General Practitioners, Dr C and Dr D

Specialist Physician, Dr F

Registrar, Dr G

House Surgeon, Dr H

The Public Hospital

A Report by the

Health and Disability Commissioner

(Case 00HDC05800)

Parties involved

Ms A	Complainant / Consumer's daughter
Mrs B (deceased)	Consumer
Dr C	Provider / General Practitioner
Dr D	Provider / General Practitioner
Mr E	Consumer's husband
Dr F	Provider / Specialist Physician
Dr G	Provider / Registrar
Dr H	Provider / House Surgeon
Dr I	General Practitioner
Dr J	Specialist Intensivist
Dr K	Clinical Leader, Medical Services
The Public Hospital	Provider

Complaint

On 7 June 2000 the Commissioner received a complaint from Ms A about the care her mother, Mrs B, received from the providers, Dr C and Dr D, as well as from a number of providers who attended her mother at a public hospital. The complaint is that:

Dr C

- *On Wednesday, 26 April 2000, Mrs B consulted Dr C at a medical centre after feeling unwell for a period of five days. Dr C did not examine Mrs B adequately, and told her to continue taking Panadol at home.*
- *Dr C did not diagnose Mrs B's pneumonia.*
- *Dr C did not fully familiarise himself with Mrs B's relevant medical history, which included a history of tuberculosis at age 18.*

Dr D

- *On Friday, 28 April 2000, Mrs B returned to the medical centre for the second time in three days, and saw Dr D. Dr D did not examine Mrs B adequately, and sent her home.*
- *Dr D did not diagnose Mrs B's pneumonia.*
- *Although Dr D had not met Mrs B before, he did not take an adequate history, and did not ask sufficient questions about her present condition, nor did he ask any questions about her lifestyle or usual level of activity to assist him in establishing how unusual her present condition was.*
- *Mr E supplied answers to Dr D's questions, as Mrs B was not able to respond. Dr D did not listen closely to the information provided by Mr E about his wife's condition.*

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HDC

The Public Hospital, Dr F, Dr G and Dr H

- *Mrs B was admitted to the public hospital with pneumonia at approximately 5:00pm on 29 April 2000. The serious nature of her condition was not recognised until approximately midnight that evening, when she was transferred to Intensive Care.*

An investigation was commenced on 19 July 2000.

Information reviewed

- Mrs B's medical records from the medical centre and the public hospital.
- Expert advice from Dr Chris Kalderimis, an independent general practitioner in private practice, in relation to the services provided by Dr C and Dr D.
- Expert advice from Dr Ross Freebairn, an independent consultant in intensive care medicine, about the hospital providers.

Information gathered during investigation

On 22 April 2000, Mrs B started to feel unwell. She had aching muscles, a headache, was tired and nauseous, and had a lack of appetite. She put herself to bed and took some Panadol. Mrs B's daughter, Ms A, advised me that on Sunday, 23 April, "Mum rung to say she did not feel up to cooking dinner for my partner and me on Monday night. She was in bed feeling unwell and had lost her appetite."

Ms A explained that her mother was normally a very fit and active person. Mrs B lived with her 76-year-old husband in a two storey house, and they did all the cooking, cleaning, household chores, and maintenance themselves. Mrs B played golf using a power caddy (an electric golf trundler) because it was easier on her back not having to push the trundler.

Ms A advised that on Monday, 24 April:

> "I went to see Mum. She was in bed and said she was having trouble eating. She felt nauseous and had been sick. … I said she should go to the doctor, but being a long weekend and pensioners she thought she could wait till Wednesday."

26 April 2000
On Wednesday, 26 April 2000, Mrs B was no better so went to see Dr C at the medical centre.

Dr C advised me:

> "I first encountered [Mrs B] in July 1985 and since then saw her infrequently. Prior to her last illness, I had not seen her since 18 December 1997. She had been attending

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this medical centre infrequently since 1978 seeing various medical staff in the practice. … [Mrs B] last consulted me on 26 April 2000. Her husband brought her to the surgery but he did not accompany her from the waiting room down the passageway to my office.

She gave a history of not feeling well over the previous four days with symptoms of aching muscles, headaches, tiredness, nausea and lack of appetite. There was also a suggestion of shivering probably an indication of fever. She had self medicated herself with paracetamol. No respiratory symptoms were volunteered.

Clinical examination included taking of her temperature with an electronic oral thermometer, which failed to reveal that she had a raised temperature. Pulse was a little elevated at 108/min with occasional irregularity suggesting ectopic beats. Blood pressure was 114/70. Heart sounds were normal except for the occasional irregularity. No murmurs were noted. The lung fields were clear and no signs of reduced air entry, fluid or bronchospasm was found.

The abdomen was checked and no abnormality was found. There was no ankle swelling that might suggest heart failure. She did not seem at that time to be in any acute distress.

On the premise of the relative negative clinical findings and her account of her illness, I concluded that she probably had a viral illness, which was resolving.

I prescribed Maxolon tablets to be taken up to eight hourly if necessary to relieve her symptoms of nausea, and further supply of paracetamol."

Dr C's consultation note states:

"Unwell after the past 4 days. Began with general myalgia beginning in the shoulders. Self medication w panadol. Assoc headache, tiredness, and nausea, anorexia. Also ? fever – shivering.

o/e [on examination] T n [temperature normal] P108 Bp 114/70 occas. ectopic heart sounds dual, no murmurs, chest clear. No ankle edema abd soft, liver/spleen not palp, no mass, no tenderness, no guarding, no hernia.

Prob resolving influenza."

Mr E advised me that his wife was in the consultation room for approximately three minutes, before she came out and told him Dr C had told her she had the flu. Ms A clarified that her father dropped off her mother at the surgery and went to park the car. By the time Mr E returned to the surgery, Mrs B's consultation with Dr C had ended.

Dr C could not recall exactly how long the consultation was, but presumed it would have been between 15 and 20 minutes in length. Dr C advised he had time to listen to what Mrs B had to say, take her temperature and her blood pressure, and feel her stomach.

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Dr C advised me:

> "I didn't ask specifically about her medical history. I already had a record of her relevant medical history in my notes. I am aware that her daughter has complained that I didn't take note of her history of TB [tuberculosis]. I don't believe I needed to do so. It wasn't particularly relevant in this situation, with [Mrs B's] presenting symptoms."

Dr C said that Mrs B did not volunteer a lot of information, although there was no problem with her ability to respond to his questions. Dr C said that although he had not seen Mrs B frequently as a patient, she used to come in sometimes with her husband. He did know her to be a fit and active person. He was not particularly worried about Mrs B when he saw her, as his impression was that her illness was resolving.

27 April 2000
Ms A rang her mother again on Thursday, 27 April. Ms A advised:

> "I thought she had run up the stairs to answer the phone she sounded so breathless. She had only walked around the edge of the bed. She said that after she took the tablet [the Maxolon prescribed by Dr C] that she had become really hot and sweaty, so hot in fact that she had to strip her clothes off. She only took the one tablet. I told her to go back to the doctor. She said she would go Friday if she didn't improve."

28 April 2000
Mrs B returned to the medical centre on Friday, 28 April. Dr C was unavailable, so Mrs B saw Dr D instead. Ms A advised:

> "She was so weak my father had to virtually carry her into the surgery. He had to park the car, but was back in time for the consultation. My father had to support her and she stumbled into [Dr D's] room. She was breathless and weak. She complained of passing black/very dark bowel motions. He did a rectal exam and found nothing untoward. It was as though from that point on he took what my Mother said lightly. …"

Ms A also advised me that uncharacteristically, her mother did not get changed before going to see Dr D, and visited him in her pyjamas. This was because she had no energy to get changed.

Dr D confirmed that Mrs B appeared to be very weak when he saw her, and she stumbled on her way into the examination room. He advised me:

> "I saw [Mrs B] on the afternoon of Friday, 28 April 2000. She had seen [Dr C] on Wednesday the 26th of April and was prescribed Maxolon. She took one tablet and this made her feel very hot.
>
> When I saw [Mrs B] with her husband she was nauseous and dizzy, she said that she had bowel motions over the past week which were black. I had access to [Dr C's] notes which I perused.

