Lessons to be learned from Commissioner's findings

The Health & Disability Commissioner has begun to send the the findings of specific cases to the College of GPs in order to allow an educational opportunity for its members. These cases have been reviewed by Dr Philip Jacobs who is on the Executive of Council and Cathy Webber, Senior Policy Analyst at the College office, and some educational points raised. The commentary presented is a brief summary and some questions are raised for discussion. Further peer discussion around these cases is encouraged and any feedback gratefully received to cw@rnzcgp.org.nz

Case 99HDC13046

This is a case where a GP failed to diagnose a case of haemachromatosis. The man was suffering from vague symptoms of lethargy and anxiety and had arthritic pain. He also had a mild anaemia, abnormal lipids and liver function tests, a high iron saturation, a very high ferritin level and mildly elevated blood sugar. The GP treated the mild anaemia with iron supplements on two separate occasions.

Haemachromatosis is an insidious disease that can present in a number of guises. Its incidence in the general population is much higher than previously thought. The diagnosis must be excluded in all new diabetics and considered in existing ones. Also considered in those with atypical arthritidies or abnormal liver function tests. The treatment by regular venesection at an early stage can prevent diabetes, destructive arthritis, cardiac and liver failure. Genetic studies in family members will pick up those at risk and generate appropriate surveillance with timely treatment.

The Health and Disability Commissioner (H DC) considered:

1 The GP breached right 4(1) and (2) (Right to have services provided with reasonable care and skill and right to have services provided that comply with legal, professional, ethical and other relevant standards) in that the GP did not *manage* the patients abnormal blood test results in an appropriate manner, that is:

- € The protocol of three abnormal blood tests requiring action was unacceptable practice.
- Prescribing iron tablets when the patient had a significantly elevated iron saturation was inappropriate.
- Patient medical record keeping did not meet the requirements laid out by the Medical Council in *Good Medical Practice - a guide for doctors (2000) MCNZ*

4. The GP breached Right 6(1)(f) (Right to information that a reasonable consumer, in that consumer's circumstances would expect to receive, including the results of tests) in that the GP did not adequately follow up the results and did not explain the significance of them to the patient.

The actions resulting from the opinion were:

1 A referral of the matter to the Director of Proceedings.

2 A recommendation to the Medical Council that the GPs competence be reviewed.

3 The GP write an apology to the patient.

4. The GP review their practice to ensure that abnormal blood test results are followed up in a timely and appropriate manner and are properly explained to patients and ensure that test results are accurately and comprehensively recorded in patient notes.

5. The GP amends their record keeping to ensure clear, accurate and contemporaneous records are kept which record the relevant clinical findings, decisions made, information given to patients and any drugs or other treatment provided.

Case 99HDC01756

This is a case where a 32 year old woman died suddenly of a pulmonary embolus. She was on a third generation oral contraceptive (OC) at the time of her death. She had been on the same OC for at least 5 years. She had no obvious risk factors but her father had suffered a myocardial infarction. She was not obese and did not have any history of recent surgery or prolonged travel.

The case against the GP in question was argued on two counts:

1 The practice system of providing repeat prescriptions allowed the

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patient to receive a script for a third generation OC without specifically being seen to review the contraception options. In particular, this was at a time when very real concern was being expressed about the increased incidence of thrombotic events. The patient had been seen within that time but for intercurrent illness, and no mention was made of discussion re risks of third generation OCs.

2 The GP failed to specifically recognise the recommendations coming from the Ministry of Health (MOH) and should have insisted that the woman have a consultation specifically to discuss the risks and record weight and blood pressure.

Please note that:

1 The repeat script was issued at a time when a locum was in place on more than one occasion; and
2 The woman had been instructed at an earlier visit that she should attend the surgery for a well woman's check but never did.

This is a tragic case where a young person has died possibly as a result of being on a third generation OC. The GP argued strongly that, yes the system had failed to warn the patient and allow her to make an informed choice, but the patient had not followed up advice to attend for a check up and rang for a repeat prescription without choosing to have a consultation. The medical advisors to the HDC varied in their responses to this case and the decision to find against the GP was in part based on the advice of an epidemiologist who reviewed the information from the MOH at that time.

This is a landmark case and the full transcript should be reviewed at peer group meetings around the country. The transcript is available on the Commisioner's web site www.hdc.org.nz. Issues that may be discussed:

1 Who would be liable if the woman had attended as directed, the risks of the medication explained and chose to stay on the OC and subsequently died?
2 Rules concerning the issuing of repeat prescriptions at a practice level. What is safe practise in this area and how do we balance the need of the GP to ensure safe prescribing with the wish of the patient to avoid the cost and inconvenience of a consultation?
3 The liability of the prescribing GP where a patient chooses not to follow advice about attending for a consultation.

The Health and Disability Commissioner (H DC) considered:

1 Both the GP *and the medical centre* breached right 4(1) and (2) in that the GP did not review the medication, contraindications and risk factors to ensure that the pre-

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scription remained clinically appropriate.

- The HDC considered that if a patient decides *not* to have her medication reviewed, it is clinically inappropriate to renew the prescription. He conceded that in some cases one month's cover might be appropriate to "tide a patient over".
- The HDC opinion is based on the belief that although refusal to renew a prescription may lead to an unwanted pregnancy, that most women in this situation would use other forms of contraception.
- The HDC considers that the practice policy for repeat prescriptions of the nurse ensuring that the patient had been seen by a GP in the past year was not sufficient to ensure that her medication had actually been reviewed in that consultation.

2 Both the GP *and the medical centre* breached Right 6(1)(b) (e), 6(2) and 7 (1) (Right to be fully informed) in that the GP has an *ongoing* responsibility to provide the patient with information that a reasonable person, in the patient's circumstances, would expect to receive when medication is reviewed. This includes *updated* information about the risks associated with the medication (in this case the third generation OC) that is different to the information that must be initially supplied before the patient decides to take the OC. The HDC considered that the patient did not make an informed decision in refusing to have her medication reviewed as new information had arisen in respect of her OC since she first went on it.

The actions resulting from the opinion were not as serious as the above case:

1 The GP write an apology to the patient.
2 The GP review their policy and practice in relation to prescribing oral contraceptives.