General Practitioner, Dr B

An Accident and Medical Clinic

A Report by the

Health and Disability Commissioner

(Case 03HDC08987)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Mr A	Complainant / Consumer's father
Mrs A	Consumer's mother
Dr B	General Practitioner / Provider
An Accident and Medical Clinic	Provider

Complaint

On 18 June 2003 the Commissioner received a complaint from Mr A about the care his daughter, Ms A, received from Dr B at an accident and medical clinic (the clinic) on 20 November 2003. The complaint was summarised as follows:

On 20 November 2002 Dr B did not provide services of an appropriate standard to Ms A. In particular, Dr B:

- *did not undertake adequate investigation into Ms A's condition*
- *did not diagnose Ms A with meningococcal disease*
- *did not refer Ms A to secondary medical services for follow-up*
- *did not advise Ms A what symptoms would indicate meningococcal disease and to be alert for in the immediate period after leaving the clinic.*

An investigation was commenced on 19 September 2003.

Information reviewed

- Information provided by Dr B
- Information provided by Mr and Mrs A
- Information provided by the clinic
- Information provided by the first public hospital

Independent expert advice was obtained from Dr Niall Holland, a general practitioner.

Information gathered during investigation

Background
On 20 November 2002 Ms A (aged 16) called her mother and asked her to pick her up at the local shopping mall as she had a cramp in her leg. By the time she arrived home at 5pm she was feeling unwell. Ms A complained to her mother of mild nausea and a headache. At 6pm Ms A lay down on her bed as she was feeling worse. She asked her mother to take her to a doctor at 8pm as she thought she had meningitis.

Mrs A took Ms A to the clinic. Ms A was shivering, and the nurse recorded her temperature as 39.4ºC and pulse as 120.

Dr B examined Ms A at the clinic. Dr B's notes record Ms A's temperature at 39.1°C and pulse at 120. Mrs A described Dr B listening to Ms A's heart and lungs, performing a knee reflex, and looking in her eyes.

Mrs A stated that Dr B said Ms A had the flu. Ms A said three times that she thought she had meningitis. Mrs A recalled that Dr B said: "No, you don't have any sign showing up on your skin."

Dr B stated that he was under the impression that Ms A had a virus, and that the abdominal tenderness made him consider a possible urinary tract infection. In order to discount this possibility, Dr B requested a urine sample to be sent to the laboratory. Dr B did not feel there was anything to be gained from further tests at that time. Mrs A recalled Dr B saying that if the tests showed an infection he would contact them the following day.

Dr B told Ms A to take fluids and Panadol and gave her a prescription for Voltaren. Dr B does not specifically recall what other advice he gave, but his usual practice is to advise patients to seek further medical attention immediately if their condition changes for the worse.

Ms A and her mother returned home. Ms A had a restless night, with headaches, vomiting, shivering with a fever, stiffness and pain all over her body.

Ms A deteriorated the next morning. By 1pm she noticed some blemishes on her legs, had difficulty breathing, and suffered pain when she tried to move. The pinpoint bruising on her legs spread out in a circle from a central point, and did not disappear when pressed. Her father carried her to the car and took her to the clinic, where she was seen by a doctor. After what Mr A described as a rapid examination, Ms A was given penicillin, and transferred to a public hospital at approximately 1.30pm. Mr A stated that by the time Ms A was admitted to hospital, her condition had significantly worsened, with her breathing compromised, almost no pulse, and her skin covered in bruising, which was turning black.

In the Emergency Department at the hospital Ms A was given further penicillin, along with ceftriaxone and hydrocortisone. At 4.45pm Ms A was transferred to the Department of Critical Care (DCCM) at another public hospital, where she remained critical for 24 hours. She continued to receive penicillin over the next 72 hours.

Ms A was transferred back to the first public hospital on 22 November, and discharged home on 26 November, when she was haemodynamically stable. Her systemic meningococcal skin lesions had improved, with no evidence of cellulitis.

Ms A was seen as an outpatient at the first public hospital on 9 and 13 December 2002. She is slowly recovering. Her parents report that she still has a number of ongoing problems as a result of having had meningococcal disease, and believe that Ms A should have been admitted to hospital immediately following her consultation with Dr B.

