Medical Centre
General Practitioner, Dr A

A Report by the
Deputy Health and Disability Commissioner

(Case 21HDC01781)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man in July 2021, in particular the management of his worsening clinical symptoms when he presented to a medical centre on multiple occasions prior to his self-presentation to hospital and subsequent emergency surgery for a blocked artery in his leg.

Findings

2. The Deputy Commissioner considered that when the man presented on 29 July 2021 with worsening right leg symptoms, the locum GP did not carry out an adequate physical examination or complete an acute vascular referral and did not complete an adequate level of documentation. The Deputy Commissioner found the GP in breach of Right 4(1) of the Code. The worsening symptoms were not recognised, and an opportunity was missed to identify an acute emergency and provide timely escalation of care.

3. The Deputy Commissioner made educational comments concerning the lack of peripheral vascular assessment undertaken by a nurse practitioner and concerning the prescribing of Trental by Dr E, as this was considered to be of limited benefit for the man's condition.

4. However, on balance, the Deputy Commissioner was satisfied that there were no broader systems or organisational issues at the medical centre, and therefore did not find it in breach of the Code.

Recommendations

5. The Deputy Commissioner acknowledged the extensive changes made by the GP in improving her practice but recommended that the GP undertake a Royal New Zealand College of General Practitioners clinical notes audit and provide HDC with the results.

6. The Deputy Commissioner recommended that a nurse practitioner reflect on this incident and on the clinical advisor's opinion and provide HDC with a report on this learning.

7. The Deputy Commissioner recommended that a second GP review the regional HealthPathways Guidelines for peripheral vascular disease and report back to HDC on any changes made to her practice.

8. In light of the ongoing rural workforce shortages, the Deputy Commissioner recommended that the medical centre consider training clinical staff members to undertake ankle brachial index measurements if this service continues to be difficult to access externally, and report back to HDC on the outcome of this consideration.

Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Ms C about the services provided by Dr A to her father, Mr B, at a medical centre. The following issues were identified for investigation:

- *Whether Dr A provided Mr B with an appropriate standard of care on 29 July 2021.*
- *Whether the medical centre provided Mr B with an appropriate standard of care in July 2021.*

10. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

11. The parties directly involved in the investigation were:

Dr A[1]	Locum general practitioner (GP)
Mr B	Consumer
Medical centre[2]	Rural general practice
Ms C	Complainant

12. Further information was received from:

Te Whatu Ora 1[3]	District health provider
Te Whatu Ora 2	District health provider
Nurse Practitioner (NP) D	Nurse practitioner
Dr E[4]	GP

13. In-house clinical advice was obtained from Dr David Maplesden, GP, and is included as Appendix A.

14. Relevant standards are included in Appendix B.

[1] Dr A is a fellow of the Royal New Zealand College of General Practitioners. Dr A has worked as a rural GP for many years within the Te Whatu Ora 1 region. At the time of the events, Dr A was an independent contractor who worked on a casual basis at the medical centre's acute walk-in clinic.
[2] The medical centre provides health services to a rural region.
[3] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, resulting in all district health boards being disestablished and Te Whatu Ora|Health New Zealand being established in its place.
[4] Dr E graduated from an overseas university. Dr E has been living and working in rural health settings for many years, both overseas and in New Zealand.

Information gathered during investigation

Background

15. This report discusses the primary care services provided by the medical centre to Mr B in July 2021. The report discusses the management of Mr B's vascular symptoms and whether there was a delay in the diagnosis of a blocked popliteal artery in his right leg.[5]

16. Mr B, aged in his late fifties at the time of events, had a medical history that included atrial fibrillation,[6] atrial flutter,[7] high cholesterol levels, and long-term cigarette smoking. In July 2021, Mr B presented three times to the medical centre with complaints of right leg pain and other symptoms. There were varying working diagnoses, and he was given pain relief on each occasion.

17. On 30 July 2021, Mr B self-presented to the Emergency Department at the local hospital (Te Whatu Ora 1) with ongoing right leg symptoms (severe lower leg pain, swelling, change in foot colour) and was transferred urgently to a main centre hospital (Te Whatu Ora 2) as he required emergency surgery for a blocked artery.[8]

Chronology of events

18. On 8 July 2021, Mr B presented to the medical centre with a four-day history of right leg pain. Mr B was seen by NP D, who completed a clinical assessment and documented: '[N]o pain on calf on palpation, superficial swollen vein seen, tender on palpation.' NP D told HDC:

> '[Mr B] did not have a known history of [peripheral arterial disease][9] and from the history of symptoms [Mr B] provided and from my clinical exam, I believed that [Mr B] had superficial thrombophlebitis.[10]'

19. No peripheral vascular assessment[11] was documented, and NP D could not recall whether this was completed.

20. NP D prescribed ibuprofen (an anti-inflammatory medication)[12] and another pain relief medication. It is documented that Mr B was also instructed to apply elasticated bandages (Tubigrip) to support his leg with the aim of alleviating symptoms and decreasing inflammation. The clinical notes state that NP D then advised Mr B about when to seek further help based on a discussion around identification of 'red flags'. Although specific red

[5] Acute popliteal artery occlusion. This is a blocked artery, leading to poor blood flow to the legs.
[6] A heart condition that causes irregular heart rhythms and increases the risk for blood clots.
[7] A heart condition that causes irregular heart rhythms and increases the risk for blood clots.
[8] Right popliteal embolectomy and patching.
[9] Peripheral arterial disease (PAD) is a narrowing of the arteries causing a decrease in the supply of fresh oxygenated blood to limbs.
[10] Superficial thrombophlebitis is an inflammation of a vein just below the surface of the skin, which results from a blood clot.
[11] A physical assessment performed when a patient is experiencing symptoms that may be related to the function of the peripheral vascular system, to look for a possible cause.
[12] Ibuprofen is used to treat pain and can reduce blood flow to the kidneys. Caution is required when prescribing ibuprofen in people with kidney issues.

flags were not documented, NP D told HDC that in a presentation such as Mr B's, the discussion would normally include worsening pain, swelling, calf pain, numbness, or change in colour of the leg.

21. On 9 and 12 July 2021, warnings [13] were placed on the medical centre's Practice Management System for Mr B about his impaired kidney function (low estimated glomerular filtration rate (eGFR))[14] and to avoid anti-inflammatory medication.

22. NP D was aware of Mr B's low eGFR and, therefore, he prescribed only 20 tablets (a short course) of ibuprofen on 8 July 2021.

23. On 26 July 2021, Mr B presented again to the medical centre for his 'tingly', 'sore', and 'sometimes cold' right lower leg. The medical centre said that no nurse triaging occurred on this occasion and Mr B was seen directly by Dr E.

