General Practitioner, Dr F

A Report by the

Health and Disability Commissioner

(Case 03HDC11066)

Parties involved

Ms A	Consumer (deceased)
Mr B	Complainant, consumer's partner
Ms C	Complainant, consumer's twin sister
Miss D	Complainant, consumer's daughter
Mr E	Complainant, consumer's father (now deceased)
Dr F	Provider, GP − formerly of the first medical centre
Dr G	GP, the first medical centre
Dr H	GP, the first medical centre
Dr I	GP, the accident and medical centre
Dr J	GP, the second medical centre
First medical centre	Medical centre
Second medical centre	Medical centre
Accident and medical centre	Accident and medical centre
Clinic	Clinic
Public hospital	Public hospital

Complaint

On 25 July 2003 the Commissioner received a complaint from Mr B, Ms C, Miss D, and Mr E, regarding the services provided to Ms A by Dr F of the first medical centre, between September 2000 and December 2002. The following issues arising from the complaint were investigated:

Whether Dr F provided services of an appropriate standard to the late Ms A. In particular:

- *the adequacy and appropriateness of investigations, diagnosis and treatment of Ms A's abdominal symptoms while under Dr F's care*
- *whether referral of Ms A to another medical practitioner was indicated*
- *the adequacy and accuracy of Dr F's records in relation to Ms A*
- *the appropriateness of the type and the amount of medication prescribed to Ms A by Dr F.*

An investigation was commenced on 17 November 2003.

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

Information reviewed

Information from:

- Mr B
- Ms C
- Miss D
- Mr E
- Dr F
- Dr G
- Dr H
- Dr I, the accident and medical centre
- Dr J, the second medical centre
- A registered nurse, the clinic
- The Medical Council of New Zealand

Copies of Ms A's medical records were obtained from the public hospital, the accident and medical centre and the second medical centre, and Dr F.

Independent expert advice was obtained from Dr Ian St George, general practitioner.

Information gathered during investigation

Overview

Ms A was a patient of the first medical centre, from 1998 until January 2003. Between September 2000 and December 2002, Ms A consulted the practice for relief of ongoing abdominal pain, discomfort, and chronic constipation. She usually saw general practitioner Dr F, with whom she was registered. Dr F's impression was that Ms A had "irritable bowel syndrome" ("IBS") and over time she prescribed Normacol, Buscopan, Lactulose, and once, a Fleet phosphate enema at Ms A's request. Ms A's symptoms did not improve and were not further investigated. On 5 January 2003, at a public hospital, a surgeon diagnosed Ms A with advanced cancer of the colon. Metastases were identified in the liver. Ms A was referred for hospice and palliative care. Ms A died 7 weeks later.

The first medical centre

At the time of these events, the first medical centre was the trading name of three individual general practitioners − Dr F, Dr G and a third general practitioner − who worked at the same premises, cost-sharing the practice expenses. Dr H was employed as a part-time permanent locum GP. Patients initially registering with the practice were "assigned" to a specific GP, but "cross-cover" was provided by the other practice GPs if necessary (for example, if a patient attended when their own doctor was unavailable).

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Ms A was registered under Dr F's care in 1998 and by December 2002 had seen all four GPs at the practice. Ms A's children were also registered to Dr F, as was her partner, Mr B.

On 1 October 2003, the first medical centre became a limited company for contracting with the local Primary Health Organisation. Its doctors work as self-employed individuals and cost-share in the running of the practice. Dr F left the practice in June 2004.

Dr F

Dr F qualified overseas in July 1987 and holds full registration with the medical council in that country, although she has not worked there as a doctor since 1994. At the time of the events giving rise to this complaint, she was a member of the Medical Council of New Zealand with an annual practising certificate, and a member of the New Zealand Medical Association. She had completed her first triennium certificate for Maintenance of Professional Standards (1999−2001) issued by the Royal New Zealand College of General Practitioners, and in 2003 was working towards her second triennium certificate. Dr F advised that the College accepted her documentation for completion of this certificate in 2004, as she had "already met all their requirements a year ahead of schedule".

In late 2004, Dr F advised the Commissioner that she intended to leave New Zealand to work overseas. On 30 May 2005, Dr F confirmed that she is now living overseas, but is not working as a doctor. She said:

> "My New Zealand annual practising certificate was due for renewal in May 2005. I wrote to the Medical Council at that time, confirming that I was still [overseas and] that I would contact them on my return to New Zealand, when I intended to resume work as a GP and would need a current annual practising certificate."

Dr F remains registered as a medical practitioner in New Zealand.

Ms A

Ms A was a solo parent to three children, and at the time of her death was engaged to Mr B, her partner of some years. She had a longstanding problem with constipation. Mr B recalled that during 2001 Ms A had told him that she often used laxatives for relief, which had either been acquired over-the-counter or on prescription. Ms A's daughter, Miss D, also recalled that "for years" her mother had taken various medications to ease her constipation. Mr B described how during 2002 Ms A "often had episodes of extreme pain and [discomfort] in her lower abdomen. This [discomfort] could last several hours and was intense for up to 45 minutes. By intense I mean she would not walk, did not want to talk and would lie on the bed clutching herself and moaning. She would double up clutching her lower body. She got temporary relief by taking laxatives and staying in the bathroom." Mr B described Ms A as "physically a tough person who could handle a lot of pain". He also recalled that she took sleeping tablets (including Halcion) "quite extensively" because she often had trouble sleeping. Dr F stated that the intensity and frequency of Ms A's symptoms, as described by Mr B, had not been conveyed to her.

Mr B stated that in the latter half of 2002 he could feel two "lumps" in Ms A's lower abdomen and suggested that she "exercise her options with specialists". Ms A's father, Mr

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E, advised that they often discussed her medications and condition, and he was “alarmed by [Dr F’s] failure to refer [Ms A] to a specialist for a second opinion”. His concern was based particularly on their family’s high incidence of grain allergy, and intestinal, colon, and rectal cancers. Mr B noted that Ms A’s grandfather had died of bowel cancer aged 46.

According to Mr B, Ms A was “confident that [Dr F] had it [her bowel condition] all under control”. Mr B and Ms A’s immediate family understood that Dr F had advised Ms A that her problems were related to her long history of dieting and weight loss and, possibly, the Caesarean deliveries of her children. Mr B believed Ms A might require surgery to remove “lesions” or “adhesions” on her bowel. Ms A’s family recall her saying that Dr F had told her she had “a lazy bowel”.

Dr F denies advising Ms A to that effect, and is adamant that her consistent advice to Ms A was that she had irritable bowel syndrome.[1] Dr F stated that she remembered Ms A well for a number of reasons:

> “[Ms A’s] consultations with me always took a long time – significantly longer than usual. I also remember her refusal to follow advice to undergo standard medical investigations regarding her bowel symptoms. I remember her strong beliefs in alternative therapies. Much of her long consultations with us were taken up with discussion of her anxiety and stress related symptoms … In her clinical notes from her previous general practitioners, … there is a documented history of abdominal pains dating back to 1989. These were variously diagnosed and treated. By the time [Ms A] registered with [the first medical centre], she had very fixed ideas about her bowel problems and how she liked to treat them. She had already embarked on a pattern of self-medication.”

Consultation and prescription chronology

Consultation lists and medical records provided by Dr F show that between August 1999 and October 2002 Ms A consulted Dr F 13 times, Dr G four times, and Dr H twice. Sometimes Ms A consulted the GPs by telephone. The occasions when the first medical centre discussed Ms A’s bowel symptoms or issued prescriptions in relation to these are set out below.

25 September 2000 (Dr F − telephone call)

Dr F states she first became aware of Ms A’s abdominal symptoms during a telephone call on 25 September 2000, when Ms A said she had epigastric pain for which a previous GP had prescribed Zantac. Dr F suggested that Ms A try Zantac 300mg at night for six weeks, and, if this did not settle her symptoms, she should make an appointment for a consultation. Dr F “never heard [Ms A] mention this type of pain again”. Dr F’s notes of

[1] Irritable bowel syndrome (“IBS”) is “a common condition in which recurrent abdominal pain with constipation and/or diarrhoea continues for years without any general deterioration in physical health. … The cause is unknown, but the condition is often associated with stress or anxiety ... . Treatment is based on removing anxiety … dietary adjustment and faecal softening agents, and drugs to reduce spasm or diminish pain sensitivity.” (*Oxford Concise Medical Dictionary*)

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this conversation state: “phone call: epigastric pain, has had Zantac before which has settled it, ‘too busy’ [to come in], try [six weeks] Zantac. If no relief must come in.”

6 September 2001 (Dr F)
Dr F stated that this appointment lasted the “standard time” of 15 minutes. The notes for this consultation, in full, read:

> “1. RIF [right iliac fossa] pains come and go 4/7 [four days], mid cycle, [no signs] + symptoms. Bowels – was constipated for 1/52 [one week], took laxative – eased bowels but still stressed. O/E [on examination] abdo soft.
>
> 2. CX [cervical] smear – healthy cx spatula + cytobrush.
>
> 3. Didn’t take Aropax[2].”

Dr F advised that this consultation included:

> “Taking a routine cervical smear, discussion of [Ms A’s] anxiety and persisting refusal to start treatment with Aropax … and discussion of her bowel symptoms. She described right iliac fossa pains which had come and gone over four days. … She did not describe the pains further. I asked her about her bowel habit and she reported that she had been constipated for a week. She had taken a laxative (I did not record which laxative or where she had got it from but there is no record in her medical notes of either myself or my colleagues … having prescribed her one at this time). … I performed an abdominal and vaginal examination and took a routine cervical smear. Her abdominal examination was normal. Her abdomen was soft, non-tender with no palpable masses. I concluded that her right iliac fossa pains might have been related to ovulation pain, constipation or perhaps Irritable Bowel Syndrome [which] is often characterised by abdominal pain, usually in an iliac fossa, constipation and examination is normal. Her history of a week’s constipation had resolved after self-administration of a laxative. I found no evidence of constipation during my examination of her abdomen. I concluded that her constipation had resolved. I did not prescribe any medication although I encouraged her to reconsider her decision about refusing to take the Aropax prescribed by [Dr G].”

22 February 2002 (Dr F)
Ms A next saw Dr F six months later when she complained of longstanding constipation and pain when passing urine. Dr F did not carry out a physical examination, but tested a sample of Ms A’s urine, which was positive for infection. The notes for this consultation, in full, read:

> “Long standing constipation + pain when wees. Dipstick – leucs + blood. Lactulose 20mls od (1L). Noroxein [sic] 400mg Tbd (6).”

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[2] An antidepressant/anti-anxiety medication.

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Dr F stated:

> "I concluded that [Ms A] had a urinary tract infection and prescribed Noroxin 400mg twice a day for three days. As she was leaving the consultation, she mentioned she was intermittently constipated. She requested a prescription for Lactulose. I prescribed Lactulose 20mls once a day, giving her a total of one litre. This was the first prescription any of us in the practice had given her for abdominal symptoms except for the Zantac over the phone seventeen months earlier.
>
> … I concluded she had … a tendency towards constipation, which may have been part of an Irritable Bowel Syndrome. I reached this conclusion based on the combination of documented evidence and information she had imparted to me [which included anxiety and panic attacks]. … She fitted the typical picture of a sufferer of Irritable Bowel Syndrome, which is the commonest bowel disorder which occurs in young adults, more often female than male, with constipation. In my experience Irritable Bowel Syndrome symptoms are often exacerbated by stress, anxiety and irregular eating patterns. [Ms A] had told me issues related to her weight and dieting had plagued her all her adolescent and adult life."

Responding to Dr F's comments, Ms A's twin sister Ms C stated that while Ms A may have fitted the "typical picture" of IBS, she also had the typical picture of bowel cancer. She disputed Dr F's explanation regarding IBS occurring in "young adults", noting that Ms A was in her early 40s and therefore "more defined as a middle aged adult".

6 March 2002 (Dr G)
Ms A saw Dr G and advised that the constipation had "finally cleared" with the use of a herbal medication and Normacol that she had bought and with which she wished to continue. Dr G prescribed Normacol granules to Ms A.

11 March 2002 (Dr F)
Dr F's notes of this consultation, in full, state:

> "piles – external v. sore – still constipated. Fleet phosph soda (48mls x 2)".

