind when writing the prescription. Dr C told HDC that he has never made a similar error in his career, either before or since this incident.

62. Dr C advised HDC that he is careful to check his patient's notes before administering medication and he regrets that on this occasion he failed to identify Mr A's history of gastric ulcer. He said that in the future he will ensure his patients' medical histories are well recorded and he will be careful to check a patient's history before giving advice or prescribing any medication. He further advised that in instances where medication is contraindicated, he will ensure that there is an alert in the patient's notes. Dr C advised HDC that since this incident he has worked closely with his employers to ensure there are appropriate systems and safeguards in place to prevent a similar incident recurring, and that the health clinic was currently going through all patient files to ensure that necessary classifications and alerts were recorded.

63. Dr C also advised HDC that this incident has reminded him of the importance of ensuring there is a full discussion of potential side effects of NSAIDs and steroids, as well as advising patients to return immediately to attend hospital if they have any side effects, and documenting this discussion in the patient's notes.

64. On 31 March 2012 Dr C sent Mr A a letter apologising for his prescribing mistake.

[22] Normal pulse rates range from 60–100bpm.

[23] A diagnosis of "gastritis and duodenitis" was entered as a classification in Mr A's notes on the patient management system on 27 June 2008 by Dr E, but was evidently not activated as a medication or diagnosis alert.

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Dr D's response to complaint

65. Dr D's response to the complaint has been incorporated into relevant sections of the report.

66. On 29 March 2012, Dr D sent Mr A a letter apologising for any "distress or inconvience that this episode has caused you", and noting that he has carefully reviewed his practice and is confident that the events that occurred will not be repeated.

The health clinic's response to complaint

67. The CEO advised HDC that a doctor's decision to prescribe a particular medication or treatment is ultimately a clinical decision which is made using experience and all the information available to the doctor at the time. While the systems at the health clinic "are aimed at making sure all relevant information is available for the doctor to make that decision on an informed basis", it "cannot dictate the actual decision that should be made …" In this regard, the CEO noted that Dr C did have knowledge of Mr A's previous gastric ulcer when he prescribed the medication.

68. The CEO advised HDC that following this incident, a debrief and discussion occurred amongst clinic staff. He said that during this discussion, the need to accurately record patients' histories, and to check those histories before prescribing medication to ensure there are no contraindications, was reinforced. He advised that the contents of its policy, "Documentation and Management of Clinical Records", was also reinforced at the debrief and discussion.

69. This Documentation and Management of Clinical Records policy states that at each patient visit the record must contain "a history pertinent to the condition being treated, including relevant details of: Present and past medical history; Family history; Social considerations; Any allergies …"

70. In addition to the debrief and discussion, the CEO told HDC that staff have attended an in-house education session on history taking, classifications, patient examinations, note taking, telephone calls and transportation, with this complaint being used as a case-study.

71. The CEO also advised HDC that since the beginning of 2012, patients' drug intolerances are being recorded in the dedicated drug reaction module of its patient management system.[24]

[24] By doing so, any drug intolerance will appear when any electronic prescribing takes place. This module generally self-populates into electronic referral forms, whereas the more generic patient alert module may not. The CEO advised HDC that the ability to record patients' drug intolerances in the dedicated drug reaction module only became available at the beginning of 2012.

Professional standards

72. In April 2010, the Medical Council of New Zealand issued a document entitled "Good prescribing practice".[25] Its stated aim is to "assist doctors to maintain appropriate prescribing practice", and advises that it may be used as a standard by which a doctor's conduct is measured.

73. The document advises doctors to prescribe medicines or treatment only in instances where they have adequately assessed the patient's condition, and/or have adequate knowledge of the patient's needs and are satisfied that the medicines or treatment are in the patient's best interests.