24. The clinical notes record that Mr B indicated that his pain was a 'deep ache' and that he was unable to walk very far due to the pain. The documented physical assessment noted that the right lower leg was pale in comparison to the left leg, and neither the dorsalis pedis (DP) nor the posterior tibialis (PT) pulse were palpable on the right foot. A Doppler ultrasound, which assesses the blood flow through the blood vessels, recorded no DP pulse, whilst the PT pulse was 'barely audible' on the right leg. However, the popliteal pulse was present on the right leg and all pulses were present on the left leg.

25. The clinical notes from 26 July 2021 do not document Mr B's vital signs, although these are referred to in the vascular referral form (see next paragraph). The medical centre did not provide a copy of Mr B's vital sign recordings. Dr E told HDC that a healthcare assistant (who is no longer employed at the medical centre) completed the vital sign recordings.

26. The working diagnosis was documented as 'intermittent claudication [muscle pain when walking] due to PAD [peripheral arterial disease] on right leg'. In response to the new symptoms, Dr E prescribed Trental (a medicine used to improve blood circulation) and completed a referral to Te Whatu Ora 1's vascular outpatient service for follow-up and ankle brachial index (ABI) testing[15] on 26 July. The referral form listed the reason for the referral as being PAD on the right leg and included Mr B's physical examination findings.

27. In the vascular referral form, Dr E wrote: 'Informed this [morning that] ABI wait list is long and some being turned away.'

28. Dr E said that she discussed what to watch out for (worsening pain, colour changes, loss of feeling, etc) and provided Mr B with smoking cessation advice. Dr E told HDC:

> 'Although not documented, I also provided safety netting advice, advising him to either return to the Clinic or go to the Emergency Department if any of the above occurred.

[13] A warning alerts the clinician to important clinical information without having to read complete medical notes.
[14] eGFR shows how well kidneys are working.
[15] A test that compares the blood pressure in the upper and lower limbs, to diagnose peripheral artery disease.

> Even though it is not written, I do this with every patient I see and I have improved on documenting this with every patient I see.'

29. Te Whatu Ora told HDC that this referral was triaged on 26 July 2021. Te Whatu Ora offered Mr B a routine appointment at the vascular surgery clinic, which usually had a wait time of 4–5 months. Te Whatu Ora stated:

> 'In general, the priority given to a patient is highly dependent on the information given in the GP referral along with the GP assessment of urgency. For patients with peripheral arterial disease, claudication symptoms are most often managed on a non-urgent basis and would be given a routine appointment.'

Events on 29 July 2021

30. Mr B re-presented to the medical centre on 29 July 2021 with worsening right leg symptoms. He was triaged by the practice nurse just before 11am. The triage form indicates that Mr B was in severe pain.[16]

31. The practice nurse completed a verbal assessment and vital signs. The nurse documented on the triage form that Mr B was last seen on 26 July 2021 and that his right lower leg pain was noted to be 'throbbing' with 'pins and needles' and swelling, with the pain worsening at night. A reference was made to Dr E's notes and that Mr B had been started on Trental. The nurse then referred Mr B to Dr A for review of his pain.

32. The following was documented by the practice nurse on the Practice Management System:

> '[Mr B] sta[r]ted his pills yesterday that he was prescribed by [Dr E] but today his leg is worse, its swelling up [and is] strange colour.
>
> Reviewed medical warnings, classifications, and current medications.
>
> Next step to be undertaken by acute clinic
>
> Advice given to patient:
> If condition gets worse, contact the practice.'

33. Dr A told HDC that she has no recollection of seeing the nurse triage notes, and she is confident that they were not provided to her. She stated that this can happen when the clinic is busy, and, when under pressure, sometimes nurses would complete electronic notes retrospectively.

34. Mr B told HDC: '[Dr A] came to see me in the waiting area holding hands with pre-schoolers.' He said that the conversation was minimal, and Dr A did not physically examine him or provide any safety-netting advice.

35. Dr A's full clinical notes for the consultation with Mr B were as follows:

[16] He had circled this as one of his symptoms.

> '40 — Tramal 50mg Cap — 2 nocte for pain in leg
>
> [Occupation] — off For 4 weeks holiday
>
> Trental not doing much
>
> P/ [trial] tramadol
>
> persist with vascular Appointment.'

36. No working diagnosis, physical examination findings, or safety-netting advice was documented by Dr A. In addition, there was no documentation in relation to whether an acute vascular referral was considered or whether vascular services were consulted.

37. Despite the limited documentation, Dr A told HDC that she remembers the consultation with Mr B well because 'Trental is not a drug normally used on a daily basis. In the consultation, [Mr B] expressed that Trental was not working for the pain.' Dr A initially told HDC:

> '[A]s part of my usual practice, I would have listened to [Mr B's] concerns, done an appropriate physical examination, and then updated myself using the computer notes …
>
> From my note of trialling the tramadol and persisting with vascular appointment, I must have felt at the time that there had been no deterioration in [Mr B's] condition such that he required an acute admission, in which case I would have done an acute referral to the ED doctor at [the local hospital] for advice and review.'

38. In a later statement, Dr A told HDC that at this consultation she assessed Mr B's leg and Mr B had informed her of his occupation, and she recalled him stating that he had worked that day. Dr A said that Mr B's leg was slightly swollen, which she considered had occurred because he had been sitting all day.

39. Dr A told HDC that she did not document her physical examination findings or complete detailed notes for this consultation as she was under time pressure to see all her patients. She stated that the walk-in clinic became extremely busy after 3pm, and there was an expectation to have all the 'walk-ins' cleared by 5pm or 5.30pm.

40. Dr A said that she did not complete an acute vascular referral as she considered that Mr B's leg pain and swelling had not been a sudden onset. She noted that he had been seen by Dr E three days earlier, Mr B's bloods were normal, and his vascular referral was prioritised as routine.

41. In relation to safety-netting advice, Dr A initially told HDC:

> 'I am confident that, as per my usual practise, I would have discussed the updated information including bloods and specialist response priority and advised him to ring through to the vascular service outpatient receptionist and find out where he was on the list to be seen. I would have also advised that since this was his 2nd GP appointment, if tramadol did not improve his pain then he should access the ED doctor at [the local

> hospital], who would acutely assess him again. Dependent on the outcome of that ED Assessment, he would be referred through to specialist service either acutely or with advice that a 2nd outpatient referral from the ED doctor would add more weight to the first GP referral.'

42. In a later statement to HDC, Dr A said that she advised Mr B to go to the hospital if his leg was not feeling better or if he was still in pain. She said that as Mr B had been seen twice by their practice in July, she was very clear with him to present to the hospital if his pain did not improve, and she recalls advising that if he remained worried, he should go straight to urgent care rather than visiting the GP again. Dr A said that in making these recommendations, she believes that she did not consider his presentation acute and considered it was reasonable for him to continue with the outpatient appointment and referral.