Dr F advised that at this consultation she performed a visual examination of Ms A's anus, which revealed external haemorrhoids which were not thrombosed. Dr F does not recall Ms A's description of her abdominal symptoms at that time, only that she said she was constipated. Dr F recalled:

> "[Ms A] demanded a Fleet phosphate enema. I disagreed with this treatment since I believed that it was inappropriate. She insisted on having it, saying that she could get it over the counter but it would be cheaper if I put it on prescription for her. I acquiesced reluctantly on this occasion, being aware of her financial difficulties as a solo parent. I did not perform any other tests at this consultation. I concluded that she had haemorrhoids, which may have contributed to her ongoing constipation due to pain when evacuating her bowels. I still considered that she might have Irritable Bowel Syndrome."

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24 May 2002 (Dr F – consultation for Ms A's daughter, Miss D)
Miss D advised that whenever she visited the doctor her mother would go with her. On 24 May 2002, when Miss D was 16, she visited Dr F for a "follow-up on stomach pains" which she had been experiencing for a few days. Ms A sat in on the consultation with her. Miss D stated:

> "During the visit, Mum also asked about her bowel, as she had stopped taking the medicines [Dr F] had given, for her constipation, because it had stopped.[3] However the problem had returned again. I don't remember the exact words [Dr F] used, but I remember having the distinct feeling Mum was definitely being 'told off'. Patronising tones were used and the overall message was something like how she had been dieting all her life and it was 'her fault' and to deal with the consequences. Discussing it in the car with Mum, she found it demeaning, and quite humiliating and considered changing doctors."

Mr B also recalled Ms A telling him about this consultation and that she felt "like a silly girl" because it seemed [Dr F] had "told her off". Mr B said that around this time Ms A discussed finding another GP, but had a lot of trust in Dr F and so he believed she did nothing about it. Ms A's father, Mr E, recalled that he "frequently advised my daughter to change her GP, but apparently this did not happen".

Dr F recalled that this was a standard 15-minute consultation, and that as Miss D and Ms A were leaving Ms A had mentioned that she was still constipated, volunteered that she was eating irregularly because of her studies, and asked for a prescription for Normacol and Lactulose.

Dr F denied that she "told off" Ms A, and stated that she would be particularly careful how she spoke to a mother in front of her daughter about any symptoms she might have. She acknowledged that she "may have appeared dismissive to a sixteen-year-old but this was only because I was having to be brief". In her initial response to the complaint, Dr F stated:

> "The appointment was for [Miss D] and I had attended to her needs. [Ms A] merely mentioned her constipation in passing and requested a prescription. I recorded 'constipation again, admits irregular eating patterns' in [Ms A's] medical notes and the prescription she requested and I did not charge [Ms A] for this prescription."

The computerised consultation lists provided by Dr F record that a fee of $10 was charged to Ms A on this date, while Miss D was charged $25. In response to my provisional opinion, Dr F stated:

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[3] In response to my provisional opinion, Dr F clarified that prior to this consultation the only medication she had prescribed for Ms A's constipation was Lactulose (on 22 February 2002) and a single Fleet phosphate enema (on 11 March 2002).

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> "It had not been my intention to charge [Ms A] for the prescription I provided for her at her request at the end of [Miss D's] consultation on 24/5/2002. I believe the $10 charge may have arisen from [Dr H's] prescription for Kenacomb ear drops [at a previous consultation on 7 May 2002]. I suspect that [Ms A] was asked to pay for [Miss D's] consultation and the cost of the prescription written by [Dr H] … at the same time and both fees were erroneously given to me."

The entry in Ms A's notes for 24 May 2002 reads "constipated again. Admits irregular eating patterns.[4] Normacol 500g [x 2] Lactulose 20mls [1 litre]" (Commissioner's emphasis). Dr F also provided a copy of Miss D's notes for this date, in which she has recorded that Miss D's signs and symptoms were "probably IBS".

27 June 2002 (Dr H)

On 27 June 2002, Dr H saw Ms A for the first and only time. Dr H advised that Ms A did not have an appointment booked on that day, but had arrived at the surgery and asked one of the nurses for a prescription for "a laxative or an enema". Dr H recalled that the nurse had wanted Dr H to sign the prescription, but she was not comfortable doing so, and had "bad vibes" about what Ms A was asking for and why. As it was Dr H's lunch break, she had time to see Ms A, and did so.

The history Dr H elicited was that Ms A dated the onset of her bowel problems, particularly constipation, from the beginning of 2002 when she had stopped eating because she was upset; since then she had had ongoing bowel problems and had not undergone any investigations for possible causes. The notes for Dr H's consultation with Ms A read:

> "Was away – stopped eating as upset → became constipated beg of this year, problems since. Yest took some dulcolax x 4 – vomiting, painful. Dehydrated + terrible pains. Took x 4. Hasn't passed proper bowel motion for 2/52 [2 weeks]. Above medications[5] – no help. Has had problems over the years usually when travelling. No investigation. Grandfather ca [cancer] bowel - + aged 43 yr.[6]
>
> Up since 4am. Supposed to be attending course today. Has had good result [with] Fleet [enema] before. Has had a temp + feeling unwell. Feeling cold. No breakfast this [morning]. [Last menstrual period] 1/52 ago (normal), [Blood pressure] 105/40. [Pulse rate] = 90/min reg.
>
> Afebrile, T37°C Active bowel sounds ++ (nothing to eat). No obvious bloating/distension, generally uncomfortable, no specific masses palpable.
>
> PR – soft faeces on glove, nothing to feel. Proctoscope – normal, a little faeces seen

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[4] In a letter dated 1 December 2004, Dr F advised that she had not recorded the words "Admits irregular eating patterns" on 24 May 2002, but added them on or about 17 January 2003. See "Medical records" discussion below.

[5] Normacol and Lactulose as prescribed by Dr F on 24 May 2002.

[6] Ms C advised me that her grandfather was in fact 46 when he died.

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Discussed possibilities. ? 2° [secondary] to dulcolax – pain NIV, 2° constipation? gastroenteritis

Discussed excluding other pathology – she wishes this to start – FOB [faecal occult blood tests] x 3

? Ba [Barium] enema/colonoscopy after. She would like to try Fleet enema anyway (has) will do @ home. If worse, no impvt → review."

Dr H explained her notes as follows:

"[Ms A] told me that on 26/6/02 she had taken four dulcolax tablets as a treatment for this most recent episode of constipation. She was concerned that she had not passed a proper bowel motion for two weeks despite taking the normacol and lactulose previously prescribed for her. Following this ingestion she described the development of terrible pains and vomiting and said that she had been up since 4am that morning. She recalled having had a similar feeling after the ingestion of two dulcolax on a previous occasion. This time she thought she had a temperature, felt cold and unwell, and hadn't eaten any breakfast. … [She] was hoping that, because she had had a good result with a Fleet enema before, this would help her symptoms …

Note was made that her grandfather died of bowel cancer aged 43 years … My examination findings were as follows:

Her blood pressure was 105/40 mmHg, pulse rate 90/minute with a regular rhythm and her temperature was normal at 37 degrees celcius. Her abdomen was not obviously bloated nor distended but generally uncomfortable, especially in the lower half. I did not identify any specific masses. There were active bowel sounds. Digital rectal examination did not reveal any abnormality. There was some soft normal faeces on the glove. Proctoscopy was normal and a little faeces was seen.

We discussed the findings from the history and examination and some of the possible explanations for these. In particular it was a possibility that her pain and nausea was a result of the dulcolax she had taken as treatment for her constipation. Because she had felt feverish and unwell, there was a possibility that these were secondary to gastroenteritis. However, we did also spend some time talking about her constipation and the change in her bowel habit over the past six months. We discussed the fact that her grandfather had died at an early age of bowel cancer and that bowel cancers can run in families and [Ms A] seemed keen to exclude pathology in herself. To start with I gave her a form to have faecal occult blood testing with a view to continuing investigation with colonoscopy/? Barium enema.

I was under the impression that [Ms A] attributed her current symptoms to being faecally loaded and unable to evacuate despite the dulcolax. She was very keen to use a Fleet enema in the hope of achieving a result … So in the interim, additional to the plan above, she was going to use a Fleet enema and was advised to seek review if there was

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> no improvement or she became worse. Such a review would have been to relook at the diagnostic possibilities and arrange further appropriate investigations/referrals."

Dr H said her feeling was that this had been an "emergency visit" because Ms A wanted a "quick fix" for her symptoms. However, having discussed with Ms A why she was having problems and whether there could be an underlying cause, Dr H felt Ms A "was seeing where I was coming from" and had agreed to further tests.

Dr F stated:

> "I discussed [Ms A] with [Dr H] after [Ms A] had consulted with her … Both [Dr H] and I were in agreement that it would be wise to exclude Bowel Cancer in view of [Ms A's] grandfather having had bowel cancer … ."

Dr H advised that she could not remember whether she had spoken to Dr F, or what may have been said, but that it was likely that a discussion had occurred, as her normal practice after seeing another GP's patient in the practice was to provide a verbal handover to the lead carer (that is, the GP with whom the patient was registered) and address any matters of concern. Dr H was worried that Ms A had signs of cancer and for that reason she had made full notes and believes she would have told Dr F, "this is an alert". Dr H said that at that point it would have been Dr F's role, as Ms A's GP, to call her in for another appointment and follow up.

Miss D spoke to her mother after this consultation. Ms A told her that Dr H had "raised the possibility of cancer and recommended that she have a bowel check up". Miss D said this scared her mother. She formed the impression that Dr H had been "quite concerned" about her mother's health. Mr E advised that around this time he was also concerned about his daughter's ongoing health problems, and had advised her to attend a specialist for colonoscopy.

In response to my provisional opinion, Ms C expressed concern that despite the "alert" from Dr H, Dr F did not contact Ms A − one of her "fairly regular patients" − regarding "such a serious possible condition". She noted that it was Ms A who made the next appointment herself, for Miss D. Ms C asked: "One wonders how many more weeks may have gone by since [the] alert, if [Miss D] had not needed to see the doctor?"

19 July 2002 (Dr F – consultation for Miss D)
Ms A attended another consultation with her daughter on 19 July 2002. Dr F entered the following in Miss D's notes: "Constipation again, Normacol… Lactulose." Dr F recalled that during the consultation Ms A had mentioned a recurrence of her otitis externa,[7] for which Dr F gave her a prescription. Dr F entered the following in Ms A's notes: "L ear sore again, o/e otitis externa, Colymycin … drops 2 drops tds (1)."[8]

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[7] Inflammation of the canal between the eardrum and the external opening of the ear.
[8] The computerised consultation list provided by Dr F on shows that the fee charged to Ms A on this date was $10; the fee charged to Miss D was $20.

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Miss D recalled:

> "Mum had been very concerned with [Dr H's advice regarding further investigations], obviously, and when with me, visiting [Dr F] again, asked the Doctor and told her about [Dr H's] recommendation. I witnessed [Dr F] immediately dismissing this recommendation, saying the other Doctor can 'overreact'. I don't remember the exact words however, it was something like this: '[Dr H] often overacts – you don't have to worry, you stuffed up your bowel when you were younger with all your dieting'. Mum was very relieved to hear this, as there was no cause for concern. On [Dr F's] advice, Mum did not get checked for Bowel Cancer, and continued as she had over the months of advice from [Dr F], to [take] medicine and laxatives for constipation – desperate means for pain and bowel relief."

Mr B believes that Dr H's recommendation of "a specialist exam … was overturned by [Dr F]". He stated that Ms A told him Dr F had advised that her symptoms were insufficient to suggest cancer, in particular as there was no bleeding from the bowel. Miss D recalled telling her mother that she should perhaps still have a check-up, despite Dr F's reassurance, but "nothing came of this".