74. The statement advises doctors to take the following precautions to ensure their prescribing is appropriate and responsible:

- *"Be familiar with the indications, side effects, contraindications, major drug interactions, appropriate dosages, effectiveness and cost-effectiveness of the medicines that you prescribe. Be aware that promotional and other drug information distributed by commercial interests is unlikely to be impartial; independent sources of information (such as bulletins certified by www.isdbweb.org) are preferred where available.*

- *Take an adequate drug history of the patient, including: any previous adverse reactions to medicines; current medical conditions; and concurrent or recent use of medicines (including non-prescription, complementary and alternative medicines).*

- *Consider whether a prescription is warranted given the nature of the patient's complaint and presentation, and whether a non pharmacologic treatment could be as effective and safe.*

- *Ensure that the patient (or other lawful authority) is fully informed and consents to the proposed treatment and that he or she receives appropriate information, in a way they can understand, about the options available; including an assessment of the expected risks, side effects, benefits and costs of each option. Satisfy yourself that the patient understands how to take any medicine prescribed and is able to take it.*

- *Never prescribe indiscriminately, excessively or recklessly.*

- *Prescribe in accordance with accepted practice and any relevant best practice guidelines. Prescribing outside of accepted norms should only occur in special circumstances with the patient's informed consent. In such circumstances, it might be useful to discuss the proposed treatment with a senior colleague before completing the prescription."*

[25] Available at www.mcnz.org.nz.

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Opinion: Breach — Dr C

Ibuprofen and prednisone prescription

75. Mr A had a history of two episodes of peptic ulceration associated with bleeding requiring operative intervention. This information was known to Dr C and was clearly documented in Mr A's patient notes. The first episode of peptic ulceration occurred in 1993, and this history was obtained by Dr C at Mr A's first appointment with him in January 2008. The second episode occurred in January 2008 when Mr A collapsed while attending an appointment with Dr C, who urgently referred Mr A to the public hospital. On 25 January 2008, Dr C received a discharge summary from the hospital, which noted a diagnosis of acute duodenal ulcer. On 27 June 2008, Dr E entered a diagnosis of "gastritis and duodenitis" as a classification in Mr A's clinical record.

76. Dr C prescribed ibuprofen for Mr A, which Medsafe advises should not be used in patients with a history of recurrent peptic ulceration or gastrointestinal haemorrhage. Recurrent is defined as the patient having had two or more distinct episodes of proven ulceration or bleeding. Dr C also prescribed prednisone for Mr A, which Medsafe advises should be used with caution in patients with peptic ulcers.

77. Prescribing doctors must ensure they are familiar with their patient's medical history, in order to accurately assess the patient's needs and satisfy him- or herself that the medication will be in the patient's best interests. Failing to do so can have serious and potentially fatal consequences for the patient.

78. My in-house clinical advisor, general practitioner Dr David Maplesden, advised that prescribing ibuprofen and prednisone to Mr A, with the knowledge of his medical history, would be met with severe disapproval by Dr C's peers.

79. Dr C acknowledged that he knew previously about Mr A's history of gastric ulcer and bowel haemorrhage. However, it is clear that Dr C failed to refresh his memory by reviewing Mr A's medical records and did not have an adequate discussion with Mr A about his medical history and the potential risks and side-effects of the medication Dr C was prescribing.

80. This Office has previously highlighted the importance of taking a comprehensive history from the patient, reviewing risk factors, and having a discussion with the patient about the medication before prescribing it.[26]

81. I do not accept Dr C's explanation for failing to note Mr A's history of peptic ulceration at the time of writing the prescription, which is that the history had not been "classified or alerted" in Mr A's notes. Mr A's diagnosis of gastritis and duodenitis had been entered as a classification in Mr A's clinical record on 27 June 2008 by Dr E, and Dr Maplesden advised me that the diagnosis of gastric ulcer is not something that would be entered as an "alert" in the clinical record.

82. Dr C's failure to adequately review Mr A's medical history or discuss his history with him before prescribing him ibuprofen and prednisone was a significant omission to

[26] See Opinions 03HDC00837and 03HDC04005.

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make in the context of a doctor's duty to ensure his or her prescribing is appropriate and responsible. Accordingly, Dr C did not provide services with sufficient care and skill and breached Right 4(1) of the Code.

83. Before prescribing the medication, Dr C also had a duty to provide Mr A, as with any patient, information that a reasonable consumer, in that consumer's circumstances, would expect to receive.[27] This includes information about the nature and purpose of the proposed medication, and its expected risks, side effects and benefits.[28] Although at the time he prescribed the medication Dr C had overlooked Mr A's previous history of gastric bleeding, Dr C should nonetheless have discussed with Mr A the general contraindications and possible side effects of the medication.

