Dr C – General Practitioner

GP On-call Visiting Service

A Report by the

Health and Disability Commissioner

(Case 03HDC00575)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Complainant/Consumer
Mr A	Complainant's husband
Mrs B	Complainant's sister
Dr C	Provider/General practitioner
Dr D	General practitioner/Director, GP On-Call Visiting Service (the Service)
Dr E	General practitioner
First public hospital	
Second public hospital	

Complaint

On 16 January 2003 the Commissioner received a complaint from Mrs A about the medical services provided to her. On 10 October 2003 an investigation was commenced. The following issues were investigated:

Whether Dr C, general practitioner, provided services of an appropriate standard to Mrs A. In particular, whether Dr C:

- *appropriately assessed and treated Mrs A at the first consultation on 18 October 2002*
- *appropriately disposed of the needle and syringe he used when he treated Mrs A on 18 October 2002*
- *appropriately assessed and treated Mrs A at the second consultation on 19 October 2002.*

Information reviewed

- Information was received from
  - Mrs A
  - Mr A, complainant's husband
  - Mrs B, complainant's sister
  - Dr C, who provided copies of his clinical records for Mrs A but, despite requests from the Commissioner, failed to provide a transcript of these to assist legibility.
- Mrs A's clinical records from the first public hospital

Independent expert advice was obtained from Dr Steven Searle, general practitioner.

Information gathered during investigation

Mrs A was diagnosed with meningitis and meningococcal septicaemia at the first public hospital on 21 October 2002 following a four-day history of abdominal symptoms, headaches and a generalised rash. Mrs A recovered from the illness and was discharged home after nine days in hospital.

18 October 2002 consultation
Mrs A became ill with diarrhoea and vomiting on 17 October 2002. On the afternoon of 18 October she contacted the surgery of her general practitioner, Dr E, and spoke with the receptionist. Mrs A told the receptionist that she had been unwell for 24 hours with persistent diarrhoea and vomiting and needed to see a doctor. The receptionist contacted the Service for Mrs A, and requested that a doctor visit her at home.

At 3.30pm Dr C from the Service visited Mrs A at her home. Mrs A recalled that Dr C took her temperature under her arm, told her that there was a virus going round, and gave her an intramuscular injection of Stemetil (into her left thigh) and two codeine tablets. Mrs A stated that when Dr C gave her the injection he failed to see a petechial rash on her thigh, which was plainly visible to her sister, Mrs B, who was in the room during the examination.

Dr C's record of the visit states:

> "HISTORY
> 15.30: d&v, dizzy
>
> EXAMINATION
> Abdo soft
> 36.7°C
> [two further lines were undecipherable]
>
> ASSESSMENT/DIAGNOSIS
> gastroenteritis
>
> PLAN
> Rx Stemetil 12.5 – im stat
> Buscopan 20
> Cod Phos 30mg x 6qh x 2."

Mrs B informed me:

> "I was present when [Dr C] attended a house call at my sister's home. He was called out because she was complaining of headaches and vomiting. When I arrived prior to [Dr C] arriving, I was very concerned looking at [Mrs A] in bed – she looked weak and lethargic. I watched her go to her ensuite toilet and witnessed her difficulty getting there. Her head was pounding and she felt sick moving around. I tried to make her bed while she was up to the toilet, but in the event made it around her – she

> felt too nauseated standing. She looked terrible – I remember noticing how extremely weak she was.
>
> While I was there [Dr C] checked [Mrs A's] temperature and pulse. He gave her an injection into her left leg for vomiting and some pills for an episode of diarrhoea. I remember noticing [Mrs A's] leg while [Dr C] was injecting into it. I distinctly remember noticing her leg covered in red pin spots.
>
> …
>
> [Dr C] gave my sister pills for her diarrhoea, she had one and he gave me one to give her 30 minutes later."

Dr C stated:

> "On [18 October Mrs A] complained of diarrhoea, vomiting and dizziness and was aching all over. Her temperature was recorded as **36.7** degrees Celsius, her pulse rate was normal, her abdomen normal in appearance and nowhere tender, and she did not admit to a headache. I observed an area of pink discolouration, about three inches in diameter, on her thigh, as I was injecting her with *Stemetil* and *Buscopan*. It had the appearance of pressure from her clothes or blankets. There were no 'petechiae' at that time, her neck was fully mobile and she had no other signs of meningeal irritation. However, she was feeling very out of sorts and left most of the talking to her relatives. Kernigs and Brudzinskis signs [both neurological signs of meningitis] were negative, there was nothing to suggest meningitis or septicaemia."

Dr C stated that the subject of meningitis was discussed during the consultation. He said that he told Mr A that although he could not justify a diagnosis of meningitis, the disease could develop rapidly and that they should remain vigilant and not hesitate to call for medical assistance if Mrs A deteriorated in any way. However, Dr C's recollection that Mr A was at this consultation is not correct. Mr A confirmed that he was at work when Dr C made the first house call.

In response to my provisional opinion Mrs A stated:

> "[Dr C] did not perform tests for Kernigs and Brudzinskis signs during his visit on the 18 October. I have no recollection of him doing this at any time. On this visit a meningitis diagnosis was not discussed."

Mrs A informed me that she was concerned that Dr C did not appropriately dispose of the syringe he had used to give her the Stemetil and Buscopan, but left it in her bathroom. Dr C stated that Mr A "kindly agreed to dispose of the sharps safely" – however, as noted above, he was not present. Mrs B disposed of the syringe after Dr C left.

Dr C stated that about half an hour after he left Mrs A's house, Mrs B telephoned him to report that Mrs A's head had started throbbing badly and her ears were pulsating.

Mrs B informed me:

> "[Mrs A's] head was pulsating badly soon after [Dr C] left and we decided that I would ring to inform him. He dismissed my concerns in a patronising manner stating that in his opinion my sister was being over dramatic, and that he felt this was a drug reaction. He ended the call by saying to ring back if we were concerned."

Dr C recalled that he asked Mrs B questions about Mrs A's symptoms and when he had reassured himself that she was not displaying signs of shock, he advised Mrs B to wait until the immediate effect of the injection passed. He said that he gained the impression that the problem was resolved, as he did not receive a further message about Mrs A that day.

19 October 2002 consultation

The following day, 19 October, Mrs A was worse; she had a generalised rash and a stiff neck. She was photophobic and vomiting and thought that she had contracted meningitis. Her husband contacted the Service. Dr C visited at 1pm and Mrs A told him her concerns. Mrs A's husband was present during this consultation; this was the first occasion he had met Dr C. Mrs A informed me:

> "I told him [Dr C] in front of my husband, 'I'm covered with a rash, my neck is sore, the lights are bright and I'm being sick a lot – every 15 mins'. He asked me if the diarrhoea had cleared up – I said yes. He briefly looked at my abdomen and moved my head from left to right once (this took well under a minute) and said that he thought the rash was a side effect from taking the codeine rather than meningitis. I showed him the 'ganglion' on my left hand, and said that there were four more up my arm which he looked at while taking my pulse. I remember telling him that although I knew they weren't, they looked like melanoma secondaries. I made a joke of it saying that was my line of work. He thought it unremarkable and told me to discuss it with my GP. His closing comments were not to lie there distressing myself thinking I was sicker than I was – 'I suggest you start drinking fluids and I suggest you try to keep them down'."

