General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 03HDC01366)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Complainant
Mr A	Complainant's husband
Dr B	General Practitioner/Provider
Dr C	Complainant's General Practitioner

Complaint

On 29 January 2003 the Commissioner received a complaint from Ms A about the services provided to her by Dr B on 2 January 2003 after she had an accident resulting in an injury to her head. The complaint is that:

Dr B
Dr B, general practitioner, did not provide services of the appropriate standard to Ms A. In particular, at a consultation in January 2003, Dr B did not:

- *adequately assess, monitor and treat the injury to Ms A's head, despite being advised that she had nausea, a headache, visual distortion, poor coordination in her legs, extreme tiredness and was finding it difficult to articulate words;*
- *refer her for further investigation and treatment;*
- *properly inform her of the nature of symptoms which would warrant further urgent assessment and treatment.*

An investigation was commenced on 29 April 2003.

Information reviewed

During the course of my investigation I carefully considered information from Ms A, Dr B, Mr A, Dr C, Accident Compensation Corporation (ACC) and a Public Hospital.

Independent expert advice was obtained from Dr Tony Birch, a general practitioner in a rural practice.

Information gathered during investigation

Ms A
Ms A advised that on 2 January 2003, while tramping with her husband in an area, she fell on loose rocks and scree and sustained a significant head injury. She said that she immediately developed a bump on her temple and experienced significant visual distortion. Within an hour her vision had corrected and they walked four hours to the main road and drove to Dr B's surgery in a town. At this point Ms A was very tired, nauseous and had a headache. She was struggling to find words, so her husband dealt with the receptionist and was given an ACC pamphlet about head injuries.

Ms A said that at the consultation she told Dr B she had hit her head after a fall, and had double vision, nausea, a headache and extreme tiredness. Ms A said that, because she was struggling to articulate words, her husband had to complete her sentences, but Dr B did not notice this. Dr B examined the swelling on her head, prodded it and told her it was not serious and she would be fine. Ms A said that Dr B did not examine her eyes with an instrument with a light source or move his finger or other object in front of her eyes. He also did not ask whether she had become unconscious after her fall.

Ms A said Dr B advised her that if she deteriorated she should ring her doctor or seek emergency assistance. Mr A referred to the ACC pamphlet and asked Dr B whether by deterioration he meant vomiting, and if his wife needed to be woken at night to assess her. Dr B said that it was not necessary to wake Ms A at night, which was in conflict with the ACC pamphlet. Dr B then completed an ACC form and indicated on it that she was ready for work. Ms A said that the consultation took no more than five minutes.

Ms A said that her husband was so dissatisfied that he asked the receptionist if there was another local doctor available to assess her. He was informed that there was not until the next day. Although they had planned to stay in the town, she and her husband returned to a city in case medical attention was required.

Ms A returned to work on 6 January but struggled with daily headaches, lack of concentration and extreme tiredness. Ms A said that she left work after a week and it took her three months to return part-time. She advised me (on 20 August 2003) that she is still working part-time and continues to have symptoms of post-concussion syndrome.

Mr A
Mr A said that his wife's forehead struck a rock with a "sickening hit" and for the next 45 minutes she reported double vision, distorted vision and nausea. He was unsure whether she was knocked unconscious or was stunned but he noticed that her eyes were open less than ten seconds after her fall. They were able to leave the area because Ms A's co-ordination improved and she became more "with it". Mr A said that staff from a local airport referred them to Dr B after they made enquiries about the availability of a doctor.

Mr A said that the consultation with Dr B took place about five hours after his wife's accident. Mr A informed Dr B that after her fall Ms A had eyesight problems, lack of co-ordination in her legs and a "cracking" headache, and that he was pretty sure she had not

been knocked unconscious. He could not remember whether he mentioned that his wife had been very tired after the accident. Mr A said that the only questions Dr B asked Ms A concerned the time of the accident and her occupation. Mr A said that it was obvious during the consultation that she was not in her normal mental state because of her difficulties in articulating her words, for example she was unable to inform Dr B of her occupation. Mr A said that it was also obvious that her movement was unsteady, as she walked into Dr B's consultation room slowly.