43. In contrast, Mr B told HDC that 'there was absolutely no advice for follow up or when to seek further help'.

44. Mr B stated:

> 'I am disappointed, frustrated and angry that [Dr A] was so blasé about my concerns … I don't even want to think about what could've happened … I could have lost my leg and my ability to work and support myself or even worse, my life!'

Subsequent events

45. Mr B told HDC that following the consultation he went to the pharmacy to obtain tramadol for pain relief. He recalls the pharmacist saying, 'that looks serious' (in reference to Mr B's leg). Mr B then went home.

46. Mr B told HDC that he asked his friend to drive him to the local hospital as the pain was becoming unbearable. The Emergency Department discharge summary states that Mr B presented at 2.22pm on 30 July 2021. Upon physical examination, Mr B's right leg was found to be cold, with absent foot pulses (except for the popliteal pulse) and a capillary refill of five seconds. The documented impression was of a likely acute embolic episode of peripheral vascular disease, and his presentation was discussed with the surgical registrar at Hospital 1.

47. Mr B was transferred to the Emergency Department at Hospital 1 and arrived at 5.22pm on 30 July. A CT angiogram[17] showed acute right popliteal artery occlusion with old infarcts[18] involving kidneys and spleen, and signs of more chronic peripheral arterial disease involving both lower legs. It was documented that the sensation on his foot had decreased, and he was unable to move his ankle or toes on his right foot. He was diagnosed with 'acute on chronic right limb ischaemia'.

[17] This test looks at the arteries that supply blood to the heart.
[18] Infarction is tissue death due to inadequate blood supply to the affected area.

48. Mr B was transferred to Te Whatu Ora 2 later that evening by helicopter and underwent a right popliteal embolectomy and patching[19] on 31 July 2021. Following the procedure, Mr B required further treatment for postoperative atrial fibrillation/flutter. He was discharged on 13 August, after 14 days in hospital.

Further information received

49. Dr A apologised for the distress caused and accepted that her 'actions as a clinician did not come up to a required standard beneficial for the management and treatment of the case of [Mr B]'.

50. The medical centre also provided Mr B with an apology. The medical centre told HDC: '[Mr B] has continued to be a patient with our service and the trust relationship restored.'

Rural shortages

51. Dr A told HDC that there was a severe shortage of clinicians in rural practice and in the area, and this worsened following the COVID-19 pandemic. This has affected the upskilling and training of workers in the area, as 'time away learning means a hole in the worker network'. Dr A stated that at the time she saw Mr B, she was working long hours to cover for these shortages, in 'unsupported conditions'. She believes that the pressure she was under contributed to the deficiencies in her clinical notes and is very sorry that this occurred.

52. The medical centre told HDC that the expected level of consultations over a day in the acute clinic can range from 28 to 40 consultations (for GPs), and Dr A had 29 consultations on 29 July 2021. The medical centre stated that Dr A was supported by a registered nurse (in the morning only) and an extended care paramedic.[20] In addition, there were two floor nurses, three GPs (in the non-acute clinic with booked patients), one nurse (with booked patients), two nurses in the COVID vaccination clinic, and two GPs who returned to the clinic (following offsite consultations) during the afternoon. On 29 July 2021, one GP was on leave and three nurses and three GPs were on their rostered days off.

53. Dr A told HDC that burnout and long hours are highly prevalent in rural practice and that she has tried to support the retention of workers to provide services for this population.

Responses to provisional opinion

Ms C and Mr B

54. Ms C and Mr B were provided with a copy of the 'information gathered' section of the provisional report. Mr B said that he had no comments to make.

[19] Removal of the blood clot and widening of the artery.

[20] Extended Care Paramedics (ECPs) support patients with urgent, unscheduled primary healthcare needs. An ECP specialises in assessing patients with low acuity conditions and providing treatment for common minor illnesses and injuries.

Dr A

55. Dr A was provided with a copy of the provisional report. She said that she had no comments to make regarding the provisional decision and will comply with the proposed recommendations.

Medical centre

56. The medical centre was provided with a copy of the provisional report. It told HDC that it accepted the findings, will action all recommendations, and will take the opportunity to learn and improve its services.

Opinion

57. First, I acknowledge the challenges faced by remote and rural practices. As noted by Dr A, the recruitment and retention of medical staff in rural locations such as this remains a significant issue and, as a result, there is significant pressure on rural clinicians who work to provide a service to the community. HDC is encouraged by the recent implementation of a 24-hour rural telehealth service, which increases much-needed access to primary health care.

58. In July 2021, Mr B presented to the medical centre three times with right leg pain. Over this period, Mr B was seen by NP D, Dr E, and Dr A for his pain. On 30 July 2021, Mr B self-presented to the local hospital and required emergency surgery at a main centre hospital to treat an acute popliteal artery occlusion.

59. To help me determine whether the care provided was of an appropriate standard, I sought advice from my in-house clinical advisor, GP Dr David Maplesden. I have included relevant pieces of this advice throughout my opinion.

Opinion: Dr A — breach

Introduction

60. As a GP, Dr A has a responsibility to ensure that she provides care in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). Having carefully reviewed all the information on file, including the responses provided by the medical centre, Dr A, and Mr B, I consider that Dr A did not provide a reasonable standard of care on 29 July 2021. In my view, a number of failures by Dr A led to Mr B receiving care and treatment that fell below the acceptable standard of care. I have taken into consideration the context of the workforce shortage and high workload volumes; however, the onus remains to provide an acceptable level of care for each patient, and, in my view, the standard of care experienced by Mr B largely relates to individual deficiencies in delivering care.

Inadequate investigation of vascular symptoms

61. On 29 July 2021, Mr B presented to the medical centre for the third time that month. His right leg symptoms were worsening, with foot colour change, swelling, and increased pain levels, as indicated by the nurse triage documentation.

62. As outlined earlier in this report, Dr A's clinical notes for the presentation were limited. She told HDC that she undertook a physical examination and, based on his presentation, she considered that an acute referral was not needed, but she provided safety-netting advice.

63. In a further response to HDC, Dr A stated that she did not consider Mr B's presentation to be acute and believed that the swelling in his leg was associated with sitting for long periods. Dr A said she believed it was reasonable for him to continue with the outpatient appointment and referral.

64. However, Mr B disputed Dr A's version of events, and told HDC that she did not complete a physical examination or provide him with any safety-netting advice. Mr B recalled that '[Dr A] never let go of those pre-schoolers' hands' while he was being seen in the waiting area.