Mr A stated:

> "During his visit [Dr C] intimated that there was nothing to suggest more than gastric flu wrong with my wife. His manner at the time was casual (and in hind-sight, too casual).
>
> As her condition worsened a number of significant symptoms became evident which to a doctor, I feel should have been taken seriously – which weren't. These were apparent in the early stages (i.e. on Saturday the 19th). I noticed some of them myself, namely red spots over much of her body, headaches, nausea and continued vomiting. In addition, [Mrs A] had pea-like lumps appear on her forearm. Her neck was stiff also.
>
> The above symptoms were strong indications of a case of meningitis which I feel should have been picked up by a competent doctor and by not doing so [he] put my wife, [Mrs A], at risk."

Mrs A stated that she is a health professional (radiation technologist), and the way Dr C behaved towards her "lulled" her into a false sense of security.

Dr C's record of the visit states:

> "HISTORY
> 1300: vomit & nausea
> diarrhoea has stopped
>
> PAST HISTORY
> D7v 18.10.02 – given cod phos
>
> EXAMINATION
> Abdo soft 36.3°C
> [Indecipherable word] √
> [Indecipherable word]√
> Pulse √ Hb √
> petechial rash on legs
> [undecipherable word]
>
> ASSESSMENT/DIAGNOSIS
> Viral illness
> PLAN
> Rx Stemetil 12.5 – im stat"

Dr C stated:

> "I was called again [to see Mrs A] because of continued nausea and vomiting although the diarrhoea had stopped, possibly because of the codeine I had given her the evening before. Again her temperature was normal at 36.3 degrees and her pulse, throat, ears, chest and abdomen were also normal. She was well hydrated, alert, fully conscious and presented a normal sensorium. In fact she was very much better than she had been the day before and my fears with regard to meningitis were allayed. She did now have a different rash on her thigh which her sister called 'petechial' but close examination of the tiny spots showed that they blanched under pressure so were neither haemorrhagic nor thrombotic. Even at that stage they were not evident elsewhere. No rash was present on her abdomen or elsewhere. Her neck was quite mobile. The disease had now been present for the best part of two days and appeared to be waning in the expected manner of a viral gastroenteritis. I regret I have no recollection, or notes of 'ganglion' on her left arm and hand. Perhaps they developed the next day."

Mrs A informed me:

> "With regard to the presence of the rash and my neck mobility on the 19th, my husband showered me that day. I was too unwell to shower myself on my own. When he took my nightie off, his exact words were, 'You're covered with a rash'. I had hundreds of spots all over my body and limbs. I remember trying to look at them, and I couldn't bend my neck because it felt tight and sore. I had to look in the mirror to see them."

In response to my provisional opinion, Dr C stated:

> "There are acceptable ways of examining rashes to determine the presence of 'petechial' haemorrhages and/or thromboses which were applied and found wanting, but you and Dr Searle, on no grounds whatever, have preferred to accept Mrs A's untrained guess. … I have seen minor rashes due to codeine myself – their relative rarity is irrelevant: it has always to be considered."

Subsequent events

By 21 October Mrs A's condition had deteriorated further. Her husband again contacted the Service. Dr D, general practitioner and the director of the Service, visited at 11.40am. Mrs A recalled that when Dr D entered her room and turned on the light she asked him not to as the light hurt her eyes. When he was told that Mrs A had had a rash for three days and had been vomiting for five days, he verified the rash, telephoned for an ambulance and arranged for Mrs A to be admitted to the second public hospital.

Dr D's record of the visit states:

> "HISTORY
> Vomiting + DIARR 6/7 ago
> Dizzy
> s/b Dr C 3/7 & 2/7
> Dx Gastro
> Given Stemetil IM which worked
> No Hx of FEVER
> Today – Headache, no vomiting since last night
> stiff neck
> RASH noticed on legs ? SAT
> Not drinking much."

Dr D noted that Mrs A's temperature was 36.2°C and her blood pressure 90/60. He recorded that she had a rash, possibly petechial, on her legs, arms and possibly on her eyelids, and that she had a degree of neck pain and stiffness.

Mrs A recalled that she was vomiting often and because her head was so sore she had given up trying to sit up to be sick. She said that she also remembers having a left hemiparesis (left-sided paralysis). In response to my provisional opinion, Mrs A stated that she was concerned that "crucial signs and symptoms were not recorded by Dr D".

Dr D's assessment of her condition and provisional diagnosis was gastric illness and petechial rash. He referred her initially to the second public hospital, but because of a bomb scare at the hospital, Mrs A was transferred to the first public hospital for review by the general medical team.

Mrs A was admitted to the first public hospital Intensive Care Unit (ICU) where she was diagnosed with meningococcal meningitis and meningococcaemia.

Mrs A recovered well and was discharged on 29 October. The first public hospital clinical summary stated:

> "Presented with a 3 day history. Had fever/headache and petechial rash. LP showed pus and grew neiseria meningitides. Blood cultures grew the same. She had a CT head scan which was normal. D/w infectious diseases and treated with 4 days of IV rocephin. Settled well. Developed polyarthritis during the stay in hospital, presumed to be 2° [secondary] to the joint pain. She was found to be slightly anaemic while here and has been given a FBC [full blood count] form so her GP can monitor this. ENT clinic for follow-up."

Additional information

Dr C
Dr C summarised his report in response to Mrs A's complaint as follows:

> "This is a most unusual case. I have long been aware that the distinctive signs of this illness [meningitis] are frequently absent or modified but all my experience and reading reinforced the idea that meningococcal septicaemia and meningoencephalitis are febrile [feverish], and so rapidly and relentlessly progressive that they can lead to coma and death in less than twenty-four hours. [Mrs A] survived five days before even beginning specific treatment.
>
> I am afraid I was led completely astray by this feature, in combination, as it was, with its persistently afebrile [no fever] nature … and lack of convincing meningeal irritation. Although a rash was present, it too showed none of the specific features of meningococcal infection.
>
> …
>
> The visits took place on Friday and Saturday afternoons, a time when outpatient services are clogging up toward the end of the normal working week. Admission to hospital at any time, but especially then, is liable to be followed by long hours of waiting to be seen by junior or inexperienced staff and over the years many widely publicised cases have shown that meningitis fatalities occur when people attend there prematurely with under developed signs and are sent home falsely reassured. In [Mrs A's] case there is no question that the possibility of meningitis was considered and discussed. In my opinion, as outlined previously, there was insufficient evidence of a serious danger to life at that

stage to ensure that she would be treated or given special priority at the hospital. I took the view, and still do, that she would be safer left in the attentive, intelligent and informed care of her family than in an hectic outpatients department. I was confident, after speaking to them, specifically about meningitis, that they could be relied on not only to look after her well, but to notice any deterioration in her condition more quickly than a busy nurse. And this [proved] to be the case: I was rung shortly after I left about a minor untoward reaction and again the next day to bring about my prompt return. Unexpectedly she proved to be in better health then than she had been the day before and so I decided to continue the established plan which was clearly working well.

I have been doing out-of-hours calls throughout [the city] for about 40 hours per week for fifteen years and the number of patients I have visited with headache, photophobia, a stomach upset and often a non-specific rash, is enormous. Not one has died of meningitis although that diagnosis has of course arisen on many occasions. The early signs and symptoms of meningitis are quite indistinguishable from those of any acute systemic infection such as influenza, and hence exceedingly common. If the Service was to admit, or even to treat with antibiotics, all such cases, the national cost would be unsupportable. In my humble opinion the strategy, of vigilant and informed supervision, is the only available method of preventing meningeal tragedies and that in this case her family were eminently qualified to administer it. They did not hesitate to call a third time two days later when my colleague, [Dr D], found sufficient evidence to justify admission. The reaction of the junior hospital staff was predictably alarmist but cooler heads soon prevailed and she was treated calmly and sensibility with the outcome we all hoped for. Tragically this is not always the case hence the critical need for vigilance.