Mr A said that after the accident his wife had a puffy forehead, which was raised by 12-15 millimetres and was the size of an orange. By the time of the consultation the swelling had significantly reduced to 5-6 millimetres and was raised only across half her forehead. No blood or abrasions were apparent on the injury site. Mr A said that Dr B felt the puffy area but did not examine his wife's eyes with an instrument with a light source or move his finger or other object in front of her eyes. Dr B also did not inform her of his diagnosis. He said that Dr B advised them to contact the emergency services if Ms A's condition deteriorated, including any vomiting, but that it was not necessary to wake her at night to assess her.

Mr A said that they returned to the city that night and his wife returned to work. However, this was not successful as she had ongoing headaches, was irritable, could not concentrate and was inarticulate.

Dr B

In his response Dr B advised that he assessed Ms A about 4.30pm on 2 January. She complained of a headache and soreness to the left side of her head from a contusion received from a fall on a scree slope four to five hours previously. In a telephone interview on 2 July Dr B said that Ms A also informed him that she was a bit dizzy and had poor co-ordination, although she did not appear to have poor co-ordination when she entered his surgery. He could not remember whether she mentioned the symptoms of visual distortion, extreme tiredness or nausea.

In his response Dr B also said that he examined the injury site for a possible fracture and that Ms A's pupils were normal and reacting normally. He did not detect any sign of concussion. During the telephone interview Dr B stated that he also examined Ms A's neck and did not use a torch when examining her eyes for reaction to light. He assessed reaction to light and also to accommodation visually. He also stated that Ms A's bruise was "nasty", his diagnosis was contusion and the consultation lasted five to ten minutes. Dr B could not remember whether he assessed Ms A as fit for work or whether Mr A referred to an ACC pamphlet during the consultation.

Dr B recalled that he advised Ms A to ring 111 if she deteriorated. Dr B advised that since this incident the medical centre's protocols have been changed so that all patients with a head injury receive an ACC pamphlet about head injuries.

Dr B recorded the consultation as follows:

> "02 – Jan – 2003 contusions on L side of head from fall no signs of concussion
>
> Dx: Contsn fce, sclp + neck, exc eye(s) (SEO.00) – not applicable
>
> 02 – Jan – 2003 ACC4 ACC45 – DF34842 – Descending scree slope and fell injuring head."

Response to provisional opinion
In response to my provisional opinion Dr B advised that he was sure he would have used the light from his auriscope (an instrument with a light usually used to examine ears) to examine Ms A's pupils because that is his standard practice when looking for signs of intracranial pressure.

Dr B also noted the A's comment that at the consultation he had not asked any questions about Ms A's condition. He recalled asking whether she lost consciousness after her fall and being informed that Ms A felt "woosy", was aware of her fall and had not lost consciousness. Ms A also informed him that her vision was blurred after the accident but cleared prior to leaving the area.

Dr B explained that he made no comment about whether Ms A was fit to work on the ACC form he completed, because she informed him that she was not due to return to work for several days and he thought that by that time she would have recovered enough to cope.

Dr B noted that after a "heavy blow" a head could ache for a day or two, or for much longer periods; had he thought that Ms A might have a skull fracture he would have referred her for treatment in another city, which is a two-hour drive from his surgery. He thought Mr and Ms A were going to stay in the town overnight and therefore he advised them to ring 111 if Ms A's headache became worse or her consciousness diminished. Dr B said that he did this because the local ambulance service could contact him more quickly than Ms A – she would have been obliged to ring his surgery for the emergency telephone number he used when on call. It puzzled him that Mr and Ms A drove back to the city and did not seek any further medical assessment for several days.