65. I acknowledge that the events relating to this case happened some time ago and that there may be difficulties in recalling the exact details of what occurred. Although the documentation from 29 July 2021 does not outline the findings of a physical examination or what safety-netting advice was given, Dr A told HDC that it is her usual practice to undertake a physical examination during a consultation and provide safety-netting advice. I note Mr B's recollection that their conversation was minimal, and that Dr A saw him in the waiting room. As such, it is my view that any physical examination or safety-netting advice provided by Dr A was likely to have been cursory rather than detailed.

66. Dr Maplesden advised that the history of rapidly evolving symptoms over the last few days in July 2021, necessitating a second GP visit within a short period, was suggestive of an acute limb ischaemia. Dr Maplesden stated: '[T]he symptoms presented required a careful and thorough reassessment of the vascular status of [Mr B's] right leg and I would be severely critical if this was not done.'

67. Dr Maplesden further advised that while symptoms and signs of acute limb ischaemia can evolve rapidly over 24 hours, Mr B's presentation on 29 July 2021, when considering the previous examination findings, necessitated the exclusion of acute ischaemia as a diagnosis, and acute referral for vascular review was indicated. Dr Maplesden was at least moderately critical that this was not done. Dr A told HDC that she agrees that an acute on subacute issue needed to be considered, and that this is why she advised Mr B to present directly to hospital if his leg was not improving and remained painful.

68. I accept Dr Maplesden's advice. A physical examination was clinically indicated in this situation. Mr B required careful attention given his current smoking history, gradually worsening vascular symptoms over July 2021, and multiple presentations to the clinic. On review of the clinical documentation, there is no evidence to suggest that acute ischaemia was considered as a differential diagnosis. Although nurse triage documentation may not

have been made available to Dr A, Mr B's rapidly evolving symptoms were evident from previous GP documentation.

69. I am concerned that Dr A failed to recognise the seriousness of Mr B's symptoms and decided to treat him symptomatically. This was a significant missed opportunity to identify an acute emergency through an assessment and provide timely escalation of care. For most people, primary care is the first point of contact with health services and is a 'front door' to the rest of the health system. Therefore, robust primary care structures are key to ensuring that people receive timely and effective care.

70. I am also concerned that Mr B was seen in the waiting area, where other patients may have been present, and I remind Dr A of the importance of maintaining consumer privacy.

Inadequate clinical documentation

71. Dr A's documentation for the consultation on 29 July 2021 was minimal. No working diagnosis, safety-netting advice, or clinical reasoning for her decisions were recorded, and the contents of her discussion with Mr B and the plan for managing his symptoms was minimal.

72. The medical centre told HDC that Dr A's clinical documentation was 'not as per the standard expected from a general practitioner' and did not follow the required 'SOAP' format in the medical centre's guidelines (see Appendix B).

73. Dr Maplesden advised:

> 'It is very difficult to comment on [Dr A's] management in the absence of appropriate clinical notes … I believe my peers would be moderately to severely critical of the standard of clinical documentation of this consultation.'

74. I accept this advice. Clinical records reflect a doctor's reasoning and are an important source of information about the patient's care. The Medical Council requires doctors to maintain clear and accurate patient records that report relevant clinical findings and decisions made, and the reasons for them. Clear and complete clinical documentation is therefore a cornerstone of good care, and a required standard of professional practice. It enables more effective communication between clinicians to ensure appropriate continuity of care for the patient. In addition, poor clinical notes hamper later inquiry into what happened — thereby compromising the opportunity to address issues raised by or on behalf of a consumer, as well as quality improvement measures that may flow from such inquiry.

75. Regarding Mr B's consultation notes on 29 July 2021, Dr A acknowledged that her documentation was 'substandard' and said that she sincerely regrets this. Dr A told HDC: 'This case has shown me that I need to improve my documentation [and] always document my physical examination findings.'

76. I acknowledge that Dr A was a locum GP at the time and that there was significant pressure on rural clinicians during the pandemic. However, I consider that as a locum, Dr A needed

to implement sufficient strategies to mitigate the risks associated with burnout and a high workload and ensure that her documentation remained of an appropriate standard.

Conclusion

77. On 29 July 2021, Mr B presented to the acute walk-in clinic at the medical centre with worsening right leg symptoms. Dr A prescribed pain relief and told Mr B to persist with his vascular appointment. The lack of an adequate physical assessment meant that Mr B's worsening symptoms were not recognised. This was a missed opportunity to identify an acute emergency and provide timely escalation of care. When Mr B presented to the local hospital, he was told that he needed urgent medical intervention (a right leg embolectomy).

78. In summary, I consider that on 29 July 2021, Dr A failed to provide Mr B services with reasonable care and skill, as she did not:

a) Carry out an adequate physical examination;

b) Complete an acute vascular referral; and

c) Complete an adequate level of documentation.

79. Accordingly, I find that Dr A breached Right 4(1) of the Code.[21] However, I acknowledge the significant number of changes Dr A has made to her practice, and I make further recommendations below.

Opinion: Medical centre — no breach

80. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. At the time of the events, Dr A worked at the medical centre as a locum GP. I have considered whether there were broader systems or organisational issues that may have contributed to Mr B receiving poor care.

81. I acknowledge Dr A's concerns that the acute clinic was busy and that she felt unsupported. The medical centre stated that the acute clinic was short of a registered nurse during the afternoon. However, I note that two other nurses were working across the floor, an extended care paramedic was present to support Dr A, and two GPs had returned from their off-site consultations in the afternoon. The medical centre told HDC that Dr A undertook 29 consultations over the day, and it was usual for a GP working in the acute clinic to have between 28 to 40 consultations per day. Whilst there are no formal standards that require a specific staffing level within general medical practice, Dr Maplesden advised that in his view, the morning shift was staffed adequately. He considered that the staffing levels did not have a direct impact on the consultation with Mr B. As such, it is my view that on this

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

occasion Dr A was not working beyond the usual pressures of a busy general practice medical centre.

82. Dr A was a very experienced rural GP at the time of events, and Dr A told HDC that she had completed the orientation at the medical centre. In light of Dr A's extensive experience and her confirmation that she had completed the orientation programme, it was reasonable for the medical centre to rely on her skill and expertise. Whilst Dr Maplesden acknowledged the impact of the primary care workforce crisis on the rural health workforce, he did not identify any systemic issues at the medical centre, and I am satisfied that there were no broader systems or organisational issues at the medical centre. Accordingly, I find that the medical centre did not breach the Code.

Opinion: NP D — educational comment

83. On 8 July 2021, Mr B was seen by NP D, who completed a clinical examination and provided a working diagnosis of superficial thrombophlebitis. Following the examination, NP D prescribed pain relief, encouraged the use of Tubigrip, and provided Mr B with safety-netting advice.