May I humbly submit that, far from being incompetent, the strategy I adopted assured her safety when premature admission has failed on too many occasions.
…

Please convey my deepest sympathy and regret to [Mrs A] and my delight that she managed somehow to survive my inept attention and make a full recovery. My only consolation is that my bumbling did not discourage her and her family from seeking more help when mine had failed her."

Independent advice to Commissioner

The following expert advice was obtained from Dr Steven Searle:

"This report has been prepared by Dr S J Searle, under the usual conditions applying to expert reports prepared for the Health and Disability Commissioner. In particular Dr Searle has read the guidelines for Independent Advisors to the Commissioner (Ref. 1) and has agreed to follow them. He has been asked to provide an opinion to the Commissioner on case number 03/00575/KH.

He has the following qualifications: MB.ChB (basic medical degree Otago University), DipComEmMed (a post graduate diploma in community emergency medicine – University of Auckland), FRNZCGP (Fellow of the Royal New Zealand College of General Practitioners – specialist qualification in General Practice which in part allows him to practise as a vocationally registered practitioner). As well as the qualifications listed Dr Searle has a certificate in family planning and a post graduate diploma in sports medicine. He has completed and renewed a course in Advanced Trauma – ATLS (Advanced Trauma Life Support). He has a certificate (Nov 2003) in Resuscitation to Level 7 of the NZ Resuscitation Council. More recently he has completed a PRIME course (May 2004). He has worked in several rural hospitals in New Zealand as well as in General Practice and accident and medical clinics and currently works in his own practice as well as in the Emergency Department in Dunedin Hospital. He is also actively involved in local search and rescue missions and training.

Dr Searle is not aware of any conflict of interest in this case – in particular he does not know the health provider(s) either in a personal or financial way. Dr Searle has not had a professional connection with the provider(s) to the best of his knowledge.

Basic Information:
Patient concerned: [Mrs A]
Nature of complaint: Possible inadequate assessment and treatment of her illness and related issues.
Complaint about: [Dr C].
Also seen by: [Dr D].

Expert Advice Required:
To advise the Commissioner whether, in your professional opinion:

- [Dr C] provided [Mrs A] with services of an appropriate standard. In particular:

1. Was [Dr C's] assessment of [Mrs A] when he visited on 18 October 2002 appropriate?
2. What are the symptoms of meningitis?

3. What assessments/tests should a general practitioner visiting a patient at home perform to exclude meningitis?
4. Was it reasonable in the circumstances for [Dr C] to conclude that [Mrs A] was suffering from viral gastroenteritis on 18 October?
5. If not, why not? What else should he have done?
6. Was it reasonable for [Dr C] to conclude on 19 October that [Mrs A] was continuing to suffer from viral gastroenteritis?
7. If not, why not? What else should he have done?
8. What is the accepted method for a visiting doctor to dispose of used syringes?

Additionally:

- Are there any other professional, ethical and other relevant standards that apply and, in your opinion, were they complied with?

- Are there any other comments you consider relevant to this case?

Documents and records reviewed:
Supporting Information

- Letter of complaint to the Commissioner from [Mrs A], dated 7 January 2003, and accompanying document addressed to [the Service], marked with an 'A'. (Pages 1–6)

(NB Pages 7 & 8, marked with a 'B' were repeat pages of [Mrs A's] letter copied in error)

- Notes taken during a telephone call with [Mrs A] on 12 December 2003, marked with a 'C'. (Page 9)
- Letter of response to the Commissioner from [Dr C], dated 10 May 2003, marked with a 'D'. (Pages 10 & 11)
- Letter of response, and supporting documents, to the Commissioner from [Dr C] dated 3 November 2003, marked with an 'E'. (Pages 12–15)
- Clinical records received from [the first public hospital], relating to [Mrs A's] admission on 21 October 2002, on 13 February 2004, marked with an 'F'. (Pages 16–57).

Possible missing information:

I would have preferred to have a typed record of the providers' notes as all I have is a copy of the original hand written notes – my understanding is that attempts to obtain typed copies [from Dr C] have been unsuccessful.[1]

[1] A typed transcript of the records was requested from [Dr C], but not provided.

There appears to be no record of the information, if any, passed on from [Mrs A's] own GP (general practitioner) to the house call service. It is also not clear to me who at [Mrs A's] own GP took the phone call. [Mrs A's] letter of 20 December 2002 states that on Fri. 18th Oct 'I called my GP's receptionist, who called your service requesting a home visit for myself'. There may well be a record of this phone call at [Mrs A's] GP's rooms and it could provide further information about what symptoms were being experienced at the time. However given it is not that likely to change my opinion I think it would only contribute to further delays in the processing of this case and I have decided not to seek this information before coming to a conclusion. This does however raise the issue of should someone other than a receptionist, such as a doctor or a nurse, have been asked to take [Mrs A's] call. If so would a different pathway of care have occurred if that happened? It is possible that it would have only delayed her in being referred to the house call service as it may well have been impossible for the GP or practice nurse to take her call at the time it was made – in which case delayed care might have occurred. However if the GP or the practice nurse had taken the call then it might have been possible for the GP to do a house call themselves, or to pass on information to the house call service if [Mrs A] had any significant past history or medications. This issue is beyond the scope of the report but it is something that [Mrs A's] GP might want to review as part of practice procedures. Certainly there is some evidence that patients do better if they see their own GP or failing that a doctor with access to their records.

There is no note or written record of the phone call from [Mrs A's] sister [to Dr C] regarding the throbbing head – however Dr C does acknowledge this phone call took place. I do not think my opinion is likely to be changed by having a copy of such a record if it exists, however if anyone does want me to consider this information in future I would be happy to do so if it does become available.

To clarify my interpretation of the notes I am typing them out in full as follows – the capitals with underlining are the already printed standardised headings used in the form used to record the notes. I clarify the meaning of abbreviations to make this easier to read – the abbreviations are generally well accepted common place medical abbreviations used in common practice every day medical record keeping and there is no problem as such with their use.

> Note from 18/10/02 [Dr C]:
> HISTORY 1530 (time on 24h type clock meaning 3.30pm) D&V (short for diarrhoea and vomiting), 'some word I find hard to read' (probably 'dizziness' – because this makes sense and is what [Dr C] wrote in his letter of explanation dated 10/5/03)
> PAST HISTORY / REG. (short for regular) MEDICATION Left blank – i.e. no notes written.
> <u>EXAMINATION</u> abdo (short for abdomen) soft (I think this is what is written – meaning feeling her abdomen it was soft with no signs of intra-abdominal complications that sometimes show up as a rigid feeling abdomen).
> 36.7 degrees C – (meaning her temperature)

P regular 80 (meaning her pulse was 80 beats per minute and regular)
Hydration tick (meaning there were no signs of dehydration – there are various things checked for this and this may vary from doctor to doctor).
ASSESSMENT/DIAGNOSIS gastroenteritis
PLAN Rx stemetil 12.5mg buscopan 20mg IM stat (meaning both these medications were given intramuscularly at the time ('stat' is short for 'statim' meaning at once)
Codeine phos (short for phosphate) 30mg 6qh (meaning each 6 hours) 2 with a circle around it (meaning 2 tablets were prescribed or dispensed/given to her).
PRESCRIPTION this is blank – presumably no prescription was written unless this was on a separate pad.

