General Practitioner/Private Hospital

Report on Opinion - Case 99HDC04797

Complaint

The complainant complained to the Commissioner concerning the treatment provided to the consumer by her general practitioner and when attending the private hospital.

The complaint about the GP is that:

- *For several years, up until her death in March 1999, the GP failed to treat the consumer's severe cough appropriately*
- *In early December 1997 the GP prescribed the consumer medication which included penicillin despite the consumer's records stating that she had an allergy to penicillin. Further to this, the GP failed to appropriately treat the consumer when she reacted to the penicillin.*
- *During her admission to the hospital during February and March 1999 the GP did not inform the consumer's family of her condition and prognosis.*

The complaint about the private hospital is that:

- *During her admission to the hospital in late February 1999 the consumer was not given appropriate care by staff resulting in a fall from her bed. Further to this, staff did not appropriately examine and treat the consumer for a head injury after this fall.*

Investigation

The complaint was received by the Commissioner on 23 April 1999. An investigation was undertaken and information obtained from:

The Complainant
The General Practitioner
The Manager of the Private Hospital

Medical records relating to the treatment of the consumer were obtained and reviewed. The Commissioner sought advice from an independent General Practitioner.

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Information Gathered During Investigation

The consumer consulted the GP ten times between May 1988 and early July 1996 with a cough and nasal discharge. During this period she was given antibiotics, two chest X-rays (which were normal), a sinus X-ray which showed opacification of her maxillary sinuses, and a consultation with an ear, nose and throat specialist. In 1988 she suffered a rash as a result of being treated with *amoxil*.

The consumer saw the GP early in March 1997 with sinusitis. The GP again prescribed antibiotics.

The consumer consulted another doctor in late October 1997 with sinusitis. This doctor recorded that in spite of the cough she seemed "*quite well*" and prescribed antibiotics.

In early December 1997 the GP visited the consumer because of a virulent nasal discharge. At this time the GP reported she seemed somewhat vague and incoherent. She was started on *rulide*.

At 9.25pm on the following day an ambulance was summoned to the consumer's house. She was taken to the on-call doctor, who believed that her symptoms were a side effect of the *rulide* and who sent her home.

The following day, the GP was called to the consumer's house and found that she had apparently suffered a stroke. She was incoherent and had a definite weakness in her right arm. The GP transferred her to the hospital for on-going care. On admission her temperature was 38.2C, she was incoherent and had definite weakness in all muscle groups of her right arm. Her right leg was normal. She also had some signs of a chest infection.

In view of her chest symptoms and the fact that she had appeared to have had a reaction to *rulide* the previous day, the consumer was started on *augmentin*. The GP reports that in light of her reaction to *amoxil* in 1988 this was an error.

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Information Gathered During Investigation, *continued*

The GP stated that the consumer was unable to declare her allergy due to her condition. Further, the hospital had only recently opened and did not possess any notes relating to the consumer. In addition, the GP did not have access to his notes relating to the consumer, as she was seen in her home and at hospital, but not in his practice. The GP cannot recall any family member mentioning her allergy at this time.

The GP reported that the consumer recovered quickly with this antibiotic treatment. Her temperature settled and her chest improved. By mid-December 1997 her mental state had improved as well. The consumer was discharged to the care of her daughter.

In late December 1997 the consumer developed a rash on her upper leg and groin and became feverish. Her daughter rang a GP (the complaint's letter stated that it was the GP who took this call, medical records indicate that it was actually another GP). The other GP reportedly stated that as the chemist was closed he could not prescribe anything and suggested that the consumer be given a cold bath. By 1.30am on the following day the consumer was reported to be delirious so the other GP was rung once more. The other GP visited the consumer at home and phoned an ambulance.

The consumer was admitted to a public hospital two days after she became feverish. She had a temperature of 37.5C on admission. The consumer's rash cleared within 2 days. However, she remained confused and this was presumed to be the result of a stroke. The consumer's camden scores were 13/20 and 11/20. The services for the elderly team assessed her as requiring continuing care.

The consumer's discharge diagnosis was multi-infarct dementia and this was confirmed by a CT scan in late February 1998 which showed evidence of a previous significant stroke.

The consumer was transferred to a rest home in her home town in January 1998, returning to her own home when her daughter decided to move in with her in April 1998.

In April 1998 the consumer was again admitted to the hospital with a urinary infection.

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Information Gathered During Investigation, *continued*

In late February 1999 the consumer became unwell in her home and collapsed. When seen she was frail, shaking, unable to stand unaided, had a temperature of 37.5C and was admitted to the hospital and started on antibiotics and oral fluids. The GP and a consultant physician for services for the elderly, agreed that her confusion had increased. This was thought to be brought on by her chest infection. The GP reported that the consumer's condition started to improve on antibiotics, fluids and some chest physiotherapy.