Dr F refutes the complainants' statements that she dismissed Dr H's recommendation that Ms A have her bowel symptoms further investigated. Dr F is adamant that, "being aware of the family history, I advised [Ms A] … to undergo a proper investigation". Dr F stated:

> "I have the highest regard for [Dr H]. She is very thorough and caring. She often stays two to three hours after she has finished her morning's consulting, to complete very detailed notes about her consultations. … [Ms A] and I had discussed her appearance and low self esteem and how she had sought, (as she thought) to improve her appearance and hence her self esteem, by dieting. I did not blame her current constipation on her previous dieting, rather on irritable bowel syndrome exacerbated by her anxiety. In my experience, patients (and their relatives) sift out what they do not want to hear in a consultation. This may leave comments, which, if taken out of context, can imply the opposite of what was actually said. … By this time, I had known [Ms A] three years and we had established a certain rapport. The tone of my brief conversation with [Miss D's] mother may have been misinterpreted [by Miss D]. [Miss D] says that I said that her mother 'stuffed up her bowels' which are the words of an untrained sixteen year old and not a medical professional."

Responding to Dr F's comments, Miss D objected to the suggestion that at this consultation, and at that on 24 May 2002, she had misinterpreted what had been said to her mother. Miss D also refuted Dr F's inference that she had been confused because she was young. Miss D said that at 16 years old, "You are an adult and know what you are hearing. If I had been 12, I might agree I could have been confused, but I was 16 and I wasn't confused and I know what I heard [Dr F] say."

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Ms C responded to Dr F's comments as follows: "[Dr F says] she advised [Ms A] to undergo a proper investigation. But this is not recorded in her notes. Even bypassing the personality and character comments made by [Dr F] about [Miss D] and [Ms A], the fact is that [Dr F] never proactively pursued [Ms A] to undergo tests, as agreed with [Dr H]."

2 October 2002
Dr F issued a repeat prescription for Normacol (3 months' supply) and Lactulose (1 litre) following a telephone request to the surgery from Ms A. Dr F advised that she did not speak to Ms A on this occasion, but "would have requested that [Ms A] make an appointment to see me" had she done so.

Ms C expressed concern that this was "a relatively passive and contradictory prescription, if there is 'an alert' of bowel cancer [for] the patient".

11 October 2002 (Dr F)
Dr F stated that the last time she saw Ms A was on 11 October 2002 when Ms A presented with abdominal pain, saying she had self-medicated with "an unspecified amount of Normacol Plus, which had caused her 'bowel spasms' and pain". Dr F's notes for this consultation, in full, state: "Took Normacol plus + caused bowel spasms ++ + pain. O/E Still constipated. Not keen on further Ix [investigations].[9] Relationship discussed. Buscopan 10mg 2 qid (60)." (Commissioner's emphasis.)

Dr F advised that she does not usually prescribe Normacol Plus, and did not prescribe it to Ms A. She commented that "[Ms A's] response to self medicate with Normacol Plus 'and other solutions' was typical of her management of her problem."

Dr F also advised that this was the first time that a physical examination of Ms A's abdomen had revealed any palpable masses. She emphasised that while "partly reassured" by Dr H's normal abdominal, rectal, and proctoscope examinations on 27 June, she became concerned – for the first time − that Ms A might have a condition other than IBS. Dr F recalled:

> "[Ms A] denied passing any blood or mucous per rectum and she denied any recent weight loss. I performed an abdominal examination. [Ms A] was always very thin so it was easy to feel any masses. During the examination, I palpated soft masses on the left side of her abdomen. As the masses were easily indented, I concluded that I was palpating faeces in the descending colon. She was not in any discomfort during this examination. There was no organomegally or ascites. She was not jaundiced or clinically anaemic. I concluded that she was indeed constipated. I suggested she undergo standard routine tests to exclude a more serious underlying pathology since we were both well aware of her family history of bowel cancer. I suggested faecal occult blood tests, blood tests (including Carcino-embryonic antigen) and a referral to a

[9] On 1 December 2004, Dr F advised that she had not recorded the words "Not keen on further Ix " on 11 October 2002, but had added them on or about 17 January 2003. See "Medical records" discussion below.

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specialist for colonoscopy. She had accepted the forms for faecal occult blood tests from [Dr H] on 27/6/2002 but had failed to get the tests done. She was adamant that she did not wish to undergo any further investigations, so I took no further action. I simply prescribed the antispasmodic Buscopan 10mg, two tablets up to four times a day, total of sixty tablets, in case her bowel spasms were to recur. This medication is often prescribed for Irritable Bowel Syndrome. I found her vehemence quite surprising since she had already, at my suggestion, welcomed a referral for a mammogram and proceeded to a core biopsy of her breast for investigation of a possible breast lump previously … The outcome was that [Ms A] chose to gloss over both my and [Dr H's] suggestions and refused to act on our advice."

Ms C responded to Dr F's advice that this was the first occasion she became concerned that Ms A might have a condition other than IBS: "This seems to be a contradiction to the knowledge, and agreement to have bowel cancer investigated, [of] June 2002 with [Dr H]."

Mr B stated:

"[Ms A] was not resistant to specialist visits – [on an earlier occasion] I accompanied her to a woman's clinic where she had a breast examination and biopsy. She was terrified of getting cancer and would not hesitate to take action. She wanted me there to support her and in case she was given bad news. I also had her fully covered with [medical insurance] so there was no financial reason why she would not undertake examination by medical specialists. She did not insist on seeing a specialist as her doctor told her she had ruined her gut with dieting earlier in life and would just have to live with it."

1 December 2002 (the accident and medical centre)
On 1 December 2002 Ms A attended an accident and medical centre where she consulted with Dr I. He noted the following:

"Constipation. Gripping pain. Has not had normal BM [bowel movement] for 10/7 [ten days]. Abdo distended. Meds – lactulose, normacol. Halcion ½ tab. NKDA [no known drug allergies]. Triage category 4.

Consultation
Hx longstanding tendency to constipation. Usually manages with lactulose and normacol. Has tried [Fleet] PO [orally] and PR [per rectum]. No sig response. Significant colicky pain overnight.

O. abdo mildly distended. BS active, not obstructed. Appx [appendix] and LSCS [Caesarean] scars, DRE [digital rectal examination] rectum empty (nurse present).

A. High [constipation].

P. Trial [phosphate] enema. Buscopan tabs. No significant return from the enema but feeling a little better.

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> RX: 30 − Buscopan TAB 10MG – 2 every four hours prn for ab
> RX: 3 – Fleet Phosphate Enema – [use as directed]"

Notes provided by the accident and medical centre show that Ms A had attended the Centre periodically as a "casual" patient, including on occasions in December 2000 and May 2001 for complaints other than her constipation.

2 December 2002 (Dr F – telephone call)
On 2 December 2002 Ms A telephoned Dr F advising that she had become constipated for two or three weeks after missing her regular Normacol and Lactulose for two or three days. She reported that she had self-referred to accident and medical centre the day before, where abdominal and rectal examinations had been performed and she had been told her rectum was empty. Dr F's notes of this conversation, in full, read:

> "Ph call − constipated ++ 2−3 weeks after missing regular Normocol + Lactulose for 2-3 days. S/B [seen by] A/E – PR rectum empty enema – little result no high phosphate enema available wishes to try colonic clinic <u>advised TCI for Ix [investigations] if no success at colonic clinic</u>".[10] (Commissioner's emphasis.)

Ms C expressed concern that Dr F's notes of this consultation reflect "tacit approval" of Ms A's visit to a clinic, and show she "passively endorsed rather than protested to [Ms A's] actions".

2, 5 and 16 December (The clinic)
On 2, 5 and 16 December 2002, Ms A attended a clinic where colonic lavage/enema was performed.[11] The notes for these visits read as follows:

> "2.12.2002 c/o [complaining of] constipation, seen by [Dr …], lumps in ascending, transverse. Fair result only.
>
> 5.12.2002 Some result, lumps still palpable suggested castor oil compress.
>
> 16.12.2002 Still no complete clearance, some release. Poor result. Referred back to Dr and is waiting on 4th colonic appt."

A fourth appointment at the clinic was scheduled for 23 December, which Ms A did not attend.

Miss D recalled that from July to December 2002, her mother's condition had progressively worsened, to the point that "she almost looked pregnant" as a result of abdominal distension. She believed it was possible that one of her mother's friends had recommended her mother to the clinic, although she was not certain. She also recalled that

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[10] On 1 December 2004 Dr F advised that the words "advised TCI for Ix if no success at [the clinic]" were added to the record on or about 17 January 2003. See "Medical records" discussion below.
[11] The branch of the clinic has closed since these events occurred.

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her mother kept some enemas at home but she did not know whether these were bought over the counter, or if they had been prescribed by a doctor. Mr E was concerned that "alternative treatment" high colon enemas had been prescribed for his daughter by Dr F. Mr B recalled that Ms A had been losing weight, despite eating well, and was suffering mood swings. He stated, "In desperation and with the approval of [Dr F] she tried a colonic wash treatment which gave her temporary relief."

Dr F responded:

> "[Ms A] told me she wanted to try [the clinic] for a colonic lavage or wash out. This was entirely her idea. I have never, either before or since in my entire medical career, prescribed or recommended colonic lavage. [Ms A] was keen on alternative treatments and told me in no uncertain terms that she was determined to do this. I told her I had little or no knowledge about either the colonic clinic, or colonic lavage and therefore could not support her using such methods. She repeated that she was going to try it anyway. I did what I felt I could in the circumstances, which was advise her to come in and see one of us if she had no success with colonic lavage. I again reinforced that I thought she should undergo investigations for her continuing constipation to exclude underlying pathology. She continued to dismiss my suggestions. I wish to make it absolutely clear that I did not suggest, recommend, prescribe or refer [Ms A] for colonic lavage. This was entirely her idea."

Dr F advised that she knew about only one of Ms A's proposed visits to the clinic (as a result of the 2 December telephone call). She reiterated that she had not approved of this, but "could not stop [Ms A] from doing what she wanted".

December 2002 – January 2003 (Trip overseas)

On 27 December 2002 Ms A travelled overseas to take a holiday with her twin sister, Ms C, because she was feeling "uncharacteristically exhausted and stressed". Ms C recalled, "[Ms A] had had a busy and productive year, but told me her health, sleeping, and general wellbeing was suffering." She had not seen Ms A for 12 months and was shocked to see her looking "exhausted, thin and yellowish". She recalled:

> "[Ms A] did very little [that week] except sit on the veranda and progressively got very much worse. During the holiday we were both constantly aware of her 'constipation'. Although in her mind she wanted to do more things, her physical condition would not allow her. She could not even go for a swim as she felt weak. … I knew she was constantly in the bathroom trying to make her bowel move from the 'constipation'. All the time we thought it to be chronic constipation, something I have never experienced. We tried things such as prunes, lychees, bananas and roughage in the first few days, but as the days went on, we both were at a complete loss as it did not work. Eating and drinking only gave her pain. In the end we decided she [would] go immediately to the doctor on return to New Zealand."

Ms C stated that while on holiday Ms A obtained Normacol Plus from a pharmacy. Ms C was aware that this was not pleasant to take and needed to be taken with a lot of liquid.

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Having taken one "dose" of Normacol, Ms A experienced terrible pain, cramp, and dehydration. Ms C commented:

> "The purchase and consumption of the Normacol by [Ms A] is evidence … of an innocent and completely trusting patient of her GP's diagnosis, being a 'lazy bowel'. [Ms A] was taking these substances for 'constipation' and 'lazy bowel' as diagnosed by [Dr F]. This kind of substance was incorrect medication and a danger to her cancer condition. Plus [Ms A] had to experience unnecessary agonising pain, (due to taking laxatives for wrong diagnosis) when she was already coping with the pain of cancer, unknowingly." ([Ms A's] emphasis.)

Ms C also said:

> "One thing I am witness to during this time, is that [Ms A] completely believed in [Dr F's] diagnosis."

4 January 2003 (Admission to a public hospital)
On 4 January 2003, Mr B collected Ms A from the airport. He recalled that she was doubled up in pain, dry-retching, and had to be assisted from the plane by cabin staff. Mr B took Ms A directly to a accident and medical centre, where she was seen by a doctor who noted:

> "Subjective
> Hx of constipation, never been investigated, vomiting and abdo pain … severe colicky pain this am, … tried enema and buscopan, still painful, FHX grandfather has stomach cancer …
>
> Objective
> In moderate distress
> Abdo distended, tender LIF [left iliac fossa], quite [sic: quiet?] B/S [bowel sounds], nil peritonism
> PDX large bowel obstruction ? cause
> Plan: Refer to surgical [at the public hospital]."