Note from 19/10/02 [Dr C]:
HISTORY 1300 (time on 24h type clock meaning 1pm) Vomiting & nausea.
Diarrhoea has stopped.
PAST HISTORY / REG. (short for regular) MEDICATION d&V (short for diarrhoea and vomiting), 18.10.2 (i.e. the date of the day before) – given cod. Phos. (referring to the codeine phosphate medicine given the day before)
EXAMINATION abdo (short for abdomen) soft (meaning feeling her abdomen it was soft with no signs of intra-abdominal complications that sometimes show up as a rigid feeling abdomen).
36.3 degrees (meaning her temperature)
throat tick (meaning her throat was clear)
ears tick (meaning her ears were normal)
pulse tick (meaning her pulse was normal) HS tick (meaning heart sounds normal)
petechial rash on legs (I am fairly certain that the first word on this line is 'petechial' – I can not see how it can read as anything else – this was one of the main reasons I wanted a typed version of the notes from [Dr C]. 'Petechial', refers to small spots generally reddish or purple and ranging in size from pinpoint to a pinhead, that appear under the epidermis (the outer protective layer of the skin) and that are caused by extravasation of blood).
sensorium intact (meaning she seemed to be alert and rational – or no alteration in mental state.)
ASSESSMENT/DIAGNOSIS viral illness
?codeine reaction (meaning that there might have also been a reaction to the codeine as well as the viral illness)
PLAN Rx stemetil 12.5mg IM stat (meaning this medication was given intramuscularly at the time)
PRESCRIPTION this is blank – presumably no prescription was written unless this was on a separate pad.

Note from 21/10/02 [Dr D]:
HISTORY Vomiting + Diarr (diarrhoea), Dizzy (both lines bracketed suggesting the following words applied) 4/7 ago – (suggesting the vomiting and diarrhoea and dizziness were 4 days ago but possibly meaning ongoing for the last 4 days).
S/B (seen by) Dr C 3/7 & 2/7 (3 and 2 days ago)
Dx (diagnosis) gastro (gastroenteritis)
Given stemetil IM which worked initially (these last two words not that readable but this is probably not that important) No Hx (history) of fever; (on the next line just past half way along some word I am not sure of possibly 'diet' or 'diar' (short for diarrhoea) – this word is probably not that important)
Today headache, no vomit since last night; – some nausea
Rash noticed on legs ?SAT? (meaning possibly on Saturday (extra question mark suggesting not certain (the date of this note – 21/10/02 was a Monday and the Saturday would have been 19/10/02 when [Dr C] last saw this patient))
(next line first word I am not sure of – possibly 'with') drug rash.
PAST HISTORY / REG. (short for regular) MEDICATION
Nil (underlined)
Small raised circle (common medical abbreviation for 'No') meds (medications)
EXAMINATION
T=36 2 (meaning temperature of 36.2 degrees celcius) dry mouth 90/60 (meaning blood pressure of 90 systolic and 60 diastolic)
& (Towards the end of the next line 3 or 4 words or abrieviations I can not make out).
Chest: clear
Rash: ?PETECHIAL
Legs/ less on arm
Poss (short for possibly) around eye lid(s)
Some ??? (word I can not make out ?R (for right) NECK) PAIN + STIFFNESS
Not photophobic
ASSESSMENT/DIAGNOSIS
GASTRO ILLNESS +/- PETECHIAL RASH
PLAN
Med Reg [The second public hospital] (Meaning medical registrar (specialist senior doctor training in general medicine) at [the second public hospital] contacted), Bomb Scare in progress (a good note explaining why this patient ended up being sent to [the first public hospital]).
??? (some word I can not make out) to [the first public hospital] E.D. For RV by medical reg (meaning the patient was to go to [the first public hospital] Emergency Department for review by the medical registrar).
AMBUL (underlined – meaning transportation by ambulance).
PRESCRIPTION this is blank – presumably no prescription was written unless this was on a separate pad – given the patient was sent to hospital this would usually mean no prescription was written at the time.

Quality of providers' records or lack of them

I consider [Dr D's] notes from 21/10/04 to be adequate or more than adequate.

[Dr C's] notes are brief on the first occasion (18/10/02) in general. In particular the history section is very brief listing only two symptoms – not mentioning their duration or if they were worsening or improving – I think there should have been a note about these things. The presence or absence of other symptoms was not recorded. Given there was dizziness some sort of more detailed description of this and a history of the severity of this or how much it affected her should have been noted. This could include things such as if she could stand up or not and if she could walk without feeling she would fall over etc. Nothing was recorded in the section on past history and regular medication – this can either mean there was no significant past history or medications or it was simply not asked about. Even a brief note with a dash or 'nil' or something similar can show it was enquired of and I think this should be documented. The template for the notes for the house call has pre-formatted headings to make this easier and it is a good standard to have such headings as it makes writing good notes easier and it is easier for other doctors to refer to should the need arise. The notes on the examination show clearly what was examined. The diagnosis was clearly documented which is good. The plan documented the medication given which is good. However there was no documentation of other advice such as what food or fluids to have, and more importantly what the follow up plan was – such as when and why she should seek further medical attention or not.

[Dr C's] notes on the second occasion (19/10/02) have similar problems to his notes from the first occasion. In particular no clear reason was given for why a second house call the day after she had been seen was asked for. The history section actually lists less symptoms than the day before. I think if a patient seeks a second doctor's visit for the same illness that the reason for their concern or request for the visit should be documented. Once again this note has no documentation of other advice such as what food or fluids to have, and more importantly what the follow up plan was – such as when and why she should seek further medical attention or not.

Describe the care as documented and describe the standard of care that should apply in the circumstances.

Safety

Is the patient now in a safe environment (safe from further injury) & is it safe for the provider?

The environment is usually safe in most medical clinics and hospitals, but in patient's homes this is not always the case. Most homes do lack certain facilities that medical clinics and hospitals have such as sharps containers (used for disposing of sharp objects such as needles and glass vials that may or may not have been contaminated by body fluids). It is important for doctors doing house calls to safely dispose of 'sharps' both for their own safety and the safety of the patient and anyone else in the household or anyone handling this waste once it leaves the house. This is

commented on in more detail later in the report, however the documentation clearly shows injectable medication was given, and so a needle and syringe would have been used and needed to be disposed of.

Any Serious Injury/Illness?

Is there any life threatening injury or illness – this is important as most medical problems will resolve but some can be serious and need specific investigation, treatment, and/or follow up.

In this case checking for signs of serious illness did occur – at [Dr C's] first visit temperature, pulse, and state of hydration were all checked for (a good standard of care). Given the vomiting and diarrhoea the abdomen was examined to check for serious problems in the abdomen – a good standard of care. However the brief history in the notes does not allow comment as to if anything else needed to be checked or not. It is unclear what if any follow up advice was given based on the notes so the standard of care regarding this is hard to determine.

At [Dr C's] second visit checking for serious illness also did occur as at the first visit. In particular [Dr C] did examine the patient in more detail – extra parts of the body were examined and a particular note on her mental state was recorded indicating that he had considered this aspect of how she was – this is all a good standard of care. However once the petechial rash was found further examination did not occur. It seems clear from the notes that this rash was considered to be a reaction to codeine. As will be commented on later, this was not a good comment to make as it was erroneous, and not based on any known facts about codeine, and in my opinion falsely reassured the patient about the cause of her rash. Once again the lack of documentation on any follow up advice makes it difficult to comment on the standard of care given with respect to communicating to the patient what she should watch out for and when to consult a doctor again or not.