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> On examination her blood pressure was 110/70, pulse 100 regular, chest clear, and I found nothing abnormal on abdominal examination. I did a rectal examination and found the colour of her motions to be light brown.
>
> I formed the opinion that [Mrs B] was suffering from a post-viral debility and likely labyrinthitis [inflammation of inner ear] with ? melaena [black faeces due to the presence of partly digested blood] which had now ceased.
>
> She was given Stemetil 12.5mg intra-muscular and a prescription for Stemetil 5mg t.i.d.
>
> I did examine [Mrs B] and at no time did I take what she said lightly. Both [Mr E] and [Mrs B] answered my questions."

Dr D's note for the consultation states:

> "Still feels nauseous. Maxolon made her feel very hot, so did not take them, frequent bowel motions which she says are black over the past week. O.BP 110/70, P 100 reg. Chest clear. Abdomen nad [no abnormality detected]. PR [per rectal] colour of motion light brown. Given Stemetil 12.5 i.m. [intramuscular]."

Dr D advised me that he had met Mrs B only once previously for a consultation in 1982. He confirmed that he did not ask any questions about Mrs B's lifestyle or usual level of activity when he saw her on 28 April 2000.

Dr D's communication with Mr E and Mrs B
Mr E advised me that his wife was breathless, and was unable to say anything throughout the course of the appointment. He therefore communicated with Dr D on his wife's behalf. He told Dr D about his wife's dark bowel motions. Mr E advised that the consultation was short, maybe five minutes or perhaps a bit longer. Dr D did not ask many questions, and Mr E could not recall what the questions were. Mr E advised me he did not offer Dr D much information because Dr D did not ask them very much. The only comment he specifically recalled making was advising Dr D of his wife's dark bowel motions. He could not remember further details of their conversation.

Ms A was concerned that Dr D did not listen closely to what her father was telling him about his mother's condition. Ms A explained that her father has a heavy accent, and she is concerned that Dr D may not have made a sufficient effort to understand his accent. Mr E confirmed that he supported this aspect of the complaint.

Dr D advised me that both Mr E and Mrs B answered his questions, although Mrs B was fairly quiet and Mr E answered more. Although Mrs B was fairly quiet, she did not have difficulty answering questions and was not confused. Dr D also informed me he did not have any difficulty understanding either Mr or Mrs B's accents. He could no longer recall the length of his consultation with Mrs B, but said his consultations usually average 10 to 15 minutes.

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Conclusion of consultation with Dr D

Dr D advised that at the conclusion of his consultation with Mrs B, he told her he would let Dr C know about her dark bowel motions. He advised:

> "I was concerned about the black motions because it indicated there had been bleeding, although it had stopped when I examined her because the motions were light brown. I thought this needed to be further investigated."

Dr D could not specifically recall telling Mrs B he was concerned, but feels sure he would have. Dr D said he did speak to Dr C on the following Monday, 1 May. However, Dr C informed him that Mrs B had been admitted to the public hospital on 29 April, so any report to Dr C became redundant.

29 April 2000

Mr E advised me that on Saturday, 29 April, he was hanging out the washing when he heard a crash. Mrs B had fallen or collapsed. Mr E decided to call the emergency doctor from his home, and then called his daughter. Ms A drove to her parents' house in time for the emergency doctor's consultation.

The emergency doctor who attended Mrs B was Dr I. He saw Mrs B at 3.10pm. His records note that Mrs B had been seen by a GP the previous day, and outline her recent symptoms as well as her medical history. He noted that on examination, Mrs B was short of breath, panting, and pale, her abdomen was soft, and that she had passed four bloody bowel motions that day. Under 'Assessment/Diagnosis' Dr I recorded a two day history of melaena (blood in the faeces), and anaemia; also that her relatives had advised him that her condition was similar to the day before. Dr I arranged for Mrs B to be sent to the public hospital by ambulance.

Mrs B's arrival at the public hospital

The nursing triage report from the public hospital shows that Mrs B arrived at the hospital at 5.20pm on 29 April. A nurse assessed her at 5.25pm before she was triaged to a monitored bed in the resuscitation area of the Emergency Department. Mrs B had continuous heart, blood pressure, and oxygen monitoring performed in the intensive monitoring room.

Assessment by Dr H

Dr H, the duty house surgeon, saw Mrs B at 6.05pm. Dr H advised me:

> "I was the junior doctor (house surgeon) attending to her. I had a student with me while I was assessing the patient and we took the history together to find out what had been happening. I did an initial work up by taking bloods and organising a chest x-ray."

Dr H recorded that Mrs B had been previously fit and healthy, but noted that over the last ten days to two weeks Mrs B had been nauseous, tired, had achy joints and a fever. He noted that she had experienced rectal bleeding for four days. He retrieved and reviewed her previous hospital records, and recorded her medical history. The x-ray that Dr H had

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ordered was returned, revealing extensive left lung "white out". Dr H then presented Mrs B to the registrar, Dr G.

Dr H advised me that he and Dr G discussed the possibility of the white out being caused by pleurodesis [the artificial production of pleurisy], as a result of treatment of Mrs B's TB.

Assessment by Dr G

Dr G also took a record of Mrs B's history, and viewed her x-rays. The time of Dr G's assessment of Mrs B is not recorded in the medical notes. Dr G advised:

> "According to her daughter she had played 18 holes of golf two weeks prior (with the aid of a power caddy) and she was a non-smoker. She had a past medical history that included pulmonary TB as an adolescent for which some surgical procedure had been performed on her left lung at the time. She also had a history of systemic lupus erythematosus, a chronic connective tissue disorder initially diagnosed in 1973 which on perusing the old notes was known to have affected her lungs with biopsy proven pleuritis in 1973. She also had had bilateral Raynaud's disease necessitating left upper thoracic sympathectomy in 1966 and had had a renal biopsy in 1975 which showed mild to moderate glomerulonephritis. She had been on steroids in the past but was on no regular medication at the time of admission. …
>
> At the time of my assessment her blood pressure was stable at 120 systolic and 50 diastolic with a rapid irregular pulse rate of between 140-160. She was febrile at 39°C with a respiratory rate of 24. At this stage blood cultures were taken to exclude bacteraemia as well as serology to exclude atypical pneumonia. Her oxygen saturation on six litres of inspired oxygen was adequate at 93%. Her Glasgow coma scale was normal. Her peripheries were cool, a finding difficult to interpret in view of her previous Raynaud's disease. Her clinical chest findings revealed dullness and decreased breath sounds over the whole of her left lung with decreased vocal resonance on that side. She had bronchial breathing at the left mid zone. Her cardiac and abdominal examinations were unremarkable and a rectal examination revealed no melaena."

Dr G also reviewed Mrs B's x-rays. Dr G advised me:

> "No previous films were available for comparison however a chest x-ray dated 1973 reported changes consistent with left upper lobe collapse, an elevated hemidiaphragm and pleural thickening with leftwards mediastinal shift. In view of the dense opacification of the entire left lung I was unsure whether this represented fluid (in particular empyema), consolidation or an underlying lung mass. The interpretation of the changes on the x-ray was further complicated by her previous pulmonary Tuberculosis and a surgical procedure, the exact details of which were unavailable, but may have involved removal of part of the lung.
>
> The x-ray was personally discussed by my House Surgeon with the on call Radiologist at [7.35pm] who reported a massive left pleural effusion and that there were air bronchograms in the left upper zone, suggesting possible pneumonia. Should fluid in

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the pleural cavity be present a large bore chest tube would need to be inserted so the management differed depending on its presence."

Dr G requested an ultrasound scan to determine whether the white out was solid or liquid. The ultrasound was performed at 9.00pm. Dr G stated that the ultrasound "showed soft tissue filling the left hemithorax. There was no drainable collection.

Dr G advised me:

> "The impression was that of pulmonary sepsis with effusion having been ruled out, rapid atrial fibrillation secondary to the underlying infection and associated dehydration. The presence of an underlying pulmonary malignancy could not be excluded."

At 9.30pm Mrs B received triple antibiotics and amiodorone intravenously. Dr G advised the amiodorone was to slow down her heart rate. The antibiotics were to cover the possibility of a chest infection. Mrs B received a second dose of amiodorone at 11.00pm.

Involvement of Dr F, consultant physician
Dr G made a routine telephone call to Dr F, the consultant physician on call, at approximately 11.00pm, outlining the details of Mrs B's case. Dr F advised me:

> "I was satisfied during this conversation that [Dr G] had investigated and treated [Mrs B] appropriately, and according to best practice."

