Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 20HDC00289)

Introduction

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

- *Whether Dr C provided Ms A with an appropriate standard of care during 2015 to 2019 (inclusive).*
- *Whether the medical centre provided Ms A with an appropriate standard of care during 2015 to 2019 (inclusive).*

2. This report is the opinion of Deputy Commissioner Deborah James and is made in accordance with the power delegated to her by the Commissioner.

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

3. The parties directly involved in the investigation were:

Ms B	Complainant
Dr C	General practitioner (GP)/provider
Medical centre	Provider

4. Further information was received from:

Dr D	GP/provider
Dr E	GP/provider

5. Endocrinologist Dr F is also mentioned in the report.

6. These parties had an opportunity to comment on relevant parts of the provisional opinion. Their responses have been incorporated into the report where appropriate.

7. Independent advice was obtained from GP Dr Lynda Gee (Appendix A).

Background

8. Ms A had been under Dr C's care since March 2013. Ms A had a history of anxiety, depression, post-traumatic stress disorder (PTSD) and low body mass index (BMI[1]). Between 2015 and 2019, Dr C was responsible for Ms A's health care and assisted with social issues such as her ACC claims. Sadly, Ms A's health deteriorated, and she died of heart failure when she was aged in her sixties.

9. This report focuses on the care provided to Ms A by Dr C at the medical centre between 2015 and 2019, in particular the management of her heart issues, her weight and nutrition, and her mental health conditions. The report also discusses other aspects of her care, including the adequacy of Dr C's documentation.

10. I take this opportunity to extend my sincere condolences to Ms A's whānau for their loss.

Opinion: Dr C — breach

Introduction

11. From the outset, I acknowledge that Ms A had a complex medical and social history. Dr C was Ms A's GP and had a duty to provide services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). Dr C also was required to follow the Medical Council of New Zealand guidelines and the medical centre's policy on clinical records. As outlined below, I consider that aspects of the care Dr C provided to Ms A fell below accepted standards.

12. In carrying out my investigation and endeavouring to establish the standard of care provided, I have drawn on all relevant information, including Dr C's recollection and the

[1] BMI is a measure of body fat based on height and weight.

clinical documentation available. I have also taken into consideration the recollection of Ms B, when she accompanied Ms A to some consultations and was party to the discussions that occurred. As Ms A died prior to Ms B's complaint being made to HDC, it follows that direct evidence from her is not available.

13. I acknowledge the passage of time since the events described in this complaint occurred, and the difficulties this presents in terms of assessing the recollections of the discussions held. Therefore, I have had to place significant weight on the contemporaneous clinical documentation. Dr C's clinical documentation was of a poor standard (discussed further below), which has created challenges in my assessment of whether an appropriate standard of care was provided to Ms A between 2015 and 2019. Notwithstanding this, I have significant concerns about the care provided to Ms A by Dr C during this time and the assumptions Dr C made regarding Ms A's health conditions and the management of these conditions.

14. In response to the provisional opinion, Dr C told HDC that the context of Ms A's care was an important and relevant consideration. For example, because of her significant past trauma she was reluctant to take medication. Dr C said: '[She was] very uncomplaining as a patient and did not express to me any distress with her mental health.' Dr C stated that in circumstances where Ms A did not complain about symptoms related to heart failure, anxiety, or post-traumatic stress disorder, 'it was difficult to manage and provide the usual and expected cares'.

15. To assist my assessment of the care provided by Dr C, I sought independent advice from a vocationally registered GP, Dr Lynda Gee.

Management of heart issues 2016–2019

16. Ms A presented with symptoms suggestive of heart failure in June 2016 and had consultations with Dr C and two other doctors (Drs D and E) at the medical centre. Ms A's symptoms at that time included shortness of breath and swollen ankles. Blood tests indicated that Ms A had an elevated BNP,[2] suggestive of heart failure. Drs D and E recommended an X-ray and echocardiogram be undertaken.

17. On 20 February 2017, Dr C saw Ms A for swelling of the feet and 'chest signs'. It was noted that she was not on any particular medications. Dr C prescribed two types of inhalers, medication for depression, and an antibiotic. Ms A's blood pressure (BP) was recorded as 120/80mmHg (normal), and Dr C ordered blood tests, including a BNP. In response to the provisional opinion, Dr C said that at this point he considered her illness to be an exacerbation of chronic obstructive pulmonary disease[3] (COPD).

18. On 21 February 2017 the BNP level was reported as 202pmol/L (high), which was suggestive of heart failure. Dr C said that he wrote to Ms A about these results on 23 February 2017.

[2] Brain natriuretic peptide (a hormone). During heart failure, pressure builds up in the chambers of the heart, which releases large amounts of BNP.
[3] A group of diseases that cause airflow blockage and problems with breathing.

19. Ms A saw Dr C on 30 August 2017 for a chest infection and was prescribed antibiotics. There is no documented reference to Dr C discussing Ms A's latest BNP results with her, or if any follow-up plan was considered.

20. Ms A next saw Dr C on 15 January 2018. It was documented that Ms A was dizzy, had headaches and was not putting on weight but was eating well. Her BP was recorded as 140/80mmHg (upper limit of normal). Dr C referred Ms A for further tests, including a BNP level, which returned a result of 309pmol/L[4] the next day — an increase from her previous result in August 2017, continuing to suggest heart failure. The other blood tests were normal.

21. Two days later, on 17 January 2018, Ms A had a further consultation with Dr C for shortness of breath and chest pain. A chest X-ray was completed that day and the results concluded that Ms A's heart size was at the upper limits of normal. Congestive cardiac failure[5] was not indicated, but COPD was documented as a possibility.

22. Dr C noted the following:

> '[Ms A] has some shortness of breath, swelling of the ankles and raised BNP of 330.[6] She has a murmur consistent with mitral regurgitation she does get chest pains and we have done a cardiogram which is fairly normal …
>
> BP 85/65 [low]. We've also done a chest x-ray which shows borderline cardiac enlargement and no interstitial oedema or pleural fluid although the lungs do appear overinflated …'

23. In response to the provisional opinion, Dr C noted that the options at that point were extremely limited or absent given Ms A's low blood pressure.

24. In January 2018 Dr C referred Ms A to a cardiologist. She was seen in May 2018 and diagnosed with left ventricular hypertrophy (LVH [7]), likely due to hypertension,[8] and she was prescribed a low dose of an ACE inhibitor.[9] The cardiologist documented that further cardiology follow-up was not arranged, as she did not have ongoing cardiac problems. In response to the provisional opinion, Dr C said that the cardiologist noted that Ms A had 'excellent right and left ventricular function' and asked her to drink more fluids and take her medications on a regular basis.

[4] The test results document a level of 309, but the clinical notes record a level of 330.
[5] A serious condition in which the heart does not pump blood as well as it should.
[6] See footnote 4.
[7] A thickening of the walls of the lower left heart chamber.
[8] Ms A's documented blood pressure that day was 148/67mmHg.
[9] There is significant variability in Ms A's recorded blood pressure readings, with many consistent with hypotension (low blood pressure) and others (noted particularly at hospital appointments) consistent with hypertension (high blood pressure). The finding of left ventricular hypertrophy on echocardiogram in May 2018 (at the cardiology appointment) with concurrent elevation in blood pressure was consistent with a history of chronic hypertension.

25. In June 2018, Ms A consulted Dr C for a 'heart check'. Her chest was recorded as 'clear', with no issues noted. The notes record the medications prescribed by the cardiologist at Ms A's appointment in May. Dr C told HDC that he prescribed a further three months' supply of these medications.

26. Ms A next consulted Dr C in December 2018. It was noted that she had a mild wheeze in her chest and that her blood pressure was low (80/60mmHg). She also complained of issues with circulation in her legs and being unsteady when she walked. Dr C noted Ms A's temperature, pulse, and blood pressure. No other observations are recorded and no treatment plan for Ms A is noted. In response to the provisional opinion, Dr C accepted that it would have been prudent to re-evaluate Ms A's heart condition at this point but noted that he put her presenting issues down to COPD. He also stated that it is well known that BNP levels are raised in people with COPD.

Medications prescribed

27. Dr C told HDC that nifedipine[10] was prescribed from July 2016 mainly because Ms A had quite severe Raynaud's disease,[11] which on occasion led to ulceration of the tips of her fingers. In December 2018, Ms A was also prescribed Vedafil[12] for this problem.

28. Dr C told HDC that the cardiac treatment prescribed to Ms A in June 2018 was cilazapril.[13] He said that given Ms A's low blood pressure and raised BNP, it was very difficult to treat her heart failure, as the usual medications used to treat heart failure lower blood pressure even further, and Ms A's blood pressure was low already. As such, in 2018 he referred her to the cardiology team at the public hospital.

Opinion — management of heart issues 2016–2019

29. My independent advisor, Dr Gee, stated that the 'Heart Failure' Auckland Region Community HealthPathways contain an extensive list of assessment guidelines for the management of heart failure, including checking signs and symptoms, assessing causative and underlying factors, and performing an examination. The HealthPathways also contain management guidelines. Dr Gee accepts that while it would not always be possible to complete a comprehensive checklist, there is a subset of symptoms and signs from an examination and investigations that are important and indicative to make a diagnosis of heart failure.[14]

30. Dr Gee stated that Dr C's referral to a cardiologist in January 2018 was appropriate, and I accept this advice. However, Dr Gee considered that Dr C's consultations between 2016 and

[10] Nifedipine is used to treat hypertension and angina (chest pain).
[11] Raynaud's disease causes some areas of the body such as fingers and toes to feel numb and cold in response to cold temperatures or stress.
[12] Usually, Vedafil is used to treat erectile dysfunction, but it can also be used to treat Raynaud's disease. Dr C prescribed Ms A Vedafil on 11 December 2018 at a dose of 50mg BD (twice a day).
[13] Cilazapril is used to treat high blood pressure and heart failure.
[14] These include the 'typical' symptoms of breathlessness, reduced exercise tolerance, ankle swelling; examination of the cardiac system, including heart sounds and rate, blood pressure, jugular venous pressure (JVP), chest, peripheral oedema (ankle swelling) and weight; blood tests for BNP; +/- ECG; +/- chest X-ray; arrange echocardiography; arrange cardiology assessment.

2019 do not contain a full record of symptom history, such as duration of shortness of breath, and there are omissions in terms of recording the absence of symptoms and examination measurements such as heart rate, rhythm, jugular venous pressure (JVP), and extent of ankle swelling.

31. Dr Gee concluded that Dr C's failure to maintain a clear and systematic record in relation to Ms A's heart failure was a moderate to severe departure from the accepted standard of care.

32. I accept Dr Gee's advice. Dr C maintains that he provided Ms A with an appropriate level of care. However, the lack of documentation relating to treatment plans, impressions, and recording of vital signs and symptoms at these consultations between 2015 and 2019 leads me to consider that Ms A's heart failure was not managed by Dr C appropriately based on the HealthPathway assessment and management guidelines. I am also concerned that no further action was taken regarding the recommendation for a chest X-ray and echocardiogram following Ms A's consultations with Dr D and Dr E in 2016. In response to the provisional opinion, Dr C acknowledged that he should have organised these tests earlier.

33. I also have concerns that Ms A was prescribed Vedafil by Dr C. The contraindications listed by Medsafe[15] include hypotension <90/50mmHg. Ms A's recorded blood pressure at the consultation of 11 December 2018 was 80/60mmHg. Accordingly, I believe it was inappropriate to use this drug given Ms A's recorded blood pressure. I also note that in response to the provisional opinion, Dr C highlighted that other medications Ms A was taking (including nifedipine) were contraindicated owing to her low blood pressure.

