General Practitioner

A Report by the

Health and Disability Commissioner

(Case 01/09589)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Dr B	Provider, General Practitioner
Dr C	Consumer's new General Practitioner

Independent expert advice was obtained from Dr John Cheesman, general practitioner.

Complaint

On 3 September 2001 the Commissioner received a complaint from Mr A about Dr B. The complaint is that:

Dr B did not provide services of an appropriate standard to Mr A in that he:

- *Did not examine or adequately assess Mr A's physical condition when Mr A attended his surgery in February 2001 complaining of pain in the chest, stomach and back and of feeling tired and unable to do much.*
- *Did not examine or adequately assess Mr A's physical condition when Mr A attended his surgery complaining of still feeling tired, continuing stomach pain, having black stools and flu-like symptoms in June 2001.*

An investigation was commenced on 17 October 2001.

Information reviewed

- Letter of complaint from Mr A including copies of discharge summary from a public hospital, Dr B's clinical notes, the public hospital's laboratory results and medication dispensing printout.
- Letter of response from Dr B, including Dr B's clinical records.
- Copy of Mr A's medical records and associated correspondence from the public hospital.
- Letter of response and associated clinical documentation from Dr C.
- Copy of the public hospital's laboratory blood results for Mr A.
- Copy of chemist dispensing printout for Mr A, September 1998-July 2001.

Information gathered during investigation

Mr A first saw Dr B in September 1998 and was prescribed a number of medications. Dr B changed Mr A's arthritis medication to Brufen SR as he considered it was less likely to cause gastric effects.

On 22 February 2001 Mr A visited Dr B. Mr A stated that this was for his "usual every three monthly check-up for arthritis of the spine" and that he reported pain in the back, chest and stomach and a feeling of tiredness. Dr B stated that Mr A came to see him for a routine repeat and check-up and that he complained of occasional back pain radiating to the chest on both sides. Dr B stated that Mr A had "a history of squirmy tummy which I had seen him for in the past (21 November 2000)".

Dr B said that he examined Mr A's back and that there was evidence of osteoarthritis with increased curvature of his thoracic spine, a finding which Dr B thought may have caused the chest pain on both sides. Mr A said that Dr B ran his hand down his spine and said he had "softening of the spine joints" which is why he was experiencing pain in his chest, stomach and back.

Mr A again saw Dr B on 19 June 2001 for his three-monthly check-up. Mr A stated that his condition was "quite bad" and that he felt he had a bad flu he could not get rid of. Dr B stated that on this occasion Mr A told him he had a bad flu with sore muscles and nausea but that it was improving. He examined Mr A's neck and throat. Mr A was taking iron pills and commented that his stools were dark. In response to my provisional opinion Dr B said that the fact that Mr A was self-medicating with his wife's iron pills "clouded the issue". Dr B advised Mr A to stop taking the iron pills, said that the flu would resolve and suggested Mr A return for a flu vaccine if his symptoms had improved the following week. Mr A stated that Dr B did not examine him. Dr B's clinical notes do not record a visit for 19 June 2001. An entry dated 22 June 2001 notes "for flu shot – Flurix18554B9 1/2002". Dr B stated that his locum administered the flu vaccine when Mr A returned to the surgery following his visit on 19 June 2001.

In response to my provisional opinion Dr B said that this advice was quite adequate follow-up and that Mr A should have told the locum that he was having symptoms when he returned for his flu injection.

Three days after seeing Dr B, Mr A went to see his wife's general practitioner, Dr C, on 22 June 2001. Mr A stated that he did not tell Dr C he had seen Dr B but simply said that he felt very unwell and had a sore stomach. Dr C stated that he had not had contact with Mr A since 1994 and assumed he was seeing another doctor as he was taking a number of medications, including Acupan. Dr C said that Mr A looked pale and presented with an infection. Dr C ordered blood tests and stated that he would have told Mr A to ring the next week and get the results. Mr A stated that Dr C gave him an examination, stomach tablets and tablets for the virus.

On 9 July 2001 Mr A returned to see Dr C as he was very unwell. Dr C admitted him acutely to a public hospital. Mr A was told he had a bleeding ulcer from years of taking

anti-inflammatory drugs and his haemoglobin was 57. The admission letter written by Dr C stated that Mr A presented with a history of not being able to walk far, central chest pain, diarrhoea, pain in the back and chest and black bowel motions. The blood tests taken when Mr A first saw Dr C on 22 June 2001 showed a haemoglobin of 101. Dr C made a diagnosis of bleeding peptic ulcer and myocardial ischaemia. The public hospital clinical records note that on 9 July 2001, Mr A had melaena (bleeding from stomach or bowel) for 3 to 4 weeks, epigastric pain (pain between the diaphragm and the stomach) for 3 to 4 weeks, intermittent vomiting for 3 to 4 weeks, chest pain for 2 weeks and abdominal pain for 1 week. It is also recorded that Mr A had recently changed from an unknown non-steroidal anti-inflammatory drug (NSAID) to Voltaren (an NSAID) and the diagnoses were acute chronic gastrointestinal bleed secondary to NSAID, and myocardial infarction. Mr A's haemoglobin was 57 on admission.