Other information
On 10 January 2003 Ms A was assessed by her usual general practitioner, Dr C, who recorded that Ms A had hit her head after a fall down a scree slope with a heavy pack. Dr C also recorded that Ms A had not been knocked unconscious, had sustained swelling to the left anterior part of her head and had blurry vision for the first hour. Dr C further recorded that Ms A had a large persisting bruise on her head and that she had experienced headaches, tiredness and lack of concentration during the last week.

The Medical Director of the brain injury rehabilitation service at the Public Hospital wrote to ACC on 3 March. He said that he had examined Ms A on 26 February. Ms A told him that for about an hour after her accident she had been aware of diplopia (double vision), a

colourful distortion of her vision, and a headache at the point of impact, and felt nauseous but did not vomit. She had also been very tired, verbally inarticulate and unco-ordinated.

The Medical Director stated that Ms A informed him that, since her fall, she had been easily fatigued, particularly in social and work settings where multi-tasking is demanded. He also reported that she was still tender over her left temple, which was the point of impact. On most days she had a dull aching headache and most mornings felt "hung over". The Medical Director further stated that Ms A informed him that she had developed travel sickness for the first time, occasionally had mild vertigo, her co-ordination had not fully returned and she had a profound sensitivity to small quantities of alcohol. Her husband also reported subtle changes to her personality. The Medical Director concluded that Ms A was experiencing post-concussional syndrome and was not yet fit for work.

Independent advice to Commissioner

The following expert advice was obtained from Dr Tony Birch, general practitioner:

> "Although Dr [B] asserts that he made an assessment of Ms [A's] injuries and gave appropriate advice, there are absolutely no notes of this apart from what is on the ACC45 form. I can, therefore, only go by the recollections of the patient and her partner.

1. Did Dr [B] properly assess, monitor and treat the injury to Ms [A's] head?
   - Given that Dr [B] is an experienced medical practitioner and that he looked at the site of injury, I feel sure that he observed the pupils. There is no evidence, however, that he ascertained that they reacted normally to light and to accommodation – the usual examination.
   - Ms [A] and her partner state that they did not feel that any history had been taken. Dr [B] avers that 'there were no signs of concussion'. The symptoms described are absolutely typical symptoms of concussion. Again, there is nothing in the notes to explain on what basis Dr [B] had made his assessment.
2. Were there any further investigations that Dr [B] should have undertaken?
   - In my practice situation, I would have at least organised an X ray of the skull, or even (at a future date) a Computerised Tomogram of the head. In my situation, however, X rays are easy to obtain. I note, however, that there is no record of these investigations being done in [the city].
3. Should Dr [B] have referred Ms [A] for further investigation and treatment by another provider?
   - I believe it would have been prudent for Dr [B] to impress upon Ms [A] the importance of seeking further help when she returned to her home. The fact that he did not give her time off work despite the obvious severity of her symptoms,

leads me to believe that his assessment was faulty. I wonder if he even listened sufficiently to register the severity of her symptoms. The notes give us no clues!

4. Did Dr [B] properly inform Ms [A] of the nature of the symptoms which would warrant her urgently seeking further assessment and treatment?

    - Neither Ms [A] nor her partner seemed to have been clear as to what they needed to look for and were confused when they left the surgery. That the practice now has a handout is revealing; this should be standard in an area like [this], where such accidents must be quite common.

In summary, it is not possible to give the benefit of any doubt to Dr [B], as there are no clinical notes to help. He diagnosed Ms [A's] injury as a 'contusion to the face' and apparently took no cognizance of the fact that she had suffered a significant head injury with obvious concussion. Although it is doubtful that the outcome for Ms [A] would have been different should an adequate assessment and management plan been made, I view Dr [B's] care as falling well below acceptable standards.

Ms [A], in her final paragraph, expresses her hope that her complaint might 'prevent the compromise of patient health and safety in the […] area'. I believe that my colleagues would share with me my severe disapproval of the services provided by Dr [B] in this instance."

