

Management of elderly patient over eight-year period (06HDC12164, 29 February 2008)

General practitioner ~ Documentation ~ Weight monitoring ~ Metastatic carcinoma ~ Alternative therapy ~ Standard of care ~ Rights 4(1), 4(2), 6(1)

A man complained about the care provided to his mother by her GP. He queried whether his mother's cancer could have been diagnosed earlier and treated, given the frequency with which his mother consulted the GP over the eight years she was his patient. The son also contacted the GP several times for information regarding the management and diagnosis of his mother's cancer, and made several requests for copies of her death certificate.

From late 2002, the woman's family noticed that she had lost weight, and was experiencing tiredness and a lack of appetite. Several aspects of blood test results taken in August and November 2002 were abnormal, and subsequent tests in February and May 2003 reported further abnormalities. She was referred for a liver ultrasound in June 2003 which showed a mass on the right side. The following month she underwent a liver biopsy which found advanced cancer in her liver. The primary site of the cancer could not be identified. In light of her poor prognosis, she was referred for palliative care. She was also given a letter about Iscador, an alternative treatment for cancer using mistletoe extracts. She died aged 80.

It was held that the GP's clinical notes were inadequate and contained limited recordings of symptoms, signs and examination findings, breaching Rights 4(1) and 4(2). Owing to the paucity of information, it was difficult to ascertain the standard of care that the GP provided, and to determine what investigations should have occurred at various points of his care. He also departed from an appropriate standard of care and breached Rights 4(1) and 4(2) in relation to his ordering and interpretation of tests and his follow-up systems. Although the GP ordered a large number of tests during the period he cared for the woman, he often failed to document the basis for his ordering. He also failed to respond appropriately to relevant findings in some test results.

It was also held that the GP omitted to document in his notes any explanation he may have provided about Iscador and did not highlight that Iscador is not a medically recognised and accepted form of treatment of cancer. In failing to provide adequate information about this treatment, he breached Right 6(1).

This case highlights the importance of keeping good clinical notes and, in relation to a GP, this includes the need for recording a patient's symptoms, signs and examination findings, and the basis for initiating and ordering investigations. It also highlights the importance of providing adequate information about various treatment options, and documenting such discussions in the clinical records. In addition, it is a reminder to providers of the importance of responding promptly and sensitively to requests for information from a patient or his/her family to assist them in addressing any unresolved concerns they may have about the provider's care.