Management of Ms A's weight and nutrition

34. Ms A had a history of a low BMI. At her appointments at the medical centre, her weight was recorded three times in 2015 and three times in 2016. Her weight was not recorded at the medical centre during 2017. Her weight was recorded twice in 2018, but again there are no records of Ms A's weight in 2019.[16]

35. Ms B told HDC that for most of the time she knew Ms A, her weight had been in the 30–40kg range, which was an outward indication of the struggle Ms A was having to stay alive.

36. At both of Ms A's 2019 appointments, Dr C documented that she was underweight or her BMI was very low, but he did not record her weight or a treatment plan.

37. Dr C told HDC that it is his understanding that Ms B weighed Ms A at home during the time they lived together. Ms B would discuss Ms A's weight with him at Ms A's appointments,

[15] Medsafe sets out that one of the contraindications of Vedafil includes hypotension (blood pressure <90/50mmHg) and hypertension (blood pressure >170/110mmHg).

[16] Ms A's weight was documented, primarily by Dr C, over 2015–2018 as follows: 36kg in January 2015, 35kg in May 2015, 38.8kg in August 2015, 41kg in March 2016, 42kg in May 2016 (another doctor at the medical centre), 44.5kg in June 2016 (another doctor at the medical centre), 34kg in January 2018, and 35kg in July 2018.

and Ms B's input informed his management of Ms A's nutritional supplements and several of the changes made over the years.

38. Dr C told HDC that it was his view that as a result of Ms A's trauma, she had developed anorexia nervosa, but with the atypical feature of simply not wanting to eat, rather than wanting to lose weight. Dr C said that substantively addressing Ms A's eating issues would have required psychological treatment directed to Ms A's underlying issue, which was her PTSD, and he did not believe that this was the right choice for Ms A and directed his efforts to helping Ms A achieve stability as well as treating her physical health needs.

39. Dr C said that he did not think a dietitian's advice would address Ms A's challenge in maintaining a healthy weight. From his discussions of Ms A's weight, he understood Ms B to have a robust, common-sense approach to what a person needs to eat to stay healthy. In response to the provisional opinion, Dr C said that it was a problem to get dietitian input because ACC approval was needed, and he was not aware that ACC had granted cover for this until well after Ms A's death.

40. Dr C said that he had consulted with Ms A previously on 14 May 2014, and on the same visit she had also seen a practice nurse, who had provided Ms A with advice on diet and exercise. Dr C told HDC that by early 2015 Ms A's weight had continued to track downwards, and that the appropriate next step was to commence Ms A on a nutritional supplement.

41. Dr C prescribed Ensure Powder[17] in May 2015 and completed a special authority[18] application to subsidise this.

42. Ensure (and Fortisip, which was later prescribed to Ms A) required a special authority, which sets out criteria that must be met for funding to be approved by Pharmac. The special authority form in place at that time sets out the three requirements as:

(I) Patient is malnourished BMI less than 18.5;

(II) Patient has not responded to first-line dietary measures over a 4 week period by increasing their food intake frequency or using high energy foods or using over the counter supplements; and

(III) A nutritional goal has been set.

43. Of the three criteria required for this application, Dr C documented that Ms A's BMI was less than 18.5, but he documented 'false' for the requirement of a nutritional goal having been set and the requirement that the patient had not responded to first-line dietary measures over a four-week period. There are no further records of examinations or findings in relation to this. However, Dr C told HDC that the nutritional goal was to get some sort of weight gain.

[17] Ensure is a powdered milkshake-style oral nutritional supplement for people with, or at risk of developing, disease-related malnutrition.

[18] A special authority is an application process in which a prescriber requests government subsidy on a community pharmaceutical, and Pharmac sets specific criteria that must be met before some medicines will be funded.

44. Dr C believes that the prerequisites for the special authority application were substantially satisfied, and he does not understand how the adherence to these criteria or otherwise could be said to detract from the standard of care Ms A received, particularly since her weight loss did stabilise for a time after the addition of Ensure to her diet.

45. Dr C told HDC that Ms A was prescribed Ensure until July 2016, and then prescribed Fortisip from January 2018 until early 2019. He said that Ms B then asked him to prescribe Ms A Ensure liquid in tins, and he explained that she would have to pay extra for this, and she said that she would get ACC to pay the extra cost.

46. Ms A and Ms B had a further consultation with Dr C on 23 Month1[19] (2019) to obtain Ensure. Dr C documented that he had written to ACC to get medication 'to supplement [Ms A's] food'. The ACC letter completed by Dr C noted:

> '[Ms A] is emaciated due to her post-traumatic stress disorder following terrible events in the past which ACC is well aware of and now she is as thin as a Belsen Camper and she would benefit from Ensure Plus Hn Liquid 250ml tin pack which will be very helpful to put on weight. She has tried the powder form of this but cannot cope with it but is able to drink from the liquid form. Unfortunately there is an extra charge on top of the prescription for the tin rather than the powder form and I trust that she will urgently be given financial assistance to pay for this because it is crucial for her health and ability to stay alive.'

47. In response to the provisional opinion, Dr C stated that Ms A was unconcerned about her low weight and appetite, did not have a specific nutritional deficiency or underlying cause such as malignancy (confirmed by blood test), and was not underweight enough to require hospitalisation, and her weight loss was not acute. For these reasons, he did not seek specialist advice or refer Ms A for psychological or nutritional help.

48. Dr C acknowledged that he did not strictly comply with the special authority applications and should have recorded the information supporting the applications in the notes.

Opinion — monitoring of Ms A's weight and response to dietary requirements

49. Dr Gee referred to the 'Older Adults Weight and Nutrition Auckland Region Community HealthPathways' in discussing the standard of care for older adults with unintentional weight loss.[20] Dr Gee stated that in accordance with this HealthPathway, she would have expected to see regular weight measurements as part of Ms A's medical assessment, particularly as she was underweight, in addition to documentation regarding past history relating to weight, a dietary history, a full medical examination, and blood tests for

[19] Relevant months are referred to as Months 1–2 to protect privacy.

[20] The guidelines outline the need for measurement of BMI, the consideration of chronic conditions, medications, and dental problems in relation to weight and nutrition concerns, as well as investigations relating to renal and liver function. In terms of management, this includes treating the underlying cause and requesting dietitian assessment if BMI is under 18.5 or unintentional weight loss over 10% in the past three to six months. If weight gain is to be considered, then lifestyle nutritional information is to be provided. If there is not improvement, then supplements such as Complan, Ensure powder or liquid, and Fortisip powder or liquid are to be considered as well as a reassessment of the patient's history and investigations.

investigation. Ms A's weight was not recorded at the medical centre during 2017 and 2019 despite her attending for multiple consultations. Ms A was, however, examined more fully from 10 August 2015 onwards, and the relevant investigations (27 April 2016) were performed during later consultations, although these were not specifically to address the problem of the low BMI recorded at the first consultation in January 2015.

50. Dr Gee considers the absence of a documented history to be a mild departure from the accepted standard of care. While Dr Gee accepted that there were no specific guidelines for the management of Ms A's weight, she is mildly critical that there is no documentation relating to this and concluded: 'Records still need to indicate that monitoring has continued with physical and mental examinations or enquiries performed periodically to confirm conditions remain stable.'

51. Dr Gee noted that there were no attempts to assess, diagnose, or treat the possible underlying causes of Ms A's low BMI, and there was an absence of any nutritional advice and/or referrals to dietitian services. Dr C's management appears to be limited to special authority applications and the prescription of Ensure and Fortisip.

52. Dr Gee noted that while Dr C completed a special authority form for both Ensure and Fortisip, there is no record of him having assessed the criteria (II) and (III) in respect of Ms A as set out in the special authority as required.

53. Dr C has stated that Ms A had complex health needs and there were no specific guidelines for the management of her weight, and that treating Ms A's eating issues would have in turn required psychological treatment directed to Ms A's underlying issue, which he considered to be her PTSD.

54. I consider that Dr C's response is based on several assumptions about the appropriate management of Ms A's weight. While there may have been no specific guidelines to address Ms A's particular complex health needs, I am critical that Dr C appears to have made assumptions about the value of psychological treatment for Ms A and whether a dietitian's advice would have assisted her. Dr C did not seek specialist advice on these matters or make any referrals for Ms A to receive psychological or nutritional support. There is no documented discussion with Ms A or Ms B about his clinical reasoning for not doing more to address Ms A's low BMI.

55. I am also critical that there is no documentation from Dr C as to why there was no treatment plan other than the prescription of Fortisip and Ensure and/or why Ms A's weight was not monitored more closely despite Ms A being seriously underweight for a number of years. I do not accept his reasoning that he considered that Ms B was responsible for weighing Ms A at home or that he considered Ms B to understand what Ms A required in terms of nutrition. The fact remains that Ms A was underweight, with no substantial improvement during this period, and this was also noted by Ms B. There was no treatment plan in place or close monitoring of Ms A's weight, and no discussion with her as to how to manage her low BMI.

56. I am also concerned that Dr C did not assess or record the criteria set out in the special authority for the applications for Fortisip or Ensure. Dr C has explained that he considered that the prerequisites for the special authority application were substantially satisfied, and he does not understand how the adherence to these criteria or otherwise could be said to detract from the standard of care Ms A received, particularly since her weight loss did stabilise for a time after the addition of Ensure to her diet.

57. I do not accept this response. There are clear criteria set out in the application form, and the fact that Dr C did not record his assessment is directly relevant to the issue of the difficulty in determining whether Ms A received an adequate level of care. While Dr C may consider that Ms A's weight had stabilised following the introduction of Ensure, Ms A remained underweight following the addition of Fortisip and Ensure.

58. I will discuss the standard of Dr C's documentation further below.

Management of Ms A's mental health conditions 2015–2019

59. Medical centre records note that Ms A had classifications for PTSD, depression, and anxiety. During 2015 to 2019, Dr C did not refer Ms A for mental health assessments or treatment, and there are no clinical notes relating to the reasoning for not making these referrals.

60. Dr C told HDC that Ms A had suffered from longstanding PTSD, which pre-dated Ms A's time at the medical centre. In addition to PTSD, Dr C said that Ms A experienced mild intellectual disability and borderline intellectual functioning (MID-BIF).

61. Dr C told HDC that Ms A's PTSD manifested in several secondary problems and what Dr C believed to be an unusual presentation of anorexia nervosa, low-level depression, and the more transient periods of anxiety Ms A would experience. Dr C stated that the underlying combination of Ms A's PTSD and MID-BIF substantially constrained the options for treatment.

62. Dr C considers that this position is well illustrated by his documented consideration of the possible treatment options for Ms A's mental health issues. Although Dr C had previously referred Ms A to ACC for counselling for her PTSD and associated issues,[21] he said that he was always conscious of the potential for therapy to be harmful or destabilising to her. Dr C presumed that Ms A had decided not to pursue this line of treatment, as ACC never updated him with any reports from counselling sessions.

63. Dr C told HDC that when Ms B became involved in Ms A's visits in 2015, he learned more details about Ms A's experience, which solidified his view that further intrusions into Ms A's mental health would not be in her best interests. Dr C understood from Ms B that Ms A's experiences had the effect of retraumatising her.

64. Dr C said that Ms A had suffered among the worst abuse of any patients he had encountered and had developed a defence mechanism of holding her traumas locked away, and he

[21] Dr C stated that he had referred Ms A to ACC previously in 2012 and 2014.

considered that he could best contribute to helping Ms A maintain a stable life by facilitating a safe and secure living environment for her.

65. Dr C stated that neither Ms A nor Ms B asked him to refer Ms A to a specialist for mental health assessment or treatment. Ms A herself did not readily discuss mental health issues, and Ms B would not ask him for input into Ms A's mental health care except in the context of advocating for her entitlements from ACC or placement with a residential service provider.