84. Dr Maplesden advised that the management of Mr B's presentation on 8 July 2021 was reasonable — superficial thrombophlebitis was a reasonable explanation for Mr B's presentation, and the treatment provided was appropriate for the diagnosis. I accept this advice.

85. NP D was aware of Mr B's low eGFR and therefore prescribed only 20 tablets of ibuprofen (a short course) on 8 July 2021. Dr Maplesden advised that caution was required with prescribing anti-inflammatory medication (ibuprofen) due to Mr B's impaired renal function, as demonstrated by his blood test results, but that a short course was prescribed in light of this.

86. NP D was unable to recall whether a peripheral vascular assessment was completed, and there is no documentation of this information. Although there was no information at this stage to raise suspicions of chronic peripheral arterial disease, Dr Maplesden noted that 'best practice would be to assess peripheral circulation in an older smoker complaining of acute leg pain'. Dr Maplesden advised that if no alternative likely cause was found for the symptoms during the assessment, he would be critical if such an assessment was not documented. However, Dr Maplesden considered that with the benefit of hindsight and the safety-netting advice provided, Mr B's management on this occasion was reasonable.

87. NP D told HDC:

> 'I know smoking is a risk factor for PAD, and AF is a risk factor for arterial occlusion. I agree with your observation that I did not document assessing peripheral circulation …

> I will incorporate the learning from this case and make sure I will assess peripheral circulation with a similar presentation in the future.'

88. I accept Dr Maplesden's advice and NP D's comments. I encourage NP D to reflect further on this incident and consider completing peripheral vascular assessments on all patients with a known history of smoking.

Opinion: Dr E — educational comment

89. On 26 July 2021, Mr B presented to the medical centre with ongoing vascular symptoms. Mr B was seen by Dr E, who completed a physical assessment, prescribed Trental, and referred Mr B to vascular services.

90. Dr Maplesden noted that the clinical assessment undertaken by Dr E was 'detailed and appropriate'. Mr B's vital signs were not recorded in the clinical notes, but the medical centre advised that as this was a prescheduled appointment, no nurse triage was undertaken. Mr B's vital signs were recorded on the referral form, and Dr E confirmed that these were taken by a healthcare assistant who is no longer employed at the medical centre. Dr Maplesden advised that considering this information and noting that Dr E assessed Mr B's pulse rhythm during her vascular assessment, he was not unduly concerned at the absence of recording of vital signs in the clinical notes.

91. Dr E prescribed Mr B with Trental to treat symptoms associated with PAD. Dr Maplesden advised that Trental is not 'specifically recommended in the cited HealthPathway[22] but it is noted that some international guidelines recommend consideration of clopidogrel for patients with established PVD'. Other sources also indicate that the benefit of Trental is marginal[23] and, according to the NZ Formulary, it has not been established whether Trental is effective in treating peripheral vascular disease.

92. The medical centre stated that Trental was not indicated in its local or national guidelines.

93. Dr E told HDC:

> 'My initial treatment plan was to prescribe Pletal, an antiplatelet and vasodilator, which is not available in New Zealand. I opted for Trental as it decreases the viscosity of the blood and helps improve blood flow in vascular disease. I understand the benefits are marginal, however, I was hopeful this would get him through until the Vascular team saw him.'

94. Dr Maplesden confirmed that Pletal (cilostazol) is licensed in Dr E's country of medical training for use in patients with peripheral vascular disease but is unavailable in New

[22] Community HealthPathways. Section: Peripheral Arterial Disease. Accessed 30 May 2022.
[23] Davies, M, 'Management of claudication due to peripheral artery disease'. Uptodate, literature review current through April 2022: www.uptodate.com, accessed 31 May 2022.

Zealand. Dr Maplesden noted that Dr E prescribed Trental while recognising its marginal benefits but hoping that it could be of some assistance while Mr B awaited a vascular review. Dr Maplesden reviewed the referral and stated that it accurately summarised the history and findings recorded in Mr B's clinical notes. Dr Maplesden said that even if Dr E had telephoned vascular services and verbally relayed all the details in Mr B's assessment, it is possible that Mr B still would have had to wait for an appointment.

95. Dr Maplesden concluded that Dr E's overall management of Mr B on 26 July 2021 would be met with approval from his peers. However, Dr Maplesden remained of the view that Trental would have been of limited benefit and recommended that Dr E review the HealthPathways guidelines on peripheral arterial disease.

96. I accept Dr Maplesden's advice and agree that Trental was likely of limited benefit to Mr B. I encourage Dr E to review the HealthPathways guidelines for managing peripheral vascular disease, to ensure that her clinical care is in keeping with best practice.

Changes made

97. Dr A was deeply apologetic for the distress caused and offered to meet with Mr B to discuss the matter through mediation. Accordingly, a facilitated restorative hui was offered to Mr B by this Office. However, Mr B declined the offer.

98. Dr A told HDC that she attended a two-hour vascular assessment update on 13 June 2023 and used this as a learning opportunity to reflect on the management of Mr B's condition. She told HDC: 'The learning on this evening made the regret for my lack of action for [Mr B] even more poignant.'

99. Dr A told HDC that the vascular assessment update was part of the effort to establish a one-year pilot for a vascular nurse specialist service in the region, to upskill the community's medical workers and involve them more actively in the vascular medical network. In August 2023 Dr A attended two vascular clinics to increase the one-on-one teaching in a practical environment.

100. Dr A told HDC that she has reviewed the HealthPathways guidance on peripheral arterial disease, and she thanked Dr Maplesden for this recommendation.

101. Dr A has reviewed the Medical Council's statement on managing patient records and appreciates that records must be clear and accurate. She stated that she has improved her clinical documentation by seeking to include set templates and keywords that are personalised to her practice, and she now ensures that her electronic records are specific, relevant, correct, and complete for each individual patient following consultations.

102. Dr A attended virtual education sessions to manage her burnout and has reduced her working hours to 36–42 hours in total per week. She no longer works as a locum GP and is

established part-time at two medical practices, which has improved her documentation. Dr A told HDC: 'I have a better quality of life and a safer practice, and I am very happy in my work.'

103. The medical centre told HDC that it has stopped taking further new enrolments across all locations and will reopen only when it hires new doctors, as a safety precaution. The medical centre has also changed its service delivery model to incorporate 'expanded care teams and roles to better support access in a timely and safe manner'. In particular, it has altered the 'same day demand team' to allow for better triage process at first point of contact for all walk-in patients. The new system will allow for shared monitoring and continuity of care, regardless of the doctor working in the clinic.

Recommendations

104. I am pleased that Dr A has taken this case very seriously and has reflected on the care provided. I acknowledge the extensive actions Dr A has already undertaken to improve her practice and have taken this into account when making my recommendations. I have also taken into account Dr A's offer to meet with Mr B to discuss the issues outlined.