The hospital registrar's notes following Ms A's admission at 9.30pm on 4 January record that her presenting problems were "abdo pain 3/7 [three days], constipation worsening over 1y [one year]". Notes on her history included: "Has had problems with bowels all her life. 1 year ago problems with severe constipation began. [Prescription]: lactulose + normacol/Metamucil by GP: some intermittent success. Never passed blood PR [rectally]. Distended recent days … No weight loss. Has been vomiting repeated last day … [Family history] of gastric cancer …"

On 5 January 2003 Ms A had a single contrast barium enema which suggested an obstruction at the level of the sigmoid colon. She subsequently underwent a laparatomy, total colectomy and ileorectal stapled anastomosis, performed by a consultant general surgeon. She was diagnosed as having two rectal tumours with liver metastases. She was

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referred by the general surgery team to a liver surgeon and a oncologist. The clinical summary recording Ms A's discharge from the public hospital on 14 January 2003 states:

> "Admitted [with] a clinical picture of large bowel obstruction. Laparatomy revealed 2 rectal carcinomas, had a total colectomy + ileorectal anastomosis, liver lesions noted. Sluggish bowel post op which resolved spontaneously. Had a low Hb count to 78 so was transfused 2Ux RBCs. Has had staging CT + has been referred to oncology + liver surgeons re: liver lesions. Bowels still a little loose. Need high fibre diet +/− bulking agent as needed. SOPC in 2 weeks/See GP as needed."

Mr B recalled that as soon as Ms A was told she had cancer, she "knew immediately that this had been there for a long time and understood immediately what position she was now in". He recalled that the surgeon at the public hospital had told them that he believed the tumours had been present for five to seven years and that Ms A's condition was "so serious she may not last a week".

Events post-diagnosis

On 13 February 2003, Dr G at the first medical centre received a letter from the Oncology Service at the public hospital. She was "very surprised" to receive this, as Ms A was not her patient, and she was shocked at the advanced nature of Ms A's bowel cancer. Dr G reviewed Dr F's notes of her consultations and discussed the matter with her colleagues. Dr H was similarly shocked at the poor outlook for Ms A. Dr F subsequently recorded the following in Ms A's notes:

> "13/01/03 Total colectomy plus ileorectal anastomosis on 5/1/03 [the public hospital]– see operation note. Multiple nodules on R lobe, liver + a few on L.
>
> 14/1/03 D/w [discussed with] staff nurse at [the public hospital] apparently CT scan shows secondaries. Discharged to oncology + palliative care team. Asked to speak to [Ms A] on ward at [the public hospital] + she said to phone at home later.
>
> 15/1/03 Unable to contact [Ms A] at home or at partner [Mr B's]. Messages left to contact me."

Mr B recalled that Dr F had made a number of calls to Ms A and her family. Ms A did not want any contact with Dr F and sought another GP. On 16 January 2003, Ms A asked that her medical notes, and those of her children, be transferred to Dr J at a second medical centre. Miss D recalled that this was because her mother wanted to "forget about … the whole episode with [Dr F]. She wanted to focus on the time remaining and marrying [Mr B]." Dr F transferred Ms A's medical notes to Dr J on or about 17 January 2003. She recorded the following before doing so:

> "16/1/03 Requests to transfer notes (+children's notes) to [the second medical centre].
>
> 17/1/03 Ph call to [Dr J] as [Ms A] seeing him today explaining Hx of constipation etc. Note [Ms A] has been seen by [Dr G], [Dr H], myself, at [the public hospital] at least twice + after hours clinics with constipation. She has been encouraged to undergo

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> investigations (FOB, colonoscopy +/- Ba enema) and has declined Ix – or agreed + not done it (see 27/6/02). [Dr F]."

On 17 January 2003, Dr J spoke to Dr F, and saw Ms A. He recorded the following:

> "17.01.2003 ([Dr J]): MALIGNANT NEOPLASM OF COLON
>
> HX: Phoned by [Dr F], constipation 1y, total colectomy 6 Jan, multiple nodules liver, sigmoid tumour, CT bad, has ref to oncol and palliative care, declined invests in past, poss FH GF [positive family history grandfather], 3 kids, sep. Smoking status ex smoker, Alcohol status Ex drinker 14 standard units/week.
>
> With partner [Mr B], adm with bowel obstruction 5 Jan, dx [diagnosed] 4d [four days] ago, 3 kids aged 16, 14, 11, […], aiming to marry [Mr B] soon, he has 3 children, CT showing in liver, denies that she has been advised to have invests previously, normally 55kg, lost since adm only, runny motions, diarr x 10 per day, waking in the night, crawling feeling in skin, agitated at night, sleeping from 11pm, waking from 1 to 4, then sleeping, few nights.
>
> OE: BP = 90/70, Wt (kg) = 47.0, Ht (cm) = 165.5, BMI=12.2. Ab wound healing well liver np [not palpable]."

Ms A died at home seven weeks later. She was 43 years old.

In response to the complainants' concerns about the standard of her clinical care and diagnosis, Dr F emphasised that she had been aware of the "possibility" of bowel cancer but that it was Ms A's choice not to undergo further investigations. She expressed the view that Ms A had repeatedly "ignored" her advice, Dr H's advice, and the recommendations of her father to "seek a second opinion or referral and … change her GP". Dr F stated, "I can only offer advice and recommendations." She also advised, "I did diagnose constipation clinically – when I examined [Ms A] on 6/9/2001 and 11/10/2002. It was [Ms A] herself who refused referral for investigations to discover a possible underlying cause ..."

In summarising her response, Dr F stated:

> "The sad truth is, that [Ms A's] bowel cancer was not detected until it was too late because of [Ms A's] persistent refusal to undergo standard medical investigations, as recommended by at least three doctors, including her father, her insistence on self medicating and her belief in, and reliance on, alternative treatments."

Medical records

Mr B complained about the adequacy of Dr F's notes and, with Ms A's family, raised concern that Dr F had "tampered" with them. The complainants state that Dr J told them that Dr F's notes recorded she had advised Ms A to seek a second opinion. Mr B (and Ms A, before her death) refuted this, stating that Dr F had not given such advice.

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Dr G also raised concerns about Dr F "amending" or "tampering" with medical records, specifically in relation to entries for Dr F's consultations with Ms A on 11 October 2002 and 2 December 2002.

On 11 December 2003, Dr F explained her process for making consultation notes and why, on occasion, her notes were short. She advised:

> "I usually make my consultation notes at the time of the consultation by writing in biro on A4 sheets of lined paper. I record the date of the consultation in the left hand margin, then the presenting complaint in the middle of the page, followed by any findings on physical examination, a diagnosis and an action plan, which might include tests, referral and follow up arrangements as appropriate. Any prescriptions are recorded in the right hand margin and underneath I sign '[Dr F]'.
>
> There are occasions when consultation notes are short. Examples of cases when this might arise are with recurrent conditions, or ongoing problems that have been detailed earlier in the notes; for example 'recurrent otitis externa', 'depression review', 'relationship discussed'. The latter two examples incorporate a volume of patient details, the vast majority of which, I do not write down. Another occasion when consultation notes may become minimised, is when there are time constraints as occurs, for example, when a consultation runs over time. Some patients take very much longer to see than others. [Ms A] was one such patient. She was well known to the reception staff. If they knew [Ms A] had made an appointment, they would block off two (not just the standard one) fifteen minute appointments to allow her time to talk so I would not keep the patients booked for consultations after her, waiting. At other times, [Ms A] would rush in, invariably late, demand the prescription she wanted and rush off …
>
> When [Ms A] had talked at length about an ongoing problem such as her anxiety and I was feeling pressurised to see the next patient, my consultation notes would be short; for example 24/5/2002 and 11/10/2002. Rather than record details of a discussion about what investigations were appropriate and why, when all this had been explained to [Ms A] before and recorded in detail by [Dr H] on 27/6/2002, I amalgamated/shortened the discussion of investigations, referral and outcome together and recorded it as 'Not keen on further Ix' (Ix = investigations). Both [Ms A] and I were well aware of what investigations had been discussed.
>
> So there was no departure from my usual practice making consultation notes in the case of [Ms A].
>
> When [Ms A] requested that her and her children's notes be transferred to [the second medical centre] on 16/1/2003, I highlighted (using a blue highlighter) in [Ms A's] notes, the occasions on which discussion about appropriate investigations for her abdominal symptoms had taken place. I did this after a phone call with [Dr J], so he would have the relevant medical history readily accessible at a glance (highlighting the notes of 27/6/2001, 11/10/2001 and the phone conversation on 2/12/2002) as [Ms A] was consulting him the following day on 17/1/2003.

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This was the only departure from my normal consultation notes and did not affect the MAKING of the consultation notes."

Dr F advised that she uplifted Ms A's original medical records from Dr J in mid-November 2003 on the advice of her lawyer, following receipt of a letter from my Office notifying her of the complaint. A photocopy of the records was left with Dr J. In subsequent correspondence via her lawyer in November 2004, Dr F confirmed that she still had the original medical records. In addition, in a letter dated 1 December 2004, Dr F stated:

"I am writing to correct what I have earlier said in my letter to you of 11 December 2003. This is with respect to the allegation that I had amended the medical notes for [Ms A]. It is correct that I have made three additions to the notes. They are:

(a) For the entry of 24 [May] 02 I have added the words '*admits irregular eating patterns*'

(b) For the entry of 11/10/02 I have added the words '*Not keen on further Ix*'

(c) For the entry of 2/12/02 [I have added] the words *'advised TCI for Ix if no success at colonic clinic.'*

I believe I made these additions to the notes on or about 17 January 2003. I do however want to emphasise that the additions are correct – that is to say they record observations that did occur at the particular consultations and which I could remember on 17 January 2003. That was a date shortly after I had learned of [Ms A's] diagnosis.

They were most certainly not made with the purpose of any 'cover up'. They were issues that I had discussed with [Dr J] to whom I was transferring the notes and I highlighted them for him as I referred to in my letter to you of 11 December 2003.

I do want to apologise for this and I sincerely regret having misled you in this regard in my report of 11 December [2003].

I should confirm that the remainder of what I have said in my report to you is true and correct to the best of my knowledge and belief. Again I am sorry for not having drawn to your attention, when I wrote my report on 11 December, that these alterations had been made."

Other matters

Dr F advised that in January 2004 she decided to leave the first medical centre because she had a job offer overseas. After selling her share of the practice, Dr F left on 30 June 2004.

In response to this investigation, Dr G advised the Commissioner and the Medical Council of her concerns about Dr F, and alleged, that in addition to altering Ms A's notes Dr F had "set up patient dependency", blurred doctor/patient boundaries, and tended to "belittle and blame patients, get angry with them, and tell them off". Dr G stated that she was also concerned because Dr F had told her that when she moved overseas to work she "would

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not be ticking a box on a form which asks whether there is a current complaint against her".

Dr F refutes Dr G's suggestion that she intended to conceal the Commissioner's investigation from the Medical Council. In response to my provisional opinion, Dr F advised that before her departure to go overseas she informed both the Medical Council and the Royal New Zealand College of General Practitioners that she was under investigation by my Office. Dr F stated:

> "At no time have I concealed, or attempted to conceal the investigation from the Medical Council. I informed the Medical Council of my intention to go [overseas] in 2005 and received a Letter of Good Standing (not a Certificate of Good Standing) from the Medical Council because I was under investigation by the HDC. As a Certificate of Good Standing is required for registration as a doctor [overseas], I have not sought medical registration [overseas], nor have I worked as a doctor since I have been [overseas]. As the direct result of this investigation I have been unable to obtain a Certificate of Good Standing, unable to register with [the overseas medical council] and unable to take up my position as a GP in an area of unmet need [overseas]."