66. In October and November 2015, it was recorded that Ms A had seen Dr C in relation to ACC support for previous trauma and a referral to the Needs Assessment and Service Coordination (NASC) service. Under 'previous history', it was noted that Ms A had PTSD, depression, anxiety, and extensive abuse. On 4 November 2015, Dr C noted the following:

> '[Ms A] is unsafe in the house and the person who has been looking after her needs to go to hospital for a long time in the very near future. She needs at least respite care because she has nowhere else to go as a result of her depression caused by post-traumatic stress disorder. the NASC refuses to accept her for rest home care but this is most likely what she needs.'

67. Ms A had subsequent appointments with Dr C in November and December 2015 relating to the ACC referrals made after the referral to the NASC had been declined. Dr C wrote to ACC on 27 November requesting assistance for arranging rest-home care for Ms A due to PTSD.

68. On 13 February 2017, Ms A was seen by an endocrinologist, Dr F, who queried whether Ms A's depression was connected to Ms A's low BMI and lack of appetite. Dr C did prescribe medication for depression at a later consultation on 20 February 2017, but there are no notes relating to the discussion around, or rationale for, the prescription of antidepressants.

69. Dr C accepts that Ms A's care often focused on the practical social needs related to the consequences of her mental health conditions rather than the medical conditions themselves. Ms A's practical social needs arising from her mental health conditions, along with her physical health needs, were substantial, and Dr C believed that focusing on these is what a patient-centred approach to primary care required in Ms A's case. Dr C said that he monitored perceivable shifts in Ms A's mental state when she presented to him, and he would have taken appropriate action as necessary to protect Ms A's continued safety and wellbeing should the need have arisen.

70. Dr C told HDC that neither the Auckland Region Community HealthPathways 2020, nor the guidelines for PTSD available to him at the relevant time, nor the more recent guidelines Dr Gee has cited, seem to him to provide appropriate management for a patient with a dual diagnosis of PTSD and MID-BIF. Dr C said that recently he reviewed the literature for guidance on treating this combination of conditions, and he considers that these comments illustrate the uncertainty in the profession around employing traditional treatment options for patients with these conditions.

71. Dr C told HDC that his opinion is that psychiatric interventions may have caused Ms A more harm than good, and that the articles make clear that until recently there has been little in the way of research, let alone medical consensus on how to assess and treat patients with PTSD and MID-BIF.

Opinion — management of Ms A's mental health conditions

72. Dr Gee advised that despite Ms A's classifications for PTSD, depression, and anxiety, there is no record related to any medical management of PTSD, nor any notes recording any requests from Ms A for treatment of mental health symptoms or clinical mental health presentations relating to PTSD, nor is there any record of what action was taken following the comments made by Dr F.

73. While Dr Gee accepts that there may have been no guidelines relating to Ms A's complex health issues and Ms A may not have wished to pursue treatment, Dr Gee is critical that there is no documentation in relation to the management of Ms A's mental health conditions and considers this to be a mild departure from the accepted standard of care.

74. Dr C stated that Ms A's PTSD manifested in secondary conditions such as anorexia nervosa, low-level depression, and more transient periods of anxiety, and he considered that psychiatric interventions would have resulted in further trauma for Ms A. He also stated that Ms A did not seek any treatment for her mental health conditions.

75. As I have noted above, Ms A clearly was a vulnerable health consumer and had complex health and social needs. I am concerned that Dr C made assumptions about the treatment (or lack of treatment) of Ms A's mental health conditions without seeking specialist advice or input and without any discussion with Ms A or Ms B about the decision not to address Ms A's PTSD. I note that Dr C did prescribe antidepressants following Ms A's consultation with Dr F but there is no treatment plan or further action taken as a result of Dr F's comments. Given the complex nature of Ms A's health needs, I would have expected Dr C to have sought input from a mental health specialist as to the appropriate management of these conditions. I would also have expected these significant decisions to be discussed with Ms A and Ms B and clinical notes made regarding the management of her mental health conditions. I am critical that none of this was done. I will discuss the standard of Dr C's documentation further below.

76. In response to the provisional opinion, Dr C stated that he believes he managed wraparound care and community-based support reasonably well, and he endeavoured to advocate for Ms A. He also told HDC that he could not think of a better person to look after Ms A than Ms B because of her experience in counselling and looking after people who had experienced abuse. Dr C also explained that there was difficulty in accessing specialist psychiatry care for someone who is covered by ACC.

77. I acknowledge that Dr C did make referrals to ACC, the NASC, and Older Persons, Rehabilitation and Mental Health and Addiction Services for residential care support, and to a kaupapa Māori organisation between 2015 and 2019 on behalf of Ms A, but I consider that

these referrals alone were not sufficient to address or manage Ms A's mental health conditions.

Consultation — 8 Month2

78. Ms A and Ms B were seen by Dr C on 8 Month2, the day before Ms A's death.[22]

Ms B's version of events

79. Ms B told HDC that by this consultation Ms A had become unsteady, was weak in her whole body, and was having difficulty holding up her head. Ms B said that she asked Dr C to refer Ms A to hospital, and he told her to take Ms A to hospital herself, before changing his mind and referring Ms A for blood tests instead.

80. Ms B stated that she took Ms A for a blood test, but Ms A was too cold, and her veins collapsed on the needle. Ms B said that she had to take Ms A home for several hours to warm her up before returning for a blood test, which was successful. Ms B told HDC that Dr C said that he would telephone or text the results in the evening, but she had no contact from him.

Dr C's version of events

81. Dr C told HDC that his notes reflect that Ms A reported that she felt okay in herself and that objectively the only signs were the swollen ankles, and the likely cause was a degree of renal failure or heart failure. In response to the provisional opinion, he said that this was the first time in the months before Ms A died that she had complained of undue shortness of breath or swelling of her legs.

82. Dr C documented the consultation as follows:

> '[Ms A] has chronic lung disease and has always been short of breath but recently she's had to stop walking due to shortness of breath. Just today she is presented with quite marked swelling of both ankles and we need to do some blood tests straight away. She tells us that she feels okay in herself even though her temperature is 34 and she [is] dizzy and weak.'

83. Dr C referred Ms A for blood tests, which included BNP. There is no documentation relating to a treatment plan.

84. Dr C told HDC that his impression was of a degree of renal or heart failure, and that Ms A had had heart failure previously. He stated that if Ms A had said that she felt unwell, he would have referred her to the hospital straight away, and he told Ms B to take Ms A to hospital if she was worried and especially if Ms A got worse. Dr C said that referring Ms A for blood tests was part of his usual practice of sending patients for appropriate investigations before sending them to hospital if necessary. In response to the provisional opinion, Dr C noted that in the context of extreme overload of the Emergency Department,

[22] In his response, Dr C told HDC that this appointment was on 9 Month2. The clinical notes record that the appointment was on 8 Month2.

GPs try to at least do some investigations before sending people to the ED, and they prefer to refer patients to the appropriate service.

85. Dr C told HDC that the blood test results, excluding the BNP result, were sent to the medical centre at 4.28pm on 8 Month2, and it takes at least half an hour to one hour after receipt for them to be available to him in the patient's file or in his inbox. It is recorded in the clinical notes that on 9 Month2, Dr C texted the HbA1c[23] result to Ms A, and in relation to the BNP result, that he left a message on Ms A's phone. Dr C stated that the BNP result (which was high at 2,158) was not reported until 4.25pm on 11 Month2.

86. Dr C stated that the decision on whether to send Ms A to hospital was complicated by the fact that the blood test was taken so late in the day, and he was unable to view all the results until Monday morning (11 Month2). He said that at 8.47am on 11 Month2 he sent Ms A a text stating: '[T]he basic blood tests including how well the kidneys are working are okay so far and we are waiting for the one for heart failure.' At this time, Dr C was unaware that Ms A had been admitted to the public hospital.

Hospital admission

87. Ms A was admitted to the Emergency Department on the morning of 9 Month2 as she had become increasingly unwell. On arrival, Ms A was observed to have a high heart rate, low blood pressure, poor circulation, a low temperature, and a low weight, and it was noted that she had 'minimal air movement' in her chest.

88. Ms A deteriorated and was unable to breathe unless supported by a bag valve mask. Her blood parameters were serious, with high potassium and pH levels. A senior medical officer (SMO) in the Emergency Department informed Ms A's whānau that Ms A would receive end-of-life care. It is documented that the SMO also advised them that Ms A's condition would not have been foreseeable the previous day when Ms A had been reviewed by Dr C.

89. Ms A passed away on 9 Month2 because of decompensated heart failure[24] due to chronic heart failure and hypertension.

Opinion — 8 Month2 consultation

90. Dr Gee advised that Dr C's consultation notes on this occasion record a short clinical history, a description of only two examination findings, and no impression or plan. Dr Gee commented that while it is likely that Dr C's impression was heart failure, Dr C did not document his findings in accordance with the 'Heart Failure' Auckland Region Community HealthPathways.

91. Dr Gee concluded that what Dr C told HDC describes an acceptable management strategy based on his subjective recollection, but that this was not documented fully. Dr Gee also advised that Dr C did not record important negative and positive findings and failed to

[23] The haemoglobin A1c (HbA1c) test measures the amount of blood sugar (glucose) attached to the haemoglobin.

[24] Decompensated heart failure (DHF) is a sudden and severe worsening of heart failure symptoms, such as difficulty breathing, swelling, and fatigue.

provide sufficient information to allow another doctor to arrive at a similar conclusion or be able to justify the management plan. Dr Gee considers this to be moderate to severe departure from the accepted standard of care.

92. Dr C accepts Dr Gee's criticisms of his record-keeping, particularly in not noting all of Ms A's vital signs and his impression and plan in the consultation on 8 Month2. Dr C accepts that the documentation of negative findings could have been useful to the hospital doctors undertaking investigations into Ms A's condition the next day.

93. Dr C said that he had anticipated considering Ms A's situation further upon receipt of her test results in the afternoon of 8 Month2, and he would have updated the consultation note accordingly, but unfortunately the blood results, including the crucial BNP result, could not be reported back on that same day, such that a hospital admission could have been facilitated (prior to her own presentation on 9 Month2).

94. Dr C further stated that while it is correct that the safety-netting advice was not documented, in Ms B's complaint she acknowledged his advice about taking Ms A to hospital.

95. Dr C maintains that he provided an acceptable level of care to Ms A on 8 Month2, including his reasoning for ordering blood tests and his treatment plan. I note Dr Gee's advice is that Dr C did not record important negative and positive findings and failed to provide sufficient information to justify the management plan. I accept this advice and consider that there is no documentation to support the contention that Ms A was managed appropriately at this consultation.

96. In response to the provisional opinion, Dr C submitted that he does not believe that Ms A had slowly progressive heart failure over a period of time, rather her final consultation was a decompensation of her heart function.

Documentation

97. Dr Gee advised that records are an essential part of the provision of a patient's safety and continuity of care. The Medical Council of New Zealand (MCNZ) statement on 'Managing patient records' (2020[25]) (see Appendix B) outlines that practitioners must maintain clear and accurate patient records that note clinical history, including allergies, relevant clinical findings, results of tests and investigations ordered, information given to, and options discussed with, patients (and their family or whānau where appropriate), decisions made and the reasons for them, consent given, requests or concerns discussed during the

[25] Dr Gee refers to the statement that was issued by MCNZ in 2020. The MCNZ statement in place at the time of these events was 'The maintenance and retention of patient records', which was applicable from August 2008 until Month1. This statement includes the requirements of keeping clear and accurate patient records that report relevant clinical findings, decisions made, information given to patients, and drugs or treatments prescribed. In Month1, MCNZ updated the August 2008 statement and re-named it 'Managing patient records'. The Month1 statement was further updated in December 2020 in reference to the 2020 Privacy Act and 2020 Health Information Privacy Code. No changes were made in the December 2020 statement apart from updating the new legislation.

consultation, the proposed management plan, including any follow-up, and medication or treatment prescribed, including adverse reactions.