Mr A stated that he had been on Brufen for a number of years and had only recently changed to Voltaren. Mr A stated that he had not had regular blood tests. Laboratory results obtained for Mr A record that blood tests were ordered twice by Dr B, on 30 September 1998 and on 12 April 2000. A printout of prescriptions dispensed to Mr A records that for the period September 1998 to 19 June 2001, Dr B prescribed Brufen Retard 800mgs and Ibuprofen 400mgs or Ibuprofen SR 800mgs at approximately three-monthly intervals (Ibuprofen (Brufen) is a non-steroidal anti-inflammatory agent that has analgesic action). On 19 June 2001 Dr B prescribed Diclofenac (Voltaren) SR 75mgs. Dr B stated that he had not prescribed Voltaren for Mr A. Dr B advised me that although in the past he did not take regular blood tests on patients on long-term anti-inflammatories, he has now changed his practice.

Independent advice to Commissioner

The following independent expert advice was obtained from Dr John Cheesman:

"**Documentation:**

1. Letter of complaint, discharge summary from [the public hospital], [Dr B's] clinical records, [the hospital laboratory] results and medication dispensing printout from [Mr A] (labelled A)
2. Action notes of discussions between [Mr A] and investigation officer (labelled A 1)
3. Letter of response from [Dr B], including [Dr B]'s clinical records: (labelled C)
4. Copy of [Mr A's] medical records and associated correspondence from [the hospital]. (labelled D)
5. Letter of response and associated clinical documentation from [Dr C] (labelled E)
6. Copy of [the hospital's laboratory] blood results for [Mr A] (labelled F)
7. Copy of [chemist] dispensing printout from [Mr A] Sept 1998 until July 2001 (labelled G).

[Mr A] consulted [Dr B] on 22nd February 2001. There is a discrepancy in the notes: one copy documents the first consultation as 22nd February 2001. This corresponds with the chemist's record of medication prescribed on 22/2/2001.

However there is a second copy stating the date of consultation as 22nd of June 2001, with no record of consultation on 22nd February 2001.

1. In the clinical notes there is no recording of history or examination findings. [Mr A] mentioned in his letter that he had complained of pain in the back, chest and stomach along with the feeling of tiredness.

2. He said that [Dr B] examined his spine and [Mr A] was told that his stomach and the chest pain may be related to his spine. However [Dr B] should have examined [Mr A] further and in particular his abdomen and chest with the history of the above symptoms.

   Depending on the result of this examination there may have been some indication as to a possible cause of the stomach pain and hence appropriate management of this may have been able to be undertaken.

   Also in the history of "squirmy" stomach when last seen on 21/11/2000 may have alerted [Dr B] as to a possible connection with the 'stomach pains' [Mr A] now presented with. However 'squirmy' stomach is a very common presenting complaint.

   As [Mr A] consulted for a repeat of his regular medication, a review of these and in particular the Ibuprofen (anti arthritis pain relief medication which can cause gastric irritation) may have given an indication as to the possible cause of the stomach pain. This medication should have been stopped. (If only initially temporarily.) The ordering of the blood tests including a haemoglobin would have been appropriate because of [Mr A's] symptom of 'tiredness'.

   Also further follow-up should have been arranged if [Mr A's] symptoms had not resolved and also to review the blood test result. [Dr B's] actions were therefore inappropriate and did not comply with professional standards for the above reasons.

3. [Mr A] consulted [Dr B] again on 19th of June 2001. Again the discrepancy of the date on the clinical notes. Again there is no record of consultation, examination and management. In [Dr B's] 'letter of response' (labelled C) he stated that he examined the throat and neck but there was no mention of abdominal or any other examination. This should have been done particularly in light of the history of dark stools, feeling tired and taking Ibuprofen. [Mr A] in his letter of complaint said that he had a 'flu' and said that he was told that he had a virus, that it was resolving and that antibiotics were not advisable. [Mr A] stated that he said his stools were dark and he was told that this was because

he was taking iron tablets and told to stop them. Again there was no mention of this in the notes.

If not previously done so, [Dr B] should have ordered blood tests including a haemoglobin level. Dark stools should have been an alert to bleeding from the stomach/bowel, again due to possibly the taking of Ibuprofen.

Again this medication should have been stopped if not done so previously.

[Dr B] arranged for follow-up in one week's time for the flu vaccine if symptoms had improved.

Again [Dr B's] actions did not comply with professional standards.