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Independent advice to Commissioner

The following expert advice was obtained from Dr Ian St George, general practitioner:

> "I respond to your letter of 12 January 2005 seeking advice in relation to the late [Ms A's] fiancé and family's complaints against [Dr F]. I am asked to advise the Commissioner whether [Dr F] provided services to [Ms A] that complied with appropriate standards.
>
> My full name is Ian Michael St George. I am an Otago Medical School graduate and have MD, FRACP, FRNZCGP. I work as a general practitioner in Wellington, am Medical Adviser to the Medical Council of NZ, and Medical Director of Healthline. I have held various academic appointments at Senior Lecturer level, and was Postgraduate Dean at the Wellington School of Medicine, and recently Chief Censor for the Royal NZ College of General Practitioners. I am an advisor for the Health and Disability Commissioner, and have given independent advice on medical misadventure for the ACC since 2001.
>
> I state here I have no personal, financial or professional connection with any party that could bias my assessment. […].
>
> ***I am asked to advise as follows:***
>
> 1. *General*
>   a) What professional, ethical or other relevant standards are applicable to this case?
>   b) What observations, examinations, and/or follow-up steps should a GP undertake to assess, diagnose and treat a patient presenting with ongoing chronic constipation?
>   c) In such a patient, what, if any, investigations are recommended if Irritable Bowel Syndrome is suspected?
>   d) What, if any, further investigations are recommended to exclude a more serious underlying pathology, and when should these be considered?
>   e) What is the extent of a GP's responsibility for a patient who declines or refuses further investigations, despite appropriate advice?
>   f) In relation to a patient presenting as at (b)–(e) above, what details should be recorded in the medical notes, how, and when?
>
> 2. *Medical records*
>   a) Are [Dr F's] medical records/patient notes for [Ms A] appropriate and adequate? If not, why not?
>
>   In answering this question, please comment on:
>   i. [Dr F's] description of her process for recording patient notes;

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ii. [Dr F's] explanations for making brief notes;

iii. [Dr F's] actions in highlighting specific notes (for consultations on 27 June, 11 October 2002, and her telephone call with [Ms A] on 2 December 2002) on/about 17 January 2003;

iv. [Dr F's] actions in making three additions to the notes (for consultations dated 24 May, 11 October, and her telephone call on 2 December 2002), on/about 17 January 2003;

3. *Clinical care*

a) Based on [Dr F's] medical records for [Ms A], and her recollection of events (letter to Commissioner dated 11 December 2003), in relation to each consultation/telephone call when [Ms A] spoke about her bowel symptoms, did [Dr F]:

i. Undertake adequate and appropriate observations and/or examinations?

ii. Provide appropriate and adequate advice?

iii. Prescribe appropriate and adequate medication?

iv. If so, on which occasions? If not, why not?

b) In answering the questions at 3(a), please also specifically address the following issues:

i. Was it appropriate for [Dr F] to have concluded, on 22 February 2002 and thereafter, that [Ms A] had Irritable Bowel Syndrome? If not, why not?

ii. Should [Dr F] have considered alternative explanations for [Ms A's] bowel symptoms before 11 October 2002? If so, when?

iii. If [Ms A] expressed reluctance to undergo further investigation of her symptoms, what steps, if any, should [Dr F] have taken?

iv. Should [Dr F] have referred [Ms A] to a specialist for further investigation of her symptoms? If so, when?

v. Should [Dr F] have made contact and discussed [Ms A's] symptoms/treatment with any other identified providers seen by [Ms A], eg [Dr G, Dr H, the clinic] and the accident and medical centre]?

c) Would your advice in relation to any of the above questions be different had [Dr F's] notes for 24 May, 11 October, and 2 December 2002 included, contemporaneous with the consultation, the additions she acknowledges were subsequently entered on 17 January 2003? If so, how?

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I have read the following documents

- Covering letter of complaint dated 23 July 2003 by [Mr B], with attachments from [Mr B] (14 June 2003), [Ms C] (16 July 2003), [Miss D] (15 July 2003), [Mr E] (14 June 2003), (pages 1–9)
- Letters from Commissioner to [Dr F, the first medical centre, and Mr B], notifying investigation, 17 November 2003, (pages 10–16)
- Confirmation of [Dr F's] registration status (Medical Council of New Zealand), and employment status (NZ Companies Office), (pages 17–18)
- Response to complaint by [Dr F], 11 December 2003, with copy clinical records for [Mrs A], [Mr B], [Miss D], (pages 19–73)
- Letter from [Dr F] to Commissioner, (email) dated 2 December 2004; (hard copy, signed) dated 1 December 2004, (pages 74–76)
- Letter from [Dr G], 6 December 2003, with attachments letter from [Dr H], 24 December 2003, and copy clinical records for [Ms A] from [the first medical centre], (pages 77–108)
- Attendance notes, HDC investigator's telephone discussions with [Dr G], 4 and 10 August 2004, (pages 109–112)
- Attendance note, HDC investigator's telephone discussion with [Mr B], 30 September 2003; record of interview, HDC investigator and [Mr B], 24 November 2004; record of evidence (medication packaging) provided to HDC by [Mr B]; copy clinical notes (invoices/prescriptions) provided by [Mr B], (pages 113–129)
- Letter from C, 1 December 2003; record of evidence (medication packaging), 15 December 2003, (pages 130–132)
- Record of interview, HDC investigator and [Miss D], 22 November 2004, (pages 133–137)
- Attendance note, HDC investigator's telephone discussion with [Mr E], 26 November 2003; record of evidence (medications and packaging) provided by [Mr E] 28 November 2003; handwritten notes provided by [Mr E] and typed transcript, (pages 138–148)
- Records for [Ms A] provided by [the clinic], (pages 149–154)
- Records for [Ms A] provided by [the accident and medical centre] re consultations on 1 December 2002 and 4 January 2003, (pages 155–160)
- Records for [Ms A] provided by [Dr J], [the second medical centre]; attendance note of HDC investigator's telephone discussion with [the second medical centre] staff, 10 August 2004, (pages 161–205)
- Records for [Ms A] provided by [the District Health Board], (pages 206–362)

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I give my advice as requested:

General

What professional, ethical or other relevant standards are applicable to this case?

I have assessed whether the doctors' actions were reasonable in the circumstances by the standards of the profession, as far as they have been stated or previously judged, at the time of the incidents. I have referred to The New Zealand Medical Association's Code of Ethics, as reproduced in 'Cole's Medical Practice in New Zealand', to Chapter 10 of that work, on medical records (I note in the latter, the admonition 'do not alter notes or disguise additions'), and to Appendix C: 'Good Medical Practice'.

a) What observations, examinations, and/or follow-up steps should a GP undertake to assess, diagnose and treat a patient presenting with ongoing chronic constipation?

   Change in bowel habit is the 'classic' symptom that should alert a doctor to the possibility of bowel cancer. Continuing chronic constipation is however also a symptom, and when associated with the finding of an empty rectum, should prompt further investigation. The family history and subsequent presentation with haemorrhoids should have underlined that necessity.

b) In such a patient, what, if any, investigations are recommended if Irritable Bowel Syndrome is suspected?

   Irritable bowel syndrome is a diagnosis of exclusion – in other words, it should be diagnosed only after investigation has ruled out other structural causes of the constipation. Colonoscopy is the investigation of choice, but barium enema would suffice.

c) What, if any, further investigations are recommended to exclude a more serious underlying pathology, and when should these be considered?

   See (b) above.

d) What is the extent of a GP's responsibility for a patient who declines or refuses further investigations, despite appropriate advice?

   The general practitioner's responsibility to investigate ends when the patient refuses investigation, but there remains the responsibility to continue management (or refer to another doctor), and to try at each contact to persuade the patient to accept investigation.

e) In relation to a patient presenting as at (b)–(e) above, what details should be recorded in the medical notes, how, and when?

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At every visit there should ideally be a record of subjective symptoms, objective findings on examination, an assessment and a management plan. While in many general practice consultations this amount of detail is neither necessary nor helpful, in a case such as [Ms A] presented, with chronic symptoms, with longer than usual consultations, and with a putative disagreement on management, a full record should have been made.

2. **Medical records**
   (a) Are [Dr F's] medical records/patient notes for [Ms A] appropriate and adequate? If not, why not?

   No.

In answering this question, please comment on:

- [Dr F's] description of her process for recording patient notes (page 28 of your documents);

Her description follows the recommendations for a standard problem-oriented medical record. Her actual records do not adhere to her description.

- [Dr F's] explanations for making brief notes;

All general practitioners at times make brief notes, and often in the circumstances [Dr F] lists; the exception would be the long consultation, especially when there was disagreement about the need for investigation.

- [Dr F's] actions in highlighting specific notes (for consultations on 27 June, 11 October 2002, and her telephone call with [Ms A] on 2 December 2002) on/about 17 January 2003;

Highlighting specific notes is common and perfectly acceptable practice.

- [Dr F's] actions in making three additions to the notes (for consultations dated 24 May, 11 October, and her telephone call on 2 December 2002), on/about 17 January 2003;

Making additional notes in retrospect is commonplace, but the date of the alteration should always be added; otherwise there is the appearance of dishonesty. In [Dr F']s case, the impression of dishonesty is enhanced by her original statement (later changed), that she was merely highlighting (not adding to, not altering) the notes of those three days, and 'This was the only departure from my normal consultation notes and did not affect the MAKING of the consultation notes'.

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3. **Clinical care**
(a) Based on [Dr F's] medical records for [Ms A], and her recollection of events (letter to Commissioner dated 11 December 2003), in relation to each consultation/telephone call when [Ms A] spoke about her bowel symptoms, did [Dr F]:

- Undertake adequate and appropriate observations and/or examinations?

  No. She should have ordered colonoscopy at the next visit after [Dr H] had found an empty rectum.

- Provide appropriate and adequate advice?

  No. As above.

- Prescribe appropriate and adequate medication?

  One of the medicines prescribed (lactulose) was apt, but only once the diagnosis was established by exclusion of serious pathology. The advice to use high colonic irrigation (if [Dr F] gave it, and she insists she did not) was entirely inappropriate, as this is generally considered a quack cure or fetish activity.

  If so, on which occasions? If not, why not?

  On 25 September 2000 [Dr F] prescribed Zantac without seeing [Ms A]; she should have insisted on examining her at that time.

  On 6 September 2001 [Ms A] complained of constipation and abdominal pain. Dr F examined her abdomen but did not do a rectal examination; she did not prescribe.

  On 22 February 2002 [Dr F] prescribed lactulose when [Ms A] mentioned as she was leaving, that she was intermittently constipated; lactulose is a proper treatment for constipation, but the symptom had not been investigated.

  On 11 March 2002 [Ms A] presented with painful haemorrhoids; a rectal examination at that consultation would have been uncomfortable, and Dr F should have asked [Ms A] to return for that purpose, and she should have reinforced the need for further investigation (haemorrhoids are also a symptom of colonic cancer). The prescription of the enema was not appropriate, despite [Ms A's] 'insistence'.

  On 11 October 2002 [Ms A] presented with abdominal pain and constipation. [Dr F] prescribed Buscopan, which would be likely to aggravate the constipation, and is thus inexplicable.

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(b) In answering the questions at 3(a), please also specifically address the following issues:

- Was it appropriate for [Dr F] to have concluded, on 22 February 2002 and thereafter, that [Ms A] had Irritable Bowel Syndrome? If not, why not?

  No. This is a diagnosis of exclusion, and should have been made only after proper investigation.

- Should [Dr F] have considered alternative explanations for [Ms A's] bowel symptoms before 11 October 2002? If so, when?

  Yes. Certainly by 22 February 2002.

- If [Ms A] expressed reluctance to undergo further investigation of her symptoms, what steps, if any, should [Dr F] have taken?

  She should have brought the subject up at every consultation, while carefully examining the patient, offering second opinions, and recording the consultation fully. I note that [Ms A's] reluctance is a matter of some dispute, and that [Dr F's] accounts differ from those of the complainants.

- Should [Dr F] have referred [Ms A] to a specialist for further investigation of her symptoms? If so, when?

  Yes. At the consultation of 22 February.

- Should [Dr F] have made contact and discussed [Ms A's] symptoms/treatment with any other identified providers seen by [Ms A], e.g. [Dr G, Dr H, the clinic and the accident and medical centre]?

  [Dr F] had available the clinical records of [Drs G and H].

  While integrated primary care is an ideal, it must be balanced with patient choice, and [Ms A] was free to seek help when and where she chose. It was not [Dr F's] responsibility to make contact with the accident and medical clinic, nor with the performers of colonic irrigation.