Independent advice to Commissioner

The following expert advice was obtained from Dr Niall Holland, an independent general practitioner:

> "I have been asked to provide an opinion to the Commissioner on case number 03/08987/…. I have read and agree to follow the Commissioner's Guidelines for Independent Advisers.
>
> I am a general practitioner working in an urban setting. I practise from a suburban family practice and do regular shifts in our local 24 hour acute care facility. I have been a general practitioner for 25 years.
>
> **Expert Advice Required**
>
> To advise the Commissioner whether, in your professional opinion, the standard of care [Ms A] received from [Dr B] was of an appropriate standard. In particular:
>
> *Was [Dr B's] examination of [Ms A] reasonable, given her symptoms and concerns when she presented to the clinic on 20 November 2002?*
>
> [Dr B], when he examined [Ms A], was working in a clinic targeted to provide acute primary care. In this setting there is usually a high throughput of patients with acute illness. While meningococcal meningitis is not a common infection, it is likely to first present to a doctor in this type of clinic. Therefore every doctor working in an acute care clinic must have a high index of suspicion for meningitis at all times.
>
> The Complainant Contact Note for 2/9/2003 describes alarming symptoms. They state that 'her head was going to burst, and her back was very stiff, and she was restless, moaning and drowsy'. This also states that she said to [Dr B] 'about 3 times that she had meningitis'. These statements are based on recollections rather than contemporaneous notes and have to be weighted accordingly.
>
> With the frequent publicity of meningitis cases in recent times it is now common for patients to present to primary care quite anxious about having meningitis. It has always

been a very difficult challenge to sort out the early presentation of meningitis from more minor illness. The anxiety that patients now experience also has to be addressed.

Therefore the goals of the examination are both to try to exclude meningitis and to relieve the patient's anxiety.

The patient indicated she was concerned about having meningitis. The nursing notes indicate the presence of a fever of 39.4, irritability, photophobia, frontal headache and some neck discomfort. These are the symptoms of meningitis.

The difficulty in this case is to determine whether sufficient examination has occurred to achieve these goals.

The doctor's notes do not make any mention of these symptoms and show no record of a central nervous system examination. They show no record of testing for neck stiffness. Nor do they record examination for a rash.

We do know from the patient that an examination of her fundi and reflexes did occur. These are elements of a central nervous system examination (CNS) and would support a claim that a proper CNS examination has taken place.

The patient and family appear to have had a good understanding of meningitis and did seem to depart from this consultation reassured.

Due to important omissions from the records I cannot confirm whether or not an adequate examination did occur.

Were the conclusions that [Dr B] drew from this examination of [Ms A] and diagnosis reasonable in the circumstances?

Meningitis is a difficult diagnosis to make in the early stages of the illness. The presentation of fever, headache, with some neck pain and stiffness is also the first presentation of a number of much more commonly seen viral illnesses.

Particularly in primary care, diagnosis is a probability judgement. It is almost always provisional and subject to a test of time. This is a period in which the evolution of the illness tends to confirm or refute the diagnosis. Due to limited access to resources, it is rarely possible in general practice to do sufficient tests to achieve a high level of certainty about most diagnoses in the early stage of illness. To deal with this limitation, a common strategy for general practitioners is to describe to the patient the anticipated course of the illness and to advise return if this does not eventuate. [Dr B] has stated that it is his usual practice to describe what changes to look for and what action to take.

The diagnostic decision by the doctor for any given patient also depends not just on the symptoms of that patient but on the general pattern of illness being seen at that time. For instance, if there was a current epidemic of influenza that mimicked meningitis, as does often happen, then the doctor would have to take this into account in determining

the most probable infection for that patient. [Dr B] has made no comment on the illnesses prevalent at that time.

In this case the patient herself raised the possibility of meningitis. According to the patient and her family [Dr B] had concluded that because [Ms A] did not have the characteristic rash, then she did not have meningococcal disease.

The family quite rightly points out that the rash is a manifestation of meningococcal septicaemia, a later stage of illness. Its absence does not exclude the presence of meningococcal infection. If, as the family says, [Dr B] concluded that she was not at risk because she did not have a rash, then this was a mistake. However, it is usual practice to carefully examine the patient for a rash and to take additional reassurance from its absence, if there are no other signs of meningitis.

The fact that the patient raised the possibility of meningitis does put an extra duty of thoroughness on the doctor to exclude this, since one of the principal purposes of the consultation is to reassure the patient.

The process of reassurance requires a thorough physical examination. It is also prudent to discuss the symptoms of meningitis and the progression of the illness, alerting the patient and the family as to the particular signs to look for and the action they would need to take if any of these appeared. This clearly signals to all concerned that the diagnosis has been given serious consideration.

The family, at least, do appear to have been reassured by the contact with [Dr B].

However, I do not find sufficient evidence from either the written records or the recollection of the parties involved to determine whether [Dr B] drew the right conclusions at this consultation.

What information would you expect a GP practising in similar circumstances to give to a parent about meningococcal disease?