98. The MCNZ recommends recording information following a structure of *(S) subjective, (O) objective, (A) assessment and (P) plan*. Dr Gee advised that within the medical centre's consultation records there appears to be a template format that includes a structure similar to the above recommendation, but it appears that Dr C has not followed this consistently. Dr C told HDC that omissions of detail in record-keeping would often arise from the substantial time spent advocating for Ms A to receive support from various agencies so that she could maintain a decent quality of life. Dr C considers that it does not follow from these omissions that Ms A did not receive an acceptable standard of care from him.

99. Dr C accepts that ideally every GP's consultation notes should always conform to the MCNZ statement on 'Managing patient records', which lists nine categories of information. Dr C stated that he does not believe that it is possible to do this in every consultation. He said that for both himself and his colleagues, strict adherence at all times to the Medical Council's statement, such as to be able to defend their care against a complaint, would inevitably be at the expense of the time and effort devoted to assessing and managing their patients' problems. However, he said that a balance must be struck, and he accepts Dr Gee's recommendations and intends to upskill in this regard by undertaking an audit of the medical records of his patients with PTSD and undertaking further annual audits using the RNZCGP audit tool.

Opinion

100. As discussed in the sections above, Dr C's level of documentation has fallen well below the standards of both the medical centre's policy on clinical record-keeping and the MCNZ statement on 'Managing patient records'.

101. The medical centre had in place a clinical records policy (Appendix C). The purpose of the policy is to ensure that patient records meet the requirements to describe and support the management of the health care provided in accordance with best practice and statutory requirements. The policy sets out the minimum requirements for history taking as set out in the triage template and includes medical alerts/known drug allergies, examination, assessment/diagnosis, treatment, and follow-up. The policy also highlights the requirement that the examination entails full observations and thorough investigation upon which a working assessment/diagnosis is made.

102. Dr C has accepted that his record-keeping was inadequate, and I am critical that he did not follow the medical centre's clinical record policy or MCNZ's 'Managing patient records' statement. Keeping clear and accurate records is an essential part of the provision of a patient's safety and continuity of care. Furthermore, the lack of documentation has posed challenges in assessing the appropriateness of the care provided to Ms A.

103. As detailed above, I am critical of Dr C's documentation as follows:

a) The lack of documentation relating to treatment plans, impressions, and symptoms concerning Ms A's heart failure;

b) The absence of documentation relating to the management or treatment of Ms A's weight, including Dr C's assessment or impressions of underlying causes and whether the criteria were met on the special authority applications for Fortisip and Ensure;

c) The absence of documentation relating to the medical management of PTSD or mental health symptoms, including Dr C's assessment of Ms A's mental health; and

d) The lack of documentation in relation to the consultation on 8 Month2, including Dr C's reasoning for ordering blood tests and Dr C's treatment plan.

Conclusion

104. I have significant concerns about the standard of care that Dr C provided to Ms A, who was an extremely vulnerable individual. The lack of documentation completed by Dr C does not give me confidence that I can accept his version of events as to the care he provided to Ms A. Based on the HealthPathway assessment and management guidelines, I consider that Ms A's heart failure was not managed appropriately by Dr C, and I am concerned that Dr C made assumptions about the reasons for Ms A's low weight and mental health conditions, and did not do more to investigate, seek specialist input, or support Ms A to manage or resolve these issues.

105. Accordingly, I consider that Dr C did not provide an adequate standard of care regarding Ms A's heart issues, weight management, and mental health conditions, and that as a result, Dr C breached Right 4(1)[26] of the Code.

106. I also consider that Dr C did not comply with professional standards by failing to maintain clear and accurate patient records in relation to Ms A's health issues. Accordingly, I find that Dr C breached Right 4(2)[27] of the Code.

107. In response to the provisional opinion, Dr C said that he has no hesitation in apologising for the significant deficiencies in documentation and for breaching the Code, and he acknowledged that aspects of his care could have been better. Dr C has undertaken to comply with the recommendations set out later in this report.

108. Dr C also acknowledged Ms A's complex health history and told HDC that he endeavoured to provide Ms A with the best possible care and acted only with her interests in mind at all times. He said that he also wanted to ensure that Ms A was in a safe place where she would not be treated badly in the future.

Appropriateness of comments included in documentation — adverse comment

109. On 23 Month1, Dr C sent the following letter to ACC as part of the referral process:

> '[Ms A] is emaciated due to her post-traumatic stress disorder following terrible events in the past which ACC is well aware of and now she is as thin as a Belsen Camper …'

[26] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'
[27] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

110. I find the comparison of a chronically underweight person to that of a victim of the Holocaust to be entirely inappropriate and extremely insensitive. I ask Dr C to reflect on his inclusion of this comment and refrain from using such language in the future.

Opinion: Dr E — adverse comment

111. Dr E saw Ms A on two occasions in June 2016. At the first consultation on 3 June, Dr E noted that Ms A was still coughing (having presented in March to May with a cough), she was short of breath on walking 20 meters, and she had swelling in her feet.

112. Dr E told HDC that following his examination,[28] his diagnosis was COPD, and he added a short-acting antimuscarinic (SAMA) — a medication typically used to treat COPD and asthma — to help with Ms A's symptoms. A plan was made to review Ms A in two weeks' time (which occurred but with a different doctor).

113. Dr E saw Ms A again on 24 June 2016. His examination findings include that Ms A had mild oedema (swelling) of her ankles. Her chest was noted to be clear, but Dr E queried the possibility of congestive heart failure (CHF). Accordingly, Dr E ordered blood tests, including a BNP, and a further review.

114. Three days later, Ms A's BNP level was reported as 177pmol/L — indicative of heart failure. On 28 June 2016, Dr E recorded that congestive heart failure was likely and to consider an angiotensin-converting enzyme (ACE) and a beta-blocker swap[29] from Adalat. Dr E noted: 'Needs echo so will refer for echo.' Ms A was sent a text message to make an appointment to see her GP.

115. A referral for echocardiogram was not made by Dr E. Dr E told HDC that a text and a letter had been sent to Ms A asking her to make an appointment at the medical centre, given there were some issues with Ms A continuing to present at the afterhours clinic rather than making an appointment with a GP. Dr E then recorded on 28 June 2016 (ie, after their appointment) that Ms A should be referred for an echocardiogram.

116. Dr E said that his usual practice was to explain to the patient the reason for the referral (prior to making the referral), as otherwise the patient could get a surprise call and not understand the reason for the referral. Dr E told HDC that he did not make the referral in 2016 as he was waiting until he next saw Ms A (to explain to her the reason for the echocardiogram referral). Dr E did not see Ms A again.

117. The medical centre had a referral tracking policy (see Appendix D) with the purpose being to identify and track potentially significant investigations. The policy states that the staff

[28] Dr E told HDC that Ms A's chest findings were clear, with reduced breath sounds and no crepitations or wheezing, and Ms A was on long-acting beta-agonists (LABA) and short-acting beta-agonists (SABA) to manage her COPD.

[29] Angiotensin-converting enzyme (ACE) inhibitors and beta-blockers are both used for conditions such as high blood pressure and heart failure.

member initiating the referral is responsible for following up and actioning any investigations.

118. Dr E appears not to have undertaken any follow-up in relation to the referral, contrary to the medical centre's policy and despite his note that the referral was needed, and that Dr D had also noted this previously. While I accept that Dr E wished to explain the reasons for a referral to Ms A in person, I am critical that the referral was not followed up or discussed with Ms A at a later consultation. Nor is there any documentation to suggest that the need for a referral was discussed with Ms A's GP, Dr C.

119. Dr Gee advised that Dr E's consultation notes contain omissions for symptom history and omissions of relevant negative symptoms (eg, the absence of orthopnoea[30]) and relevant examination measurements (such as heart rate or rhythm, JVP, or the extent of ankle swelling). However, Dr Gee considers that the notes are probably complete enough in checking signs and symptoms, assessment, and investigations.

120. I accept this advice. In my view, Dr E should have documented Ms A's symptom history more accurately, and he should have included the relevant negative symptoms and the relevant examination measurements.

121. In response to the provisional opinion, Dr E said:

> 'I would like to convey my condolences to the family of [Ms A]. I also appreciate the feedback from HDC and I do accept the HDC's report and recommendations. I have taken the recommendations from the HDC on board, and I will incorporate this in my daily practice.'

Opinion: Dr D — other comment

122. Dr D saw Ms A on 17 June 2016 and noted that a chest X-ray or echocardiogram would be helpful for Ms A.

123. A referral for chest X-ray or echocardiogram was not made. Dr D told HDC that it was not his intention to make a referral in 2016, but he was querying in the notes whether a chest X-ray and/or an echocardiogram would be helpful. Dr D recalls that Ms A's visit on 17 June 2016 was at the afterhours urgent care service. Dr D did not usually work that day but was filling in for Dr E, and Ms A had advised that she wished to see Dr E and noted that she had an appointment with him the following week on 24 June. Dr D said that his note querying whether a chest X-ray or echocardiogram would be helpful was a question to be considered by Dr E, rather than a note confirming the referral. Dr D did not see Ms A again.

124. I am critical that Dr D did not follow up with Dr E on the need for a referral for a chest X-ray and echocardiogram, given that he had documented a possible need for this.

[30] Shortness of breath or difficulty breathing when lying flat.

125. Dr Gee stated that Dr D's consultation notes contain omissions for symptom history and omissions of relevant negative symptoms (eg, the absence of orthopnoea) and relevant examination measurements (such as heart rate or rhythm, JVP, or the extent of ankle swelling). However, Dr Gee considers that the notes are probably complete enough in checking signs and symptoms, assessment, and investigations.

126. I accept this advice. In my view, Dr D should have documented Ms A's symptom history more accurately and included the relevant negative symptoms and the relevant examination measurements.

127. In response to the provisional opinion, Dr D stated:

> 'I would like to extend my sincere condolences to [Ms A's] whānau for their loss. I do accept the HDC's report and recommendations. Upon reflecting on my [note] keeping and discussing about the follow up plan with the colleague, I certainly should have done better. I have taken the recommendations from the HDC on board, and I will incorporate this in my daily practice.'

Opinion: Medical centre — no breach

128. The medical centre was responsible for providing services to Ms A in accordance with the Code. Dr C was employed as a GP at the medical centre at the time of these events.

129. Dr Gee advised that the medical centre had a template within the consultation records that included a structure similar to the MCNZ statement on patient records, and that this was acceptable, but Dr C did not follow the format consistently. At the time of these events, the medical centre also had in place a clinical records policy detailing the patient information required to meet best practice and legislative requirements.

130. In this case, I consider that the deficiencies in Dr C's care were individual failures and therefore I find that the medical centre did not breach the Code.

Changes made since events

Medical centre

131. The medical centre told HDC that as a result of the complaint it was agreed that doctors and healthcare assistants at the medical centre are to complete height, weight, and blood pressure tests on all patients, but especially those who present with a low weight and/or a low or high BMI. This amendment is recorded in the medical centre's updated medical assistant guidelines and has been communicated to all practitioners (across the medical centre's centres) through email and the Microsoft Teams messaging platform, and staff were also reminded at team meetings.

132. Following receipt of the complaint, the medical centre assisted Dr C in undertaking a detailed review of Ms A's care and treatment. The medical centre told HDC that a review of Dr C's clinical notes was completed and, following the review, the medical centre concluded

that Dr C's notes were inadequate and not reflective of the standard of other practitioners at the medical centre.