4. Unless there were any recent symptoms of stomach pain, malena (bleeding from stomach/bowel) or any reason to suspect underlying problems, I would not routinely check any blood tests (including haemoglobin) on any patient taking long-term anti-inflammatory medication. Blood tests are not helpful in predicting underlying gastric irritation/bleeding from anti-inflammatory medication.

   Apart from the history of events as mentioned above, [Dr B's] monitoring of [Mr A] was appropriate prior to this. However it is not recorded in the records whether [Dr B] had asked if there were any problems and in particular gastrointestinal symptoms, at previous consultations.

5. It is noted in the hospital admission notes of 19 June 2001 that [Mr A] was taking Voltaren (see [chemist] printout: Voltaren [Diclofenac] SR 75 mg prescribed on 19th of June 2001). Voltaren is an anti-inflammatory medication like Ibuprofen but it is well known that this medication is much more likely to cause stomach irritation/bleeding in some people.

   The documentation of the history and examination findings is inadequate and needs to be more complete."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

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

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

Other relevant standards

Good Medical Practice: A Guide for Doctors (Medical Council of New Zealand, 2000)

Keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed; …

Opinion: Breach – Dr B

Right 4(1)

Visit on 22 February 2001
When Mr A visited Dr B on 22 February 2001 for a three-monthly check-up, he complained of pain in the back, chest and stomach and of tiredness. Dr B simply examined Mr A's spine, advised that the pain in his chest and stomach was related to osteoarthritis of the spine and issued him with a repeat prescription for his medications including Ibuprofen (anti-arthritic pain relieving medication).

Dr B was aware that Mr A had "a history of squirmy tummy" and had been taking Ibuprofen, a known gastric irritant, since 1998. My expert advisor noted that, given the symptoms Mr A presented with, Dr B should have examined his abdomen and chest, ordered a blood test and made a follow-up appointment. The combination of previous history and presenting symptoms should have alerted Dr B to the possible cause of the stomach pain. My expert advised that such an analysis pointed to the need to discontinue the Ibuprofen, at least temporarily.

Visit 19 June 2001
On this occasion Mr A stated that his condition had become "quite bad" and that he felt as if he had a flu that he could not get rid of. Mr A also complained of having black stools.

Dr B examined Mr A's neck and advised him that the flu would resolve and to stop taking his wife's iron tablets which Dr B believed to be the cause of the black stools.

My expert advisor noted that given Mr A's presenting symptoms, the fact that he had black stools, was feeling tired and was taking Ibuprofen, Dr B should have examined Mr A's abdomen and ordered blood tests. My expert advised that "dark stools should have been an alert to bleeding from the stomach or bowel". Instead, Dr B advised Mr A to return in one week if he had recovered (for a flu injection). Additionally, although Dr B stated that he did not prescribe Voltaren for Mr A, the pharmacy records identify that Dr B changed Mr A's anti-arthritic medication from Ibuprofen to Voltaren SR 75mgs at this time. Voltaren is an anti-inflammatory known to be more likely to cause stomach irritation or bleeding.

In my opinion, Dr B did not adequately assess Mr A's condition based on his presenting history and clinical signs and did not carry out the appropriate investigations or treatment when Mr A saw him on 22 February 2001 and again on 19 June 2001. Dr B failed to exercise reasonable care and skill in treating Mr A and accordingly breached Right 4(1) of the Code.

Right 4(2)

In keeping with professional standards, Dr B was required to "keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed".[1]

According to Dr B's clinical notes there is no record of any history or examination findings for Mr A's visit on 22 February 2001. Dr B simply recorded the repeat prescriptions and Mr A's blood pressure. There is no record at all for Mr A's visit on 19 June 2001. According to the pharmacy prescribing record, Dr B prescribed Mr A Voltaren SR 75mgs in place of Ibuprofen at this visit. Given the absence of records, it is not surprising that Dr B has no memory of having prescribed Voltaren for Mr A at this time.

Accurate record taking, which includes clinical findings, diagnoses, information provision, medication and treatment prescribed, is an essential part of good primary care. The lack of an adequate record of Mr A's visit on 22 February 2001 and the absence of any record for his visit on 19 June 2001 contributed to Dr B's inability to make an accurate diagnosis on the basis of all the information available.

In my opinion, Dr B failed to comply with professional standards of record taking in treating Mr A and accordingly breached Right 4(2) of the Code.

[1] Good Medical Practice: A Guide for Doctors (Medical Council of New Zealand, 2000).

Actions taken

In response to my provisional opinion, Dr B provided an apology for Mr A and informed me that he has reviewed his practice in light of this report.

Further actions

- A copy of this report will be sent to the Medical Council of New Zealand with a recommendation that it consider whether a review of Dr B's competence is indicated.
- A copy of this report, with all identifying details removed, will be sent to the Royal New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.