The minimum information to provide to the family is a careful description of the symptoms of meningitis and what to expect with the progression of the illness. The purpose of this is to alert the patient and the family as to the particular signs to look for and the importance of urgent action should any of these signs appear.

Were [Dr B's] actions reasonable in respect of treatment?

Of concern is the discrepancy between the nurse's notes regarding symptoms suggestive of meningitis and the absence of any doctor's notes regarding reviewing the symptoms of meningitis or any examination for signs of meningitis.

The nurse has noted photophobia, frontal headache and some neck discomfort – all of which are important indications of the possibility of meningitis. She also appears to have examined the patient for a rash. She must have considered meningococcal infection as unlikely since she has triaged the patient as Category 3.

Diagnosis within a nurse triage system is to some extent a team process. This means the doctor may have depended on the nurse's notes to be the record of the symptoms.

I cannot determine from the records provided whether or not his actions were reasonable. This is discussed further below.

In particular, should he have referred [Ms A] to secondary medical services?

It is not possible for me to give an unqualified and definite answer to this question. As noted above the early symptoms (what the patient describes) and signs (what the doctor finds on examination) of meningococcal meningitis are often indistinguishable from those of a number of acute infections. The symptoms and signs described in [Dr B's] notes are not necessarily characteristic of meningococcal meningitis and could well have reflected another acute infection. Early diagnosis of meningitis is notoriously difficult.

On the other hand the nurse's notes do describe relevant and important symptoms of meningitis.

Whether or not to admit is often a difficult judgement to make in primary care. If a doctor refers to hospital everything that could possibly turn out to something nastier, then he or she is not doing the job properly. Not only would the hospital service be dangerously overwhelmed if primary care doctors had too low a threshold for referral but those doctors would also earn a reputation [for] unnecessary referral that could be detrimental to their future patients. Each doctor tends to carefully guard his or her reputation as a responsible referrer.

The decision to send a patient home rather than to admit for further observation is a very difficult part of primary care. We should be very cautious in making a retrospective judgement, especially when we do not have all the information available to the doctor through face to face contact with the patient.

There is no clear indication that [Dr B] should have referred [Ms A] to hospital at the time that he saw her. As noted elsewhere, the symptoms of early meningococcal infection are similar to those of a number of other common and minor infections. If he did a careful examination and satisfied himself that there were no signs of meningitis, then admission at that time was not warranted.

What other follow-up by a GP would have been reasonable in similar circumstances after [Ms A] left the surgery?

Given the anxiety of the patient regarding the possibility of meningitis, a planned follow-up in this case might have been wise.

However most general practitioners handle this sort of case by describing what to expect from the course of the illness and advising return if the patient has any concerns. A formal follow up would not be usual practice once the doctor had concluded that the most likely diagnosis was one of minor illness.

What are the relevant standards relating to this complaint and did [Dr B] comply with those? If you consider that relevant standards were not met, was the departure minor, moderate, or major?

The standard history where there is a possibility of meningitis should seek for symptoms of:

Fever, headache, nausea, drowsiness, neck stiffness, photophobia, joint pain and rash.

The nursing record shows that these symptoms were revealed to the nurse. The doctor's note makes no mention of them. Given that the nurse's findings were positive on several important symptoms, the doctor would have been wise to note whether or not he confirmed the nurse findings. If he has reviewed these symptoms, failing to record this is a moderately serious omission for his own protection. If he has not reviewed these symptoms then this is a major deviation from the appropriate standard of care.

The standard examination where there is a possibility of meningitis should look for the following signs:

Vital signs including level of consciousness, temperature and pulse but not necessarily blood pressure
A check for neck stiffness by flexing the head forward to place the chin on the chest
A check for spinal stiffness
Throat examination for signs of inflammation
A full skin examination for petechial rash

The doctor's notes confirm that he checked for fever and throat inflammation but do not provide any means for confirming whether other elements of the examination have occurred. Again, if he has checked these signs, failing to record this is a moderately serious omission for his own protection. If he has not checked these signs then this is a major deviation from the appropriate standard of care.

A standard record in a case where meningitis has been considered should show:

Evidence that the above symptoms and signs have been sought.
Evidence that the patient and or family have been advised what to expect.
A signal that a follow-up plan in the case of contingencies has been discussed.

The records appear to be quite comprehensive. They consist of two elements: a nurse triage record which includes the important vital signs and a triage status as well as the doctor's consultation note.

The doctor's note would usually be more than adequate for this setting.

However, given that meningitis has since been diagnosed and a complaint has occurred, there are notable omissions.