133. The medical centre told HDC that Dr C has now been provided with dictation software to improve his clinical notes. The dictation software has also been provided to any doctors or healthcare assistants at the medical centre who are struggling to type clinical notes.

Dr C

134. In response to the provisional opinion, Dr C's legal representative stated that Dr C has learnt from this complaint and findings, he has taken the criticisms on board, and he has amended his practice accordingly.

135. Dr C underwent a voluntary preliminary competence enquiry at the request of the Medical Council of New Zealand (MCNZ) as a direct result of the care provided to Ms A. This included a detailed and comprehensive review of his practice and a records review. Dr C also agreed to a voluntary undertaking in which he was supervised by a vocationally registered GP. Dr C's legal representative noted that following these processes, no further action was required by MCNZ, and the supervision was revoked.

136. Dr C stated that this case has been a useful reminder that communication is a critical aspect of care. He reflected that clear and careful communication is especially important with those who are vulnerable.

137. Dr C intends to adopt Dr Gee's recommendations and to undertake a careful audit of the records of his patients with PTSD. Dr C stated that he routinely undertakes the RNZCGP notes audit as part of his continued professional development.

Recommendations

138. I recommend that Dr C:

a) Use this decision (anonymised) as the basis for discussion with his peers on the appropriate threshold for seeking specialist input for patients' conditions that require more than primary care input. Details of the learnings from this discussion should be provided to HDC within three months of the date of this report.

b) Undertake a review of the Auckland Region HealthPathways guidance in the areas of heart failure, mental health, and older adults' weight and nutrition. Confirmation of this review and an explanation of how this guidance will be incorporated into Dr C's practice should be provided to HDC within three months of the date of this report.

c) Undertake an audit of the medical records of 20 of his patients with PTSD, using the 'clinical record self audit checklist' of the Royal New Zealand College of General Practitioners, and report the results of the audit to HDC within three months of the date of this report.

d) Complete the Medical Protection Society eLearning 'Medical Records in Primary Care' modules and the 'Record safely for you and your patient (NZ)' webinar and provide evidence of completion to HDC within three months of the date of this report.

e) Attend workshops such as the 'Medical Protection Society: Achieving Safer and Reliable Practice and Reducing Medicolegal Risk' and provide evidence of completion to HDC within six months of the date of this report.

Follow-up actions

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

140. A copy of this report with details identifying the parties removed, except the independent advisor on this case, will be sent to the Royal New Zealand College of General Practitioners and Te Tāhū Hauora|Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from GP Dr Lynda Gee:

'29 May 2021

Health and Disability Commissioner
Complaint: [Dr C] and [the medical centre]
Ref: C20HDC00289

I have been asked to provide an opinion to the Commissioner on case number C20HDC00289.

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors, and I am not aware of any conflicts of interest.

I have been provided with and reviewed the following documents:

1. Letter of complaint dated 12 February 2020
2. [Dr C's] responses dated 5 September 2020 and 6 December 2020
3. Clinical records from [the medical centre] covering the period 2015 to 2019.

Referral instructions from the Commissioner:

"Please review the enclosed documentation and advise whether you consider the care provided to [Ms A] by [Dr C] and [the medical centre] was reasonable in the circumstances, and why.

In particular, please comment on:

1. Whether [Dr C's] management of [Ms A's] mental health was appropriate.
2. Whether [Dr C's] management of [Ms A's] weight was appropriate, including the adequacy of any referrals completed, and monitoring of her health.
3. Whether any other actions should have been taken in relation to [Ms A's] heart failure.
4. The examination of 8 [Month2], including whether the assessments and treatment plan made was appropriate.
5. Whether [Dr C] took appropriate steps to ensure [Ms A] had adequate wraparound care and community based support.
6. Any other matters in this case that you consider warrant comment.

For each question, please advise:

a. What is the standard of care/accepted practice?

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

c. How would it be viewed by your peers?

d. Recommendations for improvement that may help to prevent a similar occurrence in future."

1. Whether [Dr C's] management of [Ms A's] mental health was appropriate

Review of Clinical Records

1.**"Post-traumatic stress disorder"** (PTSD) is the only mental health condition listed under **Classifications** (page 6) within [Ms A's] general practice clinical notes dated from 1 Jan 2015 to 7 April 2021.

1.1. [Dr C's] Copy of responses letter states: "I initiated her ACC claim on 14-5-2014 for post-traumatic stress disorder due to horrific events in the past."

1.2. In the absence of any ACC form records, I deduce that the PTSD [Dr C] refers to was sustained as a result of … based on consultation notes containing the following information:

1.2.1. 16 Jul 2015 "ACC Lump sum … for Sensitive claim in 1995/96"

1.2.2. 12 Aug 2015 …

1.3. There were no consultations related to any medical management of the PTSD, nor any notes recording any requests from [Ms A] for treatment of mental health symptoms or clinical mental health presentations relating to PTSD.

1.4. [The medical centre's] management of the Sensitive Claim which produced the PTSD related to practical and physical management only:

1.4.1. ACC form renewals

1.4.2. Documentation for additional financial support and information eg:

1.4.2.1. 10 Feb 2015 …

1.4.2.2. 18 Mar 2015 "I have completed form for Independence allowance for her … injuries following serious … abuse over a number of years".

1.4.2.3. 12 Aug 2015 "ACC need to know how bad … was …"

1.4.3. Multiple letters and referrals in support of social issues relating to the need for residential placement (as a result of PTSD) eg:

1.4.3.1. 3 Nov 2015 "She needs a referral to the NASC in order to be considered for going to a rest home …"

1.4.3.2. 17 Nov 2015 "She needs help to get assessed for rest home care and the NASC refuses to do this. I trust ACC will be able to do this for her"

1. **"Impression: 'Anxiety state'** and '**Prev Hx'** (previous history): '**PTSD, depression anxiety states'. Hx extensive abuse"** was recorded by [a] (Nurse Practitioner in training) at consultation dated 4 Nov 2015.

"Impression: PTSD Anxiety and depression" was recorded by [a] (Medical Assistant) at consultation dated 9 Dec

On both occasions:

2.1. The anxiety state was not formally assessed.

2.2 The management was a letter of support to ACC for placement issues.

2. **"Depression, post-traumatic stress disorder"** listed in Summary from Endocrinology Department Outpatients Clinic letter 13 Feb 2017

   1.1. [Dr F], Endocrinologist states:

   "She felt well in herself today, although she did admit that she was depressed and she rated this at 5/10. She said the depression never goes away. At the moment she feels that she is coping well. I note that she is not on medication for depression and I wonder if that is not a factor influencing her appetite and her drive to do things.

   [Ms B] said that although they have got Ensure at home and they follow a very healthy diet, [Ms A] just doesn't want to eat. She mostly sleeps, She smokes a lot and she does not have any appetite. She just wouldn't eat, and they find it difficult to deal with that, since [Ms A] has to do this on her own. I wonder if depression is not at the bottom of all of this, but it is difficult to know."

   3.2. No further comments from [the medical centre] or [Ms A] are made following on from these statements made in this letter.

<u>"What is the standard of care/accepted practice?"</u>

- PTSD, anxiety state and depression are the mental health conditions identified in [Ms A's] medical notes.
- The standard of care/accepted practice for these conditions, as found in the Auckland Region Community HealthPathways[1], includes assessments, screening tools, history taking, monitoring, investigations and targeted management.
- Apart from general baseline and periodic blood test investigations, the focus of care received at [the medical centre] appears to address the practical social needs related to the consequences of the mental health conditions rather than the medical conditions themselves.

"If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?"

- It is possible [Ms A] had already received an adequate standard of care in the past as the PTSD and anxiety state and possibly the depression (although this was not documented) stemmed from abuse sustained many years prior in 1995/96. This information may be in clinical records from care prior to attending [the medical centre] and/or prior to the enclosed period. [Dr C] states "I first saw [Ms A] on 11-2-2013" but the enclosed records begin on 14 Jan 2015.
- As there is an absence of any requests by [Ms A], or any specific mental health symptoms documented in the clinical records, it is possible that [Ms A] did not wish to pursue medical management.

How would this be reviewed by your peers?

- The lack of information in these records would likely lead to the same conclusions above.
- If [Ms A's] mental health has not been addressed in the past then I would expect my peers to agree that this would be viewed as a large departure from the standard of care/accepted practice.

Recommendations for improvement

- Document any prior mental health management received.
- Record current mental health state at regular intervals eg at the consultation at which ACC for PTSD forms are renewed would be appropriate
- Offer medical management and record patient's response to offer, even if declined.

2. Whether [Dr C's] management of [Ms A's] weight was appropriate, including the adequacy of any referrals completed, and monitoring of her health.

Review of Clinical Records

1. [Ms A's] weight was recorded and blood tests ordered at the first consultation at [the medical centre] by Dr … dated 14 Jan 2015.
2. Consultations related to weight:

2.1. 14 Jan 2015 Dr …: "thinly built" wt 36kgs, blood test ordered

2.2. 13 Apr 2015 [Dr C]: Weight measured WE 35, Application for Subsidy by Special Authority (SA form) and prescription for Ensure powder nutritional supplement.

2.3. 10 Aug 2015 [Dr C] "Weight 38.8kg (weighed 35kg 5 weeks ago)", prescription for Ensure.

2.4. 13 Feb 2017 Endocrinology Department [public hospital] Outpatients Clinic letter "Low BMI, weight today 38.1kg, height 158.5cm" listed in Summary:

[Dr F], Endocrinologist, states:

"She felt well in herself today, although she did admit that she was depressed and she rated this at 5/10. She said the depression never goes away. At the moment she feels that she is coping well. I note that she is not on medication for depression and I wonder if that is not a factor influencing her appetite and her drive to do things.

[Ms B] said that although they have got Ensure at home and they follow a very healthy diet, [Ms A] just doesn't want to eat. She mostly sleeps, She smokes a lot and she does not have any appetite. She just wouldn't eat, and they find it difficult to deal with that, since [Ms A] has to do this on her own. I wonder if depression is not at the bottom of all of this, but it is difficult to know."

2.5. 15 Jan 2018 [Dr C] "… eating well but not putting on weight … she certainly is very slim at the moment and has a lot of stress dealing with ACC …", Application for SA form and prescription for Fortisip powder nutritional supplement.

2.6. 1 May 2018 Cardiology Department [public hospital] Outpatients Clinic letter "Low BMI, weight today 35.6kg, height 158.5cm" listed in PROBLEMS: [Cardiologist] states:

"As you know [Ms A] has been on a sickness benefit and stopped working approximately 4 years ago. She used to work as a … Unfortunately she continues to smoke 5–6 cigarettes per day although has cut down from a packet a day some years ago. [Ms A] is adamant she doesn't drink any alcohol. She has a low BMI."

2.7. 5 June 2018 [Dr C]: "here to get a script for Fortisip, we 35.7 …", prescription for Fortisip.

2.8. 25 Jul 2018 Dr …: "Wt 35 No other complain[t]s"

2.9. 19 … 2019 [Dr C]: "… [losing] more weight …" O/E — Underweight", prescription for Fortisip.

2.10. 25 … 2019 [Dr C]: "… BMI is very low needs ensure …" "O/E — Underweight", prescription for Ensure Plus liquid.

2.11. 23 [Month1] [Dr C] "… needs a small pack of Ensure but is provided with big pack which is not good for her. We have written a letter to ACC so that she will get her medication to supplement her food". Letter to ACC.

"What is the standard of care/accepted practice?"