Dr F also advised me that she was not directly involved in Mrs B's care, as she did not see Mrs B that evening, but she was the named senior on the admitting team that evening. In addition, she stated:

> "[Dr G] had worked for the team since December 1999 and was an extremely diligent, thorough and competent registrar. Between us we had discussed on several occasions routes of communication, which were always re-established prior to each admitting day. She was in the habit of phoning me whenever she was particularly concerned about the clinical condition of a patient. In this case she did not do so."

Transfer to DCCM
Dr G advised me:

> "Between [10.30pm] and [11.00pm] I discussed [Mrs B's] condition with the DCCM [Department of Critical Care Medicine] Registrar following discussion with my consultant [Dr F]. She was maintaining her oxygen saturations and a blood gas at that stage showed a low normal pO_2 of 9.5 with a normal pCO_2 of 4 with saturations of 95% showing some impaired oxygenation but no evidence of respiratory failure.
>
> In view of her previous lung history, general weakened state, history of previous immune dysregulation as well as her age I was concerned about the development of respiratory fatigue and ultimate development of respiratory failure. I felt this would best be performed in an intensive care environment.

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The DCCM Registrar came down to the Emergency Department, Resuscitation Bay, where he assessed her between [10.30pm] and [11.30pm]. Following discussion with his consultant they accepted the patient and she was transferred from one closely monitored situation to another in DCCM. At the time of transfer, [12.40am], she was still breathing rapidly with a respiratory rate of 40, normal saturations of 98% on 10 litres and a normal blood pressure of 135/50 and a pulse rate of 120. Her temperature at this stage was 37.6.

My duty officially finished at [10.00pm] but in view of the complicated nature of this patient's illness I stayed on until her care was taken over by DCCM."

Dr F summarised Mrs B's assessment and treatment at the public hospital as follows:

"[Dr I], a house call services doctor, saw [Mrs B] at home at [3.10pm] and transferred her to [the public hospital] by ambulance. On his referral note, he had written as a diagnosis two weeks of melaena (upper gastrointestinal bleeding), and anaemia. In the ambulance, her heart rate was high, between 160 and 170, and she had an increased respiratory rate, although her blood pressure was stable. On arrival at the hospital at [5.25pm], she had a high fever, her heart rate was still elevated at 155, her respiratory rate had settled down, and her oxygen saturation on oxygen was also normal. Her blood pressure was normal. She was placed in an intensive monitoring room on arrival in Hospital, in which she had continuous heart, blood pressure, and oxygen monitoring, in close proximity to the nurses' station. She was seen first by my House Surgeon, [Dr H] at [6.05pm], then shortly thereafter, by [Dr G] although the time is not stated in the medical notes. This was between [6.30pm] and [8.30pm] that evening.

The history was not straight forward, as [Mrs A] had had a history of bleeding from the bowel, abdominal pain, aching joints, shortness of breath, fevers, and a productive cough. It was recognised that she had been active two weeks earlier, having played 18 holes of golf, but that she had been unwell for the previous two weeks and had had several consultations with her GP.

There was a past history of pulmonary tuberculosis and lung scarring, and also of a connective-tissue disease which caused her to have bluish fingers. She had had a lung biopsy and a renal biopsy done in the 1970s. She had previously been treated for this connective-tissue disease, with prednisone. She also had an operation to try and improve the circulation of her hands in the past.

Both [Dr H] and [Dr G] recognised that she had very poor breath sounds in the left side of her chest, with cool peripheries (but noting the past history of circulation disturbances). Her initial cardiogram showed rapid atrial fibrillation (irregular heartbeat), but no signs of a heart attack. Her initial chest x-ray showed a complete 'white-out' in the left side of her chest, which could have been either extensive pneumonia, or fluid filling up the left side of her chest. Her initial blood test showed a high white count, which could have indicated infection or other stress responses, but her kidney function and blood clotting were normal. There were no signs of heart damage on the initial blood test.

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[Dr H] thought she may have had a chest infection, and [Dr G] thought about chest infection, or else fluid in the chest cavity complicating a chest infection, which can be seen with pneumonia or tuberculosis, and she also wondered about an underlying lung malignancy. Because of the question as to whether the 'white out' on the left side was solid or liquid, she requested an ultrasound scan, which was done at approximately [9.00pm]. As soon as she returned from ultrasound she was given intravenous antibiotics to cover the possibility of a chest infection, and further antibiotics, to give better cover against unusual organisms, were started at [11.00pm]. In an effort to control her heart rate, she was given amiodorone intravenously at [9.30pm] and again at [11.00pm]. While she was given this, her blood pressure dropped into a low range, which is a recognised effect of the medication.

When the result of the ultrasound scan showed a solid lung, suggesting pneumonia, and she continued to be unwell, [Dr G] requested a Department of Critical Care Medicine (DCCM) review. It is not clear when they were contacted. At this stage the DCCM team agreed to transfer her, although she was transferred at approximately midnight. At this stage, my nominal involvement with the case ceased, as her case was taken over by […] and the Intensivists."

Transfer to Department of Critical Care Medicine (DCCM)
Dr F advised me:

"On transfer [Mrs B] was labelled as having moderately severe pneumonia and there was no intention to put her on a ventilator straight away. If anything her clinical situation had improved slightly."

Mrs B continued to be monitored by DCCM, and she received amiodorone and low dose noradrenaline.

Mrs B experienced pain in her right arm at approximately 3.00am. An ECG indicated she had experienced an acute myocardial infarction (heart attack). This was later confirmed by blood tests. Following this she was electively intubated and ventilated. Her general condition deteriorated markedly after the heart attack and she developed severe shock and multiorgan failure.

In response to my provisional opinion, Ms A advised me that she observed her mother's heart rate to have been over 180 beats per minute, but she did not specify when this occurred. Ms A was sitting beside her mother's bed and the nursing staff would respond to the alarms on the heart rate monitor, and reset it.

Subsequent events
Dr J, specialist intensivist, completed a morning ward round update on the morning of 1 May 2000, which states in part:

"In summary we have a 75 year old woman who has been reasonably well in the past, presented to hospital with moderately severe pneumonia and respiratory failure. This was complicated by acute myocardial infarction and onset of cardiogenic shock. She has had a number of haemodynamic manipulations which have improved her cardiac

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state somewhat but she remains anuric. The overall scenario and prognosis from this situation is likely to be rather poor however."

Mrs B died at 3:35pm on 2 May 2000.

Following an internal clinical review of Mrs B's case, Dr K, Clinical Leader of Medical Services at the public hospital, stated:

"My review of the clinical notes suggests that this patient had a complex and serious illness, the nature of which only became apparent as time went by. This may be relevant not only to her hospital management, but to her management at home prior to admission. My reading of the notes indicates that the initial hospital management was appropriate. The medical assessment accurately determined the underlying medical issues and when she did not respond to initial treatment, she was transferred to the Department of Critical Care where she had appropriate and aggressive therapy for serious underlying lung and heart disease. My review of the notes suggests that she died despite appropriate treatment and I do not think that anything different could have been done during her admission."

Dr K noted that "whether or not earlier admission to hospital might have led to a different outcome … is entirely speculative".

Independent advice to Commissioner

General practitioner advice – Dr Chris Kalderimis

The following expert advice was obtained from Dr Chris Kalderimis, an independent general practitioner, in relation to the services provided by Drs C and D:

"This is a complaint made by the daughter of [Mrs B] about [Drs D and C]. It would appear that on 26th April 2000 [Mrs B], after several days of what appears to have been a flu like illness, saw [Dr C] because of this.

At that consultation it was [Dr C's] opinion that [Mrs B] was suffering from a flu like illness. He therefore prescribed Paracetamol, which she was going to take every four hours and, because she had been complaining of nausea, he also gave her tablets for the control of this.

[Mrs B] went to see [Dr D] two days later because of increasing malaise and shortness of breath. She mentioned at the time also that she had passed black bowel motions and this was duly investigated as well by [Dr D] who after a rectal examination felt that he did not need to pursue this at the time.

Clearly [Mrs B] was quite unwell because her husband needed to help her get dressed and apparently her husband answered most of the questions for her because she was unable to do so easily.

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The next day [Mrs B] had clearly deteriorated and she was admitted to hospital and died on the subsequent Tuesday, 2 May 2000.

I will first of all answer the questions you have raised regarding [Dr C].