Omissions include the absence of any reference to a central nervous system examination. There is no record of the doctor's findings regarding the signs of meningitis. There is no record to establish whether he warned the family or patient re the signs of progression of meningococcal infection. There is no record that he provided a contingency plan in the event of signs of meningitis.

Given that the patient expressed concern about having meningitis and the nurse recorded several symptoms of meningitis, these are major omissions.

Are there any other matters relating to professional standards which you believe to be relevant to this complaint?

No."

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.

…

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

RIGHT 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

(a) An explanation of his or her condition; and
(b) And explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option;…

Opinion: Breach – Dr B

Examination
Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) patients are entitled to services provided with reasonable care and skill. Mr and Mrs A have complained that their 16-year-old daughter, Ms A, was not diagnosed appropriately. An important part of forming a diagnosis is an examination that is properly and carefully carried out in accordance with relevant guidelines and policies.

In addition, under Right 4(2) of the Code the services provided must comply with relevant professional standards. The Medical Council publication 'Good Medical Practice – A Guide for Doctors' (2000) states that practitioners must:

> "keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed".

Dr B cannot recall the details of the examination or the conversation with Ms A and her mother. Chest and throat examinations were noted, with the throat recorded to be red and purulent. Abdominal tenderness was also recorded. Dr B's comment to Mrs A that there was no sign of meningitis on Ms A's skin suggests he looked for signs of a rash.

The nurse who first saw Ms A recorded that she had fever, nausea, vomiting, irritability, photophobia, frontal headache, right groin pain, general body aches, no rash noted, some neck discomfort and a sore throat. The nurse recorded Ms A's temperature as 39.4°C, blood pressure as 140/70 and pulse 120.

Mrs A recalled Dr B looking in Ms A's eyes, and examining her reflexes by performing a reflex test on her knees. My advisor noted that these are elements of a central nervous system examination. However, these tests were not noted, and could not be recalled by Dr B.

My advisor stated that where there is a possibility of meningitis, a standard history should include investigating whether the patient has experienced any symptoms such as a rash, fever, drowsiness, headache, nausea, a stiff neck, photophobia and joint pain.

According to my advisor, "the standard examination where there is a possibility of meningitis, should look for the following signs:

> Vital signs including level of consciousness, temperature and pulse but not necessarily blood pressure
> A check for neck stiffness by flexing the head forward to place the chin on the chest
> A check for spinal stiffness
> Throat examination for signs of inflammation
> A full skin examination for petechial rash."

When a patient raises the possibility of meningitis, it places an extra duty of thoroughness on the doctor to exclude this, as one of the principal purposes of the consultation is to relieve the patient's anxiety.

My advisor commented:

> "The process of reassurance requires a thorough physical examination. It is also prudent to discuss the symptoms of meningitis and the progression of the illness, alerting the patient and the family as to the particular signs to look for and the action they would need to take if any of these appeared. This clearly signals to all concerned that the diagnosis has been given serious consideration."

My advisor noted that the nurse recorded several important symptoms of meningitis. There is no mention in Dr B's notes of the symptoms recorded by the nurse. It would have been prudent for Dr B to note whether he confirmed the symptoms. If Dr B did not review the symptoms, that was a major departure from the appropriate standard of care. If he did review the symptoms recorded by the nurse, his lack of records was a moderately serious omission.

It is unclear from the medical notes and Dr B's response, whether an appropriate examination took place. Ms A and her mother cannot recall everything that occurred at the consultation, but the details that they can recall, and Dr B's minimal records, suggest that most of the elements of the examination occurred but were not recorded.

Tests

To investigate the possibility of a urinary tract infection, Dr B sent a mid-stream urinary sample to the laboratory. Dr B considered that nothing would be gained by performing further tests at that time. He advised me that laboratory facilities were not immediately available at 9.00pm.

My advisor commented:

> "Due to limited resources, it is rarely possible in general practice to do sufficient tests to achieve a high level of certainty about most diagnoses in the early stage of illness. To deal with this limitation, a common strategy for general practitioners is to describe to the patient the anticipated course of the illness and to advise return if this does not eventuate. [Dr B] has stated that it is his usual practice to describe what changes to look for and what action to take."

My advisor stated that "due to important omissions from the records I cannot confirm whether or not an adequate examination did occur".

Diagnosis

There is no dispute that Dr B did not diagnose Ms A with meningococcal disease.

Dr B stated in his response that he was under the impression that Ms A was suffering from a viral infection. She had some abdominal tenderness, which Dr B said led him to consider a possible urinary tract infection.