105. Accordingly, I recommend that Dr A undertake a Royal New Zealand College of General Practitioners clinical notes audit and provide HDC with the results of the audit, along with any improvement strategies she has or will implement as a result, within three months of the date of this report.

106. I recommend that NP D reflect on this incident in light of this report and my clinical advisor's opinion and report back to HDC on the learning, within three months of the date of this report.

107. I recommend that Dr E review the regional HealthPathways Guidelines for peripheral vascular disease and report back to HDC on any changes made to her practice as a result, within three months of the date of this report.

108. In light of the ongoing rural workforce shortages, I recommend that the medical centre consider training clinical staff members to undertake ABI measurements if there continues to be difficulty accessing ABI services externally, and report back to HDC on the outcome of its consideration within three months of the date of this report.

Follow-up actions

109. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Medical Council New Zealand, and it will be advised of Dr A's name.

110. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Royal New Zealand College of General Practitioners and Te Whatu Ora|Health New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following advice was obtained from in-house clinical advisor GP Dr David Maplesden, initially on 22 May 2022 and again on 3 October 2023:

'…

1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a practising general practitioner. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from Ms C about the care provided to her father, Mr B, by Dr A. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information:

- Complaint from [Ms C]
- Response from [Dr A]
- [Medical centre] notes from 29 June 2021
- Clinical notes [Te Whatu Ora 1]
- Clinical notes [Te Whatu Ora 2]

Addendum 3 October 2023. Additional information has been reviewed as below and incorporated as addenda into the body of this report:

- Response from [Dr A] to my preliminary advice
- Statement from [Dr E]
- Response to notification from [the medical centre]
- Response from [Te Whatu Ora 1] (TWO)

3. The complaint relates to delays in the diagnosis of [Mr B's] acute right popliteal artery occlusion. [Mr B] had presented to clinicians at [the medical centre] on three occasions in July 2021 complaining of right leg pain with the last consultation being with [Dr A] on 29 July 2021. On 30 July 2021 he presented to the local hospital unhappy with the advice given to him by [Dr A] the previous day. Here he was diagnosed with an acutely ischaemic right foot and was transferred to [Hospital 1] where CT angiogram confirmed an embolic occlusion right popliteal artery. This led to emergency transfer to [Te Whatu Ora 2] where [Mr B] underwent embolectomy and patch repair of the popliteal artery on 31 July 2021. [Ms C] is concerned that [Dr A] in particular failed to recognise the seriousness of her father's condition.

4. [Mr B] was aged [in his late fifties] at the time of the events in question. Medical records refer to past history of atrial fibrillation and flutter (prescribed metoprolol) and hyperlipidaemia (prescribed atorvastatin). [Mr B] was a long-time cigarette smoker.

There is no record of known history of peripheral arterial disease (PAD) although smoking is a risk factor for PAD, and AF is a risk factor for embolic arterial occlusion. At routine review on 29 June 2021 [Mr B] was apparently well and usual medications were repeated. On 8 July 2021 [Mr B] was seen at [the medical centre] by provider [NP D] with a four-day history of right leg pain: *woke up with pain Saturday, not going away, no pain in calf O/looks well, right leg — no pain on calf on palpation, superficial swollen vein seen, tender on palpation, raised smoke 20 a day. A/ superficial thrombophlebitis P/ 1. Tubigrip 2. Short course anti-inflammatory* [ibuprofen prescribed] *and Paracode 3. Red flags discussed, if any review.*

Comment: Based on the recorded notes, as the GP proceeded with assessment of [Mr B's] right leg, he found signs suggestive of superficial thrombophlebitis which was a reasonable explanation for the presentation. The treatment provided was appropriate for the diagnosis, although noting recent blood tests had shown impaired renal function, caution was required with prescribing of anti-inflammatory medication. There was no apparent additional history provided to raise suspicion of chronic PAD. Best practice would be to assess peripheral circulation in an older smoker complaining of acute leg pain and if there had been no alternative likely cause found for the symptoms during the assessment, I would be critical such an assessment was not documented. However, in the circumstances described, and without the benefit of hindsight, I believe [Mr B's] management on this occasion was reasonable, noting particularly that safety netting advice was apparently provided.

Addendum 3 October 2023: The clinic[ian] on this occasion was [NP D] who has provided a statement as part of the [medical centre's] response. He confirms his clinical findings on 8 July 2021 were consistent with superficial thrombophlebitis and he is unsure if he checked [Mr B's] peripheral circulation but has incorporated that as a learning point in the future. A short course of NSAID was prescribed in light of [Mr B's] known renal impairment. Red flags discussed were *pain or swelling getting worse or not improving, calf pain, numbness or change in colour of the leg.* I remain of the view that [Mr B's] management by [NP D] was reasonable.

5. [Mr B] presented again to [the medical centre] on 26 July 2021 and was triaged by a practice nurse prior to being reviewed by provider [Dr E]. There is reference to triage recording but I could not find these on file. GP notes read: *Here for problems with his right lower leg feeling tingly and sore, sometimes cold. Worse when he is laying down. He gets a pain in his lower leg as well just above the ankle. He was seen a few weeks ago and was told it was "nothing" and was given a little stocking to wear. The pain is on the opposite side and is a deep ache. He is unable to walk very far before he gets the pain in his right leg … Right distal leg is pale compared to left. No DP pulse palpable on R, palpable on left. No PT pulse palpable on R, 1+ on left. Popliteal pulse on R: 1, L: 2+. Doppler: no DP on R, Barely audible PT pulse on R. Doppler DP ++ on L; PT pulse on L +++*

A/P: Intermittent Claudication due to PAD on Right. Start Trental 400mg tds and ABI, referral to Vascular. Long discussion about smoking cessation.

Blood tests were ordered (non-contributory results) and prescription provided for Trental as above. Referrals were evidently made for ankle brachial pulse index (ABI) testing and vascular review (requested priority not clear).

