General Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 01HDC12788)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A (deceased)	Consumer
Ms B	Complainant
Dr C	Provider/General Practitioner

Complaint

On 1 November 2001 the Commissioner received a complaint from Ms B about Dr C. The complaint was summarised as follows:

Between November 2000 and August 2001 Dr C failed to provide services with reasonable care and skill, in that he:

- *did not adequately investigate Mrs A's ongoing symptoms and health problems;*
- *failed to take into account Mrs A's history in investigating her ongoing symptoms and health problems;*
- *failed to diagnose Mrs A's cancer until August 2001.*

An investigation was commenced on 2 May 2002.

Information reviewed

- Letter of complaint from Ms B, received 1 November 2001
- Information from Dr D, ophthalmologist, dated 20 March 2003 and 3 April 2003
- Mrs A's medical notes from the Medical Centre, dated 14 January 2003
- Mrs A's medical notes from the District Health Board, dated 23 December 2002
- Letter from Ms B, dated 7 May 2003

Independent expert advice was obtained from Dr Niall Holland, general practitioner.

Information gathered during investigation

Background
In mid-1997 Mrs A experienced reduced vision in her right eye. She consulted her local optician, who referred her to Dr D, an ophthalmologist, with a suspected separation of the retina.

Dr D reviewed Mrs A on 18 June 1997, and diagnosed her with choroidal melanoma, which is a melanoma of the retina. Dr D wrote to Dr C, Mrs A's general practitioner, asking him to give her a complete medical check, particularly looking at her breasts for carcinoma, and to arrange a liver ultrasound, before he referred her to a consultant ophthalmologist at a Public Hospital, for treatment.

Dr C reviewed Mrs A on 19 June 1997, when he took her history and blood pressure, and examined her heart, lungs, breasts and abdomen. Mrs A also received blood tests, including a full blood count, and liver function, protein, and kidney tests. An abdominal ultrasound was ordered and performed on 7 July 1997. Dr C noted that his examination of Mrs A and her test results were all normal.

Mrs A was then referred to the consultant opthalmologist with an appointment on 7 August 1997 for radioactive plaquing of the tumour. Mrs A had several follow-up appointments with Dr D following her treatment. At these appointments it was noted that her melanoma had steadily and slowly reduced in width from 10.7mm in November 1997, to 3.8mm in April 1999.

Dr C saw Mrs A again on 20 August 1998 for a general health review. He performed an abdominal and a pelvic examination, which showed no abnormality or organ enlargement. Blood tests to check her blood count, liver function, calcium, and protein levels were all normal.

On 10 February 1999 Mrs A underwent a routine screening mammogram, which was clear.

Consultation with Dr C on 7 December 2000
Dr C stated that Mrs A consulted him for three reasons on 7 December 2000. First, to discuss her follow-up with Dr D. Dr C had not received a letter from him since April 1999. He stated that Mrs A informed him that her retina was stable, and the melanoma was not growing.

Secondly, Dr C and Mrs A discussed a skin lesion she had above her right eyebrow. Dr C examined the lesion and concluded that it was probably a basal cell carcinoma or a squamous cell carcinoma, which needed removal. Dr C excised the lesion on 15 December 2000, and it was sent to the laboratory for analysis. The result showed that the lesion was a squamous cell carcinoma in situ. The excision was complete and it was not related to Mrs A's previous melanoma.

Thirdly, Mrs A was suffering from severe pain in her abdomen, bloating, and diarrhoea. Dr C examined her abdomen and, although it was slightly tender, no masses were palpable, including in her liver, spleen or kidneys. Dr C queried whether her pain was the result of irritable bowel syndrome, and referred her for tests, including a blood count, liver function test, and kidney, thyroid, glucose and cholesterol checks, all of which were normal. Mrs A was referred to Dr C's practice nurse for dietary advice.

Consultation with Dr C on 18 July 2001
Mrs A consulted Dr C again on 18 July 2001, having woken at two o'clock that morning with a sudden onset of severe abdominal pain and nausea. Dr C examined her and noted some tenderness in the right upper quadrant, and a palpable liver edge, although no mass or loin tenderness was noted. Dr C's impression at the consultation was that Mrs A might be suffering from gall bladder disease, and he ordered a number of tests, including a blood count, inflammatory test, liver function, and kidney function. Dr C prescribed dihydrocodeine (a medium-strength painkiller) and ordered an abdominal ultrasound from Public Hospital 1.