Taking a full history

As commented on above under 'quality of the providers' records or lack of them' there was not a good description from [Dr C] on either occasion of the details of the history.

Do an appropriate full examination

The physical examination by [Dr C] on the first occasion was adequate and appropriate. On the second occasion the presence of the petechial rash should have led to a more detailed examination and/or note of such an examination. This would include if there was a rash elsewhere, or not, and if there were any other signs or symptoms of meningitis (such as photophobia, sore and/or stiff neck etc). I note that [Mrs A] states in her letter of 20 December 2002 that her temperature was taken in the axilla (armpit). There is no information from the notes or [Dr C's] letter stating how the temperature was taken but if her temperature was taken in the axilla

there are problems with this – see later in my recommendations for [Dr C] at the end of this report.

Order appropriate investigation

On the first occasion there was no need for [Dr C] to order investigations. On the second occasion in my opinion (see notes later about this point as well) given there was no referral to hospital then there should have been at least some sort of investigation such as blood tests, if need be taken at home, and a careful follow up plan or a referral made. Admission to hospital or observation in an emergency department, or at the very least a detailed plan of follow up advice on what the patient should watch out for to prompt her seeking further medical attention was needed. This is based on the presence of the rash without a definitive diagnosis. You could say that given [Dr C] thought the diagnosis was a reaction to medication then no investigation was required. Hence his lack of investigation was not necessarily inappropriate given he had made a diagnosis that did not require investigation – the error was the diagnosis (or the failure to consider alternative diagnoses) rather than the lack of investigation.

Decide on appropriate management [Dr C's] management in the form of drug treatment given was satisfactory on each occasion and within standard common medical practice given the diagnoses made on each occasion by [Dr C]. However on both occasions based on the notes there appears to have not been adequate follow up advice given and/or documented. Also [Dr C] in my opinion made an error of judgement in deciding that the rash was possibly caused by the codeine. Whilst he put a '?' mark in front of this diagnosis indicating he was not certain, I do not think from what was documented that there was an adequate enough attempt to convey to the patient that there were other possible serious causes of her rash. Based on the notes there is no evidence that she was told that there were things she should watch out for in case there was some other more serious cause of her rash. [Dr D's] management was appropriate except it was unclear as to how suspicious he was of meningococcal disease. If he was fairly certain of the diagnosis then pre-hospital antibiotics should have been given (Ref. 7 to 14, and 16). If he was less certain but concerned and wanted urgent hospital assessment then given the unavailability of the nearest hospital due to a bomb scare he should have given pre-hospital antibiotics. If he was of a low grade of suspicion only then not giving pre-hospital antibiotics was within standard practice. I can understand that in this case the condition seemed to either evolve slowly or that there were two problems (an initial viral illness followed by or triggering Meningoccal disease) and/or [Mrs A] survived for a long time with the condition at home. Whilst this might seem unusual, and is to some extent a reason why the doctors involved might have found the diagnosis difficult, slowly evolving cases can occur (Ref. 15). Doctors should realise that preceding viral illness does not exempt patients from getting meningitis and might even trigger this.

Give the patient appropriate advice on follow up, and any complications to watch out for that might need earlier follow up. This has been commented on above.

Have appropriate systems in place to reduce errors

This is where there is great potential to improve the management for all patients (Ref. 2). Doctors are human and errors can occur – however they can be minimised and/or the effects of these errors reduced or mitigated by having systems in place to check for errors and if possible to take action to prevent harm or to prevent sub-optimal outcomes for patients. One system that was in place was for the notes to have pre-printed headings to remind the doctor to do (and/or document) key aspects of the case. It is possible that the house call service should consider changing the heading titled 'Plan' to 'Plan including follow up advice' or even to add a specific section on 'Follow up advice'. At least one after hours service in New Zealand uses the headings 'Treatment' and then 'Further Management and instructions' on their house call form. I think the term 'instructions' is adequate but that given follow up advice is important, and in my experience a common source of error and confusion and uncertainty for patients, it may be that more specific structured advice needs to be given. I would favour all doctors considering advice in a format that utilises the doctor's knowledge of the natural history of conditions and communicates this information to patients in a clear non-ambiguous way. For example:

- See your own doctor in (insert appropriate number) days/hours if you are not back to 100% normal for you
- See your own doctor if you are not improving in (insert appropriate number) days/hours
- See a doctor/after hours/emergency department sooner or at any stage if you are worse (or in some cases worse than expected if an explanation of this has been given) or develop new symptoms

For example for a common viral illness 'see Dr at 2 weeks total illness if not 100%; see Dr in a few days if not improving, sooner if worse/new symptoms' is much better helpful and safe advice to patients than vague statements that I have often heard such as if you aren't better get seen again (leaving out when to get seen or how long to wait for an improvement etc). Another example would be for bacterial infections 'see Dr at end of antibiotics if not 100%; see Dr in a few days if not improving, sooner if worse/new symptoms.' These suggestions are my own personal opinion of a way in which communication could be improved, without taking too much time, and with less ambiguity than other approaches. However, ideally, follow up advice should be researched properly to prove its safety and effectiveness but given the lack of funding and skilled personnel in the health systems of the western world at present I doubt if such research will be performed in the near future.

Another system to reduce errors is to try and get doctors to think about thinking. Metacognition has been suggested and shown to be one such system (Ref. 3). I would

recommend that [Dr C] and even all doctors in general read and act on this type of approach to their everyday work/clinical decision making.

Describe in what ways, if any, the providers' management deviated from appropriate standards and to what degree

I believe that as outlined above there were omissions in the notes – these were a minor breach of an adequate standard of care. Based on the notes it is hard to say about some aspects of the case as already discussed above. However I think the key factor in this case was that Dr C decided that the rash was possibly caused by codeine. This was an erroneous piece of medical thinking for the following reasons:

1. I have not seen a rash with codeine and nor have any of just over half a dozen experienced general practitioners who I asked about this aspect of this case (Ref. 7). None of them felt attributing a rash to codeine was a reasonable thing to do no matter what type of rash it was.
2. The MIMS medical data base on drugs and the MedSafe data sheet for codeine do not list a rash as a side effect of codeine – I checked this information in 2004. An old New Ethicals Catalogue (the likely source of drug information available to [Dr C] on a house call as it was smaller than the New Ethicals Compendium and was the source of drug information available to [Dr C] at the time of this case) also does not list a rash as a side effect of codeine.
3. A drug search performed by [a New Zealand hospital] drug information service in July 2004 found only two case reports world wide of a rash with codeine and both were thought to probably not be attributable to codeine with other causes being possible.
4. In this case attributing the rash to a medication reaction was potentially falsely reassuring for the patient. If the patient was instead told that the cause of the rash was not apparent, and that initially for many rashes this is the case, and that many rashes can only be diagnosed accurately after more time goes by, then a different standard of follow up may have been able to occur. She could have been told what to watch out for such as other symptoms in case the rash had some more serious cause and if such symptoms were explained to the patient then a better standard of care would probably have occurred.

It is interesting to note that [Dr C's] explanatory letters of 10/5/03 and 3/11/03 contain some extra and/or different information to that contained in the hand written notes.

I note in the letter from [Mrs A] 11 July 2003 that she felt there was an issue with 'the division I see between our accounts of the events'. For the purposes of my report I think I can make decisions based on the common accounts of all persons and the evidence from the various supporting documents and where there is a difference I will leave it to the Commissioner to decide if this matters. I do not think these differences would significantly change my decisions. But if the Commissioner wishes to use this information to modify his interpretation of my decisions or to address other aspects of the case this would be understandable but beyond the scope of my report. If however the Commissioner wants me to give another, or a modified, opinion on the assumption

that certain things happened beyond what I have considered to be the case in this report then I would be prepared to consider this.