Comment: There is no response from [Dr E] on file and a response should be sought, together with copies of nurse triage recordings (if available) and referral documents. The GP quite correctly identified [Mr B] as having a peripheral arterial issue involving his right lower leg, and the vascular assessment undertaken was detailed and appropriate. Pain symptom had been present by now for more than three weeks (definition of acute arterial occlusion/acute limb ischaemia is *a sudden loss of limb perfusion for up to 2 weeks after the initiating event*) [1] with the presence of paresthesiae, change in temperature and colour, and some rest pain noted (*worse when he is laying down*) together with exacerbation of pain with walking (distance not quantified). The issue at stake here is whether [Mr B's] presentation was most suggestive of critical limb ischaemia[2] on a background of chronic PAD in which case urgent but non-acute vascular referral is indicated, chronic symptomatic but non-critical PAD with progressive claudication symptom (non-urgent vascular referral might be considered), or whether the picture was more suggestive of acute limb ischaemia which requires acute vascular referral. It was appropriate to arrange an ABI which might have helped to clarify the diagnosis (ABI < 0.4 indicates critical limb ischaemia[3]). However, I believe if [Mr B's] symptoms had evolved rapidly over three weeks and were severe with no preceding history suggestive of longer standing PAD issues, together with the current observations of paresthesiae, pallor and coolness of the foot, rest pain at times particularly when the leg was elevated, and documented absence of PT and DP pulses on the right, some of my colleagues might have considered acute vascular referral or advice particularly if [Mr B's] pain was severe, although I cannot predict what that advice might have been. If [Mr B] was noted at this time to be in atrial fibrillation (AF), the possibility of an embolic cause of his symptoms secondary to AF might have been considered. On the other hand, if it seemed [Mr B's] symptoms were slowly evolving by now over three weeks and not particularly severe, and particularly if there had been longer standing symptoms suggestive of PAD, acute limb ischaemia would appear a less likely diagnosis than critical limb ischaemia in which case urgent rather than acute referral was indicated as per local guidance[4]. I believe [Mr B] is likely to have exhibited more severe symptoms and signs than were evident on 26 July 2021 if the symptoms he had noted for the past three weeks were due to acute limb ischaemia, and in my personal experience of managing patients with acute limb ischaemia they have invariably presented within 24–48 hours of symptom onset because of the severity of ischaemic pain. In summary, assuming the triage nurse took [Mr B's] vital signs on 26

[1] Smith DA, Lilie CJ. Acute Arterial Occlusion. [Updated 2022 May 2]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK441851/ Accessed 30 May 2022

[2] Defined in the region's Health Pathways as: *Absent peripheral pulses with: persistently recurring rest pain requiring analgesia for more than 2 weeks; or ulceration; or gangrene of the foot or toes.*

[3] BPAC. The ankle-brachial pressure index: An under-used tool in primary care? Best Practice Journal. 2014; Issue 60.

[4] Community HealthPathways. Section: Peripheral Arterial Disease. Accessed 30 May 2022

July 2021 and these were normal, the assessment by [Dr E] was of a very reasonable standard. I believe some of my colleagues might have considered seeking acute vascular advice in the circumstances described, but equally (and without the benefit of hindsight) the actions taken by [Dr E] could be described as appropriate for a patient with history suggestive of critical limb ischaemia or rapidly worsening PAD without critical limb ischaemia. The prescribing of Trental is not specifically recommended in the cited HealthPathway but it is noted that some international guidelines recommend consideration of clopidogrel for patients with established PVD and *there is no funded drug therapy in New Zealand that has been shown to improve symptoms of intermittent claudication*. Uptodate[5] notes that *the available data indicate that the benefit of pentoxifylline* (Trental) *is marginal … studies investigating the efficacy of pentoxifylline have yielded conflicting results, leading to variable recommendations for its use by various society guidelines …* Nevertheless, NZ Formulary lists indication for pentoxifylline as *peripheral vascular disease* but includes the qualifier: *Pentoxifylline is approved for use in peripheral occlusive vascular disease, however it is not established as being effective for the treatment of intermittent claudication or Raynaud's phenomenon*. Smoking cessation (advised) is the most important intervention in patients with claudication together with an exercise programme.

Addendum 3 October 2023: A response was received from [Dr E] who was the clinician. [Dr E] states a health care assistant (HCA) no longer employed at [the medical centre] performed the vital signs (?not recorded) although the [the medical centre] response states that as this was a prescheduled appointment there was no nurse triage undertaken (notes refer to "[first name]" undertaking observations but not the observations themselves). Noting [Dr E] assessed [Mr B's] pulse rhythm during her vascular assessment (see below) I am not unduly concerned at the absence of recording of vital signs on this occasion. [Dr E] states [Mr B] was walking without a limp did not report any leg pain on walking the 50m or so from the carpark into [the medical centre] although he reported developing pain ambulating over longer unspecified distances. There was no rest pain present at the time of the assessment. Pulse was regular and peripheral pulse assessment and doppler assessment was as documented. [Dr E] notes: *I did explain to [Mr B] my concerns at that time about his lower leg. I contacted Vascular Services; [Mr B] was hesitant about this. I ordered ABI's and put my referral through to Vascular Services as he sat in my room. I also ordered blood tests, he was also hesitant to have them done, I had to explain how important it was. I discussed what to watch out for (worsening pain, colour changes, loss of feeling, etc). I had a long discussion with him about the importance of smoking cessation. Although not documented, I also provided safety netting, advising him to either return to the Clinic or go to the Emergency Department if any of the above occurred. Even though it is not written, I do this with every patient I see and I have improved on documenting this with every patient I see.* [Dr E] intended to prescribe [Mr B] Pletal (cilostazol) which is licensed in [Dr E's] country of medical training) for use in patients with peripheral vascular disease but is unavailable in New Zealand.

[5] Davies M. Management of claudication due to peripheral artery disease. Uptodate. Literature review current through April 2022. www.uptodate.com Accessed 31 May 2022

She prescribed Trental (pentoxyfilline) recognizing the marginal benefits but hoping it could be of some assistance while [Mr B] awaited vascular review. An electronic referral to the vascular service was completed and sent immediately. I have viewed the referral and I believe it accurately summarises the history and findings recorded in the notes. In summary, I believe [Dr E's] management of [Mr B] on 26 July 2021 would be met with approval by my peers although prescribing of pentoxyfilline was likely to have been of limited benefit. I recommend [Dr E] review the cited HealthPathways guidance on peripheral arterial disease. I recommend [the medical centre] consider training a staff member to undertake ABI measurements if there continues to be difficulty accessing this service externally (see BPAC reference 3).

6. [Mr B] was next seen at [the medical centre] on 29 July 2021. Nurse triage notes refer to [Mr B] commencing Trental the previous day *but today his leg is worse, its swelling up and a strange colour.* Vital signs are not recorded but may have been recorded manually and scanned (more complete medical records required including all inbox and outbox documents for the period in question). [Mr B] was then seen by [Dr A] whose notes, in their entirety, read:

[Occupation] — off For 4 Weeks holiday. Trental not doing much. P/ Trial tramadol, persist with vascular Appointment. A prescription was provided for tramadol 2 x50mg caps nocte *for pain in leg* x 40 caps.

Addendum 3 October 2023. Nurse triage form dated 29 July 2021 was scanned into the notes and has been provided and reviewed. This notes [Mr B] was currently experiencing severe right lower leg pain, worse at night, throbbing in nature with pins and needles with some associated swelling of the lower leg. Vital signs were BP 164/88, P 61, resps 19, temp 37.2 and O2 sats 100%. Blood tests results from 26 July 2021 showed borderline leucocytosis (normal neutrophils), CRP 13 mg/L, mild elevations of GGT and ALP (liver function) and mildly elevated creatinine with eGFR 60mL/min (improved from previous results).