In the "Older Adults Weight and Nutrition" Auckland Region Community HealthPathways[2] all older adults with unintentional weight loss advice includes:

- medical assessment, examination and appropriate investigation including:
- Measurement of BMI

- If weight and nutrition concerns: consider chronic conditions, medications, dental problems
- Investigations if indicated eg FBC, ferritin, CRP, TSH, renal function, liver function

Management:

- Treat underlying cause and request dietician assessment if BMI <18.5 or unintentional weight loss >10% in the past 3 to 6 months.
- If the patient may benefit from weight gain, consider the Food First approach (lifestyle nutritional information) and provide nutrition information.
- If after 4 weeks using the Food First approach there is no improvement, consider oral nutritional supplements
- supermarket/pharmacy supplements eg Complan
- Special Authority supplements eg Ensure Powder, Fortisip Powder, ready mixed liquid forms of Ensure and Fortisip
- Reassess history, examination and investigations
- Advise physical exercise and a range of activities that include the three core components

"If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?"

I consider the absence of regular weight measurements, as part of the medical assessment in a patient with an initial weight of 36kg = BMI of 14.4 classified as "underweight"[2], a significant departure from the accepted standard of care. Over the period 2015–2019 measurements of [Ms A's] weight were performed:

- 2015 x3
- 2016 x2
- 2017 x1 (at hospital clinic)
- 2018 x4 (1x at hospital clinic)

There were no weight measurements at [the medical centre] during the years 2017 or 2019 despite [Ms A] attending for multiple consultations.

I consider the absence of a past history relating to weight, a dietary history, a full medical examination and blood tests for investigation[2] of an underweight patient to be a significant departure from the accepted standard of care. [Ms A] was, however, examined more fully (10 Aug 2015 onwards) and the relevant investigations[2] (27 Apr 2016) were performed during later consultations but these were not specifically to address the problem of the low BMI recorded at the first consultation dated 14 Jan 2015.

I consider [Dr C's] management a significant departure from the accepted standard of care:

- There were no attempts to assess, diagnose or treat any possible underlying causes[2] of [Ms A's] low BMI.
- There was an absence of any nutritional advice and/or referrals to dietary/dietician services[2].
- [Dr C's] management was limited to SA applications for, and the prescription of, the nutritional supplements Ensure and Fortisip, which [Ms A] only qualified for in the first of the three prerequisites:

THE APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY Form SA1859[3] for Standard Supplements (Ensure; Fortisip: …) INITIAL APPLICATION requires that the:

I. Patient is malnourished BMI less than 18.5 AND

II. Patient has not responded to first-line dietary measures over a 4 week period by: increasing their food intake frequency or using high energy foods or using over the counter supplements AND

III. A nutritional goal has been set

[Dr C] failed to fulfil prerequisites II and III.

<u>How would this be reviewed by your peers?</u>

- I would expect my peers would agree with my conclusions but they would accept that some of the recommended assessment strategies or investigations could be dealt with over the course of several consultations but should be as complete as possible.
- The fact that [Ms A's] weight remained stable from the first measurement of 36kg on 14 Jan 2015 to the last recorded 35kgs on 25 Jul 2018 3½ years later, along with the absence of any nutritional deficiencies on blood tests may imply that any further interventions by [Dr C] may have been ineffectual. The brief nutritional history obtained by the hospital specialist on 13 Feb 2017 would support this.
- It is possible that [Ms A] may have always been underweight but there are no records or history to determine this.
- Two possible causes of [Ms A's] low BMI could be Chronic Obstructive Airways Disease (as listed in **Classification** in the records 11 May 2016) and the Left Ventricular Hypertrophy cardiac condition diagnosed at the Cardiology Department clinic on 1 May 2016.

<u>Recommendations for improvement</u>

- Consult and follow guidelines for management of low BMI including referrals to ancillary services
- Monitor weights regularly

- Comply with APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY prerequisites
- Consider and treat potential causes of a low BMI

3. Whether any other actions should have been taken in relation to [Ms A's] heart failure

Review of Clinical Records

Consultations related to heart failure:

1. 3 Jun 2016 [Dr E] "SOb on walking about 20 meters … main concern is swelling in the feet" "Ass COPd" (Chronic Obstructive Pulmonary Disease)

2. 17 Jun 2016 [Dr D] "imp: edema ?nifedipine related ?cor pulmonale nil acute at present …?cxr echo will be helpful ECG next time"

3. 24 Jun 2016 [Dr E] "ass ?CHF", BNP, blood tests and for review

4. 28 Jun 2016 [Dr E]:

   "BNP 177 >100 in 50–70

   … so likely to be CHF" (congestive heart failure), "Consider ACE and B-blocker swap from Adalat.

   TXT to come in and letter sent as well. Needs Echo so will refer for Echo"

5. 20 Feb 2017 [Dr C] "… swelling of the feet and she does have chest signs …", blood tests including BNP ordered.

6. 17 Jan 2018

   6.1. [Dr C] "She has some shortness of breath, swelling of the ankles and raised BNP. She has a murmur consistent with mitral regurgitation and she does get chest pains and we have done a cardiogram which is fairly normal … We've also done a chest x-ray which shows …"

   6.2. [Medical assistant]

   "Impression: heart Failure

   Plan: CXR ECG Blood test and based on the results referral to Cardiologist"

   1.3 X-RAY CHEST PA AND LATERAL CONCLUSION

   "… No CCF." (congestive cardiac failure)

   2. 1 May 2018 [Cardiologist], Cardiology Department outpatients clinic, [public hospital]:

7.1. PROBLEMS:

1. Concentric left ventricular hypertrophy …

7.2 INVESTIGATIONS;

3. The BNP is 309 … suggestive of myocardial dysfunction, probably secondary to the left ventricular hypertrophy

4. Chest x-ray … There is no evidence of congestive heart failure.

7.3 "SUMMARY:

The impression today is that [Ms A] has indication of LVH and the most common reason for this would be hypertension. She has a background history of hypertension and was hypertensive in clinic today. I have started her on a low dose of ACE inhibitor and hope this will improve her hypertension …"

8. 5 Jun 2018 [Dr C] "Here for … heart check …", meds repeated

9. 11 Dec 2018 [Dr C] heart examination performed

10. 8 Nov 2019 [Dr C] "She has chronic lung disease and has always been short of breath but recently she's had to stop walking due to shortness of breath. Just today she is presented with quite marked swelling of both ankles and we need to do some blood tests straight away. She tells us that she feels okay in herself even though her temperature is 34 and she has dizzy and weak", blood test ordered.

"What is the standard of care/accepted practice?"

The "Heart Failure" Auckland Region Community HealthPathways[3] contains an extensive list of Assessment guidelines which include:

- checking signs and symptoms
- assessing causative and underlying factors
- performing an examination and record
- Management guidelines

I believe my peers and I would agree that within each of the categories above, none of us, nor even a cardiologist would complete such a comprehensive checklist. However, I/we would consider that a certain subset of symptoms, signs from an examination and investigations to be more important and indicative to make a diagnosis of heart failure:

- "Typical" symptoms of types of breathlessness, reduced exercise tolerance, ankle swelling
- Examination of the cardiac system including heart sounds and rate, blood pressure, jugular venous pressure (JVP), chest, peripheral oedema (ankle swelling) +/- weight

- Investigations including:
  - blood tests for BNP ("BNP is most useful to 'rule out' the diagnosis of heart failure. Significant confounding effects mean that thresholds for BNP that are absolutely confirmatory of heart failure cannot be established."[3]) + others
  - +/- ECG
  - +/- chest X-ray
  - Arrange echocardiography
  - Arrange cardiology assessment

"If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?"

[Ms A] was attended by three GPs at [the medical centre] for consultations related to heart failure (or symptoms which may have been due to heart failure). I consider all of the consultations to contain some departure from the accepted standard of care:

- [Dr C's] and [Dr D's] consultations contain some omissions of symptom history taking (eg duration of shortness of breath) and omissions of relevant negative symptoms (eg the absence of orthopnoea) and relevant examination measurements (eg heart rate or rhythm or JVP or extent of ankle swelling) but I consider they are probably complete enough in checking signs and symptoms, assessment and investigations and comparable to our peers.
- [Dr C's] consultations contain many omissions of symptom history taking (eg duration or presence of shortness of breath) and omissions of relevant negative symptoms (eg the absence of orthopnoea) and a lack of many relevant examination measurements (eg heart rate and rhythm and JVP and extent of ankle swelling). His impression/assessments and management plans are unclear. The consultation notes do not maintain a clear and systematic record. I consider this to be a significant departure from the accepted standard of care.
- The last consultation on record for assessment of heart failure will be addressed below

Despite some departure in the standard of care of assessments and examinations during the consultations, [Ms A] was referred for the appropriate investigations and services in 2018 at which point the cardiologist did not diagnose heart failure but another heart condition.

How would this be reviewed by your peers?

- I would expect my peers to agree that the consultations are lacking many important details but we all understand that consultation time sometimes does not allow for as full an assessment as ideal leading to some brevity of history taking, possibly omission of one or two examination assessments (or omission of annotations) but it is important to document a clear plan of management.

Recommendations for improvement

- More complete records of subjective and objective (examination) measurements relevant to the presenting complaint/s

4. The examination of 8 [Month2], including whether the assessments and treatment plan was appropriate.

Review of Clinical Records — entire consultation:

8 Nov 2019 [Dr C] "She has chronic lung disease and has always been short of breath but recently she's had to stop walking due to shortness of breath. Just today she is presented with quite marked swelling of both ankles and we need to do some blood tests straight away. She tells us that she feels okay in herself even though her temperature is 34 and she has dizzy and weak"

Bloods tests ordered: HbA1c, Bnp (nt Pro), CEA, Tfts, Iron Studies, General Chem, Cbc, Crp, B12 And Folate

Bnp (nt Pro) — "Left a message on the answerphone — from [Dr C]"

This consultation documents:

- a short clinical history
- a description of only two examination findings
- No impression or plan

"What is the standard of care/accepted practice?"

In my opinion, [Dr C's] greatest departure from the standard of accepted practice is:

- his failure to maintain clear and accurate patient records throughout [Ms A's] records.

The Medical Council of New Zealand (MCNZ), "Managing patient records" statement 2020[4] requires that:

Maintaining clear and accurate patient records

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 (and their family or whānau where appropriate)

e decisions made and the reasons for them

f consent given

g requests or concerns discussed during the consultation

h the proposed management plan including any follow-up

i medication or treatment prescribed including adverse reactions.

MCNZ recommended format from Cole's Medical Practice in New Zealand 2017[5]:

Structures for recording information usually follow a pattern of (S) subjective, (O) objective, (A) assessment and (P) plan.

- I note within the [medical centre's] consultation records that there appears to be a template format which includes a structure similar to the above recommendation:

  Complaints/Past Hx/Allergies/Examination/Impression/Plan (see consult 13 May 2015)

  but this template was not used consistently or when used, in particular by [Dr C], much of the information is absent or the template areas are blank.

- I deduce that [Dr C's] likely impression is that of heart failure, for which the accepted standard of care is described in the above section 3. There is a large departure from the accepted standard of care in particular:
  - An incomplete record of vital examination findings
  - A lack of documentation of impression or plan

Cole's Medical Practice in New Zealand 2017[5] states:

A common error found in clinical notes is failure to record important negative findings. This particularly applies to vital signs. A record showing that there was no fever, a normal pulse, blood pressure and respiratory rate and a normal oxygen saturation is very useful information if the patient subsequently deteriorates and the doctor is criticised for not taking a more proactive stance at the time of the consultation.

- I am unable to assess whether [Dr C's] treatment plan was appropriate, as [Dr C] has insufficiently recorded important examination findings which would allow me to determine the severity of the symptoms nor has he documented the diagnosis or management plan

Cole's Medical Practice in New Zealand 2017[5] states:

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?