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(b) Would your advice in relation to any of the above questions be different had [Dr F's] notes for 24 May, 11 October, and 2 December 2002 included, contemporaneous with the consultation, the additions she acknowledges were subsequently entered on 17 January 2003? If so, how?

No. Unfortunately [Dr F] did not divulge at first that the additions were not made contemporaneously with the other clinical records. While raising questions about credibility, that does not alter my opinion about her management.

[Dr F] did not provide an appropriate standard of care, and in my opinion her departure from that standard would be viewed by her peers with moderate, or severe disapproval.

I have no other comments about [Dr F's] care of [Ms A]. I have read the notes of the telephone conversation with [Dr G], and am thus aware of [Dr G's] concerns about [Dr F's] clinical care, personal relationships and behaviour. If indeed [Dr F] failed to disclose that there was a complaint about her when she applied to the Medical Council for a practising certificate or a certificate of good standing, then that is seriously dishonest. I note there are other allegations of dishonesty, but I cannot comment on the credibility of any of the parties, on the papers alone."

Responses to provisional opinion

Ms C

Ms C responded to information set out in my provisional opinion and summarised her concerns as follows:

"All along this period of treatment by [Dr F], the salient facts remain that [Ms A] was a 'middle aged' (middle adulthood) woman (early 40s), when first seen by [Dr F], and 43 when last seen, with consistent bowel problems throughout that time, and a family history of bowel cancer. This was all known to [Dr F]. In this case, there should have been a full assessment of ALL the likely causes, including cancer and not just exclusive assumption of Irritable Bowel Syndrome.

[Dr F] was 'attached to the diagnosis' of IBS, without under[taking] proper exclusive testing for other conditions well known for people of [Ms A's] age and history.

… [As] late as 2 October 2002, [Ms A] was still being treated (prescribed Normacol and Lactulose) as a patient with constipation issues alone. This is after 'agreement [between Dr H and Dr F] that it would be wise to exclude bowel cancer in view of [Ms

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A's] grandfather having had bowel cancer'… [and] there was no proactive behaviour from [Dr F] to contact [Ms A] to make sure she had gone for the tests. …

It would seem to the reader of this report that [Dr F] repeatedly advised [Ms A] to undergo investigations, [and that Ms A] repeatedly refused. There is no evidence in [Dr F's] notes of being 'proactive', e.g. a phone call, getting [Ms A] back for an appointment, as per [Dr H's] comments on actions that should have been taken in 'an alert' situation. It is a fact that it was only [Dr H] who acted towards testing for cancer, not [Dr F]. …

[Dr F] comments about [Ms A's] 'selective' self prescribing and beliefs behaviour, however [Dr F] also illustrates 'selective' behaviour herself, with the continual 'single-mindedness' of IBS diagnosis. …

There is constant blame [in Dr F's response to the complaint] of [Ms A's] character, as a patient who was stubborn, self-medicating, had strong beliefs in alternative medicine, etc. It seems to be all the fault of the patient. For example, when [Dr F] says she could not take notes due to relationship discussions. Rather this would appear to be a lack of proficiency to manage her responsibilities as a professional general practitioner. It would appear that [Dr F] is trying to build up a case for her lack of medical thoroughness towards [Ms A]. The training [doctors] have is to handle 'patient anxiety'. [Dr F] appears to hide her flaws behind it."

Dr F

Dr F commented on the following matters raised in my provisional opinion:

Medical records
Dr F accepted that her standard of record-keeping was inadequate on account of the brevity of her consultation notes. She also stated: "I sincerely regret my non-contemporaneous additions to [Ms A's] medical records and my failure to acknowledge this in my initial response to the complaint. I accept that in doing so I have breached Right 4(2) of the [Code of Health and Disability Services Consumers' Rights]."

Communications
Dr F expressed "alarm" that her "communication style" had caused concern to the complainants:

"I deeply regret that, as you have suggested, [Ms A] may have felt humiliated either by what I may have said, or by my manner. I have no hesitation in apologising to her family for this.

I am also sorry that you have found my approach, in correspondence with your Office, to be 'reflective of an abrupt and somewhat dismissive approach'. This was not my intention. Until this investigation, I had had no experience of dealing with the HDC before and I was trying to be concise."

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Expert advice

Dr F challenged three of Dr St George's conclusions as follows:

> "25/9/2000: Zantac prescription
>
> I discussed [Ms A's] symptoms on the phone with her. There was documented evidence that she had taken Zantac before which she said had settled her symptoms. This was therefore, neither a 'new medication' nor a 'new symptom' for her. I advised her to try a six week course of Zantac and if no relief to come in, thereby arranging a clear follow-up. I do not agree that this was inappropriate or inadequate.
>
> 6/9/2001
>
> This consultation was for 15 minutes. [Ms A's] main agenda was to have a cervical smear and discuss her stress and relationship problems. She only mentioned her constipation briefly at the end of the consultation. This was the first occasion she had mentioned constipation. At the time she said her symptoms had resolved after a self-prescribed laxative. I examined her abdomen. It is not always possible, or acceptable to the patient, to perform a rectal examination at every abdominal examination. I had already performed one invasive procedure during this consultation, a cervical smear. I did not prescribe any medication for her constipation on 6/9/2001 because her symptoms had resolved and she already had a laxative. Not every consultation has to, or should result in giving the patient a prescription. I maintain that it was appropriate and adequate not to prescribe any medication at this consultation.
>
> 11/10/2002
>
> I disagree that the prescription for Buscopan was inappropriate or 'inexplicable'. Buscopan is commonly prescribed for symptom relief, as an antispasmodic for patients who experience bowel spasms, or have [colicky] pains. [Ms A] may have exacerbated her bowel symptoms by self medication with Normacol Plus (which I had not prescribed her) and I sought to alleviate her symptoms with Buscopan. [Dr I], at [the accident and medical centre] on 1/12/2002, also prescribed Buscopan (in the same dosage) for [Ms A's] 'significant [colicky] pains'."

Dr F does not accept that she had failed to provide appropriate and adequate advice to Ms A, or that each medication she prescribed to Ms A was inappropriate or inadequate. She conceded that her clinical notes "unfortunately do not support me on this".

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Further expert advice

On 29 June 2005 Dr St George provided further advice responding to Dr F's comments:

> "I respond to your email of 13 June 2005 seeking further advice in relation to the late [Ms A's] fiancé and family's complaints against [Dr F].
>
> You have told me that [Dr F] 'challenges 3 aspects of [my] advice' (on which the Commissioner relies), and submits that:
>
> 1. Her prescription of Zantac for [Ms A] on 25/9/00 was appropriate because 'there was documented evidence that [Ms A] had taken it before'.
>
> *The repeat prescription of Zantac was inappropriate without seeing the patient; Zantac is prescribed to reduce the production of stomach acid in acute and chronic gastric and gastro-oesophageal inflammation. The fact that [Ms A] had taken it before is insufficient reason for prescription sight unseen.*
>
> 2. It was appropriate for her not to perform a rectal exam or offer a prescription on 6/9/01 because [Ms A's] 'main agenda' that day was to have a cervical smear and discuss stress problems; also because she had performed an invasive procedure on that date already (the cervical smear) and 'not every consultation has […] to result in giving a prescription'.
>
> *I concede a second invasive procedure on that day may have been perceived as too much. Did [Dr F] discuss the options with [Mrs A] then? ie to have it done there and then, or to return soon afterwards? My comment on her non-prescription that day is an observation rather than a criticism.*
>
> 3. Her prescription of Buscopan on 11/10/02 (which I have described as 'inexplicable') was appropriate, because [Ms A] had 'exacerbated her bowel symptoms by self medication' and required an antispasmodic; in any event, [Dr I] at [the accident and medical centre] also prescribed Buscopan in the same dosage. [NB: Dr I did prescribe Buscopan, six weeks later, shortly before the diagnosis of cancer.]
>
> *Two wrongs do not make a right. Buscopan is symptomatic treatment for bowel spasm, and should be prescribed only once the diagnosis is established. Here the symptoms were described as constipation and abdominal pain, and the diagnosis was not established.*"

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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.

…

RIGHT 5
Right to Effective Communication

…

2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

Other relevant standards

The professional standard for medical records is set out in the Medical Council of New Zealand's guidelines, "The maintenance and retention of patient records" (2001):

"1. Maintaining patient records

a. Records must be legible and should contain all information that is relevant to the patient's care.
b. Information should be accurate and updated at each consultation. Patient records are essential to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory."

The New Zealand Medical Association *Code of Ethics* (2001) includes the following statement:

"<u>Responsibilities to the patient</u>
Standard of care…

- *Ensure every patient receives a complete and thorough examination into their complaint or condition.*
- *Ensure accurate records of fact are kept*"

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Opinion: Breach – Dr F

Adequacy and appropriateness of investigations, diagnosis and treatment

Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), Ms A had the right to have medical services provided with reasonable care and skill. Under Right 4(2), she was entitled to services that complied with relevant standards, including those established by the Medical Council of New Zealand and the New Zealand Medical Association ("the NZMA"), of which Dr F was a member at the relevant time. Fundamental to the provision of services of an appropriate standard is a provider's adequate assessment and treatment of their patient's condition − a responsibility that is specified in the NZMA *Code of Ethics*. My expert advisor Dr St George concluded that, overall, Dr F did not undertake adequate and appropriate observations of Ms A, failed to provide appropriate and adequate advice, and failed to prescribe appropriate and adequate medications. I agree with this advice. Accordingly, for the reasons that follow, I consider that Dr F breached Rights 4(1) and 4(2) of the Code.

On 25 September 2000, Dr F prescribed a six-week course of Zantac to Ms A over the telephone, without seeing her. Zantac is prescribed to reduce the production of stomach acid in acute and chronic gastric and gastro-oesophageal inflammation. In response to my provisional opinion, Dr F submitted that there was "documented evidence that [Ms A] had taken Zantac before which … had settled her symptoms", and therefore her prescribing on this occasion was appropriate. This explanation is unconvincing and misleading, as it implies that the notes of Ms A's consultations at the first medical centre prior to 25 September 2000 contain reference to her experiencing epigastric pain and taking Zantac. This is not the case. What *is* documented, on 25 September, is that Ms A told Dr F that she had previously taken Zantac. This was the first that Dr F knew of Ms A's abdominal symptoms, and she should therefore have insisted that Ms A attend the clinic to be examined. My advisor Dr St George is clear – that Ms A may have taken Zantac before is "insufficient reason for prescription sight unseen". In addition, it was insufficient to advise Ms A to make an appointment at a later date if the Zantac did not settle her symptoms. This did not constitute "arranging a clear follow-up", as Dr F suggests. In these circumstances the prescription of Zantac was inappropriate.

On 6 September 2001, Ms A complained of constipation and abdominal pain. Dr F says that these were mentioned only briefly at the end of a 15-minute consultation, the main focus of which was a cervical smear and discussion regarding Ms A's stress. Dr F performed a vaginal examination and took a routine cervical smear, and palpated Ms A's abdomen but did not undertake a rectal examination. Dr St George concedes that performing this further invasive procedure at that time may have been perceived as "too much". I accept this may have been the case, bearing in mind that this was the first occasion Ms A had mentioned her constipation to Dr F, and her advice that it had resolved after taking a laxative. However, a change in bowel habit is a classic symptom that should alert a doctor to the need for an examination. Accordingly, as Dr St George notes, it would have been prudent for Dr F to have discussed with Ms A her options – ie, she could either have a rectal examination on 6 September, or made an appointment for this to be done soon

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afterwards. Instead, Dr F concluded that Ms A's presenting abdominal pains might have been related to "ovulation pain, constipation or perhaps Irritable Bowel Syndrome". She gave weight to the latter, based on Ms A's known history of stress and anxiety. However, irritable bowel syndrome ("IBS") is a "diagnosis of exclusion" which should be used only after investigation has ruled out other causes of the constipation itself. Dr F did not conduct any further investigations in September 2001.

