Commissioner's Comment

Ovarian cancer and expert advice

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A recent complaint to the Commissioner's Office highlights the responsibility of a patient's regular general practitioner in a patient's overall care. This case also illustrates the problem of conflicting expert advice on clinical issues under investigation.

Mrs A's consultations – early 2002

In 2002 Mrs A was 52 years old and had enjoyed good health for most of her life. Dr B had been her GP for about 26 years. Between January and July 2002 Mrs A saw Dr B numerous times presenting with various symptoms including bloating, abdominal pain, indigestion, lower pelvic pain and diarrhoea.

Mrs A saw Dr B three times during February 2002, with symptoms of vaginitis and residual thrush, and then with hot flushes, painful breasts, indigestion, and a sore throat. Dr B ordered blood tests including an assessment of hormone levels. The results were consistent with menopause.

On 26 February Mrs A saw Dr K (a GP) at the after-hours service, with indigestion and vomiting. Dr K made a provisional diagnosis of gastritis and prescribed ranitidine. On 27 February Mrs A spoke with Dr B's practice nurse about her ongoing problems and was advised to see Dr B. The following week, Dr B started Mrs A on hormone replacement therapy (HRT). Mrs A had no abdominal pain at the time.

On 9 March Mrs A was seen by another GP at the after-hours service, with a two to three week history of a burning sensation in the epigastric region. The GP felt that she was suffering from reflux disease or a peptic ulcer. Dr B then organised blood tests checking for pancreatitis, liver function and Helicobacter pylori antibodies and prescribed a course of Losec HP7.[1] Mrs B developed oral and vaginal thrush while taking Losec HP7; she was informed that the blood tests were normal and given an antifungal agent.

While holidaying in Australia in April, Mrs A saw Dr C (a GP) with intermittent acute epigastric pain; on examination Dr C noted epigastric tenderness. Mrs A was advised to increase the daily dosage of Losec. Two days later she complained of nausea and epigastric pain; Dr C prescribed Stemetil and Somac and advised Mrs A to see a specialist after her holiday.

Referral for further investigations

On the day of her return Mrs A saw Dr B and asked, 'Do I have cancer?' He performed an abdominal examination and declared that there was 'no cancer present'. Dr B prescribed Mylanta and famotidine; ordered a barium meal and abdominal ultrasound scan; and made a referral to Dr L (a general and gastrointestinal surgeon), for an assessment and endoscopy. The barium meal revealed some minor motility abnormality but otherwise the investigations were unremarkable.

On 24 April Dr B saw Mrs A, who was tearful, irritable and complaining of a tension headache. She was given clonazepam and advised to increase the dosage of her HRT. On 2 May Dr B noted that Mrs A was 'feeling a lot better'.

In May, Dr L noted Mrs A's history of upper gastrointestinal tract symptoms and performed an upper endoscopy, which was normal. Dr L considered that Mrs A had oesophagogastric dysmotility/oesophageal spasm and recommended ongoing treatment with a trial of reflux suppressants until she found one that suited her. A biopsy specimen of the stomach later revealed Helicobacter pylori.

Management of abdominal symptoms

On 29 May Mrs A informed Dr B's practice nurse that she had finished the Losec and was about to commence famotidine. Mrs A was advised to see Dr B if she had no symptom relief.

On 7 June Mrs A informed Dr B that she was still suffering from reflux and throat discomfort. Dr B advised her to increase the amount of famotidine and started her on a course of Flagyl and Merbentyl (an antispasmodic). Dr B noted: 'I still think it is all related to bloating and GI [gastrointestinal] rather than a sore throat.'

On 3 July Mrs A complained to Dr B of frequent bowel motions with the Flagyl and was advised to take

1. A combination package containing Losec, amoxicillin, and clarithromycin, to eradicate Helicobacter pylori.

acidophilus tablets and Dicap. Dr B stated that this was the only occasion where Mrs A complained of lower pelvic pain. Dr B recalled he examined Mrs A's abdomen on most occasions and there was no evidence of a mass or lower abdominal pain. Over the next six months Mrs A consulted Dr B on a number of occasions. There was no further report of epigastric pain.