Dr C did not consider the referral for the ultrasound to be urgent because of the very short history and the clinical findings. Dr C informed me that the waiting time for ultrasound varies, but is usually no more than eight weeks. The service at Public Hospital 1 is a visiting one from Public Hospital 2, and scans are not available locally on a day-to-day basis.

Mrs A's test results were reported one or two days later. The inflammatory tests were positive, and the liver tests were slightly abnormal. A note from the laboratory suggested the possible cause of the abnormality as drug therapy, diabetes, or high alcohol intake. Ms B noted that none of these applied to her mother, and this should have "set off alarm bells" for Dr C, especially since Mrs A had enjoyed good health for many years.

It is noted in her medical file that Mrs A phoned Dr C's practice on 23 July 2001 to say that she was still in pain and vomiting. She spoke with the practice nurse, who informed another general practitioner at the practice. No other details of the conversation were noted.

Dr C phoned Mrs A on 24 July 1997. She was still vomiting and was not passing bowel motions. An appointment was arranged for the following day.

Consultation with Dr C on 25 July 2001
Mrs A consulted Dr C again on 25 July with persistent abdominal pain, vomiting and wind. She also had mild urinary symptoms. Dr C examined Mrs A and noted mild tenderness in the central upper abdomen, but no other abnormality. Dr C's initial impression was that the problem was gastric or urinary related, although it was not specifically clear because of the mixture of symptoms and the minimal findings on examination. Accordingly, Dr C ordered more tests, and gave Mrs A a prescription for ranitidine, a medication for gastric conditions, and an antibiotic for urinary infection. The tests ordered by Dr C showed minimal inflammatory changes and a small improvement in liver function.

The practice nurse phoned Mrs A on 27 July 2001 and informed her of the test results.

Phone call on 8 August 2001
On 8 August 2001 Mrs A phoned Dr C's practice to say that she was still unwell and vomiting. Dr C was away at this time, and Mrs A spoke to the practice nurse. Mrs A asked the nurse to bring forward the ultrasound, but Public Hospital 1 refused, as it was their policy not to do so unless ordered by a doctor. Ms B commented that Dr C had not authorised the locum doctor to bring forward the ultrasound.

Consultation on 16 August 2001
Mrs A consulted Dr C again on 16 August 2001. She had initially improved on the ranitidine, but was still suffering from vomiting, diarrhoea, and bloating. She reported that her nausea was worse after eating, and she was passing a lot of wind. Dr C examined Mrs A, and noted that her upper right abdomen was tender, with her liver or a mass palpable, and her right lower abdomen was also slightly tender. Dr C noted that her bowel sounds were normal, as was a rectal examination.

Dr C was concerned at Mrs A's lack of progress. He ordered further tests and, on 17 August, phoned Public Hospital 1 to obtain an urgent ultrasound, and chest and abdominal x-rays. X-rays are sent to Public Hospital 2 for reporting, and Dr C asked that they be reported urgently.

Dr C noted that the x-rays were reported as showing no abnormality. Mrs A's test results showed mild inflammation, and her liver function was unchanged from the previous test. Mrs A was booked in for the next ultrasound clinic at Public Hospital 1, which was in late August.

Ultrasound
Mrs A received an ultrasound at Public Hospital 1 on 23 August 2001. Dr C received a verbal report from the ultrasound technician. (Dr C informed me that a formal report from the specialist usually takes a few days.) The report showed that Mrs A's liver was enlarged with a 10cm lesion in the right lobe of the liver, with two small lesions in the left lobe. In the verbal report, cancer was suggested as the most likely cause of the lesions. The written report stated that the nature of these lesions was uncertain and recommended further investigation by CT scan.

Dr C discussed the findings immediately with the Oncology Department at Public Hospital 2, and arranged for Mrs A to be seen as soon as possible. He also contacted Mrs A that day and arranged an appointment to discuss the results. The ultrasound findings were discussed with Mrs A, and she was told that Public Hospital 2 would contact her.

Dr C advised me that because the scan report was less than conclusive, he could not establish a clear relationship between Mrs A's melanoma and the liver lesions. However, further CT scans and biopsies at Public Hospital 2 confirmed the liver lesions as metastases from her melanoma.