The 22 February 2002 consultation was critical. On that occasion, Dr F concluded that Ms A had a urinary tract infection for which she required antibiotics. When Ms A reported "longstanding constipation", Dr F maintained her diagnosis of IBS, in the absence of an abdominal or rectal examination, or any further investigations such as a barium enema or colonoscopy to exclude serious pathology. Dr St George is clear that Dr F should "certainly" have considered alternative explanations for Ms A's bowel symptoms by this time and referred Ms A to a specialist. Had Dr F done so, and had Ms A expressed reluctance to undergo further investigation at that time, Dr F should have brought up the matter and carefully examined Ms A at every subsequent consultation, recording her findings and discussions fully. She did not do so. In respect of this issue, I note Dr St George's advice that "the general practitioner's responsibility to investigate ends when the patient refuses investigation, but there remains the responsibility to continue management (or refer to another doctor), and to try at each contact to persuade the patient to accept investigation". In my view there is no credible evidence that Dr F took these steps in the consultations that followed.

On 11 March 2002, Ms A presented with painful haemorrhoids and told Dr F that she was still constipated. While it was appropriate not to conduct a rectal examination at that time (because it would have been uncomfortable), continuing chronic constipation and haemorrhoids are symptoms of colonic or bowel cancer, and Dr F should therefore have asked Ms A to return at an early date. In light of these presenting factors it was again inappropriate for Dr F to have maintained that Ms A "might" have IBS, and too simplistic to conclude that the haemorrhoids had "contributed" to her constipation. It was substandard practice for Dr F not to have emphasised the importance of colonoscopy or barium enema to exclude the possibility of cancer, and taken active steps to encourage and arrange such an investigation. Moreover, as my advisor noted, it was inappropriate for Dr F to concede to Ms A's request for a Fleet phosphate enema at this time. Doctors are not beholden to their patients' demands or insistence that they provide treatments which the practitioner believes to be inappropriate.

Not having ensured that Ms A returned for a further consultation in March or April, it is concerning that Dr F also failed to better utilise the opportunity to discuss Ms A's condition on 24 May. I appreciate that this consultation was a 15-minute appointment for Miss D, and it was not possible or appropriate for Dr F to fully address the concerns of both her patients in that time. However, it would have been prudent for Dr F to ask Ms A to book a further appointment for herself later that day or week. Instead, Dr F again issued Ms A with a prescription for Normacol and Lactulose without carrying out an examination to assess her condition.

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On 27 June Ms A had her first and only consultation with Dr H. It is noteworthy that Dr H elicited and documented the family history of bowel cancer at this first consultation. Dr H undertook a rectal examination which did not reveal any abnormality. This prompted Dr H to plan for further investigations. Dr H and Dr F discussed Ms A's situation after this consultation and agreed that it would be wise to exclude bowel cancer. As Ms A's primary GP, it was Dr F's responsibility to ensure that appropriate follow-up occurred. Ms A's family has expressed concern that Dr F did not do so, despite Ms A being a regular patient with a "serious possible condition".

As Dr St George notes, Dr F should have ordered colonoscopy for Ms A at "the next visit". Technically, this was 19 July, albeit an appointment for Miss D's abdominal complaint, made by Ms A. As Ms C commented, "one wonders how many more weeks may have gone by … if [Miss D] had not needed to see the doctor". There is some evidence that Dr F discounted Dr H's advice regarding the need for further investigations at that time. What is clear is that Dr F did not arrange a separate appointment with Ms A to fully discuss the need for further investigations. A prudent doctor would have done so.

On 2 October Dr F issued Ms A a repeat prescription for three months' supply of Normacol following a telephone request. Ms C is concerned that, in the context of Dr H's "alert" to Dr F that bowel cancer needed to be considered and excluded, this was a "passive and contradictory prescription". However, I note Dr F's advice that she did not speak to Ms A on this occasion. Had she done so, it would have been appropriate to ask Ms A to make an appointment to come in for further investigations and discussion. In any event, on 11 October 2002, Ms A presented to Dr F with abdominal pain and constipation. Dr F examined Ms A's abdomen (the first time she had done so since 6 September 2001) and recalled (although did not record) that palpable masses were present. She did not perform a rectal examination. She prescribed Buscopan, a symptomatic treatment for bowel spasm.

It is of concern that Dr F says this was the first time she considered there might be an underlying cause of Ms A's symptoms other than IBS, and that despite this she initially sought to justify prescribing Buscopan on the basis that it "is often prescribed for Irritable Bowel Syndrome". I agree with Ms C's observation that this explanation seems to contradict Dr F's assertion that she had agreed with Dr H, in June, that the possibility of bowel cancer should be investigated.

My advisor stated that Buscopan should be prescribed only once a diagnosis is established. Dr F had not established that Ms A was experiencing bowel spasms and was aware only that Ms A had constipation and abdominal pain. In these circumstances, Dr St George said that prescribing Buscopan was "inexplicable", because it was likely to aggravate Ms A's constipation. I accept that advice.

In response to my provisional opinion, Dr F sought to further justify her prescribing on this occasion, stating that "[Ms A] may have exacerbated her bowel symptoms by self medication with Normacol Plus (which I had not prescribed her) and I sought to alleviate her symptoms". She noted – with the benefit of hindsight – that Dr I at the accident and

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medical centre had also prescribed Buscopan to Ms A on 1 December 2002. These are not persuasive reasons for prescribing an antispasmodic drug to a patient with a longstanding history of unexplained constipation, in the absence of a clearly established diagnosis and appropriate investigations. As Dr F had approved a three-month prescription of Normacol to Ms A just nine days before, it would have been prudent to enquire why she was taking Normacol Plus as well. In regard to the prescription of Buscopan by Dr I six weeks later, I agree with my advisor that "two wrongs do not make a right". I also note that Dr I specifically recorded Ms A's "gripping [and] significant colicky pain" on examination. The circumstances of his prescription of Buscopan were therefore not analogous to those of Dr F. In any event, it was Dr F – not Dr I – who was Ms A's regular GP, with detailed knowledge of her medical history.

In my view, on 2 December 2002, Dr F did not act appropriately on Ms A's advice that after two to three weeks of ongoing constipation her rectum (on examination at the accident and medical centre the previous day) was still empty. While I accept that it was not necessary for Dr F to contact the accident and medical centre to discuss this, she was responsible for giving appropriate and adequate advice to Ms A. Dr F states that she advised Ms A to come in for further examination if colonic lavage had not relieved her symptoms. Although I do not agree with Ms C that this advice – if it was indeed given – amounted to tacit approval or endorsement of Ms A's attendance at the clinic, it was nevertheless inadequate.

A patient's regular general practitioner is best placed to maintain the most complete record of the health problems of an individual under his or her care and to understand the individual's personal circumstances. While Ms A had seen a number of providers with the same symptoms over many months, it was Dr F alone who had seen her repeatedly, knew that her constipation was longstanding, chronic and accompanied by haemorrhoids, and was aware of the family history of bowel cancer. Significantly, it was Dr F who knew that Ms A had not had the further investigations recommended by Dr H. In these circumstances it was incumbent on Dr F to take an overview of Ms A's multiple consultations, and advise Ms A specifically that her symptoms and history were, by December 2002, suggestive of cancer and potentially life-threatening. It was insufficient to leave it up to Ms A to return if colonic lavage was not "successful"; Ms A should have been strongly counselled about the need for further investigations, irrespective of any colonic lavage. Dr F should have explained to Ms A that, whatever the merits of colonic lavage, it is not an "investigation" that can exclude the possibility of cancer.

Ultimately, over the course of 15 months, Dr F failed to provide an appropriate standard of care to Ms A, to a degree which Dr St George concludes would be viewed by her peers with moderate or severe disapproval. I agree. In my view, Dr F's failure to adequately assess, diagnose and treat Ms A – bearing in mind that her predominant presenting symptom persisted for so long and Dr F knew of the family history of bowel cancer − was significant, and amounted to a major failure to provide services with reasonable care and skill. In these circumstances Dr F breached Rights 4(1) and 4(2) of the Code.

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Medical records

Introduction

A further fundamental element of good medical practice and the doctor-patient relationship is good record-keeping. *Cole's Medical Practice in New Zealand* (2001) ("*Cole's*") states:[12]

> "[Record-keeping] is a tool for management, for communicating with other doctors and health professionals, and has become the primary tool for continuity of care in many large practices, as well as in hospitals. To fulfil these tasks the record must be comprehensive and accurate."

In terms of the Code, it is a general practitioner's responsibility when making a record of a consultation with a patient (particularly a handwritten record, as in this case), to do so in accordance with professional and ethical standards − which include writing legibly, recording the date and time, signing the notes legibly, and not altering the notes or disguising additions. Further, as my advisor noted, at every consultation there should ideally be a record of subjective symptoms, objective findings on examination, an assessment and a management plan. Dr St George advised: "While in many general practice consultations this amount of detail is neither necessary nor helpful, in a case such as Ms A presented, with chronic symptoms, with longer than usual consultations, and with a putative disagreement on management, a full record should have been made." In my opinion Dr F's standard of record-keeping was inadequate and breached Right 4(2) of the Code, for the following reasons.

Brevity and missing information

Dr F explained her process for recording patient notes, stating that she records "the date of the consultation in the left hand margin, then the presenting complaint in the middle of the page, followed by any findings on physical examination, a diagnosis and an action plan, which might include tests, referral and follow up arrangements as appropriate. Any prescriptions are recorded in the right hand margin and underneath I sign '[Dr F]'."

Dr St George noted that while Dr F's description follows the recommendations for "a standard problem-oriented medical record", her actual notes of her consultations with Ms A do not. In particular, her notes do not clearly and in sufficient detail record the findings on physical examination (or what examinations were undertaken), a diagnosis or differential diagnoses (IBS is not mentioned), an action plan or any discussion as to recommended tests, referral and follow-up.

Dr F justified the brevity of her notes on the basis that her consultations with Ms A dealt with "recurrent conditions", and that Ms A created "time constraints" and pressures by taking more time than other patients, attending with a relative, arriving late, "demanding a prescription", and "rushing off". I find Dr F's excuses unconvincing. In Ms C's words, while Dr F attempted to lay on her patient the blame for inappropriate notes, Dr F's

[12] 2001 edition, page 80.

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standard of record-keeping demonstrates "a lack of proficiency to manage her responsibilities as a professional general practitioner". Dr F has now accepted that her standard of record-keeping was inadequate.

As Dr St George noted, all GPs at times make brief notes, and often in circumstances such as those Dr F has described. However, there are also specific circumstances when it is incumbent on the GP to make careful, detailed notes. *Cole's* states:[13]

> "While the details are the doctor's choice, good notes are an insurance against wrongful statements, and there are instances when the doctor is frankly foolish if notes are not made. These instances include changes of a drug regimen, date of referral, patient doubt or non-compliance, drug reaction … or 'out of character' comments by the patient."

In my opinion, Dr F should have made more detailed notes of her consultations with Ms A, particularly on 22 February, 11 March, 19 July (despite being Miss D's consultation) and 11 October 2002.

The notes for the 22 February 2002 consultation read:

> "Long standing constipation + pain when wees. Dipstick – leucs + blood. Lactulose 20mls od (1L). Noroxein [sic] 400mg Tbd (6)."

Dr F's conclusions on this date were that Ms A had a urinary tract infection and IBS. These diagnoses are not recorded. Dr F says the latter diagnosis was based on Ms A's advice that she was "intermittently constipated", and information gathered at the previous consultation on 6 September 2001. While the notes for that consultation refer to Ms A being "stressed", other mention of Ms A's anxiety and panic attacks in the contemporaneous notes is limited and historical: Dr F had recorded that Ms A had "anxiety attacks" on 20 August 1999; Dr G had recorded an "acute stress attack … panic attack" on 24 July 2001. There is no mention of Ms A's irregular eating patterns, or concerns about her weight and dieting. There is also no recorded plan for managing the possible cause of IBS – or, in particular, for excluding it – and no proposed follow-up to check whether the prescribed antibiotics and laxatives had relieved the symptoms. These are all matters that should have been recorded.

On 11 March, Ms A presented with external piles. Dr F's notes, in full, state: "piles – external v. sore – still constipated. Fleet phosph soda (48mls x 2)". Dr F's recollection is that on this occasion, Ms A "demanded" a Fleet phosphate enema, a treatment with which Dr F disagreed on the basis that it was inappropriate. It was also a new medication that she had not previously prescribed (the previous prescription for constipation relief was Lactulose). Dr F states that she "acquiesced reluctantly" and remained of the view that Ms A had IBS. These matters should have been recorded in the notes.