7. On 30 July 2021 [Mr B] self-presented to [the local hospital] with worsening right leg pain and was transferred to [Hospital 1]. ED notes include:

[Right leg pain] *started 1 week ago. Went to bed on Friday night. Woke up one hour later with. Went to GP on Monday — started on pentoxifylline for ?blocked artery. Since then ongoing pain and foot is cold and has become swollen. Pain is helped by hanging down — worse when tries to sleep in bed — has had to try and sleep in chair. No hx of trauma. No hx of gout. No hx of cut or abrasion.*

Examination: Right leg is cold from just above the ankle down. Absent foot pulses bilaterally. Cannot feel right pop pulse. Bilat femoral pulses normal. Foot red, not pale/ Cap refill 5 seconds. Decreased sensation of right foot. Unable to move ankle or toes on right foot — small flicker of movement.

CT angiogram was performed which showed acute R popliteal artery occlusion together with old infarcts involving kidneys and spleen (suggesting prior arterial thromboembolic

disease), and signs of more chronic PAD involving both lower legs. [Mr B] was transferred to [Te Whatu Ora 2] where he underwent popliteal artery embolectomy and patching on 31 July 2021 with satisfactory salvage of his right leg.

8. In her response to HDC, [Dr A] acknowledges her clinical documentation was deficient and outlines her usual approach to patient management including routine provision of safety netting advice (see GP or attend local ED if symptoms are worsening). She states she would have reviewed [Mr B's] notes and recent blood tests results and discussed these with him, including the fact a vascular referral had been made by his previous provider. The response includes: *I would have listened to his concerns, done an appropriate physical examination, and then updated myself using the computer notes … From my note of trialling the tramadol and persisting with vascular appointment, I must have felt at the time that there had been no deterioration in [Mr B's] condition such that he required an acute admission, in which case I would have done an acute referral to the ED doctor at [the local hospital] for advice and review … I would have also advised that since this was his 2nd GP appointment, if tramadol did not improve his pain then he should access the ED doctor at [the local hospital], who would acutely assess him again.*

Comment: The nurse triage notes indicate [Mr B] gave a history of worsening of his right leg symptoms in the previous 24 hours with foot colour change, swelling and increased pain (noting tramadol was required). It is very difficult to comment on [Dr A's] management in the absence of appropriate clinical notes, but the symptoms presented required a careful and thorough reassessment of the vascular status of [Mr B's] right leg and I would be severely critical if this was not done. The symptom history of rapidly evolving symptoms and signs over the previous few days necessitating a second GP visit over a short period I believe was by now most suggestive of an acute limb ischaemia but in the absence of a record of assessment findings I am unable to state the physical signs would have supported this diagnosis although findings 24 hours later are noted. While I acknowledge symptoms and signs of acute limb ischaemia can evolve rapidly over 24 hours, I believe [Mr B's] presentation pattern at this point (taking into account the previous examination findings and rapid progression and nature of symptoms) necessitated exclusion of acute ischaemia as a diagnosis and that acute referral for vascular review was indicated, and I am at least moderately critical this was not done. A mitigating factor is the overall length of symptoms (by now almost a month) which would not be consistent with an acute limb-threatening event, but an acute on subacute issue needed to be considered. I believe my peers would be moderately to severely critical of the standard of clinical documentation of this consultation. [Dr A] has noted some remedial measures she will take to improve her standard of documentation. I recommend she review the cited HeathPathways guidance on peripheral arterial disease. More detail from [Mr B] as to his recollection of the events of 29 July 2021 might be helpful to clarify the nature of assessment undertaken on that date.

9. Addendum 3 October 2023: I have reviewed [Dr A's] response dated 18 July 2023 and the documentation supplied regarding professional development activities. While there is no additional clinical information provided that alters my comments

above, I would like to acknowledge the impact the primary care workforce crisis has on my colleagues, particularly in [this region] where the acuity of the workforce crisis combined with a particularly high needs population creates a "perfect storm" for provider burnout, difficulties with adequate service provision and less than optimal health outcomes for patients. This situation has been allowed to develop and worsen over many years, a situation that is out of the control of the providers themselves. It is clear [Dr A] has reflected at length on [Mr B's] complaint and would welcome a restorative approach as part of resolving the complaint. I note the remedial measures undertaken by [Dr A] which include further education on vascular medicine, a change in work patterns that enables more time for attention to clinical documentation, and ongoing professional development that covers both of these issues. These actions appear very reasonable, and I support any further actions that enable [Dr A] to continue serving her community.

10. I have reviewed the TWO response which notes the referral from [Dr E] was received on 26 July 2021 and triaged the same day as routine (4–5 month wait). The referral was interpreted as requesting *review of a patient with symptoms of intermittent claudication from probable peripheral arterial occlusive disease.* This implies that even had [Dr E] spoken with the vascular service on 26 July 2021 and verbally conveyed the history and examination findings (which were well represented in the referral document), it is quite possible she would have been advised to send in the referral and await the outcome of the referral.'

The following advice was received on 28 November 2023:

'I believe the morning shift was adequately staffed but having only two floor nurses in the afternoon to cover five fully booked GPs and the acute service seems a bit light although there are no formal standards I am aware of that require a specific staffing level. However, I note the patient was triaged by a nurse on 29 July 2021 prior to seeing [Dr A] so I'm not sure this issue impacted directly on the consultation in question.'

Appendix B: Relevant standards

'Managing patient records' (written by the Medical Council of New Zealand in December 2020) states:

> 'Patient records reflect a doctor's reasoning and are an important source of information about a patient's care.
>
> Patient records … help ensure good care of patients and clear communication between doctors and other health practitioners.
>
> …
>
> 1 You must maintain clear and accurate patient records that note:
>
> a clinical history including allergies
>
> b relevant clinical findings
>
> c results of tests and investigations ordered
>
> d information given to, and options discussed with, patients …
>
> e decisions made and the reasons for them
>
> …
>
> g requests or concerns discussed during the consultation
>
> h the proposed management plan including any follow-up
>
> …'

[The medical centre's] Locum Orientation Guidelines demonstrate that documentation needs to follow the 'SOAP' format. [The medical centre] provided the following explanation for this format:

> 'Structures for recording information usually follow a pattern of (S) subjective, (O) objective, (A) assessment and (P) plan … A useful rule of thumb about how much information to include is to think about another doctor reading the notes. Is there sufficient information to allow another doctor to arrive at the same or similar conclusion and could justify the management plan? Could this doctor reasonably exclude other important diagnoses on the basis of the clinical information?'