Following the diagnosis, Mrs A received palliative care under another general practitioner at the Medical Centre, until her death on 20 February 2002. Mrs A was 54 years old at the time of her death.

Independent advice to Commissioner

The following independent expert advice was obtained from Dr Niall Holland, a general practitioner:

> "**The Complaint**
> That between November 2000 and August 2001 [Dr C] failed to provide services with reasonable care and skill, in that he:
>
> - did not adequately investigate [Mrs A's] ongoing symptoms and health problems
> - failed to take into account [Mrs A's] history in investigating [her] ongoing symptoms and health problems
> - failed to diagnose [Mrs A's] cancer until August 2001.
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> **Advice Required:**
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> ***On the basis of the information provided, did [Dr C] use reasonable care and skill in assessing [Mrs A]?***
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> Contextual thoughts to consider:
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> The notes of 19/6/97 include a past history and full medical examination. From this it appears that Mrs A became a patient of [Dr C] after the retinal choroidal melanoma of her right eye was diagnosed. If so there is a risk that this would tend to lend it a lesser prominence in the doctor's mind than if it occurred when the person was already a patient.
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> Metastatic melanoma is a particularly nasty and untreatable disease and the course towards death almost inevitable once it has occurred. So, while it does remain important prognostically, and any doctor would wish to detect this as soon as possible from the perspective of demonstrating diagnostic acumen, there is a sense in which it is a diagnosis that is no longer of value to chase. That is to say there is no health gain to be made by rapid detection and there is a lot of hope and wellbeing to be lost as soon as the diagnosis is made. For this reason also it may not remain uppermost in the doctor's mind. This may be a difficult idea to convey to the patient's family.
>
> Of most importance the family needs to clearly understand that metastatic melanoma disease is not preventable and not successfully treatable. Once seeding has occurred it tends to be in multiple sites. Removal of secondaries as they are detected may reduce some of the severity of the disease but is unlikely to alter the outcome significantly.

It is important to completely remove the initial lesion as thoroughly as possible as this is the only hope of prevention. But detection of the metastatic disease at an early stage does not contribute to prevention.

In particular:

Did [Dr C] give sufficient weight to [Mrs A's] medical history when investigating and treating her condition?

[Dr C] was clearly mindful of the history of melanoma at the consultation of 7/12/2000.

On 18/7/2001 he saw [Mrs A] with R flank pain and in retrospect this is likely to have been the first hint of liver disease. There is no indication that [Dr C] considered the diagnosis of metastatic disease but he certainly did arrange all the appropriate investigations for both this and gallbladder disease which he has considered the most likely cause of the pain.

Over the ensuing month [Mrs A] continued to feel unwell with a predominance of abdominal symptoms and the doctor monitored blood tests appropriately and awaited the scan. This was delayed because it was ordered through the public system and he had not considered urgency important given the expectation that it was gall bladder disease. This remained an appropriate working diagnosis given the symptoms recorded and the blood test findings of altered LFTs and elevated WCC.

I note [Mrs A's] daughter is concerned that no blood pressure recordings were made but I do not see the relevance of doing this, given the symptoms.

Dr C has recorded a further thorough examination on 16th August and ordered further tests appropriate to the symptoms. He appears to have done what he could to speed up the ultrasound scan when he detected liver enlargement at this time.

Therefore I believe that even if [Dr C] had not recollected her history of melanoma, he has taken her illness seriously and has provided the same management as would be necessary had he considered metastatic melanoma in his differential diagnosis.

Did [Dr C] carry out all appropriate tests and examinations in assessing [Mrs A's] condition?

Yes. He appears to have been quite exemplary in his thoroughness. I do not think that I would have done anything differently other than perhaps offer the opportunity of private referral for a scan, if it were available locally. [Dr C's] notes state that 'Scans are not available locally on a day to day basis.' I assume this includes privately.

Could any of the steps that [Dr C] took, or could have been expected to take, reasonably have led to [Mrs A's] cancer being diagnosed prior to August 2001?

The diagnosis would probably have become apparent as soon as a scan of the liver was done. However, on the history available, I do not believe there was any indication to do this any faster.

Of relevance to this question is also the lack of any impact earlier detection would have had on the outcome for the patient.

If on answering any of the above you consider that [Dr C] did not treat [Mrs A] with reasonable care and skill please indicate the severity of [Dr C's] departure from that standard of care.