84. It is possible that had Dr C had this discussion with Mr A, the unsuitability of the medications he was intending to prescribe would have become apparent, either to Dr C or Mr A himself. However, Dr C failed to provide Mr A with information about the risks, benefits and side effects of the medication he proposed to prescribe and, accordingly, Dr C breached Right 6(1)(b) of the Code. Without information about the possible risks and side effects of the medication, Mr A was not in a position to make an informed choice, and give his informed consent to taking the medication. Accordingly, Dr C also breached Right 7(1) of the Code.

Summary

85. In my view, by prescribing NSAIDs and steroids to Mr A, Dr C failed to provide services to Mr A with reasonable care and skill. Dr C's failure to adequately review and discuss Mr A's medical history before prescribing him ibuprofen and prednisone was not reasonable care. Accordingly, Dr C breached Right 4(1) of the Code.

86. In addition, by failing to provide Mr A with information about the risks, benefits, and side effects of the medication he was prescribing, Dr C breached Right 6(1)(b) of the Code. Without sufficient information about the medication, Mr A was unable to make an informed choice and provide informed consent to taking the medication. Accordingly, Dr C also breached Right 7(1) of the Code.

Opinion: Breach — Dr D

Consultation on 21 June 2010

87. Mr A consulted Dr D on 21 June 2010 complaining of lower chest pain and having had 2–3 black bowel motions the previous afternoon.

88. Dr D examined Mr A and noted lower sternal and epigastric discomfort. Dr D documented his assumption that Mr A had suffered a GI bleed secondary to ibuprofen and prednisone, and entered a diagnosis of "Gastritis and duodenitis (probable)" as a long-term classification in Mr A's record. Dr D's alternative diagnosis was that the

[27] Right 6(1) of the Code.
[28] Ian St George (ed), "Informed Consent", *Cole's Medical Practice in New Zealand* (2009) at pg 87. Available from www.mcnz.org.nz. See also Right 6(1)(b) of the Code.

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lower sternal pain was musculoskeletal in origin. Dr D recorded "For bloods. Advised."

89. Dr D stated that as Mr A had had some normal bowel motions since the initial black motions, and in light of Mr A's and Ms B's advice that he was feeling and looking much better than the previous day, he made the decision not to admit Mr A to hospital, but instead to observe him, but with a low threshold for admission to hospital. He requested immediate blood tests for Mr A, and recalls advising Mr A to attend the emergency department at the public hospital immediately if any of his previous symptoms occurred.

90. I note that Dr D did not document anything about Mr A's general appearance or whether his bowel motions had since returned to normal, and consequently, he has had to rely on his recollection five months after the consultation. As noted by the High Court, it is through the medical record that doctors have the power to produce definitive proof of a particular matter. Doctors whose evidence is based solely on their subsequent recollections (in the absence of written medical records offering definitive proof) may find their evidence discounted.[29]

91. Mr A recalls that he told Dr D that he had continued to have abnormal bowel motions on the morning of the appointment. Ms B agreed that Mr A did not say his bowel motions had returned to normal.

92. In the absence of medical records to the contrary, I accept the evidence of Mr A and Ms B that Mr A did not tell Dr D that his bowel motions had returned to normal.

93. Both Mr A and Ms B deny that they told Dr D that Mr A was feeling and looking better than the previous day. As stated, Dr D did not record this information. In the absence of any records to the contrary, I accept the evidence of Mr A and Ms B that Mr A continued to be pale and unwell and could not walk properly.

94. Mr A recalls that Dr D advised him to go to hospital "if things get worse", but did not specify what symptoms to be alert to.

Decision not to immediately refer Mr A to hospital

95. Dr Maplesden advised that if Mr A's bowel motions had not returned to normal this would have been evidence of ongoing bleeding and would have further lowered the threshold for seeking immediate hospital admission. Dr Maplesden considers that failure to immediately admit Mr A to hospital in these circumstances would be a moderate departure from an expected standard of care and would raise some concerns as to Dr D's clinical competency. As stated previously, I accept the statements of Mr A and Ms B that Mr A did not tell Dr D that his bowel motions had returned to normal. Accordingly, Dr D had no reasonable basis for assuming that Mr A's GI bleeding had stopped.

[29] *Patient A v Nelson-Marlborough District Health Board* (HC BLE CIV-2003-406-14, 15 March 2005).