In particular [Dr C] includes in his letter the symptoms of aching all over on the first occasion. This is in my opinion consistent with my previous comment that his notes were brief. The notes appear not to adequately document the symptoms in such a way that if another doctor had to reassess the patient that they would be able to make an adequate comparison (which is one purpose of medical notes that is important). Also he recalls a rash – 'an area of pink discolouration about 3 inches in diameter, on her thigh … '. Other information suggests he recalls noting '… that she appeared more ill than her temperature suggested … '. He also recalls the phone call from [Mrs A's] sister regarding the throbbing head. It is disappointing that there is no record of this phone call – I would suggest that records be kept of phone calls for all sorts of reasons including enabling other doctors to reassess a patient more accurately, and of course for medico-legal reasons (being able to more accurately establish what happened) and for being able to learn from cases about what went well and what could have been improved on. Sometimes recording phone calls can simply be an addition to the note already made thus avoiding the need to have separate notes but there are pro's and con's to the ways phone call records are kept that are beyond the scope of this report.

Although [Dr C] states in his letter 10/5/03 that Kernigs and Brudzinskis signs were negative there is no written record of this.

With respect to the issue of the disposal of the syringe(s) and needle(s) I note [Dr C] suggests that 'Her husband kindly agreed to dispose of the sharps safely'. Thus there was a sharp (needle) and not just a syringe. I think the question as to if the husband or anyone else offered to dispose of the sharps is irrelevant. It is very unusual for most households to have sharps containers and hence the ability to safely dispose of a sharp. In other words even if well meaning household members offered to dispose of the sharp they almost certainly had no means of doing so and doctors should know this. There is really an ethical obligation to safely dispose of sharps, regardless of regulations, due to the risk of harm to other persons.

Answering Questions put to me by the Commissioner's Office

To advise the Commissioner whether, in your professional opinion:

1. **Did [Dr C] provide [Mrs A] with services of an appropriate standard.** (I believe I have already answered this – there has been a lack of adequate documentation of some aspects of care, and a serious error in his diagnosis of the rash.)

2. **Was [Dr C's] assessment of [Mrs A] when he visited on 18 October 2002 appropriate?** I have already commented on these issues – in short the documented history was brief but the examination as documented appeared appropriate on both occasions up to the point of the erroneous diagnosis of the rash being made.

3. **What are the symptoms of meningitis?** The symptoms overlap those of many other conditions. Discussion of these symptoms is in my opinion distracting in this case as the petechial rash suggested a more serious illness regardless of the presence or absence of symptoms of meningitis. The rash in this case was from meningococcal (the bacteria that can cause one form of meningitis and/or cause other illness) septicaemia (blood/widespread infection) – hospital blood cultures confirmed this in this case. Meningococcal septicaemia can occur with or without meningitis.

4. **What assessments/tests should a general practitioner visiting a patient at home perform to exclude meningitis?** This question is not simple to answer and is a loaded question based on an assumption that there is some simple way to exclude meningitis. There is no simple way to exclude meningitis. Also it is likely that meningitis may be triggered by other illnesses and to tell patients it is not meningitis needs to be clarified by a statement that although it does not appear to be meningitis now, it is possible this could develop later in addition to the current illness. The correct approach is to look for serious illness (including meningitis and/or meningococcal septicaemia), AND to give appropriate advice of when and why the patient should seek reassessment.

5. **Was it reasonable in the circumstances for [Dr C] to conclude that [Mrs A] was suffering from viral gastroenteritis on 18 October?** Yes if there was no petechial rash.

6. **If not, why not?** Only if there was a petechial rash – I am not sure if it was present on 18 October but it was not mentioned in the notes**. What else should he have done?** Given there was no petechial rash what was done was adequate with the proviso that better advice on follow up should have been given and/or documented.

7. **Was it reasonable for [Dr C] to conclude on 19 October that [Mrs A] was continuing to suffer from viral gastroenteritis?** No. It seems likely that a petechial rash was present and as already stated an error in diagnosis occurred.

8. **If not, why not?** As previously commented on the diagnosis of a rash from codeine was erroneous and potentially dangerous in that it probably falsely reassured [Mrs A]. **What else should he have done?** He should have considered other diagnoses, and emphasised the diagnostic uncertainty to [Mrs A] and her family. Also given that it was a petechial rash further investigation and/or referral for such urgent investigation was required.

9. **What is the accepted method for a visiting doctor to dispose of used syringes?** The accepted method is to place the sharp part (the needle +/- its cover) in an appropriate container and arrange for it to be disposed of safely. The non-sharp part (the syringe) is usually detachable from the needle and it is less of a hazard than the sharp part however regulations New Zealand wide, or at

least in certain local body districts, also require the safe disposal of this non-sharp rubbish. There are problems with this including the lack of economic appropriately safe sharps containers that can be easily transported to house calls. There are also technical regulatory aspects to the transporting of such containers to and from house calls to another site – such as does the vehicle need bio-hazard labelling. My limited understanding of the regulations is that they are not necessarily practical and even if they are they are often not enforced. Given this I think the ethical stance should be used – i.e. the need to prevent harm. That is that a sharp needle can not easily be disposed of by someone who does not have immediate access to an acceptable sharps container. Also ethically I believe we should be ensuring the safety of ourselves, bystanders, and the patient, and therefore leaving a sharp in a house is in my view not a safe or an ethical practice. Thus regardless of if it was [Dr C] who left the syringe in the house without the householders' knowledge, or if it was offered to be taken away by a household member, I believe [Dr C] was in error to allow the sharp (needle) to be left in the house. The syringe part is not likely to be a hazard if the needle has been disconnected – in that it would be of similar risk to people as say a blood stained tissue after someone used it to dab a minor wound. However local bodies don't like syringes going in ordinary household waste as if there is a waste spill on the street for example it raises the possibility of more dangerous rubbish along side it such as needles. I believe it is for this reason that local bodies regulate to prevent various business people (doctors, dentists, vets, body piercers etc.) from disposing of body fluid contaminated materials in the ordinary refuse collection.

Additionally:

- **Are there any other professional, ethical and other relevant standards that apply and, in your opinion, were they complied with?** I think I have commented on this adequately elsewhere.

Are there any other comments you consider relevant to this case?
I believe I have done this in the previous and following parts of this report.

Conclusion:
I have tried not to believe or disbelieve any evidence presented to me in this case that appeared to conflict and I have tried to show that given the common evidence reasonable decisions can be made. I hope this speeds up the final processing of this case and avoids further delays for everyone involved. Even if I gave a decision accepting all the evidence from [Dr C], (not all of which was in the notes made at the time), I do not think I would have made a significantly different decision on the questions put to me. Likewise if I accepted all the evidence from [Mrs A] that was not necessarily in the notes made at the time, I do not think I would have made a significantly different decision on the questions put to me.

I think the key factor in this case was that [Dr C] decided that the rash was possibly caused by codeine. This was an erroneous piece of medical thinking for the reasons previously given.

Recommendations:

For [Mrs A] and her family:

Thank you for bringing this to the attention of the medical profession. I agree with your wishes that you have been 'doing this in the hope that it will lessen the chance of this ever happening to someone else under [Dr C's] care' – but I would extend this to applying to all doctors rather than a particular doctor.