As noted above I do not believe that [Dr C] has deviated from a reasonable standard of care in terms of clinical management. Nor do I consider that there are any other aspects of the care that warrant further exploration. The contemporaneous notes and the detailed response from [Dr C] suggest to me that, at least from a clinical perspective, he is a very thorough and thoughtful doctor."

Response to Provisional Opinion

In response to my Provisional Opinion, Ms B noted that the option of a private referral for a scan was available at a private hospital only one hour from Public Hospital 1.

Ms B challenged my advisor's view that, in relation to metastatic melanoma, "there is no health gain to be made by rapid detection and there is a lot of hope and wellbeing to be lost as soon as the diagnosis is made". Ms B responded:

"Maybe this is so in some cases where people give up hope and just lie down and die. This is not so in ours and many other people's view. Once the diagnosis was made clear Mum started planning what she could do in the time allowed and the condition she was in. The more time she would have had if the diagnosis was made 9 months earlier. And as far as 'health gain' goes, she went 9 months taking panadol and disprins because we couldn't get anything stronger until she was diagnosed. That's 9 months of 'putting up' with the huge pain of a 'cancerous tumour' growing and splitting her liver in half. If they had known earlier she could have been put on a decent pain relief regime, instead of boxes and boxes of panadol and unnecessary pain and discomfort."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4(1)

Right to Services of an Appropriate Standard

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

Opinion: No Breach

Ms B's complaint was that Dr C did not adequately investigate her mother's ongoing symptoms and failed to consider the history of choroidal melanoma, which led to an unreasonable delay in the diagnosis of her mother's liver cancer.

My expert advisor informed me that Dr C's clinical management of Mrs A was appropriate and of a reasonable standard.

Investigation of symptoms and failure to diagnose cancer before August 2001
Mrs A consulted Dr C four times between December 2000 and August 2001. The evidence indicates that during each consultation, Dr C conducted a thorough clinical examination and ordered the appropriate tests for Mrs A's symptoms. My advisor informed me that although there is no indication that Dr C considered the diagnosis of metastatic disease during the consultation of 18 July 2001, the tests he ordered, including the ultrasound, were appropriate to both metastatic disease and gall bladder disease, which Dr C considered the most likely cause of Mrs A's pain.

Dr C continued monitoring Mrs A's persisting symptoms between 18 July and 16 August with a working diagnosis of gall bladder disease. My advisor informed me that gall bladder disease remained an appropriate working diagnosis at that time given Mrs A's symptoms. Dr C phoned Mrs A on 24 July to check her condition, and he repeated the appropriate tests, monitoring inflammatory changes and changes in her liver function.

On 16 August, concerned about Mrs A's lack of progress, Dr C ordered an urgent x-ray, and rang Public Hospital 1 to bring forward the ultrasound he ordered on 18 July. He asked for the results of the ultrasound to be given to him verbally, to avoid any unnecessary delay in diagnosis and, upon obtaining the results, immediately contacted the Oncology Department at Public Hospital 2 to organise a referral.

I am satisfied that although Mrs A's cancer may have been diagnosed earlier if a scan of the liver had been performed earlier, on the history available there was no indication to bring

forward the ultrasound. Dr C appears to have been thorough in investigating Mrs A's symptoms. I accept my expert advice that Dr C did not deviate from a reasonable standard of care in terms of his clinical management of Mrs A. Accordingly, in my opinion Dr C did not breach Right 4(1) of the Code in his investigation and diagnosis of Mrs A's cancer.

Consideration of Mrs A's history of melanoma
Dr C was aware of Mrs A's history of choroidal melanoma. It is not possible to know the extent to which Dr C considered Mrs A's history during his examinations. However, it is clear that he did specifically consider her history during the consultation of 7 December 2000.

I note the statement of my advisor that even if Dr C did not recollect Mrs A's history of melanoma, he took her illness seriously and provided the same management that would be appropriate to metastatic melanoma, had he considered it as a differential diagnosis. I accept this advice. Accordingly, in my opinion Dr C provided care of an appropriate standard to Mrs A and did not breach Right 4(1) of the Code when investigating her symptoms.

Actions

- A copy of this report will be sent to the Medical Council of New Zealand.

- A copy of this report, with identifying details removed, will be sent to the Royal New Zealand College of General Practitioners and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.