1. Was the examination performed by [Dr C] appropriate and complete?

This examination does appear to be complete from the notes that have been entered into the computer. Firstly, the history that was obtained was complete and the examination was also complete, although I suppose some notes could have been made regarding the presence or otherwise of any respiratory distress. In other words, was there any sign of indrawing, accessory muscle use and what was her respiratory rate? That apart, the examination appears to have been complete. In particular it is noted that [Dr C] took [Mrs B's] temperature, ascertained that her chest was clear and came to the conclusion that she was suffering from an influenza that was resolving.

2. Please comment on the complaint that [Dr C] did not diagnose [Mrs B's] pneumonia.

Diagnosing pneumonia, especially when it is relatively early, on purely clinical grounds is notoriously difficult. This is especially so if it is localised and localised lobar pneumonias have often been misdiagnosed and not picked up; often a diagnosis is not made until a chest x-ray is performed. Obviously we do not know what [Mrs B's] respiratory rate was nor whether there were any signs of respiratory distress such as indrawing or accessory muscle use. And of course it is possible that [Mrs B] did not have pneumonia at this consultation.

3. Please comment on whether there was a need for [Dr C] to alter his examination or treatment of [Mrs B], in view of her medical history, which included a history of tuberculosis at age 18.

This was possibly so, as the nature of [Mrs B's] tuberculosis may have affected her lungs and made her more susceptible to lung complications."

Dr Kalderimis was asked to clarify his response concerning the history of tuberculosis. He stated that Dr C should "possibly" have altered his examination and treatment of Mrs B in view of her medical history. My advisor explained that the reason he responded to this question this way is that someone who specialises in this area, such as a chest physician, may have said that something additional should have been done. However, my advisor said that answering from the perspective of a general practitioner, Dr C did all that could reasonably be expected of him. My advisor informed me that he is quite satisfied that Dr C demonstrated reasonable care and skill in his treatment of Mrs B.

Dr Kalderimis provided the following advice about the services provided by Dr D:

"*1. Was the examination performed by [Dr D] appropriate and complete?*

Clearly by the time [Dr D] saw [Mrs B] she was more unwell and had been unwell now for about a week. Thus one could argue that in fact the examination was not complete

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because I note no mention in the notes of her temperature, her respiratory rate or any signs of respiratory distress. I feel that [Dr D] was probably somewhat side-tracked by the reporting that [Mrs B] had black bowel motions and he was obviously concerned that she might have bleeding from the bowel. Nevertheless, I think at this stage it was really important that we know what [Mrs B's] temperature was and at the same time it was probably important, given the fact that she had been unwell for about a week, that further investigation was warranted. These investigations would have included a blood screen and a chest x-ray.

2. *Comment on the complaint that [Dr D] did not diagnose [Mrs B's] pneumonia.*

On purely clinical grounds once again, it might have been quite difficult to diagnose pneumonia, but obviously a chest x-ray would have picked this up, while a blood test at this stage could have been very useful.

3. *Please comment on the complaint that [Dr D] did not ask sufficient questions about [Mrs B's] present condition, or any questions about her lifestyle or usual level of activity to assist him in establishing how unusual her present condition was.*

[Dr D] did not know [Mrs B] and this again is a problem where a patient is seen by different doctors when in an ideal situation she would have been seen by the same doctor. Clearly it would have been very useful for [Dr D] to have ascertained just how sick [Mrs B] was. She was quite sick given the fact that she was normally a very fit and active person and was now presenting in a quite different way to what she was normally.

It is impossible to judge from the notes whether in fact this issue was gone into in any detail and thus it is very difficult to actually pass any comment about this.

4. *Please comment on any other additional matter that you think should be brought to the Commissioner's attention.*

Influenza can be a very serious condition for the elderly. It would appear that what happened to [Mrs B] was that she probably did develop influenza and then went on to get a secondary complication – pneumonia. It is impossible to know at which point the condition became pneumonia but obviously somewhere around the fifth to seventh day this probably happened. But one cannot say this with any accuracy.

Influenza will present with high temperature, muscular aches and pains and a feeling of quite intense malaise, especially when the patient is 75 years of age. Influenza is potentially, because of its complications, a life-threatening illness. When [Dr C] first saw [Mrs B] I feel his diagnosis was probably reasonable and I don't think that on that first consultation further investigations were necessarily indicated.

However, by the time she saw [Dr D] two days later, given that she was more unwell, then I do believe that probably further investigations were warranted. As I mentioned before, a chest x-ray and blood screen would have been very useful and would have diagnosed pneumonia somewhat earlier. However, it is impossible to say whether this would in fact have saved [Mrs B's] life or not.

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I feel that rather than just making a diagnosis of post viral debility and likely labyrinthitis [Dr D] really should have investigated the situation a bit more thoroughly.

Therefore in summary, [Dr C] did provide [Mrs B] with services with reasonable care and skill that complied with professional standards while [Dr D] possibly did not provide an appropriate service.

However, it is obviously impossible to say whether or not there would have been a different outcome had [Mrs B] been admitted to hospital earlier. She died from having suffered a heart attack and whether or not earlier intervention would have made a difference is impossible to say. She certainly did not display any signs of myocardial problems to either [Dr C] or [Dr D]."

Response from Professor L
In response to my provisional opinion, Dr D submitted the following advice from Professor L, who disputed Dr Kaldermis' conclusions:

"Thank you very much for asking me to comment on the document from the Health and Disability Commissioner in regard to [Dr D]. I have not undertaken any literature review nor seen any of the original documentation and this report is based purely on the information provided in the Health and Disability Commissioner's commentary. I have also kept my comments in regard to this case, purely to the actions of [Dr D].

The complaints against [Dr D] are:

- On Friday, 28 April 2000 [Mrs B] returned to the [medical centre] for the second time in three days and saw [Dr D], and [Dr D] did not examine [Mrs B] adequately and sent her home.
- [Dr D] did not diagnose her pneumonia.
- As [Dr D] had not met her before, he did not take an adequate history and did not ask sufficient questions about her present condition nor did he ask any questions about her lifestyle or usual level of activity to assist in establishing how unusual her present condition was.
- [Mr E] supplied answers to [Dr D's] questions, as his wife was not able to respond. [Dr D] did not listen closely to the information provided by [Mr E] about his wife's condition.

When [Dr D] saw [Mrs B] on 28 April, it was with the knowledge she had seen a partner in the medical centre on 26 April. The partner had made a diagnosis of probable resolving influenza based on the history of myalgia, associate headaches, tiredness, nausea, anorexia and possible fever. The partner had not found any localised signs, specifically no chest signs. At the time of the consultation on 28 April there was a commentary from [Mrs B's] daughter, but it does not appear that she was actually present during the consultation. However, she does state that her mother's presenting complaint was that of passing very black bowel motions and that she was breathless and weak. [Dr D's] notes state that she was still complaining of nausea and she felt that the maxolon had made her very hot and she'd stopped taking them. Also that there had been frequent bowel motions which had been black over the past week. The

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examination did not reveal any untoward signs apart from slightly elevated pulse, in particular the chest was said to be clear.

It appears that [Mrs B] answered some of the questions although her husband most probably provided most of the commentary. In review [Dr D] stated that he felt that the patient did not have any difficulty answering questions and was not confused at the time.

The following day [Dr I] saw [Mrs B] and it is stated that he noted on the examination that she was short of breath, panting and pale. However the records from the hospital were summarised as saying that [Dr I's] referral note had included a diagnosis of two weeks of melana and possible anaemia. It did not appear evident that [Dr I] considered that this patient may have had pneumonia, but that the likely diagnosis was one of blood loss. It was also noted by the Duty House Surgeon that there had been rectal bleeding for four days. With this history of bleeding from the bowel there was also a history of abdominal pain, aching joints, shortness of breath, fevers and productive cough. This is the first time that cough appears to have been mentioned in any of the accounts.

In the summary provided by the hospital it states that the House Surgeon and Registrar recognised that she had very poor breath sounds on the left side of her chest and it will be interesting to note whether these breath sounds were recorded before or after the chest x-ray was seen. The reason I raise this is that it is now common practice for patients to have a chest x-ray prior to being seen by the Medical Registrar in A&E. Even with the result of the chest x-ray it did take some time for the hospital to determine that this patient was suffering from pneumonia and that the x-ray features were not secondary to previous treatment for pulmonary tuberculosis.

Independent Advice to the Commissioner

Independent advice was gained from Dr Chris Kalderimis in regard to the services provided by [Dr D].