For the [the Service] involved:

That they consider having a system for recording phone calls from patients they have already seen. That they review the headings on the notes form and consider having a heading for follow up advice or even pre-printed specific follow up advice statements as I have mentioned earlier in my report.

For [Dr D] and the [the Service]:

That they review the pre-hospital approach to suspected meningitis or suspected meningococcal sepsis. I am not sure how suspicious he was of the diagnosis, but given some suspicion and particularly given that the closest hospital was closed because of a bomb scare, it could have been prudent to give pre-hospital antibiotics.

For [Mrs A's] GP:

It may well be that they have a good system for dealing with house call requests but from the limited information I had I am not sure about this. Should someone other than a receptionist, such as a doctor or a nurse, have been asked to take [Mrs A's] call? If so would a different pathway of care have occurred if that happened? It is possible that it would have only delayed her in being referred to the house call service as it may well have been impossible for the GP or practice nurse to take her call at the time it was made – in which case delayed care might have occurred. However if the GP or the practice nurse had taken the call then it might have been possible for the GP to do a house call themselves, or to pass on information to the house call service if [Mrs A] had any significant past history or medications. This issue is beyond the scope of the report but it is something that [Mrs A's] GP might want to review as part of practice procedures. Certainly there is some evidence that patients do better if they see their own GP or failing that a doctor with access to their records – they should see my comments above in the section headed 'possible missing information'.

For [Dr C]:

That he review his standard of note taking and review his decision making processes. He needs to review his personal and work place systems for reducing errors. This would include having a personal system to reduce errors in thinking. One such system is to try and get doctors to think about thinking. Metacognition has been suggested and shown to be one such system (Ref. 3). I would recommend that [Dr C] and even all

doctors in general read and act on this type of approach to their everyday work/clinical decision making.

If he did/does take axillary (armpit) temperatures in adults then he should review this practice and consider taking oral (in the mouth) or tympanic (ear drum) temperature readings. In Harrison's Principles of Internal Medicine (Ref. 4), in the section on Alterations in Body Temperature, it states 'The temperature may be taken orally or rectally, but the site used should be consistent. Axillary temperatures are notoriously unreliable'. This problem with axillary temperatures is well known to doctors and nurses. The exact role of tympanic (ear drum) temperatures is not yet clear but it is partly discussed in Harrison's and more recent evidence should help clarify this. On house calls tympanic thermometers can be problematic as the machines need a minimum ambient (or room) temperature that usually also has to be a stable temperature – more modern machines may be able to overcome this. However taking yet another piece of equipment on a house call is problematic and tympanic temperatures can not for this and other reasons be considered routine for house calls.

Dr Stephen John Searle: Monday, 18 October 2004.

References.

1) Guidelines for Independent Advisors – Office of the Health and Disability Commissioner – Appendix H of the Enquiries and Complaints Manual – effective date: 1 September 2003.
2) BMJ 2000; 320:768-770 (18 March) Education and debate: Human error: models and management, James Reason, professor of psychology.
3) Cognitive Forcing Strategies in Clinical Decision Making, Pat Croskerry, Annals of Emergency Medicine 41:1, Jan 2003, p110-120.
4) Harrison's principles of internal medicine 15th ed./editors, Eugene Braunwald ... [et al.] INTERNATIONAL EDITION ISBN 0-07-118319-1.
5) Mims Medicines Database – MIMS NZ Version 1.00 copyright 2003, MediMedia NZ Ltd, 3 Shea Terrace, Milford, Auckland.
6) Personal discussion, of Dr Searle the author of this report, with several general practitioners of the general situation of an adult female with a non-specific illness such as diarrhoea and/or vomiting, and a rash. The response as I talked them through the scenario was that they would not have attributed the rash to codeine. They asked what sort of rash and I asked them for their responses for rashes ranging from non-specific blanchable rashes through to petechial rashes. I avoided stating the final diagnosis until after I asked each doctor what they would do – this method of discussion was in an attempt to avoid getting a retrospective opinion with the benefit of hindsight knowing the final diagnosis of the serious illness. Many would not have admitted this lady to hospital given a non-specific rash only without other signs of serious illness. If the rash was petechial then of the doctors I asked all would have either at least organised further investigations (blood tests) along with close follow up if they had not sent her to hospital.

7) BMJ 2000; 320:1290 (13 May) Editorial – Guidelines for managing acute bacterial meningitis. This includes reference to meningococcal disease without meningitis – and contains extensive references to other medical literature.
8) BMJ 1998; 316:1511-1514 (16 May) Clinical review ABC of allergies adverse reactions to drugs Daniel Vervloet, Stephen Durham.
9) BMJ 1997; 315:774-779 (27 September) Papers Epidemiology and clinical management of meningococcal disease in west gloucestershire: retrospective, population based study.
10) BMJ 1992; 305: 143-147 Cartwright K, Reilly S, White D, Stuart J. Early treatment with parenteral penicillin in meningococcal disease.
11) BMJ 1997; 315:757-758 (27 September) Editorial – Optimising the investigation of meningococcal disease.
12) BMJ 2000; 320:768-770 (18 March) Education and debate: Human error: models and management, James Reason, professor of psychology.
13) SIXTEENTH EDITION, THE MERCK MANUAL OF DIAGNOSIS AND THERAPY, Published by: Merck Research Laboratories Division of: Merck & Co., Inc., Rahway, N.J. 1992.
14) Personal communication with patient's father who happened to be a doctor. Unusual case of meningococcemia with typical rash but without symptoms or signs of system illness (i.e. the patient was surprisingly well) – this case took two weeks to diagnose.
15) BMJ 1997; 315:774-779 (27 September), Epidemiology and clinical management of meningococcal disease in West Gloucestershire: retrospective, population based study.
16) Clinical Microbiology Reviews, January 2000, p. 144-166, Vol. 13, No. 1 – Update on Meningococcal Disease with Emphasis on Pathogenesis and Clinical Management."

Response to Provisional Opinion

In response to my provisional opinion Dr C stated:

> "The very real possibility, in this case, that [Mrs A] suffered two separate illnesses in succession appears not to have been considered at all. The report ignores the whole question of the behaviour of an acute infection of the meninges.
>
> …
>
> You and your advisors have also failed to bring your minds to bear on the consequences of having an intracerebral infection. I would have thought that even a lay person would recognise confusion of mind and memory among them yet you seem to accept the patient's recollections as inviolable. …

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

> I am prepared to apologise to [Mrs A] if you insist, for I bear her no malice whatever, but I have to say that I am very disappointed by the superficiality of your investigations and opinions. There is scope for the Health and Disability Commission to make a real improvement to medical services but you appear determined to avoid any issues that could lead that way."

My provisional opinion was also forwarded to Dr D and his comments sought. Dr D did not respond, and I have assumed that he does not wish to do so.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are 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.

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

Relevant standards

The New Zealand Medical Association *Code of Ethics* (2002):

> "…
>
> **Responsibilities to the Patient**
>
> …
>
> 4. Doctors should ensure that every patient receives appropriate investigation into their complaint or condition, including adequate collation of information for optimal management.
>
> 5. Doctors should ensure that information is recorded accurately and is securely maintained."

Medical Council of New Zealand *Guidelines for the Maintenance and Retention of Patient Records* (October, 2001):

"…

Maintaining patient records

Records must be legible and contain all information that is relevant to the patient's care.

(a) Information should be accurate and updated at each consultation. Patient records are essential to guide future management, and invaluable on the uncommon occasions when the outcome is unsatisfactory."