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96. In cases where the patient faces a real risk of serious harm or death if left untreated, the threshold for referring the patient immediately to hospital should be low.[30] As Dr Maplesden has noted, the consequences of a GI bleed if ongoing and left untreated can be catastrophic. I consider Dr D's response to Mr A's presenting symptoms demonstrates a lack of care and skill and is a breach of Right 4(1) of the Code. It is fortunate that Mr A and Ms B chose to seek further advice the following morning, or the outcome for Mr A could have been much worse.

97. I note that Dr D has acknowledged that, in the future, he would have no hesitation in referring a patient in Mr A's circumstances directly to hospital, rather than awaiting blood test results.

Cardiovascular assessment and documentation

98. At the consultation on 21 June 2010, Dr D did not record Mr A's pulse, blood pressure, or his general condition or appearance. Dr D acknowledged that he should have recorded Mr A's pulse rate in the notes, and added that if Mr A's pulse had been above 80–85bpm, he would have documented it.

99. Dr D also advised HDC that if Mr A had been "obviously pale and/or felt faint" he would have noted and documented this, and taken a blood pressure reading. He recalled that Mr A "did not look pale and appeared of quite normal colour … he did not look particularly unwell". However, this is in contrast to Ms B's statement that Mr A looked pale and unwell.

100. Dr Maplesden noted that establishing cardiovascular stability is part of the basic assessment of both chest pain and possible hypovolaemia,[31] and that failure to do so "is a significant omission in a patient presenting with a GI bleed". He expressed concern about the lack of evidence of any assessment of Mr A's cardiovascular status, as there is no record of pulse or blood pressure, and no comment regarding pallor or general condition. Dr Maplesden considers that the failure to record Mr A's pulse rate and undertake a blood pressure measurement in these circumstances was a moderate departure from the expected standard of care.

101. Dr D stated that he took Mr A's pulse but did not record it. I do not accept Dr D's reason for not recording Mr A's pulse (that the pulse rate was not above 80–85bpm). The Medical Council of New Zealand guidelines state that doctors must keep clear and accurate clinical records that report relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed.[32] Clear, accurate and contemporaneous records are essential components of good patient care. It is important to document relevant clinical findings, both negative and positive. Accordingly, Dr D breached Right 4(2) of the Code by failing to comply with professional standards by not recording Mr A's pulse rate and information about Mr A's general appearance.

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[30] See Opinion 99HDC01986. In this case a GP was found to have breached Right 4(1) for failing to refer a seven-week-old baby, suffering from a codeine overdose, to hospital. It was held that, given the gravity of the risks associated with codeine overdose (depression of respiration causing brain damage and potentially death), the GP should have referred the baby to hospital.

[31] A state of decreased blood volume.

[32] "The maintenance and retention of patient records" available at www.mcnz.org.nz.

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102. I also do not accept Dr D's reason for not taking Mr A's blood pressure measurement, which is that on examination of Mr A's chest there was clear, localised, musculo-skeletal cause for his lower chest pain, and he did not consider there was any evidence of a cardiac cause for Mr A's chest pain. As Dr Maplesden has commented, establishing a patient's cardiovascular stability (which includes taking a blood pressure reading) forms part of the basic assessment of a patient presenting with chest pain and possible hypovolaemia, and failure to do so is a "significant omission in a patient presenting with GI bleed".

103. Dr D's decision not to take Mr A's blood pressure measurement was a failure to provide services with reasonable care and skill and a breach of Right 4(1) of the Code.

Telephone consultation on 22 June 2010

104. Ms B called the health clinic on the morning of 22 June 2010 and advised the practice nurse, Ms F, that Mr A's condition was worse than the previous day and that he was continuing to pass blood with his bowel motions. I note that Dr D cannot recall whether or not he advised Ms F that Mr A should travel to hospital by ambulance, and Ms F did not document in the file note that an ambulance was recommended. Ms B does not recall being advised to call an ambulance, and Mr A travelled by public transport to hospital. I therefore find it more likely than not that Dr D did not advise that transportation to hospital should be by ambulance.