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[13] 2001 edition, page 86.

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In relation to the 19 July consultation, resolution of the conflict between Miss D's and Dr F's recollections about what was discussed regarding Dr H's recommendations for further investigation is not assisted by Dr F's records, which are limited to brief reference to Ms A's recurrent ear infection. I am satisfied that there must have been some discussion of Ms A's bowel condition on this date, irrespective of the detail of what was said. It would have been prudent for Dr F to record *all* the details of the conversation, regardless of the fact that the consultation mainly concerned Miss D. As Dr St George noted, where there is a "putative disagreement on management", a full record should always be made. While Dr F is adamant that there was such disagreement between herself and Ms A (which developed from this point on), her notes add no weight to her argument. As *Cole's* states, "the absence of a … record makes the task of establishing the truth very difficult".[14] In a recent High Court case, Justice Baragwanath also noted the importance of the doctor's written record, commenting that the power to produce definitive proof − for example, of advice given to one's patient − is in the doctor's hands.[15]

As to the 11 October consultation, Dr F stated that she carried out a physical examination of Ms A's abdomen which revealed palpable masses, for the first time questioned whether there might be a more serious underlying cause than IBS, and discussed the need for "standard routine tests". Dr F recalled that Ms A was adamant that she did not wish to undergo further investigations, so she took no further action and made no formal time for follow-up. In the original notes for this consultation none of these matters were recorded.

In December 2003, Dr F explained the brevity of her notes for the 11 October consultation as follows:

> "Rather than record details of a discussion about what investigations were appropriate and why, when all this had been explained to [Ms A] before and recorded in detail by [Dr H] on 27/6/2002, I amalgamated/shortened the discussion of investigations, referral and outcome together and recorded it as 'Not keen on further Ix' (Ix = investigations). Both [Ms A] and I were well aware of what investigations had been discussed."

I find this explanation disingenuous. The words "not keen on further [investigation]" were *not* recorded by Dr F on 11 October 2002, but entered 15 months later, around 17 January 2003.

Non-contemporaneous notes

When Dr F was first notified of my investigation she was provided with copies of the complainants' letters in which their concerns – including allegations that she had "tampered" with the medical records – were clearly expressed. Dr F responded directly to these allegations. She initially explained that when, around 17 January 2003, Ms A asked that her notes be transferred to a second medical centre, she used a blue highlighter pen to mark in the notes the occasions when discussion about investigations for Ms A's abdominal symptoms had occurred. The notes highlighted were for 27 June 2001 (Dr H's

[14] 2001 edition, page 85.

[15] *Patient A v Nelson-Marlborough DHB* (unrep, HC Blenheim, CIV-2003-204-14, 15 March 2005).

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consultation), 11 October 2002 and the telephone conversation of 2 December 2002. Dr F advised that highlighting the notes was done with the intention of assisting the new GP, Dr J, and she was emphatic that this was "the only departure from my normal consultation notes" and did not affect the way they had been made.

In her narrative recalling the consultation on 24 May 2002 (which had been for Miss D) and the consultation for Ms A on 11 October 2002, Dr F specifically referred to what she had recorded in the notes, giving the unequivocal impression that each complete entry was contemporaneous. In relation to the 2 December telephone call she was emphatic that she had advised Ms A to return if the colonic lavage was not successful, again implying that her note was contemporaneous in its entirety.

However, in December 2004, Dr F corrected herself, and advised that not only had she highlighted the 11 October and 2 December notes, but she had added to them, on or about 17 January 2003. She acknowledged that she had added the words "not keen on further [investigations]" (11 October) and "advised [to come in] for [investigations] if no success at colonic clinic" (2 December), as well as "admits irregular eating patterns" (24 May 2002). Dr F's comment that these were not made with the purpose of any "cover up" is, in the circumstances, dubious.

In response to my provisional opinion, Dr F belatedly expressed "sincere regret" for her non-contemporaneous additions to the medical records and her "failure to acknowledge this in [the] initial response to the complaint".

In my view, Dr F's additions, her failure to date them as non-contemporaneous, and her failure to acknowledge and explain at the outset of this investigation when and why they had been made, call into question her credibility, particularly regarding any advice she gave to Ms A about the need for further investigations and follow-up. This issue is at the heart of the complaint against her. In my view it is not a coincidence that two out of three of Dr F's non-contemporaneous additions, made prior to transferring the notes to another practice, and after the diagnosis of cancer, relate to the need for further investigations. They cast doubt on whether Dr F discussed these matters with Ms A at all. On balance, the evidence suggests that she did not: Mr B states that he and Ms A told Dr J that Dr F did not advise seeking a second opinion; Miss D states that on 24 May and 19 July Dr F was dismissive of the need for investigations – and Miss D is emphatic that she did not misinterpret what was said; Ms C is adamant that her sister had complete trust in Dr F's advice, and asserts that Dr F "never proactively pursued [Ms A] to undergo tests"; and Dr G correctly suspected that the notes for 11 October and 2 December had been amended without explanation.

I accept my expert's advice that "highlighting specific notes is common and perfectly acceptable practice". I also accept that it is common to make additional notes in a patient's record in retrospect. However, as Dr St George has noted, whenever this is done the date of the alteration should always be added, otherwise there is "the appearance of dishonesty". *Cole's* provides helpful guidance on why this is so important:

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> "Non-contemporary notes, or additions purporting to have been made originally, reveal a form of deliberate or ingenuous dishonesty … even though they may be made in good faith. … [N]ever add a late comment, or record an event, out of time without making a note that this is the case; while there may be a good reason to do it, it can be interpreted as deceitful."[16]

Summary

Overall, Dr F's notes were inadequate and inappropriate and failed to meet the standards expected of a general practitioner in such circumstances. They did not comply with the NZMA *Code of Ethics* requirement that they be "accurate records of fact". The extent of the shortcomings of Dr F's record-keeping is highlighted by comparison with the comprehensive notes of her colleague, Dr H. Based on Dr St George's advice and the guidance provided by *Cole's*, it is my view that Dr F's failure to contemporaneously record fundamental matters, such as her diagnosis, management plan, discussions as to further investigations and Ms A's (alleged) refusal to undergo these, was substandard practice. Moreover, Dr F's failure to date her subsequent additions to her notes (and her failure to acknowledge these in response to the complaint) has resulted in the very outcome which *Cole's* chastens practitioners to avoid – the appearance of dishonesty and deceit. In these circumstances Dr F breached Right 4(2) of the Code.

The First Medical Centre

At the outset of this investigation, the first medical centre was notified of its potential liability arising from the complaint, on the presumption that it was Dr F's employer. However, information received from Dr G and Dr F indicated that this presumption was incorrect, and that "[the first medical centre]" was, at the relevant time, simply the trading name of three individual self-employed GPs who worked together on a cost-share basis. Dr F is thus solely responsible for her actions, and the question of the first medical centre's liability does not arise.

Other comments

Communication with other providers

A matter that was not notified for investigation, but on which the parties and my expert advisor have touched, is the degree to which Dr F could have been expected to liaise with other practitioners providing care to Ms A. This is particularly relevant in light of evidence which shows that Ms A consulted other doctors outside of the first medical centre – for example at the accident and medical centre, and the clinic.

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[16] 2001 edition, page 86.

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In respect of this issue I am mindful of my advisor's comments that integrated primary care must be balanced with patient choice, and that Ms A was free to seek help when and where she chose. I accept that it was not Dr F's responsibility to make contact with these other clinics, had she known Ms A had visited them. Dr F has advised that no notes or correspondence from the other clinics were made available to her. I note this would have been helpful and could have assisted with continuity of care.

Communication with patients and third parties
A further matter which has caused considerable concern to the complainants is Dr F's communication style. In particular, Miss D recalled that Dr F spoke to her mother in patronising tones and caused Ms A to feel demeaned and scolded. Mr B also remembered Ms A feeling "like a silly girl" as a result of Dr F's manner. Similar concerns were raised by Dr G. Dr F has denied that she "told off" Ms A but admitted she may have appeared dismissive and her tone may have been "misinterpreted". It is worrying that Ms A seems to have been torn between her feelings of humiliation and the trust she had placed in Dr F's care. In response to my provisional opinion, Dr F expressed regret that Ms A may have felt humiliated, and apologised for this.

I am also concerned that some of Dr F's explanations for her actions, in correspondence to my Office, are reflective of an abrupt and somewhat dismissive approach. In particular, I note Dr F's justification for not referring Ms A to a specialist, on the basis that it was "surely [Ms A's] choice" to "ignore" and "gloss over" the advice she received from her GPs, and her family. In my view these comments show a lack of insight and sensitivity and a failure to accept that her professional obligations to undertake open, frank discussions with her patient (and record these) had not been fully discharged. Ms A's family have voiced similar concern, with Ms C commenting: "There is constant blame … of [Ms A's] character, as a patient who was stubborn, self-medicating, had strong beliefs … . It would appear that [Dr F] is trying to build up a case for her lack of medical thoroughness … . The training [doctors] have is to handle 'patient anxiety'. Dr F appears to hide her flaws behind it."

In response to my provisional opinion, Dr F apologised for any perceived abruptness or dismissiveness in her correspondence, and explained that she had "no experience of dealing with the HDC".

Good communication, respect and trust are the cornerstones of an effective doctor–patient relationship. They are also helpful qualities when doctors respond to regulatory authorities. While the adequacy and effectiveness of Dr F's communication is not a matter under investigation in this case, I take this opportunity to remind her of the importance of open and honest communication and a facilitative approach with patients and third parties.

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Acknowledgement of complaint
Incidental to the investigation of this complaint was Dr G's advice to my staff that Dr F had suggested that she would not be disclosing to the Medical Council that a complaint about her was being investigated, when she applied for a certificate of good standing for the purposes of seeking registration and employment overseas. Dr F emphatically refutes this and states that prior to her departure overseas she informed both the Medical Council and Royal New Zealand College of General Practitioners that she was under investigation by my Office. She advises that she sought and obtained from the Medical Council a Letter of Good Standing. I make no findings on this matter, and note in any event that on 17 November 2003 the President of the Medical Council was notified by my Office that this investigation had commenced.

Registration
Dr F advised that she has not sought medical registration with a state medical board in an overseas country, and is not working as a doctor there. She remains registered with the Medical Council of New Zealand, although her annual practising certificate expired in May 2005. Dr F intends in the future to return to New Zealand, renew her practising certificate, and resume work as a general practitioner.

Recommendations

I recommend that Dr F take the following actions:

- Provide a written apology to Ms A's family for her breaches of the Code. This apology is to be sent to my Office and will be forwarded to Ms A's family.
- On her return to New Zealand, engage the assistance of the Medical Council of New Zealand to undertake training to address the standard of her general practice knowledge, consultation skills, and record-keeping.

Follow-up actions

- Dr F will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- Dr F will be referred to the Medical Council of New Zealand for the purposes of deciding whether a review of her competence and fitness to practise should be undertaken at such time as she returns to New Zealand and seeks to renew her practising certificate.

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- A copy of this report will be sent to the overseas Medical Council where Dr F has existing registration, the professional organisation in that country, the Medical Council of New Zealand, and the Royal New Zealand College of General Practitioners.

- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes upon completion of the Director of Proceedings' processes.

Addendum

The Director of Proceedings issued proceedings before the Medical Practitioners Disciplinary Tribunal and, on 31 August 2006, a charge of professional misconduct was upheld. The Tribunal considered that Dr F failed to take appropriate steps to thoroughly investigate Ms A's condition, and also made other findings of professional misconduct in relation to additions made to the clinical notes without recording the date the additions were made, and in relation to Dr G intentionally misleading the Commissioner about that fact during the course of the HDC investigation. This last part of the charge was seen as the most serious. Dr G was censured and fined $15,000, of which $10,000 relates to the last part of the charge, and costs of $10,000 were awarded to the Tribunal and also to the Director of Proceedings (see Decision No 58/Med05/15D, www.hpdt.org.nz). Permanent name suppression was declined.

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