Opinion: No Breach – Dr C

Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) give patients the right to have services provided with reasonable care and skill and in compliance with relevant standards.

Consultation − 18 October 2002
On 18 October Mrs A had been suffering from diarrhoea, vomiting and dizziness of 24 hours' duration, and her GP's receptionist telephoned the Service after-hours medical service. Dr C, a general practitioner employed by the Service, arrived at Mrs A's house at 3.30pm in response to her request for medical attention. Dr C examined Mrs A and considered that she was suffering from a viral infection. He gave her two codeine tables and an intramuscular injection of Stemetil.

Mrs A and her sister, Mrs B, who was present during the examination, recall that Mrs A had a red rash on her thigh, which Dr C did not appear to notice. However, Dr C informed me that when he gave Mrs A the injection, he did observe an area of pink discolouration, about three inches in diameter, on her thigh. He thought it was pressure markings from the bedclothes. Dr C recalled that when he examined Mrs A, her neck was fully mobile and she showed no signs of meningeal irritation or septicaemia – although this was not documented.

Dr Searle advised that overall, although the documented history was brief, Dr C's assessment of Mrs A on 18 October was adequate, provided Mrs A did not have a petechial rash. On balance, I accept that Dr C did note a specific area of discoloration on Mrs A's leg on 18 October; that Mrs A's rash developed after his visit on 18 October; and that, based on her presenting symptoms not including a petechial rash, his assessment and diagnosis of viral gastroenteritis was of an appropriate standard.

Opinion: Breach – Dr C

Disposal of needle and syringe – 18 October 2002
Dr C left Mrs A's family to dispose of the syringe and needle he had used to give her the intramuscular injection of Stemetil on 18 October.

Dr Searle advised that the accepted standard expected of a doctor making a house call is that the doctor will dispose of both the needle and the syringe to ensure the safety of the patient and others handling the waste. Dr Searle noted that although the syringe itself is less of a hazard if the needle has been disconnected, regulations require the safe disposal of materials (such as syringes) contaminated by body fluid. Accordingly, doctors should dispose of both needles and syringes.

He stated:

> "Regardless of if it was [Dr C] who left the syringe in the house without the householder's knowledge, or if it was offered to be taken away by a household member, I believe Dr C was in error to allow the sharp to be left in the house."

I agree with Dr Searle's advice. Accordingly, in my opinion, by leaving the needle and syringe to be disposed of by Mrs A and her family, Dr C did not comply with appropriate standards and breached Right 4(2) of the Code.

Consultation – 19 October 2002
On 19 October Mr A contacted the Service to report that his wife's condition had deteriorated since the previous day. Mrs A had developed photophobia and continued to vomit, and was concerned that she had contracted meningitis. Dr C visited Mrs A, for the second time, at 1pm that day.

Dr C examined Mrs A and recorded his assessment, noting that she had a rash on her legs and that her temperature was within normal limits at 36.3°C. He found that her pulse, throat, ears, chest and abdomen were all normal. She was well hydrated, alert and conscious. Dr C recalled that in his opinion Mrs A appeared better than the previous day and his "fears with regard to meningitis were allayed". He stated that although he described the rash in his clinical notes as "petechial", in fact it blanched under pressure (a petechial rash does not), and therefore he determined that it was neither haemorrhagic nor thrombotic. He concluded that it was a result of an adverse reaction to codeine. He has no recollection of Mrs A reporting any nodular swellings on her arm.

Dr Searle considered that the presence of a petechial rash should have led to a more detailed examination and a note of such an examination. He also considered that in the presence of a rash without a definitive diagnosis, at the least Dr C should have ordered further investigations such as blood tests, and have had a careful follow-up plan or made a referral to the emergency department.

Dr Searle stated that Dr C's decision that the rash was possibly caused by codeine was "erroneous medical thinking" and not reasonable, as there is no evidence in medical literature to support this conclusion. He also considered it a serious error of judgement for Dr C not to consider other diagnoses, and that by advising his patient of his view that the rash was caused by codeine, Dr C "falsely reassured the patient about the cause of her rash". Dr Searle advised that Dr C should have conveyed to Mrs A that there were other possible serious causes of her rash, and told her the things she should watch out for.

I accept Dr Searle's advice that Dr C made a serious error of judgement in not considering other causes of the rash, not having a plan to organise follow-up investigations such as blood tests or referral for further assessment, and not advising Mrs A that there were other possibly more serious causes for the rash and explaining what to watch out for. In relation to his assessment and treatment of Mrs A on 19 October, in my opinion Dr C did not provide services with reasonable care and skill. Accordingly, he breached Right 4(1) of the Code.

Clinical records

Dr Searle advised that Dr C's records were scanty. He did not record the phone call from Mrs A's sister advising of Mrs A's deteriorating condition, and he did not record full details of assessments (such as checking for Kernig's and Brudzinski's signs) which, in response to the investigation, he subsequently advised that he had undertaken. The history recorded on both visits was brief and inadequate. There was also no documentation of advice given on the follow-up plan – such as when and why Mrs A should seek further medical attention.

In response to my provisional opinion on this issue, Dr C stated:

> "[I]t has always been acceptable to the medical directors of [the Service] and its predecessors. May I point out that I went to [Mrs A's] home to try to assist her with her illness, not to write my biography or hers."

Dr Searle advised that the notes do not adequately document Mrs A's symptoms in such a way that if another doctor had to reassess Mrs A, he or she would be able to make an adequate comparison.

I accept Dr Searle's advice and am concerned by Dr C's response to it. As the Medical Council of New Zealand's *Guidelines for the Maintenance and Retention of Patient Records* make clear, medical records are essential to guide future management, and should be accurate and legible, and contain all the information relevant to the patient's care. In my opinion Dr C did not meet the standards set out in the Medical Council Guidelines, and breached Right 4(2) of the Code.

Opinion: No breach – (the Service)

Vicarious liability
Under section 72(2) of the Health and Disability Commissioner Act 1994, employers are responsible for ensuring that their employees comply with the Code, and may be vicariously liable for an employee's failure to do so. 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 doing, or omitting to do, the things that breached the Code.

Dr C was employed as a general practitioner by (the Service). As an employer, the Service is potentially vicariously liable for Dr C's breaches of the Code. However, I am satisfied that Dr C's errors and omissions were beyond the scope of what the Service, as an employer, could have prevented at a "systems" or "management" level, and were not matters for which it could reasonably be held liable.

Other comments

Taking temperature in axilla
Dr Searle noted that Mrs A recalled that Dr C took her temperature in her armpit (axilla). Dr Searle advised that axillary temperatures are unreliable, and that if Dr C did take her temperature in this fashion, he should review his practice and consider taking oral or tympanic temperatures.

In response to my provisional opinion on this issue, Dr C stated:

> "[Mrs A] does refer to a normal axillary temperature and [Dr Searle] makes much of its unreliability. I could not agree more but in point of fact I have **never** taken such a measurement on any adult. I took oral temperatures on both occasions and they too were normal."

Actions

I recommend that Dr C take the following actions:

- Apologise in writing to Mrs A for his breaches of the Code. The apology is to be sent to the Commissioner's Office and will be forwarded to Mrs A.

- Review his practice in light of this report.

Follow-up actions

- A copy of my final report will be sent to the Medical Council of New Zealand with a recommendation that it consider whether a review of Dr C's competence is necessary.
- A copy of my final report will be sent to the Royal New Zealand College of General Practitioners.
- A copy of my final report, with details identifying the parties removed, will be sent to Mrs A's GP, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.