105. Dr D stated that he was not aware of Mr A's blood test results at the time of Ms B's telephone call to the practice. Irrespective of this, Dr Maplesden considers that the advice given to Ms B, which was that Mr A was to proceed to hospital as soon as possible, was appropriate, as Mr A was continuing to bleed and was unwell. Dr Maplesden considers that, in light of the clinical situation, an ambulance was the most appropriate mode of transport, and Dr D should have ensured that this was relayed to Ms B by the practice nurse. I agree. The clinical picture was that Mr A was having ongoing GI bleeding and feeling unwell. He had a past history of peptic ulcer disease and had recently been taking NSAIDs and steroids. Additionally, Dr D could not determine Mr A's cardiovascular status over the telephone. In my view, Dr D should either have spoken to Ms B or Mr A himself to assess the situation and provide advice and reassurance. At the very least, he should have ensured the nurse told Ms B that Mr A should immediately call an ambulance.

Blood test results and subsequent actions

106. Mr A's blood test results were sent to the health clinic on the evening of 21 June. They were reviewed by Dr D sometime the next morning. Dr D's recollection is that he probably had not reviewed Mr A's blood test results at the time Ms B telephoned the practice (which Dr D recalls was "early to mid-morning"), and he claims he could not access the results at this time as his computer, and possibly other computers at the practice, were "down" and unable to be used. However, he did review the results around the time of Ms B's telephone call and recalls that he was surprised by the results, which were consistent with acute blood loss, as Mr A had "presented as well" during the half hour he had spent with him the previous day.

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107. Dr D advised HDC that when he became aware of Mr A's blood test results he organised for the results, together with relevant pages of Mr A's clinical record, to be faxed to the hospital's ED. These are recorded as being received at 10.06am on 22 June. Dr D did not check with the practice nurse, Ms F, whether Mr A had been told that an ambulance was the most appropriate form of transport.

108. While it is concerning that Dr D did not advise Mr A to travel to hospital by ambulance when Ms B had called earlier that morning, it is even more alarming that he took no steps to check Mr A's transport arrangements once he was aware of the blood test results. Dr Maplesden has advised that, in view of the blood test results, which indicated acute blood loss, and the knowledge that Mr A had had ongoing bleeding since the blood test was taken, it would have been appropriate for Dr D to have ensured that either he or Ms F contacted Ms B and Mr A to check their transport arrangements, and arrange for an ambulance if they had not already left for the hospital.

109. Dr D's failure to take adequate steps to ensure that Mr A was advised to go to hospital by ambulance was a lack of reasonable care. Mr A was continuing to bleed from his gastrointestinal tract and required urgent medical attention. Dr D was sufficiently concerned to advise that Mr A should be told "to go straight to hospital". In my view, it was also necessary for him to ensure that Mr A was aware that this was a potential emergency and that an ambulance should be called immediately. It is even more concerning that Dr D took no action to assist Mr A once Dr D was aware of the blood test results. This was a failure to exercise reasonable care and skill and, accordingly, Dr D breached Right 4(1) of the Code.[33]

Summary

110. When Mr A consulted Dr D on 21 June, there was evidence to indicate that Mr A had suffered, and was continuing to suffer from, a GI bleed caused by NSAIDs. Dr D did not exercise reasonable care and skill, and breached Right 4(1) of the Code by:

- failing to measure Mr A's blood pressure at the consultation on 21 June;
- failing to seek immediate admission to hospital for Mr A on 21 June; and
- failing, on two occasions on 22 June to advise Mr A of the seriousness of his condition and that he should go to hospital immediately by ambulance.

111. Dr D's documentation in relation to the consultation on 21 June was inadequate and did not meet professional standards. He did not document Mr A's pulse rate, appearance or general condition. These were all important observations in view of Mr A's presentation and should have been recorded. Accordingly, Dr D also breached Right 4(2) of the Code.

[33] See Opinion 99HDC01975. In that case a GP was found in breach of Right 4(1) of the Code for failing to ensure his patient had immediate transport to hospital.

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Other comments

The health clinic

112. The health clinic was not the subject of my investigation. However, consideration was given to its policies and procedures, and whether these could be improved to prevent, or reduce the risk of, a similar event recurring.

113. Dr Maplesden considers that the health clinic's policies and processes in relation to obtaining relevant patient history and transcription of such history to the electronic record appear to be robust but "remain dependent on the documented processes being followed".