1. In his opening section Dr Kalderimis states that when the patient went to see [Dr D] she was clearly quite unwell because the husband had to help her get dressed and apparently the husband answered most of the questions because she was unable to do so. I would like to see the documentation that Dr Kalderimis used to reach this opinion, as from my reading it appears to be based on the commentary of the patient's daughter who was not present at the consultation.

   Dr Kalderimis states that the next day [Mrs B] had clearly deteriorated and she was admitted to hospital. I would assume that this is correct as [Dr D] did not believe that the patient required admission to hospital on the day he saw her, but at the time of [Dr I's] consultation the need for hospitalisation was apparent. However, even at this consultation it appears that [Dr I] thought that the main complaint was one of blood loss, secondary to rectal bleeding and not necessarily pneumonia.

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2. I will not specifically comment in regard to the commentary by Dr Kalderimis of [Dr C] however I must state that I am surprised at some of the comments which are made in parts 1, 2 and 3 of the report in regard to [Dr C's] care.

   In regard to the comments of [Dr D]:

   (1) 'Was the examination performed by [Dr D] appropriate and complete?'

   Dr Kalderimis uses the word 'clearly' at the commencement of his commentary to this and then goes on to state that one could argue that the examination was not complete because he could not find any mention in the notes of any signs of respiratory distress. One has the feeling that Dr Kalderimis' report is based on knowing what the final diagnosis was and then going backwards from that final diagnosis and looking for fault in the clinical encounter. However, it is my opinion one should try and interpret the information based on the knowledge that was available to the practitioner at the time, and compare that to what would be expected of a competent general practitioner.

   At the time the patient presented to [Dr D], the main complaint appeared to be that of the passage of frequent black bowel motions, with associated nausea. The clinical records, as stated in the opinion of the Health and Disability Commissioner, are perfectly acceptable given that presenting complaint. In particular the practitioner observed that the patient was haemo-dynamically stable ie adequate blood pressure and pulse, with no abdominal signs nor signs of acute rectal bleeding. The practitioner also noted that the chest was clear. At that consultation it was not apparent to the practitioner that the patient had an acute respiratory infection. There is ample international evidence pointing out the difficulties of diagnosing pneumonia in elderly patients.

   Further in the paragraph Dr Kalderimis states that he believes that further investigations were warranted because the patient had been unwell for a week. I would not necessarily disagree with that but would not necessarily agree that these would include a chest x-ray. Certainly a blood screen, in my opinion, would have been worthwhile. Particularly looking for evidence of blood loss secondary to rectal bleeding. However a blood screen may not have demonstrated an elevation in her white blood count as it is not uncommon in the elderly, with pneumonia to have a normal white blood count.

   The question of whether a chest x-ray would have been ordered would to a large extent, be dependent upon the history obtained and the index of suspicion held by the practitioner. In this case it did not appear that either [Dr C] previously or [Dr D] had an index of suspicion that the patient may be suffering from pneumonia. It is easy for myself and Dr Kalderimis to indicate the need for a chest x-ray knowing in fact what the patient's final diagnosis was.

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(2) 'Comment on the complaint that [Dr D] did not diagnose [Mrs B's] pneumonia.'

I would agree with Dr Kalderimis on clinical grounds ie history and examination, it is sometime extremely difficult to diagnose pneumonia. He states however that obviously a chest x-ray would have picked this up but I would argue that given the difficulty that the hospital clinicians had on interpreting the chest x-ray this might not have been so easy. I have already commented on the benefit of a blood screen at this stage.

(3) 'Please comment on the complaint that [Dr D] did not ask sufficient questions about the patient's present condition or anything about her lifestyle or usual level of activity to establish how unusual her presenting condition was.'

As pointed out by Dr Kalderimis, [Dr D] did not know the patient. It is therefore difficult for a practitioner to always get a correct assessment of the change in condition of a patient without having any previous knowledge of that patient. However, we have no factual knowledge in regard to the questions or commentary that actually occurred within the surgery to indicate that [Dr D] did not take an adequate history given the presenting complaint. We cannot say for certain that either the patient or her husband pointed out to [Dr D] how different she was at the time of the consultation compared to her normal state. I therefore agree with Dr Kalderimis' final point that it is difficult to actually pass any comment on this.

(4) 'Please comment on any additional features you think should be brought to the Commissioner's attention.'

Dr Kalderimis' comments on influenza and the [e]ffect it can have upon the elderly. He states that it is probable that she did develop influenza and then went on to get a secondary complication ie pneumonia. I have no information available to me, which would indicate that this is in fact correct. Unless laboratory testing was undertaken, looking for evidence of influenza, one cannot say whether the pneumonia was secondary to influenza or primary infection. I could not find anything in the report from the hospital records, which would help clarify this situation. I therefore think it is unwise to indicate that the patient's pneumonia was secondary to influenza. I don't believe that there is any evidence or any basis on which we can say that the patient did not have pneumonia when she first saw [Dr C] nor [Dr D] nor [Dr I]. Pneumonia in the elderly is difficult to diagnose at times, particularly in the community setting.

Dr Kalderimis then goes on to comment about the issue of chest x-ray and blood screen, which I have previously commented upon. He also comments in regard to the need for further investigation when the patient saw [Dr D] and in hindsight I would agree with this, but at the time of the consultation it appears that the practitioner was comfortable in the diagnosis based on the history and

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signs at the time. I would note that Dr Kalderimis only indicates a possibility that [Dr D] did not provide an appropriate service.

Summary

The Commissioner has determined that a breach has occurred in regard to Right 4(1). The basis of forming this opinion appears to have been whether [Dr D's] examination of the patient was appropriate and complete. It is my opinion that given the history at the time, that the examination undertaken by [Dr D] was neither necessarily inappropriate nor incomplete. There is ample international evidence to point out that patients who present with pneumonia may not have a raised temperature and that examination of the chest for signs of pneumonia is not easy in the primary care setting. A chest x-ray would certainly have provided further information but even within the secondary sector it still took some time to determine whether the chest signs on the x - ray were secondary to a previous history of tuberculosis. However there were no indicators that [Dr D] considered that a chest x-ray should be undertaken as he was focusing on the issue of possible rectal blood loss. The examination that he undertook in that regard was, in my view, appropriate.

The Commissioner also comments that the practitioner did not ask appropriate questions about the patient's usual lifestyle. I have no information available to me to say that this is necessarily correct. It appears to be on the basis of the information provided by the patient's daughter who was not present at the time of the consultation.

The Commissioner then states that given the second presentation in a short period of time and that her condition had deteriorated, and she was very weak, then a more detailed history and examination should have been undertaken. I cannot agree with this view and I would point out that when seen on the following day the general practitioner who saw her at that time determined that she obviously required hospitalisation but still believed that the main problem was that of blood loss."

General practitioner advice – Dr Chris Wright

In light of Professor L's criticism of Dr Kalderimis' advice, I obtained additional independent advice from general practitioner Dr Chris Wright. Dr Wright was not provided with a copy of Dr Kalderimis' advice or Professor L's advice in preparing the following advice:

"**<u>Background</u>**

After an illness of four days, [Mrs B] consulted [Dr C]. He thought she had a resolving viraemia. She worsened over the next two days and was seen by [Dr D]. He felt [Mrs B's] weakness and physical state could be explained as part of a post viral fatigue and she was sent home.

The next day, [Mrs B] fell and was visited by the Emergency Housecall Services doctor and admitted to hospital.

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She deteriorated in hospital and died three days after admission of generalised sepsis with multiple organ failure secondary to pneumococcal pneumonia and acute myocardial infarction.

Opinion

[Mrs B] visited [Dr C] on April 26 and he described the following symptoms from that visit; achiness, fatigue, headache, nausea and loss of appetite. There was further history obtained – she had taken Paracetamol and possibly had experienced fever and shivering. [Dr C] then performed an examination which included temperature, pulse, blood pressure, listening to both heart and lungs and examining the abdomen and the ankles for swelling.

At this stage of her illness, [Mrs B] presented with rather general symptoms where serious and life-threatening conditions were unlikely to be initially considered. She walked in herself, was able to answer [Dr C's] questions and his impression of her was that she did not seem that unwell.

[Dr C's] examination would have further given him the strong feeling that her illness was not life threatening. [Mrs B] had some elevation of the pulse rate but her temperature was normal. Lungfields and abdomen were quite normal, there was no ankle swelling and heart rhythm was normal, except for occasional extra beats, a minor problem of no consequence or concern. Her blood pressure was in the normal range.