Further independent expert advice

My staff subsequently discussed the matter with Dr Birch for the purpose of elaboration on some aspects of his initial advice. Dr Birch advised the following:

- It is important to make a diagnosis of concussion, as the diagnosis has significant ramifications for the way in which the patient must lead his or her life for the next few weeks so as to protect the brain. For example, contact sports must not be played for a period of time.

- A diagnosis of concussion also has ramifications in terms of what signs the patient should be on the lookout for. If a patient has been concussed, there has clearly been a significant head injury, and it is critical that the patient be given clear guidelines as to what warning signs or symptoms need to be watched for, and the serious potential consequences of concussion (ie, compression due to a bleed in the brain).

- A diagnosis of concussion is a recognition that there has been a significant brain injury. It is normal for the patient to be advised that he or she might experience difficulties with concentration and might need to take time off work and seek medical help if the symptoms persist.

- In relation to the issue of the examination of the eyes, it is best to do the "reactive to light" test with a torch as it is the easiest. The accommodation test is generally performed by moving the finger in front of the eyes to see if they react to the moving finger. Normally one would see "PERLA" written in the notes, which means "pupils

equal, reactive to light and accommodation". If the eyes were just visually examined, and no examination was done with the torch and no finger-moving test done, then the most that could be said would be "PE", ie, "pupils equal", as this is the only thing that could be observed without further tests.

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.

Opinion: Breach – Dr B

In my opinion Dr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) for the reasons set out below.

I am satisfied that Dr B was informed that Ms A experienced symptoms of nausea, a headache, visual distortion, poor co-ordination and extreme tiredness as a result of her fall. This view is supported by the record of symptoms Ms A subsequently described to other providers involved in her care and by the account of her husband. Dr B has not provided me with any contrary information and acknowledged, in response to my provisional opinion, that Ms A had a "heavy blow" to the head and reported that she became "woosy" and experienced blurred vision.

I consider that, in the circumstances of this case, Dr B failed to properly diagnose Ms A with concussion. I accept the advice of my independent expert, Dr Birch, that the symptoms described to Dr B were typical of concussion. I also accept the advice of Dr Birch that Dr B should have assessed whether Ms A's pupils reacted normally to light (with a torch) and to accommodation (with a finger-moving test), to assist with his diagnosis, and that his visual examination of Ms A's pupils was insufficient. It was not reasonable for Dr B to conclude that Ms A did not have concussion on the basis of his limited eye examination.

I am satisfied that Dr B is misguided in his belief (expressed in response to my provisional opinion) that he would have used an auriscope to determine whether Ms A's pupils reacted normally to light. This is inconsistent with the earlier account of the consultation he gave to my investigation staff in his telephone interview, and with the recollection of Mr and Ms A.

I acknowledge that Dr B advised Mr and Ms A to contact the emergency services if Ms A's condition deteriorated. However, even if this advice was sufficient to minimise the potential harm to Ms A, it does not excuse Dr B's failure to properly examine her in the first place.

I also wish to emphasise that even if Dr B had diagnosed Ms A with concussion, the clinical course of her condition and treatment may not have been different.

Nonetheless, I accept Dr Birch's advice that the actions of Dr B fell well below acceptable standards and would be viewed by his colleagues with severe disapproval.

In my opinion Dr B did not provide Ms A with services with reasonable care and skill and therefore breached Right 4(1) of the Code.

Other Comment

In light of the issues raised by this case, on 23 May 2003 I referred this matter to the Medical Council of New Zealand to consider whether a review of Dr B's competence was warranted.

Proposed actions

- This matter will be referred to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report, identifying only Dr B, will be sent to the Royal New Zealand College of General Practitioners.
- A copy of this report, with identifying details removed, will be sent to the Royal New Zealand College of General Practitioners and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings considered this matter and decided not to issue proceedings before the Medical Practitioners Disciplinary Tribunal or the Human Rights Review Tribunal.