114. In relation to Dr C's failure to record a diagnosis of gastritis as a classification in Mr A's past medical history, Dr Maplesden has advised that the only way the health clinic could have been alerted to this omission would have been if Mr A's notes had been selected as part of a clinical notes audit, where the notes of randomly selected patients are examined. Dr Maplesden has added that it would not be practical to routinely audit every patient's clinical notes, as this would need to be carried out by a clinical person and would be very time consuming.

Management of back pain

115. Dr Maplesden advised that Dr C's approach to the management of Mr A's acute back pain by the concurrent use of prednisone and an NSAID would not be a common way to treat musculoskeletal back pain in New Zealand, noting that it would increase the risk of gastric side effects, and also that there is little evidence of the clinical efficacy of prednisone in the treatment of acute back pain. Dr Maplesden also advised that the use of prednisone does not feature in the ACC guidelines on the management of acute back pain.[34] However, Dr Maplesden has noted that the ACC guidelines are "essentially recommendations rather than an inflexible protocol".

116. Dr Maplesden also advised that it is not uncommon for prednisone to be used in the treatment of acute back pain in the United States, and a minority of doctors in New Zealand would take this approach, arguing that it is accepted practice internationally. Dr Maplesden therefore regards Dr C's approach to the management of Mr A's back pain to be consistent with acceptable practice, albeit not a common practice.

117. The CEO advised HDC that Dr C has now reviewed the ACC guidelines on the management of acute back pain, and that patients will be managed in accordance with those guidelines in the future.

Recommendations

118. I recommend that Dr C enter into a mentoring relationship with a general practitioner appointed by the Royal New Zealand College of General Practitioners (RNZCGP) (including at least three face-to-face meetings with the mentor each year) until **31**

[34] www.nzgg.org.nz/guidelines/0072/acc1038_col.pdf.

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December 2013. The mentor should focus on those areas of Dr C's practice that were identified in this report as substandard or needing attention. The mentor should provide written confirmation to RNZCGP and HDC that the mentoring has occurred and his/her evaluation of Dr C's practice in the identified areas of concern.

119. I recommend that Dr D provide to HDC a copy of the most recent PHO performance appraisal in relation to his clinical documentation, and of the most recent Cornerstone accreditation audit in relation to his clinical documentation, by **6 July 2012.**

Follow-up actions

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and the Royal New Zealand College of General Practitioners, and they will be advised of Dr C's and Dr D's names.

- A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix — Independent clinical advice to Commissioner

The following clinical advice was obtained from my in-house clinical advisor, general practitioner, Dr David Maplesden:

> "My name is David Maplesden. I am a vocationally registered general practitioner practising in Hamilton, New Zealand. My qualifications are MB ChB (Auckland University 1983), Dip Obst (1984), FRNZCGP (2003).
>
> Thank you for the request that I provide clinical advice in relation to the complaint from [Mr A] about the care provided to him by [Dr C]. The care provided by [Dr D] has also been considered. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have examined the available documentation which includes: complaint and additional correspondence from [Mr A]; correspondence from [Mr A's] partner [Ms B]; responses from [Dr C]; responses from [Dr D]; response and practice policies from [the health clinic]; GP notes; [public] Hospital notes.

[At this stage in his report Dr Maplesden sets out the background facts to the complaint. This detail has been omitted for the purpose of brevity.]

> **Comments**:
>
> (i) Ibuprofen prescribing information (Medsafe) states that it should not be used in patients with active, or a history of, ulcerative colitis, Crohn's disease, recurrent peptic ulceration or gastrointestinal haemorrhage (defined as two or more distinct episodes of proven ulceration or bleeding). Similar prescribing information for prednisone states that caution is necessary in patients with peptic ulcers since glucocorticoids have been implicated in causing peptic ulceration. [Mr A] had a history of two distinct episodes of peptic ulceration associated with bleeding and requiring operative intervention. [Dr C] had previously obtained this history although had evidently not activated a medication or diagnosis alert in the practice management system. [Dr C] acknowledges he should not have prescribed the ibuprofen and prednisone to [Mr A] — to have done so with the knowledge of [Mr A's] medical history would be met with severe disapproval by my peers.
>
> (ii) [Mr A] presented with back pain — acute on chronic — on 1 June 2010. The documented assessment was adequate and appeared to indicate a musculoskeletal cause for the pain even though no diagnosis was recorded. There was no indication of radiculopathy. Prednisone and ibuprofen were prescribed. Placing the issue of contraindications to medication aside, the approach used by [Dr C] in the prescribing of prednisone for acute back pain is not commonly used in this country, and does not feature in the ACC guidelines for management of acute back pain. However, such treatment is not uncommonly used in the United States. I refer to a 2008 randomised controlled study of the efficacy of prednisone in the treatment of acute sciatica that notes: Many physicians use prednisone to treat acute sciatica with the hope of speeding recovery. There is little clinical evidence to support this practice. Our objective was to determine whether early administration of oral prednisone affects parameters related to recovery from acute sciatica … Prednisone