As a result of the history and examination, [Dr C] made the diagnosis of a viral influenza-like illness. He felt this was resolving, possibly because [Mrs B] had no current elevation of temperature and there had been the suggestion of fever in the preceding days.

[Dr C's] inability to diagnose [Mrs B's] pneumonia at such an early stage cannot be seen as a criticism. She presented with generalised symptoms, none of which were overly worrying, and her examination was virtually normal. She had no fever, no respiratory symptoms, no vomiting and did not look particularly unwell to [Dr C]. I do not think that eliciting [Mrs B's] past history of tuberculosis at this consultation would have made any difference to the examination or eventual treatment by [Dr C].

I believe [Dr C's] history taking and examination to have been perfectly adequate and complete. He made a very reasonable presumptive diagnosis of viral illness on the basis of his findings and I cannot find fault with his conduct.

[Mrs B's] condition slowly worsened over the next two days with [Ms A] stating that she sounded breathless on the phone on April 27 and [Mr E] later stating that [Mrs B] had increasing weakness. They sought the opinion of [Dr D] on April 28.

There is a divergence of evidence at this stage.

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[Dr D]

[Mrs B], who had had a diagnosis of viral infection made by [Dr C] two days earlier was not at all well known by [Dr D]. [Dr D] states that both [Mr E] and [Mrs B] answered his questions at consultation and that [Mrs B] had complained of nausea, dizziness and black bowel motions. He denies problems with their accents. There was no mention of fever or breathlessness. He found her blood pressure to be in the normal range, pulse was slightly less than at the previous visit, chest clear to auscultation and abdominal examination normal. He performed a rectal examination to establish the situation as regards to the given history of black bowel motions, which can indicate bleeding from the upper gastro-intestinal tract. [Mrs B's] temperature was not taken. He examined her reasonably for the condition/s he believed to be the problem. [Dr D] admits on 22 March 2001 that 'she was obviously very weak when I saw her' and he came to the conclusion that [Mrs B] was debilitated from a viral illness and had possibly had an upper bowel bleed which had ceased spontaneously. He gave her symptomatic relief.

I am moderately critical of the fact that a temperature reading, a basic and easy part of the examination, was not taken in this case. It is difficult to know whether this may have altered his treatment decisions. If [Dr D's] evidence is to be believed, I feel that, apart from the absent temperature, his examination was adequate.

[Mr E (and Ms A)]

[Mr E] states that he alone answered [Dr D's] questions as [Mrs B] was unable to talk. [Mr E's] and [Ms A's] evidence is that [Dr D] failed to establish that [Mrs B] was normally fit and well, and therefore did not recognise the dramatic change in her, including the fact that she wore her pyjamas to the surgery, something that was very uncharacteristic of her. They state that [Mrs B] could not reply to his questions and believe this was because of breathlessness. [Mr E] told [Dr D] that his wife was very weak and had had dark bowel motions. [Ms A] writes that her mother had been breathless, but this is not noted in [Dr D's] notes, nor seems to have been part of the history given by [Mr E] to [Dr D]. Little information was asked for by [Dr D] according to [Mr E] and he states that he did not volunteer [Dr D] much information as not much was asked for. The [family] feel that [Dr D] did not listen adequately to [Mr E] and that [Mrs B] could not answer his questions, the implication being that this was secondary to her breathlessness. [Mr E] and [Ms A] feel that [Dr D's] failure to listen was due to [Mr E's] and [Mrs B's] heavy accents. Complaints of shoulder pain and sweating seem not to have been elucidated or volunteered. There is no evidence that the [family] have questioned the content of [Dr D's] examination however. He took a history from both [Mr E] and [Mrs B], which tended to suggest the passage of black bowel motions and unfortunately not much more in the way of symptoms that would point towards a diagnosis of worsening infection. [Dr D] is unable to recall the questions he asked and these are not in the notes. He believes that he would have given instructions to them in the case of further black bowel motions.

There is evidence from Ms and [Mr E] that [Mrs B] was breathless prior to her second consultation yet it remains unclear if this very important symptom was present at that

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consultation or not. It is not mentioned by [Dr D] in his notes and is unclear if he asked about this symptom, and in fact does not appear to have been brought up by the [family] either. It is quite unclear how breathless she was at the time.

[Mrs B's] weakness has been mentioned by [Dr D] in his interview of 22 March 2001, and by [Ms A] in her letter of complaint (page 2). The degree of weakness has been hinted at by the fact [Mrs B] stumbled at [Dr D's] surgery door and needed support from her husband. As weakness could be the result of a number of possible causes, failure to specifically diagnose pneumonia cannot be seen as a criticism, but even the rather vague symptom and vaguer sign of generalised weakness must be carefully assessed and a course of action decided upon. [Dr F] states, 'the history was not typical of a streptococcal pneumonia', and [Dr K] has written that 'the patient had a complex and serious illness, the nature of which only became apparent as time went by'. Presumably, the specific diagnosis of pneumonia would have been even harder in the preceding days. Even so, despite the frequently vague nature of early presentation of serious illness, the role of the primary care physician is often not to make an accurate specific diagnosis, but is to judge the degree of 'unwellness' in any patient and make a decision on the appropriateness of either hospital admission or home care.

Summary

It is difficult to determine how severe [Mrs B's] symptoms of weakness and breathlessness were on the day of her visit to [Dr D].

Agreed on by both sides is the fact that [Mrs B] was weak on that day. She required assistance from her husband when she tripped at the door. [Dr D] notes she was 'very weak, ... she stumbled outside my room, ... she didn't fall over however'. [Ms A] recalls that her father told her that he 'had to support her, ... she stumbled into [Dr D's] room, ... my father had to virtually carry her into the surgery' (which [Dr D] may possibly not have witnessed).

There is disagreement on the presence or not of breathlessness. This has been addressed earlier.

The [family] did mention the fact of [Mrs B's] dark bowel motions to [Dr D]. This symptom, unfortunately but understandably, seemed to lead [Dr D] to concentrate more on the bowel as an area of possible pathology, as I note it did for [Dr I] and the Emergency Department staff later the next day. There appears to have been a communication problem between the [family] and [Dr D], revealed both in the sense the [family] had of [Dr D's] listening skills, but also in the amount and type of information given to [Dr D] by the [family]. I think it is reasonable to assume that [Dr D] could understand the [family's] accents.

Information gathering and giving in a consultation is a mutual responsibility between patient and doctor, in my opinion. I also believe that this particular responsibility is biased more towards the doctor. This means that it is important for the doctor to understand his/her patient's vocabulary, and to ask relevant questions to eliminate concerns of potentially serious illness. Patients are often unaware what information is important and may feel unwell or anxious. Good medical practice does not necessarily

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mean that every potential question must be asked of a patient at each visit; indeed, very few questions can be posed and the consultation can be perfectly safe and adequate.

[Dr D] appeared to obtain a basic patient-based history which he seems to have thought about reasonably. The [family's] main complaint appears to have been the black bowel motions, rather than breathlessness. Her weakness was present, obvious and noted by [Dr D]. The fact that more detail of his questioning was not noted in his medical records would incur criticism from our peers.

I have been asked to comment on [Dr D's] failure to initiate further investigations into [Mrs B's] illness. I see no fault in a lack of investigations for the particular illness [Mrs B] had developed if the history and examination as described by [Dr D] are believed. If the [family's] version is believed, investigations would still have been impractical on a Friday evening. In this scenario however, hospital admission would have been mandatory.

If not obviously breathless at consultation and if she was able to answer [Dr D's] questions, this clinical state, taken with the examination, may be seen as a non life threatening situation and one caused by a number of possible illnesses. [Dr D's] fairly non-specific, but nevertheless not unreasonable diagnosis and management could be seen as appropriate in this situation. This would also only be appropriate in circumstances where some form of discussion about follow-up and advice as to when further medical help would be needed had been given.

[Dr D] is unsure if instructions were given, but feels it is his usual policy to tell patients to get back in touch if black motions recurred. The [family] have not specifically stated that [Dr D] did or did not give them information at the end of the consultation.

If breathless, very weak and unable to answer questions put to her, despite the relatively normal examination, I believe that [Mrs B] should have been admitted to hospital. Failure to have done so would be a serious departure from the accepted standard of care.