From late February 1999 nursing notes constantly refer to the consumer as being "*sleepy*".

During a night in late February 1999 the consumer was found on the floor. In falling she had lacerated the right orbital region of her head and bruised both knees. Nursing staff immediately lowered the consumer's bed and erected cot sides the next morning to lower the risk of the consumer injuring herself in another fall. It was reported that problems were later experienced with the consumer attempting to climb over the cot sides.

The following day, a registered nurse recorded that the consumer was sleepy and incontinent (urine). She went on to report that, apart from some bruising, the consumer did not appear to have suffered any untoward effects from the fall. An incident form was completed.

Two days after the fall the consumer was again recorded as being sleepy and incontinent (urine and faeces). At 2.00pm she was found lying on the floor. The consumer was assisted into her chair and it was noted that, although she was sore, she had no specific complaint arising from this fall. A further incident form was completed.

In early March the consultant physician's notes indicate that the consumer's condition had deteriorated markedly over the previous week. He suggested a change in antibiotic, and that change was made. The consumer's condition appeared to improve and she began to drink more.

Five days later the GP met with the consumer's son. The consumer's long-term prognosis was discussed. Nursing notes on this day record that the consumer's condition had improved slightly each day.

At 8.00pm on the following day the consumer passed away.

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Independent Advice to Commissioner

During the course of this investigation the advice of an independent general practitioner was sought. My advisor reported that:

Treatment of the Consumer's Cough

> *"... The GP did treat* [the consumer's] *cough appropriately. She responded well to antibiotics, she had a number of chest x-rays (seven I believe between 1988 and 1999) and as well she was seen by* […], *ENT Surgeon,* […], *for her nasal and sinus discharge. The GP followed the advice given to him by* [the ENT Surgeon]*."*

The Consumer's Falls

> *"... I believe that the hospital treated* [the consumer] *appropriately when she fell and hurt her head twice. Each time the appropriate procedure was followed.*
>
> *It is impossible to say* [whether the consumer's deterioration in late February 1999 resulted from her fall]. *In view of her multi-infarct dementia I believe that this is probably not the case ..."*

Prescription of Augmentin

> "[Taking General Practitioner notes with you when have to do an acute house call is] *for the most part impractical …* [and it] *is not something done routinely ... Thus, I do not believe that* [the GP] *should be judged harshly for not having his GP notes with him when attending* [the consumer] *in her home.*
>
> *Obviously to prescribe Augmentin to someone who is allergic to Penicillin was a mistake and* [the GP] *acknowledges this. This should not have been done but the deterioration in her health could not be attributed to this and, although she did develop a rash, it settled down rapidly after three days and what happened to her after that could in no way be due to the administration of the Augmentin.*
>
> *I believe that* [the GP's] *treatment of* [the consumer's] *reaction to the Augmentin was appropriate in view of the very mild reaction that she sustained."*

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Independent Advice to Commissioner, *continued*

Communication With The Consumer's Family

"I believe that [the consumer] *was in fact improving reasonably during her stay at* [the hospital] *and her death, although perhaps not entirely unexpected in any 84-year-old, was not foreseeable. I do not believe that the family could have been told about or warned about her impending death because this cannot be accurately foreseen."*

Summary

"I believe that [the consumer] *was in fact well looked after by her General Practitioner and the* [the hospital] *and a great deal of care and attention was in fact taken over her. You only need to see the number of times that she was seen and visited to be aware that in fact a great deal of care and caution was taken with* [the consumer].

In summary, therefore, I believe that [the GP] *and* [the hospital] *provided* [the consumer] *with health services that did comply with professional and other relevant services."*

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

...

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

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Opinion: No Breach The GP

In my opinion the GP did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights as he took reasonable actions to diagnose and treat the consumer.

I accept my independent advice on this matter. The consumer's cough was treated appropriately. When the GP administered augmentin to the consumer he did not have access to his practice notes relating to the consumer. He was not informed by any family member that the consumer had an allergy to penicillin. I am also advised that, while it is possible that the rash experienced by the consumer eight days after receiving augmentin may be attributed to her allergy, none of her other symptoms were related to this allergy.

My advisor further stated that the consumer's death could not have been foreseen. Medical notes indicate that her condition was improving in the time leading up to her death and the GP could not have reasonably been expected to provide the family with a more accurate prognosis than he did.

Opinion: No Breach The Hospital

In my opinion the hospital did not breach Right 4(1) of the Code of Health and Disability Services Consumers' Rights as reasonable actions were taken to treat the consumer after her falls and to prevent the consumer from being injured further.

Actions

This file will now be closed.