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and control groups showed no statistically significant differences in physical findings, use of nonsteroidal anti-inflammatory drugs or narcotic medications, or rates of patients returning to work at any time interval studied. Compared with controls, patients who received prednisone had more rapid rates of improvement from baseline in pain, mental well-being, and disability scores. These changes were subtle but statistically significant. Patients who received prednisone tended to receive fewer epidural injections for pain. CONCLUSIONS: Early administration of oral steroid medication in patients with acute sciatica had no significant effect on most parameters studied. It did, however, lead to slightly more rapid rates of improvement in pain, mental well-being, and disability scores. The impact of oral steroids on other outcomes is suggested by this study, but its small sample size limited its statistical power. Thus, while this treatment was not consistent with NZ ACC guidelines for treatment of acute lower back pain, it is likely a minority of doctors here would use this approach arguing that it is accepted practice internationally even if there is not a strong evidence base behind it. The NZ guidelines are essentially recommendations rather than an inflexible protocol. I would therefore regard [Dr C's] approach as being consistent with acceptable practice even if it was not common practice, and could not be deemed a departure from an appropriate standard of care here (assuming there were no contraindications to the use of such medication). Similarly, the concurrent use of prednisone and an NSAID increases the risk of gastric side effects of the medications, and would not be a common approach for the initial treatment of musculoskeletal back pain in this country. However, for the reasons stated above, and again assuming there were no contraindications, the use of this regime could not be regarded as a departure from accepted practice.

(iii) [Mr A] saw [Dr D] on 21 June 2010. He had a history of lower chest pain and melaena with epigastric discomfort on examination. [Dr D] assumed [Mr A] had a GI bleed secondary to the medication prescribed and presumably had noted his relevant past history. However, there is no documentation to suggest [Mr A's] cardiovascular status was assessed — no measure of pulse or blood pressure and no comment regarding pallor or general condition (although see [Dr D's] response above). The failure to assess cardiovascular status is a significant omission in a patient presenting with a GI bleed. Such bleeds can occasionally be catastrophic. In a patient with a known history of peptic ulceration requiring surgical intervention on two occasions in the past who has been taking medication known to increase the risk of peptic ulceration and who is currently symptomatic (melaena and upper abdominal pain), a significant proportion of my peers might have instigated emergency hospital admission after establishing cardiovascular stability, and initiating resuscitation measures if required, rather than sending the patient home to await blood tests. However, assuming [Dr D's] overall assessment of [Mr A] on 21 June 2010 was accurate (although I note the discrepancy between [Dr D's] documentation and [Mr A's] recollections as to how he felt on that day and whether his melaena was persisting) a proportion of my colleagues might have managed [Mr A] as [Dr D] did although with documentation of cardiovascular status undertaken ie assume the bleeding had probably stopped as [Mr A] appeared well (although with a haemoglobin that had dropped acutely to 71g/L it is perhaps surprising that no pallor was evident and [Mr A] was feeling well), the offending agents were being removed, a check on haemoglobin was being undertaken and

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instructions had been given on what to do should the symptoms recur. It may have been advisable to commence a proton-pump inhibitor under these circumstances while awaiting blood results. Overall, I consider [Dr D's] management of [Mr A] on 21 June 2010 to be a moderate departure from accepted standards and some concerns as to clinical competency must be raised in that he did not perform a blood pressure reading on a patient presenting with chest pain and a GI bleed, and although he states he took the pulse, the pulse rate was not recorded. Establishing cardiovascular stability, particularly in the presence of hypotension, is part of the basic assessment of both chest pain and possible hypovolaemia. Furthermore, there is some doubt over the accuracy of the bowel history obtained by [Dr D] particularly in light of the subsequent haemoglobin readings suggestive of significant ongoing GI blood loss.