Diagnosis of ovarian cancer in 2003

On 19 January 2003 Mrs A was seen by Dr F (a GP) at the after-hours service, with a two day history of sudden abdominal distension and mild lower abdominal pain. She was advised to have an ultrasound scan if she felt no better. A scan taken on 23 January revealed generalised ascites and a pelvic mass. Dr B referred Mrs A to a gynaecologist. Soon afterwards, Mrs A was diagnosed with stage III ovarian cancer. She died in November 2003.

ACC claim and complaint to HDC

Mr A lodged a medical misadventure claim to ACC in respect of his wife's misdiagnosis of ovarian cancer. ACC sought independent expert advice from a general and colorectal surgeon, who stated: *'The investigations Mrs [A] had during 2002 were appropriate for the symptoms noted at each visit.'* He found no evidence that Mrs A's cancer should have been diagnosed at an earlier stage. ACC declined Mr A's claim for cover.

In April 2003 Mr A laid a complaint with HDC about the standard of care provided by Dr B. In June 2004, after obtaining independent general practitioner advice from Drs Jim Vause and Helen Moriarty, HDC concluded that Dr B appropriately referred Mrs A for investigation and assessment of her epigastric problems. There was insufficient evidence to support the claim that Dr B failed to refer Mrs A for further tests for lower pelvic pain and abdominal bloating in 2002. HDC found that Dr B did not breach Right 4(1) of the Code of Consumers' Rights.

What the HDC experts said

Both HDC experts agreed that ovarian cancers can be very difficult to detect as they are often clinically silent in onset and associated with symptoms that might be misinterpreted. Delay in diagnosis is not uncommon. Dr Vause stated: *'GPs need to have a high index of suspicion to detect this cancer early.'* Both experts also commented on the paucity of information recorded by Dr B in Mrs A's clinical records. HDC found that Dr B failed to meet professional standards for record-keeping and accordingly breached Right 4(2) of the Code.

Dr Vause advised that Dr B followed accepted practice in terms of history, clinical examination, and investigation in relation to Mrs A's reported alimentary tract symptoms in 2002 (apart from his poor record-keeping). Dr B appropriately referred Mrs A to a specialist in April 2002 for investigation of her upper abdominal symptoms.

Dr Moriarty, on the other hand, advised that the key consideration was whether Dr B's overall management was appropriate given that he was Mrs A's regular GP. Dr Moriarty advised that the records indicate that by the end of April 2002 there was a picture emerging of:

1. consultations occurring much more frequently than previously;
2. multiple ill-health complaints with no clear explanation; and
3. failure of the symptoms to respond to standard treatment.

Dr Moriarty considered that this triad, if recognised, should have indicated *'that something of significance was happening to the health of this particular patient'* and *'had this been recognised, it could have provoked [Dr B] to reflect upon the possibility of an underlying problem for this overall clinical scenario'*. She then stated: *'Instead the response was an escalation of the prescribing of remedies for individual symptoms, and a tendency to attribute unexplained complaints [to] menopause and to an unspecified stressor.'* Guided by this advice, HDC criticised Dr B for failing to consider Mrs A's overarching clinical presentation in its entirety.

Gender bias?

HDC had initially obtained expert advice from Dr Vause and relied on his advice in forming a provisional opinion that Dr B did not breach Right 4(1) of the Code. Mr A's lawyer then requested that the complaint be referred to a female GP, and asked Dr Vause to review his advice, and raised the possibility of gender bias and that Mrs A might have had a better outcome if she had been cared for by a female GP.