- [Dr C's] "Copy of responses" statements related to this consultation, describes an acceptable (but not fully documented) management strategy based on his subjective recollection. He states "I did tell her to take [Ms A] there (hospital) herself if she was worried, and especially if she got worse." but this was not documented.

How would this be viewed by your peers?

- I would be certain that my peers would agree that [Dr C] has not maintained clear and accurate patient records for this (and other) consultations
- Structured consultation notes is important
- [Dr C] has made the error of failing to record important negative and positive findings
- [Dr C] has failed to provide sufficient information to allow another doctor to arrive at a similar conclusion or be able to justify the management plan

Recommendations for improvement

- Read, familiarise and accept responsibilities outlined in The Medical Council of New Zealand, "Managing patient records" statement 2020[4]
- Use a consultation structure similar to that described in Cole's Medical Practice in New Zealand 2017[5]:
- Consider notes review by peers or colleagues to critique quality of consultation records
- Discuss consultation with peer group for feedback

5. Whether [Dr C] took appropriate steps to ensure [Ms A] had adequate wraparound care and community based support

Review of Clinical Records

1. [Dr C]/[the medical centre] wrote multiple requests in support of community based support including:

    1.1. ACC sensitive claim application

    1.2. WINZ Independence Allowance form

    1.3. ACC lump sum form

    1.4. ACC letters for further information

    1.5. [NASC] referral for residential care

    1.6. Mental Health referral for residential care support

    1.7. Letters of support for accommodation

    1.8. ACC letters for residential care

    1.9. Older Persons and Rehabilitation referral

    1.10. ACC letter for dietary supplements

2. [Dr C] referred to appropriate secondary services

   2.1. Foot X-ray

   2.2. Orthopaedic surgeon

   2.3. Facial bones X-ray

   2.4. Chest X-ray

   2.5. Cardiology outpatients clinic [Public hospital]

   2.6. Older Persons and Rehabilitation referral

3. [The medical centre] performed routine screening procedures regularly

   3.1. Smoking cessation advice given

   3.2. Smoking cessation support

   3.3. Smear recalls

   3.4. Mammogram screening

I consider this meets an acceptable standard of care.

6. Any other matters in this case that you consider warrant comment

In the Copy of complaint submitted by [Ms B], she states:

My perception …:

- "This GP had no care for the wellbeing of my protege"
- "He has always been indifferent in our dealings …" "… his apathy was appalling"
- "… he had not developed any empathy for her."

These appear to address difficulties encountered with communication and the perceived lack of empathy rather than the medical management of conditions. How [Dr C] conveyed information, the manner of his interactions and the empathy he had for [Ms A] is almost impossible to determine from medical records, and is outside the scope of the advice requested.

Dr Lynda Gee
BHB, MBChB, Dip Paeds, Dip Obs, FRNZCGP (1999)

REFERENCES

1. Auckland Regional HealthPathways:
Post-Traumatic Stress Disorder
https://aucklandregion.communityhealthpathways.org/124589.htm
Anxiety in Adults: Generalised Anxiety Disorder screening assessment
https://aucklandregion.communityhealthpathways.org/50595.htm
Depression in Adults and Older Persons
https://aucklandregion.communityhealthpathways.org/48351.htm

2. Auckland Regional HealthPathways:
Older Adults Weight and Nutrition
https://aucklandregion.communityhealthpathways.org/31470.htm

3. THE APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY Form SA1859
https://schedule.pharmac.govt.nz/2021/06/01/SA1859.pdf

4. The Medical Council of New Zealand, "Managing patient records" statement
DECEMBER 2020
https://www.mcnz.org.nz/assets/standards/0c24a75f7b/Maintenance-patient-records. pdf

5. Cole's Medical Practice in New Zealand 2017:
Chapter 6 Page 114 "The purpose of the medical record and notes"
https://www.mcnz.org.nz/assets/standards/da3a9995b9/Coles-Medical-Practice-in-N ew-Zealand.pdf

Nb: Although do not practice in the Auckland District, guidelines in regions outside Auckland would not vary significantly.

Health and Disability Commissioner

Complaint: [Dr C] and [the medical centre]

Ref: C20HDC00289

I have been asked to review new information and confirm whether it causes me to make any changes to the conclusions drawn in my report dated May 2021.

I have been provided with and reviewed the following documents:

1. [Dr C] — final response to HDC 14 Jan 2022
2. [Dr E] (letter to the HDC) 1 Nov 2021
3. [Dr D] (letter to the HDC) 28 Oct 2021
4. Response to the HDC (25 November 2021) [medical centre] lawyers

I have no doubt that [Ms A] had many needs as a consequence of her complex history but absence of documentation of previous treatments (or reference to), baseline recordings, a more full documentation of the patient's complexities and GP's assumptions/thinking at the time of consultations makes for a more difficult assessment of the care provided. Recollections and undocumented statements

regarding care are likely to be less reliable than notes recorded at the actual time of the consultations.

[Dr C's] latest letter outlines an extensive background history and personal insights into his approach to [Ms A's] care, including practical and advocacy care management. Taking this into account, I shall revise these statements from my previous report:

1. Whether [Dr C's] management of [Ms A's] mental health was appropriate

- The lack of information in these records would likely lead to the same conclusions above.
- If [Ms A's] mental health has not been addressed in the past then I would expect my peers to agree that this would be viewed as a large departure from the standard of care/accepted practice.

2. Whether [Dr C's] management of [Ms A's] weight was appropriate, including the adequacy of any referrals completed, and monitoring of her health.

I consider [Dr C's] management a significant departure from the accepted standard of care.

I consider the management mild departures from the accepted standard of care. Records still need to indicate that monitoring has continued with physical and mental examinations or enquiries performed periodically to confirm conditions remain stable. I acknowledge that specific guidelines may not have been available.

Regarding: THE APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY Form SA1859 (for the prescribing of the nutritional supplement Ensure and Fortisip). To clarify, the Pharmac website states:

- Pharmac sets specific criteria that must be met before some medicines will be funded. We do this to ensure medicines are targeted to those who would benefit most from treatment.
- In order to receive a Subsidy for a Community Pharmaceutical, all relevant requirements of these rules must be observed in each case.
- Users of these rules should be aware that there are other requirements relating to the prescribing, dispensing, and Giving, of Pharmaceuticals including legislative and regulatory requirements, as well as contractual obligations.

The regulatory criteria required to fulfil an application for special authority medications usually correlates with best practice care. Adherence ensures management with the appropriate clinical strategies prior to the use of medications requiring a special authority. Practitioners are required to complete the Special Authority Forms declaring that these prior strategies have been attempted.

As to these statements from my previous report:

3. Whether any other actions should have been taken in relation to [Ms A's] heart failure

- The consultation notes do not maintain a clear and systematic record. I consider this to be a significant departure from the accepted standard of care.

4. The examination of 8 [Month2], including whether the assessments and treatment plan was appropriate.

In my opinion, [Dr C's] greatest departure from the standard of accepted practice is:

- his failure to maintain clear and accurate patient records throughout [Ms A's] records. I shall redefine these as moderate–severe departures from the accepted standard of care.

The main issue is the paucity of history, examination findings and impressions recorded in the medical records of a large number of [Dr C's] consultations, including that of [Ms A's] last consultation where lack of documentation makes it impossible to determine the quality of care [Ms A] received and whether appropriate management occurred.

Large numbers of challenging patients undoubtedly negatively impacts on the time a practitioner has to record good quality notes, however, as they are a transcript of the care provided, scant notes yield insufficient information about the adequacy of the care received. Time, or other strategies, must be made available to perform this duty to an acceptable standard. Records are an essential part of the provision of a patient's safety and continuity of care.

The Medical Council stipulates:

- You must maintain clear and accurate patient records.
- Patient records reflect a doctor's reasoning and are an important source of information about a patient's care. Patient records are a crucial part of medical practice. They help ensure good care of patients and clear communication between doctors and other health practitioners.

[Dr C] has acknowledged that his documentation did not provide a certain level of detail and contained omissions. It is commendable that [the medical centre] conducted a notes review (which concluded that [Dr C's] notes were inadequate compared with his colleagues within the practice), have introduced … voice-to-text software and will undertake annual clinical notes audits. I also recommend [Dr C] undertake a two round clinical notes audit and consider further education such as the Medical Protection Society eLearning Medical Records in Primary Care modules and Record safely for you and your patient (NZ) — Recorded Webinar.

The complainant expressed dissatisfaction with [Dr C's] manner which she claimed to have observed over a number of years. I recommend [Dr C] undertake a patient satisfaction survey to assess the general level of satisfaction among his patients.

Attending workshops such as the Medical Protection Society: Achieving Safer and Reliable Practice and Reducing Medicolegal Risk may provide awareness and tools to assist with managing patient expectations.

Dr Lynda Gee
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Appendix B: Medical Council of New Zealand —The maintenance and retention of patient records August 2008

Introduction

Records form an integral part of any medical practice; they help ensure good care for patients and also become critical in any future dispute or investigation.

01 Maintaining patient records[1]

(a) You must keep clear and accurate patient records that report:

- relevant clinical findings
- decisions made
- information given to patients
- any drugs or other treatment prescribed.

(b) Make these records at the same time as the events you are recording or as soon as possible afterwards.

02 Practice systems

(a) Council recommends that every practitioner has access to systems for recall of patients who need regular checks or treatment.

(b) Doctors should have systems in place to ensure that test results are acted upon in a timely manner, including notification of patients as appropriate.

03 Fees and patient records

(a) Section 22F of the Health Act 1956 states that transfer of patient records cannot be refused because of money owing or conflicting commercial interests.

(b) A patient or representative of the patient cannot be charged for copies of his or her records unless they have previously requested the information within the past year. Video recordings, x-rays and CAT scans are exceptions to this rule.[2]

(c) Patients have a right of access to information in their records because the information belongs to the patient, whereas the record belongs to the doctor.[3]

(d) When sending information to patients it is advisable to ask the patient what method is preferred because message services, facsimiles and e-mails are not always secure.

[1] Refer to *Good medical practice*. Cole's Medical Practice in New Zealand contains further guidance on record management.
[2] Part III (6) Health Information Privacy Code 1994
[3] There may be situations where a doctor feels it is unwise to provide access to all the information. Rule 11 of the Health Information Privacy Code 1994 provides situations where a doctor may not have to disclose all health information about the patient.

04 Transferring patient records

(a) It is advisable to transfer patient records using some form of registered mail so that tracing the records is possible if they go missing in the mail.

(b) The Medical Protection Society strongly recommends that medical practitioners retain a copy or summary of any patient records that are transferred, for subsequent reference, particularly if there may be disciplinary action to follow.

05 Retaining patient records

How long should PHOs, private hospitals and doctors in private practice keep patient records?

(a) The Health (Retention of Health Information) Regulations (*the Regulations*) outline the legal requirements for the retention of patient records by PHOs, private hospitals and doctors in private practice. The regulations state that all records must be retained for a minimum of 10 years from the day following the last date of the patient consultation.

(b) Retention of records for longer than the minimum 10 years is recommended for children with significant problems or patients with conditions in paediatrics, psychiatry, obstetrics and gynaecology, orthopaedics or other problems likely to persist in the long-term.

(c) The Regulations state that health information does not have to be retained in any particular form. If the material on which the health information is contained will deteriorate before the minimum 10-year retention period, it is sufficient compliance for an accurate summary, or interpretation of that information to be made and retained.

How long should DHBs keep patient records?