There are some criticisms of [Dr D] that are independent of whichever description of events above is believed by the Commissioner:

- Temperature not taken in a weak unwell patient
- Lack of a more detailed general interrogation of [Mrs B] at consultation ([Dr D] had gathered basic information from the [family], which told him that she was unwell, nauseated and had black bowel motions. The presence of further questioning about possible abdominal pain, vomiting, breathlessness or chest pain would have been appropriate).
- No obvious detailing of verbal instructions at the end of the consultation.

It is unclear if these missed parts of the consultation would have made a difference, but despite that, I believe that this would be regarded as a less than optimal standard of care, the departure from the normal being a moderate one (on a scale of *minor/moderate/severe*)."

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Dr Wright was subsequently asked to review Professor L's advice, and commented as follows:

> "Having read [Professor L's] report I would generally agree with his comments.
>
> In his last paragraph I understand the point [Professor L] is making, viz. [Dr D's] information gathering and the [family's] responses, suggested bowel bleeding. However, I believe the correct response in the presence of a second presentation of an unwell and weakened patient should be a more detailed history taking, in this case, at least around the suspect area (bowel) and possibly review of other symptoms. Further examination would then be guided by the information gained by the questions asked."

Intensivist advice – Dr Ross Freebairn
The following independent advice was obtained from Dr Ross Freebairn, a specialist intensivist, about the services provided by the public hospital, Dr F, Dr G and Dr H.

> "The questions to be answered are whether there was a significant delay in the transfer of [Mrs B] to Intensive Care (the Department of Critical Care Medicine, DCCM), and was her care compromised by any delay in transferring.
>
> On admission to hospital at [5.10pm] on the 29th April 2000, the medical team assessed [Mrs B] and further review occurred during the first four hours. Although [Mrs B] was clearly unwell and required hospital admission, there was no indication that urgent Intensive Care admission was warranted at that stage. Specifically, apart from her fast heart rate, her cardiovascular parameters were acceptable, with reasonable arterial oxygenation, and she did not require any additional respiratory support at that time. It would be reasonable to manage the clinical condition in an Emergency Department, pending further investigations.
>
> She was placed in a monitored bed in the Emergency Department, while further assessment and treatment were arranged. Throughout her stay, she remained constantly monitored. The investigation of her respiratory complaint included an electrocardiograph (ECG) and a chest radiograph (X-ray). As a result of the Chest X-ray findings an ultrasound of the chest was arranged. Interventions included treatment for the Pneumonia, and management of the tachy-arrhythmia (fast heart rate) with an amiodorone infusion. The first period of significant hypotension (Low Blood Pressure) occurred at about [9.30pm]. This occurred at the time of the amiodorone infusion. Hypotension is a known side effect of amiodorone. By [9.45pm] her Blood Pressure had become raised again and remained so until [11.30pm]. At approximately [11.00pm], the registrar from DCCM reviewed [Mrs B] and subsequently arranged admission to DCCM. Admission to DCCM occurred just after midnight.
>
> On admission to the DCCM, [Mrs B] was not distressed, and no specific additional interventions were implemented at the time of admission to DCCM.
>
> Interventions that occurred later were in response to a deteriorating cardiovascular status, and the indication for this intervention did not exist at the time of DCCM admission.

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From the observations made the interventions made, both before and during her ICU stay were both timely and appropriate. There were no additional interventions that would have changed the course of her disease.

There is no indication that [Mrs B's] admission, or referral to the DCCM was delayed, nor that there was any clinical advantage in having her admitted to the DCCM earlier.

The interventions of intubation, ventilation and subsequent organ support, occurred some time after her admission to DCCM. The timing of the myocardial infarction is unclear, but shock (cardiogenic and possibly septic shock) developed around the time the central venous access was ordered and placed. The subsequent management in DCCM is standard and unremarkable.

The documentation with the note is comprehensive, although the format (as with any hospital system) makes interpretation by a third party difficult. [Dr J's] dictated clinical notes and [Dr F's] review and summary of the notes provide a comprehensive account of the events.

There are clinical notes made by staff around the time of admission that are not 'timed'. This makes the interpretation of the times of assessment and interventions difficult. Although this can be established through other means, the record would be more robust if assessment time were recorded as a standard. The assessment by the DCCM registrar obviously took place sometime in the mid-evening but I am unable to find a record of this assessment in the clinical notes provided.

In summary, [Mrs B] was admitted to [the public hospital] and later transferred to DCCM. Although there was seven hours from the time of admission to the time [Mrs B] was physically admitted to the Intensive Care Unit, she was monitored at all times. The deterioration in her condition in the monitored bed prompted the review and subsequent admission to DCCM. The timing of this appears appropriate.

The family may have felt the seven-hour period before [Mrs B] finally arrived at DCCM was an indicated failure to appreciate the severity of her illness. However, there is no indication that [Mrs B's] referral, or admission to the DCCM was unduly delayed, nor that there was any clinical advantage in having her admitted to the DCCM earlier than was arranged.

They should be assured that there is no evidence that [Mrs B's] care was compromised by a failure of monitoring, observation, assessment or intervention, at any stage during her admission to [the public hospital]."

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Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

Opinion: No Breach – Dr C

Right 4(1)

On 26 April 2000, Mrs B consulted Dr C with symptoms of nausea, aching muscles, headaches, tiredness, and a lack of appetite for a period of five days. Dr C examined Mrs B's heart, lungs, abdomen and ankles. He recorded Mrs B's temperature, pulse and blood pressure. On the basis of his examination findings, he concluded that Mrs B probably had a viral illness (influenza) that was now resolving, and prescribed Maxolon and further paracetamol.

I accept my expert advice that Dr C's conclusions were justified on the basis of the information available to him at the time. Although Dr C did not diagnose pneumonia, my advisor informs me that it is possible that Mrs B had not yet contracted it. Even if she had, pneumonia is difficult to diagnose in its early stages.

I have noted my first general practitioner advisor's comment that Dr C did not look for signs of respiratory distress. However, Dr Kalderimis noted that Dr C obtained a complete history and his examination was also complete.

I have also considered the complaint that Dr C did not fully familiarise himself with Mrs B's relevant medical history. Dr C has advised me that he had a record of Mrs B's medical history in his notes. He also advised me that he did not believe that it was necessary to take specific note of Mrs B's history of tuberculosis. This is contrary to Dr Kalderimis' view that Mrs B's history of tuberculosis may have affected Mrs B's lungs and made her more susceptible to lung complications. Dr Kalderimis informed me that Dr C should "possibly" have altered his examination or treatment of Mrs B for this reason. However, when further clarification was sought from my advisor, he explained that someone who specialises in this area, such as a chest physician, may have expected that something additional should have been done in Mrs B's case. However, from the perspective of a general practitioner, Dr C did all that could reasonably be expected of him.

I also note my second general practitioner advisor, Dr Wright, considered that Dr C's history taking and examination were of an acceptable standard, and that his presumptive diagnosis of a viral illness was reasonable.

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In determining whether Dr C has breached the Code, I am required to consider whether he acted with the care and skill reasonably expected of a general practitioner in similar circumstances. I have carefully considered the facts. In my opinion there is no evidence that Dr C's assessment and treatment of Mrs B fell short of the standard expected of a responsible general practitioner. Accordingly, Dr C did not breach Right 4(1) of the Code.

Opinion: Breach – Dr D

Right 4(1)

On 28 April 2000, Mrs B returned to the medical centre for the second time, and saw Dr D. It appears that Mrs B's condition had deteriorated over the previous two days, and Dr D acknowledged that Mrs B appeared to be very weak when he saw her. Mr E advised Dr D that Mrs B had been passing black or very dark bowel motions. Dr D's examination consisted of taking Mrs B's blood pressure, checking her pulse and her chest. He examined her abdomen and did a rectal examination, which revealed the colour of her motions to be light brown.

In response to the question whether Dr D's examination of Mrs B was appropriate and complete, my first general practitioner advisor, Dr Kalderimis, informed me:

> "One could argue that in fact the examination was not complete because I note no mention in the notes of her temperature, her respiratory rate or any signs of respiratory distress. I feel that [Dr D] was probably somewhat side-tracked by the reporting that [Mrs B] had black bowel motions and he was obviously concerned that she might have bleeding from the bowel. Nevertheless, I think at this stage it was really important that we know what [Mrs B's] temperature was and at the same time it was probably important, given the fact that she had been unwell for about a week, that further investigation was warranted. These investigations would have included a blood screen and a chest x-ray."