(iv) Following the consultation of 21 June 2010, [Mr A] evidently continued to bleed with his haemoglobin dropping from an already depleted 71g/L on 21 June 2009 to 54g/L on admission to [hospital] the following day. This incident had the potential for a poor outcome had [Mr A's] partner not sought further advice from the surgery on the morning of 22 June 2010. She was given appropriate advice by the practice nurse (following brief discussion with [Dr D]), to seek hospital attention immediately. The advice to attend hospital as soon as possible was appropriate irrespective of the blood result (which was not immediately available at that point), as [Mr A] was continuing to bleed and was unwell. However, the advice from both [Dr D] and the practice should have been that ambulance was the most appropriate mode of transport given the clinical situation (ongoing GI tract bleeding, patient feeling unwell — white and with abdominal pain, past history peptic ulcer disease, recent ingestion of NSAIDs and steroids, inability to determine cardiovascular status over the phone). Following the telephone call [Dr D] states he obtained [Mr A's] blood result and faxed this, and the relevant clinical records, to [the public hospital's] ED. Given the degree of anaemia and knowledge [Mr A] had had ongoing bleeding since the blood test was taken, it would have been appropriate for [Dr D] to have confirmed with the practice nurse the degree of urgency required for transport, and for her to have reinforced the need for ambulance transport, or to have arranged it, if [Mr A] had not already left for the hospital. The failure to ensure [Mr A] had appropriate transport to hospital was, under the circumstances, a moderate departure from expected standards. Whether [Dr D] assumed the practice nurse would have advised ambulance transport is not clear.

(v) The account given by [Dr D] regarding receipt and processing of lab results is entirely credible and consistent with my own experience of the Medtech system whereby results will appear in the patient notes under the date they were processed at the laboratory rather than the date they were annotated/filed by the provider. The information [Dr D] has obtained from [the medical laboratory], together with the description of his personal process for handling laboratory results (which is entirely consistent with usual and expected practice), leads me to conclude that he would have been first able to access [Mr A's] blood count result (showing significant anaemia consistent with blood loss) when he reviewed his results prior to 0800hrs on 22 June 2010. The only circumstance under which he may have had

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earlier access to this result was if the laboratory had contacted him at home after 1907 hrs on 21 June 2011 (when the result was validated by the laboratory) and this does not appear to have been the case. I note, however, that there were IT problems on the morning of 22 June 2010 (again not an uncommon problem with the PMS) and access to results was delayed until later in the morning. The [health clinic] response notes the results were downloaded at 0903hrs on 22 June 2010. I conclude that the handling of [Mr A's] blood result by [Dr D] was consistent with expected standards. If a significant bleed had been suspected, hospital admission without delaying for a blood test would have been the most appropriate management. As such, there was no marked urgency in accessing the blood tests taken.

(vi) Practice policies and processes relating to obtaining of relevant patient history on registration, transcription of such history to the electronic record, and practice management of prescribing errors have been described and provided. These appear to be robust but remain dependent on the documented processes being followed.

(vii) The only way the medical centre could have picked up on [[Dr C's] failure to enter a past history of gastric ulcer as a classification in [Mr A's] medical record] is if [Mr A's] notes happened to have been selected as part of a clinical notes audit (part of the Cornerstone assessment process when I think the notes of 20 randomly selected patients are examined) and the GP had reviewed the clinical notes and detected the history of gastric ulcer present in the notes was absent under classifications. It is not practical to routinely audit every patient's clinical notes as a clinical person would need to undertake this activity and it would be very time consuming.

(viii) A patient alert regarding intolerance to anti-inflammatories and steroids was added to [Mr A's] file on 9 July 2010. I recommend the intolerances also be documented in the dedicated drug reaction module of the PMS. This would provide an additional precaution as the intolerances appear when any electronic prescribing takes place, and this module generally self populates into electronic referral forms whereas the more generic patient alert module may not. The diagnosis of gastritis and duodenitis has been recorded under long-term classifications (duodenal ulcer had been demonstrated on gastroscopy), and an ACC claim recorded for adverse reaction to drugs.

Summary

(i) Aspects of the care offered to [Mr A] by [Dr C] departed from expected standards to a severe degree.

(ii) Aspects of the care offered to [Mr A] by [Dr D] departed from expected standards to a moderate degree."

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