(d) Under the Public Records Act 2005 most records held by government agencies (including patient records held by DHBs) are public records and may not be disposed of (whether by transfer, destruction, alteration, sale or discharge) without the authorisation of the Chief Archivist. DHBs should contact Archives New Zealand for information regarding authorisation for disposal of records and, in any case, once they reach 25 years of age.

Planning for retirement

(e) Meeting all the requirements for the retention of patient records can be difficult, especially for sole practitioners, who form a large section of the medical workforce. Before retiring doctors should:

* make prior arrangement for another practitioner to accept responsibility for them (through power of attorney); and/or
* arrange for patients to pick up their own records.

The important thing is to make some arrangement well before retirement

(f) The Regulations state that when a patient dies a doctor may transfer the record to the representative of the deceased.

(g) In the situation where arrangements have not been made for the retention of patient records and the doctor dies, the Executor of the estate or Power of Attorney should endeavour to return records to the patient (the patient's family if the patient is dead), or another doctor.

06 Storage requirements

(a) The Health Information Privacy Code 1994 outlines the requirements for storage of patient records.

(b) Patient records should be filed securely and away from public areas but also be easily accessible in case a request is received for a copy. They should only be visible and accessible to appropriate members of staff.

Computer files must be protected by password and have backups in case of technical difficulties.

07 Destruction of patient records

(a) Destruction of a patient record must be done in such a manner as to preserve the privacy of the patient. Burning or shredding the documents is acceptable and there are security companies that destroy documents.

Notes:

Contact the Privacy Commission for any information about the storage, transfer and privacy of patient records: 0800 803 909. *On the Record* is a useful guide about privacy of health information and is available from the Commission.

Relevant legislation

- Health Act 1956
- Health (Retention of Health Information) Regulations 1996 Health Information Privacy Code 1994
- Code of Health and Disability Services Consumers' Rights August 2001
- Amended October 2005 and August 2008

This statement is scheduled for review by August 2013. Legislative changes may make this statement obsolete before this review date.

Medical Council of New Zealand — Managing patient records

Introduction

Patient records reflect a doctor's reasoning and are an important source of information about a patient's care.

Patient records are a crucial part of medical practice. They help ensure good care of patients and clear communication between doctors and other health practitioners.

Health information is confidential and sensitive. This statement refers to the Health Information Privacy Code 1994,[1] which sets out how health information, including patient records, should be handled. Health agencies (including doctors)[2] must comply with the 12 rules of the Code.

This statement also sets out the legal requirements for maintaining, storing and destroying patient records. It applies to any patient records you make whether that is on paper or electronically.

Maintaining clear and accurate patient records[3]

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 (and their family or whānau[4] where appropriate)
- e decisions made and the reasons for them
- f consent given[5]
- g requests or concerns discussed during the consultation
- h the proposed management plan including any follow-up
- i medication or treatment prescribed including adverse reactions.

2 It is good practice to record information that may be relevant during the patient's health-care journey. Relevant information could include their next of kin, donor status, and whether the patient has a disability, health passport,[6] advance care plan, or an enduring power of attorney.

3 Records must be completed at the time of the events you are recording, or as soon as possible afterwards.

4 Your record about the patient must be accurate and respectful. Consider the impact on the patient when they read what is written about them.

5 Your records must be easy to understand and sufficient for other doctors and health practitioners to follow up.

6 If you need to correct or add notes to your patient's records sometime after an event, these must be clearly identified as corrections or additions. The notes must be initialled or signed, and accurately dated as to when the changes were made. The earlier entry must not be changed or deleted as that might raise suspicion about covering up an error in treatment or diagnosis.

When a patient is referred for a test or to another doctor or health provider

9 Sometimes, you may need to refer your patient to another doctor or health provider, or to request a test or investigation. This information must be documented in your patient's records. We recommend that you use a system for recalling patients who need regular checks, investigations, or treatment.

If you are a doctor making a referral or request

10 You should have systems in place to follow up:

a test results promptly including informing the patient about the results

b referrals that are not actioned, or if there is an unreasonable delay for the patient to see the health provider you have referred them to.

If you are a doctor receiving a referral or request

11 You should have systems in place to:

a acknowledge that you have received referrals

b process referrals within a reasonable timeframe

c communicate with the referring doctor about the referral.[9]

[1] The Health Information Privacy Code 1994 is a regulation under the Privacy Act 1993. The 12 rules of the Code are consistent with the Privacy Act.

[2] Refer to clause 4(2) of the Health Information Privacy Code for a full definition of 'health agency'.

[3] Refer to *Good medical practice. Cole's medical practice in New Zealand* contains further guidance on record management and patient access to information.

[4] Whānau refers to the extended family and family group.

[5] See Right 7(6) of the Code of Health and Disability Services Consumers' Rights which outlines several instances where the patient's consent must be in writing.

[6] A Health Passport is a booklet the patient brings to hospital or when they use a health or disability service. It is intended to guide health and disability providers on communicating with and supporting the patient. See the Ministry of Health's website (https://www.health.govt.nz/your-health/services-and-support/health-care-services/health-passport) for more information.

[7] The New Zealand Medical Association and New Zealand Private Surgical Hospitals Association have issued a guide on key ethical and legal issues to be aware of before using a personal mobile device to take or transmit

clinical images of patients. See *Clinical images and the use of personal mobile devices: A guide for medical students and doctors* for more information.

[8] See also the statement on *Non-treating doctors performing medical assessments of patients for third parties.*

[9] See also the statement on *Safe practice in an environment of resource limitation* that discusses assessing referrals and assigning priority to patients.

Appendix C: Medical centre — Clinical records

AFE Indicator 21 Patient records meet requirements to describe and support the management of health care provided

Urgent Care 2015: 3.7 The service user medical records detail each consultation episode in accordance with best practice and statutory requirements

1. Criteria

1.1 Patient records contain information to identify the patient and document — the reason(s) for the visit, relevant examination and assessment, management, progress and outcomes (management, progress and outcomes (management/risk factors/screening/continuity/referral/tests/investigations)

1.2 The service provider shall maintain a medical record of each consultation episode with sufficient information to describe the consultation and meeting current best practice and legislative requirements

1.3 The Clinical Notes Audit template is to be used for completion of a clinical note audit.

2. Standards

★★ Aiming for Excellence July 2016
★ RNZCUC Urgent Care Standard 2015

3. Procedure

3.1 Each new patient that attends our clinic is allocated a unique identification filing number. This number is on the F3 screen that also contains all identifying markers for the patient, including full name, date of birth, address and NHI number. All patient search processes involve either the file number (if known), the NHI number and or the name and DOB

3.2 Clinical notes are the responsibility of the doctor and nurse who attended to the patient. In the **history** taking the following is the minimum requirement as set out in the triage template

— history
— medical alerts/known drug allergies
— examination
— assessment/diagnosis
— treatment
— follow-up

Additional information if applicable as follows

— consent
— diagnostic tests and results
— referrals made
— progress
— unique ID alerts
— surgical records

— transfer letters
— letters from secondary care providers
— letters from referrers

3.3 The **examination** entails full observations and thorough investigation upon which a working assessment/diagnosis is made. Transfer letters are attached to the medical desk-top of the patient and a letter is given to the patient to inform them of a procedure to follow should the referral not be actioned. Appropriate **investigations** are conducted, and relevant **treatment** administered. Appropriate **follow-up** is arranged as necessary.

3.4 Consent for all procedures is obtained after full explanation of the procedure is given. The consent form is then signed by the patient and scanned to their file

3.5 Each clinician must have completed a medical record review of 15 patient files within a six-month care period for Urgent Care doctors and on an annual basis for General Practice Patients

3.6 Patients are entitled to include their comments in the health record. Parents do not have the unreserved right to view or discuss their child's health record. Where there are custody disputes the medical practitioner must establish who the custodian is before disclosure

3.7 As part of the consultation

— Ensure any new allergies are recorded into the medical warning screen
— Use read codes classifications to record diagnosis or care
— Ensure the pt dashboard is open and any overdue recalls are discussed/actioned

3.8 All clinical records shall identify the care provider (initials of attending nurse, computerised link to the logged on provider that is colour coded for assisting the provider with name identification), be accurate and not defaced in any manner, be a permanent record (security locked after seven days), be objective and factual, use only approved abbreviations (kept in front of policy folder) and be dated.

— The attending provider is to ensure that the data entry is under his name
— Clinical records pertaining to visits within past twelve months are to be readily available.

4. References

4.1 NZS Health Records NZS 8153:2002
4.2 NZS 8151:2004 Accident & Medical Standards
4.3 Health (retention of information) Regulations 1996
4.4 NZMA Good Medical Practice A Guide for Doctors
4.5 Good fellow Legal Issues Resource: Patient health information, collection of information, security and safeguards, physical security, systems the medical record
4.6 NZ Health information Service

5. Useful websites

www.rnzcgp.org.nz

Any breaches of this policy are linked to the Harm Reduction Policy.

Appendix D: Medical centre — Referral tracking

AFE indicator 23.4: The practice can demonstrate how they identify and track potentially significant investigations and urgent referrals

5. Criteria

   a. The Clinic has a documented referral tracking process.
   b. The practice can provide evidence of effective electronic linkages between the practice and secondary care interfaces.

6. Standards

   **Aiming for Excellence July 2016

   + RNZCUC Urgent Care Standard 2015

7. Policy

   To provide specialised services to patients to increase accuracy of diagnosis and treatment when it is deemed necessary and/or taking into consideration the request of individual patients.

   The co-ordination and continuity of care is a vital aspect of patient care in the primary sector.

   To ensure that there is a 'close-out' for every patient that has a referral made through [the medical centre].

   The staff member initiating the referral, or a clearly designated employee, is responsible for following up and actioning any investigations or referrals made in a timely manner.

8. Responsibilities

   The Operations Manager is responsible for ensuring the criteria are met and that the effectiveness of links with other key providers is evaluated. The Operations Manager may delegate the responsibility for monitoring and auditing these criteria.

9. Referral status

   - The referral has been initiated but no appointment has been scheduled;
   - The referral appointment has been scheduled but the patient has not received appointment;
   - The referral has been accepted but the patient is unable to be contacted to confirm appointment
   - The referral has been initiated but was declined
   - The appointment has been made but the patient did not arrive
   - Referral has been acknowledged and the appointment has been made

10. Procedure

    a. All significant results (those where subsequent follow up is essential and the risk of not following up with the patient is high) are to be followed up in a timely

manner. The urgency of the follow up will be entirely dependent on the received result.

b. All referrals must include appropriate patient and clinical information. Minimum requirements are

- Up to date patient demographic information
- Medication and allergies
- Medical summary
- Progress notes
- Reason for referral
- Diagnosis
- Referral marked as routine, semi-urgent or urgent

c. [The medical centre] has a list of selected external providers on a contact list within Med-tech Evolution.

d. All staff are shown, as part of their orientation programme, our electronic referral links.

- Referrals sent through 'Specialist Search & Referrals' have a link at the bottom of the referral to allow the provider to have a reminder task sent to their personal task box
- Referrals to our District Health Board are made through Best Practice who send an automated response on acknowledgement of referral
- Any problems with assessing outside providers is highlighted and discussed at management meetings

e. All pathology and radiology investigations ordered through the outbox have an automated task box reminder sent.

f. A fax is sent to the relevant clinic if there are any abnormal results. These faxes are read by the registered nurse on duty and brought to the attention of the ordering clinician

g. Any abnormal pathology results are colour coded red in the providers inbox

h. [The medical centre] has the following services available for our clinicians to assist with patient care

- Shared Electronic Health
- InterRai
- Clinical workstation
- Radiology services links on desktops
- Pathology associates

11. Outcome measures

a. There is a contact and referral list available.
b. Any areas of non-conformance are linked to the Incident Management system.