Dr D did not diagnose Mrs B's pneumonia. However, it cannot be known for certain that Mrs B had pneumonia at the time of her consultation with Dr D. My first general practitioner advisor informed me that pneumonia may have developed somewhere around the fifth to seventh day of Mrs B's illness, but this cannot be stated with accuracy. If pneumonia had been present at the time of Dr D's examination, a chest x-ray would have revealed this.

Dr D acknowledged that he did not ask questions about Mrs B's usual lifestyle or level of activity to assist him in establishing how unusual her present condition was. My first general practitioner advisor commented that there can be a problem when a patient is not known to the doctor and is seen by different doctors. Knowing her history would have been very useful for Dr D in ascertaining just how sick Mrs B was. If Dr D had taken a more detailed history from Mrs B it may have indicated to him that Mrs B's presentation was unusual for her, and that further tests were warranted.

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My second general practitioner advisor, Dr Wright, agreed that Dr D's care of Mrs B was a moderate departure from an optimal standard of care.

Dr Wright concluded that although most of Dr D's examination was adequate, Dr D should also have taken Mrs B's temperature. Although Dr D obtained and considered a reasonable basic history, he should have recorded more of his questioning. In these circumstances (the second presentation of an unwell and weakened patient) a more detailed interrogation about Mrs B's symptoms and condition, particularly with reference to the suspect area (bowel), was warranted.

Dr Wright observed that it is unclear on the available evidence whether Mrs B was in fact breathless during this consultation. If Dr D's recollection is accurate, that Mrs B was not breathless, then his decision not to investigate her symptoms further at that stage was a reasonable decision in the circumstances, although his follow up instructions were unclear. If Mrs B was breathless, weak and unable to answer questions during the consultation (as described by her family), then it would have been appropriate to have organised her admission to hospital at that point. The general practitioner's role at this point was not to make the diagnosis of pneumonia (which I note would have been difficult given Mrs B's atypical presentation), but to judge the degree of her unwellness and decide between the appropriateness of hospital or home care.

Although Mrs B was ultimately diagnosed with pneumonia, her presentation was atypical. It appears that the symptom emphasised to Dr D, and indeed to Dr I the following day, was her abnormal bowel motions. It must also be emphasised that it is by no means certain that an earlier diagnosis of pneumonia (Mrs B died as a result of a heart attack) or an earlier hospital admission would have saved her life.

In my opinion, taking into account that this was Mrs B's second presentation, her condition had deteriorated in a short time, and she was obviously very weak, Dr D should have taken a more detailed history and undertaken a more detailed examination. By failing to obtain sufficient information to assist him to reach an appropriate decision about Mrs B's condition and care needs, Dr D did not provide Mrs B with services with reasonable care and skill. Accordingly, Dr D breached Right 4(1) of the Code.

Opinion: No Breach – Dr D

Right 4(1)

In order for Dr D to provide appropriate medical services, it was necessary for him to listen closely to the information provided by Mr E and Mrs B about her condition. There is some dispute over whether Mrs B spoke directly to Dr D during the consultation. Mr E advised me that he spoke, as his wife was unable to do so. Dr D advised me that both Mr E and Mrs B answered his questions, although Mr E did more of the talking than Mrs B. In the absence of witnesses, I am unable to reconcile these conflicting accounts.

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Ms A raised the concern that Dr D did not listen closely to the information that Mr E did provide, and that Dr D may not have been able to understand her father's accent.

There is no evidence to substantiate Ms A's concerns in this respect. Dr D advised me that he did not have difficulty understanding Mr E's accent. In any event, Mr E cannot recall what information he gave to Dr D, apart from advising him of Mrs B's dark bowel motions. Dr D was clearly aware of the problem with Mrs B's motions and performed a rectal examination because of it. In my view, there is no evidence to indicate that Dr D did not listen closely to Mr E. Accordingly, Dr D did not breach Right 4(1) of the Code in relation to this issue.

Opinion: No Breach – Dr H

Right 4(1)

On 29 April 2000, Mrs B was admitted to the Emergency Department of the public hospital at approximately 5.20pm. Mrs B was placed in an intensive monitoring room where her heart, blood and oxygen were continually monitored. Dr H first saw Mrs B at 6.05pm, and assessed her with the assistance of a medical student. Dr H recorded Mrs B's recent symptoms, retrieved her old medical notes, and recorded her medical history. He took blood samples and organised a chest x-ray.

Following his initial examination and the return of the chest x-ray, Dr H presented Mrs B to the registrar, Dr G, for review.

My intensive care advisor informed me that although Mrs B was clearly unwell when she was admitted to hospital, there was no indication that she required urgent admission to intensive care. I accept the opinion of my advisor that it was appropriate to manage Mrs B's condition in a monitoring room in the emergency department, pending further investigations. I am satisfied that Dr H appropriately assessed Mrs B, and that his interventions were timely and appropriate.

Accordingly, in my opinion Dr H did not breach Right 4(1) of the Code.

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Opinion: No Breach – Dr G

Right 4(1)

Dr G reviewed Mrs B after Dr H had seen her. She completed a full assessment of Mrs B, including blood pressure, temperature, blood cultures, oxygen saturation, and chest, rectal and abdominal examinations. Dr G reviewed the chest x-ray ordered by Dr H, which showed 'white out' of Mrs B's lung. In order to determine whether the white out was solid or liquid, an ultrasound was performed at 9.00pm. Mrs B was administered intravenous antibiotics and amiodorone at 9.30pm, with a repeat dose of amiodorone at 11.00pm.

Dr G discussed Mrs B's care with Dr F, consultant, and then the DCCM registrar, at around 11.00pm. Dr G advised me that she was worried about the development of respiratory fatigue, and felt that Mrs B would best be monitored in an intensive care environment. Dr G stayed at the hospital after the completion of her shift until Mrs B's care was taken over by DCCM.

My intensive care advisor informed me that no additional interventions were implemented when Mrs B was first admitted to DCCM. Mrs B was not distressed, and she was not ventilated at the time of her transfer. Although additional interventions took place in DCCM later, these occurred following Mrs B's myocardial infarction, and as a result of her deteriorating cardiovascular status. My advisor informed me that the reason for these interventions did not exist at the time of Mrs B's initial transfer to DCCM.

I accept the opinion of my consultant advisor that the timing of Mrs B's transfer to DCCM was appropriate, and that there were no additional interventions that could have changed the course of her disease.

In my opinion, Dr G provided careful and competent care to Mrs B, and did not breach Right 4(1) of the Code.

Opinion: No Breach – Dr F

Right 4(1)

Dr F was the consultant physician on call for the Emergency Department at the time of Mrs B's admission, and was consequentially responsible for the care given to Mrs B from the time of her admission to the time of her transfer to DCCM.

Dr F advised me that she had discussed routes of communication with Dr G on several occasions, and they were re-established prior to each admitting day. Dr F advised that on this occasion, Dr G did not contact her specifically about Mrs B, as was her habit when she had particular concerns about a patient. However, Dr G did discuss Mrs B with Dr F during a routine telephone call at approximately 11.00pm that evening. Dr F informed me that on the basis of this call, she was satisfied that Mrs B had been appropriately investigated and treated. My independent consultant advisor endorsed this view.

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Accordingly, in my opinion Dr F acted appropriately and did not breach Right 4(1) of the Code.

Opinion: No Breach – The Public Hospital

Right 4(1)

Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from omitting to take the action that breached the Code.

As previously outlined, in my opinion Drs H, G and F provided services to Mrs B with reasonable care and skill. Accordingly, no question of vicarious liability on the part of the public hospital arises.

However, I note my intensive care advisor's comments that Hospital staff did not always note assessment and intervention times in Mrs B's clinical records. In my advisor's opinion, the record would be more robust if assessment times were included.

Actions

I recommend that Dr D take the following action:

- Provide a written apology to Mr E and Ms A for breaching the Code of Health and Disability Services Consumers' Rights. The apology is to be sent to my Office and will be forwarded to Mr E and Ms A.
- Review his practice in light of this report.

I recommend that the public hospital take the following action:

- Remind hospital staff of the need to record assessment and treatment times in clinical records whenever possible.

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Further actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.
- A copy of this opinion, with identifying features removed, will be sent to the Royal New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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