We believe this is the first case in which an HDC expert has been challenged on the basis of alleged gender bias. Although HDC considered that Dr Vause's advice showed no evidence of gender bias, to avoid allegations of procedural unfairness (made by a grieving husband threatening litigation) we took the precautionary step of seeking further advice from a female GP, Dr Moriarty (like Dr Vause, nominated by the Royal New Zealand College of General Practitioners). What HDC did not anticipate was that Dr Moriarty would take a very different approach to Dr Vause, and to some extent validate the complainant's concerns that Dr B had missed the overall picture.

Dr Vause reviewed the response from Mr A's lawyer and saw no reason to change his opinion. The new advice from Dr Moriarty was vigorously challenged by Dr B's lawyer, who submitted that Dr Moriarty's special interest in women's health and her work in academic (rather than clinical) general practice made her an unsuitable expert, with a *'somewhat ivory tower/academic based opinion'*.

The *Bolam* principle

During the investigation of a complaint, it is not unusual for HDC to be faced with conflicting expert advice. The English case of *Bolam*[2] was for several decades the leading decision on the standard of care expected of a medical practitioner. Faced with conflicting medical views, Justice McNair stated: *'The test is the standard of the ordinary skilled man exercising and professing to have that special skill. He need not possess the highest expert skill at the risk of being found negligent. It is well established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.'*

The judge went on to say: *'A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in a particular art. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice merely because there is a body of opinion that takes a contrary view.'*

In a later House of Lords decision, *Maynard v West Midlands Regional Health Authority*,[3] Lord Scarman stated: *'It is not enough to show that there is a body of competent professional opinion which considers that there was a wrong decision if there also exists a body of professional opinion equally competent which supports the decision as reasonable in the circumstances'* and *'In the realm of diagnosis and treatment, negligence is not established by preferring one respectable body of professional opinion to another'*.

In *Bolitho v City and Hackney HA*,[4] the House of Lords qualified the *Bolam* principle in the rare cases when professional opinion is not capable of withstanding logical analysis. A court is entitled to hold that a body of opinion is not reasonable or responsible if a standard practice is flawed or illogical.

The Code of Consumers' Rights – in particular the statement in Right 4(1) that *'every consumer has the right to have services provided with reasonable care and skill'* – does not require the Commissioner to be bound by the *Bolam* principle. Rather, HDC is expected to form an independent opinion on the reasonableness of the care provided. Rejection of slavish adherence to the *Bolam* principle, in favour of the approach taken by the Code of Consumers' Rights, is consistent with the *Bolitho* decision and with the approach of courts in Australia, Canada, Ireland, and indeed New Zealand.

In practice, HDC is very cognisant of the reasons that underpin the *Bolam* principle, and accepts that there can often be a legitimate range of responsible opinion and practice. We closely scrutinise any conflicting opinions, bearing in mind that our own GP advisors are independent experts nominated by the Royal New Zealand College of General Practitioners, in contrast to experts contracted by one party in a medico-legal dispute.

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We are well aware of the unfairness of finding a doctor 'in breach' for following a practice recognised as acceptable within the profession. But we are also conscious of HDC's responsibility, as an independent guardian of patients' rights, to distinguish between mediocre and good practice. On rare occasions, even a commonly accepted practice may, when viewed objectively, fall short of a patient's entitlement to 'reasonable care and skill'. In the areas of assessment, diagnosis and treatment, we will naturally tend to defer to expert clinical opinion. But in areas such as communication, referral, and follow-up, we are prepared to question accepted practice, to see if it reflects custom rather than care.

Conclusion

Although Dr B was ultimately exonerated by HDC (save in respect of his records), Mrs A's case emphasises the importance of a patient's regular GP in taking a holistic view of the patient's management. The regular GP is best placed to maintain the most complete record of a patient's health problems and to understand the individual's personal circumstances. A primary health service may be the only health service that knows about any departure from a patient's expected pattern of heath care.

2. Bolam v Friern Hospital Management Committee [1957] 2 All ER 118.
3. Maynard v West Midlands Regional Health Authority [1985] 1 All ER 635.
4. Bolitho v City and Hackney HA [1998] AC 232.

The full report (03HDC04996) may be viewed at www.hdc.org.nz.