Dr B stated:

> "… [M]eningococcal disease can be very difficult to diagnose as many of the symptoms overlap greatly with those of more common conditions such as upper respiratory infection and gastro-enteritis."

My advisor agrees and commented:

> "Meningitis is a difficult diagnosis to make in the early stages of the illness. The presentation of fever, headache, with some neck pain and stiffness is also the first presentation of a number of much more commonly seen viral illnesses."

Ms A's parents believe that Dr B should have arranged for Ms A to be immediately admitted to hospital. However, I accept my expert advice that there was no clear indication for referral to hospital at the time Dr B saw Ms A.

Information and follow-up
Under Right 6 of the Code, patients are entitled to information that is reasonable in the circumstances, and an explanation of their condition. It is unclear from the records or Dr B's response, what explanation of Ms A's condition or what information about meningococcal disease was given.

Dr B does not specifically recall the advice he gave to Ms A or her mother about Ms A's condition, nor does he remember explaining the symptoms of meningitis. Dr B stated that he usually advises patients and parents to monitor the symptoms closely and seek further medical care immediately if there are any changes for the worse. Such changes include uncontrollable fever, deterioration in mental state, vomiting, diarrhoea, worsening headache, and abdominal pain. Dr B usually tells patients that another of its clinics is open 24 hours, and that they may also go directly to the first public hospital or call an ambulance.

My advisor stated that "a standard record in a case where meningitis has been considered should show:

> Evidence that the above symptoms and signs have been sought.
> Evidence that the patient and or family have been advised what to expect.
> A signal that a follow-up plan in the case of contingencies has been discussed."

There is no record to establish whether Dr B warned Ms A or her mother about the signs of progression of meningococcal infection. Nor is there any record that Dr B provided a contingency plan in the event of any further signs of meningitis.

Mrs A said that Dr B did not tell them what other signs of meningitis to look for, or what to do if Ms A did not get better.

In the absence of adequate records, it is unclear exactly what explanation was given to Ms A about her condition. Nor is it possible to draw a conclusion about whether Dr B told her mother the signs of the progression of meningococcal infection, or if a contingency plan was made in the event of signs of meningitis. However, I note my expert's comment that "a planned follow-up in this case might have been wise".

Conclusion
Given that Ms A expressed concern about having meningitis, and the nurse recorded several symptoms of meningitis, Dr B's records are clearly inadequate and do not describe an examination that excludes the possibility of meningitis. Dr B has also failed to describe an appropriate examination in his response to the investigation.

Meningococcal disease can undoubtedly be very difficult to diagnose. However, given the potentially serious consequences of the disease, it is important for practitioners to examine patients carefully to ensure that symptoms of the disease are not missed. When patients raise the possibility of meningitis but the disease is not evident, it is important to reassure them, explain the symptoms of the disease, and prepare a contingency plan if the symptoms worsen.

In Ms A's case, it appears that an adequate examination took place, but it is not clear what information was provided about her condition, or what advice was given about meningitis. What is clear is that the medical notes do not record the consultation in sufficient detail, particularly regarding the examinations and discussions that took place. This is a departure from appropriate professional standards. Accordingly, I have formed the view that Dr B breached Right 4(2) of the Code by failing to keep accurate and detailed patient records in this case.

Opinion: No breach – The Accident and Medical Clinic

Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 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 breaching the Code.

The clinic has provided a copy of the Meningitis Policy and Drug Protocol for the clinic, as well as meningitis cards, which were available at the front desk at the time of Ms A's consultations. The clinic advised me that last winter they offered every person with a flu-like illness one of the cards and will continue to do this as a matter of policy.

I am satisfied that at the time that Ms A attended the clinic, there were appropriate policies in place in relation to diagnosing and treating meningitis. Accordingly, the clinic is not vicariously liable for Dr B's breach of the Code. However, I have received no evidence of any steps taken by the clinic to ensure that medical and nursing staff keep proper records.

Actions taken

Dr B has provided a written apology to Ms A and her family.

Recommended actions

I recommend that Dr B take the following actions:

- Review his note-taking to ensure his records accurately describe examinations, treatment, information and advice provided to patients, and any follow-up measures to be taken.
- Re-familiarise himself with the presenting symptoms for meningococcal disease and the relevant guidelines issued by the Ministry of Health to general practitioners.

I recommend that the clinic:

- Review its policies and procedures to ensure that medical and nursing staff keep clear and accurate patient records.

Further actions

- A copy of my report will be sent to the Medical Council of New Zealand.
- A copy of this report, with details identifying the parties removed, will be sent to the New Zealand Accident and Medical Practitioners Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.